

**A MODEL OF THE RETRAUMATIZATION PROCESS:
A META-SYNTHESIS OF CHILDHOOD SEXUAL ABUSE
SURVIVORS' EXPERIENCES IN HEALTHCARE**

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ABSTRACT

Childhood sexual abuse survivors frequently report feeling violated and reabused during routine healthcare encounters. The goal of the current study was to develop a model that will aid in understanding difficulties abuse survivors face when accessing healthcare. Meta-synthesis was used to combine data from 20 papers representing 15 independent, qualitative studies. The combined studies represented interviews with 411 sexual abuse survivors (113 males and 298 females). Study themes and concepts were reciprocally translated using the technique developed by Noblit and Hare (1988) using a grounded theory approach. The resultant Healthcare Retraumatization Model was revised based on input from eight experts including the lead investigators of five studies included in the synthesis. The Model postulates that retraumatization is a cyclical process with four interrelated subprocesses: hypersensitivity to threats to safety, exposure to triggers, post-traumatic stress reactions, and avoidant coping. Hypersensitivity to threats to safety causes childhood abuse survivors tend to feel threatened in situations which require trust and evoke vulnerability, powerlessness, and/or loss of control. Triggers are situations and events that cause abuse survivors to feel threatened and elicit stress reactions. Triggering is caused by the interplay of internal factors (hypersensitivity to threats to safety) and external factors (threatening situations and dynamics encountered during healthcare) and is associated with survivors feeling that their current safety is being threatened. Survivors typically cope with retraumatization by employing avoidant coping strategies originally developed during childhood to cope with the original abuse. The experience of retraumatization appears to lower survivors' threshold for future retraumatization by confirming survivors' view of healthcare as a threatening experience. Without intervention, retraumatization can result in unhealthy outcomes due to the negative effects of stress on survivors' mental and physical health along with

interruptions in healthcare caused by avoidant coping. Interruptions in healthcare can take the form of avoiding preventive care, delaying treatments, poor compliance with therapeutic regimes, and prematurely terminating treatment. Through therapeutic actions that recognize and respect survivors' safety needs, healthcare providers can help survivors interrupt the retraumatization cycle and help abuse survivors heal from their childhood trauma.

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CHAPTER 1

If [health care providers] could really understand how traumatic it is to even be touched on your arms, that it just brings back old feelings and helpless feelings ... and if they could know, too, that, you know, things are flashing before your mind and that you're not just in the physiotherapy room, you're also stuck back in past time, so it's an extremely stressful thing, it's not just mildly stressful.

(Sexual abuse survivor describing physical therapy experience, Schachter, Stalker, & Teram, 1999, p. 258)

Childhood sexual abuse is a frequent, yet often hidden, experience in patients seeking healthcare. National surveys have documented that the sexual victimization of children is a prevalent problem in the United States affecting at least 20% of American women and 5% to 10% of American men (e.g., Briere & Elliott, 2003; Finkelhor, 1994; Finkelhor, Hotaling, Lewis, & Smith, 1990). Perpetrators of abuse are often related to their victims, compounding the harm experienced by child victims. According to the National Child Abuse and Neglect Data System, in 2005, 79.4% of perpetrators of child abuse or neglect were parents and 6.8% were other relatives (U.S. Department of Health and Human Services, 2007).

A history of sexual abuse is also prevalent among women attending primary care (Carlson, McNutt, & Choi, 2003; Walch & Broadhead, 1992; Walker et al., 1993) and specialty care clinics (Read, Stern, Wolfe, & Ouimette, 1997). Carlson et al. conducted a cross-sectional survey of a large primary care sample comprised of 557 low-, middle-, and high-income women. Over 70% of the women reported experiencing of some form of childhood and/or adult abuse. Rates of victimization appear to be even higher among patients seeking specialty care. Read et al. found that women with gynecologic problems were more likely to be victims of childhood sexual assault than those seeking routine care (53.3% versus 22.6%, respectively).

The high prevalence of childhood sexual abuse histories among those seeking healthcare is not surprising given that childhood maltreatment is associated with a wide variety of

emotional, behavioral and physical sequelae (Kendall-Tackett, 2003; Dallam, 2001). Childhood maltreatment is associated with increased physical and psychosocial symptoms (Hulme, 2000; Lechner, Vogel, Garcia-Shelton, Leichter, & Steibel, 1993), lower subjective ratings of overall health in adults (Moeller, Bachmann, & Moeller, 1993; Walker et al., 1999), increased healthcare utilization (Koss, Woodruff, & Koss, 1990; Plichta, 1992), and unexplained medical complaints and functional disorders including somatization, particularly in women (Dallam, 2001; 2005).

Unfortunately, patients' abuse histories are rarely communicated to healthcare providers (Drossman et al., 1990; Friedman, Samet, Hudlin, & Hans, 1992; Hilden, Sidenius, Langhoff-Roos, Wijma, & Schei, 2003; Mazza, Dennerstein, & Ryan, 1996; McCauley, Yurk, Jenckes, & Ford, 1998; Nicolaidis, Curry, McFarland, & Gerrity, 2004; Springs & Friedrich, 1992; Walch & Broadhead, 1992; Walker, Torkelson, Katon, & Koss, 1993; Wijma et al., 2003). In a study of 511 female family practice attendees, fewer than 2% of sexually abused women had discussed abuse with a physician (Springs & Friedrich). Similarly, among 162 women attending a primary care clinic, only 4% reported ever having been asked about sexual victimization (Walker et al.). A large scale Nordic study found that 95% of the women with a sexual assault history had not talked to their gynecologist about their abuse history (Wijma et al.). Friedman et al. surveyed 164 patients and 27 physicians at private and public primary care sites about preferences related to inquiry about victimization, defined as both physical and sexual abuse experienced across the life span. Only 6% of patients surveyed had ever been asked about their victimization history in a medical setting. Sixty-one percent of the survivors surveyed indicated that, unless asked, they would not volunteer this type of information. Among the physicians surveyed, over 85% reported that they never inquire about abuse histories, either at the first patient visit, or the annual

patient visit. Together these findings seem to indicate that discussions about abuse appear to be rare during healthcare visits with both patients and providers reticent to raise the issue.

Despite reluctance to raise the issue, a growing body of evidence suggests that healthcare encounters can be a significant source of distress to survivors of childhood sexual abuse and may trigger post-traumatic symptoms. A report by the American Medical Association (AMA, 1995) listed a variety of medical situations that may cause re-experiencing of trauma in abuse survivors, particularly procedures that require disrobing, confinement, restricted mobility, and/or are invasive. Studies show that physical therapy (Schachter, Stalker, & Teram, 1999), dental care (Hays & Stanley, 1996; Leeners et al., 2007a, 2007b; Stalker, Russell, Teram, & Schachter, 2005), cancer treatment (Gallo-Silver & Weiner, 2006), ostomy care (Hudson, Jones, & Weber, 1999), and endoscopy and colonoscopy (Davy, 2006) are situations that may trigger post-traumatic symptoms in sexual abuse survivors. Gynecological examinations and prenatal care are also situations that have been reported to trigger post-traumatic reactions in childhood sexual abuse survivors (see e.g., Bohn & Holz, 1996; Chalfen, 1993; Courtois & Riley, 1992; Hobbins, 2004; Kitzinger, 1990a; Kitzinger, 1990b; Robohm & Buttenheim, 1996; Roussillon, 1998).

Statement of the Problem

Despite numerous reports in the literature suggesting that reactivation of trauma symptoms in healthcare is a significant problem, data is limited regarding the prevalence of the problem and no conceptual models are available to guide research or clinical practice. In Robohm and Buttenheim's (1996) community survey of 44 sexual abuse survivors, almost two-thirds (62%) reported having been overwhelmed by emotions such as panic, terror, helplessness, shame, humiliation, rage and fear during gynecological examinations. In addition, 45% of the survivors surveyed reported having memories or flashbacks of being sexually abused triggered

during gynecological examinations. Two of the survivors reported never having sought gynecological care due to fear and mistrust. These are similar to the findings reported by Leeners et al. (2007a) who found that 43.5% of abused women experienced memories of their original abuse situation during gynecologic consultations. If these numbers are representative of the population as a whole, then the problem of retraumatization is likely to be a significant factor influencing the health behaviors of abuse survivors.

The current literature offers little conceptual clarity on how to recognize the reactivation of trauma symptoms during healthcare encounters, or even what term should be used to describe it. The most common term used to describe the distress that abuse survivors experience during healthcare situations is “retraumatization.” This term is generally used to refer to the re-experiencing of trauma symptoms due an event or interaction that reminds victims of previous traumatic experiences (see e.g., Hooper & Warwick, 2006; Rosenberg et al., 2001).

Unfortunately, retraumatization is a complex construct that is often vaguely constructed and poorly defined. Currently, a variety of others terms are also used to describe the re-experiencing of trauma symptoms and those who have used the term “retraumatization” often failed to offer any definition of the term or description of the process. These problems are reviewed in more depth in the next chapter.

In addition to definitional problems, no models are available to guide clinical practice and no empirically-tested interventions are offered to prevent retraumatization from occurring. For instance, Leeners, Richter-Appelt, Imthurn, and Rath (2006) reviewed 43 studies examining the influence of childhood sexual abuse on pregnancy, delivery, and early parenthood. They found that memories of sexual abuse can be triggered during routine healthcare and care for abuse survivors is compromised due to the lack of adequate models on how to care for victimized

patients. This gap in the scientific literature underscores the need for more in depth theoretical treatment of the subject.

Statement of the Purpose

The purpose of this study is to generate a model that represents the social processes adult survivors of childhood sexual abuse engage in when experiencing retraumatization during healthcare encounters. The research question guiding this study is **“What are the basic social processes adult survivors of childhood sexual abuse engage in when dealing with healthcare situations they find distressing?”** The question was addressed by synthesizing qualitative research on survivors’ experiences in healthcare and analyzing the results using a grounded theory approach.

CHAPTER 2 - CONCEPTUAL BASIS

Because the current construct of retraumatization has not been adequately delineated, it is important to clarify its predicates. The concept of retraumatization is largely predicated on the concept of trauma and various theoretical models of trauma's lasting effects on the neurobiology and psyche of the traumatized individual. For instance, Post-traumatic Stress Disorder (PTSD) is considered by Monahan and Forgash (2000) to be part of a complex interplay of physiological and psychological symptomatology that can compromise childhood sexual abuse survivors' ability to access health care treatment and forge a positive relationship with their providers. As such, the trauma literature provides a foundation for the development of model specific to the experience of retraumatization.

According to the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-IV; American Psychiatric Association [APA], 1994), a traumatic event is defined as one "that involves actual or threatened death, serious injury or threat to physical integrity" and gives rise to feelings of intense fear, horror or helplessness (p. 424). The most traumatic are those events that induce terror, shame, and humiliation by reducing individuals to objects and thereby challenging deeply held assumptions of safety, fairness, ability to control events, and predictability (Cardena, Butler, & Spiegel, 2003). As such, personal human cruelty has far more devastating effects on individuals than natural disaster or accident (Foa, 1997). In community epidemiological studies of men and women, traumatic violence was associated with substantially greater risk of developing PTSD (e.g., 46%-65%) than nonviolent forms of traumas (8%-20% risk of PTSD; Chilcoat & Menard, 2003). Childhood sexual abuse has been recognized as a particularly traumatizing form of trauma (Herman, 1992).

Sgroi (1982), an early researcher in the field, offered the following definition of childhood sexual abuse in her classic text *Handbook of Clinical Intervention in Child Sexual Abuse*:

Child sexual abuse is a sexual act imposed on a child who lacks emotional, maturational, and cognitive development. The ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult or older adolescent perpetrator, which is in sharp contrast to the child's age, dependency, and subordinate position. Authority and power enable the perpetrator, implicitly or directly, to coerce the child into sexual compliance. (p. 9)

Sgroi's definition is consistent with research showing that rather than being a sudden, violent occurrence by a stranger, most sex between children and adults involves a gradual "grooming" process in which an adult known by the child skillfully manipulates the child into participating (Berliner & Conte, 1990; Christiansen & Blake, 1990; Conte, Wolf, & Smith, 1989). Victims typically do not disclose their abuse out of embarrassment along with fear that they will not be believed or will be blamed for what happened to them. In addition, perpetrators usually demand secrecy and often control their victims through the use of bribes or threats (Paine & Hanson, 2002). Victims have been found to accommodate the abuse psychologically by using coping mechanisms such as denial, minimization, and dissociation regarding the abuse itself or its damaging effects (Coons, Bowman, Pellow, & Schneider, 1989).

Studies have consistently demonstrated that childhood sexual abuse is associated with a broad range of behavioral, psychological, and physical problems that persist into adulthood. Psychological sequelae include anxiety, depression, PTSD, self-destructive behavior, dissociation, substance abuse, sexual maladjustment, and a tendency towards revictimization in subsequent relationships (Browne, & Finkelhor, 1986; Roesler & McKenzie, 1994). Because childhood sexual abuse is an experience rather than a disorder, it is difficult to predict how any single individual will respond. Research findings indicate that long-term effects of childhood

sexual abuse range from children being asymptomatic to showing evidence of severe distress (Kendall-Tackett, Williams, & Finkelhor, 1993). No single factor has been found to explain individual variations in outcome following childhood sexual abuse. Some abused children remain asymptomatic, some outcomes are delayed until later stages of development, and some outcomes may only be expressed with cumulative trauma (Putnam, 2003). Factors that have been found to influence outcome can be viewed as falling into three broad categories: (1) individual factors (e.g., attributions, coping strategies employed); (2) abuse-related characteristics (e.g., age at the time of abuse, use of force, multiple versus single assault, penetration, relationship to perpetrator); and (3) interactions with others (e.g., responses to disclosure, quality of attachment relationships) (see Barker-Collo & Read, 2003, for a review). In addition, numerous studies have found evidence of a dose-response relationship with more severe forms of sexual abuse being associated with worse outcomes (e.g., Felitti et al., 1998; Kendler et al., 2000; Mullen, Martin, Anderson, Romans, & Herbison, 1993).

Theoretical Perspectives on Childhood Maltreatment

A number of theorists have tried to explain the linkages between maltreatment in childhood and subsequent social, psychological and health problems in adulthood. Theories include attachment theory, personal space boundaries theory, betrayal trauma theory and sensitization of stress response systems.

Attachment Theory

The interpersonal difficulties associated with experiencing maltreatment during childhood may be due to the effect that maltreatment has on attachment. Bowlby's (1988) theory of attachment is a descriptive and explanatory framework for understanding interpersonal relationships between human beings. Bowlby theorized that later relationship patterns can, in

part, be predicted based on the quality of early attachment relationships. Bowlby defined attachment as a biologically based system of behavior that exists between the attachment figure (usually the parent) and the child to ensure the child's proximity to the attachment figure. The primary function of attachment behaviors is to protect the young and to maintain their survival. Bowlby proposed that during the first year of life infants learn to deal with stressful circumstances and negative emotions in an organized manner. Bowlby categorized infant behavior into two attachment categories, *secure* and *insecure*. If children develop secure and healthy attachments to their caregivers, they develop expectations of the self and others as trustworthy and expect to have their needs met (Bowlby, 1988).

Further research has resulted in infant behavior being categorized into four attachment styles: *secure* attachment, *ambivalent-insecure* attachment, *avoidant-insecure* attachment, and *disorganized-insecure* attachment. Secure attachment is fostered by a caregiver who skillfully attends to the needs of the child. These children tend to have a high trust in themselves and others. The three major insecure styles are all hypothesized to lead to relationship difficulties in adulthood. Avoidantly attached infants are suggested to minimize the expression of negative emotions in the presence of a parent whom tended to reject or ignore negative emotions. Ambivalently attached infants are considered to maximize the expression of negative emotions in order to draw the attention of their supposedly inconsistently responsive parent. Children with a disorganized-insecure attachment style respond to their caregivers with a mix of behaviors, including avoidance or resistance (Main & Solomon, 1986).

Child maltreatment is associated with insecure adult attachment styles, especially disorganized attachment (Crittenden & Ainsworth, 1989). Disorganized attachment behaviors are considered to be indicators of stress and anxiety in the child which cannot be resolved as the

parent is both a source of fear and comfort. These children are unable to develop an organized style of attachment as their maltreating parents confront them with an inescapable paradox: the parents are potentially the only source of comfort for their children, while at the same time they frighten their children through their abusive behavior. Crittenden (1992) found that physically abused children have working models of the self as incompetent and unworthy, while relationships with others are based on ideas of power struggles and coercion.

Traumagenic Dynamics of Childhood Sexual Abuse

Based on a comprehensive review of the literature, Finkelhor and Browne (1985) provided an organizing framework for explaining the unique effects of child sexual abuse. They postulated that the experience of sexual abuse can be analyzed in terms of four traumagenic dynamics: traumatic sexualization, betrayal, powerlessness, and stigmatization. According to Finkelhor and Browne, *Traumatic sexualization* refers to a process in which a child's sexuality (including feelings and attitudes about sex) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse. For example, frightening memories and events can become associated in a child's mind with sexual activity. The dynamic of *betrayal* involves experiencing betrayal by someone on whom the abused child is dependent. Children can experience betrayal not only at the hands of offenders, but also by nonoffending family members who were unable or unwilling to protect or believe them. This betrayal can lead to a generalized distrust of others and the expectation of being revictimized in subsequent relationships. The dynamic of *stigmatization*, refers to the negative connotations (e.g., badness, shame, and guilt) that may become incorporated into an abused child's self-image.

The dynamic of *powerlessness* refers to the process in which the child's will, desires, and sense of efficacy are continually contravened. Finkelhor and Browne (1985) theorized that a

number of factors can contribute to this dynamic. For example, a sense of powerlessness can occur when a child's body space is repeatedly invaded against the child's will. Powerlessness is then reinforced when attempts to halt the abuse are frustrated or when the child is unable to make adults understand or believe what is happening to them. The dynamic of powerlessness can distort children's sense of self-efficacy and impair coping skills. Finkelhor and Browne held that the conjunction of these four dynamics in one set of circumstances create the trauma and long-term adverse effects associated with childhood sexual abuse by distorting children's self-concept, worldview, and affective capacities.

Betrayal Trauma Theory

Dissociative amnesia is a well documented coping mechanism that develops in response to trauma. Betrayal Trauma Theory (Freyd, 1996) builds on attachment theory to explain why dissociative amnesia can be adaptive. The theory also predicts the types of traumas most likely to be forgotten. The theory posits that betrayal by a trusted caregiver is the core factor in determining the use of dissociative defenses and developing memory deficits for childhood trauma. Freyd proposes that humans are sensitive to betrayal, and when one is betrayed the normal reaction is to feel pain and avoid further contact with the betrayer. However, when attachment processes are involved such a response may not be in the victim's survival interests. If an abused child processes betrayal by an essential caregiver in the normal way, he or she would be motivated to stop interacting with the betrayer. Yet if the child was to withdraw from a caregiver on whom he or she is dependent, the child's life would be placed in even greater danger. As Freyd points out, "A child who distrusts his or her parents risks alienating the parents further, and thus becomes subject to more abuse and less love and care" (p. 10). In these circumstances, Freyd suggests that the need to survive may prevail over the need to avoid of

betrayal. Consequently, victims of intimate betrayals learn to cope with inescapable social conflict through internal disconnection (i.e., dissociation), rather than external avoidance (Freyd, 1999).

Freyd's (1996) theory is supported by numerous empirical studies demonstrating that the lowest rates of dissociative amnesia are found in accidental injuries such as car accidents. The highest rates are found in victims of interpersonal violence particularly individuals who were sexually abused during childhood (Brown, Schefflin, & Hammond, 1998). Freyd, DePrince, and Zurbriggen (2001) found that neither age nor duration of abuse were significant predictors of memory impairment. However, childhood sexual abuse was associated with greater memory impairment than physical abuse, and sexual or physical abuse perpetrated by a caregiver was associated with more memory impairment than abuse perpetrated by a non-caregiver.

Sensitization of the Stress Response System

Sophisticated neurobiological studies provide evidence suggesting that childhood trauma can result in abnormalities in brain structure and permanently alter the functioning of biological stress-response systems in the brain (De Bellis, 2002; Penza, Heim, & Nemeroff, 2003; Teicher, 2002; Teicher et al., 2003). Maltreatment during childhood appears to be especially harmful as it occurs during a time of neuronal plasticity when the brain is shaped by external signals (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). Theoretical work by Bruce Perry, a psychiatrist who has done extensive research on traumatized children, provides a framework for understanding how childhood trauma may result in long-term changes in the functioning of the children's nervous systems. Perry's (2000) research found that chronically traumatized children will often, at baseline, be in a state of low-level fear that is reflected in their bodies' physiology (e.g., increase heart rate, muscle tone, rate of

respiration). According to Perry, stressful events such as physical or sexual assaults cause increased catecholamine (primarily epinephrine and norepinephrine) levels resulting in hyperarousal and activation of the sympathetic nervous system. This is called the “fight or flight” response, as the body prepares itself to fight with, or run away from, the potential threat. When fighting or physically fleeing is not feasible, such as with a child, victims may use a “freeze” or surrender response in which children dissociate from the events around them and withdraw inwardly.

After the trauma has ended, feedback mechanisms are activated to counteract the stress hormones and return the heart rate, blood pressure and other physiological adaptations to normal. However, the repetitive neural activation caused by repeated exposure to threatening stimuli may cause sensitization of the nervous system as it comes to anticipate the trauma. Over time stress-induced neural activation can be elicited by decreasingly intense stimuli. The result is that full-blown hyperarousal or dissociative reactions can be elicited by apparently minor stressors (Perry et al., 1995). The longer the activation of the stress-response systems (i.e., the more intense and prolonged the traumatic event), the more likely that the neural system will become sensitized. The predominant adaptive style of the affected children in the acute traumatic situations will determine which post-traumatic symptoms will develop -- hyperarousal (i.e., PTSD) or dissociative (Perry, 2000).

Van der Kolk (1994) also theorized that prolonged stress can lead to sensitization of stress-response systems resulting in enduring disruptions in neuroendocrine function. During acute stress, the body's stress response is terminated with the end of the trauma. However, when trauma is severe and on-going, compensatory mechanisms can become over-activated and incapable of restoring the brain's previous state of equilibrium. Consequently, basal patterns are

reorganized and the brain becomes increasingly sensitive to stress related cues (Plotsky, Owens, & Nemeroff, 1998; Van der Kolk, 1994). This theory of sensitization is supported by research findings that indicate that child abuse survivors experience more severe post-traumatic and dissociative symptoms when confronted with a traumatic event in adulthood such as sexual assault (Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996) or combat exposure (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993; Engel et al., 1993; Zaidi & Foy, 1994).

Effects of Childhood Sexual Abuse on Mental Health

Post-Traumatic Stress Disorder

Multiple psychiatric and behavioral problems are associated with trauma; however, PTSD is the most common and best-defined consequence of trauma (Rosenberg et al., 2001). The essential features of PTSD are the development of three characteristic symptom clusters following exposure to an extreme traumatic stressor: (1) symptoms of hyperarousal; (2) re-experiencing of the traumatic event (e.g., flashbacks), and (3) avoiding reminders associated with the trauma and numbing of general responsiveness (APA, 1994).

Symptom Structure

Although numbing and avoidance have been grouped together by the DSM-IV (APA, 1994), more recent research suggests that these are distinct aspects of PTSD. In contrast to the PTSD symptoms of re-experiencing, avoidance, and hyperarousal that focus on negative affect, emotional numbing focuses on diminished positive affect. Thus, the latent structure of posttraumatic stress is better represented by four-factors: (1) hyperarousal, (2) re-experiencing, (3) effortful avoidance, and (4) emotional numbing (Palmieri & Fitzgerald, 2005).

Hyperarousal. Increased physiological reactivity in response to trauma cues appears to be the most robust correlate of PTSD. Symptoms of hyperarousal include irritability,

hypervigilance, exaggerated startle response, impaired concentration, panic attacks, and insomnia (Schnurr et al., 2002). Hyperarousal symptoms appear to be the result of hyperresponsivity of the sympathetic nervous system. Trauma survivors with PTSD have been found to have higher heart rate, blood pressure, and skin conductance responses on exposure to trauma reminders as compared to trauma survivors without PTSD (Orr & Roth, 2000). A physiological hyperarousal state is most likely to be reactivated by traumatic stimuli reminiscent of the index trauma (Dobbs & Wilson, 1960). However, hyperarousal can also be induced by everyday stressful events that would not be experienced as traumatizing to others (Koopman, Gore-Felton, Classen, Kim, & Spiegel, 2001). In fact, symptoms may be triggered by almost *any* event that resembles or symbolizes an aspect of the original trauma. For example, flashbacks may be triggered by a situation, a noise, a smell, or any environmental sensory stimuli that reminds affected individuals of the past trauma. As Schnurr, Friedman, & Bernardy (2002) noted, “the adrenergic system in people who have PTSD appears to have been recalibrated to deal with a permanent life-threatening crisis” (p. 883).

Re-experiencing. Re-experiencing refers to reliving aspects of the trauma as if it were happening in the present. Re-experiencing is considered a core feature of PTSD and its presence distinguishes PTSD from other emotional problems. The 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV, APA, 1994) states that intrusive memories are recurrent, distressing, and involuntarily triggered. Re-experiencing can take the form of “distressing recollections of the event, including images, thoughts or perceptions” (p. 428). Other terms used to describe re-experiencing include “flashbacks” (e.g., APA, 1994), “intrusive recall” (e.g., Blank, 1985), or “spontaneous abreaction” (e.g., Steele & Colrain, 1990). In a flashback, the individual loses all awareness of present surroundings, and appears to relive the experience

as if it were happening right now, rather than being aspects of memories from the past (Hackmann et al., 2004). Steele and Colrain (1990) defined spontaneous abreactions as “a reflexive, incomplete, uncontrolled, and fragmentary re-experiencing of trauma, with much of the content occurring unconsciously” (p. 19).

Ehlers and Clark (2000) reported that intrusive traumatic memories associated with PTSD mainly consist of relatively brief sensory fragments of the traumatic experience that are often accompanied by a sense of serious current threat. These sensory fragments can take the form of visual images, sounds, smells, tastes, or bodily sensations such as pain. Ehlers and Clark further noted that individuals with PTSD sometimes re-experience physiological sensations or emotions that were associated with the traumatic event without a recollection of the event. A study that assessed the characteristics and content of intrusive trauma memories in 22 patients with PTSD found that patients had a small number of different intrusive memories (1-4, $M = 2.2$) that occurred in an invariable, repetitive way (Hackmann, Ehlers, Speckens, & Clark, 2004). The intrusions were distressing and had a vivid perceptual content. They appeared to the patient to be happening in the “here and now.” Visual intrusions and bodily sensations were most prominent form of intrusive memory experienced. Bodily sensations included both manifestations of autonomic arousal and other proprioceptive material. For example, many patients experienced pain or feeling physically trapped.

Effortful avoidance. Effortful avoidance refers to deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event, and phobic avoidance of situations, activities, or people who arouse recollections of it (APA, 1994). For instance, a study of children traumatized by an earthquake found that traumatized children did not want to go to places which

reminded them of the earthquake or did not want to see people or survivors who would talk about earthquakes.

Emotional Numbing. Emotional numbing consists of disinterest in activities, detachment from others, and a restricted range of emotional expressiveness, or a foreshortened sense of the future (APA, 1994). Emotional numbing symptoms represent a form of low arousal nonagitated dysphoria or anhedonia and may reflect compensatory mechanisms associated with hyperarousal (Foa, Riggs, & Gershuny, 1995). Emotional numbing has been found to predict an increased risk for comorbid major depressive disorder (Kashdana, Elhaib, & Frueh, 2006).

Post-traumatic symptoms can range in intensity from mild to severe and may alternate with each other. For instance, PTSD is frequently characterized by re-experiencing of the traumatic event, during which the sufferer experiences the hyperarousal and emotions associated with the original trauma alternating with periods of avoidance and numbing (Foa & Street, 2001).

Chronicity. The likelihood of developing symptoms of PTSD tends to increase as the intensity of and physical proximity to the stressor increase. Interpersonal violence or violation in childhood is associated with particularly high (i.e., 50%-75%) risk of PTSD in adulthood (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). PTSD symptoms from childhood maltreatment can persist for many years after the original traumatic event and may never fully remit (Zlotnick et al., 1999). Research suggests that these individuals can have significant difficulties coping with everyday life stressors. A study by Kooperman, Gore-Felton, Classen, Kim, & Spiegel (2001) examined symptoms of Acute Stress Disorder (ASD) among 54 women who already had PTSD related to childhood sexual abuse for which they were seeking treatment. Acute Stress Disorder is characterized by the development of severe anxiety, dissociative, and

other symptoms within one month after exposure to an extreme traumatic stressor. Individuals with ASD may experience difficulty concentrating, feel detached from their bodies, and experience the world as unreal or dreamlike. They also have a decrease in emotional responsiveness, often finding it difficult or impossible to experience pleasure in previously enjoyable activities. The investigators found that 44% of the women met all symptom criteria for ASD, but only three of these 24 participants described a recent traumatic life event. Moreover, ASD symptoms were significantly related to trauma symptom scores. These findings suggest that a significant proportion of women with PTSD for childhood sexual abuse may be highly symptomatic for everyday stressful events that would not be experienced as traumatizing to others.

Complex Post-Traumatic Stress Disorder

For a substantial number of abuse victims, PTSD symptoms only capture a small portion of their difficulties. The current diagnostic formulation of PTSD derives primarily from observations of trauma survivors who have experienced relatively circumscribed traumatic events. Cumulative abusive experiences, particularly when the trauma begins during childhood, appear to add to the severity and complexity of traumatic symptoms. Thus, while PTSD has been found to be a useful diagnostic construct with wide applicability to different victim populations; it fails to capture many of the aftereffects associated with chronic interpersonal trauma including dissociation, difficulties with relationships and somatization (Van der Kolk & Courtois, 2005). It also fails to capture the effects of trauma on victims' their loss of self-worth, along with their loss of a sense of safety, trust, and their frequent revictimization (Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). As a result of these limitations, a new diagnostic category was developed in order to better represent the range of symptoms found in victims of childhood

sexual abuse. These complex posttraumatic impairments in abuse survivors are theorized as forming a spectrum of disorders has been termed “disorders of extreme stress not otherwise specified” (DESNOS; Herman, 1992) or complex posttraumatic stress disorder (Zlotnick et al., 1996). Herman’s work suggests a complex traumatic stress response is an adaptation to chronic interpersonal violence that can be found in many people subjected to ongoing abuse, control, and terror.

Complex posttraumatic stress disorder involves a broad set of self-regulatory impairments that take the form of profound and enduring problems with overwhelming emotional distress, loss of a basic sense of trust in relationships and meaning in life, periods of severe dissociation, and chronic health problems that cannot be explained by medical causes (Ford, Stockton, Kaltman, & Green, 2006). Characterologic sequelae of prolonged victimization include pathological changes in relationships and identity (Herman, 1992; van der Kolk & Courtois, 2005). Features of complex posttraumatic stress disorder are outlined in Table 1.

Table 1. Proposed Features of Complex Post-Traumatic Stress Disorder

1. A history of subjection to totalitarian control over a prolonged period such as childhood physical or sexual abuse.
2. Alterations in affect regulation such as persistent dysphoria, chronic suicidal preoccupation, self-injury, and explosive or inhibited anger.
3. Alterations in consciousness such as reliving traumatic experiences and transient dissociative episodes.
4. Alterations in self-perceptions including feelings of helplessness, shame, guilt, stigma, and self-blame.
5. Alterations in perception of the perpetrator such as unrealistic attribution of total power to perpetrator and acceptance of belief system or rationalizations of perpetrator
6. Alterations in relationships with others such as isolation and withdrawal, persistent mistrust, disruptions of intimate relationships, repeated search for rescuer, and failures of self-protection.
7. Altered systems of meanings such as loss of sustaining faith and a sense of hopelessness and despair.

Adapted from Herman (1992, p. 121)

Dickinson, deGruy, Dickinson, & Candib (1998) used structured interviews to look for evidence of complex posttraumatic stress syndrome in 99 women patients at 3 family practice outpatient clinics who reported a history of sexual abuse. Empirical evidence from cluster analysis of the data supported the theory of a complex posttraumatic syndrome. The severity gradient of symptoms followed a linear pattern, with the most severely abused subjects characterized by symptom patterns that the description of complex posttraumatic stress syndrome. The findings of the DSM-IV Posttraumatic Stress Disorder (PTSD) Field Trial also supported the existence of complex posttraumatic stress disorder (Van der Kolk et al., 2005). The Field Trial studied 400 treatment-seeking traumatized individuals and 128 community residents and found that victims of prolonged interpersonal trauma, particularly trauma early in the life cycle, had a high incidence of DESNOS symptoms. The younger the age of onset of the trauma, the more likely participants were to suffer from the cluster of DESNOS symptoms in addition to

PTSD. Both physical and sexual abuse were risk factors for complex posttraumatic stress disorder among women. Sexually abused women had a higher risk than those who experienced physical abuse and those who experienced both forms of abuse were at the highest risk (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). Similar results were reported by Ford and colleagues (2006) who studied the prevalence of DESNOS in a healthy population of 345 sophomore college women. In structured clinical interviews 11% of respondents met criteria for lifetime (i.e., current or past) PTSD diagnosis. Prevalence of the full DESNOS syndrome was relatively rare (1%); however, many of the abused women met partial criteria. DESNOS symptom severity was associated with interpersonal trauma in a dose-response manner.

Depression

Depression is a mental illness characterized by sad mood and/or diminished ability to enjoy things accompanied by other symptoms such as changes in appetite, sleep patterns, decreased energy level, and poor concentration (APA, 1994). Childhood maltreatment is been found to be an important risk factor for developing depression. Researchers who prospectively followed a randomly selected cohort of 776 children found that adolescents and young adults with a history of childhood maltreatment were three times more likely to become depressed or suicidal compared with individuals without such a history (Brown, Cohen, Johnson, & Smailes, 1999). In a large, nationally-representative sample of women, the odds of depressive symptoms were 63% higher among women who sustained child abuse compared to respondents who reported no child abuse after adjusting for adjusted for the confounding effects of age, marital status, employment, educational status, and insurance status (Fogarty, Fredman, Heeren, & Liebschutz, 2008). Two community surveys found the incidence of depression to be 100% in

women who suffered sexual abuse involving penetration during childhood (Bifulco, Brown & Alder, 1991; Cheasty, Clare, & Collins, 1998).

Dissociation

Dissociation is defined as constituting “a structured separation of mental processes (e.g., thoughts, emotions, conation, memory, and identity) that are normally integrated (Spiegel & Cardena, 1991, p. 366). Dissociation is believed to be an automatic defense mechanism that serves to mitigate the impact of highly aversive or traumatic events (van IJzendoorn & Schuengel, 1996), by allowing a person to distance themselves from overwhelming emotional or physical pain. Dissociation may be triggered by a strong emotional reaction such as feelings of terror, surprise, shame, helplessness, or being trapped or exposed (Sharkansky, 2005). In contrast to increased physiological activation associated with PTSD, research has found peritraumatic dissociation to be associated with *decreased* psychophysiological activation (Griffin, Resick, & Mechanic, 1997). This suppression of autonomic physiological responses has been linked to activation of the parasympathetic nervous system and the secretion of endogenous opioids, promoting analgesia and immobility (Faneslow, 1986 as cited by Halligan, Michael, Wilhelm, Clark, & Ehlers, 2006). A strong link has been reported between childhood trauma and dissociation in adults and children (Spiegel & Cardena, 1991; Silberg, 1996). Dissociative defenses often continue to be utilized long after the traumatic event in an attempt to reduce the emotional responses associated with triggered traumatic memories (Chu, Frey, Ganzel, & Matthews, 1999).

The main symptoms of dissociation are amnesia, depersonalization, and/or derealization. Dissociative amnesia is the absence of memory for a specific and significant period of time (APA, 1994). Peritraumatic dissociation (i.e., dissociation during or immediately after a

traumatic event) has been associated with persistence of trauma-related pathology and has been described as an attempt by an individual to protect oneself from the emotions that occur during a traumatic event by experiencing a sense of detachment. Ross (1994, p. vii) stated that at its core, dissociation is a child imagining that the abuse is happening to someone else.

Depersonalization is described as the sensation that one is in some way detached from his- or herself. The depersonalized individual may feel as though they are in dream or a movie, that they are out of their body, or that they are not real or even that they are dead (Steinberg, 1994). While depersonalization concerns feelings of unreality regarding one's self, derealization refers to the sensation that the outside world is not real (APA, 1994). Thus, an individual experiencing derealization may feel as though they have lost contact with external reality or that their home, workplace, friends or relatives are unfamiliar or strange.

Effects of Childhood Sexual Abuse on Intrapersonal and Interpersonal Relationships

Childhood sexual abuse can have grave consequences on victims' ability to develop and maintain interpersonal relationships later in life. According to Herman (1992) the core experience of psychological trauma, including childhood sexual abuse, are disempowerment and disconnection from others. Survivors have been found to have in forming therapeutic relationships with caregivers due to mistrust, emotional lability, and relational instability (e.g., Chu, 1998; Courtois, 1988; Dalenberg, 2000; Herman, 1992; Pearlman & Courtois, 2005). Victims of severe interpersonal violence often develop major cognitive distortions about their self-worth and the motivations of others (Pearlman, 2003). Pearlman and Courtois (2005, p. 450) note that these negative beliefs "are reinforced when relationships in adulthood recapitulate the dissatisfactions, abandonment, and abuses of the past." Not only do these problems make it difficult for victims to feel close to others, they can also impact others ability to feel close to the

victim. This can lead to considerable social isolation and alienation thus compounding the negative effects of the original trauma (Pearlman & Courtois, 2005).

One of the most prevalent and pervasive effect of childhood sexual abuse is impairment of the ability to trust (Bacon & Lein, 1996). A review by Browne and Finkelhor (1986) found that a history of sexual abuse is associated with feelings of isolation and stigma, poor self-esteem, and difficulty in trusting others. Zlotnick et al. (1996) found that childhood sexual abuse can lead to maladaptive schemas including feelings of defectiveness, incompetence, mistrust, and vulnerability. A study by Hunter (1991) revealed that CSA survivors had less satisfaction in their intimate relationships, lower self-esteem, and more symptoms of sexual dysfunction than the control subjects. A similar study found that a history of childhood sexual abuse is associated with a disruption of intimate relationships in adulthood including difficulties with trust as well as a propensity to perceive their partners as uncaring and over-controlling (Mullen, Martin, Anderson, Romans, & Herbison, 1994).

Experts in the field have noted that children abused by a caretaker often blame themselves for the abuse and grow up feeling fundamentally flawed and unworthy of being cared for by others. In regard to victims of childhood abuse, Chu (1998) noted:

They experience self-loathing and feel little kinship with other human beings. They long for a sense of human connection, but are profoundly alone, regarding other people with great mistrust and suspicion. They want to feel understood, but cannot begin to find the words to communicate with others about their most formative experience. They wish for comfort and security, but find themselves caught up in a world of struggle, hostility, disappointment, and abandonment that recapitulates their early lives. (p. 17)

Lenore Walker, a nationally recognized authority on the effects of interpersonal violence, noted that parents who sexually abuse their children rarely need to resort to force. Instead, they tend to use more “loving” types of behaviors to gain the child’s trust and submission. She noted, “This was one reason why incest victims have so much more difficulty in learning to trust adults and

others in positions of authority as they can't trust themselves to protect against such trickery again" (Walker, personal communication, May 17, 2008),

Effects of Child Sexual Abuse on Physical Health

In addition to the well-documented adverse effects of trauma on mental health and interpersonal relationships, the experience of childhood maltreatment has also been found to exert a long-term negative impact on overall physical health (Kendall-Tackett, 2003; Dallam, 2001; 2005). The effects of childhood maltreatment on physical health can be divided into four overlapping categories: (1) subjective health perceptions; (2) health care utilization; (3) unexplained symptoms and functional disorders; and (4) occurrence of serious illness and chronic disease (Dallam, 2001; 2005).

Childhood sexual abuse is strongly associated with increased physical and psychosocial symptoms (e.g., Finestone et al., 2001; Hulme, 2000; Lechner et al., 1993), lower subjective ratings of overall health (e.g., Moeller et al., 1993; Walker et al., 1999), and a number of chronic pain conditions (Finestone et al., 2001; Golding, 1994; Laws, 1993; Moeller et al., 1993; Parris & Jamison, 1985; Salmon & Calderbank, 1996; Springs & Friedrich, 1992). Childhood sexual abuse is also strongly associated with unexplained medical complaints and functional disorders including somatization, particularly in women (see Table 2). In addition, a history of physical or sexual assault during either childhood or adulthood has been found to be a powerful predictor of subsequent increased health care utilization (Bergman & Brismar, 1991; Farley & Patsalides, 2001; Felitti, 1991; Finestone et al., 2001; Koss et al., 1990; Plichta, 1992). Individuals with a history of abuse use a disproportionate amount of health care services, including primary care medical visits, emergency room visits, community mental health center visits and prescriptions. Individuals who have a history of abuse also tend to be admitted to the hospital more frequently

and undergo more surgical procedures than their nonabused peers (Finestone et al., 2001; Moeller et al., 1993; Salmon & Calderbank, 1996).

Table 2. Functional Health Problems Associated with a History of Childhood Victimization

Chronic fatigue ^{2,8}
Chronic musculoskeletal pain ^{2,7}
Chronic pelvic pain ^{2,4,5}
Chronic headaches ^{2,8}
Fibromyalgia ^{1,6}
Irritable bowel syndrome ²
Premenstrual dysphoric disorder ³
Somatization ⁹

¹ Boisset, Esdaile, & Fitzcharles, 1995; ² Drossman et al., 1990; ³ Girdler et al., 2003; ⁴ Harrop-Griffiths et al., 1988; ⁵ Heim, Ehlert, Hanker, & Hellhammer, 1998; ⁶ Imbierowicz & Egle, 2003; ⁷ Linton, 1997; ⁸ Romans, Belaise, Martin, Morris, & Raffi, 2002; ⁹ Salmon & Calderbank, 1996

In addition to increases in physical symptoms and greater medical utilization, childhood maltreatment also is associated with increased rates of serious illness and chronic disease during adulthood. The most comprehensive study of the effects of childhood maltreatment on adult health is the Adverse Childhood Experiences study. The Adverse Childhood Experiences study is large-scale, ongoing epidemiological study that assesses the impact of numerous adverse childhood experiences on a variety of health behaviors and outcomes in adulthood. In 1998, investigators surveyed over 9,000 adults on adverse childhood experiences soon after they had a standardized medical evaluation at a large HMO. Participants were questioned about the presence of eight adverse experiences during childhood including psychological, physical, or sexual abuse; violence against the mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned. The results revealed a strong, consistent, graded relationship between the number of types of adverse experiences and the presence of serious adult diseases including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Individuals who experienced four or more different types of

childhood adversities were 60% more likely to have diabetes, and over twice as likely to suffer cancer, stroke, or heart disease (Felitti et al., 1998). Similar results were reported in a survey of a random community sample New Zealand women. Seven out of the 18 medical conditions examined were found significantly more often in women who had experienced one or more types of sexual or physical abuse. These included chronic fatigue, bladder problems, headaches, asthma, diabetes and heart problems (Romans et al., 2002). Taken together, these findings suggest that childhood maltreatment and household dysfunction may be related to the development of chronic diseases that are among the most common causes of death and disability in the U.S. (see Table 3).

Table 3. Serious Health Problems Associated with a History of Childhood Victimization

Asthma²
 Cancer¹
 Chronic lung disease¹
 Diabetes^{1,2}
 Heart disease^{1,2}
 Liver disease¹
 Obesity¹
 Skeletal fractures¹
 Stroke¹

¹ Felitti et al., 1998; ² Romans et al., 2002

It is not clear how experiencing abuse or adversity in childhood translates into increased morbidity and mortality later in life; however, emerging research findings reveal a number of factors that may mediate the relationship between early stress and health in the years that follow. These factors include neuroendocrine changes (De Bellis, 2002; Penza et al., 2003; Perry et al., 1995; Teicher, 2002; Van der Kolk, 1994), changes in the immune system (Kiecolt-Glaser et al., 2003), and premature cellular aging (Epel et al., 2004; Kiecolt-Glaser et al., 2003). Childhood

maltreatment also is associated with increased participation in a wide variety of hazardous behaviors (see Dallam, 2001, for a review). Health risk behaviors are those behaviors that have been shown to contribute dramatically to leading causes of morbidity and mortality in adults. These include tobacco use, alcohol and other drug use, unhealthy dietary behaviors, inadequate physical activity, high risk sexual behaviors, and behaviors that may result in violence or accidents (Centers for Disease Control, 2003).

Potential for Retraumatization

Retraumatization is generally used to refer to the reactivation of trauma symptoms due an event or interaction that reminds victims of previous traumatic experiences (see e.g., Hooper & Warwick, 2006; Rosenberg et al., 2001). However, usage of the term is not universal and variety of others terms have also been used to describe this same phenomena. Kitzinger (1992) used the term “re-enacting” to describe situations in which abuse survivors experienced interactions with providers that reminded them of their abuser. Others have discussed this process in terms of “triggers” and “flashbacks” (e.g., Courtois & Riley, 1992; Simkin, 1992). Moreover, numerous papers which have discussed retraumatization have failed to offer any formal definition for their usage of the term or description of what retraumatization during healthcare entails (see e.g., AMA, 1995; Doob, 1992; Rosenberg et al., 2001). So while a paper by the American Medical Association cautioned physicians against inadvertently retraumatizing their patients, it failed to provide any formal definition for the term (“Because many medical procedures involve touch, are invasive, or are performed by authority figures in positions of control or power, physicians must be sensitive to the risk of re-traumatizing vulnerable patients during examinations and testing” [p. 17]). An unpublished report by Human Rights Watch (2000), a group dedicated to

protecting the human rights of people around the world, is one of the few scholarly works that attempted to offer a definition. No citation for the definition was provided.

[Retraumatization] occurs when a when a “triggering” event causes the victim to be overwhelmed by memory and feelings from the previous trauma. It has been described as the psychological equivalent of having a scab torn off. It is painful, and can deplete what little emotional resources the victim has built up.

Further confusing the issue, some writers use the words *retraumatization* to denote experiencing a new trauma (see e.g., Kammerer & Mazelis, 2006; Moinzadeh, 1998). For example, Kammerer and Mazelis defined retraumatization as referring to the experiencing of another traumatic event and the impact of that experience. For example, “[e]xperiencing the repetition of a traumatic event – another rape, another molestation, another beating – is retraumatization” (p. 10). At the same time, Kammerer and Mazelis noted that the term *retraumatization* has also been used in the scholarly literature to denote delayed onset or reactivated symptoms related to something traumatic experienced in the past. For example, “[e]vents or circumstances that echo the violation and lack of control of an earlier trauma can be retraumatizing” (p. 11).

Obviously using the same term to describe both *experiencing* another traumatic event and *being reminded* of a prior traumatic event is problematic. In the first instance, *retraumatization* in healthcare would refer to actually being abused by a healthcare professional. In the latter instance, it would refer to being reminded of prior abuse during a healthcare interaction. This inconsistent usage of the term “*retraumatization*” along with an associated lack of conceptual clarity has been noted in the literature. Layne et al. (2006) reported being unable to find any published sources that provided either a definitive conceptual or operational definition for the term. Similar problems were noted by Orth and Maercker (2004) who recommended that the concept of *retraumatization* be distinguished from that of *revictimization*. Orth and Maercker

recommended that the term revictimization should be used to discuss situations where trauma survivors experience a second traumatic event, while the term retraumatization should be reserved to discuss situations in which an individual experiences distress in response to *reminders* of a traumatic event. Orth and Maercker noted that these reminders are not necessarily in and of themselves considered traumatic.

The use of the term retraumatization in the current study will follow of Orth and Maercker's (2004) recommendation and be used to denote reactivated symptoms or memories related to something traumatic experienced in the past. This definition is consistent with the one offered by Human Rights Watch and is in accordance with the way the term is used in the majority of scholarly research reviewed for the current study.

Retraumatization in Mental Health Settings

A number of reports suggest that mental health patients may experience exacerbation of post-traumatic symptoms due to encounters in the mental health system, such as violence by other clients or forcible restraint by male attendants (Center for Mental Health Services & Human Resource Association of the Northeast, 1995; Geanellos, 2003; Jennings & Ralph, 1997; Smith, 1995). A Massachusetts task force investigating the effect of restraints on abused populations reported that research indicates at least half of all women treated in psychiatric settings have a history of physical or sexual abuse. The task force found that the use of restraints on people who have been previously abused often results in the reactivation of trauma symptoms and can cause setbacks in treatment (Carmen et al., 1996). The task force developed a specific set of guidelines for assessing clients' trauma history and recommended altering restraint and seclusion policies to reduce risk of retraumatization. Similarly, Geanellos (2003) cautioned nurses to be careful in their work with abuse survivors in mental health units to avoid repeating

boundary violations and retraumatizing clients. Geanellos cautioned that “any use of force should be carefully considered as it triggers images of powerlessness and helplessness when clients were unable to protect themselves” and reinforces beliefs that the world is a dangerous place and people are untrustworthy and abusive (p. 191).

The interpersonal style of the therapist has also been recognized as an important factor that can lead to reactivation of trauma symptoms. Herman (1992) noted that chronically traumatized patients have “an exquisite attunement to unconscious and nonverbal communication” of clinicians who treat them (p. 139). Hooper and Warwick (2006) suggested that abuse survivors run the risk of retraumatization when mental health services or professionals unwittingly replicate the dynamics of abuse, for example by reinforcing stigma and powerlessness. Rosenberg et al. (2001) noted a growing movement among consumers who are dissatisfied with how they are treated in the mental health system:

[An]...important thrust was an emphasis on victimization or retraumatization at the hands of providers or the mental health system itself, including events that served as triggers, reevoking memories of trauma. Providers were often seen as insensitive or demeaning in their responses to trauma survivors. Consumers suggested that clinicians needed to be more aware of trauma-related difficulties and that the treatment system should develop better mechanisms to ensure that trauma survivors receive humane treatment and that their personal rights are respected. (p. 1454)

Retraumatization in Healthcare Settings

The potential for retraumatization of previously traumatized populations during healthcare visits received limited attention in the scientific literature until recently. Current knowledge regarding the experience of retraumatization during health care comes from three main sources: (1) anecdotal accounts and case reports; (2) quantitative studies comparing abused and nonabused women’s experience during dental and gynecological examinations; and (3) interviews with survivors about their healthcare experiences. Because the qualitative literature

will form the basis for data analysis, only anecdotal and quantitative and case studies will be summarized in this section.

Many reports of retraumatization in the healthcare literature are anecdotal (e.g., Anonymous; 2004; Rose, 1992) or case reports geared toward educating nurses and other healthcare professionals on the potential for reactivation of trauma symptoms among sexual abuse survivors during gynecological and obstetrical care (e.g., Bala, 1994; Chalfen, 1993; Courtois & Riley, 1992; Doob, 1992; Holz, 1994; Hudson et al., 1999; Rhodes & Hutchinson, 1994; Roussillon, 1998; Simkin, 1992). These reports typically describe how reactivation of trauma symptoms can complicate patients' care. For example, Hudson et al. described two case studies involving sexually abused women the authors had encountered in their practices as wound/ostomy nurses. Both of the women profiled had extreme reactions to having ostomies. The first woman experienced depression and attempted suicide after 9 surgeries failed to correct a urethral stricture and chronic cystitis. After her last surgery, she remained hospitalized due to the fact that the ostomy failed to heal. The mystery of her failure to heal was solved when the woman was found to be engaged in self-abusive behavior that involved cutting her ostomy site with razor blades. The second case study is of a 59-year-old woman with intractable urinary incontinence who had undergone 6 genitourinary surgeries before the creation of a continent urinary diversion. The woman refused to even touch the catheter and required home care due to her inability to learn self-catheterization. The woman finally revealed that she had been sexually abused. Her care was complicated by the fact that she would experience extreme fear reactions to many triggering events during healthcare. These reactions included nightmares, fainting and dissociation.

A number of quantitative studies have compared childhood sexual abuse survivors' reactions to healthcare with those of nonabused patients. The studies are grouped according to focus. Most studies focused on traumatic reactions in childhood sexual abuse survivors undergoing gynecological or dental examinations. Several studies focused on childhood sexual abuse survivors' relationships with healthcare providers and one study investigated the relationship between childhood abuse and healthcare avoidance.

Traumatic Reactions to Gynecological Examinations

Researchers have found that gynecologic healthcare is problematic for women in general (Domar, 1985), with almost all women reporting some anxiety associated with pelvic examinations (Osofsky, 1967). Eighty-five percent of women surveyed by Weiss and Meadow (1979) reported negative feelings toward the pelvic examination. Haar, Halitsky, and Stricker (1977) surveyed 409 female patients and found that overall the women surveyed had predominantly favorable attitudes to both examination and gynecologists. However, a number of specific criticisms were found. The traditional lithotomy position and breast examination were the most difficult aspects of the examination emotionally. Across studies complaints about pelvic examinations included embarrassment about undressing, fear of pain, inadequate feedback from the physician, and position on the examination table (Haar et al., 1977; Millstein, Adler, & Irwin, 1984; Petravage, Reynolds, Gardner, & Reading, 1979). Unfortunately, none of these early studies asked about participants' sexual abuse history making it impossible to determine how the experience of gynecologic care might differ between abused and nonabused women.

Studies that have compared sexually abused women to nonabused women have found that sexually abused women have more difficulties tolerating pelvic examinations. Problems include avoidance (Farley, Golding, & Minkoff, 2002; Robohm & Bittenheim, 1996; Springs &

Friedrich, 1992), emotional distress (Lee, Westrup, Ruzek, Keller, & Weitlauf, 2007; Leeners et al., 2006; 2007a; Robohm & Buttenheim, 1996; Smith and Smith, 1999; Weitlauf et al., 2008), discomfort (Hilden et al., 2003; Robohm & Buttenheim, 1996; Weitlauf et al., 2008), and intrusive memories of past abuse (Leeners et al., 2006; Leeners et al., 2007a; Robohm & Buttenheim, 1996).

Springs and Friedrich (1992) found that despite higher utilization rates for general medical and psychiatric care, older women with sexual abuse histories scheduled Pap smears less frequently than women without abuse histories. Farley et al. (2002) performed a case-control study in an age-stratified random sample of adult women members of a large health maintenance organization to evaluate the effect of trauma on cervical screening. The sample included 364 control women who had received medically appropriate cervical cancer screening and 372 women that had not had cervical cancer screening within 2 years prior to the study. Women who had been sexually abused in childhood were significantly less likely to have had a Pap smear within the past 2 years (36.0% vs. 50.4%, $p = .050$). Childhood sexual abuse remained associated with reduced odds of Pap screening in logistic regression analyses that controlled for clinic location, demographics, attitudes about Pap screening, and PTSD symptoms (adjusted OR = .56, 95% CI .34 to .91). Nonsexual childhood abuse and neglect were not related to screening.

Robohm and Buttenheim (1996) surveyed a convenience sample of 44 childhood sexual abuse survivors and 30 nonabused controls regarding the experience of seeking gynecologic care. Abuse survivors were also significantly less likely to seek regular gynecological care ($X^2 [1, N=72] = 3.73, p < .05$). In fact, two of the abuse survivors reported never having sought gynecological care due to fear and mistrust. In addition, abuse survivors rated the experience as significantly more negative and reported being more uncomfortable during almost every stage of

the gynecological examination when compared to their nonabused counterparts. When asked to recall their most recent gynecological visit, both survivors and controls rated anxiety as their highest concern. However, abuse survivors cited vulnerability and shame as their next highest concerns; whereas, controls ranked physical discomfort as theirs. Moreover, abuse survivors expressed particular discomfort in having their sexual organs examined, while controls attributed their discomfort to physical reasons. Survivors also reported more trauma-like responses during the gynecological examination, including overwhelming emotions, intrusive or unwanted thoughts, memories, body memories, and feelings of detachment from their bodies. However, when survivors were compared to their nonabused counterparts, Robohm and Bittenheim found no significant differences in ratings of provider trustworthiness or perceived ability to “get along with” their provider at their most recent gynecological visit.

Smith and Smith (1999) surveyed 69 women who were gynecological or obstetric patients at a multidisciplinary women’s health ambulatory center and a private practice in gynecology. One-third of the women reported a history of childhood sexual abuse. Sexual abuse survivors reported significantly higher trait anxiety than women without abuse histories, and had higher state anxiety during gynecological exams as compared to women without histories of sexual abuse ($p = .01$).

Leeners et al. (2006) reviewed 43 studies that examined at the influence of childhood sexual abuse on pregnancy, delivery, and early parenthood. Compared to non-abused women, childhood sexual abuse survivors were more likely to experience distress during obstetric care. Sequelae included hypervigilance, dissociation and disturbance of delivery by sudden memories of sexual abuse situations. Leeners et al. also found evidence that memories of sexual abuse can be induced by body changes during pregnancy along with pregnant women’s increased

dependency on others. Moreover, the words or touches of healthcare providers could also act as a trigger. Leeners et al. concluded that among abuse survivors, prenatal care is often complicated by the tendency to avoid situations that can trigger memories.

Similar results were reported in Leeners et al. (2007a) who compared the experiences of 85 women exposed to childhood sexual abuse with those of 170 matched-controls. Results revealed that women with a history of childhood sexual abuse sought more treatment for acute gynecologic problems and were significantly more likely to report that gynecologic examinations were anxiety-provoking. In addition, 43.5% of abused women experienced memories of the original abuse situation during gynecologic consultations.

Lee et al. (2007) explored the impact of clinician gender and examination type (breast, pelvic, rectal, and dental) on anticipated examination-related anxiety among 31 female veterans with a history of sexual trauma. Women's self-reported examination-related anxiety was impacted by both gender of the physician and examination type. Participants reported that all examination types would be more difficult when administered by a male provider but anticipated significantly more anxiety about breast, pelvic, or rectal examinations administered by a male clinician ($p < .05$).

Weitlauf et al. (2008) examined severity of distress and pain during pelvic examinations among 67 female veterans with and without lifetime histories of sexual violence. Reports of distress and pain were collected immediately after the exam; PTSD was measured two weeks later during a telephone interview. Self-rated anxiety associated with the pelvic examination was highest for women with prior sexual violence and PTSD (median 5.49), next highest for women with sexual violence only (median 2.44), and lowest for women with neither (median 0). There were significant between group differences ($p = .015$). In addition, significantly higher ratings of

pain associated with speculum insertion were found among women with sexual violence (median 2.5) compared with those without (median 0) ($p = .04$).

Hilden et al. (2003) examined possible factors associated with experiencing discomfort during the gynecologic examination in 808 consecutive gynecologic patients. Patients were asked about their sexual abuse history, their emotional contact with the gynecologist, and their experience of discomfort during the gynecologic examination. A total of 165 (20.7%) of respondents reported a history of sexual abuse, among these, 29.7% reported discomfort during the examination (adjusted OR 1.85, CI 1.19-2.87). Only 7.6% had told their gynecologist about their history of abuse. The strongest factor associated with discomfort was negative contact with the examiner (OR 8.21; CI 3.91-17.24). Gender of the examiner was not associated with discomfort. Other factors significantly associated with discomfort were young age, mental health problems and dissatisfaction with present sexual life.

Traumatic Reactions to Dental Care

Going to the dentist is distressing for many people within the general population (Gatchel, 1992); however, some people experience dental anxiety to the extent that it adversely affects their oral health. Researchers report a strong association between dental fear and inadequate oral health, avoidance or irregular dental attendance, sensitivity to pain, and poor cooperation with care (Hägglin, Hakeberg, Ahlqwist, Sullivan, & Berggren, 2000; McGrath & Bedi, 2004; Willumsen, 2004). A history of childhood abuse or neglect has been found to be significantly associated with problems in tolerating dental care. Abuse survivors have been found to have elevated rates dental fear (Walker, Milgrom, Weinstein, Getz, & Richardson, 1996; Willumsen, 2001), emotional distress (Hays & Stanley, 1996; Leeners et al., 2007b), avoidance (Hays & Stanley, 1996; Leeners et al., 2007b; Willumsen, 2001), abuse-related memories

(Leeners et al., 2007b), difficulty seeing a male dentist (Leeners et al., 2007b; Willumsen, 2004), and difficulty establishing a trusting relationship with the dentist (Willumsen, 2004).

Walker, et al., (1996) collected data from 462 female members of a large urban health maintenance organization about their dental fear and histories of childhood and adult traumas. Women with high dental fears were significantly more likely to have been victims of trauma than women with low dental fear scores. There were no significant differences between the groups with respect to age, marital status, education or income. Among women with high levels of dental fear, 34% reported a history of childhood molestation, 15% reported attempted rape and 13% reported rape or incest. The Odds ratios for women with high dental fear were: 1.37 for a history of childhood sexual molestation, 2.11 for a history of attempted rape, and 1.96 for a history of rape or incest.

Willumsen (2001) surveyed 99 sexually abused women regarding dental fear and dental attendance. Women were divided into three groups according to the type of abuse they reported: sexual touching only, intercourse, and oral penetration. The mean score on dental fear assessments was significantly higher for all groups compared to the general populations. The highest amount of dental fear was found in women who reported abuse that included oral penetration; 75% of abuse women who reported oral penetration had high levels of dental fear. Forty percent reported having cancelled an appointment or not having made an appointment due to fear “often” or “almost every time” (30.8% in the sexual touching group, 26.8% in the intercourse group and 51.2% in the oral penetration group). Eighty-four percent (46.7% in the sexual touching group, 76.8% in the intercourse group and 95.5% in the oral penetration group) reported that they had had problems with regard to dental treatment. Despite the fact that almost all women who had been orally penetrated reported that being sexually abused had caused them

problems during dental treatment situations, most reported that due to suppression or repression of the abuse experiences, they had not always been aware of the relationship. In fact, only one victim of oral penetration reported that she had always been aware that having been sexually abused had caused problems during dental treatment situations. In addition, only a minority, even among the extremely fearful women, had informed their dentist about their sexual abuse.

Hays and Stanley (1996) compared 132 women with a history of sexual abuse to 49 women with no abuse history. A history of abuse was found to be predictive in different patterns in making and keeping dental appointments and PTSD- type symptoms while at the dentist. Survivors of sexual abuse were more likely to have difficulty calling to make dental appointments and more likely to cancel appointments once they had been made ($p < .01$). The more chronic the abuse experienced, the less likely the survivor was to go to the dentist. Survivors of sexual abuse were also much more likely to experience distress symptoms (fear, anxiety, dissociation, flashbacks, nausea, and shame) while at the dentist than those without an abuse history ($p < .05$). Distress was partially mediated by the gender of the dentist; nausea was significantly lower among respondents who visited a female dentist ($p < .01$). There was also a significant correlation between negative experiences during the examination and a history of childhood sexual abuse ($p < .05$). Survivors reported the most discomfort with having to lie in a horizontal position and with the dentist being too close to or touching them.

Leeners et al. (2007b) surveyed 85 women recruited from support centers for women with childhood sexual abuse experiences on stress during dental treatment. Data from the 85 abused women were compared to the data of 170 matching controls who were mothers of children attending kindergarten. Compared to controls, women exposed to childhood sexual abuse exhibited greater psychological strain during dental treatment (36.5%/18.8%; $P < .005$), a

lower number of prophylactic visits (72.9%/89.4%; $P < .005$), and preference for a female dentist to a male dentist (29.4%/8.2%; $P < .0001$). Abused women also rated four of five stressors associated with dental treatment as more intense. In addition, 28% of abused women suffered from memories of their original abuse situations during dental treatment, and 29.4% believed that the dentist should be informed about their history of abuse.

Willumsen (2004) compared 58 women who reported both childhood sexual abuse and dental fear, to 25 women who reported dental fear only. Twenty-five women without dental fear acted as a control group. Compared with controls, among those with dental fear, the level of fear and tendency to avoid dental care was similar regardless of abuse status. However, significant differences were found among the dental fear groups regarding *interpersonal* aspects of the dental experience. Compared to both controls and the nonabused fear group, abuse survivors reported feeling significantly more vulnerable in communications with the dentist and found male dentists to be more fear-provoking. Abuse survivors also expressed significantly more fear over losing control, had a greater fear of receiving negative information, and reported more difficulties in establishing a trusting relationship with the dentist than the other groups studied.

Relationships With Caregivers

Salmon et al. (2007) examined whether adverse childhood experiences damage the ability of women with primary breast cancer ($N=355$) to form supportive relationships their healthcare providers. After surgery, the women reported their abuse history; perceived social support; support experienced from the surgeon and nurses; and current emotional distress. Patients who recalled abuse or lack of parental care during their childhood were less likely to report being fully supported by clinical staff around the time of their diagnosis and primary treatment of breast cancer. In logistical regression analyses the relationship was mediated by the influence of

parental care on experiencing good social support in general, which was in turn associated with feeling fully supported by clinical staff. These relationships were independent of current emotional distress. Thus, those who did not perceive themselves as having good social support outside of the hospital also tended to not feel fully supported by their caregivers when they were inside the hospital. In addition, abuse selectively impaired relationships with clinical staff, even after controlling for the ability to obtain general social support. The investigators concluded that patients' ability to feel supported by clinical staff reflects not only how much support staff make available but also patients' experience of close relationships in childhood.

The findings of a group of Swedish studies suggest that trauma survivors perceive more problems in their interactions with healthcare providers than other patients. The Swedish studies examined lifetime prevalence of experiences of “abuse in health care” using a tool created for this purpose called the The NorVold Abuse Questionnaire¹ (NorAQ; (Swahnberg, Schei, et al., 2007; Swahnberg, Wijma, Schei, et al., 2004; Swahnberg, Wijma, Wingren, Hilden, & Schei, 2004). Abuse in healthcare was defined very broadly. The act could range from an overtly abusive act, to merely feeling offended or degraded receiving health services. For instance, the event could be an ordinary procedure during which the physician/nurse perceived that nothing special happened, while the patient experienced the situation as frightening, insulting or

¹ Questions about abuse in health care in NorAQ:

Mild abuse: Have you ever felt offended or grossly degraded while visiting health services, felt that someone exercised blackmail against you or did not show respect for your opinion—in such a way that you were later disturbed by or suffered from the experience?

Moderate abuse: Have you ever experienced that a “normal” event while visiting health services suddenly became a really terrible and insulting experience, without you fully knowing how this could happen?

Severe abuse: Have you experienced anybody in health service purposely—as you understood—hurting you physically or mentally, grossly violating you or using your body and your subordinated position to your disadvantage for his/her own purpose?

(Adapted from Swahnberg, Schei, et al., 2007)

disrespectful. The character of the abusive act was not investigated any further. Prevalence of those reporting abuse in healthcare was 16% in a population sample ($N = 1,168$) and ranged between 14 and 20% in the clinical samples ($N = 2,439$). An association was found between lifetime experiences of emotional, physical and/or sexual abuse and reporting abuse during interactions with health care providers. In a survey of 2439 consecutive acute and non-acute patients at three Swedish gynecological clinics, Swahnberg, Wijma, Wingren, et al. found that patients with a background of childhood abuse were more likely to report feeling victimized by the healthcare system than nonabused patients. The highest odds ratio was found for the combination of all three kinds of childhood abuse. These findings also held after adjustment for age and educational level.

Further research was conducted to map prevalence of abuse during healthcare and associated variables among abused and nonabused patients ($N = 3,641$; Swahnberg, Schei, et al., 2007). The prevalence of abuse in healthcare was 2.1% among women who did not report an abuse history; 2.9% in women who reported some form of childhood abuse; 3.2% in women who reported abuse during adulthood only; and 4.5% among women who reported both childhood and adult experiences of abuse ($p = .000$). Two factors were associated with reports of abuse in healthcare among women not reporting abuse in their background: higher education level and higher levels of post-traumatic symptoms. The association between feeling abused during healthcare and post-traumatic symptoms in those not reporting a history of abuse suggests that many of these women had experienced some type of trauma in their background.

Healthcare Avoidance

As part of a dissertation, Melia-Gordon (2003) investigated reports of avoidance of medical and/or dental care in relation to participants' experiences of familial childhood

emotional, physical and sexual abuse. The results are based on a survey of 153 women (18-63 years; 102 survivors of child abuse, 51 nonabused) recruited from the community and local university. Healthcare avoidance was positively correlated with experiences of forcible sexual abuse ($r = .22, p < .01$), and experiences of other trauma ($r = .22, p < .01$). A comparison of rationales that 67 abused and 22 nonabused patients provided for avoiding healthcare avoidance are outlined in Table 4. The most common reason that abused women provided for avoiding healthcare was retraumatization; 33% of child abuse survivors reported retraumatization. Abused women also reported avoiding healthcare due to psychological discomfort, and a sense of discouragement and/or disillusionment regarding visits. None of the nonabused women reported these problems.

Table 4. Treatment Avoidance: Comparison of Rationales Provided by Abused and Nonabused Women for Avoiding Healthcare

Rationales	Abused	Nonabused
Experiences of retraumatization during treatment <i>n</i> = 28	100%	0%
Fear of pain during treatment <i>n</i> =25	65%	35%
Self-healing or self-neglect <i>n</i> = 23	70%	30%
Dislike or mistrust of healthcare professionals <i>n</i> = 20	85%	15%
Financial concerns <i>n</i> = 19	75%	25%
Extreme psychological discomfort <i>n</i> =14	100%	0%
Inconvenience <i>n</i> = 14	66%	33%
Fear of receiving bad news <i>n</i> = 10	20%	80%
Sense of discouragement/disillusionment regarding visits <i>n</i> =6	100%	0%
Adapted from Melia-Gordon (2003); Table 14 and information found in the text (pp. 114-134); Results are from 89 women (67 child abuse survivors, 22 nonabused)		

Summary

The available literature constantly demonstrates that that childhood sexual abuse is associated with a broad range of behavioral, psychological and physical problems that persist into adulthood. A number of theories have been developed to help explain the wide ranging deleterious effects of childhood abuse. Sophisticated neurobiological studies have shown evidence that childhood trauma can lead to sensitization of stress-response systems resulting in enduring disruptions in neuroendocrine function. These neuroendocrine changes are believed to underlie many of the somatic and post-traumatic symptoms frequently found in adult survivors of childhood abuse. At the same time, several psychological theories have been developed to

address interpersonal aspects of trauma. For instance, attachment theory explains adult survivors' relationship difficulties by connecting them to mental models developed during childhood based on treatment by caregivers. Geanellos (2003) provided a model that explains relational problems in incestuous abuse survivors by tying these problems to the failure to learn to regulate personal space boundaries during childhood. Freyd (1996) provided Betrayal Trauma Theory, a model that explains how social betrayal during childhood may lead to dissociative reactions.

PTSD is the most common and best-defined psychological consequence of trauma (Rosenberg et al., 2001) resulting in symptoms such as anxiety, intrusive or unwanted thoughts, avoidance, and re-experiencing past traumas as if they were currently occurring. Cumulative abusive experiences, particularly when the trauma begins during childhood, appear to add to the severity and complexity of traumatic symptoms experienced resulting in psychological disturbances beyond the level characterized within the classic diagnostic criteria for PTSD. These complex posttraumatic impairments form a spectrum of disorders that has been termed "disorders of extreme stress not otherwise specified" (DESNOS; Herman, 1992) or complex posttraumatic stress disorder (Zlotnick et al., 1996). Symptoms associated with DESNOS include PTSD symptoms along with dissociation, difficulties with relationships and somatization.

In addition to the well-documented adverse effects of trauma on mental health and interpersonal relationships, a growing body of literature exists about the long-term negative impact of childhood maltreatment on overall physical health. The effects of childhood maltreatment on physical health can be summed up as leading to: (1) poorer perceptions of subjective health; (2) increased health care utilization; (3) increased unexplained symptoms and functional disorders; and (4) increased occurrences of serious illness and chronic disease.

Quantitative findings indicate that the healthcare encounter itself can be a significant source of distress to survivors of childhood sexual abuse. Investigators examining childhood sexual abuse survivors' reactions to gynecological or dental examinations have found that abuse survivors experience significantly more distress during these examinations than their nonabused counterparts. Survivors' reactions to gynecological or dental examinations include many of the classic symptoms of PTSD including anxiety, avoidance, and re-experiencing past traumas as if they were currently occurring. It is important to note that no measures have been developed that are specific to the experience of abuse survivors' experience in healthcare. As a result, quantitative studies addressing this subject have used generic measures that may not capture the full range of potential reactions that abuse survivors may experience.

There also is evidence to suggest that abuse survivors tend to feel more vulnerable in communications with their providers and find male healthcare providers to be more fear-provoking than female ones. Childhood sexual abuse survivors have also been reported to and report more difficulties in establishing a trusting relationship with providers than those who have not been abused. However, the data are not entirely consistent on this latter point. When Robohm and Bittenheim (1996) compared abuse survivors to controls, they found no significant differences in ratings of provider trustworthiness or perceived ability to "get along with" their provider at their most recent gynecological visit. Robohm and Bittenheim's findings conflict with those reported by Willumsen (2004) who found that compared to nonabused controls, abuse survivors reported more difficulties in communicating with and establishing a trusting relationship with their dentist. Willumsen's findings are supported by those of Salmon et al. (2007) who found that, among women being treated for breast cancer, those with a history of childhood abuse tended to feel less supported by the doctors and nurses who cared for them after

their surgery. The relationship was mediated by the influence of parental care on experiencing social support in general. Those who did not perceive themselves as having good social support outside of the hospital also tended to not feel fully supported by their caregivers when they were inside the hospital. Willumsen's and Salmon et al.'s findings are consistent with the results of several large-scale Swedish studies that found that patients with a background of childhood abuse were more likely to report feeling violated in their interactions with healthcare providers than nonabused patients (Swahnberg, Schei, et al., 2007; Swahnberg, Wijma, Schei, et al., 2004; Swahnberg, Wijma, Wingren, et al., 2004). Thus, as a whole, it appears that sexual abuse survivors have greater difficulty forming a trusting relationship with caregivers and are more likely to feel violated during healthcare interactions.

Another inconsistency in the data is the fact that a history of childhood sexual abuse is associated with both increased healthcare utilization and healthcare avoidance. More research is needed to determine the basis for this inconsistency. One potential explanation is that some abuse survivors over-utilize healthcare while others avoid it. For example, some survivors may increase healthcare visits seeking help for unexplained physical symptoms and/or chronic pain, while others fail to seek healthcare due to their difficulties tolerating examinations and forming trusting relationships with healthcare providers. It is also possible that some abuse survivors over-utilize certain types of healthcare while avoiding others. For example, survivors with unexplained physical symptoms and/or chronic pain may visit a number of healthcare providers seeking solutions to their complaints while at the same time avoiding preventive dental or gynecological care due to difficulties associated with these types of examinations. This explanation is supported by Springs and Friedrich's (1992) study. They found that despite higher utilization rates for general medical and psychiatric care, older women with sexual abuse

histories scheduled Pap smears less frequently than women without abuse histories. The potential for abuse survivors over-utilize certain types of healthcare while avoiding others is consistent with Ackerson and Preston (2009) explanation of why women decide to engage or not engage in cancer screening. Ackerson and Preston found that, depending on the source of the fear, women could either be shown to avoid (when fearing the medical establishment, the test, or the results) or to seek (when fearing cancer itself) screening. In both cases, women acted to reduce the risk most salient to them. Thus, fear may cause childhood sexual abuse survivors to avoid risk, but the way in which women frame the risk, or the source of their fear, can create opposing effects on their behavior.

Additional research is needed to understand the associations between a history of childhood sexual abuse and difficulties in healthcare. Most research has been focused on female childhood sexual abuse survivors. As a result, little is known about the experiences of males and whether male childhood sexual abuse survivors' experiences in healthcare differ from those of females. In addition, while numerous case reports and research findings suggest that sexual abuse survivors are prone to retraumatization during healthcare, knowledge in this area is limited by the lack of consistent definitions and conceptual models to aid in understanding retraumatization. For instance, the current literature offers little conceptual clarity regarding the factors that cause survivors distress, how to recognize the problem of retraumatization, or even what term should be used to describe it. Accordingly, no measures of retraumatization are available and no empirically-tested interventions are offered to prevent retraumatization from occurring. This gap in the scientific literature underscores the need for more in depth theoretical treatment of the subject.

CHAPTER 3 - DESIGN AND METHODS

Quantitative research findings show that for childhood sexual abuse survivors medical or dental treatment can lead to significant distress, trigger memories of abuse, and result in avoidance of care. What these studies are unable to convey; however, is the experience of retraumatization from the viewpoint of abuse survivors. Nor can quantitative research describe the social processes involved in retraumatization. This information is best conveyed via qualitative research. Creswell (1998) defined qualitative research as “an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting” (p. 15). Since abuse survivors are the best “knowers” of their own experiences and reactions, qualitative research methodology is the most appropriate way to understand the subtleties and complexities of their experiences in the healthcare setting-- particularly in complex patient situations where there is no prior systematically generated knowledge or understanding of the phenomenon.

To date, a number of qualitative studies examined the health care experiences of abuse survivors. However, no syntheses of these findings have been conducted and no models of retraumatization are currently available to guide knowledge development and practice. The goal of the current qualitative study is to advance substantive knowledge in the field of nursing by synthesizing the qualitative literature in order to develop a model that will aid in understanding and anticipating the difficulties abuse survivors are likely to face when accessing healthcare. The development of such a model is essential to the construction of effective and psychologically-sensitive interventions for abuse survivors.

Stern and Harris (1985) were the first to coin the phrase “qualitative meta-synthesis” with reference to integrating results from a group of inter-related qualitative studies in order to develop an explanatory theory or model that could explain the findings. Meta-synthesis has been defined as “the theories, grand narratives, generalizations, or interpretive translations produced from the integration or comparison of findings from qualitative studies” (Sandelowski, Docherty, & Emden, 1997, p. 336). According to Sandelowski et al., “The overall aim of qualitative meta-synthesis is to account for all important similarities and differences in language, concepts, images, and other ideas around a target experience” (p. 369). Qualitative meta-synthesis provides a means by which the findings of multiple qualitative studies in a target area can be formally combined to reach a new conceptual level of understanding and development (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004).

Meta-synthesis is analogous to quantitative meta-analysis in its intent to systematically combine the findings in a target domain of scientific research. However, qualitative meta-synthesis is not about averaging or reducing findings to a common metric; instead, the aim is to create larger interpretive renderings of all of the studies examined and remain faithful to the interpretive rendering in each particular study (Sandelowski & Barroso, 2003). Meta-synthesis is particularly useful for theory building. Schreiber, Crooks, and Stern (1997) noted that with meta-synthesis findings from diverse sources can be used to “push the level of theory beyond the level possible using data from only one sample” (p. 315).

Analytic Framework

Meta-synthesis was used to combine data from 20 papers representing 15 studies in order to understand how abuse survivors interpret their experiences and interactions within the healthcare setting. The varied conditions for retraumatization were also explored in order to find

the common strands of the process in varied situations and settings. A grounded theory approach served as an analytic framework for this investigation. According to Paterson, Thorne, Canam, and Jillings (2001), identification of a theoretical framework is important when conducting a meta-synthesis, as it assists in identification of relevant concepts and constructs, guides sampling, and serves as a basis for interpreting findings.

A grounded theory approach is perhaps the most appropriate method for the current project as the research question concerns an experience (retraumatization), the phenomenon in question is a social process (healthcare interactions), and the goal is theory development (Denzin & Lincoln, 2000). The primary purpose of grounded theory is to inductively analyze data in order to generate explanatory theories of human behavior (Denzin & Lincoln). This approach is based on the belief that as individuals within groups define situations with the self and others, common patterns of behavior emerge (Glaser & Strauss, 1967). Grounded theory is, by definition and purpose, grounded in and tested against human experience (Sandelowski, 1997). According to Crooks (2001), “Grounded theory gives us a picture of what people do, what their prime concerns are, and how they deal with these concerns” (p. 25).

The primary theoretical underpinning of grounded theory is symbolic interactionism. Symbolic interactionism focuses on a process-oriented model of human behavior that is imbedded in the meanings people make of events they experience in natural settings (Crooks, 2001). This viewpoint acknowledges that perceptions, understandings, and actions change over time as new experiences and information are integrated. According to Crooks (2001), “It is the job of the symbolic interactionist to discover phases or stages of that process, factors within stages, or links between them that propel a phenomena into existence and, once in existence, to sustain or re-create itself” (p. 16). Ritzer (1992) identified three points critical to any study using

symbolic interactionism: 1) a focus on the interaction between the individual and the world; (2) a view of the individual and the world as dynamic processes; and (3) the importance of the individual's ability to interpret the social world.

When using a grounded theory approach, data collection consists primarily of in-depth interviews with a relatively small number of informed participants. In the beginning of a grounded theory study, purposeful sampling is the norm (Creswell, 1998), with researchers seeking out participants who have the most experience in the topic of interest. As the study progresses, investigators employ theoretical sampling. Theoretical sampling is defined by Glaser and Strauss (1967) as "the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop the theory as it emerges" (p. 45). In their guidelines for conducting grounded theory research, Glaser and Strauss stressed that participants selection should be guided by the desire to find informants with a wide variety of experiences. Lincoln and Guba (1985) made similar arguments noting that maximum variation sampling is typically the sampling mode of choice in grounded theory research. Meta-synthesis appears particularly suited for generating grounded theories since by definition it includes data from multiple, diverse samples.

A prime directive for qualitative researchers, no matter what their method or research purpose, is to preserve the integrity of each sampling unit or case (Sandelowski, 1996). In qualitative meta-synthesis, this involves preserving the integrity of and the richness of findings in each individual study (Sandelowski, 1996). Kearney (1998) noted that with meta-synthesis, the grounded theorist must remain faithful to the sample's experiences while reaching for a core structure with which to describe a wider range of variation than captured by each study alone.

Further, Kearney stated that the challenge of creating a formal theory based on a synthesis of qualitative reports is “to develop a meaningful and rich theory that represents the varieties of experience without being cumbersome in complexity or overly general in its simplicity” (p. 185)

Methods

Defining the Boundaries of the Study

The broad substantive area encompassed qualitative studies focused on the experiences of childhood sexual abuse survivors in healthcare situations. The initial data set for this study was all qualitative studies published and/or conducted through 2008 in which some aspect of childhood sexual abuse survivors’ experience in the healthcare setting was the primary subject matter. Only studies available in English were included. To avoid missing potentially valuable data, the synthesis included findings from all empirical research conducted in the target area using largely qualitative techniques for sampling, data collection, data analysis, and interpretation, regardless of their epistemological origins (e.g., phenomenology, grounded theory, etc.). This course appeared prudent as the 15 studies located used a variety of analytic approaches with no more than three using the same approach. Restriction to any one analytic approach would have meant discarding the majority of the studies available on childhood sexual abuse survivors’ experiences in healthcare.

The question as to whether it is preferable to limit a meta-synthesis to studies using a single method remains under debate (see e.g., Sandelowski et al., 1997; Schreiber et al., 1997). Some scholars have argued for only synthesizing studies using the same methodology. For instance, Noblit and Hare (1988) proposed the use of meta-synthesis in the context of ethnographic research, and their contention was that it could only be applied to papers embracing the same method. Noblit and Hare’s method requires translating metaphors, ideas and concepts

from one study into those of another. They contended that mixing phenomenology and grounded theory with ethnography would make this type of translation impossible. Despite Noblit and Hare's concerns, many investigators have synthesized findings from studies using multiple methodologies and found the results to be useful (e.g., Jensen & Allen, 1994; Nelson, 2003; Paterson, Thorne & Dewis, 1998; Sandelowski & Barroso, 2003).² In her meta-synthesis of studies examining the transition to motherhood, Nelson reported that including studies with diverse methodologies in her study "allowed for the emergence of a broader interpretive understanding of maternal transition than would have been possible if studies using only one method had been included" (p. 467). Zimmer (2006) suggested that during synthesis studies using different qualitative methods may provide a multivocal interpretation of a phenomenon, just as the voices of different participants might be in a single qualitative study. In their meta-synthesis of experiences of women with HIV/AIDS, Sandelowski and Barroso subgrouped studies according to methodology but, in the end, found it more relevant to group studies by the aspects of women's experiences of HIV/AIDS rather than grouping studies by method. Sandelowski et al. (1997) proposed an approach which allows for combining studies from different methodologies through explicit recognition of them prior to and during the analytic stage. In accordance with Sandelowski et al.'s recommendations, rather than restricting the meta-synthesis to a single methodology, studies were evaluated for inclusion on the basis of their focus

² Although Noblit and Hare's (1988) framework was initially intended for synthesizing ethnographies, it has been successfully applied to a variety of other qualitative methods. For instance, Noblit and Hare's approach was used by Nelson (2003) to synthesize nine qualitative studies of mothering; four used grounded theory methodology and five used either phenomenologic or phenomenologic/hermeneutic methods. Similarly, Paterson (2001) and Meadows-Oliver (2003) used Noblit and Hare's method to synthesize studies representing a wide variety of interpretive research methods. Paterson (2001) synthesized 292 studies on chronic illness, while Meadows-Oliver (2003) synthesized 18 qualitative studies on homeless women.

and the methodologic comparability of their findings, along with their ability to provide valuable information.

The issue of whether the data set for meta-synthesis should be limited to those that exhibit trustworthiness also remains under debate. Established quantitative concepts such as validity, reliability, objectivity and generalization are not applicable to qualitative research as the naturalistic form of inquiry is not based on a positivist paradigm (Sandelowski & Barroso, 2003). Lincoln and Guba (1985) offered trustworthiness as an alternative. They refined their concept of trustworthiness by introducing four criteria: (1) credibility, which corresponds roughly with the positivist concept of internal validity; (2) dependability, which relates more to reliability; (3) transferability, which is a form of external validity; and (4) confirmability, which is comparable with objectivity or neutrality. However, the use of these types of criteria is not universally accepted (Sandelowski & Barroso, 2002; 2003) and a number of synthesists found that rigid application of standards and quality criteria to be too restrictive (e.g., Nelson, 2003; Paterson, Thorne & Dewis, 1998; Sandelowski et al. 1997). Moreover, some researchers have found little agreement across investigators in how quality criteria are applied. In their review of qualitative studies focusing on women with HIV/AIDS, Sandelowski and Barroso (2002) reported little agreement among their expert panel on which studies should be excluded because of poor quality. Quality judgments were complicated by their finding that “absence of something in a report does not mean the absence of that thing in the study itself” (p. 13), and “the presence of something in a report does not necessarily mean it was present in the study itself” (p. 14). Sandelowski and Barroso noted that existing guides for evaluating qualitative studies tend to confuse the research report with the data it represents. Further, they noted the “futility” of their efforts to create a quantitatively reliable tool to appraise qualitative studies. In the end they

concluded that the search for a generic framework for assessing the quality of qualitative research should be abandoned in favor of individual judgments of each study's merits. According to Sandelowski and Barroso,

The appraisal of qualitative studies requires discerning readers who know and take account of what their reading preferences are and who are able to distinguish between non-significant representational errors and procedural or interpretive mistakes fatal enough to discount findings. The appraisal of qualitative studies also requires discerning readers able to distinguish between a report that says all of the right things, but which contains no evidence that these things actually took place. (p. 15)

In addition, as Rolfe (2006) noted, because there is no unified qualitative research paradigm, it makes little sense to attempt to establish a set of generic criteria for making quality judgments about qualitative research studies. Rolfe advocated that "the search for a generic framework for assessing the quality of qualitative research should be abandoned in favor of individual judgments of individual studies" (p. 309). In the end, Rolfe along with Sandelowski and Barroso (2002) have argued that the quality of a research study is not only revealed in the writing-up of that research, but also resides in the research report, and is therefore, "subject to the wise judgment and keen insight of the reader" (Rolfe, p. 309).

Thus, while the studies in the data set were appraised for their "trustworthiness" using criteria outlined by Lincoln and Guba (1985) to assess for credibility, dependability, confirmability, and transferability (see Table 5), studies were not excluded based solely on quality assessments. Instead, each study was judged on its individual merits. All studies judged to provide valuable information about childhood sexual abuse survivors' experiences in healthcare were included provided that they met the inclusion criteria and the informational content was found to be scientifically credible based on a review of the study's methods and findings.

Table 5. Criteria for Judging the Quality of Individual Studies

Four Aspects of Trustworthiness With Example Strategies:	Yes	No
1. CREDIBILITY Can you believe the results?		
• Prolonged engagement		
• Quotes support interpretations		
• Field journal		
• Subjects judge results as credible		
• Triangulation—multiple data sources		
• Establish competence of researcher		
2. DEPENDABILITY Would the results be similar if the study was repeated?		
• Detailed description of methods		
• Two or more researchers independently judge the data		
• Triangulation—multiple data sources, methods, or investigators		
• Peer examination/external audit		
3. CONFIRMABILITY Was there an attempt to enhance objectivity by reducing research bias?		
• Evidence of reflexivity		
• Triangulation of investigators		
• External audit		
• Field journal		
4. TRANSFERABILITY Can the results be transferred to other situations?		
• Detailed description of sample and context		
• Compare sample to larger group		
• Representative sample		

Adapted from Lincoln and Guba (1985) and Henderson and Rheault (2004).

Retrieving Literature

Studies were located using a number of different techniques for information retrieval, including the use of online computer databases, supplemented with the “ancestry approach”, which involves consulting reference lists (White, 1994), and the “descendency approach”, which examines who has cited key articles (Cooper, 1982). The following computer library databases were searched for publications: Applied Social Sciences Index and Abstracts (ASSIA), ESRC Qualitative Data Archival Resource Centre (QUALIDATA); ProQuest: Dissertations and Theses, ProQuest: Nursing and Allied Health Source, Medline, and PsychInfo. The search was accomplished using keywords such as *child abuse, sexual abuse, childhood sexual abuse, health care, retraumatization, qualitative research, naturalistic research, grounded theory, phenomenology, ethnography, and interview*. The employment of all of these approaches helped ensure that all relevant studies were retrieved. In addition, a number of authors of the original studies were contacted and asked if they were aware of any studies not found through computer and hand searching.

Detailing the Studies

As each study was retrieved, it was analyzed for its structure, informational content, and methodological orientation. Data were collected from each study report, organized systematically, and coded. For example, the following were examined and documented: description of the sample; the research question; the core categories and subordinate concepts and categories; and evidence of rigor (see Appendix A for an example). If the study used a grounded theory approach, social-psychological processes were also identified. Just as researchers write field notes or a summary sheet after conducting an interview or observation, a

personal reaction note was made about the context, quality, and usefulness of each study (see Appendix B for an example).

Overview of the Dataset

The Samples

The sample for this meta-synthesis consisted of 20 papers published between 1992 and 2008 representing the results of 15 independent qualitative studies. Fifteen of the papers were published in health related journals. Four unpublished doctoral dissertations were included in the meta-synthesis; three from the discipline of nursing and one from the discipline of psychology. The 15 studies looked at experiences in a wide variety of healthcare settings. The majority of studies ($n = 7$) focused on experiences on women's experiences during reproductive health and childbearing. Three studies asked about experiences in any healthcare setting, while each of remaining studies focused on experiences in different settings including physical therapy, cancer treatment, the emergency room, dental offices, and primary care.

The mean sample size for the studies was 30 participants with sample sizes ranging from 5 to 95 participants. Twelve samples only included female participants, while 4 included both male and females. The combined studies represented interviews with 411 different sexual abuse survivors (113 males and 298 females). The age of study participants across studies ranged from 18 to 81 years. The men and women studied came from a variety of backgrounds and countries. Although most samples were drawn from the United States, samples were also drawn from Canada and Australia. Although most participants were white and drawn from urban areas; most samples also included some minorities. One study restricted its sample to homeless women (Van Loon et al., 2004). Participants were mainly recruited through primary care providers, therapists, and support groups. Study demographics are displayed in Table 6.

Table 6. Demographic Characteristics of Participants in Studies Included in this Meta-synthesis

Study	Sample Size	Gender	Age Range	Location & Ethnicity
Alpern (1992)	5	F	20-44 ¹	Northeast, US Not specified
Gallo-Silver & Weiner (2006)	18	F=12 M=6	19-81	Northeast, US 11 Caucasian 3 African-Americans 3 Hispanic 1 Asian
Kondora (1994)	5	F	26-48	Midwest, US Caucasian
Lasiuk (2007)	7	F	23-60	Canada 4 Caucasian 3 Aboriginals
Lee (2001)	7	F	26-38	Northeast, US Caucasian
Melia-Gordon (2003)	67	F	18-63	US Caucasian Asian Middle Eastern African East Indian Aboriginal
Palmer (2005)	46	F	19-56	Canada 33 Caucasian 11 Aboriginals 2 East Indians
Parratt (1994)	6	F	27-43	Australia Not specified
Rhodes & Hutchinson (1994)	7	F	Not specified	Southeast, US Not specified
Roberts et al., 1999	18	F	26-44	Northeast, US Predominantly Caucasian
Schachter et al., 1999; 2004; Stalker et al., 1999; Teram et al., 1999	27	F	19-62	Canada 26 Caucasians 1 Aboriginal
Schachter et al., 2008 ²	76	F=27 M=49	24-62	Canada
Seng et al., 2002; 2004	15	F	Teens-30s ¹	US 13 Caucasian 1 African-American 1 Hispanic
Stalker et al., 2005	77	F=19	24-62	Canada

		M=58		68 Caucasians 9 Aboriginals
Teram et al., 2006	95	F=46 M=49	Not specified	Canada Not specified
Van Loon et al., 2004	11	F	Not specified	Australia Not specified

Note. ¹ Exact ages not provided; ² Reanalyzed data from samples studied by Schachter et al., 1999; Stalker et al., 2005; and Teram et al., 2006; Complete citations are in the reference list

Sexual Abuse Status of Participants

Of the 15 unique samples, eight investigators reported data on participants' abuse history (Alpern, 1992; Gallo-Silver & Weiner, 2006; Lee, 2001; Melia-Gordon, 2003; Palmer, 2004; Parratt, 1994; Roberts et al. 1999; Seng et al., 2004). The remaining studies did not provide any data other than the fact that their participants had experienced childhood sexual abuse or incest. Most participants of the various studies reported that their perpetrator was male. However, a few men and women indicated that they had been sexually abused by a female. The majority of those asked about characteristics of their abuse reported having experienced forms of childhood sexual abuse associated with increased abuse severity. According to the literature, traumatic effects from sexual abuse are most highly correlated with abuse that includes one or more of the following characteristics: early onset, a greater number of perpetrators, the use of force or aggression, extended and frequent abuse, abuse by a biological parent, and abuse that includes penetration (Barker-Collo & Read, 2003; Beitchman et al., 1992; Finkelhor, 1994; Mennen & Meadow, 1995; Nash, Zivney, & Hulsey, 1993; Toth & Cicchetti, 2004). Traumatic effects are also predicted by the presence of other concomitant forms of child maltreatment such as physical or emotional abuse or neglect, and/or subsequent revictimization during adulthood (Finkelhor, 1994; Follette, Polusny, Bechtle, & Naugle, 1996). Consequently, these characteristics are considered indicators of increased abuse severity.

Many of these indicators of severity were reported by participants in the eight studies that reported data on abuse history. Most of the women interviewed by Parratt (1994) reported abuse by a close family member. Three reported abuse by their father and three by an older brother. Four had been abused by more than one perpetrator, and most participants indicated that the abuse began in early childhood and had continued over a number of years. Palmer (2004) interviewed 46 abuse survivors. All reported having experienced chronic abuse and many reported having been abused by more than one perpetrator. Most perpetrators were male family members or close family acquaintances. Other abusers were individuals in positions of trust such as day care workers, clergy, or neighbors. The average age of onset of abuse was six years, and the average length of abuse was seven years. All seven women interviewed by Lee (2001) had been abused by family members and the abuse lasted a number of years. Of the 18 survivors interviewed by Roberts et al. (1999), all reported multiple abuse episodes over time; two had more than one perpetrator. Most were abused by male relatives and approximately half were first abused when they were younger than 5 years of age. Eleven of the women noted violence as an element of the abuse.

Four of the five women interviewed by Alpern (1992) reported chronic abuse that lasted over a number of years. One reported that in addition to the sexual abuse, she had been physically abused. All 18 participants interviewed by Gallo-Silver and Weiner (2006) reported chronic, penetrative sexual abuse by family members prior to puberty. Fifteen reported being sexually abused by more than one perpetrator. Seng et al. (2004) did not report details of the abuse of study participants; however, she noted that in addition to childhood sexual abuse, three of the 15 women she interviewed had experienced adult sexual assault, and seven reported experiencing violence by an intimate partner.

As part of a larger quantitative study, Melia-Gordon (2003) reported the results of a thematic analysis of treatment avoidance in 89 women; the majority of whom were abuse survivors. Data on types of abuse experienced were reported for the total sample. Of the 153 participants in the study, 102 women (66.7%) reported childhood familial emotional, physical and/or sexual abuse. Twenty-six percent of the total sample reported penetrative sexual abuse perpetrated, on average, 53 times, usually starting at age seven. Forty-one percent of the total sample reported experiencing severe childhood physical abuse (i.e., having been hit with enough force to cause bruising, bleeding or broken bones) on average of 37 times.

Overall, these results suggest that the participants recruited for the studies included in the current meta-synthesis tended to experience severe forms of childhood sexual abuse. This is likely due to self-selection bias in which only those most severely abused volunteered to be interviewed.

Data Synthesis

Data synthesis largely followed the classic method of Noblit and Hare (1988) using an analytical framework based on the grounded theory approach developed by Strauss and Corbin (1998). Noblit and Hare's (1988) method involves four main steps. The steps were performed as outlined by Noblit and Hare with modifications as noted.

Step 1: Comparative Analysis

The first step involved determining how the studies were related, or dissonant, through a compare and contrast exercise. As recommended by Noblit and Hare (1988), studies were first placed in a descriptive table that summarized the methodological and theoretical basis of each study. The tables were constructed based on guidelines developed by Sandelowski and Barroso (2007) for synthesizing qualitative research. Original authors' understandings of key metaphors,

phrases, ideas, concepts, and relations in each study were identified, preserving as much as possible the meaning from the original text. As far as theoretical orientation, three studies were phenomenologic inquiries, five took a grounded theory approach, one was an ethnography, two were based on participatory action research, one was based on PTSD taxonomy, and one was a general qualitative inquiry. The remaining seven studies were each qualitative inquiries that did not identify a specific philosophical orientation and are perhaps best described as general descriptive designs. Table 7 summarizes studies, the authors' affiliations and their methods, including methodological orientation, strategy for data analysis and sampling plan. Codes, themes and categories from the various studies were compared and contrasted for similarities and relationships among the data (see Table 8). The construction of tables allowed key concepts to be juxtaposed in order to identify homogeneity of categories/codes/themes and to expose any discordance and dissonance (Noblit & Hare, 1988).

Table 7. Cross-Study Display for Comparative Appraisal: Methods

Authors	Profession	Analytic Approach	Data Analysis	Sampling Plan	Sample
Alpern (1992)	Nursing	General qualitative	Constant comparative method	Recruited through counseling and support groups	N = 5 female survivors
Gallo-Silver & Weiner (2006)	Social work	None specified	Not specified	Adult cancer patients referred due to disruptions in treatment	N = 18 female survivors
Kondora (1994)	Nursing	Phenomenology	Hermeneutic analysis	Recruited with advertisements	N = 5 female survivors
Lasiuk (2007)	Nursing	Phenomenology	Not specified	Recruited through advertisements	N = 7 females survivors and recently birth
Lee (2001)	Psychology	None specified	Not specified	Recruited through counseling, community centers, midwives, and therapists	N=7 female survivors who had recently given birth
Melia-Gordon (2003)	Psychology	Mixed methods	Not specified	Recruited through local community and university	N=89 women (67 survivors, 22 nonabused)
Palmer (2005)	Nursing	Grounded theory	Constant comparative method	Recruited through advertisements	N = 46 survivors and 22 healthcare professionals
Parratt (1994)	Nursing	Phenomenology	Constant comparative method	Recruited from incest support groups	N = 6 women who had experienced both incest and childbirth.
Rhodes & Hutchinson (1994)	Nursing	Ethnography	Developmental Research Sequence	Recruited from a labor and delivery unit	N= 7 incest survivors, 5 nurse-midwives, and 3 labor and delivery nurses

Roberts et al., 1999	Nursing	None specified	Not specified	Recruited through primary care providers, therapists, support groups	N = 18 female survivors Focus group/questionnaire
Schachter et al., 1999	Physical therapy	Grounded theory	Constant comparative	Recruited through counseling and support groups	N = 27, female survivors referred for PT
Schachter et al., 2004	Physical therapy	Grounded theory	Constant comparative	Recruited through counseling and support groups	N = 27, female survivors referred for PT
Schachter et al., 2008 ¹	Multi-disciplinary	Participatory action research	Not specified	Recruited through advertisements	N = 76 survivors; 49 males, 27 females
Seng et al., 2002	Nursing	PTSD framework	Narrative analysis	Recruited through advertisements	N = 15 females
Seng et al., 2004	Nursing	PTSD framework	Content analysis	Recruited through advertisements	N = 15 females
Stalker et al., 2005	Dentistry	None specified	Constant comparative	Recruited through counseling and support groups	N = 68 survivors ; 49 males, 19 females
Stalker et al., 1999	Physical therapy	Grounded theory	Constant comparative	Recruited through counseling and support groups	N = 27 female CSA survivors referred for PT
Teram et al., 2006	Multi-disciplinary	None specified	Constant comparative	Recruited through counseling and support groups	N=46 female survivors, 49 male survivors
Teram et al., 1999	Multi-disciplinary	Grounded theory	Constant comparative	Recruited through counseling and support groups	N = 27, female CSA survivors referred for PT
Van Loon et al., 2004	Nursing	Participatory action research	Combined narratives into a “common story”	Recruited through social worker	N=11 survivors at inner city service for homeless women

Note. . ¹Reanalyzed data from samples previously reported by Schachter et al., 1999; Stalker et al., 2005; and Teram et al., 2006; Shading is to show related samples. Complete citations are in the reference list. PT = physical therapy; CSA = childhood sexual abuse.

Table 8. Cross-Study Display for Comparative Appraisal: Results

Report	Focus and Research Question or Purpose	Type of Findings	Categories and Subordinate Concepts or Themes
Alpern (1992)	Reproductive Health <i>What is the impact of being a survivor of childhood sexual abuse on the experience of reproductive health care?</i>	Thematic-interpretative survey	Category 1: Past history of health care Childhood experiences of health care The first gynecological exam Memory loss Category 2: Survivor issues Vulnerability Trust Triggering Touch Category 3: Healing health care Health maintenance vs. self-neglect dichotomy Survivor needs or all women's concerns? Survivor sensitive health care Disclosure of a history of childhood sexual abuse
Gallo-Silver & Weiner (2006)	Cancer Treatment <i>To describe the impact of CSA on cancer treatment</i>	Narrative summary	Not organized by categories or themes
Kondora (1994)	Healthcare: <i>To explore the experiences of adult women survivors of childhood sexual abuse as told in narrative form by the women themselves.</i>	Thematic survey	The remembering as a coming of what has been The centrality of remembering The healing nature of stories
Lasiuk (2007)	Birth <i>What is the lived experience of pregnancy and birthing of women with histories of childhood sexual abuse?</i>	Thematic-interpretative survey	Living in the wake of childhood sexual abuse Response-ability to motherhood Regeneration

Lee (2001)	<p>Childbearing <i>To explore ways that being a survivor of sexual abuse interacts with the childbearing experience</i></p>	Thematic-interpretative survey	<p>Themes related to childbearing Pregnancy Labor and birth Early parenting and formation of maternal identity Other themes Confrontations, reconciliations and moving beyond sexual abuse in childbearing Intrusions and remembering Shut down Open and dissociation Illness Body perception Bodywork Coping Care providers and hospitals</p>
Melia-Gordon (2003)	<p>Healthcare <i>To investigate women's reasons for healthcare discomfort and avoidance</i></p>	Thematic survey	<p>Retraumagenic dynamics Fear of pain during treatment Self-healing or self-neglect Dislike or mistrust of healthcare providers Financial concerns Extreme discomfort Inconvenience Avoiding bad news Extreme discouragement</p>
Palmer (2005)	<p>Childbearing <i>To explore the experience of childbearing for survivors of childhood sexual abuse through listening to and embracing survivors' life stories.</i></p>	Thematic-interpretative survey	<p>Protecting the Inner Child (over) protecting self (over) protecting their child</p>
Parratt (1994)	<p>Childbirth <i>To discover what experiences, including feelings, women who are survivors of incest have during childbirth</i></p>	Thematic-interpretative survey	<p>Categories Aspects of the childbirth experience which are related to aspects of the abuse. Consequences or reactions to the childbirth experience when it is related to the abusive experience. Includes protective mechanisms used at this time. Needs recognized – mechanisms which would or did allow a positive experience to occur.</p>
Rhodes & Hutchinson (1994)	<p>Labor & Delivery <i>To describe and analyze the labor experiences of childhood sexual abuse survivors</i></p>	Thematic-interpretative survey	<p>Themes Forgetting and remembering Forced remembering: body memories The betraying body Labor styles of sexually abused women: Fighting; Taking control; Surrendering</p>

Roberts et al., 1999	Primary care <i>To explore how a history of childhood sexual abuse affects experiences with primary care</i>	Thematic survey	Themes (regarding avoidance of primary care) Authority/power/control Trust Problems with history taking Problems with physical examinations System problems
Schachter et al., 1999	Physical therapy <i>To explore the reactions of adult female survivors of childhood sexual abuse to physical therapy and to listen to their ideas about how practitioners could be more sensitive to their needs</i>	Thematic-interpretative survey	Safety Establish and maintain a positive rapport with the client Establish a partnership with the client Offer the client a choice of male or female provider Share information Convey understanding and work with the survivor concerning her attitudes about the body and pain Work with the client on difficult physical factors Understand and respond sensitively to “triggers” and dissociation Respond carefully to disclosures of abuse Practice holistic health care
Schachter et al., 2004	Physical therapy <i>To explore how health professionals can practice in ways sensitive to adult women survivors of child sexual abuse</i>	Thematic-interpretative survey	Need for sense of safety Issues around disclosure Desire for sensitive practice Themes related to physicians
Schachter et al., 2008	All forms of Healthcare <i>To develop practice knowledge that will help healthcare practitioners practice in a manner that is sensitive to the needs of adult survivors</i>	Thematic-interpretative survey	Nine Principles of Sensitive Practice Respect Rapport Taking time Sharing information Sharing control Respecting boundaries Mutual learning Understanding nonlinear healing Demonstrating an understanding of sexual abuse

Seng et al., 2002	Maternity care <i>What do pregnant women who have experienced abuse-related PTSD during their maternity care experience want from maternity care providers?</i>	Thematic-interpretative survey	Not organized by categories or themes
Seng et al., 2004	Maternity care <i>To apply an established, pre-existing taxonomy or coding scheme of the PTSD diagnostic criteria to the manifest content of communication</i>	Survey using PTSD framework	Intrusive re-experiencing Avoidance and numbing Arousal Sequelae of childhood sexual abuse Somatization Dissociation Interpersonal sensitivity Substance abuse and disordered eating High-risk behavior, revictimization, and self-harm
Stalker et al., 2005	Dental care <i>To explore how a history of childhood sexual abuse affects the experience of dental treatment</i>	Thematic-interpretative survey	Being asked about a history of abuse Tendency to cancel appointments Discomfort with body positioning Sense of loss of control Fear of judgment and sensitivity to perceived criticism.
Stalker et al., 1999	Physical therapy <i>To explore practices in physical therapy that are sensitive to the needs of survivors.</i>	Thematic-interpretative survey	Safety: The essential experience Combine Psychotherapy and touch therapies. Don't give up: It's a learning process
Teram et al., 1999	Physical therapy <i>To inform physical therapists about the feelings and thoughts of childhood sexual abuse survivors regarding their disclosure of their history of abuse to health professionals.</i>	Narrative interpretative summary	Not organized by categories or themes

Teram et al., 2006	Healthcare <i>To increase understanding of male survivors' experience, particularly as it relates to their encounters with health professionals</i>	Thematic-interpretative survey	Themes (Impediments to the recognition and acknowledgement of men as victims of CSA) Lack of concern regarding sexual abuse of boys by women Homophobia The image of male survivors as potential perpetrators Manhood and the vulnerability of victims Men don't cry Men's difficulty acknowledging and expressing feelings
Van Loon et al., 2004.	Emergency room experiences	Narrative summary	The health encounter Triggers Memories can resurface Need for control Difficulty with touch Need for preparation Disclosure Need to be believed, treated with respect Need for privacy and confidentiality Feelings of embarrassment, humiliation, lack of privacy Feelings of being ridiculed, exposed, abused again
<i>Note.</i> Shading is to show related samples. Complete citations are in the Reference list.			

Step 2: Translation

The second step of Noblit and Hare's (1988) method involves translating studies into one another. This process involves making linkages among categories by examining relationships in the data using the constant comparison technique developed by Strauss and Corbin (1998).

According to Noblit and Hare, three different assumptions can be made about the relationships between the studies being synthesized. These key assumptions are "(1) the accounts are directly comparable as reciprocal translations; (2) the accounts stand in relative opposition to each other and are essentially refutational; or (3) the studies taken together present a line of argument rather than a reciprocal or refutational translation" (p. 27). The "lines-of-argument" synthesis employs a grounded theory approach to identify the categories emerging from the data. The constant

comparison technique is used to identify key categories that are more powerful in representing the entire data-set. These categories are then linked interpretively to create a holistic account of the phenomenon.

The data were found to be directly comparable, and as a result, a reciprocal translation was performed. Reciprocal translation involves the iterative process of translating one study's findings (i.e., metaphors, themes and concepts) into another. Noblit and Hare (1988) consider translations to be "especially unique syntheses, because they protect the particular, respect holism, and enable comparison. An adequate translation is one that maintains the central metaphors and/or concepts of each account in their relation to other key metaphors or concepts in that account" (p. 28). Constant comparison refers to the simultaneous collection and analysis of data. The process involves the researcher constantly going back and forth between the data and participant interviews (e.g., see Marcellus, 2005). This is a circular process that serves to keep the data and the theory closely linked, thus minimizing the risk of bias. For the purpose of meta-synthesis, this process was adapted so that the synthesist was constantly comparing the data being generated with the findings of the individual studies being synthesized.

At the same time, the data were examined for signs of refutation. Noblit and Hare (1988) consider divergent data to be especially meaningful in that it may contribute to another emergent category or understanding which has not been identified in the original accounts. Indeed, the absence of divergent data may arouse suspicion as to the rigor of the reciprocal translation as qualitative inquiry rarely results in complete congruence of meaning. Barbour and Barbour (2003) noted that divergent data may be used to further interrogate the synthesist's tentative explanations, as discrepant findings can provide further information about the possible limitations of emergent explanations.

Step 3: Synthesis of Translation

The third step involved comparing translations to determine if some metaphors or concepts were able to encompass those of other accounts (Noblit & Hare, 1988). With the grounded theory approach, this consisted of fitting together categories using the constant comparative method in order to identify the most important or core category or categories with which other categories are linked. When possible, codes and themes are collapsed into categories, and categories are grouped to formulate superior categories. This process was assisted by writing analytic memos and drawing diagrams to illustrate the developing theory. According to Glaser (1998), memos are the write-up of ideas about substantive codes and their theoretically coded relationships as they emerge during coding, collecting and analyzing data. Analytic memos help the researcher explore ideas about the data, codes, categories, or themes (Charmaz, 1983). Diagrams were used to identify links and inter-relationships among categories, and to attempt to articulate the social processes at work.

Substantive codes that were identified were reflected upon to determine how they may relate to each other as hypotheses, which enables the substantive codes to be integrated into a theory (Glaser, 1978). The ultimate goal of analyzing qualitative data for process is to account for, or explain, change in the social phenomenon being studied over time (Glaser & Strauss, 1967). To reveal the basic social psychological process and basic social processes, the researcher begins by querying of the data (Strauss & Corbin, 1990). The basic social psychological process is a problem shared by participants in the study sample, but may not be articulated by them (Hutchinson, 1986). A basic social process is similar to a core category, except it must have at least two distinct stages or phases to account for process, change, and movement over time (Glaser, 1978). The researcher begins this phase by posing questions such as, “What is this?”,

“What are the components of this social process?” A basic social process is usually labeled with an action word that summarizes themes and patterns within the data. For example, Draucker and Stern (2000) studied women experiencing sexual violence. They identified a basic social process they termed “forging ahead in a dangerous world”, which referred to the process by which these women struggled to get on with their lives in a social world they know to be unsafe.

The emergent theory was then compared with the extant literature and examine what is similar, what is different, and why. Tying the emergent theory to existing literature has been cited as a means of enhancing the internal validity, generalizability, and theoretical level of the theory building when using qualitative methods (Eisenhardt, 1989).

Step 4: Expressing the Synthesis

The last step entails communicating the final product. According to Noblit and Hare (1988) the synthesis should be communicated in a form that is relevant and appropriate to the intended audience. Because the ultimate objective of the current project is to create knowledge that can be used in nursing practice, the resultant report and model will be expressed in language and visual style appropriate for publication in health-related research journals.

Addressing Validity and Rigor

In qualitative methodology, validity and rigor refer to whether the conclusions being drawn from the data are credible, warranted, and able to withstand alternative explanations. In order to be counted as evidence, researchers must assure that the processes of research especially around data collection, analysis, and interpretation, are rigorous enough for the results to be worthy of consideration by clinicians and other researchers. Jensen and Allen (1996) suggested that the criteria of credibility, auditability, fittingness, and confirmability should be used to judge a meta-synthesis. Sandelowski and Barroso (2007) offered four criteria for judging the rigor of

qualitative research integrations. They suggested that qualitative integrations should show evidence of descriptive, interpretive, theoretical, and pragmatic validity. These criteria include the following:

Descriptive validity refers to the factual accuracy of the data. It is promoted by identification of all relevant research reports and the accurate identification and characterization of information from each report included in the study. *Interpretative validity* is similar to the member checking, but rather than ensuring that participants' view points were accurately portrayed, it refers to the full and fair representation of the points of view expressed by the researchers who conducted and authored the individual reports included in the study. *Theoretical validity* refers to the credibility of the synthesist's interpretation of the data. In other words, it refers to the credibility of the methods that the synthesist developed to produce the research integration and the credibility of the synthesist's interpretation of the original researchers' findings. *Pragmatic validity* refers to the utility and transferability of the knowledge generated. Similar to what some call fittingness, it refers to the applicability, timeliness, and translatability for practice of the synthesis produced. The main mechanisms that promote these various forms of validity include: maintenance of an audit trail, ongoing negotiation of consensual validity among researchers, and having integrated findings evaluated by research and clinical experts in the target area of study. Accordingly, each of these was addressed during the data analysis.

To ensure *descriptive validity*, the researcher used multiple search strategies to uncover all qualitative studies focusing on the experiences of sexual abuse survivors' experiences in the healthcare system. In addition, an audit trail was maintained so that the reader would be able to track and verify the research process. The audit trail contains documentation of the data collection process and explicates decisions made during the research process. The audit trail included both

“methodological” and “analytic documentation” (Rodgers & Cowles, 1993, pp. 221-222). With the grounded theory method memos are written records of analysis related to the formulation of theory and represent the researcher’s thinking (Strauss & Corbin, 1990). Methodological documentation refers to the design decisions made throughout the life of the project. These decisions included what sources of data will be sampled and what studies were excluded and why. Analytic documentation refers to memos explaining decisions made in coding, categorizing, and comparing data (see Appendix C for an example).

Interpretative validity refers to the full and fair representation of actors’ understanding or points of view and is usually accomplished through the use of “member checks” (e.g., Bloor, 1983). Interpretative validity was addressed by detailing each study and extracting the findings in a systematic manner as detailed in the previous section. In addition, emergent concepts were validated against the original authors’ analyses. Finally, expert member checks were employed to determine whether the meta-synthesis and derived model was consistent with study investigators original findings. Because a meta-synthesis is a study of texts, the actors are the researchers who conducted and authored the reports of the studies included in the meta-synthesis (Sandelowski & Barroso, 2007). Sandelowski and Barroso recommended returning to the original researchers and asking them if the integrity of their original research is intact following meta-synthesis. Similar recommendations were made by Thorne et al. (2002). In accordance with these recommendations, after receiving exempt status from the University of Kansas Internal Review Board (see Appendix D), six of the lead investigators of studies included in the dataset were contacted. Five investigators responded and provided feedback. No response was received from the sixth investigator. Each investigator was given a set of six questions (see Appendix F) and

asked to critique the model derived from their work. Answers were provided either via phone interview or in written form, based on the individual preference of the investigator.

Theoretic validity was addressed through the use of a reflexive journal in which the researcher addressed the potential for her own background to adversely influence the inductive process. Robson (2002) defined reflexivity as "...an awareness of the ways in which the researcher as an individual with a particular social identity and background has an impact on the research process" (p. 22). Because background knowledge and experience can affect how one interacts with the data, it is important for the researcher to openly acknowledge the influence of prior work or experience on their perspective (Charmaz, 2000). In the reflexive journal, the researcher acknowledged her prior knowledge, attempted to bring such knowledge into the open so that it can be bracketed, and discussed how it has affected theory development (see Appendix G, for an example).

The *pragmatic validity* of the analysis was tested in a variety of ways. As noted previously, pragmatic validity is similar to the concept of fittingness. According to Glaser and Strauss (1967), to be credible, a grounded theory should "fit" the area of study and work for a variety of situations by explaining, interpreting, and predicting the phenomenon of interest. To ensure pragmatic validity the synthesis was tested by comparing emergent concepts against the theoretical, qualitative and quantitative literature on abuse survivors. A second means by which pragmatic validity was tested is through expert peer debriefing. After determining that the study was exempt by the University of Kansas Internal Review Board, three clinicians experienced in working with abuse survivors who have experienced retraumatization in healthcare were contacted and asked to review the final meta-synthesis products for their utility and applicability to their work. More specifically, the clinicians were asked six questions asking them to review

the grounded theory and comment on the completeness of the theory and whether they feel that any important areas are missing (see Appendix H). Clinicians were interviewed either in person or over the phone.

CHAPTER 4 - RESULTS

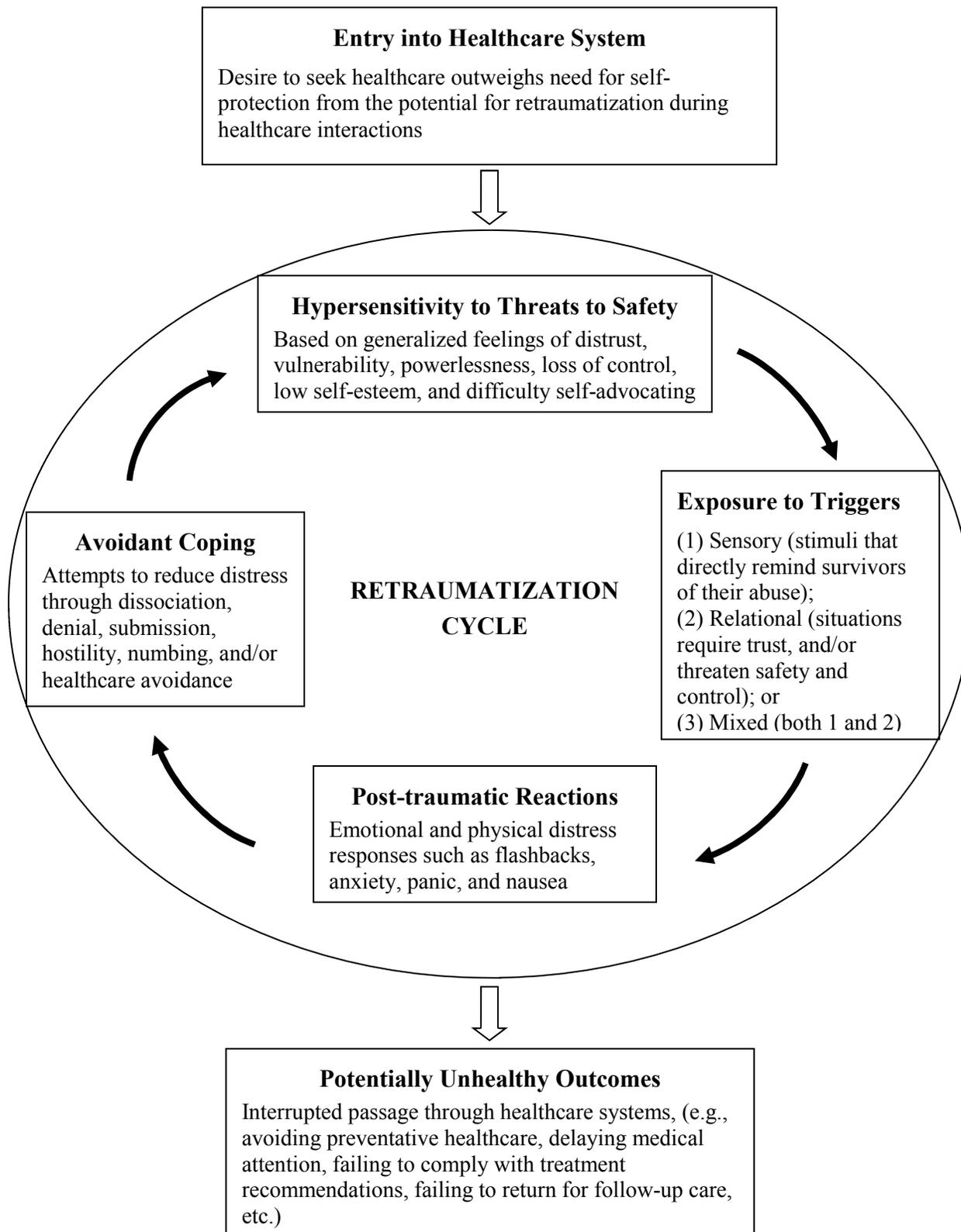
The goal of the current qualitative study was to develop a model that will aid in understanding and anticipating the difficulties childhood sexual abuse survivors are likely to face when accessing healthcare. Using a grounded theory approach, meta-synthesis was used to combine data from 15 qualitative studies which explored childhood sexual abuse survivors' experiences in healthcare. The combined studies represented interviews with 411 sexual abuse survivors (113 males and 298 females) sampled from a variety of healthcare settings in the United States, Canada, and Australia.

In conducting this meta-synthesis, detailed tables of metaphors, themes, concepts and phrases from each study were constructed. Study themes and concepts then were reciprocally translated using the technique developed by Noblit and Hare (1988). Reciprocal translation involves the iterative process of translating one study's findings (i.e., metaphors, themes and concepts) into another. The analysis revealed a four-step cyclical process inherent in the experience of retraumatization. The resultant Healthcare Retraumatization Model was verified by returning to the studies to determine that all data fit within the Model framework. This verification process yielded an impressive fit between themes and a parsimonious description of extracted data across samples and healthcare settings. A second form of verification was provided through expert member checks. The Model was reviewed by eight experts, including lead investigators of five of the studies included in the meta-synthesis and three clinicians working with abuse survivors, and the Model was revised based on their recommendations. The final Model is depicted in Figure 1.

First, a short summary of the Healthcare Retraumatization Model is presented and explained. No bibliographical references will be cited within the Model overview. The overview

of the Model is followed with a detailed referenced presentation of the meta-synthesis results and expert feedback from which the Model is derived.

Figure 1. Model of the Healthcare Retraumatization Process



Overview of the Healthcare Retraumatization Model

Healthcare Retraumatization is a process in which evocative events in healthcare replicate stimuli or dynamics associated with childhood trauma, causing childhood sexual abuse survivors to be overwhelmed by post-traumatic stress symptoms related to their the original trauma. Numerous types of healthcare situations can result in survivors feeling retraumatized. While retraumatization is not inevitable, it appears to be a relatively common experience for survivors during healthcare interactions.

Although the Healthcare Retraumatization Model speaks of survivors collectively, it should be emphasized that survivors are not a homogenous group as each survivor has a unique history and point of view. Despite this, when retraumatization occurs, the processes involved are remarkably similar. Retraumatization can be conceptualized as a cyclical process consisting of four interrelated subprocesses: (1) hypersensitivity to threats to safety, (2) exposure to triggers (i.e., situations in healthcare setting which were perceived as threatening), (3) post-traumatic stress reactions, and (4) avoidant coping. Entry into healthcare is the beginning point in the healthcare retraumatization cycle. Survivors enter healthcare when their desire to improve or maintain their health or address a problem outweighs their need to protect themselves from the potential for retraumatization during healthcare interactions. The endpoint for the cycle is the potential for unhealthy outcomes when passage through the healthcare system is interrupted due to retraumatization.

The Healthcare Retraumatization Model proposes that when entering healthcare, the main determinant of retraumatization is survivors' *hypersensitivity to threats to safety*. This hypersensitivity is an underlying condition emanating from chronic childhood sexual abuse that can cause childhood sexual abuse survivors to view routine interactions and situations in

healthcare as threats to their personal safety. Hypersensitivity to threat has its foundation in trauma's corrosive effects on victims' core beliefs and assumptions about the world. Child abuse victims, especially those who were abused by parents or other primary caregivers, may have internalized a view of all persons as potential abusers. Even those who have gone on to develop successful relationships and careers may continue to view the world as a dangerous place where people in positions of authority and caretaking roles cannot be trusted. At the same time, chronic sexual abuse can result in deep-seated feelings of powerlessness and low self-esteem. Survivors also may experience a sense of betrayal by their bodies and view themselves as helpless to defend against further abuse. Survivors' distrust of both themselves and others can result in a state of hypersensitivity to situational cues that suggest that their safety is at risk. For example, sexual abuse survivors tend to be extremely sensitive to issues surrounding power and control, and consequently may be hypervigilant in situations in which another person has power over them. Safety may be of particular concern when accessing healthcare, as survivors often fear being revictimized by healthcare providers.

When survivors enter healthcare, they are exposed to numerous triggers. *Triggers* are defined as any event or situation in healthcare that evokes a sense of threat and results in post-traumatic stress reactions, whether or not the survivor is consciously aware of the connection to their past trauma. Because triggering is based predominantly on survivors' perception of threat, almost any aspect of healthcare can be a trigger. This proposed conceptualization of triggers recognizes that an interaction of internal and external factors is required for triggering to occur. Internal factors are related to survivors' hypersensitivity to situational and interpersonal cues that are interpreted as threatening. External factors are the events and situations in healthcare that survivors view as threatening. Because hypersensitivity to threats to safety is a necessary

antecedent, it can be considered a *precipitating factor* in regards to triggering. Events and situations in the treatment environment that are perceived as threatening are *initiating factors*. Thus the healthcare system (i.e., healthcare setting, providers, staff, etc.) plays an important role in initiating the triggering process.

Triggers are conceptualized as falling into one of three broad categories depending on the type of healthcare event or situation that initiates the triggering process: sensory stimuli, relational dynamics, or a mixture of both. *Sensory triggers* cause distress because they closely resemble stimuli present at the time of the abuse. These evocative stimuli are usually in the form of body sensations or sights, sounds, and smells in the treatment environment. Because of the individualized nature of the environmental contexts in which children are abused, these stimuli are usually specific to the environmental cues survivors were exposed to when they were abused. Thus sensory stimuli tend to be unique to the individual survivor's experience and other survivors may not find similar stimuli distressing.

Relational triggers, on the other hand, are situations that caused distress, not because they necessarily resemble the abuse, but because they replicate common power dynamics between victims and perpetrators. Relational triggers gain their potency from survivors' hypersensitivity to threat and thus tend to generalize across survivors. Generalized triggers can be further delineated based on frequently recurring themes. Commonly described relational triggers include: power imbalance/authority figures, disinterested or insensitive providers, lack of control, uncertainty/surprise, submissive positioning, exposure/lack of privacy, and touch.

Mixed triggers are situations containing a combination of both sensory and relational triggers. Invasive procedures such as pelvic examinations appear to be the epitome of a triggering situation in healthcare. The Healthcare Retraumatization Model postulates that one

reason that gynecologic and rectal procedures may be so triggering is because these procedures closely replicate stimuli and dynamics associated with sexual abuse and thus are likely to overwhelm survivors with a large number of both sensory and relational triggers.

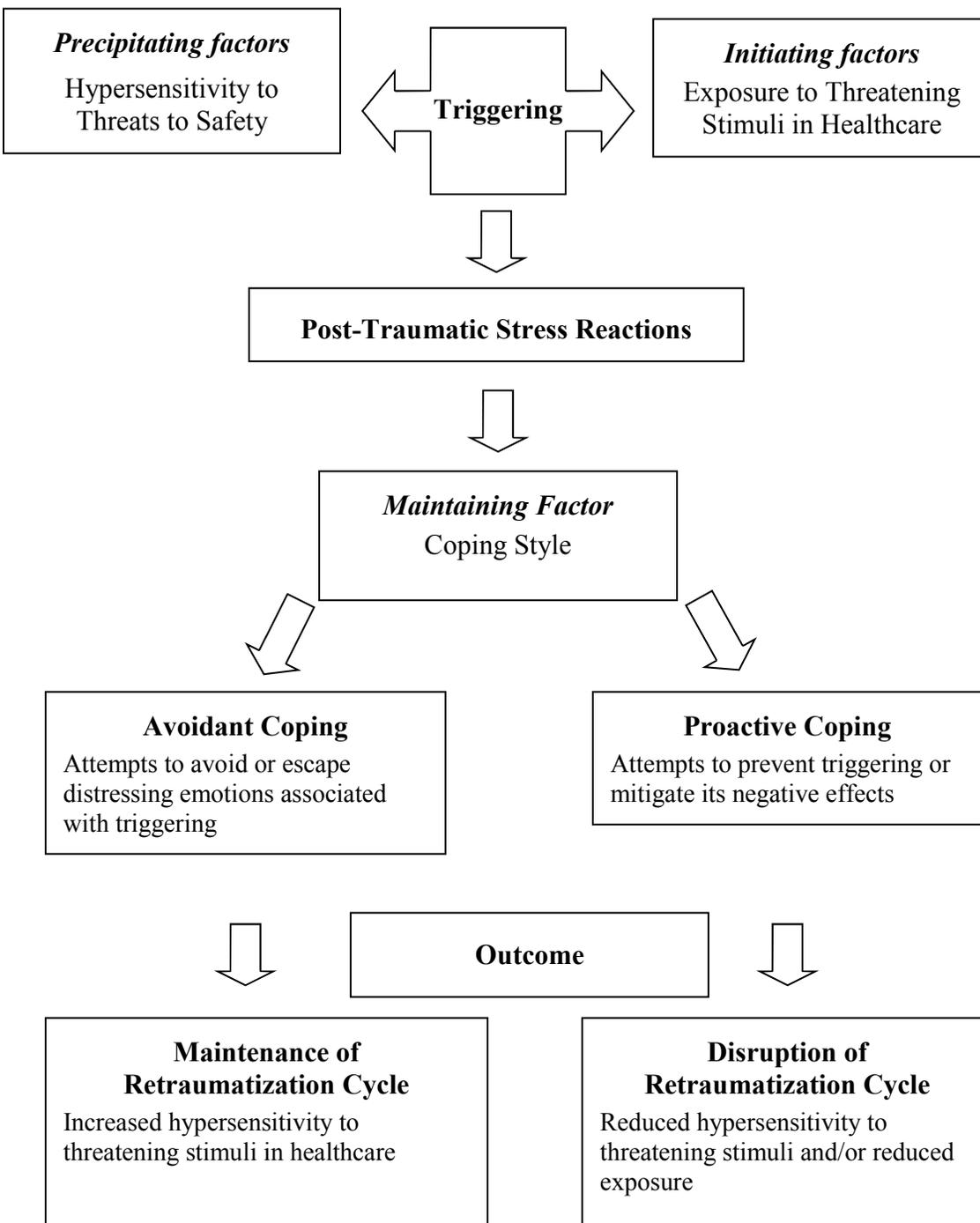
Irrespective to the type of trigger encountered, survivors typically react to being triggered by experiencing emotional and/or physical stress reactions that are similar to those experienced when they were originally abused. Emotional reactions may include anxiety, panic, flashbacks, crying, guilt, shame, anger, grief, fear, sadness, despair, and/or hopelessness. Triggering can also result in physical reactions such as dizziness, headaches, shaking, nausea, and/or vomiting. Delayed reactions may also occur such as nightmares and insomnia. These reactions often surface without warning compounding survivors' perceptions of feeling powerless and unable to self-protect.

Coping strategies employed by survivors influence whether or not the cycle of retraumatization repeats. In the context of retraumatization, coping strategies are understood as strategies employed to help mediate the effects of stress reactions elicited during triggering. The two main coping styles used to deal with triggering are avoidant and proactive coping. *Avoidant coping* is focused on trying to avoid or escape distressing emotions associated with triggering; while proactive coping is aimed at trying to find positive healthcare solutions that minimize or eliminate triggers. Proactive strategies tend to be used by survivors further along in recovery as they require recognition of potential triggers along with the ability to plan ahead and self-advocate. When successfully employed, proactive strategies help survivors exit the retraumatization cycle and form positive relationships with their caregivers.

Feeling powerless to protect themselves, survivors typically respond to triggering by using avoidant coping strategies similar to those employed when they were abused in childhood.

Survivors may use a variety of avoidant coping strategies including: dissociation, denial, submission, hostility, numbing, and healthcare avoidance. Avoidant strategies tend to be reactive in nature and may be employed automatically when survivors began to feel distress. While avoidant coping can help survivors manage post-traumatic stress reactions, any relief gained comes at a cost, as these strategies tend to impair survivors' ability to effectively problem-solve or self-advocate thus reinforcing feelings of powerlessness. Avoidant coping also impedes the development of trusting relationships with healthcare providers and can interfere with survivors' ability to obtain the care necessary to maintain or improve their health. Avoidant coping also impedes the development of trusting relationships with healthcare providers and can interfere with survivors' ability to obtain care necessary to maintain or improve their health. Because these avoidant coping strategies reinforce survivors' hypersensitivity without addressing external threatening stimuli, avoidant coping becomes a *maintaining factor* that allows the retraumatization cycle to continue (see Figure 2).

Figure 2. How Coping Style Influences Persistence of the Retraumatization Cycle



The process of retraumatization can be viewed as a self-reinforcing cycle in which retraumatization begets retraumatization. The experience of retraumatization confirms survivors' view of healthcare as a threatening experience thus increasing their sensitivity to threat-related cues during subsequent healthcare visits. Coping through avoidance, rather than by proactively addressing factors involved in triggering, allows the cycle to continue. As a result, survivors may experience increasingly intense stress reactions in response to a growing number of stimuli in the healthcare setting.

Retraumatization results in *potentially unhealthy outcomes* when survivors' need to self-protect outweighs their desire to improve or protect their health. This need to self-protect can result in survivors failing to participate in preventative healthcare, failing to seek timely treatment for serious illnesses, refusing treatments they find objectionable, failing to adhere to treatment regimens, leaving treatment against medical advice, and/or failing to return for follow-up care.

Meta-synthesis Results

The Healthcare Retraumatization Model is based on the meta-synthesis of 20 papers representing the results of 15 qualitative studies. Retraumatization during healthcare was frequently reported by study participants. All of the childhood sexual abuse survivors studied by both Palmer (2004) and Parratt (1994) reported that their experience of childbirth was negatively affected by their history of abuse. Six of the seven (86%) of the survivors interviewed by Lee (2001) talked about being reminded of sexual abuse during their childbearing experiences. According to Lee, "sexual abuse shaped their experience in such powerful ways that at certain moments, it became defining of the childbearing experience" (p. 87). Roberts et al. (1999) studied female sexual abuse survivors' experiences in primary care. They reported that 14 of the

18 (78%) participants indicated that their abuse had adversely affected their primary care experiences. Melia-Gordon (2003) studied all healthcare experiences of 153 abused and nonabused women recruited through the local community. The majority (75%) of 89 the women who reported treatment avoidance were survivors of some form of trauma. Distress related to retraumatization was the most frequently mentioned reason for treatment avoidance and all of those who reported retraumatization were survivors of childhood abuse.

Retraumatization was found to be a cyclical process involving four subprocesses: (1) hypersensitivity to threat, (2) exposure to triggers (i.e., situations in healthcare setting which were perceived as threatening), (3) stress reactions, and (4) avoidant coping. Each subprocess contributes to the ensuing one and each appears necessary for retraumatization to occur.

Hypersensitivity to Threats to Safety

Participants were very concerned with safety when accessing healthcare and were hypersensitive to situational cues that suggested that their safety was at risk. In these cases survivors appeared to be responding to environmental and interpersonal cues consistent with prior threatening situations. In addition, many participants had low-esteem and found it difficult to trust their own perceptions or self-advocate. This preexisting orientation appeared to have its origins in corrosive effects of childhood sexual abuse on victims' developing sense of self in relation to others and was conceptualized as "hypersensitivity to threat". Participants tended to feel threatened by situations which required trust or which made them feel vulnerable, powerless, and out of control of what was happening to them. Safety was of particular concern when accessing healthcare as participants feared being unable to protect themselves from revictimization by their healthcare providers, and tended to view even routine interactions and situations in healthcare as a threat to their personal safety.

Safety Concerns

Safety was a major theme that appeared repeatedly in the qualitative data. For example, in their study of 27 childhood sexual abuse survivors' experiences in physical therapy, Schachter et al. (1999) identified the *Need for Safety* as a core theme based on their finding that feeling safe was the most crucial element for survivors during physical therapy. In a study of 46 sexual abuse survivors' experiences during childbearing, Palmer (2004) developed a core theme she termed *Protecting the Inner Child* to describe participants' underlying feelings of vulnerability and their need to self-protect in order to survive in the world. Similarly, in her study of five survivors' experiences in reproductive health care, Alpern (1992) concluded that vulnerability was at the root of all survivor issues that emerged from her data.

According to the *Merriam-Webster Online Dictionary* (2008), vulnerability is defined as: “(1) capable of being physically or emotionally wounded; (2) open to attack or damage.” In contrast, safety is defined as “the condition of being safe from undergoing ... hurt, injury, or loss” (*Merriam-Webster Online Dictionary*). Thus, vulnerability is essentially the opposite of safety. An element that contributed to survivors' sense of vulnerability was the fact that they continued to struggle to deal with the abuse that they suffered during childhood and, at times, still felt as if they were that unprotected child. Lasiuk (2007), who studied seven survivors' childbearing experiences, characterized the childhoods of her participants as “living with fear and uncertainty about their survival and safety [with] few resources to do anything about it” (p. 173). These feelings resulted in some participants feeling that they were living dual lives. A participant in Palmer's (2004) study described this process stating, “It was like there was two of me ... the little girl who felt so unsafe in the world, and the woman who had to live in an unsafe world” (p. 121). Another stated, “I very much had two different lives going on and still feel like

that now.... I've always had to keep secrets. I guess it's to protect myself and the part I don't want anyone to know. I have two different lives" (pp. 121-122). Palmer observed, "In essence, participants described a blurring of child and woman, and a struggle for their integration" (p. 122).

Feeling betrayed both their abusers and by those who failed to intervene, participants had difficulty trusting people. Difficulties with trust led her participants to be hypervigilant in their relationships, especially with caregivers. Lasiuk (2007) reported that participants in her study "described living with a heightened awareness ... of the potential danger that other people represent. They remain constantly vigilant, even suspicious that other people may not be what they seem" (p. 194). Similarly, Palmer (2004) observed that all the women in the study "learned from an early age not to trust or believe in the intentions of others. They learned not to be 'vulnerable' to others" (p. 106). Alpern (1992) noted the interrelationship between vulnerability, safety and trust stating, "If vulnerability was not present trust and safety would not be concerns of these survivors" (p. 32).

Male survivors interviewed by Teram et al. (2006) and Schachter et al. (2008) also expressed a feeling of vulnerability which had its roots in childhood. As a whole, men found it difficult to express their vulnerability and tended to compensate by putting up a tough façade. Schachter et al. noted that "Men in our study spoke about their need to appear 'tough' and 'in control' despite feeling anxious and fearful during encounters with health care practitioners (p. 10)." One male survivor stated,

When people see us as adults they don't understand that this trauma didn't happen to us as adults, it happened to us as children and we feel vulnerable I did my share of scrapping and stuff like that. But you know, I was scared a lot of the time. Just scared, afraid to show my vulnerability. (Teram et al., p. 509)

For some survivors distrust of healthcare providers had its roots in childhood when indicators of child sexual abuse were missed or ignored by healthcare professionals. A survivor interviewed by Lasiuk (2007) said that her mistrust of medical professionals started in fifth grade when she disclosed her abuse to a school nurse. The nurse responded by calling her a liar.

...and so when I started being pregnant and started having to talk to doctors and nurses, I had a lot of problems because I didn't trust any of them. They were the ones who originally told me this wasn't happening. I sort of connected all the medical professionals with that one nurse and it has taken me a lot of work to get over that. (p. 145)

Similarly, Alpern (1992) found that having indicators of abuse ignored by healthcare providers during childhood was experienced as painful and contributed to participants' conflict with authority figures in adulthood. Some survivors felt that doctors should have suspected the abuse and should have tried to help them when it was occurring. Conversely, Alpern noted that one of her participants perceived doctors as safe people and hospitals as safe places. The survivor noted, "When I was a kid, going to the doctor was the one place where, if I was sick, I would be taken care of ... I thought hospitals were great" (p. 21). She described how she would try to keep herself safe by getting sick in the hope that she would be put in the hospital. These findings suggest that participants' feelings toward healthcare providers were influenced by prior healthcare encounters.

Feeling vulnerable was closely related to feeling *powerless*, which is defined as "devoid of strength or resources" (*Merriam-Webster Online Dictionary*, 2008). According to Palmer (2004), participants in her study of survivors' experiences with childbearing "reiterated the theme of powerlessness again and again..." (p. 178). Palmer explained that the majority of her participants were abused by more than one offender and the acts were not isolated incidents. Over time, the women learned that they were powerless to change their childhood situations.

Because the abuse was unpredictable and random participants “never felt they had any control. In essence, they never felt safe” (p. 106).

Feelings of powerlessness were closely associated with concerns around not being in control. For instance, Palmer (2004) reported that among the survivors she studied, “issues of power, choice, and control were paramount” (p. 130). The connection between power and control makes sense as one definition of *control* is “to have power over; the power to direct or determine” (*Merriam-Webster Online Dictionary*, 2008). Thus participants tried to compensate for feelings of powerlessness by attempting to control themselves and the environment around them. For example, Lasiuk (2007) reported that an issue that came up repeatedly in her inquiry was “the importance of having a sense of control over one’s self, one’s life, and the environment” (p. 176). One survivor interviewed by Lasiuk stated, “I am the kind of person who likes to be in control and to have everything set” (p. 172). Another described being afraid to leave the safety of her house, “because inside my house I could control the environment, but outside I was really afraid of what would happen...” (p. 174). Lasiuk interpreted survivors’ need for control as their attempt to increase predictability and personal agency.

This interrelationship between themes such as vulnerability, safety, distrust, power, and control flowed through almost every study in the dataset. For example, in her study of childbearing women, Parratt (1994) included feeling vulnerable, lack of trust, and lack of control as aspects of a theme she called *Aspects of the Childbirth Experience Which are Related to Aspects of the Abuse*. Two of the major themes that emerged in Roberts et al.’s (1999) study of 18 female sexual abuse survivors’ experiences with primary care were *Power/Authority/Control* and *Trust*. The two themes were highly interrelated. For example, the theme of *Power/Authority/Control* included participants’ difficulty with someone in authority having

power over them; while the theme of *Trust* included difficulty trusting providers, especially if they are insensitive or authoritarian.

Self-Esteem Issues and Difficulty Self-Advocating

Another issue that contributed to survivors' hypersensitivity to threats to safety was low self-esteem and difficulty self-advocating. Survivors' sense of powerlessness and betrayal had considerable impact on their sense of value and efficacy in the world. Some participants in Palmer's (2004) study described strong feelings of hatred toward their bodies due to their abuse. One survivor described her body as being "poisoned" by the abuse (p. 148). In some cases, participants viewed their body as an enemy. A woman interviewed by Rhodes and Hutchinson declared, "My body is my enemy because it is the one who let it happen ... it was helpless ... and who allies with the helpless [?]...." (p. 216). Lasiuk (2007) found that a number of the abuse survivors she interviewed not only believed that they were bad, but also felt that this badness was constitutional and had always been a part of them. Lasiuk quoted one survivor who stated, "For a long time I thought that I was intrinsically flawed, that I came into this world somehow broken or damaged or something, and that is what drew the abuse to me" (p. 198). Another survivor noted that the abuse left her with a lot of guilt. She stated "I thought, 'Maybe it is my fault', 'If I hadn't done this, then [the abuse] wouldn't have happened'..." (p. 169).

In addition to feelings of shame, badness and guilt related to having been abused, participants frequently described feelings of mistrust toward their bodies and its sensations (Roberts et al., 1999; Rhodes & Hutchinson, 1994; Lee, 2001). For example, Lee developed a theme she called *Body Perception*. Lee noted that after being abused, some of her childbearing participants felt that their body no longer belonged to them. She further noted that some of her participants did not trust their bodies and viewed them as damaged, defective, untrustworthy

and/or bad. Similar findings were reported by other investigators. Rhodes and Hutchinson (1994) developed a theme they called *The Betraying Body*. This theme included data indicating that participants felt estranged from and/or mistrusted their bodies. Similarly, in their study of the primary care experiences of 18 female survivors, Roberts et al. developed a theme called *Trust*. This theme included participants' mistrust of not only caregivers but also of their own feelings and body symptoms. Some of Roberts et al.'s participants distrusted their own ability to describe symptoms, to know if their symptoms are real or flashbacks, and in general, to feel sensation in their bodies. A woman interviewed by Roberts et al., explained, "I don't trust my body." Another stated, "I don't know how my body really feels" (p. 42).

Low self-esteem coupled with feelings of shame, badness and guilt made it difficult for participants to take the steps necessary to help them feel safe during healthcare. For instance, participants often expressed difficulty communicating their fear to providers and when distressed, participants tended to acquiesce, while weakly communicating their disagreement through passive nonverbal signals (Schachter et al., 1999; Stalker et al., 1999). Low self-esteem also impacted survivors' ability to properly care for themselves and their bodies. A survivor interviewed by Schachter et al. commented that taking care of her body was difficult for her "because when you don't live there, it's just sort of a vehicle to get around" (pp. 255-256). A 29-year-old Canadian survivor of childhood abuse noted that she often doesn't go to doctors. Instead, she said, "Sometimes I just learn to live with pain; I have a high tolerance level and can ignore my body easily" (Melia-Gordon, 2003, p. 120).

Some survivors also described feeling unworthy of receiving healthcare. A woman interviewed by Roberts et al. (1999) said that she had a hard time talking to doctors because she feels "inferior" (p. 43). Another woman reported that she did not seek care because "I have

trouble speaking up—feeling I have the right to do so” (p. 43). Similarly, another woman stated, “My body problems are my fault ... I don’t want to bother others with them” (p. 43). A woman interviewed by Seng et al., 2002 stated, “I don’t want to ask anybody [for help] because I was already carrying around enough shame and guilt and embarrassment” (p. 363). Some Canadian abuse survivors did not feel that public resources should be “wasted” on them (Melia-Gordon, 2003, p. 128).

Exposure to Triggers

Defining Triggers

Datasets were analyzed to determine how to best conceptualize and define triggers. Based on meta-synthesis of the available data, *triggers* were defined as any event or situation in healthcare that evokes a sense of threat and results in stress reactions related to a past trauma, whether or not the survivor is consciously aware of the connection. This view of triggering differs from many of the original studies in that it emphasizes stress reactions rather than traumatic recall. Investigators whose studies were included in the dataset often described triggers as flowing from situations which reminded participants of their trauma. For example, Alpern (1992) defined triggers as “an experience that may evoke an emotional feeling or a physical sensation which may remind the survivor of their sexual abuse” (p. 43-44). Defining triggers as trauma reminders, however, was inconsistent with investigators’ findings many of their participants failed to recognize the connection between distressing situations in healthcare and their past abuse.

Across datasets, reactivation of memory occurred on a continuum with varying degrees of conscious recall of abuse-related content during triggering. At the extreme end of the continuum, triggering could result in a full-blown flashback where survivors experienced the

abuse as if it were currently occurring. At the other end of the continuum; however, were survivors who said they experienced distress in healthcare situations before realizing that they had even experienced childhood abuse. In the middle of the continuum were participants who knew they had been abused, but at the time of their healthcare visit, failed to connect their reactions with their abuse. Moreover, many of the “reminders” that provoke triggering are often subtle making it difficult for some survivors to recognize what it was about the situation that triggered them or how this situation relates back to their abuse. For example, despite experiencing numerous triggers during labor and childbirth; the majority of participants in Palmer’s (2004) study did not connect their stress responses to their histories of childhood sexual abuse. As a result, these women felt traumatized without understanding the underlying reasons for their feelings. Not knowing what was causing their reaction, could compound participants’ distress. For example, women interviewed by Alpern (1992) found herself crying when her healthcare provider left the exam room. She found this particularly upsetting because she was unable to identify exactly what had brought on the tears.

Focusing on stress reactions rather than memory helps ensure that the experiences of survivors who are not yet able to articulate the connection between their reactions and their abuse history are recognized. Parratt’s (1994) study is particularly helpful in understanding how survivors with varying degrees of memory recall respond to triggering in healthcare. Parratt studied the birthing experiences of six women all of whom indicated that their experience of childbirth was affected by their history of incest. Three had conscious memory for their abuse when they gave birth and three did not. For the women who always remembered their abuse, childbirth tended to provoke both stress reactions and memories of the childhood abuse. Those without conscious memories of the abuse when they gave birth experienced similar distress in

response to triggers; however, triggering did not provoke conscious abuse-related memories. Thus, rather than traumatic memory, the commonality among participants' descriptions of being triggered was experiencing stress reactions.

Another reason for focusing more on stress reactions rather than traumatic reminders is definitional clarity. A trigger is only recognized as such because of the reaction provoked. In other words, stress reactions are what are actually being "triggered". Moreover, stress reactions are ultimately why survivors find triggering to be so disturbing. Finally, memory is an internal phenomenon that is inherently unobservable. Stress reactions, on the other hand, are both potentially observable and measurable. Focusing on stress reactions thus allows for triggering to be operationalized, which may aid in future testing of interventions developed to decrease triggering.

At the same time, a potentially problematic aspect of the proposed reconceptualization is that it stipulates that stress reactions are related to past abuse even if survivors fail to make the connection at the time. Obviously, until this connection is made, it is not possible to determine that triggers are related to past abuse. Nonetheless, the definition recognizes that the connection between triggers and abuse is frequently only made in hindsight. Many participants of the various studies included in the dataset were not able to piece together what triggered them, or how the trigger related to their abuse, until a later time when they had a chance to more fully process the situation. For example, despite experiencing numerous triggers during labor and childbirth, the majority of the 46 participants in Palmer's (2004) study did not connect their stress responses to their histories of childhood sexual abuse until sometime later. As a result, these women felt traumatized without understanding the underlying reasons for their feelings.

The proposed definition of triggers recognizes that an interaction of factors both internal and external to survivors is required for triggering to occur. Internal factors are related to survivors' hypersensitivity to threat. This hypersensitivity is often associated with feelings of distrust, vulnerability, low-esteem, powerlessness, and loss of control. This hypersensitivity can be considered a *precipitating factor* as what survivors find threatening determines what they will find triggering. External factors are situational and interpersonal cues in healthcare that the individual survivor interprets as threatening. Because triggering does not occur without these external cues being present, they can be considered *initiating factors* for the triggering process.

The recognition of the initiating role of external factors is important as triggering does not happen in a vacuum. The healthcare system play a role in the process and the behavior of healthcare providers and staff can influence whether or not a survivor will become triggered in their care. The healthcare system is a hierarchical structure formed mainly for the convenience of healthcare providers and their staff. Healthcare providers are at the top of the healthcare hierarchy; patients tend to be at the bottom. Healthcare providers can conduct themselves in such a way as to accentuate or mitigate the power differential between provider and patient. As such, the healthcare providers can influence the degree of threat survivors feel when interacting with healthcare providers. For example, one survivor attributed retraumatization to how patients are treated by healthcare providers.

It's critical that they understand that we can be retraumatized as a result of how we are treated by them ... Not that they're meaning to go there, but by not treating us respectfully – giving us what we need to feel safe, and being allowed to be seen as co-partnering and not as having no power at all – [they are making it] possible for us to be retraumatized. (Schachter et al., 2008, p. 23)

While anyone in a patient position can feel vulnerable and less powerful, childhood sexual abuse survivors are different in that they are stressed in reaction to feeling powerless.

Some survivors clearly articulated the relationship between being triggered and feeling vulnerable and powerless. A 23-year-old woman indicated that “pelvic exams and paps are hard for me because I feel really vulnerable to someone who has that power over me” (Melia-Gordon, 2003, p. 117). Similarly, a woman interviewed by Seng et al. (2004) described what it feels like to be triggered.

I feel like I'm sitting naked in a room in front of a group of really antagonistic men who are all about to hurt me...that's the best way that I can describe it ... and I'm sitting there thinking, 'Oh my god, I've got to protect myself' ... I would say powerlessness and vulnerability are the two main feelings, to an overwhelming extent... (p. 608)

Numerous triggers were described by participants of the 15 studies included in the dataset. Almost any situation in healthcare had the potential for being perceived as threatening and thus numerous aspects of healthcare triggered stress reactions in participants. Descriptions of triggering were compared for similarities and differences and triggers were grouped into three main categories based on participants' descriptions of what initiated the triggering process: sensory or environmental stimuli, relational dynamics, or a mixture of the two. Sensory triggers conform to the traditional definition of triggers in that they are environmental stimuli that closely resemble stimuli present during the initial trauma such as sights, sounds, and smells in the treatment environment. These stimuli tended to be specific to the circumstances of the abuse experienced and often reminded participants of their abuse. Relational triggers, on the other hand, were frequently encountered situations in healthcare that tended to replicate the interpersonal power dynamics between victims and their perpetrators. Relational triggers often elicited feelings of distrust, vulnerability, powerlessness, and/or loss of control similar to those experienced during abuse. Because these affective states are nonspecific to abuse, participants were not always aware of their connection with their abuse. The majority of triggering episodes reported by participants across studies were categorized as relational. Thus, it appears that the

main source of triggering is the type of relational dynamics survivors encounter in the healthcare system. Mixed triggers were situations in which both sensory and relational triggers contributed to triggering.

Sensory Triggers (Environmental or Sensory Stimuli Reminiscent of Abuse)

Sensory triggers were stimuli in the healthcare environment that closely resembled stimuli present at the time of the abuse. Because of the individualized nature of the environmental contexts in which children are abused, these stimuli were usually specific to the circumstances of the abuse experienced by the individual. In other words, sensory stimuli that one participant reported as triggering was not necessarily triggering to another. These stimuli were usually in the form of body sensations or sights, sounds, smells in the treatment environment.

Body sensations. Some survivors reported being triggered by body sensations similar to those experienced during their abuse. These sensations could be elicited by healthcare interventions or be associated with a patient's underlying health condition. Two separate studies reported on participants who experienced reactivation of trauma symptoms due to the gel used during ultrasound treatments (Palmer, 2004; Schachter et al., 1999; 2008). Schachter et al. (2008) noted that the sensation of ultrasound gel was a trigger to some participants as the sensations elicited was similar to those caused by lubricants or semen. In addition, a male survivor interviewed by Schachter et al. reported being triggered by having his arm placed in water during post-operative therapy. "[After] surgery on my arm ... the [clinician] would put my arm in water ... [That was something] that my perpetrators had done, had victimized me ... [in] bathrooms" (p. 52).

Participants could also be triggered by body sensations related to their underlying illness or condition. For example, several investigators mentioned that the sensation of breathlessness was a trigger to participants who reported that suffocation was a component of their childhood abuse. Gallo-Silver and Weiner (2006) reported that breathlessness due to lung cancer reawakened the feeling of being choked during sexual abuse in one of the abuse survivors they interviewed. Kondora (1994) reported that a woman she interviewed became depressed each time she had an upper respiratory infection. The participant did not understand why she had this reaction until she realized how having a stuffy nose replicated sensations present during her abuse. Her father would hold her nose as he kissed her, making her feel as if she were suffocating.

The pain of labor was frequently mentioned as a sensation that reminded women of their abuse (Lee, 2001; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994). Rhodes and Hutchinson conducted an ethnography of childhood sexual abuse survivors' experiences during labor. They described four laboring styles of sexually abused women. "Fighting" was described as a panicked and defensive response in which the women interpreted the bodily sensations of labor as an attack on their bodies. A woman interviewed by Rhodes and Hutchinson noted that the pain she felt during childbirth reminded her of the pain she experienced during sexual abuse, "That was probably the worse pain up to that point that I had experienced but it was not the first time that I had felt that way..." (p. 218). Similarly, a woman interviewed by Lee also was reminded of her abuse by the pain of labor. "[I]t was very, very painful, and it felt like being raped again, because it was just this incredible pain and tearing, that's what it felt like" (p. 95).

Physical sensations related to breastfeeding such as leaking breasts, newborn suckling, and the let-down reflex could also trigger abuse-related memories. A participant interviewed by

Palmer (2004) was triggered by the physical sensation of breastfeeding: “She suckled on my breasts like a little bit and I got freaked out, it was disgusting and I couldn’t reconcile, you know, that part of my body which was for sexual purposes should be for nourishment of this child...” (p. 202). A woman interviewed by Seng et al. (2004) described a similar reaction to breastfeeding.

...every time [the infant] would latch on to nurse I would just sort of be hit with these uncomfortable...kind of nauseating...I call them flashbacks, but it’s not like I am reliving the incident, it’s just sort of the physical manifestation of the incident. (Seng et al., 2004, p. 608)

Several other participants found the manual expression of breast milk to be particularly distressing. One stated, “When the nurse tried to show me how to breastfeed she squeezed my breasts and the milk came out ... and I wanted to gag ... throw up ... it made me really sick. I felt really dirty then” (Palmer, 2004, p. 199).

Environmental stimuli. Environmental stimuli in the form of sights, sounds, and smells in the treatment that closely matched sensory stimuli experienced during abuse was also identified as triggering to some participants. For example, a survivor in dental care interviewed by Stalker et al. (2005) reported difficulty with procedures requiring the use of latex gloves, noting that “the gloves smell like condoms” (p. 1281). A participant in Palmer’s study was triggered by visual aspects of childbirth. She commented, “The blood was everywhere ... and I was ripped open from the inside before ... so it was just as terrifying as back then” (p. 174). A woman interviewed by Alpern (1992) had difficulty when being examined under low lighting conditions which she connected to her abuse.

Triggering could also be caused when providers unwittingly acted in ways that reminded participants of their abuse. One woman described having difficulty with gynecological examinations due to the similarity between the examination and her abuse.

“I was just crying, I think, because I was scared and it did trigger memories. Like I remembered back, “Oh god, [the man who abused me] did [this].... And although it was a very professional thing that [the doctor] was doing, it was just not [OK].... It’s hard to separate the feeling that was bad. (pp. 44-45).

Survivors also reported being triggered by healthcare providers using specific words and phrases similar to those used by their abusers. A woman interviewed by Palmer (2004) reported being triggered by words a nurse used during her labor.

The nurse kept telling me to just “let it happen” to just “let go.” I couldn’t ... I wouldn’t ... I was scared and alone. He [the abuser] used to say that to me and horrible things would happen. I didn’t want that to happen again. (p. 171)

Van Loon et al. (2004) cautioned healthcare providers to avoid using child-like endearments like “relax sweetie” during gynecologic exams as such phrases may be similar to ones used by an abuser.

Triggering could also occur in response to exposure to environmental settings that were similar to those experienced by participants during their abuse. Several examples of this form of triggering were described by Gallo-Silver and Weiner (2006) in their study of abuse survivors undergoing treatment for cancer. In one case, a 20-year-old man with recurrent Hodgkin’s disease was being prepared for a bone marrow transplant. He abruptly left treatment after the reverse isolation procedure was explained to him. When later interviewed by a social worker, the young man tearfully disclosed abuse by his grandfather starting at age six. His grandfather would lock him in a closet and would release him only after he promised to fellate him. The description of isolation procedures reminded the survivor of being locked in his grandfather’s closet, which was a situation that he did not feel that he could tolerate. In another instance, an 81-year-old woman with breast cancer stormed out of her radiation treatment planning session, refused further treatment and became suicidal. When a social worker intervened, the elderly woman disclosed that her father sexually abused her at night in her bedroom. She reported that the

darkness required for simulation, being partially disrobed, and the technician coming in and out of the treatment room was “too much to bear” (p. 118).

Relational Triggers

Relational triggers were situations in healthcare which resulted in a sense of threat due to relational dynamics between the patient and the healthcare provider and/or staff. In many instances, these situations seemed to bear little overt resemblance to participants’ original abuse. Instead, relational triggering tended to involve interpersonal interactions with caregivers that heightened participants’ sense of vulnerability, powerlessness and being out of control. Many survivors described the distress they experienced in reaction to relational triggers as being similar to the distress they experienced when they were abused by their perpetrators.

Relational triggers were the most commonly described source of triggering. Because similar aspects of healthcare interactions were described as triggering across studies, relational triggers were further delineated to reflect frequently recurring themes. Relational triggers were subdivided into eight categories based on themes developed by investigators of the studies included in the dataset along with participants’ descriptions of aspects of healthcare they found triggering. The categories are as follows: (1) power imbalance/authority figures/powerlessness; (2) gender of provider; (3) disinterested or insensitive provider/feeling objectified; (4) lack of control; (5) uncertainty/surprise; (6) submissive positioning; (7) exposure/lack of privacy; and (8) touch. Each category was supported by data from at least four separate studies. The studies contributing data to each of the eight categories are listed in Table 9. Relational triggers along with representative quotes from female and male sexual abuse survivors are provided in Table 10.

While each category is able to stand on its own, triggering was rarely due to a single relational trigger. Instead, a single event or situation in healthcare could contain a number of different relational triggers. For example, the power imbalance between the provider and patient contributed to almost every triggering situation in healthcare; however, the addition of triggers from other categories such as a provider's gender could intensify participants' distress. An example of this overlap can be found a female participant's explanation for her difficulty with male providers. "That goes back ... to the men that hurt me... And the authoritative thing, they are in control—they have the power" (Roberts et al., 1999, p. 42).

Table 9. Studies Contributing Data on the Different Categories of Relational Triggers

	Power/ Authority ¹	Gender of Provider	Disinterested Provider ²	Lack of Control	Uncertainty /Surprise	Submissive Positioning	Exposure/ lack of privacy	Touch
Alpern (1992)	X	X	X	X	X	X	X	X
Gallo-Silver & Weiner (2006)	X			X	X			
Kondora (1994)						X		X
Lee (2001)	X		X	X			X	X
Palmer (2005)	X	X		X	X			X
Parratt (1994)	X		X	X	X		X	X
Roberts et al., 1999	X	X	X	X	X			X
Schachter et al., 1999; 2004; 2008; Stalker et al., 1999; Teram et al., 1999	X	X	X	X	X	X	X	X
Seng et al., 2002; 2004	X	X		X				X
Stalker et al., 2005	X			X	X	X		
Van Loon et al., 2004.	X		X	X			X	X

Note. Complete citations are in the Reference list. ¹Includes difficulty with power imbalance and authority figures; ²Includes disinterested provider, insensitive provider, feeling objectified.

Table 10. Relational Triggers with Representative Quotes by Both Female and Male Participants

Triggers	Representative Quotes	
	Female Participants	Male Participants
Power imbalance/ authority figures/ powerlessness	“[With an authoritarian doctor] I felt like a victim ... go and do what they say ... like abuse all over again.” (Roberts et al., p. 42).	“[having a health care provider standing] ... over the top of me, I find that very threatening.” (Schachter et al., 2008, p. 44)
Gender of provider	“It was difficult to see a male obstetrician. I had all these sexual abuse issues that were still kind of fresh to deal with and some of them are still surfacing I was pretty raw. I was kind of scared. I didn’t feel safe.” (Palmer, 2004, p. 159)	“My abuser was my mother. I don’t like to be touched by women, especially strange women.” (Schachter et al., 2008, p. 13)
Disinterested or insensitive provider/ Feeling objectified	“The doctor was kind of cold, not personable at all, and those feelings [emotional memory of being abused, shame, vulnerability, nakedness] would come back to me in his office, and I found myself crying at every visit.” (Seng et al., 2002, p. 367)	“As a survivor of abuse, [I feel that today’s health care system] is reobjectifying ... to the point where I scarcely exist ... as a whole being...” (Schachter et al., 2008, p. 29)
Lack of control	“It [triggering during gynecological examinations] is so much about loss of control ... feeling somebody is invading your body with their hands or instruments of some sort and you don’t have control and you are totally vulnerable...” (Palmer, 2004, pp. 170-171).	“[With dental care] I just get that feeling ... when you have no control because you’re in the chair, your mouth is frozen and you’re pretty much at the mercy of that person.” (Stalker et al., 2005, p. 1277)
Uncertainty/ surprise	“The second visit, again, I had to lay on the table and ... he didn’t warn me and all of a sudden ... I heard the whirring, and he raised the table and [I was] coming toward the ceiling, I just felt attacked” (Schachter et al., 1999, p. 258)	“The surprises are the worst thing.” (Schachter et al., 2008, p. 20)
Submissive positioning	“For most of the abuse, I was lying down ... No matter how relaxed or grounded [I am while reclining in the dental chair], or who I bring with me, I get dizzy, nauseous, my head hurts. I come out disoriented, and if I’m alone it can take me a long time to get home because I keep dissociating.” (Melia-Gordon, 2003, p. 119)	“[Reclining in a dental chair] you are ... supine ... with your head lowered ... so you are really vulnerable physically...” Stalker et al., 2005, p. 1280)

Exposure/ lack of privacy	“I felt really awful, sick to my stomach when I had to put my feet in those stirrups and expose my body parts and I felt really self conscious and shameful. It felt really personal” (Palmer, 2004; p. 175).	“If I had to take off clothing ... for a male [clinician] it’s ... hard because there’s the trust issue there and for me there was a lot guilt and shame I feel powerless then.” (Schachter et al., 2008, p. 32)
Touch	“If [physical therapists] could really understand how traumatic it is to even be touched on your arms, that it just brings back old feelings and helpless feelings...” (Schachter et al., 1999, p. 258)	[Being touched by a clinician], it’s an extremely difficult situation to deal with. It triggers a lot of memories ... and then you completely lose whatever you are there for.” (Schachter et al., 2008, p. 40)

Note. Complete citations are in the Reference list.

Power imbalance/authority figures. One of the most basic aspects of the patient-provider relationship that many survivors found triggering was the power imbalance between patient and provider. Years of sexual abuse at the hands of someone viewed as more powerful made it difficult for survivors to interact with authority figures without the expectation of being re-victimized. For example, in interviews with women about their experiences in primary care, Roberts et al. (1999) reported that encounters with providers who were authoritarian or controlling led to anxiety and feelings of retraumatization in many of the survivors they interviewed. One participant summed up her feelings by stating, “Doctors often are authoritative. Men who abuse had to have power/control” (p. 42).

Childbearing women interviewed by Alpern (1992) and Palmer (2004) also indicated problems with authority figures. Palmer noted that the vulnerability of pregnancy brought on a sense of powerlessness and/or violation among all the survivors she interviewed. These feelings were exacerbated by their fear of authority figures along with the feeling that they themselves had “no authority” (p. 179). Explaining why she never goes to the doctor, a woman interviewed by Alpern declared, “I think that my problem with power and authority comes from the fact that I was violated at a really young age by somebody who was supposedly in a position of power” (p.

41). Another participant noted that the power hierarchies found in healthcare such as "...the male doctor, the male/female, doctor/the patient ... taps back into survivor issues" (p. 58). The power imbalance between care provider and patient was often reinforced by other aspects of the healthcare situation. For example, a survivor in physical therapy spoke about how the power imbalance was reinforced with disrobing.

...They tell you to get undressed, and then this person comes in and talks to you ... and you're sitting there talking to someone who's fully [clothed].... It's a totally unequal ... situation..." (Schachter et al., 1999, p. 257)

Gender of the provider. A healthcare provider's gender could be a powerful trigger that caused some participants to feel unsafe. Most male and female participants' reported that they were abused by males and consequently many participants found it difficult to trust men. Roberts et al. (1999) noted that going to a male doctor was a situation in which the abuse dynamic was relived for many participants who had been abused by male perpetrators. Similarly, Palmer (2004) found that caregivers who were male were triggering to most of her participants. One of Palmer's participants explained, "If I ended up having a man [as a provider] ... that was really, really hard for me. I didn't want a man anywhere around me" (p. 159). Conversely, some males who had been abused by women and expressed a preference for male providers. In addition, a few women preferred to see male providers even though they had been abused by men. A woman interviewed by Alpern (1992) felt that men are more sensitive, but was unable to explain why she felt this way.

Difficulties with male providers often overlapped with participants' difficulties with authority figures. Palmer noted that the fact that male caregivers were also perceived as representing authority and power further contributed to her participants' sense of vulnerability around males. Similarly, both Alpern (1992) and Roberts et al. noted that many of the survivors

they interviewed indicated both a distrust of males and a fear of authority figures. One of Roberts et al.'s participants explained that her difficulty with male providers goes back to her relationship with her abusers. "That goes back ... to the men that hurt me...And the authoritative thing, they are in control—they have the power" (p. 42).

The main reason participants offered for feeling more comfortable with female providers was their expectation that a female would be more sensitive and less authoritarian. Participants also felt that female caregivers would be more empathetic toward abuse survivors and would allow their patients more control over the examination process (Roberts et al., 1999). Three of the five women interviewed by Alpern (1992) said that seeing a female provider was one way they sought to assure safety and allow for trust. One explained, "I feel more comfortable speaking up if something is making me uncomfortable with a woman than with a man..." (p. 42). Another woman indicated she was more comfortable with a female provider doing her gynecologic exams because then she didn't have worry that something abusive was happening.

...I don't think that I ever had a [male] doctor who was, genuinely [abusing me], but there was always the uncomfortability. That this was a situation in which I was vulnerable in this incredibly creepy way. Whereas, with my female gynecologist, I never had to feel that fear. (p. 42).

Male participants who had been abused by other males also tended to be wary of male healthcare professionals. Some men worried that male providers' touch was sexually motivated. A man interviewed by Teram et al. (2006) was cautious around male healthcare professionals saying, "It was always in my head this guy [a healthcare professional] likes to touch men and maybe he's a fag. It was always in my mind. Always..." (p. 506). Another man reported refused to be cared for by a male nurse because he believed that the nurse was "effeminate ... I didn't want him touching me" (p. 506).

Disinterested or insensitive providers/objectification. Another aspect of the provider relationship that many survivors found triggering was disinterested or insensitive behavior by providers. Schachter et al. (1999) found that survivors in physical therapy tended to not feel safe when a provider seemed disinterested, detached, impersonal, or rushed. In addition, when providers failed to take time to connect to them on a personal level, participants tended to feel objectified. Another survivor did not feel safe with her physical therapist because she did not feel like the therapist cared about her.

...I was just another name on a [referral].... She wasn't interested. She had no warmth.... I didn't experience being safe with her because I didn't think that this was somebody I could talk to at all, about anything! She just was not interested... (Schachter et al., 1999, p. 252)

Participants also described feeling objectified when providers treated them as a medical problem rather than a whole person. A physical therapy patient explained how crucial it was for her to be treated as a whole person rather than a "body part" by her physical therapist in order for her to be able to participate in treatment.

Well, when I was abused, they weren't abusing me as a person, it was because of a body part, that's what the whole action was, and to see me as a pulled muscle and every interaction you make with me is based because you have a pulled muscle, to me, I realize, like it makes a lot of sense now when I can think back, they're not interacting with me as a person, it's that whole detachment, "I'm doing this because you have this part." (Stalker et al., 1999, pp. 182-183)

Lack of sensitivity was frequently mentioned as a source of distress in studies of survivors' experiences during childbearing (Alpern, 1992; Lasiuk, 2007; Palmer, 2004; Parratt, 1994; Seng et al., 2002). A woman interviewed by Alpern had a negative experience with a nurse practitioner who was not sensitive to her needs. She found herself crying when the practitioner left the exam room. She found this particularly upsetting because she was unable to identify exactly what had brought on the tears. Similarly, a woman interviewed by Seng et al. found

herself unexpectedly triggered by the remoteness of the physician providing her prenatal care. She reported that dealing with a “cold” provider brought up the type of emotions that she felt when was being abused and she found herself crying at every visit (p. 367). A survivor interviewed by Palmer described feeling objectified when faced with the turmoil of a busy delivery room. “When the room was really busy I felt overwhelmed, more out of control, more specimen-like. I felt like I was an object being studied” (p. 173). A woman interviewed by Lasiuk described the nurses in the hospital as “horrible” because they were not sensitive to her discomfort with breastfeeding (p. 213).

There was no sort of sensitivity, no sort of softness or gentleness or anything...there was no sort of recognition...about the needs that I had as [a survivor].... There was no recognition that I might need more time to adjust to a small baby on my breast that other women don't need.... Eventually I just made my Mum get my stuff and I left. It was really awful.” (p. 213)

Lack of control. Participants frequently described feeling threatened or violated in situations in which they felt they had no control over what was happening to them and a number of the original investigators reported that a sense of control was a core component of feeling safe. For example, the theme *Sense of Loss of Control* was developed by Stalker et al. (2005) in their study of survivors' experiences in dental care. This theme included examples of participants' difficulties with dental care based on the fact that someone else had control over what was happening to them. For example, a male survivor described difficulty going to the dentist saying, “I just get that feeling ... when you have no control because you're in the chair, your mouth is frozen, and you're pretty much at the mercy of that person” (p. 1277). A sense of control was also important in survivors in physical therapy. Schachter et al. (1999) asserted that without a sense of control, many survivors in physical therapy could not continue treatment.

Control also emerged as a central theme in studies of survivors' experiences during childbearing (Alpern, 1992; Palmer, 2004; Parratt, 1994; Rhodes & Hutchinson, 1994). Parratt identified *Desire for Control* as the core theme of her study of survivors' experience during childbirth. Parratt concluded that, among her participants, the need for control superseded all other needs. Similarly, Alpern found that a universal need among all the participants was the desire for a sense of control during examinations. Palmer reported that among her participants "issues of power, choice, and control were paramount" (p. 130). According to Palmer, a key element regarding whether touch would be perceived as traumatic was whether or not survivors felt they had control over the experience.

Pregnancy, itself, could trigger survivors due to the lack of control survivors felt over the changes happening to their bodies. Two survivors interviewed by Lasiuk (2007) described being triggered by having a baby inside them. Lasiuk noted that, "[b]oth of these women, feeling unsafe and out of control, experienced pregnancy as invasion that was reminiscent of their past abuse" (p. 192). Similar feelings of violation were described by some of Palmer's (2004) participants. One explained how her pregnancy brought up abuse-related memories.

Once again I didn't feel like my body was mine anymore. When I was sexually abused I felt that way It was weird feeling violated by a baby! It was like this baby was going to take over my body without my control. When he [the abuser] used to take over my body, I just let it go because I could remove myself from it....but I couldn't do that with a baby....This baby was inside of me, needing me, and I was no longer in control. It was really scary. (p. 152)

Childbirth was particularly difficult due to the lack of control participants felt during labor. In fact, the lack of control experienced during childbirth caused many survivors to associate childbirth with rape. A woman interviewed by Rhodes and Hutchinson (1994) stated,

The birth terrified me. I thought I was going to die. I felt like that during the sexual abuse. When you get in a situation where you feel like you've been violated or you feel like your life is in danger, or someone has so much power over you they can do anything,

you're out of control ... That's terrifying and that's the feeling I remember when I was giving birth... (p. 219)

A survivor interviewed by Palmer (2004) related her labor experience to a gang rape. She reported that "It felt like I was being raped all over again ... I was nothing ... and everyone was standing around cheering it on" (p. 173).

Uncertainty/surprise. Participants described feeling threatened in situations in which they were uncertain about what was happening around them or if something unexpected took them by surprise. Palmer (2004) attributed her participants' difficulties with uncertainty to their childhood experience of never knowing when they would be abused. In their reanalysis of data first reported by Schachter et al. (1999), Stalker et al. (1999) included uncertainty in a theme they termed *Ways to Enhance Safety*. Stalker et al. found that to feel safe, survivors needed to be able to anticipate what would happen to them during healthcare visits. One survivor said she felt anxious prior to doctor visits because she never knew what to expect. "I was anxious when I first was going because I do not trust doctors to begin with ... and I never knew what was going to happen, so that causes anxiety" (Stalker et al., p. 184). Another said she felt "apprehensive, not exactly knowing what was going to happen.... Just as far as clothing was concerned or ... touch, just not knowing..." (Schachter et al., p. 252). In describing medical personnel busily going about their business around her without explaining what they are doing or why, a survivor in physical therapy revealed, "That's when I get really uncomfortable and I tense up. And I want to push them away, and I want to run, leave" (Schachter et al., p. 255). Similarly, seven of the ten women in a focus group conducted by Roberts et al. (1999) felt that rushing or quick movements by providers and "not explaining what they are doing" were particularly negative aspects of healthcare.

In some instances, the desire for predictability was related to survivors' need to avoid being triggered. A survivor interviewed by Parratt (1994) explained,

If something happens without me realizing it's going to happen and it touches a part of me that has a memory ... then that's going to give me a fright, and without consent, just, lots of things that I don't even recognize can just spin me backwards." (p. 31).

Similarly, a survivor in physical therapy noted that the element of surprise was really difficult to deal with because she never knew when "I will be triggered by something that is done, you know, into remembering something that is abusive for me" (Schachter et al., 1999, p. 255).

Because of their difficulty dealing with uncertainty, accurate information and preparation were very important to survivors. A physical therapy patient noted that if "there's preparation [then] there's not that fear of the unknown..." (Schachter et al., 1999, p. 255). Stalker et al. (1999) noted that before being touched or asked to take off their clothes, survivors would like healthcare provider to first explain what they are doing and why. Participants also wanted to be forewarned if a procedure would be painful. Two women interviewed by Alpern (1992) described becoming very angry when they experienced pain during a procedure that their healthcare providers denied would be painful.

Submissive positioning. Submissive body positioning was triggering for many participants as it heightened feelings of vulnerability and feelings of not being in control. Alpern (1992) found that the lithotomy position can be very threatening and can create a situation of vulnerability. One of Alpern's participants asserted, "Laying on the table with your knees, with your feet in the stirrups, that's just an incredibly exposed, like literally exposed and vulnerable [position] and vulnerable situation" (p. 38). Similarly, a survivor in physical therapy had difficulty lying on face down on the exam table "... 'cause I can't see and I feel pinned..." (Schachter et al., 1999, p. 257).

Reclining in a dental chair was particularly difficult for survivors. In their study of survivors' experiences with dentistry, Stalker et al. (2005) developed a theme they termed *Discomfort With Body Positioning*. Stalker et al. reported that reclining backwards in a dental chair heightens the power imbalance between provider and patient and can feel threatening to abuse survivors. For example, a male participant interviewed by Stalker et al. reported that having his head lowered makes him feel "really vulnerable physically" (p. 1280). Similarly, a woman interviewed by Kondora (1994) stated, "if you think about the vulnerability you have when you are in a chair laying down and somebody's got their hands in your mouth and you're totally unable to do anything, um, it triggers me like crazy..." (p. 24).

Exposure/lack of privacy. A lack of privacy and feeling exposed were frequent sources of distress among survivors. Van Loon et al. (2004) developed a theme they called *The Need for Privacy and Confidentiality* in a study of homeless survivors' experiences in the emergency room. Parratt (1994) noted the importance of privacy in the theme *Aspects of the Childbirth Experience Which Are Related to Aspects of the Abuse*. For one woman, having lots of people come in and out of the room while she was in labor made her feel vulnerable, which she said "took me back to the way I felt when I was a child" (p. 31). Schachter et al. (1999) included lack of privacy and discomfort with exposure in a theme that included physical factors that contributed to survivors in physical therapy feeling unsafe. Schachter et al. found that their participants tended to feel unsafe when wearing paper gowns or being left in curtained cubicles. A physical therapy patient they interviewed described her reaction to being left in curtained cubicle.

I felt ... uncomfortable 'cause I thought, anybody could just open up those curtains at any time.... I didn't feel as safe as if this was my space. I felt like, at any time it could be invaded or that—I was really vulnerable.... (p. 252)

Another physical therapy patient was upset with having to put on a paper gown. She stated, “The first time I went there and I had to wear this thing, I felt so exposed and so naked and, and hated it” (p. 257). Yet another patient emphasized the importance of privacy for survivors.

So, the whole thing of privacy is very important. Make sure there’s a room for you to go to. Make sure the gown is half decent. There were also men in the room. It was just one large room. So when you’re wearing a gown and so on, you know, I felt exposed. (Stalker et al., 1999, p. 186)

Exposure was a particularly upsetting aspect of gynecological examinations. Among the childbearing women she interviewed, Palmer (2004) noted that many felt violated when their “private parts” were exposed, making them feel ashamed and self-conscious. For example, one survivor described being triggered during childbirth. “I felt really awful, sick to my stomach when I had to put my feet in those stirrups and expose my body parts and I felt really self conscious and shameful. It felt really personal” (p. 175). Referring to a pelvic examination, a woman interviewed by Alpern (1992) stated, “I don’t want to go through that again, I don’t want to have to take my clothes off ... And it’s very difficult to actually walk in the door and get undressed and get on this table” (p. 38).

For some participants privacy was connected to a sense of control. A survivor interviewed by Parratt (1994) explained, “...privacy to me is where I’m in control of myself and I’m safe and I don’t have to concentrate on other people and what they are doing” (p. 33). A similar sentiment was expressed by a survivor interviewed by Lasiuk (2007) who had difficulty initiating breastfeeding because of a lack of privacy.

Giving birth was fine, but afterward, it was awful. The nurses in the hospital were horrible. They kept trying to force me to breastfeed, and it was like, “This is my body! It’s my body! Stay the fuck away from me!”, but they wouldn’t, they wouldn’t listen. It wasn’t that I didn’t want my daughter to breastfeed; I just didn’t want other people seeing my breasts.” (p. 148)

Touch. Touch was the most commonly mentioned trigger across studies (Alpern, 1992; Lasiuk, 2007; Lee, 2001; Palmer, 2005; Parratt, 1994; Rhodes & Hutchinson, 1994; Roberts et al., 1999; Schachter et al., 1999; 2004, 2008; Stalker et al., 1999; Teram et al., 1999; Seng et al., 2002; 2004; Van Loon et al., 2004). Because touch is intrinsic to childhood sexual abuse, the experience appeared to be associated with painful feelings and memories for many participants. A survivor interviewed by Schachter et al. (1999) noted that just the thought of going to see someone who is going to touch her ignites memories of her abuse. She stated that it was hard for her to see a physical therapist “because I don’t like to go to a place where people are going to be touching me.... Whether it’s my head or my toe, I don’t like that” (p. 257).

Participants had widely differing thresholds for touch. For example, some participants had difficulty with touch in general; while others had certain areas that they did not want touched. In some instances, survivors became triggered just by having a healthcare provider enter their personal space (Schachter et al., 2008). In addition, participants’ ability to tolerate touch was not static. Some felt better able to handle touch on some visits and less on others (Schachter et al. 1999).

Being touched by caregivers caused some participants to feel vulnerable and out of control. A survivor explained her difficulty with touch during childbirth, “I felt like I had no choice, it’s like whomever came in had a right to touch me. It’s a pretty vulnerable place to be in” (Palmer, 2004, p. 170). A survivor interviewed by Parratt (1994) expressed similar sentiments.

With the people touching me when I was having the baby, that left me at a vulnerability stage ... being in all that pain and not being able to control the pain and being at the mercy of everybody else ... I didn’t like them touching me. (p. 32)

Aversion to touch by childbearing survivors sometimes extended to concerns about others touching their babies. For example, Lasiuk (2007) interviewed a survivor who refused a procedure during her fifth month of pregnancy to stop the leak of amniotic fluid. She placed her baby's life at risk due to her fear that the doctor might touch the baby during the procedure.

Because the baby's life was at risk, they wanted me to do this procedure where they stitch your cervix, but I refused. I had a feeling that this baby was going to come and nobody must touch this baby. I can see now that that was a traumatic response. It affects me even now, as I talk about it – I was afraid for anybody to touch the baby or for anybody to have any contact with the baby. Whether that was a medical person or anyone else ... (p. 109)

Alpern (1992) found that many of her participants expressed ambivalence regarding touch. At times, touch could be experienced as a positive comfort; while at other times it was seen as a threat. For instance, one survivor felt very negatively about being touched by her healthcare provider during a gynecological exam, yet was comforted when a nurse offered to hold her hand during the procedure. Alpern concluded that among her participants there was a baseline fear of touch with a concomitant desire for nurturing, appropriate, safe touch. For many participants, the difference between how touch was perceived was related to whether providers asked permission before touching them.

Mixed triggers. Some relational triggers also included sensory components. For example, touch could function as both a sensory and relational trigger. Touch in certain areas could act as a direct sensory stimulus that reminded participants of abuse; however, it could also be a relational trigger that brought up feelings of vulnerability and loss of control. This may explain why various participants had widely varying thresholds and tolerances for touch. For example, some participants only indicated difficulty with touch in specific areas; whereas others were triggered by being touched anywhere on their body. In the extreme, some indicated being triggered by caregivers merely entering into their personal space. The same was true for

vulnerable positioning. Some survivors were bothered by having to lay flat, as this was the position they had been in when abused. However, others were bothered by any position in which they felt vulnerable in relation to the provider. Thus, many survivors were bothered by reclining backwards in a dental chair, although none indicated that they had been abused in this position.

In addition, a single healthcare interaction could include a combination of both sensory and relational triggers. In these instances, distress associated with exposure to relational triggers appeared to be intensified when sensory triggers also were present. For instance, difficulties interacting with male providers and authority figures could be intensified when the provider had more specific characteristics in common with the abuser, such as appearance or age. An example of how sensory and relational triggers can interact can be found in an incest survivor's discussion of a flashback she had during an infertility treatment.

“(I)t brought up a humongous flashback... I wound up having a male physician for the embryo transfer, which is not good ... He was old, too, which is bad. He was, like, my dad's age.” (Lee, 2001, p. 87)

Invasive procedures such as pelvic and rectal examinations appeared to be the epitome of a triggering situation in healthcare. For instance, most survivors interviewed by Palmer (2004) considered their first gynecological examination to be a crisis point. One reason that gynecologic and rectal procedures may be so triggering is because the procedure is likely to present survivors with a wide variety of both sensory and relational triggers. Gynecological and rectal procedures can elicit physical sensations that provide direct sensory reminders of prior abuse. At the same time, these procedures may include numerous relational triggers which heighten survivors' feelings of vulnerability and powerlessness. Common relational triggers experienced during gynecological and rectal examinations or procedures include exposure, submissive positioning, loss of control, and a heightened power differential between the patient and examiner. The

combination of sensory and relational triggers present during gynecological examinations at times overwhelmed participants' ability to cope. One woman described becoming overwhelmed by sensory and relational triggers during labor.

I didn't want the doctor down there [perineum] looking at me ... touching me.... I felt so dirty just spread out like that for everyone to see.... I didn't want them to have anything to do with my body but they kept touching me and telling me to just breathe through it. I puked right then and there ... just like I used to do when he [her abuser] was touching me. I was so ashamed.... I felt so vulnerable and I had no one to turn to. (Palmer, 2004, p. 179)

Post-traumatic Stress Reactions

Triggering resulted in a wide variety of emotional and physical stress reactions. The most commonly reported responses to triggers were emotional reactions such as anxiety, panic, crying, guilt, shame, anger, grief, fear, sadness, despair, and hopelessness (Alpern, 1992; Palmer, 2004; Roberts et al., 1999; Schachter et al., 1999; 2008; Van Loon et al., 2004). Flashbacks were another commonly reported response. For instance, Rhodes and Hutchinson (1994) reported that some survivors respond to stress of labor by appearing to relive their abuse. These survivors at times spoke in childlike voices or assumed protective body postures such as curling into a fetal position. An incest survivor described having a flashback during labor saying, "...everybody said I was just like a little girl, I wasn't myself anymore...I became somebody else like a crying child shut up in a closet or something ... they didn't recognize me" (p. 218). Triggering also resulted in feelings of isolation. During labor, one participant was surrounded by people; yet described feeling scared and alone, saying "I had no one to turn to" (Palmer, 2004, p. 179).

Triggering could also result in physical reactions such as dizziness, headaches, shaking, nausea, and/or vomiting. For example, a participant in Palmer's (2004) study reported getting nauseated when a nurse tried to show her how to breastfeed, "...I wanted to gag ... throw up ... it made me really sick" (p. 199). Triggering could also result in "body memories" or sensations

of pain in previously traumatized area. For example, a male survivor described what happens to him if he has a rectal examination. “It can trigger ... physical night sweats and severe rectal pain, enormous inexplicable attacks of anxiety” (Schachter et al., 2008, p. 40). Nonverbal indicators of discomfort or distress often accompanied stress reactions. Schachter et al. noted that when triggered, survivors may display the following nonverbal behaviors: rapid heart rate and breathing; pallor or flushing; sweating; muscle tension and inability to relax; trembling or shaking; cringing, flinching or pulling away; and startle responses. Schachter et al. concluded that these behaviors are best understood as signs of sympathetic nervous system arousal that are occurring in response to the perception of a threat. For example, a male participant reported feeling frightened during any kind of healthcare situation. “To some degree the fight or flight syndrome kicks in where I’m ready to hit the floor and head for the door” (p. 36).

Stress reactions often surfaced without warning compounding survivors’ perceptions of being powerless and unable to self-protect. Moreover, these emotional responses could occur in combination, resulting in some participants feeling completely overwhelmed. One participant described triggering as “just like a huge tornado of emotions going on inside me” (Palmer, 2004, p. 177). Another woman noted that she had been in denial about her abuse until she experienced flashbacks during labor. “I seriously thought I had gone to hell.... I was very close to being in ‘screaming maniac’ mode” (Lasiuk, 2007, p. 196). Another woman had difficulty finding words to describe how triggering affects her. She said, “It’s really hard to describe ... it just feels awful. I feel like turning into a little black hole and disappearing” (Seng et al., 2004, p. 608). Some participants found triggering to be unbearable. A male participant reported that he could not participate in healthcare interactions that triggered him saying, “The feelings and the stress and the emotions that are created in me are just too hard on me” (p. 21).

Triggering could also result in cognitive deficits which impaired decision making (Gallo-Silver & Weiner, 2006; Palmer, 2004; Roberts et al., 1999; Schachter et al., 1999; Seng et al., 2004; Van Loon et al., 2004). Van Loon et al. reported that, after being triggered, participants were left feeling confused and less able to make decisions. A 36-year-old female abuse survivor in Melia-Gordon's (2003) study described becoming so disoriented during dental visits that she had difficulty driving herself home afterwards.

Some stress reactions were long-lasting. For example, some survivors reported having nightmares and insomnia after being triggered during healthcare (e.g., Schachter et al., 1999; 2008; Van Loon et al., 2004). A male survivor reported that he had nightmares three nights in a row after having braces placed on his teeth. "All of a sudden I'm having nightmares being that little kid again because of all this prodding and pulling going on in my mouth" (Schachter et al., 2008, p. 55).

Coping Style

Both triggering and the anticipation of being triggered during healthcare resulted in a wide range of stress reactions and survivors coped using a variety of strategies. *Coping* is defined as efforts to deal with demands taxing or exceeding the resources of the person (Lazarus & Folkman, 1984). In other words, coping is a cognitive or behavioral response to something appraised as stressful. In the context of the Healthcare Retraumatization Model, coping strategies can be seen as safety behaviors directed at avoiding the negative consequences of activating post-traumatic reactions during triggering. Since most of the studies included in the dataset did not focus on coping, saturation can not be presumed to have been reached. However, enough information was available to develop a list of coping strategies. These strategies tended to fall

into one of two broad-based categories: *Avoidant* or *Proactive*, based on survivors' general approach to dealing with the stress of being triggered.

Avoidant strategies were the most frequently described response to triggering and were usually a continuation of the types of coping strategies that participants had developed as children to deal with their abuse. Because they had been powerless as children, these strategies mainly involved trying to psychologically or physically escape the source of threat and to control stress reactions associated with triggering. Because avoidant strategies did not resolve either the internal (i.e., hypersensitivity to threats to safety) or the external factors (threatening aspects of healthcare interactions) associated with triggering, their use tended to perpetuate the retraumatization cycle and they resulted in mainly negative consequences for survivors ranging from continued psychological suffering to serious disruptions in care.

Proactive strategies were less frequently described and tended to be used by survivors further along in recovery. The use of proactive strategies required more maturity and psychological strength as participants had to be aware of the cycle they were in and plan ahead in order to interrupt it. Moreover, participants had to have enough of a sense of personal power to believe that they could affect their experiences in healthcare and self-advocate (Palmer, 2004). Proactive strategies were aimed at either modifying the internal factors associated with coping (i.e., hypersensitivity to threats to safety) or the external factors (threatening aspects of healthcare interactions) or both. When successfully employed, proactive strategies resulted in predominantly positive outcomes; participants were able to exit the retraumatization cycle and form positive relationships with their caregivers.

The relationship between coping style and retraumatization was noted by Lee (2001). Lee found that participants who planned for their difficulties with triggering seemed less affected by

triggering during childbearing. Conversely, women who did not expect or plan for triggering seemed to be overwhelmed by their feelings. Lee noted that those who relied on avoidant coping ultimately “regarded their childbearing experiences as having been invaded once more by sexual abuse” (p. 110). Each coping style and associated strategies are presented in more detail below. It is important to note that coping strategies were not discrete. Survivors often used more than one strategy, sometimes simultaneously. In addition, survivors often switched to a different strategy if the first one did not provide adequate relief.

Avoidant Coping

The main avoidant coping strategies described were: dissociation, denial, submission, hostility and anger, numbing, and healthcare avoidance. Strategies were often used in conjunction. For example, denial or submission was often accomplished through the use of dissociation. In addition, avoidant strategies tended to be employed automatically and unconsciously. At the same time, avoidant strategies did not prevent triggering. Instead, they were mainly used by survivors to mitigate the negative effects of triggering through psychologically and/or physically distancing themselves from threatening situations and emotional reactions to these situations. With psychological distancing survivors tended to dissociate, shutting down their emotions and mentally distancing from what was happening around them. With physical distancing, survivors sought to physically remove themselves from triggering situations by refusing treatments they found objectionable.

Although, avoidant coping helped participants manage some of the distress associated with triggering, any relief gained came at a cost. Avoidant coping tended to increase survivors’ hypersensitivity to threat by reinforcing feelings of powerlessness and by impairing survivors’ ability to self-advocate or problem solve. Thus, avoidant coping helped maintain the cycle of

retraumatization and ultimately resulted in interruptions to survivors' passage through the healthcare system.

Dissociation. The most frequently described coping mechanism reported across studies was dissociation. While dissociation could occur in response to any trigger, it was especially common during gynecological procedures and labor (Alpern, 1992; Lee, 2001; Palmer, 2004; Parratt, 1994; Rhodes and Hutchinson, 1994; Seng et al., 2004). For example, Palmer found that for the 46 survivors she interviewed, dissociation was the main strategy used to endure abuse during childhood and was also the main strategy employed when triggered during healthcare as an adult. In addition, Palmer found that labor that the birth process was a traumatic experience for all the women in the study who had given birth and all experienced dissociation during labor. Palmer noted that as children, dissociation allowed her participants to distance themselves from overwhelming emotional or physical pain and to set a mental boundary between themselves and their abusers. Dissociation also gave participants a sense of control, allowing them to retreat to an inner place where they could pretend that the abuse was not affecting them. Palmer found that the dissociative process was often reactivated in healthcare as a result of triggering in order to cope with feeling threatened, vulnerable, in pain, and/or out of control. Alpern (1992) described dissociation as a coping mechanism used to deal with feelings of vulnerability.

Because dissociation tended to occur automatically, participants often did not feel that they had any control over the process. As a male survivor reported, "The health care practitioner would come into my personal space and.... I would just dissociate" (Schachter et al., 2008, p. 54). In some instances, survivors reported that, initially, they did not understand dissociation or even recognize that this is what they were doing. One male participant explained,

When [the doctor] did the physical examination I just basically dissociated myself from my body and I never had any idea why ... or how I did it. But looking back now, I used to do that quite a bit. (Schachter et al., 2008, p. 53)

During dissociation, participants often described themselves as being out of their bodies. For example, Alpern (1992) noted that, in order to get through pelvic examinations, a survivor may find it necessary “to split” her mind from her body (p. 35). A woman interviewed by Palmer (2004) described this process saying, “I just went away and watched from above” (p. 170). A survivor interviewed by Lee (2001) described how during labor she lifted herself as far out of her body as she could manage which was how she coped with abuse as a child. She explained, that while she could not get out of the whole scene “but I didn’t have to be in the center of it” (p. 88). By disconnecting from their bodies, survivors were able to shut down their emotions and block physical pain. A woman interviewed by Seng et al. (2004) blocked the pain of labor by dissociating. She explained that this was a skill she learned when she was molested as a child.

You know what I would do is I would just close my eyes real tight and just imagine my spirit being lifted up out of my body and sitting on the bed until he [her perpetrator] was done. Then I would come back into myself. [And in labor] what happened was [the doctor] left and while I was going through labor I just blocked myself out. I blocked myself out through the pain and just took it. (pp. 609-610)

Similarly, a woman interviewed by Seng et al. (2004) that she could see herself screaming during labor but had no feelings about what was happening.

I dissociated when I delivered my son. I could see my body, I could see me screaming but I also knew I couldn’t move and I just had this out of body experience just watching over me and I stayed out of my body, I had no feeling then... (Palmer, 2004, p. 184)

When dissociated, participants tended to be passive and nonresponsive. Consequently, dissociation impaired participants’ ability to convey information to their healthcare providers. One survivor explained,

The question-and-answer thing was always before the actual physical exam and I would be really stressed out and really kind of paralyzed feeling, and so I don't think I ever gave really great information because of that. (Schachter et al., 2008, p. 41)

The psychological and physical distancing associated with dissociation impaired survivors' memories of what had happened during healthcare and often left them feeling confused and disoriented. A male participant who dissociated during an examination remarked, "After the examination was over I had no idea what he said to me. The only thing I wanted to do was get out of there. I felt extremely violated" (Schachter et al., 2008, p. 53). Another woman could not remember her labor. She stated, "I can only remember [labor up to] a point, and then it just all goes away..." (Seng et al., 2004, p. 609).

Although they recognized that it had its shortcomings; overall, many participants considered dissociation to be an effective way of managing triggering. Palmer (2004) reported that a number of the survivors she interviewed viewed dissociation as an asset to their childbirth experiences and felt that taking that away would be damaging for them given that it was their only coping strategy. A female abuse survivor interviewed by Alpern (1992) considered dissociation a "great" coping mechanism, as on some level it "obliterates" the emotional pain she feels during pelvic examinations (p. 37). At the same time, the woman acknowledged that dissociating leaves her with emotional baggage that is ultimately detrimental to her. She noted, "While dissociation from any kind of experience, it still has an impact on me. But I'm not processing that impact, so it gets stuffed somewhere" (p. 37).

Denial. Some participants coped by denying their medical condition. This was the least common coping strategy reported and was described mainly in the context of childbearing. For example, Palmer (2004) noted that one participant in her study denied her pregnancy as part of her coping strategy. The participant explained that when her baby was kicking "it was like I had

gas or something because there's nothing in me, there's not a baby" (p. 151). Another woman resorted to denial after experiencing repeated episodes of preterm contractions.

I went in four times [for preterm contractions], and by about the third time ... the abuse stuff had really started to kick up, and I was convinced that I was imagining the whole thing ... By the end of it I was convinced that I wasn't even pregnant ... you know how denial works. (Seng et al., 2004, p. 609)

Another survivor used denial in conjunction with dissociation to cope with the loss of her baby when her pregnancy ended with a stillbirth. She stated,

The whole experience left me in shock for a long time. My in-laws and my husband became very concerned because they thought I wasn't grieving appropriately. Of course, I was dissociated, so it was not as if it was a real baby ... my baby. It was just something that happened. It was something that just happened, but it was not connected to me. It was as if it was somebody else's baby. It was not part of me or my body or my consciousness. I felt no connection to that baby whatsoever. (Lasiuk, 2007, p. 188)

Submissive Behavior. Some survivors described coping with upsetting events in healthcare by becoming passive and submissive to situational demands. In their study of physical therapy patients, Schachter et al. (1999) and Stalker et al. (1999) noted that survivors may initially present themselves passively, inhibit expressions of pain and fear, hoping that the provider will "fix" whatever the problem is. When distressed, their participants tended to acquiesce, while weakly communicating their disagreement through passive nonverbal signals. Similarly, Palmer (2004) noted survivors' tendency to be quiet and compliant with healthcare providers even in situations in which they were experiencing significant distress. Palmer viewed this as a result of having lived in an environment of physical, sexual, and/or emotional abuse where expressing emotions was not safe.

Passive submission was often accompanied by a sense of powerlessness. A female survivor noted that during her first pregnancy she was not able to voice her needs to her caregivers. "I didn't have that voice to be able to speak out and say, you know, this is what I

need and this is what happened to me” (Schachter et al., 2008, p. 43). A survivor interviewed by Seng et al. (2002) described how the submissive behavior she used to cope with abuse was automatically reactivated in maternity care. The survivor stated, “. . .my reactions to pregnancy, becoming submissive again. . .I was completely passive. . .I didn’t advocate for myself at all. . .” She attributed her response to a lack of control, and someone else in authority “calling the shots no matter what I really wanted” (p. 367).

Hostility and Anger. In contrast to submissive behavior, aggressive behavior and anger were notable reactions, particularly among male survivors. Many male participants, along with a few female participants, described responding with anger when they were anxious or fearful. One male participant explained, “Anger shows up often when you are triggered – like [when] somebody touches you in the wrong place” (Schachter et al., 2008, p. 56). Based on analysis of the available data, hostility was conceptualized as a defensive posture in which survivors sought to hide their feelings of vulnerability and self-protect by pushing their providers away. As a male participant noted, “You are frightened and everybody is frightened of you” (Schachter et al., 2008, p. 56). A female participant discussed how being violated at a young age by someone in a position of authority makes it difficult for her to go to the doctor. She noted that her preferred form of coping is avoiding doctors altogether. “And if I have to go to the doctor, I don’t like it and I question them and I’m rude to them. I’m your typical rude patient because I don’t trust what they’re saying to me. . .” (Alpern, 1992, p.41).

Numbing. Numbing strategies included engaging in self-harm or substance abuse. These behaviors appeared to be used in order to avoid feeling pain feelings associated with triggering. Although numbing strategies were mentioned by numerous investigators, they were not discussed in depth. In addition, data were missing as most studies targeted survivors who were

relatively psychologically stable. For example, Lee (2001) excluded participants who reported self-harming behaviors or substance abuse in the preceding year. Only Seng et al. (2004) specifically asked participants about involvement in self-harm, substance abuse, or eating disorders. Seng et al. interviewed 15 women with self-reported abuse-related PTSD about their maternity care experiences. Of the 15 women, 11 reported engaging in numbing behaviors at some point since being abused. Five reported high risk behaviors or self-harm, three reported substance abuse or disordered eating, and three reported both. Seng et al. reported that some were already sober prior to pregnancy and others stopped using substances because they were pregnant; however, two participants reported they were currently addicted to cocaine. In addition, one woman saw her overeating as a form of substance use, and attributed it to having not worked through her traumatic experiences. “And while I don’t do drugs, I would say that my over-eating is probably the same thing.... As it happens, I can get my drug at McDonald’s...” (p. 610).

Both Palmer (2004) and Schachter et al. (2008) found that some of their participants engaged in self-harm (e.g., cutting, scratching, or burning the skin) in an attempt to replace emotional pain with physical pain. Schachter et al. also noted that self-harm may target pain to one area of the body and thus help survivors regain a sense of control over their bodies. Lasiuk (2007) interviewed several participants who reported abusing substances to avoid or reduce their distress. One participant was pregnant and struggling with her addiction to drugs. She considered hard drugs her “best friends” and relied on them “just to have the numbness of not feeling those feelings of my sexual abuse” (p. 175). Similarly, Van Loon et al. (2004) noted that some participants chose to “numb away” negative feelings and escape suffering by using alcohol, drugs, food, sex and other addictive activities to obtain relief from pain. Van Loon et al. noted

that relief was only temporary “and the shame, guilt, and self-loathing increase, effectively lowering self-esteem and increasing physical health problems” (p. 211). Palmer (2004) reported that some participants who self-mutilated and abused substances stopped when they became pregnant due to fears of harming their babies. However, relinquishing these coping strategies left participants feeling even more vulnerable during their pregnancies.

Healthcare Avoidance. Study investigators cited numerous instances in which survivors attempted to protect themselves from the emotional and physiologic effects of triggering by avoiding healthcare. Healthcare avoidance included: failing to seek preventative care or medical attention for illnesses, refusing prescribed procedures or medications, stopping procedures before completion, withdrawing from treatment, and/or failing to return for follow-up care. For example, a female survivor reported that she avoids primary care because she feels “very anxious if anyone touches my body” (Roberts et al., 1999, p. 43). A male survivor described his tendency to repeatedly make and then cancel dental appointments.

I put it off for about five or six times ... my wife has been bugging me for a while now: ‘The dentist has been calling you, you’ve got to go now.’ [I say] ‘OK, I’ll call her back’ and I don’t call her back. (Stalker et al., 2005, p. 1280)

In some instances, avoidance was associated with survivors’ desire to remain in control. For example, the fear of losing control led some survivors to avoid using medications or to refusing certain medically-indicated treatments. A woman interviewed by Seng et al. (2004) resisted using medication for hyperemesis during pregnancy. She stated, “I cried for three days before I finally used them [pills] and I was terrified at what they might do. I was very ... I don’t want anything else in my body” (p. 609). Several women interviewed by Parratt (1994) resisted taking analgesics during labor because of their fear that the drugs would interfere with their ability to maintain control over themselves. In maternity care, survivors’ need for control often

extended to what happened with their infants both before and after birth. As previously mentioned, a survivor interviewed by Lasiuk (2007) refused a procedure during her fifth month of pregnancy to stop leakage of amniotic fluid. She placed the life of her fetus at risk due to her fear of the doctor “touching” the baby during the procedure. Similarly, a survivor interviewed by Parratt (1994) left the hospital early because the staff was “interfering” with her baby too much and “I wasn’t allowed a say over what I wanted” (p. 33).

Healthcare avoidance was the way many participants avoided being triggered. For example, one woman reported that she no longer gets pelvic examinations. “I don’t think I would allow anybody to touch me now ... nobody would get an internal on me. No. I will not allow myself to be that vulnerable again” (Schachter et al., 2008, p. 41).

Proactive Coping

Proactive strategies were less frequently described and tended to be used by survivors further along in recovery. A proactive coping style involved seeking to reduce triggering through seeking to modify either internal or external factors related to triggering. Proactive strategies included: seeking social support, “taking control”, and planful problem solving. The least effective form of proactive coping was “taking control” in that this strategy often placed participants at odds with their healthcare providers. The most effective strategy was planful problem solving, especially when combined with seeking social and/or professional support. When successfully employed, proactive strategies helped survivors exit the retraumatization cycle and form positive relationships with their caregivers.

Social Support. Some participants coped with their fear of retraumatization by bringing a support person with them to healthcare visits. Having a support person present appeared to help survivors feel safe by balancing the power differential between themselves and their provider. A

woman interviewed by Stalker et al. (1999) explained, “Whenever I go to see a new health professional, I always take someone.... just some sort of like a witness.... I have to have someone there with me” (p. 185). Another participant appreciated her physical therapist’s suggestion that she could bring someone with her to her treatments. She noted that arranging to have a companion with her “...kind of defuses the anxiety” (p. 186). Having someone with them helped some survivors feel more capable of tolerating childbirth. One survivor said that having a close friend with her helped “make it all OK. I just knew that I would make it through. She helped me feel capable” (Palmer, p. 189). A woman interviewed by Parratt (1994) discussed how choosing the people who would attend her at the birth of baby helped her feel less objectified. “I made the choice and I knew who was going to be [at the birth] and I knew those people and so I’m never going to feel like I’m on display” (p. 54).

Taking Control. To avoid being triggered, abuse survivors sometimes sought to take control over external factors related to triggering. Those who coped by “taking control” often attempted to control the actions of their healthcare providers and what happened to them during healthcare procedures. This was the least commonly described strategy and was mainly found in childbearing women who had been encouraged to develop their own birthing plans. Seng et al. (2002) noted that one woman and her partner developed a birthplan and then shopped around until she found a midwife willing to comply with the plan. The participant explained, “[W]e just really laid down.... This is what we want. This is what we’re gonna do. Can you provide this for us?” (p. 365).

In their study of labor styles, Rhodes and Hutchinson (1994) noted that survivors who coped with childbirth by “taking control” can be very demanding, seeking to take control of their bodies, their management, and their environment. Some women sought to control the actions of

healthcare providers down to the smallest detail. Rhodes and Hutchinson found that those who coped by taking control were often inflexible about changes to treatment plan and resisted changes even when their clinical situation warrants modifications. Moreover, if their demands are not met with traditional providers, they may seek nontraditional care where the survivor can maintain more control over the process. Seng et al. (2002) made similar observations. They noted that survivors' attempts to take control of the treatment process often elicited negative responses in healthcare providers who usually failed to recognize the women's demands were an attempt to cope with posttraumatic responses.

Lasiuk (2007) reported a participant who described a very difficult labor in which she attempted, without success, to control the process. Her need to control the situation led to an adversarial relationship between her and the medical staff. "I had a very bad, had a very bad relationship with the medical people.... We were at complete odds with each other, the doctors, and me... I was quite determined that this baby not be touched" (p. 109). Her many hours of labor culminated in a forceps delivery. "I was yelling at my husband to get the baby away from these people. I had complete distrust for everyone in that room ... it was really quite traumatic" (p. 110).

Planful Problem Solving. Survivors further along in recovery attempted to manage triggering by proactively addressing internal and external factors associated with triggering. The way participants dealt with internal factors was through psychotherapy. For example, some participants recognized that their difficulties in healthcare were related to their past abuse and sought psychological counseling in order to deal with the aftereffects of their trauma. The most common way that participants sought to address external factors related to triggering was by seeking out "sensitive" providers who would be open to a collaborative relationship where

control was shared. For example, Roberts et al., (1999) found that many participants specifically sought out female providers who were less authoritarian and who allowed them to have more control during healthcare visits. When participants found a provider they could trust, they were more likely to disclose their abuse and to explain to the provider aspects of care that gave them difficulty. Similarly, Palmer (2004) noted that many of the women in her study described attempting to prevent triggering by making deliberate choices about who their healthcare providers would be. For example, some of the participants in Palmer's study chose to have a female doctor, while others sought out a midwife or doula to manage their care. A common reason for choosing a midwife was because participants believed the midwife would take more time to explain things and would be more open to sharing control. One survivor explained, that she didn't feel "supported" by the medical model where doctors tell patients what to do. She found midwives to be more supportive, saying,

"I needed to be informed of what they were doing, I needed to be asked for permission to do things and clearly they did that ... and I think the critical piece of information is that I was able to explain why, why I needed to know what was going to happen to me and ... they implicitly understood why I needed that (p. 160).

When providers listened to and honored participants need for control, participants reported positive relationships with their providers and reduced episodes of triggering. For example, childbearing participants who reported a greater sense of control over what happened to them during labor also expressed greater satisfaction with their birth experiences. In one instance, a woman interviewed by Lee (2001) experienced considerable triggering during a surgical treatment for kidney problems. When faced with a cesarean-section, she asked for modifications of the induction process to help her tolerate the procedure. Her physicians complied and she reported that she did not feel traumatized by the surgery because she was able to feel some control over the process.

Planful problem solving was especially effective when participants addressed both internal and external factors related to triggering. In these cases, participants sought out sensitive healthcare providers while at the same time participating in psychotherapy with therapists knowledgeable about abuse. Outcomes associated with this combined strategy were especially positive (Lee, 2001; Palmer, 2004). For example, Palmer reported that one of her participants received specialized prenatal care from a therapist experienced in working with childbearing women who were survivors of sexual abuse. The participant developed her birth plan with her therapist's guidance and then discussed it with her caregivers. Her caregivers were supportive of the plan and, of all the women interviewed by Palmer, this participant reported the most positive birth experience. Similarly, Lee reported that several of their participants sought help from therapists during pregnancy. One participant spent several months in therapy with a psychologist preparing for childbirth. Another participant developed a birthplan with the help of her husband and a mental health professional. The plan made it clear that there was a potential for flashbacks during childbirth and explained how her nurses and doctors could be helpful if this happened. Lee reported that both participants considered childbirth to be the first time in their lives that things had gone as they hoped and planned. The participants considered these positive healthcare experiences to be a turning point in their lives.

Potential for Unhealthy Outcomes

Retraumatization resulted in a wide range of potentially unhealthy outcomes for abuse survivors. Some outcomes resulted from the tremendous stress they experienced during triggering. As noted previously, investigators reported that participants often described experiencing extreme emotional and physiological distress when triggered. In several instances, triggering caused participants to become suicidal (Gallo-Silver & Weiner, 2006).

Other unhealthy outcomes were a secondary consequence of avoidant coping, with healthcare avoidance placing survivors' health at greatest risk. Investigators reported numerous instances in which participants avoided preventative health care, delayed seeking medical attention for serious illnesses, or failed to return for follow-up care. They also reported instances in which participants refused prescribed procedures or medications, stopped procedures before their completion or refused medical interventions to safeguard the health of their fetus. The most sobering examples of how healthcare avoidance can negatively impact health were provided by Gallo-Silver and Weiner (2006) in their study of survivors in cancer treatment. Several survivors abruptly left cancer treatment preferring death over the distress caused by aspects of care they found triggering.

Less extreme forms of avoidant coping also had the potential to result in negative outcomes. For example, investigators reported that dissociation impaired participants' ability to convey important information, make medical decisions and/or remember health related instructions. Denial could cause delays in seeking treatment. Gallo-Silver and Weiner (2006) reported that a 52-year-old woman ignored symptoms of ovarian cancer until the mass was so large it blocked her intestine and she was throwing up fecal matter. Submissive behavior also led to negative outcomes as those who coped through passive submission tended to suffer in silence. In these cases, participants' failure to self-advocate led them to miss opportunities to discuss questions with their provider or find solutions to issues that are bothering them. Moreover, without a means of resolving their distress, submissive patients tended to resort to other forms of coping, such as healthcare avoidance. As noted previously, Schachter et al. (1999) described an instance in which a participant was triggered by the unexpected raising of the table she was laying on. Rather than discuss her distress with her physical therapist, she kept her feelings

inside. She also never returned for her next appointment and thus never received physical therapy for her physical problems.

Desired Interventions

Childhood sexual abuse survivors are not doomed to retraumatization, as all investigators identified ways in which healthcare providers can reduce the likelihood that survivors will be retraumatized during care. Another survivor explained the need for healthcare providers to intervene in this cycle.

Because otherwise you're going to have a certain segment of patients that are going to walk away feeling as though they've been abused all over again, quietly abused, just walking away and seeking another health care practitioner, just going through the cycle, again and again and again, and maybe not understanding why, maybe not knowing how to say it, how to voice that, just keep going through that whole cycle over and over again. (Schachter et al., 2008, p. ix).

The data revealed that the core need for survivors during healthcare was a sense of safety. Based on their interviews with survivors, investigators offered a number of strategies that healthcare providers can employ to help survivors feel safe during healthcare interactions (Alpern, 1992; Gallo-Silver & Weiner, 2006; Roberts et al., 1999; Schachter et al., 1999; 2004; 2008; Stalker et al., 1999; 2005; Van Loon et al., 2004). Strategies recommended for creating safety were analyzed and grouped into five categories: (1) show respect and build rapport; (2) display sensitivity to abuse related issues; (3) share power and control; (4) provide continuity of care and appropriate referrals; and (5) recognize the dilemma of disclosure. Together these interventions make up the core of what can be termed survivor-sensitive healthcare.

It is important to point out that all of these interventions are aimed at modifying relational dynamics between providers and patients. This focus makes sense given that most triggers in healthcare are relational in origin. In addition, while the analysis confirmed Schachter et al.'s 1999 finding that safety is the core need for survivors in healthcare; it also revealed that a sense

of safety is not possible without first building a basis of trust. In other words, in order to feel safe in healthcare, survivors must first develop a trusting relationship with their healthcare provider. To build trust, healthcare providers must provide tangible evidence to survivors that they are trustworthy. No one intervention was sufficient to build trust. Rather, each of the five recommended interventions can be understood as building blocks necessary for constructing trust. It is on this foundation that a sense of safety can be developed.

Show Respect and Build Rapport

Investigators reported that their participants want a provider who takes the time to establish rapport and who helps them feel that they are viewed as unique individuals. For example, Alpern (1992) reported that all her participants viewed being able to trust their healthcare provider as an important component of a good client/provider relationship. Yet, before participants could trust their provider, they first needed to feel like the provider cared about them. Investigators also reported that survivors want providers who are gentle, personable, open, who display acceptance, empathy, real caring, are available for questions, and show that they believe their patients when they disclose abuse (Alpern, 1992; Schachter et al., 1999; Van Loon et al., 2004).

A sense of connection with the provider was particularly important. To create a sense of connection, investigators emphasized the importance of providers listening to survivors and letting them know that they had been heard. A survivor in physical therapy explained how she needed to connect to her providers in order to trust them.

And to me, the main thing would be being able to sit down and talk, to know that person and feel some kind of trust, because they're a stranger ... and you don't know them from anyone. Whereas, if you can sit down, talk with them, find out a little bit ... [it's better] ... (Schachter et al., 1999, p. 252)

Display Sensitivity to Abuse-Related Issues

Investigators reported that survivors expressed a preference for caregivers who demonstrate awareness and knowledge of the dynamics of and long-term sequelae of childhood sexual abuse. Survivors also wanted providers who understood how stressful healthcare can be for them and who were willing to help them manage triggers. Because survivors often had difficulty with caregivers who were the same gender as their abuser, they wanted to be offered the choice of a male or female provider. Participants wanted healthcare personnel to offer them this choice upfront, as they indicated that they often felt uncomfortable advocating for themselves on this issue (Schachter et al., 1999). Seng et al. (2002) noted that if a provider is unable or unwilling to address survivors' trauma-related needs, they should refer survivors to a more appropriate provider.

Healthcare providers who displayed sensitivity to survivors' difficulties in healthcare were generally viewed as trustworthy and associated with positive healthcare experiences. One of Alpern's (1992) participants described her experience with a female doctor who responded sensitively to her abuse disclosure.

I had a doctor there who was really great.... One of the things that was really great about her was that I could tell her that I was an incest survivor. And she was educated enough to know what that meant. (p. 60)

The provider's response included willingness to talk about the participant's abuse history without asking "invasive questions" and letting her know that she was not the only client who had revealed an abuse history (p. 61). In addition, the physician was knowledgeable about local resources available for childhood sexual abuse survivors and made sure that the participant was aware of these resources.

Share Power and Control

One of the most frequently mentioned attribute that participants wanted in a healthcare provider was willingness to share power and control. (Alpern, 1992; Gallo-Silver & Weiner, 2006; Roberts et al., 1999; Schachter et al., 1999; 2004; Stalker et al., 1999, 2005; Teram et al., 1999). Investigators listed a number of actions that providers could perform in order to instill a sense of power and control in their patients (Alpern, 1992; Gallo-Silver & Weiner, 2006; Palmer (2004). The most basic of these actions involve not rushing the examination and sharing information with the patient (Alpern, 1992). Alpern suggested that before performing an examination, providers should first explain what will be done and show their patients the instruments to be used in the exam. According to Alpern, explanations and sensory descriptions about what survivors could expect, along with allowing them to retain control, helped decrease their anxiety levels during examinations. Gallo-Silver and Weiner (2006) and Palmer (2004) offered similar suggestions saying that in order to feel safe, survivors need to understand what is happening around them, and what will happen next. A survivor interviewed Palmer explained how a nurse helped her feel safe during gynecological examinations. “It really helped me when she told me what she was doing, why she had to do it, and where she would be touching me. It just helped me to prepare for it better” (p. 171).

The second way that providers can instill a sense of control is to help survivors feel that they have a choice in the process. Actions as simple as asking permission to perform a procedure can reduce feeling of anxiety and powerlessness by increasing survivors’ sense of control (Palmer, 2004; Roberts et al., 1999; Stalker et al., 2005; Schachter et al., 1999; 2004; 2008). Palmer and Schachter et al. found that survivors also wanted providers to ask permission before touching them, as being touched without their consent was viewed as a threat to their safety. A

survivor interviewed by Palmer explained how her provider asking permission prior to initiating touch helped her feel both safe and valued.

It was really important for me to feel like I had some choice in all of it and it was really helpful when she asked me if it was OK for her to touch me. It was like she was respecting me. (p. 171).

Because survivors' level of comfort can change quickly, investigators recommended that providers seek consent before each step of an examination or treatment while checking on patients' level of comfort (Schachter et al., 1999; 2004; 2008; Seng et al., 2002; Stalker et al., 1999; Van Loon et al., 2004). Schachter et al. suggested that the consent process needs to be ongoing as survivors can manifest different levels of tolerance for touch in different areas of their bodies and over time. For example, some survivors in physical therapy were able to tolerate touch in some areas of their body but not others; while others found it difficult regardless of where they were touched. In addition, some survivors were able to tolerate touch as they developed trust in their physical therapists; however, for others touch was difficult regardless of the circumstances.

Despite their difficulties with being touched, Schachter et al. reported that their participants were reluctant to raise the issue with their healthcare providers. One woman explained that she did not feel comfortable raising the issue of touch with her physical therapists because "I didn't want them looking at me like, "What are you, bonkers?" (Schachter et al., 1999, p. 257). For this reason, survivors preferred that healthcare providers seek their consent upfront rather than expecting patients to inform them if they have a problem. As part of the consent process, it was recommended that providers give patients permission to stop the examination at anytime if they become uncomfortable. Schachter et al. (1999) noted that many survivors have difficulty self-advocating because they "learned as children that they were not

allowed to speak up, that they were not allowed to say ‘no,’ and that their feelings were not important” (p. 254). For this reason, providers need to invite feedback during care and to give survivors explicit permission to decline any aspect of an examination or treatment. A survivor suggested that providers make a clear statement giving patients explicit control during the first visit.

Making an open statement in the first visit, just saying, “If you’re not comfortable with me, there are other options.... Or if you’re uncomfortable with anything that I do, please raise that issue.” Just having more control. (Schachter et al., 1999, p. 254)

The importance of setting up a signal and allow for a break during treatment was also emphasized. Setting up a signal prior to a procedure helped survivors retain a sense of control and decreased their risk of being triggered (Schachter et al., 1999; 2004; Stalker et al., 2005).

One survivor spoke about the importance of a stop signal.

I think [it s important that the physical therapist offer] a real clear statement and reminders throughout---you can say, “Stop,” or “Wait,” or “Change”.... And it has to be instant. If somebody says, “Stop,” you stop... (Schachter et al., 1999, p. 254)

It was also suggested that providers frequently check on their patients’ level of comfort, while saying alert for nonverbal signs indicating anxiety, tension, or discomfort (Stalker et al., 2005; Teram et al., 1999). If they do become triggered, survivors said they need reassurance and a caring response from their provider.

When providers were willing to share power and control, participants tended to report a sense of being empowered and respected. They also reported feeling more trust in their provider and were less likely to become triggered during healthcare interactions. For example, one of Alpern’s (1992) participants described receiving a pelvic examination from a healthcare provider who responded with sensitivity to her abuse disclosure. “[The provider] told me we could go as slow I wanted and she would tell me what she was doing every step of the way, and that I could

stop at anytime” (p. 62). In addition, the provider reminded her to breathe during the examination and encouraged her throughout the process. The woman described a positive experience during which she was able to be examined without becoming triggered.

Provide Continuity of Care and Appropriate Referrals

Participants expressed a preference for providers who offered them continuity of care, individualized follow-up, and referrals that take into account their special needs (Alpern, 1992; Roberts et al., 1999). Continuity of care was particularly important as it allowed survivors time to build trust with their provider and made it less likely that previously established safety would be violated (Alpern). A survivor interviewed by Roberts et al. emphasized the importance of having an ongoing relationship with a provider with whom she could “negotiate” and maintain control of her own care (p. 42). Individualized follow-up care also helped survivors feel cared about holistically.

Participants also emphasized the need for written instructions as dissociation can impair survivors’ memory. Written instructions helped participants remember what their providers had told them and made it possible for them to follow through with recommendations. Participants also appreciated it when providers checked on their well being after a procedure or sent them follow-up information. A woman interviewed by Alpern (1992) talked about how much it meant to her that her doctor called her up at home to check on her after a surgical procedure. Another woman stated that her doctor “had this really cool thing that she would write you a letter a few days after your examination And she would talk about, what happened in the examination and what recommendations she had made That was really good” (p. 71). The woman noted that the follow-up letter gave her a sense of completion and it helped her remember what the doctor had told her. She explained that written instructions were important because “it can get a

little blurry while you're in there ... especially for people like me, incest survivors. It gets really blurry, especially if you're talking about a gynecological exam" (p. 71). She also described how the letter from her doctor made her feel valued. "I really felt like I was her client. As opposed to just sort of this nameless, faceless [patient] who, kind of, got processed. You know, she was what I consider to be the perfect, perfect GP" (p. 71).

When a medical referral was necessary, survivors who had disclosed their abuse wanted their providers to take their abuse-related issues into account. Survivors wanted to be referred to practitioners who are sensitive to survivor issues and knowledgeable about the effects of traumatic experiences (Schachter et al., 2004). Women interviewed by Van Loon et al. (2004) recommended that healthcare providers be prepared to refer survivors with abuse-related difficulties to appropriate psychotherapists.

Understand the Dilemma of Disclosure

Disclosure was not easy an easy decision or process for abuse survivors. Disclosing abuse was a very personal decision and there was considerable diversity of opinions about the subject among the participants of the various studies. While there was widespread agreement that past abuse was relevant to the therapeutic relationship, before disclosing abuse, survivors first weighed the benefits of disclosure versus the risk of harm. Factors that influenced survivors' comfort with disclosure included: survivors' own acceptance of their personal abuse history and their level of trust in their provider. Survivors also were concerned with privacy issues and the risk of stigmatization.

Teram et al. (1999) reported that their participants were in different stages of dealing with their abuse resulting in varying abilities and willingness to handle disclosure. Some participants could not have disclosed their abuse to healthcare providers because they reported having no

memory for their abuse until after being triggered during healthcare. For example, Gallo-Silver and Weiner (2006) reported that of the 18 abuse survivors in their sample, 15 reported that their traumatic memories were inaccessible to conscious thought processes prior to their cancer diagnosis. Other participants were unwilling to disclose their abuse as they themselves had not yet come to terms with it. Still others said that they would not disclose because they considered their abuse history to be a private matter that they did not feel comfortable talking about. For these reasons, participants cautioned against providers assuming there is no history of abuse even when clients do not disclose it. One survivor explained,

Some people have never gotten treatment [such as counseling or psychotherapy] and they would deny it and I found that with myself, for years, I knew something was wrong, I knew why I felt uncomfortable, but I would never tell anybody. I was in denial for like 30 years. I knew what happened to me ... but I wasn't about to tell anybody if they had asked me, like no way." (Teram et al., 1999, pp. 95-96)

Another issue that affected participants' willingness to disclose their abuse was concerns about whether or not their healthcare provider could handle hearing about abuse along with apprehension about how their provider might respond. Stalker et al. (2004) found that disclosure will not occur if the survivor is unsure about how such information will be received. A survivor in physical therapy indicated she would not disclose her abuse even when directly asked saying, "I didn't know how they were going to react or if they would shy away from it, or if that's something they wanted to hear" (Teram et al., 1999, p. 94). Teram et al. concluded that some survivors "prefer the known pain of secrecy over the unknown predicament of disclosure" (p. 96).

Survivors were particularly concerned with not being believed when they disclosed abuse and with being blamed or judged. Palmer (2005) noted that some participants who had previously disclosed their sexual abuse histories to providers believed that a label had been

attached to them and that as a result they were treated “differently” (p. 161). According to Palmer, being labeled as different was perceived as threatening to the survivors she interviewed, as they had worked their whole lives to be accepted by others. In other instances, participants reported that healthcare providers had reacted to abuse disclosures in a judgmental and insensitive manner, thereby reinforcing their sense that they were “bad”, “dirty” and “unworthy” (p. 162). One participant said she did not feel safe enough to disclose her abuse because she fears rejection. She revealed,

I've had experiences before where I have mentioned it, and someone has just freaked out or else they've looked at me like I'm from a different planet.... I don't want to talk about it or mention it, and get that rejection. Because that is the worst. (Teram et al., 1999, p. 94)

Another participant reported that when she told her physical therapist about her history of abuse, the provider went right on with her work without saying anything. The participant stated, “Oh boy! If someone says it, then you've got to acknowledge it. Because then what [the lack of response] says to me, is that it's not valid, it's not important...” (p. 95).

Male participants expressed even greater apprehension than females about disclosing sexual abuse to healthcare professionals. Men interviewed by Teram et al. (2006) raised numerous impediments to disclosure including difficulty acknowledging vulnerability and were concerned that their disclosure would not be believed. They were also concerned that their disclosure would be met with minimizing reactions indicating that the abuse was not that bad and they should “just shake it off and carry on” (p. 510). Schachater et al. (2008) reported that their male participants believed that healthcare providers are skeptical about men who disclose sexual abuse and believed that many people take male sexual abuse survivors' experiences less seriously than those of females. Men whose perpetrator was also male expressed fear that others would view them as gay; while men who were abused by women feared minimization of its

abusive aspects based on society's normalization of boys having sex with women. Men also worried about others viewing them as potential perpetrators due to the widespread societal belief that it is only a matter of time before abused males themselves become perpetrators.

There was also considerable diversity about whether or not participants wanted providers to routinely ask about an abuse history and ambivalence about whether they would truthfully answer direct questions about sexual abuse. Preferences expressed can be viewed as occurring on a continuum ranging from believing all inquiries about abuse were inappropriate to believing abuse should be routinely inquired about at the initial healthcare encounter. Most participants' opinions fell somewhere in the middle between these two positions and supported limited forms of inquiry. The majority of survivors felt comfortable with an indirect problem-solving approach that would allow survivors to disclose as little or as much as they felt comfortable discussing.

Teram et al. (1999) suggested that providers initiate a discussion of clients' feeling about touch, disrobing, difficult body positions and other potential triggers that may interfere with treatment. A survivor interviewed by Teram et al. suggested that providers ask, "Is there anything that you would like me to know in treating you?" (p. 93). Another suggested that providers ask all patients whether they have any difficulty getting undressed or being touched. Teram et al. contended that this type of questioning conveys to patients that the provider is sensitive to abuse-related issues. Such questions also provide a starting point for engaging in a conversation that might lead to disclosure or at least encourage patients to identify aspects of the treatment process that could cause them difficulty. This indirect approach was supported by the findings of other investigators (Alpern, 1992; Lasiuk 2007; Stalker et al., 2005). In their study of survivors in dental care, Stalker et al. recommended that providers ask general questions directed at making all patients more comfortable during exams. As an example, Stalker et al. suggested

providers could ask, “Are there any parts of dental treatment that are particularly difficult for you? Is there anything we can do to help you feel more comfortable?” (p. 1280). Stalker et al. also suggested checking in with patients during treatment and watching for fearful body language.

While Schachter et al. (2008) acknowledged that not all survivors want to be asked about their abuse history, they nonetheless recommended that practitioners routinely ask patients about violence and abuse. Schachter et al. noted that by asking about past violence and abuse, healthcare providers open the door for survivors to disclose which may reduce their risk for retraumatization. By merely raising the issue, Schachter et al. suggested that practitioners can achieve the following:

- (a) demonstrate that they have an understanding of the relationship between interpersonal violence and health; (b) break the harmful silence surrounding abuse and violence; (c) signal that they recognize interpersonal violence as a health issue; and (d) validate their patients’ experiences. (p. 60)

When abuse is inquired about directly, investigators emphasized that these queries should be done in a safe, confidential environment where the conversation cannot be overheard by other patients and staff. Alpern (1992) cautioned against inquiring about a history of sexual abuse during gynecological examinations. Instead, questions should be posed when patients are fully clothed and not in a vulnerable position. Van Loon et al. (2004) contended when providers query patients about abuse, the questions should be asked with sensitivity and the provider should convey genuine concern.

Most participants indicated that they would decide whether or not to disclose their abuse history based on the sensitivity and trustworthiness of the provider (Alpern, 1992; Stalker et al., 2004; Teram et al., 1999). According to Teram et al., for many survivors, the key to disclosure was a feeling of comfort and connection with their provider. Stalker et al. emphasized that

survivors are more likely to take the risk if a provider gives them a reason to believe that the disclosure will be believed and responded to with calmness, compassion and concern. In the absence of disclosure, Seng et al. (2002) suggested that patients who show evidence of posttraumatic reactions should be assumed to be potential survivors and providers should respond therapeutically without forcing the issue.

Investigators also provided guidance regarding how survivors want providers to respond to abuse disclosures. Schachter et al. (1999) contended that the most appropriate response to disclosure is for the provider to verbalize acceptance and acknowledgment of the abuse and its consequences for the survivor. Van Loon et al. (2004) suggested that providers respond to abuse disclosures by letting patients know that they are believed and by offering to refer them to appropriate counseling. Van Loon et al. also found that survivors also want control over whether or not information about their abuse history goes into their chart. Participants indicated that it was inappropriate for providers to respond to a disclosure by pressing for unnecessary details. One participant commented that when a survivor discloses abuse, “it’s not necessary to delve into their past and find out all the nitty-gritty stuff...” (Teram et al., 1999, p. 95). Teram et al., found that, rather than asking for details about the abuse, survivors would like providers to respond to an abuse disclosure by asking what they can do to make the healthcare experience more comfortable for the patient. Silver and Weiner (2006) cautioned against focusing too intently on the abuse as this can have a destabilizing effect on patients. Pressing for details can cause survivors to experience intense affect and suicidal thoughts, or activate self-harming behaviors. This point was reiterated by Van Loon et al. Their participants reported that talking about their abuse tends to bring up feelings of despair, anger and desperation. Women interviewed by Van Loon et al. described past experiences with voyeuristic staff who had talked

about them behind their backs and asked for embarrassing details about their abuse. Some women said that they felt as if the staff wanted to know their awful story, but were disinterested in helping them find the resources to heal. As a result, the women said they felt “abused again” (p. 212).

How Empowering Survivors Can Aid in Healing

When healthcare providers were sensitive to their abuse-related issues and were willing to share control, participants often reported feeling empowered rather than retraumatized during healthcare. Participants also reported becoming more active participants in their healthcare. Feeling safe allowed abuse survivors to relax and thus be able to hear what providers were saying, to ask questions, to cooperate during treatment, and to follow clinical instructions and recommendations (Stalker et al., 1999). A sense of empowerment during healthcare not only improved healthcare experiences, it could be an important step in healing from childhood trauma. Stalker et al. (1999) suggested that empowering survivors can help them realize that they do not need merely to submit to experiences that frighten or confuse them. A sensitive provider can provide a safe place where survivors can begin to express their needs, take charge of what happens to their bodies, and take more responsibility for their own health and comfort.

Lee (2001) suggested that when relationships with healthcare providers went well, they could be a cornerstone of the healing process. One of Lee’s participants “Fay” had been hospitalized on several occasions during which she felt she had been violated emotionally and physically. Fay stated “all my rights were sort of out of the window” (p. 102). A difficult experience with a doctor in another hospital resulted in her filing charges against the doctor. When she became pregnant, Fay decided to avoid doctors and have her baby delivered by midwives. She had a positive experience which she attributed to the fact that the midwives were

nonjudgmental and supportive. In addition, she explained “no one took away my rights” and when “I told everyone what I needed, and they did it” (p. 102). She discussed how their positive healthcare experience helped heal her negative belief system about the world.

I used to look out at the world like it’s going to happen, someone’s going to do something nasty, something’s going to happen, and it’s not that way anymore.... [Now] it’s not my first line of defense, to look at something skeptically and assume it’s going to be bad.... And for that, I will always be indebted to those women, that hospital. (pp. 102-103)

Summary of Expert Feedback

The Healthcare Retraumatization Model was reviewed by eight experts and revised based on their recommendations. The experts included the lead investigators of five of the studies included in the meta-synthesis and three clinicians experienced in working with abuse survivors. In addition to critiquing the Model, these experts provided feedback on how well the Model fit with their own research or clinical experience. All expert reviewers considered the Model to be useful and generally representative of their findings either in research or in their clinical practice. A summary of the eight expert responses are provided in Table 11.

No substantive changes were recommended regarding the Model as illustrated in Figure 1. However, based on expert feedback, several arrows in Figure 1 were moved to better clarify the interrelationship between Model components. In addition, self-harm was added to the list of potential coping strategies used by survivors to cope with retraumatization and a definition of retraumatization was added to the Model description. One expert raised the issue of whether the cycle would be better represented as a spiral; however, due to a lack of data of participants’ reactions to retraumatization over time, it was determined that a cycle best represented the data synthesized.

The main criticism of meta-synthesis results was that female abuse survivors were over-represented, mostly due to the fact that most studies failed to include males in their samples. Drs.

Schachter and Stalker provided a recent paper (Schachter et al., 2008) they had written which contained more data regarding the experiences of the male survivors from several of their past studies already included in the dataset (Schachter et al., 1999; Stalker et al., 2005; Teram et al., 2006). The new data was incorporated into the meta-synthesis results providing greater gender inclusivity. For example, Table 10, which provides representative quotes by abuse survivors regarding relational triggers, was revised. Prior to revision, the table only included quotes from female participants. After revision, quotes from both females and males were presented. In addition, additional quotes by males were added to the meta-synthesis results to illustrate key findings.

Another source of criticism was on the terms and explanations for the different categories of triggers. While experts generally liked the division of triggers into different categories, concerns were raised about overlap between categories and the use of the term “generalized” to represent triggers based on interpersonal dynamics. One expert noted that the term was not descriptive and lent itself to confusion. After an in depth discussion with this expert, the decision was made to replace the term “generalized triggers” with “relational triggers”. In addition, the Model description was revised to better emphasize the overlap between the two categories of triggers (i.e., sensory and relational) and to clarify that some relational triggers could at times also be sensory (e.g., touch). In the discussion about triggers, information on the roles of both healthcare providers and staff in the triggering process were expanded. In addition, several sections were reworded to clarify that the findings were applicable to all healthcare providers and not limited to nurses and physicians. Finally, data showing anticipatory reactions and autonomic arousal was added to description of stress reactions.

Table 11. Summary of Experts' Answers to Questions Regarding the Model and Meta-synthesis Results¹

Experts	Questions					
A ²	1. Aware of studies not included?	2. Is Model adequately supported by the data?	3. Are quotes adequately support the main conclusions?	4. Is Model consistent with your research or clinical practice?	5. Do you have suggestions for how the Model could be strengthened?	6. What do you view as the most pressing need for future research?
B ²	No	Yes. Use gender-inclusive language	Yes	Yes. have not captured is the heterogeneity of survivors and their responses to health care encounters Yes.	Need more gender inclusivity; Include autonomic arousal	Education of healthcare professionals and development of practice guidelines
C ²	No	Yes	Yes	Yes. We also included physical pain associated with past abuse, ambivalence about the body, and self-harm	Discuss increased utilization of the health care; More on relationship between patients and providers	Explore ways in which CSA survivors have successfully coped with their healthcare experiences; Testing interventions. More research on male survivors' experiences affect health care. Longitudinal research to test Model
D ²	Schachter et al., 2008	Yes, but explain why Avoidant Coping lead to Hypersensitivity; define retraumatization; add ambivalence about body and concerns about worthiness for care	Yes, but need additional quotes from male survivors	Yes, illustrate the range of Potentially Unhealthy Outcomes; include autonomic arousal in Stress Reactions; In Coping found hostility/anger - particularly among male survivors.	More gender inclusivity; focus more on general healthcare rather than medical care; problems with explanation for generalized versus abuse-specific triggers;	Not sure

Experts		Questions					
	1. Aware of studies not included?	2. Is Model adequately supported by the data?	3. Are quotes adequately support the main conclusions?	4. Is Model consistent with your research or clinical practice?	5. Do you have suggestions for how the Model could be strengthened?	6. What do you view as the most pressing need for future research?	
E ²	No	Yes, but show more examples of how one process leads to another; Should it be a spiral rather than a cycle?	Yes	Yes.	Need to make explicit that the healthcare setting is a player in the Model; include points of intervention, counter examples	Explore potential for retraumatization in patients who have undergone extensive invasive procedures; How to identify who is having trouble	
F ³	No	Yes	Yes	Yes	Dislike term "generalized" trigger	Research into what we can do to help professionals change their behavior toward abuse survivors.	
G ³	No	Yes	Yes	Yes. Some clients have anticipatory reactions; Stress reactions can manifest as physical sensations – i.e., stomach tightening	None	Research looking at retraumatization as a form of chronic stress	
H ³	No	Yes	Yes	Yes. But Model doesn't mention potential for clients to stay with healthcare provider who mistreats them.	None	Education of healthcare professionals	
<p>Note.¹ Feedback was provided by five of the lead investigators whose studies were synthesized and three clinicians who work with sexual abuse survivors; ²Capital letters represent feedback from lead investigators who reviewed the Model. These included: Gerri C. Lasuk, PhD; Susan Jo Roberts, DNSc; Julia Seng, PhD; Candice L. Schachter, PhD; Carol A. Stalker, PhD; and Julia Seng, PhD, in no particular order; ³ Capital letters represent feedback from clinicians who provided expert feedback. These included: Luci Lee, PhD; Christine Courtois, PhD; and Joyanna Silberg, PhD, in no particular order.</p>							

CHAPTER 5 - DISCUSSION

The purpose of this study was to determine, through meta-synthesis and grounded theory analysis, the social processes adult survivors of childhood sexual abuse engage in when experiencing retraumatization during healthcare encounters and to generate a model of the retraumatization process. Although retraumatization has increasingly been recognized as a significant obstacle to sexual abuse survivors' ability to access and tolerate healthcare, knowledge in this area has been limited by the lack of a conceptual model to guide assessment and intervention. A number of qualitative studies have been done on survivors' experiences in the healthcare system. These studies are rich in data but are limited by their small sample sizes and focus on specific settings. In addition, most studies only asked about experiences in a limited service area such as dental or obstetric care. Meta-synthesis provided a means of transcending limitations posed by small sample size and limited focus by providing a systematic means to combine qualitative results across studies.

The limitations posed by the disparate and narrow focuses of individual qualitative studies can become a strength when combined via meta-synthesis. For example, a strength of the current meta-synthesis is the heterogeneity of the survivors and settings sampled. The 15 studies synthesized represented experiences of 411 participants from a variety of backgrounds and countries. Despite the heterogeneity of participants and methods, broad similarities were found in participants' concerns and experiences during their passage through the healthcare system. Such variation in subjects and the greater range of interview data can result in the wider applicability of a grounded theory (Carpenter, 1995; Glaser & Strauss, 1967).

One of the main functions of meta-synthesis is theory building (Schreiber et al., 1997). Without a theoretical context, patients' symptoms and behaviors have no particular meaning. A theoretical context not only gives symptoms meaning, it provides a framework through which potential treatment options can be developed. Careful analysis allowed for the recognition of key elements and processes of retraumatization resulting in the Healthcare Retraumatization Model. This model describes cognitive and behavioral dimensions associated with the construct of healthcare retraumatization specific to childhood sexual abuse survivors' experiences in the healthcare system.

Theoretical and Quantitative Support for the Healthcare Retraumatization Model

Although the Healthcare Retraumatization Model has yet to be tested, one indication of its validity is how well aspects of the model tie in with prior theoretical work and quantitative research. The Model is strengthened by the fact that it mirrors much of our current understanding of PTSD, a well conceptualized, articulated, and empirically supported theory. The Model views retraumatization in healthcare as a process composed of four interrelated subprocesses: hypersensitivity to threats to safety, exposure to triggers, post-traumatic stress reactions, and avoidant coping. These processes tend to reinforce one another and, when left unchecked, can result in unhealthy outcomes. A similar pattern is found in PTSD. In fact, the alternation between, and coexistence of, re-experiencing traumatizing events and avoidance of reminders of the trauma are hallmarks of posttraumatic stress disorder (APA, 1994). Theoretical and quantitative support for each of the subprocesses involved in retraumatization along with their relationship to PTSD is explored below.

Support for a Hypersensitivity Reaction to Threats to Safety

The Healthcare Retraumatization Model proposes that chronic abuse causes victims to become very focused on self-protection as they seek to detect and avoid situations that may threaten their safety. This orientation toward threat was conceptualized as “hypersensitivity to threats to safety” and is viewed as a precipitating cause of retraumatization in the current model. Participants tended to feel threatened by situations which required trust or which made them feel vulnerable, powerless, and out of control of what was happening to them. At the same time, low self-esteem and feelings of powerlessness made it difficult for survivors to self-advocate in healthcare situations thus reinforcing feelings of powerlessness and contributing to their safety concerns.

The potential for childhood maltreatment to negatively affect adult survivors’ views of themselves and expectations of others has been discussed extensively in the attachment literature. Attachment theorists suggest that maltreatment during childhood can lead to atypical or insecure attachment patterns and potentially affect adult functioning. Cicchetti and Toth (1995) noted that, “Internal representational models of these insecure and often atypical attachments, with their complementary models of self and other, may generalize to new relationships, leading to negative expectations of how others will behave and how successful the self will be in relation to others” (p. 541). It stands to reason that mental models of oneself in relationship to caregivers may be activated in healthcare, as healthcare is an experience that can evoke the extreme vulnerability and dependence experienced during childhood.

Cognitive theorists (e.g., Epstein, 1987; 1991; Janoff-Bulman, 1992) have proposed that early social interactions form the basis for our fundamental assumptions about ourselves and the world around us. For example, Epstein (1987) proposed that all individuals have *personal*

theories of reality that are composed of *self-theories*, *world theories*, and beliefs about the relationship between the two. Epstein (1991) posited that there were four beliefs central to a personal theory of reality: The belief that the world is benign; that the world is meaningful (including controllable, meaningful and just); that the self is worthy (including competent, loveable and good); and that people are trustworthy. Similarly, Janoff-Bulman noted that through appropriate parenting, we come to assume the benevolence of the world, the meaningfulness of the world, and the self as worthy. When traumatic events contradict victims' preexisting assumptions about the world, this disruption can result in the development of PTSD. According to Janoff-Bulman, victims of trauma *know* that the world is not a safe place and that they are not protected. Moreover, when the trauma is human-induced, victims are confronted with human malevolence and trust in others is seriously disturbed. Victims' views of themselves are similarly tarnished. Janoff-Bulman observed, "The very nature of the world and self seems to have changed; neither can be trusted, neither guarantees security" (p. 62).

Similar cognitive distortions are proposed by Foa and Rothbaum (1998) in their emotional processing theory of PTSD. Emotional processing theory integrates learning, cognitive, and personality theories of PTSD to explain why some victims develop PTSD while others do not (Foa, Steketee, & Rothbaum, 1989). The theory holds that two broad categories of negative cognitions mediate the effects of traumatic events on PTSD development and maintenance. The first refers to a belief that the world is extremely dangerous and the second reflects victims' beliefs about being incompetent. Using a scale developed to measure cognitive distortions after trauma (Posttraumatic Cognitions Inventory [PTCI]; Foa, Ehlers, Clark, Tolin, & Orsillo, 1999), a number of studies have shown that PTCI scores correlate with PTSD symptoms (Foa et al., 1999; Kolts, Robinson, & Tracy, 2004; Laposa & Alden, 2003) and can

discriminate between trauma victims with and without PTSD (Beck et al., 2004; Foa et al., 1999). This body of research supports the contention that traumatic events such as childhood sexual abuse can lead to changes in personal beliefs and that these changes may contribute to the development of trauma symptoms. As such, these studies provide preliminary support for the Healthcare Retraumatization Model's proposition that hypersensitivity to threats to safety has its foundation in trauma's corrosive effects on sexual abuse survivors' core beliefs and assumptions about themselves and the world around them. Participants in the 15 studies synthesized appeared to have internalized a view the world as a dangerous place where people in positions of authority and caretaking roles cannot be trusted. At the same time, participants tended to view themselves as helpless to defend against further abuse making safety a major concern.

Another source of empirical support for viewing child sexual abuse survivors as having an heightened orientation toward threats to safety is provided by studies showing that maltreatment can change children's interpretation and understanding of the emotional signals of those around them (Pollak, Cicchetti, Hornung, & Reed, 2000; Pollak & Kistler, 2002; Pollack & Sinha, 2002). Pollack and colleagues studied physically abused children, who were presumed to have experienced high levels of threat during their abuse. Compared with nonabused controls, physically abused children were more highly attuned to facial displays of anger (Pollack & Sinha). Abused children also had a lower threshold for perceiving faces as angry, but did not differ from controls in perceiving happy, sad, or fearful faces (Pollak & Kistler). These findings suggest that physically abused children may become hypersensitive to any sign that someone is angry, presumably as a way to predict when they might be harmed. In an interview, Pollack noted that this hypersensitivity likely works to children's advantage when they are in the

presence of an abusive parent; however, it can also lead children to perceive threat in situations where no threat is present (Reynolds, 2003).

Support for the role of sensitization in initiating and maintaining triggering and stress reactions can also be found in the PTSD literature. Sensitivity to threatening stimuli is a prominent feature of PTSD (e.g., Ehlers & Clark, 2000; Litz, Orsillo, Kaloupek, & Weathers, 2000). Some theorists view PTSD as a conditioned fear response involving marked anxiety and physiological arousal to things which remind victims of the traumatic incident (e.g., Dykman, Ackerman, & Newton, 1997; Perry et al., 1995; Van der Kolk, 1994). Dykman et al. postulated that PTSD develops as the result of the sensitization of fear and anxiety to stimuli and memories associated with intensely emotional events. The conditioned fear response elicited by these events can subsequently expand to include increasing numbers of traumatic reminders. Similarly, Van der Kolk and Perry et al. theorized that prolonged stress can lead to sensitization of stress-response systems resulting in the brain becoming increasingly sensitive to stress-related cues. As a result, full-blown post-traumatic reactions can be elicited by relatively minor stressors. The sensitization theory of trauma is supported by research findings that indicate that child abuse survivors experience more severe post-traumatic and dissociative symptoms when confronted with subsequent traumatic events in adulthood such as sexual assault (Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996) or combat exposure (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993; Engel et al., 1993; Zaidi & Foy, 1994) when compared to those without a history of childhood victimization.

Sensitization theory lends conceptual support to the Healthcare Retraumatization Model by helping to explain why trauma survivors were often emotionally reactive to stimuli only tangentially related to their abuse, such as the lighting in a treatment room or the gender of their

provider. Sensitization theory also helps account for why, when faced with similar stimuli, participants often displayed widely varying thresholds for becoming triggered. As noted in the results, some participants were triggered when touched in certain places, while others were triggered when touched anywhere on their bodies. Still others were triggered simply by having healthcare providers enter into their personal space.

Further support for the Healthcare Retraumatization Model is provided by the fact that many of the factors postulated to underlie sexual abuse survivors' hypersensitivity to threat (i.e., vulnerability, distrust, feelings of powerlessness, loss of a sense of control, low self-esteem, and difficulty self-advocating) have been found to be important sequelae of sexual abuse. For example, the role of low self esteem, distrust, and powerlessness were recognized by Finkelhor and Browne (1985) in their organizing framework for explaining the unique effects of child sexual abuse. In addition, several quantitative studies reported an association between feelings of vulnerability, distrust, and/or loss of control with abuse survivors' distress during healthcare. Two studies comparing how abused and nonabused individuals perceived their healthcare experiences found that feelings of vulnerability, distrust, and/or loss of control differentiated the two groups (Robohm & Buttenheim, 1996; Willumsen, 2004).

Distrust of authority figures may help explain research findings suggesting that, compared to their nonabused counterparts, sexual abuse survivors tended to feel less supported by their healthcare providers (Salmon et al., 2007) and were more likely to report feeling violated in their interactions with healthcare providers (Swahnberg, Schei, et al., 2007; Swahnberg, Wijma, Schei, et al., 2004; Swahnberg, Wijma, Wingren, et al., 2004). It is possible that this tendency to feel violated is also related to abuse survivors' heightened need for a sense of control during healthcare. As noted previously, one of Lee's (2001) participants felt that she

had been violated emotionally and physically during several hospitalizations. She attributed her difficulties to the fact that during these hospitalizations all of her “rights were sort of out of the window” (p. 102). This same participant reported a positive experience with midwives who listened to what she wanted and allowed her to maintain control over her birthing experience.

Viewing retraumatization as a process based on a hypersensitivity reaction may be rendered more comprehensible by recognizing the similarity between psychological hypersensitivity reactions found in abuse survivors to physiological hypersensitivity reactions associated with asthma. Asthma is a chronic disorder of the airways that causes variable and recurring symptoms. Asthma is characterized by an underlying inflammation of the airways and bronchial hyper-responsiveness to certain stimuli (e.g., allergens; also known as triggers) that provoke symptoms in susceptible individuals (National Heart, Lung and Blood Institute, 2007). In asthma, triggers are often substances that, through repeated exposure, result in sensitization of the immune system and inflammation of the bronchial mucosa. Inflammation leads to hyper-responsiveness to certain triggers, which, in turn, enhances susceptibility to bronchospasm causing more inflammation. The retraumatization process is similar as it also involves a hypersensitivity reaction to certain stimuli which are also commonly referred to as triggers. Retraumatization, according to the Healthcare Retraumatization Model, is characterized by an underlying psychological sensitivity to threats to safety with hyper-responsiveness to stimuli perceived as threatening. Exposure to stimuli (also known as triggers) perceived as threatening can provoke stress reactions related to fear and anxiety. These stress reactions reinforce perceptions of danger, thereby enhancing trauma survivors’ hypersensitivity to the similar stimuli during subsequent exposures. Thus, as with asthma, retraumatization can be viewed as a chronic condition characterized by underlying hypersensitivity to certain stimuli that cause

recurring symptoms. In asthma, exposure to triggers can cause inflammation and result in bronchospasm; while in retraumatization exposure to triggers can provoke a sense of threat and result in post-traumatic stress reactions.

Support for a Reconceptualization of Triggers

Meta-synthesis also provided for a greater level of abstraction allowing for the triggering processes to be better understood. In fact, once the role of hypersensitivity to threat is understood, triggering becomes a much less mysterious process. Triggers can be viewed as external cues that, based on past traumatic experiences, suggest to abuse survivors that their safety is at risk. Thus, triggers can be defined as any event or situation that evokes a sense of threat and results in stress reactions related to past traumas whether or not the survivor is consciously reminded of the trauma. This reconceptualization of triggers recognizes that both internal and external factors are necessary for triggering to occur. Internal factors are based on abuse survivors' hypersensitivity to situational and interpersonal cues that they interpret as threatening. In other words, what survivors find threatening will determine what they subsequently find triggering. As such, hypersensitivity to threats to safety can be considered *precipitating factors* in the triggering process. External factors are situational and interpersonal cues in the environment that survivors interpret as threatening. These external cues can trigger a sense of threat resulting in a stress response. As such, external cues can be considered *initiating factors* in the triggering process. These external cues may be present in varying amounts depending on the context and dynamics present in healthcare settings. Recognition that both internal and external factors are necessary for triggering helps explain why not all survivors are triggered during healthcare and why, even among survivors prone to triggering, some may be triggered in one setting and not in another.

Meta-synthesis also led to a refinement of our understanding of triggers. Triggers have traditionally been viewed as specific stimuli in the healthcare environment that remind patients of their abuse and caused distress (e.g., AMA, 1995; Human Rights Watch, 2000). Similarly, many of the original studies included in the dataset conceptualized triggers in terms of traumatic memory. A notable exception is Palmer (2004) whose definition focused on stress reactions, rather than post-traumatic reminders. Palmer defined triggers based solely on emotional sequelae and coping responses. Palmer defined triggers as “specific events, actions or other factors that elicited anxiety, fear, vulnerability, guilt, or other heightened emotions and coping strategies” (p. 126). It was determined that Palmer’s understanding of triggers provided the best fit with the totality of the data synthesized. However, Palmer’s definition was modified to reflect the finding that hypersensitivity to threats to safety plays an important role in precipitating the triggering process. Thus, *triggers* were defined as any event or situation that evokes a sense of threat *and* results in stress reactions related to a past trauma.

The importance of a sense of threat (i.e., internal factors) in precipitating post-traumatic reactions was recognized by Ehlers et al.’s (2002) in their *Warning Signal Hypothesis*. This theory attempts to explain the paradox in PTSD whereby patients feel anxious about the future even though their trauma lies in the past. Ehlers et al. theorized that the brain encodes and replays sensory stimuli of the events immediately preceding the trauma to serve as a warning signal (i.e., stimuli that if encountered again would indicate impending danger) of current threat. According to Ehlers et al.’s theory, when stimuli encoded as warning signals are re-encountered, victims tend to respond by feeling a sense of impending danger. The hypothesis is based on the fact that intrusive memories commonly consist of stimuli present immediately before the traumatic event happened or before the moments that had the largest emotional impact. Thus,

what trauma victims find threatening often are relatively benign aspects of environment (a sight, sound or smell) rather than key aspects of the trauma. The stimulus can also be feelings experienced prior to the moment of greatest traumatic impact such as a feeling of helplessness.

Viewing triggers as warning signals of potential threat is consistent with the data synthesized in the current study. As previously described in the results' section, a woman interviewed by Palmer (2004) reported being triggered by words a nurse used during her labor. The participant explained, "He [the abuser] used to say that to me and horrible things would happen. I didn't want that to happen again" (p. 171). Thus, this participant, like many others participants of the studies synthesized, viewed relatively a benign stimulus (the nurse telling her to relax) as signaling potential danger. Recognizing that triggering is largely based on survivors' perception of threat helps explain why so many aspects of healthcare can be triggering; *any* situation in healthcare can be triggering if it elicits a sense of threat. At the same time, differences in threat orientation explain why various survivors triggered by the same procedure may identify different aspects of the experience as upsetting. For example, among survivors triggered by gynecological examinations, one survivor may find having to remove clothing to be the most distressing aspect, while another may be most distressed by submissive positioning or by touching of her genitalia.

Meta-synthesis also provided allowed a wide range of triggers to be identified allowing distinctions to be made between different kinds of triggers based on what type of stimuli initiated the triggering process. Triggers were recognized as falling into different groups depending on whether they are sensory or relational in origin. No prior theoretical work has offered similar differentiation of triggers, although the delineation of triggers into different categories is supported by work done by Ehlers and Clark (2000). Ehlers and Clark divided the types of

stimuli encoded as warning signals into three categories: (1) physical cues similar to those present shortly before or during the traumatic event (e.g. the shape of a person, smells, a pattern of light, particular phrases said in a certain tone of voice), (2) internal cues (e.g. touch on a certain part of the body, proprioceptive feedback from one's own movements or posture), and (3) emotional states (e.g. feeling helpless or trapped). While the Model recognizes these three different types of stimuli, they were grouped different categories based on whether the stimuli were sensory reminders of the traumatic incident (i.e., environmental stimuli and/or body sensations), based on relational dynamics, or a mixture of the two. These distinctions were supported by the fact that sensory reminders were highly specific to survivors' individual experience, whereas relational triggers tended to generalize across individuals. As a result, relational triggers were reported as triggering by numerous participants across studies, while sensory triggers were not.

Numerous relational triggers were mentioned and, as a result, relational triggers were divided into categories based on themes developed by the original investigators along with participants' descriptions of being triggered during healthcare. The process of dividing relational triggers into categories was complicated by the fact that relational triggers rarely occurred in isolation and there was much overlap between these various triggers. To form a separate category, it was decided that the relational trigger had to stand on its own. In other words, it had to be distinct enough from other relational aspects of care as to sometimes cause triggering without other relational dynamics present; or if they were present, the relational trigger had to have an additive effect. In addition, each trigger had to be mentioned by more than one investigator. Triggers that were highly similar were grouped together. This process resulted in the formation of eight categories: power imbalance/authority figures/powerlessness; gender of

provider; disinterested or insensitive provider/feeling objectified; lack of control; uncertainty/surprise; submissive positioning; exposure/lack of privacy; and touch. Each category was supported by data from at least four of the 15 studies included in the dataset.

Although no controlled studies support the distinctions between triggers offered in the Healthcare Retraumatization Model, the range of potential triggers in healthcare has yet to be systematically studied. Several of the categories are supported by data from quantitative studies. For example, compared to their nonabused counterparts, sexual abuse survivors have also been found to experience more difficulty when being treated by male providers (Hays & Stanley, 1996; Lee et al., 2007; Leeners et al., 2007b; Willumsen, 2004), and report more difficulty with being touched by providers or being placed in submissive positions (Hays & Stanley, 1996).

It is possible that the distinctions between types of triggers and the categorization of relational triggers offered by the Model will become more important when more attention is paid to developing interventions aimed at preventing or reducing retraumatization during healthcare. To date, only one study has tested an intervention aimed at reducing triggering during healthcare (Smith & Smith, 1999). Examination of Smith and Smith's findings may illustrate why distinguishing between different types of triggers can be important. Smith and Smith examined the effectiveness of a new examination gown. The new gown was designed to reduce distress during pelvic exams by providing increased coverage of survivors' bodies while simultaneously allowing providers easy access for examination. The study was grounded in stimulus control theory. This theory is based on the tenet that individuals respond to situations differently based on the presence of different stimuli (Schwartz, 1984). Sixty-nine women were randomly assigned to the experimental gown condition (new stimulus) or the paper drape control group (old stimulus). One-third of the women reported a history of childhood sexual abuse. Women who

wore the experimental gown reported more positive emotional and physical experiences of the exam; however, the gown did not significantly reduce anxiety in abuse survivors. Sexual abuse survivors reported higher state anxiety during gynecological exams ($M = 34.14$, $SD = 8.89$) than women without abuse histories ($M = 28.42$, $SD = 8.65$; $F = 6.35$, $df = 1$, $p < .01$). No significant differences in anxiety scores were found based on the type of gown worn, although there was a trend in the hypothesized direction. Smith and Smith noted that despite the fact that survivors liked the gown, they were less certain that the gown would be helpful for abuse survivors.

The Healthcare Retraumatization Model provides a reasonable explanation for why Smith and Smith's (1999) intervention failed to have its predicted effects. Smith and Smith were attempting to manipulate exposure, which the Model classifies as a relational trigger,³ by modifying an environmental stimulus – the new examination gown. Thus, the investigators were attempting to modify a relational trigger with an intervention better suited for a sensory trigger. According to the Model, most of the distress caused by relational triggers emanates from survivors' hypersensitivity to threat based on feelings of vulnerability, distrust, powerlessness and loss of control. Moreover, exposure is only one of many relational triggers associated with the pelvic examination. Other potential triggers include: submissive positioning, loss of control, touch, and the power differential between providers and patients. An intervention grounded in the Model would seek to reduce overall anxiety during pelvic examination by addressing the range of relational triggers that may be present during gynecologic procedures. For example, the intervention based on the Model would address the power dynamics between providers and patients by offering patients more control over the examination process. Patients would be told

what to expect during the examination, asked for their consent prior to initiating the examination and told that they could stop the examination at any time. The examiner would also be told to watch for signs of distress and offer patients a break if they appeared to be having problems.

The types of interventions suggested by the Healthcare Retraumatization Model are supported by numerous clinically focused articles offering suggestions aimed at decreasing retraumatization of childhood sexual abuse survivors during healthcare interactions. These papers, largely based on clinicians' experiences caring for abuse survivors, report that triggering is reduced when healthcare providers share power and control with their patients (e.g., Bohn & Holz, 1996; Chalfen, 1993; Courtois & Riley, 1992; Hobbins, 2004; Holz, 1994; Kitzinger, 1990a; Kitzinger, 1990b; Robohm & Bittenheim, 1996; Roussillon, 1998). For example, Holz advised clinicians on how to empower abuse survivors during physical examinations.

“Encouraging the client to control many parameters around the exam, to ask questions and to state her preferences and needs clear are ways to build trust and empower this woman” (p. 15).

Support for Post-Traumatic Stress Reactions

Support for the potential for abuse survivors to experience high than normal amounts of stress during healthcare interactions are provided by a number of quantitative studies that have compared sexual abuse survivors' reactions to healthcare to those of their nonabused counterparts. While most of these studies only focused on a narrow range of potential reactions, each found abuse survivors to be more stressed when compared to their nonabused counterparts. Compared to nonabused controls, abuse survivors have been found to display higher amounts of anxiety or emotional distress during healthcare (Hays & Stanley, 1996; Lee, Westrup, Ruzek,

³ As noted in the previous chapter, exposure is viewed as a relational trigger because rather than the absence of clothing, it was the thought of someone seeing their uncovered body that caused triggering in

Keller, & Weitlauf, 2007; Leeners et al., 2007a; 2007b; Robohm & Bутtenheim, 1996; Smith & Smith, 1999; Weitlauf et al., 2008) and more dental fear during dental care (Walker, Milgrom, Weinstein, Getz, & Richardson, 1996; Willumsen, 2001). Hays and Stanley, who examined a wider range of possible symptoms in their study of childhood sexual abuse survivors' dental experiences, noted that in addition to fear and anxiety, survivors were significantly more likely to experience dissociation, flashbacks, nausea, and shame while at the dentist when compared to those without an abuse history ($p < .05$). Several studies also found that sexual abuse survivors often report experiencing intrusive memories of the original abuse during healthcare interactions (Leeners et al., 2007a; Leeners et al., 2007b; Robohm & Bутtenheim, 1996).

Support for the Role of Coping in the Retraumatization Cycle

Although no study specifically focused on coping, the large amount of data synthesized allowed for recognition of the important role of coping in retraumatization. In fact, coping style was found to be the main determinant of persistence of the retraumatization cycle. Child sexual abuse survivors' coping strategies in healthcare can be viewed as safety behaviors directed at preventing the negative consequences of triggering. Two coping styles were identified: avoidant and proactive. An avoidant coping style is focused on trying to avoid or escape distressing emotions associated with triggering; while a proactive style is aimed at trying to find solutions to the problem. The most frequently described coping style in response to triggering was avoidant. Avoidant coping strategies tended to feed into the retraumatization cycle and resulted in mainly negative consequences for survivors ranging from continued psychological suffering to serious disruptions in care. Proactive strategies, on the other hand, were less frequently described and tended to be used by survivors further along in recovery. When successfully employed, proactive

study participants.

strategies resulted in predominantly positive outcomes; participants were able to exit the retraumatization cycle and form positive relationships with their caregivers.

These findings raise the question of why, if proactive strategies are so successful, were they not used more often by the survivors included in the dataset. The choice of which coping strategy is used in relation to a stressor is informed by the work of Lazarus and Folkman (1984). Lazarus and Folkman postulated that the choice of coping strategies is influenced by degree of threat posed by a stressor along with the degree of perceived control one has over the stressor. Lazarus and Folkman identified two styles of coping. They noted that coping strategies can be characterized as either emotion-focused coping, by which individual attempt to regulate their emotions in dealing with a stressor, or problem-focused active coping, by which individuals seek to manage the problematic situation. They categorized avoidance as an emotion-focused coping strategy. Lazarus and Folkman suggested that the same individual might use different strategies for different events depending on whether or not the individual felt that they could control the stressor. Events viewed as outside of one's control would more likely induce emotion-focused (i.e., avoidant) strategies, while problem-focused (i.e., proactive) strategies are reserved for lower threat events viewed as within one's control. Because most participants relied on emotion-focused coping strategies, we can hypothesize that for most study participants, triggers in healthcare were perceived as high threat stressors over which they perceived little control. In other words, participants engaged in avoidant coping strategies to manage their distress because they felt powerless over the retraumatization process.

The main avoidant strategies described by participants across studies were dissociation and healthcare avoidance. Although no studies have specifically explored the role of coping in retraumatization, Robohm and Buttenheim (1996) reported dissociative-like symptoms in

childhood sexual abuse survivors during pelvic examinations and numerous studies have identified dissociation as a strategy frequently used by child sexual abuse survivors to cope with stress (e.g., Spiegel & Cardena, 1991; Silberg, 1996; Silberg & Dallam, 2009). In addition, research has found that dissociative defenses often continue to be used long after traumatic events in an attempt to reduce emotional distress associated with triggering of traumatic memories (Chu et al., 1999). As far as healthcare avoidance, numerous quantitative studies have found that sexual abuse survivors are more likely than their nonabused counterparts to cancel appointments and avoid regular healthcare (Farley et al., 2002; Hays & Stanley, 1996; Leeners et al., 2007b; Melia-Gordon, 2003; Robohm & Bутtenheim, 1996; Springs & Friedrich, 1992; Willumsen, 2001).

The association between avoidant coping and poorer outcomes suggested by the Healthcare Retraumatization Model is also supported by numerous studies in the trauma literature. For example, an avoidant coping style has been found to be more prevalent among sexual abuse survivors and is associated with poorer psychological adjustment. At the same time, a more proactive coping style has been associated with higher psychological functioning. (e.g., Himelein & McElrath, 1996; O'Leary, 2009; Sigmon, Greene, Rohan, & Nichols, 1996; Steel, Sanna, Hammond, Whipple, & Cross, 2004). Moreover, the positive relationship between avoidant coping and retraumatization proposed by the Model is supported by research showing a positive relationship between avoidant coping and diagnosis of PTSD. For example, of the three symptoms clusters required for a PTSD diagnosis (i.e., re-experiencing, avoidance/numbing, hyperarousal), avoidance is the one most predictive of meeting diagnostic criteria for the other two (North, Suris, Davis, & Smith, 2009). In a study of survivors of the Oklahoma City Bombing, avoidance and numbing symptoms virtually dictated the diagnosis of PTSD; 94%

meeting avoidance and numbing criteria had full PTSD diagnosis (North et al., 1999). Thus without avoidance, PTSD is unlikely to be diagnosed.

Support for the Potential for Unhealthy Outcomes

No studies were located that examined the relationship between retraumatization and health outcomes. However, as reviewed in chapter four, an extensive body of qualitative data suggests that childhood sexual abuse is associated with numerous outcomes that can place patients' health at risk. The results of the current meta-synthesis suggest that retraumatization can lead to poor compliance with healthcare recommendations, delays in seeking treatment, failure to participate in preventative screenings, and avoiding healthcare altogether.

Obviously, failure to seek preventive care can lead to adverse clinical outcomes. Some of the most effective cancer screening programs, including cervical, breast and colorectal cancer, involve invasive examinations of the genitalia and associated regions. These types of examinations were also associated with the highest potential for retraumatization in the participants of the 15 studies synthesized. Fear of retraumatization caused some abuse survivors to avoid these examinations altogether. Thus, while screening programs for cervical cancer has been the single most effective tool in reducing mortality and morbidity from invasive cervical carcinoma (Benedet, 2000); many of the female childhood sexual abuse survivors studied reported that they avoided regular gynecological examinations. A relationship between childhood sexual abuse and avoidance of cervical screening is supported by the results of several quantitative studies showing that, compared to their nonabused counterparts, women with a history of childhood sexual abuse were significantly less likely to engage in cervical cancer screening. Farley et al. (2002) performed a case-control study in an age-stratified random sample of adult women members of a large health maintenance organization to evaluate the effect of

trauma on cervical screening. The sample included 364 control women who had received medically appropriate cervical cancer screening and 372 women that had not had cervical cancer screening within 2 years prior to the study. Women who had been sexually abused in childhood were significantly less likely to have had a Pap smear within the past 2 years (36.0% vs. 50.4%, $p = .050$). Childhood sexual abuse remained associated with reduced odds of Pap screening in logistic regression analyses that controlled for clinic location, demographics, attitudes about Pap screening, and PTSD symptoms (adjusted OR = .56, 95% CI .34 to .91). Nonsexual childhood abuse and neglect were not related to screening. Robohm and Buttenheim (1996) surveyed a convenience sample of 44 childhood sexual abuse survivors and 30 nonabused controls regarding the experience of seeking gynecologic care. Abuse survivors were also significantly less likely to seek regular gynecological care ($X^2 [1, N=72] = 3.73, p < .05$). In fact, two of the abuse survivors reported never having sought gynecological care due to fear and mistrust.

Other types of healthcare avoidance or noncompliance can also result in unhealthy outcomes. For example, some survivors also reported nonadherence with prescribed medications. A study by Lewis (1997) found that medication non-adherence led to increases in clinic and emergency room visits, hospitalizations, laboratory tests, drugs prescribed, adverse effects, recurrences of illness, and premature deaths. Non-adherence with medications is also associated with lower quality of life (Corden, Bosley, Rees, & Cochrane, 1997).

Retraumatization may also be associated with poorer mental health outcomes. Participants of the various studies synthesized reported experiencing a great deal of anxiety and stress as a result of triggering during healthcare. These results are supported by a large number of previously reviewed quantitative studies demonstrating that abuse survivors have higher anxiety and more fear and distress during healthcare situations than nonabused controls. The results of

the current study also suggest that retraumatization involves a traumatic stress response. A traumatic stress response involves experiencing post-traumatic stress symptoms such as re-experiencing and/or avoidance symptoms, yet not fulfilling full diagnostic criteria for PTSD (Ayers, 2004).

While the relationship between retraumatization and PTSD has yet to be studied; given the symptom overlap some type of a relationship is likely. It is possible that retraumatization may constitute a risk factor for exacerbation of PTSD symptoms in those who already have the disorder, or reactivation of PTSD in individuals whose symptoms had previously resolved. It is also possible that retraumatization may contribute to the development of PTSD, particularly in light of the fact that past stressful life events (such as childhood sexual abuse) and avoidant coping are risk factors for developing PTSD (APA, 1994). In addition, interpersonal trauma appears to be cumulative in its impact; trauma symptoms have been found to increase with the number of different types of trauma experienced (Follette et al., 1996). Because retraumatization is associated with a wide range of post-traumatic stress symptoms, it may constitute a form of traumatic stress that contributes to an individual's cumulative trauma load, which in turn may contribute to the development of PTSD.

Childhood sexual abuse survivors diagnosed with life-threatening illnesses may be at particular risk for developing PTSD, especially since PTSD has been documented following life-threatening illnesses in a wide range of samples. For example, the incidence of PTSD following the completion of cancer treatment ranges from 0% to 32% (Kangas, Henry, & Bryant, 2002). Notably, cancer-related variables have not been found to be predictive of subsequent PTSD development. Instead, the most potent predictor of developing PTSD has been found to be peritraumatic dissociation (Kangas, Henry, & Bryant, 2005). Similar results have been found in

patients with other forms of life-threatening illnesses (Ozer, Best, Lipsey, & Weiss, 2003).

Harvey and Bryant (2002) hypothesized that dissociative responses following cancer diagnosis reflect a response style associated with poor coping strategies, and these are directly linked to subsequent PTSD. Because retraumatization is a stressful life event associated with avoidant coping, including dissociative responses, abuse survivors with retraumatization may be at high risk for developing PTSD, particularly if diagnosed with life-threatening illnesses requiring frequent invasive procedures and ongoing contact with healthcare professionals.

Limitations of the Study

The study was limited by the studies available for meta-synthesis and reliance on an interpretative methodology which is vulnerable to researcher bias. For the purpose of broadly summarizing the current qualitative literature, it was necessary to classify triggers and coping into manageable groupings, and this process is inherently subjective. Although every attempt was made to set aside prior knowledge and approach meta-synthesis in a systematic fashion, a different researcher may have reached a different interpretation. The study was also limited by the amount of qualitative studies available for synthesis and the transferability of respondents' experiences to other sexual abuse survivors. Employment of a systematic and extensive search strategy reduced the risk that any significant research studies in this area were missed. However, not all of the 20 papers that met inclusion criteria were independent; five papers were published based on the same qualitative study (Schachter et al., 1999; 2004; 2008; Stalker et al., 1999; Teram et al., 1999) and two papers were published based on another (Seng et al., 2002; 2004). Data were further limited by the fact that the same group of investigators conducted four of the 15 studies and published nine of the 20 papers included in the analysis (Lasiuk, 2007; Schachter et al., 1999; 2004; 2008; Stalker et al., 1999; 2005; Teram et al., 1999; 2006). Thus it is possible

that the study results were biased in the direction of the data and interpretations provided by this large investigative group.

Transferability is further limited by the method of recruitment, as most respondents volunteered to participate after learning about studies through advertisements. Samples may have been biased toward respondents from higher socioeconomic groups, who may be more likely to volunteer their time, and toward those most comfortable talking about their abuse history. Studies were only available the United States, Canada, and Australia, and were of predominantly white participants drawn from urban areas. Thus, results may not be applicable to survivors from other cultures, races and socioeconomic settings. In addition, men were underrepresented in the qualitative studies synthesized; only three of the 15 studies included males. Moreover, none of the investigators specifically targeted the experience of retraumatization from the viewpoint of male survivors. Consequently, the results of this meta-synthesis may not be completely transferable to males.

The data were also limited by the settings studied. Six studies focused on experiences during childbearing (Lasiuk, 2007; Lee, 2001; Palmer, 2005; Parratt, 1994; Rhodes & Hutchinson, 1994; Seng et al. 2002; 2004) and one focused on women's experiences in gynecologic care (Alpern, 1992). Because gynecological and obstetrical services involve more invasive and genitally-focused care, it is possible that the potential for retraumatization is overstated in the meta-synthesis. Only one study focused on primary care (Roberts et al., 1999), the setting where the majority of people receive the bulk of their healthcare. At the same time, childhood sexual abuse survivors' experiences in numerous other healthcare settings were not represented, such as the experiences of surgical patients or those attending specialty clinics providing gastrointestinal or urological services. There may be triggers that are unique to these

settings, thus a comprehensive overview of all types of triggers encountered by survivors in healthcare may not be represented.

Finally, it is important to note that participants of the studies synthesized often reported experiencing forms of abuse associated with increased post-traumatic effects (i.e., early onset, a greater number of perpetrators, the use of force or aggression, extended and frequent abuse, abuse by a biological parent, abuse that includes penetration, and/or also experiencing other forms of childhood maltreatment). As a result, this meta-synthesis likely over-represents the experiences of those most likely to experience more pronounced traumatic effects in healthcare. This conclusion is supported by Roberts et al. (1999), who found that abuse severity appeared to be an important variable in how their participants viewed healthcare. Consequently, these results may over-state the potential for retraumatization and may not be applicable to those experiencing less severe forms of childhood sexual abuse.

Future Research

Qualitative studies exploring retraumatization in more diverse samples are needed so we can better understand how factors such as age, gender, ethnic, or sociocultural differences influence the retraumatization experience. Because men were underrepresented in the qualitative studies synthesized, more qualitative exploration is needed that focuses on the experiences of male sexual abuse survivors. In addition, since the Healthcare Retraumatization Model postulates that the power differential between providers and patients often contributes to triggering; qualitative studies are needed that explore retraumatization among abuse survivors in marginalized and disadvantaged populations who may already feel powerless in relation to the dominant culture.

Studies are also needed to verify the Healthcare Retraumatization Model. For example, prospective studies of abuse survivors' experiences in healthcare are needed to better determine the natural evolution of retraumatization and to verify the conceptualization of retraumatization as cyclical and self-reinforcing. Research also is needed to verify the proposition that triggering occurs by different pathways depending on whether the trigger is related to specific sensory stimulus or is a more generalized response to relational dynamics. Clearer understanding of the triggering process would provide a foundation for designing effective interventions that may prevent triggering or interrupt the process once it starts. In addition, better understanding is needed of the hypersensitivity process and how triggering and coping translate into unhealthy outcomes.

Research also is needed to explore how survivors cope with retraumatization and the range of outcomes they experience as a result. While coping was found to be an important maintaining factor for retraumatization, saturation was not met on this aspect of the retraumatization cycle as few investigators specifically asked their participants about coping strategies. In light of the relationship between coping style and retraumatization found in the meta-synthesis, research is needed to determine whether coping style mediates outcomes for sexual abuse survivors in healthcare.

The most important area for future research is the development of effective interventions that can prevent or intervene in the retraumatization process. To date, only one study has focused on intervening in retraumatization (Smith & Smith, 1999) and it did not show a significant effect. By providing a framework of the retraumatization process, the Healthcare Retraumatization Model can provide the basis for developing instruments specifically designed to assess prevalence of retraumatization in healthcare and its impact on abuse survivors' health outcomes.

Once such an instrument has been developed and tested, it could serve as an outcome measure when testing different interventions.

Future research should also look at the effect of retraumatization on outcomes of sexual abuse survivors diagnosed with serious illnesses and/or requiring multiple invasive procedures. Research is also needed to determine whether retraumatization in healthcare contributes to survivors' cumulative stress load placing them at greater risk for developing PTSD. To determine whether retraumatization can lead to PTSD, retraumatization symptoms and PTSD symptoms could be followed prospectively in a group of abuse survivors who are scheduled to give birth or undergo a potentially retraumatizing procedure.

Finally, research is needed to determine whether healthcare retraumatization is experienced in populations other than sexual abuse survivors. Recent research has targeted serious illnesses as traumatic events and some children who have serious medical conditions requiring multiple invasive procedures have been found to exhibit some of the symptoms of PTSD including arousal, re-experiencing and avoidance (e.g., Shemesh et al., 2000; Smith, Redd, Peyser, & Vogl, 1999; Stoddard, Norman, Murphy, & Beardslee, 1989). As a result, a new form of traumatic stress has been proposed called *medical traumatic stress*. Medical traumatic stress is defined as traumatic stress reactions to pain, injury, serious illness, medical procedures, and invasive or frightening treatment (National Child Traumatic Stress Network, n.d.). Since, by definition, those who suffer medical traumatic stress were traumatized during medical care, it stands to reason that they could be prone to retraumatization during future healthcare interactions.

Practice Implications

Improving health outcomes for abuse survivors starts with professionals educating themselves and others about the impact of abuse on survivors' experiences in healthcare. Some of the distrust survivors have for healthcare providers come from providers' lack of understanding for the kinds of problems abuse survivors' experience when seeking healthcare. This meta-synthesis and the derived Healthcare Retraumatization Model offer a starting place by providing healthcare professionals with a comprehensive representation of the retraumatization process. One of the first steps in intervening in retraumatization is for healthcare providers to recognize that they – both individually and collectively -- play an important role in the retraumatization process. A routine interaction for healthcare professionals can constitute a crisis for abuse survivors leaving them feeling violated and reabused. In these instances, healthcare providers may unwittingly mimic the dynamics of sexual abuse causing abuse survivors to decompensate. Without a model to understand what they are encountering, survivors' behaviors in healthcare may seem irrational and evoke negative responses. For example, healthcare providers may find themselves becoming judgmental and irritated when patients appear to “overreact” or act “childishly” when confronted with relatively minor stressors.

One of the most important ways providers can improve health outcomes for childhood sexual abuse survivors is to listen to what they need in order to feel safe. By providing an overview of the experiences and preferences of a large number of abuse survivors, this meta-synthesis provides a means for clinicians to hear survivors' voices, even when survivors are too frightened or intimidated to articulate their needs individually. Table 12 provides an overview of the most common triggers and safety needs reported by participants along the corresponding therapeutic actions that providers can perform in order to help childhood sexual abuse survivors

feel safe. Participants reported that when healthcare providers listened to and honored their needs, they were able to relax and cooperate during treatment. Moreover, by honoring survivors' safety needs, healthcare providers can help make healthcare an empowering rather than a retraumatizing experience. As Stalker et al. (1999) noted, healthcare professionals can provide a safe place where survivors can begin to express their needs, take charge of what happens to their bodies, and begin to take more responsibility for their own health and comfort.

Table 12. Survivor Safety Needs and Recommended Therapeutic Actions to Defuse Relational Triggers

Triggers	Safety Needs	Therapeutic Actions
Power imbalance/ authority figures/ powerlessness	Sense of control Empowerment	Offer survivor-sensitive care (see actions listed below)
Gender of provider	Sense of control	Offer choice of male or female provider when possible
Disinterested or insensitive provider/Feeling objectified	Feel cared about holistically/ Connection with provider	Do not act hurried Take time to listen to concerns Express empathetic understanding Offer continuity of care
Lack of control	Preparation Sense of control Empowerment	Explain planned actions Encourage questions and feedback Obtain ongoing consent Give permission to stop procedure Allow for breaks
Uncertainty/surprise	Preparation	Explain planned actions Encourage questions and feedback
Submissive positioning	Preparation Sense of control Empowerment	Explain planned actions Obtain ongoing consent Minimize time spent in subordinate positions Offer modification of a distressing position when possible Give permission to stop procedure
Exposure/ lack of privacy	Feel respected Sense of control	Explain planned actions Ensure privacy Use drapes to minimize exposure
Touch	Preparation Sense of control Empowerment	Explain planned actions Obtain ongoing consent Give permission to stop procedure Avoid known sensitive areas if possible

An important way that providers can begin helping survivors is by talking about abuse with their patients. Inquiring about abuse can be woven into the health history. The history should be taken with patients clothed and prior to any procedures. Privacy should be ensured by closing the door and making sure that others cannot over hear the conversation. Because many people are reluctant to assume the “abuse” label, providers should ask whether patients have

experienced specific behaviors. For example, asking questions such as: “When you were a child did an adult ever touch you a sexual manner?” tend to yield higher disclosure rates than questions using emotionally laden terms such as “rape”, “molestation”, or “abuse” (Silvern, Waelde, Baughan, Karyl, & Kaersvang, 2000). Brochures about child sexual abuse and other forms of interpersonal violence in the waiting room can convey to patients that the subject is taken seriously and help them feel that their provider is comfortable talking about abuse (McCauley et al., 1998; Schachter et al., 2008).

When inquiring about abuse, care should be taken not to ask pointed or invasive questions, and patients should be told to share only as much as they are comfortable with discussing at the moment. Professional responses to disclosures can have a significant impact on the well-being of abuse victims. Unsupportive responses, such as those where professionals minimize, blame, or disbelieve victims’ allegations of abuse can intensify survivors’ distress. Such responses have been shown to hinder recovery in rape victims (Ullman, 1996; Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001) and are related to greater PTSD symptom severity (Ullman & Filipas, 2001). Supportive reactions, on the other hand, such as when professionals acknowledge and validate victims’ experiences, may enhance rapport and provide a foundation for trust. Draucker & Spradlin (2001, p. 45) provided an example of a supportive response, “I can imagine it was hard to you to share that experience with me. I respect your courage for being able to do so.”

Clinicians also should be aware that not all abuse survivors are willing to disclose their abuse, particularly prior to developing a trusting relationship with a healthcare provider. A number of participants in the various studies included in the dataset stated that they would not disclose abuse unless they felt their providers would be receptive to the information and respond

in a sensitive and caring manner. Other barriers to disclosure include survivors' own denial of the abuse, along with fears of being blamed, judged or not believed. Nevertheless, even when survivors choose not to disclose their abuse, the act of asking can help to "plant the seed," indicating that the subject is taken seriously (Holz, 1994).

Because of the widespread and hidden nature of victimization, Tudiver, McClure, Heinonen, Scurfield, and Kreklewetz (2000) recommended that healthcare providers adopt an approach of "universal precautions" which considers the possibility of prior abuse in all patients. This approach involves routinely asking questions such as: "Do you have any special concerns about this procedure?" or "Is there anything that would make this examination more comfortable for you?" A similar approach was recommended by Stalker, Schachter, Teram, and Lasiuk (2009). They recommended that healthcare providers and staff adopt a survivor-sensitive approach with all patients. A survivor-sensitive approach is basically a client-centered approach informed by awareness of the many ways that a history of childhood sexual abuse can affect health.

The following is an example of how The Healthcare Retraumatization Model can guide care. The data revealed that the core need for survivors during healthcare was a sense of safety. The most common trigger mentioned by abuse survivors across studies was that of touch. For survivors, being touched by someone in a position of authority and power can cause them to feel vulnerable and out of control of their bodies. Touch can also trigger feelings of uncertainty regarding what will happen next and whether or not they will be harmed. Thus a single touch can include the following relational triggers: power imbalance/authority figures/powerlessness; loss of control, uncertainty/surprise, and touch. Healthcare providers can address all of these potential triggers in seeming small ways, such as by informing their patients of what to expect during

examinations, encouraging them to ask questions, and obtaining consent before proceeding. Since information is widely recognized as power, providers share power when they share information. In addition, by explaining the purpose for the touching and describing what the touching will entail, providers decrease uncertainty. Asking permission before initiating touch can empower patients by conveying that patients retain control over their bodies during examination and treatment processes. In addition, allowing patients input into even small decisions can help to build trust. These simple steps can help lessen survivors' concern that providers will overwhelm and hurt them like their abusers did, and make it less likely that they will be retraumatized during an examination.

Unfortunately, it may not be possible to entirely avoid triggering situations. However, even when triggers cannot be avoided, or when triggering occurs despite a healthcare provider's best efforts, survivors can still be helped. If patients appear to be distressed during a procedure, providers can help by projecting a calm and unhurried demeanor and allowing patients to stop examinations and compose themselves before proceeding. A brief break, not only allows patients a moment to regain emotional control, it offers them a sense of control over what is happening to them. If patients still have difficulty with examinations, providers can offer to postpone the examination and suggest that they bring a trusted friend with them to future examinations. Having a support person present can help shift the power differential and thus help abuse survivors feel less vulnerable. In addition, if the survivor is not in therapy, referral to a psychotherapist skilled in working with abuse survivors may be helpful. Mental health professionals can be of particular help when they work in collaboration members of the healthcare team to help survivors to develop and implement strategies to overcome triggers. For example, mental health professionals can help survivors determine what they need to feel safe

during healthcare encounters and advocate on behalf of survivors who do not yet feel strong enough to do so for themselves. Mental health professionals can also help develop a plan to guide healthcare professionals on how to best help if the survivor has a flashback or dissociates during an upcoming procedure.

Because stress and dissociation may interfere with the retention of information; it is important for healthcare professionals to provide written instructions for any therapeutic recommendations or aftercare. Continuity of care is also important. Efforts should be made to allow survivors to see the same provider at each visit to facilitate the development of a sense of connection and trust. It is also important to take clients' abuse histories into account when making referrals. A survivor is more likely to comply with the referral when they know that the new provider will respect their safety needs.

Conclusions

The current study reflects a synthesis of current knowledge on the experiences of childhood sexual abuse survivors in healthcare. Retraumatization during healthcare is a frequent, yet often hidden, experience in sexual abuse survivors seeking care. Retraumatization can compromise childhood sexual abuse survivors' ability to access health care treatment and forge a positive relationship with their providers. Moreover, without intervention, retraumatization may result in unhealthy outcomes that place sexual abuse survivors' mental and physical health at risk.

The results of this meta-synthesis demonstrate that child sexual abuse is damaging, not simply because it is frightening, but also because of the many ways in which it disrupts normal child development and the capacity for normative relational functioning. One of the most damaging effects of childhood sexual abuse is the disrupted capacity to trust either one's self or

other people. Sexually abused children may develop working models of the self as incompetent and unworthy, while relationships with others may be viewed as primarily based on power and coercion. Survivors often have a heightened awareness of the potential danger that other people represent and may believe that hypervigilance and absolute control is the only way to protect one's self from further harm. Safety can be of particular concern when childhood sexual abuse survivors enter healthcare as they are faced with a hierarchical, authoritarian system that in many ways mirrors many of the dynamics of their childhood trauma. To access healthcare, survivors must assume a vulnerable position in relation to an authority figures on whom they are dependent for care.

Healthcare providers have an enormous opportunity to make a difference in the healthcare experiences of sexual abuse survivors, a difference that can ultimately result in the prevention of chronic retraumatization and associated unhealthy outcomes. Unfortunately this opportunity is often lost as healthcare providers rarely ask about the abuse histories of their patients and often receive inadequate training on how abusive experiences in childhood can affect their patients' long-term health and ability to participate in healthcare. An important first step in improving health outcomes for sexual abuse survivors is for healthcare practitioners to become more aware of the effects of sexual childhood abuse on patients' health and to recognize the potential for retraumatization during routine healthcare interactions. This meta-synthesis and the derived Healthcare Retraumatization Model provide a starting place for understanding the difficulties childhood sexual abuse survivors experience when accessing healthcare by providing healthcare professionals with a comprehensive representation of the retraumatization process. Ultimately, educational programs need to integrate knowledge about retraumatization into the

curricula of nursing, medical, and allied health programs so that all healthcare providers are trained in recognizing the safety needs of abuse survivors in their care.

The model described in this paper also has implications for both research and intervention. As the health implications of retraumatization become better defined, the development of screenings tools and interventions aimed at reducing retraumatization may represent important avenues for improving health outcomes in sexual abuse survivors. By delineating the cycle of retraumatization, the Healthcare Retraumatization Model provides a framework for developing instruments specifically designed to identify patients at risk for retraumatization in healthcare and to assess its impact on abuse survivors' health outcomes. The Model also provides a conceptual basis for developing effective interventions to prevent retraumatization from occurring or to intervene in the retraumatization process. It is possible that the most effective interventions will be those that take into account the type of triggers that are most threatening to the individual and timed to where survivors are in the retraumatization cycle. Effective interventions can not only interrupt the cycle of retraumatization, they can also help survivors to improve their health and begin healing from their childhood trauma.

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Appendix A

Example of Abstract and Summary Appraisal

Title and date of Report: Toward Sensitive Practice: Issues for Physical Therapist Working With Survivors of Childhood Sexual Abuse (1999)

Authors: Schachter, Stalker, & Teram

Research Purpose: To explore the reactions of adult female survivors of childhood sexual abuse to physical therapy and to listen to their ideas about how practitioners could be more sensitive to their needs.

Theoretical framework: Grounded theory approach

Sample size and key characteristics: 27 female survivors of childhood sexual abuse and who had received physical therapy or who had considered seeking physical therapy upon referral. Survivors were recruited through agencies, groups and individuals providing counseling and support for survivors in Canada.

Data collection techniques: Interviews

Data analysis techniques: Constant comparative method.

Evidence of Trustworthiness: Member checks were used regarding interpretation of the data. Peer consensus achieved on categories and themes among the three investigators. In addition, the investigators met with group of eight survivors develop guidelines for sensitive practice and to confirm identified themes.

Type of findings: Thematic-interpretative survey

Core category: Need for Safety

Secondary themes or categories: (geared toward what the clients want from the therapist)

Establish and maintain a positive rapport with the client

Establish a partnership with the client

Offer the client a choice of male or female provider

Share information

Convey understanding and work with the survivor concerning her attitudes about the body and pain

Work with the client on difficult physical factors

Understand and respond sensitively to “triggers” and dissociation

Respond carefully to disclosures of abuse

Practice holistic health care

Extracted Findings: (what the clients say they want from the therapist)**Need for Safety** (overarching need)**Establish and maintain a positive rapport with the client**

Even before visit, fear and anxiety prohibited them from feeling safe; fear of being hurt or abused

Importance of good communication (listening and letting the client know she had been heard – also paying attention to and responding to client’s body language)

Connecting with the client and building a trusting relationship -- If provider was perceived as detached and impersonal, survivor did not feel safe

Objectification (feeling like a body part) reminded of being abused

Need for individualized pacing, to not feel rushed or that provider didn’t have time for them

Need for validation that they have a right to be there, a right to seek treatment.

Establish a partnership with the client**Need for sense of control over their own body**

Need for clinician to seek consent before each step of treatment

Need for their wishes to be respected regarding what they are able to handle that day

Need to be given permission to say “no” and for the provider to invite feedback

Need the treatment to be paced to their needs rather than those of the provider

Without a sense of control, many could not continue treatment

Offer the client a choice of male or female provider

Many feel vulnerable and unsafe with male provider or when around male clients

Felt they should be offered the choice of male or female provider as many felt uncomfortable asking upfront

Share information – 2-way exchange

Need for explanation about what treatment involves, updated on on-going basis

Want opportunity to share information about their reactions, provider should invite feedback or doing daily “check-in” with client

Convey understanding and work with the survivor concerning her attitudes about the body and pain

Feel disconnected from bodies, and feel of hate or shame about their bodies

Pain contributes to feelings of being unsafe

Provider should encourage and model self-care of the body

Work with the client on difficult physical factors (that contribute to feeling unsafe)

Sensitivity to the environment (don’t want to be confined or don’t want to be in the open where everyone can see them), lack of privacy, discomfort with paper gowns (feeling exposed, naked).

Sensitivity to power imbalance reinforced with disrobing, or being placed in certain positions.

Fear and apprehension around being touched. Touch is associated with painful feeling and memories.

Understand and respond sensitively to “triggers” and dissociation

Transference issues with therapist, difficulty trusting.

Strong emotions surface without warning after being triggered by some aspect of the treatment. Some have awareness of factors likely to trigger them; others have reactions that they did not understand until later.

Desire to have information repeated and written down because of dissociative reactions that interfere with memory.

Need for reassurance, caring reaction from provider

Respond carefully to disclosures of abuse

Diverse preferences expressed on a continuum ranging from believing inquires about abuse are inappropriate to believing they should be inquired about routinely at the initial encounter. Some suggest an open-ended approach that would allow the survivor to choose her level of disclosure, or want provider to ask about difficulty with certain aspects of therapy.

Elements of appropriate response to disclosure: acceptance and acknowledgment of the abuse and its consequences for the survivor.

Expressed desire for therapist to address difficulties by engaging in mutual problem solving and implementing alternative strategies

Practice holistic health care

Want recognition that one’s life experiences and emotional state as well as one’s body contribute to health and well-being

Want provider to facilitate links between clients and other health care professionals

Want provider to understand the dynamics of and long-term sequelae of childhood sexual abuse.

Appendix B

Sample Personal Reaction Note Regarding Context, Quality, and Usefulness of Each Study

Article: Schachter, Stalker, & Teram (1999). Toward Sensitive Practice: Issues for Physical Therapist Working With Survivors of Childhood Sexual Abuse

This is the best qualitative study that I have found thus far. The article is very on point regarding my research question. It is in the form of a thematic-interpretative survey. It shows good evidence of rigor; both member checks and focus groups were used along with peer-negotiation among the investigators regarding themes. The findings are useful and robust and supported through the use of quotes.

The authors have used this material to generate several other articles, so I will need to look at these also.

Appendix C

Sample Reflexive Journal Entries Regarding Theme “Objectification”

August 20, 2008: I have been struggling with where to place objectification. First, I thought of it as a separate category of generalized trigger. In writing data and descriptions of situations in which participants reported feeling objectified, I began to look at it as the opposite of sensitive care, i.e., insensitive care. I placed it in with insensitive provider category. It seems to fit as it appears that providers being in a rush tends to cause survivors to feel objectified.

June 1, 2009: Regarding objectification, I have been rethinking my categorization of objectification as a variant of insensitive provider. For example, one participant spoke about the gynecological examination as objectifying but didn't talk about the provider. So maybe it isn't really about the provider's behavior as much as the circumstance. Is it the exposure and positioning which focuses on certain body parts that participants find objectifying? Is it when the focus is off them as a person, and on them as a body part? Is it an aspect of not feeling in control? I will need to look into this more. For now I am moving it out of insensitive provider category.

September 14, 2008: Regarding objectification. Rereading the data has led me to believe that objectification is best categorized with the material on insensitive providers. There may be other elements involved, but the main descriptions have to do with feeling like the provider doesn't care about them as a whole person. The sense of objectification also appears a lot in data discussing providers being busy and rushing around. Some participants described feeling like an object on an assembly line, or like a “body part”. So it does appear to be a relational issue with providers and staff not having time to really focus on the patient's needs. I moved it back into the category with insensitive provider. It is possible if I had more data, it might be a stand alone category but I don't have enough data to warrant this based on the current synthesis.

Appendix D**Copy of Internal Review Board Letter****The University of Kansas Medical Center**

Human Research Protection Program

June 5, 2009

Project Title: A Model of the Retraumatization Process: A Meta-Synthesis of Childhood Sexual Abuse Survivors' Experiences in Healthcare
Principal Investigator: Sue Popkess-Vawter, RN, PhD
Department: School of Nursing
Determination: Not human subjects research

Dear Investigator:

Thank you for your submission. This is to certify that the above referenced project has been evaluated by the KUMC Human Research Protection Program (HRPP). Your project involves professional consultation about your research model. The persons who are providing the consultation do not belong to the population you plan to study. Therefore, the HRPP has determined that this phase of your research does not involve human subjects.

Please note that if you revise your activities to interact directly with human subjects, or to obtain identifiable data about individuals from the population you are studying, you should contact our office immediately. If this were to occur, the HRPP would re-evaluate your project's regulatory status. Please feel free to contact our office with any questions.

Very truly yours,


Karen Blackwell, MS, CIP
Director, Human Research Protection Program

Appendix E

Letter of Introduction

(Date)

Dear (Name of professional)

I am contacting you because of your expertise in investigating retraumatization of childhood sexual abuse survivors in healthcare. I would appreciate your input in the development of a model that seeks to account for the experience of retraumatization in healthcare settings. As you are aware, numerous studies, including your own, have found that aspects of healthcare situations can pose difficulties for abuse survivors. Investigations in this area, however, have been limited by the lack of a model that accounts for the retraumatization process during healthcare.

The goal of the current qualitative study is to develop a model that will aid in understanding and anticipating the difficulties abuse survivors are likely to face when accessing healthcare using a grounded-theory approach. Meta-synthesis was used to combine data from 19 studies involving 15 unique samples. The combined studies represent data from 411 sexual abuse survivors (113 males and 298 females) sampled from a wide variety of healthcare settings in the United States, Canada, and Australia. The resultant model depicts the retraumatization process and shows how retraumatization can lead to unhealthy outcomes for abuse survivors.

Your participation in the model review process is valuable as the model will provide a basis for future research investigating the prevalence and correlates of retraumatization in healthcare settings. If you choose to participate, you will be asked to review both the model derived from meta-synthesis results and its descriptions, and to comment on their completeness. You will be asked to answer six questions that can be completed in about 45-60 minutes. These questions ask you to comment on the relevance of the model to your research findings and to indicate whether you feel that any relevant information is missing. These questions can be answered either in writing or in a telephone interview arranged at a time convenient to you.

This research was reviewed by The University of Kansas Medical Center Internal Review Board and judged to be exempt (see attached letter). Your answers to the questions are for the purposes of professional development and model validation prior to publication. Your answers will not be published or made available to anyone outside of the research team. Your participation will be acknowledged in any publications that issue from this research unless you ask that your participation remain anonymous. Of course, your participation in this study is voluntary and the choice not to participate or to quit at any time can be made without any repercussions.

If you have any questions, don't hesitate to contact me. I will follow-up with you in several weeks if I haven't heard back from you. Thank you for your consideration.

Sincerely,

Stephanie Dallam, RN, MS
Doctoral Candidate, University of Kansas, Kansas City

Appendix F

Questions Posed to Study Authors

You were provided with a diagrammatic model of the healthcare retraumatization process and its description along with the meta-synthesis results it is based upon. These were abbreviated to decrease the amount of time that it takes to review them.

I would like you to address the following questions either in a written response or during a 30-45 minute telephone conference at a convenient time of your choosing.

1. Are you aware of any qualitative studies or articles not included in the meta-synthesis that you feel should have been? (The studies are listed on the last page of the results.)
2. Is the model adequately supported by the data presented in the meta-synthesis results?
3. Do the quotes adequately support the main conclusions drawn?
4. Is the presented model consistent with what you found in your research on childhood sexual abuse survivors' experiences in healthcare?
Please explain how the model supports or does not support your research findings.
5. Do you have any suggestions for how the model could be strengthened?
6. What do you view as the most pressing need for future research in this area?

Thank you for your participation. If you have any questions don't hesitate to contact me.

Also, please indicate if you would like to be acknowledged in the published study, or would you prefer your participation to remain anonymous?

Appendix G

Human As Instrument

June 19, 2008

In qualitative work the researcher is the primary instrument for data collection and analysis. Data are, therefore, mediated through a human instrument, rather than through inventories or questionnaires. Consequently, there is always the potential for bias to color this process. I recognize that my nursing education and background as a trauma nurse and nursing school instructor could influence my views on this subject and could bias my study. In addition, I am a mother, a friend and confidant of many abuse survivors, and I currently work for a scientific nonprofit group that at times advocates on behalf of abuse survivors. These factors have not only influenced my views, they ultimately led to my interest in exploring this topic.

For example, I have accompanied friends who are abuse survivors to appointments with physicians and acted as an advocate for them in the system. In one instance, I had to work to convince staff nurses to take a friend's fears and concerns into account during a long inpatient stay. In another instance, a different friend, also an abuse survivor, called me very upset. She talked with me at length about an incident in which she felt retraumatized during an emergency room visit. She had been in an automobile accident and was taken to the hospital. She was placed on a gurney and taken by a male attendant to the basement for X-rays. She was alone and became convinced that the man was there to harm rather than help her. She had a full-blown panic attack, and to this day, the fear for her personal safety in the hospital was much more traumatic than the accident itself, despite the fact that she suffered a severe neck injury. These personal experiences have also influenced my views on retraumatization. I feel strongly that abuse survivors continue to remain largely invisible and voiceless in society, and their concerns often go unaddressed in the healthcare setting. In this instance, my bias goes toward listening to abuse survivors' concerns and taking their concerns seriously.

My biases, however, could prove problematic. For the grounded theory to emerge, I will need to set aside, as much as possible, the theoretical ideas or notions I have encountered in during my professional and private life so that the substantive theory can emerge. I will have to work to distance myself from what I already know, in order to approach the subject with new eyes. It should be noted that there is an ongoing conversation in the literature about how naive researchers should be regarding in their approach to grounded theory investigations. For example, a literature review is avoided in the early stages to reduce bias and enhance the likelihood that "the emergent theory will be grounded in the data" (Cutcliffe, 2000, p. 1480). Another view is offered by Hutchinson (1993), who suggested a literature review should precede data collection and analysis in grounded theory. Hutchinson argued that the review of the literature can identify the current gaps in knowledge and help provide a rationale for the proposed research.

Since I am already familiar with the literature on abuse survivors in healthcare, special care will need to be taken to set aside prior theoretical ideas or notions. For example, when I review the data, I will have to be careful not to overvalue those data that confirm what I already have experienced firsthand, and remain open to data that shows something new or different. I think one way to do this is to consult with my advisors and other experts in the field when I find

myself making these types of decisions. This will give me another view point and help me insure that my interpretative decisions are grounded in the data and not based on my own personal biases. I will also keep a reflexive journal in which I explore my biases as they arise.

While there are drawbacks to my level of familiarity with this area, I believe that my exposure also provides some benefits. For instance, my biases, while present, are not unidirectional. I have also worked in the healthcare setting and know firsthand the strain that hospital staff experience as they juggle multiple patients and responsibilities. In addition, I believe that my background forms the basis for “theoretical sensitivity”. Theoretical sensitivity refers to a personal quality of the researcher. According to Strauss and Corbin (1990), “It indicates an awareness of the subtleties of meaning of data. ... [It] refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn’t.” Thus, grounded theorists’ prior knowledge, experiences and practice can provide sensitivity to and awareness of the subtleties of mean in data and thus help to formulate a theory faithful to the reality of the phenomenon being investigated. Strauss and Corbin believe that theoretical sensitivity comes from a number of sources, including professional literature, professional experiences, and personal experiences. I have all of these, and thus hopefully my background will provide me with greater insight into the data.

Appendix H

Questions Posed to Expert Clinicians

You were provided with a diagrammatic model of the healthcare retraumatization process and its description along with the meta-synthesis results it is based upon. These were abbreviated to decrease the amount of time that it takes to review them.

I would like you to address the following questions either in a written response or during a 30-45 minute telephone conference at a convenient time of your choosing.

1. Are you aware of any qualitative studies or articles not included in the meta-synthesis that you feel should have been? (The studies are listed on the last page of the results.)
2. Is the model adequately supported by the data presented in the meta-synthesis results?
3. Do the quotes adequately support the main conclusions drawn?
4. Is the presented model consistent with what you have found in your practice regarding child sexual abuse survivors' experiences in healthcare?
Please explain how the model supports or does not support your experiences.
5. Do you have any suggestions for how the model could be strengthened?
6. What do you view as the most pressing need for future research in this area?

Thank you for your participation. If you have any questions don't hesitate to contact me.

Also, please indicate if you would like to be acknowledged in the published study, or would you prefer your participation to remain anonymous?