The RESOURCE

www.nsvrc.org NSVRC Newsletter

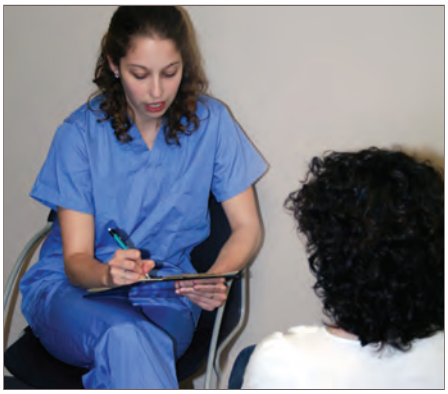
Spring/Summer 2009

Expanding Treatment for Survivors through Collaboration

BY JENNIFER PIERCE-WEEKS, RN, SANE-A, SANE-P, IAFN PRESIDENT

As members of the medical community, Sexual Assault Nurse/Forensic Examiners (SANE/SAFE) are in the unique position to have a positive impact on the lives of sexual assault sur vivors. Through our understanding of the health implications faced by sexual assault survivors, we can focus our health care efforts on ensuring access to evidence collection, pregnancy prevention, and more recently, HIV prevention through education and utilization of our resources. Although we continue to make strides in comprehensive care for sur vivors, there often appears to be a chasm between appreciating the acute and chronic health implications our patients experience, and facilitating improvements in our own system's response to meet their immediate and long-term needs.

When victims come forward for intervention and treatment after an assault, their journey is often just beginning. It is common for victims to experience significant post traumati stress disorder (PTSD) and anxiety-related symptoms, clinical depression, substance abuse problems and repeated episodes of sexual victimization. Women's health service providers are continuing to reach out to SANE programs in an effort to assist pregnant assault survivors while educating themselves on the psychological and physical complications of sexual violence. Although the SANE/SAFE



approach to caring for this specifi patient population is recognized as the most effective, a greater emphasis is currently placed on evidence collection rather than overall patient health. The International Association of Forensic Nurses (IAFN) is working to change that by collaborating with victim advocates.

IAFN was deliberate in choosing *Collaboration with Victim Advocates* as its first official position statemen It is imperative for SANE/SAFEs to offer financially affordable se vices that extend beyond a one-time visit and employ an empowerment model approach to recovery. A wrap-around support system in the form of victim advocacy is critical, as victims may also be engaged in the criminal justice system during their road to recover y.

Many hospital-based forensic nursing programs have developed expansion strategies to better ser ve victims of violence. One of the most effective approaches SANE/SAFE programs can take is to expand established SANE programs to forensic nursing patient populations that readily intersect with sexual assault victims. The advocacy community can look to forensic nurses who assist sur vivors of intimate partner violence, child maltreatment, strangulation, and elder abuse as potential partners in expanding sexual violence ser vices. Through education, both the advocates and forensic nurses can become familiar with the range of ser vices each profession provides. When SANE services and victim advocates work together, the immediate and long-term needs of victims are best addressed.

For more information and resources, visit www.iafn.org.

Inside

NSVRC national sexual violence resource center

Contributors to *The Resource*

Chrys Ballerano has co-directed Building Connections, the Sexual Assault/ Mental Health Project since 1999 for NYSCASA, providing technical assistance, resour ces and overall support to 78 Rape Crisis Centers and other professionals and sur vivors throughout NYS, particularly regarding issues of mental health.

Tatiana A. Diaz, MA, was born and raised in Bogotá, Colombia, graduated from Penn State University with a B.A. in Political Science and Minor in W omen Studies and a master's in Community Psychology and Social Change. From 2005-2009, Ms. Diaz worked at the National Sexual V iolence Resource Center as an Information Specialist. Currently she is the Director of Multicultural Programs at Messiah College.

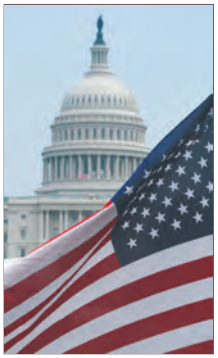
Lorraine McMullin coordinates the Mental Health Association in New Y ork State's (MHANYS) Parents with Psychiatric Disabilities Initiative and ser ves as the Co-Director of Building Connections, the Sexual Assault and Mental Health Project jointly operated with the New York State Coalition Against Sexual Assault.

Jennifer Pierce-Weeks, RN, SANE-A, SANE-P is President of the International Association of Forensic Nurses (IAFN). Ms. Pier ce-Weeks is coordinator of the Forensic Nurse Examiner program at Memorial Health System in Colorado Springs and a practicing nurse examiner at the local Child Advocacy Center .

Holly Ramsey-Klawsnik, PhD is a Sociologist and Licensed Marriage and Family Therapist engaged in research, training professionals, and consultation. She is also a contributing editor of *Victimization of the Elderly and Disabled* and a member of the National Committee for the Prevention of Elder Abuse Board of Directors.

E. Lauren Sogor, MPH is the Prevention Campaign Specialist at the NSVRC. She primarily focuses on the national Sexual Assault A wareness Month campaign.

Karla Vierthaler, MPA, the Outreach Coordinator for the Pennsylvania Coalition Against Rape, is currently working on various projects addressing sexual violence in populations historically underserved by the anti-sexual violence movement.



In the next issue...

The Fall/Winter 2009 issue of *The Resource* will focus attention on how policy affects the anti-sexual violence movement. We plan to offer information on various aspects of this topic, including:

- The impact of poverty and economic insecurity on victims
- Policies on sex offender management
- Legislative advocacy

NSVRC

The NSVRC invites your comments:

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Director's Viewpoint

The NSVRC recognizes the important intersections between sexual violence and physical and mental health and addresses the issue in many of our activities. This issue of *The Resource* focuses on that theme.

Through the *Practicing Prevention* initiative, we raise awareness of sexual violence within the healthcare community and recognize the crucial role healthcare professionals play. Primary goals of this initiative are to increase the capacity of healthcare providers in understanding the scope and impact of sexual violence; enlist them as active partners in prevention; enhance skills for early identification of at-risk victims and potential perpetrators; and advocat for effective health-related public policy and resour ces.

The NSVRC works with the **American Academy of Pediatrics**, the **American College Health Association**, and the **International Association of Forensic Nurses (IAFN)** to expand the leadership role of health care membership organizations in addressing sexual violence prevention. W e also work with state, territor y, and tribal Sexual Assault Nurse Examiner (SANE) coordinators to build capacity and resour ces for those providing training and technical assistance to local SANE programs. The NSVRC promotes the SANE/SAFE program as the gold standard in care for victims of sexual assault. Towards that end, we provide intensive, sustainability-focused technical assistance for SANE programs around the countr y.

We work with federal, state and local partners to promote comprehensive, quality healthcare for sexual assault survivors.

We work with federal, state and local partners to promote comprehensive, quality healthcare for sexual assault sur vivors that consists of access to a full range of reproductive health information and options, including emergency contraception. We provide resources to victim service and health care professionals about the risks of HIV for sexual assault sur vivors; and work with the National Online Resource Center on Violence Against Women (VAWnet) to develop quality applied research papers on topics such as substance abuse, screening, and healthy sexual development.

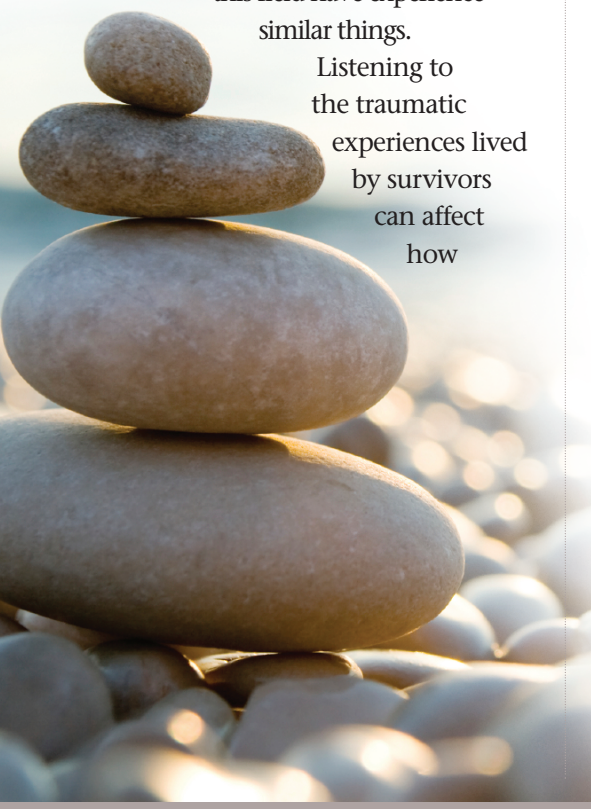
Through our response to Gulf Coast Hurricanes and Midwest flooding, the NSVRC learned the critical nature of disaster planning in relation to health care issues. As a result, we collaborate with IAFN and others regarding proactive disaster planning.

The NSVRC knows that issues relating to the physical and mental health of survivors and those who advocate for them are essential to the work we do every day. For additional information please contact us or visit www .nsvrc.org.

Coping with Vicarious Trauma:
Strategies for Advocates working with Communities of Color

BY TATIANA DIAZ, MA

As a former court advocate and Latino outreach coordinator, I worked directly with survivors. Within this role I gained insight into the complexities of working with this population, including issues of racism, immigration status, and socio-economic status. All are intricately connected and needed to be taken into account in the healing process. I quickly realized that this work, although incredibly rewarding, was also very stressful. The complex multi-dimensional work I was doing left me emotionally drained and, as a result, I experienced vicarious trauma. I know many individuals in this field have experience similar things.



Listening to the traumatic experiences lived by survivors can affect how advocates view and interpret the world around them, which can ultimately affect their lives. This is called "Vicarious Trauma" (McCann & Pearlman, 1990). Vicarious trauma is a common experience for people who work with victims of trauma. Advocates can experience intrusive thoughts or images that can result in painful emotional feelings. As well as dreams, flashbacks and thoughts fill with images from the victim/survivors' accounts can become embedded in the advocate's mind.

This study sought to identify the strategies that Pennsylvania advocates working with sexual assault victims/survivors from communities of color use to prevent vicarious trauma. Focus groups were done in the summer of 2007. A total of 18 advocates from rape crisis centers participated in this study—15 from predominantly urban areas and three (3) from predominantly rural areas. All of the advocates were women whose advocacy experiences ranged from two (2) months to decades.

Vicarious trauma is a common experience for people who work with victims of trauma.

In the focus groups, advocates had the opportunity to touch upon specific stressors faced when workin with marginalized communities. They shared difficult experiences particularly related to situations where oppressions like racism, classism, and immigration status intersected with victimization. I categorized their experiences as follows: lack of diverse staff, lack of cultural competency among current staff, tokenism, other marginalized populations, other agencies and partners.

Lack of diverse staff: In some communities, changing demographics have challenged not only rape crisis centers but entire communities. Marcie*, an advocate, shared the following:

"I don't think they [people who come to this area from the outside] get the same support than perhaps somebody [local would]. So it's a different type of animal."

Lack of cultural competency among current staff: Since all staff will have some type of interaction with clients, there is a need for all staff to have a basic knowledge of how to appropriately serve survivors from marginalized communities. As Amber* shared. "I think [there's] a lot of stereotyping… though we're not supposed to, some people still do stereotype."

Tokenism: A common practice among rape crisis centers has been to

create programs or positions specifically to work with communities of color. For example, a center may hire bilingual or Latino advocates. While this opens the door for better services and diversity among staff, it is not always easy for individuals in these positions to do their work. This is especially so when these staff turn out to have "token" status in the organization, meaning they are the only bilingual speaker or only member of a certain minority racial/ethnic group on staff. Because the need for these services is great and the availability of staff to supply these is inadequate in many communities, these advocates feel pressured to serve as interpreters, translators, and immigration experts in addition to their work as advocates. "I'm pretty sure they [my advocate colleagues] would love to help me, if I asked for the help, they're all very helpful, but they can't do my job when it comes to… the immigration piece. Just like the Spanish person, no one can translate it but me, so everything falls back on me. So, I need the help, but, of course, funding." (Gena*) *(Continued on page 6)*

It is not always easy for individuals in these positions to do their work

Understanding Vicarious Trauma

BY JESSICA SHOMPER

As many of us in the anti-sexual violence field know, the impact of sexual violence on victims can be both short- and long-term and can include physical, emotional, financial, and social problems. Some survivors may choose to seek services from healthcare providers, counselors, therapists, and a variety of other service providers in developing a support system for their recovery. For advocates, assisting survivors is their life's work. However, it may come at a great cost.

Vicarious trauma, or VT, is a common consequence for advocates and is not limited to those providing direct services, but can also affect anyone working with trauma survivors. VT is described as, "pervasive changes that occur within clinicians over time as a result of working with clients who have experienced sexual trauma" (McCann & Pearlman, 1990). These changes typically affect advocates in the three ways described below.

First, VT is an individual reaction that affects each advocate differently depending on factors such as education, supervision support and victimization history, among others. Not everyone reacts the same way to stress; likewise, not everyone's experience with VT will be the same. One worker may hear a survivor's story and internalize the experience differently. Secondly, VT is often a cumulative process, as the effect on advocates typically intensifies over time with multiple contacts. Lastly, VT can affect all areas of an advocate's life including personal relationships, her/his view of the world, sense of well being, and overall emotional health.

Those who bear witness to the emotional pain of survivors of sexual assault on a regular basis are vulnerable to both direct and vicarious sources of traumatic stress. Likewise, we also experience the affirmative, life-changing, and positive impact our work has on victims and the anti-sexual violence field. The organizations listed below offer additional resources on vicarious trauma:

- National Center for Post-Traumatic Stress Disorder—www.ncptsd.org or 802.296.6300
- Sidran Institute—www.sidran.org or 410.825.8888
- Traumatic Stress Institute—www.tsicaap.com or 860.644.2541
- International Society for Traumatic Stress Studies—www.istss.org or 847.480.9028

Coping with Vicarious Trauma:

(Continued from page 5)

Other marginalized populations: Advocates not only shared their experiences working with survivors of color; they also shared stories about similar struggles with other marginalized communities such as the lesbian, gay, bisexual, transgendered and intersexed (LGBTI) communities. Advocates reported that as they strived to work with underserved communities, they were challenged to find adequat services for survivors at other agencies.

Other agencies and partners: Staff feel challenged when other agencies and partners are not culturally sensitive to the clients with whom they are working. "I just sort of get this feeling of 'you're treating this person badly because they're a different race or class.' I feel a little bit defensive, so that's why I'm glad I'm there at least for what I can do." (Jada*)

The study found that sexual assault advocates were using a number of individual and organizational coping mechanisms to respond to their vicarious traumatization. For example, advocates shared using the following: self-care, self-accomplishment and recognition, spirituality, and even some negative coping strategies. Organizationally, the following were found to be helpful: supportive organizational culture, vacation and time off, caseload support, and having a supervisor that understands vicarious trauma. However, advocates working with underserved populations, including communities of color, seem to have a number of individual coping strategies but were found to need more support organizationally to appropriately help survivors and themselves.

These same advocates experienced different sources of stress. In some instances, the lack of diversity within their own organization and other agencies where survivors reached out for aid challenged advocates' ability to do their job. This all placed a great burden on advocates by adding extra responsibilities such as translation, transportation, and issues relating to immigration. Mainly, it was found that rape crisis centers and other organizations working with survivors of color need to create organizational approaches to better support both survivors and advocates.

The work done in rape crisis centers is difficult because it take a toll on everybody working on the issue.

It is recommended that rape crisis centers assess their communities and create an ecological approach to better serve all survivors in their communities. It is critical that organizations hire advocates that are culturally competent and provide new and current advocates with organizational support in working with marginalized communities—not just as an individual project or position. In addition, it is important to accompany the above efforts with the creation of opportunities for training all staff on issues regarding marginalized communities that can improve service delivery.

Finally, it is recommended that organizations create a holistic ecological approach to ending sexual violence, where individuals, micro-systems, organizations, localities, and macro-systems work together to provide services and prevent sexual violence of all survivors including those from marginalized populations. A holistic approach to coping with vicarious trauma must be multilevel, including organizational and individual approaches that include not only rape crisis centers but community partners as well.

The work done in rape crisis centers is difficult because it takes a toll o everybody working on the issue. Learning from those doing the work and creating proactive responses to help advocates cope with vicarious trauma can be invaluable for agencies and advocates.

McMann, I. L., & Perlman, L. A. (1990). V icarious traumatization: A framework for understanding the psychological effects of working with victims. Journal of Traumatic Stress, 3, 131-149.

*Names have been changed to protect individual's identities.

The Intersection of Substance Abuse and Sexual Violence

BY JESSICA SHOMPER

Colleen Tillger, an Associate Counselor at Caron Treatment Center in Wernersville, Pennsylvania, works with women seeking addiction counseling who also identify as survivors of sexual violence. Ms. Tillger has seen women at Caron between the ages of 20 and 70 seeking counseling for both substance abuse and sexual violence. I had the opportunity to talk with her recently concerning her experiences in both the anti-sexual violence and substance abuse fields and how they intersect.

Artwork by Arielle Sekula, a participant in Monroe County Women's Resources STOP Abuse peer education program "Relationship Violence; Expressions in Art" show.

Many of the female survivors Ms. Tillger works with feel an overwhelming amount of shame and guilt associated with their assaults and may use substances such as alcohol and illegal drugs to cope with their feelings. However, the cause and effects of alcohol and victimization are difficult to ascertain. Alcohol an substance abuse may make someone more vulnerable to violence, while on the other hand, an individual may turn to substances to cope with the assault. The high rates of Post Traumatic Stress Disorder (PTSD) among survivors may correlate with later substance dependence based on several issues including family history and environmental factors (Kilpatrick, 1998).

When victims of sexual violence with addictions reach out for help, they face many barriers:

- Providers may not believe them or see them as credible
- Providers may deny them support if they are currently using substances to cope
- Services may be fragmented.

Those in the anti-sexual violence field have a responsibility for increasin access to quality services.

In many cases the victim's abuser is also her supplier causing her to make a difficult choic between possible further abuse and being cut off from her alcohol or drug supply. Many victims feel pressured to barter sex for drugs or alcohol and may experience further victimization while purchasing drugs. It is estimated that one-third to one-half of women with addictions are living with a man who also is addicted to drugs or alcohol (McCaul & Svikis, 1999).

Ms. Tillger shared some trends she's noticed concerning the age of first use among sexual assaul survivors. For most, it coincides with their victimization. Adult victims of child sexual abuse with children may begin using when their children reach the age of their own assault. For example, a mother who was assaulted at age nine may find her PTSD symptoms return, alon with increased substance abuse, as her daughter reaches nine years old.

Ms. Tillger views her role as helping to empower victims of sexual violence to see how substance abuse is connected to their assault. Both anti-sexual violence advocates and substance abuse counselors could coordinate their efforts to assisting victims in a holistic manner. Through cross-promotion of resources and multidisciplinary trainings, communities could come together and guide victims in choosing healthy coping mechanism for their recoveries.

Kilpatrick, D.G. (1998). Victimization and posttraumatic stress disorder. Drug addiction research and the health of women: Executive summary (C.E. Wetherington & A.B. Roman, Eds.). 77-80.

McCaul, M.E., & Svikis, D.S. (1999). Intervention issues for women. Sourcebook on substance abuse: Etiology, epidemiology, assessment, and treatment (P.J. Ott, R.E. Tarter and R.T. Ammerman, Eds.). 430-439.

The Role of Healthcare Providers in Sexual Violence Prevention

BY E. LAUREN SOGOR, MPH

In recent years, the NSVRC has focused on disseminating messages about primary prevention. In the 2006 publication, *Sexual Violence and the Spectrum of Prevention: Towards a Community Solution*, one level of the spectrum is focused on reaching providers,

Healthcare providers have multiple roles to play in the prevention of sexual violence.

those individuals who serve as models for the general public, with messages about primary prevention. One such subset of providers includes the nurses, doctors, physician's assistants, medical technicians, students, and other professionals that make up our healthcare workforce. Healthcare providers have multiple roles to play in the prevention of sexual violence. Not only do they speak with authority and expertise to their patients, they also have strong voices in their communities and can influence polic .

Healthcare providers can take various actions along all three levels of prevention: primary, secondary, and tertiary. The Centers for Disease Control and Prevention (CDC) define the three tiers of prevention as follows (CDC, 2004):

- *Primary Prevention:* Approaches that take place before sexual violence has occurred to prevent initial perpetration or victimization.
- *Secondary Prevention:* Immediate responses after sexual violence has occurred to deal with the short-term consequences of violence.
- *Tertiary Prevention:* Long-term responses after sexual violence has occurred to deal with the lasting consequences of violence and sex offender treatment interventions.

Promising practices for primary prevention include educating people on being an engaged bystander, teaching adults and children about healthy relationships, and using social norms campaigns to show young adults that respectful behavior is common and "cool." For healthcare providers, primary prevention includes working with patients of all ages to recognize healthy sexual behavior and foster respectful relationships. The American Academy of Pediatrics recently produced *Prevention of Sexual Violence: An Educational Toolkit for Health Care Providers* focused on various ways that doctors can promote primary prevention. An online version of the toolkit is available at http://www.aap.org/pubserv/PSVpreview/start.html.

Secondary prevention addresses the short-term consequences of violence. Sexual Assault Forensic Examiners (SAFE or SANE) can work with other healthcare providers to collect evidence and treating immediate injuries resulting from the assault. Referring patients to local rape crisis services is a critical role healthcare providers can play in secondary prevention.

Healthcare professionals also have a role to play in tertiar y prevention, which refers to longer-term responses to sexual victimization and its effects. This may include ongoing mental healthcare for victims and offenders, treatment for

Primary prevention includes working with patients of all ages to recognize healthy sexual behavior and foster respectful relationships.

physical injuries, and prevention and treatment of other conditions and chronic illnesses. For example, victims may seek medical care for sleeping disruptions, sudden weight gain or loss, depression, and many

other symptoms. It is critical that healthcare providers and anti-sexual violence advocates work together to provide the best short- and long-term care for all victims, regardless of age or gender.

Recently, there have been more materials and resources available regarding screening patients for sexual violence. Screening can fall into any of the three levels of prevention. Screening patients for risk factors for perpetration, and using this information to change rape-supportive attitudes or beliefs, is primary prevention. In addition, healthcare providers may prevent further abuse if victimization is identified through screening. This is also a form of secondary prevention, as providers can identify recent victims and refer them to appropriate treatment. Even screening that occurs many months, or years, after an assault can help victims seek needed care, falling into the tertiary prevention category. For any screening to be successful, it is important that providers use pre-validated screening tools, receive adequate training, and have a good knowledge of the resources available to victims and survivors in their local communities. Local rape crisis centers and state, Territory, and Tribal anti-sexual violence coalitions often provide training and technical assistance to healthcare providers on tailoring screening tools to specif c patient populations.

While there is no doubt that healthcare providers are faced with many competing tasks and limited time, the statistics clearly show the health impact sexual violence has on women, men, and children in our society. Healthcare providers are an important source of information and support for people, and they can play a large role in preventing and responding to sexual violence. As we continue to work with more diverse constituencies to develop and implement effective ways to collaborate for prevention, the healthcare sector is an increasingly important piece of the puzzle.

Even screening that occurs many months, or years, after an assault can help victims seek needed care

Centers for Disease Control and Prevention. (2004). Sexual violence prevention: Beginning the dialogue. Atlanta, GA: Centers for Disease Control and Prevention.

Resources for Healthcare Providers

- *Prevention of Sexual Violence: An Educational Toolkit for Healthcare Providers,* available from the American Academy of Pediatrics, provides strategies and tools to assist healthcare providers in addressing sexual violence prevention in their communities. Visit: http://www.aap.org/pubserv/PSVpreview/start.html.
- *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings* is a collection of existing tools to assist healthcare providers in determining intimate partner violence and sexual violence victimization. Visit http://www.cdc.gov/NCIPC/pub-res/ipv_and_sv_screening.htm.
- The NSVRC provides a PowerPoint presentation, entitled *The Healthcare Community's Role in Preventing Sexual Violence*, featuring eight prevention modules on the prevalence of sexual violence, the health impact of sexual violence, and action steps for healthcare providers. To request the PowerPoint email resources@nsvrc.org or call 877.739.3895.

Pennsylvania

The Cross System Advocacy Coalition

BY KARLA VIERTHALER, MPA

In late 1989, **The Pennsylvania Coalition Against Rape** and Pennsylvania Protection and Advocacy (currently the Disability Rights Network; a statewide, non-profit corporation designated as th federally-mandated organization to advance and protect the civil rights of adults and children with disabilities) met to discuss the provision of services to a segment of the population that is many times overlooked—people with disabilities. After several meetings, it became apparent that both movements, the disability movement and the anti-sexual violence movement, needed to join forces to train and educate each other. The effort ended in the creation of the Co-opt victim empowerment project (COVE) manual, a training manual for disabilities services providers on sexual violence.

In 2004, Disability Rights Network of Pennsylvania (DRN) contacted several state and nonprofit agencies t join the Cross System Advocacy Coalition. The goal was to be proactive on a state level in addressing trauma in the lives of people with disabilities. Members of the group, co-chaired by the Pennsylvania Coalition Against Rape (PCAR) and DRN, include representatives from Pennsylvania Coalition Against Domestic Violence (PCADV), The Arc of Pennsylvania, Pennsylvania Mental Health Consumers' Association, Department of Public Welfare's Office of Menta Health and Substance Abuse Services (OMHSAS) and Office of Developmenta Programs, Pennsylvania Commission on Crime and Delinquency, Drexel University College of Medicine (Behavioral Healthcare Education), and the Institute on Disabilities at Temple University. The mission of the Cross System Advocacy Coalition is to foster, encourage, support, and advocate for cross-systems communication, training, and the provision of attitudinally and physically accessible direct care services on all levels.

Through discussions on the prevalence of trauma in the lives of people with mental health issues, it became clear to the Cross System Advocacy Coalition that training for professionals was needed. Oftentimes, the trauma response from sexual or other violence was being misdiagnosed and medicated as co-occurring mental illness, and this was a particular problem in Pennsylvania's state mental health hospitals. The group recognized that people in residential mental health facilities are more likely to have a histor y of sexual violence and trauma, and also at risk for further victimization. In 2006, the group discussed and facilitated an effort to conduct training on domestic and sexual violence, trauma-informed responses, and the free and confidentia services of Pennsylvania's sexual and domestic violence centers at each of the eight state-operated mental health hospitals. The idea was to help staff understand that many of the people they worked with had likely experienced trauma, and educate staff on how to address trauma and utilize community resources. PCAR, PCADV and DRN representatives created the four-hour training on the topics outlined above, inviting advocates from the local centers to present on their services, for state hospital staff. An OMHSAS representative set up the trainings, drove the group to each location across Pennsylvania, and provided accommodations.

The trainings were conducted over a yearlong timeframe, and were received with great support. Staff at the hospitals seemed excited to receive the information, and many shared 'ah ha' moments of how probl em behavior was likely a trauma response. Next steps for the group are to standardize the domestic and sexual violence screening tool used by the state mental health hospitals. Currently, each hospital creates and uses their own screening tool, which is generally part of intake and initial screening.

For more information about this project, please contact PCAR's Outreach Coordinator, Karla Vierthaler at (800) 692.7445 or kvierthaler@pcar.org.

New York

Building Connections: The Sexual Assault and Mental Health Project

BY CHRYS BALLERANO & LORRAINE McMULLIN

In 1995 the **New York State Coalition Against Sexual Assault** (NYSCASA) and the Mental Health Association in New York State (MHANYS) created the Sexual Assault and Mental Health Project. This unique project, known as *Building Connections*, fosters collaboration among mental health programs, victim assistance and rape crisis programs, and diverse community partners to serve and support survivors of sexual trauma.

Building Connections was started to raise community awareness of the profound societal and personal impact of sexual trauma and to improve support services for survivors. Historically, mental health, substance abuse, and many other service providers focused on symptoms and pathology without a thorough trauma history and without providing trauma-informed services. The lack of understanding of the extensive impact of childhood and adult trauma limited the benefit o therapeutic alliance and recovery. In contrast, advocates from rape crisis services used more of a peer support model with acknowledgement of strengths and strategies enabling survival and recovery from trauma. They at times however, lacked the resources and training to best serve survivors with more complex post traumatic stress disorder (PTSD) and other mental health challenges.

Building Connections worked to bring together and educate providers and survivors from these diverse systems about trauma-informed practices and strategies for recovery.

Today, *Building Connections'* mission is to provide New York State residents with education, advocacy and support to strengthen trauma-informed services for survivors of sexual violence with mental health needs. The project provides technical assistance, consultation and training to agencies and individuals serving survivors of trauma and to trauma survivors. It distributes resources on a wide range of topics relating to trauma and mental health, support groups, trainings, courses and opportunities for professional collaboration in trauma-sensitive skill building.

Building Connections supports the development of county and regional sexual trauma task forces across the state. These task forces bring together mental health and sexual assault providers along with others providing services to children and adult survivors of trauma to address service gaps and develop strong alliances to support healing. Task force activities include a myriad of resources for both service providers and survivors such as support groups, retreats, conferences and cross-disciplinary trainings.

Building Connections offers workshops and presentations for professionals and survivors highlighting the project's work and community-based trauma task forces. It works to build collaboration among mental health staff and other providers at statewide and regional meetings. In the past year, training topics have included:

- Collaborating with Clergy in our Communities to Prevent Sexual Abuse and Domestic Violence
- Healing the Healer: Addressing Secondary Stress through Rhythms and Restorative Self-Care
- Rhythms for Building Community and Wellness: Experiencing the Healing Power of the Drum
- Self Nurturing, Resiliency and Empowerment: Engaging our Passions as Adults who have Experienced Trauma
- The Use of Mindfulness in Healing the Trauma of Self.

For additional information, visit the New York State Coalition Against Sexual Assault's website at www.nyscasa.org or the Mental Health Association in New York State's website at www.mhanys.org. You may also contact Chrys Ballerano (cballerano@nyscasa.org) or Lorraine McMullin (lmcmullin@mhanys.org), Co-Directors of *Building Connections*.

Sexual Assault Awareness Month

Spotlight on Healthcare Workers

BY E. LAUREN SOGOR, MPH

The NSVRC continued the Sexual Assault Awareness Month (SAAM) campaign theme, *Prevent Sexual Violence… in our workplaces* in 2009. This campaign encourages prevention advocates to examine an array of workplace settings within their communities. The goal is to assist employers and others in examining policies, procedures and workplace culture through a lens of preventing sexual harassment and other forms of sexual violence.

Those in the healthcare field ar at a particularly high risk for violence from both patients and co-workers. Several factors, including frequent interaction with many people throughout the work day, increased workloads, a high population of female employees, and an overall lack of policies and programs to prevent and reduce violence incidents are thought to contribute to a heightened risk of violence (NYSNA, 2005). Studies indicate that one in three nurses report career exposure to physical and verbal abuse and/or sexual harassment (Carroll & Goldsmith, 1999).

Due to these high risks, it is important that healthcare workers and employers recognize and respond to sexual violence in the workplace. Sexual violence on the job correlates with decreased productivity, higher rates of absenteeism, and lower employee morale (NIOSH, 2002). For hospitals and healthcare facilities, this means losing valuable and skilled medical professionals.

A strong anti-violence workplace policy is a key component to protecting workers. Such policies include detailed instructions for victims of sexual violence at work, a commitment from the employer that claims will be taken seriously and thoroughly investigated, and protection from retaliation when a victim reports an assault. Employers play a critical role in creating safe and respectful workplaces through policymaking and by modeling appropriate behavior. Particularly in the healthcare industry, individuals in positions of higher authority have substantial influence with othe employees. It is important that all employees educate themselves on specific workplace policies an recognize and respond to inappropriate behavior at work.

Sexual Assault Awareness Month is an opportunity for anti-sexual violence advocates to expand local partnerships with healthcare systems and create a dialogue among healthcare administrators and providers about sexual violence. In addition, advocates can provide educational materials and workshops to healthcare employees in local settings. Volunteering at anti-sexual violence organizations is another way for healthcare workers to learn about how this issue impacts them, their coworkers, and their patients. The 2009 national Sexual Assault Awareness Month campaign contains resources for both employees and employers on this important issue. To access related materials, please visit www.nsvrc.org/saam or call the NSVRC at 877-739-3895.

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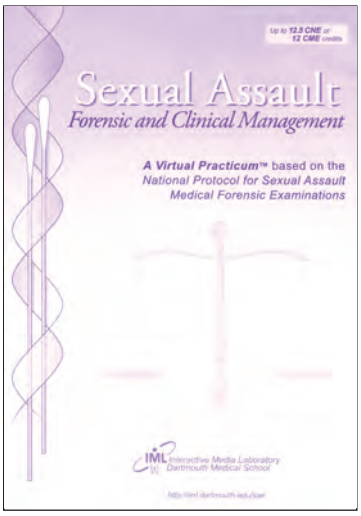
From the Library

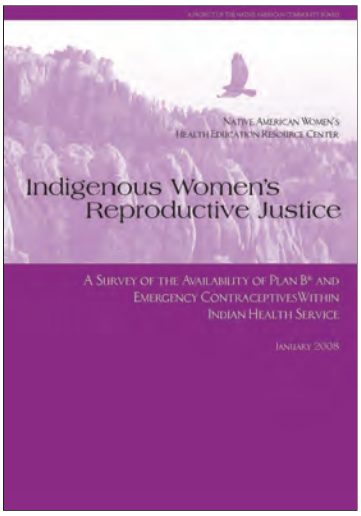
Sexual Assault-Forensic and Clinical Management



Based on the National Protocol for Sexual Assault Forensic Examinations, this highly interactive DVD-ROM tool provides an insider's look at a quality sexual assault forensic medical examination and sexual assault response team (SART) collaboration. From visiting a virtual sexual assault exam facility to practicing critical skills and learning from experts, users will find thi learning experience indispensible. Additionally, critical issues are discussed through focus groups and inter views with actual SART members and victims of sexual assault. V isit http://iml.dartmouth.edu/education/cme/sae/ for a tour of the virtual facility.

This virtual practicum can be pur chased through the International Association of Forensic Nurses for $25 at www.iafn.org. Nursing and Medical Continuing Education Units are available.

Indigenous Women's Reproductive Justice



A Survey of the Availability of Plan B® and Emergency Contraception within Indian Health Services. The Native American Women's Health Center, a project of the Native American Community Board, conducted a survey to investigate Indian Health Service's compliance with contraceptive options available to American Indian and Alaska Native women. The survey results indicate some startling findings includin that only 50% of the IHS pharmacies contacted (40) have Plan B® available and that only 10% of IHS pharmacies surveyed have Plan B® available over-the-counter (OTC) which has been approved by the FDA for OTC availability .

The report is available from the Native American Women's Health Education Resource Center by calling 605-487-7072.

The Vulnerability of Elders to Sexual Assault

BY HOLLY RAMSEY-KLAWSNIK, PH.D.

The many physical changes and health declines of advanced age bring increased risk of interpersonal violence. Older individuals, particularly those unable to care for themselves, are targeted by sexual predators because they are often unable to defend themselves and less likely to be believed. Research and clinical practice are demonstrating that elderly individuals are vulnerable to sexual assault and tend to be seriously physically and psychologically harmed when it occurs.

What We Are Learning

Research indicates that the majority of elder sexual assault victims are female while the majority of offenders are male. Of the 82 elder victims of sexual abuse within Virginia Adult Protective Services, most had cognitive, functional, and physical limitations and resided in nursing homes (Teaster & Roberto, 2004).

Family members and care providers perpetrate the majority of sexual violence against elders, as they often have the power and opportunity to do so. A National Institute on Aging study of elders sexually assaulted in a care facility found that the largest group of perpetrators were facility employees (43%), the second largest were facility residents (41%), and the remainder of perpetrators were family members (Ramsey-Klawsnik et al., 2008). In 2005, there were 795 registered sex offenders living in nursing homes (Bledsoe, 2006). Individuals who need facility-level care often have physical disabilities, dementia, or have lost the ability to speak or understand spoken language due to damage to the brain. A sexual predator employed or residing within a facility poses extreme danger to such individuals whose disabilities impede their ability to protect themselves or ask for help when victimized.

Family members and care providers perpetrate the majority of sexual violence against elders

Characteristics of offenders who sexually victimize elders within their families have been found to include mental illness, substance abuse, domineering or sadistic personality traits, and sexual deviancy. Older abusive spouses often justify forced sexual contact, rationalizing that sex is a normal and expected part of marriage. A sense of male privilege and a historically based view of wives as the sexual property of their husbands contribute to their rationalizations (Ramsey-Klawsnik et al., 2003). While it is abhorrent to most to conceive of an elderly woman being sexually assaulted by her adult son or other relative, it is critical that helping professionals understand the complexity of the situation for that victim.

"Assault is more psychologically injurious when inflicted by someon expected to provide love, protection, and support. Many elderly victims of familial sexual abuse experience powerful ambivalent feelings towards their abusers. These feelings complicate the trauma response, and make it difficult to accept inte vention. Many victims fear that intervention will

In 2005, there were 795 registered sex offenders living in nursing homes

Cases of sexual assault against elders span the following categories:

- Sexual victimization within care facilities
- Assault perpetrated by community care providers
- Incest
- Intimate partner violence
- Assault perpetrated by strangers or acquaintances

lead to negative consequences for their abusers—perhaps displacement from the home and consequent homelessness or even criminal prosecution and imprisonment. Familial bonds of attachment make it difficult for victims to trigger such consequences" (Ramsey-Klawsnik et al, 2003).

Additional Barriers Faced by Victims

"While elder sexual assault victims may require more assistance and specialized help because of age-related disabilities and other factors, they often receive fewer services and intervention than younger victims" (Vierthaler, 2008, p. 307).

Older individuals are less likely to be perceived as at-risk for sexual assault or believed when they disclose an assault occurred. Such disclosures are often dismissed as untrue or attributed to flashbacks, paranoia psychosis, or dementia. Physical indicators of abuse—such as genital irritation, redness, and abrasions—are often presumed to be the result of incontinence and aggressive personal care, rather than possible evidence of sexual assault.

Elders who have been sexually assaulted are not likely to fin services that can accommodate the special needs of older people. Older sexual assault victims are considered less credible and reliable witnesses in a civil or criminal investigation or prosecution. National Institute for Justice-funded research demonstrated that the older a sexual assault victim, the less likely it was that the offender was found guilty (Schofield, 2006). All of these barriers contribute to our society's failure to protect older victims. Many are left in situations where they are at high risk for re-victimization with no escape.

Conclusion

It is disturbing that older people have been historically and widely ignored as potential and actual victims of sexual violence. Sexual assault advocates and others involved in service to victims can be influentia in ensuring that older victims are not forgotten. We must educate others that, unfortunately, sexual violence is a potential risk to humans across the lifespan. People of all ages, regardless of health status and level of ability, need and deserve protection from sexual predators. Professionals must be alert to indicators of sexual assault in elders whom they serve. Elders who have suffered sexual victimization are entitled to an informed and effective response, including justice under the law.

Older people have been historically and widely ignored as potential and actual victims of sexual violence

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