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Review Article

Sexual Victimization: Universal Screening and Education in Trauma-Informed Medical Practice

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Abstract

Sexual victimization and other forms of interpersonal violence are traumatic, common, and often have a significant impact on individuals' lives, relationships, and health. The impact of interpersonal violence is compounded by social norms that continue to foster a culture of silence and shame. However, health care providers are very well positioned to invite conversations about interpersonal violence, to legitimize trauma and trauma healing as pertinent to health, and to alter the silence that thwarts healing and perpetuates victimization. The purpose of this paper is to summarize universal screening and education in the context of trauma-informed medical practice. We outline a rationale for universal screening and education, describe implementation strategies, and point to readily accessible materials for use in daily practice. This article highlights sexual coercion and acquiescence as an important part of the screening and education process. We urge providers to adopt universal screening and education in their practices, to educate themselves about trauma-informed care, and to incorporate often overlooked questions about non-physical sexual coercion and acquiescence in screening and education protocol.

INTRODUCTION

Sexual assault is a prevalent human rights, social justice, and public health issue. By one estimate, more than 1 in 3 U.S. women (35.6%) and more than 1 in 4 U.S. men (28.5%) have experienced rape, physical violence, and/or stalking by an intimate partner [1]. More than 1 in 3 U.S. women (36.3%) and nearly 1 in 6 men (17.1%) experienced some form of contact sexual violence (SV) during their lifetime [2]. And, 19 percent, or 23 million U.S. women, have experienced completed or attempted rape. Although stranger rape also occurs at unacceptable rates, it is far more likely that health care providers will encounter sexual violence survivors who were sexually assaulted by someone known to them. Contact lifetime sexual violence by an intimate partner is experienced by 1 in 6 women (16.4%) and 1 in 14 men (7.0%) [2]. Among children, the lifetime sexual assault prevalence for 17-year-old U.S. youth is 26.6% for girls and 5.1% for boys [3]. These data likely underestimate actual prevalence.

Although many health-care seeking patients have experienced sexual assault and other forms of interpersonal violence, they infrequently voluntarily share their victimization with providers. Several individual-level factors contribute to survivors' reluctance to disclose their trauma – and those factors are compounded by community norms that deny and minimize abuse, silence victims, and that offer few clear invitations for open, confidential, and safe conversation about interpersonal violence [4,5]. For example, a randomized community sample of adult IPV and child abuse survivors asked participants: "During the time when you first experienced abuse, how often did anyone try to help or protect you?" To this question, 47% of all respondents reported "never;" 19% responded "rarely" [6]. Among a sample of 216 high school students, 47% said they had not shared their abuse with anyone [7]. Consequently, many survivors live in silence with their traumatic experiences and have many reasons to believe their assaults are unspeakable, including with their health care providers.

Given these factors, and given the known relationship between trauma and health, medical providers are very well positioned to both alter the culture of silence and create conversations that support trauma healing. Providers who actively acknowledge the existence of sexual assault and other forms of interpersonal violence foster healing opportunities and act as a bridge to the larger community by countering the collective silence that so often accompanies violence. The U.S. Preventive Services Task Force recommends that providers screen for violence in women of reproductive age, and The American Academy of Pediatrics Committee on Child Abuse and Neglect, the American Academy of Family Physicians, and the Academy of Nurse Practitioners all urge providers to universally screen their patients [8-10]. The American College of Obstetricians and Gynecologists recommend routine screening for sexual abuse and violence during annual examination visits.

Despite these strong recommendations, most providers do not routinely screen for violence [11,12]. Lapidus, et al., in a survey of pediatricians and pediatric care-providing family physicians, concluded that 12% of respondents routinely screen for interpersonal violence at well-child visits [13]. Elliot, Nerney, Jones and Friedman reported an overall screening rate of 10% among surveyed physicians [11]. Stayton and Duncan, in a review of the literature, indicated that 3% to 41% of physicians routinely conduct interpersonal violence screens [12]. A study that directly asked patients about their screening experiences concluded that 40% of female and 27% of male patients had been screened by a health care professional in the previous 12 months [14]. Health care providers, however, are much more likely to screen for violence when they: a) have been trained to screen, feel competent in screening, and receive institutional support; b) believe violence is prevalent among their patient population; and c) believe screening is within their role and a part of their responsibility as a health care provider [8].

When interpersonal violence screening and education are conducted universally with a nonjudgmental attitude, in private, and with a clear rationale, patients are supportive of screening [15-17]. Evidence also suggests that universal screening can be conducted safely, increases rates of disclosure, and can lead to more appropriate handling of presenting and underlying concerns [18,8]. For example, in a survey of 1,313 women, 98% believed it is a "good idea" to screen for violence and 97% "felt OK" during the screen process. Interpersonal violence is significantly under-reported when providers employ a 'red flag' strategy, i.e., screening only in response to perceived signs of interpersonal violence [19].

Todahl and Walters argue that the "decision *not* to screen and provide universal interpersonal violence education comes at a price" [17]. Providers who do not universally and skillfully inquire about interpersonal violence or offer educational materials may: 1) demonstrate ignorance about interpersonal violence prevalence; 2) inadvertently communicate that abuse, even if it were occurring, is not relevant; 3) indirectly communicate that the provider is not equipped to competently address interpersonal violence; and 4) perpetuate harmful social norms that deny and minimize abuse.

Proponents initially more narrowly emphasized screening for intimate partner physical violence and forcible rape [20,21]. Over time, the screen frame has expanded to include more types of interpersonal violence, a continuum of risk behaviors, imminence, and lethality [22]. More recently, researchers and advocates have urged the pairing of universal screening with universal education [23-25]. Others have advocated for including questions about non-physical sexual coercion and acquiescence in routine screening [16].

Many universal screening models have been proposed, from targeted protocols for specific populations to danger assessment and tiered strategies [26-29]. These protocols include written questionnaires (Table 1). The questionnaires typically include sexual victimization questions, such as: "In the past year, has anyone forced you to have sexual activities" [30]? However, these tools do not typically include non-physical sexual coercion and acquiescence and, consequently, overlook common and widely misunderstood forms of sexual victimization. For the purposes of this review, we will outline a protocol that incorporates 1) non-physical sexual coercion and acquiescence, and 2) universal violence prevention education in the context of a trauma-informed practice

Defining Non-Physical Sexual Assault and Acquiescence

Sexual violence is any type of non-consensual sexual contact or behavior, including forced sexual intercourse or sodomy, child molestation, incest, fondling, and attempted rape. Common law

Table 1: Examples of IPV Universal Screening Instruments and Items.

STaT (Slapped, Things and Threaten) Questionnaire [46]	
a)	Have you ever been in a relationship where your partner has pushed or slapped you?
b)	Have you ever been in a relationship where your partner threatened you with violence?
c)	Have you ever been in a relationship where your partner has thrown, broken or punched?
HITS (Hurt, Insult, Threaten, and Scream) Questionnaire [47]	
On a 5-point scale from "never" to "frequently", over the past 12 months, how often did your partner:	
a)	Physically hurt you
b)	Insulted or talked down to you
c)	Threatened to harm you
d)	Screamed or cursed at you
AAS (Abuse Assessment Screen) [30]	
a)	Have you ever been in a relationship where your partner has pushed or slapped you? Have you ever been emotional or physically abused by your partner or someone important to you?
b)	Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
c)	Since you've been pregnant, have you been slapped, kicked or otherwise physically hurt by someone?
d)	Within the last year has anyone forced you to have sexual activities?
e)	Are you afraid of your partner or anyone you listed above?

definitions of rape in the United States historically required at least slight penetration of the penis into the vagina, though many states have expanded the definition to include oral and anal penetration, as well as penetration with objects [31]. Non-physical sexual coercion and acquiescence to unwanted sex are also traumatic, though are easily misunderstood and often overlooked by health care providers and survivors themselves [32].

Non-physical sexual assault is coercive, not physically violent, often leads to acquiescence, and includes a wide array of manipulative behavior including untenable levels of pestering, threats of harm, threats cheating, withholding money or other resources, or general anger and retribution if sex is not given [32]. Basile defines five types of non-physical sexual coercion: 1) unwanted turns to wanted, 2) it's my duty, 3) easier not to argue, 4) don't know what might happen if I don't, and 5) know what will happen if I don't [32]. "Unwanted turns to wanted" is sensitive and particularly complex. In our view, if one party in a sexual experience does not initially want to engage in sexual activity, but following non-coercive invitations – and as a result of those invitations – freely changes to want the sexual activity, this is not sexual assault. A key marker between consent and assault is whether the activity is *initially wanted and remains wanted,* or moves *freely from unwanted to wanted*. If the sexual activity was coerced (by any means), *remains unwanted* (despite acquiescence), and results in any form of harm (psychological, emotional, relational), then it belongs on the spectrum of sexual assault.

Developing a Trauma Informed Practice

Many researchers and survivor and prevention advocates now urge pairing universal screening with universal education within a trauma-informed framework [24]. Miller and Decker advocate for survivor-centered and trauma-informed provider-patient relationships that serve to acknowledge that violence is a part of many patients' history and/or current experiences, and to normalize conversations about this reality [24]. Moreover, Miller and Decker caution that screening questions, in and of themselves, can create a forensic-like context, though this can be mediated with empathy, clear explanations for screening and education, and universal practice. In the screening and information process, it is most important to understand the patient's immediate experience and the kind of support they are receptive to at a given point in time.

The power of a trauma-informed practice is that it counters the isolation, shame, and self-blame that perpetuates sexual victimization and other forms of interpersonal violence. Trauma-sensitive practitioners and workplaces communicate several key messages to patients and staff: a) we know that many of our patients (and staff) are experiencing or have experienced interpersonal violence; b) you can talk about those experiences here; c) addressing trauma is relevant to your health; d) we are competent to support you in a safe, skilled, and non-judgmental manner; and e) your trauma-related symptoms are a natural response; there is nothing wrong with you, our focus is on supporting you to address, to the extent you wish, what happened to you.

Many useful guidelines and recommendations for trauma-informed practice and protocols now exist [33-35]. Fallot and Harris encourage health care organizations and practitioners to begin with a self-assessment to determine the degree to which their setting and practitioners demonstrate trauma-sensitivity [36]. For more information about the features of trauma-informed practice and self-assessment, please see Table 2.

Universal Screening

Universal screening is the practice of inquiring about violence with all patients regardless of risk factors. Proponents of universal screening argue that routine screening is warranted because a) violence is prevalent in society and, as such, many patients have experienced or are experiencing it; b) violence and unprocessed trauma are negatively correlated with health outcomes; c) if violence is occurring or has occurred, it is a pertinent factor in health care planning; and d) spontaneous disclosure is unlikely [20,24].

Several models for violence screening exist and most have been designed, specifically, to identify physical assault and controlling behavior [37,17]. Generally, screening models include: a) a set of questions asked of all patients in writing and followed-up orally early in the treatment relationship or at annual wellness visits; b) questions are asked privately; and c) the questions are often tiered, moving from general screening questions to a more thorough violence assessment and risk assessment, if warranted. For an example of common screening questions see Table 1. For a thorough description of a tiered universal screening model, see Todahl and Walters [38].

As mentioned, many of these models do not specifcially screen for non-physical coercive sexual assault and acquiescence. In order to acknowledge these forms of sexual victimization, the following types of questions can be added to any screening protocol:

- Has your partner ever had sex or intimate contact with you when you didn't really want to? (If yes) Were you afraid that they might be angry or that something might happen if you didn't go through with it? [29]
- Was there a time when you had sex with your partner because you felt like you couldn't refuse? Has any of this happened to you in previous relationships? Does this happen all of the time, some of the time, or very rarely? [29]
- Have you been persuaded to have sexual contact against your will? [16]
- Do you sometimes give in to sexual pressure? How do you ensure consent in your sexual relationship(s)? [16]
- Do you feel that you have control over your sexual relationships and will be listened to if you say "no" to sexual activities? [10]
- Do you and your partner ever disagree about sexual things? Like what? How do you resolve these conflicts? [39]

Table 2: Trauma-Informed Self and Institutional Assessment Questions.

1. To what extent do our patients and staff feel physically and emotionally safe here?
2. Does everyone here acts in a respectful, caring and professional manner?
3. Are there direct and indirect messages in this environment that tell me it is OK to discuss interpersonal violence?
4. If a patient discusses interpersonal violence, do they in advance have a good idea of how it will be handled; can they trust that it will be handled skillfully?
5. Are providers and staff as sensitive as possible when they ask patients about difficult or frightening experiences our patients have had?
6. Do patients feel like they are partners with our staff and providers? Are most of our patients able to say we listen to what they think, what they want, and use that information in our treatment planning and decision-making?
7. Do our patients have the impression that our practice is healthy, i.e., people seem to enjoy working here and working with each other? [33,34,35]

Universal Education

In recent years, proponents have argued that universal screening is more effective when paired with interpersonal violence universal education [40,24]. Universal education provides information about how healthy and unhealthy relationships impact health, along with information about violence and relationship resources. As described by O'Connor, "Universal education is a process that normalizes conversations about violence and provides information to all, not just those who are suspected of or disclose abuse" [25,4]. In this way, universal screening and education act as a form of primary prevention, countering the culture of silence that historically serves as a central factor in survivors' isolation and that reduce healing opportunities and connection [18, 41-43].

Many universal education materials are readily available and vary from wallet-sized pamphlets to posters and safety cards, and typically include website links. Materials can be adapted to include local resources. For example, Futures without Violence includes posters and safety cards specifically designed for health care settings and for specific populations ranging from teens, to elder abuse, American Indian/Alaska Native populations, and information for parents to support developmentally appropriate sexuality and healthy relationship education. Table 3 lists useful violence prevention and healthy relationship education resources.

Implementation

A disclosure of abuse is not the goal or intent of universal screening and education. Instead, the purpose is to "create an environment that legitimizes a conversation about violence if and when a patient chooses to discuss it, and to engender confidence in the provider's ability to competently respond," if or when pertinent [38]. By screening and providing educational materials universally, providers can effectively communicate that interpersonal violence and sexual victimization are common, relevant to health and well-being, and important to provider's themselves. Table 4 outlines several recommendations for framing these conversations. Table 5 lists prominent abuse prevention national organizations.

Table 3: Violence Prevention and Healthy Relationship Education Materials.

Organization	Access
National Health Resource Center on Domestic Violence Futures Without Violence	https://ipvhealth.org
Futures Without Violence	https://www.futureswithoutviolence.org/?s=safety+cards
Oregon Sexual Assault Task Force; Oregon Coalition Against Domestic and Sexual Violence	http://oregonsatf.org/wp-content/uploads/2020/03/2020-Prevention-Resources-for-Parents.pdf
Iowa Coalition Against Sexual Assault	https://www.parentsforprevention.org

Table 4: Implementation Frames.

Organization	Access
Written Questionnaire – Framing Universal Screening and Education	Please answer each of the following questions. They are personal and sensitive; we ask all of our patients about interpersonal trauma they may have experienced. Feel free to leave blank those questions you do not wish to answer at this time. Your [provider] will discuss your responses with you.
Verbal Statement – Normalizing the Topic	Because violence is so common in many people's lives, I've begun to ask all my patients about it. This may not be something you have experienced, though many of my patients have been emotionally, physically, or sexually mistreated or are being mistreated now. Many people are uncomfortable to bring it up themselves, so I've started asking about it routinely. May I ask you about this now?
Confidentiality	I'm asking these questions because I believe personal experiences, like trauma, impact health and are important to discuss, when and if you would like to. If you share a trauma experience, our conversation will be private and confidential – with these exceptions [state/country limits to confidentiality].
Verbal Statement – Normalizing Sharing of Education Materials	For the same reasons I ask about interpersonal trauma, I give this information to all of my patients – in case it is useful for you right now or at any time. Please also feel free to share it with family and friends [48]

Responding to Abuse Disclosures and Safety Planning

Providers who demonstrate comfort and sensitivity to conversations about IPV and trauma, and who create an empathetic and inviting relationship with their patients, will encounter many disclosures. We encourage grounding a response to disclosures in several core principles. First, open and empathetic listening is the most important response to an abuse disclosure. Second, working in partnership with a patient who discloses is respectful and empowering, i.e., "what do you need?" and "what would be most helpful right now?" Third, assessing for risk and imminence at the time of a high-risk disclosure is essential. This includes asking, "are you safe now?" Table 6 provides additional information about safety planning. For more information about lethality and risk assessment, see Messing and Campbell and Messing, Campbell, Sullivan Wilson, Brown, and Patchell [44,45].

Table 5: Resources for Health Professionals and Survivors of Violence.

Resources	Description
National Domestic Violence Hotline	1-800-799-SAFE Advocates available 24/7 to talk to individuals experiencing domestic violence, questioning unhealthy aspects of their relationship, and/or seeking resources
National Child Abuse Hotline	1-800-4-A-CHILD Crisis counselors available 24/7 in 170 languages to provide crisis intervention, information, literature, and referrals
National Coalition Against Domestic Violence	www.ncadv.org National organization that aims to empower survivors, promote direct service programs, educate the public, and promote partnerships
National Sexual Violence Resource Center	www.nsvrc.org The NSVRC's mission is to provide leadership in preventing and responding to sexual violence through collaboration, sharing and creating resources, and promoting research
Rape, Abuse & Incest National Network	www.rain.org National Sexual Assault Hotline and resources. Free. Confidential. 24/7.

Table 6: Safety Planning.

If you had the perpetrator evicted or are living alone, you may want to:
1. Change locks on doors and windows.
2. Install a better security system -- window bars, locks, better lighting, smoke detectors and fire extinguishers.
3. Teach the children to call the police or family and friends if they are snatched.
4. Talk to schools and childcare providers about who has permission to pick up the children.
5. Find a lawyer knowledgeable about family violence to explore custody, visitation and divorce provisions that protect you and your children.
6. Obtain a restraining order.
7. What are other threats that worry you (e.g., threats to immigration status, controlling important documents, threats to take kids out of state or out of the U.S)?
8. How are you feeling about this conversation? Do you have any questions or concerns about our conversation?
If you are leaving your abuser, ask yourself the following questions:
1. How and when can you most safely leave? Where will you go?
2. Are you comfortable calling the police if you need them?
3. Who can you trust to tell that you are leaving?
4. How will you travel safely to and from work or school or to pick up children?
5. What community and legal resources will help you feel safer? Write down their addresses and phone numbers, and keep them handy.
6. Do you know the number of the local shelter?
7. What custody and visitation provisions will keep you and your children safe?
8. Is a restraining order a viable option?
If you are staying with your batterer, think about:
1. What works best to keep you safe in an emergency?
2. Who you can call in a crisis?
3. If you would call the police if the violence starts again. Can you work out a signal with the children or the neighbors to call the police when you need help? 4. If you need to flee temporarily, where would you go? Think though several places where you can go in a crisis. Write down the addresses and phone numbers, and keep them with you.
5. If you need to flee your home, know the escape routes in advance.

6. Have the following available in case you have to flee:
   a. Important papers such as birth certificates, social security cards, marriage and driver's licenses, car title, lease or mortgage papers, passports, insurance information, school and health records, welfare and immigration documents, and divorce or other court documents
   b. Credit cards, bank account number, and ATM cards
   c. Some money
   d. An extra set of keys
   e. Medications and prescriptions
   f. Phone numbers and addresses for family, friends, doctors, lawyers, and community agencies
   g. Clothing and comfort items for you and the children

Note. Adapted from "*Prevent, assess, and respond: A domestic violence toolkit for health centers & domestic violence programs*," by National Health Resource Center on Domestic Violence, 2017, retrieved from https://www.futureswithoutviolence.org/?s=safety+plan on May 8, 2020.

DISCUSSION & CONCLUSION

Health care providers are in a powerful position to directly participate in changing the culture of silence that continues to surround sexual victimization and other forms of interpersonal violence. Interpersonal violence universal screening and education create an opportunity for conversations about safety, trauma, and trauma healing and legitimizes violence and abuse experiences as a pertinent and natural part of medical practice [18,25,41,42]. Moreover, embedding questions about non-physical sexual coercion and acquiescence in screening protocols is essential in order to acknowledge and foster opportunities to discuss these often-overlooked forms of sexual victimization.

A disclosure of abuse is not the central aim of universal screening and education. Instead, their routine practice is designed to communicate that providers and the institutions within which they are employed understand that sexual victimization and other forms of interpersonal violence are common, relevant, and that we – as practitioners and in this setting – are available and equipped to discuss traumatic experiences and to provide accessible resources and referrals.

Health care providers are much more likely to universally screen and provide IPV education when they have been trained to screen, feel competent in screening, receive institutional support, and believe screening is within their role and their responsibility. This is much more likely in settings that establish efficient screening and education protocols, trauma-informed attitudes and policies, and – in particular – that are strongly supported by administrators and supervisors [33,34,40].

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