DRIVING CHANGE 2023
THE URGENT CARE CONVENTION

Addressing (and Preventing) Sexual Violence

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Learning objectives

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- Proactively address consent when obtaining a sex-positive health history.
- List substances that may impair a person's judgment and/or are commonly used in orchestrated (drug-facilitated) sexual assault.
- Understand the principles of trauma-informed care (TIC).
- Describe current testing and treatment guidelines for victims of sexual assault.
- Consider ways in which you can bring about positive change in your community.

Clinical vignette #1

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- C.H. is a 21 year-old undergraduate man who presents for STI screening. He has never been tested before. He's had 7 lifetime sexual partners, all female. Neither he nor his sexual partners engage in IVDU, and he has not participated in the sex trade. Upon further conversation, patient confides that he did not consent to sexual contact the night before. He was intoxicated, but he doesn't think he was drugged. He denies being anally-penetrated. He is upset because he doesn't want to expose his girlfriend to anything.
- *What would you do?*

PLiSsIt model (Annon 1974)

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- In the context of addressing sexual health,
  - Obtain explicit permission to discuss this topic
  - Offer limited information that addresses the concern without overwhelming the patient
  - Give specific, individualized suggestions
  - Refer patient for intensive therapy (ie, counseling/intervention) if needed

What does it mean to be “sex positive”?

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- Recognize sex as a healthy part of life and something to be enjoyed
- Feel able to discuss sex without shame or awkwardness
- Open to learning more about sex and the various aspects of intimacy
- Understand the importance of safer sex practices including emotional safety

  (eg, supporting a partner with ED or Hx of abuse)
- Acknowledge that the person – or potential partners – may not want to engage in sexual contact
- Accept others’ sexual practices (and orientations) as long as the participants consent and feel safe

https://www.issm.info/sexual-health-qa/what-does-sex-positive-mean/

Being a “sex positive” clinician

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- **Service**
  - Do no harm
  - Elevate service above self-interest
  - Check your bias and privilege
- **Social justice**
  - Non-discriminatory
  - Open and non-judgmental
- **Dignity and worth of the person**
  - Supporting autonomy
  - Trust clients to make choices for themselves
  - Provide information and resources
  - Right to privacy and confidentiality must be supported
- **Importance of human relationships**
  - Model appropriate boundaries and empathy
- **Integrity**
  - Be truthful and honest
  - Create an authentic and affirming environment
  - Be aware of laws in your state
  - Veracity in diagnosis
- **Competence**
  - Practice only within the scope of your training
  - Only practice within modalities for which you are trained
  - Seek out continuing education opportunities to expand your expertise

The sexual history (the CDC's "5 P's")

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- *Screen based on behavior, not identity*
- Partners
- Practices
  - Types of sexual activity
- Protection (from STIs)
  - Consistency of safer sex practices
  - Vaccination and HIV PrEP
- Past history (of STIs)
- Pregnancy
  - Is this the goal? If not, how is it avoided?
- *Consider asking about preferences (word choice), pleasure, and partner violence*

The sexual history (the DOUPE Model)

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- **Description**
  - The presenting issue or concern from the patient's perspective
- **Onset**
  - When the issue occurs, if it is 1x or chronic, if it happened suddenly or gradually
- **Understanding**
  - What the client thinks is causing or contributing to the problem
- **Past**
  - Any previous attempts to treat or address the problem and how successful those have been
- **Expectations**
  - What outcome do they hope for? How would they define successful resolution? Is it realistic?

Example “checklist” for STI screening

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- Any symptoms/concerns?
- Any known exposures?
- Last screening?
- PHx STIs?
- Last sexual contact?
  - Was it consensual?
- Gender-identities of partners?
- Forms of sex (eg, vaginal, anal)?
- Consistency of condom use? *
- Types of birth control? *
- Number of sexual partners:
  - In the last 60 days?
  - Lifetime?
- Hx of IVDU in self or partners?
- Hx of involvement in sex trade?
- If on HIV PrEP:
  - Any side effects?
  - Any missed doses?

** Not all questions are applicable to all patients*

Consent

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- Sexual consent is clear, coherent, willing, and ongoing
- Consent for sexual contact can be withdrawn *at any time*

- FRIES:
  - Freely-given (ie, you aren't pressured)
  - Reversible (ie, you can change your mind)
  - Informed
  - Enthusiastic
  - Specific (ie, you are saying yes to *something*, not *all* things)

https://www.plannedparenthood.org/learn/relationships/sexual-consent

What is sexual violence (SV)?

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- Someone, often leveraging their privilege, forces or manipulates someone else into unwanted sexual activity without their consent
- Reasons someone might not consent:
  - Fear, age, illness, disability, and/or influence of alcohol or other substances, not wanting to engage in the act at that time or with that person
- Anyone (and in particular, marginalized populations) and any age can experience SV
- SV can occur in person, online, or through technology

Forms of SV

- Rape
- Sexual assault
- Sexual exploitation
- Sexual harassment
- Unwanted sexual contact, touching, and/or exposure
- Reproductive coercion

What are the consequences of SV?

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- Physical injuries and infections
- Psychological sequelae
  - PTSD, anxiety, depression, suicide ideation/attempts
- Somatic symptoms
  - Re-occurring reproductive, gastrointestinal, cardiovascular and sexual health problems
- Negative health behaviors
  - More likely to smoke, abuse alcohol, use drugs, and engage in risky sexual activity
- Economic problems
  - Time off from work, diminished performance, job loss, or inability to work
    - These disrupt earning power and have a long-term effect on the economic well-being of survivors and their families
- Difficulty maintaining interpersonal relationships

Chances are you know a victim…

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- By age 18,
  - 1 in 4 girls will be sexually abused
  - 1 in 13 boys will be sexually abused
- At some point in their lives,
  - Half of all women and one-third of men experience some form of sexual violence in their lifetime
  - 1 in 4 women will have experienced attempted or completed rape
    - 80% before age 25
    - >50% occurred before age 18
  - 1 in 26 men will have experienced attempted or completed rape
  - Higher rates for racial/ethnic and sexual/gender minority groups (Native Americans and multiracial women at highest risk)

Campus statistics

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- Approximately 26.4% of women and 6.8% of men will be sexually assaulted during their time at college
  - Female survivors report being sexually assaulted during their first 4 semesters on campus (the so-called “red zone”), with about 50% of sexual assaults occurring August-November
- 23.1% of TGQN (transgender, genderqueer, nonconforming) college students have been sexually assaulted
- 5.8% of students report being stalked during their time in college
- Only 20% of collegiate survivors report the assault to police

https://www.knowyourix.org/issues/statistics/

Who perpetrates the crime and where?

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- Victims usually know the person who commits assault:
  - 91-93% of child victims are abused by a family member or someone known and trusted by the family
  - 80% of adult victims
    - 39% were an acquaintance
    - 33% were an intimate partner
    - 19.5 % were strangers
    - 6% by more than 1 person
    - 2.5% were relatives
- Sexual assault often occurs in a private residence:
  - 55% in the victim's own home

Why does rape go unreported?

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- Victims may not disclose their assault or report it to the police due to:
  - Embarrassment or shame
  - Fear of being blamed (or, conversely, self-blame)
  - Concern for not being believed and/or that there is not enough evidence
  - Distrust in authority figures
  - Pressure from others not to tell
  - Desire to protect the assailant (usually someone they know)
  - Worry that the rapist will harm them and/or someone else
- More than 66% of sexual assaults go unreported
- Only 16% of reported sexual assaults result in an arrest

A note about male victims

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- Male victims are more likely to describe the assault as “hazing” or “bullying” and report it was intended to humiliate or shame them
- *Male victims may experience an erection or ejaculation; that does not mean the contact was wanted or pleasurable*

SV and other forms of violence

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- SV is connected to other forms of violence
  - Physical abuse for children
  - Adolescent relationship abuse (ARA) may include controlling behaviors (eg, telling partners what they can wear)
    - These behaviors are not necessarily physical or violent
    - Some victims may conflate abuse with “true love”
  - IPV among adults
- Addressing and preventing one form of violence may have an impact on preventing others

Identifying victims of SV (or not)

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- The WHO, AMA, and ACOG recommend screening all women for Hx of SV; the USPSTF recommends universal IPV screening for women of reproductive age (but provides no guidance on SV screening or for men/trans/nonbinary folks)
- Though people who commit sexual assault often use threat or force, the absence of physical injuries to the victim does not indicate that they consented
- Research suggests survivors want support, information, and resources regardless of whether they disclose being victimized
  - The goal is *not* to extract disclosure; that is not essential to provide information and to motivate the patient to take action to improve their safety

Examples of specific questions

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- "Do you feel safe talking to me right now?"
- "Has anyone threatened your family or friends?"
- "Have you ever had to exchange sex for something you needed or wanted?"
- "Has anyone ever asked you to have sex with someone else?"

Disclosure

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- Approximately 66% of survivors of SV do disclose the assault to their primary care physician
- SAVE model:
  - Screen all patients for sexual assault
  - Ask direct questions in a nonjudgmental way
  - Validate the patient
  - Evaluate, educate, and refer
- Follow a survivor-centered, trauma-informed approach immediately after as well as years after victimization and disclosure
  - "What happened *to* you?" rather than "what is wrong with you?"

General principles of trauma-informed care

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- Physical and psychological safety
- Trustworthiness and transparency
- Peer support
- Collaboration of mutuality
- Focus on shared decision-making
- Incorporate survivor's individual context and values into care

TIC in practice

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- Give them the opportunity to have a trusted person in the room with them
  - Especially if a forensic nurse or special victims advocate is not available
- Get informed consent for every step of the exam
  - Explain what you are going to do and why. Do not proceed until their questions have been answered and they consent to moving forward.
- NORMALIZE the experience of sexual violence and AFFIRM that the assault is not their fault
  - NEVER ask victim-blaming or stigmatizing questions “what were you wearing, etc.” It is not your job to judge whether what occurred was assault or to insert your opinions.
- Complete the exam at the pace of the victim
  - Give the victim the opportunity to stop/pause the exam at any time to collect themselves
- Document as you complete the exam to ensure preservation of evidence should the victim decide they would like to pursue legal action
  - DO NOT FORCE the victim to contact authorities; they are the experts on their situation and whether that is something they choose to pursue.

What *is* trauma?

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- Event
  - The actual or threatened harm (experiencing sexual violence)
- Experience
  - How the individuals conceptualizes and labels the event (eg, “What happened to me was rape”)
  - Influenced by individual characteristics and contexts (eg, “It was my husband so it can’t really be rape, can it?”)
- Effects
  - Adverse symptoms following a traumatic experience (PTSD symptoms, unhealthy coping, etc.)

Managing trauma reactions in the moment

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- Grounding
  - Breathing exercises
    - Box breathing, longer exhalations than inhalations
  - 5,4,3,2,1 senses method
- Distraction
  - Ask questions about positive/neutral topics
- "Window of tolerance"
  - Provide timeframes for each step of the exam so they know how long they need to endure a sensation

Responding to trauma: SAMHSA's "4 R's" framework

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- Realize the effects of trauma and understand paths to recovery
  - Being prepared to encounter trauma in your professional realm
- Recognize signs and symptoms of trauma
  - Using trauma screening to recognize who is most at risk or who is displaying symptoms
- Respond by integrating knowledge about trauma into policies and practices
  - Using open, non-stigmatizing language, creating physical and psychological safety for the patient
- Actively avoid re-traumatization
  - Informed by the needs of the client in front of you

Trauma recovery from SV

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- PTSD or other DSM diagnoses
- Flashbacks or vicarious re-experiencing
- Nightmares and sleep difficult
- Anger, rage, depression
- Trouble feeling positive emotions
- Difficulty concentrating
- Hypervigilance
- Panic attacks – may present with concerns of a heart attack
- Learning to recognize and cope with triggers
- Legal process (justice)
- Therapy
- Medication
- Body-Mind-Spirit interventions
- Sexual Interventions

Harm reduction strategies

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- If the patient fears reprisal, consider helping them inform past partners of an STI diagnosis, either by directly speaking with the other person or using anonymous modes of contact
  - Consider your state's laws regarding expedited partner therapy (EPT)
- Counsel patients on safer sexual practices, including HIV PrEP, and safer substance use (if appropriate)
  - Practice how to "negotiate" condom use
    - Role play is a useful tool to build confidence and assertiveness in these scenarios
  - Explore contraceptive options that do not require partner knowledge

“Date rape drugs”

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- Willful and unintentional ingestion of alcohol and “party/club drugs” can affect a person’s judgment, impulsivity, situational awareness, memory, and ability to give consent
  - Alcohol is the most common substance involved in sexual assault
- Some substances may be used in orchestrated sexual assault:
  - Flunitrazepam (Rohypnol – aka, Roofies)
  - Ketamine (aka, Special K)
  - Gamma-hydroxybutyric acid (GHB – aka G, Gina)
  - MDMA (aka, Ecstasy, Molly, E, X, M&Ms)

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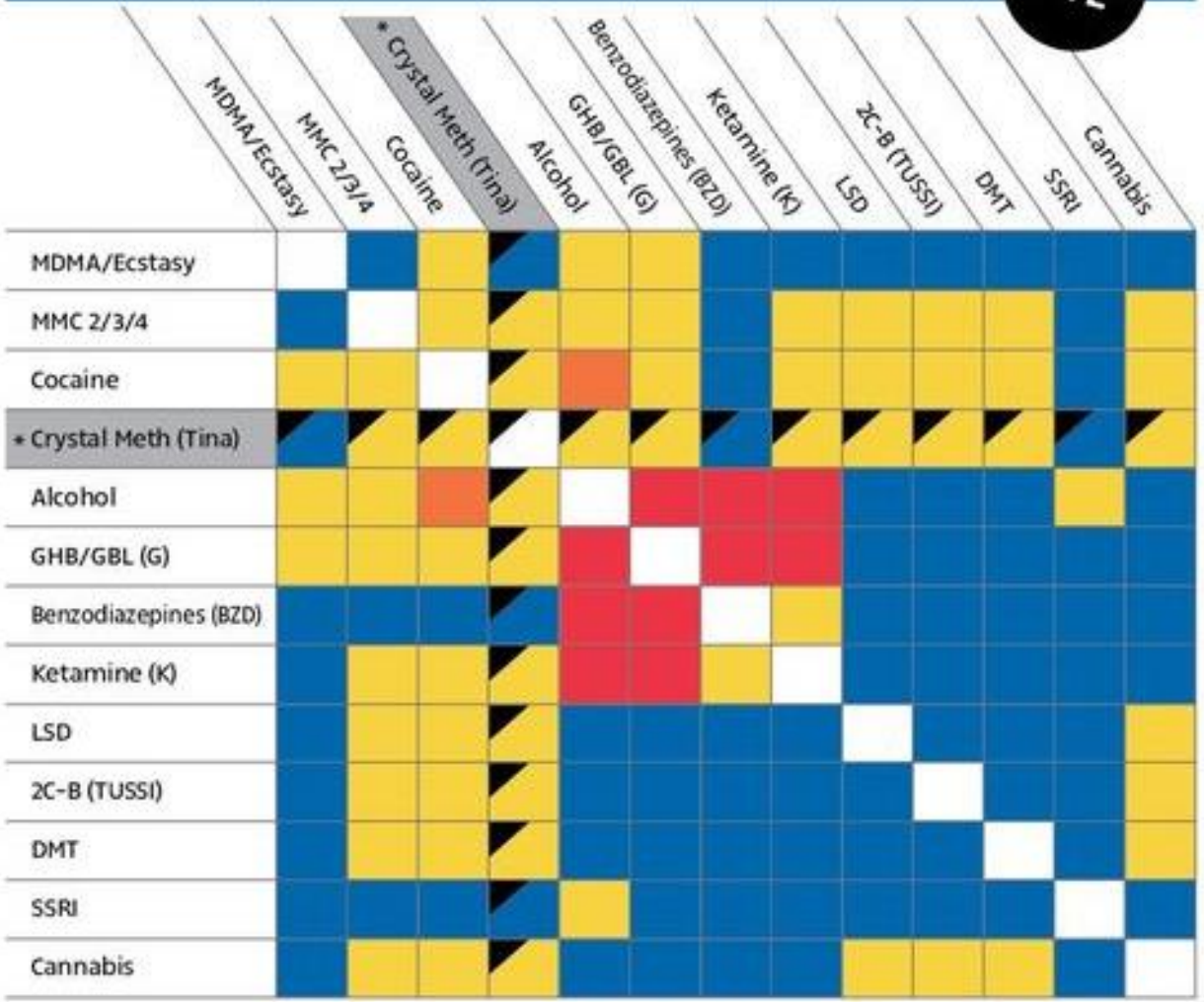
Harm Reduction Works!

Dangerous Mixology

V#2



- Low risk
- Caution
- Unsafe
- Highly dangerous
- Highly dangerous and addictive

*** The use of Crystal Meth (Tina) is highly dangerous and addictive wither alone of in mixture with other substances.**

Disclaimer: Drug use or drug dealing is illegal in Israel and other countries. The data in the table should not legitimize the use of those dangerous illegal drugs either alone or in combination. The aim of the table is to warn about the most dangerous combinations that might be life threatening. The data is taken mostly from articles and tripsit.me

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Initial medical care after an assault

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- Treatment of physical injuries
- Prophylaxis for STIs, including immunizations if needed
- Management of mental health sequelae

- Many hospitals employ certified Sexual Assault Nurse (Forensic) Examiners;

  if unavailable, consider calling the SAFE Technical Assistance program for guidance

Testing recommendations

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All survivors	
Urine pregnancy *	Repeat if missed menses
NAAT for GC/CT at all sites of (attempted) penetration	Repeat in 1-2 weeks if not treated or symptomatic
NAAT for *T vaginalis* *	Repeat in 1-2 weeks if not treated or symptomatic
Serum HIV	Consider repeat in 6 weeks, 3 months, and 6 months if assailant status unknown
Serum hepatitis B antigen	Repeat at 6 months
Serum RPR for syphilis	Consider repeat at 4-6 weeks and 3 months if assailant status unknown
Serum hepatitis C	Consider repeat at 3 months and 6 months if assailant status unknown

If symptomatic	
Wet mount for BV *	Repeat if symptomatic

If concern for drug-facilitated assault (eg, partial or complete amnesia)	
Urine drug screen (including chloral hydrate, gamma hydroxybutyrate, ketamine, and BZDs)	On presentation *if* within 72 hours of assault

** If victim has a vagina/uterus*

https://www.cdc.gov/std/treatment-guidelines/sexual-assault-adults.htm

A note about toxicology screens

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- Substances typically used in drug-facilitated sexual assault (DFSA) not included in standard drug screening panels
  - Rohypnol is not identified in routine tests for benzodiazepines
  - Clinicians may consult Poison Control Centers for guidance on detection

Treatment guidelines

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- Emergency contraception
  - Levonorgestrel (Plan B) 1.5mg PO within 72 hours (120 hours off-label)
  - Ulipristal (Ella) 30mg PO within 120 hours (ie, 5 days)
  - Copper IUD placed within 5 days
- Empiric treatment for GC/CT and trichomoniasis
  - Ceftriaxone 500mg IM x1 (1g if patient ≥150kg)
    + doxycycline 100mg PO BID x7 days
    +/- metronidazole 500mg PO BID x7 days (if the patient has a vagina)
- HIV post-exposure prophylaxis (nPEP) on a case-by-case basis, and if it can be initiated within 72 hours of exposure

https://www.cdc.gov/std/treatment-guidelines/sexual-assault-adults.htm

Treatment guidelines *(con't)*

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- Tetanus booster based on vaccination status and injuries
- HPV vaccination if aged 9-26 years and not already fully vaccinated
  - Shared decision-making for patients 26-45 years of age
- Hepatitis B booster if patient previously-vaccinated *but* either has unknown antigen status *or* assailant has unknown antigen status
  - Hep B series if patient has unknown vaccination status or unknown immunity
  - Hep B series + HBIG if patient or assailant is known to be antigen positive
  - Hep B PEP not indicated if patient previously-vaccinated *and* is antigen negative

https://www.cdc.gov/std/treatment-guidelines/sexual-assault-adults.htm

Developing your referral network

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- Identify local domestic violence agencies and/or rape crises centers and invite them to meet with your staff
  - Know how to reach them
  - Have their informational materials in your exam rooms
- Connect with social workers, lawyers, and other specialists in mental health, etc so you can provide “warm referrals” if ever needed (and to potentially learn answers to questions before you receive them)

Key components of prevention (CDC)

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- Awareness and education
- Research
- Surveillance at all levels
- Hazard evaluation
- Improvement of the public health system
- Proactive behavior by individuals

Social ecology model

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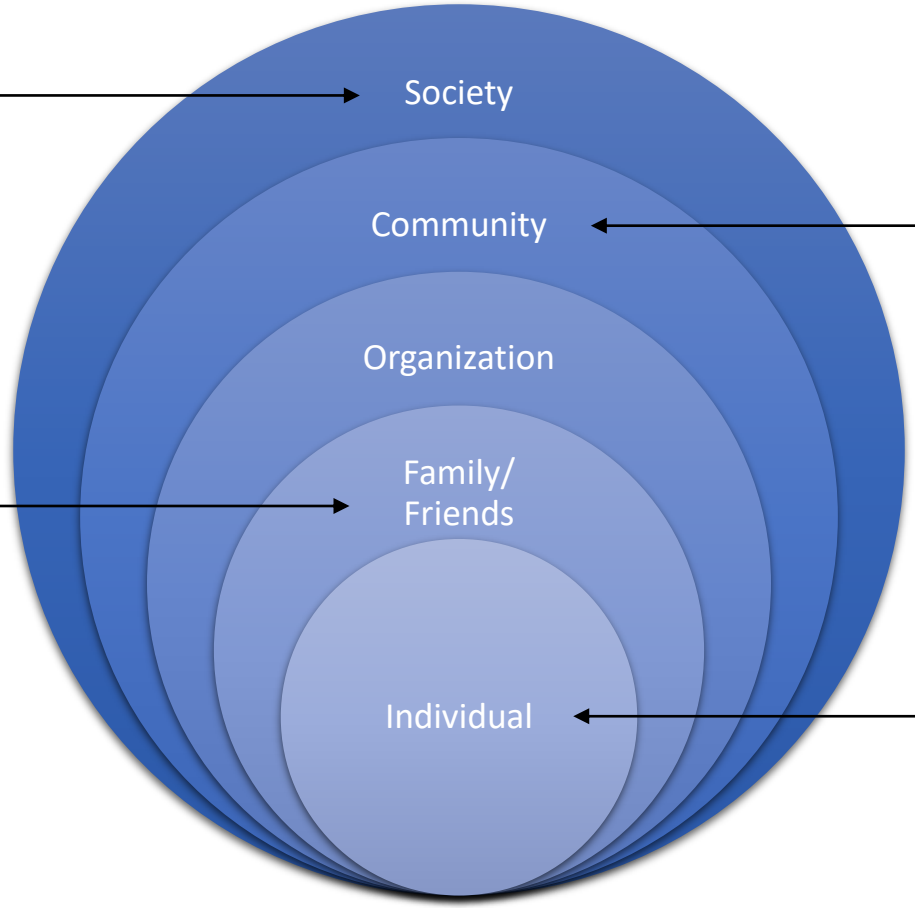
National leadership
Per capita income
Income inequality
Health policy and infrastructure
Mass media
Religious and cultural values
Gender norms



Local leadership
Level of participation
Information equity
Access to resources
Shared ownership
Collective efficacy
Social capital
Value for continual improvement

Communication
Trust
Understanding
Agreement
Power
Peer influence
Gender equity
Bounded normative influence

Behavior and attention
Knowledge and skills
Beliefs and values
Emotion
Perceived risk
Self-efficacy
Self-image
Subjective norms

Whole School Approach (WSA) frameworks

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- Have been used to address health promotion and bullying prevention, and may be useful in guiding campus SV prevention as well (and other forms of violence and harassment on campus such as homophobia)
- Consider the role of the larger school environment (eg, policies, student/teacher interactions, school atmosphere) as a protective factor
  - ie, This is a strengths-based framework, rather than one addressing problematic individual behaviors (or even thinking of students just as potential bullies or victims)

Engaging a school's ecology

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Students

- Active bystander training (especially of student leaders)
- Involvement of minority and underrepresented groups
- Encouraging student activism

Faculty

- Serve as role models (including intervening when necessary) and educators
- Also trained to be effective bystanders
- Include information about resources in class syllabi
- Allow students to select their own partners for projects

Administration

- Meet with counselors and other staff who directly care for victims
- Demonstrate "institutional courage" in addressing the problem (rather than giving the perception they failed to prevent it or respond in a meaningful way)

Parents

- Ensure their views and opinions are heard
- Provide families of incoming students information on alcohol and sexual assault for them to discuss with their children

Community

- Identify "hot spots" where victimization may occur
- Prevention and awareness events (eg, Take Back the Night)
- Collaboration between campus and local NGOs and criminal justice agencies

STOP SV

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- Promote social norms that protect against violence
- Teach skills to prevent SV
- Provide opportunities to empower and support girls and women
- Create protective environments
- Support victims to lessen harms

What does this mean for clinicians?

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- Be familiar with your state and institution's mandated reporting requirements and rules regarding confidentiality
  - Remind patients (especially minors) of these parameters up front
- Encourage healthy adolescent sexual relationships by offering universal education and brief anticipatory guidance with all adolescent patients about healthy relationships and sexual consent
  - Discuss concrete and specific behaviors, avoiding technical words or jargon
  - If your patient denies SV, share information so they can "help a friend"
    - It is not uncommon for (adolescent) victims to disclose to their friends rather than their parents or other authority figures

Key points

- Sexual violence involves force or manipulation, whether attempted or successful, whether in-person or remotely, of another person to engage in unwanted sexual activity without their consent
- SV is unfortunately quite common but underreported, and linked with other forms of violence
- Anyone can be a victim (or perpetrator), but marginalized populations are at particular risk of victimization
- Primary prevention through education may help prevent future victimization, shift social norms, and develop “positive upstanders”
- Counseling should be universalizing, educational, and concrete

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Clinical vignette #2

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- U.K. is a 19 year-old woman who presents for possible sexual assault. Though the patient herself is fairly quiet, the friend who accompanies her is causing a scene in the waiting room, incredulous that the clinic doesn't offer urine drug screening for Rohypnol. The clinician on-duty speaks with both students, encouraging transfer to the Emergency Department and offering support with a peer advocate. The friend declines this, stating it took a lot of "convincing" for the patient to even come to an outpatient clinic. Both women are alert and oriented, and no visible injuries are seen.
- *What would you do?*

Resources for patients and clinicians

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- Rape, Abuse, and Incest National Network (rainn.org)
  - National Sexual Assault Hotline (1-800-656-4673)
- National Sexual Violence Resource Center (nsvrc.org)
- Central Minnesota Sexual Assault Center (cmsac.org)
- Minnesota Coalition Against Sexual Assault (mncasa.org)
- STOP SV: A Technical Package to Prevent Sexual Violence
  - www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf
- SAFE technical assistance (safeta.org)
- National Hotline for Human Trafficking (1-888-373-7888)
- Sexual Assault Support and Help for Americans Abroad (sashaa.org)

Resources *(con't)*

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- www.guttmacher.org/state-policy/explore/overview-minors-consent-law
- www.futureswithoutviolence.org/hanging-out-or-hooking-up-teen-safety-card
- www.thatsnotcool.com (helping teens set their own "digital line")
- www.sotheycanknow.org (allows anonymous notification of STI exposure)
- www.loveisrespect.org
- www.youthrelationships.org ("Fourth R," a high school curriculum)
- www.livethegreendot.com ("Green Dot," a bystander intervention program)
- www.coachescorner.org ("Coaching Boys to Men")
- www.knowyourix.org (high school and college resources)

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Session Evaluation

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- Your feedback is valuable, take a moment to complete the survey for this session.
- To claim CME, you must complete a separate survey available after the convention.