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Barriers to Healthcare Provision for Victims of Sexual Assault: A Grounded Theory Study

Shadab Shahali,[1] Eesa Mohammadi,[2,*] Minoor Lamyian,[1] Maryam Kashanian,[3] Mohammad Eslami,[4] and Ali Montazeri[5]

[1]Department of Reproductive Health and Midwifery, Faculty of Medical Sciences, Tarbiat Modares University, Tehran, IR Iran
[2]Department of Nursing, Faculty of Medical Sciences, Tarbiat Modarress University, Tehran, IR Iran
[3]Department of Obstetrics and Gynecology, Iran University of Medical Sciences, Tehran, IR Iran
[4]Population Family and School Health Department, Ministry of Health and Medical Education, Tehran, IR Iran
[5]Mental Health Research Group, Health Metrics Research Center, Iranian Institute for Health Sciences Research, The Academic Center for Education, Culture and Research (ACECR), Tehran, IR Iran

*Corresponding Author: Eesa Mohammadi, Department of nursing, Faculty of Medical Sciences, Tarbiat Modarress University, Tehran, IR Iran. Tel: +98-2182883550, Fax: +98-2182883856, E-mail: mohamade@modares.ac.ir

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Abstract

Background: Victims of sexual assault need comprehensive healthcare services to deal with the consequences of their experience. However, there are still many girls/women that delay seeking healthcare after they experience sexual assault.

Objectives: To explore the process of health care and clinical services for victims of sexual assault in the health care centers of Iran.

Patients and Methods: This was a qualitative study based on the grounded theory method. The sample consisted of 23 health care providers and 10 victims of sexual violence. Unstructured interviews and observations were used for data collection. Constant comparative analysis was used according to the Strauss and Corbin method.

Results: The analysis of all data led to the extraction of four categories: "performing routines", "victims' expectations", "conflict between expectations of victims and existing healthcare services", and the core category of "neglect of healthcare providers to address the needs and expectations of victims". Providers were offering health care to the victims of sexual violence regardless of their needs. Due to this neglect, victims sought illegal solutions to overcome the consequences that led to social stigma.

Conclusions: The findings indicate the lack of mutual understanding between health care providers and victims of sexual violence in relation to the expectations and priorities of victims.

Keywords: Sexual Violence, Victim, Healthcare, Qualitative Research

1. Background

Sexual violence is a major global health concern and it has been recognized as a public health issue by human rights entities as well as by international organizations, such as the world health organization (WHO) (1).

Survivors of sexual violence experience numerous short-term and long-term negative physical and mental health outcomes, including physical injury, sexually transmitted infections (STIs), unwanted pregnancy, unsafe abortion, anxiety, shame, posttraumatic stress, and depression (2). In many cases, victims of sexual violence are confronted with problems that are not necessarily medical emergencies. For example, the psychological consequences of sexual violence can affect their career, social, emotional, and sexual activity and may lead to an increased use of health services (3). Thus, they may require comprehensive health services in order to cope with the physical and mental health consequences resulting from their experience (2).

However, there are still many women who either delay in seeking help after a sexual assault or do not seek help at all. Many investigators have shown several factors that affect what types of services rape survivors seek, including the victim/offender relationship, gender, and ethnicity (4-8). For instance, survivors of stranger rape and women who were physically injured during an assault are more likely to seek legal and medical help than others (4, 5). A large proportion of victims may not have access to formal support services post-violent encounter. Ullman and colleagues (2007) showed that only one out of five survivors in their sample received medico-legal services (6). Also, Kaukinen (2004) noted that 52 percent of assault victims sought support from informal sources (4). These findings raise questions about whether there are barriers that lead to the reduced demand of survivors for medico-legal services.

There are no precise statistics for sexual violence in Iran. It has been estimated that an overall 10 percent of women In

Iran experience sexual assault in one way or another during their lifetime [personal communication]. The same figure for women who escape from their home or those who live as sex workers might be even higher, up to 20 and 35 percent, respectively (8). However, it is argued that sexual violence is severely underreported due to extreme cultural concerns surrounding it. The community almost blames the victim, rather than the criminal. The consequences associated with sexual violence might ruin the future life of victims, as well as the lives of their families. Therefore, it is essential to explore the topic in the context of Iranian society from different perspectives. As such, exploring health care provisions for women who experienced sexual assault might be of prime importance. Thus, this study aimed to understand the process behind health care and clinical services for victims of sexual assault in Iran, and to then investigate the experiences of victims within the medical and health care system.

2. Objectives

To explore the process of health care and clinical services for victims of sexual assault in the health care centers of Iran.

3. Patients and Methods

3.1. Design

This was a qualitative study carried out to investigate sexual assaults in Iran. The study was conducted between January and November of 2013. We used the grounded theory method based on the Strauss and Corbin approach (1998). We thought this approach to be appropriate because the investigator could discover patterns of behavior among particular groups of people in specific contexts, and could then describe any underlying social processes shaping interaction and behavior (9).

3.2. Participants

The participants consisted of 23 health care providers who were working at private or public hospitals in Ahvaz, Khuzestan (a province in southern Iran) and Tehran (Iran's capital). In addition, 10 sexual violence victims who were seeking help in the same hospitals were approached to enter the study. Participants were selected if they had experience providing direct or indirect services to victims of sexual violence (for the clinical care team), and were willing to describe their experiences and were able to answer the questions (for both groups). The victims were excluded if they lacked the ability to speak Persian or have been diagnosed with post-traumatic stress disorder (PTSD). According to the emerging codes and categories, more data was collected by means of theoretical sampling. For example, virginity loss was the major concern in most victims for seeking help. Therefore, the main investigator (SS) interviewed healthcare providers and victims about this issue and its impact on care-seeking behaviors of sexual assault survivors, as well as the challenges that service providers faced when assisting survivors. The interviewer was trained to prepare participants about giving intense responses to the interview. Also, the interviewer (a midwife and PhD candidate for reproductive health) had sufficient clinical knowledge, skills, and competence in regards to the subject matter and population of interest. The sampling continued until data saturation was reached. Of the victims who agreed to be interviewed, 6 women were raped by someone they knew and 4 were raped by strangers. The victims ranged from 15 - 31 years of age and were interviewed 2 - 3 months after their sexual assault. The age range for healthcare providers was 28 - 70 years old, with their work experiences ranging anywhere from 1 - 40 years. The characteristics of study participants are shown in Table 1.

3.3. Data Collection

A total of 33 in-depth interviews were conducted to collect data. In order to begin the interview and to reach an overall understanding, victims were asked to explain their experiences within the medical and healthcare context, while healthcare workers were asked about their perceptions and experiences during caregiving to sexual assault victims. The participants chose the interview location. All interviews were tape-recorded and transcribed word by word. Each interview lasted approximately 30 minutes.

3.4. Data Analysis

Data were analyzed immediately after each interview according to the Strauss and Corbin method. Constant comparative analysis was used to process the data; field notes with nonverbal gestures such as crying, smiling, and bouts of silence were also incorporated. Written interview texts were read with precision. Open, axial, and selective coding was applied to data. In open coding, the interviews were reviewed several times and the data reduced to codes; the categories were then formed from the codes and memos regarding the conceptual and theoretical ideas that emerged during the course of analysis. Through axial coding, data were fractured together in new ways to make connections between categories and their subcategories. Finally, in selective coding, a core category and its interrelations that answered our research question were identified (10). During the analysis, the main investigator (SS) used the memo note technique to hypothesize connections between categories and their properties in order to integrate these connections with clusters of other categories to generate the theory (11). All categories are described in the Results section.

3.5. Trustworthiness

Trustworthiness of the data was examined using the Lincoln and Guba's model (12). Credibility was established through member check and peer check. The participants were contacted after the analysis and were given a

full transcript of their respective coded interviews with a summary of the emergent themes to determine whether the codes and themes were in accordance with their experiences. Then, two experts and three fellow investigators performed the peer check. Maximum variation in sampling (considering age, profession, and years of working in healthcare and their place of duty) also enhanced the confirmability and credibility of the data.

3.6. Ethics

The ethics committee of Tarbiat Modares University approved this study (ethical approval code: 1070710). Written informed consent was obtained from all participants before the interviews. Participants were assured of their anonymity and confidentiality. The right to withdraw at any time and moral commitments were explained in all interviews.

4. Results

Findings were organized in two separate ways to address subcategories, while primary categories were extracted from interviews and narrations. We then synthesized the core category to offer a hypothesis, and consequently, the outcome was indicated. In the following sections we summarize our findings.

4.1. Healthcare Providers

We found "performing routines" to be a main category. This category was generated from five subcategories: 1) focus on history and physical examination, 2) commitment to legal formalities, 3) offering diagnostic and para-clinic services, 4) prevention and treatment of complications, and 5) counseling and referral to appropriate services.

4.1.1. Focus on History and Physical Examination as a Routine

The first routine service delivered by healthcare providers to sexual violence victims is history-taking and performing physical assessments, including genito-anal examination. A midwife working in a public hospital made this comment that reflected the focus: "We take their history and perform physical examination, as our routine" [p2].

The first thing that needs to be asked when forming a patient's history is the chief complaint. Victims of sexual violence may seek medical help with several complaints, but most of them do not report the sexual assault incident. Hiding the assault may lead to misdiagnoses and ineffective or untimely treatments. One of the emergency medicine specialists stated: "Considering specific cultural issues in our city and community, most victims are not diagnosed and we can't do anything for them" [p13].

Therefore, the healthcare providers may recognize this event through clinical examination, observation, and the establishing of friendly relations with victims of sexual violence. For example, one midwife said: "They said that they are not the victim of rape but appearances indicate nothing else. We had a little girl that was raped and she hid this event, we understood that she was a victim of sexual violence and gave her a chocolate and she had trusted us and told us everything about this event" [p3].

4.1.2. Commitment to Legal Formalities

When the healthcare providers visit victims of sexual assault, they carry out a routine process that includes completing standard forms for victims of sexual violence, notifying their supervisor, documenting examination findings under the supervision of a hospital security officer, and having these documents signed by those directly involved in the treatment of the case.

A midwife said: "If we have a victim of sexual assault we notify our supervisor and she also informs the security and they prepare the minutes of observations and examinations" [p3].

4.1.3. Diagnostic and Para-clinic Services

Performing the diagnostic and para-clinic services are another task-orientation and routine characteristic. Diagnostic services are performed in accordance with the university training completed by healthcare providers. Pregnancy testing was not performed in most centers routinely, as most victims are chiefly concerned about the possibility of having lost their virginity (as a result of rape); therapists only check the hymen and no further tests are performed. STI tests that detect trichomoniasis, chlamydia, gonorrhea, syphilis, HIV, and hepatitis B are only offered in clinical centers that primarily provide healthcare services to women with high-risk sexual behavior. In other care centers, these diagnostic tests are not performed for victims. A reproductive health expert that did not perform these tests had mentioned: "I think that they (victims) are not looking for sexually transmitted disease diagnosis ... (pauses) I do not know, maybe (my understanding) it's not true. But I believe that if we tell them that they may have AIDs they may be afraid so it's may be harmful" [p11].

4.1.4. Prevention and Treatment of Complications

Routine prophylactic treatment for STIs and prescription of emergency contraceptives (IUD, HD, or Levonorgestrel), have been offered for victims in public hospitals. However, most private clinics did not perform these prophylactic treatments.

Other prophylactic treatments that were prescribed for victims of sexual violence, and only in the case of a visit from infectious disease specialists, were immunization through hepatitis B vaccines, administration of hepatitis B immune globulin (HBIG), and post-exposure prophylaxis for HIV.

Psychiatric and psychological treatments were performed for victims that experienced psychological problems according to national psychiatric protocols.

A clinical psychologist said: "We use CBT (cognitive-behavioral therapy techniques for treatment of rape victims suffering from low self-esteem and teach them to feel self-worthy and increase their efficiency and control over their lives" [p8].

4.1.5. Consult and Referral Request

Similar to diagnosis and treatment, most of the counseling and referrals have been requested as a part of the routine, with few actually following up. A gynecologist stated: "A psychiatric consultation that has been requested and done in our hospital is not as it's expected to be. In just a few seconds, a psychiatrist speaks some words with the patient and writes something in the patient file" [p4].

4.2. Victims

Expectations emerged as the main category. This category was separated into two subcategories: 1) Expressed Need for Hymenoplasty, and 2) Expressed Need for Abortion.

4.2.1 Expressed Need for Hymenoplasty

In Iranian culture, virginity loss outside of marital relations is a significant taboo. The loss of virginity carries extreme importance, as it has an influential role in the victim's future marriage and honor. For example, when the interviewer asked one of the victims of sexual assault about why virginity is so important to her, she explained: "Virginity is important to me because I lost my honor, my future life depends on it" [p12]. This highlights that this social issue will affect her future life.

Two other interviewees mentioned that virginity loss may drastically affect their chance of marriage by saying: "For me, virginity is very important, every girl who wants to marry needs to be virgin, I want to show that I look like a good girl" [p18]. Another mentioned: "It was so important to me. A girl who wants to get marry, the first thing that she must have is an intact hymen" [p19]. Victims often experience guilt or feelings of shame after losing their virginity as a consequence of this social pressure. An interviewee explained: "Once I called a counselor and told her that my mental state is not good. I always have nightmares and I think someone wants to kill me, I always think it happened to me because I'm a bad girl" [p17].

Consequently, due to the importance of virginity and its relationship to victims' honor, marriage, future life, and the stigma of virginity loss, these victims seek medical care to meet their needs. This includes surgical reconstruction of the hymen (hymenoplasty) to make themselves "virgin" again. A victim of sexual violence who sought to find a way to receive hymenoplasty services, said: "I went to the forensic medicine physician and told her I've had this problem. She examined me and said that my hymen was torn at 7 o'clock position, so I went to the midwife that I knew her to repair my hymen" [p19].

4.2.2. Expressed Need for Abortion

As a consequence of the importance of virginity in Iran, prenuptial pregnancies are severely denounced. In the case of unwanted pregnancies after rape which are also associated with several social problems victims seek illegal abortion. In Iran, abortion is legal, but only if the continuation of the pregnancy would put the fetus or mother's life in danger. Pregnancy termination, however, is not permitted after rape or incest (9).

An incest survivor who was seven months pregnant says: "I went to the midwife. She performed a blood and urine test and told me I'm about 4 months pregnant. I asked her if she could abort my baby, but she said no. Wherever I ask for abortion, they said no and did not perform it" [p24].

Conflict between expectations of victims and existing healthcare services (Main concern)

As mentioned already, victims of sexual assault expressed their need for abortion and/or hymenoplasty, but surgical reconstruction of the hymen is culturally and religiously prohibited in the Islamic Republic of Iran (13), and abortion is not allowed after rape (9). These laws lead Iranian physicians to often reject these requests due to the risk of punitive consequences if they were discovered to be offering hymenoplasty procedures or abortions. So this category is the main problem faced by victims and healthcare providers in this study. This conflict goes unresolved and remains unanswered by therapists, opting instead to focus on routine corporate culture and task orientation.

However, there are those professionals who perform such procedures out of a moral obligation. An interviewee who had lost her virginity said: "I went to the doctor to check my hymen, after examination the doctor said, it was torn and if you want to marry, you need to repair it. That doctor gave me the address of a midwife who has performed the operation. I went there and she said the operation cost is between 500 or 600 million IRR ($ 160 - 200 USD)" [p31].

111Neglect of healthcare providers to address the needs and expectations of victims (Core Category).

This category represents how victims and healthcare providers deal with the conflict between victims' expectations and the medical services provided to them. This category serves as a core category in this study because it conceptualizes the basic social problems that are addressed by the participants (14).

Victims decide to use healthcare services by challenging the social stigma that confronts them. This social condition creates worry due to the stigma, along with the shame and fear felt over facing a future after the loss of virginity or an unwanted pregnancy. It further causes expectations and demands for the victims of sexual violence to protect themselves against these social conditions. Victims feel the need to seek healthcare services for a hymenoplasty or an abortion. In the healthcare field, due to legal prohibition, religious, and cultural backgrounds, there is no practical possibility to repair the hymen or perform an abortion for victims via public health sectors. As a result

of this neglect of healthcare providers to meet victims' expectations, victims turn to illegal alternatives that are only offered in private sectors. A victim of sexual violence says: "The midwife said you're pregnant, what you want to do? What am I supposed to do? I did not know what I could do. I cried so hard, I felt so miserable. I went to several places to abort my baby, but they did not accept to do that" [p24].

As mentioned, the healthcare providers did not respond to the victims' needs when they requested a hymenoplasty or abortion. One gynecologist explained: "We're not doing hymenoplasty or abortion for them; these two issues are religiously banned (haram) and illegal." Another gynecologist said: "Do not worry about them, they will find the illegal ways" [p32].

As a result of social and legal constraints, the neglect of healthcare providers to address the needs of victims, and the difficulties faced in performing a hymenoplasty or abortion, rape victims are often left with feelings of anger, frustration, and dissatisfaction. For example, when the interviewer asked one of the victims about her satisfaction with her physician's performance, she said: "I am not satisfied with my doctor because she makes me disappointed" [p18].

This event represents the healthcare provider's focus on procedures, routine corporate culture, and task orientation. Thus, the apt category title, "Neglect of Healthcare Providers to Address the Needs and Expectations of Victims" was conceptualized.

Table 1. Demographic Characteristics of the Study Sample (n = 33)[a]

Demographic Characteristics	Values
Victims	
Age	19.37 (5.97)
Education	
None	1 (10)
Primary	0
Secondary	8 (80)
College/University	1 (10)
Healthcare Providers	
Age	43.82 (10.88)
Gender	
Female	12 (52.2)
Male	11 (47.8)
Profession	
Forensic Physician	2 (8.7)
Reproductive Health Specialist	1 (4.3)
Gynecologist	4 (17.4)
Midwife	2 (8.7)
Psychologist	2 (8.7)
Infectious Disease Specialist	1 (4.3)
Sexual Medicine Specialist	1 (4.3)
Emergency Medicine Specialist	2 (8.7)
Health Workers at Community Emergency Center	5 (21.7)
General Physician	1 (4.3)
Surgeon	1 (4.3)
Duration of Work in Healthcare	14.65 ± 8.86

[a]Data are presented as No. (%) or mean ± SD.

5. Discussion

The findings of this research documents the concerns of victims over how the health system deals with their expectations. The neglect of the legal healthcare system to address their needs and expectations leads to victims not seeking care through the health system following a sexual assault, and instead seek illegal solutions to overcome their issues.

As mentioned, all study participants were concerned about social issues and stigmatization. Several research studies have revealed that victims are the least likely to report a rape or sexual assault and delay seeking medical and forensic help if a social stigma is prevalent and the nature of such an event is a societal taboo (7, 15, 16).

The Australian institute of criminology (2005) showed that the special needs of sexual assault victims include safety and protection, emotional needs (e.g. support, understanding, not being blamed), immediate medical help post-assault, and practical help or advice (e.g. help getting to the police) (17). However, in our study, hymenoplasty and abortion are the primary special needs victims require from medical services, which may be due to the prohibition of sexual relations outside of marriage and the importance of virginity in Iran due to its impact on the victim's honor, marriage, and future life.

The absence of society and family member support due to the stigma toward virginity loss and unwanted pregnancy after rape prevents victims from accessing further help when seeking medical care resources. Family members have an interest in keeping the sexual assault private in an effort to protect or defend the honor of their family. Many research studies have confirmed these findings. The women's safety survey in Australia (2004) found that victims of sexual assault consult their family before they consult police and doctors about the crime, citing that they often encountered disbelief from family members (17). A qualitative study by Taylor and Norma also revealed that victims' families contribute to the underreporting of sexual assault by women in Australia (18).

The prominent finding uncovered in this research was the gap that participants felt between victim expectations and medical services rendered. Results of our study indicate that, in the majority of cases, female victims of sexual assault have expectations and demands such as hymenoplasty or abortion, which cannot be addressed through routine physical and psychological treatments or the prevention of disease. This finding is somewhat unique to studies of Muslim countries, as its shows the importance of virginity and the social issues that these females face after losing their virginity or getting pregnant outside of marriage (19). Therefore, to resolve this conflict, an appropriate clinical guideline must be designed that focuses on the specific health needs of sexual assault victims that also considers the availability of resources as well as national and organizational norms and procedures.

In a qualitative study in Congo, Jean Claude et al. (2013) showed that stigmas for victims of sexual violence are associated with the perception of rape and rigid social norms to the detriment of women. Additionally, these stigmas were rooted in fears of the spread of sexually transmitted infections, as well as the shame and guilt felt because of the families and communities (15). Their study confirmed our findings that social stigma is a barrier for victims to seek treatment. In the Jean Claude study, the fear of sexually transmitted infections spreading throughout the community was introduced as a cause of social exclusion for victims. However, that it was not found in the present study, perhaps due to the widespread use of collective rape in the Congo and the high prevalence of HIV infection among soldiers and armed fighters that committed the rape in that country.

Koss (2006) has stated in her research that survivors feel their legal needs are the most poorly met and that legal services and health outcomes served only as forms of attrition and retraumatization (20). The findings from the Koss study confirm our findings about the dissatisfaction of victims with legal and medical services due to social and legal obstacles.

The results of our study indicate social exclusion and labeling in respect to rape survivors. The findings confirm the need to strengthen both the capacity and resources of the current health system. This can be achieved through the work of policymakers and administrators within the health system. Their primary goals should be to solve problems that sexual assault victims are already facing through the design of basic social programs, and to change existing societal attitudes and eliminate the judgmental behavior of health workers toward victims of sexual violence. These goals are essential to assist victims and promote access to the necessary health services.

This study was conducted in Tehran and Ahvaz. Thus, the generalizability of results is limited.

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Footnotes

Authors' Contribution: Shadab Shahali is main researcher who initiated, designed, collected, analyzed the data, and wrote the paper. Eesa Mohammadi, Minoor Lamyian, Maryam Kashanian, Mohammad Eslami, and Ali Montazeri were the co-researchers who helped in the paper's design and in data analysis.

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References

1. Yari A, Nouri R, Rashidian H, Nadrian H. Prevalence and determinants of sexual intimate partner violence against women in the city of marivan, iran. *J Family Reprod Health.* 2013;**7**(4):157–63. [PubMed: 24971119]
2. World Health Organization. Geneva: 2003. Guidelines for medico-legal care of victims of sexual violence.
3. Martsolf DS, Draucker CB, Cook CB, Ross R, Stidham AW, Mweemba P. A Meta-Summary of Qualitative Findings about Professional Services for Survivors of Sexual Violence. *Qual Rep.* 2010;**15**(3):489–506. [PubMed: 21837284]
4. Kaukinen C. The help-seeking strategies of female violent-crime victims: the direct and conditional effects of race and the victim-offender relationship. *J Interpers Violence.* 2004;**19**(9):967–90. doi: 10.1177/0886260504268000. [PubMed: 15296612]
5. McCart MR, Smith DW, Sawyer GK. Help seeking among victims of crime: a review of the empirical literature. *J Trauma Stress.* 2010;**23**(2):198–206. doi: 10.1002/jts.20509. [PubMed: 20336674]
6. Patterson D, Greeson M, Campbell R. Understanding rape survivors' decisions not to seek help from formal social systems. *Health Soc Work.* 2009;**34**(2):127–36. [PubMed: 19425342]
7. Kamimura A, Bybee D, Yoshihama M. Factors Affecting Initial Intimate Partner Violence-Specific Health Care Seeking in the Tokyo Metropolitan Area, Japan. *J Interpers Violence.* 2014;**29**(13):2378–93. doi: 10.1177/0886260513518842. [PubMed: 24470569]
8. Hegarty KL, O'Doherty LJ, Chondros P, Valpied J, Taft AJ, Astbury J, et al. Effect of type and severity of intimate partner violence on women's health and service use: findings from a primary care trial of women afraid of their partners. *J Interpers Violence.* 2013;**28**(2):273–94. doi: 10.1177/0886260512454722. [PubMed: 22929341]
9. McCann TV, Clark E. Grounded theory in nursing research: Part 1--Methodology. *Nurse Res.* 2003;**11**(2):7–18. [PubMed: 14708425]
10. Lewis SF, Resnick HS, Ruggiero KJ, Smith DW, Kilpatrick DG, Best CL, et al. Assault, psychiatric diagnoses, and sociodemographic variables in relation to help-seeking behavior in a national sample of women. *J Trauma Stress.* 2005;**18**(2):97–105. doi: 10.1002/jts.20012. [PubMed: 16281201]
11. Ullman SE, Filipas HH, Townsend SM, Starzynski LL. Psychosocial correlates of PTSD symptom severity in sexual assault survivors. *J Trauma Stress.* 2007;**20**(5):821–31. doi: 10.1002/jts.20290. [PubMed: 17955534]
12. Maljoo M. Rape incest: contexts, strategies of rapist and victim reactions [in Persian]. *J Soc Welfare.* 2009;**9**(34):83–113.
13. Heath H, Cowley S. Developing a grounded theory approach: a comparison of Glaser and Strauss. *Int J Nurs Stud.* 2004;**41**(2):141–50. [PubMed: 14725778]
14. Walker D, Myrick F. Grounded theory: an exploration of process and procedure. *Qual Health Res.* 2006;**16**(4):547–59. doi: 10.1177/1049732305285972. [PubMed: 16513996]
15. Jean Claude OK. Stigma of victims of sexual violence's in armed conflicts: Another factor in the spread of the hiv epidemic? *Epidemiol Open Access.* 2013;**03**(02) doi: 10.4172/2161-1165.1000124.
16. Lievore D. No longer silent: a study of women's help-seeking decisions and service responses to sexual assault. A report prepared by the Australian Institute of Criminology for the Australian Government's Office for Women. Canberra; Australian Institute of Criminology. 2005.
17. Cope DG. Methods and meanings: credibility and trustworthiness of qualitative research. *Oncol Nurs Forum.* 2014;**41**(1):89–91. doi: 10.1188/14.ONF.89-91. [PubMed: 24368242]
18. Ahrens CE, Aldana E. The Ties That Bind: Understanding the Impact of Sexual Assault Disclosure on Survivors' Relationships with Friends, Family, and Partners. *J Trauma Dissoc.* 2012;**13**(2):226–43. doi: 10.1080/15299732.2012.642738.
19. Hedayat KM, Shooshtarizadeh P, Raza M. Therapeutic abortion in Islam: contemporary views of Muslim Shiite scholars and effect of recent Iranian legislation. *J Med Ethics.* 2006;**32**(11):652–7. doi: 10.1136/jme.2005.015289. [PubMed: 17074823]
20. Koss MP. Restoring rape survivors: justice, advocacy, and a call to action. *Ann N Y Acad Sci.* 2006;**1087**:206–34. doi: 10.1196/annals.1385.025. [PubMed: 17189507]