Hildegard Peplau's Theory and the Health Care Encounters of Survivors of Sexual Violence

Tamra J. Courey, Donna S. Martsolf, Claire B. Draucker, and Karen B. Strickland

BACKGROUND: *Individuals who experience sexual violence often seek services in a variety of health care settings. Although research indicates that survivors often report that interactions with health care professionals are distressing, little is known about what renders these encounters helpful or hurtful.* ***OBJECTIVE:*** *The purpose of this study was to use Hildegard Peplau's (1952) conceptualization of nurses' helping roles (i.e., stranger, resource person, teacher, leadership, surrogate, counselor, technical expert) in nurse–client interactions to explore how survivors of sexual violence perceive their encounters with health care professionals.* ***STUDY DESIGN:*** *Content analysis was conducted on the transcripts of 60 minimally structured interviews in which participants discussed their experiences of sexual violence.* ***RESULTS:*** *The results revealed that the helping roles of counselor and technical expert, as identified by Peplau, were most important to survivors of sexual violence. Regardless of role, participants perceived health care professionals to be helpful when they exhibited interpersonal sensitivity, especially in regard to the participants' experiences with violence.* ***CONCLUSIONS:*** *The findings indicate that health care professionals need to maintain an attentive and compassionate stance when working with survivors of sexual violence. Those who serve in a counselor role need to create an atmosphere of trust so that clients may explore in depth how violence has affected their lives.* ***J Am Psychiatr Nurses Assoc,*** **2008; 14(2), 136-143. DOI: 10.1177/1078390308315613**

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Sexual violence is a serious public health problem. As many as 1.2 children per 1,000 experienced sexual abuse in the United States annually between 2000 and 2004 (U.S. Department of Health and Human Services, 2006). The National Crime Victimization Survey (U.S. Department of Justice, Bureau of Justice Statistics, 2005) estimated that 0.8 individuals per 1,000 experienced rape/sexual assault in the United States in 2004 to 2005. The National Violence Against Women Survey (National Institute of Justice Studies, 2006a), sponsored by the National Institute of Justice and Centers for Disease Control, found that 14.8% of surveyed women had experienced a completed rape, and 2.8% had experienced an attempted rape; 2.1% of the men had experienced a completed rape, and 0.9% had experienced an attempted rape.

Myriad negative health outcomes stem from sexual violence experienced in either childhood or adulthood. In addition to injuries sustained during an assault, common long-term physical concerns associated with sexual violence include headaches (Golding, 1999), pelvic pain (McCauley et al., 1997), gastrointestinal complaints (Heitkemper et al., 2001), and chronic nonmalignant pain (Goldberg & Goldstein, 2000). Mental health sequelae of sexual violence may include depression, anxiety disorders, posttraumatic stress disorder, and substance abuse (Elliott, Mok, & Briere, 2004; Koss, Figueredo, & Prince, 2002; Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999).

Tamra J. Courey, MSN, is an assistant professor at Ashtabula Regional Campus, Kent State University, 3300 West 13th Street, Ashtabula, OH 44004; tcourey@kent.edu.

Donna S. Martsolf, PhD, is a professor at Kent State University, Kent, Ohio.

Claire B. Draucker, PhD, is a distinguished professor at Kent State University, Kent, Ohio.

Karen B. Strickland, MSN, is a research associate at Kent State University, Kent, Ohio.

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Because survivors of sexual violence often seek services in a variety of health care settings, they have frequent contact with health care professionals. Although many survivors of sexual violence report benefit from their encounters with professionals, others describe encounters that leave them feeling distressed, distrustful, and reluctant to seek further services (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). Experts suggest this may be attributable to secondary victimization, defined as "the victim-blaming attitudes, behaviors, and practices engaged in by community services providers, which result in additional trauma for rape survivors" (Campbell, 2005, p. 56). Researchers have reported that 29% of rape survivors who receive medical services, 25% who receive mental health services, and 12% who receive rape crisis services report the services to be hurtful (Campbell et al., 2001). Survivors of childhood sexual abuse also report negative experiences with professionals who treat them harshly, do not listen to their stories of abuse, and, in some cases, further victimize them (Armsworth, 1990; Baker, 2003; Draucker, 1999). Despite reports of survivors' negative experiences with health care professionals, little is known about what renders encounters with health care providers helpful or harmful.

In 1952, Hildegard Peplau, a legendary nurse theorist, introduced a theory of interpersonal relationships in nursing. She argued that the purpose of the nurse–client relationship is to provide effective nursing care leading to health promotion and maintenance. Within the nurse–client relationship, the nurse adopts one or more of six helping roles when providing care: stranger, resource person, teacher, leader, surrogate, and counselor. A seventh role, technical expert, was added later (Fawcett, 2005). Although the seventh role was not included in Peplau's original theory, all the roles are referred to as "Peplau's helping roles" in this article as is customary in the nursing literature. The helping roles have been described as follows:

The stranger role occurs when the nurse and the client meet and become acquainted. They begin the relationship as strangers, each with preconceived expectations for the first encounter. The goal of the nurse is to establish the relationship and build trust with the client. Peplau (1952) believed that compassionate verbal and nonverbal communication, a respectful approach, and nonjudgmental behavior are essential to this role. Successful implementation of the stranger role is the foundation for development of a therapeutic relationship and a necessary condition for the establishment of the other roles.

In the resource person role, the nurse provides specific factual health information in response to a client's questions (Lego, 1998) and interprets the clinical plan of care (Peplau, 1952). Essential to this role are expert professional knowledge, the ability to deliver information in a sensitive manner, and critical thinking skills needed to process the client's questions and offer a therapeutic response.

Assisting the client to attain knowledge to improve health is the primary goal of the teacher role (Forchuk et al., 1989). This process may be formal, such as providing detailed instructions for individuals or conducting training sessions for groups to teach a health-related behavior, or the process may be informal, such as modeling patterns of health and wellness in the therapeutic relationship (Lego, 1998).

The leadership role involves collaboration between the nurse and the client to meet desired treatment goals. The nurse offers guidance, direction, and support to promote the client's active participation in maintaining his or her health. The goal of the nurse is to help the client accept increased responsibility for the plan of care (Peplau, 1952).

In the surrogate role, the nurse functions as an advocate or a substitute for another human being who is well known to the client, such as a parent, sibling, other relative, friend, or teacher (Lego, 1998). Through this process a client may unconsciously transfer behaviors or emotions that are connected to a significant other onto the nurse. The nurse addresses this reaction and assists clients to recognize the differences as well as similarities between themselves and the other.

In the counselor role, the nurse encourages the client to explore his or her current situation or presenting problem. The nurse must be aware that such exploration often engenders anxiety and, therefore, must facilitate an atmosphere that is conducive for the client to safely express his or her concerns (Peplau, 1952). To successfully implement the counseling role, the nurse must demonstrate active listening skills, apply therapeutic communication techniques, provide guidance and support in the process of self-discovery, and maintain professional boundaries and self-awareness (Gastmans, 1998).

Although Peplau (1952) did not include the technical expert role in her original work, it is now considered to be one of the primary helping roles of the nurse–client relationship (Peplau, 1965, 1992). As a technical expert, the nurse demonstrates technical skills to perform nursing care. The technical expert role includes physical assessment and interventions and the use of equipment, such as intravenous pumps, blood pressure cuffs, and ventilators.

The implementation of the helping roles (Peplau, 1952) has been described in a number of settings, including psychiatric and mental health (Doncliff, 1994; Feely, 1997; Forchuk et al., 1989; Forchuk, Jewell, Schofield, Sircelj, & Valledor, 1998; Lego, 1998), surgical (Marchese, 2006; Price, 1998), medical (Hall, 1994; McGuinness & Peters, 1999), and palliative care (Fowler, 1994, 1995). The roles have also been described in relation to nursing care for specific clinical scenarios, including AIDS (Hall, 1994), end of life (Fowler, 1994), multiple sclerosis (McGuinness & Peters, 1999), urinary diversion (Marchese, 2006), and body image after mastectomy (Price, 1998).

When analyzing transcripts of semistructured interviews conducted for a study of women's and men's responses to sexual violence (referred to as the parent study), the authors, who are advanced practice psychiatric mental health nurses, were struck by how the participants' descriptions of their encounters with health care professionals were reminiscent of Peplau's (1952) descriptions of nurse–client relationships and decided to use Peplau's theory to better understand the nature of these encounters. The purpose of the study reported here, therefore, is to explore survivors' perceptions of their encounters with health care professionals according to Peplau's helping roles. The research questions were as follows:

1. When survivors of sexual violence describe their encounters with health care professionals, do they describe roles performed by professionals that are consistent with one or more of the Peplau's helping roles?
2. When survivors of sexual violence describe their encounters with health care professionals, do they describe roles performed by professionals that are not consistent with one or more of the Peplau's helping roles?
3. When survivors of sexual violence describe their encounters with health care professionals who perform one of Peplau's roles, what about these encounters do they perceive as helpful?
4. When survivors of sexual violence describe their encounters with health care professionals who perform one of Peplau's roles, what about these encounters do they perceive as hurtful?

THE PARENT STUDY

In the parent study, grounded theory methods are being used to develop a theoretical framework that describes, explains, and predicts women's and men's responses to sexual violence. After institutional review board approval was obtained from Kent State University, 64 women and 57 men living in the greater Akron, Ohio, metropolitan area who had experienced sexual violence at some point in their lives were recruited via fliers placed in their communities, referrals from community leaders, and snowball sampling among participants (Martsolf, Courey, Chapman, Draucker, & Mims, 2006).

After providing informed consent, the men and women participated in minimally structured interviews conducted in their communities by advanced practice nurses. Initially, participants were asked broad, open-ended questions to encourage them to describe their experiences of sexual violence, the context in which it occurred, and how they responded to it. Because one of the aims of the parent project is to develop a sexual violence assessment guide to be used by nurses in their daily practices, a series of more structured questions regarding health care experiences were asked at the end of the interview. These questions included: Have you had contact with any agencies, such as health care, police, court, or rape crisis? What were those experiences like? Based on your experiences, what advice would you give to health care professionals who encounter women or men who have experienced sexual violence or other types of abuse? The interviews were audiotaped, transcribed, and entered in the N6 computer software program (QSR, 2002).

METHODS

For this study, content analysis (Miles & Huberman, 1984) was conducted on the transcripts of the first 30 women and 30 men recruited into the parent study. Although Peplau's (1952) work focused on the nurse–client relationship, the researchers believe the helping roles are applicable to a wide variety of health care disciplines and, therefore, decided to include participant references to encounters with any health care professionals, regardless of discipline, in the analysis. Health care professionals are considered to be any individuals who provide services to promote the physical and mental well-being of others and to care for those who are ill or injured. Because most participants spontaneously discussed receiving health care in the early part of the interviews, and all responded to the more structured questions regarding health care at the end of the interviews, the researchers determined that ample data regarding encounters with health care professionals were provided by 60 participants. Health care professionals described by these participants included nurses, physicians, psychologists, social workers, counselors, and therapists.

Two advanced practice psychiatric/mental health nurses from the parent study research team (the first and fourth authors) served as raters. They independently read the transcripts, highlighted content related to health care, and divided this content into text units (i.e., paragraphs or several lines of text) that captured descriptions of participant encounters with health care professionals. The raters then compared their selected text units and agreed on which units should be included in the analysis.

At this point, it was evident that the participants had positive or negative, rather than neutral, recollections of their encounters with health care professionals. Without being prompted by the interviewer, they spontaneously indicated for each encounter whether the health care professional had been helpful or hurtful. On the coding sheets, which contained definitions of the helping roles, the raters independently coded the text units to one of the roles and indicated whether the role had been performed in a way that was helpful (done correctly) or hurtful (done incorrectly). After the raters coded 10 transcripts, they gave their coding sheets to the project director, who calculated an intercoder reliability index, that is, the number of agreements (text units coded to the same role by both coders) divided by the number of agreements and disagreements. To achieve an index above .70, as recommended by Miles and Huberman (1984), the raters met with the study investigator after coding each group of 10 transcripts to identify and adjust for coding discrepancies. After all 60 transcripts were coded, the intercoder reliability index was .68.

The co-investigator of the parent study (the second author) then met with the raters to review the 34 text units that were coded to different roles by the raters or placed in the Other category. The goal of this meeting was to determine the best disposition of these units without forcing data to the theory. For 14 of the text units, the group determined that disagreement was attributable to how the raters interpreted the definition of counselor. References to health care encounters in which the professional had used therapeutic communication skills (e.g., active listening, empathic responses) were in some cases coded to counselor and in other cases to technical expert. The group revisited Peplau's definition of counselor and concluded that although therapeutic communication skills are necessary for the counselor role, they are not sufficient because this role involves encouraging clients to explore their current situations or presenting problems with the goal of gaining insight. The group determined, therefore, that text units about professionals using therapeutic communication skills to provide health care should be coded as technical expert unless the professional was assisting the client to explore their life situations, in which case it should be coded as counselor. The text units were recoded accordingly. For 9 of the text units, the group decided that disagreement occurred because the text was not about actual health care encounters and should be eliminated from the coding. For 2 of the text units, disagreement occurred because the text seemed to be about a health care encounter but the content was unintelligible, perhaps because of the participant's thought disorder. These units were also eliminated. The remaining 7 text units were clearly descriptions of health care encounters that did not fit well with any of Peplau's roles. On examination, however, the group noted that these text units were similar in that they were all examples of encounters in which a health care professional was present with a participant in a social situation in a way that felt supportive to the participant. The group agreed that these text units constituted a new category that they labeled social support and coded as such. This process, therefore, resulted in all text units that were clear descriptions of health care encounters being coded to one of Peplau's helping roles, or to the additional role of social support, without data being forced to the framework or relevant text units being left uncoded. The group then reviewed the 189 units deemed codable to ensure that they were coded accurately.

RESULTS

The Sample

The sample included 30 women and 30 men who ranged in age from 18 to 62 years. Fifty percent of the sample (n = 30) were African American, and 35% were Caucasian (n = 21). Other ethnic groups and biracial participants were represented in smaller numbers. More than half (58%, n = 35) were single; 12% (n = 7) were married, 8% (n = 5) were divorced, 8% (n = 5) were separated, and one (n = 1) was engaged. Fifty-five percent of the informants were parents (n = 32), with the average of three children. Nearly one half of the participants (48%, n = 29) had an income less than $10,000, 22% ($n$ = 13) had an income between $10,000 and $30,000, and 30% had an income greater than $30,000. Many participants were considered "hard to reach," because the sample included people who had lived in poverty, had been incarcerated, had serious mental illness, and were suffering from serious physical illness, including

HIV and AIDS. The participants had experienced a wide range of types of sexual violence, from sexual abuse of long duration to one-time sexual assaults.

Text Units Coded to the Helping Roles

Of the 189 text units coded, female participants provided 112 and male participants provided 77. The number of text units coded to different types of professionals were therapists, 13; counselors, 63; physicians, 31; psychiatrists, 23; social workers, 7; nurses, 6; and psychologists, 3. In addition, 43 text units were coded to health care professionals because the participants did not specify which specific discipline the professional practiced. The findings answered the four research questions:

First, when survivors of sexual violence describe their encounters with health care professionals, do they describe roles performed by professionals that are consistent with one or more of the Peplau's helping roles?

Of the 189 text units describing encounters with health care professionals, 182 were coded as one of Peplau's (1952) helping roles. The numbers of text units coded to each role were counselor, 79; technical expert, 78; stranger, 13; resource person, 2; teacher, 4; leadership, 6; and surrogate, 0. Clearly, counselor and technical expert were the helping roles that were most salient in the participants' narratives.

Second, when survivors of sexual violence describe their encounters with health care professionals, do they describe roles performed by professionals that are not consistent with one or more of the Peplau's helping roles?

As mentioned above, 7 text units were not consistent with one of Peplau's roles, and the researchers determined that these units constituted an additional role that the researchers labeled as social support. Melanie, a 43-year-old biracial female with a lifetime of sexual abuse who attended a daily methadone clinic, stated, "Mainly all of my support group was either nurses or mental health professionals." Other ways in which health care professionals enacted the social support role was by being available to the participants in a social milieu, engaging in social activities with them in the context of a therapeutic treatment center, and providing ordinary social interactions. Sarah, a 19-year-old Caucasian female who had experienced multiple events of sexual abuse by family members, described the role of social support: "There's a nurse in the health clinic [who] would always come talk to me, and always know my name and like when I'd come into the health clinic, when I come in for therapy [with another counselor], she'd come down and sit next to me and ask, 'How are you?' She's really nice. I don't know, it's just really, that's nice."

Third, when survivors of sexual violence describe their encounters with health care professionals who perform one of Peplau's roles, what about these encounters do they perceive as helpful?

The participants provided many examples of encounters in which the health care professionals performed one of Peplau's (1952) roles in a helpful way. One hundred forty-seven of the 189 text units were coded as helpful interactions. Of these, 57 were coded to the counselor role and 66 to technical expert role. The numbers of text units coded to the remaining roles were stranger, 6; resource person, 2; teacher, 3; leadership, 6; and social support, 7.

Health care professionals in the counselor role were perceived by the participants to be helpful because they fostered trust, encouraged reflection, conveyed understanding, facilitated insight, and/or asked thought-provoking questions. Those in the counselor role who were viewed as helpful created an atmosphere in which the participants were able to explore the effects that violence had on their lives, rather than just deal with "surface" issues. Ella, a 25-year-old African-American female who experienced a rape by an acquaintance, said of her experience with a counselor:

> I guess just being able to talk with her and being able to have somebody that I know that's going to understand and I can trust and just know any time. . . . I can come in and I can see you. . . . Um, I guess basically I meet with my counselor and we talk and we just set different little goals and she explained some stuff that happened to her and I explain stuff that happened to me and I feel real open to express how I feel.

Melvin, a 38-year-old African American who had experienced childhood sexual abuse (CSA), described how his psychiatrist facilitated insight: "My psychiatrist has gotten me to the point of [understanding that] a 14-year-old kid can't be blamed for being locked up in the house, for being thrown around, for being raped." Michael, a 50-year old African-American male who also had experienced childhood sexual abuse, was helped by thought-provoking questions from his counselor: "I was just so fascinated with her [the counselor's] voice and the questions she was asking me. But it was, she was insightful because it was things that she was asking me questions that I wasn't asking myself."

Health care professionals in the technical expert role were perceived as helpful if they engaged in positive therapeutic communication. Specifically, participants felt helped if a health care professional listened attentively and provided empathic responses when they talked about the violence. Health care professionals were also seen as helpful if they effectively managed the participants' symptoms that stemmed from their experiences of violence. Nancy, an African American female who had experienced a lifetime of sexual violence, stated, "I started back into therapy and then the [health care provider] put me on Paxil and I responded really well." Jennifer, a 23-year-old Caucasian survivor of CSA and an assault in adulthood, said, "My psychiatrist has helped me because I was having trouble sleeping. I was very paranoid. I was locking all the doors, locking all the windows, [closing] all the blinds, [closing] all the curtains, you know."

Health care professionals in the stranger role who had interacted with participants in a single encounter (e.g., an emergency room nurse) were helpful by showing interest and compassion. Brenda, a 57-year-old African American who had survived a stranger rape, stated, "They [emergency room nurses] were comforting. I felt like they felt sorry for me. . . . They didn't say that, but [they] more or less tried to pamper me. 'Are you feeling all right? Are you sure?' They were very nice [at] that place [the emergency room]."

Those in the role of a resource person were perceived to be helpful when they made appropriate referrals to needed services. When Melanie, a 43-year-old biracial female who had experienced a lifetime of sexual violence, asked a health care professional what she should do with her children who were exhibiting problematic behavior. She revealed, "She [her therapist] told me that it's, it's, you deal with you, no one's fighting you to get those kids, and I was like, 'Yeah but really they need help.' And she gave me a referral for child guidance."

Health care professionals who performed the teacher role provided health-related literature or information. Jennifer, the 23-year-old Caucasian who had survived CSA, said, "Yes, it is a very positive [experience at rape crisis] because they'll [nurses at the clinic] help you. . . . They give you literature like on gonorrhea and I think syphilis."

When participants felt health care professionals in the leader role were working with them "as a team" or providing direction without taking charge, the professionals were considered to be helpful. Jennifer explained, "I was going to counseling for something, I didn't realize what it was at the time and he [her counselor] told me, you know, that we can work together and get me not blocking, cause I would start having flashbacks." Maria, a 36-year-old Caucasian survivor of date rape, said, "Specifically to address that [the sexual violence], about six years ago [I went into therapy]. She [the therapist] suggested that I write him [the perpetrator] a letter."

Fourth, when survivors of sexual violence describe their encounters with health care professionals who perform one of Peplau's roles, what about these encounters do they perceive as hurtful?

The participants provided a number of examples of encounters with health care professionals that were hurtful; 42 of the 189 text units were descriptions of encounters in which the health care professional performed their role "incorrectly." Twenty-two of these encounters occurred with a professional in the counselor role; the remaining occurred with those in the role of the technical expert, 12; stranger, 7; and teacher, 1.

Negative experiences with professionals performing the counselor role often involved therapists who did not believe the participant when he or she revealed the sexual violence, who minimized the importance of the violence, who failed to provide in-depth mental health care, or who violated professional boundaries. Alvin, a 42-year-old Caucasian male who had been raped while in the military, described a series of hurtful encounters with a therapist:

> I decided on the third day that I saw that guy [a therapist] I was going to say, if I had to take three issues that I want to deal with over the next five months, this is issue number 1 [hits the table], which was the assault. And this is issue number two [hits the table] which is my feelings that I'm more sexually attracted to men than I am to women. And this is issue number three, and that was to deal with my marital problems. But, in that order. So we went back through all of the assessment tests and all that other stuff and then he immediately jumped to issue number four which I didn't even give him. . . . And then at the end of the session he said, 'Well, I'd really like to give you a hug.' And it's just like, we've talked about everything, me being attracted to men, to being sexually assaulted, to having marital problems, and now you want to give me a hug?

Hurtful encounters with health care professionals in the technical expert role often occurred when they had poor communication skills or provided physical care in an insensitive or unskillful manner. Alvin stated, "I mean like my family, my primary care

physician, he's very thorough, and he's very blunt with me, but I go into his office and the nurses, they don't listen to you, his reception staff doesn't listen to you." June, a 40-year-old Caucasian survivor of CSA, said, "Memories of junior high school is going to the nurse one day because there was blood on my pants and the nurse just assumed that I had started my period so she just gave me a note and sent me home with a note that I had started my period and I wasn't bleeding that way, I was bleeding anally [as a result of a sexual assault by a guardian]."

Examples were provided of problematic encounters with professionals performing the stranger role who failed to show respect or compassion and were perceived by the participant to be judgmental. Sally, a 36-year-old African American female who survived intimate partner violence in adulthood, talked about a social worker who showed lack of respect by not coming to a scheduled appointment. "Like, yeah, I want to talk to a social worker, but the social worker never came."

DISCUSSION

Although only two of Peplau's (1952) helping roles, counselor and technical expert, were frequently described by the participants, the theory nonetheless provided a useful lens by which to explore the participants' experiences with health care professionals. The process of coding participants' descriptions of encounters with the health care professionals to Peplau's helping roles revealed that the health care professionals who are most important in the life stories of survivors of sexual violence are those who help them understand the violence and gain insight into their life situations (counseling role) or who engage in therapeutic communication and help manage symptoms related to the violence (technical expert role). Once the team clarified the definitions of the roles and standardized their coding procedures, all but 7 text units fit well into one of the roles. Because the 7 units were similar to one another, the researchers proposed a new role of social support. Although there were too few text units to suggest adding a new role to Peplau's theory, future researchers might consider that health care professionals may be helpful to survivors of sexual abuse by being present with them in ordinary social encounters.

Peplau's theory also facilitated our examination of what the participants found to be helpful or hurtful in their encounters with health care professionals in the various roles. Although the participants perceived some encounters to be helpful because the professional provided needed information or gave useful advice or direction, most encounters were perceived to be helpful because the professional was supportive and compassionate. Conversely, hurtful encounters were most likely to occur when health care professionals were insensitive or dismissed the suffering caused by the violence. Although the need for sensitive, compassionate care is probably universal to all those who seek health care, it seems to be particularly important to survivors of sexual violence.

Although we failed to find empirical support for all but two of the helping roles, our findings are consistent with literature that suggests that Peplau's roles capture important aspects of the helping relationships (e.g., Forchuk et al., 1998; Lego, 1998; Marchese, 2006; McGuinness & Peters, 1999). Because much has been written about Peplau's roles from the nurse's vantage point (Feely, 1997; Fowler, 1994; Hall, 1994; Lego, 1998; Marchese, 2006; McGuinness & Peters, 1999), the results of this study contribute to the literature by offering the perspective of the client.

The major limitation of the study is that it was a secondary analysis of an existing data set. Because the researchers were not able to probe about health care encounters with professionals in all the helping roles, we cannot conclude that the roles not mentioned frequently by the participants were not experienced. Because receiving information is such a routine aspect of health care, for example, participants might not have thought to describe how professionals served the role of resource person. Similarly, all health care professionals who established an ongoing relationship with participants at one time enacted the stranger role, but this might not have been addressed by participants who chose to relate a more memorable aspect of the relationship. Future researchers might inquire about encounters with professionals in all the roles and obtain a more nuanced understanding of how such encounters contribute to recovery.

The findings, nonetheless, have implications for health care professionals who work with survivors of sexual violence. Survivors report encounters with health care professionals as either helpful or harmful and convey that such interactions play significant roles in their healing. The findings suggest that health care professionals in the counselor role need to create an atmosphere in which clients can explore in depth the effects of sexual violence, and all health care professionals, regardless of role, need to be skillful in therapeutic communication. Avoidance of

all hurtful encounters is important because these encounters discourage survivors from seeking further help and create or intensify a distrust of health care professionals. Because interpersonal interactions are so important when working with survivors of sexual violence, consultation and supervision by professionals who specialize in therapeutic communication, such as advanced practice psychiatric nurses, are recommended in settings where sexual violence survivors are likely to receive health care.

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