Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) Webinar Series

August 27, 2015, 1-2:30 p.m. (ET)

"The Impact of Sexual Assault and Treatment Options"

Good afternoon and thank you for joining us today for the DCoE Psychological Health August webinar. My name is Dr. Vladimir Nacev. I'm a clinical psychologist and a senior program manager for the Deployment Health Clinical Center at Defense Centers of Excellence for Psychological Health and Traumatic Bring Injury. I will be your moderator for today's webinar.

Before we begin, let us review some webinar details. Live closed captioning is available through Federal Relay Conference Captioning. Please see the pod beneath the presentation slides. Should you experience technical difficulties, please visit dcoe.mil/webinars, and then click on the "Troubleshooting" link under the "Monthly Webinars" heading. There may be an audio delay as we do advance the slides in this presentation. Please be patient as the connection catches up with the speaker's comments.

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I will now move on to today's webinar topic, "The Impact of Sexual Assault and Treatment Options." According to a Department of Health and Human Services Children's Bureau for fiscal year 2012 report, the U.S., state, and local Child Protective Services received an estimated 3.4 million referrals of children being abused or neglected. Of these child victims, 9% were victims of sexual abuse. The National Institute -- sorry -- the National Intimate Partner and Sexual Violence Survey of 2010 report identified that one in two women, 44.6%, and one in five men, 22%, experienced sexual violence other than rape in their lifetime.

Victims of sexual assault often experience a range of psychological and emotional disorders, including rape trauma syndrome, depression, anxiety, and post-traumatic stress. The psychological and emotional trauma these victims experience can also manifest itself in physical reactions such as stomach aches, headaches, and back problems. Well-researched informed treatment approaches and applicable prevention methods have shown positive outcomes for reducing the impact of the abuse. The webinar participants will illustrate the acute and long-term consequences of sexual abuse and assault relevant to

providers; will describe treatment considerations for both child and adult victims; and identify prevention initiatives.

So I would now like to introduce our presenter, Jennifer Pierce-Weeks. Ms. Weeks is a graduate of St. Mary's Hospital School of Nursing in Amsterdam, New York. She is board certified as a Sexual Assault Nurse Examiner for adults and pediatrics, and currently serves as the Education Director for the International Association of Forensic Nurses. She was a contributing author to an edition of the Atlas of Sexual Violence and Forensic Health Online and has published her research in the Journal of Forensic Nursing and the Journal of Emergency Nursing. Welcome, Ms. Pierce-Weeks.

Thanks very much for having me. So -- oops, I'm sorry. I interrupted your list of items you have to go through, I think. Can you hear me?

We hear you now.

Okay. Thank you very much for the invitation.

Welcome. I don't think she's talking.

So, as you can see here, I have no financial relationships of any vendor or contractor. And the opinions expressed in my presentation are mine and not representative of the Department of Defense or the United States Army or DHCC. And I won't be discussing any off-label use of commercial products or devices. I just want to check that you can still hear me okay.

Yes, we can.

Okay, so with that, I'll just move on to my presentation. The doctor was kind enough to review the objectives for us already, so I will just skip through that and say that it's worth just acknowledging that the Centers for Disease Control describe a lack of consensus regarding definitions around sexual violence. So you're going to see me just give you a couple of definitions as they relate to sexual assault or sexual abuse in the case of children because there is no uniform definition system. And I would also say available to you, certainly if you're interested, or you're in a place where you take care of a number of sexual violence victims, that they have a surveillance [ph] uniform definitions document available for the Centers for Disease Control. So you certainly can go to that.

But I thought I would put up just a couple relevant definitions. This one is the World Health Organization's definition of sexual violence, which is any sex act, attempt to obtain a sex act, or unwanted sexual comments, advances, sex trafficking. And of course you can certainly read this for yourself, but it's really in any setting, including but not limited to home and work.

So the World Health Organization stays pretty broad in their definition, whereas the CDC gets a little bit more specific in their definition. And they go into details of penetration as part of sexual violence, and the penetration can involve a penis, a hand, a finger, any object, the mouth of another person, all of those things are included. It also includes in their definition abuse that is not penetrative in nature, which we see a lot in clinical practice, and especially with children, things like exposure to pornography, being part of pornography, or having voyeurism as part of the sexual violence.

But, basically, all definitions of sexual violence, in one way or another, include the fact that the victim does not consent to the sexual activity, or that the victim is not able to consent to the sexual activity, and that can be due to a lot of things. It can be due to age. It can be due to the fact that they're unconscious or they have an illness or something that alters their capacity to consent. So those are basic definitions.

Child sexual abuse goes a little bit further because of what we know about the way children are groomed in sexual abuse situations. So in that instance you'll see some of the behaviors listed here. For sure, for those of you in clinical practice where you're spending a lot of time with children or you're taking care of the pediatrics population, becoming comfortable talking about when photographs are taken of children

and how they're taken is very helpful. And we'll talk about this as we talk about treatments. But we see a lot of children now that have been solicited for child pornography and sexual abuse in that way, as well as just photography, in general, that is sexual related.

There also is non-contact sexual abuse, as we've talked about, the filming of children in a sexual manner, pornography, but also a quid pro quo arrangement, sexual harassment of a child, and that can be, of course, by a caregiver, it can be by a non-caregiver.

And then sex trafficking, and this is the same, at least from a provider standpoint. I think providers are a little less familiar with, but it's something that is much more on the radar of folks working in the sexual violence field than it has been in years past. And this is sort of the working definition of sexual trafficking. But it is really the commercial sexual exploitation of children. And it is the Trafficking Victims Protection Act of 2000 that has been renewed multiple times over -- I believe, 2013 was its last renewal -- for the recruitment, harboring, transportation, provision, or obtaining for commercial sex, and that can be through force, fraud, coercion, or when the person is induced to perform those acts and they haven't turned 18 yet. So we're seeing a lot of this in federal laws associated with this. And anywhere that there is interstate borders, we're seeing sexual trafficking of children, women, and men in those circumstances as well.

What we do know about sexual violence is that, really, it impacts all races, all ethnic backgrounds. So if you're caring for people, you're caring for people who've been impacted in one way or another by sexual violence, maybe directly, maybe indirectly, but it's estimated, depending on the literature you read and the studies you look at, that one in four girls and one in six boys will be sexually abused by the time they reach 18 years. Females appear, on the face of it, to be at higher risk for sexual abuse than males do, but there are quite high numbers of men who report child sexual abuse as boys. Adolescents are more likely to report than younger children. And we generally look at that as related to the abusive conditioning that goes on from a child sexual abuse standpoint, or fear of reporting or what will happen if nobody believes them or their sexual abuse report is not validated. All of those things we see commonly.

So let's just talk about prevalence for a second, and prevalence being really the proportion of cases in a population at a given time rather than the rate of new occurrences of cases. I want to separate out a little bit children from adults in the sense that high numbers of children are reported to be neglected and abused in the United States every year, approximately 3.2 million, and you can see that here. But only 8% of those cases involved sexual abuse. So on the scale of child maltreatment, sexual abuse reporting is relatively low in regards to the types of abuses. However, if they're entering the health system, it's high, whether it be health systems engaged in services like counseling or the hospital setting, or family practice setting, or even settings that are multidisciplinary in nature, like child advocacy center or family justice center settings. The highest number of kids who are abused that are seen in those settings tend to fall into the category of sexual abuse, particularly the multidisciplinary settings.

In adults, that prevalence rate, one in five women, one in 71 men, has been raped in their lifetime, that shows you the dramatic difference, particularly with men, of the number in regards to prevalence versus some of the new cases that we're seeing coming forward. 12% or 22 million women report having experienced completed forced penetration, which, again, falls under some of the specific definitions around sexual violence. And only 1.4% -- but that's still a huge number -- 1.6 million men report having been raped. And the National Intimate Partner and Sexual Violence Survey that the doctor alluded to in the beginning really shows one in two women, or 44%, one in five men, experiencing sexual violence other than rape in their lifetime.

And so in clinical practice, as far as taking care of acute cases of sexual assault go, roughly 10% of the patient population that we see in, say, emergency department setting, 10% of those cases are male patients who are reporting that sexual abuse has happened, the rest are typically female, and that's children and adults sort of across the board. So, as we look at the prevalence and incident studies that go on, and the high number of men who have reported that sexual violence has occurred, it's really important as practitioners that we understand we know it's occurring and we know they're not talking about it certainly at the time that it has occurred.

And just a couple of things also about offenders. What we know about offenders with adult victims is what you see here. So most of the female victims know their perpetrator, and that probably comes as no surprise to any of you, with 51% reporting perpetration by a current or past intimate partner. And in a clinical setting, at least 20% of the patients we take care of who are adults are sexually assaulted by their intimate partner. So sexual violence in an intimate partner violence relationship is really high in number and something that clinicians should consider as they're talking to patients about their relationships and their social history and whether or not abuse is part of that.

40% of women report being raped by an acquaintance, whereas 12% report being raped by a family member, and, again, this is adults. 2.5% by a person of authority, and typically we're talking about correctional settings and that level of authority. And then 13%, a little more than that, raped by a stranger. So, still fairly low numbers of stranger sexual assaults.

Male victims, same thing, they knew their perpetrator more than half the time, 52% by an acquaintance. Only 15% raped by a stranger. And certainly that plays out in my clinical practice as well as in the research, the adult men, in particular, that I've taken care of, really the vast majority of them have known their assailant.

When it comes to child victims, and this is looking at child maltreatment in all forms, this is what the offenders look like in the research. So 81% of kids who are victimized, any form of child abuse, are victimized by a parent, either acting alone or with someone else. And I think that's just really important clinically to recognize that the vast majority of kids who are abused are abused by somebody in their own home. 36.8% are abused by the mother acting alone. And, again, this is child maltreatment generally. 19% by the father acting alone. 18% victimized by both parents, and then 12% by a perpetrator who is not a parent of the child. So, again, this is child maltreatment generally. So this is physical abuse, this is neglect, and sexual abuse also, all wrapped up into one neat package.

If you're talking about sexual abuse, the vendor numbers look dramatically different. And you no longer see the high rates of mother acting alone, for instance. You see much higher rates of the father being the perpetrator, and the stepfather in particular being the perpetrator, and then followed by both parents acting together and that sort of thing. So the dynamic change is a little bit if you tease out the sexual abuse piece.

So the question really for me as a clinician is so what are the consequences of all of this, both acute and long-term? And probably one of the most important studies of our time, at least that I've seen in the almost 30 years I've been practicing, is the study called the Adverse Childhood Experiences, or ACE Study. And many of you may already be familiar with this. If you're not and you're a clinician practicing, I strongly encourage you to take a look at the resources in the web links that are available to you so that you can familiarize yourself with this study.

So I'm just going to talk to you a little bit about this study specifically. Back in the 1990s a doctor named Vincent Felitti was supervising a weight loss program out in California with Kaiser Permanente, and that is how this sort of accidental study happened. And what he saw was -- he believed that they could take morbidly obese patients and really teach them, without surgery and without medication, how to control their weight, lose the weight and be successful in their weight loss. So that was the premise of the weight loss program.

And what he saw was that many women were able to lose a really substantial amount of weight, so 100-plus pounds being a substantial amount of weight, relatively quickly, but they also regained the weight after a really short period of time. And he, if you ever have the opportunity to hear him speak about this study, I encourage you to do that, because it became noticeable to him that they were successful and then they gained the weight back, plus some. And he didn't have a good explanation for it, so he started really following up with these women and interviewing them.

And what he identified as one of the common threads for them was a history of childhood sexual abuse. So he wasn't expecting that. He didn't think -- he readily admits he didn't think he had a population of

patients that was even experiencing childhood sexual abuse. And so he took that information and worked collaboratively with a doctor named Robert Anda, and they developed this study. And what they really looked at was adverse childhood experiences.

So in childhood, if you experienced one episode of contact child sexual abuse, then that was -- that gave you an ACE score of one, for instance. If you lived in a household where one of your parents was an alcoholic or a drug addict, that would give you another point on the ACE scale. Keeping in mind that if you were sexually abused 50 times by 50 different people, you still only got one point on the ACE scale. If you lived, growing up as a child, with a parent who was incarcerated, that was another. If you watched your dad beat your mom in a domestic violence situation, that was another. So there was a series of things that they identified as adverse childhood experiences, and they came up with a scoring system for it, and that is where the ACE score comes from.

I've provided you with all the links to this information because I think it is really so critical to clinical practice, because basically what he says is the patients were hiding right in plain sight in clinical practice in medicine, and they were the patients that he just couldn't help. You know, you couldn't get them on the right medication or you couldn't get them to lose weight, or so on and so forth.

So, basically, over the course of this study, they looked at 17,000-plus patients. And the study is ongoing in the San Diego community. But what they found was the patient -- the higher the ACE score, the more health risky behaviors patients had. So they abused substances more often or they had increased rates of smoking. But what he also found was that they had much higher rates of the health issues that we see kill people in adulthood, heart disease, chronic obstructive pulmonary disease -- no surprise with the health risk behaviors -- and clinical depression.

But the other thing is 16% of those 17,000 patients, 16% of the men in that adult population, had reported child sexual abuse. 25% of women had reported child sexual abuse. And with the men, they reported female perpetrators 40% of the time, which is interesting data that really we haven't seen anyplace else. So for me clinically, having my work sort of wrapped up in sexual abuse, that is a very interesting fact.

The other thing is, though, what they saw is, you know, if child sexual abuse was part of the equation, then the patients who reported child sexual abuse had two times the suicide attempt rate than patients that didn't report that. They also, for women as another example of some of the data coming out of the ACE study, had a 40% increased chance of marrying an alcoholic, again, if they reported childhood sexual abuse. And the list sort of goes on and on with all of the really challenging health issues that we see today in adulthood. So I encourage you to go and really take a look at this study because they teased out much more as it relates to child sexual abuse specifically, but also some of the other adverse childhood experiences that they studied.

So we know even before the ACE study that with sexual violence there are a variety of adverse psychosocial outcomes. I'm sure many of you on the call are well aware of this. There are much higher rates of depression, suicide attempts, conduct disorders in adolescents and childhood; alcohol and nicotine dependence, social anxiety, and actually multiple episodes of sexual assault, as well as divorce in the patient population who has experienced sexual abuse. That's not to say that's the direct cause, right, but it's something that really as clinicians we should really be looking at.

Specifically in relation to sexual assault, if you know, as a clinician, that your patient was a child sexual abuse victim, they have an exponentially higher rate of being sexually abused in adulthood than someone who lived through their childhood without experiencing child sexual abuse. So all of that, really, we should be taking into consideration in our clinical practice to make sure that the way that we're addressing these patient needs is appropriate [inaudible] form.

Some of the other health consequences we see include all of these issues that you see here, from anxiety to PTSD. And, you know, from a military perspective, we've been able to learn a great deal from the research coming out of the military on PTSD and be able to look at that as it relates to sexual violence as well. So that's very helpful. Sleep disturbances, rape trauma syndrome, which is the retired, at this

point, nursing diagnosis, but sexual dysfunction and eating disorders, psychosomatic complaints, and I sort of already mentioned the suicidal ideation.

The chronic disease, aside from what I mentioned with the ACE study with the COPD and heart disease and so forth, also is including things like increased rates of autoimmune disorders, which we totally don't have a handle on at this point, I think, in medicine. But the headaches and liver disease, not surprising when you consider the alcohol and drug abuse that is basically a coping mechanism of being an abuse victim, and the ischemic heart disease.

From a reproductive health standpoint, though, we see all sorts of things. And I think this is what people typically expect to see with sexual violence, reproductive health issues versus chronic disease that really increases the morbidity and mortality later on in life. So the reproductive health stuff we see all the time, sexually transmitted diseases, as well as teen pregnancy and rapid repeat pregnancies, and unintended pregnancies, as well as promiscuity, because when you're a child sexual abuse victim and there aren't boundaries related to sexual assault in your house, sometimes we see that materialize in adolescents as promiscuous behavior on the part of the adolescents. Also, just sexually risky behaviors, 50-plus sex partners by the time you're 30 or that sort of thing, as well as, you know, fetal demise.

Probably some of the most common things, though, involve alcohol and drug abuse, morbid obesity, and smoking in the patient populations. And so if you have these patient populations in your practice, I can't recommend to you enough really asking questions related to sexual abuse and trauma so that you can better get a handle on what might be the way for this person to move toward recovery versus, you know, the health risk behavior and the, really, absence of good health moving forward.

The other thing we see are health consequences that are acute in nature so when the person has just been sexually assaulted we may see injuries, both physical to the body and genitals. They may have gynecological complications. A little bit depends on your community. Sexual assault looks a little different from one community to another, but women certainly have bleeding and infections, chronic pelvic pain that results from sexual abuse, pelvic inflammatory disease, urinary tract infections, and HIV, all of those things we see on a fairly regular basis.

When it comes to children, we see some of these things, certainly not all of these things. And children tend to have fewer injuries than adults do, and we'll sort of talk about that. But all of these things are health consequences you may see acutely, meaning in the first several days after the sexual abuse or sexual assault. For sure, trauma is cumulative, so trauma upon trauma upon trauma -- and I feel a little bit like I'm preaching to the choir here on this -- really adds to the health consequences, and so I think one should just keep that in mind, you know, as they work more with sexual abuse victims.

So let's talk about the treatment options. So when a patient is sexually assaulted they kind of fall into two treatment categories, the acute sexual assault and non-acute sexual assault, and then they fall into other categories. Children, meaning prepubertal children, and adults and adolescents. So we split those categories based on what we know about the science.

And when it comes to children, and, again, this is prepubertal children, an acute sexual assault is considered one that has happened in the last three days, 72 hours; whereas with the adults and adolescent, it's considered within 120 hours or five days of the contact. And the reasons that we split hairs on this a little bit is because this window of opportunity relates to whether or not evidence collection should or could occur and be successful in some way. So that's what that split is. That does not mean if a 7-year-old old who was sexually assaulted four days ago, they shouldn't receive acute care. It just separates out whether evidence collection might be part of that care, and we'll talk more about that.

So hopefully this slide is not too horrible to look at, but this is sort of what it looks like for children. When they're within that first 72 hours, which most children are not, because children are most commonly, again, sexually abused by someone in their own home for starters, and there are a lot of -- they're children, and so their priority is not necessarily the same as our priority as an adult. So while we may think that the first thing on their mind should be reporting that an adult sexually abused them, that's not

how children think, and there are lots of different separate and distinct reasons why children do not immediately come forward.

So children often don't present in the first 72 hours. If they happen to present in the first 72 hours, then seeing, then, and obtaining consent, and by "consent" in children, it really means ascent or a non-offending parent that's consenting, having that physical exam, identifying any injuries the child may have, and the risk for disease that they may have been exposed to, collects the evidence that's necessary, makes sure that all of that is documented because in all of these cases, the potential exists that court will happen, that a criminal case will be forthcoming.

Consider STD testing is something that we do with children, and HIV non-occupational post-exposure prophylaxis on a fairly regular basis in the child population. And of course, then, mandatory reporting because all of us are mandatory reporter when we suspect that child sexual abuse has gone on. The only difference between that in the first 72 hours and what happens after 72 hours is that the evidence collection may not occur. Everything remains just as important.

And, you know, how we try to train health-care providers, particularly sexual assault nurse examiners, about how to look at this is no matter when the sexual abuse took place, there are health consequences associated with it, and for that reason, the child should be seen. For that reason, as someone who was just recently disclosed, they should be seen. Oftentimes children need the reassurance that their bodies are okay, that they're okay, that it was the right thing to tell, even though it was 30 days or two years since the last time there was contact with the perpetrator, all of that. So all of that should always be considered as an acute approach to kids or an approach to kids that have disclosed in any way.

When it comes to the adults or the adolescent -- so, again, pubertal adolescent means, for girls, any girl that has reached the age of menses, and for a boy, any boy that's reach ten or stage two of sexual maturation, and then they fall into the category of sort of how we tree adults, in the sense that evidence collection may be warranted.

So evidence collection in the adolescent adult is based on 120-hour window that is part of the national protocol, but also, that protocol is based on where we have been successful at finding DNA. So in the child population of victims we don't do things like speculum exams on children. It's unnecessary in most instances, and when it is necessary, it's usually because you have to go to the operating room anyway. But in adults and adolescent we do.

For females, we do speculum exams because adults and adolescents are at risk of acquiring ascending infection, so infection that goes from the vagina up into the uterus, the fallopian tubes, the ovaries, whereas children actually rarely get an ascending infection. The cellular material of their cervix is different in little girls, it hasn't matured yet, and so they tend not to get those ascending infections that the adolescents and the adults get very easily.

So in adolescent adults, we will do a speculum exam, and where DNA is most commonly found for the longs period of time is in the swaths from the vagina and the cervix, so that is why that window is 120 hours. They have easily found DNA material from offenders out to the five-day mark. They actually have found DNA materials past the five-day mark, but the five-day mark is the national recommendation at this point.

So in the adult adolescent population, we're doing, really, all the same things that we do with prepubertal children, except we also have to worry about emergency contraception, making sure that they have some type of pregnancy prevention available to them, if that is a part of the risk. Some sexual assaults don't actually involve pregnancy risk, others do.

The other thing that I would say, too, is depending on where you live and where you practice, sexual assault, I think I mentioned, looks a little different from place to place. So, for instance, I have a colleague who works in Alaska, and they have some pretty high rates of injury in the patient populations that they see in Alaska; whereas if you tried to compare that to some of the statistics we have in the lower 48, you

might not see that level of injury. So the data does differ a little bit from location to location, and I would keep that in mind too.

The other thing that is available that I think many providers -- if this isn't your line of work, so to speak, many providers are unaware that this exists as an option. But there is such a thing as unrestricted reporting in the military, or anonymous reporting options for evidence collection. So the restricted reporting, or unrestricted and restricted reporting has been around for longer than the Violence Against Women Act has actually called for anonymous evidence collection. But this basically allows the adult victims to go in, and if they don't know whether or not they want to report the crime to law enforcement yet but they're still within the window of evidence collection, it allows them to have that evidence collection without necessarily cooperating with law enforcement at that time, but it allows that evidence to be preserved in the event they decide to report the crime moving forward. Because many, many states do not have mandatory reports for sexual violence in adults.

The other thing that has come to light in more recent years is something we call the neurobiology of sexual assault really. But it goes to the way we're looking at the brain and how the brain helps us or doesn't help us react a certain way to the trauma around us. So I'm not going to show you this presentation because we wouldn't have had enough time. But if you have never seen this, I would encourage you to go to the site. It's about a 90-minute presentation from Dr. Rebecca Campbell, and she really talks about what is happening in the brain when a traumatic episode goes on, and that traumatic episode in this case is sexual violence, but it certainly doesn't have to be.

And what she does is talk about the pathophysiology about what's going on in the brain that causes that fight, flight, or the freeze response. And it's the freeze response that we particularly see commonly reported with sexual assault victims, and this really goes a long way to explaining why a victim might have frozen during the assault and not said anything, and because of their own freezing maybe is afraid to report because no one will believe them because I didn't do anything, I didn't say anything, I just froze. I didn't know what to do.

So I strongly encourage you -- and if you have law enforcement partners that you work with -- to really take a look at this. It goes a long way to explaining some of the behaviors that we see in sexual assault victims that seem counterintuitive. And anything that seems counterintuitive can be challenging in court when you're testifying.

So let's talk a bit about the trauma-informed approach. This is language that's getting a lot of play most recently, but a trauma-informed approach to care is the type of care that we would like to see for every sexual assault victim regardless of age. And basically it talks about shifting the language of sort of what's wrong with you as the patient, sort of what's wrong with you, to what has happened to you.

I know one of my colleagues who is a nurse-midwife in the Midwest has changed her whole practice around based on the ACE study. Instead of asking specific screening questions about whether or not they've experienced this form of violence or that form of violence, she actually goes in making the assumption that the person has experienced some type of trauma, and she just says "Talk to me about the trauma you may have experienced," you know, and is surprised at the rate at which patients really open up about what has gone on in their life.

So, really, trauma-informed care says that we know trauma exists. We know that it's pervasive,. It's certainly not just sexual violence; right? I certainly don't need to tell this audience that. But the impact is broad. It certainly has huge health implications and it can be really life shaping if there isn't some type of intervention; that violent trauma specifically is kind of self perpetuating, and I think that we see this, even just watching the news, and that it really preys on vulnerable populations.

It's easier, if you're vulnerable, to become a trauma victim than if you are less vulnerable in a population. That's why we have much higher rates of sexual abuse among people with disabilities. It's also why we see higher rates of sexual violence in native Americans and Alaska Native populations. The populations are vulnerable. So this trauma-informed approach basically says we know trauma exists. We know it has

health impact on you, and that we need to incorporate an approach that takes into consideration your trauma in our treatment plan.

And one of the ways that I think we all take a trauma-informed approach with patients is by acknowledging Maslow's hierarchy of need; right, which has been around; right, since the '40s. And it remains absolutely accurate today in that it's imperative for patients, for the people that we take care of, to get past that bottom layer, to get to the place where they can really recover, to get to that self-actualization place, and that really requires these things. It requires safety, both physical and emotional safety, and that may need to happen over and over again for this person. For an adult, that might be you as the provider saying you believe them. For a child, it might be helping them reestablish a relationship with a non-offending parent that they felt like didn't respond well when they disclosed the views. Attachments, you certainly all know what attachment is and making sure you have that secure base, particularly children. We see many children with attachment disorders now, and particularly kids who have been sexually abused. Self regulation; right, and, again, this is something we sort of teach children as we raise them, to self regulate, to control their emotions. And self regulation is part of a healing process, and if it's not learned because of abusive behavior in childhood, then it's something that needs to be retaught and may be something that comes in cognitive behavioral therapy and things like that.

And certainly self esteem, we see this with our kids all the time, that whether it's kids we're taking care of our own children that we're taking care of, that they can internalize thing. They can end up with a low self esteem regardless of what's going on around them, and it's because you're not the only influence on them. You're not the only influence as a provider on them, certainly. They have other influences. So being able to address their self esteem becomes a big issue in their recovery.

And what we see with Maslow's, in clinical practice, is we can't -- even in simple acute care setting we can't get past certain stages in Maslow's without addressing these issues, and I just want to say, I'll just give you one example. I took care of a woman at one time who -- she came into our emergency room, and it was a very busy emergency room with a lot of violent patients at the forensic nursing team saw, but she happened to be a domestic violence sexual assault victim who came in through the trauma bay because she had been stabbed by her intimate partner. And she did not die from her injuries. She was certainly lucid and able to talk to us, but she wouldn't talk.

And in most cases clinically most patients will talk to me. But she would not, and it wasn't until I finally said to her, tell me what it is that is the biggest concern to you right now, which was the fact that -- no one knew in the emergency was -- she was holding the baby at the time she was stabbed, and she dropped the baby, and she didn't know if the baby was okay. And we couldn't even have a conversation until she was able to effectively say, "Can you find out if the baby is okay." And once we established where the baby was and the baby was okay, she was actively able to participate in her care, which is certainly gathering a history and getting an assessment.

So don't forget about Maslow's hierarchy. Sometimes it really is just a matter of the patient needs to eat something before they can talk to you, because maybe they done have enough food. And the other thing is the role of advocacy cannot really be underscored in sexual abuse cases because they provide ongoing services that you may or may not be able to provide for the patient depending upon your role.

There are community-based advocates which hold privileged communication. There are victim witness advocates. There are military advocates. The key is understanding who has the privileged communication, who can have a one-of-one conversation with that patient and have it kept private within the confines of what is a mandatory report. I worked in a large military community, and we always had both the military advocates and the community-based advocates present, so that the patient could get the introduction to both parties but then they could choose sort of what they needed. Sometimes it was both, sometimes it was one or another. But always offer that level of ongoing, usually free, care and resources.

I'm sure you are all familiar with the Sexual Assault Prevention Response Office through the Department of Defense, but I put it up here, and I put the web link up also for you so that you have immediate access to those folks, as I think that is key. What I found in the community I lived in with the multiple military

installations was there were a huge number of resources available to military victims, and a lot the victims were not necessarily aware of them.

So now I want to make sure we have time for questions, so I'm going to just briefly touch on prevention because many of you do this. All of do prevention in one way or another because prevention, I think a lot of people think prevention is solely primary prevention, but that's certainly not the case. Primary prevention is definitely the prevention that occurs before the violence and stops the violence from happening; right?

But secondary prevention really looks at reducing the impact of the abuse after it's already occurred. So a lot of the work I do when I'm in clinical practice is secondary prevention, and I suspect that a lot of the folks on this call, the same thing applies. And then there's tertiary prevention, which really looks to soften the impact of the lasting effects that occur as a result of the abuse. So what happens let's say, between my exam, if the patient was sexually assaulted two days ago, and a year from now. How much counseling did this person have access? Did they have access to any? Did they ever meet with advocacy to know what the community resources were that were available to them? Because it's those types of resources in the community, and support systems, that we know best assist sexual abuse survivors, whether they're childhood sexual abuse survivors or adult sexual violence victims.

In either event, whether you're a child victim or whether you're an adult victim, the implications moving forward are pretty significant from a health perspective, so being connected and knowing that it's going to be okay if a year from now if you have to access services again, where you thought you were doing fine, that typically is common, common practice.

Now there may be some of you that do actual primary prevention work, strictly primary prevention work on the call, and so I'm going to show you a couple of programs. But the prevention institute has a document called the spectrum of prevention when it comes to violence. I think it's on their website. It's on the Centers for Disease Control website. But it really talks about the different levels of prevention that we all work at, whether it's baseline level, you know, promoting safety for victims in the clinical settings to the higher level legislation and policy change. I think many things you have seen go on in the Department of Defense actually falls into that category of high-level policy and legislation change, and everything in between.

And for those of you really interested in prevention work and doing it all the time, so "Spectrum of Prevention" is a really helpful document when it comes to sexual violence. It teases things out pretty effectively. But when it comes to promising prevention efforts from the primary prevention perspective, there are four specific prevention efforts that have been identified for the Centers for Disease control, and they're listed here. They also made sure you had some attachments and web links to them and where they come from. Excuse me.

You can certainly read up on them yourself, but the safe dates is really designed for relationship building in eighth and ninth grade level students, with the goal of changing dating norms, gender role norms and dating violence issues, because we definitely see the adolescent and young college student as the highest population of sexual assault victims that we see. The bell curve goes right across the top of 13- to 23-year-olds as far as the high number of patients we see.

Shifting boundaries is one that really works toward addressing the incidence and prevalence of both dating violence and sexual harassment in the adolescent population, and it's intended, though, for middle school students part in the classroom, part across the school, and they really do a lot in regards to sexual abuse, harassment, the negative view of dating violence, sexual harassment, all those sorts of things.

Coaching Boys Into Men is just an exceptional program. It exactly what it says it is. The Future Without Violence folks have that. And then Bringing in the Bystanders is a project that is out of the University of New Hampshire, and where they really looked a it the bystander accountability and teaching bystanders about how to respond effectively to sexual violence. So those are really the practices that I wanted to mention to you from a prevention standpoint. You're going to see the references come across the screen

for some of these information that I have talked to you about today, but also provided for you in web links and in, I believe, PDF handout forms.

I just want to make sure that we have enough time for questions if you have specific questions, I know there are probably an array of providers on the call, and so you may be coming from very different perspectives on this topic. You may have very specific questions. You may not have any questions at all, but either way, I just want to make sure that you have opportunity to answer those, to get those answers.

Okay, so I'm just going to -- my presenter questions moved around a little bit. So I don't know if everyone can see the questions or not. Is it okay if I just read the question aloud and answer? I cannot hear you, so I'm going to assume, yes, and go ahead and do that.

Why does a person who was sexually abused in childhood have a greater propensity to experience adult sexual assault? Yeah, that's a good question. I mean, I think there are a lot of thoughts as to why that might be, but there's no actual -- what we do know is the numbers are much greater in that population, but we can't really say why. We can sort of speculate a little bit on why. And one of the reasons that many clinicians believe that is the case is because you have already experienced the boundary violation in childhood, that, one, you may have riskier behaviors to begin with, and they may put you in riskier situations.

So, for instance, let's say you're a child sexual abuse victim and one of your coping strategies throughout adolescence and adulthood is to drink alcohol heavily; right? We know that girls in those situations are at greater risk of being sexually assaulted simply because they're vulnerable. So a lot of reasons like that, but no solid data saying here's why if you are a child sexual abuse victim you are more likely to be an adult sexual survive survivor as well.

Yeah, that's a good point. I think one of the things we need to highlight, there is no cause-and-effect relationship, and just because one faction doesn't mean the other will occur or exist.

Exactly.

Yeah. Another question that I had is, "Do you happen to know what the current data is with regards to abuse in military children and families and related to post-deployment psychological health?"

In military children specifically, I can't say that I do, although the military is pretty good about providing all of their annual reports data, so I suspect you may be able to find some of that on the Department of Defense website. There's a lot of available data from the DoD.

Okay. What are the rules that you can summarize what the rules are for when and who needs to report sexual abuse?

Sure. So for sure any health-care provider, and that means social worker, physicians, nurse, essentially anyone working in the health-care provider status who suspects child sexual abuse is a mandated reporter. That's one category. Every state has a little bit different take on the vulnerable adult or the elder, so if you have someone that is an elder that is sexually abused, that may or may not be reportable. It's very jurisdiction dependent, because elder can be defined differently from jurisdiction to jurisdiction.

What I will say is that if you need that specific information, as far as vulnerable adults go, the Department of Health and Human Services website is one place to get that, and elderly and adult services you're going to look at. But they will break it down by state for you. So let's say you're in a certain state and following their laws, you can look it up by state and they'll tell you exactly when you have to report.

So, for instance, I live in New Hampshire, and if a senior adult was sexually assaulted in New Hampshire, that would not automatically become a mandatory report. If they lacked capacity, so they weren't their own guardian, then I would be obligated to report, but it does change from jurisdiction to jurisdiction, so

that's why you sort of want to be familiar with the jurisdiction in your area. The thing that doesn't change is minors, so children who you suspect, only the suspicion enough is enough to report.

There are also some states that still call sexual assault, as an adult, a mandatory report, and that means I still have to call. For instance, the State of Colorado, adult sexual assault victims is a mandatory report by health-care providers. So if an adult sexual assault victim came into a hospital in Colorado I was working in, I would have to report that. But that's not to say that the victim would have to cooperate with law enforcement; right, but I would just have to report that.

So, but those laws are changing across the country because of this anonymous system of reporting. So one thing to always do is to research your own specific jurisdictions so that you make sure you're following that requirement. There are many people who think everything is a mandatory report and so they report before they realize that it actually is a violation of the patient's privacy. Did I fully answer that question?

Oh, yeah, you did, very well. Another question that someone had was you if you can explain to us perhaps how is it that a child who was raped by a stranger is likely to have a higher risk of being raped as adult?

Yeah, this sort of goes to the first question. We don't know why being a childhood sexual abuse survivor puts you at greater risk of being sexually violated as an adult. We just know it does. Everything that I would give you as a why answer to that would be my assumption sort of based on clinical practice. This is what I see in clinical practice. I would have to say it would interesting to tease out that data, because, if I had to guess, I would say there would be less likely a chance of that in a stranger assault, only because the implications of a stranger assault are less significant psychologically than the implications of a known assailant child sexual abuse case and the myths that our society continues to sort of believe in regards to sexual abuse. But, again, that is not science, that is squarely my opinion.

Okay. Another question I have is, "Do you know what the link is between childhood abuse and autoimmune disorders?"

I don't think anyone knows what the link is, with the exception of saying that where childhood sexual abuse exists, there seems to be a higher rate of auto immune disorders, sort of the same -- it's the same thing. The rates are higher in that category. If you looked at patients without any history of sexual abuse and you looked at patients with a history of child sexual abuse, the autoimmune disease rates seem higher in those who have been sexually abused. And the autoimmune stuff is newer on the horizon than some of the other health consequences we've seen over the years, like chronic migraines and stuff like that. And we can't even say why that is. We just know the rates are much higher for that population.

Okay. Another question, "In the event sexual abuse is suspected, what are some physical and/or psychological signs that might reveal the need for reporting?"

Could you just repeat the beginning of that question again.

Sure. In the event, in other words, if we suspect sexual abuse, what would be some of the physical or psychological signs or indicators that would suggest a need for reporting?

So can I assume we're talking about children here?

Sure.

Okay. So, with children, the interesting thing is 15, 20 years ago we thought this was a little different than what it turns out to be now. We have all sorts of behavioral indicators for child sexual abuse, things like bedwetting and those sorts of things, and very rarely have those turned out to be high-level indicators of child sexual abuse at all. There are a couple that stand out. The first is the child discloses sexually

inappropriate behavior. You might be surprised at the number of people that ignore us and absolute disclosure of sexual abuse. So that's one big thing that I would say should raise suspicion.

Another few things for child sexual abuse that should raise suspicion, at least until the child can get checked out, is, you know, vaginal discharge or bleeding from the genitalia in any way. And that's not because children experience injury and at high rate during child sexual abuse, it's because definitely, in our practice, we saw it be common place that something was assumed to be an accidental injury that was not accidental on closer inspections.

But keep in mind, though, it's really hard to give you an answer to that question, because just as many kids, children, show no sign of having been sexually abused as those kids that show a sign of having been sexually abused; right? Kids with violent behavior inside and outside the home are kids that -- it doesn't mean that they're sexually abused, but it does mean somebody should be talking to that child to find out whether or not that's a problem, because we see increased rates of violent behavior in kids who have been sexually abused, just like we see it in kids who have violence going on at home.

I see that my room is, like, making me look darker now. I'm trying to get it so that I'm not quite so dark.

Oh, it's just the sunset setting.

I think that's right.

Another question for you, focusing a bit more on therapy. Can you elaborate a little bit more on the psychological therapies, long-term or short-term, that a person or family can expect? And also a follow up question to that is what kind of recoveries is expected with children with sexual abuse? So two parts.

So child sexual abuse victims should always, as part of their sort of treatment plan, be connected with a counselor that is familiar with, you know, trauma-based therapy; right? So, and that's not to say that they will use it right away, but that they know how to access somebody who treats trauma victims as a counselor. That is very helpful, because the sooner that kids are -- one of the things that we see nationally is the kids often will have a forensic interview. They may even have a medical forensic exam, but they don't necessarily get connected with a counselor that really provides trauma counseling.

And having that person available to them on a regular basis can --it depends on the developmental level of the child; right? So really young children, it might be something as simple as play therapy, getting them involved in play therapy; whereas adolescents, in particularly, really need somebody that knows something about sexual violence and trauma and can do regular counseling with them and potentially have access to group therapy situations, which we see lots of crisis centers doing, where they're really engaged with other sexual violence victims.

So it depends on the developmental age of the kid, and it depends on what they might be exhibiting for behaviors. Some kids don't actually show any behaviors. Maybe they're a sexual abuse victim at 6, and you don't actually see any adverse behaviors in that child until they're 13. Right then the parents need to know that this can come up at 13. This is when you can get some -- I mean you already get behaviors at 123 that most parents would prefer not to have. With sexual abuse you might get more or more significance, and, you know, maybe at that point is when the parent need to engage the child with somebody that knows something about trauma.

Not every counselor is comfortable with the issue of sexual abuse and providing therapy when somebody has experienced sexual abuse. And one of the things to always keep in mind is what exactly is the child experiencing, what age are they at, what developmental level are they, because that's going to help guide your decisions, I think, about counseling and therapy. And I think traditional counselors who have basic trauma experience from a sexual violence perspective are incredibly helpful and useful. It's different for every single patient.

So we've seen patients who have only needed a couple of counseling sessions. We're we've seen patients who have had counseling for years, not needed it for a couple years, had some triggering event and had to go back. So all of that, not expecting a norm is a good idea with sexual violence victims, not expecting any norm, just dealing with them right as they are, sort of in that moment what are they experiencing, what they need, and how can you achieve that with them. I hope that's a helpful answer.

Yes, that's a very good helpful answer. And I'd like to highlight the point that we need to keep in mind it's not what we as providers think that needs to happen, as to, well you've been abused, you need to be in therapy right now, but more where the child is developmentally and so we don't end up re-victimizing, if you will, the child just because we believe we know what the right answer is or what right solution is to the problem. The child needs to be ready to understand and deal with the issue, so I think that was a very good point.

What I want to follow up with on that is can you talk about -- the question was asked in terms of evidence-base therapies that have shown greater efficacy with sexual abuse victims. Can you briefly touch on that.

Well, so to suggest that it's only sexual abuse would not be the case, but cognitive behavioral therapy models, particularly with children, are very effective. And, you know, they're even effective for adults to a certain degree, but I think that I have seen more in regards to children with trauma-based, specifically trauma-based cognitive behavioral therapy. But, again, it is what you said, it's what is the child exhibiting, what's their developmental level, and are they the ones with the need.

Sometimes it's the parent that has the need, the parent that lacks coping as a result of the fact that they did not know that their husband or their boyfriend was engaging in sex acts with the kids. They're the one with the coping issue, sometimes more than the kids, and they are often left out of the equation as far as therapy goes. There is the -- I'm sorry, the name is escaping me, and you probably will have it right on the tip of your tongue, but it's an eye movement therapy.

EMDR.

Yes, thank you, EMDR. EMDR is really effective in sexual assault victims, but the key to its effectiveness is you have to know the sexual assault happened, and you kind of have to get them there right away. It works very sort of acutely. It seems to be very effective. So that's another thing to keep in mind. We keep that in mind for adolescent adults, particularly because they're the ones that tend to come in right away, whereas children don't. So cognitive behavioral therapy that's trauma based tends to be better for them.

Yeah, I think that the other part that would be worthwhile to highlight is that therapy for child abuse may not even occur until later on in early adult life. It doesn't necessarily happen right at an early age, at the time of occurrence.

Yeah, absolutely.

Let me follow up with another question, my second half of the question I asked earlier, and that is can you talk about the -- what is the recovery? What kind of recoveries is expected in terms of for kids who have been sexually abused?

Right. From a psychological perspective.

So one of my pet peeves is listening to the media describe child sexual abuse victims as, you know, sort of quote, unquote ruined for life. Sometimes you hear this as the depiction that comes across on the media, and I think, dear God, you know, what are these people thinking. That's just no true. I mean, there are just a many kids that become Oprah; right? As that become the homeless person that you might see.

So it really has to do with -- there's just as much chance for recovery into adulthood that is well established and meaningful as there is to wind up in a situation where you're having chronic mental health issues sort of for the rest of your life. It really seems to be related to the resiliency factor, you know, what

are the protective factors around that person, and it doesn't have to be family members. It can be sometimes be schoolteachers. Schoolteachers seem to play a big role in the lives of kids and being a protective factor for them.

It's really more about what are the protective factors in place for kids, certainly also a little bit for adults, but being able to get them into a system, whether that's formalized counseling, whether it's crisis intervention from a community-based advocacy agency, where the person learning to understand that the event does not define them; right, the sexual abuse does not define them. It is an event. It is not the thing that sort of changes them as a person. So it's really getting access to some type of third services whether it is formalized counseling in adulthood or peer-based counseling, which is a lot of what the community-based crisis centers do, and in childhood, the resiliency that comes with having protective factors around, good friends and, you know, someone else's family. Your best friend's family might be that resiliency factor for you, or protective factor.

It seems difficult to gauge a person's recovery, and I don't think that we have the data to say, well 60% of all childhood sexual abuse victims recover without any residual effects, because we're not seeing that. We're not seeing that in the data. The data clearly shows that there are some health effects going on in adulthood. The question is at what point in the intervention are we not doing a good enough job, you know? What else can we do to improve their adult health down the road to decrease the effects from a mental health perspective, to decrease the risk-taking behavior, from a chronic medical health perspective, those sorts of things.

Okay. Last question for us, for those of us in the military, we tend to move around the country and sometimes overseas as well, and the question was asked, "Is there a quick place or like a website to see which states have mandatory reporting laws for adults?"

Yeah, there is. It's the -- okay, so I'm going to tell you the easiest way to get to it is to Google "Mandatory reporting for adults." But it's the Department of Health and Human Services, it's their website, so it's DHHS that you're going to Google. But they have a whole site that you can look specifically at for those adult reporting requirements, as well as the child reporting requirements and a list of all your state laws. And I can also, if it's helpful for you, I can certainly provide that website link myself once we wrap up the questions. And can that be posted later, perhaps?

Yes, we can.

Okay. I can certainly do that.

Very well, thank you so much again. This concludes our webinar presentation. After the webinar, please visit dcoe.cds.pesgce.com to complete the online CE evaluation and download or print your CE certificate or certificate of attendance. The online CE evaluation will be open through Thursday, September 10th, 2015.

Thank you again to our presenter, Jennifer Pierce-Weeks Today's presentation will be archived in the monthly webinar section of the DCoE website. To help us improve future webinars, we encourage you to complete the feedback tool that will open in a separate browser on your computer. To access the presentation and resource list for this webinar, visit the DCoE website at dcoe.mil/webinars. A downloadable audio podcast and edited transcript of the closed-caption text will be posted to that link.

The chat function will remain open for an additional ten minutes after the conclusion of the webinar to permit ten days to continue to network with each other. The next DCoE Psychological Health webinar topic "Therapeutic Risk Management," is scheduled for September 24th, 2015, from, again, 1:00 p.m. to 2:30 p.m..

Thank you again for attending. Have a great day.