Screening Patients for Sexual Violence

An Accredited Curriculum for Nurses in Pennsylvania

Screening Patients for Sexual Violence

An Accredited Curriculum for Nurses in Pennsylvania

Developed by the Pittsburgh Action Against Rape of Allegheny County, Pennsylvania

Produced by the Pennsylvania Coalition Against Rape

May 2007

This project was funded by PCAR as a special initiative with funds from the Commonwealth of Pennsylvania Department of Public Welfare.

Purpose of Tutorial and Guide

Have you felt that your attempts to collaborate with local healthcare providers have missed the mark because you didn't know how to speak their language? Are you in need of training materials in order to effectively prepare your local healthcare providers to screen for sexual violence? If so, this CD tutorial program, *"Screening Patients for Sexual Violence,"* and implementation guide are the perfect tools to help you strengthen your current program or launch a new one. The purpose of this guide is to help you implement *"Screening Patients for Sexual Violence"* and provide you with a menu of options to most effectively use it within the community you serve.

Collaboration is key

The focus of this program and guide is sexual violence. However, it is important that health care providers also screen for domestic violence and other public health issues. Often, individual patients experience multiple victimizations and social struggles such as sexual violence, domestic violence, substance abuse, depression and anxiety, and others over the course of their lifespan or within their families. Therefore, sexual violence advocates are encouraged to collaborate with domestic violence advocates and other allied professionals in their efforts to educate health care professionals about these critical and interrelated public health issues. To these ends, your center may want to consider recruiting a small advisory committee comprised of nurses and/or other medical professionals as well as allied community partners to guide outreach and implementation strategies.

Why this program is important

Prevalence of Sexual Violence

It is estimated that one in four girls and one in six boys will be sexually assaulted by their 18th birthday (Finkelhor, 1990). Adverse childhood experiences, such as sexual abuse, can follow an individual into adulthood, manifesting themselves in an array of social, psychological, and physical illnesses and struggles (Felitti, 2002). Despite the prevalence of sexual violence, less than 15 percent of female patients report that their health care providers have asked them about abuse (Elliott, Nerney, & Jones, 2002).

Although the Joint Commission on Accreditation of Health Care Organizations has mandated that outpatient clinics and emergency rooms ask at least one question related to intimate partner violence, we know that this is not routine practice. Furthermore, screening for sexual violence does not necessarily occur within an intimate partner context.

Reasons Why Health Care Professionals Don't Ask

- Sexual violence is a sensitive subject, and many fear broaching the topic
- They lack the time to screen all patients
- They do not have a private place in which to screen patients

- They are not sure how to ask
- They are not sure how to respond when patients say "yes"

Reasons Why Health Care Professionals Should Ask

- Sexual violence is prevalent and most health care providers do treat patients who are victims of current or past abuse, whether they know it or not
- Women with histories of abuse have higher levels of health care use, experiencing somatic and stress related illness, chronic pain, depression and substance abuse disorders
- Primary care practices are safe, confidential places to address sexual violence in a non-judgmental manner
- If asked, victims/survivors can disclose and receive the care and services they need

The *"Screening Patients for Sexual Violence"* program is an effective way to expand screening and increase health care professionals' knowledge about the prevalence and treatment for victims of sexual violence. In order to screen effectively, it is important that health care professionals receive the resources, training, and assistance they need. Rape crisis advocates can utilize "*Screening Patients for Sexual Violence*" as well as other expertise to help prepare healthcare professionals to screen patients for sexual violence and connect them to services in the community.

More about the CD Rom Tutorial

The *"Screening Patients for Sexual Violence"* tutorial is accredited by the Pennsylvania Nurses Association and can serve as an educational resource for health care providers in your community. It is a self-guided CD tutorial program appropriate for nurses, nurse practitioners, physician assistants, physicians, medical students, residents and nursing students. It is interactive and self-paced. Because the tutorial is on CD, individuals can complete it at home or in the workplace (see Appendix C for system requirements for running CD Rom). Individuals can complete the entire tutorial in approximately one hour or complete one module at a time, to accommodate busy schedules. Nurses can receive one continuing nurse education (CNE) credit by completing the online evaluation at the end of the tutorial (see Appendix B). For more information about receiving CNE credit, contact the education and resource coordinator at the Pennsylvania Coalition Against Rape (PCAR) at 1-800-692-7445, ext. 115.

The tutorial includes modules on the importance of screening for sexual violence in a healthcare setting, barriers to screening, screening methods, responses to disclosures, the neurobiology of trauma, and tips for creating more victim/survivor-friendly environments in the healthcare setting. The tutorial also features an interactive video clip that walks participants through the screening process with a standardized patient.

How to get started

Begin by reviewing the entire tutorial and become familiar with all of its components. For your reference, the tutorial's script is provided as an appendix to this guide (see Appendix A). After reviewing the tutorial, decide if you will use the *"Screening Patients for Sexual Violence"* CD tutorial to enhance your center's current educational program for health care professionals, or to establish a new health care professional outreach program. It can be used as a stand-alone program or one that supplements existing efforts.

Questions to Ask Yourself

Your center should first assess what staff time and other resources can be committed to this program. Here are some questions that need addressed before getting started:

1. Who in our agency can commit the time to contacting health care professionals to introduce them to this program?
2. Does this person have a comfort level interacting with health care professionals? Does s/he have a general understanding and knowledge of health care provision and resources in the community?
3. How much time will we devote to providing health care professionals with this program?
4. If we do not have enough staff time to devote to this initiative, can we coordinate with volunteers or board members to assist?
5. Do we have access to adequate technology to support the delivery of this program in primary care settings, including a laptop and projector?
6. Can we budget for additional patient education materials and giveaways to complement the program?
7. How can this program support our agency's overall mission and strategic plan?

Your Answers and Strategies

The answers to these questions will vary across communities and will ultimately determine the most effective way for your center to implement the *"Screening Patients for Sexual Violence"* CD tutorial with health care professionals in your community. For instance, if you do not have a staff member who is comfortable interacting with health care professionals or someone who can devote enough time to outreach to health care professionals, perhaps volunteers can help. If your agency is uncertain about the resources it can commit to the program, it might make the most sense to start with a more modest implementation plan.

There are a number of strategies your agency can use to implement the *"Screening Patients for Sexual Violence"* program:
1) Contact a pre-defined number of primary care offices or clinics and deliver the program in a short visit
2) Coordinate a multi-hour training opportunity at your center or within a health care training program.

Before deciding the extent to which you will use this program, you must first identify the size and scope of your audience.

Identifying and Contacting Your Audience

Target Audience

Primary care practitioners often see patients in settings that are conducive to screening for sexual violence. Primary care settings often provide confidential, private places in which screening can occur. Therefore, rape crisis centers may wish to target primary care providers as primary audiences of the *"Screening Patients for Sexual Violence"* program. However, screening for sexual violence should not be limited to primary care settings. Other audiences/settings may include the following:

- Medical Residency or Fellowship Programs
  - Family Practice
  - Obstetrics/Gynecology
  - Pediatrics
  - Internal Medicine
  - Emergency Medicine

- Schools of Nursing

- Other Health Care Provider Training Programs (Physician Assistants, Nurse Practitioners)

Start with Research

First, develop a list of primary care offices and clinics in your community. If a list already exists, take time to make sure the list is up-to-date. There are a number of ways to develop a good directory for your community. Consider these resources:

- Adagio Health (Formerly Family Health Council, Inc., Western PA)
  www.adagiohealth.org
- Family Health Council of Central Pa
  www.fhccp.org
- Family Planning Council of Southeastern PA
  www.familyplanning.org
- Planned Parenthood
  www.plannedparenthoodpa.org
- Medical insurance provider directories
- Yellow page listings under family practice, internal medicine, obstetrics/gynecology and pediatrics
- Your county's medical society

Identifying Contact People and Prioritizing Your List

Many medical practices as well as medical and nursing schools have Web sites where you can learn more about their programs and practices and obtain contact names and email addresses. Your comprehensive list may appear overwhelming, so it is important to prioritize outreach efforts.

If you are uncertain how to begin prioritizing your list, consider the following: anyone can be a victim of sexual violence, but we also know that poverty and violence are highly correlated. Therefore, you may want to identify clinics and primary care offices that serve a high number of economically distressed patients and put these practices high on your contact list. You may also want to consider grouping your contact list into three categories: high, medium, and low priority and developing target time frames in which to contact each group.

Making First Contact

Before you begin making visits, it is important to determine what, if anything, your organization can offer, beyond the *"Screening Patients for Sexual Violence"* program. For example, are you able to provide patient education materials and professional education lectures? This program is flexible and can stand alone, or it can be used in conjunction with your existing programming with health care professionals.

When you are ready to begin outreaching to your priority list, making initial contact via email may be most effective. Advocates can then follow-up with a phone call to the appropriate contact person at the healthcare facility, using the following suggested script:

"As I indicated in my email to you, the (center's name) is launching an initiative to provide health care professionals with a new, self-guided CD tutorial about how to screen patients for sexual violence. I would like to coordinate a five- minute meeting with you and your nurse manager/program manager to share this program. Additionally, I would like to share other patient care materials to provide your practice/training program with community referral information to help you best serve patients. When might be a convenient time for me to visit?"

Choosing the Options that Work for Your Center

Program Delivery Menu

There are a number of ways to begin using the *"Screening Patients for Sexual Violence"* program. Based on your center's resources, you can select as many of the options as appropriate to implement the program. This program may serve as the basis for a new initiative for your center or to enhance your existing health care professional outreach program.

There are at least four program options to consider for implementing the *"Screening Patients for Sexual Violence"* program, ranging from providing the program and some patient education materials to conducting a clinical rotation session at your center. Each option builds upon the

relationships you establish on your first contact. Therefore, it is important to be organized and deliver what you promise so that you develop credibility with health care providers.

Option 1—The Five-Minute Meeting

Strategy At A Glance	
Strategy:	**Five-Minute Meeting**
Location:	**Clinic or Primary Care Office**
Prep Time:	**20 Minutes**
Delivery Time:	**Five Minutes**
Staff:	**Education Coordinator**
Budget:	**Minimal (Hand-Out Materials/Staff Time)**

The first approach is to coordinate a five-minute meeting with an office nurse manager. Keep in mind that clinics and doctors' offices are very busy places and that you will only have a five-minute meeting with your contact person. Respect your time limitations. For this meeting, you should take the following:

- The *"Screening Patients for Sexual Violence"* CD
- Patient Teaching Materials
- Community Referral Information
- Your Business Cards
- Giveaway Item with your center information, such as a Penlight (optional)

Packaging Your Materials

To best present your materials, you may want to consider packing them together in a simple box, perhaps the size of a small pizza box, which can be purchased in bulk at office supply stores. You should label the front of the box and include your center's contact information. The patient education materials can be organized in sleeves within the box. As an added incentive for the office staff to read the materials, you could also include candy in the bottom of the box.

Medical office staff is inundated with materials and giveaways from pharmaceutical companies; packaging your materials so that they stay together and are attractive is an important step in getting them recognized and used.

What to Say in Five Minutes

During your five-minute meeting with the nurse manager, you should:

- Briefly highlight the prevalence of sexual violence, the importance of the problem;

- Talk about the barriers to screening for sexual violence in primary care settings and how you can provide resources that will guide health care providers in screening and referring their patients;
- Discuss the purpose of the *"Screening Patients for Sexual Violence"* CD; and
- Review the patient education materials and the services your center offers in the community.

Make sure that the staff knows how to re-order materials and contact you when needed. At the end of this meeting (if your center has decided that it can pursue this strategy), you can ask if you might make a 20-minute presentation at one of the office's "Lunch & Learn" programs.

Before leaving, thank your contact for her/his time and ask if it would be appropriate for you to check in every few months to see if the office needs more materials. Mark your calendar with the follow-up date prior to leaving the office.

Option 2—The Lunch & Learn

Strategy At A Glance

Strategy:	**Lunch & Learn**
Location:	**Clinic or Primary Care Office**
Prep Time:	**One Hour**
Delivery Time:	**20-30 Minutes**
Staff:	**Education Coordinator and potentially a Health Care Volunteer**
Budget:	**Moderate (Hand-Out Materials/ Optional Give Away Items/ Staff Time)**

Most physicians' offices regularly schedule "Lunch & Learn" programs. These programs, as the name suggests, are conducted over a lunch and offer some type of educational information for the health care professionals who work in the office or clinic. Pharmaceutical companies, who provide a catered lunch, often sponsor Lunch & Learn programs. However, when you ask to present a Lunch & Learn program, you may wish to propose to office staff that they bring a brown bag lunch. (The office will likely understand that your organization does not have a budget similar to a pharmaceutical company and accommodate your request.) You could also ask local restaurants to donate or offer a discounted lunch.

Presentation Format for Health Care Professionals

Lunch & Learn programs are typically 20-minute presentations made in a conference or lunchroom within the office or clinic. In addition to planning what information to include in your presentation, you also need to ensure that appropriate technology, such as a laptop and projector, is available or that your equipment can be set up in the meeting room prior to lunch.

Health care professionals are accustomed to learning through lecture presentations and seem to be most comfortable with this learning style for lunch programs. You should plan a 15-20 minute PowerPoint presentation, leaving time for questions and answers. If you are not comfortable with computer technology or the use of PowerPoint, you may want to consider having someone else attend the program with you to connect the computer and projector. The PowerPoint program is part of the Microsoft Office suite. If you are not familiar with the program, you can visit the Microsoft PowerPoint home page at www.microsoft.com/powerpoint/ and select the training for the module called "creating your first presentation."

Lunch & Learn Agenda

Here are some topics that you might want to address in your Lunch & Learn presentation:

- Overview of the prevalence of sexual violence problem in the United States;
- Reasons why sexual violence is not reported during primary care visits;
- Most appropriate screening questions;
- Demonstration of key modules in the *"Screening Patients for Sexual Violence"* CD; and
- Overview of the programs and services your center provides.

You must be organized, arrive early to set up your technology and present a well-articulated message. Remember that you are the expert on the subject of sexual violence. Your presentation should reflect this fact.

Option 3—Going to Classes

Strategy At A Glance

Strategy:	**Going to Classes**
Location:	**Medical or Nursing Schools, Teaching Hospitals**
Prep Time:	**1-3 Hours**
Delivery Time:	**One Hour**
Staff:	**Education Coordinator or Health Care Professional Volunteer**
Budget:	**Moderate (Hand-Out Materials/Staff Time)**

If your service area includes medical residency training programs, nursing schools, and other health care training programs, you can contact them to ask if you can present the *"Screening Patients for Sexual Violence"* CD tutorial and information about sexual violence during a class. The information you provide at a class session would be similar to the presentation outlined for

the Lunch & Learn program; however, you may have more time to discuss more detailed information regarding sexual violence.

Talking the Talk

When making presentations in an academic setting, you need to be especially careful to use appropriate medical terminology and to present in a style that best accommodates the learner, typically a lecture format. Your center may want to consider enlisting a medical professional volunteer, such as a sexual assault nurse examiner (SANE nurse), to help with presentations in medical and nursing schools.

When preparing a class session for medical or nursing students, consider the following:

- Have a clear agenda for the class that articulates learning objectives;
- Ask the program coordinator or instructor about the typical class format (lecture, group discussion, etc.) and plan your presentation according to the students' learning style;
- Recruit medical professionals who have experience in treating victims of sexual violence to assist with the class presentation; and
- Ask about technology available in the classroom and coordinate your technology needs prior to class.

Being a guest lecturer for health care professionals at class presents your center with another opportunity to offer more in-depth training—an on-site visit to your agency.

Option 4—Agency Site Visits

Strategy At A Glance

Strategy:	**Agency Site Visits**
Location:	**Your Center**
Prep Time:	**1-3 Hours**
Delivery Time:	**2-3 Hours**
Staff:	**Education Coordinator, Other Center Staff and Health Care Professional Volunteer**
Budget:	**Moderate to High (Hand-Out Materials/Prep Time for Multiple Staff)**

While the *"Screening Patients for Sexual Violence"* program does provide important information and screening protocols for patients that participants can learn independently, an agency site visit can be the most powerful method of providing health care professionals information about sexual violence. If your center can accommodate this level of programming,

residents, primary care physicians, nursing students and other health care professionals should be invited to your center for a clinical rotation.

Clinical Site Visit Agenda

A sample agenda for this 2.5-hour session would include the following:

- A facility tour and discussion of your center's services;
- Power Point presentation that discusses
  - Sexual violence statistics and prevalence,
  - Neurobiology of trauma (You most likely need a medical volunteer to address this topic.),
  - Universal screening as a tool to identify sexual violence,
  - Barriers to disclosure in a medical setting and strategies to overcome these barriers,
  - What to do if a patient says, "Yes, I am a victim,"
  - What to do if a patient says, "No" but there are still concerns, and
  - Referral information and practical suggestions on how to validate the experience;
- Rehearsal of information learned through role-playing; and
- Meeting with medical advocate to review forensic examination and the role of medical advocacy in patient care.

In addition to conducting on-site clinical rotations, it is also important to visit the family practice clinics to which the residents and students are assigned. This will allow you to make sure that the supervising attending physicians and nurses working with the residents are also oriented to the *"Screening Patients for Sexual Violence"* program, patient care materials, and your center's programs. This will reinforce the on-site training offered.

A Few Final Helpful Hints

Regardless of how you choose to proceed with the *"Screening Patients for Sexual Violence"* program, here are a few tips to increase your effectiveness:

- **It's natural to get intimated by health care professionals.** Remember that you are the expert on the subject of sexual violence and that you are providing essential information for health care providers. You need to confidently deliver your message.

- **We are all busy people, but health care settings are especially busy.** Always be prepared before making introductory telephone calls, short visits or conducting longer training sessions. Use written scripts, agendas and learning objectives.

- **Health care professionals are accustomed to learning through lectures.** It typically is not effective to force small group discussion and interaction (except during role plays in clinical rotation site visits). The old adage of "When in Rome, do as the Romans do" is appropriate here.

- **Don't be offended if health care providers come and go during Lunch and Learn or other lecture presentations.** It is the nature of their work to be interrupted by sick patients and emergencies. It is not necessarily a reflection of your presentation content or style.

- **Package your materials professionally.** Medical professionals are used to receiving professionally printed materials from pharmaceutical companies. To establish that your center is a credible source of information, the quality of your materials must also be very professional. Consider using PCAR's color brochures with your agency information printed on the back or investing in one new professionally printed piece. You will make a better impression with a small number of professionally printed pieces rather than a broader range of in-house printed or copied materials.

- **Be savvy with technology.** Make sure that you have access to the appropriate equipment for your presentations and have a back-up plan. If you do not know how to develop a PowerPoint presentation, go through an on-line tutorial.

- **Develop ongoing relationships.** Keep a calendar of follow-up visits and appointments and make sure that your clinics and doctors offices always have supplies. If they can trust you to provide accurate, helpful information and follow-up regularly, health care professionals will be more likely to use your materials and refer patients to your center for services.

For More Information

If you would like more information about how to use the *"Screening Patients for Sexual Violence"* program in your health care professional outreach program, contact the medical advocacy coordinator at PCAR. You may also find the resource, "*Put down the Chart, Pick up the Questions: A Guide to Working with Survivors of Sexual Violence*" helpful in developing and implementing sexual violence screening tools in your community's health care facilities. This resource is also available through the medical advocacy coordinator at PCAR. Also, this program's primary focus is on screening and identifying sexual violence, not on domestic violence or legal and medical concerns and standards of care for rape victims. More information on these topics can be obtained from the following sources:

American College of Obstetricians and Gynecologists: www.acog.org

American Medical Association: www.ama-assn.org

American College of Emergency Physicians:
http://www.acep.org/webportal/PracticeResources/PolicyStatements/violabuse/ManagementofthePatientwiththeComplaintofSexualAssault.htm

Massachusetts Medical Society Domestic Violence Screening Tool: http://www.massmed.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=7491

National Resource Center on Domestic Violence: www.nrcdv.org

National Sexual Violence Resource Center: www.nsvrc.org

Pennsylvania Coalition Against Domestic Violence: www.pcadv.org

Pennsylvania Coalition Against Rape: www.pcar.org

References

Elliott L., Nerney M., & Jones T. (2002). Barriers to screening for domestic violence. *J Gen Intern Med 17(2),* 1-6.

Felitti, V. J. (2002). *The relationship of adverse childhood experiences to adult health: Turning gold into lead*. San Diego, CA: Kaiser Permanente Medical Care Program.

Finkelhor, D., et al., (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors, *Child Abuse and Neglect, 14*, 19-28.

Appendices

Appendix A

CD-ROM Curriculum:
Working with sexual violence in a health care setting
Script

Learning Objectives

Upon completing this Interactive CD-ROM, health care providers should be able to:

1. Ask screening questions in a non-judgmental way.

2. List the barriers that may hinder a patient's disclosure of sexual violence and abuse in a health care setting.

3. Respond to disclosures of sexual violence and abuse in a way that is validating to patients.

4. Recite and screen using the S.A.V.E method.

5. Describe the ways that traumatic memories differ from normal memories and why this is clinically significant.

6. Assist a patient who has experienced abuse, feel safe during a health care encounter and in particular during invasive examinations.

Welcome

Patients undoubtedly value all of the skills and diagnostic advances of a medical practice. But what a patient may value most in the moment is awareness, supportive statements and compassionate health care providers who are willing to talk about sexual violence. Even if none of your patients have ever talked about sexual violence, be aware that current statistics suggest that very few practices escape this national health care epidemic.

While you may already be screening for domestic sexual violence in your practice, which is important; it is equally important that you also screen for sexual violence – the focus of this curriculum.

Although sexual violence can occur within the context of domestic sexual violence, it is critical that medical professionals understand the full continuum of sexual violence, which includes but is not limited to: rape resulting in murder, blocked access to birth control and protections from disease, child sexual abuse, forced abortions and/or sterilization, incest, unwanted sexualized exposure, marital and partner rape, ritual abuse, sex trafficking, sexual exploitation, sexual harassment, stalking, statutory rape, stranger and non-stranger rape, voyeurism and any other unwanted sexual contact.

This tutorial's guide is to help you find the right words in working with your patients. There is also a component that deals with the neurobiology of trauma. We hope that this will help to give the physiologic underpinnings, and help make sense of the notion that trauma is timeless and may continue to effect your patient's lives for many months and even years after the trauma ends. Remember, it is often your words that will afford the greatest impact.

The human cost of sexual violence is great in terms of injuries, chronic health problems and quality of life, yet the human cost of screening for sexual violence is minimal in terms of money, time and opportunity. By screening for sexual violence, you can make a significant and lasting difference in the lives of your patients. We thank you for taking the time to complete this tutorial and hope that it will help you in working with patients for many years to come.

Why don't Patients Talk about Sexual Violence?

Sexual violence is an epidemic that has fallen squarely in the hands of health care. There are many standards of care related to pregnancy prevention, STD and HIV prophylaxis, and health care is often the entity responsible for forensic evidence collection. Also, it is critical for health care to assess for the development of Post Traumatic Stress Disorder.

Unfortunately, there are not always enough resources attached to training health care professionals to ask about sexual violence. This section is intended to give you some ideas about how to talk to patients in a way that feels both comfortable for you as well as the patients you are seeing. First let's begin with understanding the dynamics that are necessary for disclosure to occur. Click the next button to proceed to this section.

Why don't Patients Talk about Sexual Violence?

Recall the sexual assault

There are several reasons why a patient might not recall the sexual assault. First the abuse may have happened prior to the development of narrative memories. Second, we will discuss later in the tutorial the ways that traumatic memories are stored. This will help give us insight into the reasons why memories are not always complete and accurate. Sometimes, victims of sexual violence may block out the memory of their abuse as a way to cope.

Finally, sexual assaults can be facilitated with drugs and/or alcohol and often the victim has no recollection of the actual events of the trauma. In these cases, the lack of memory may greatly hinder a victim's healing and well-being. A lack of details may make it difficult for a victim to move on from the abuse, remaining preoccupied with what may or may not have happened.

Label the sexual assault as such

While the label we give an assault may seem very straightforward, many victims may not label their experiences the same way. For example, many victims will not label aggravated assault or rapes as such when the perpetrator is a relative, a spouse, a family member or somebody well known to the victim, or, when there was limited force or threat of force in the victimization. Often times there will be too much psychological distress in labeling these crimes as such. Therefore if we ask, "Have you ever been raped?" it may prevent disclosure and result in overly

conservative prevalence estimates. Regardless of the labels used in charts and with other medical providers, it is important that nurses speak the same language as their patients during the interview and exam.

Be asked by a health care professional using the same label or language as the patient
Health care providers have to develop particular screening tools that feel comfortable for each practitioner. However there are some important guidelines to consider. Many patients do not relate to terms like sexual abuse or rape.

Often, people only consider sexual violence to be a situation where someone is raped at the hands of a stranger. Therefore, the term "rape" in a screening question or interview may not address the full continuum of sexual violence that patients may experience, which includes but is not limited to: rape resulting in murder, blocked access to birth control and protections from disease, child sexual abuse, forced abortions and/or sterilization, incest, unwanted sexualized exposure, marital and partner rape, ritual abuse, sex trafficking, sexual exploitation, sexual harassment, stalking, statutory rape, stranger and non-stranger rape, voyeurism and any other unwanted contact.

Our questions must be behaviorally specific and should generally be closed ended. Questions we might ask about sexual experiences include the following (from *Put down the chart, pick up the questions: a guide to working with survivors of sexual violence*, Pennsylvania Coalition Against Rape, 2006):

- Have you ever been touched sexually against your will or without your consent?
- Have you ever been forced or pressured to have sex?
- Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?

Willing and psychologically able
There are social stigmas attached to being a victim, which often exacerbate and prolong the shame and secrecy a victim experiences. Society discriminates against victims of sexual violence, which often results in victims feeling re-victimized when they come forward, especially in the healthcare and criminal justice settings. Furthermore, if a victim is a person of color; lesbian, gay, bisexual, or transgendered; poor; functioning at a low literacy level; an immigrant, refugee, a victim of sex trafficking; a prostitute; a child; a senior; or a male, the layers of social stigma may be too great to allow disclosure.

Many patients fear being blamed for the abuse that has happened or may have had a history of negative outcomes following a previous disclosure. But most importantly, the fear of psychological consequences may leave many people unable to disclose. For example a patient may experience depression, anxiety upon revisiting the event, or possibly even flashbacks upon discussing the situation. Again, this will be addressed in more detail in the neurobiology of trauma section of the tutorial.

Feel it is safe to disclose
Fear of retribution, opening Pandora's Box, disbelief, harsh judgment, hurting one's family, and being ostracized from loved ones are powerful deterrents to the disclosure of sexual violence. It

is important to remember and address the needs of adult survivors of childhood sexual abuse, who are often overlooked. Even if the incident may have occurred long ago, they may still feel uncomfortable discussing it with loved ones (and possibly their perpetrators) in the room.

Screening should never be done with anyone else in the room. This includes husbands, wives, boyfriends, girlfriends, parents, extended relatives, friends of the family, and children over the age of three. It is important not to make assumptions about the relationships between the patient and his or her accompaniments. If you are working with a patient that has a disability or a language barrier that requires interpretation, this must never be done with a friend or family member. In these cases, a professional should be called in—from a community-based translation service—to assist.

Feel safe with a health care provider

Primary care practice presents a confidential, safe and powerful opportunity to confront sexual violence. In many primary care settings a patient may develop a long term trusting relationship with a health care provider or a practice. Therefore, accessing primary care is not generally associated with potential risks and stigma that accessing a rape crisis center may present.

By going to a primary care provider for help, a fearful or traumatized person does not have to identify with the label of "rape victim." For various cultural groups in the United States, going to a health care provider is a socially condoned way of seeking help. The focus of primary care on health and well-being presents an ideal opportunity for sexual violence to be addressed as an important health concern in a nonjudgmental way.

One of the most important things we can do to create safety in the health care relationship is to encourage patients to discuss victimization experiences and then be well-prepared to offer support and referrals to community-based services. We do this by continually screening over time and letting patients know that if s/he or others they know become victims of sexual violence, that your practice is a safe place to discuss the situation.

How do I Ask?

The SAVE method is adapted from the Florida Council Against Sexual Violence. This is an excellent framework to help you remember the steps you can follow.

1. **S**creen all of your patients for sexual violence
2. **A**sk direct questions in a non-judgmental way
3. **V**alidate your patient's response
4. **E**valuate, Educate and make referrals

Click the arrow button to work through a scenario to see how this works.

Case Study
Jen is a 35 year old woman who is new to the office. She is married, has two children and lives in a neighboring community. She states that she hasn't been to the doctor since her kids were born, which has been six years. She is scheduled to have a pap smear today, and Jen tells you that she is absolutely terrified to be here and to have the examination done.

Her past medical history includes:

- Irritable bowel syndrome
- Asthma
- Panic attacks
- Alcoholism
- Depression

You are the health care professional who is going to screen Jen about sexual violence, click next and decide what you might ask:

Which Would You Choose (Video Vignettes)

1. Option 1: Jen, how are things at home? Do you feel safe?

2. Option 2: Jen, have you ever experienced sexual violence?

3. Option 3: Jen, we know that sexual violence is common in the lives of many women, men, girls, and boys and it can affect their overall physical health and well-being. So, we make it a practice to ask all of our patients these questions:

   Have you ever been touched sexually against your will or without your consent?
   Have you ever been forced or pressured to have sex?
   Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?

<u>Video for option 1:</u>
Nurse: Jen, How are things at home? Do you feel safe?
Jen: Umm, yeah I feel safe enough.
Nurse: Well, you seem uncertain. Is there anything you want to talk about?
Jen: Umm, well what do you mean by that?
Nurse: Is there anything that concerns you about your safety, or anything you are worried about?
Jen: (long pause) No.

<u>More Information</u>
Do you feel safe at home is a highly subjective question. It is sometimes considered a gateway question into more direct tools. If an individual grew up in a very chaotic, abusive environment, his/her sense of safety will be very different then someone who has never experienced abuse. Also the term safety may also imply that you are asking about current issues related to physical

sexual violence at home. A person may not be experiencing current sexual violence, but may have still experienced sexual violence in their lifetime.

Video for option 2:

Nurse: Jen, have you ever experienced rape or sexual violence?
Jen: Oh no….I don't even know why you would ask me that?

More Information

Many people do not relate to the terms sexual violence and rape. As discussed in the section "Why don't people talk about sexual violence", many individuals are fearful of the stigma attached to those terms, or do not label what has happened to them with these terms. This is especially true of the term rape when the perpetrator was very close to the victim, and if no physical sexual violence was used.

Also, many people have a hard time understanding why this information is important for a health care provider. Therefore, it is important for us to make a connection to physical health and well being. An example of this is given in the third question.

Video for option 3:

Nurse: Jen, we know that sexual violence is common in the lives of many women, men, girls, and boys and it can affect their overall physical health and well-being. So, we make it a practice to ask all of our patients these questions:

Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?

Jen: Umm, yeah (seems unsure)
Nurse: Have you ever been forced or pressured to have sex?
Jen: Well I guess …pressured…I don't know that feels like a strong word. I think that I have just had sex when I didn't really want to, just because it was easier.
Nurse: I want you to know that you always have the right to say no; even if it is somebody you are in a relationship with, or married to.
Jen: (Nod)
Nurse: Have you ever been touched sexually against your will or without your consent?

Jen: Well, I really wasn't expecting to be asked this today. There was when I was a little. I had an experience with my uncle where he did do stuff….sexually inappropriate stuff to me and…it's big. It's been there, I think about it every day…It is really big.

More Information

Starting the questions with a statement that helps to provide context is an important part of the process. This statement helps the patient know that he/she is not being singled out, and it helps to normalize the questions. When you connect sexual violence to the patient's physical health and well being it then makes perfect sense that a health care provider is inquiring about sexual violence. Finally because the questions you are asking are very direct, it helps to provide a transition or warning before directly asking a patient about being victimized.

It is recommended to name specific behaviors rather than the subjective terms that you heard in the first two examples. Instead of using the term rape or sexual violence, the recommendation is

to ask about sexual experiences that were unwanted or made the person feel uncomfortable. This helps to eliminate the problem of the patient not labeling their experience as rape or abuse.

Responding to Disclosures of Sexual Violence

What Should I Say?

Regardless of the type of incident that patients disclose, our response should always begin with a validating message. This is true if the patient talks about acute sexual violence or sexual violence that happened 30 years ago. The time span that has elapsed should not alter our words.

In fact, many people have never heard messages of being believed, or hearing how much courage it takes to talk about abuse. Many people have felt minimized, ashamed and felt like they were not believed. The impact a person can make when a victim first discloses their experience is truly life altering for the victim. A judgmental, skeptical, cold response can re-victimize and further shame a victim. A supportive, compassionate, and validating response can help a victim begin to heal.

Click the start video button to watch the disclosure again, and then decide which response you would choose.

Video option 3

Nurse: Jen, we know that sexual violence is common in the lives of many women, men, girls, and boys and it can affect their overall physical health and well-being. So, we make it a practice to ask all of our patients these questions:

> Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to having sex?

Jen: Umm, yeah (seems unsure)

Nurse: Have you ever been forced or pressured to have sex?

Jen: Well I guess …pressured…I don't know that feels like a strong word. I think that I have just had sex when I didn't really want to, just because it was easier.

Nurse: I want you to know that you always have the right to say no; even if it is somebody you are in a relationship with, or married to.

Jen: (Nod)

Nurse: Have you ever been touched sexually against your will or without your consent?

Jen: Well, I really wasn't expecting to be asked this today. There was when I was a little. I had an experience with my uncle where he did do stuff….sexually inappropriate stuff to me and…it's big. It's been there, I think about it every day…It is really big.

Video option 1:

Nurse: Wow, is that something that happened one time? Or a lot? How did that happen…I mean, how old were you when that happened?

Jen: You know what; it is really not a big deal…not a big deal (irritated).

More Information

When responding to a disclosure, we should always start with validating messages. Talking about sexual violence takes a tremendous amount of courage, and the words we choose in the moment will set the stage

for a trusting patient relationship. When we ask a lot of questions initially, it may make the patient feel ashamed or cause them to think that they are not believed. It is not necessarily helpful initially to have a great deal of detail. However, what is helpful for the patient is to feel safe and validated. Try the other response.

Video option 2:
Nurse: I'm really sorry that happened to you. It sounds like it was a terrifying experience. And I'm really glad you had the courage to tell me. I want you to know it wasn't your fault.
Jen: Thanks…that was really hard to tell. I haven't really told that many people about it before. And like I said, it's been really hard.
Nurse: Are you aware that there are trained sexual assault counselors that are available to you in your community?
Jen: Not, but what happened to me was so long ago. They probably can't help me now.
Nurse: Actually, they work with all types of victims, including people like you who are survivors of childhood abuse.
Jen: Really? Do you have their number? Maybe I'll give them a call.
Nurse: Yes, the Pennsylvania Coalition Against Rape has a toll-free number that you can call to find services in your community: 1.888.772.PCAR (7227).

More Information
These simple messages allow the patient to feel heard and believed. They have no value judgment or expectations attached to them. The patient can finally here that what he/she went through was a trauma and a terrifying experience.

You can always ask questions and do assessments later. It is your words right now that are the biggest part of the intervention.

Welcome to the Brain

Memory Introduction:
Welcome to the brain. Don't worry, this tutorial is user friendly and is intended to give a simplified presentation of how memories of trauma are stored differently than normal memories.

Just a few Guidelines:
OK, we'll be heading into the brain in a minute. First I want to tell you about a few guidelines. When I'm finished talking I'll send you directly into the brain. I want to tell you that the page is going to look a little bit busy. But here is how it is going to work. You are going to start at the top right hand picture of the sensory data. You are going to work clockwise until you are finished. When you finish with all of the pictures, click next until you finish this section. Here are guidelines about how to work the mouse and cursor.

- When you move your cursor over the pictures, you will see the name of the brain part.
- When you left click the mouse, you will here an explanation of the function of each brain part.
- In order to stop the sound, if you don't feel like waiting until it's finished, right click the mouse to stop the explanation.
- Now remember, stop the brain part by right clicking, or wait until it is finished before you move on to the next brain part. OK, let's go.

Normal Memory

Sensory data:
Sensory data enters the central nervous system via the sensory organs. This includes the nose, the eyes, the ears, the skin and the mouth. This information will be passed onto the thalamus where some of it is integrated.

Thalamus:
The thalamus can be thought about like a switchboard or an operator. It functions as a routing station to sensory data. The thalamus will in turn take the information it has received and pass it on for further evaluation to both the amygdala and to the pre-frontal cortex.

Amygdala:
The amygdala is involved in the evaluation of the emotional meaning of the incoming sensory data. It assigns feelings of emotional significance that the pre-frontal cortex will eventually elaborate on. So think of a gauge that determines emotional significance and determines whether data coming in is dangerous or not dangerous. It will then guide the other brain structures, such as the hypothalamus in determining appropriate emotional behavior.

Hippocampus:
The hippocampus is actually adjacent to the amygdala. It plays a critical role in categorizing and storing the incoming data. It is essentially the "what, where and when" of a memory. Think of a book as an appropriate metaphor. Typically you start at the beginning and move sequentially through the chapters. The hippocampus is what allows us to remember the sequence of events. In other words, what happened first, and then what happened, what happened next, and so on.

Finally when you consider a book, you can always find information about the publication dates. This is how you can remember the hippocampus's role in establishing a sense of time to a memory. For example, if I ask you to think about what you had for dinner last night, you probably will not be overwhelmed and feel like you are currently having your "meatloaf" over again. That is because the hippocampus attached an appropriate sense of time to that memory.

Pre-frontal Cortex*:*
Finally, we are getting up into the cortex of the brain. This is really our smarter part of the brain. This is why we have the metaphor of the chess set. Generally speaking, the pre-frontal cortex has a tremendous capacity related to functioning and memory. But, it does allow us to integrate information and plan for the future.

So consider our example of having meatloaf for dinner last night. Let's say our meatloaf tasted a little dry. Our pre-frontal cortex might allow us to have thoughts like maybe next time I'll use less bread crumbs. Perhaps I'll find another recipe, or what can I do differently in the future. One last final thought about the pre-frontal cortex is that it does provide some amount of feedback to the amygdala. If the amygdala is sensing some emotional arousal, the pre-frontal cortex can send information back to the amygdala, either confirming or not confirming the

information as relatively valid. So, in other words, it can provide feedback about the emotional reaction.

Broca's Area:
This is the part of the brain known as Broca's area. Most studies agree that this is the area in the frontal lobe, in the dominant hemisphere of an individual that is primarily related to speech production. So, in other words, as we process this memory and I ask you what you had for dinner last night; Broca's area will be the part of the brain that will allow you to tell a narrative story of the memory.

Traumatic Memory

Let's go through a Scenario:
Before we start on traumatic memory, let's go through a scenario, and then walk through the different brain processes to put this all together. In this scenario, we will talk about Sheila.

She is an 18 year old college student on a local campus. She is walking back to her dorm after spending several hours at a party. A car pulls up beside her and she realizes it is a man she had talked to at the party for several hours. He offers her a ride back to the dorm. And because he seems so nice, and it's late…she is really tired, she accepts the ride. On the way back, he pulls into an isolated parking lot and rapes her.

Now go on to the different parts of the brain, starting with the sensory data, like we did before, and let's go through this scenario.

Sensory Data:
Let's go through some examples of sensory data that may be inputted into the brain. The sense of smell may be the cologne the perpetrator is wearing, sweat, or even the smell of leather upholstery. She may be seeing the dash board, perhaps a jean jacket, brown hair and the fist of the perpetrator. She may hear the sound of the person's voice, her own voice, and the sound of the car engine. The sense of touch may be a feeling of cold against her skin, feeling leather, feeling a hand on her neck, or perhaps her fingers squeezing the seats. Her sense of taste may be a dry mouth or even the taste of semen.

Thalamus:
The thalamus can be thought about like a switchboard or an operator. It functions as a routing station to sensory data. The thalamus will in turn take the information it has received and pass it on for further evaluation to both the amygdala and to the pre-frontal cortex.

Amygdala:
Based on the data received from the thalamus, the amygdala at this point will signal an alarm. Once this happens the hypothalamus will send messages to the pituitary gland and the adrenal glands to release the appropriate neurohormones that will allow the body to either get ready to do battle, to flee from the situation or to freeze.

Let me just talk for a minute about how the body decides which reaction it will take. It is important for victims to understand that these reactions, whether the body will mobilize and get ready to do battle, or if the limbic system determines that there is not sufficient energy to fight but instead there is a way for the person to exit or to flee.

If the brain determines that there is not sufficient energy or force to fight, and there is no where to run, the last ditch attempt to survive may be the freeze response. It is important that people understand that these are instantaneous, instinctive responses to a perceived threat and not made with conscious decision. When we can convey this to victims, this often times helps with the sense of shame about not fighting back, or it being about weakness of character, or somehow wanting the sexual violence to happen.

Norepinephrine:
Norepinephrine is released when the autonomic nervous system is activated. It serves to increase heart rate, respirations, and mobilizes the body for fight or flight. However, massive secretions of norepinephrine can lead to memories being over-consolidated. The trauma then is remembered at the expense of other memories and causes intense reactions whenever triggered. Therefore, months or years after the rape, Sheila may have intense memories and reactions from the sight of blood, seeing a Chevrolet, sitting on leather upholstery, or even seeing a person that reminds her of the rapist.

Opioids:
Endogenous opioids are released to cause pain inhibition. This is a survival mechanism, because during a battle, attending to pain or a wound would get in the way of self-defense. However, this release of what researchers suggest may be equivalent to eight milligrams of morphine, can affect memory processing. An individual may not consciously experience many or all parts of the trauma.

Cortisol:
Cortisol is released in trauma to regulate the catecholamines that are released. Its job is to get the body back to normal. After Sheila's trauma, cortisol will be the chemical that helps to decrease the heart rate and her respiratory rate. The problem with cortisol is that it is toxic to the hippocampus, and affects its overall functioning. We'll talk more about this when we discuss the hippocampus.

Hippocampus:
Once the amygdala fired the alarm of extreme arousal, we may as well build a brick wall around the hippocampus. This is a major problem when it comes to storing this memory. Remember, the function of the hippocampus is to contextualize a memory, provide sequencing, and help to establish a sense of time. Unfortunately, the hippocampus is very sensitive to cortisol release, and essentially cannot function with the high levels of cortisol secretion.

So, the sensory data gets through, but may be stored as highly charged bits of sensory data that may feel out of context and will be timeless. This is at the core of why trauma is so difficult to get over. When Sheila is triggered by something in the environment, or even health care

providers asking questions about sexual violence, it can lead her to feel as if the memory is happening in the present and may lead to the development of flashbacks.

Pre-frontal cortex:
Though the pre-frontal cortex is receiving information throughout the memory, there is not room for higher thought processes in the middle of a trauma. In other words, while Sheila is being attacked, her body must attend fully to the battle at hand. The brain is not sending blood flow to parts of the brain responsible for doing algebra problems. Essentially, the pre-frontal cortex is hijacked while the brain is sensing danger.

Days, weeks and even years later, it will be the pre-frontal cortex that will be the only hope of managing the flashbacks and intrusive memories. Let's say years later Sheila is dating and gets into a car that has the same colors. The amygdala may react before the pre-frontal cortex has time to fully appraise the situation. Over time, the healing involves teaching techniques that may enhance the ability of the pre-frontal cortex to give feedback and stop the hard-wire of terror.

Broca's Area:
Remember, Broca's area is a left cortical structure responsible for speech production. During a traumatic incident, oxygen utilization to this area is markedly decreased. From a physiologic perspective, this makes perfect sense. Generally, during a battle or running from a dangerous situation is not the best time to have a discussion. Blood flow is sent to the appropriate areas required for survival. This is responsible for the phenomenon of speechless terror. It can leave Sheila with an inability to put feelings and thoughts into words. This same pattern of shut down can be shown via PET scans, years after the trauma. So, even if a person wants to tell their health care provider about an experience of trauma, he/she may not be able to. Earlier in this tutorial, we discussed reasons that people don't talk about sexual violence. This is the neurobiological explanation.

Test Your Cranium

1. This part of the brain signals danger...

    A. Hippocampus
    B. Amygdala
    C. Cortisol
    D. Parietal Lobe
    E. Thalamus

2. This neurohormone helps restore the body to a normal state...
    A. Oxytocin
    B. Vasopressin
    C. Hydrochloric Acid
    D. Endogenous Opioids
    E. Cortisol
3. Attaching a sense of time and sequence to a memory is the job of the…
    A. Amygdala
    B. Medulla Oblongata

C. Broca's Area
D. Hippocampus
E. Pre-Frontal Cortex

4. "Speechless terror" is a phenomenon caused by a lack of blood flow and oxygen utilization to…

   A. Pre-frontal Cortex
   B. Pons
   C. Broca's Area
   D. Wernicke's Area
   E. Thalamus

5. This part of the brain routes incoming sensory data…
   A. Thalamus
   B. Cerebellum
   C. Sympathetic Nervous System
   D. Amygdala
   E. Hippocampus

Keeping Patients Feeling Safe

Many people in general fear medical examinations. Medical examinations can include an invasive procedure and some degree of discomfort or pain. Survivors of sexual violence may find any medical examination difficult, but prenatal exams and procedures may be particularly troubling. Many people find similarities between medical procedures and past abuse experiences. Some similarities include:

Lying down
Being touched
Being alone in a room with someone of authority
Having an object inserted into the body

It may be helpful to talk to patients about the differences between past abuse and current medical procedures. For example, unlike past abuse, the medical exam is intended to help or benefit the patient; the patient has control over the date and time of the appointment and can refuse or stop any procedure.

The next page has some ideas to help get a patient through a medical examination. These are some suggestions that many survivors have found helpful. What works for one person may not work for another. Ultimately, the patient is the best judge of what will be useful to him/her.

Interventions

- Conduct the interview, history, and debriefing portions of the exam with the patient fully dressed. This may make the patient feel more in control and comfortable. Only conduct the physical exam while the patient is undressed/in the gown. Minimizing the time the patient is undressed is good practice with any patient, and especially with a victim of sexual violence.

- Raise the top of the exam table up so the patient can see the doctor or nurse.
- Talk to the patient about keeping her eyes open and scan the room. This can help her stay connected to the present. You also might have her say out loud the things she sees.
- Adjust the drape so the patient can see the person doing the examination.
- Explain everything that you are doing and why before each part of the examination.
- Ask the patient if they would like to have someone he trusts with him during the examination.
- It is helpful to talk to the patient in advance about using things that have worked to make her feel safe in the past. For example listening to music with headphones, rubbing a coin or rock.
- Set up a signal before the procedure starts. This is often helpful if the patient has difficulty verbalizing "stop." (Remember what happens to Broca's area!) This signal will alert the health care provider to stop the procedure and check in with the patient. Also, it is important that the health care provider proactively check in regularly during the exam and ask questions such as “how are you doing? Do you need a break?” The patient may or may not feel comfortable initiating or asking for a break.
- Provide appropriate referrals to community-based services such as rape crisis centers, via PCAR’s 24-hour Statewide Information & Referral Line: 1-888-772-PCAR (7227).

Bibliography

Acierno, R. (2000). *Screening measures for domestic violence, sexual assault, and physical assault.* Retrieved January 29, 2007 from www.nvaw.org/research/screening.shtml.

American College of Obstetricians and Gynecologists. (2007). *Screening tools: Sexual assault.* Retrieved January 29, 2007 from http://www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=1477.

Canadian's Women's Health Network. (2005). *Getting through medical examinations: A resource for women survivors of abuse and their health care providers.* Retrieved January 29, 2007 from http://www.cwhn.ca/resources/csa/faq1.html.

Ergorul, C. & Eichenbaum, H. (2004). The Hippocampus and memory for "what," "where," and "when." *Learning Memory Online*, 11, 397-405. Retrieved January 29, 2007 from www.Learnmem.org.

Fortin, N.J., Agster, K.L., Eichenbaum, H.B. (2002). *Critical role of the hippocampus in memory for sequences of events.* Retrieved January 29, 2007 from http://www.bu.edu/psych/faculty/eichenbaum/nn-order.pdf.

Nursing World. (2000). *American Nursing Association position statement on violence against women.* Retrieved January 29, 2007 from http://www.nursingworld.org/readroom/position/social/scviol.htm.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* New York, NY: W.W. Norton and Co.

Sullivan, T.P., Meese, K.J., Swan, S.C., Mazure, C.M., & Snow, D.L. (2005). *Precursors and correlates of women's sexual violence: Child abuse traumatization, victimization of women, avoidance coping and psychological symptoms.* Retrieved January 29, 2007 from http://people.cas.sc.edu/swansc/precursors.pdf.

Van der Kolk, B. & McFarlane, A. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body and society.* New York, NY: Guilford Press.

Appendix B

Evaluation Tool

Pennsylvania Coalition Against Rape
Working with Sexual Violence in a primary care setting – Self guided interactive CD-ROM

Please use this scale to rate the following:

5=Excellent
4= Very good
3=Good
2=Fair
1=Poor

Using the above scale rate the following:

Degree to which you were able to achieve the activity objectives

1. Ask screening questions in a non-judgmental manner	
2. List the barriers that may hinder a patient's disclosure of violence and abuse in a health care setting.	
3. Respond to disclosures of abuse and violence in a way that is validating to patients.	
4. Recite and screen using the S.A.V.E method.	
5. Describe the ways that traumatic memories differ from normal memories and why this is clinically significant.	
6. Assist a patient who has experienced abuse feel safe during a health care encounter and in particular during invasive examinations.	

Please select one response to each question:

1) All of the following are generally reasons patients don't talk about sexual violence, except:
   A. They do not remember the sexual assault
   B. They are trying to trick the health care providers

C. They do not use the same labels as health care providers
D. They don't feel safe

2) The SAVE method stands for
   A. Stop, Ask, Value, Educate
   B. Screen, Argue, Value, Elate
   C. Screen, Ask, Validate, Evaluate-Educate
   D. Slowdown, Assess, Validate, Educate

3) The question: Do you feel safe at home…
   A. Is the only question you need to ask
   B. Can make somebody cry
   C. Should only be asked by a social worker
   D. Is highly subjective and sometimes considered a gateway question.

4) Before asking a screening question, a health care provider should start with a statement that provides context because of all of the following ***except***:
   A. It helps the patient understand he/she is not being singled out and it helps to normalize the questions.
   B. Otherwise you would sound rude
   C. It provides a transition or warning before asking direct questions
   D. It helps to connect the questions to physical health and well being

5) A helpful way that a health care provider can validate a person's experience after disclosing sexual violence is:
   A. Why didn't you ever tell anyone before?
   B. I'm so sorry that happened to you, I'm really glad you had the courage to talk about that with me.
   C. Good thing it was so long ago.
   D. Thank god you never got raped.

6) This part of the brain signals danger...

   A. Hippocamus
   B. Amygdala
   C. Cortisol
   D. Parietal Lobe
   E. Thalamus

7) This neurohormone helps restore the body to a normal state...
   A. Oxytocin
   B. Vasopressin
   C. Hydrochloric Acid
   D. Endogenous Opioids
   E. Cortisol

8) Attaching a sense of time and sequence to a memory is the job of the…

A. Amygdala
B. Medulla Oblongata
C. Broca's Area
D. Hippocampus
E. Pre-Frontal Cortex

9) "Speechless terror" is a phenomenon caused by a lack of blood flow and oxygen utilization to…

A. Pre-frontal Cortex
B. Pons
C. Broca's Area
D. Wernicke's Area
E. Thalamus

10) This part of the brain routes incoming sensory data…

A. Thalamus
B. Cerebellum
C. Sympathetic Nervous System
D. Amygdala
E. Hippocampus

11) Some of the similarities that some sexual violence survivors find between medical procedures and past sexual abuse experiences include all of the following except:

A. Being touched
B. Lying down
C. Being alone in a room with someone of authority
D. Having objects inserted into the body
E. They chose to make the appointment

12) The following is a good way to help get a patient who is a sexual abuse survivor through a medical examination:

A. Go as fast as you can
B. Try not to make eye contact
C. Talk to the patient about keeping his/her eyes open and scanning the room
D. Try to make him/her not cry
E. Assume it isn't a current problem so don't talk about it

Appendix C

System Requirements to run the CD-ROM tutorial:

Windows 2000, XP
Windows Media Player 9
667 Mhz, Pentium 3 and 192 mb RAM
Speakers
Sound card
Mouse

Installation Instructions

Direct Play CD

1. Insert CD into CD-ROM drive.
2. The CD will automatically start.
3. If the program does not start please double click the "My Computer" Icon.
4. Click the CD-ROM drive Icon to start the program.

*If the videos do not show please see the directions below to install a codec to view

Installation CD-ROM version.

1. Insert the CD into the CD-ROM drive.
2. Double Click "My Computer.
3. Click CD-ROM drive.
4. Follow Wizard and Install the program in desired location.

*If the video's do not show please see the directions below to install a codec to view

Video codec install
Use this option if the videos DO NOT play on your computer. You must have admin rights to install the decoder(Codec) for the videos.

1. Browse the cd and open the folder labeled codec.
2. Run file Dscaler5008.
3. Follow the wizard and install the codec to your PC.