PCAR

PENNSYLVANIA COALITION AGAINST RAPE

put down the chart
pick up the questions

a guide to working with survivors of sexual violence

A Note to the Healthcare Provider

Even if none of your patients have talked to you about sexual violence, be aware that current statistics suggest that very few practices escape this national health care epidemic.

The goal of this information guide is to help you find the right words. Often, it is 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… while the human cost of screening for violence is minimal in terms of money, time and opportunity.

*"When I began to **heal**,*
*the world became a **safer** place..."*

Pennsylvania Coalition Against Rape and sexual violence crisis centers

The Pennsylvania Coalition Against Rape (established 1975) is a statewide, nonprofit organization widely respected for its services and leadership in the field of sexual violence. At the core of PCAR's success is its statewide network of 52 sexual violence crisis centers. These centers offer free and confidential crisis counseling to victims of sexual violence in Pennsylvania's 67 counties.
Counselor/advocates at these centers receive a minimum of 40 hours of professional training and are fully equipped to provide counseling and other needed services for both immediate and past victims of sexual assault.

This booklet is adapted from its original version,
which was developed by Marlo Boyle, community trainer, from
the Pittsburgh Action Against Rape.

Wanda Filer, MD, President, Strategic Health Institute,
York, PA, served as the consultant for this version.

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why should I ask?

- Approximately two-thirds of abused females have not discussed their abuse with a medical professional.[1]
- Over 85% of those surveyed favored physician screening.[2]
- Physical and/or sexual violence occurs in 20% of adolescent dating relationships.[3]
- 11% of all sexual assault victims are men.[4]
- In one large study, 1 in 5 women had experienced previous childhood sexual abuse. The study also confirmed that previous childhood sexual abuse is associated with adult physical complaints, psychological distress, substance abuse, suicide attempts and suicidal ideation, even when women have not suffered additional abuse in adulthood.[1]

"I learned that it wasn't my fault and that I could heal."

how should I ask?

The SAVE method is adapted from the Florida Council Against Sexual Violence.
http://www.fcasv.org/2005_Web/Content/Guide%20for%20Health%20Care%20Prof.pdf
Be sure to explain to your patient that you are asking about both recent and past sexual abuse experiences, including any child sexual abuse.

Screen all of your patients for sexual violence

Anyone could be a victim of sexual violence.

- Ask the patient when no one else is in the examining room.
- Make direct eye contact and actively listen to the response.

Ask direct questions in a non-judgmental way

Avoid technical or medical language.
Begin by first normalizing the topic. For example:

- "I need to ask you some personal questions. Let me explain why. Asking these questions can help me care for you better."
- "Since I am your doctor, we need to have a good partnership. I can better understand your health if you would answer some questions about your sexual history."
- "I ask all of my patients this question because it is important for me to know what has gone on in their lives."

Next ask the patient directly:

- 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?

what if your patient says yes?

Validate your patient's response.

- "Thank you for telling me about such a difficult experience."
- "I'm sure that was hard for you to tell me. It is good that you told me."
- "Rape is devastating in many ways. Let's talk about some of the ways you need support."

Be sure to document the response in your chart using the patient's own words.

Evaluate, Educate and make Referrals

If your patient says "yes"

- immediately evaluate present-day level of danger, other violence, drug and alcohol use and health habits. Mention the disclosure again during another visit and ask about the patient's needs.
- request a one to two week follow-up appointment if necessary.

If your patient says "no"

- offer education and prevention information and provide follow-up at next visit.

If your patient is "not sure"

- evaluate the experience(s) with the patient and provide education about violence and consent.

Offer all patients the local rape crisis center information.

why should I ask?

Studies indicate that as many as 44% of women presenting to primary care medical practices have been abused sometime in their lives.[1]

Despite the seriousness of sexual violence in your patients' lives, they rarely volunteer current abuse or histories of abuse. Most studies suggest that if asked directly, patients are more likely to talk about victimization experiences. It is important to remember, that disclosure does not always happen just because a health care practitioner asks once. Often, disclosure requires frequent inquiry in a compassionate, nonjudgemental way.

"If someone would have brought it up I would have definitely ***talked*** *about it."*

The fear of opening "Pandora's Box"[1] can feel very real in an era of less time to do more, and feeling unprepared to respond can exacerbate this fear. In considering reasons to routinely screen for sexual violence, consider that the "wounds" of violence are often difficult to heal. If healing is to occur, recognition is a first step in breaking an all too common cycle of violence and silence.

So, ask the key questions that may not have been asked. Primary care practice presents a confidential, safe and powerful opportunity for patients to disclose and receive help for sexual violence. In these settings, a patient may develop a long-term, trusting relationship with a provider and/or a practice.

what if your patient says yes?

Things to remember:

- If the sexual assault occurred within the past 5 days (120 hours), tell female patients about emergency contraception (EC) and provide the medication or a prescription if the patient wants it.
  For more information about EC go to "ec.princeton.edu"

- Depending on when the assault occurred, and a few other factors, your patient may be eligible for Pennsylvania's Victims Compensation Assistance Program. Staff at the local sexual assault crisis center can talk to your patient about eligibility and filing a claim.

  For more information go to www.pccd.state.pa.us

Information & Referral Line: 1.888.772.PCAR(7227)

comorbid conditions

Be aware of these clues from your patient's medical history. They could be linked to past or present sexual assault.

- Depression, suicide attempts
- Eating disorders
- Alcohol/drug abuse
- Somatizing disorders or recurring physical complaints with no physical signs of organic disease (migraines, gastrointestinal disorders, chronic pelvic pain, lifetime surgeries, dyspareunia, numbness and tingling, choking sensation)
- Self-injury or self destructive behaviors
- Anxiety, panic attacks
- Signs of Post Traumatic Stress Disorder (increased arousal, sleep difficulties, irritability, difficulty concentrating, hypervigilance, flat affect, substance abuse)
- Poor contraceptive compliance
- Early initiation of sexual activity
- Previous treatment for victimization
- Injury during pregnancy, or spontaneous abortions, premature labor, low birth weight babies and fetal injuries.
- A non-progressive disability that appears to be progressively worsen (for example, cerebral palsy)

pregnancy and gynecological care

According to the American College of Obstetricians and Gynecologists and the Centers for Disease Control and Prevention (2000):

- Pregnant women may experience sexual assault or physical violence for the first time by their partner, or it may escalate
- A pregnant woman who is an adult survivor of childhood sexual abuse may experience anxiety and stress as a result and may benefit from counseling and support groups
- If the patient is a young teen, the pregnancy may be the result of incest
- Sexual abuse as a child may be related to early pregnancy

For many women, pregnancy may present a unique opportunity for repeated contact with health care providers. For this reason, pregnancy can be an important window of opportunity to identify patients experiencing violence and refer them to the appropriate services for help.

The frequency of prenatal visits offers an opportunity to develop trust between the patient, her health care provider, as well as other staff. Trust is a key factor in a woman's decision to disclose information about sexual assault or intimate partner violence.

immediate victims

Patients who visit your practice within 72 to 84 hours of a sexual assault should be told that a forensic exam can be provided at the local emergency department. Some patients may not wish to have one, therefore, appropriate medical and emotional needs should be provided for in the office.

Most survivors of sexual violence do not seek medical care because of shame or fear. Validate the fact that seeking medical care is a good step in taking care of oneself. It also lets the patient know that what happened was a traumatic event, and one that deserves and requires appropriate care.

Medical Needs:

- Acute injury intervention
- Evaluation of potential sexually transmitted infections and treatment
- Evaluation of pregnancy risk and provision of emergency contraception if desired by the victim
- Discussion of HIV counseling and testing at the office or at an anonymous testing site - make sure the patient understands the difference

Emotional Needs:

- Acute crisis intervention
- Referral for appropriate follow-up counseling

Advocates from your local sexual assault crisis center are invaluable when it comes to providing crisis intervention, counseling and legal information. They can be called on the hotline right from your office. They can also be called to explain the forensic exam and help your patient determine what steps to take.

Information & Referral Line: 1.888.772.PCAR(7227)

pregnancy and gynecological care

A routine vaginal exam, whether prenatal care or an annual exam can be very difficult for a patient who has been victimized. Keep this in mind if a patient becomes uncomfortable or seems to have great difficulty with the exam. Screening for sexual assault is best done while the patient is clothed rather than when in an office gown and stirrups.

During pregnancy, it is important to allow the patient to control the vaginal exams and the delivery process as much as possible. Allow the patient to take breaks when needed and have a trusted person present during this time. However, patients should always be screened in private.

Patients should also be screened for STIs and HIV. Ongoing assault victims who are pregnant have special screening needs and present an opportunity to prophylax for HIV and avoid or reduce neonatal transmission.

male patients

Male victims of sexual assault experience post-traumatic stress reactions similar to all victims.

Men need the same level of crisis intervention and follow-up care as women. Males may be less likely than females to seek and receive support from family and friends. Their ability to seek support will vary according to the level of stigmatization they feel, the circumstances of the sexual violence and the sensitivity of care they receive.

Things to remember and teaching points to talk about:

When a man is rectally raped, pressure on the prostate can produce erection and even orgasm, which may be confusing to male victims. A man may struggle with issues surrounding sexual orientation, or feel that his body betrayed him. You can allay fears and confusion by explaining that this is a physiological reaction.

Be sure to discuss risks of STIs and prophylactic care. There is likely to be fear about the development of HIV.

Men who have been sexually assaulted by women suffer feelings of helplessness, fear and anxiety. They will need anticipatory guidance in considering how friends and family members may react. Certain reactions may leave the victim's feelings extremely invalidated and he is unlikely to talk about the situation again.

Men are not immune to the long-term effects of violence.

patients with disabilities...

In a 1996 survey asking women with a variety of disabilities to rank the most important research topics affecting their lives, 92% ranked violence as their top priority.[6] some studies suggest that women with developmental disabilities are 4 to 10 times more likely to be sexually assaulted as other women. Compared to women without disabilities, women with disabilities experienced:

- Abuse for a longer duration
- A higher number of health care workers and attendants as perpetrators
- Fewer options for escaping or resolving the abuse.[7]

Be aware that individuals with disabilities are at a high risk for abuse and neglect, which can come from a caregiver. Therefore, if a patient comes with a companion, provide the opportunity to speak with the patient alone. Abuse screening should always be done in private.

Studies have also identified a new dimension of abuse, called disability-related abuse, in which perpetrators withhold needed orthotic equipment (wheelchairs, braces), medications, transportation or essential assistance with personal tasks, such as dressing or getting out of bed.

male patients

Sexual assault in general is one of the most underreported crimes. It is estimated that only 10-25% of sexual assaults are ever reported. Sexual violence against males is generally less likely to be reported than violence against women. Some of the reasons for the underreporting are:

- Societal expectations for boys to be dominant and self-reliant
- Societal notions that early sexual experiences are a normal part of boys' lives
- Males' fears of being considered homosexual
- Societal pressures on males not to express vulnerability

A study done by Kaufman et al (1980) comparing male rape victims to female rape victims found that males were more often injured. Men are also more likely to be the victims of multiple assaults by multiple assailants. They are also more likely to seek treatment without revealing the sexual assault.[5]

It is important for emergency personnel to ask men who present for treatment of physical injuries if they have also been sexually assaulted. This should be done in a private setting and in a nonjudgemental way that preserves patient dignity. Consider asking:

> "I'm sorry this happened to you. You didn't deserve to be assaulted. I want to be as thorough as possible in checking for injuries. It is common that when a physical assault has occurred, that sexual violence also occurred. Were you forced into doing something sexually?"

adolescent patients

According to the Journal of the American Medical Association[3]

- One in five adolescent girls becomes a victim of physical or sexual violence
- The experience of such violence is frequently associated with serious health problems, including drug abuse, unhealthy weight control practices, risky sexual behavior, teenage pregnancy and suicide attempts.

Any adolescent you see in your practice who has exhibited any of the above health problems should raise a red flag for past or present sexual victimization.

Disclosure of sexual abuse can create intense conflicting feelings and psychological needs for the adolescent and the family. At disclosure, your patient may be relieved, yet fearful. If abuse is occurring within the family context, the adolescent may feel responsible for disrupting the family situation. Common feelings shared by adolescents after disclosure of sexual violence include shame, guilt, anger, confusion, fear, betrayal, isolation, sadness and fear of abandonment. This intense emotional state is difficult for a teenager.

adolescent patients

Risk Reduction:

"Although victims are never responsible for rape, there are things they can do that may reduce their risk of sexual assault. Do you know how to reduce your risk of sexual assault?"

Consider giving adolescents a copy of PCAR's Risk Reduction Brochure; you can obtain copies by calling **1.800.692.7445**.

When you are talking to adolescents about sexual violence and reducing risks, talk to them about the fact that this information is intended to give tips for reducing risks. There are no absolutes in rape prevention, and in fact, the only person who can stop rape is a rapist.

Risk taking is often peaked in adolescence. Taking risks should never imply fault on the part of a sexual assault victim. The priority in dealing with victimization is to validate the experience and to offer appropriate referral and follow-up information. Assigning a degree of blame is never a therapeutic activity.

If an adolescent engaged in an activity that placed her or him at risk, that needs to be handled as a separate issue.

*"...**nobody** asks for this*
*...nobody **deserves** this."*

adolescent patients

Information about Statutory Sexual Assault:

Statutory Sexual Assault: A person commits a felony of the second degree when that person engages in sexual intercourse with a complainant under the age of 16 years and that person is four or more years older than the complainant and they are not married to each other. (PA Crimes Code)

Statutory Sexual Assault laws hold the older person responsible even if:

- He or she does not know the law
- He or she plans to marry the younger person
- He or she did not know the younger person's age
- The younger person consented to the sexual activity

It is a crime even if the younger person:

- Agreed to or initiated sex
- Pretended to be older or lied about his or her age
- Had sexual experience prior to the incident

Talk to adolescents about emotional coercion, the practice of pressuring a girlfriend or boyfriend to have sex by threatening them, putting them down or making them feel guilty. This is something that younger teens are especially vulnerable to when dating older people. A counselor/advocate at your local sexual violence crisis center can address this as well.

adolescent patients

How to ask adolescents about sexual violence:

It seems to be especially helpful with adolescent populations to frame sexual experiences as wanted vs. unwanted instead of labeling experiences as rape or abuse. Exploration of gender roles and relationship parameters (exploitative, non-consensual vs. healthy) are critical. Patients need the opportunity to describe the experience in their own words.

"Because sexual violence is an enormous problem in this country and can affect a patient's health and well being, I now ask all my patients about exposure to violence and about sexual assault."

1. Do you have someone special in your life? Someone you're going out with?
2. Are you now... or have you been... sexually active?
3. Think about your earliest sexual experience. Did you want this experience?
4. Has a friend, a date or an acquaintance ever pressured or forced you into sexual activities when you did not want them? Touched you in a way that made you uncomfortable? Anyone at home? Anyone at school? Any other adult?

(Screening questions from ACOG, www.acog.org)

pediatric patients

Care of children who have been sexually abused or sexually assaulted involves all of the skills utilized for an adult, but with a need for additional knowledge of pediatric growth and development. It is essential that care be tailored to meet children's developmental needs.

Child sexual abuse can be defined as contacts or interactions between a child and an adult when the child is being used for the sexual stimulation of the perpetrator or another person.

Since one of the greatest needs of a child who "tells" is to believe and to know that it was not the child's fault, the medical care and interview techniques utilized will need to address those major concerns.

The medical interview has become a critical component of the diagnostic, therapeutic and legal aspect of child sexual abuse. Although interviews must adapt to the individual needs of children, care must be taken to prevent undermining the child's credibility by improper questioning. For this reason, PCAR recommends an evaluation take place where there is a comprehensive team available to meet the complex needs of the child and family. An integrated approach to medical care, emotional needs, legal concerns and forensic evidence collection is essential.

pediatric patients

Needs of Children at Disclosure:

To be believed. When responding to disclosures of victimization there is a compelling need to meet emotional needs, while also sorting out legal ramifications of reports of sexual violence. In the moment when a child discloses violence a major risk has been taken. Health care practitioners often play a vital role in the healing process when a message of validation is given. Believing helps in building trust, which will facilitate more ongoing communication and create a safe environment.

To be safe. This means different things to different children. Sometimes it is difficult to determine the next step in maintaining safety after the child leaves your presence. But, at minimum, children need to feel as safe as possible with the interviewer and to be reassured about particular fears as much as possible.

To not be tricked into disclosure. The victim may be reluctant to give information and the interviewer may be tempted to falsely reassure the child about what will happen after disclosure (most commonly saying that they [the clinicians] won't tell anyone else). Abused children have already been tricked by the perpetrator and need to have honest age-appropriate answers to their questions about disclosure and follow-up.

pediatric patients

Information and choice about what will happen following the disclosure. Again, children need information that is age-appropriate and specific about the next step. Often, it is possible to give some choice about the next step and further disclosure to a family member, etc. and still stay within the parameters of agency policy and mandated reporting laws.

Input into what they need following disclosure. Children and adolescents, in particular, may be able to articulate what they need regarding how follow-up to disclosure is handled, what will help them feel safe, what will be comfortable, etc. Asking for input and making every effort to meet reasonable requests can prevent or minimize acting out and other problem behaviors that are likely to follow disclosure.

To have time and space for feelings. Victims need to have a chance to talk about whatever feelings emerge during the course of the disclosure. A rape crisis advocate can provide assistance to the child and family.

To report suspected child sexual abuse call:
Childline 1-800-932-0313

pediatric patients

Physical clues

- Chafing or bruising to the genital region, anus or back
- Penile discharge, painful urination, penile swelling
- Bite marks to the genital region, anus or back
- Bruising, scars or anal tears
- Other anal findings include: the loss of rugal pattern to anus, loss of sphincter tone, scars, anal dilation (without stool present), edema, venous congestions, skin tags or contusions to natal cleft or perianal tissues
- Tears to the labia frenulum or palatal petechiae
- STIs, enuresis, encopresis, vaginal discharge

However, A normal physical examination is most often what is found and can be consistent with abuse!

You may see a child in the office with a clinical presentation that is suspicious for physical or sexual abuse. Or a caregiver may have suspicions and bring the child to you for an examination. Sometimes you will have to ask initial questions about experiences of violence, or a child could disclose and you will have to immediately respond. The following page includes some guidelines on how to respond to a disclosure of sexual violence.

how we can help...
PCAR centers

PCAR sexual assault crisis centers offer free and confidential crisis counseling to victims of sexual violence throughout Pennsylvania.

Counseling Services

- Individual and group counseling for children, adolescents, adults and their families
- Support groups
- Counseling for adult survivors of child sexual abuse
- Information and referral

*"We extend our services to **all victims** of sexual assault -- women, men, & children and their families."*

Crisis Intervention Services

- 24-hour hotline
- 24-hour medical accompaniment
- 24-hour police/legal advocacy
- Crisis intervention support
- Assistance with filing for the Victims Compensation Assistance Program

Education and Training Services

- Programs in schools and community groups
- Professional training tailored to community mental health and social service agency needs
- Health care systems training
- Programs for survivors of sexual abuse

*"Your local **rape crisis center** can help put it together."*

Information & Referral Line: 1.888.772.PCAR(7227)

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NOTES

RESOURCES

Pennsylvania Coalition Against Rape
Business Line 1-800-692-7445
24-hour Referral Line 1-888-772-PCAR (7227)

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Florida Council Against Sexual Violence
SAVE Screening Tool
http://www.fcasv.org/2005_Web/Content/Guide%20for%20Health%20Care%20Prof.pdf

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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/PolicyStatementsByCategory/ViolenceAbuse/ManagementofthePatientwiththeComplaintofSexualAssault.htm

◆

CDC HIV PEP Recommendations (January 21, 2005)
www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm

◆

Victims Compensation Assistance Program
1-800-233-2339

◆

Childline 1-800-932-0313

◆

EPIC-SCAN Educating Physicians in their Community on Suspected Child Abuse and Neglect
1-866-823-7226

◆

National Domestic Violence Hotline
1-800-799-SAFE (7233)

125 North Enola Drive, Enola, PA 17025
1.800.692.7445 or 717.728.9740 web: www.pcar.org