# Sexual and Gender-Based Violence

## A Complete Clinical Guide

Veronica Ades
*Editor*

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# Preface

## Why This Book Is Needed

As an obstetrician-gynecologist, I never received any explicit training on sexual trauma. Although I learned to perform pelvic exams, care for pregnant women, and discuss sensitive and taboo subjects like sex, contraception, abortion, and reproduction, trauma itself was never taught. During my medical school and residency training in New York City, I came across young women who were diagnosed with bipolar disorder or other serious psychiatric illnesses in their teens but who did not seem to fit the clinical picture. When I was able to spend more time with these patients, I found that they nearly always had a history of sexual violence and that they had residual anger from that trauma.

I also treated many women with a history of female genital cutting and learned how to evaluate and manage these patients under one of my mentors, Dr. Nergesh Tejani. During my global health work in Uganda, South Sudan, and Jordan, I came across many forms of sexual and gender-based violence, including rape, incest, and intimate partner violence. In my first position as faculty, I treated a patient who had been sex trafficked, and her plight inspired me to start the EMPOWER Clinic for Survivors of Sex Trafficking and Sexual Violence at Gouverneur Health in 2013.

What I learned through this clinic is that trauma has not only mental health consequences but physical sequelae as well. Through experience, I learned how to take a trauma history, how to perform a trauma-sensitive gynecological examination, and how to incorporate trauma awareness into the management of various obstetric and gynecologic conditions. I realized that trauma-informed care, like other aspects of medical care, requires explicit training, supervision, and knowledge.

The authors of the chapters in this book are all experts in different fields. Some are medical providers, while some are mental health clinicians. Nonclinical authors include two lawyers (a former public defender and a former prosecutor) and an advocate and community organizer. The chapter topics were specifically chosen to cover areas that medical providers may not be familiar with, such as legal aspects, or additions to the clinical expertise that medical providers already have. Some readers may choose to read the book in its entirety, while others may select chapters that are relevant to them in the moment. The book is intended to be a concise clinical guide in order to help providers treating sexual and gender-based violence (SGBV) survivors to provide trauma-informed care.

## A Word About Terminology

The terminology used in this book was carefully considered. The issues covered in this book are relevant across many nations, cultures, and communities. While the authors and editors are located in the United States, our increasingly globalized world allows information to be transmitted quickly and easily in ways that were not possible even in the recent past. However, terminology, even in English-predominant environments, is neither consistent nor universally accepted. Language is a constantly evolving organism, and terms become outdated more quickly than in the past. Our intention in this book is to be as clear, concise, sensitive, and widely comprehensible as possible.

## Women and LGBTQ

In nearly all of the chapters in this book, we avoided the use of gendered pronouns in order to create a more inclusive text. However, in three of the chapters, the content was difficult to communicate without the use of a gendered pronoun: Family Planning, The Trauma-Informed Examination, and Female Genital Cutting. These chapters discussed medical circumstances in which the majority of patients are cisgender women, and therefore, female pronouns are used. We recognize that not all patients receiving gynecological care identify as women. In clinical situations, individuals' pronouns should always be respected, and we encourage providers to be mindful of the spectrum of gender diversity that exists among patients.

That said, merely eliminating the use of gendered pronouns in this book would be inadequate for the subject matter. Gender plays an important role in the perpetration of sexual and gender-based violence. As defined by the United Nations High Commissioner for Refugees, "SGBV refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships" [1]. While men can be victims of SGBV, it is by and large a phenomenon perpetrated by men against women. Women worldwide have less social, economic, political, physical, and individual power than men.

Individuals who violate gender norms are often at risk of violence. This can include women who seek education and independence, people in same-sex and non-hetero-normative relationships, or individuals who do not conform to gender stereotypes in appearance, dress, or mannerism. Transgender and gender-nonconforming individuals, while a small proportion of the total population, are at increased risk of SGBV. While challenging rigid gender norms and expectations, societal stigma may impede their access to SGBV-related services. Therefore, SGBV is a gendered phenomenon, and the effect of sex and gender cannot be ignored.

## FGM/FGC

Female genital cutting has a number of different terms. It can be referred to as "female genital mutilation" (FGM), often used in advocacy circles to highlight the destructiveness of the practice. Female genital cutting (FGC) is similar but potentially more neutral.

Female circumcision is a common colloquial term, but one that I do not use, in order to avoid confusion with male circumcision, which is a very different practice. The French term for the practice translates to “excision.” Many women only know it by a local name in their tribal language and may not be aware of the existence of a global term. In my clinical practice, I use “female genital cutting” to avoid offending patients who may not feel that they are mutilated. If a patient uses a specific term, I will echo her use of that term. In this book, we used female genital mutilation/female genital cutting (FGM/FGC), which is now the internationally accepted term for the practice and most likely recognized worldwide.

## Trauma-Informed Care

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides excellent resources in describing trauma-informed care. Their guidelines list six principles of a trauma-informed approach [2]:

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

However, for clinicians, these guidelines remain vague. As a clinician, it can be difficult to know whether specific choices will adhere to these principles or whether a specific approach, even if within the guidelines, is consistent with what the patient wants. Additionally, specific clinical scenarios may arise that require more specificity for the busy clinician trying to take a trauma-informed approach.

There is insufficient evidence to make every trauma-informed recommendation one based on data. Rather, this book relies on subject matter experts who use both data and experience to examine a topic and make recommendations on trauma-informed care. Additionally, the needs and preferences of patients with trauma may vary widely, and each interaction must be individualized. We hope that in the future, additional research will help us to better understand how to provide optimal trauma-informed care.

## Summary

This book is needed because sexual trauma is underappreciated as a cause of many medical and social sequelae. The intention of this book is to provide clinicians with a concise guide to various types of SGBV that they may encounter in their clinical practice, with suggestions for management and trauma-informed care. We have chosen topics that may not be included in a traditional medical education or may until recently have been taboo. Mental health specialists can provide excellent care to individuals suffering from trauma, but medical clinicians also need to understand trauma and incorporate this knowledge into their practice in order to provide holistic care. Medical providers may be the first or only clinically trained professional a patient interacts with, and that interaction can determine the patient's subsequent willingness to disclose and seek help for trauma. Normalizing the discussion and consideration of trauma within medical practice can help reduce shame and give the patient space to consider the wide-reaching effects of the trauma.

Not all providers need to be specialists in sexual trauma, but all of us will at some point encounter patients who have experienced sexual and gender-based violence. It can be stressful to handle a situation in which a patient is communicating a trauma and the provider does not know how to handle it. By writing this book, I hope to transmit some of the knowledge that I and others have gained by working with specific SGBV survivor populations.

New York, NY, USA Veronica Ades, MD, MPH, FACOG

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# Acknowledgments

The origin of this book is indebted to my patients. There is the first patient I ever saw as a medical student, on my surgery rotation, whose relatively simple surgery belied her tragic medical history and social situation; she taught me that my most powerful tool as a doctor is my compassion. Another patient is a woman I call Patient Zero – she is the patient who inspired the EMPOWER Clinic. Her story helped me see how many of the challenges my patients faced were rooted in trauma. The patients who trusted me with their stories, crises, and sometimes the buried secrets causing them so much pain – they taught me how very personal and sacred medicine can be. It has always been an honor to be in a position in which people graced me with their trust, simply because of my position. This book is my attempt to take that education and share it with other healthcare providers so that we can progress in our knowledge and ability to provide care with empathy.

A medical education is impossible without good mentorship, and yet mentoring is an unpaid and time-consuming endeavor that often goes unacknowledged. Throughout my career, I have had mentors who believed in me. Dr. Amitasrigowri Murthy has always been my champion, my defender, and my unwavering support. She was my first research mentor, and my experience with her provided the foundation for a career I couldn't have anticipated. It has been an honor to grow from her mentee into her colleague and research partner. Dr. Shohreh Shahabi is a truly extraordinary individual. She broke the myth that doctors are either compassionate or excellent; she is both and so much more.

From the time that I felt like a nameless intern, she saw in me a seed of promise, expressed her confidence, and challenged me to be my best. Dr. Nergesh Tejani, who wrote her own book about her fascinating life and training in Uganda, taught me about global health when it wasn't an academic discipline and was thought to be peripheral. She taught me to evaluate and manage patients with female genital cutting, and it was only after I left residency that I realized how rare and valuable that training was, even for a gynecologist.

In my fellowship in reproductive infectious disease, I received rigorous hands-on training in the implementation and conduct of research, and I am indebted to several UCSF mentors for this: Dr. Grant Dorsey, Dr. Deborah Cohan, Dr. Diane Havlir, Dr. Phil Rosenthal, and Tamara Clark. Two of my Ugandan colleagues were also instrumental in helping me acclimate and succeed: Dr. Julia Mwesigwa and Dr. Emmanuel Arinaitwe. During my fellowship, I had the freedom to work as an obstetrician-gynecologist at Tororo General Hospital while living in Tororo, Uganda. The 17 midwives on staff taught me a great deal about obstetrics that I had not learned in residency, and working with them, as well as other hospital staff, was the opportunity of a lifetime. Many of the cases I saw involved clinical and social situations that were wildly unfamiliar to me, and their unflappable resilience was a model in how to adapt to a setting with very limited resources and often very sick patients.

In my post-training career, I continued to find mentors who always took the time to help me succeed in both work and life. Dr. Morris Gagliardi has championed the EMPOWER Clinic since its inception and has always been my behind-the-scenes navigator and supporter. Dr. Francine Hughes was my model for not only how to be a clinician/researcher but also how to be a whole person/doctor. Dr. David Keefe, my department chair, has continually expressed his full confidence and has thrown his support behind my unusual career in a multitude of ways. Dr. Scott Sherman has a talent for mentoring in his ability to find the unique potential in each mentee and provide a sounding board for them to thrive and succeed. Dr. Olugbenga Ogedegbe believes passionately in the power of education and opportunity; his piercingly candid advice makes each interaction with him a golden opportunity.

Several organizations have been instrumental in my education, training, and in the writing of this book. Without Wellesley College, I would never have had the confidence to become a doctor. My medical education and residency at the State University of New York at Downstate and Albert Einstein College of Medicine, respectively, were not only phenomenal training institutions but allowed me to be trained in an environment in which service to the community and to the underserved was paramount. It is the ethos of these institutions that inspired this book. My public health degree at the Harvard School of Public Health allowed me to explore public health, especially maternal mortality, a subject I became passionate about in residency, and taught me to grapple with medicine from a systems perspective. My work with Médecins Sans Frontières (Doctors Without Borders) exposed me to environments and medical situations that were both extremely challenging and highly rewarding; its ethos of témoignage has informed my work and advocacy since then. My current position at the New York Harbor Veterans Affairs Medical Center has allowed me to develop a specialization in post-sexual trauma gynecology and has encouraged my interest in addressing military sexual trauma from a health perspective. I admire the VA's commitment to supporting those veterans who experienced military sexual trauma, and I have learned from the system it has implemented how trauma can be addressed holistically. I have also encountered many inspiring individuals at the VA, especially within mental health, who are trauma experts from all over the country and who have taken the time to educate and advise me.

The EMPOWER Clinic for Survivors of Sex Trafficking and Sexual Violence provided an extraordinary opportunity for me not only to create targeted services to survivors of sexual trauma but also to educate myself in trauma and conceive a new model of care. This could not have been possible without the support of the Health & Hospitals Corporation, the public hospital network of New York City, and Gouverneur Health. Having trained and worked in several different H&H facilities throughout my career, its mission of providing excellent healthcare to all those to enter its doors has inspired me. Gouverneur Health in particular provided a welcoming and community-based environment for EMPOWER patients. Its staff and leadership always saw the value and importance of EMPOWER and have often bent over backward to ensure its success. Sanctuary for Families, a domestic violence service organization, partnered with me as I was conceiving and starting the EMPOWER Clinic, has been one of my strongest referral bases and closest collaborators. Much of my knowledge of trafficking comes from its current and former staff, including Lori Cohen, Kate Okamoto, and Ilana Herr.

Every doctor needs assistance to practice, and the EMPOWER Clinic is eternally indebted to Jinette Vasquez, the EMPOWER Patient Care Associate since its inception. She is not only a medical assistant but also a friend, supporter, and mother hen to EMPOWER patients. Their interaction with her when they walk in the door helps establish that EMPOWER is a welcoming place, and they often maintain their connection with her even when they no longer need medical services.

In 2015, I started the Empower Lab, a public health lab at NYU, to create an opportunity for students to help with my research on the intersection of sexual and gender-based violence and health. Since then, I have had many wonderful and extraordinary students come through the lab, all of whom have changed the lab for the better and created a foundation for other students to then build on and further. The students' voices and passion for the work have in turn educated me, as their natural curiosity leads to excellent questions and often forces me to reconsider things I had taken for granted. I knew I could not put together this book without the help of the lab and my associate editors: Tiffany C. Hamidjaja, Jennifer K. Leigh, Sonya Chemouni Bach, and Lydia Mason worked hard to gather and edit the chapters within this book. Several additional students also helped with the book and should be noted here, including Emily Rabinowitz, Clarie Liu, Jayne Caron, and Nicole Acero.

The authors all generously contributed their knowledge and time to make this book a success. In addition, Dr. Gwen Quinn, Amani Sampson, and Tiffany Cook helped me consider how to implement gender-neutral language within the context of each specific chapter.

Lastly, I must thank my family. My partner, Garrison Scott, my son, Zeno, and my stepdaughter, Hazel, are my joy at the end of the day. They help me decompress and forget the emotional strain of the work that I do. My parents, Lee and Alicia Ades, have always encouraged my passion, drive, and unique spirit. When I began traveling to Uganda and South Sudan, they initially worried about my safety and questioned the wisdom of these ventures. But they very quickly became so proud of my work that they were my biggest fans and champions, even visiting me in rural Uganda. It is from them that I learned that the most important factor in success is not talent but perseverance.

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# Part I

# Defining Trauma

# What Is Psychological Trauma?

# 1

Katherine R. Buchholz, Virginia K. McCaughey, and Amy E. Street

## Introduction

Experiences of psychological trauma are unfortunately common. Most people will experience at least one potentially traumatic event during the course of their life [1–3]. While traumatic events like combat exposure, motor vehicle accidents, and natural disasters can have significant impacts on those who experience them [2], experiences of sexual and gender-based traumatic events (e.g., sexual assault, childhood sexual abuse, intimate partner violence) represent the greatest source of post-trauma psychopathology

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[1, 2, 4, 5]. Traumatic events can alter people's fundamental beliefs about themselves, others, and the outside world, changing the way they take in information and behave in their day-to-day lives [6–10]. Furthermore, trauma can contribute to short- or long-term mental and physical health concerns. For any medical provider, a basic understanding of psychological trauma and its effects is essential to providing quality, trauma-informed care. This chapter reviews psychological trauma with a special focus on sexual and gender-based violence.

## What Is Psychological Trauma?

As defined by the "Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition," a traumatic event is "exposure to actual or threatened death, serious injury or sexual violation" [11]. This exposure may be one in which the individual (1) directly experiences the traumatic event, (2) learns that the traumatic event occurred to a close family member or close friend, or (3) experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (e.g., having to collect human remains as a first responder or hearing detailed accounts of sexual assault as part of a job). Although many people label stressful experiences that do not meet the above criteria (e.g., divorce, job loss, ailing family member) as "traumatic," mental health practitioners and researchers generally differentiate these types of stressful events from traumatic events. It can be helpful to think of all of these experiences existing on a continuum that ranges from a stressor (divorce, job loss, ailing family member) to a trauma as defined by the DSM-5 (combat exposure, life-threatening motor vehicle accident, physical or sexual assault) [12]. Events from the entire stress/trauma continuum can contribute to or exacerbate mental health symptoms such as depression or anxiety, affect overall physical health, and impair daily functioning. However, events that meet the DSM definition of trauma are often associated with specific psychological sequelae, like posttraumatic stress disorder (PTSD), and more strongly associated with other mental health concerns, including depression and anxiety. Therefore, the differentiation between stressor and trauma is important when considering the psychological effects of the experience of trauma and how best to work with trauma survivors.

## Sexual and Gender-Based Violence

Broadly defined, sexual violence is "a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse" [13]. Gender-based violence refers to acts of violence that disproportionately impact one gender, typically women, and arise from normative gender role expectations and unequal distributions of power [14]. Sexual and gender-based traumas include sexual assault, childhood sexual abuse (CSA), sexual harassment, stalking, and intimate partner violence (IPV). By nature, sexual and gender-based violence is personal and intrusive and generally falls under the DSM definition of a traumatic event. A wealth of research has established significant associations between sexual and gender-based violence and mental and physical health concerns [15–19].

Sexual violence is relatively common. According to the CDC's National Intimate Partner and Sexual Violence Survey, 44% of women and 25% of men in the United States experience some form of sexual violence in their lifetime [20]. Sexual violence includes a broad range of unwanted sexual behaviors including rape (forced sexual penetration), being forced to penetrate, sexual assault (e.g., a broad term for a range of unwanted physical sexual contact), sexual coercion (unwanted sexual contact due to pressure or threats), and noncontact sexual assault (e.g., flashing or masturbating in front of the victim). Victims of sexual violence often know the perpetrator, who may have been a former or current intimate partner, friend, or acquaintance [16]. For female victims, the vast majority of perpetrators are male (97% for rape, 92% for noncontact sexual assault, and 93–96% for other types of sexual violence including being made to penetrate, sexual coercion, and unwanted sexual contact). Male victims of rape and noncontact sexual assault also report that the majority of perpetrators are male (87% for rape and 48% for noncontact sexual assault). However, male victims of other types of sexual violence (e.g., being made to penetrate, sexual coercion, and unwanted sexual contact) report the majority of perpetrators are female (53–82% depending on type of violence) [16].

## Characteristics of Sexual and Gender-Based Violence

Experiences of sexual and gender-based violence can differ based on a variety of characteristics such as duration of the event (single event vs. ongoing series of events), age at the time of the trauma, the environmental context in which the trauma occurred [21, 22], and other contextual factors (e.g., relationship between victim and perpetrator, use of alcohol by any party, type of coercion used, level of physical injury, experiences with help-seeking following the assault). These characteristics can affect how survivors respond to trauma as well as how they make sense of this experience in the context of their lives.

Generally, survivors who have experienced a traumatic event as a single isolated event have a better prognosis than those who experience ongoing or chronic trauma [23]. While a single trauma can be thought of as an anomaly, survivors of chronic or ongoing trauma may develop dysfunctional beliefs that are confirmed over and over again by a pattern of traumatization. Sexual and gender-based violence that occurs in childhood or adolescence can have strong implications for victims' emotional development and well-being. This childhood trauma can disrupt a child's sense of self before it is fully developed. It may isolate a child from people and environments the child once considered to be safe and is often associated with difficulties regulating emotions during future stressful events [23]. Consistent with this, survivors of childhood sexual abuse often experience significant mental health symptoms and are more vulnerable to experiencing further traumatic stressors throughout their lives [24].

Environmental and contextual factors of sexual and gender-based trauma also affect the experience, prognosis, and response of survivors. For example, assaults that occur within occupational or educational settings can result in strong feelings of distrust of authority and betrayal by the specific people involved and the larger institution [21]. Assaults that involve weapons or result in physical injuries are associated with greater mental health symptomatology [25]. Assaults that were facilitated by alcohol or drugs, as compared to those facilitated by physical force, are associated with lower rates of treatment and help-seeking by survivors [26]. Furthermore, the negative psychological effects of sexual violence are not fully determined by the effects of the violence itself, but also impacted by survivors' positive or negative experiences interacting with medical and legal helping systems [27].

## Reactions to Sexual and Gender-Based Violence

### Mental Health Reactions to Trauma

Experiencing sexual and gender-based trauma can profoundly impact a person's life affecting both their mental and physical health [13–17]. However, it is important to recognize that traumatic experiences do not always lead to long-term impairment in functioning or chronic mental health symptoms. In fact, resilience and recovery are the most common reactions to trauma [28–32]. People who demonstrate a resilient reaction may experience mild-to-moderate mental health symptoms (e.g., slight decrease in mood or a bit more anxious) following a sexual assault, but these symptoms do not significantly impact their day-to-day functioning. Multiple factors such as the intensity of sexual violence, the context of the assault, and the level of support following a trauma contribute to resiliency.

A recovery reaction involves greater symptomatology and functional impairment than a resilient reaction. However, a person who has a recovery reaction finds that their symptoms decrease over a few months post trauma [31–33]. Rothbaum and colleagues illustrated the recovery reaction in a study with female rape survivors [32]. In this study, most survivors (94%) met symptom criteria for PTSD within the first 2 weeks following their experience of being raped. After 5 weeks, the percentage of survivors who met symptom criteria for PTSD had dropped to 65%, and by the end of three and a half months, only 47% of the survivors reported significant enough symptoms to warrant a PTSD diagnosis (although note that a substantial percentage remained symptomatic) [32]. Studies suggest that, for many, a process of natural recovery can take place following the experience of trauma.

In contrast, there are others who develop long-term, chronic, trauma-related symptoms that impair their general functioning. PTSD is the mental health diagnosis most commonly associated with the experience of trauma [1, 2, 23]. PTSD includes symptoms from four symptom clusters: intrusive symptoms (intrusive trauma-related thoughts, unpleasant dreams, flashbacks, and emotional distress and physical reactions in response to reminders), avoidance (avoiding thoughts and feelings related to the event or avoiding people, places, and things associated with the trauma), altered mood and cognitions (inability to recall important parts of the trauma, negative thoughts about oneself and the world, exaggerated blame, negative affect, decreased interest in activities, feeling isolated, and emotional numbing), and hyperarousal (sleep problems, irritability, risky behavior, difficulty concentrating, hypervigilance, increased startle) [11].

Other mental health disorders that have strong associations with the experience of sexual or gender-based traumas include depression, anxiety disorders (such as panic disorder or generalized anxiety disorder), substance use disorders, and borderline personality disorder [17, 23]. Many times, these disorders co-occur with PTSD, leading to complex mental health presentations [2]. Furthermore, experiences of sexual and gender-based violence can exacerbate a preexisting mental health condition and increase symptomatology. Effective treatments, both psychotherapies and medication, exist for the treatment of mental health disorders secondary to the experience of trauma [34, 35].

## Cognitive Reactions to Trauma

One reason that traumatic experiences can have such a profound reaction on mental health is that these experiences can uproot victims' foundational beliefs of themselves, others, and the world they live in. Traumatic life events can challenge basic assumptions or beliefs about the self and the world, including the belief in personal invulnerability, the view of oneself (and others) in a positive light, and the belief in a meaningful, orderly world [8]. These basic assumptions are innately relevant to sexual and gender-based violence because traumatic experiences have the power to shatter existing beliefs and replace them with belief systems characterized by deception, betrayal, a loss of safety, helplessness, vulnerability, a restriction of freedom, diminished esteem, and isolation from others [6, 7].

When preexisting belief systems are challenged by a traumatic event, the survivor faces the struggle of reconciling pre-trauma and post-trauma beliefs. Survivors often make sense of traumatic belief systems through the process of assimilation or altering beliefs about the trauma to fit their preexisting beliefs about themselves and the world. For example, survivors may hold a preexisting belief in a "just world" (i.e., that bad things don't happen to good people). In an effort to uphold that belief, following objectively terrible traumatic experiences, survivors may begin to believe that they must be bad people [34, 36]. Alternatively, survivors may reconcile pre- and post-trauma belief systems by overaccommodating preexisting beliefs to make sense of what happened to them. For example, survivors who were victimized by trusted friends or acquaintances may adopt beliefs that no one can be trusted [37, 38]. The process of accommodation, or addressing apparent contradictions between pre- and post-trauma belief systems in a way that avoids broad generalizations and "all or nothing thinking," is a critical aspect of recovery from traumatic experiences. Trauma-focused therapies such as cognitive processing therapy often aim to increase accommodation, or make sense of discrepant pre- and post-trauma beliefs, while decreasing assimilation and overaccommodation [38].

## Social Reactions to Trauma

Sadly, survivors of sexual and gender-based violence often report significant feelings of shame and guilt, blaming themselves for their victimization and experiences, and questioning their self-worth.

Frequently, these reactions are reinforced by widespread cultural beliefs around sexual and gender-based violence such as rape myths (e.g., women who dress certain ways are "asking for it;" people frequently lie about being raped; it was not rape if either person had been drinking; men cannot be raped) and other negative societal messages (e.g., dismissing inappropriate sexual behavior as "boys will be boys" or "locker room talk"). These views are often reflected in media and popular culture with inaccurate representations of sexual violence (e.g., suggesting that rape is most commonly perpetrated by a stranger, implicating women's sexual history as a factor in victimization, romanticizing men aggressively pursuing "hard to get" women). If survivors decide to disclose their experiences of sexual and gender-based violence, they can face strong negative reactions that stem from these rape myths and negative societal messages. These negative social reactions to survivors' disclosures can significantly increase psychological distress, intensifying symptoms of PTSD, depression, and alcohol abuse [39–42].

Even survivors who choose to never disclose their experiences are not excluded from feeling the effects of negative social reactions—these negative messages can be internalized, increasing survivors' fear of judgment and feelings of guilt and shame [43]. In contrast, positive social reactions to disclosures, such as connecting survivors to helpful resources or offering emotional support, can aid survivors' ability to effectively cope with traumatic experiences [44]. Given the high risk of negative reactions and emotional distress following disclosure of sexual or gender-based violence, it is not surprising that many survivors disclose their experiences only to a small number of trusted others or choose not to disclose these experiences at all. Unfortunately, a decision not to disclose traumatic experiences comes with potential costs. Without disclosure, survivors may not have access to social support and tangible mental health and medical resources that could play a critical role in their recovery. Of course, decisions to disclose also come with high potential costs beyond the distress associated with negative social reactions. In some situations, including experiences of intimate partner violence or child abuse, disclosure may have direct implications for victims' safety.

Disclosure of traumatic victimizations that occur in occupation settings can result in threats to a victim's employment status and financial security.

The magnification of survivors' feelings of deep shame, guilt, and powerlessness, as a result of negative experiences during help-seeking, has been referred to as a "secondary victimization" following the assault [45]. For many survivors, invalidating reactions from others following a traumatic experience can be more distressing than the traumatic experience itself. However, positive experiences of disclosure and help-seeking can be critical steps toward long-term healing. When survivors are believed, treated with empathy and respect, and connected with the necessary services as a result of disclosure, this support from their social structures can benefit them in their recovery [45, 46]. For this reason, it is critical that victims who choose to disclose to informal systems of support (e.g., family members, friends) or formal systems of support (e.g., medical or mental health providers, legal systems) receive compassionate, validating responses.

## Physical Health Reactions to Trauma

In addition to the significant mental health consequences associated with experiences of sexual and gender-based violence, survivors of these experiences often experience a wide range of negative physical health consequences. Compared to those without an abuse history, people with a history of childhood sexual and physical abuse are more likely to report health problems such as difficulties with sleep, gastrointestinal problems, headaches, chest pain, and back or joint pain [47]. Survivors of intimate partner violence have been found to be at risk for chronic pain, digestive problems, headaches and migraines, back pain, sexually transmitted diseases, vaginal bleeding, vaginal infections, and abdominal pain [19, 48]. Additionally, women who have experienced any sexual violence are more likely than women without a history of violence to have asthma, irritable bowel syndrome, frequent headaches, chronic pain, and difficulty sleeping [16]. The same results were also found in men who had a history of any sexual violence compared to men with no history of violence [16]. Furthermore, sexual and gender-based violence is associated with poor overall physical health [16, 18] and a greater number of total health problems [19]. There also appears to be a dose-response effect. People who experience a greater number of traumatic events have a greater likelihood of experiencing poor physical health [47], and those who experience more frequent or severe violence have more physical health symptoms [48]. Research on the associations between traumatic experiences, mental health, and physical health is mixed. Some research suggests that the relationship between traumatic experiences and physical health symptoms can be explained by mental health symptoms, like PTSD [18]. Other research suggests that the number of traumatic events in a patient's history is related to poor physical health regardless of the level of mental health symptoms like PTSD symptomatology [49].

## The Trauma Survivor as a Patient

Given the frequency of sexual and gender-based violence, all medical providers care for people who have experienced sexual or gender-based violence, even if they are unaware that the patient is a survivor. Therefore, providing medical care that is informed by an understanding of the impact of sexual and gender-based violence on an individual is essential [50]. Medical providers and the systems in which they work can make modifications to create an environment that helps a survivor feel safe, respected, and empowered. Although not every patient who has experienced a sexual or gender-based trauma will disclose this experience to medical providers, having knowledge of patients' trauma histories can inform medical practices to help keep patients engaged in care. Trauma histories may help explain frustrating or confusing patient behaviors (e.g., not following treatment recommendations). Having knowledge of patients' histories may inform adaptations to clinician's exam techniques. Additionally, given that trauma survivors typically present to physical healthcare settings first, a trusted medical provider can potentially assess the need for and help bridge survivors to mental healthcare, assisting the patient in receiving the treatment that would be most beneficial for them.

Screening for current or past sexual and gender-based violence is important in routine medical care to potentially improve the health and well-being of patients [51]. It is wrong to assume that patients will volunteer information regarding their experiences of violence. While some may, many will not opt to disclose. Therefore, screening measures offer a routine way to assess for current and past experiences of violence in a way that maximizes disclosure from patients. Research suggests that patients are in support of routine screening for experiences of violence, although it is important that they are provided with options of how much and how to disclose [52, 53].

Some medical providers may feel uncomfortable discussing patients' experiences of violence. Providers may think these experiences are too personal or too difficult for patients to talk about. Well-meaning providers may worry about upsetting or retraumatizing their patients or may feel unsure of how to respond if patients disclose experiences of sexual or gender-based trauma. Raising these issues can also feel like opening "Pandora's box"—given the time constraints of many physicians, there may be concerns that one does not have enough time to thoroughly assess for history of or ongoing traumatic experiences. These concerns are generally alleviated with more practice discussing sexual and gender-based violence with patients. The most important response is relatively simple: maintaining a nonjudgmental approach and expressing empathy for the survivor. Patients may not be ready to disclose all of the details of their experience, or they may not be ready to leave an abusive situation. Allowing the patient to make decisions on how much they disclose or whether they would like a referral to other services communicates confidence that you, as a provider, believe that the patient is capable of making their own decisions. This increased sense of efficacy can provide the patient with a sense of control and help them engage more fully in their healthcare.

## Conclusion

Psychological trauma is defined by the DSM-5 [11] as "exposure to actual or threatened death, serious injury or sexual violation." Sexual and gender-based violence constitutes a type of psychological trauma with strong risks of mental and physical health problems [13–17]. Given the frequency of sexual and gender-based violence—44% of women and 25% of men in the United States are estimated to experience some form of sexual violence in their lifetime [20]—all medical providers will provide care for survivors of these experiences. Understanding how individuals are impacted by sexual and gender-based violence is a critical piece in providing trauma-informed care for survivors of these experiences.

Sexual and gender-based trauma can profoundly impact a person's life. It can challenge people's foundational beliefs about themselves, others, and the world [7], making it difficult to make sense of the traumatic experience and deeply altering the way survivors view their lives. Feelings of shame and guilt that are common in survivors of sexual and gender-based violence contribute to personal distress and, at times, a reluctance to disclose their experience of trauma. Additionally, many survivors avoid reminders of sexual and gender-based traumas leading to a restrictive day-to-day life. Seeking treatment through psychotherapy or medication can ameliorate trauma-related distress and mental health symptomatology.

Sexual and gender-based violence also may lead to poor physical health. Physicians and healthcare systems that provide care, informed by an understanding of the impact of traumatic experiences, can more effectively engage survivors in care. Routine screenings can assist physicians in identifying victims and survivors of sexual and gender-based violence in order to provide these patients with resources or referrals, adjust exam methods to account for the patients' experiences, and provide patients with general support. In this way, physicians play a critical role in systems of care for trauma survivors, representing a critical link in the chain that helps survivors to recover some of what has been taken from them.

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# 2

# Psychoeducation: Discussing Trauma with Patients

Josie Torielli

## Introduction

Trauma is best described as an experience that is perceived as life threatening. It includes fear, helplessness, and horror; involves an automatic body response geared toward survival; and has physical and emotional impacts which extend beyond the original event. With our evolving knowledge of trauma and human behavior, sexual violence has been identified as an experience with a high probability for trauma response and resultant trauma symptoms. In order to provide trauma-informed care and integrate it into their practice, healthcare providers should have an understanding of trauma and neurobiology. Providers should also be able to translate this knowledge into conversations with their patients. Proper use of language can be helpful in translating medical and psychological knowledge into dialogue with the patient. One of the central aspects of the experience of trauma is feelings of isolation and helplessness.

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By carefully incorporating mindful language into practice, medical providers can address this sense of aloneness, and seek to replace it with being seen, heard, felt, and understood.

The objective of this chapter is to increase mindful reflection on how medical professionals use trauma-informed language when interacting with patients. Language is an influential tool that can be triggering (increased symptoms of depression, negative self-regard, isolation) or stabilizing (increased sense of comfort, safety, belonging, understanding). The use of trauma-informed, empathic language can be one of the most powerful ways to increase a patient's sense of support, self-respect, and safety. When utilized mindfully and intentionally, it paves the way for a collaborative relationship, reduces shame, and promotes healing [1]. Increasing the patient's knowledge of trauma, the brain, and how these structures interact with present experiences of symptoms can shape their sense of ownership of their treatment and internalize the patient's feeling of being an expert in their own life and experiences.

This chapter will review specific themes related to psychoeducation. These themes are interspersed throughout the chapter, and summarized in Box 2.1.

**Box 2.1: Psychoeducation Themes Covered in This Chapter**

*Basic Trauma Themes*

- Theme 1: Fight, flight, and *freeze*
- Theme 2: Automatic response to trauma
- Theme 3: Body responses connect to survival
- Theme 4: Trauma is about experience, not exposure
- Theme 5: Symptoms of hyper- and hypo-arousal are normal

*Themes on the Patient-Provider Interaction*

- Theme 6: Messages of guilt, shame, and fault are common
- Theme 7: Messages of self-blame and shame can and should be addressed within the provider/patient relationship

Psychoeducation is an intervention that involves providing education and knowledge to those seeking medical and/or mental health care. It can include increasing understanding of common reactions to trauma, normalizing responses, discussing adjustment challenges, identifying symptoms, and exploring past and current coping skills. Traumatic events cannot be predicted or controlled; the ability to understand one's functioning and responses can contribute to a greater sense of mastery on the other side. While there are several methodologies used in psychoeducation, most practices involve supplying information, increasing support via medication and treatment, augmenting self-care and self-help, and creating an environment where it is acceptable to share emotional reactions. In contrast to a traditional medical model provision of care, psychoeducation "reflects a paradigm shift to a more holistic and competence-based approach, stressing health, collaboration, coping, and empowerment" [2].

## Basic Trauma Themes

The information being communicated can start with the following themes and topics within trauma. As providers gain comfort and utility with this way of working, and as the provider/patient relationship grows and expands, the topics can be limitless and can be determined by the dyad as part of the collaborative process.

### Theme 1: Fight, Flight, and ∗Freeze∗ (Table 2.1)

Many people are familiar with automatic survival responses within the animal kingdom. Assessment and response happen in less than a millisecond, and the response is automatic. Each of the responses involves nervous system response, and often, the survival mechanisms remain as trauma symptoms after the danger has passed. Survival responses are also present for humans experiencing fear, helplessness, and horror.

Freeze is highlighted above because human beings are evolutionarily wired to freeze first, giving time for the limbic structures

**Table 2.1** Fight, flight, and freeze responses

| Survival response | Concept | Potential behaviors |
|---|---|---|
| Fight | Defeating the threat | Increased adrenaline; anger; racing heart; clenched fists; increased activation; clenched jaw; tensed muscles |
| Flight | Leaving the threat | Anxiety; rapid and shallow breathing; nausea; vomiting; loose bowels; increased adrenaline |
| Freeze | Neutralizing the threat | Numbness; dissociation; feeling "out of the body"; sense of stiffness; heart pounding; sense of unreality; feeling stuck or frozen |

of the brain to organize for fight or flight. However, many people remain in freeze after a traumatic experience, and do not engage in fight or flight. This can and should be explained as an automatic response, one that is best designed for survival. Trauma survivors often feel shame around freeze response.

Within the freeze response, two subsets have been identified which can be common for sexual violence survivors. *Tonic immobility* can be indicated as an "extreme freeze" and often occurs within the context of fear. It has been described as a feeling of paralysis, stiffness, muteness, and the inability to move. *Collapsed immobility* can be conceptualized as a feeling of faintness, numbness, sleepiness, and loss of muscle tone/muscle slackness. Patients describing these reactions may benefit from conversation around their commonality and normalization of same. For example, people may not understand why someone would feel sleepy during a life-threatening event, and therefore may express doubt about the trauma or narrative. An explanation of collapsed immobility may help to bridge an understanding.

## Theme 2: The Response to Trauma is Automatic

It is chosen by the body and then the brain (in that order) in the interest of survival. Most trauma survivors experience shame about the ways in which their body and brain reacted and continues to react to their experience. For example, many survivors do not understand why they did not fight or call out for help *during* an assault. Most people have a belief that they would fight back against an assailant, and so many times, the internal belief of the survivor (that they failed to respond in the "right way") is reinforced by the people around them and the messages of society and culture. In addition, many survivors do not understand the ways in which their body can *continue* to react as though the trauma is still happening. Understanding that these reactions during and after are normal and dictated by automatic body functions can be immensely helpful in reducing shame. Providers can include basic information about the cortex, prefrontal cortex, and limbic systems of the brain, and how each is less/more active in instances where there is a threat to survival.

*Example (DURING): Patients and providers can think about a reflexive action that the body takes to protect itself. For example, if a person accidentally touches a hot kettle left on a stove, there is an automatic response of removing the hand from the heat. There is an immediate jerk back to avoid a burn. This action is not a cognitive decision that the individual makes but a reflexive response, chosen by the nervous system. If the person paused to think through the potential harms and responses, the burn could be more severe. The same reflexive, split-second, automatic response occurs during trauma. Before the thinking brain can be involved, the body and the nervous system have already taken the lead.*

## Theme 3: Body Responses Connect to Survival, Both During and After

When someone survives trauma, the automatic body response during the event is designed to sustain the life of the organism. These automatic responses are often experienced as symptoms following trauma. Responses of racing heartbeat, numbness in extremities, digestive shutdown, digestive discharge (vomit, defecation, urination), shortness of breath, and others are all body responses that are designed to support survival. These body responses enable the organism to prepare for fight, flight, or freeze. Responses correspond with surges in adrenaline, cortisol, or other survival-activated hormones. Following trauma, explicit triggers (being in the place where the trauma occurred), and hidden triggers (a similar light pattern or scent) can catalyze a trauma response sequence.

*Example: Trauma survivors often have systems that are wired for trauma, instead of everyday living. A survivor may have a lower threshold for entering a trauma response. A corresponding example: a smoke alarm that is equally reactive to burnt toast as it is to a 5-alarm fire. This does not mean that something is wrong with the survivor; it just means that they might need to develop strategies to help "reset the alarm."*

## Theme 4: Trauma is About the Experience, not the Exposure

In trauma, the experience (sensations, responses, reactions) of the person is more important than the exposure (the actual event itself). In other words, the effects of the trauma (during and after) have more impact than dissecting what happened. As a first step to addressing and healing trauma, it is essential to discuss and address the symptoms and experience of the person rather than to parse the timeline or details of the event. This theme attempts to address the tendency of trauma survivors (and those around them) to minimize the experience. It also addresses the human tendency to attempt to logically make meaning of the story of trauma, rather than to attend to the overwhelming feelings of loss of control and terror.

*Example: Two people can be pushed into a swimming pool. Person 1 can emerge laughing, chasing the person who pushed them, and thinking that this is a funny prank. Person 2 can emerge angry, upset, shut down, and/or activated. The exposure is the same (being pushed into a swimming pool), yet the experience is vastly different (joke versus activating event).*

## Theme 5: Symptoms of Hyper- and Hypo-arousal are Normal

Trauma survivors often experience symptoms that cluster between active and numbing. The stark difference between the two can often create feelings of dysregulation and of “being crazy.” Active symptoms (hyperarousal, intrusive thoughts, exaggerated startle response, etc.) and passive symptoms (numbing, avoidance, depression) are the hallmarks of trauma.

*Example: Patients and providers should work together to discuss the patient’s present symptoms and their impact on functioning. Rather than the discussion focusing on medical intervention, it can be helpful to first reach an understanding of why the symptoms are in place. Active symptoms, like rapid heartbeat, are connected into the body’s survival response. Heart-rate increasing is the body’s way of preparing for fight or flight. Passive symptoms are also connected to survival response. Dissociation can be the body and mind’s way of mediating the trauma. Numbness and depression can help the survivor avoid the experiences of the trauma and the pain that comes along with knowing. Trauma survivors can often be engaged in a struggle to both emphasize and exclaim their experiences, while at the same time wishing that they could forget.*

## Themes on the Patient-Provider Interaction

Providers can use this analogy: controlling and containing trauma symptoms is like trying to hold an inflated ball underneath water. It takes a lot of concentration and effort, and despite our best efforts, the ball (symptoms, reminders, memories) will eventually pop up.

## Theme 6: Messages of Guilt, Shame, and Fault are Common

When human beings experience a traumatic event, they universally go through a process of blaming themselves for its occurrence. Often this self-blame about actions (“I shouldn’t have trusted that person," "I should have been more careful") transforms from guilt to shame. Self-blame about behaviors (survival response) can be equally damaging. Examining and regretting actions can become a false belief about oneself (shame). Messages of guilt and shame can often be echoed and reinforced by a survivor's support system, by their culture, by their community, and by the everyday messages we hold about victimization and sexual violence. Victim blaming is common across all cultures, and can come from self and from others, which serves to internalize feelings of shame. Providers should listen carefully for messages of self-blame and seek to address these messages within a context of exploration.

*Example: Discussion of the reasons behind victim blaming can be helpful. Some people victim blame from a place of wanting to keep themselves "safe." If they can believe that the survivor brought their experience on themselves via their actions, they can avoid those actions to avoid the experience. The provider should take this approach to explore the context of victim blaming, without releasing the holder of these beliefs from their accountability. Victim blaming may come from a place of wanting safety; people are still responsible for not furthering these attitudes.*

## Theme 7: Messages of Self-blame and Shame Can and Should Be Addressed Within the Provider/Patient Relationship

Providers should be aware of signals around internalized self-blame and shame when they arise within the interaction. If we understand that isolation and loneliness are central aspects of trauma, acknowledging and addressing the instances when they arise can work toward undoing those feelings. Patients who share feelings of self-blame and shame are opening a door and exposing vulnerability. Providers who "walk through the door" will be much better able to establish an equal and collaborative relationship. Providers should spend some time reflecting upon their beliefs and biases, and recognizing where these might enter into the relationship in the form of questions or judgment. For example, does the provider have experience with victimization or violence that informs their current practice? If their responses were/are different, could there be judgment about the patient's coping? Do certain circumstances or identities engender more questions or doubt? Does the provider tend to respond to anxiety and helplessness with wanting to know "facts" about the assault? Above all, conversations about self-blame should resonate authentically with the provider and the patient.

- First, one must recognize how these feelings are communicated by the patient. As with all patient situations, experiences, and methods of coping are unique, methodology will vary. The provider's presence and observation will go a long way to determine how self-blame and shame show up for the patient.
- Next, the provider should verbalize what they've noticed. For example: "It sounds like you're blaming yourself for what happened. Is that what's happening? Can we talk more about that?"
- Next, careful listening about how the patient is making their experience their fault and reflecting for understanding. "So, what I hear you saying is that you went out and had drinks, and you're feeling like that made you responsible for this experience you had. Do I have that right?"
- *Validating*. Communicate understanding but also refute the faulty link. "I can understand why you'd make that connection, but to me, it sounds like you went out and had some drinks. That doesn't give anyone the right to do something to you without your consent."
- *Further validation*. "I'm really glad you told me this. How did it feel to talk about it with me?"

## Stance and Approach

As we approach the use of language within psychoeducation, it is vital to note the importance of all the types of communication possible during a provider/patient interaction. Along with refining skills in cognitive interventions (use of words, language, and creation of dialogue related to trauma), it is equally significant to consider power dynamics, presence, body language, and sense of humility that can take place within the dyad. *Power dynamic* refers to both the real and perceived identities of people within the communicative dyad. Traditionally, there is an imbalance in power within the provider/patient relationship because of the provider's identity as a caregiver and the patient's identity as a care recipient. Imbalance of power can also occur based upon the perceived/real identities of race, class, gender, socio-economic status, religion, and immigration status, to name a few. Psychoeducation seeks to mediate some of these undercurrents, but providers should be aware of how these dynamics play out when providing information to their patients. For example, patients may communicate understanding of the material to please the provider even if they have questions.

- *Presence* refers to the capacity of the provider to be present in the current moment with the patient. To the best of one's ability, this includes being free from distractions; aware of thoughts, feelings, and reactions; and noticing the responses of the patient, both verbalized and felt.
- *Body language* also relates to the presence of the provider. Is the provider mindful of what is being transmitted along with their words? This awareness is critically important as patients who have experienced trauma may be more sensitive to micro-signals, and thus more sensitive to nonverbal messages communicated by posture, stance, facial expression, eye contact, voice tone, and voice volume. Body language can easily be misread and misinterpreted, so transparent dialogue about what the provider and patient are noticing from the other is helpful.
- *Sense of humility* encompasses the provider's methodology and style in utilizing the tools of language and psychoeducation. A successful approach will include the unshakeable belief that the patient is the expert on their life and life experiences. The provider should come from a place of knowledge

as well as attuned curiosity. In choosing this frame, the provider's knowledge of trauma, symptomatology, and neurobiology is not something that is given to the patient. It includes room for the provider to make errors, to learn from the patient, and to have their ideas about symptoms and functioning be rejected by the patient. Within this construct, empowerment is a strength which arises naturally when attention is given to relationship dynamics. Within this frame, language is co-created with the patient, and the patient guides the interaction and outcomes.

## Basic Principles of Psychoeducation

In general, providers should consider the below-mentioned tenets as guiding principles of psychoeducation.

### Reduction of Shame

Guilt can be understood as "I did something wrong," and shame as "I *am* wrong." Providers need to be aware when shame pops up within the interaction. This may be indicated by patient presentation: a shift in eye contact, posture, language, or presence. It can be verbalized as "I am stupid/bad/ugly/unworthy." Providers should address the differences between guilt and shame, thus teasing out what feelings are related to actions and what feelings are related to core feelings about self. Mindful language seeks to reduce shame.

Within an attuned dyad, providers encourage the patient's expression of shame—simply verbalizing its existence can reduce its power. What remains hidden remains triggering. The provider can name the appearance of shame, along with normalizing the instinct to keep it hidden. The provider can name the universality of shame; it is an element present within all people. Providers are not engaging in an argument to eradicate shame, but working to create a space where this emotion is accepted, noticed, and explored.

Finally, providers can discuss shifting the shame from the patient to the person who harmed them, for example: “It sounds like you believe that you are a bad person because of what X did to you. Those feelings are normal, and I hear them from a lot of people that I work with. I wonder if you think it would be helpful to explore how to separate the things that happened to you from the person who you are?”

## Titration of Information

Providers should pay attention to how psychoeducation is being absorbed and internalized. Is the patient responding with a sense of relief? Asking questions? Looking confused? Providers should note the patient’s reaction and response to the material and ask clarifying questions if needed. One such area is the amount of information presented. Is there too much information? Too little? How does the patient prefer to discuss the material? Would visual aids or a different way of explaining be helpful? Most of all, providers should strive to remain in sync with the patient to determine how the information is being understood.

## Use the Language of the Patient, Not of Pathology or Disorder

Think about the difference between describing someone as a “sexual assault patient” and a “patient with experiences of sexual assault.” Within the first frame, the patient is defined by the thing that happened to them. The sexual assault is the whole of their being. The second frame allows room for other parts of the patient to emerge. Providers will not be able to eliminate the fact that patients have experienced traumatic events, but they can have an impact in not having those events define the patient’s life. Working in this way allows room for the whole person.

## Think About Diagnoses Within a Frame of Helpfulness (or not) with the Patient

Some patients may find it helpful to understand their symptoms as fitting within the context of post-traumatic stress disorder (PTSD) rather than experiencing them as random and unexplainable. Others may resist the label of a mental health diagnosis, due to related stigmas associated with mental health conditions and/or previous experiences of misdiagnoses and misunderstanding within the health system.

## If You Make a Mistake, Apologize and Mindfully Move Along

If your language upsets/hurts/alienates/offends the patient, notice and start a dialogue about how to get it right. If the provider is grounded in the present moment, they will be able to notice the reaction(s) of the patient even if the error is not verbalized. For example, if the provider begins to discuss the patient's symptoms within a diagnostic framework, and the patient becomes more silent and crosses their arms, this may be a signal that the information is not helpful. In this case, the provider can gently call out the noticed behavior and offer that the frame may not fit. To work in this way, the provider must be aware of their own attachment to the patient's acceptance. The provider should anticipate their response to interventions being rejected or discarded, and strategize as to how this might impact the relationship.

## If the Patient Closes off (Shift in Body Language, Affect, Speech, or Contact), Notice and Discuss

It is quite normal for trauma survivors to shut down in this way. According to Judith Herman, "The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma" [3]. Sometimes, the provider is bumping up against the patient's wish to forget. The provider can bring awareness to the context of a shift in affect. For example, the provider should note if there is a change when particular material or language is used, and then vocalize the pattern by saying, "I'm noticing that when I ask about your mood, you become quiet. Is this a subject that is hard to talk about?" or "I notice that when I talk about trauma symptoms, you look down. I'm wondering if this information isn't helping, or if there is a different way for us to talk about it?"

## Embolden Curiosity

Use the language of exploration and seek to increase curiosity when thinking about trauma. Allow yourself and the patient to wonder: explore new narratives, new ways of thinking, new ways of being together in the treatment space, and new ways of developing your relationship. Use of the phrase "I wonder…" or "Could we talk about…" can open the door to exploration. Often, when we are uncovering layers of experiences, self-blame and shame can present as barriers to delving into other ways of thinking. This might sound like: "Up to now, you've talked about not fighting back during the assault as something that you did wrong. I wonder what it would be like to look at that as a necessary and biological response that helped you to survive."

## Minimize Surprise Within the Provider/Patient Relationship

This can be both a stated intent and expressed as a way of working together. What it can sound like is: "Part of what makes trauma so difficult is that it is an experience that overwhelms and takes us by surprise. There is no way to prepare for trauma. I want to avoid duplicating that experience when we are working together, so I will do my best to check in with you before each intervention that I'd like to try. What do you think about that?"

What it can look like is: consistently knocking and asking for permission to enter before coming into a treatment room; asking permission before examining the body; explaining procedures and giving time for questions; providing warning and explanation of touch or sensations during an exam; and allowing the patient time to prepare and adjust before an exam.

### Consider the Patient as a Whole Person, Not Only a Survivor

Allow for the experience(s) of trauma being one part of the narrative, rather than the whole narrative. Sexual and gender-based violence trauma has deep, lasting impacts. However, providers can make room for other feelings and emotions.

Above all, providers can frame their approach while keeping this idea in mind: “An exchange of empathy provides an entry point for a lot of people to see what healing feels like” [4].

## Working with Patient Reactions in the Moment

Despite provider’s best practice and intention, patients may become activated within the interaction. Reminders of the trauma, both physical and cognitive, can trigger a negative response. As noted repeatedly above, a provider who is engaged and aware will notice such reactions. Perhaps the most familiar and expected are outward expressions of distress: crying or shaking, or even anger. Some patients may demonstrate withdrawal or blankness, perhaps a mirroring of the freeze response activated during the trauma. Others may express no noticeable outward expression, but providers may note a feeling of emptiness—that the patient has somehow “left” the encounter even though physically present. These occurrences are normal, and can be a way to introduce the concept of grounding. The sequence can be understood and processed as follows:

- The provider notes trauma response, and verbalizes “I’m noticing that you’re [insert response]. How are you feeling?”
- If patient confirms activation, the provider asks “Could we try something together to help you feel more present/grounded/here/peaceful?”

- If there is consent, the provider leads the patient through a grounding exercise.

  "Can you name *5 things* that you *see* right now?"
  "Can you name *4 things* that you *hear* right now?"
  "Can you name *3 things* that you *feel/touch* right now?"
  "Can you name *2 things* that you *smell* right now?"
  "Can you tell me *1 good thing about yourself*?"

- The provider checks in with the patient: "How was that exercise? How are you feeling? Any different than before?"
- If the patient expresses a difference in mood/feeling/affect, the provider can explain grounding. "We just did an exercise to help you feel more grounded. Often, when people are reminded of trauma, their brain and body work to protect them. Sometimes it can feel like the trauma is happening all over again. Grounding is a way to be more in the present time—and to remind us that we are here and that the trauma is not currently happening."
- The provider and patient can talk about the exercise, and explore its use outside of the clinical encounter.

The provider should come up with a way of discussing grounding that fits with their language and feels authentic. Providers and patients can explore ways of grounding that fit with the patient's life. Grounding can be accomplished by feeling one's feet on the floor, holding a cold object (like ice), naming objects (US states in alphabetical order, favorite movies), or registering sights, sounds, taste.

## Ways to Explain Trauma Therapy and Provide a Referral

While discussing and addressing trauma symptoms and healing within the medical encounter is helpful and necessary, providers do not need to work this way on their own. Collaborative and supportive counseling/therapy can be very helpful for survivors.

A skilled, trauma-informed therapist can continue the work of addressing and healing trauma symptoms, develop healing and stabilization techniques, activate or enhance the survivors' support system, and process traumatic memories (when appropriate and when the survivor is equipped with coping mechanisms). Perhaps the fundamental work of trauma therapy and recovery is to *decentralize* the story of what happened to someone; to help the survivor understand that the trauma is not the totality of their being. Effective trauma therapy encourages other stories and parts of the person emerge. It encourages joy, connection, balance, and compassion. It allows for pain to be expressed and recognizes areas of feeling stuck.

Providers should research and connect with appropriate resources for referral. Often, a referral is most impactful if the provider has experience and a connection with the therapist. The provider should also develop a way of offering the referral in ways that don't stigmatize the patient. This might sound like: "I'm really glad that you've shared your experiences with me, and that you've trusted me with this information. Many of the people I've worked with have found counseling to be very helpful to continue to understand their responses and reactions to trauma, and to heal from it. Would you like a referral to someone who I think would be a good match for addressing what you've described?" Providers should be prepared to discuss patient's feelings of being viewed as overwhelming, or feeling "crazy," or feeling rejected by the provider. Sometimes the patient will want to only work on trauma response with the medical provider, or the patient has experienced previous negative responses from counselors/therapists/helping systems.

Providers often have a wealth of knowledge about trauma, from both their studies and practice experience. This information, when applied mindfully and consistently, can catalyze meaningful shifts in relational work with patients. When providers engage in trauma-informed work, they are starting a pathway to emotional recovery. Shining light on sexual violence and recovery is necessary and long overdue.

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# Part II

# Context-Specific Trauma

# 3

# Intimate Partner Violence and the Training of Healthcare Providers

Sandolsam Cha

## Background

Intimate partner violence (IPV) is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation, and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other [1]. Reproductive coercion (RC) and sexual coercion (SC) are forms of abuse that intersect with IPV. They involve behaviors aimed to maintain power and control in a relationship related to reproductive health (i.e., birth control sabotage, pressuring someone to become pregnant or to terminate a pregnancy) or related to types of sexual violence, such as rape, threatening to end a relationship if a person does not have sex, intentionally exposing a partner to a STI or HIV, or retaliation by a partner if notified of a positive STD result [1].

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The prevalence of intimate partner violence (IPV), reproductive coercion, and sexual coercion in the USA is astonishingly high. According to Breiding et al., approximately 1 in 4 women have been physically and/or sexually assaulted by a current or former partner [2].

A substantial body of research has previously described the impact of IPV on women's health. IPV can most visibly lead to direct injury or death, or cause emotional and psychological distress. However, the impact of IPV is far more wide reaching. IPV has been associated with adverse obstetrical health outcomes, such as poor pregnancy, weight gain, chronic anemia, tobacco use, stillbirth, pelvic fracture, placental abruption, fetal injury, preterm delivery, and low birth weight [3–6].

In a systematic review of the impact of IPV on sexual health, IPV was consistently associated with sexual risk taking, inconsistent condom use, partner nonmonogamy, unplanned pregnancies, induced abortions, STIs, and sexual dysfunction [7]. In fact, in a study from Australia, IPV was found to be responsible for 7.9% of the overall disease burden for women aged 18–44; this is a larger risk factor for disease than elevated blood pressure, tobacco use, or obesity [8]. IPV costs the US economy $12.6 billion dollars on an annual basis from hospitalizations, ED visits, and indirect costs to healthcare [9].

Given these staggering impacts on the individual IPV survivor, as well as society as a whole, the silent epidemic of intimate partner violence is being recognized as a public health crisis. As such, a public health framework for addressing IPV means that this is not just an issue for a specific "silo"—law enforcement, healthcare system, community service organizations, social services. Rather, every specialist and nonspecialist that may potentially come in contact with an IPV survivor should at least have a basic understanding of how to look for it, how to address it, and how to effectively communicate among partners in this work.

Obstetricians and gynecologists are in a unique position to screen and to provide support for women who experience IPV, due to the nature of the patient-physician relationship and the opportunities for intervention that occur during the course of pregnancy, family planning, annual gynecological exams, and other women's health visits. However, according to LaPlante et al. [10], while 100% of OB/GYN residents surveyed felt prepared to counsel patients on smoking, diet, and exercise, only 9% felt prepared to counsel on IPV. Moreover, less than half felt prepared to ask their patients about reproductive coercion or contraceptive sabotage, give a referral, or call a hotline with a patient [11].

What is preventing providers from effectively addressing IPV? There are many barriers that have been identified:

- Comfort levels with initiating conversations with patients about IPV
- Feelings of frustration with patients when they do not follow a plan of care
- Not knowing what to do about positive disclosures of abuse
- Worry about mandatory reporting
- Lack of time

There are several ways to address these barriers:

1. Using tools like safety cards: Safety cards, such as the one available at Futures Without Violence, are easy-to-carry cards designed by IPV experts that can be used to facilitate screening. The safety card, titled, "Is your relationship affecting your health?," shifts the focus of screening from just checking off boxes as a part of taking the social history, to the reason why talking about healthy relationships matter, and why it should come from a healthcare provider. In addition, safety cards contain the number for a 24-hour hotline, and even if the patient is not currently experiencing IPV, extra cards can be given to be shared with patients' family and friends, thereby normalizing screening and empowering patients.
2. Simplifying the idea of reporting and documenting: most states do *not* mandate that you report intimate partner violence against a competent adult over the age of 18. The one exception to this would be if an act of violence occurred with deadly weapons, including firearms, knives, or burn injuries. A provider should document the response given to screening,

interventions used, and plans for follow-up, as one would for any issue that arises during an office visit.

3. Knowing the basics of risk reduction strategies: Even though healthcare providers may not be experts in IPV, understanding the basic concepts behind risk reduction strategies can be helpful. These include forming safety plans specific to the patient's situation, recommending discrete methods of contraception, providing the office phone (so that it can't be traced) to contact local community resources, and even providing blank envelopes to conceal emergency contraceptive pills.
4. "Warm referrals" to social work: Providers should not stop at an order in EMR; go a step further to characterize the IPV situation as thoroughly as possible for the social worker, as one would for consulting any expert. This ensures that the transition from the provider's care in the office to resources in the community.

Providers need easily accessible training materials to learn about the above elements so that addressing IPV is demystified. Futures Without Violence is one place to start, where providers can order as many safety cards as they need and can access numerous helpful guides.

SAIF (Screen-Assess-Intervene-Follow Up) is a workshop built on the backbone of Futures Without Violence safety cards, in order to break down the barriers as described above. In the following sections, the contents of the SAIF curriculum will be described, followed by discussion of effective strategies of training students and healthcare providers in an interactive classroom setting.

## SAIF Curriculum Content

The Screen-Assess-Intervene-Follow Up (SAIF) curriculum to address intimate partner violence is a project developed by healthcare providers in training, for healthcare providers in training (resident physicians and medical students). In particular, it was created with obstetricians and gynecologists in mind. However, this can be broadly applied to anyone who works with potential

IPV survivors. The curriculum is at most 2 hours in length, and does not require specialized pre-training in IPV for the organizer or leader in order to be meaningful.

The learning objectives are:

- Understand the scope of the problem for intimate partner violence (IPV), reproductive coercion, and sexual coercion.
- Understand the health impacts of IPV.
- Identify barriers to managing IPV and address them.
- Learn to screen, assess, intervene, and follow up on IPV

After 30–40 minutes of discussing the scope of the problem and the barriers to care in addressing intimate partner violence, the SAIF curriculum breaks down the daunting and sensitive task of addressing IPV into discrete and practical parts that are easy to remember. Much of the content is based on a second edition of the guide, *Addressing Intimate Partner Violence, Reproductive and Sexual Coercion: A Guide for Obstetric, Gynecologic and Reproductive Health Care Settings* by Dr. Linda Chamberlain and Rebecca Levenson at Futures Without Violence [12], but has been rearranged for a workshop format. The core contents of the workshop are shared in the following sections.

## Screen

### Framing Statements

The first step of screening is hardest to take. Providers may feel awkward asking probing questions about their patient's relationship and current and/or past history of physical, emotional, or sexual trauma. One way to circumvent this is to use the language of *healthy relationships:* "I want to ask you questions about your relationship because your relationship can really affect your health."

Statements such as "I ask all my patients these questions about healthy and safe relationships because it can have such a large impact on your health" can also normalize the conversation and clearly demonstrate that this is an important health topic to address during a visit to the healthcare provider.

## Limits of Confidentiality

When addressing an issue as sensitive as IPV, it’s important to reassure the patient at the start of the encounter that everything discussed is confidential. However, there are situations in which the provider is mandated to report, such as abuse of a minor, or injury with a firearm, knife, other deadly weapons, and burns. Mandated reporting criteria may differ slightly from state to state.

These limits of confidentiality should be addressed at the beginning of the clinical encounter, because if a patient discloses an event that requires reporting and the provider follows through with mandated report without first informing them of the limits of confidentiality, it may extinguish any hope of a therapeutic alliance. Survivors of IPV are in a relationship where there is an unequal power dynamic, and their agency may be taken away from them. If the provider takes steps to report against the wishes of the survivor, agency is further eroded away and there cannot be a therapeutic alliance.

## Screening Questions

It can be jarring and uncomfortable to jump into a screening question for intimate partner violence during the clinical encounter. Often this part of the history is in the midst of questions on substance use and sexual history which further creates an atmosphere of an inquisition of sorts. To alleviate these challenges, one can utilize the safety card as a simple information handout like any other found in the clinic, paired with the phrase, “we like to give everyone these cards” to normalize the screening process.

The title of the safety card is “Is your relationship affecting your health?” The content of the card goes on further to ask, “Is my partner or the person I am seeing kind to me and respectful of my choice? Is my partner willing to talk openly when there are problems? Does my partner give me space to spend time with other people?" On the next side, attributes of unhealthy relationships are described: "Are there times my partner or the person I'm seeing shames or humiliates me, makes me feel bad about myself, or controls where I go and how I spend my money? Ever hurts or scares me with their words or actions? Makes me have sex when I don't want to? Keeps me from seeing my doctor or taking my medications?" [12].

These questions can start a conversation about what a healthy or an unhealthy relationship looks like. Although at first glance the concept of a respectful, healthy relationship may seem obvious, the healthcare provider may in fact be the first person to be talking about healthy relationships in such explicit manner. This act itself can be an intervention.

There are numerous other tools that have been used in IPV screening. Many, like the safety card, purposely ask broad questions regarding an intimate relationship, while others focus on specific actions. An example of a screening tool that asks pointed questions is HITS (Hurt, Insult, Threaten, and Scream):

- How often does your partner physically *H*urt you?
- How often does your partner *I*nsult or talk down to you?
- How often does your partner *T*hreaten you with physical harm?
- How often does your partner *S*cream or curse at you?

Each question is answered in a 5-point scale (1 = never, 2 = rarely, 3 = sometimes, 4 = fairly often, 5 = frequently). In previous research, a HITS cut off score 10 or greater was used to classify participants as "victimized" [13, 14]. The downside of this tool is that it may be too narrowly focused on physical forms of IPV and neglects to screen for sexual or reproductive coercion.

The advantage of such directed survey tools is that they could also be utilized in paper format in the waiting room—similar to PHQ2 for depression screening. Given concerns about who could be accompanying the patient in the waiting room, there are different methods (such as color-coded stickers) to signal a positive screen in a clandestine manner.

## How Often, When, Where

Following guidelines from the American College of Obstetricians and Gynecologists (AOCG), every patient should be screened at least annually, and in particular in the following kinds of visits:

- Obstetrical visits
  - First prenatal visits
  - At least once per trimester
  - Postpartum visits
- Gynecologic visits
  - Annual visits
  - Sexually transmitted illnesses screening visits
  - Repeat pregnancy test requests
  - Family planning visits

Because violence can escalate or be unmasked during pregnancy (as a particularly vulnerable situation for a patient), there should be repeat screenings at least once per trimester even if the initial screen on a new OB visit is negative.

Lastly, it's important to note the physical space in which the screening takes place. Patients must be screened in private, without family members or friends present, even if the patient appears to give permission for them to stay in the room. It goes without saying that if translation is required, family members or friends cannot be used to translate.

## Assess

It's important to have an idea of how to initially respond, even if there appears to be dismissal or resistance from the patient, and move the conversation forward. Being prepared with this step—the initial assessment—can allow providers to also be more comfortable with screening in the first place.

Different types of IPV may be disclosed (physical or emotional abuse, sexual coercion, reproductive coercion), and oftentimes more than one form of IPV is occurring concurrently. Characterization of IPV is therefore essential to address the issue holistically.

## Negative Response (Does Not Endorse IPV Situation)

A negative response to screening is still an opportunity to raise awareness and to empower the patient to reach out to friends and family who may be experiencing IPV. Patients can keep the safety card that was used to start the conversation and pass it along to someone they want to reach out to. Using this framework of helping others also normalizes the conversation about healthy relationships.

## Unclear Response

At times, a patient may not disclose an IPV relationship, but something may feel “off.” It’s important to convey to the patient that the provider’s door is open for future conversations. The goal of screening is not to force a disclosure, but to start the conversation. Like in a negative response, safety cards should be handed out so that patients can learn about the harmful effects of IPV and risk-reduction strategies without needing to disclose.

The safety card also contains the number for the National Domestic Violence Hotline, available 24/7 (1-800-799-SAFE), as well as a crisis text line (text “START” to 741741) where trained counselors are available. Such methods can be another way for the survivor to seek assistance in safety planning, resources, and support at a time of their own choosing.

## Positive Response

The very first and foremost step when faced with a positive disclosure is to simply pause and *believe*. At first glance, the concept may seem too obvious or simple. Countless stories of IPV survivors share a commonality in not being believed, which further makes disclosures difficult, for the fear of not being believed. Survivors encounter dismissive attitudes from people who are supposedly there to help them—including healthcare providers—who may consciously or subconsciously shift to victim blaming, even before a word is uttered by a survivor. Implicit biases and society's concept of what a "good victim" should look like—meek, innocent, waiting to be rescued—color one's perceptions, and when an IPV survivor does not seem to fit this picture, it is easy to be dismissive, even in part, or in subtle body language.

Therefore, it is of critical importance to acknowledge and to truly *hear* a positive disclosure, to explicitly express, "I believe you. I am here to support you without judgment." It's important to be comfortable with giving pause, and not rushing into the next steps to check off boxes or to call social work in a haste attempt to take a challenging case off of one's hands. Only with a careful, nonjudgmental, and validating stance, can one allow the door that's beginning to crack open to stay open.

The next steps are to characterize the IPV. If the nature of IPV that is disclosed is physical violence, there should be an assessment of immediate safety. The following questions must be asked:

- "Are you in immediate danger?"
- "Is your partner at the health facility now?"
- "Do you want to (or have to) go home with your partner?"
- "Do you have somewhere safe to go?"
- "Has the violence gotten worse or is it getting scarier? Is it happening more often?"

Through this initial assessment, necessary steps can be taken for the patient's immediate safety. Every clinic or hospital should have policies and plans in place to be able to escort the patient through an alternate route if the patient does not want to leave the clinic with the partner.

These series of questions should be followed by questions to assess the pattern of abuse:

- "How long has the violence been going on?"
- "Have you ever been hospitalized because of the abuse?"
- "Can you tell me about your most serious event?"

IPV is often not a one-time event. It is a pattern of abuse, and as such, once the immediate situation is discussed, the full history of the IPV relationship should also be explored.

Lastly, there are specific questions that should be asked regarding reproductive and sexual coercion:

- “Does your partner support you in using birth control?”
- “Does your partner ever refuse to use condoms when you ask?
- “Have you ever hidden birth control from your partner?”
- “Does your partner support your decisions about if or when you want to have (more) children?”
- “Has your partner told you they would leave you if you didn’t get pregnant?”
- “Has your partner told you they would have a baby with someone else if you didn’t get pregnant?”
- “Does your partner force you to have sex when you don’t want to?”
- “Are you afraid your partner would hurt you if you told them that you had an STI and they needed to be treated too?”

When discussing sexual coercion, it should be noted that patients may not respond to the use of the term “rape” because of the perception that perpetrators of rape are strangers, and not an intimate partner. More general terms such as “forced sex” or “sex when you don’t want to” may be more appropriate.

## Intervene

Once the provider has assessed the situation, there are basic interventions that can be done in partnership with the clinic, hospital, or community resources and a social worker to help navigate those resources.

Many of these interventions are “risk reduction strategies,” that is, actions that can be taken to decrease the chance of physical harm, and discrete methods of contraception for those experiencing reproductive coercion.

## Safety Planning

A safety plan is a set of actions that can help lower the risk of physical harm from the abusive partner. The plans should be tailored to the survivor's individual situation, and be made for home, school, work place, or other locations that the survivor may frequent.

A sample safety plan may contain the following elements:

- Safety at home
  - Cash, extra keys, important documents
  - Escape plans
  - Who to call and where to go in a volatile situation
- Safety at work/public place
  - A copy of an order of protection
  - Knowledge by building security
- Safety plan involving children
  - Code words for calling 911 or escaping
  - Authorized persons to pick up from day-care
- Technology and safety
  - Don't forget phone bills
  - Use public computers (library, internet café, etc.)

Ideally, an expert in IPV should be conducting safety planning with the patient face-to-face. If this is not an option, there is a mobile application called myPlan. This app not only has elements similar to the safety card—screening questionnaire, assessment tool, educational resources on healthy relationships—but also a self-guided tool to craft a personalized safety plan. The app is pin-protected, and can masquerade as a different app at the touch of a button.

What follows are four risk reduction tips highlighted in the SAIF curriculum.

Risk reduction tip #1:

- Offer use of a private phone in clinic so that the survivor can make the call to an advocacy program without the number being traced by their partner.

Risk reduction tip #2: Sexually transmitted infection (STI) notification.

- Disclosing a positive STI result can escalate violence in a volatile IPV relationship. Instead of asking the patient to disclose the positive result, the provider can offer to have the health department call the partner anonymously, saying that someone the partner has slept with in the past year has (name of STI) and the partner needs to be treated.

Risk reduction tip #3: The IUD

- Some controlling partners may monitor bleeding patterns and menstrual cycles.
- The safest option may be the copper T IUD (Paragard) as it does not change their cycles.
- Consider cutting strings short in the cervical canal so that the device can't be detected by partner.
- Difficult IUD removal is preferable to an IPV situation becoming more dangerous.

Risk reduction tip #4: Emergency contraception

- Emergency contraception (EC) comes in a large box with bold lettering and can easily be discovered.
- Consider strategies such as giving them an envelope so that remove the EC from package and conceal it.

## Follow-Up

At least one follow-up appointment (or referral) with a healthcare provider, social worker, or IPV advocate should be offered after disclosure. An important aspect of setting up a follow-up appointment is that many clinics or hospital systems have automated reminder calls regarding upcoming appointments, which may not be safe to leave as a voicemail on a survivor's phone. Therefore, it is critical that the patient’s phone numbers are reviewed while the patient is with the provider to ensure that it is a safe number to call or leave a message. Similarly, automated letters to home addresses must not be overlooked. The following clarifying questions are suggested:

- “Is there a number or address that is safe to use to contact you?”
- “Are there days or hours when we can reach you alone?”
- “Is it safe for us to make an appointment reminder call?”

When the patient returns to the office, review the medical record. Let the patient know that you are still concerned for their health and safety and ask the following questions:

- “Have you sought counseling, a support group or other assistance?”
- “Has there been any escalation in the severity or frequency of the abuse?”
- “Have you developed or used a safety plan?”
- “Have you informed any family or friends about the abuse?”
- “Have you talked with your children about the abuse and what to do to stay safe?”

## Documentation

In most states, there are no specific requirements for documentation of a clinic encounter related to IPV. Take note of the mandatory reporting rules of your state.

Routinely, the following should be documented:

- Confirmation that the patient was screened for IPV and reproductive/sexual coercion
- Patient response to screening
- Documentation of resources provided (such as safety cards)
- Any referrals provided

## SAIF Curriculum Design and Implementation

As discussed thus far, the content of the SAIF curriculum focuses on the practical steps, and the integration of a specific tool—the safety card—to address IPV. As such, the content presented in the previous section is not something that can be effectively conveyed via a handout or a dry PowerPoint presentation. There are seven key elements to the curriculum to increase its meaningfulness and utility.

1. Flipped classroom methods: The concept of flipped classroom has taken off in recent years, predominantly in undergraduate medical education. In the flipped classroom approach, there are pre-class materials such as articles or videos that the participants should review prior to the workshop. The first few minutes of the workshop quickly review these basic materials, so that the rest of the session can focus on discussions and hands-on activities that build on the basics. SAIF incorporates audience response systems to review basic concepts within the first few minutes. This way, the speaker can also gauge how prepared and knowledgeable the participants are. The concepts polled were:

    (a) Have you ever met a patient experiencing IPV?
    (b) Definition of IPV
    (c) Health impacts of IPV
    (d) Prevalence of IPV
    (e) Impact of speaking to patients about IPV

2. Hands-on practice with Safety Cards and role-playing: Becoming familiar with the Futures Without Violence Safety Cards is at the crux of the SAIF workshop. As such, almost 10 minutes are spent on pairing up and taking turns going through the cards, practicing screening, framing statements, risk reduction strategies outlined on the cards, and the hotline.
3. Video of an example clinical encounter versus actor: Woven into role playing exercise is a video of a clinical encounter

using the safety card, available from Futures Without Violence. The participants have an opportunity to compare how they use the safety cards with another provider interacting with a standardized patient. Group discussions take place with critiques of the video.

4. Group discussions: Throughout the workshop, there are opportunities for the participants to share about their previous experiences with survivors of IPV, to voice the barriers they have faced and possible solutions.
5. Protected time: If the participants are medical residents (also called "house staff"), finding a block of time in their workday is exceedingly difficult. Any resident didactics or formalized training sessions run into the same issue, but for a topic as sensitive as IPV, such a workshop cannot be rushed, truncated, or interrupted. There should be break time built into the workshop so that participants can take a physical and emotional break from the subject. Other IPV training curriculums are often whole days or at least half days with multiple breaks and exercises built in to support the emotional wellbeing of their participants.
6. Location-specific hospital/community resources: Not knowing about what services are available at the hospital or community level is a significant barrier in itself. Thus, it is incredibly valuable to invite guest speakers from local community resources or hospital social work departments. Not only are their insights enriching to the conversation, the relationship-building that occurs through the workshop means that participants are now aware of their allies on a personal level, and therefore are able to refer their patients with confidence.
7. Pre-/post-surveys: Subjective and objective measurements must be made to validate the workshop, to continue to improve the educational experienced based on feedback, and use the data collected to demonstrate the need for long-term sustainability of the workshop. Subjective measurements often involve surveying the participants through pre-/post-surveys.

    (a) Ideally, obtaining a pre-workshop survey ahead of time would allow the speaker or workshop leader to have a sense of the backgrounds of the participants, but if that is not feasible, administering the pre-workshop survey at the start of the workshop would be needed. The SAIF workshop then administered a post-workshop survey within 1 week of the workshop to gather changes in knowledge, opinions, self-reported behaviors, and feedback regarding the workshop. Six months later, another post-workshop survey was conducted, this time focused more on self-reported behaviors and experiences in the months following the workshop.

(b) In addition, objective measurements of the impact of the workshop include number of patients screened, number of interventions offered, volume of referrals, and the change in patient experience as a result of a healthcare provider more attuned to this issue. While it is more challenging to collect such data, these objective measurements are often more illuminating and impactful to observe than subjective measurements from surveys of workshop participants.

## Evaluation of the Workshop

Curriculum evaluation is an integral part of the training. As mentioned above, in order to assess the impact of this curriculum on the competence and comfort that providers have with IVP, SAIF workshop utilized pre-/post-workshop surveys. Fortunately, there are pre-existing, validated surveys, such as the Physician Readiness to Manage Intimate Partner Violence Survey (PREMIS), a 15-minute survey developed by the CDC and other experts in the field [15].

PREMIS comprehensively and reliably measures physician readiness to manage IPV, and has been validated (Cronbachs $\alpha \geq 0.65$). It is broken down into four sections:

1. Background (3 questions)
   (a) Previous IPV training?
   (b) How prepared do you feel in managing IPV?
   (c) How much do you think you know about IPV?

2. Factual knowledge (8 questions)
3. Opinions and attitudes (27 questions)
4. Practical issues, i.e., resources available in clinic (13 questions)

The PREMIS should be administered as a pre-test prior to the start of the workshop. After the curriculum, the same PREMIS can be administered and collected as an immediate post-test. Three to six months after the curriculum, PREMIS can be re-administered for long-term follow-up. In order to allow for Wilcoxon signed-rank test, each participant should be self-assigned with an anonymous study ID which should remain consistent through the three surveys.

The immediate post-testing can be expanded with an acceptability survey to gather feedback. Potential questions to include are:

- Overall satisfaction
- Satisfaction with training materials/didactics
- Satisfaction with time allotted
- Would the participant recommend the curriculum to another provider
- Free text for comments

PREMIS is not a perfect tool. There are terminologies that are outdated (such as the word “batterer”) and many will find its length to be prohibitively long. For these reasons, SAIF curriculum modified PREMIS to choose questions that were felt to be most meaningful, while retaining the overarching structure of background, knowledge, opinions/attitudes, and practical issues.

## Conclusion

The public health crisis of intimate partner violence requires a public health approach of multidisciplinary, concerted efforts to address IPV. Like any other public health issue, only when we address intimate partner violence together—and not in isolated silos—can we truly make an impact.

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# 4

# Reducing Barriers to Medical Care for Survivors of Commercial Sexual Exploitation

Ane Mathieson and Anjilee Dodge

## Introduction

### Definitions

Commercial sexual exploitation (CSE) is a form of sexual abuse, gender-based violence, and sex discrimination with significant implications for public health and social equity. CSE is a global

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The authors would like to thank the interviewees who contributed extensive and invaluable knowledge and expertise to this article. The authors of this chapter conducted ten interviews with Survivor Leaders, advocates, service providers, experts, and activists, many of whom are leaders within the field of commercial sexual exploitation. Interviewees reflected on the barriers CSE survivors face when seeking medical care and strategies for reducing these barriers. From these interviews, seven primary themes arose as CSE-specific areas requiring physician attention. The authors would like to express their deepest gratitude to Trisha Baptie, Alisa Bernard, Marie DeLeon, Melissa Farley, Ph.D., Lexxie Jackson, Martha Linehan, Marin Malisa, Chelsea Olsen, Cherry Smiley, and Hamida Yusufzai.

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issue. An exploiter may use any number of tactics, including, but not limited to, encouragement, seduction, manipulation, force, fraud, and coercion to compel a person to engage in sexual activity in exchange for something of value. The buyers of sexual acts are nearly exclusively men, and the vast majority of individuals bought are women and girls [1–3]. CSE includes all forms of prostitution, sex trafficking, stripping, and pornography, as well as brothel, familial, street, gang, and hotel-based exploitation. The terms to be used in this chapter are defined in Table 4.1.

## How Trafficking Works

Prostitution, patronizing (sex buying), and promoting (pimping) are illegal in all parts of the USA excluding 11 counties in Nevada [8]. Though illegal, the commercial sex industry is a widespread,

**Table 4.1** Definitions

| Term | Definition |
|---|---|
| Commercial sexual exploitation (CSE) | Occurs when a person obtains sexual access to another person through an exchange of something of real or perceived value (e.g., money, housing, food, clothing, drugs, love, protection). CSE includes all forms of prostitution, sex trafficking, stripping, and pornography industries, as well as brothel, familial, street, gang, and hotel-based exploitation |
| Commercial sex act | "Any sex act on account of which anything of value is given to or received by any person." (per Trafficking Victims and Protection Act (TVPA) of 2000) [4] |
| Sex trafficking | "The recruitment, harboring transportation, provision, or obtaining of a person for the purpose of a commercial sex act." [5] |
| Patronizing (sex buying) | A person patronizes another person for prostitution when: (a) Pursuant to a prior understanding, he or she pays a fee to another person as compensation for such person or a third person having engaged in sexual conduct with him or her; or (b) He or she pays or agrees to pay a fee to another person pursuant to an understanding that in return therefore such person will engage in sexual conduct with him or her; or (c) He or she solicits or requests another person to engage in sexual conduct with him or her in return for a fee [6] |

**Table 4.1** (continued)

| Term | Definition |
|---|---|
| Pimping | Colloquially, individuals who profit from the commercial sexual exploitation of another person are referred to as "pimps." "Pimping," though a term commonly used by individuals within the industry, the media, lawyers, and others, is not often explicitly defined legally, though an exception can be found in California's "Pimping and Pandering" laws [7]:<br>1. Pimping occurs when a person knowingly receive financial support or maintenance from the earnings of someone engaged in prostitution; or<br>2. Receive or try to receive compensation for soliciting for a prostitute (i.e., finding customers for them) |
| Promoting | In the New York State Penal Code, "promoting" is defined as [6]:<br>1. "Advance prostitution." A person "advances prostitution" when, acting other than as a person in prostitution or as a patron thereof, he or she knowingly causes or aids a person to commit or engage in prostitution; procures or solicits patrons for prostitution; provides persons or premises for prostitution purposes; operates or assists in the operation of a house of prostitution or a prostitution enterprise; and/or engages in any other conduct designed to institute, aid or facilitate an act or enterprise of prostitution.<br>2. "Profit from prostitution." A person "profits from prostitution" when, acting other than as a person in prostitution receiving compensation for personally rendered prostitution services, he or she accepts or receives money, or other property, pursuant to an agreement or understanding with any person whereby he or she participates or is to participate in the proceeds of prostitution activity. |

multi-billion-dollar global industry [9]. As a consequence largely of criminalization, social stigma, trauma-coerced bonding, trauma, and self-blame, the majority of prostituted persons, in particular those actively being exploited, do not self-identify as victims or survivors of CSE or sex trafficking.[1]

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[1] The authors use the word "victim" in this chapter to reflect its usage in legal parlance to indicate a person who has suffered physical or emotional harm, property damage, or economic loss as a result of a crime.

Most individuals exploited in the commercial sex industry are under the control of a third-party profiteer. Third-party profiteers in the sex trade means to lure someone into the sex trade that include enticement, procurement, harboring, psychological manipulation, coercion, abuse of power, abuse of positions of vulnerability, all of which can be elements to either the federal or state laws' legal definitions of human trafficking for purposes of sexual exploitation. In the commercial sex industry, men, and sometimes women, colloquially referred to as "pimps" or "traffickers," often control the women and youth who are sold to buyers of sexual acts. The legal definitions of "promoting," "pimping," "pandering," and "procuring" for purposes of prostitution vary slightly from state to state (see Table 4.1), but each term refers to a relationship in which a third-party facilitates the sale of a commercial sex act. The facilitator, or third-party profiteer, typically keeps all or the majority of the money or items of value obtained by the person he or she is selling for commercial sex acts. Pimps and traffickers may be family members, strangers, or romantic partners. Pimps and traffickers intentionally target women, children, and members of marginalized communities who are homeless, have been in foster care, are poor, and/or have been subject to childhood neglect and maltreatment [10].

Some pimps and traffickers subject their victims to a "grooming" stage during which they exploit a victim's vulnerabilities by promising love, care, affection, protection, or support in order to gain the victim's trust. Pimps and buyers often use psychological manipulation, pressure, violence, threats, and intimidation to manipulate, force, coerce, or compel their victim into exchanging sexual acts for something of value. After recruiting a person, pimps/traffickers use tactics of psychological manipulation to maintain control over their victim. The abuser may subject their victim to intermittent reward and punishment throughout the relationship. This process can create a trauma-coerced bond between the victim and exploiter [11]. Traumatic-coerced bonding is a result of ongoing cycles of abuse in which the intermittent reinforcement of reward and punishment creates a powerful emotional bond between the abuser and the abused. Exploiters may "punish" victims violently and unexpectedly for irrelevant things the exploiter deems as infractions. The exploiter may then “reward” a victim with jewelry, manicures, attention, care, and affection. This psychological manipulation and unpredictability keeps victims confused, scared, and hoping they can regain the abuser’s care or love. The strength of the trauma-coerced bond makes it very difficult for survivors to leave, report, or testify against their abuser [11].

## Working with Survivors

Many healthcare providers will encounter survivors of commercial sexual exploitation (CSE) in the course of their work. Currently, there is limited training for medical providers on how to best provide care for this population. There are currently no standards of care for working with survivors of CSE (Phone interview with Melissa Farley, PhD, Executive Director, Prostitution Research and Education (9 Jan 2018)).

Deep-seated inequity is integral to the continued existence of the commercial sex industry. If medical practitioners hope to adequately serve and understand the barriers to medical care faced by survivors, they must possess a basic understanding of systemic oppression. The conditions of unequal resource and power distribution created by colonialism, sexism, racism, and classism coerce women, youth, and members of marginalized communities into the commercial sex industry [10, 12] (Phone interview with Cherry Smiley, PhD Candidate, Founding member of indigenous women against the sex industry (30 Dec 2017)). In situations of poverty, marginalized women and youth are coerced by pimps, traffickers, and sex buyers to trade sexual access to their bodies in order to meet their basic needs. By endeavoring to understand the full ramifications of the social contexts that limit opportunity and choice for survivors, medical providers can cultivate deep empathy for their patients’ lived experiences.

Survivors of CSE endure intersecting forms of severe violence including sexual and physical assault, including, but not limited to, rape; stabbing, strangulation, and penetration with foreign objects; food and sleep deprivation; and other acts rising to the level of non-state sponsored torture [13–17]. Sex buyers, pimps, traffickers, law enforcement, and the general public perpetrate high rates of violence against survivors often without accountability. Survivors live with extensive health issues caused by this violence and abuse. Physical violence and verbal abuse are widely documented across systems of CSE including in saunas, massage parlors, strip clubs, escort services, street-based exploitation, brothels, the pornography and stripping industries, and online [18–20].

CSE survivors need and deserve to be seen by medical providers trained to identify and address their specific needs. (Interview with Chelsea Olsen, Youth Counselor, in Seattle, WA (21 Jan 2018); Interview with Alisa Bernard, Survivor Advocacy Coordinator, Organization for Prostitution Survivors (8 Jan 2018); Interview with Marin Stewart, CSEC Community Advocate, in Seattle, WA (4 Jan 2018); Phone interview with Hamida Yusufzai, Anti-Sexual Violence Practitioner (3 Jan 2018); Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)). Survivors may seek emergency medical care for injuries resulting from sexual and physical assault. Though CSE is associated with acute and chronic medical illnesses and injuries, survivors may be in denial about the condition of their health (Personal communication with Marie DeLeon, GEMS Alumni and Survivor Advocate (19 Mar 2018)). Exploiters may prohibit survivors from seeking medical care and may force survivors to accommodate physical pain and discomfort [21].

The importance of the clinician's role in providing sensitive care to survivors cannot be overstated. Most survivors who are still "in the life," actively being sexually exploited, are severely isolated. These survivors may encounter medical professionals before engaging with social service providers. If survivors seek medical care, they create a critical window of opportunity for medical professionals to connect them to much needed services and to build a positive, albeit possibly temporary, relationship with them. Medical professionals are positioned to address survivors' acute and chronic medical needs, but equally importantly, to meet survivors' right to holistic, trauma-informed care that reaffirms their humanity and dignity.

This chapter provides insight and recommendations for physicians working in the USA to more effectively engage and treat CSE patients.

## Epidemiology of Sex Trafficking

Epidemiological information on CSE, including distribution, determinants, and populations most impacted, is limited. The available data indicates that a large percentage of people are first exploited as children and adolescents, are women and girls, and are people of color. However, research is limited by the illegal and hidden nature of the commercial sex industry, and these generalizations must be considered alongside the substantial sampling limitations inherent in research on the subject [22, 23]. The vulnerabilities and characteristics of those victimized, though, often overlap in the existing studies that use convenience sampling [22]. Prevalence data on the number of individuals exploited in the sex industry and demographic data, including age, race or ethnicity, immigration status, are limited.

Socioeconomic factors, such as poverty, history of sexual abuse, and ongoing trauma, are important factors pushing individuals into and preventing them from exiting the commercial sex industry. Table 4.2 lists the known socioeconomic and psychosocial risk factors for entering and remaining in prostitution [24–27].

**Table 4.2** Risk factors for entering and remaining in prostitution [1, 2, 9, 14, 15, 22–27]

| |
|---|
| Membership in a marginalized community |
| Foster care placement |
| Homelessness |
| History of running away one or more times |
| Sexual abuse by a family member |
| Childhood abuse/neglect |
| Chronic truancy |
| Gang involvement |
| Immigration/undocumented status |
| Poverty |
| Community violence |
| Intimate partner violence |
| Substance abuse |

## Identifying Survivors

Patients are unlikely to disclose experiences of CSE [28]. Survivors of sexual trauma may also fear invasive tests and the re-traumatization that may occur while seeking medical services; anticipating these fears and difficulties, survivors may repeatedly cancel appointments for exams or avoid disclosing important symptoms to providers [29]. In disclosing, patients may risk losing custody of their children, judgmental attitudes, and re-victimization [28].

Since disclosure is rare, it is important that medical service providers be cognizant of the indicators of CSE. Identification will allow clinicians to proceed sensitively with a treatment process using trauma-informed methods while also offering potential survivors access to additional resources. Some potential red flags for CSE are shown in Table 4.3.

While attire is not the best indicator of CSE, providers should note if a patient's attire does not match her means, the season, or environment; for example, if a patient is wearing a short skirt in cold weather or has expensive clothing or items without a source of income (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)). The storyline of events that brought a patient in for medical care may also be an indicator of CSE. Providers should note whether the patient's narrative includes inconsistencies or if their identity appears to be falsified. Furthermore, if a patient is accompanied by an overly protective or controlling person, this person could be a potential trafficker. Patients should be consulted alone for a safety assessment. If a patient exhibits bruising, cuts, burns, and old or current injuries; a lack of knowledge about the community she is in; or an unclear assessment of her recent whereabouts, these may be signs of CSE.

If a provider suspects a patient is at risk of or is currently experiencing CSE, the provider should engage gently and nonjudgmentally. The provider should not demand self-disclosure. The provider may want to have a screening tool available to assist with asking questions that can help identify instances of sex trafficking. Similar to a suicide assessment or substance use screening, these assessment tools can help identify risk factors, encourage self-disclosure, or assist in educating individuals who may not

**Table 4.3** Red flags for CSE

| |
|---|
| Multiple or chronic sexually transmitted infections |
| Multiple pregnancies, miscarriages or abortions with short interpregnancy interval |
| Disclosure of multiple, anonymous sexual partners |
| Tattoos or brandings that imply ownership |
| Unexplained injuries |
| History of substance use or abuse |
| Attire inconsistent with means, season or environment |
| Inconsistent narrative |
| Falsified identity |
| Controlling or overly protective accompanying person |
| Bruising, cuts, burns, or old injuries |
| Lack of knowledge about location or community |
| History of homelessness or unstable housing |
| History of running away (minors) |
| History of truancy (minors) |
| Gang affiliation |
| Possession of large amounts of money or multiple cell phones, disproportionate with financial resources |
| Uses lingo/slang terms referencing CSE[a] |
| Not in control of their own money, identification, or passport |
| Has exchanged a sexual act for money, food, shelter |

[a] Examples of lingo include: “the life”; “the game”; “daddy”; “bottom bitch”; “the track”; “the stroll”; “the blade”; “dates”; “johns”; “in calls”; “out calls”

realize that the exploitation they are enduring is illegal and that resources are available. Providers who choose to implement a formal screening or identification procedure should be prepared to engage with compassion and have the resources available to support patients after disclosure.

## Physical Needs of Survivors

Survivors may seek medical services for the extensive physical illnesses and injuries commonly associated with CSE. “According to one estimate, a third of prostituted women are disabled as a result of emotional traumas and physical injuries, including brain

**Table 4.4** Physical illnesses and injuries associated with CSE [30–34]

| | |
|---|---|
| General | |
| | Malnourishment |
| | Untreated chronic medical conditions |
| | Physical developmental delays |
| Injuries | |
| | Broken bones |
| | Burns |
| | Stab wounds |
| | Head injuries/traumatic brain injuries |
| | Rectal injuries |
| | Vaginal injuries |
| | Internal injuries |
| | Dental trauma |
| Chronic pain | |
| | Hip, neck, jaw, back, or stomach pain |
| Reproductive health | |
| | Sexual dysfunction |
| | Sexually transmitted infections |
| | Pelvic inflammatory disease |
| | Genitourinary complaints (discharge, pelvic/abdominal pain, abnormal bleeding) |
| | Complications of spontaneous or induced abortion |
| | Preterm birth and/or low birth weight |
| Substance abuse | |
| | Addiction/withdrawal |
| | Abscesses |
| | Overdose |

injury, suffered in prostitution" [28]. Table 4.4 shows some of the physical illnesses and injuries commonly seen in victims of CSE.

Survivors may seek services because their injuries or illnesses are so acute that they have no other recourse but to obtain medical care. If they have a pimp or trafficker controlling their access to care, the pimp or trafficker may be compelled by the severity of their condition—and their consequent inability to continue to make money—to allow them to seek medical care. Though an exploiter may permit critical care, follow-up appointments are rare because pimps and traffickers intentionally keep survivors isolated (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)). Survivors who are separated from their pimp or trafficker during a medical visit may exhibit distress and may be considering leaving the industry and their exploiter (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)). As such, the medical community is positioned to identify these survivors and to intervene with crucial services and resources. Though survivors may not be prepared to leave, they may seek out additional services when they are ready to safety plan and exit the sex industry (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)).

## Trauma-Informed Intake and Pace

A negative encounter with a medical provider may discourage patients from seeking future services. A negative response to disclosure may exacerbate a patient's post-traumatic stress disorder symptoms, feelings of self-blame, and distrust in others [35, 36]. By incorporating a behavioral health practice into physical health settings, providers can reduce the barriers to care faced by CSE survivors (see Chap. 8).

Trauma-informed care is defined by Cuevas et al. as:

> In TICP [trauma-informed care and practice], every aspect of care is assessed and potentially modified to incorporate a basic understanding of how trauma affects a person's life. Specifically in the medical setting, TICP uses universal trauma precautions for all patients and trauma-specific strategies for patients with a known history of trauma. Universal trauma precautions focus on patient-centered communication and care and require an understanding of the effects of trauma on health [37]

When engaging potential CSE patients, providers are encouraged to start with broad questions and to avoid pressuring clients for intrusive details about their life experiences. Healthcare providers are encouraged to determine what information is necessary to address the patient's medical needs, and otherwise strive for flexibility. If intrusive questions are necessary, they should be withheld until rapport has been established. Rapport is established by empathizing with the survivor, allowing the survivor to lead initial conversations, and treating the patient with respect [38, 39]. For many survivors, rapport must be established before they will feel comfortable disclosing; many patients will never disclose. The experience of CSE is often deeply humiliating and traumatizing—to have to explain these experiences to a stranger can exacerbate feelings of shame.

Providers can listen patiently and empathetically, as well as encourage patients to ask questions and share their concerns or fears regarding the examination and treatment processes. They can allow patients to decide which areas of the body they are comfortable having touched, make decisions regarding their care, and not pressure patients into treatments or testing. Providers should believe the client even if the narrative is shocking or confusing, maintain a neutral, but friendly, nonjudgmental facial expression and body posture. Incorporating these techniques into medical visits can enhance trauma recovery and the development of long-term relationships [40]. These techniques will convey and confer dignity and respect towards the patient enabling a medical professional to gain trust and potentially become an invaluable resource for survivors of CSE.

Addressing the most pressing needs of survivors can help to create a sense of validation and support. Some immediately accessible needs include physical safety, mental health, physical health (e.g., injuries, malnutrition, illness, and disability), and social service needs [41].

Though many individuals are domestically trafficked, many women and youth are also trafficked from countries and communities with limited resources into affluent, industrialized countries and communities. Undocumented immigrant women face additional barriers to receiving health care services. The threat of deportation may prevent survivors from seeking services. Survivors may also have limited English proficiency and may require translation services and access to legal advocacy [41]. Pimps or traffickers may instruct survivors, particularly those who are undocumented, to use an alias. The movement of these victims is highly monitored, so it is not appropriate to ask family members, friends, or boyfriends, who may actually be pimps or traffickers, to translate for a patient. All patients should initially be seen alone. Avoid pushing patients to take written materials or to seek help immediately; they may be navigating a dangerous situation and carrying written materials may put them in increased danger.

## Building Healing Patient-Provider Relationships

Professionals may be motivated to immediately intervene when they have identified a potential survivor; however, the survivor needs to feel safe, healthy, and cared for before any long-term changes can take place. Survivors are highly attuned to social shaming, having endured significant social violence, judgment, and unjust treatment. Many CSE survivors avoid seeking medical, legal, social service, and psychiatric care because of the judgment they perceive from professionals (Phone interview with Trisha Baptie, Community Engagement Coordinator for Formerly Exploited Voices Now Educating (19 Dec 2018)). Academic language and demeanor, or an unwelcoming medical setting, can be intimidating to survivors (Phone interview with Trisha Baptie, Community Engagement Coordinator for Formerly Exploited Voices Now Educating (19 Dec 2018)). Healthcare providers who are cognizant of the messages conveyed by their body and verbal language, clothing, and medical setting may be better able to build rapport with patients (Phone interview with Trisha Baptie, Community Engagement Coordinator for Formerly Exploited Voices Now Educating (19 Dec 2018)).

### Nonjudgmental and Strength-Based Language

Much of survivors' healing depends on the success of the nonexploitative relationships and diverse social networks they build outside of the commercial sex industry [42, 43]. A provider can build rapport by utilizing motivational interviewing techniques, including positive affirmations, paraphrasing, and reflecting what

**Table 4.5** Examples of nonjudgmental phrases and questions [44]

| |
|---|
| "Tell me more about that." |
| "Can you help me understand…?" |
| "We need to get X done, what suggestions/fears/input do you have?" |
| "One option I see is X, does that work for you?" |
| "I'm confused about…" |
| "That seems really difficult." |
| "You're in a lot of pain." |
| "How are you staying safe?" |
| "What are you doing to care for yourself?" |
| "Who in your community is supportive of your health?" |
| "You're working hard to survive." |
| "You want to care for your body, I'm glad you're here." |

the patient is saying back to them. These techniques are used to engage without conveying judgment. Nonjudgmental phrases and questions are shown in Table 4.5.

A provider's transparency with a patient about her health and health care options builds trust and allows the patient to make informed decisions. The provider may disagree with a patient's decision, but it is important to respect and affirm the patient's right to make autonomous choices about their body and wellbeing. Patients are more likely to return for services if the provider respects their opinion and decisions; they will feel more confident that their health care decisions will always be at their own discretion (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)).

Survivors are repeatedly made to feel unworthy of services, social support, and respect. Providers can avoid perpetuating this harm by creating a comfortable, inviting, and less formal clinical and office settings (Phone interview with Trisha Baptie, Community Engagement Coordinator for Formerly Exploited Voices Now Educating (19 Dec 2018)). A provider can create a space that is welcoming, rather than one that is intimidating, academic, or over-professionalized (Phone interview with Trisha Baptie, Community Engagement Coordinator for Formerly Exploited Voices Now Educating (19 Dec 2018)). The waiting area can be made to feel welcoming and warm by keeping the space clean and devoid of harsh smells; providing comfortable seating; ensuring that the lighting is warm and not abrasive; displaying artwork that is not triggering (e.g., watercolors in soothing colors like blues, greens, and purples); soothing and quiet music; using plants as decorations; providing toys and books for children; and ensuring that there is space for strollers and easy access to bathrooms. Receptionists and staff that are knowledgeable about trauma and the ways trauma manifests are indispensable. Receptionists who respond to patient questions in a friendly, calm, and compassionate manner can set the stage for a successful medical visit. The visit's success will be enhanced by multilingual staff who have language capacity reflecting that of the patients. Humor, tone, and body language are powerful communicators of respect, concern, compassion, and safety. Providers are encouraged to create medical visits that feel secure and safe by reminding patients that their visit is confidential; providing patients the opportunity to ask questions while fully dressed in an office, rather than the exam room; minimizing the amount of time that patients are undressed/in a hospital gown; and limiting the number of people that enter the exam room.

Professionals can build authentic relationships that supersede power imbalances by honoring and acknowledging a patient's humanity and right to self-determination. Validating the strength and resilience of survivors by using positive, strength-based language communicates worthiness and values the individual wherever they are at in their journey to health and healing [45–47]. Some examples of using strength-based language are listed in Table 4.6.

## Avoiding a Rescue Approach

Pimps, traffickers, and sex buyers violate the physical autonomy and integrity of CSE survivors; they repeatedly appropriate control over survivors' lives through kidnapping and control of their movement (Personal communication with Marie DeLeon, GEMS Alumni and Survivor Advocate (19 Mar 2018)). Survivors endure oppressive, violent, resource-devoid circumstances by mobilizing their own ingenuity and internal resources, and providers should honor their survival and avoid adopting a rescue mentality when

**Table 4.6** Strength-based language [48]

| Original term | Strength-based term |
|---|---|
| Minimize risk | Maximize growth |
| Manipulative | Resourceful; able to get one’s needs met |
| Helpless | Unaware of one’s capabilities |
| Hopeless | Unaware of opportunities |
| Don’t | Do |
| Shouldn’t | Try to |
| Can’t | Can |
| Discharge to aftercare | Connect to long-term recovery management |
| Dangerous | (avoid characterizing; instead specify behavior) |
| Clinical decompensation/relapse/failure | Re-experiencing symptoms of illness/addiction<br>Opportunity to develop<br>Opportunity to apply coping skills<br>Draw meaning from managing an adverse event<br>Reoccurrence |

serving these resilient patients (Phone interview with Trisha Baptie, Community Engagement Coordinator for Formerly Exploited Voices Now Educating (19 Dec 2018)). Healthcare providers are encouraged to think of themselves as “walking alongside” and “accompanying” CSE patients on their healing journey. During each exchange, a provider can endeavor to create opportunities for choice (Phone interview Martha Linehan, Chemical Dependency Professional, Certified Integrated Movement Therapist, and CSE Recovery Advocate, Organization for Prostitution Survivors (1 Jan 2018)). Survivor Leader and mentor Marie DeLeon notes that for survivors, “choice is something that has been taken away … being given choice builds trust” (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)). If providers attempt to control, rescue, or make decisions for a patient, they risk further disempowering the patient. Rescue behavior abridges a survivor’s control over her body. Rescue behavior can also be taxing for the service provider and may cause secondary-trauma burnout (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)). Healthcare providers can involve survivors in their own medical care by creating opportunities for collaboration during medical visits. For example, the provider can work with a survivor to create a safety plan, recommend tests but seek the patient's input regarding which tests they feel are important, and ask them if there are particular resources they need (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)).

Survivors of CSE have had their bodily integrity severely violated often through childhood physical and/or sexual abuse, and toxic, violent, and exploitative interactions with strangers and nonstrangers alike [13]. These experiences can disempower and disconnect a survivor. Providers can empower and connect survivors by modeling healthy relationships by endeavoring to build a relationship based on respect and empathy, even during a brief office or emergency room visit. Trust building requires utmost patience; in order to build a strong, useful relationship with a patient, a provider may have to gently work through a survivor's life-preserving emotional guards.

This can be accomplished by reminding the patient that they are the experts of their own experience; the information they share will be kept confidential; they have control over any examination or procedure that may take place; they do not have to answer questions that make them uncomfortable; their questions are valued; their appointment will not be rushed; and they will not be judged for any information they decide to share. A practitioner should allow and encourage the survivor to take time to assess whether they feel that the relationship is a good fit. Despite commonalities in life experience, survivors are not a homogenous group. Healthcare providers should consult with the patient about their specific medical needs, fears, and desires. Honor the patient's strengths—do not approach survivors as though they need to be "fixed" (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018)).

Though entering the commercial sex industry is very easy, exiting is extraordinarily difficult. Setbacks, including re-entry into CSE, are a normal part of the exiting process. And although CSE is dangerous and traumatizing (physically, emotionally, and psychologically), exiting may require surmounting significant additional barriers. Numerous studies indicate that exiting CSE is a long and multistaged process in which victims may leave and reenter repeatedly before finally exiting [49]. In a study of women who were able to exit CSE, the women made an average of 5.6 exit attempts before they were successful in leaving. Many of the factors that push women into CSE are also barriers to exiting. Providers are encouraged to gain comfort with the lengthy exiting process. Medical providers should not be frustrated by how slow, long, difficult, and nonlinear the process is. Providers are encouraged to value small successes, such as the patient coming in for medical services, and to be nonjudgmental about setbacks. A setback does not indicate failure, rather it is a normal part of the healing and exiting process for survivors. Medical providers can affirm the patient's efforts and encourage them to remain committed to their goals. An accomplishment, such as exiting for a short period, does not need to last to be celebrated as a success. What may seem small to a clinician may in fact be an admirable accomplishment in a survivor's life.

## Common Coping Mechanisms

Many survivors experience extreme emotions while being exploited, such as: rage, paranoia, moodiness, and terror; many become accustomed to seemingly uncontrollable emotions. A seemingly nonthreatening situation can easily trigger a strong emotional response. A medical provider may find it beneficial to ask a survivor about their triggers and what helps them to feel grounded and safe. A medical provider who is able to anticipate potential triggers or respond calmly with basic grounding strategies, when strong emotions are triggered, will have greater success meeting the medical needs of a survivor.

Survivors develop coping mechanisms and survival strategies to keep themselves alive and safe while in the commercial sex industry. These strategies may include violence, substance use, hypersexualization, theft, lying, self-harm, defiance, and oppositional behavior; such actions are normal responses to an abnormal situation, namely, the trauma of CSE [48, 50, 51]. The Substance Abuse and Mental Health Services Administration notes, "An essential component of being trauma-informed is to understand these behaviors not as character flaws or symptoms of mental illness, but as strategies or behavioral adaptations developed to cope with the physical and emotional impact of past trauma" [52]. Medical providers are encouraged to acquire knowledge of the biological impacts of trauma and to work to predict and treat the medical and behavioral manifestations of long-term traumatic stress.

Substance use is one example of a common coping strategy used to survive extensive trauma, not a lifestyle decision or individual shortcoming (Interview Lexxie Jackson, CSEC community advocate, In: Seattle; 2018). Knowledge of co-occurring disorders, including substance use and dependence, is essential for working with survivors of CSE. Healthcare providers should be comfortable talking to survivors about the substance use that often accompanies CSE.

A trauma-informed, therapeutic medical environment is essential to providing survivors with a sense of safety. Dr. Nadine Burke argues that the most important components of a practitioner's therapeutic influence on a survivor are (1) empathy, nonjudgment, and warm demeanor; (2) providing education about their diagnosis and strategies to resolve their difficulties; and (3) offering hope that a patient's situation will improve [53]. Survivors do not choose maladaptive behaviors and coping skills consciously, but rather, they arise from the need to numb, distract, or survive traumatic stress.

## Mental Health Needs of Survivors

Providers should be prepared to identify and respond to mental health issues that arise from the trauma of CSE. A medical visit can catalyze a trauma reaction in a survivor. While mental health for trauma survivors is discussed in Chap. 8, this section addresses issues specific to survivors of CSE.

Some providers may find working with a survivor challenging, but it is vital that providers are patient and nonjudgmental.

Survivors of CSE may have multiple stressors or traumas that inform their temperament, such as childhood physical or sexual abuse, the trauma of CSE itself, and homelessness [30] (Phone interview with Marie DeLeon, Survivor Leadership Institute and Resource Center Manager (31 Jan 2018); Personal communication with Marie DeLeon, GEMS Alumni and Survivor Advocate (19 Mar 2018)). Patients may struggle to remember life details because of traumatic brain injuries, memory damage, blocked traumatic memories, or dissociation. Survivors of CSE report high rates of psychiatric disorders including depression, anxiety, schizophrenia, eating disorders, sexual dysfunction, substance use, suicidal ideation or attempts, self-harm, post-traumatic stress disorder (PTSD), and dissociative disorders [54]. Survivors may need simultaneous support and treatment for sexual trauma, PTSD, and substance abuse. Dissociation, a particularly severe trauma-related symptom, is common among survivors of CSE. Dissociation serves as a coping strategy for surviving life-threatening, extremely painful or frightening life events and develops in response to extreme pain and fear. Heightened emotional reactions, such as "terror, surprise, shame, or helplessness, or feeling trapped or exposed" can catalyze a dissociative state [29].

## Knowledge of Community Resources

CSE is a complex social issue and barriers to exiting are extensive, spanning individual, relational, structural, and societal factors [55]. A survivor may require assistance accessing rehabilitation, transportation, income, education, safe and low-barrier housing, employment training, self-protection and safety planning; language and literacy training, self-care, childcare, substance abuse treatment, social reintegration, and legal advocacy.

A single healthcare provider cannot address all of a survivor's needs and barriers alone, but providers can create a network of trained and trusted professionals to whom they can refer a patient.

Healthcare providers who are knowledgeable about available resources and who have a strong referral network will contribute invaluably to a survivor's holistic healing. Providers with an advocate, peer care navigator, or case manager on staff, or in one's referral network, are better able to meet the multifaceted needs of these patients, offer survivors access to much needed resources, and to help a survivor navigate complex medical, mental health, and social service systems. Providers that have identified essential resources such as housing, food, chemical dependency treatment, mental health care, and strategies for connecting survivors to community advocates will greatly impact the patient's ability to maintain their health [6].

Pervasive cultural biases and misinformation about CSE limit and negatively affect the ability of survivors to receive quality, informed care. Medical professionals can obtain training around the issues of sex trafficking, commercial sexual exploitation, and providing trauma-informed care to attenuate misconceptions and unconscious biases.

## Survivor Community

Researchers Baker, Dalla, and Williamson, authors of "Exiting Prostitution: An Integrated Model," propose an "integrated six-stage model that is comprehensive in scope and sensitive to women's attempts to exit prostitution" [55]. Models that successfully facilitate a survivor's intentions to exit CSE are those that maximize contact with trauma-informed, survivor-informed advocates and that build supportive community outside of CSE (Phone interview with K.D., Survivor Leader (10 Feb 2016); Personal communication with M.C., Survivor Leader (20 Feb 2016); Phone interview with M.M., Survivor Leader (21 Feb 2016)). In our interviews, nearly all interviewees identified the connection that survivors make to other survivors as an important component of the healing process. For many, Survivor Advocates play a vital role in the exiting and healing processes of other survivors.

Though medical providers will likely not be responsible for organizing support groups for their patients, it is useful to know of the survivor groups that exist within one's community. For survivors, a connection to others who have shared similar experiences can facilitate healing and provide a safer person with whom to discuss and process experiences.

## Summary

Commercial sexual exploitation is a widespread problem that has important implications for the health of its survivors. Many members of the medical community may come into contact with CSE survivors, or those currently exploited in the commercial sex industry. Medical providers can serve as an important resource to help address the health and psychosocial needs of survivors. However, it is important that providers engage in respectful, non-judgmental, trauma-informed practices. Providers should avoid a rescue mentality, as many survivors may not be ready to leave, or may not be able to leave due to safety or other factors unknown to the provider. Instead the provider should work with survivors to meet their stated needs, and provide support, resources, and education to aid in the survivor's journey of recovery.

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# 5

# Providing Medical Care to Survivors of Sexual Assault and Harassment in the Military

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## Introduction

Experiences of sexual assault and sexual harassment during military service are addressed together in this chapter, because they are intimately intertwined and can have similar effects on survivors.[1] For example, at a most basic level, sexual assault in the military context is simultaneously workplace sexual harassment, given that the military environment is a workplace. Also, few people experience sexual assault in the military without also experiencing verbal or other nonphysical sexual harassment [1]. Finally, in the military, survivors work, live, and socialize in a relatively closed environment, potentially interacting with their perpetrator

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[1] Note: Issues of sexual violence by enemy combatants and as a weapon of war are beyond the scope of this chapter. We also focus in particular on experiences of sexual assault and harassment occurring in the United States Armed Forces.

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and his/her friends across multiple settings throughout the day. In this context, ongoing or repeated experiences of sexual harassment may create chronic fear and a sense of being trapped that is comparable to the reactions triggered by a single instance of sexual assault.

As we detail in this chapter, these types of experiences can have a profound impact on survivors' health and healthcare needs. Fortunately, medical professionals who are knowledgeable about the issues involved can provide strong support to survivors' recovery, by helping to ensure that their healthcare needs are addressed, by adapting care to be sensitive to the ways sexual assault and harassment may affect their experiences of healthcare, and by generally offering reparative experiences that stand in opposition to the devaluing, powerlessness, and helplessness that very often characterize experiences of sexual assault or harassment. To help medical professionals do this, this chapter provides an overview of issues pertinent to providing medical care to survivors of military sexual assault and harassment, including: (1) definitions, prevalence, and elements involving gender-based violence; (2) unique aspects of military sexual assault and harassment relative to other potentially traumatic experiences; (3) the impact of these experiences on survivors, including commonly associated conditions and effects on healthcare needs; (4) strategies for addressing this impact in a trauma-sensitive manner; and (5) key resources and ways to learn more. We hope that readers find this chapter a helpful introduction to the topic and an accessible reference that can guide ongoing care to survivors.

## Definitions

In this chapter we use the terms military sexual assault and sexual harassment (MSA/H) jointly to describe a continuum of unwanted sexual experiences occurring during military service. This includes experiences that are verbal in nature, such as threatening or offensive remarks about a person's body or sexual activities or repeated or threatening unwelcome sexual advances, and those physical in nature, such as unwanted touching or grabbing, or nonconsensual sexual intercourse. Perpetrators may have been fellow service members, whether superiors, peers, or subordinates in the chain of command, or civilians. Experiences may have occurred on or off a military installation and while the victim was on or off duty. They may have occurred once or been time-limited, such as experiences in the context of hazing or initiation, or have been part of an ongoing pattern of harassment or coercion.

As with sexual assault/harassment in other contexts, victims of MSA/H may have been physically forced into sexual activities or drugged, intoxicated, or otherwise incapacitated and unable to consent. Beyond physical coercion, they may have been pressured or coerced into unwanted sexual activities with threats of consequences (like poor performance evaluations) or promises of rewards (like less-dangerous duty assignments). The military context can introduce unique elements to this sort of coercion. For example, even when threats are not explicit, survivors may have felt forced to comply, given the military's emphasis on hierarchy and obedience to command and de-emphasis of personal needs. Survivors also may have feared retaliation or consequences for being seen as someone who did not just "go along with things" or who disrupted unit cohesion. For example, they may have had concerns that peers or commanding officers might not have "had their back" during combat encounters or other life-threatening situations if they protested harassment or refused to engage in sexual activities.

In this chapter, we focus particularly on the experience of "veterans"—that is, individuals who were previously in the military. However, much of the content reviewed can also help professionals who treat service members currently serving in the military.

## Prevalence

Department of Defense data from 2018 revealed that 6.2% of current female service members and 0.7% of current male service members indicated that they had experienced a sexual assault in the previous 12 months, and 24.2% of current female service members and 6.3% of current male service members indicated that they had experienced sexual harassment in the previous 12 months [2]. Insight into lifetime prevalence can be drawn from the Department of Veterans Affairs' (VA) universal screening program, in which every veteran seen for healthcare is asked about experiences of military sexual trauma (the term used by VA to refer to MSA/H). Current VA data from this program show that about 1 in 4 women and 1 in 100 men seen in VA screen positive for military sexual trauma [3]. Notably, although rates are higher among women, almost 40% of the veterans who screen positive are men due to the larger number of men in the military and among VA healthcare users. Rates are similar among new veterans as compared to those who served in earlier eras [4].

Although these rates convey how widespread experiences of MSA/H are, it is important to remember that some survivors may not disclose their experiences even when asked directly, so it is impossible to know with certainty which of your veteran patients may have experienced MSA/H. As such, it is best to approach all veteran patients in a manner sensitive to the possibility that they may have a history of sexual (or other) trauma experiences.

## Military Sexual Assault/Harassment as Gender-Based Violence

With regard to this book's focus on gender-based violence, the relevance of sex and gender to MSA/H is immediately visible in the elevated prevalence among women relative to men. Studies have shown that the risk factor most strongly and consistently associated with military sexual assault/harassment is being a woman [5]. Women's lower sociocultural power in the military and other factors contribute to this risk, but other factors related to gender, beyond just the fact of being a woman, also may be influential (see Bell et al. [6] for a review of additional risk factors for experiencing MSA/H). For example, Franke et al. conceptualized sexual harassment as a means of enforcing traditional gender roles, describing how it can be a means of punishing women who deviate from traditional feminine gender role behaviors and men who deviate from traditional masculine gender role behaviors [7].

In the military, the emphasis on gender role conformity may be paired with the promotion of highly masculine norms (e.g., physical strength, lack of emotionality, and self-sufficiency) for both men and women [8]. Thus, sexual victimization may function as a punishment for a woman not being "woman enough" (while simultaneously expected to be "man enough") or a man not being "man enough," which also may help explain data showing that transgender veterans are more likely than matched controls to have experienced MSA/H [9]. Lesbian, gay, and bisexual service members, who may be perceived to be gender nonconforming or to otherwise violate expectations for how women and men "should be," also appear to be at increased risk [6]. Potential contributors to and amplifiers of the primacy of gender roles in the military include: (a) a culture valuing extreme forms of masculinity; (b) a high ratio of men to women; and (c) a history of exclusionary policies or practices related to women and individuals who do not conform to proscribed gender norms, such as transgender people or individuals who identify as (or are suspected to be) lesbian, gay, or bisexual. For a more in-depth review of these issues, please consult Burks, Castro et al., and Turchik and Wilson [10–12].

## Unique Aspects of Military Sexual Assault/Harassment

Relative to other potentially traumatic experiences, including other forms of interpersonal violence and other military traumas (e.g., combat), MSA/H may have particularly toxic effects on health. For example, sexual assault in the military appears to be more strongly associated with posttraumatic stress disorder (PTSD) and other health consequences than civilian sexual assault, and is comparably or more strongly associated with negative mental health consequences than is combat exposure [13–16]. Bell and Reardon review factors that may contribute to this toxicity, but in brief, some key factors include [17]:

- *Military environment and ongoing contact with perpetrator.* The nature of the military environment means that military personnel often find themselves interacting with the same group of individuals in both work and home life. Survivors may need to live, work, and socialize with perpetrators over an extended period of time, leaving them feeling trapped, helpless, and vulnerable to additional experiences of MSA/H or other revictimization. In the case of MSA/H occurring during combat deployments, survivors may have additional concerns about increased risks of physical harm or other forms of retribution if they try to refuse or report these experiences. This can further heighten the ongoing stress that can be associated with experiences of MSA/H and their aftermath.

- *Military culture and values.* The dissonance between MSA/H and core values promoted by the military can be very difficult for survivors to reconcile and can challenge their sense of themselves, others, and the world in profoundly destabilizing ways. For example, in the military, tremendous value is placed upon loyalty, teamwork, and functioning as a cohesive group with a shared mission. Military culture also prioritizes being strong, tough, and physically powerful, and these attributes can become a central part of veterans' self-identity. MSA/H requires survivors to confront the idea that betrayal is possible even from deeply trusted others and that even those who are strong, tough, and self-sufficient may not be able to protect themselves from victimization. With these core beliefs thrown into question, survivors often understandably do not know what to believe about trust, safety, and control in any context or with any individual, including themselves. Losing this fundamental sense of control and predictability can be disruptive to well-being and daily functioning.
- *Limited social support.* Many survivors of sexual trauma in any context lack social support [18], but unique aspects of the military environment can create additional complications for accessing support. For example, service members may be deployed or otherwise far from home at the time of the MSA/H or may be reluctant to reach out to formal sources of help for fear that this may mean "going public." They may also believe

that being strong means they should be able to cope on their own and "soldier on," particularly to the extent that MSA/H is perceived to be a less legitimate stressor than combat. They may also remain silent because of concerns about unit cohesion and fears of being ostracized for speaking out about another service member. Social support is one of the strongest and most consistent predictors of recovery from traumatic and stressful experiences [19], so MSA/H survivors' tendency to lack support, particularly in the immediate aftermath of the experiences, may be a significant contributor to the particularly negative impact of MSA/H on health and well-being.

## Impact of Military Sexual Assault/Harassment

Although MSA/H can be particularly toxic relative to other potentially traumatic events and significant life stressors, individual survivors vary in their reactions. Many are tremendously resilient and go on to lead healthy lives without significant long-term difficulties. Others may have some areas of continuing impact, whether in one or more ongoing physical or mental health conditions or in strong emotional reactions when encountering reminders of their experiences. Still others may struggle more profoundly and be significantly impaired in daily functioning. Given this variability, it is important both to be watchful for and to actively assess for potential health concerns that may have developed secondary to experiences of MSA/H, even when those conditions or their effects may not be immediately evident, and yet also to not make assumptions about survivors' current functioning and treatment needs. In this section, we review some of the most common physical and mental health conditions and psychosocial impacts that may arise after experiences of MSA/H, including how they may show up during medical encounters and impact these encounters. Although many of these issues are common after experiences of sexual trauma in any context and interpersonal trauma more generally, when possible we include information about ways in which the specific nature of MSA/H may be influential.

## Associated Physical and Mental Health Conditions and Psychosocial Effects

Regarding physical health impact, survivors may have medical conditions directly resulting from MSA/H, such as physical injuries and conditions resulting from a sexual assault (e.g., contusions, bone fractures, joint dislocations, pelvic, gynecological, or rectal pain, sexually transmitted diseases, sexual dysfunction), and long-term chronic sequelae arising from such injuries, particularly if they went untreated at the time. Medical conditions may also arise secondary to a survivor's behavioral reactions to or attempts to cope with MSA/H. These include the following:

- Conditions associated with drug or alcohol abuse, such as liver disease
- Conditions associated with smoking, such as chronic obstructive pulmonary disease or cardiovascular disorders
- Conditions associated with disordered eating, such as obesity or severe weight loss
- Conditions associated with unprotected sexual behavior, such as HIV/AIDS

Finally, medical conditions such as headaches, chronic pain, or gastrointestinal problems may arise or be exacerbated by physiological changes secondary to undertreated mental health conditions and traumatic stress.

VA data show that the specific medical conditions most commonly associated with military sexual trauma among veterans seen for VA healthcare are liver disease and chronic pulmonary disease (among women and men), obesity, weight loss, and hypothyroidism (among women), and HIV/AIDS (among men) [20]. More generally, other studies have documented increased odds of poorer overall physical health and more physical symptoms among MSA/H survivors as compared to nonsurvivors [21–23].

Survivors' mental health can also be negatively affected by experiences of MSA/H. The most common mental health conditions seen in VA associated with MSA/H are PTSD, depressive disorders, anxiety disorders, and substance use disorders [20]. Research has also documented increased rates of dissociative disorders, eating disorders, and personality disorders [16, 24], and increased sexual health concerns such as difficulties with arousal, pain, or decreased sexual activity, desire, or satisfaction [25, 26]. Survivors also have increased rates of suicide and risk factors for suicide, even after accounting for the effects of mental health conditions such as depression and PTSD [27–29].

In terms of psychosocial impact, survivors may also struggle with a range of interpersonal issues such as difficulties with forming or maintaining relationships, negotiating self–other boundaries, or being appropriately assertive. Parenting may involve additional challenges for survivors as compared to nonsurvivors due to these and other issues. MSA/H is also associated with unemployment and difficulties at work or school and increased risk for homelessness [22, 30].

## Issues in Medical Care and Encounters

As noted earlier, survivors' healthcare needs and their experiences of medical encounters are often affected by MSA/H. Even veterans who are doing well in general may still have difficulties in certain situations or with certain aspects of their medical care. For example, physical exams and procedures may be especially anxiety-provoking, because they can be physically intrusive, provoke feelings of being vulnerable or not in control, or mimic physical sensations or experiences reminiscent of MSA/H experiences. Specific procedures that may be particularly difficult include: rectal exams; urologic exams; pelvic exams and Pap tests; breast exams and mammograms; invasive procedures such as endoscopies or colonoscopies; dental exams; and any procedure that involves physical restraint, sedation, or standing behind or over patients.

In addition, survivors' interpersonal interactions with medical professionals may be complicated. This is because even the most supportive patient–provider relationships can at times entail some elements that are also involved in victim–perpetrator interactions, such as the following:

- Power differential
- Exposure and touching of body parts
- Physical pain or discomfort
- Uncertainty about what will happen next
- Feeling vulnerable and not in control

Because of this, even routine healthcare encounters may trigger intense emotional or other reactions or amplify any interpersonal or emotional concerns survivors may have. Readers are encouraged to consult Bell, Turchik and Karpenko, Street et al., and Street, Bell and Ready for more information [31–33]. Four critical areas to be sensitive to are:

- *Difficulties with trust.* The betrayal associated with MSA/H can negatively affect survivors' ability to trust others, particularly individuals perceived to have power or control. The inherent power differential involved in healthcare, where medical professionals have authority and specialized knowledge and control access to treatment and other resources, can be associated with feelings of helplessness. Survivors may disengage emotionally during an appointment or avoid treatment entirely if they feel too emotionally or physically vulnerable. Difficulties with trust can also manifest in a reluctance to answer questions or admit to symptoms, in excessive concern about the chosen treatment approach, or in a need for repeated explanations that does not seem to be due to memory issues or lack of understanding. Survivors also may place heightened emphasis on secrecy or privacy and attend intently to nonverbal cues and behaviors that seem to indicate someone's predictability and dependability. For example, they may have strong reactions to any procedures they perceive as lax or behaviors that may impact perceived privacy and confidentiality.

- *Shame and self-blame.* Shame and self-blame haunt many survivors of MAS/H and can result in long-lasting mental health and relationship difficulties [34]. Deeply held beliefs from military service about the importance of being strong, independent, and never weak or vulnerable can add an additional dimension and intensity to shame and self-blame. Survivors may blame themselves for their own reactions or others' responses during or after the experience or think they should have been able to prevent it [35, 36]. These feelings can be amplified for survivors who received negative or blaming responses from others when disclosing their experiences or seeking help. During medical encounters, self-blame can take the form of evasiveness, avoiding eye contact, or intense emotional reactions to perceived criticism.
- *Power and control.* MSA/H involves an abuse of power. In an effort to protect themselves from future harm, survivors may be exceptionally sensitive to potential signs that others may coerce, manipulate, or hurt them. This hypervigilance can be particularly strong in settings where they feel vulnerable (such as during medical appointments) and with individuals who are in a position of power and authority (such as medical professionals). To counteract these feelings of vulnerability, survivors may attempt to assert control over a situation, such as by being quick to anger or by making demands for information, procedures, or accommodations that seem significantly beyond what is warranted, even in light of the flexibility and sensitivity called for given their history of MSA/H.
- *Emotional and cognitive dysregulation.* Survivors may struggle with difficulty regulating emotions, evidenced as extreme or sudden emotional "highs" or "lows," difficulty modulating emotional responses, or emotional numbing or flatness. In medical settings, intense or sudden emotional reactions to pain, to perceived missteps on the part of a professional, or to feeling vulnerable may also occur. Survivors may have significant anxiety and shame or self-blame, though sadness and anger may be more likely to be expressed. Men are even more likely than women to express intense anger or use substances to manage emotions [37, 38]. This may be because sadness

and anger are also natural reactions to the experience, or because they may feel easier to express or more socially acceptable than shame or anxiety. Survivors also can have difficulties with attention, concentration, and memory, which can interfere with their ability to participate fully in medical encounters and/or manage follow-up recommendations.

When aspects of a medical encounter intersect with these areas, it is common for survivors to have an MSA/H-related reaction during the appointment. Such reactions can include:

- Appearing highly anxious, agitated, or “jumpy”
- Appearing tearful, with no obvious cause
- Physically withdrawing or becoming very quiet or “frozen”
- Having difficulty concentrating or seeming very distractible or disoriented
- Minimizing or denying symptoms that might require an intrusive exam
- Refusing needed care
- Exhibiting strong emotional reactions (e.g., crying, panic, irritability, anger) to interactions that may seem benign
- Appearing to dissociate (looks “checked out”)

These reactions can be confusing or challenging, and some professionals may initially assume they are driven by lack of motivation or interest, hostility, or a rejection of help. However, when viewed in light of the impact of MSA/H, these behaviors can be understood as natural reactions to the triggering aspects of the medical environment. Fortunately, as discussed at the end of this chapter, these reactions can often be mitigated with simple interventions that can help restore a patient’s sense of safety and control over what is happening.

## Effects of Identity and Cultural Variables

We have described some of the impacts of MSA/H for many survivors, regardless of their gender, ethnic/racial background, sexual orientation, religion, socioeconomic background or other factors. However, aspects of identity and culture such as these can amplify and/or intersect with that impact. For example, consider how being raised in a conservative religious tradition that forbids sexual contact before marriage may amplify a survivor's sense of shame, self-blame, and reluctance to disclose an experience to others or seek help. Or, how MSA/H can add additional complexities to the recovery process and help seeking for individuals from a group that is a numerical minority or historically marginalized and who feels or has been told that they do not belong. For these individuals, MSA/H may feel like an attack on or shaming of their identity, a reinforcement of feelings that they are "less than," or a sign that they need to be hypervigilant for future victimization. Even if the MSA/H is not perceived to have occurred because of their identity, general societal stigma or perceptions of their cultural group still may create challenges. For example, lesbian, gay, and bisexual service members who are victimized often need to overcome additional barriers to come forward or get support, since seeking help may involve disclosing their sexual orientation and negotiating negative reactions from others.

Among the variables listed above, gender may be an especially salient one, particularly given the focus of this book. For a more comprehensive review of issues related to gender and MSA/H, see Bell et al. and Bell, Turchik and Karpenko [6, 31]. Briefly however, experiencing MSA/H and any problems afterward can feel like weakness, so they may violate men's most basic view of what it means to be "a man." This can result in struggles with their gender identity or sexual orientation and beliefs that they experienced MSA/H because they "weren't man enough" [31, 37]. For women, MSA/H may intensify their sense of vulnerability living in a world where women often have less social power. They may feel even more of a need to be "twice as good" as male military peers or a stronger sense that no matter what they do, they are not good enough. Transgender women and men may have MSA/H-related concerns consistent with their gender identity, their assigned birth sex, or their sense of belonging to a highly stigmatized minority group.

These issues also may shape disclosure and help-seeking in the medical context. For example, research has shown that men are less likely than women to disclose sexual trauma experiences, including MSA/H, and to access formal sources of help, such as by making reports to authorities or seeking mental health or medical treatment. This is likely influenced not just by men's reduced healthcare use overall but also by gender-specific influences on recovery from MSA/H and sexual trauma.

Importantly, not all veterans with a given combination of identity and cultural variables will have additional struggles or concerns like those described above. However, being attuned to the possible influences of these variables can help you provide the most effective treatment to survivors from a range of different backgrounds.

## Key Principles for Addressing the Impact of Military Sexual Assault and Harassment

Fortunately, much of what you already know about addressing the effects of other forms of gender-based and/or interpersonal violence applies to providing care to survivors of MSA/H. This section reviews six key principles for doing this.

### Principle 1: Interact with All Patients in Trauma-Sensitive Ways

Because you will not know with certainty who among your veteran patients experienced MSA/H, or which encounters or procedures may be particularly challenging for a given patient, it is best to adopt a "universal precautions" approach and interact in trauma-sensitive ways with all patients. For example, when possible and still consistent with appropriate professional boundaries, do what you can to reduce the power differential between you and them. Seek to establish an environment that reduces patients' feelings of vulnerability and promotes a sense of control over what is happening to them. You can accomplish this with simple strategies:

- Sit at the same level as patients, preferably without a desk in between you and them
- Make good eye contact

- Have them remain fully dressed during appointments and exams whenever possible
- Give options and choices whenever possible
- Be transparent, explaining your reasoning for choosing or suggesting certain courses of action
- Recognize them as experts on their own bodies and functioning
- Attend carefully to patients' identified concerns and respond sensitively and compassionately when they disclose concerns to you.

Resources with additional strategies for caring for patients in trauma-sensitive ways are detailed in the table at the end of this chapter. Efforts such as these can reduce the chances of patient distress during appointments, foster a stronger and more effective patient–provider relationship, and enhance the positive effects of medical care.

In addition to specific strategies, providing trauma-sensitive care also involves adopting a strengths-based mindset and conceptualizations. This may be especially appreciated by veterans, as they often have personal identities that are aligned with strength, resilience, and independence. From a strengths-based perspective, survivors' struggles and any confusing or challenging behaviors can be interpreted as reflecting their best attempts to reestablish safety and internal stability in the aftermath of MSA/H. For example:

- Angry or aggressive outbursts may be a way to feel more in control of a situation or stay safe by pushing others away
- Reacting to benign details or interactions as if they have life-or-death significance can be an attempt to prevent bad things from happening again
- Downplaying or denying symptoms, or not seeking out needed healthcare may be ways to be a "good warrior" or to avoid feeling weak or vulnerable
- Self-blame may be a way to avoid accepting that we sometimes have limited control over bad things happening to us and that we can be hurt by deeply trusted others, even in a system (the military) that one may have a deep respect for and connection to.

In short, while they may seem confusing or challenging to others, these behaviors help survivors to meet an important need, often related to safety, power and control, or personal identity. It may not be an optimal way to meet the need in the long run, but it still reflects strength and a drive to recover. Honoring and building on this strengths-based mindset while also providing corrective and reparative experiences can be particularly helpful when working with veterans and may make a significant contribution to their recovery.

## Principle 2: Screen for Unwanted Sexual Experiences and Veteran Status

Because many survivors of sexual assault or harassment occurring at any point in their lifetime do not spontaneously disclose their experiences to professionals, it is important to include questions about sexual trauma in general (not just MSA/H) in your routine initial assessment process [39, 40]. This can be as simple as asking, "Have you had any sexual experiences during your life that continue to bother or upset you today, like unwanted sexual experiences or being touched or spoken to in ways that made you uncomfortable?" and "What would be helpful for me to know about that experience, to make sure I'm providing you with the care you need and that you feel comfortable during our appointments?" You do not need to discuss the experiences themselves in detail; however, getting a general sense of how recent or remote the experiences are and any significant impact they are having on current functioning will shape your sense of the acuteness of intervention needed. When there is time and/or a clinical indication that it would be beneficial, additional assessment of when experiences occurred (e.g., childhood, adulthood, military or civilian life), the scope of their current impact on functioning, health, and well-being, any related treatment needs, and any concerns patients have about procedures or healthcare visits (e.g., small spaces, interacting with unfamiliar people, having someone standing behind or over them) can also help. Responding empathically and supportively to the information provided is crucial.

Asking all patients whether they served in the military is beneficial in identifying potential risks for a variety of service-linked problems and conditions and so is a general best practice. Ask “Have you served in the military?” as opposed to “Are you a veteran?” because some individuals, particularly women who served in an earlier era, may not realize that certain forms of service qualify them for veteran status or alternately, may not have formal veteran status. Specific to MSA/H, knowing whether an individual served in the military will also cue you to ask, if appropriate, whether any sexual trauma they disclosed occurred during their military service. This in turn will allow you to be mindful, as needed, of the information reviewed earlier about the impact of MSA/H relative to civilian sexual trauma.

Additional key principles for asking about MSA/H and sexual trauma more generally are reviewed in Table 5.1 and in Bell and Reardon and Street, Bell, and Ready [17, 33].

## Principle 3: Monitor Health Impact, Key Risks, and Personal Reactions

In addition to assessing the health impact and risk issues described above when a patient first discloses a history of MSA/H, you should also monitor these issues on an ongoing basis. This is because symptoms or difficulties can fluctuate over time, particularly in response to acute life stressors, and/or arise in a delayed fashion. Alternatively, a survivor may not feel ready to acknowledge the extent of current difficulties when initially asked.

Be particularly vigilant in assessing and monitoring risks for suicide, revictimization, substance use, homelessness, or disordered eating. Suicide risk assessment and suicide prevention strategies are especially critical; see the final section of this chapter for key resources that can help. For example, veterans

**Table 5.1** Screening for military sexual assault and harassment. (Adapted from Bell and Reardon [17])

| Steps | Key elements | Example |
|---|---|---|
| 1. Establish a comfortable climate for disclosure | Conveying comfort with the topic and your sense that this is an important issue | Ensure it is a private setting without interruptions; adopt a nonjudgmental stance, unhurried speech, and good eye contact |
| 2. Provide a rationale for asking | Normalizing the topic | *"Many of the patients I've worked with have had upsetting experiences in their lives that may still bother them today."* |
| 3. Ask the question | Using behaviorally based language that avoids jargon (e.g., rape, sexual assault) and negative phrasing (e.g., *"nothing like that has ever happened to you, right?"*) | *"During your military service or at any other time in your life, did you experience any unwanted sexual attention?"*<br>*"During your military service or at any other time in your life, were you ever forced or pressured into having sex? Did someone ever threaten you in order to have sex with you when you did not want to?"* |
| 4. Respond to disclosure | Providing support | Validation and empathy: *"I'm sorry this happened to you while you were serving our country, but I'm glad you felt you could tell me about it today."*<br>Education and normalization: *"Many veterans have had experiences like yours and for some, it can continue to affect them even many years later. It is important to know that people can and do recover, though."* |
| 5. Ask essential follow-up questions | Assessing current impact | Assess current difficulties: *"How much does [use survivor's words about experiences] continue to affect your daily life today? In what ways?"*<br>Assess social support: *"Have you ever been able to talk with anyone about this before? How did they respond?"*<br>Assess coping strategies: *"How do you deal with [use survivor's words about current difficulties] when it happens? Does that help? What happens next?"*<br>Implications for care: *"How do you think this might affect our work together?"* |

**Table 5.1** (continued)

| Steps | Key elements | Example |
|---|---|---|
| 6. As appropriate, conduct or refer for more comprehensive assessment | Gathering information about the experiences and their impact, the patient's current functioning, and implications for care | *"It sounds like this experience continues to affect you a great deal today, which is understandable. It makes me think that it would be good for me to have a better understanding of how this fits into your life. Would it be okay to spend a bit more time talking about how it has affected you?"*<br>*"We should definitely think about whether there are ways this might affect your needs during medical appointments, and what I can do to help. I'm also thinking that it might be useful for you to speak to someone with particular expertise in these issues. She or he might have thoughts about other services that might be helpful. What do you think about that?"* |

have likely been well trained in the use of guns and other weapons and may have them in their homes, so means assessment and means restriction are critical in the care of veterans who may be at risk for suicide. Monitoring survivors' level of social support and connection with others is also critical, given evidence of the importance of this in recovery from trauma. Encouraging veterans to connect with local veteran-specific or sexual trauma-specific treatment resources may be one way of ensuring access to support.

Professionals also need to remain vigilant in monitoring their own reactions to providing care to survivors. It is normal and understandable to have reactions to your work with survivors, particularly when the problems they are encountering are complicated, confusing, and emotionally difficult. It is understandable to have strong positive or negative emotional reactions to certain interactions, to make quick judgments or assumptions, to have urges to avoid or protect certain patients, or to feel more emotionally drained at times. It is also normal to have feelings and beliefs about military service, veterans, or government institutions. The important thing is to be aware of these reactions and the impact they may be having on your verbal and nonverbal behavior, the patient–provider relationship, and your ability to provide the best care possible. Then, make necessary adjustments to mitigate that impact.

When we notice strong personal reactions or changes in our behavior, this can indicate it is an important time to engage in extra restorative or social activities, such as talking with supportive colleagues, increasing engagement in meaningful activities outside of work, and reminding ourselves of the meaningfulness and importance of our work. Thinking about how to view a patient's behavior through a trauma-sensitive, strengths-based lens as an attempt to reestablish a sense of safety, control, or predictability may also help. See the brief discussion in Principle 1 about a strengths-based mindset, review a more extensive discussion of this in Bell and Reardon [17], or consider consultation with colleagues with trauma-and military-related expertise.

## Principle 4: Anticipate Difficult Situations and Respond Effectively to Strong Patient Reactions

Adopting the strategies described earlier for how to interact with all patients in trauma-sensitive ways will serve you well in reducing the potential negative impact of MSA/H on medical encounters and survivors' healthcare experiences. As noted, however, there are aspects of the medical environment and healthcare that may be inherently triggering or distressing for survivors, and there will inevitably be difficult moments to manage. Table 5.2 reviews some general strategies to help in anticipating and planning for these situations, to help you avoid or minimize patient distress.

**Table 5.2** Strategies to plan for difficult situations and minimize distress

| |
|---|
| *Anticipate and prepare* |
| Explain that it is normal for survivors to have strong reactions to certain kinds of appointments, exams, and procedures |
| Describe the reasons for and steps involved in the exam or procedure and ask what the patient anticipates will be the most difficult part |
| Brainstorm with the patient potential coping strategies or ways to make the situation as comfortable as possible. For example, seeing the procedure suite and tools in advance; having a chaperone or family member present; considering sedation or pain medication if clinically appropriate; using distraction (e.g., headphones, music, focused breathing, imagining a pleasant event); using other strategies the patient has found helpful in the past |
| *Give control and choice when possible* |
| Ask permission before touching |
| Let the patient know you will stop or pause if asked |
| Describe what you will do before you do it and then keep a running commentary of what you are doing as you do it. For example: "*Okay, I am picking up an instrument now. This is for looking in your ears; it shouldn't hurt. I am going to move close to you and briefly touch your ears while I am looking at your inner ear, is that okay?*" |
| Check in periodically and ask how he/she is doing |

Despite your best efforts and planning, survivors still can have strong reactions during medical appointments. When this happens, even well-intentioned professionals may be unsure how to respond and sometimes hurry through or try to skip over those moments to "protect" patients. However, it typically will be more helpful to stop what you are doing, if possible, or slow down and explain why, if not. It is important to respect the patient's subjective experience, even if it seems extreme to you given the objective circumstances. Never ignore or dismiss a patient's request or expression of distress. This may feel distressing to survivors who were previously ignored, dismissed, or blamed, particularly in relation to their experiences of MSA/H. Table 5.3 reviews additional strategies that will help in these situations.

**Table 5.3** Strategies for managing strong patient reactions

| Goal | Strategies |
|---|---|
| Minimize additional triggering or distress | • Stop what you are doing, if possible<br>• Avoid further touching without asking first<br>• Avoid moving closer or "invading" the patient's personal space<br>• Avoid making sudden loud noises (e.g., hand clap, finger snap) |
| As needed, help the patient return to the present moment ("grounding") | • Call the patient's name in your regular speaking voice: "*Are you still here with me?*"<br>• Ask the patient to focus on sensations and/or the external environment: "*Can you feel your feet on the floor? Good. Now how about focusing your attention on the sensation of sitting in your chair. What sounds do you hear in the room right now?*"<br>• Ask the patient to focus on the present: "*Can you tell me what day of the week it is? And where are we? How did you travel here today?*" |
| Demonstrate concern and restore control | • Ask the patient how he/she is doing and what he/she needs from you in that moment<br>• Listen empathically, acknowledging his/her distress<br>• Apologize for distress you may have caused, even if unintentionally<br>• Explain the reasoning behind your behavior<br>• Explore with the patient what you can do to restore a feeling of being in control |

## Principle 5: Refer for Specialized Care When Needed

You can make significant contributions to an MSA/H survivor's recovery, not only by addressing any medical impacts of MSA/H but also by offering a reparative, caring experience that counteracts a survivor's previous experiences. Your own knowledge paired with consultation with knowledgeable colleagues when needed may be sufficient to address a survivor's needs. However, there will be times when a MSA/H survivor's treatment needs may be beyond the scope of your practice or expertise and a referral for specialty or other services may be warranted. For example, patients with complex medical or psychosocial presentations, or with multiple comorbidities, may benefit from specialist attention and/or a coordinated team approach. Likewise, survivors who are interested in mental health treatment or who are struggling with significant mental health difficulties would benefit from a referral for mental health services. Treatment from professionals or systems with particular expertise in treating residuals of MSA/H in veterans also may be helpful and appealing to some survivors.

When considering a referral, keep in mind that the Department of Veterans Affairs (VA) provides free care for any mental or physical health condition related to a veteran's experiences of MSA/H. VA refers to these experiences as military sexual trauma, or MST. Veterans do not need to have reported the MST or have any evidence or documentation of it to receive this free care. They also do not need to have a VA disability rating or have applied for disability compensation or to have sought treatment within a certain timeframe, and they may be able to receive MST-related care even if they are not eligible for other VA care. Services are available at every VA medical center. To connect with care, veterans (or you, on their behalf) can contact the nearest VA healthcare facility and ask to speak with the MST Coordinator.

## Principle 6: Consult Resources and Continue Expanding Your Knowledge

We encourage you to continue expanding your knowledge of MSA/H, its impact on veterans and their healthcare needs, and things you can do to address those needs. Table 5.4 lists additional resources and ways to learn more.

**Table 5.4** Resources and ways to learn more

| Topic | Key resources |
|---|---|
| Military sexual assault/ harassment | *Web-based resources*<br>• VA military sexual trauma website: http://www.mentalhealth.va.gov/msthome.asp<br>• National Center for PTSD continuing education course, "PTSD and Experiences of Sexual Assault During Military Service": https://www.ptsd.va.gov/professional/continuing_ed/sexual_assault_military.asp<br>• PsychArmor Institute continuing education course, "Military Sexual Trauma": https://psycharmor.org/courses/military-sexual-trauma-2<br>• Make the Connection website, military sexual trauma section: http://maketheconnection.net/conditions/military-sexual-trauma<br>• Department of Defense Safe Helpline for active duty Service Members: https://www.safehelpline.org/<br>*Articles and book chapters:*<br>• Bell ME, Dardis CM, Vento SA, Street AE. Victims of sexual harassment and assault in the military: understanding risks and promoting recovery [6].<br>• Bell ME, Reardon A. Experiences of sexual harassment and sexual assault in the military among OEF/OIF veterans: implications for health-care providers [41].<br>• Bell ME, Turchik JA, Karpenko JA. Impact of gender on reactions to military sexual assault and harassment. Health & social work [31].<br>• Castro CA, Kintzle S, Schuyler AC, Lucas CL, Warner CH. Sexual assault in the military [11].<br>• Skidmore WC, Roy M. Male Veterans' recovery from sexual assault and harassment during military service [37].<br>• Turchik JA, Wilson SM. Sexual assault in the US military: a review of the literature and recommendations for the future [12]. |
| Suicide prevention | • Veterans Crisis Line and suicide prevention resources: https://www.veteranscrisisline.net/ and https://www.veteranscrisisline.net/education/veteran-programs |
| Trauma-informed care | • Handbook on Sensitive Practice for Health Care Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse http://www.integration.samhsa.gov/clinical-practice/handbook-sensitivve-practices4healthcare.pdf<br>• Substance Abuse and Mental Health Services Administration TIP 57: Trauma-Informed Care in Behavioral Health Services [42]<br>• Survivors of Childhood Sexual Abuse: A guide for primary care providers: http://www.csacliniciansguide.net/index.html |
| Military culture | • National Center for PTSD continuing education course, "Understanding the Context of Military Culture When Treating the Veteran with PTSD": https://www.ptsd.va.gov/professional/continuing_ed/military_culture.asp<br>• Center for Deployment Psychology military cultural competence course: http://deploymentpsych.org/online-courses/military-culture |

## Conclusion

This chapter reviewed key information to consider when providing care to survivors of military sexual assault and harassment, including the impact of those experiences on survivors' health and healthcare needs. Although the experience and effects of MSA/H mirror those of other forms of gender-based violence in some ways, there are also unique aspects to consider. In addition, every veteran's experience and recovery is different; some survivors may be doing quite well without significant subsequent problems, while others struggle with acute or chronic health and/or psychosocial concerns. Identity and cultural variables also intersect with and influence both the experience of and recovery from experiences of MAS/H.

Adapting your practice in simple but powerful ways to be sensitive to how MSA/H can impact health and healthcare will help you address the full range of each survivor's healthcare needs and facilitate more effective and efficient medical care. In doing so, you also have the opportunity to play a pivotal and reparative role in their healing process and help them move forward in their lives. This can be an incredibly rewarding experience. We hope you find this chapter a helpful and enduring resource to assist you in this work.

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## 6

# Sexual and Gender-Based Violence in Lesbian, Gay, Bisexual, Transgender, and Queer Communities

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## Introduction

Before the LGBTQ movement gained increasing visibility in the late twentieth century, gender and sexuality were regarded with rigid boundaries. However, the LGBTQ acronym now encompasses an ever-expanding spectrum of sexual orientations and gender identities. The chapter that follows will provide a basic foundation for understanding the continuously shifting landscape of gender and sexuality, before delving into a discussion of sexual and gender-based violence as it affects members of LGBTQ communities.

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## Defining LGBTQ

In Western society, gender has historically been constructed as a male/female dichotomy—in which one's genetic makeup and subjective gender identity were viewed as necessarily concordant, and with male the opposite of female. Gender was an "either/or" with no overlap. Those who did not ascribe to binary gender norms were pathologized and diagnosed with a psychiatric disorder. In recent decades, gender has become increasingly understood to fall along a spectrum, allowing for more nuanced approaches to self-identity and self-expression.

### Cisgender and Transgender

The term "cisgender" (or simply, "cis") has emerged to describe individuals who self-identify with the gender concordant with their sex assigned at birth (i.e., a person assigned female at birth identifying as a woman). Transgender is an umbrella term referring to those whose gender identity differs from their assigned sex. Under this umbrella, a trans woman is a person who identifies as a woman and was assigned male at birth, while a trans man is a person who identifies as a man and was assigned female at birth. People who identify outside of the male and female binary may be non-binary, gender queer, gender fluid, gender non-conforming, etc. The acronym TGNC (transgender and gender nonconforming) can be used to refer to this larger population.

### Gender Identity Versus Gender Expression

Another layer to add to our understanding of gender is the notion of gender expression. Complementary to gender identity, which refers to an internal state, gender expression refers to the external display of one's gender identity. Gender expression is how an individual conveys their masculinity and/or femininity through appearance, including clothing, mannerisms, speech, and hairstyle.

## Gender Identity Versus Sexual Orientation

Gender identity and expression must not be mistakenly conflated with sexual orientation. Ascribing to a particular gender identity does not imply any specific sexual orientation (i.e., being cisgender does not imply heterosexuality). Sexual orientation refers to the types of people to whom one feels sexual attraction, and encompasses attraction to men, women, both, or neither. Some people identify as pansexual and are open to a range of attractions. Many people of various sexual orientations are attracted to transgender and nonbinary people.

### LGBTQ Acronym

Since the turn of the twenty-first century, the LGBTQ acronym has expanded as new gender identities and sexual orientations come to light. The acronym itself stands for “lesbian, gay, bisexual, transgender, and queer or questioning.” The term “queer” is often used interchangeably with “LGBTQ” in reference to the fluidity of identities and orientations that are not heterosexual and/or cisgender. Queer is not just an umbrella term for gender and sexual minorities, but also often represents a political stance against enforced heterosexuality.

Sexual orientation and gender identity intersect in unique ways for the LGBTQ community; accordingly, we must consider the particular ways in which sexual and gender-based violence affects this community, and practical implications for clinicians. In this chapter, we will examine violence against the LGBTQ community both as a whole and for specific subgroups.

# Background

## Prevalence of Sexual and Gender-Based Violence (SGBV) in LGBTQ Communities

Members of LGBTQ communities experience significant discrimination, stigma, and violence—underpinnings of elevated rates of morbidity and mortality [1]. Violence against sexual and gender minority individuals is considered a form of hate crime, defined as “criminal offenses against a person (or property) motivated...by an offender’s bias against a race, religion, disability, sexual orientation, ethnicity, gender, or gender identity” [2]. In 2016, the Federal Bureau of Investigation reported 1255 hate crime incidents based on sexual orientation (anti-LGB) and 131 based on gender identity (anti-TGNC), accounting for intimidation, assault, rape, and murder [3]. Yet these statistics likely represent only a portion of the true extent of anti-LGBTQ violence in the USA due to lack of mandatory reporting and difficulty assessing perpetrator motives [4]. Other forms of bias-driven victimization are also disproportionately felt by the LGBTQ community, including bullying; physical and sexual assault; and verbal and physical harassment [5].

Furthermore, greater rates of violence are seen when gender identity and sexual orientation are considered in the context of race and ethnicity. The 2011 National Transgender Discrimination Survey found that transgender people of color experienced greater discrimination than whites across the board, with African American and American Indian/Native American respondents reporting the highest rates of police harassment, workplace harassment, and sexual assault. This ultimately contributes to low levels of educational attainment, job loss, and homelessness. Therefore, violence anchored to gender identity must be evaluated hand-in-hand with race and ethnicity—the hate crimes stemming from their confluence elucidate the potentially devastating effect of racism on the wellbeing of LGBTQ people of color.

## Special Considerations in Select LGBTQ Communities: Sex Work, Prisons

### Sex Work

Public spaces portend visibility, unwanted attention, and subsequent harassment/violence for sexual and/or gender minorities. This ultimately corrals LGBTQ individuals into the only spaces open to them—those that occupy the margins of society. This often means sex work and other underground economies (i.e., illicit drug trade). Some transgender people make a choice to participate in sex work as a good source of income that feels comfortable and rewarding. However, others, especially those transgender people who have faced family rejection, poverty, homelessness, or barriers to employment—all products of systematic, institutional, and interpersonal anti-LGBTQ discrimination—often find themselves turning to sex work for income, food, a place to sleep, or other basic goods and services essential for survival [6]. Trans sex workers, many of whom are trans women, are at greater risk for being victims of homicide (17 times the rate of the general population) [7], police-perpetrated physical and sexual violence, and discrimination in access to social services and shelters [8].

Sex workers face major barriers to reporting SGBV due to the criminalization of sex work in the USA and in many other countries around the world. Due to the criminalizable nature of sex work, violence that occurs in the context of sex work is not monitored by any formal bodies, and sex workers can claim little protection from the legal system [9]. As noted previously, contacting the police may only serve to incite additional SGBV against sex workers. Therefore, transgender individuals who engage in sex work are an especially vulnerable population and require considerably more attention from service providers.

## Prisons

Prisons are intimately linked to the sex work industry, and represent another site of disempowerment for the LGBTQ population. Sexual minorities are incarcerated at disproportionately higher rates relative to the general adult population (1882 per 100,000 LGB people vs. 612 per 100,000). Furthermore, those who are incarcerated experience higher rates of sexual victimization by staff and other inmates, higher rates of punitive isolation and other measures of punishment, and longer sentences [10]. Such discriminative measures converge onto the higher prevalence of psychological distress and mental health problems seen in incarcerated LGBTQ people. For this uniquely vulnerable population, excess sexual victimization and violence places them at higher risk for detrimental health outcomes. Providers who find themselves working with these marginalized populations should be aware of their heightened need for quality healthcare and likely distrust of providers or those in powerful positions.

## Intimate Partner Violence

An often-overlooked space in which SGBV against LGBTQ people occurs is the home. In contrast to other forms of bias-motivated violence (e.g., religion, race) in which perpetrators are more likely to be strangers, LGBTQ individuals are more likely to suffer verbal, physical, and sexual violence at the hands of close relatives or intimate partners [5]. This type of violence is classified as intimate partner violence (IPV), which includes "physical violence, sexual violence, stalking, and psychological aggression (including coercive acts) by a current or former intimate partner" [11].

Statistics from the Center for Disease Control's 2010 National Intimate Partner and Sexual Violence Survey (NISVS) found that lifetime rates of sexual assault were highest among bisexual women (46%) when compared to heterosexual women (17%); overall, a greater percentage of lesbian (44%) and bisexual (61%) women experienced physical or sexual violence by an intimate partner over the course of a lifetime, compared to heterosexual women (35%) [12]. Estimates of the lifetime prevalence of IPV among men who identify as gay (25–33%) and bisexual (37–87%) are strikingly higher than rates of IPV among heterosexual men (8–29%) [13, 14]. (This range comes from three studies that used representative sampling to examine IPV prevalence among gay men. Goldberg and Meyer [13] estimated 26.9%, Walters et al. [14] estimated 25.2%, and Messinger [15] estimated 33.3% lifetime prevalence of IPV among gay men. Other studies [16, 17] using purposive sampling report a greater range of estimates for the lifetime IPV prevalence among gay men, ranging from 13.9% to 44.0%.) Limited data inquiring into the rate of IPV among TGNC populations suggests that transgender people are more likely to experience IPV (31.1%) in their lifetime than cisgender people (20.4%) [18]. Taken as a whole, these numbers speak to the disproportionate impact that sexual and gender-based violence has on the LGBTQ community, with bisexual individuals and transgender people being most severely victimized.

## Underreporting of Violence

It is important to remember that the prevalence of violence is likely higher than what the data show. A discrepancy can be expected because the nature of IPV within the LGBTQ community may present differently from that between heterosexual partners, and thereby fail to be identified as IPV. Since the prevailing paradigm of IPV is the combination of a male perpetrator/female victim, deviations from this societally-defined "rule" of violence are more likely to be missed. Unconsciously ascribing to this ingrained perspective likewise informs the way we speak of the "ideal rape victim"—a conservatively-dressed woman who is sober, tells a consistent story, and was raped by a man who is a stranger [19]. This stereotype of the "ideal rape victim" was first identified by sociologist and criminologist Nils Christie, who explored the particular attributes of victims and perpetrators that legitimize their status as victim and perpetrator, respectively [20]. When these expected characteristics are not met, the public (i.e., media, police, doctors, etc.) is biased to reject the case as less believable. Therefore, in LGBTQ relationships, which largely fall into the category of "not ideal" perpetrator/victim stereotypes, there is a greater possibility that IPV and sexual violence fails to be correctly identified and compliants are less likely to be believed.

This theoretical framework is supported by the unique methods of abuse specific to LGBTQ relationships that are not seen in heteronormative relationships. The relationship between a perpetrator and victim can be illustrated by the widely recognized "Power and Control" wheel [21], which describes methods of perpetrating physical, emotional, and sexual abuse in a manner that renders victims powerless and without self-autonomy [22]. The prototypical pattern of IPV in simplified form, applicable to heteronormative relationships, comes down to an abusive man exerting control over a powerless woman. In LGBTQ relationships and in many heterosexual relationships, this well-defined male/female power dynamic is not always present. While the principles of perpetration remain the same, the arsenal of abuse differs: threatening to “out” one’s partner, questioning whether one’s partner is a “real” woman/man, or words and actions otherwise reinforcing internalized homophobia, biphobia, or transphobia [23]. Sexual and gender-based violence often manifests differently in LGBTQ relationships, in a way specific to the gender identities and sexual orientations of those involved, and therefore recognition requires a shift in mentality.

While all identities on the LGBTQ spectrum are subject to greater risk of victimization relative to the general population, research indicates that TGNC individuals may be at an even higher risk when compared to cisgender counterparts [18]. Forms of violence that are unique to TGNC individuals are largely a consequence of their greater visibility. Katz-Wise and Hyde note that “sexual orientation is often a hidden status, resulting in less victimization for those who are not visibly a sexual minority” [24]. In contrast, gender nonconforming individuals are more likely to be visibly “out” [25]—their visibility a consequence of the perceived discrepancies in secondary sex characteristics (voice, hair, build, etc.) and gender expression and presentation (makeup, hair, dress, etc.) that instigate violence. There are undoubtedly consequences associated with not conforming to historical notions of gender, such that conforming becomes a “strategy of survival” [26]. Gender nonconforming individuals and transgender individuals in the midst of transitioning are therefore especially at risk of experiencing gender-based violence.

Paradoxically, despite the higher prevalence of SGBV in the LGBTQ community, there is a greater likelihood that the violence goes unreported. Victims who identify as LGBTQ face additional barriers to reporting such crimes that heterosexual or cisgender victims do not face. Most prominently, there may be a reluctance to report due to fear of “outing” oneself to law enforcement, family, and/or friends, compounded with a fear of potential homophobia, biphobia, or transphobia [27]. For some individuals, being “out” may be a situation of life or death, should their support systems harbor anti-LGBTQ sentiments, or withdraw resources and isolate the victim, inflicting further victimization. Therefore, clinicians have the potential to play an important role in screening for, identifying, and addressing SGBV experienced by LGBTQ patients.

## Working with LGBTQ Clients Who Have Experienced SGBV

### Historical Considerations

LGBTQ communities have a long history of maltreatment by healthcare providers, including being labeled as “disordered,” attempts at “conversion” therapy, and refusal to be seen. Appropriately, LGBTQ individuals are often distrustful of healthcare providers. It is important for providers to take this into account when approaching LGBTQ clients, especially those with the additional trauma of SGBV. LGBTQ individuals are less likely to use primary care services, less likely to be forthcoming with their health care providers, and less likely to seek health care services when needed due to the history of discrimination [28, 29]. While this difference is documented nationally, the disparity is far greater in rural areas of the USA. Health care centers dedicated to LGBTQ populations, largely found in urban areas, have started to address these concerns, but there is significant work left to be done.

#### In the Room with LGBTQ Clients

Training in LGBTQ healthcare is not required by medical or mental health professionals in the USA. Because of a lack of training, many providers are unsure how best to approach LGBTQ clients, and especially those who are at high likelihood of having experienced SGBV. Starting with open-ended questions, which allow the client to bring in their chief concerns, can help provide a more comfortable space. Establishing the language a client would like the provider to use to refer to them is also important. Many transgender and nonbinary clients use names that differ from their legal names. Many of transgender people use traditional pronouns (i.e., he/him or she/her) but some do not. Nonbinary clients may prefer gender neutral pronouns, the most common of which is they/them. Providers may find it nerve-wracking to ask about names and pronouns, but clients typically respond well to straightforward, earnest inquiries, often as simple as, "What name would you like me to call you?" or "What pronouns do you use?"

When taking a medical or mental health history with LGBTQ clients, the goal is to strike a balance between approaching the client as you would any other and asking about elements of the history that may be specific to this population. One straightforward method of history-taking is to go through the traditional categories/questions, asking LGBTQ-specific questions at appropriate times during the process. As an example, a physician who does not know much about transgender populations might believe it is important to know right away whether a patient has had any surgeries, but the more natural place in conversation to ask about past surgeries would be during the surgical history that is asked of all patients.

With questions about SGBV, LGBTQ clients may be particularly guarded when speaking with new providers, for a number of reasons. If the client suspects that the provider is uneducated about LGBTQ people, the client may worry that the provider will not understand the circumstances of the abuse (e.g., violence in a same-sex relationship) or will not have proper resources to offer them. It is also not uncommon for LGBTQ people with a history of SGBV as children to make (erroneous) connections between their abuse and their sexual orientation or gender identity. Men who identify as gay, for example, may have complicated feelings, often rooted in shame, about childhood abuse by male perpetrators. For example, perpetrators may have chosen them due to percieved sexuality or victims may have experienced some pleasure during these episodes, leading them to believe that they "asked for it," or may have a sense that their gay identities are a result of these early experiences. One way to help put clients more at ease when asking about SGBV is to be up front with them that it is common to have conflicted feelings about their experiences.

After a thorough history, medical providers proceed to a physical exam. Like the history-taking part of the session, the physical exam can also be a vulnerable experience for LGBTQ people, particularly those with a history of SGBV. As with all clients, it is important to proceed slowly and to ask for consent before touching. Transgender and nonbinary clients, especially, may have complex relationships with their bodies. One approach that can help make the physical exam more comfortable for these clients is to ask about body parts and how they would prefer to have them named. Some transgender men, for example, refer to themselves as having a "front hole" rather than a vagina. Asking for and using the language a client prefers can make the experience of the physical exam less scary.

## Mental Health in LGBTQ Populations

Minority stress theory describes the ways in which the everyday stress of living as a minority in society has a negative effect on wellbeing. Because of increased rates of societal stigma and discrimination, LGBTQ people have been shown to be at higher risk for certain mental illnesses, as well as suicidality, self-harm, and substance abuse. Substance abuse rates in LGB populations are typically reported as three times the general population and LGB people have two to three times the risk of suicide. Among transgender people, staggering statistics show that up to 76% have a history of suicidal ideation and up to 41% a history of suicide attempts.

Though the subject has not been well-studied, the consensus among many clinicians is that LGBTQ populations have elevated rates of posttraumatic stress disorder, including complex PTSD, stemming from their increased likelihood of having experienced SGBV. These illnesses can often make clients guarded, suspicious, and difficult to interact with. Providers who routinely remind themselves of the reasons for these behaviors often have an easier time working with traumatized clients.

It can be easy to become discouraged when faced with the glum statistics about mental health in LGBTQ populations. However, there is also evidence that LGBTQ people demonstrate remarkable resilience in the face of difficult odds. Specifically, experiences of social support, family acceptance, and community connectedness have been identified as key promoters of resilience. Internal resilience factors such as individuals defining themselves, embracing their identities and oppression, taking pride in identity, and engaging in health-promoting behaviors and coping processes promote resilience against adversity. External activities such as finding empowering communities, seeking out connections in the LGBTQ community, and taking part in activism can also promote resilience in this population. Overall, as health professionals, while there are marked challenges for the LGBTQ population, the remarkable resilience and strength exemplified by this community can teach us all something about growing through adversity.

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# Part III

# Clinical Care

# The Trauma-Informed Examination

# 7

Veronica Ades

A note about terminology: Wherever possible, we have tried in this chapter to avoid gendered pronouns. The recommendations in this chapter come from experience in the EMPOWER Clinic, which is an OB-GYN clinic, and therefore when necessary, she and her pronouns are used to describe the patient and s/he to describe the provider. However, we encourage providers to be cognizant that not all patients in need of contraception or abortion identify as women and that an individual patient's gender identity and pronouns should be respected.

## Introduction

Examination of a patient with sexual trauma can be daunting, as most obstetrician- gynecologists are not explicitly taught how to manage patients with sexual trauma. The author of this chapter is the founder and director of the EMPOWER Clinic for Survivors of Sex Trafficking and Sexual Violence; therefore, the advice offered includes methods used by the EMPOWER Clinic, as well as potential alternatives to meet the needs of clinics that are structured differently. There is very little evidence to demonstrate

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many of the best practices described in this chapter; where little evidence exists, recommendations are made based on experience.

## Making Appointments, Checking In, and Registration Process

The patient visit starts with the process of scheduling an appointment. The scheduling, check-in, and registration process alone can be barriers to care. When a patient calls to schedule an appointment, the first attempt may be unsuccessful or frustrating because of a phone tree, reaching an incorrect department and being rerouted, or a number of other reasons. A typical patient may experience frustration but try again. However, patients with trauma may be more ambivalent about the care they are seeking and may be less persistent in seeking an appointment.

### Office Workflow

Careful consideration should be taken toward designing the office workflow and selecting office personnel to interact with survivors. For example, while the scheduling process for a typical patient may involve a centralized scheduling mechanism that can distribute patients to many providers and allow for flexibility of time and date, it may be more useful to route scheduling for survivors through a single staff member or through the provider directly. Or, rather than an appointment-based system, the facility could consider a walk-in appointment system for both new and follow-up visits, if feasible. This process depends on the workflow of the facility itself and the feasibility of arranging this. Furthermore, some patients, especially those with language barriers or severe trauma, may have their appointments scheduled by case managers or social workers. This can be of benefit to providers as well, since those case managers are usually then responsible for ensuring the patient's attendance at the visit, and can be a resource for follow-up.

## Training of Office Staff

While individual providers may be trained in trauma-specific care or may be aware of the impact of trauma, office staff rarely have access to resources or training in trauma-informed care. Therefore, it may be valuable to train office staff on trauma and provide specific procedures and parameters around interacting with patients identified as trauma survivors. Furthermore, the same trained office staff could offer sensitivity to all patients, even those not previously identified as having trauma, as many survivors exist in the general population.

Safety is a major concern for abused populations and especially for survivors of human trafficking. If patients may be vulnerable to revictimization by abusers or traffickers, it may be helpful to have an office that allows patients to be brought inside the clinic out of the main waiting room and have a more secure place to wait for their appointment. This may also be helpful to individuals who struggle with crowds, noise, and other overstimulation due to trauma.

## Accepting Patients by Referral Versus Self-Referral

The EMPOWER Clinic is dedicated to serving traumatized patients of the highest need: those who otherwise do not have access to care, have previously been too traumatized to seek care, or have had negative experiences in healthcare due to their trauma. For this reason, patients are accepted only by referral. These referrals can be made by a social service organization (i.e., an organization that provides social and/or legal services), case managers, lawyers, or therapists. This is helpful in triaging patients, confirming their appropriateness for enrollment in EMPOWER, and assisting with follow-up after the visits. These patients have high social service needs that would overwhelm a medical provider, so having contact with a referring source is invaluable.

However, this limits the access of other patients to trauma-informed services, and so this model may not be appropriate for every provider or clinic. In deciding on a referral system for a clinic devoted to trauma, providers should consider their target population, their capacity to accommodate a specific volume of patients, and the need to follow up with a referring source. Allowing self-referral improves access to care for patients who do not need or do not have a connection to a social service organization, but risks overwhelming providers with requests for appointments. Providers who choose to accept self-referral may want to create a triage system in order to screen the appropriateness of patients enrolling in their services (i.e., need for trauma-specific services) and consider which staff would be the most appropriate to receive and process referrals and make decisions regarding scheduling.

## Resources for New Identification of Trauma

Many patients with trauma have never disclosed their trauma to anyone or are not aware of social services available to them. Providers may encounter patients with trauma in the course of their typical practice and may not have the benefit of being able to contact a referring organization or individual. For this reason, it can be useful to be aware of the referring mechanisms within one's own practice and in the local community. Some practices may have a social worker on-site who can counsel patients and provide resources. In the community, there may be organizations that address domestic violence, legal services (such as legal aid), trafficking, and sexual violence. The appendix to this chapter lists national Web-based resources that may be valuable in helping providers identify local resources.

## Scheduling

It may be helpful to consider an alternate method of scheduling patients with trauma. There are several reasons for this: (1) patients with severe trauma may require longer visits than traditionally scheduled in routine outpatient care; (2) it is essential that patients disclosing or discussing trauma do not feel rushed during their visit and are confident that they have the provider's undivided attention; (3) scheduling can be better individualized to the needs of the patient prior to the visit, based on the anticipated trauma issues and clinical concerns. If patients with trauma are being seen in a specialized clinic, this can facilitate alternate scheduling methods, whereas this may be more difficult when patients with trauma are incorporated into routine panels.

The EMPOWER Clinic found, through trial and error, that the ideal visit duration is 1 hour for intake (new) visits and 30 minutes for repeat visits, with little to no overbooking if it can be avoided (though there are exceptions). While some intake visits require more than 1 hour, missed visits are common, and the extra room in the schedule allows some flexibility in timing. Duration of intake visits can also be varied depending on the information provided by the referring organization; based on the patient's trauma history, clinical needs (e.g., both exam and affidavit), or previous experiences with healthcare, the provider may decide to lengthen the intake duration to 90 minutes if needed.

## Registration Process

Registration processes can vary between outpatient facilities. Some have patients register in the same area in which they are to be seen, while others have a separate registration area or office. Providers who plan to see patients with trauma should be aware of their facility's registration process and consider which aspects of the process may present a barrier to care. For example, if registration is done in a separate area from the care services, patients may be turned away if they lack specific paperwork and registration personnel are not aware of the vulnerability of these patients. Therefore, it can be helpful to communicate a contingency plan and contact person if patients are turned away. For facilities in which registration takes place at the location of care delivery, this process may be easier to facilitate; nonetheless, patients may still encounter obstacles to registration that may need to be triaged by providers or clinic personnel who are familiar with trauma.

A patient with trauma who is turned away, especially if the encounter is adversarial, may be disinclined to return or seek care in the future, as the experience can reinforce their sense of disempowerment.

### Insurance Issues

Patients with trauma may or may not have health insurance. Access to health insurance varies greatly depending on location, and so providers should be aware of insurance eligibility in their area. Some patients, especially those who have experienced sex trafficking, may be undocumented and therefore ineligible for Medicaid or other health insurance options. Some facilities may have processes for providing care to uninsured populations, and these processes should be made explicit to referring personnel and/or patients prior to scheduling appointments.

## Obtaining Patient History

Providers who are aware of their patient's trauma history prior to the appointment may want to modify their history-taking in the ways illustrated below. Patients may also disclose previously unreported trauma in the course of a routine visit; this is addressed at the end of this section.

### Privacy

Patients should always be seen alone. Some patients may be accompanied by family members, friends, or case managers. Many of these accompanying individuals may help to comfort the patient and may be an overall beneficial influence; however, there is no way to verify this prior to the visit. Patients with a history of trauma are uniquely vulnerable to revictimization, and therefore, the provider must initiate the visit and take the history without any accompanying personnel. The presence of another individual in the room may also make it more difficult for patients to disclose elements of their trauma history that the survivor feels ashamed of.

Furthermore, patients may not want to disclose any or all of the trauma to the provider, but may feel obligated to do so. In order to avoid this awkwardness, seeing the patient alone and allowing her to disclose only what she is comfortable disclosing help to empower the patient to make this decision for herself. The presence of case managers may especially make patients feel that they have to disclose everything, or case managers may feel obligated to correct the information given by the patient.

## Introduction to the Patient

A formal introduction to the patient by the provider can help to create a sense of respect and welcome. In a clinic or setting specifically dedicated to seeing patients with trauma, the provider can ask the patient what the referring organization told the patient about what kind of medical care to anticipate and introduce herself or himself as a specialist in sexual trauma (or the specific trauma that the patient has experienced). This can help in two ways: (1) the provider is the first person to openly state the type of trauma, relieving the patient of this responsibility; (2) it acknowledges that this type of trauma is important and deserving of specialized attention and care.

## Modifications to Routine History-Taking

The typical history includes a history of present illness, past medical and surgical history, past obstetric and gynecological history (for obstetrician-gynecologists), current medications, allergies, social history, and family history. We recommend starting the visit with the routine history; this helps to give time to form a trust bond with the patient prior to initiating a discussion of trauma, which may be stressful. Once the full history is taken, the provider can then broach the subject of the trauma.

## Taking a Social History

The social history typically includes exposure to toxic substances (tobacco, alcohol, drugs). In addition, it can be helpful to ask where the patient lives (e.g., shelter vs. apartment), who the patient lives with, and whether there is any ongoing domestic or intimate partner violence (IPV) (patients with prior trauma are vulnerable to future IPV). In addition, asking about current employment or enrollment in school can help to assess the patient's economic vulnerability and engagement with the workforce, which may be a resilience factor.

## Discussion of Trauma

We recommend providing an opportunity to disclose trauma but specifying that it is not required or necessary. Having the patient recount the narrative or provide too many details runs the risk of re-traumatizing her, creating flooding (excessive emotional and psychological reaction to recounting her history) and/or solidifying the memory. The provider can ask specific questions that are necessary to assess safety, for example:

- When did the trauma occur?
- When did the traumatic experience end?
- How did the patient escape or stop the traumatic experience?
- Who was the abuser, and is the patient still in contact with the person/people?
- Is the patient at risk of revictimization by the abuser (e.g., reentry into trafficking)?

If the patient chooses to narrate the history of trauma, the provider should carefully monitor her emotional status for signs of flooding. This can include pressured speech, uncontrolled crying, hyperventilation, and dissociation. If flooding seems to be occurring, the provider should intervene to calm the patient and redirect the discussion away from the more psychologically difficult aspects of the trauma. In order to reassure the patient that the interruption is for her own benefit, the provider can openly note that the patient seems upset and that it may be helpful to calm a little or talk about something else for the time being. This can help reassure the patient that a discussion of trauma is not being rejected by the provider, but that the provider is looking out for the patient's best interests.

While taking a trauma history, it is important that the provider is not typing or otherwise distracted. The provider should appear calm, should make eye contact, and should try not to divert attention from the patient's narrative. The provider can interrupt to guide the narrative, or to express sympathy or concern, but should allow the trauma discussion to be relatively open-ended.

The trauma history can be recorded later in narrative form, or whatever is most helpful to the provider. The only exception is when a trauma history is being taken for the purpose of providing an affidavit. In this case, it is important to record the history in real time as accurately as possible and some of the patient's wording verbatim. The provider can explain that s/he needs to type as the patient speaks in order to record directly for accuracy, so that the patient understands the reason for potentially diverted attention.

## Standardized Assessments

Certain assessments may be of value in ascertaining current psychological status or assessing for other traumas. These assessments can be completed by patients independently prior to the visit, or they can be administered verbally by the provider or clinic staff. A more complete description of these assessments can be found in Chap. 8.

- The Adverse Childhood Experiences (ACE) questionnaire assesses for childhood traumas that occurred before the age of 18.
- The Patient Health Questionnaire-9 (PHQ-9) is used to screen for depression.
- The PTSD module of the Mini-International Neuropsychiatric Interview (MINI) can be used to screen for PTSD.

## The Role of the Clinician

A clinician caring for patients with sexual trauma has multiple roles. First, the clinician provides medical care, as expected. But the clinician also has a powerful role to play in a patient's recovery. Many people ascribe to doctors (and other clinical care providers) a high degree of authority and respect. This is a double-edged sword; providers' status can be intimidating, but it can also be wielded to reinforce positive messages regarding trauma and encourage psychological healing. When a doctor addresses a patient's trauma, the doctor is usually reinforcing many of the messages communicated by a therapist or case manager, but the fact of the message being reinforced by someone in a position of authority in the patient's mind can make it especially powerful. A clinician who takes the time to listen to a patient's trauma narrative, and who frames the trauma within the context of clinical care, can help the patient confront and grapple with the trauma in a way that may hopefully seem less shameful or insurmountable.

This also means that a clinician can do damage by transmitting the wrong messages. Many survivors are struggling with negative stereotypes and assumptions from society and from their own shame. A clinician who seems impatient or brusque and who belittles or dismisses a patient's trauma will reinforce these negative messages. This will, in turn, limit the ability to build rapport and could interfere with the patient's willingness to seek care in the future.

The role of the clinician is not to be a social worker or therapist, and this should remain explicitly clear. Clinicians are limited in time and must attend to multiple patients in a short amount of time. Patients with sexual trauma may have a high number of social and psychological needs. The clinician should express concern for these issues and attempt to harness resources to help but risks becoming occupied with time-consuming nonclinical tasks if s/he does not delegate the handling of these needs to other individuals.

## Helpful Tips and Phrases

If the trauma is already known to the clinician at the beginning of the encounter (e.g., if the patient was referred for this purpose), it can be helpful for the clinician to broach the subject first, relieving the patient of the burden of disclosure. If the clinician has experience with sexual trauma or the specific issue that the patient is presenting with (e.g., female genital cutting), explicitly stating that expertise at the beginning of the visit can help reassure the patient that the care will be trauma-informed.

Patients may feel too tense at the beginning of an encounter to discuss their trauma, and therefore, it is usually helpful to take a full medical history before inquiring about the trauma. This sets the tone, establishes that the patient's medical concerns will be taken seriously, and gives the patient time to decide that she has sufficient rapport with the clinician to discuss a difficult subject in detail.

Many patients with trauma carry a burden of shame and often blame themselves for their own victimization. They may use terminology that implies this self-blame, such as "I am ruined" or "I am worthless." The clinician should point out this terminology and try to reframe the narrative. It can be helpful to talk about trauma and specifically about PTSD, as a common response to trauma. The clinician can focus on the internal strength required by the patient to survive their trauma and reframe the narrative as one of strength and survival, rather than weakness or self-condemnation.

When taking a trauma narrative, it is imperative to demonstrate empathy, but not exaggerated horror or shock. Many patients' stories can be upsetting, but the patient should not feel that theirs is particularly unnerving, nor should the patient be in the position of comforting the clinician or managing the clinician's emotions.

The use of the ACE questionnaire, as well as a thorough trauma narrative, can help the clinician to broach the subject of trauma and discuss with the patient what impact the patient feels trauma has had on her life and medical care. The clinician can also discuss the augmenting impact of multiple traumas, which is a phenomenon often instinctively recognized by patients but rarely openly acknowledged.

## Previously Undisclosed Trauma

In some cases, the clinician may not be aware of the patient's trauma in advance of the visit, but it is disclosed during history-taking. In this situation, it is important for the clinician to show that her or his full attention is on the patient. If the clinician is typing or otherwise distracted when the trauma is disclosed, it is important to stop and calmly focus on the patient and offer the opportunity to provide more information. Long silences are common while the patient summons the courage to elaborate. The clinician can offer tissues if the patient starts to cry and can reassure the patient that it is OK and normal to be upset and can encourage her to disclose if she feels ready. The clinician can also emphasize that many people have experienced sexual trauma and that the patient is not alone.

Once the patient has disclosed trauma, she may be upset. The clinician should ask if she is ready to move forward with the exam (if one is indicated) or if she prefers to return another day. This decision can be entirely up to the patient, and making the decision is often empowering.

## The Physical Examination

### Pace of the Exam

A typical routine exam is fairly quick and efficient. However, individuals with trauma may exhibit anxiety or jumpiness when it comes time for the exam and may need a slower pace. The clinician should ensure that the patient is fully covered by a gown and/or sheets (if the patient needed to change). When uncovering body parts, the clinician should try to uncover only one body part at a time, with as little exposure as possible. The clinician should briefly explain each element of the exam and the purpose, pausing slightly to allow the patient to process. Often patients exhibit a fight-or-flight response that makes it difficult to listen to instruction and explanation, so a calm, slow pace can be helpful in providing time for the patient to listen.

## Presence of Other Personnel

It is helpful to limit the number of people in the room. Many clinicians, especially gynecologists, have an assistant in the room to handle materials and instruments. This can be helpful, as the assistant can monitor for signs of distress or dissociation and can hold the patient's hand if needed. The assistant should be positioned so that she cannot see the patient's perineum, and the assistant can explain the purpose for her presence in the room. Having observers (e.g., students) in the room can be detrimental, as many survivors already feel self-conscious.

Patients may request to have a friend or family member accompany them for the exam; this request should be accommodated as long as the accompanying person would likely be helpful as per the judgement of the clinician. This person should also be positioned at the patient's head so that the perineum is not visible. If a procedure is expected to be painful, the clinician can explain this to the accompanying person so that s/he is prepared.

## Tips on Conducting Exam

Each aspect of the exam should be explained to the patient, as described above. The breast and pelvic exams tend to be the most stressful elements. During the breast exam, the clinician can explain what she is feeling for and how the patient can conduct a breast self-exam.

To prepare for the pelvic exam, the clinician can ask if the patient has had a pelvic exam before and, if so, whether there are any modifications she has noted to be helpful in tolerating the exam. For patients who have never or rarely had a pelvic exam, the clinician can explain the exam in advance and reassure the patient that she will go slowly and walk her through it.

The patient is asked to place her feet in the footrests (never "stirrups") and how to position herself on the table. Many survivors will tightly close their knees and need encouragement to open the legs for the exam. The clinician should avoid using her hands to position the legs but instead explain to the patient how to open her knees and why it can be helpful in tolerating the exam to open the legs further. The clinician can demonstrate with her hands where she would like the patient's knees to be when in the proper position. The process of opening their legs may be slow and require patience, but it is important to take time to do this without showing irritation as it sets the tone for the rest of the exam.

Once the patient is properly positioned, the clinician can prepare her for the speculum exam by first gently touching the leg, then the thigh, and then the labia majora, while explaining what s/he is doing. Patients with trauma may jump or react during this process, so it can be helpful to calmly repeat until she is desensitized to the touch sensation.

In order to broach the speculum and bimanual examinations, the clinician should explain involuntary and voluntary muscle control of perineal muscles. The clinician can touch the perineum in the approximate location of the perineal muscles and explain that the patient will have an involuntary reaction to contract the muscles, but she can consciously overcome the instinctive response and relax the muscles.

The clinician should then slowly introduce the speculum. If she encounters constriction of the perineal muscles, it is important not to continue inserting the speculum, but to stop and explain again the muscle control. The clinician can also touch the perineal muscles with one finger and help the patient to locate the muscle she needs to consciously relax. This part of the exam can also take a long time but should be slow and deliberate. Once the patient is able to relax the perineal muscle, the clinician can proceed with insertion of the speculum. It can be helpful to insert only the tip of the speculum and pause to detect further perineal muscle contraction and allow for relaxation. Once the tip of the speculum is beyond the perineum, insertion can be conducted more smoothly, but should still be at a gentle pace. The clinician should offer encouragement and then warn the patient that opening the speculum will create a sensation of pressure but not pain. If adjustment of the speculum is required, this should be explained to the patient, and the clinician should avoid jerky or rapid movements. Once the cervix is visualized, the visual inspection and taking of samples should be conducted efficiently, but gently, and explained throughout. The speculum can be gently removed and encouragement provided to the patient for tolerating it. The bimanual exam can be explained. Most patients can tolerate two fingers for the bimanual examination, but for patients with a small perineum, who are menopausal, or still intolerant of the exam, one finger can be used. The pace should be the same as for the speculum exam, so as to avoid startling the patient.

## Discussion of Examination Findings

Once both examinations are complete, if all findings are normal, it is important that the clinician verbalizes this and not assume the patient will realize it. Many patients with trauma suspect that their trauma is reflected physically and are anticipating some kind of abnormality to be detected on examination. The clinician's explicit statement to the contrary can be highly reassuring.

If the patient has specific symptoms that are explained by the examination (e.g., fibroids or pelvic mass), the clinician can explain and normalize this; specifically, she should address that these problems have nothing to do with the patient's trauma experience and can be present in women who have never experienced trauma.

## Planning for Follow-Up

Follow-up plans should be explicitly discussed and may require reiteration. In patients for whom the pelvic examination was unusually stressful, they may need a few minutes to regroup before they can absorb further instruction. Writing or drawing findings (if present) may be helpful.

If the patient came with a case manager, family member, or friend, the clinician can offer to explain all findings to the patient and then repeat with the accompanying person if the patient wants. However, this should be framed as strictly up to the patient, and she can decide to limit the information transmitted to others. Patients with trauma may be unusually concerned with privacy and disclosure, so privacy standards and laws (such as HIPAA) should be explicitly discussed to help the patient understand her privacy rights and reassure her of confidentiality.

## Cultural Considerations

Patients from developing countries may be unfamiliar with standards and expectations of the American healthcare system. For example, some individuals may come from places where primary care is uncommon, and the norm is to present for care only in the context of illness. Therefore, it can be helpful to discuss the expectations of primary care and care-seeking behavior. For example, annual wellness visits, Pap smears, and routine testing can be explained. In addition, the clinician can specify that the patient herself is expected to present for these visits and may or may not receive reminders, depending on the practices of the facility.

Additionally, it is helpful to keep in mind cultural differences in approaching doctors. Some patients may view doctors as having exceptional authority and may be reluctant to ask questions or indicate that they did not understand the instructions. It can be helpful to solicit verbal confirmation or ask the patient to explain the findings and instructions to confirm their understanding. The clinician can also specify that the patient can feel comfortable asking questions and that it is important that she understands the instructions.

## Follow-Up and Communication

Many patients with sexual trauma are grappling with many ongoing challenges, including poverty, food insecurity, therapy, work or work-seeking, child care, and legal issues. These demands on their time and attention can overshadow medical follow-up, and therefore, a plan for follow-up should be made, especially in cases where specific findings or conditions need to be managed. Follow-up appointments can be scheduled before the patient leaves the office, and patients can be provided with a mechanism for reaching the clinician, either through their case manager or through the office or both, to reduce the likelihood of loss to follow-up. Additionally, many low-income patients have variable access to cellular telephone service, as they have transient phone plans and may not be able to pay their bill for stretches of time. It can be helpful to have alternate contacts, whether through a case manager, family member, or email address. Facilitation of communication should be carefully considered and tailored to the patient population of the clinician.

## Summary

This chapter discusses the various considerations needed in order to design an outpatient visit for a patient with sexual trauma. Modifications should be made to the process of examining a patient to be sensitive to the survivor's trauma and potential for triggering. Similarly, the office experience should be considered from a trauma-informed perspective to reduce stress and minimize obstacles to care. Everything from the office workflow, scheduling systems, and insurance and billing must be considered in terms of how they could potentially affect the patient experience. This chapter offers the EMPOWER Clinic as a model; not all clinics for populations with trauma must follow this formula. Different clinics should consider their own settings and patient population to determine an optimal workflow process. Nonetheless, the impact of trauma should be considered at each step.

## Additional Resources

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Ades, et al. An integrated, trauma-informed care model for female survivors of sexual violence: The Engage, Motivate, Protect, Organize, Self-Worth, Educate, Respect (EMPOWER) Clinic. Obstet Gynecol. 2019; 133(4):803–9.

CDC website on Adverse Childhood Experiences (ACE) Study. https://www.integration.samhsa.gov/clinical-practice/trauma-informed.

SAMHSA-HRSA Center for Integrated Health Solutions website on trauma and trauma-informed approaches. https://www.integration.samhsa.gov/clinical-practice/trauma-informed.

SAMHSA's Concept of trauma and guidance for a trauma-informed approach. https://store.samhsa.gov/system/files/sma14-4884.pdf.

# 8

# An Integrated Mental Healthcare Model for the Patient with Sexual Trauma

Judy A. Greene

## Introduction

Sexual violence can have serious and lasting mental health consequences. While not all survivors suffer from mental health sequelae, many survivors develop post-traumatic stress disorder (PTSD), affective, anxiety, and substance use disorders [1, 2]. The risk of PTSD is particularly high after sexual violence. A 2018 systematic review yielding 39 relevant studies of more than 88,000 participants found a lifetime prevalence of PTSD after sexual assault of 36% (95% CI 31–41%) [3].

Sexual violence can also be associated with a number of physical health complaints and sequelae. These include elevated prevalence of asthma, diabetes, irritable bowel syndrome, headaches, sleep disorders, chronic pain, dysmenorrhea, vaginal infections, urinary tract infections, chronic pelvic pain, irregular menstrual cycles, dyspareunia, menorrhagia, and sexually transmitted infections [4–7].

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The epidemiology, diagnosis, and management of trauma have been covered extensively. The purpose of this chapter is to describe an integrated care model for mental health management for survivors of sexual trauma, the EMPOWER Clinic for Survivors of Sex Trafficking and Sexual Violence.

## The EMPOWER Clinic

The EMPOWER Clinic was established in 2013 in order to reduce obstacles to care and provide trauma-informed obstetric and gynecologic care to survivors of sexual trauma. The clinic is located in New York City, within Gouverneur Health, a freestanding outpatient facility that is part of the Health & Hospitals public hospital network. Initially, the clinic consisted only of an obstetrician-gynecologist and a medical assistant. A psychiatrist was added to the clinic in 2015 in an integrated care model. All patients are referred to the EMPOWER Clinic by social service organizations. A more complete description of the EMPOWER Clinic is available in a paper by Ades et al. [8]. In this chapter, the EMPOWER Clinic is used as an example of an integrated care model.

## Definition of Integrated Care

Integrated care is not one single model of care and can encompass a range of types of integration. The degree of integration may be minimal, basic, or close. Facilities, scheduling, and medical record systems may be separate or shared [9]. Traditionally, the provision of behavioral healthcare and physical healthcare has taken place within individual silos, and workflows have developed around the individual practices. Integrated care not only requires colocating services but also requires a radical shift in practice for both medical and mental health providers [10].

### Benefits of Integrated Care

There are very clear benefits of integrated care. Mental health conditions create a high burden of disease and a large unmet need for care [11]. Mental and physical health problems not only often coexist but also are interconnected, and integrating care improves outcomes for both [11]. Integration improves access to mental healthcare and improves health outcomes for both physical health conditions and mental health conditions [11–13]. Focusing on the healthcare needs of individuals receiving mental health services improves uptake of preventive health services [13]. Furthermore, integration of care is cost-effective and substantially reduces overall healthcare costs [11, 13]. No single integrated care model is most effective; instead, creating an integrated care practice requires consideration of local practice systems and logistics in applying broad principles [11].

## Challenges in Integrated Care

Integrated care may have some challenges that demand attention. The practice shift required from both specialties should not be underestimated and requires specific effort to carry out successfully [10]. The information sharing that takes place within integrated care may be unfamiliar and require creation of new systems to seamlessly integrate [10]. Confidentiality may be a concern; while HIPAA laws apply broadly to all healthcare providers, mental health and substance abuse records may have special protections unfamiliar to physical health providers [10]. While the sharing of information between providers within an integrated system is usually permitted under privacy laws, regulations around mental health and substance abuse records may be more stringent [10]. Since payment and coding structures for physical and mental health were developed separately, corresponding issues may arise with integrated care, For example, payors may restrict the ability to bill for care provision and therapy on the same day. Other issues include differing co-payments, categorizing mental health and/or substance abuse treatment as specialist care, and authorization requirements.

## Levels of Integrated Care

A standard framework proposed by the Substance Abuse and Mental Health Services Administration-Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated

Health Solutions described six levels of integrated care, depicted in Fig. 8.1. In the first two levels, systems and facilities are not shared, but providers communicate about mutual patients. In levels 3 and 4, care is colocated, either in the same facility or practice space, and some but not all systems may be shared. In levels 5 and 6, there is not only colocation but also close collaboration between providers in a way that changes the practice patterns of both, and providers work together to improve the patient experience [9]. The model described here most closely resembles level 6, as described by SAMHSA, in which previously separate systems are merged into a single practice, and both patients and providers view the operation as a single system. The overarching goal of this level is holistic care [9].

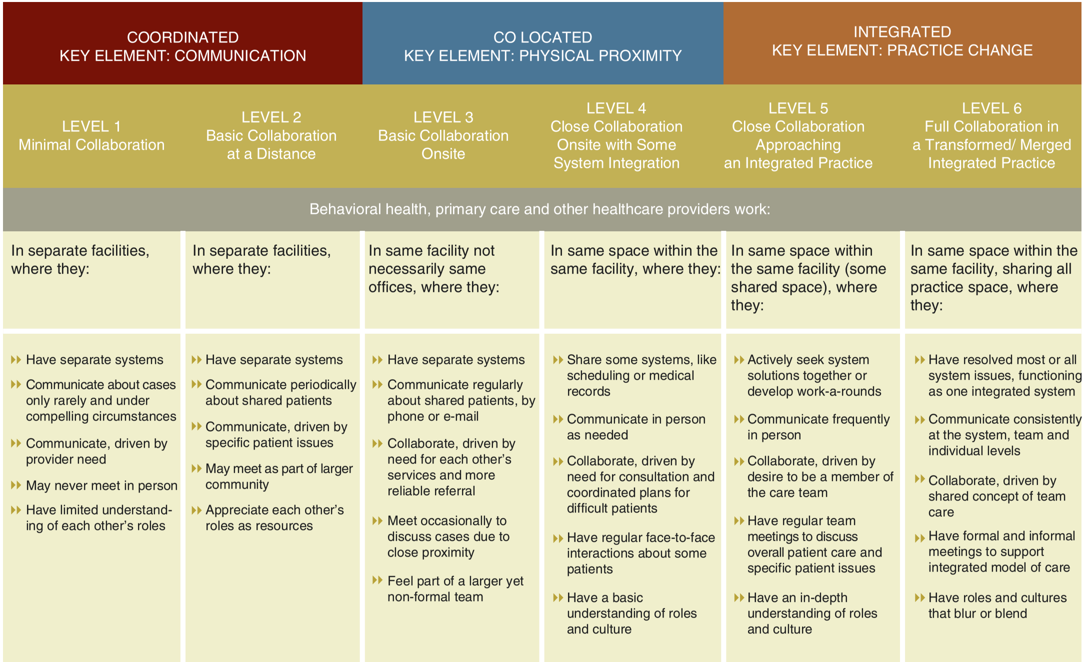
### Integrated Care in the EMPOWER Clinic

A collaborative care model between medical and behavioral health providers has been shown to be particularly helpful in the management of comorbid psychiatric and chronic illnesses [12]. Having a psychiatrist on site was integral in order to optimize the medical care for the EMPOWER population who may be reluctant to obtain mental healthcare due to fear of stigmatization and re-traumatization. The psychiatrist is present at EMPOWER for both scheduled and ad hoc visits, allowing for flexibility that meet the patient's needs. For patients who have access to a therapist through their referring organization, but do not have access to a psychiatrist, the EMPOWER psychiatrist is able to collaborate with the referring therapist to optimize the behavioral healthcare treatment [8].

## The Psychiatric Evaluation

### Timing of Visit

The integrated care model facilitates timing the mental health visit with other medical visits. The convenience of dual visits reduces barriers to care and provides an opportunity for collabora-



| COORDINATED<br>KEY ELEMENT: COMMUNICATION | | CO LOCATED<br>KEY ELEMENT: PHYSICAL PROXIMITY | | INTEGRATED<br>KEY ELEMENT: PRACTICE CHANGE | |
|---|---|---|---|---|---|
| LEVEL 1<br>Minimal Collaboration | LEVEL 2<br>Basic Collaboration at a Distance | LEVEL 3<br>Basic Collaboration Onsite | LEVEL 4<br>Close Collaboration Onsite with Some System Integration | LEVEL 5<br>Close Collaboration Approaching an Integrated Practice | LEVEL 6<br>Full Collaboration in a Transformed/ Merged Integrated Practice |
| Behavioral health, primary care and other healthcare providers work: | | | | | |
| In separate facilities, where they: | In separate facilities, where they: | In same facility not necessarily same offices, where they: | In same space within the same facility, where they: | In same space within the same facility (some shared space), where they: | In same space within the same facility, sharing all practice space, where they: |
| ▸▸ Have separate systems<br>▸▸ Communicate about cases only rarely and under compelling circumstances<br>▸▸ Communicate, driven by provider need<br>▸▸ May never meet in person<br>▸▸ Have limited understanding of each other's roles | ▸▸ Have separate systems<br>▸▸ Communicate periodically about shared patients<br>▸▸ Communicate, driven by specific patient issues<br>▸▸ May meet as part of larger community<br>▸▸ Appreciate each other's roles as resources | ▸▸ Have separate systems<br>▸▸ Communicate regularly about shared patients, by phone or e-mail<br>▸▸ Collaborate, driven by need for each other's services and more reliable referral<br>▸▸ Meet occasionally to discuss cases due to close proximity<br>▸▸ Feel part of a larger yet non-formal team | ▸▸ Share some systems, like scheduling or medical records<br>▸▸ Communicate in person as needed<br>▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients<br>▸▸ Have regular face-to-face interactions about some patients<br>▸▸ Have a basic understanding of roles and culture | ▸▸ Actively seek system solutions together or develop work-a-rounds<br>▸▸ Communicate frequently in person<br>▸▸ Collaborate, driven by desire to be a member of the care team<br>▸▸ Have regular team meetings to discuss overall patient care and specific patient issues<br>▸▸ Have an in-depth understanding of roles and culture | ▸▸ Have resolved most or all system issues, functioning as one integrated system<br>▸▸ Communicate consistently at the system, team and individual levels<br>▸▸ Collaborate, driven by shared concept of team care<br>▸▸ Have formal and informal meetings to support integrated model of care<br>▸▸ Have roles and cultures that blur or blend |

**Fig. 8.1** Six levels of collaboration/integration of integrated care. (Reprinted from Heath et al. [9] (Public domain))

tive care. For example, a somatic complaint may have physiological origin but may also be exacerbated by depression, anxiety, or other mental health conditions. If both the physical health and mental health providers are able to evaluate the patient on the same day, it can lead to a more holistic evaluation of the patient's conditions. Additionally, the integrated care model allows the psychiatrist to be readily available to patients who have not been scheduled for a psychiatric evaluation, but who are identified by another provider as needing an evaluation. The introduction to the psychiatrist by a trusted provider can reduce barriers to care by normalizing and destigmatizing the mental health visit.

Women who come for medical intake visits can be offered a consultation with the psychiatrist on the same day as their intake visit whenever possible. If the survivor offers details of the trauma history to the medical provider, this history should be documented in detail in the medical record. The psychiatrist can then avoid retraumatizing the patient by reasking many of the same questions or requesting that the patient recount traumatic events and instead rely on the narrative already documented. This permits the psychiatrist to focus on the mental health symptoms and management. The psychiatrist can explain that the integrated care clinic is a safe place to discuss the emotional and physical impact of her previous traumatic experiences.

## Intake Visit

The psychiatry intake involves a standard psychiatric evaluation. Particular attention is paid to assessing for a lifetime history of depression, hypomania or mania, post-traumatic stress disorder (PTSD), anxiety disorders, psychosis, substance use disorders, and eating disorders. The psychiatrist reviews current psychiatric symptoms and assesses safety. If a patient reports suicidal or homicidal ideation, immediate emergency assistance is obtained, and the patient is escorted to the nearest psychiatric emergency room. The psychiatrist can then resume care for the patient after discharge from the hospital [8].

## Standardized Assessments

Sexual and Gender Based Violence (SGBV) survivors have a high prevalence of psychiatric conditions; for this reason, standardized screenings should be undertaken to identify conditions such as PTSD, affective disorders, anxiety, substance abuse disorders, and suicidal ideation.

Several standardized assessments are recommended for a population with sexual trauma.

1. The Adverse Childhood Experience (ACE) questionnaire is a 10-question validated tool for asking about childhood traumas that occurred before the age of 18. This questionnaire was validated in a large study published in 1998 that demonstrated association with several behavioral risk factors that are associated with the leading causes of death in adults. The ACE questionnaire includes questions about physical and sexual abuse, family violence, and neglect. A high ACE score has been associated with an increased risk of adverse health risk factors, such as obesity, substance abuse, and smoking [14]. Survivors referred for integrated care may have had one trauma identified, but may not have disclosed all of their previous traumatic experiences, or may not have recognized earlier life traumatic experiences as traumatic. Administering the ACE questionnaire allows the psychiatrist to discuss the multiplicative impact of multiple traumas.
2. The patient health questionnaire (PHQ-9) is a standardized screening tool for depression. The risk of depression is very high in patients with sexual trauma, and even patients who do not exhibit depression at the time of intake may have experienced depression in the past and may be at risk for future depressive episodes [14]. Patients with a PHQ-9 score > 10 can be further assessed by the psychiatrist to confirm the diagnosis of depression and to consider management options. For patients who have a PHQ-9 score < 10 indicating low to mild depressive symptoms, the psychiatrist can discuss the symptoms of depression with the survivor and provide parameters for return for evaluation if symptoms develop.

3. The PTSD module of the Mini International Neuropsychiatric Interview (MINI-PTSD) is a standardized assessment that can be used for psychiatric diagnosis. Patients with sexual trauma are also at high risk for post-traumatic stress disorder (PTSD). The PTSD section of the MINI (MINI-PTSD) can be administered to all patients to permit assessment for PTSD. This questionnaire is not routinely used in primary care and other nonbehavioral health practices, and therefore, providers may be less comfortable with it than the PHQ-9 and may choose not to use it. Nonetheless, it can be a valuable tool to identify patients in need of referral. As with the PHQ-9, providers should have a referral process for patients who screen positive with the MINI-PTSD.

## Management

Patients who are diagnosed with depression, PTSD, anxiety, and bipolar disorder can be managed within the integrated care setting. Patients with substance use disorders, eating disorders, or personality disorders may require specialized treatment tailored to their condition if such treatment is not available within the integrated care setting. However, given the high prevalence of these disorders among sexual trauma survivors, it may be optimal to design an integrated care model that can accommodate the treatment of comorbid substance abuse, eating disorders, and personality disorders. For example, in a setting with a high prevalence of current or former opioid users, it may be useful to include an opioid maintenance program.

Some patients with sexual trauma may be working with social service organizations that provide psychotherapy or may have a therapist prior to intake. In these cases, it would be counterproductive to interrupt the therapeutic bond with a therapist and enroll the patient in comprehensive mental health services that include therapy. The integrated care model can provide psychiatric services and collaboration with the outside therapist and allow the patient to preserve the established therapeutic treatment. The psychiatrist performs an assessment of the patient's current mental health state and can discuss the progress and treatment plan with the therapist.

The psychiatrist provides medication management, which can augment the effectiveness of therapy in appropriate cases. Some options for medication management are briefly described below:

- Selective serotonin reuptake inhibitors can reduce PTSD severity. Patients started on SSRIs should be evaluated within 2 weeks of initiation to assess for side effects, to monitor for any suicidal ideation, and in order to titrate the medication to a therapeutic dose [15]. Once the appropriate therapeutic dose has been identified, SSRIs should be continued at that dose for 6–12 months and then gradually tapered. Patients should be counseled that sudden discontinuation can increase the risk of recurrence of symptoms [16].
- Prazosin is an alpha-adrenergic receptor blocker that can be used off-label to improve PTSD-related insomnia and nightmares [17, 18]. Prazosin is started at a low dose and titrated up as appropriate. Patients should be monitored for hypotension and advised not to discontinue abruptly as rebound hypertension can result after chronic use.
- Mirtazapine is another option for PTSD-related insomnia.
- Benzodiazepines have not been shown to be effective in patients with PTSD, can worsen PTSD symptoms, and therefore are not recommended for PTSD-related insomnia [19].

The psychiatrist can also recommend other treatment strategies if they may be of benefit, such as trauma-focused cognitive behavioral therapy (TF-CBT), dialectical behavioral therapy (DBT), or trauma-focused therapies such as eye movement desensitization and reprocessing (EMDR).

## Ongoing Management

Within the integrated care model, patients can continue their psychiatric follow-up in the medical home, even if further medical visits are not needed. If a patient needs both medical and mental health follow-up, these visits can be scheduled on the same day whenever possible to reduce barriers to care.

## Unique Aspects of Care

### Safety Concerns

Many SGBV survivors still have contact with their abusers, whether that contact is desired or not. Some survivors may share children with their abusers or may have been abused by a family member and therefore are unable to fully remove the abuser from their life. Some survivors may continue to be stalked by their abusers. Trafficking survivors who escaped their traffickers may be at risk of re-trafficking if they encounter their trafficker in a public setting. Some survivors may still be in a relationship with their abuser, given the complicated nature of abusive relationships and the difficulty of leaving them. For this reason, SGBV survivors may have heightened safety concerns that affect their ability to access care.

The integrated care model can address some of these concerns through thoughtful process design. Check-in staff, such as front desk staff and nursing staff, should be aware of safety concerns and should not disclose the presence (or appointment status) of any patient to unknown individuals. A smaller, more private waiting area can be designated for patients to wait after check-in so that they do not have to wait in the large, more publicly accessible waiting area. Patients may want to bring a companion to the appointment for support, and this should be encouraged. However, the initial interview with a patient should always take place without the companion in order to screen for abuse and allow the patient to feel comfortable openly discussing her history and symptoms without concern for privacy in front of the companion. If a survivor discloses safety concerns in a current relationship, the provider should engage in a discussion about how to maintain her safety and privacy while accessing care and should also discuss appropriate support resources (see Appendix) [8].

## Medical Assistant

Just as trauma-informed care may be new to many physicians, this is also true for nursing staff and medical assistants. While it is important to train all staff on trauma-informed care, the integrated care benefits greatly from having a medical assistant with experience and sensitivity toward patient populations with a history of trauma. The medical assistant should be assigned specifically to the integrated care model and not be in constant rotation, so that patients know they will see that person each time they present for care. After the front desk, the medical assistant is usually the first person the patient engages with in the clinic. The patient's interaction with the medical assistant can determine the tone and success of the entire clinic visit. The patient may have significant medical or social concerns and may disclose those immediately to the medical assistant. The medical assistant may not be in a position to address all of those concerns but should welcome the disclosure and communicate these concerns to the clinician. The medical assistant can also help the patient navigate any additional services at the end of the visit (e.g., pharmacy, radiology, laboratory) and can serve as an intermediary in case any obstacles arise. Additionally, the medical assistant can be the first point of contact for patients wishing to schedule or change appointments or for patients who have questions for the provider. The preestablished and consistent relationship between the patient and the medical assistant helps facilitate communication and trust [8].

## Outreach and Follow-Up

While patients will usually schedule a follow-up appointment at the end of their visit, some patients may miss their subsequent appointment for various reasons. A standard recall process for the clinic can be employed (e.g., nurse phone call, letter, rescheduling by medical assistant or clerk). However, some patients may be at increased risk of mental health decompensation, and the psychiatrist may want to conduct phone outreach or implement sending a mobile crisis unit to do outreach.

SGBV survivors may have high levels of socioeconomic instability, which can increase the risk of missed appointments, even when patients are highly motivated for treatment. Additionally, they may not be able to afford their mobile phone payments consistently or may change phone numbers frequently for safety reasons. It is helpful to confirm a phone number of the patient at each visit and also to obtain alternate or emergency phone numbers and contact information (e.g., email, address) for patients. Mental health crisis teams can be dispatched to the last known address of patients at highest risk of suicide or violence.

## Summary

Integrated care is a model of care in which physical and mental health providers are colocated and collaborate on patient care, and their processes are merged to varying degrees. While integrated care may be challenging to implement because it requires major practice shifts for both types of provider, it can have benefits in terms of improved patient health outcomes and efficiency of care. The EMPOWER Clinic model, consisting of an obstetrician-gynecologist and a psychiatrist, was designed to meet the needs of sexual trauma survivors. In addition to collaborative care, the EMPOWER Clinic addresses survivors' unique challenges and needs, such as safety and privacy concerns, sensitivity of clinic personnel, and collaboration with social service organizations.

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# 9

# Acute Medical and Forensic Care for Victims of Sexual Assault

Barbara Schnoor

## Introduction

The health professional who provides acute care for an individual following a sexual assault has an important role in that victim's recovery, both physically and emotionally. This chapter will provide a review of some considerations in caring for the adolescent and adult patient.

In the United States, starting in the 1970s, Sexual Assault Nurse Examiner (SANE) programs formed after nurses became more involved in ensuring that sexual assault victims receive optimal care from trained examiners. Forensic nursing became recognized as a nursing subspecialty, and as of 2016, there were more than 800 SANE programs around the country [1]. Some states, such as New York, have Sexual Assault Forensic Examiner (SAFE) training and certification for registered nurses and other health professionals (e.g., physicians, midwives, physician assistants). Many

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SANE/SAFE programs utilize on-call trained examiners; this allows the emergency department (ED) staff to concentrate on other patients, as medical-forensic exams can be time-consuming and require hours to complete.

In most cases in the United States, the patient will be seen in a hospital's emergency department [2]. Regardless of where the patient is seen or who provides their medical/forensic care (trained examiner or otherwise), there are several key areas of concern, which will be discussed further in this chapter.

## The Examiner's Role

The clinician who sees patients reporting a recent sexual assault should maintain a focus on their role as a health-care provider. Care should be individualized and guided by the patient's history, and the treatment should be evidence-based. The clinician is not working for law enforcement and is not a victim advocate (further described below). The clinician cannot conclude that a rape or sexual assault has occurred; that is a legal determination.

Health-care facilities should have policies in place for the care of patients reporting sexual assault. Clinicians should become familiar with their local and state regulations involving consent, confidentiality, and mandatory reporting. It is the clinician's responsibility to assess a patient's capacity to consent to treatment. State consent and confidentiality laws vary when it comes to minors (persons under the age of 18) and medical care. In New York State, for example, minors may consent or decline any aspect of post-sexual assault care [3]. Additionally, hospitals in New York State are mandated to report life-threatening injuries sustained during a sexual assault to the police [4]. If an examiner (or hospital staff) in New York State reports an assault that does not involve life-threatening injuries to the police without that patient's permission, the examiner has violated the patient's right to confidentiality. In such cases, the hospital can be sued and the provider accused of professional misconduct. Cases involving child abuse must be reported to child protective services.

## The Role of Victim Advocates

Medical professionals may find themselves working alongside victim advocates when providing care for a patient who has experienced sexual assault. Victim advocates provide important nonmedical services and are typically contacted by calling a local rape crisis program. An advocate's primary role is one of providing support to the patient, as well as to any family or friends who may have accompanied the patient to the hospital. Advocates can help explain exam options and treatment, as well as provide information on counseling, victims' compensation, and follow-up referrals. Victim advocates are an invaluable part of the emotional care for patients following sexual assault. If a victim advocate is not available, a hospital social worker may provide support.

## Triage

When a patient arrives at the hospital following a sexual assault, questioning should take place in a private area. Safety and confidentiality parameters and regulations should be discussed and law enforcement contacted if the patient wishes. The patient should be encouraged not to wash, change clothes, urinate, eat/drink, or smoke, as this can affect the forensic exam process, should the patient choose to undergo the exam. If available, the victim advocate and SAFE/SANE should be contacted. Any acute injuries needing immediate medical attention should be treated prior to considering forensic evidence collection. Clothing removed during acute medical care should be set aside and secured, in case the patient consents to evidence collection. If the patient does need to urinate, a specimen should be saved for any necessary hospital tests and not discarded in the event of possible drug-facilitated toxicology screening.

Following triage, the patient should ideally be brought to a space specifically designated for medical/forensic examinations, where specialized equipment and supplies can be kept. Regardless of whether the hospital has a designated space, comfort measures are important for both emotional and physical well-being. These measures may include providing blankets and dimming lights as needed, offering to help the patient place phone calls to family and/or friends, and assuring the patient that the hospital is a safe place.

## Taking a Medical-Forensic History

When taking a patient's history, the clinician's focus will be on obtaining information relevant to both medical treatment and evidence collection. It is crucial to remain nonjudgmental and to be aware that individuals will respond differently to stress and trauma, with a wide range of reactions being normal. The clinician must address any patient concerns and provide informed consent to treatment options, which a patient may decline at any time. Helping a patient reestablish a sense of control is important following a sexual assault, and the manner in which the interview and discussion of options is conducted is a part of this. If law enforcement is present, joint interviews with the clinician and police can be done to help avoid repetitive questions for the patient, after which each can speak privately with the patient.

While obtaining a patient's health history, the clinician should include questions about any prior surgeries, gynecological procedures (e.g., cervical biopsies), and anal-genital injuries, as well as the patient's menstrual history and the date of their last menstrual period. Clinicians should also ask about the patient's current and past medical conditions and illnesses, medications and method(s) of contraception, medication allergies, and hepatitis B and tetanus vaccine status.

In addition to collecting the patient's medical history, clinicians should ask questions about the assault, including questions that help to clarify medically relevant details of the assault and the patient's injuries. Some of these questions refer to the assault itself, such as confirming the date, time, and location of the assault, as well as the gender and number of assailants. Clinicians should also ask about the nature of the violence inflicted on the patient, for example, the use of physical force and what type (e.g., slapping, punching, grabbing, biting, burns, physical restraints, strangulation); the use of weapons and any injuries inflicted by them; the use of verbal threats; and physical actions taken by the patient toward the assailant and any injuries that occurred. The clinician may also ask for further details about the sexual assault: the type of contact (i.e., oral/genital/anal) and whether penetration occurred or was attempted, whether ejaculation occurred and its location, nongenital acts such as kissing or licking, the use of any objects, and the use of condoms and/or lubricants. The clinician should also ask if the patient has experienced any loss of consciousness.

## The Physical Examination

A physical examination is done to assess for injuries (bruises, abrasions, lacerations, edema, erythema), bleeding, and any areas of pain or tenderness. If the patient has consented to evidence collection of their body, this should be done simultaneously. The clinician should maintain respect for the patient's dignity and privacy throughout the examination, allowing support person(s) to be present if the patient wishes. During the examination, the clinician should inform the patient about each step of the process, explain the instruments and equipment being used, and ask the patient's permission before touching any part of their body. The examination should be conducted at a pace that the patient is comfortable with, allowing for breaks if needed by the patient.

The clinician should note the patient's general appearance, vital signs, gait, mental status, and emotional state. The general body assessment should include looking for findings such as defense injuries to upper arms and hands, petechiae on the hard/soft palate, tenderness and edema to the head/scalp, injuries and jewelry imprints on the neck, bite and suction marks to the breast, injuries and/or tenderness to the abdomen, and injuries to inner thighs or buttocks.

The female genital exam may include both external and internal assessment for injuries, tenderness, and bleeding. The clinician should examine a male patient's penis and scrotum. Clinicians should be familiar with genital anatomy and terminology, as well as normal findings. The examination should be conducted in the most comfortable manner for the patient, using appropriate positioning, draping, pelvic exam technique, and promoting relaxation.

A plastic or metal speculum is used for visualization of the vagina and cervix, inspecting for injuries, bleeding, and foreign bodies. If a patient declines introduction of the speculum and is unsure if a condom was used or if penetration occurred, a digital exam should be offered to rule out the presence of any foreign bodies. Speculum exams should not be routinely done on prepubescent patients. Bimanual exams can be done to assess cervical and uterine tenderness. Colposcopes can be helpful in assessment for microtrauma. Examination of the anal region should include inspection of the perianal folds and assessment of sphincter tone. An anoscope can be used to visualize the anal canal.

Genital injuries can occur with both sexual assault and consensual sex. They can heal quickly, sometimes within hours after an assault. Penetration can occur without causing injuries (including to the hymen of a virginal patient).

Photographs can provide additional documentation of injuries and should be stored securely as per program or facility protocols. Wounds should be photographed prior to cleaning and suturing/dressing. It is advisable to take three shots of each injury: one at a distance to give perspective on location and two close-ups (with and without a measurement tool in view). Draping can be used to cover adjacent body areas not needed in photographs.

## Evidence Collection

Collection of biological and physical specimens in sexual assault cases can show evidence of physical contact between two or more individuals, provide crime scene information, and help to identify assailants through DNA testing. DNA profiles can be obtained from a variety of sources. These include blood, saliva, semen, or hairs; clothing and bedding; condoms, sanitary pads, or tampons; and items such as drinking glasses, gum, and tissues.

Individual jurisdictions often use standardized evidence kits that have been developed in consultation with their local crime labs. These kits (used in forensic evidence collection done from a patient's body) contain materials such as sterile swabs, glass microscope slides, specimen storage containers, and forms for documentation of chain of custody. Paper bags are used to package clothing and other items not secured in the kit (plastic bags retain moisture, which promotes bacterial growth that can cause degradation of evidence).

The timeframe within which to offer this evidence collection should be decided on a case-by-case basis. In fact, the New York State Department of Health increased its cutoff time for evidence collection to 96 hours, based on such information. Clinicians should familiarize themselves with factors that can affect evidence retrieval such as location of sampling, testing methods (which are improving over time), and current research.

Specimens taken in collection of forensic evidence from the patient's body may include the following:

- Oral, vulvar, vaginal/cervical, penile/scrotal, anal swabs
- Buccal mucosa (for reference sample of the patient's DNA)
- Fingernail scrapings
- Foreign debris
- Skin/bite mark swabs
- Pubic hair combings

Allow the patient to participate in evidence collection, where feasible and with guidance (i.e., swabbing their mouth, combing through their pubic hair). An alternative light source (ALS) can aid in the detection of dried secretions on the skin. Any positive findings should be swabbed.

The clinician must take measures to prevent contamination of evidence (i.e., changing gloves as necessary during the examination) and keeping the evidence from contacting other people or objects in the room prior to packaging. The clinician should also be aware of measures to promote preservation of evidence, such as drying of wet items and proper packaging of all items. If evidence is not given directly to law enforcement at the time of the exam, it must be stored as per hospital protocol with documentation of the chain of custody.

If it is suspected that drugs have facilitated a sexual assault, specimens of urine and blood may be collected. Most hospitals use specially designated drug-facilitated sexual assault (DFSA) kits for these specimens. Hospitals should consult with their local crime laboratory regarding DFSA specimen collection time frames (generally done within 96–120 hours after an incident), packaging, storage, and transportation.

## Medical Treatment

Medications may include antibiotics to treat sexually transmitted infections (STIs), HIV post-exposure prophylaxis (PEP), emergency contraception, and medications to relieve pain/anxiety. Patients should be counseled on STI and pregnancy risks and be given information on possible side effects of medications.

In the United States, the CDC recommends the following for gonorrhea, chlamydia, and trichomonas prophylaxis (all in single doses):

- Ceftriaxone 250 mg IM
- Azithromycin 1 g PO
- Metronidazole 2 g PO

Alternative treatments can be found on the CDC website (see resources).

The first dose of the hepatitis B vaccination can be given to the patient whose immune status is unknown. If the assailant is known to be hepatitis B positive, hepatitis B immunoglobulin (HBIG) should also be given.

HIV PEP should be initiated as soon as possible and no later than 72 hours after an assault. The patient can be given a starter supply of medication (i.e., 3–7 days), with a referral to follow up where the patient can be given the medications needed to complete treatment (28 days in total).

The first dose of the human papillomavirus (HPV) vaccination can be considered for females aged 9–26 years and males aged 9–21 years. Tetanus prophylaxis can be offered to patients at risk.

Emergency contraception should be taken as soon as possible (and within 120 hours) following an assault.

Laboratory analysis may include tests for the following:

- Syphilis
- Hepatitis B surface antibody for immune status
- Hepatitis C antibody
- CBC and serum chemistry with liver function tests if initiating PEP
- HIV

Note: Diagnostic testing for gonorrhea and chlamydia, if done too early following an assault, i.e., within the "window period" for detection, may be reflective of an infection acquired previously and would not change treatment given at the time of an acute exam.

Female patients of reproductive age should have pregnancy testing, since a positive result may affect treatment decisions. If a patient has sustained severe genital trauma, a gynecological consultation may be needed. Patients with acute mental health issues, such as suicidal ideation, should have a psychiatric evaluation.

## Discharge Planning

Patients should be allowed to shower and brush their teeth before leaving the hospital and, if needed, be given clean clothing.

During discharge planning, the clinician should provide the patient with information on any tests performed and medications given, as well as any prescriptions. Discharge planning should also include a safety assessment, with referrals to available counseling services and shelter services if needed.

The clinician should also provide the patient with relevant follow-up information. This includes referrals to medical follow-up (STD and pregnancy testing, injury reassessment, HIV PEP treatment) and instructions on returning to the ED if necessary (e.g., in case of severe pain, heavy bleeding, breathing problems). Permission should be obtained for any follow-up contact from the hospital regarding lab test results. If permission is declined, the patient should be given information on how to obtain their results. Clinicians should explain the importance of abstinence or condom use until all STI treatment and follow-up testing are completed.

## Conclusion

This chapter has provided a basic review of medical and forensic care following a recent sexual assault. At such a time, it is crucial for a patient to receive compassionate and professional treatment from the health-care provider, the beneficial effects of which can last long after the patient has left the exam room.

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# 10

# Trauma-Informed Family Planning

Veronica Ades and Jessica A. Meyer

A note about terminology: Wherever possible, we have tried in this chapter to avoid gendered pronouns. We encourage providers to be cognizant that not all patients in need of contraception or abortion identify as women, and that an individual patient's gender identity and pronouns should be respected.

## Introduction

The family planning needs of people with a history of sexual and gender-based violence (SGBV) are complex, and influenced by their trauma experience. A survivor's specific history of trauma, known or unknown triggers, agency, and status on the spectrum of recovery all can have a dramatic impact on feelings around intimacy, vulnerability, and interpersonal relationships, including the doctor-patient relationship. Given the personal nature of

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reproductive health, it can be particularly challenging to provide adequate care to such individuals. They may not feel comfortable discussing all aspects of their reproductive health, nor may they even be fully aware of their own needs or preferences, and well-intentioned attempts to avoid retraumatization may inadvertently blind physicians to these issues [1]. Thus, it is important for the clinician to be aware of and sensitive to the ways in which such trauma can affect family planning options and needs. This chapter reviews how trauma can affect various aspects of family planning. The information in this chapter is supported by scientific evidence wherever available, and by the experience of the authors when evidence is not available.

## Unintended Pregnancy

History of SGBV may increase the risk of unintended pregnancy for several reasons. For instance, survivors with childhood or adolescent experiences of severe sexual abuse are more likely to engage in riskier sexual behavior as adults, including more sexual partners and more incidents of unprotected sex [2, 3]. SGBV survivors may have had little control throughout their lives and may be unaccustomed to having the ability to make decisions regarding their own health. Additionally, they may currently have a partner who seeks to control their contraceptive choices, a form of abuse called reproductive coercion (see below). Forced sex, fear of confrontation, and direct partner interference with not only contraception, but also overall access to healthcare, contribute to the 2–3-fold higher rates of unintended pregnancy among those with history of or ongoing gender-based violence [4].

## Reproductive Coercion

Reproductive coercion includes a spectrum of behaviors that interfere with contraceptive use and pregnancy, all with the aim of maintaining control over an individual in an intimate relationship

[5, 6]. This can include psychological influence, such as threats or emotional manipulation, and physical acts, such as partner violence and contraceptive sabotage (hiding, withholding, or destroying existing contraceptives). Coercive behavior can extend beyond the sexual encounter to include forced impregnation and forced carriage or termination of a pregnancy, even via acts of physical violence to induce pregnancy loss [7, 8]. Such interactions in survivors of SGBV are common. A survey of women presenting to a family planning clinic in California revealed that not only did more than half report physical or sexual partner violence, but nearly 15–20% also disclosed reproductive coercion including contraceptive sabotage. This study also corroborated that history of violence was strongly associated with higher unintended pregnancy rates [9, 10]. Other studies have identified the lifetime risk of reproductive coercion to be up to 7% and up to 30% of women raped by an intimate partner experienced reproductive coercion [11]. The true prevalence of SGBV and reproductive coercion is likely greater, as identification of victims is limited by the inherent challenges of healthcare access and disclosure. Thus, meeting family planning needs in these contexts is challenging but should be focused on partner-independent interventions, including routine screening, confidential counseling and awareness, as well as discreet and emergency contraceptives [7]. Engagement in such healthcare interventions has been shown to significantly reduce the risk of unintended pregnancy, as well as rates of reproductive coercion, even among those who have not experienced partner violence [12].

## Contraception

Survivors of sexual trauma should be offered the full range of contraceptive options. While preferences on contraception may be influenced by their trauma history, providers certainly should not assume that survivors will be more or less comfortable with specific methods due to their trauma. However, there are specific concerns to consider with various methods of contraception.

## Condoms

Condoms can be appealing to many people because they do not require commitment to a method (can be used at the time of intercourse) and do not involve taking a medication. Issues with effectiveness are known, but more importantly, people with sexual trauma may have more challenges in negotiating condom use with an unwilling partner [13]. Consistent use of condoms is at least in part dependent on the partner, which can compound existing power inequities within a relationship and serve as a persistent reminder during each sexual encounter. As discussed previously, individuals in ongoing coercive relationships are at particularly high risk for unintended pregnancy and sexually transmitted infections, and condoms are the only birth control method that effectively protects against both [4]. Thus, intervention should be focused on education and routine screening; the clinician can inquire about past challenges with condom use as a way to discuss concerns about condom use in the future.

## Oral Contraceptive Pills

The oral contraceptive pill is perhaps the best-known medical contraceptive, as it is well-studied, highly effective, and a viable option for most patients [14, 15]. Yet, the pill has both advantages and disadvantages for survivors. It is highly user-dependent, requiring daily administration, but does not require a painful insertion procedure and can be stopped at any time by the patient. Initiation, administration, and cessation of oral contraceptives is patient-led, which may improve a survivor's sense of autonomy and empowerment. However, because it does require daily maintenance, it reminds the user of their reproductive needs and health on a daily basis; this can be an added stressor for some survivors. Furthermore, some survivors may be heavily focused on their socioeconomic survival, mental health, or other concerns, and may not be in a position to reliably remember a daily contraceptive. Although contingency planning in the event of missed pills should be part of standard contraceptive counseling, it may be even more important in this specific patient population [16].

Survivors may have similar concerns to many patients with regard to oral contraceptives, most commonly including concerns about mood swings, weight gain, and irregular or absent menses [15]. There are mixed data on the impact of hormonal contraceptive pills on mood. While some studies demonstrate improvement in mood disturbances with oral contraceptive pills, others suggest deterioration of mood or new onset depression while on these medications [17–19]. However, studies of such interactions are limited and rife with potential for confounding given impact of sexual/interpersonal experiences on mood and commonality of inconsistent pill use [17]. Patients can be assured that the risk for such effects is low, and small modifications to hormone formulation or administration can help to augment side effect profiles. Nonetheless, given the association between sexual trauma and mood disorders, survivors should be cautioned that the hormones in the oral contraceptive pill could worsen an unstable mood disorder or negatively interact with psychiatric medications (such as increased clearance of lamotrigine with concomitant oral contraceptive use), and additional supervision by the clinician may be warranted [20].

Furthermore, reassurance can be provided to patients that weight changes with contraceptive pill use are negligible; in fact a longitudinal several-decades-long study demonstrated no significant difference in weight gain [21]. A regular menstrual cycle, although often identified as an inconvenience, can also be evidence of nonpregnancy, which may be reassuring to patients experiencing reproductive coercion without a current desire to become pregnant [22]. Maintaining an open-ended conversation and being transparent regarding potential side effects helps to ensure that these specific concerns are thoroughly addressed.

## Depo Provera

Depo Provera may appeal to survivors for ease of use and lack of need for pelvic insertion. It is a discreet and partner-independent method of contraception, which can make it a viable option for patients in sexually coercive situations. However, Depo Provera requires a repeat injection every 3 months to remain effective, which may be a problem in patients with logistical, financial, or geographical obstacles. In addition, Depo Provera has been demonstrated to cause weight gain in select patients, and may worsen pre-existing mood disorders, though again the risk for the latter is low [23–25].

## Intrauterine Device

The intrauterine device (IUD) is a highly safe and effective method of contraception. The reliability of the IUD, as well as the ease of use once inserted, may appeal to survivors who want to know that they have effective contraception without wanting to think about it often. The IUD can be removed with immediate return of baseline fertility if survivors desire pregnancy [26]. This is one of the primary advantages of the IUD as a long-acting reversible contraceptive (LARC). Further, its location of action inside the body allows it to provide effective contraception for long periods of time without the knowledge of anyone other than the patient and the healthcare provider; such “hidden contraception” may be ideal in reproductively coercive relationships.

The IUD may present a particular challenge for survivors because of the route of insertion. Some survivors may not be able to tolerate a pelvic exam at all, which would preclude IUD use. Others may tolerate the pelvic exam, but have a heightened sensation of pain, which can make the process of cervical dilation required for IUD insertion all the more difficult [27]. Additionally, the pain and the experience of the insertion itself can be triggering for survivors [28]. For those survivors who feel that the IUD is the best method for them, but have difficulty with pelvic exams, some accommodations can be made during insertion. The survivor can elect to have an accompanying family member or friend present during insertion. Listening to music or engage in other soothing activities during the insertion may help distract and reduce pain. Providers can also encourage the patient self-insert the speculum. A paracervical block can be considered for analgesia, although this may paradoxically increase pain by adding a requirement for needle injection. The provider can also try to insert the IUD without using a tenaculum or other instrument to grasp the cervix; if the cervix is sufficiently pliable, avoiding the cervical grasping can reduce one source of pain. A single pretreatment dose anxiolytic may help with pain and anxiety; this can either be prescribed by the gynecologic provider (if they are comfortable), or a mental health provider (if available). However, it is important to be aware that some survivors may be triggered by receipt of sensorium-altering medications prior to an invasive exam.

Another consideration with IUD use is the type of IUD. The Copper-T (or Paragard) IUD can increase pain and bleeding associated with menstruation, as well as increase intermenstrual bleeding and general pelvic pain [29]. Chronic pelvic pain and dysmenorrhea are associated with sexual trauma, and these may be exacerbated by the Copper-T IUD. In addition, some survivors may be triggered by menstrual symptoms of pain and bleeding; thus, increasing the frequency and severity of these symptoms may not be advisable, and survivors should be cautioned about this. Yet, the uninterrupted menstrual cycle that accompanies the Copper-T IUD may help to conceal the patient's contraceptive use, for instance, in relationships in which the abusive partner monitors the abused person's bleeding patterns. Conversely, the levonorgestrel-containing IUD may reduce menstrual pain and bleeding, sometimes resulting in amenorrhea, which may or may not be appealing to some survivors [29]. However, it can also cause irregular menstrual bleeding, and if this is a trigger for the survivor, this option may be undesirable.

## Contraceptive Implant

The contraceptive implant has a similar appeal to the IUD for its reliability, its lack of need for user maintenance, and its concealed implantation under the skin. Importantly, the contraceptive implant avoids the need for pelvic insertion, and therefore may be better tolerated by survivors. However, the increased likelihood of irregular bleeding using this contraceptive modality may be of concern to survivors who are triggered by menstrual bleeding.

## Tubal Ligation

Tubal ligation may appeal to survivors seeking a permanent contraceptive option. It requires undergoing laparoscopic surgery, which may be an obstacle for patients who have concerns about the medical system or anesthesia, as well as those who are uninsured or with minimal financial means. It is important to ascertain the patient's motivation for permanent sterilization prior to proceeding, as survivors who are still in abusive relationships may be seeking tubal ligation due to reproductive coercion from an abusive partner [4]. Thus, a provider should never assume that this is the case, but can gently discuss the permanence of the procedure and assess for any ambivalence from the patient.

## Emergency Contraception

As previously described, people with a history of or ongoing SGBV are at increased risk for unintended pregnancy. Compounding this issue is the increased rates of delayed and limited access to healthcare in this population due to fear of the healthcare system, apprehension about being triggered during medical evaluation, or restrictions by an abusive partner [30]. Thus, emergency contraception is a unique intervention that can be offered after an unprotected sexual encounter for patients not desiring pregnancy, and should be routinely offered to all victims of sexual assault. Given the time-sensitivity of efficacy, it is important to educate patients on the limitations and best timing of emergency contraception.

Choice of emergency contraceptive may be influenced by the patient's trauma history, healthcare access, and convenience. For instance, oral levonorgestrel is readily available over-the-counter with efficacy up to 72 h after unprotected sex. Alternatively, ulipristal acetate is a progestin receptor modulator with greater efficacy than levonorgestrel and a longer efficacy window (up to 120 h), but requires a prescription. Thus, it may be useful for providers to prescribe ulipristal prophylactically for survivors to obtain more easily when needed. There is some data to suggest that the hormonal modification provided by emergency oral contraceptives may even help to minimize development of PTSD symptoms for survivors of sexual trauma, providing an added benefit for this patient population [31]. The one-time dosing for oral emergency contraceptives also makes them a convenient option; however, it does limit efficacy, particularly in the setting of multiple episodes of unprotected sex before or after treatment, which may be more common for individuals in coercive sexual relationships [32].

Another option for emergency contraception is the Copper-T IUD, which is not only the most effective option (up to 120 h), but also has the advantage of providing ongoing long-term pregnancy prevention [33]. One study demonstrated a 50% reduction in unintended pregnancy in the year following treatment among Copper-T IUD users compared to levonorgestrel users [34]. However, specifically among survivors, utility of the Copper-T IUD for emergency contraception is limited as described previously, also requiring trained providers and instruments for insertion.

## Abortion

An unintended pregnancy can be an emotionally difficult experience, even when abortion services are readily available, and even more so for SGBV survivors for whom pregnancy can be a triggering event. Meanwhile, for those who have limited or difficult access to abortion services, whether it be due to emotional barriers, socioeconomic limitations, or the restrictions of an abusive partner, the obstacles to abortion may prove overwhelming. When providing abortion services, it is important to keep all of these specific points in mind.

### Ambivalent Feelings

As with nonsurvivors, survivors of SGBV may have ambivalent feelings about abortion, even if they opt for it. While some may experience relief and closure following an abortion, others may struggle with guilt or fear and are at high risk for development of PTSD [35]; these patients often need help validating and processing those feelings. Furthermore, it is important to remember that an unintended pregnancy is not always an undesired pregnancy, and this distinction may yield internal angst for survivors who desire conception (currently or at a future date), but are conflicted by their extenuating circumstances. For instance, some survivors may face poverty as a result of their abuse and trauma, with resultant limited access to gynecologic care and contraception [36]. These individuals may feel that they are not in a position to care for a child. Some patients may be concerned about the implications of abortion on their future fertility. Although history of multiple and/or late-gestation abortions have been associated with increased risk for preterm birth and low birth weight, survivors should be reassured that there are no significant adverse reproductive health outcomes following abortion [37]. When layered on top of other mental health challenges, such as depression, anxiety, and PTSD, survivors' specific feelings toward abortion can be difficult to parse.

Other survivors may have no ambivalence and should not be made to feel as though they are undervaluing the experience. Given the moral judgments surrounding abortion, survivors may be worried that their doctor will judge them for wanting an abortion and may be accustomed to having others (abusers, medical professionals, society) judge their sexuality or reproductive choices. These patients may anticipate a negative response from their doctor, making them even more reluctant to disclose their trauma history or specific motivations for seeking abortion services [38, 39]. Thus, when initiating an open and engaging conversation about how to manage an unintended pregnancy, it can be helpful for the provider to explicitly state that she or he is open to whatever option the survivor desires, and that the provider will help obtain appropriate services accordingly.

## Coercive Abortion and Multiple Abortions

Many SGBV survivors may have had forced abortions, and may be reluctant to disclose this. Some have had multiple abortions and may fear being judged by providers who are not aware of their circumstances [1, 38, 40]. Many may feel immense guilt for a variety of reasons; abusers often incorporate psychological manipulation into their abuse, creating a feeling of culpability in survivors. For this reason, a survivor may not even recognize that some of their “choices” were in fact coerced or forced decisions, and may not frame them in that way to providers. It is essential not to judge survivors who have had multiple abortions as irresponsible. Instead, healthcare providers should demonstrate compassion and neutrality. In cases in which a patient has not disclosed a history of abuse, but has had multiple abortions, it may be informative and helpful to tactfully ask about a history of abuse. A trauma-informed provider is careful to help a patient sort out their feelings and experiences without imposing judgment.

## Fertility

Among survivors of SGBV, desire and/or ability to conceive may also be affected by trauma history. Physical trauma to the pelvic region may result in physical tightening of pelvic floor muscles; consequently, survivors may experience chronic pelvic pain, which can be particularly exacerbated by sexual intercourse [27, 41]. The lasting emotional impact of trauma, including PTSD, may make it difficult for survivors to be comfortable in physically intimate relationships, due to issues with trust and the potential triggers of vulnerability and touch [42, 43]. Such sexual dysfunctions can pose unique obstacles beyond a survivor’s ability to control, even among those who strongly desire to conceive. Thus, educating survivors on the potential utility of cognitive behavioral and pelvic physical therapy may be useful in helping to minimize these barriers [44, 45].

Prior trauma may also affect fertility on a physiological level. For instance, survivors with childhood history of trauma, particularly physical or sexual, are more likely to have menstrual irregularities and fertility difficulties, potentially due to stress-induced alteration of the HPA axis [46]. Albeit, the underlying complexities of SGBV yield potential for many confounders, and the quantifiable extent to which this may impact fertility is not known. Additionally, given this population’s heightened exposure risk to sexually transmitted infection (STI), as well as delays in healthcare, it is important to counsel survivors on the potential fertility implications of pelvic infections and effective prevention strategies. Untreated ascending infections with chlamydia and gonorrhea have been shown to increase rates of pelvic inflammatory disease and tubal-factor infertility [47]; these infections may be asymptomatic, underscoring the importance of improving patient awareness, routine STI screening, emphasis on consistent condom use if possible, and prompt or empiric treatments [48].

## Pregnancy

Pregnancy, whether planned or unplanned, can be both stressful and restorative for survivors of SGBV.

On the negative side, the changing and growing of the body in pregnancy can trigger feelings of powerlessness and fear. Pregnancy may tie the survivor to an abusive partner or create additional economic and social uncertainty, sparking concerns about affording maternity/child care or impact on employment/educational opportunities. Pregnancy is also a known risk factor for additional abuse and violence. Up to 28% of pregnant women worldwide suffer from abuse or violence, predominantly by the biological father [49, 50]. Additionally, many survivors who have been victimized by men may have more trouble bonding with a male infant, or may be reminded of their abuser if the child resembles the father [51]. A survivor who chooses to continue the pregnancy may find that the demands of parenthood, which are difficult for most people, are overwhelming. Postpartum depression is also an important concern, especially when survivors have a pre-existing mood disorder due to their trauma [52].

On the positive side, many survivors worry about the impact of their trauma on future fertility, and successful conception (even if unintended) can serve as reassurance. It can also have a calming effect, allowing the survivor to become more in touch with her body, and feel strengthened by the ability to grow a fetus. If the survivor chooses to continue the pregnancy, motherhood may provide a stronger sense of purpose, which can be helpful in overcoming trauma [51]. It may also provide a welcome distraction from the challenges of trauma and survivorship. Thus, throughout the prenatal care and postpartum periods, it is important to maintain open lines of communication with the patient to assess for emotional well-being, safety, and adjustment.

## Summary

SGBV survivors' need for family planning services may be complicated by their trauma history. Survivors may be at higher risk of unintended pregnancy and reproductive coercion. Choice of contraception may be additionally challenging because the side effects and initiation or insertion methods of various contraceptives may trigger their trauma symptoms, or be influenced by reproductive coercion. Feelings of ambivalence or history of forced or traumatic abortions can complicate a survivor's ability to access or feelings around abortion. Fertility may be compromised by a survivor's trauma sequelae, and those who do become pregnant may find that the pregnancy is either retraumatizing, restorative, or both. Providers of reproductive and family planning care should consider the potential impact of trauma and have an open conversation with survivors in order to adequately address their concerns and provide optimal care.

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# 11

# Female Genital Mutilation/Cutting

Khady Diouf and Nawal M. Nour

Research on FGM/C is notably limited, and prevalence statistics generally come from international organizations such as the World Health Organization (WHO), the United Nations Population Fund (UNFPA), and the United Nations International Children's Fund (UNICF). Wherever possible, data and citations come from reliable and/or peer-reviewed sources, but some sources cited in this chapter are from information sheets or brochures from the aforementioned organizations. While unusual, this is necessary in this chapter in order to provide a complete picture of FGM/C for the reader. Additionally, there is a notable lack of published research on the nonsurgical management of FGM/C sequelae. Where evidence is not available, we have made recommendations based on our experience in managing such patients. Further research on FGM/C is needed to better understand the scope and optimal management of FGM/C.

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## Introduction

Communities worldwide have practiced female genital mutilation/cutting (FGM/C) since the fourteenth century. This practice currently affects an estimated 125 million women, and young women and girls continue to be at risk in 29 countries, mainly in Africa, the Middle East, and Asia [1]. Traditionally, FGM/C was seen as a custom geographically confined to certain parts of the world. However, as a result of migration, many providers in Europe, North America, and Australia are encountering and providing care to patients who have undergone FGM/C [2]. Recognizing the global impact of this practice on women's health, the goal of this chapter is to serve as a guide for clinicians around the world, from those working with Guinean immigrants in the Bronx, NY, to those providing care at clinics in the Sudan.

## Origins of Female Genital Mutilation/Cutting

### Cultural, Geographic, and Religious Origins

The practice of FGM/C is an ancient custom: in Victorian times, clitoridectomy was used as a cure for epilepsy, hysteria, and other ailments. It was also practiced in Ancient Egypt and many other cultures across the globe [3]. A recent UNICEF population survey found that it is still actively performed in 29 countries, mostly in the Middle East, Africa, and Asia, with a wide-ranging prevalence from 1% in Cameroon and Uganda to over 95% in Somalia, Egypt, Djibouti, and Guinea [1, 4]. Though the general prevalence of FGM/C has declined overall since the 1980s, it is still commonplace in many countries (Fig. 11.1) [4].

### Reasons for Performing FGM/C

There are various reasons why FGM/C is performed. These can be divided into four main categories [5, 6]:

1. *Sociocultural reasons*: Seen as a rite of passage into womanhood, FGM/C is often performed on girls between the ages of

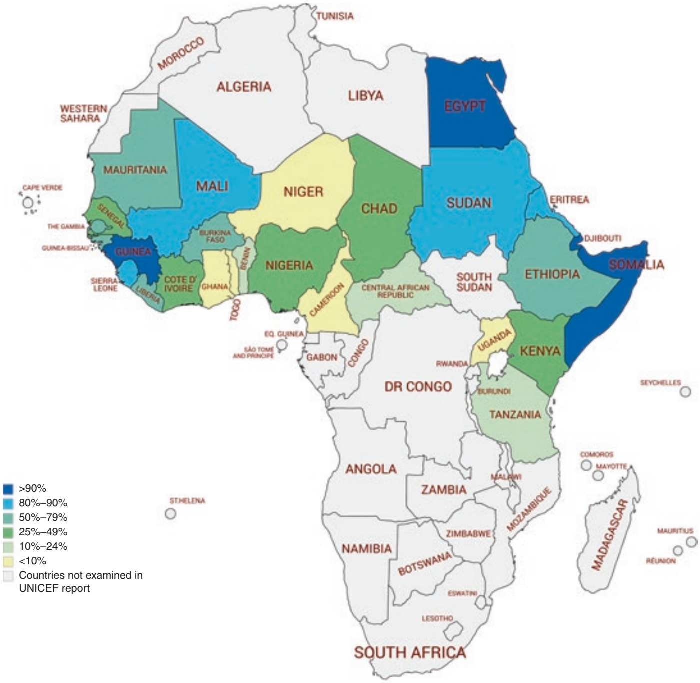


**Fig. 11.1** Occurrence of FGM. Data was drawn from the UNICEF report on FGM, which examined 29 countries. Data for countries in gray was not included in the report. FGM/C in these countries is thought to be rare. (Map created by the editorial team)

9 and 15, though some perform it in infancy or later adulthood. FGM/C is frequently associated with virginity, fertility, and control of women's sexuality [6].

2. *Psychosexual reasons*: The practice is thought to decrease women's sexual appetite (by clitoridectomy) and enhance men's sexual pleasure (a narrow introitus may be more desirable during intercourse).
3. *Hygienic and esthetic reasons*: Women in countries where FGM/C is widely practiced often consider the altered anatomy of the cut external genitalia "normal and clean"; for example, the removal of labial folds and lack of hair in scarred genitalia gives an appearance of smoothness and cleanliness appreciated in certain regions of the world [6].

4. *Socioeconomic reasons*: We often hear that women who force their daughters to have the procedure do it out of love; most often, women who enforce the custom see it as a way to raise their daughters' social status and ensure their marriageability [5, 7].

It must be noted that although FGM/C is disproportionately performed in predominantly Muslim countries, it is not a practice condoned by Islam.

## Nomenclature and Classification

### Definition/Terminology

**There are several terms associated with this practice: Female Genital Mutilation, Female Genital Cutting, or Female Circumcision** "Genital mutilation" is the term used by most activists, but when used by clinicians, it may alienate victims of the practice, whereas the term "female circumcision" may normalize it or imply erroneous association with male circumcision; hence genital cutting—an objective description of the practice—is the preferred term for this harmful act. In fact, many patients refer to themselves as having been "cut." In this chapter, we will use the term female genital mutilation/cutting (FGM/C) in order to encompass the two most commonly used terms; this is also the preferred term by the UNFPA and WHO.

### Classification and Procedures

**There are several types of FGM/C** The World Health Organization classification scheme is the most commonly used and classifies procedures from Type I through IV (Fig. 11.2) [8]. Type I refers to partial or total removal of the clitoris and/or the prepuce (clitoridectomy). Type II refers to partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Type III refers to removal of the labia

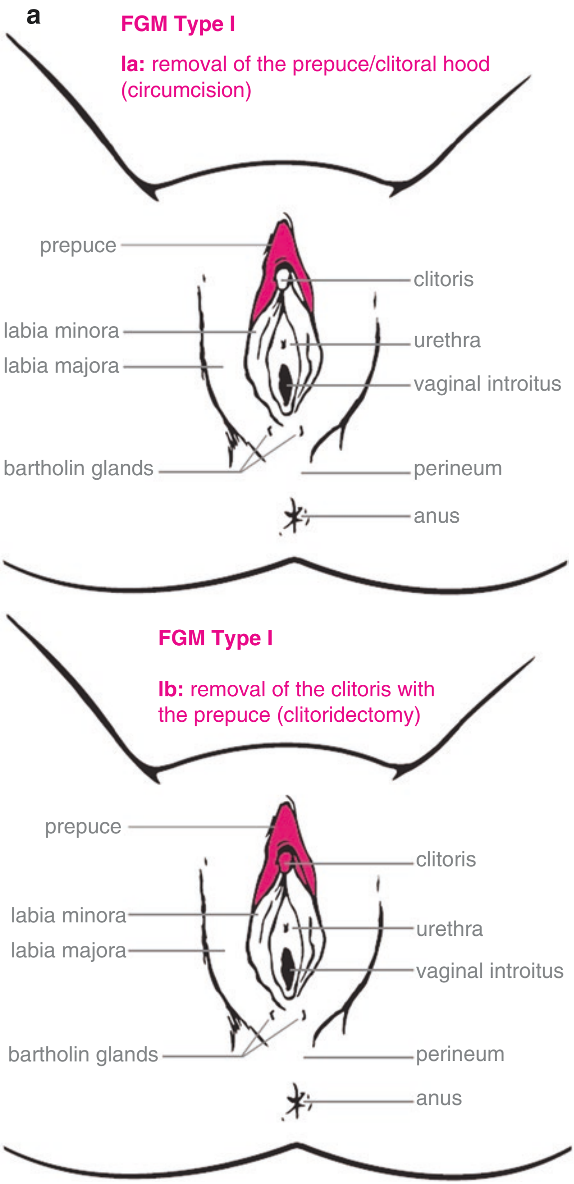
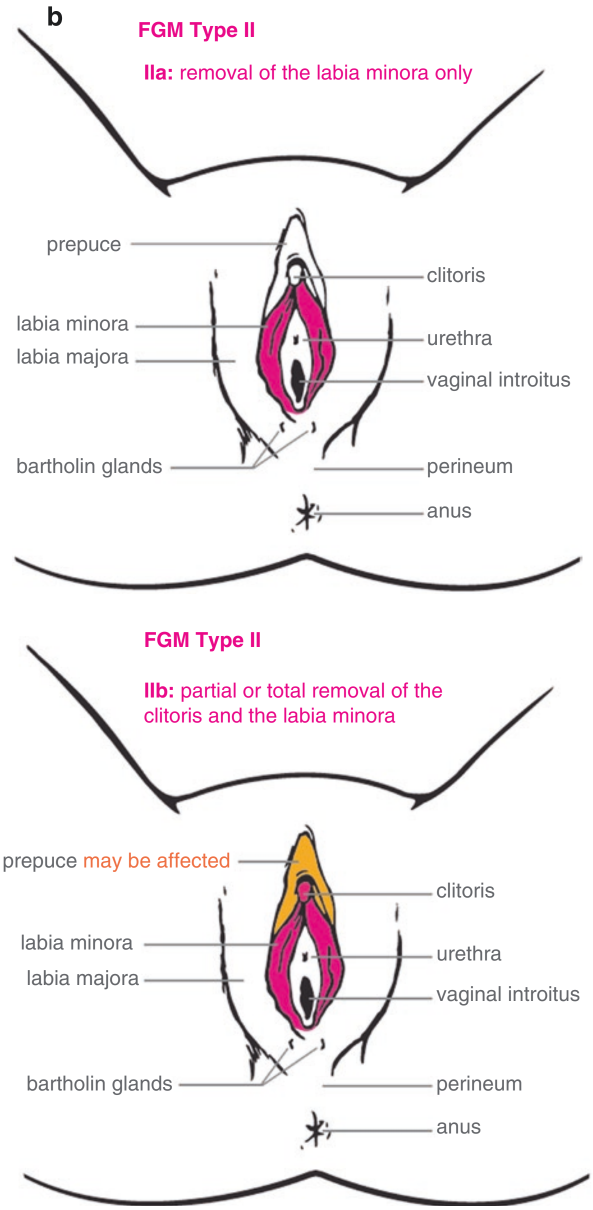


**Fig. 11.2** WHO classification scheme for FGM/C. (Reprinted from Abdulcadir et al. [8], with permission from Wolters Kluwer)



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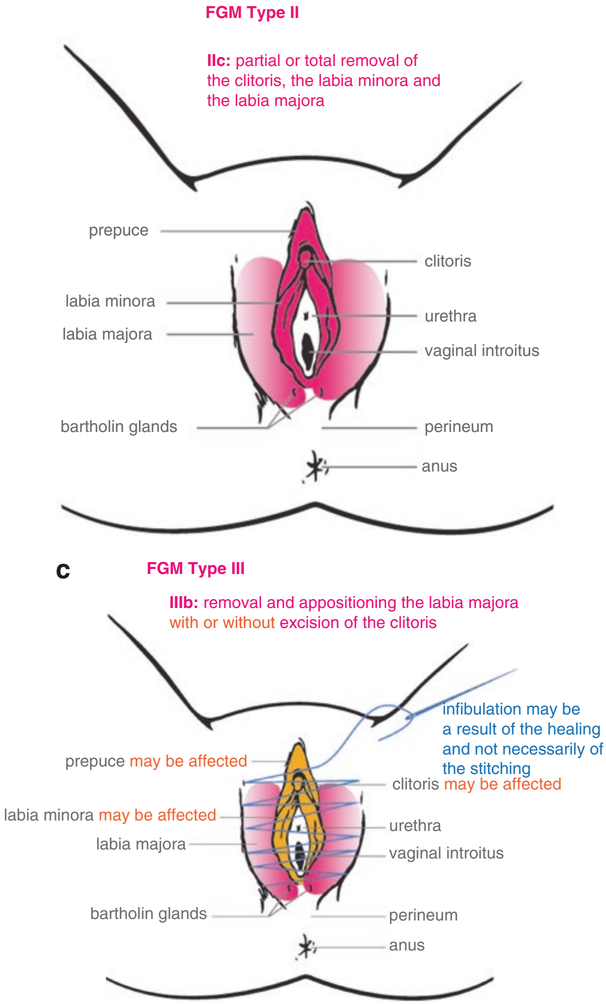

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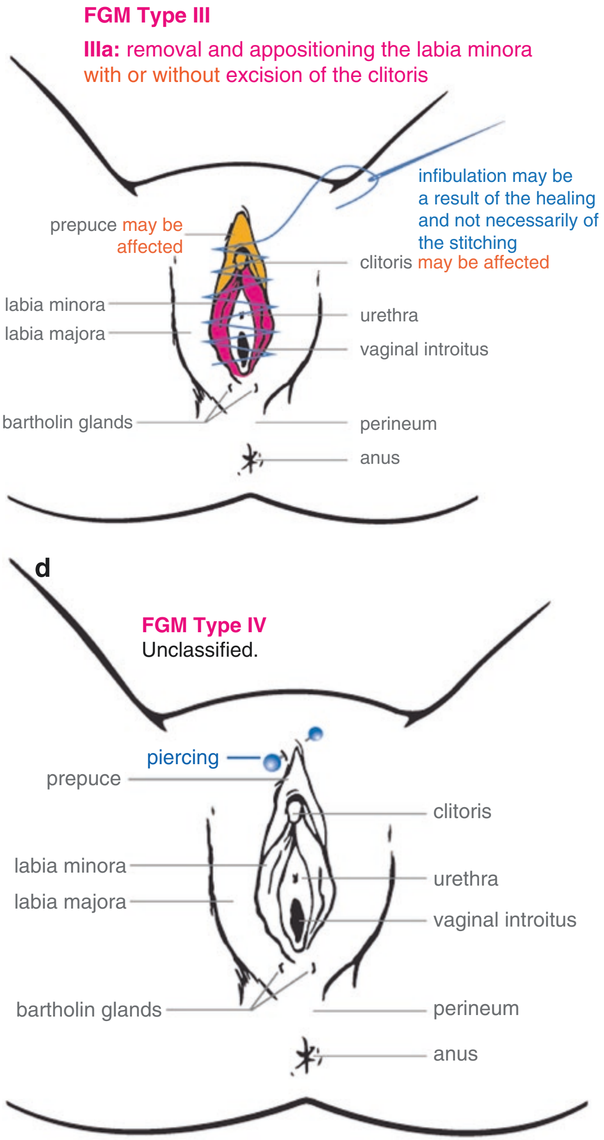

**Fig. 11.2** (continued)

minora and/or majora with or without removal of the clitoris and narrowing of the vaginal orifice by apposition of the remaining labia. Type IV refers to all other unclassified procedures on the genitalia including piercing, burning, and stretching.

## Procedure

The procedure is usually performed under nonsterile conditions by traditional providers who have little knowledge of female anatomy [6, 7]. In some countries like Egypt and Sudan, FGM/C is increasingly being performed by healthcare providers, which may eliminate some of the complications associated with anatomical knowledge, but may still leave physical and psychological sequelae [1, 9].

## Clinical Presentation

### Symptoms

- Short-term post-procedural complications

  In a recent systematic review of 56 observational studies, the most commonly reported acute complications were pain, hemorrhage, urinary retention, swelling, and delayed wound healing. Most patients experience more than one of these complications, regardless of the type of cutting, though Type III cutting (infibulation) was reported to have a greater risk of complications compared to FGM/C type I and type II [10].
- Long-term complications

  Healthcare providers are more likely to encounter patients many years after the procedure has been performed. Long-term sequelae may be seen more frequently by providers who do not reside in countries where FGM/C is actively performed. Long-term complications can range from obstetric complications, gynecologic complications to psychological and psychosocial complications [10].

## Obstetric Complications

In a large WHO observational study including over 28,000 women in six African countries and 28 health centers, women with FGM/C Type II and III were more likely to have adverse outcomes during labor and delivery compared to uncut women [11]. These risks include a higher risk of cesarean delivery, postpartum hemorrhage, extended maternal hospital stay, infant resuscitation, stillbirth or early neonatal death, and low birthweight. These obstetric sequelae can be mostly attributed to the presence of scar tissue in the vulva, which may affect labor monitoring and progress. The narrow neo-introitus of the infibulated vagina renders cervical exams more challenging, and typical obstetric interventions such as fetal scalp electrode placement and intrauterine pressure catheter insertion may not be as feasible. It has also been suggested that the second stage of labor can also be prolonged at crowning/delivery in women who have undergone FGM/C. In a 2013 systematic review, prolonged labor, perineal lacerations, operative delivery, obstetric hemorrhage, and difficult delivery were associated with FGM/C; however, cesarean deliveries and episiotomies were not increased [12]. This review was criticized for reporting unadjusted effect estimates using data from retrospective and prospective studies [13]. However, in a revised analysis of this review, the association between FGM/C and adverse obstetric outcomes still held true though the effect size could not be ascertained (wide range of odds ratios) [13]. In a case control study from Sweden, women who had undergone FGM/C were found to have a statistically significantly shorter second stage of labor: the authors of the study conclude that some of the obstetric risks described in studies in limited resource settings may be mitigated with a higher standard of care [14].

## Gynecologic Complaint

As with obstetric complications, most gynecologic issues arise in women with Type II and III FGM/C and less often in those with Type I and IV. These complications are more often a result of scarring and fibrosis in the vulvovaginal area, leading to urinary and vaginal symptoms. A systematic review of over 100 studies found that women who have undergone FGM/C are more likely to have gynecologic issues than those who have not [15]. These complications include an increased risk of urinary tract infections from urinary stasis, dyspareunia from a narrow and fibrotic neo introitus and bacterial vaginosis (BV). There also seems to be a trend toward increased dysmenorrhea, dysuria, and vaginal discharge and itching [15].

Scarring can also lead to urinary strictures and partial or complete fusion of the labia minora and majora, leading to hematometra and hematocolpos, keloids, epidermal cysts, meatitis, and urinary calculi in infibulated *Complaint* women [7, 8, 16]. Though it appears to be a rare complication, clitoral neuromas have been identified in women who have undergone clitoridectomy; these can be painful, and clitoral reconstruction has been used to alleviate pain in these women [17].

Infertility may be associated with certain forms of FGM/C. In a case control study in the Sudan, women with infertility were more likely to have undergone more extensive forms of FGM/C (type III) [18]. Many cut women suffer from dyspareunia; this may limit intercourse, and infertility can be a result of decreased *Complaint* frequency of coitus [19]. It is also possible that infection in the vagina resulting from an FGM procedure could lead to ascending infection leading to tubal factor infertility.

Sexual function, including orgasm and sexual satisfaction, has been a more difficult variable to assess in women with FGM/C [20–22]. The evidence is limited due to the sensitivity of the topic and the fact that no study has assessed sexual function in association to clitoral integrity or type of FGM/C. In a series of 32 women who underwent defibulation, Nour et al. reported increased satisfaction among women and their husbands, including 15% of women whose indication for the procedure was dyspareunia [20]. Clitoral reconstruction has also become increasingly common *Complaint* as a procedure to improve psychosexual function. However, in a systematic review of studies assessing the benefit of clitoral reconstruction in women who have undergone FGM/C, the evidence on improving outcomes was thought to be poor and scarce. The authors cautioned providers about adequately counseling patients about expected outcomes in addition to focusing on multimodal treatment approaches in these women [21].

### Psychological and Social Issues

In most countries, FGM/C is usually performed at a vulnerable age and without anesthesia. The procedure can be traumatic and psychological consequences can be expected; however, little research has been done on this topic. A recent systematic review of 17 studies found that in four studies, women who had undergone FGM/C were more likely to report anxiety, depression, somatization, and low self-esteem; however, while this finding was suggested in the individual studies, the meta-analysis for these associations did not reach statistical significance [9]. On the other hand, women who have not undergone FGM/C or who have been defibulated may experience similar feelings as they may be ostracized or outcast by being "different" from other women in their community [9].

## Physical Exam

### Approach to the Pelvic Exam

It is important to perform a thorough examination of the external genitalia in women who report having undergone FGM/C as well as in women from countries where this procedure is traditionally done. Providers should document the presence or absence of prepuce, clitoris, labia minora, and labia majora, as well as any tenderness, lack of sensation, scarring, or other sequelae noted on examination. The WHO classification system should be used to categorize the type of FGM/C. A recent systematic review of studies assessing providers' knowledge of FGM/C found that though most providers knew about the procedure, in most countries, few were familiar with the WHO classification system [23]. In the case of Type III (infibulation), the size of the introital opening should be documented; a bimanual and/or speculum examination may not be feasible prior to defibulation. Type IV FGM/C may have minimal scarring or visible evidence that is easily overlooked; careful inspection for small irregularities, such as pinprick scarring or tiny laceration, is important, especially if the patient is applying for asylum on the basis of FGM/C.

## Obstetric Issues and Management

In general, women who have undergone FGM/C are managed similarly in labor than women who have not been cut. Evidence from resource-rich settings indicates that usual and up-to-date standard of care, including fetal heart monitoring during labor and appropriate use of obstetric interventions, should mitigate some potential risks traditionally associated with FGM/C. However, in infibulated patients, defibulation before or during pregnancy (including labor) may be necessary to allow passage of the fetal head through the introitus at delivery.

### Role and Technique of Defibulation

Defibulation or de-infibulation refers to the process of opening the infibulation scar in women who have undergone type III FGM/C and exposing the vulvar vestibule, vaginal orifice, external urethral meatus, and clitoris (in some cases) (Fig. 11.3) [19, 20]. The infibulation scar is usually torn open at the time of first intercourse. However, in some cases, women may become pregnant without fully opening the infibulation scar, and the narrowed introitus can lead to obstructed labor. Therefore, if infibulation is still present in a pregnant woman, deinfibulation may be necessary for a safe vaginal delivery. Defibulation is also an option for nonpregnant women who have not yet had intercourse. The ideal time to perform this reconstructive procedure in pregnancy is not known. Antenatal de-infibulation may have the advantage of reducing vaginal and urinary tract infections, permitting vaginal examinations for pregnancy monitoring, and allowing the woman to become used to

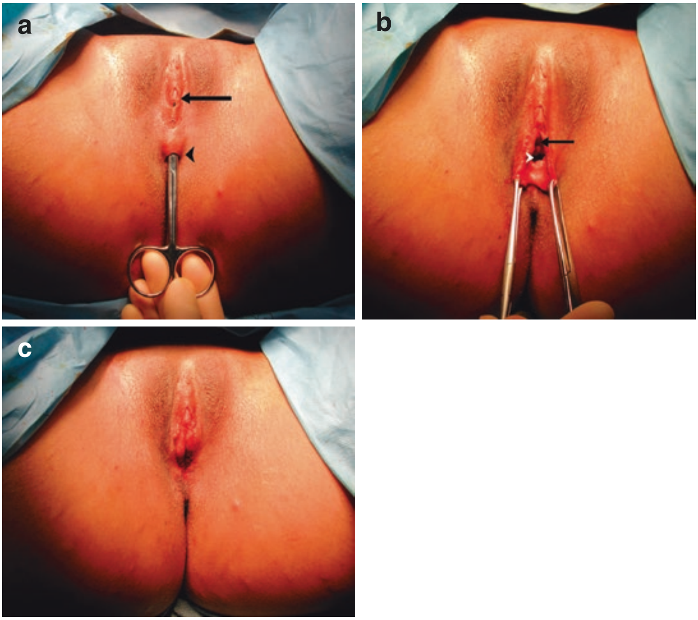

**Fig. 11.3** (**a**) *Type III female genital cutting*: scissors beneath the infibulated scar and in the neointroitus (arrowhead) measuring approximately 1 cm in diameter. A clitoris (arrow) is visible above the infibulated scar. (**b**) *Defibulation procedure I*: Anterior incision made vertically on the infibulated scar to expose the introitus (arrowhead) and urethra (arrow). (**c**) *Defibulation procedure II*: Post-defibulation reveals restoration of the external female genitalia with an intact clitoris and prepuce. (Reprinted from Nour et al. [20], with permission from Wolters Kluwer)

the change to her genitalia [19]. After counseling the patient, it can be performed before or during pregnancy (in the second trimester or intrapartum) without major complications [19].

## Intrapartum Care

1. Labor Management: Defibulation can be performed during labor after adequate counseling. The technique for defibulation does not vary depending on the timing of the procedure.
2. Postpartum care request for re-infibulation.

It is not unusual for women who have undergone defibulation to request a re-infibulation after delivery. In fact, patients may have a difficult time getting used to the change in anatomy and feeling “too open” after delivery. Though FGM/C is considered illegal in the United States, there is no statement on reinfibulation, and the American College of Obstetricians and Gynecologists (ACOG) does not have an official stance on the procedure, which is illegal in both the United Kingdom and Canada. The difference between reinfibulation and vaginal cosmetic procedures such as labiaplasty is a subject of debate. Patient counseling before defibulation is essential: some providers may not be comfortable with either the procedure of reinfibulation or the ethical implications, and this can create a challenging situation. It is important to have an open, honest, and respectful discussion with the patient about her request, to understand her reasons for wanting reinfibulation, and to explain reasons why reinfibulation may not be feasible if that is the case [24].

## Gynecologic Issues and Management

### Multimodal Approach

Gynecologic issues in patients who have undergone FGM/C should be managed with comprehensive evaluation by an experienced gynecologist, appropriate counseling, and psychological support. A surgical approach may be appropriate in some cases, although this is highly patient-dependent.

### Sexual Dysfunction

(a) Dyspareunia: Patients with FGM/C may report pain with intercourse. In the case of Type III FGM/C, this may be due to the infibulation, which creates a very small opening, and may require de-infibulation also known as defibulation before successful intercourse. In the case of Types I and II FGM/C, the scarring from the procedure may cause narrowing of the vaginal introitus. Furthermore, the scar tissue may be hardened and less pliable than normal vaginal epithelium. Additionally, the trauma of FGM/C, as well as other traumas such as sexual violence, can cause pelvic floor abnormalities that contribute to pain with intercourse. A careful inspection of the external genitalia, as well as a gentle pelvic examination, can help the provider elucidate the underlying cause(s) of the pain. Pelvic floor physical therapy may be helpful.

(b) Lack of sensation: When the clitoris is removed, sensation in the areas served by the clitoris is reduced or eliminated. Women whose sexual pleasure center resides in the clitoris may feel that they have no sensation during intercourse. Other women may find that their sexual pleasure stimulation is centered inside the vagina, and may be unaffected or less affected by the clitoral removal of FGM/C. A q-tip examination can help identify areas of numbness. Providers can also educate patients about the possibility of multiple sexual pleasure centers and encourage them to explore other ways of obtaining sexual pleasure.

(c) Lack of libido: It is unclear whether the clitoris itself is needed for libido, but many women with FGM/C complain of lack of libido. It is important to remember that they may have also suffered other traumas and may suffer from mental health conditions (such as depression and posttraumatic stress disorder) that contribute to lack of libido. Women who have experienced FGM/C may come from cultures in which women's expression of sexuality is limited, or where women's independence is suppressed, and this may complicate the libido. Providers can have an open and frank discussion about all of the potential contributing factors that may contribute to decreased libido, and try to resolve some of the other underlying potential causes, rather than assume that the lack of libido is irreversible due to clitoridectomy. Furthermore, the provider should explore the patient's feelings about her current relationship, as this may also be a contributing factor.

(d) Introital narrowing: In Type III FGM/C, the external genitalia are removed and the two sides are sewn together to close the introital opening, leaving only a small passage for both urine and menstrual blood to flow (infibulation). This opening is usually 1 cm or smaller, too small for sexual intercourse.

Patients in whom infibulation is still present may require de-infibulation prior to initiating sexual activity. In Type I and Type II FGM/C, sewing is not performed and significant introital narrowing is rare. However, on occasion where the cutting includes removal of the labia majora, spontaneous healing may occur such that the two sides heal together rather than apart, creating an effect that is similar to infibulation. These cases require the same evaluation and management as Type III FGM/C. It should be noted that in women who have undergone Type I or II FGM/C which includes removal of the labia majora and women who are petite, the introitus can appear smaller, and can be confused with infibulation by inexperienced clinicians. Attempting de-infibulation in these cases can be dangerous, as it would risk reinjuring the underlying remaining clitoral tissue, and can cause serious bleeding. De-infibulation should be attempted only by experienced providers.

## Urinary Problems

(a) Urinary outflow obstruction: As described above, infibulation and introital narrowing can cause the labial tissue to conceal the urethral opening, and leave only an opening in the posterior portion of the introitus. Urine must flow out of the urethra and posteriorly, often dribbling out instead of a normal stream.

(b) Dysuria: Painful urination in FGM/C survivors can be caused either by urinary outflow obstruction or due to urinary tract infections that occur as a result.

(c) Recurrent urinary tract infection: Urinary outflow obstruction can cause chronic or recurrent urinary tract infections due to incomplete clearance of urine.

## Scarring

(a) Keloids: Keloids can form along the FGM/C scar in individuals prone to them. This can cause an enlarged and sometimes painful scar. Management of this may be challenging, as any further surgical intervention is likely to cause additional keloids.

(b) Inclusion cysts: As with scars in other areas, inclusions cysts can form along the FGM/C scar. This can lead to additional pain, especially if the inclusion cysts form along the clitoral remnant, which may still have sensation.

(c) Other scarring issues: Because most FGM/C is performed by nonmedical personnel, and often performed quickly and without anesthesia, the specific location and amount of tissue removed can be variable. The labia minora or majora on one side may be removed while the other is still present. Only a portion of the labia, prepuce, or clitoris may be removed. Residual tissue may appear or feel abnormal as the girl/woman grows, and create discomfort or shame.

## Culturally Competent Care and Psychological Support

Care needs to be provided in a nonjudgmental manner in women with FGM/C. Women who have undergone the procedure come from cultures which consider the ritual beneficial to the social and sexual health of women. Being confronted by a provider who treats it as a barbaric act may make cut women unwilling to share their fears about delivery, their desires regarding defibulation, and any other psychosexual consequences that might have resulted from the procedure. In a survey of Somali women residing in Canada who have undergone the procedure and had recently delivered, lack of satisfaction with the care provided during pregnancy and at the time of delivery was often cited [25]. Women also need to be screened for about possible psychosexual consequences related to the procedure. For most women considering a reconstructive procedure (defibulation or clitoral reconstruction), a psychosexual evaluation and follow-up are mandatory pre- and post-procedure.

It may be helpful to involve a mental health professional to assess for posttraumatic stress disorder and depression resulting from the procedure or its sequelae. Additionally, many of the psychosexual symptoms that result from FGM/C are also a result of trauma, and it can be difficult to separate the causes. Women with FGM/C who are not candidates for surgical reconstruction may still find symptom improvement with psychological counseling and support.

## Surgical Approaches

### Defibulation

Defibulation has been previously described in this chapter and may improve dyspareunia, sexual function, and urinary flow issues.

### Clitoral Reconstruction

Clitoral reconstruction is relatively new as an option to decrease pain and improve sexual function and body image. There are no large studies on the procedure. A recent meta-analysis on the evidence linking it to improved outcomes shows that it is limited and scarce. Similar to any type of reconstructive surgery, psychosexual counseling before and after the procedure is important. Patients should be counseled about the fact that the procedure may not be successful.

## Legal Considerations

### Asylum Requests

Providers in the United States may be asked to provide physical exam documentation to women who have undergone FGM/C and are seeking asylum on this basis. The first reported case of a woman granted asylum under these circumstances was in 1996. Since then, multiple requests are processed daily, and providers who are considered specialists in the area are asked to document a confirmatory physical exam. Providers writing an affidavit for an asylum-seeker on the basis of FGM/C should include in the affidavit: (1) their own credentials and source of expertise on FGM/C; (2) a summary of the patient's narrative or recollection of the procedure (so that this narrative can be confirmed on physical exam); (3) documentation of the presence or absence of each element of the external female genitalia and whether it appears normal and intact; (4) an assessment of the WHO classification level of FGM/C; and (5) a conclusion as to whether the asylee has experienced FGM/C and whether her physical findings support her narrative.

## Conclusion

Female genital mutilation/cutting is a procedure that is harmful to the physical and psychosexual health of women who have undergone it. Women who have undergone Type II and Type III FGM/C may have more severe physical sequelae associated with the procedure due to the extent of their anatomic disfiguration. Providers should document a detailed history and perform a physical exam in patients presenting for care from countries where it is actively practiced. They should familiarize themselves with the World Health Organization Classification of FGM/C. In obstetric patients who are infibulated (Type III), a defibulation procedure should be discussed as an option before and during pregnancy, including labor. Clitoral reconstruction is a novel approach touted to improve psychosexual function in women who have undergone certain types of FGM/C, but still requires further research into effectiveness and safety. All women who are contemplating a reconstructive procedure need a thorough psychological assessment before and after the procedure. When a provider is asked to document a physical exam in a patient who has undergone the procedure, they must feel comfortable performing the assessment but may also refer patients to specialized refugee health centers that may provide this service. Until this practice has been eradicated, women's healthcare providers who may encounter patients with FGM/C should familiarize themselves with the procedure, its associated consequences, and provide appropriate medical and psychological support to their patients in a background of culturally competent care.

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# Part IV

# Medicolegal Issues

# 12

# Medical Documentation in Intimate Partner Violence Cases

Tracey K. Downing, Esq.

## Introduction: Intimate Partner Violence and Trauma

The true prevalence of intimate partner violence (IPV) is underestimated, as it often goes unreported. Nationally, 1 in 4 women and 1 in 10 men reported experiencing sexual violence, physical violence and/or stalking by an intimate partner, and an IPV-related impact during their lifetime [1]. Yet in a study of IPV homicides in New York City between 2010 and 2017, less than half (39.3%) of IPV homicide victims had contact with New York City Police Department prior to that homicide, and in only 13.2% was there an active order of protection [2]. Thus, recognizing and responding to patients who may be experiencing abuse is critical to providing appropriate care and helpful referrals that can lead to the prevention of further abuse, more serious physical injuries, and even homicide. Thorough medical documentation is essential in the legal response to IPV.

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IPV occurs in every country, neighborhood, and community. It can be found among people of all races, cultures, religions, and socioeconomic backgrounds. It can happen whatever your age, gender identity, or sexual orientation. However, the highest rates of IPV are found among women, particularly during pregnancy [3], people aged 18–24 years [4], and people who identify as transgender or nonbinary [5].

Medical providers themselves may feel ill-equipped to effectively address IPV-related trauma within the boundaries of their practice or agency protocols. But recognizing that trauma and its sequelae can cause or exacerbate behavioral health problems is the first step in creating a trauma-informed response across the continuum of care [6]. By providing trauma-informed care and thorough medical documentation of injuries, medical providers can play a crucial role in the response to IPV.

## Medical Documentation of Intimate Partner Violence

By the time a person experiencing abuse becomes your patient, it is likely that they have already experienced years of abuse and/or trauma. Their lives are often completely controlled by their abusive partner, and the only reason they're seeing you is because they have to. That is why it is so important to take the time to build a rapport with your patient. You need to get as much information as you can to effectively treat your patient. A vital part of that treatment is ongoing patient safety and health. Thus, the more your patient opens up to you, the better you will be able to treat them and help ensure future good health. Through building rapport with patients and creating environments where they feel comfortable sharing such personal information, providers can also produce higher-quality medical documentation that can lead to better legal outcomes for their patients.

## Why Is Medical Documentation So Important in IPV Cases?

Good medical documentation can help your patient get the services and support they need to survive. It can help in obtaining an order of protection in Family Court or serve as evidence in custody and divorce cases. Medical documentation can help your patient get emergency housing, immigration relief, and financial assistance for hospital bills and living expenses [7].

Medical documentation can also play a vital role in holding the abusive partner accountable for their criminal actions. Good medical documentation helps strengthen a criminal case. The stronger the case, the more likely there will be a plea instead of a trial. Why are pleas preferable for the survivor in IPV cases? The court setting can be extremely intimidating to survivors, with many in attendance including court officers, the judge, prosecutor, defense attorney, and many individuals unrelated to the case (criminal court cases are open to the pubic). In addition, the defense attorney's job is to discredit the prosecution's witnesses. Imagine as a survivor having to get up on the stand in front of all these people and talk about the most intimate, terrifying, and embarrassing parts of your life. Understandably, that may be extremely challenging, stressful, and painful for an IPV survivor. Given how trauma can inhibit a victim's ability to recall the crime in a logical and linear fashion, as well as the potential for re-traumatization during trial, it is clear that avoiding a trial is preferential in most cases. Good medical documentation can help avoid these negative consequences by increasing the likelihood of a plea in IPV cases.

However, in some cases, trial is unavoidable. Many medical practitioners are concerned about confidentiality and liability should they be called to testify [7]. However, certified medical records are often admissible as evidence without the testimony of the treating practitioner. Thus, in cases where the injuries are sufficiently detailed in the medical records and require little or no explanation, you may not be called to testify. So how and what do you document in IPV cases?

## Patient Statements

Out of court statements are generally not admissible because they are considered hearsay; however, under some circumstances a court may allow out of court statements into evidence.

1. Excited or Spontaneous Utterances

   A patient's excited or spontaneous statements may be admissible at trial as courts view these types of statements as more trustworthy because they are made while the declarant is still under the stress of the incident and hence the declaration is made without reflection and not for the purposes of future prosecution. Thus, it is essential to document anything the patient says to you, even if it is not logical or part of the screening. For example, as you walk over to the patient, they see you and say "I don't want my husband to get in trouble." It is vital that you document that in your notes, as it is evidence that your patient's husband may be culpable. It also serves to corroborate the victim's testimony, or may refresh their recollection, at trial.
2. Statements Made for the Purpose of Medical Diagnosis and Treatment

   Statements that patients make are also admissible when they are made for the purpose of medical diagnosis and treatment. Thus, if you ask your patient how they got the bruising on their back and they tell you their partner punched them repeatedly, that is admissible, as you need to know how someone sustained an injury in order to properly treat that injury and assess for additional related injuries.

When documenting patient statements, always use their own words and set apart their statements by using phrasing such as "patient states…" or "patient reports…" and putting their statements in quotations [7]. write "Patient states they were 'punched in the back'" does not indicate who is giving you that information.

Steer clear of phrases such as "patient alleges…" or "patient claims…" as that implies that you don't find your patient credible

[7]. If your observations differ from what your patient is telling you, record what the reason is for that difference [7]. Likewise, avoid using legal or law enforcement phrases such as “alleged perpetrator” or “defendant,” instead describe the person who caused the injury in the vernacular used by your patient [7]. For example, “My husband punched me in the back.”

## Patient Injuries

In a study of 184 visits for medical assistance, it was found that photos and traumagrams were rarely used by the treating professional [7]. In cases where there are visible injuries, photographs should be taken and face and body maps should also be used to indicate where those visible injuries are [7]. Your notes should document what you’re taking photographs of and where those injuries are located.

Describe your patient’s demeanor. Whether they are crying, upset, visibly shaken, angry, or even calm and happy, it should always be noted, as it may be evidence of trauma, fear, or shock [7]. In addition, you want to avoid conclusory statements on their own, such as “rape” or “abuse,” instead include all the statements and medical findings that lead you to that conclusion [7].

Medical records are extremely credible as they are an unbiased record of how someone got their injuries and an accurate account of the severity of the injuries. Thus, you want to make sure that all injuries are described in detail. For example, a “laceration” can be anything from a small cut not requiring stitches to a deep cut that requires internal and external stitches. When describing the injury, describe the length, width, depth, and exact location of the injury.

## Testifying

As a prosecutor for the Domestic Violence Bureau at the Kings County District Attorney’s Office, I know well the fear and burden having to testify can bring upon someone. But just as sometimes trials are unavoidable, so too is the need to have a medical professional testify. Here are some tips if you get called to the stand.

1. Review medical records before you meet with the Assistant District Attorney (ADA). Medical records can be cumbersome and difficult to navigate, especially for nonmedical professionals. You can help guide the ADA through the medical records and explain a complicated diagnosis much more effectively and efficiently if you come to the appointment prepared. This will help the ADA prepare questions that are relevant and logical.
2. The ADA will prepare you for what to expect on the stand. A seasoned ADA should know how to prepare you for direct and cross-examination. They will have reviewed the medical records and have questions and clarifications ready to review with you. They will have identified any statements that seem inconsistent and review with you, so you are equipped to address them when you are testifying. However, if you do not feel you've been adequately prepared, tell the ADA you would like to prepare again before trial.
3. Don't let the ADA put words in your mouth. If there is something you do not feel comfortable testifying to, let the ADA know and explain why. It is better to have that discussion in their office during trial prep rather than during their direct questioning, or on cross-examination.
4. Let the ADA know if they are misreading the medical records. ADAs are not medical professionals; if they are mistaken about something in their analysis, it's important to let them know that.
5. Most importantly, when you take the stand remember that you are an unbiased and highly credible witness. You know more about medical diagnosis and treatment than the judge or the attorneys. You may even be qualified as an expert in a particular field. Once qualified as an expert you are permitted to offer your opinion instead of just strictly explaining what's in the medical records and how you went about your examination.

One final note about medical records: In some cases, for any number of reasons, the victim may not be available to testify. In those cases, the District Attorney may decide to go forward with the trial anyway. This is known as an evidence-based prosecution. This is not uncommon; in fact, all homicide trials are evidence-based as the victim is deceased. Medical records can serve as crucial evidence in these cases because they can tell a story that the victim is not able to, and they are extremely credible because they are solely for the purposes of medical diagnosis and treatment.

## Why Strangulation Cases Require Closer Examination and Thorough Documentation

Nonfatal strangulation is one of the most lethal forms of IPV and often leaves no visible injury while being a high risk indicator for future serious physical assault and homicide. The inability to get oxygen is one of the most terrifying experiences a person can go through. Not only is it incredibly painful physically, but it has devastating effects on the victim's mental, physical, and emotional well-being. Many strangulation survivors live in constant state of hypervigilance and suffer from long-term neurological and cognitive impairments that can seriously impact their ability to perform activities of daily living.

Up to 68% of women in abusive relationships experience strangulation in the course of that relationship [8]. In a study of 300 strangulation cases, only 50% had visible injuries, and only 15% had injuries that were sufficient to be photographed [9]. There may be no visible injuries in the most serious, even fatal, strangulation cases. If pressure is maintained, loss of consciousness can occur within 10 seconds and death can occur within 3–5 minutes [10]. Victims of one strangulation are 750% more likely to become a victim of homicide by the same partner in the future [11].

Patients often refer to strangulation as "being choked," but choking is a form of asphyxia caused by an internal blockage, whereas strangulation is a form of asphyxia characterized by the closure of the blood vessels and/or air passages of the neck as a result of external pressure. Strangulation often occurs amidst other forms of physical assault and because there are often little or no visible injuries, your patient may not even tell you they've been strangled. Instead, they are more likely to focus on the visible injuries, such as a black eye or split lip. Symptoms of strangulation may also be incorrectly attributed to other factors, such as a sore throat being attributed to the fact that the victim was screaming during the assault.

Thus, strangulation is often underreported and not identified by healthcare providers. It is vital that you screen for strangulation and work closely with the person who has been strangled in order to respond with comprehensive support.

## Screening in Strangulation Cases [12]

Proper screening will help identify internal and neurological injuries. Every patient who discloses that they are experiencing IPV should be asked the following questions around strangulation:

1. *Has your partner ever put their hands or any other object on or around your neck?*
2. *If yes, was it within the last 6 months? If yes…*
3. *Did you experience any of the following symptoms?* (*see* Table 12.1)

**Table 12.1** Symptoms

| Nonvisible injuries | Visible injuries |
|---|---|
| Trouble focusing, confusion, or disorientation | Scratches, red marks, or thumb/finger/hand imprints |
| Voice changes | Petechiae (appears as red dots on skin) |
| Difficulty breathing or swallowing | Ligature marks |
| Dizziness or headaches | Neck or face swelling |
| Ear pain or tinnitus | Tongue swelling or bruising |
| Loss of consciousness or stupor | Subconjunctival hemorrhaging (blood red eyes) |
| Memory loss | Bruising on chest |
| Restlessness or combativeness | Involuntary urination or defecation |
| Shaking | Miscarriage |
| Vomiting or spitting | Defensive injuries, scratches, bite wounds to tongue |
| Difficulty balancing or walking | |

4. *If yes, recommend radiographic studies and further ER examination/monitoring to rule out life-threatening injuries.*
5. *If they experience any symptoms from a strangulation that occurred over 6 months ago, consider referring them to a neurologist to determine if there are any long-term effects that need to be monitored and/or treated.*

## Trauma-Informed Interviewing

There are several things to keep in mind when working with survivors of trauma. First, a trauma survivor's responses may be different than we would expect from someone seeking medical attention. Second, we have our own biases that can affect how we respond to someone experiencing abuse or trauma. Third, your goal is to get as much information as you can to provide appropriate care without re-traumatizing your patient. This section will discuss why and how these things can help you in treating survivors of sexual assault, IPV, and, trauma in general.

### Trauma Defined

Trauma can refer to a single event (e.g., car accident), multiple events over a period of time (e.g., child sexual abuse), or a set of circumstances (e.g., being in an abusive relationship) that is physically or emotionally harmful and has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being [6]. It can be caused by nature (e.g., natural disaster), by human beings accidentally (e.g., technological malfunction causing a car accident), or by human beings intentionally (e.g., committing a violent crime against another) [6]. It can affect an individual or a community [6]. It takes many forms and each person's experience and response to a particular trauma is unique [6]. The experience and processing of trauma is highly individualized. It is important to keep that in mind because the way people respond to you will have a lot to do with how they experience and process trauma.

## Understanding Our Own Biases

It is also important to keep in mind that we all have biases that impact the decisions we make and how we respond to other people. These biases can be explicit or implicit. It's only human to form biases based on our own experiences, but being aware of these biases and keeping them in check will help in building rapport and trust with your patients who have experienced trauma and/or IPV.

There are several cognitive biases that play a role in our decision making and how we decide whether someone is telling us the truth. The first is known as *anchor bias*. Anchor biases are formed based on our heavy reliance on the first piece of information about a topic we receive [13]. That information becomes the anchor in our future decisions about that topic [13]. All the information about that topic will be interpreted through the lens of that anchor bias [13]. For example, if you see an item of clothing for $50 at a store and then go to a discount store and see the same article of clothing on sale for $20, you will likely believe that the article of clothing is worth $50 and you are saving a lot of money! That is because the first piece of information you received about that article of clothing was that it was worth $50, and that became your anchor belief.

Another cognitive bias is *confirmation bias*. Used in much psychological literature, confirmation bias references human tendency to seek and interpret evidence that supports our underlying beliefs [14]. This tendency to interpret new evidence as confirmation of one's existing beliefs or theories is analogous to wishful thinking, wanting a certain concept to be true, and only listening to evidence that makes it seem true. For example, take people's relationship with social media. Most people likely share only articles that support what they already believe. That's because once an individual has gathered evidence that confirms their views, they will no longer take in additional information and will reject any evidence contrary to those beliefs.

Another cognitive bias that affects our decision making and reasoning is *availability bias*. Availability bias is the tendency to call to mind an example that supports a decision or rationale [13].

For example, co-worker A has a negative interaction with co-worker B, based on that interaction, forms the belief that co-worker B doesn't like them. Co-worker A will view all future interactions with co-worker B through the lens of this one interaction and they will bring this example to mind to confirm their belief that co-worker B does not like them. In reality, co-worker B may have just been having a bad day.

Although ideally medical providers seeing traumatized patients would be able to discard their own implicit biases, research has shown that these biases persist in medical settings [15–17]. A 2016 study of the impact of racial biases in the medical context showed that false beliefs, among medical practitioners, about biological differences between black and white Americans led to racial disparities in pain assessment and treatment [15]. The study revealed that black Americans are systematically undertreated for pain relative to white Americans [15]. The researchers concluded that it was the medical practitioners' deeply rooted implicit biases and difficulty relating to patients who have different experiences than their own was the cause for this disparity in treatment [15]. In research around experiences during childbirth, one survey found that 1 in 5 Black and Hispanic women recounted poor treatment from hospital staff compared to 8% of white women [16].

Being cognizant of personal biases, while addressing them honestly, is crucial. Not only will doing so help you engage your patients in a way that avoids re-traumatization, but it may lead to a more open dialogue, which may help you more effectively diagnose and treat your patients who have experienced the trauma of sexual or intimate partner violence.

## Engaging Patients Who Have Experienced the Trauma of Abuse

A trauma-informed approach to working with patients starts by recognizing the impact of trauma and trauma presentations, whether it is PTSD, depression, anxiety, anger, substance use, or some other variation of response to trauma. Patients who are currently experiencing IPV or who have experienced IPV in the past may not present with obvious signs or symptoms of medical or psychiatric distress, thus, the importance of building rapport and routine screening for IPV are paramount [17]. Trauma-informed care is about establishing a safe environment and building trust while providing your patient with as much choice as possible. It is important to acknowledge the privilege you hold and what you may represent to the patient, which historically may not have been safety. Thus, establishing a feeling of safety should be your first goal of treatment [6]. The key to providing safety is to avoid re-traumatizing or triggering the trauma survivor. This can be accomplished with some small steps before, during, and after the examination or interview.

## Tips for Before the Examination

Loud sounds, tension between people, certain smells, or types of touches can all trigger trauma reactions [6]. Having to disclose one's history in a medical setting can make the patient feel exposed and vulnerable [6]. Sudden transitions in treatment settings or unexplained changes in care can further add to feelings of instability and anxiety [6]. By providing as much information as possible and being transparent and nonshaming in your responses to the patient, you can help build a sense of control and stability necessary for trauma survivors [6]. Remember that when working with victims of IPV, they often live in a world where their partner has the power and control in the relationship. The experience of trauma itself involves a loss, or a perceived loss, of control. So give your patient as much control as you can.

1. Consider physical space and surroundings. Be sure to select as quiet and private of a location as possible. For example, if you're in an emergency room, perhaps the gurney can be wheeled to a corner where there are currently no other patients and the curtain can be drawn.
2. Address any immediate needs of the patient. If possible, ask if they would like water or to use the restroom before beginning.
3. Let them know why you're there and if other medical staff need to be present, let the patient know this and explain why.

Set the tone and ground rules for the other staff who will be present (e.g., don't interrupt, don't shout, etc.).

4. Where possible, be seated and encourage any other staff to do so as well. This will ease the power differential between patient and physician.
5. Decide how you can give the patient some control over the process. Perhaps ask if they'd like to sit up instead of lay down. Let them know they can take a break as needed.

## Tips for During the Examination

You can greatly enhance the success of treatment by taking the time to build rapport and trust with your patient. Don't make promises you can't keep and prepare your patient for what lies ahead (e.g., long waits, different tests.).

Start your questions around IPV with a general framing statement [17]. This shows that you are aware of the prevalence and complexities around IPV while avoiding making your patient feel like you are targeting them. Here are some examples of how you can frame this discussion:

1. "Many of my patients have experienced some sort of abuse in their past. So I ask all patients questions around trauma or abuse they may have or are experiencing in their lives."
2. "I ask all my patients some questions about whether they've ever experienced trauma or abuse."

Once you have framed the issue, start with a simple question to open up the discussion [17]. Use a nonjudgmental tone throughout the conversation. This will help your patient feel more at ease disclosing any history of abuse or trauma.

Here are some example screening questions to begin with. If your patient answers "yes" to any of these, you will need to conduct a safety assessment:

1. Have you ever been emotionally or physically abused by a partner? If so, by whom? [18]
2. Within the past year, have you been hit, slapped, kicked, strangled, or otherwise physically hurt or frightened? If so, by whom? [18]

3. Within the past year, have you been forced or coerced to have sex against your will? If so, by whom? [18]
4. Are you afraid of your partner? [18]
5. Do you feel unsafe in any of your relationships? [16]

If a patient discloses trauma or IPV, be empathetic, not sympathetic. Empathy involves validating and acknowledging a person's traumatic experience. Sympathy, which involves expressing pity for another person's circumstances, can come across as patronizing or condescending. Instead acknowledge the person's experience.

1. "You've been through a lot; this must be very difficult for you."
2. "I really appreciate your willingness to talk to me about this today."

> Your patient may be angry as a result of the trauma or abuse they've experienced. Allow them the space to express that. For example: "It is understandable that you're upset. That is a normal response to what you have experienced."

Try not to use medical jargon, and instead speak in layman's terms. Don't just name the procedure or results, but rather explain it to your patient as if you were talking to a family member or close friend. Answer questions as best you can, and if you don't know the answer, that's fine. Just let them know that you will do your best to find out the answer or someone who can assist them with that question.

Sometimes when patients are recounting traumatic events, they may become overwhelmed and disengage in order to avoid painful memories. Grounding is a technique that helps keep someone in the present by managing these feelings and bringing the person back into the present. When asking grounding questions, make sure your voice is calm and soothing. Don't yell, be abrupt, or become impatient with your patient. Ask questions such as:

1. "What are your thoughts right now?"
2. "Would you like a glass of water?"
3. "Do you need to take a break?"

## Tips for Ending the Interview

Try to use the same plain language and tone of voice you've been using throughout the examination. Be sure to explain the next steps and referrals that are being made. Address any safety concerns by making sure the patient meets with a DV coordinator or hospital social worker before they leave for the day if they choose to. In sexual assault cases, make sure they are provided with the Sexual Assault Crime Victim's Bill of Rights as required by New York State and remember that they have a right to have an advocate present for the entire exam if they choose. Obtain safe contact information and make sure the patient has your name and contact information stored in a safe place. It can be helpful to end the interview with these three questions:

1. "What was the most difficult part of this experience for you?" [19, 20]
2. "What, if anything, can't you forget about your experience?" [19, 20]
3. What, if anything, haven't I asked you about that you think I should know?

## Summary

As we have seen in this chapter, medical documentation is vital in IPV cases. Providers who use a trauma-informed approach are better able to build rapport, support the patient, and obtain information needed to prove thorough documentation. Statements made by the patient are admissible if they are part of the medical examination, and thus are helpful to include in the clinical note. Thorough description of injuries is essential, with photographs if possible. Particular attention should be paid to any cases in which strangulation is reported or there is evidence of strangulation, as these cases have a higher risk of recurrence and death. Because patients may not disclose strangulation and injuries may not be externally visible, it is advisable to screen every IPV patient for strangulation. This chapter is intended to serve as a guide for medical providers who encounter patients reporting IPV and/or sexual assault in order to provide the documentation needed to help them pursue legal protection, as well as begin to heal from the trauma of their experience.

## Resources

- Call 311 to get connected to free and confidential assistance for patients who have experienced IPV, sexual assault, trafficking and/or gender-based violence at one of the five NYC Family Justice Centers.
- NYC HOPE Resource Directory at nyc.gov/NYCHOPE can connect you to resources to help a patient experiencing dating, domestic, or gender-based violence.
- The Training Institute on Strangulation at strangulationtraininginstitute.com
- The National Domestic Hotline at 1-800-799-7233 or online at https://www.thehotline.org/

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# 13

# Legal Systems and Needs: Considerations for Survivors of Gender-Based Violence

Kate Mogulescu

## Introduction

Individuals who have experienced sexual and gender-based violence may be victims of crimes under various state and federal laws, including assault, sexual abuse, rape, battery, human trafficking, and many others. At first glance, one might assume that criminal and other legal systems would recognize them as victims and offer protection, safety, and recourse. However, for many victims, that is not the case. Instead, survivors of violence have often had complicated, drawn out, and harmful interactions with legal systems. Frequently, these interactions are deeply connected to their marginalization and vulnerability, and have been destabilizing or traumatizing. As a result, although many survivors have a vast array of legal needs, they view the legal systems that govern those needs with significant, and well-earned, distrust.

Legal system involvement often creates additional barriers for survivors which are commonplace, but not insurmountable. Such barriers include considerable demands on time, lack of access to

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information, coerced or pressured decision making, and further trauma in the form of a lack of control. Separate from the specific outcome of a legal case or proceeding, system involvement can have further negative impact, often labeled "collateral consequences"—a term used to describe additional penalties caused by having, or being involved in, a legal case. All direct service providers must understand these consequences in order to meaningfully assist survivors with comprehensive responses. Armed with this knowledge, medical providers can reduce the impact that survivors' legal disempowerment has on their physical and emotional health and stability. Additionally, through collaborative partnership with legal professionals, medical providers can bridge gaps to allow survivors to access resources within legal systems. This chapter provides an overview of the way in which survivors of gender-based violence encounter various legal systems, identifies survivors' common legal needs, and offers best practices for medical professionals to approach interdisciplinary support of survivors in care models.

## Legal Disempowerment: Survivors' Experiences in Legal Systems

### System Involvement as Harm

A critical feature of survivors' interaction with legal systems is that the systems, for the most part, have caused them harm. For medical practitioners working with this population, this may seem counterintuitive. However, parallels exist in the medical system. When medical professionals interact with a patient, they are also reckoning with every prior encounter the patient has had with the healthcare system, for better or worse. The same applies in legal systems. Many patients have prior negative experiences with, and views of, criminal, family, immigration, or other legal systems. Not only does this decrease their access to resources, but bad prior experiences in the legal system influence survivors' views of institutions more broadly and can lead to distrust of other large bureaucratic systems, such as healthcare or education.

In some legal systems, the disempowerment is purposeful and designed. In others, it is an unintentional consequence. For survivors of gender-based violence struggling with financial stability, marginalization is amplified exponentially. Legal systems in the USA operate on, and instantiate, problematic views of race, gender identity, class, and ability that are well documented in social science literature [1]. For example, disproportionate and discriminatory policing practices dictate who becomes involved in the criminal legal system, rather than the prevalence of crime or criminal behavior [2, 3]. Additionally, the immigration legal system codifies governing, and often fluid, views of race and class that prioritize enforcement against specific groups during specific times [4].

When one looks at which populations and communities are most impacted by, and drawn into, these systems, patterns emerge. For example, with respect to the criminal legal system, between 2010 and 2014 in New York City, over 86% of women arrested and prosecuted were non-white [5]. Women who are detained in jails and prisons across the country also are overwhelmingly non-white, mothers, and primary caretakers of children [6]. Research also shows that a significant majority of women in prison and jail experienced intimate physical or sexual intimate partner violence prior to their incarceration [7, 8].

The net effect is that legal systems are a site of trauma on an individual and community level. They are difficult to navigate and punitive. For medical practitioners working with survivors, it is important to understand how a survivor may have experienced legal systems in the past, the various legal needs a survivor might currently have, what resources are available to meet those needs, and what promising interdisciplinary practices might help mitigate or reduce the harm of legal system involvement. These legal needs are described below in section "Identifying Legal Needs and Remedies".

## Access to Counsel

Access to representation, guidance, and information about how to navigate legal systems varies widely depending on income status. Well-resourced individuals with access to legal representation fare better in the legal system; they understand the process and outcome when guided by an advocate with expertise. On the other hand, too often, poor people with legal needs must go at it alone.

Individuals facing criminal prosecution have a right to counsel in the USA. However, this right, recognized by the Supreme Court in 1963, is not without qualification [9]. In the intervening decades, courts and policymakers have chipped away at the right to counsel in criminal proceedings and diluted the notion of what effective representation means to the point where safeguards do not exist for quality control in criminal legal representation provided by the state. Nonetheless, as fictional television and movie arrests make clear, if you cannot afford an attorney and are facing criminal charges, in most instances, the government must provide you counsel. This is true for criminal charges at the trial level through the first immediate appeal, and also applies to juveniles facing delinquency proceedings or criminal charges.

Outside of the criminal context, there is no universal right to counsel for all legal needs, meaning the government is not required to provide counsel even when the legal systems function as quasi-criminal or where the stakes are very high for the people involved. For example, there is no right to counsel in immigration proceedings, even when a foreign national is detained and facing deportation; in eviction or child welfare proceedings; or when a victim of a crime seeks an order of protection or other relief against the person who committed the crime.

Women, children, families of color, the elderly, and people with disabilities are disproportionately affected by an inability to afford legal representation [10], and therefore vulnerable to additional specific harm in the legal proceedings that govern their lives. For survivors of violence, this often means that they must attempt to learn about their legal options and pursue remedies on their own. Survivors are not guaranteed counsel when, for example, they seek orders of protection or divorce, attempt to secure custody of their children, or try to navigate consumer debt caused by abuse or exploitation. Thus, survivors often must sort through frustrating, and frequently contradictory or inaccurate, information unassisted because legal systems offer inaccessible process and insufficient recourse.

## Identifying Legal Needs and Remedies

### Criminal

Much has been written about the impact of policing and criminalization in marginalized communities. Critical analysis centers the role of race, class, and gender in the criminal legal system in the USA. The criminal court system and attendant law enforcement machinery have grown exponentially over the last few decades. When coupled with efforts to respond to social issues, such as drug abuse, family violence, and commercial sexual exploitation, that heavily rely on a criminal response, the result is simply an extraordinary number of people arrested and swept into the criminal legal system across the USA.

#### Connection to Poverty

Poverty and marginalization can lead to additional interaction with the criminal legal system that creates additional complications and obstacles for survivors. Many survivors face repeated arrest because of policing practices that focus on low level offenses connected to poverty, such as trespassing, shoplifting, or accessing public transportation without paying. Additionally, for many survivors, there is an increased risk of interaction with the criminal legal system because of their race, gender identity, homelessness, or perceived nationality. Arrests, even for minor offenses, can disrupt stability and have negative consequences. Many individuals arrested and detained for even a short time risk losing shelter housing placements, or missing required appointments at social service agencies, school programs, or medical providers. Short-term incarceration can cause breaks in important routines, such as access to prescription medication or other medical care.

#### Family Violence

Survivors of intimate partner or family violence also face heightened risk of arrest directly connected to their victimization. Mandatory arrest policies in many jurisdictions mean that the police must make an arrest when responding to a call for assistance. This occurs even if all members of the family present when the police arrive indicate that the situation has been resolved and that arrests are not necessary or desired. Dual arrests, where someone who has experienced violence is arrested along with the person who committed the violence, are commonplace [11, 12].

Mandatory arrest policies, like any police interaction, are governed by assumptions and stereotypes that law enforcement officials make and rely on about the individuals involved. Notions of gender roles and gender identity impact the police determination of who may be an aggressor and who is a victim, and therefore the response. This is particularly fraught, and problematic, when police respond to alleged violence in same-sex relationships or relationships where one or more person is gender nonconforming, queer, or nonbinary [13, 14]. Police are much more likely to arrest both people in a same-sex couple when responding to a violent situation [11].

Many scholars have established how mandatory arrest policies have failed to protect women of color from violence because race also impacts how police respond to family situations [15]. Beyond just failing to protect, women of color are actually harmed and made worse off by these arrest practices. Women of color are arrested more often than white women when police respond to a home [12]. Taken as a whole, contemporary police practices around family violence render survivors less safe, and are particularly concerning for women of color [16, 17].

The risk of criminalization of survivors does not end with arrest policies. Survivors of intimate partner violence who have children risk being prosecuted for failing to protect their children from abusive spouses or partners [18]. Children are often removed from the custody of a parent who has experienced domestic abuse at the hands of a partner. Many IPV survivors may then also face criminal prosecution in addition to losing custody of their children.

Furthermore, criminal court proceedings involving alleged domestic violence are coercive. No-drop policies mean that even when a victim does not want to see their abuser prosecuted criminally, the victim does not have control over that decision or process. Prosecutors can threaten to prompt a child welfare investigation into a family if victims do not wish to cooperate in a prosecution.

When survivors do not wish to cooperate with a law enforcement investigation or a prosecution, they can be jailed to compel compliance. Specifically, with respect to sexual assault, there has been a disturbing use of prosecutors' power to deem some witnesses as "material" to their case as a way to control survivors who do not wish to testify in court. Material witness orders allow the detention of witnesses until a proceeding has concluded. This recently has included survivors of sexual assault, domestic violence, and sex trafficking [19].

In cases involving violence, courts frequently, if not always, issue restraining orders or orders of protection that mandate no contact between the parties. These orders often fail to provide any concrete protection from abuse. Instead, mandatory orders of protection create logistical obstacles and force family separation even when family members do not wish to be separated [20]. Many survivors of family violence do not want mandated separation from the person who has committed the violence. Too often, survivors' agency, self-determination, and autonomy are compromised because courts issue orders that require complete separation and are not responsive to survivors who express contrary desires [21].

### Prostitution and Trafficking

Individuals compelled to engage in, or trafficked into, the commercial sex industry, or other illegal labor sectors, face arrest for prostitution offenses, possessing false documents, and other offenses directly tied to their trafficking and exploitation. In 2016, the National Survivor Network published a survey of its members, all human trafficking survivors, that showed that 90% of respondents had been criminally prosecuted and had resulting criminal convictions on their record [22].

Victims trafficked into illegal conduct, such as sex work, often face *repeated* arrest. Central to the practical application of the law in this area is the relationship between prostitution and sex trafficking, which are distinct but often conflated. Not all sex work is trafficking. Trafficking only occurs where a person's involvement in commercial sex is induced by force, fraud, or coercion, or where the person involved is less than 18 years old. People engage in commercial sex for many different reasons and in a variety of ways. Providers, legal or medical, should make no assumptions about individuals they are working with who may have become involved in commercial sex by choice, circumstance, or coercion.

Still, people engaged in prostitution—trafficked or not—frequently interact with the criminal legal system because of their own arrest and prosecution [23]. Once involved in the criminal legal system, arrested individuals face potential detention in jail or prison, probation or other supervision and surveillance, or mandatory "programs" that are designed to offer assistance, though these programs are overshadowed by the threat of prosecution if the individual does not comply [24, 25].

### Foreign Nationals and the Criminal Legal System

For foreign national victims, any interaction with the criminal legal system creates additional danger. In a rapidly shifting immigration landscape, one of the largest risk factors for being placed in removal or deportation proceedings is an arrest. Foreign nationals who have been arrested, even if not ultimately found guilty of anything, may be placed in removal proceedings, have their lawful permanent residence challenged, and/or be unable to naturalize to become a citizen.

Arrests for prostitution-related activity, drug offenses, or other crimes that meet the definition of a "crime of moral turpitude" also present specific dangers to foreign national survivors. Noncitizens may be denied initial or return entry to the USA if immigration officials have reason to suspect they are entering for the purposes of prostitution, which can be based on arrest or conviction records. Convictions may also bar foreign national victims from a variety of forms of immigration relief, explored more fully in *Immigration* below.

### Additional Consequences

Arrests and criminal court involvement have significant consequences for any individual, though particularly for survivors. To begin with, many individuals who have been arrested or criminally prosecuted do not meaningfully understand the nature or outcome of the proceedings. In fact, the majority of people who have been arrested go through the court process without a clear understanding of what occurred and what remains on their record subject to public search, background checks, or other reporting.

This is problematic as a criminal record can control, or foreclose, access to employment, housing, financial assistance, and/or other civic participation. Although state law varies, in many places a criminal record precludes someone from being able to vote. Almost every employer now requires some form of background or criminal history check. In the employment application context, when individuals don't know or understand what might appear on their criminal record, they may answer questions pertaining to that record incorrectly, be disqualified from opportunities, or be deterred from attempting to engage in the first place.

Separate from the actual sentence, or punishment, imposed by the court, the additional collateral consequences of an arrest are far-reaching. Because these consequences are so critical, and dependent on local law and policy, the American Bar Association (ABA) developed the National Inventory of the Collateral Consequences of Conviction, a database identifying more than 44,000 separate collateral consequences. This includes nearly 17,000 licensing/occupational laws with criminal record provisions, more than 6000 of which carry mandatory/automatic exclusions [26].

Survivors of sexual violence who have been arrested due to their victimization may also have open warrants stemming from the arrest and court proceeding. When an individual fails to appear in court after being directed to do so, the court can issue a bench warrant, which authorizes any member of law enforcement to take that person into custody. For example, victims of trafficking who are arrested for prostitution and other offenses are often controlled by traffickers who manage their movement such that victims miss court dates because they have been brought to another jurisdiction or are simply not allowed to make an appearance in court. As a result, open warrants can haunt survivors both during and after their trafficking.

As a whole, resolved or unresolved criminal legal system involvement causes fear, anxiety, and stigma for survivors. For survivors who are still actively victimized, arrests and prosecution reinforce the message that their traffickers and abusers have worked to instill—that they are seen as criminals, that they have no value, and that no one will believe them should they choose to seek assistance or disclose what is happening to them. For survivors who have extricated themselves from violence, exploitation, or abuse, criminal records create high barriers to employment, safe housing, education, financial assistance, and other key components of stability and independence. The National Survivor Network survey revealed that over 80% of respondents had faced barriers with employment and 50% with housing [22]. Criminal records can even be used by the trafficker against the survivor; for example, in instances where they have children in common, traffickers have pointed to the survivor's record as evidence of unfit parenting in custody disputes.

Equally important, a criminal record serves as a constant reminder of past abuse and as a source of tremendous shame. Survivors of gender-based violence often face demands that they explain to a potential employer or housing manager the circumstances of their prior arrests or convictions and therefore must choose between sharing their victimization history or simply walking away from an opportunity. Many survivors choose not to relive this experience.

Fortunately, state law is beginning to reckon with the huge impact of collateral consequences. It is promising that many states are taking this up as a civil rights issue and as part of larger criminal reform strategies. Attempts to counteract disenfranchisement for people with criminal records are beginning to build more broadly. For example, there are campaigns to offer increased general expungement or limit employers' ability to use criminal records against an applicant in the hiring process. All direct services professionals should be familiar with local efforts in their jurisdiction and make appropriate referrals to legal services organizations or pro bono attorneys for criminal record-related issues [27].

Additionally, there has been a recent wave of development specific to survivors of human trafficking. Nearly all the states in the USA have enacted laws that allow victims to vacate, expunge, or seal prior convictions for prostitution-related or other offenses.

Although slightly different from state to state, these criminal record relief laws allow survivors to petition to have arrest or conviction records removed from their record or shielded from disclosure [28]. While most states limit record relief to situations where an arrest was a result of human trafficking, some states have begun to conceptualize criminal record relief for survivors of other forms of gender-based violence as well [29]. This is a critical area of state law that will hopefully continue to grow.

Medical professionals should be mindful of a survivor's potential interactions with the criminal legal system when working with patients and gathering information. Notably, when assessing a patient's history, decisions, or options, medical practitioners should refrain from simply suggesting a person contact the police if they have been the victim of a crime. Many jurisdictions have public defender offices that would be a good point of first contact for professionals, or survivors, with questions about the criminal legal system. This can include questions about how to handle situations with the police, one's own record, open warrants, or other concerns.

## Immigration

Immigration status can impact survivors of gender-based violence in several ways. Survivors who are foreign nationals, non-US citizens, have specific considerations related to their ability to remain in the USA if that is what they wish to do. This includes specific risks and consequences, as well as some avenues to seek humanitarian relief because of their status as a crime victim [30]. Thus, immigration status must be considered both proactively and defensively, particularly at a time when anti-immigrant rhetoric is shaping policy and making it harder for all noncitizens, particularly asylum seekers or victims of crime, to find security and stability for themselves and their families. Different forms of humanitarian relief are described more thoroughly below.

Noncitizens in the USA can be present lawfully or without documents. Lawful presence is either temporary or permanent. *Temporary status* is bestowed through the issuance of specific visas which govern the duration and activities allowed during a visit, such as a tourist, student, or employment visa. These visas often restrict or dictate an individual's ability to work, and expire after a certain period of time. On the other hand, *lawful permanent residence*, also referred to as a green card, allows a foreign national to remain in the USA indefinitely and work without restriction. One can obtain lawful permanent residence through a family member petition, an employer petition, or humanitarian relief. *Undocumented* foreign nationals either entered the country without inspection by crossing a border without detection or have overstayed a temporary visa status.

Foreign nationals living in the USA without documentation generally have a high level of anxiety and fear connected to their lack of secure immigration status. Such individuals may go to great lengths to avoid contact with law enforcement or other government agencies. They may not be eligible to receive public benefits or other forms of government assistance. Additionally, revealing their status may subject them to harassment or anti-immigrant hostility. As such, many foreign nationals living in the USA without documentation attempt to remain as far below the radar screen as possible. Still, the risk of coming to the attention of authorities and either being detained or facing removal from the country is a constant concern. Victims of gender-based violence who are undocumented may fear interaction with nongovernmental organizations that offer assistance for the same reasons. Thus, lack of secure immigration status can cause victims to remain in dangerous or violent situations and can have a harmful impact on their families.

Foreign national victims of gender-based violence who are undocumented or have temporary status may be eligible to seek specific immigration relief because of their victimization. This relief allows them to remain in the USA and, in some cases, provides a pathway to permanent residence and even naturalization. These remedies vary greatly as to eligibility and outcome, but most victims do not know such remedies exist and therefore miss an opportunity to obtain stability. Although affirmative immigration status adjustment can be oversubscribed and generally difficult to obtain, that is not always the case with the specific forms of humanitarian relief available to foreign national victims of crime.

### U Visa

A U Visa is a temporary status available to victims of a qualifying crime in the USA. Eligibility for a U Visa requires that a foreign national crime victim possess information concerning that qualifying crime; has been helpful, is being helpful, or is likely to be helpful to a law enforcement official; and has suffered substantial physical or mental abuse. Qualifying U Visa crimes include trafficking, rape, sexual assault, abusive sexual contact, domestic violence, and female genital mutilation [31].

### T Visa

Victims of human trafficking may be eligible for a T Visa. A T Visa is a temporary status available to someone who has been a victim of a severe form of trafficking, as defined by federal law; is physically present in the USA on account of trafficking; has complied with any reasonable request for assistance in the investigation or prosecution; and would suffer extreme hardship involving unusual and severe harm if removed from the USA. For a T Visa, the trafficking must be reported to a law enforcement agency except where the victim is younger than 18 or unable to cooperate due to physical or psychological trauma.

### Violence Against Women Act Self-petition

The Violence Against Women Act (VAWA) offers specific relief for undocumented survivors of domestic violence. An abused spouse or child of a US citizen or lawful permanent resident, or a parent of a US citizen, can self-petition through VAWA [32]. VAWA is available to people regardless of gender, authorizes a recipient to live and work in the USA, and provides a pathway to permanent resident status.

### Refugee Status and Asylum

Refugees/asylees are eligible to seek protection in the USA because they have been persecuted or fear persecution in their home country due to their race, religion, nationality, political opinion, or membership in a particular social group. In recent history, victims of domestic violence were considered eligible to seek asylum in the USA as a particular social group. However, a decision announced in June 2018 by the Attorney General attempts to change this by reversing the Board of Immigration Appeals where it allowed a woman from El Salvador to seek asylum in the USA because of the intimate partner violence she faced in her country of origin [33]. Although the implications of this decision are still being tested, the result may be that many victims of domestic violence who may have previously had an opportunity to seek asylum in the USA will be ineligible to do so moving forward. Questions remain about this critical area of the law, which will likely see additional changes.

Additionally, asylum is an area where there has been extensive fraud and exploitation of vulnerable immigrants by legal representatives. Unscrupulous asylum practices have led to great misunderstanding in immigrant communities about viable asylum claims and attendant requirements. Marginalized immigrants who are not connected to nonprofit legal or social services providers can fall prey to these unprofessional and unethical legal practices. As a result, many foreign nationals who believe themselves to be represented in immigration proceedings, or even believe that they have obtained temporary or permanent status, learn later that they have been the victim of fraud at the hands of their purported legal representatives [34].

Many foreign national survivors of sexual or gender-based violence are unaware that they may be eligible for humanitarian relief based on that status. Medical practitioners and staff may, in fact, be on the frontline of identifying foreign national victims who could avail themselves of humanitarian relief.

## Housing/Public Benefits/Consumer Debt

Economic instability causes many survivors of gender-based violence to struggle with legal needs related to housing, eligibility for public benefits, and debt/credit management. Often times, these surface as social service needs. Initially, survivors may struggle with access to resources such as crisis or short-term shelter, food, and transportation. Social service needs can be confused with, or mislabeled as, legal needs. Social workers and case managers can help address service needs. Legal representation comes in when there is a problem with the service provision, such as denial of services to which someone is entitled in violation of established law and policy.

Survivors without steady and reliable income may face homelessness. The need for shelter is widespread and doesn't always rise to the level where legal representation is necessary or helpful. However, survivors can require legal assistance when, for example, they are denied shelter services unlawfully or suffer unsafe conditions within temporary shelter. Survivors who rent or own property can face eviction or foreclosure when financial instability causes missed rent or mortgage payments. Additionally, survivors may face housing discrimination if they have criminal records. Public housing policy often excludes individuals with certain criminal histories. Many private landlords conduct background checks as a precondition to rental. Therefore, survivors may struggle with additional obstacles in seeking safe housing, some of which may require legal representation.

Accessing public benefits is also critical for survivors seeking to establish independence, safety, and stability. The public benefit system, like insurance systems for healthcare, is complicated and consists of an intertwined set of federal, state, and local policies. Bureaucratic in nature, the public benefits system is difficult to navigate. Some even posit that it is intentionally so [35]. Legal representation can help when survivors have been denied benefits after applying, have benefits disrupted because of issues with requalification or certification, or when they have alleged violations of program requirements. Legal and social service advocates can help survivors determine eligibility and how to satisfy proof requirements requiring need, residence, family composition, and any other extenuating factors that could impact benefits.

Finally, survivors may struggle with consumer debt or other credit issues either directly related to their victimization or as a result of the economic instability that preceded or followed [36]. For example, many intimate partner abusers and traffickers open accounts in the name of those they victimize in order to escape financial liability for nonpayment. As part of their coercion, human traffickers may take control of their victim's finances. This can even include filing fraudulent tax documents. Legal services organizations that offer debt and credit assistance can work with survivors to ascertain what appears on their credit report, repair credit, and mitigate debt caused by victimization [37].

## Family Law

Under the broad heading of family law fall various legal issues, including divorce, custody, child support, and abuse or neglect proceedings. Often, survivors have family relationships with their victimizers, and may have children with them. As a result, family law needs can fall into generally two categories: those involving the termination of the intimate partner relationship and those involving the survivors' children.

When the survivor has had an intimate partner relationship with the person who has committed the violence or abuse, survivors may need legal assistance obtaining divorces if they were married, or orders of protection, if that is what they desire. If there are children in common, survivors may need legal representation to safeguard custody or visitation rights as well as child support.

With respect to a survivor's children, it is impossible to overstate the amount of anxiety and fear that inform an interaction with the family court or child welfare system. Allegations of abuse and neglect may arise when a survivor's instability impacts their ability to care for their children. On the other hand, allegations of abuse and neglect can also be used as a weapon or tool of further manipulation by an intimate partner perpetrator. Here too, criminal records come into play, and survivors' own criminal records—for example, for prostitution—may be used to support allegations that they are not an appropriate caregiver for their children. This may happen even if there is no allegation that the children were present during any commercial sex work, left alone, neglected, or in any other way impacted by their parent's involvement in prostitution. The heavy stigma of allegations of prostitution activity can influence family court proceedings unfairly.

As with immigration and other civil legal services described above, there are nonprofit organizations that may offer assistance to survivors. Best practices, which will be discussed more fully in *Best Practices and Responses*, below, involve medical professionals identifying and forging relationships with these various organizations for mutual referrals and collaboration.

## Victims' Rights, Civil Remedies, and Restitution

If survivors are identified as such in a criminal proceeding, and the person who has committed the offenses against them is prosecuted, there are additional legal considerations for the survivor. First, the survivor has rights in terms of how they are to be treated by investigating members of law enforcement and prosecuting attorneys [38]. If those rights are not enforced, a legal advocate can help protect the survivor's interests. Additionally, when a survivor does not wish to be part of an ongoing criminal investigation or is worried about their own potential criminal liability, legal representation can serve as a safeguard. Whether pushing back the threats that may accompany noncooperation, advising how to respond to subpoenas or other law enforcement demands, or defending against prosecutor's efforts to compel testimony, a victim's rights attorney will work only with the interest of the survivor in mind.

If the person who committed the offense against the survivor is ultimately arrested, prosecuted, and/or convicted, the survivor may be entitled to victim compensation. Also, many state and federal laws allow for, or even require, restitution for victims as part of the disposition of any criminal charges. Again, victim's rights attorneys can make sure that a victim receives any restitution or compensation for which the victim is eligible.

Finally, state and federal law often provide what is called a private right of action for victims, irrespective of whether the person who committed the offense was criminally prosecuted. This means that survivors can bring a separate civil lawsuit against the person who committed the offense, and any other person or entity who may have been responsible, to recover damages related to the victimization. While survivors may have access to victim compensation funds or restitution, often these options do not sufficiently compensate the survivor for all the harm they suffered. Depending on the law, survivors may be able to further seek compensatory damages, punitive damages, injunctive relief, and attorney's fees in a civil lawsuit. Additionally, some statutes allow courts to award enhanced damages in cases where the defendant's actions were willful and malicious. In this field, there may be a broader array of attorneys available, and willing, to take on representation, because the attorneys also stand to profit from a settlement or favorable verdict.

However, it is worth noting one significant consideration for survivors contemplating civil actions: many individuals against whom survivors would be able to bring a claim are judgment-proof. This means that even were a survivor to successfully litigate a civil claim against them, the trafficker has no money or assets to satisfy the judgment. Attorneys should review this in each individual case with survivors so that expectations are clear from the beginning and that survivors understand the risks and potential benefits of civil litigation before deciding whether to bring a lawsuit.

## Best Practices and Responses

Given that the majority of patients who have experienced gender-based violence will have unmet legal needs, best practice for medical providers is to look for opportunities to speak to patients about potential referrals for assistance. Once patients have disclosed legal needs, partnerships with legal services organizations and other legal advocates can be immeasurably helpful to improving access to assistance and services. Collaboration can range in formality, but is predicated on communication and a willingness to mutually assist. Interdisciplinary approaches are truly transformative as they involve making inaccessible or obtuse large bureaucratic systems easier for survivors to navigate and improving both legal and medical outcomes.

Initially, medical practitioners may find informal collaboration sufficient in forming relationships and meeting their needs. With progress, this can lead to more formalized, and innovative, examples of collaboration which can include specialized clinics and medical-legal partnerships. Specialized clinics operate to provide medical or legal assistance to a specific population. For example, in New York, the PurpLE Clinic (Purpose: Listen & Engage) was founded in 2015 to provide primary care specifically to survivors of sexual violence [39]. The EMPOWER Clinic, founded by editor Dr. Veronica Ades, offers obstetrics, gynecology, psychiatric, and family planning services to survivors and maintains close relationships with local social services organizations for cross-referrals [40]. Similarly, many legal services organizations offer community-based clinics where individuals in need of assistance can walk-in and obtain information or referrals.

Medical-legal partnerships (MLPs) have proliferated across the country in recent years and are part of a more concerted effort to bring legal advocacy into places offering medical care. These partnerships offer medical patients on-site legal assistance and work to effectively improve medical provider/patient relationships and outcomes as well as increase access to needed services. As the National Center for Medical-Legal Partnership notes,

> Today, over 300 MLPs comprise the landscape of partnerships nationwide, demonstrating enormous diversity in terms of the patient populations served, as well as the size, structure and scope of the particular MLP. MLPs are growing and spreading at a time that other federal and state initiatives are not only recognizing, but are also investing in a systematic approach for identifying and addressing social determinants of health. [41]

Such partnerships serve as direct service providers but also help transform the practice of medical and legal institutions to be more comprehensive and responsive. In many places, MLPs have originated at academic institutions, where law faculty and students collaborate with their medical peers. For example, Yale Law School operates five separate MLPs in New Haven, Connecticut, including the Transitions Clinic for individuals who have returned to the community after a period of incarceration [42]. Transitions offer medical care, social services assistance, and legal screenings at one location. Early evidence indicates that these MLPs significantly improve outcomes for participating individuals. MLPs also allow for interdisciplinary data collection and research that can further both healthcare and legal system reform [43].

## Conclusion

Given the role that legal systems play in the lives of survivors of gender-based violence, treating medical practitioners should recognize the impact and scope of legal needs as they affect comprehensive health and social outcomes. Additionally, identifying the harms caused by the legal system and working consistently to protect against that harm can create better outcomes and reduce marginalization. Incorporating this understanding and analysis becomes part of a harm reduction approach that makes survivors safer, more empowered, and less disenfranchised.

There are insufficient resources in the legal community to meet all the legal needs of all marginalized people. There is no guaranteed counsel in almost all of the legal systems with which vulnerable individuals have most contact. However, even with these limited resources, personal and inter-organization collaboration makes a big difference. Case by case, medical and legal practitioners working in tandem in an interdisciplinary manner can make both the medical and legal systems less traumatic and harmful for survivors.

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# Appendix: Resources by Chapter

**Table A.1** Chapter 3 Intimate Partner Violence and the Training of Healthcare Providers

| Resource | Description | Link/citation |
|---|---|---|
| Futures without violence | Futures without violence is a nonprofit organization working to heal survivors of violence and create communities free of violence. Website provides support and information about several forms of violence, including domestic violence, sexual assault, bullying, and child abuse | https://www.futureswithoutviolence.org |
| Addressing intimate partner violence, reproductive and sexual coercion: A guide for obstetric, gynecologic and reproductive health care settings | Guide for healthcare providers explaining n the role of reproductive and sexual coercion in intimate partner violence, and describing best practices for health professionals addressing these forms of coercion. | https://www.futureswithoutviolence.org/userfiles/file/HealthCare/Reproductive%20Health%20Guidelines.pdf |

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**Table A.1** (continued)

| Resource | Description | Link/citation |
|---|---|---|
| ACOG Committee opinion 554, “reproductive and sexual coercion” | ACOG guidelines on the role of obstetrician-gynecologists in addressing sexual and reproductive coercion. | https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Reproductive-and-Sexual-Coercion |
| myPlan app | App to help IPV women and their friends decide if a relationship is unsafe, and make a safety plan. | http://www.joinonelove.org/my_plan_app |

**Table A.2** Chapter 5 Providing Medical Care to Survivors of Sexual Assault and Harassment in the Military

| Resource | Description | Link/citation |
|---|---|---|
| Veterans affairs military sexual trauma website | Information about military sexual trauma definition, treatment, and benefits within VA. | http://www.mentalhealth.va.gov/msthome.asp |
| PTSD and experiences of sexual assault during military service (continuing education course) | Course reviews best practices for clinicians working with patients with MST-related PTSD, including how to ask about MST and respond to disclosures | https://www.ptsd.va.gov/professional/continuing_ed/sexual_assault_military.asp |
| Military sexual trauma (continuing education course) | Course teaches viewers how to define MST, understand the impact of MST on veterans’ lives, screen veterans for MST, and know what services the VA can provide to support survivors of MST | https://psycharmor.org/courses/military-sexual-trauma-2 |
| Make the connection: Military sexual trauma | Make the connection is a website designed to connect veterans and their families to appropriate support services. | http://maketheconnection.net/conditions/military-sexual-trauma |

**Table A.2** (continued)

| Resource | Description | Link/citation |
|---|---|---|
| Department of Defense Safe Helpline for active duty service members | Anonymous and confidential 24/7 helpline for members of the DoD community who have been affected by sexual assault. | Web page: https://www.safehelpline.org/<br>Online chat: https://www.safehelpline.org/live-chat<br>Hotline: (877) 995–5247 |
| Veterans crisis line | 24/7 crisis line operated by the Department of Veterans Affairs serving all veterans, service members, National Guard and reserve, and their families and friends | Web page: https://www.veteranscrisisline.net/<br>Online chat: https://www.veteranscrisisline.net/get-help/chat<br>Hotline: 1-800-273-8255 |
| *Handbook on sensitive practice for health care practitioners: Lessons from adult survivors of childhood sexual abuse* | Handbook for healthcare professionals on how providers can adopt trauma-sensitive practice when working with survivors of CSA. | http://www.integration.samhsa.gov/clinical-practice/handbook-sensitivve-practices4healthcare.pdf |
| Substance Abuse and Mental Health Services Administration TIP 57: Trauma-informed Care in Behavioral Health Services | Treatment improvement protocol (TIP) developed by SAMHSA outlining how behavioral health providers can provide and implement trauma-informed care | https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816 |
| Survivors of childhood sexual abuse: A guide for primary care providers | Website provides information for healthcare providers on how health care experiences may trigger memories of past abuse, and recommendations on avoiding or managing triggering | http://www.csacliniciansguide.net/index.html |

(continued)

**Table A.2** (continued)

| Resource | Description | Link/citation |
|---|---|---|
| Understanding the context of military culture when treating the veteran with PTSD (continuing education course) | Course aims to help providers better understand military culture and the ways that PTSD may uniquely affect survivors | https://www.ptsd.va.gov/professional/continuing_ed/military_culture.asp |
| Uniformed Services University Center for Deployment Psychology Military Cultural Competence Course | Online course offers a brief overview of military culture, terminology, and demographics for health care providers who are treating service members | http://deploymentpsych.org/online-courses/military-culture |

**Table A.3** Chapter 6 Sexual and Gender-Based Violence in Lesbian, Gay, Bisexual, Transgender, and Queer Communities

| Resource | Description | Link/citation |
|---|---|---|
| Power and control wheel | Graphic that depicts some of the abusive behaviors that may be used to establish power and control, such as emotional abuse, economic abuse, intimidation, and isolation | https://www.theduluthmodel.org/wp-content/uploads/2017/03/PowerandControl.pdf |
| Power and control wheel for lesbian, gay, bisexual and trans relationships | Adapted from original wheel (above), includes factors that may be specific to the relationships of LGBT individuals | https://www.familyjusticecenter.org/resources/lesbiangay-power-control-wheel/ |

**Table A.4** Chapter 7 The Trauma-Informed Examination

| Resource | Description | Link/citation |
|---|---|---|
| The National Domestic Violence Hotline | Confidential and free 24/7 hotline that offers victims of domestic violence support, crisis intervention information, and referrals in over 200 languages. | Web page: thehotline.org<br>Online chat: https://www.thehotline.org/what-is-live-chat<br>National hotline: 1-800-799-SAFE (7233) |
| Rape, abuse, and incest National Network (RAINN) | Website features educational materials about sexual violence and sexual assault, links to national and local support resources, and information about relevant policies surrounding sexual violence. RAINN hotline/chat provides 24/7 support to survivors | https://www.rainn.org |
| RAINN National Sexual Assault Hotline | 24/7 phone or online support and resources for survivors | Online chat: https://hotline.rainn.org<br>National hotline: 1-800-656-4673 |
| Polaris project | Nonprofit organization working to end human trafficking through a survivor-centered, data-driven approach. | https://polarisproject.org |
| National Human Trafficking Hotline | 24/7 hotline offers support and resources to survivors of human trafficking to get help and stay safe; also receives tips about suspected trafficking cases | 1-888-373-7888 |
| BeFree Textline | Texting option for National Human Trafficking Hotline | Text "BeFree" to 233733 |

**Table A.5** Chapter 9 Acute Medical and Forensic Care for Victims of Sexual Assault

| Resource | Description | Link/citation |
|---|---|---|
| A National Protocol for sexual assault medical forensic examinations, adults/adolescents (second edition) | A DOJ-developed guideline for jurisdictions interested in developing protocols for sexual assault forensic examinations | https://nicic.gov/national-protocol-sexual-assault-medical-forensic-examinations-adultsadolescents-second-edition |
| CDC 2015 Sexually Transmitted Diseases Treatment Guidelines | Guidelines for treating individuals who have or are at risk for sexually transmitted diseases | https://www.cdc.gov/std/tg2015/default.htm |

(continued)

**Table A.5** (continued)

| Resource | Description | Link/citation |
|---|---|---|
| New York State Department of Health: Sexual assault forensic examiner (SAFE) program overview | Standards for hospitals, trainers, and examiners in New York state providing care to survivors of sexual assault | https://www.health.ny.gov/professionals/safe/docs/program_overview_and_standards.pdf |
| *Evaluation and Management of the Sexually Assaulted or sexually abused patient, (second edition)* | American College of Emergency Physicians (ACEP) handbook outlining a standardized approach to treating patients who present to the emergency department following sexual trauma or abuse | https://indianacesa.org/wp-content/uploads/2016/06/Sexual-Assault-e-book-1.pdf |
| Forensic healthcare online | Website containing scientific literature, peer-reviewed technical guidance, and low-cost educational resources to promote ongoing education around treating survivors of sexual violence | https://www.forensichealth.com/ |
| WHO guidelines for medico-legal care for victims of sexual violence | Guidelines developed by the World Health Organization for health professionals aiming to provide health professionals with the skills and knowledge necessary for treating survivors, establish standards for treatment, and guide the development of health and forensic services for survivors | https://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/ |
| International Association of Forensic Nurses | The Association's website includes educational resources developed specifically for forensic nurses, as well as information about SANE training and certification and continuing education | https://www.forensicnurses.org/ |

**Table A.5** (continued)

| Resource | Description | Link/citation |
|---|---|---|
| RAINN (rape, abuse, and incest National Network) | RAINN is the largest anti-sexual violence organization in the U.S. their website features educational materials about sexual violence and sexual assault, links to national and local support resources, and information about relevant policies surrounding sexual violence | https://www.rainn.org/ |

**Table A.6** Chapter 12 Medical Documentation in Intimate Partner Violence Cases

| Resource | Description | Contact information |
|---|---|---|
| NYC family justice centers | Five walk-in centers (one in each borough) offering free, confidential assistance for individuals who have experienced IPV, sexual assault, trafficking and/or gender-based violence. Open Monday-Friday, 9 am-5 pm. | https://www1.nyc.gov/site/ocdv/programs/family-justice-centers.page<br>Call 311 in NYC for information |
| NYC 24-hour domestic violence Hotline | Hotline to connect victims of domestic violence to support services, including counseling, temporary housing, and emergency shelter | 1-800-621-HOPE |
| The training institute on Strangulation | Program providing training, technical assistance, education, and research resources about strangulation for professionals working with survivors of domestic violence and sexual assault. | www.strangulationtraininginstitute.com |

**Table A.7** Chapter 13 Legal Systems and Needs: Considerations for Survivors of Gender-Based Violence

| Resource | Description | Link/citation |
|---|---|---|
| The clean slate clearinghouse | Resources for clearing juvenile and adult criminal records in all U.S. states and territories. | https://cleanslateclearinghouse.org/ |
| American Bar association survivor reentry project | National training and technical assistance on clearing criminal records for survivors of human trafficking | https://www.americanbar.org/groups/domestic_violence/survivor-reentry-project/ |
| United States Citizenship & Immigration Services (USCIS): Victims of human trafficking | Information on the T visa for victims of trafficking and the U visa for victims of criminal activity, including eligibility information, how to apply, and additional resources for victims | https://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes |

# Index

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