



Campus Sexual Assault: What Clinicians Need to Know

January 26, 2015

Welcome to the webinar! We will begin in a moment.

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This webinar is sponsored by the [National Health Collaborative on Violence and Abuse](#).

Learning Objectives

- Discuss the prevalence of sexual violence on campuses and identify barriers to services
- Discuss the role of alcohol in campus sexual assault
- Discuss how to engage healthcare providers in effective responses to sexual assault
- Discuss comprehensive approaches to sexual violence prevention

Speakers



Antonia Abbey, PhD, MA Professor & Area Chair of Cognitive, Developmental and Social Psychology, Wayne State University



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Lynn Rosenthal, BASW Former White House Advisor on Violence Against Women

Lynn Rosenthal



*Former White House
Advisor on Violence
Against Women*

Campus Sexual Assault: What Clinicians Need to Know about Alcohol 's Etiologic Role

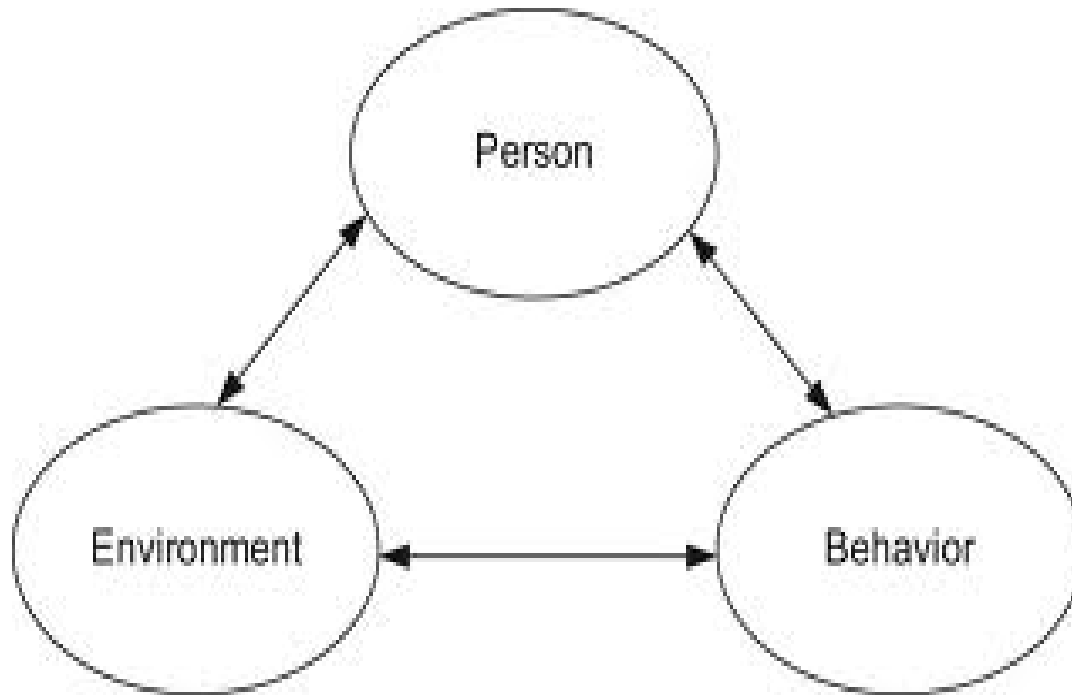
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Institute on Alcohol Abuse and Alcoholism



My Background and Perspective



Overview of Presentation

- Putting Alcohol in Context
 - Sexual Assault Prevalence
 - Etiology
- Alcohol's Effects on Perpetrators
 - Psychological
 - Pharmacological
- Alcohol's Effects on Victims
 - Psychological
 - Pharmacological
- Implications for Clinical Practice

Sexual Assault Prevalence

When questions are phrased in terms of:

- *sexual activities* obtained against the woman's wishes.
- when it was clear she didn't want to have sex.
- when she was unable to consent.

Frequently reported rates of women's victimization:

- 50 - 70% since age 14.
- 20 - 30% in past year.

Frequently reported rates of men's perpetration:

- 20% - 40% since age 14.
- 10 - 15% in past year.

Most occur in social situations -- party, bar.

- About half occur on a "date."

Alcohol-involved Sexual Assaults

Across studies, about 50%.

- Range 30% - 75%.

Usually both drinking.

Alcohol's Role is Complex!

How to interpret?

- a cause?
- an excuse?
- spurious?

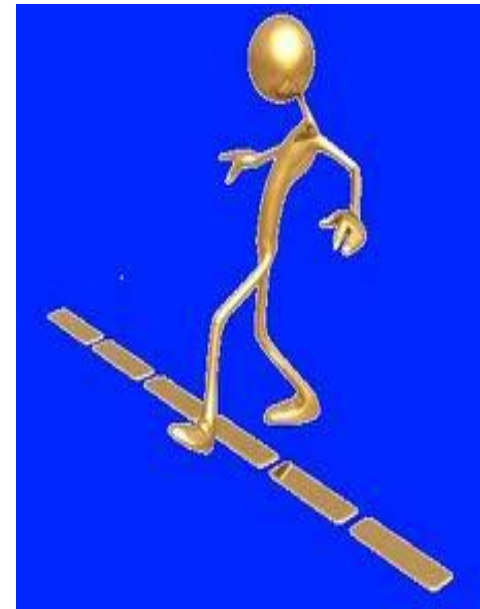


Putting Alcohol in Context

Perpetrators Require Co-occurring Risk Factors

- Childhood sexual, physical, and/or emotional abuse.
- Delinquency.
- Impulsivity.
- Narcissism.
- Lack of empathy.
- Hostility and rape supportive beliefs.
- Positive attitudes about casual sex.
- **Heavy alcohol consumption.**

Alcohol makes it easier to cross one's **personal violence threshold.**



Patterns over Time

Once a perpetrator always a perpetrator? Thompson et al. (2013)

1. Life Course Persistent

Sexual aggression as part of a larger pattern of childhood victimization, personality deficits, and antisocial behavior.

- about 30% of perpetrators in longitudinal college study.

2. Adolescent Limited Desisters

Acting out in adolescence that appears to end with maturation. Some evidence that it is associated with social environments that encourage (through peers) heavy drinking, positive alcohol expectancies, and casual sex.

- about 40% of perpetrators in longitudinal college study.

3. Adult Onset Initiators

May be same as #2, but delayed to early adulthood.

- about 30% of perpetrators in longitudinal college study.

Prior to the Assault

Psychological Effects of Alcohol on Perpetrator

- How do college students expect alcohol to affect their behavior?

Prior to the Assault

Psychological Effects of Alcohol on Perpetrator

How do college students expect alcohol to affect their behavior?

- Facilitate social interaction.
 - liquid courage
- Enhance sexual experiences.
- Decrease sexual inhibitions.
 - own and partner's
- Increase aggression.
 - especially men

Stereotypes about Drinking Women

Gender-based double standards regarding sexual behavior and alcohol are still common.

Expectancies drive perceptions and behavior.



Alcohol's Effects During the Assault

Pharmacological Effects of Alcohol on Perpetrator

Two standard drinks begin to affect cognitive processing.



Cognitive Impairments

Impairs higher-order skills:

- abstraction.
- conceptualization.
- planning.
- problem-solving.
- integration of conflicting information.
- **response inhibition.**

Consequently:

- focus on most salient cues.
- focus on short-term gratification.
- don't care about risk.

Experimental Evidence

Bring people into laboratory and randomly assign them to drink alcohol or no alcohol beverage.

Intoxicated men who are exposed to a date rape scenario:

- believe woman enjoyed it.
- think man acted appropriately.
- more sexually aroused.
- feel more **entitled** to sex.
- say they would use force in similar situation.

Stronger effect among men who are highly hostile toward women.

Victims' Alcohol Consumption

At each step that alcohol influences **perpetrators'** thoughts and actions,

- it also influences **victims'** thoughts and actions.

Prior to the Assault: Women's Alcohol Expectancies

“Walking a cognitive tightrope” trying to balance affiliation and safety needs.

Norris and colleagues (1996).



During the Assault: Cognitive Impairments and Risk Perception

Intoxicated women are less able to perceive risky situations and dangerous men.

- May miss threat cues.
- More conflict and uncertainty about how to respond.

This does **not** justify victim blame!

- Control of one's own body is a basic human right.

Perpetrators' Selection of a Victim

Some perpetrators' use the woman's intoxication as part of their strategy:

- may encourage heavy drinking.
- or target and take advantage of a woman who is already intoxicated.

At some level of intoxication, unable to consent.

Motor impairments make it difficult to resist.

Completed rapes more common.

Alcohol is the #1 date rape drug.



After the Assault: Explanations

Women held responsible for:

- Controlling men's sexuality.
- Keeping things from going too far.
- Losing control when intoxicated.

Women often judged more harshly if they'd been drinking.

- Less likely to be believed by others.
- Less concern for women who fit negative stereotypes.

Many service providers internalize society's standards.

Opportunities for Clinicians to Engage in Prevention

Sexual assault perpetration and victimization often occurs in adolescent dating relationships.

Talk to adolescents about:

- Healthy sexual communication.
 - Being able to talk to partners about sexual desires and sexual limits.
- Respecting partner's wishes.
- Ongoing active consent.
- Impairment does not excuse perpetration.

Life transitions provide opportunities for change.

- Discuss effects of alcohol on judgment.
- Many brief interventions available.

For more information:

- Abbey, A., Wegner, R., Woerner, J., Pegram, S.E., & Pierce, J. (2014). Review of survey and experimental research that examine the relationship between alcohol consumption and men's sexual aggression perpetration. *Trauma, Violence, & Abuse, 15*, 265-282.
- Abbey, A. (2002). Alcohol-related sexual assault: A common problem among college students. *Journal of Studies on Alcohol, Supplement No. 14*, 118-128.
- Norris, J., Nurius, P. S., & Dimeff, L. A. (1996). Through her eyes: Factors affecting women's perception of and resistance to acquaintance sexual aggression threat. *Psychology of Women Quarterly, 20*, 123-145.
- Thompson M.P., Swartout K.M., & Koss M.P. (2013) Trajectories and predictors of sexually aggressive behaviors during emerging adulthood. *Psychology of Violence, 3*, 247–259.

I have no financial disclosures.

Cultural Context and Campus Responses to Interpersonal Violence

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January 26, 2015



Interpersonal Violence
Prevention Program

Purpose

- This presentation will introduce you to some of the considerations practitioners should have related to campus-based interpersonal violence and how it intersects with cultural competence



What is Cultural Competence?

- Cultural competence is described as “the set of knowledge and skills that a social worker must develop in order to be effective [with] multicultural clients” (Lum, 1999, p. 3).
- It allows professionals to utilize “assessment, intervention, and evaluation skills that take into consideration the dynamics of culture, race, age, sex, and sexual orientation as well as the consequences of discrimination, oppression and degradation” (DuBois & Miley, 1996, p. 15).



What Happens When You Lack Awareness of the Cultural Context

Services that lack culturally context foster feelings of mistrust, a belief that the provider is not genuinely interested, a feeling of disconnect, and a sense that the person is not understood.

The person might therefore feel that services and supports can provide no relevant or feasible options.



Poor Communication

- Not having an understanding of how diverse communities on campus define sexual assault, domestic violence/dating violence, and stalking can hinder communication.
- Not having individuals that speak the same language and have an understanding of the cultural nuances of language can hinder communication.
- Not understanding the communication traditions and patterns of students can hinder communication and the relationship.



Impact of Stereotypes

Myths about people of color increase the likelihood of poor services

Myths can impact how a person views themselves and can deter them from seeking supports

Negative stereotypes can also impact how providers serve and support students



Challenges of Racial Loyalty

Racial loyalty serves as a barrier to receiving services.

Racial loyalty has been defined as when "the African American woman may withstand abuse and make a conscious self-sacrifice for what she perceives as the greater good of the community, but to her own physical, psychological, and spiritual detriment" (Bent-Goodley, 2001, p. 323).



Impact of Discriminatory Treatment

Many people of color do not trust formal systems and their agents, such as health providers, law enforcement officers and the courts. Students bring that with them to campus.

The result of lack of trust in formal providers on and off campus is delayed help-seeking.

Delayed help-seeking results in cases coming that are even more severe and potentially lethal in nature.



Cultural Competence Should be on Multiple Levels

- Cultural competence must be demonstrated on multiple levels. A program is not culturally competent simply because they have hired staff indigenous to the community.
- Having indigenous staff members that are culturally competent throughout the organization's hierarchy and in real position of decision-making, including within a board of overseers is critical.
- Ensuring that agency policies, rules, and procedures are culturally competent is necessary.



Importance of Cultural Rituals and Traditions

- There must be recognition and incorporation of cultural symbols, traditions, and rituals.
- For example, the use of storytelling is an important tradition in the African American community that can be better utilized when developing assessment tools and models for intervention.
- However, what is critical to realize is that one cannot call an intervention culturally competent simply because it includes a cultural activity.
- Practices and education must be inclusive of diverse traditions.

Incorporate Knowledge & Skills with Diverse Populations

- One must be able to incorporate knowledge of historical and contemporary experiences to practices and policies.
- Knowledge alone is not enough; one must be able to demonstrate understanding by integrating knowledge of culture with interventions that allow for the growth and empowerment of the student.
- This means that you must do your homework!! Learn more about the campus constituents that you are serving and build positive relationships.



Recognize Informal Networks

- In order to provide services to the individual, one must also be knowledgeable of informal networks on- and off-campus.
- Campus providers can partner with informal networks and informal network providers to build linkages
- Understanding the role that informal networks play with students is also critical both as a strength and as a limitation



Closing Remarks

- The cultural context is critical to providing effective and quality services to our students.
- Not providing such services can actually hinder and serve as a barrier to care for student survivors.
- It is critical to incorporate our knowledge of diverse groups with skill and competency development.



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The Voice of the Patient: Informing Practice, Policy and Research for Victims of Campus Sexual Assault

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Founder & Director- C.A.R.E Clinic

Coordinated Approach to Recovery and Empowerment

BRIGHAM AND WOMEN'S HOSPITAL

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Objectives:

- Discuss the current state of medical care provided to patients experiencing sexual violence in one urban trauma medical center.
- Share findings from a larger QA study:
 - What went well for you?
 - What could we have done better?
 - If I could change 2 things for you- what would they be?
 - SA patient were asked 2 additional questions
- Discuss the challenges and opportunities to improve care.






What happens after the ED?

- **Literature:**
 - Sparse evidence that:
 - explores what happens to IPV/SA patients after the ED
 - informs us on best practices for the delivery of health care after the acute assault
 - Helps us understand the experiences of patients as it relates to receiving and accessing health care services.
 - Much variability across the country
- Opportunity to explore and further understand barriers, challenges, opportunities and best practices.



Using QA to improve practice

- Reviewed by IRB
- Set up a system that all SA/DV/HT cases referred to C.A.R.E Clinic (*ED, Primary Care, Ob-GYN)
- Asked 3 question including 2 additional questions for SA victims (* majority were < 5days)
 - 353 women and 6 men 359 
 - 327 were contacted 
 - 310 participated 



Extrapolated Campus SA Cases

- Of 310 participants- 210 cases were sexual assaults-
 - * 31 cases (15%) were college students. Majority (88%) were acute (less than 5 days).
 - **All except 3 cases involved alcohol/drugs-marijuana**
 - 12/31 cases reported to the police. Only 1 case stayed involved with police.
 - 11 cases- had evidence collected, but did not report to police. 3 months out - only 2 reported but subsequently disengaged.
 - *8 cases had medical examinations without a kit/police.
 - Of cases that had an evidence collection kit and did not report to police- at 3 months none follow-up had reported and did not intend to report



Protocol

- Referral
- Phone or text (most chose text). Phones provided if needed
- Text messages used to engage
- Verbal consent used for participation
- 3-5 questions. Took approx 5-10 minutes. Notes were taken, audio recorded and transcribed. No identifiers were used. Age, sex, type of assault, student yes/no, reported or not,



Listening to the voice of patients

- What went **well** for you during your visit to ED (Ob-Gyn, Primary Care)?
- What do you think we could do **better**?
- If we could change 2 things immediately in regards to the care you received, **what changes would you like to see?**
- In cases of sexual assault that occurred within 5 days- if **unreported**- did you report to police or do you expect to report? If **reported** to police- patients were asked how their experience was going



Voice of the Patient

- **Quality Assurance Data:**
 - Received compassionate care, “nice “
 - Disjointed/Un-coordinated
 - Chaotic
 - * Too many providers
 - Being asked the same questions over and over
 - * Long waits
 - Repetitive/Redundant/Conflicting Information
 - * Overwhelming- medical, mental health, criminal justice
 - * Worried about privacy



Quotes of patients

- “ Not sure why I had evidence collected- I thought it was going to tell me if something happened to me.”
- “Going to the police was a waste of time- I basically couldn’t answer any questions they asked me.”
- “I went to the police, reported and did everything I was suppose to do....they decided not to arrest him – I wasted all my time and energy.” (patient had a suicide attempt and withdrew from school).
- “ Can’t go to police- I do not want my mother to know.”
- “ I could get kicked out of school... I was drinking and I don’t even know who he was anyways.”



Quotes from Patients

- “I am not sure I was raped, like we were both drinking I simply regret having sex and wanted to get checked.”
- “I didn’t know if anything happened...I had a kit..went to the police and basically couldn’t answer most of their questions- it was all a waste of time.”
- “Once I started (kit) I felt I had to keep going and I wished I hadn’t ...I had no intention of going to police.”
- “ I told my RA I drank too much and think I had unprotected sex- she told me I was raped and I should go to the ED. I went to school clinic and got what I needed...”



Quotes from Patients

- Patient had evidence collected -she was not sure if something happened- intoxicated and underwear missing.
 - Patient called to cancel appointment. “I am really embarrassed... I found my underwear...guess nothing did happen... I just drank too much.”
- “So many people and had to say everything over and over again- if I had to do that with you I would not have come in.”



Discussing the 'Grey Zone'

- Is sex dichotomous? Consensual or rape? Or is there a grey zone- Regret?
- Are we over 'kitting'? What about when both people are drinking and both have sex- is that always rape?
- Should all cases of sexual assault receive the same degree of investigation by law enforcement?
- What would best health care practice-model look like?



Lonsway and Archambault Violence Against Women- 2012



Unique to college students

- Inability to recall events of assault (impact of alcohol)
- Frustration with reporting
- Billing issues
- Concern about ‘getting into trouble’; being labeled; ‘not wanting parents to know; self blame; worried about school performance; peer relationship

- Note: Rolling Stone Magazine
 - <http://www.rollingstone.com/culture/features/a-rape-on-campus-20141119?page=6>



Patient and Family Advisory Council

- 2011- Identification of advisors using IPFCC guidelines
- Currently- 11- aiming for 15
 - DV/SA/Family Member/Diverse
 - Informed practice
 - Informed Research Proposal
 - Participate on hospital Committees
 - Review policy and procedures
 - Google Hang out/ Drop Box/ Text messages
- **CAMPUS SEXUAL VIOLENCE-** Needs an Advisory Council of students, bystanders, survivors to work in ***partnership*** with health care practitioners to create evidence based model of care.



What Can Health Care Providers Do:

- Trauma informed and patient centered-
- Provide patient with options
- Ask: What they need/want.
- Priority- Medical/Mental Health/ Safety/Forensic Exam
- Inquiry-
 - preventive (use of alcohol, harms reduction, role as bystander
 - Intervention- consistent close follow-up over time
- Criminal Justice Response- ways to improve, ways to partner
- Focus systems issues on overcoming silo issues.



Outcomes:

- Focus on improving health outcomes
 - School performance
 - Depression
 - Post-traumatic stress disorder symptoms
 - Sleep quality
 - Physical health
 - Safety and empowerment to escape violence
- Engagement
- Access to services
- Satisfaction



— BUILD SYSTEMS FOR PATIENTS IN PARTNERSHIP..... RATHER THAN EXPECTING THAT PATIENTS FIT INTO OUR SYSTEMS THAT WE KNOW HAVE INHERENT PROBLEMS.



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Ask ourselves:

Can we improve the care we provide and the policies we create?

Can those changes result in healthier outcomes?

Could the voice of the patient guide us in this process?

Thank YOU so much for your attention !



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Thank you!

**Please take a moment to fill
out the evaluation survey:**

<https://www.surveymonkey.com/s/HS73XQ9>