Screening for Sexual Violence: Gaps in Research and Recommendations for Change

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Introduction

Every day the media presents stories about women who have been raped and children who have been sexually abused. We may therefore think we hear a lot about women who have been victims of sexual violence. But the media does not really "talk" about this topic, it sensationalizes it. These stories are not an accurate reflection of the reality of sexual violence. The reality is that most survivors of sexual violence do not disclose their experiences to police, healthcare officials, or friends. According to the National Crime Victimization Survey, between 1992 and 2000, 63% of completed rapes, 65% of attempted rapes, and 74% of completed and attempted sexual assaults against females were *not* reported to the police (Rennison, 2002). In addition, places that may be thought of as refuges for survivors are often not accessed by them. In fact, most women who are victims of sexual violence do not go to hospitals, do not tell their families, and are hesitant to speak to their friends about it (Tjaden & Thoennes, 2006).

Yet studies have shown that a high percent of adult women in the U.S. do want to be asked about their present day or past experiences of sexual violence by their health care providers (McAfee, 1995; Littleton, Berenson, & Breitkopf, 2007). Additionally, a high percentage of adolescent women also state that they want to be screened about violence by their health providers (Zeitler et al., 2006). Although women will usually not spontaneously disclose sexual violence, they say they can and will eventually disclose if certain relational prerequisites on the part of the provider, such as trust, caring and sensitivity, are evident to the patient (Battaglia, Finley, & Liebschutz, 2003).

Survivors of sexual violence make frequent visits to health care services. A community study documented that rape survivors' visits to medical providers increase 18% in the year of the assault, almost 60 % a year after the assault and over 30% in the second year after assault (Koss, 1993). Often these women go to health care providers because they are experiencing the physical and psychological effects of sexual violence, which can manifest as headaches, gastrointestinal distress and/or the physical effects of the violence such as Pelvic Inflammatory Disease (PID) and Sexually Transmitted Infections (STI's) or Human Immunodeficiency Virus (HIV). It is clear that health care visits are the gateway to care for many survivors of sexual violence and that providers could be central in improving the outcomes of survivors of violence if they screened, educated and referred their patients.

Screening rates at health care facilities tell another story. Looking at multiple studies of screening for interpersonal violence, Stayton and Duncan (2005) found the median rate of screening rates for intimate partner and sexual violence at health care facilities to be 15.5% for physicians and 18.3% for nurses. In the same article, a study of screening interventions found that a chart review of patients' medical records showed that patients were screened a median rate of 23 %, while a patient survey of screening practices showed the median rate reported by patients at the same site was 18.8% (Stayton & Duncan, 2005).

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What This Paper Will Cover

This paper looks at the current research on screening women for sexual violence in health care facilities. Background data on the problem of sexual assault is presented. Also discussed is the reasoning and rationale behind screening women for violence at heath care sites, the work that has been accomplished so far in screening of women for intimate partner violence and the possible reasons why questions about sexual violence in the lives of women have not been included on some of these screens. This article concludes with a discussion of the research gaps about screening women for sexual violence and recommendations for a future research agenda.

Although studies show that between 3% to 22% of men have experienced sexual violence at some time in their lives, the majority of survivors of sexual violence are women (Bureau of Justice Statistics 1994 Crime Victimization Survey; Tjaden & Thoennes, 2000). Though we acknowledge that screening men for sexual violence is also important, it is a broad topic deserving of a separate paper. As such, this paper will focus on women survivors.

The intended audience for this paper includes: rape crisis coalitions, policy makers and politicians. As health care providers and hospital administrators are a crucial part of screening and the referral of victims of sexual violence, they may also find the information in this paper to be useful.

This paper acknowledges the limits of what we currently know about this topic and suggests a future path that will lead us to greater knowledge about screening women for sexual violence. This paper provides a review that will hopefully facilitate discussions as to the importance of screening women for sexual violence at health care facilities. In order for this to begin, communication and collaborations between sexual violence groups and health care facilities need to occur, policies need to be evaluated and changed, and sexual violence screening and referral programs need to be developed, implemented and evaluated. This paper will hopefully make the case for starting this process with the goal of integrating screening for sexual violence into health care systems.

Definitions

All women are vulnerable to sexual violence. It can happen to single women, older women, children, lesbians and married women. Certain circumstances, such as poverty and disability, may raise a woman's level of risk, but nonetheless, all women are vulnerable (Wenzel, Tucker, Elliott, Marshall, & Williamson, 2004).

Sexual violence against women is both a public health problem and a human rights violation. The day-to-day reality is that women's lives are constantly being affected by the possibility and actuality of violence. This shapes and affects women's lives from birth through old age. Sexual violence can take a number of forms, including: childhood sexual abuse, rape, and sexual assault. These acts take place in many different contexts: family homes, on the street, in dormitories and in public venues.

Adult (females over 18) sexual violence includes contact and non-contact acts performed without the survivor's consent. According to the Center for Disease Control and Prevention, sexual violence is defined as completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration; contact between the mouth and the penis, vulva or anus; penetration of the anus or genital opening by penis, finger, or object and intentional touching of the genitalia, anus, groin, breast, inner thigh or buttocks. Non contact acts such as voyeurism and verbal and behavioral sexual harassment are also considered sexual violence if they are nonconsensual or committed against someone who is unable to provide consent (Basile & Saltzman, 2002). Rape is a subset of sexual assault defined as oral, anal, or vaginal penetration against consent through force, threat of bodily harm, or when incapacitated and unable to give consent.

Childhood sexual abuse is defined as contact abuse ranging from fondling to rape and noncontact abuse**,** such as modeling inappropriate sexual behavior, forced involvement in child pornography, or exhibitionism (Basile & Saltzman, 2002). Child

sexual abuse involves a child who cannot consent to have sex, who often is dependent upon the abuser and who is not ready to be sexual.

For the purposes of this paper, the term sexual assault refers to adult women's experiences, and sexual abuse refers to victimization of children. The term sexual violence is used to include both child and adult experiences of sexual assault and abuse.

Background on Screening

Recommendations about Screening

The American Medical Association, the World Health Organization, American College of Obstetricians and Gynecologists (ACOG**),** American Academy of Pediatricians, and the American Nurses Association are among the health care groups that recommend that providers screen their women patients for violence. ACOG specifically recommends that obstetricians/gynecologists screen women at each visit and include inquiry about sexual violence (Rhodes & Levinson 2003; Campbell, Moracco, & Saltzman, 2000). Despite these recommendations, a study by Clark et al. (2000) showed that only 37% of pregnant women were screened for violence during prenatal visits. Another study asked different specialties of doctors likely to encounter victimized women to self report their screening behavior and found that a median of only 10% of female patients were screened by providers (Elliott, Nerney, Jones & Friedman, 2002). Additionally, Groth, Chelmowski and Batson (2001) found that 30% of physicians reported seeing victims of violence in their practice on a daily or weekly basis, but less than a third of the respondents screened at least half of their patients for violence. Studies have also found that medical residents, while aware that violence is a health care problem, screen females about 37% of the time (Varjavand, Cohen, Gracely, & Novack, 2004). Even physicians who do screen often are not prepared, as shown in a study by Lapidus et al. (2002) where they found that only 16% of physicians reported having an office protocol to use with victims of violence.

The U.S. Preventive Service Task Force's (USPSTF) 2004 report, "Screening Women and Elderly Adults for Family and Intimate Partner Violence: A Review of the Evidence for the U.S. Preventive Services Task Force on Screening" concluded that that there was insufficient evidence to recommend for or against providers screening patients for violence (though the report primarily addresses physical intimate partner violence, several of the studies evaluated also included psychological and/or sexual violence). The report's conclusion stated that there was no acceptable research showing that screening for violence was an effective intervention that could reduce violence, premature death, and disability. One of the USPSTF's main concerns was the possible harm survivors might experience from screening. These concerns included: breaking of confidentiality, lack of training of providers, increasing the psychological distress of women, and the escalation of violence and erosion of the family structure (USPSTF, 2004).

What the USPSTF did ***not*** ask is "What are the potential harms of **not** screening women for violence?" Not only are the economic costs of childhood sexual abuse, sexual assault and rape high, but there is also a high human toll. Adverse life experiences such as sexual violence affect psychological and physical health, health behaviors, quality of life, and increase morbidity and early mortality; **not** screening women for sexual violence can result in serious if not fatal outcomes (Felliti, 2002; Campbell et al., 2003).

Information and Statistics about Sexual Violence

Direct and indirect effects of childhood, adolescent, and adult sexual violence on survivors are listed in Table 1.

- Victims of sexual violence can be adults, adolescents or children. They can experiece sexual violence once, it can be intermittent, ongoing or chronic. In one study of violence, the majority (81%) of childhood sexual and

Table 1. Direct and Indirect Effects of Childhood, Adolescent and Adult Sexual Violence on Survivors

Physical	Chronic pelvic and general pain, gastrointestinal disorders, migraines, back pain, brain trauma, partial or permanent disability, loss of years of a productive life.
Reproductive Health Effects	GYN problems, STIs including HIV/AIDS, unintended pregnancies, abortion, less use of contraceptives, pregnancy complications, infertility
Health Behaviors	Unprotected sex, having sex with high risk partners, multiple partners, using substances such as: drugs and alcohol, cigarettes, trading sex for food, money and/or drugs.
Psychological	Anxiety, depression, phobias, PTSD* (which includes flashbacks, sleep disturbances, hyper vigilance and/numbing), dissociation, suicide attempts, shame, fear, guilt
Interpersonal	Mistrust of others, isolation, breaking off of or less frequent contact with others, strained relationship with family, friends and intimate partners, less support from these people, of relationships, revictimization.

*Rape survivors are one of the largest groups of people with PTSD (Stevens, 2001)

/or physical abuse was reported to be recurrent (Plichta & Falik, 2001).

- Half of all rapes victims were below the age of 18 when they were first raped (Tjaden & Thoennes, 2006).
- Childhood sexual abuse is associated with adult health risk behaviors such as having sex with risky partners and driving while intoxicated, and with an increased number of physician coded diagnoses (Walker et. al, 1999).
- Over 40% of rapes of adult women are non intimate partner assaults (Tjaden &Thoennes, 2006).
- Most rapes occur in a private setting (Greenfield, 1997; Tjaden & Thoennes, 2006).
- Even without a weapon, almost half of all victims state that they feared serious injury or death during the assault (Koss, 1993; Tjaden & Thoennes, 2006).
- Women who are raped are at high risk for physical and psychological problems that will require visits to a health care facility/ provider (Koss, 1992; Conoscenti & McNally, 2006).
- The lifetime prevalence of PTSD for adolescents ages 12-17 who have experienced sexual assault is 30% for adolescent females as opposed to 7% for adolescent females who have not been sexually assaulted (National Institute of Justice, Youth and Victimization: Prevalence and Implications, 2003).
- Almost one third of all rape victims develop Post Traumatic Stress Disorder (PTSD) sometime during their lifetime, which makes rape victims 6.2 times more likely to develop PTSD than women who had never been victims of crime (Saunders, Kilpatrick, Hanson, Resnick, & Walker, 1999).
- A study of 1400 adult female twins found that women who had been raped as girls were three times more likely to develop psychiatric disorders or abuse alcohol and drugs than their twins who had not been raped (Kendler et al., 2000).
- The costs of care are highest for women whose sexual assault is untreated, and most sexual assaults are not treated (Tjaden & Thoennes, 2006; Rennison, 2002).

After a rape occurs about 50% of all victims will have evidence of physical trauma, up to 30% will contract a sexually transmitted disease and 5% will become pregnant (Goodman & Koss, 1993; Holmes, Resnick, Kirkpatrick, & Best, 1996). Over the longer term, some rape survivors report higher rates of chronic medical conditions, more somatic symptoms, negative health behaviors and poorer perceptions of their health **(**Plichta & Falik**,** 2001). Assault by a parent, spouse or stranger and/ or experiencing more than one assault was associated with higher odds that the survivor reported poor subjective health than assault by acquaintances (Golding, Cooper, George, 1997). Rivara et al. (2007) found that the medical use of a group of survivors of interpersonal violence (IPV) (including sexual violence) was found to be 19% higher than women without a history of IPV. Five years after the violence ceased, healthcare utilization was still 20% higher than for women without a history of IPV. A history of abuse is associated with a greater number of symptoms being reporting and a greater number of health care visits (Drossman et al., 1990). Sexual abuse survivors' median annual medical costs were $245 greater than women who did not report abuse (using 1999 dollars). These higher costs were generated through more frequent use of primary care, outpatient costs and emergency room visits (Walker et al., 1990).

A study of 2,186 female high school students in Massachusetts found that 18% reported that they had been physically and sexually assaulted by someone they were dating. Of the 18%, 3.8 % had been sexually assaulted only, and 5.3% had been physically and sexually assaulted. The remainder had been physically assaulted only. In this study recent suicide ideation and actual suicide attempts were six to nine times more common among girls who reported having been sexually and physically

hurt by dating partners. Victimized young women were also less likely to report condom use and had sexual intercourse at an earlier age than young women who had not been assaulted (Silverman, Raj, Mucci, & Hathaway, 2001).

Post Rape Care Options for Survivors

Tjaden and Thoennes (2006) found that less than 1 in 5 survivors report a rape to the police or other authorities. Women who have been sexually assaulted by strangers are more likely to report the assault to the police but are less likely to report it if they know the perpetrator (Rennison, 2002; Feldhaus, Houry, & Kaminsky, 2000). Thirty seven percent of victims in which the violence was reported to the authorities and 18% of victims in which the violence was unreported received medical care after the assault (Rennison, 2002).

Realizing that a substantial number of survivors do not report rape to the police or receive hospital care post rape, and that survivors need advocacy and counseling services, a national network of rape crisis services was developed as a way to reach more survivors. The Rape, Abuse & Incest National Network (RAINN) was established in 1994 and is the nation's largest anti-sexual assault organization. RAINN provides on-line support, a national sexual assault hotline, and links to information and resources. But even with these community services there may still be barriers for survivors in accessing care. Some communities do not have rape crisis centers, or the centers may be culturally and linguistically inaccessible. Other centers cannot accommodate women with certain disabilities. Also, some survivors may be too traumatized to make contact with a rape crisis center.

For other survivors, there are a number of internal and external barriers they must overcome before contacting a rape crisis center. The survivor must first define what happened to her as sexual violence (and for women who are assaulted by people they know, what happened may not be clearly defined as sexual violence); she would then have to label herself a survivor of sexual violence (which for a number of women may be too emotionally difficult to do); then she would have to find the resources she needs, such as transportation to the rape crisis center; she must trust that she will not be blamed when she talks to a counselor and must also trust that by going to this resource, she will receive the help she needs. Although rape centers assist many survivors, studies show that most victims do not or cannot access these services after a rape (Koss & Harvey, 1991).

In addition to the physical effects of sexual violence, we know that some survivors of sexual violence are at high risk of experiencing both short- and long-term psychological conditions including PTSD, depression, and phobias, and are at increased risk for revictimization. Receiving help early becomes all the more critical, as studies show that earlier disclosure of experiences of violence is helpful in lowering the rate of depression for survivors (Broman-Fulks et al., 2007).

Intervention

There has been much well reasoned and well documented literature calling for screening of women for sexual violence. Based on programs that already screen for domestic violence, screening women for sexual violence can also be integrated into health care.

As women utilize health care services 33% more often than men, screening women for sexual violence at health care sites fits well with women's usage of health care services (Brett & Burt, 2001). In addition, research has found that women who experience sexual violence were more likely than other women to have had 8 or more doctor visits during the past year (Plichta & Falik, 2001). About half of all patients who come to a physician's office with physical complaints are not actually physically ill, but have some underlying problem or stressor that is manifesting itself somatically (Avila, 2006). Although not all the women who present this way are victims of sexual violence, this is often one of the ways that survivors of sexual violence present, and is related to survivors' increased health care usage.

A visit to a health care provider is an appropriate time and situation for women to be assessed for violence. Furthermore, women see health care providers as people with whom they can talk about this subject. Survivors of sexual violence may have been victimized a month ago, a year ago or ten years ago. But the majority of victims omit information about the violence when discussing why they are in their health care provider's office. Some survivors may not connect the reason for their visit with sexual violence. Although the research shows that most survivors of sexual violence would like to be able to disclose what has happened to them, few spontaneously do this.

Screening for Sexual Violence

In many instances when providers screen for violence, the focus of the screening is on assessing women for domestic violence. This type of screen usually covers physical, emotional/psychological and possibly financial abuse of a woman by her partner. Yet research shows an overlap between types of violence, so that women who are beaten by their partners are often also the victims of sexual violence as well (and visa versa). One study showed that almost half of women who are physically assaulted are also sexually assaulted (Coker, Smith, McKeown, & King, 2000). In another study of over 2000 women, 48% of the physically abused women also reported sexual abuse and over 84% of the women who reported sexual assaults also reported physical violence (Plichta & Falik, 2001). There is also a dose response – i.e., the more assaults a woman experiences, the more she is at risk for further revictimization (Kilpatrick, 1994). Women who have been sexually abused as children are also at higher risk of being raped as adolescents and adults, and/or becoming involved with a violent partner (Felitti, 1991).

Certain populations of women such as the homeless, the mentally ill, drug and alcohol users, and sex workers, have higher rates of early sexual abuse than other groups and are at higher risk for adolescent and adult revictimization (Goodman, Fels, & Glenn, 2006; Freeman, Collier, & Parillo, 2002; Braitstein et al., 2002). Studies have shown that between 51% and 97% of women diagnosed with serious mental illness report experiencing lifetime physical and sexual assault (Briere & Jordan, 2004). Mental illness not only increases vulnerability to reassault but also to greater symptomatic effects from the assault. Thus, the earlier the identification and intervention, the more likely it is possible to help survivors avoid further victimization (Felitti, 1991, 2002).

Some screening tools, while including a question about sexual violence, have focused solely on identifying this in the context of partner violence. Screening tools focusing solely on partner violence do not by definition screen for sexual violence perpetrated by non-partners such as a date, employer, relative, friend, or stranger, which makes up more than 40% of all sexual assaults (Tjaden & Thoennes, 2006). Research on perpetrators of sexual violence shows us that excluding screening for non-partner sexual violence fails to identify a large group of survivors**.**

Other screening tools can have limited timelines as to when the sexual violence occurs. These types of questions ask women if, for instance, in the past twelve months they have been victims of nonconsensual sex (MacFarlane, Parker, Damus, & McFreda, 1994). Asking this type of question excludes women who were victimized many years ago or even two years ago from answering "yes." A survivor of childhood sexual abuse hearing that question would answer "no," which would be true given the parameters of the question. Yet the reality for the survivor would be that she does not get to disclose the abuse she experienced nor get the help she may need.

Although there have been many studies focusing on screening for intimate partner violence, the same is not true regarding screening for sexual violence. One study that investigated provider screening practices for sexual violence was published 15 years ago. Although the majority of the patients in this study favored routine screening, almost 90 % of their providers did not screen their patients (Fried-

man, Samet, Roberts, Hudlin, & Hans, 1992). A more recent study titled "An Evaluation of Health Care Providers Sexual Violence Screening Practices" was authored by Littleton, Berenson, and *Breitkopf* in 2007. It assessed women attending family planning clinics to determine if they were 1) screened for a history of sexual violence by a provider, 2) provided with information about the physical and emotional effects of sexual violence, and 3) provided with information about community resources for survivors of sexual violence. Additionally, the researchers also asked women if they felt comfortable being screened for sexual violence by their health care providers and if the information they received about sexual violence was helpful to them. The findings include:

32% reported being screened for sexual violence by a provider
11% reported being screened and provided with all three types of information by their health care provider
36% reported being given information about the physical effects of sexual violence
20% reported being given information about the psychological effects of violence
21% reported being given information about resources available for survivors of sexual violence
52% reported that a health care provider had never screened them nor provided them with any information about sexual violence
95% of women stated they felt comfortable with being screened for a history of sexual violence
95%+ of women who received any of the types of information about sexual violence reported that this information was at least potentially helpful if not "was helpful" or "very helpful."

Barriers to Screening

Provider Barriers

Studies show that there are a number of barriers that inhibit providers from asking adolescent and adult women about the sexual violence in their lives. These barriers include: lack of time, lack of education and training about the topic and how to screen, discomfort about what to do if a woman answers "yes" to the questions about violence, cultural beliefs about women and sexual violence, the perception that they do not see many victims of violence in their practice or that screening is not part of their job, lack of available community resources, and their own personal experiences of violence (deLahunta & Tulsky, 1996). Asking patients about sexual violence specifically may be even more difficult than asking about physical violence because of a general societal discomfort about sexual violence, misunderstanding about what sexual assault is, and/or the taboos about directly asking questions regarding anything sexual. Actually, the author's experience has been that the discomfort level for inquiring about sexual violence can be so high that there have been facilities where health care providers, while agreeing to screen for physical and emotional violence, have refused to screen for sexual violence. Although the majority of providers believe that they can help victims of sexual violence, there is gap between what providers believe they could/should do and what they actually do **(**Stevens, Maffie-Lee, Wolfe, & Kent, unpublished; Friedman et al., 1992).

Client Barriers

One recent study showed that only 20% of female adolescents and young women who identified as survivors answered "yes" to their providers' questions about violence (Zeitler et al., 2007). Survivors state that they have critical requirements of providers when they are screened: providers need to listen well, not be judgmental or blaming, nor respond from their own fearfulness. Receiving support, empathy, understanding and caring are critical in the context of answering questions about sexual violence truthfully (Battaglia et al., 2003). Many sexual violence survivors do not yet feel comfortable disclosing this violence.

There can be serious repercussions to victims not disclosing violence. Research shows that survivors of childhood rape who wait longer than a month to disclose had higher levels of PTSD and major depressive symptoms (Ruggiero et al., 2004).

Women who do not disclose sexual violence and/or do not get support when they do disclose have higher rates of PTSD and more persistent symptoms (Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992). Another repercussion is that survivors of sexual violence return to providers again and again with symptoms that do not get better. Because they are not screened for violence they receive incorrect diagnoses and inappropriate treatment and the abuse goes undetected (Bohn & Holtz, 1996).

Potential Settings for Screening for SV

The Emergency Room

Research shows that only 36% of rape survivors over the age of 18 who were injured during the rape received medical treatment post-assault. Women who were raped by strangers were more likely to seek medical care post-rape (Tjaden & Thoennes, 1998). What is problematic is that a high number of rape survivors who are injured or assaulted by people they know do not get medical treatment post rape.

The Centers for Disease Control and Prevention (CDC) estimates that almost 53,000 men and women ages 12 and older sought care in the ED following sexual assault in 2006 (CDC WISQARS, 2005). However, ER providers have not necessarily been trained in the treatment of sexual assault survivors. Beginning with the first program in 1976, Sexual Assault Nurse Examiners (SANE), who are highly skilled in the treatment of survivors, have had a major role in the immediate treatment of sexual violence survivors. SANE nurses are trained in the medical and forensic care of sexual assault survivors, and are part of a larger sexual assault response team (Girardin, 2005). The overall goal of the SANE program is to provide early response and high quality clinical care and evidence collection for victims of rape and sexual assault. While standards of practice may vary among programs, SANEs generally have 2 initial forensic goals: 1) to collect evidence that would affirm or deny that the victim and suspect had sexual contact, and 2) to collect evidence that demonstrates whether findings are consistent with the history and time frame given by the victim (Girardin, 2005).

Primary Health Care

As a group, healthcare providers may have even more contact with non-urgent victims of sexual violence than they realize, since survivors tend to have more health problems than women who are not victims of violence (Plichta & Falik**,** 2001). As previously stated, though 53,000 individuals over age 12 sought care in the ED following sexual assault in 2006, this is only a small fraction of the estimated 200,000-400,000 male and female victims of completed or attempted sexual assault each year (Catalano, 2006; Tjaden & Thoennes, 2006). Given the number of victims who do not go to the ER after sexual assault, most survivors who do seek medical care go to primary care.

Since many women (because of fear, embarrassment, shame, etc.) need to be asked multiple times about violence, primary health care visits are an appropriate opportunity to screen women for sexual violence. Having protocols in place that require women to be screened regularly (for example, every year) means that women have more than one opportunity to disclose the violence. From the provider's perspective, having multiple opportunities to screen is important for a number of reasons, including that women may be sexually assaulted after the first time they are screened, or may not label themselves survivors until some time after the provider does the screen and provides information. Also, at a first meeting with a provider a relationship would not yet be established that might allow a woman to disclose.

Family Planning Services

In the U.S, approximately 72% of women ages 15-44 receive at least one reproductive health care service annually (Abma, Chandra, Mosher, Peterson, & Piccinino, 1997). For many women, their only contact with a provider is in the context of a gynecological check-up/prenatal care or receiving family planning services, treatment of a sexually

transmitted infection, or an abortion (These last two are red flags for possible sexual assault). Yet as mentioned earlier, few reproductive health providers routinely screen for sexual violence.

A few years ago some family planning facilities outside the U.S began implementing programs to screen women who attend their clinics for past and present day physical and sexual violence as part of their standard care for women (Guedes, Stevens, & Helzner, 2002). Groups who work outside the U.S, especially reproductive health groups such as International Planned Parenthood Federation/ Western Hemisphere, the United Nations Population Fund and the Pan-American Health Organization, have shown that it is possible to successfully integrate screening and referral for both child and adult physical/sexual/psychological/financial violence into health care services. Recognizing the reproductive health effects that survivors of violence face, these groups have designed and developed programming that integrates screening for violence into the basic health care services they offer women. The screening programs are only implemented after an assessment of the health facility and after the health facility has first built a systematic step-by-step program of screening and service policies, protocols and ongoing training into the activities of the site. As part of these programs, every woman is asked a standardized series of questions about lifetime violence during the intake. Several researchers have written about the development of these programs, as well as the levels of screening and disclosure (Stevens, 2001; Guedes, et al., 2002). Although the programs have not yet been evaluated for their impact and outcome on the improvement of women's quality of life, they have been assessed in terms of other criteria, such as women feeling it is appropriate to be screened by a health care provider and having felt helped by the program.

One of the possible hypotheses as to why some groups outside the U.S. seem to be more advanced in their approach to screening is that for a number of the countries who have developed these programs, including Nepal, Armenia, the Dominican Republic and Vietnam, there are few to no local resources for survivors of violence. Because of the lack of local rape crisis centers or shelters, reproductive health groups have realized that family planning clinics can utilize screening practices as a way to address women's violence-related health care needs. In addition, for many women in the developing world, a visit to a reproductive and sexual health clinic may be her only visit to a provider and/or her only chance to leave her home. Screening at health care services is an ideal, if not the only, place and time. These health care groups realized that they were the front-end services and the only services in some cases for survivors of violence (as opposed to rape services being seen as the front end), and that they needed not only to acknowledge that but to act on that knowledge. Realizing the scarcity/total lack of referral resources, groups knew that if they screened women they also needed to supply the referral resources on-site. This protocol has turned out to offer a number of advantages, including being able to follow- up on whether survivors of violence use referral resources, as well as to control and oversee the quality of these resources. While many cities in the U.S. do offer local sexual assault services, many other areas do not. And, as previously discussed, even when women do have knowledge of services, they face many barriers in accessing these services. One way to increase the availability and utilization of screening and referral resources in the U.S. may be to follow the example of these international reproductive health groups and implement screening programs at family planning facilities.

Other Potential Sites for Screening to Occur

One of the areas where screening for sexual violence has taken place is in substance abuse treatment programs. The literature clearly shows that a high percentage of women substance abusers have a history of childhood/adolescent/adult sexual violence and that screening can identify a high percentage of survivors. Screening for sexual violence in these treatment programs can help identify some of the underlying precipitants for the substance abuse and can help women obtain needed services to increase their chances of succeeding in

being drug-free (Lincoln, Liebschultz, Chernoff, Nguyen, & Amaro, 2006). Another area where screening has been implemented is in substance abuse clinics treating adolescent women (Diaz, Simantov, & Rickert, 2002).

The Veterans Administration system has also begun screening both men and women for military sexual assault. So far almost 5 million men and women have been screened as part of their post-deployment health care visit. The disclosure rate for military sexual assault is over 20% for women. When the screen is positive, a referral is automatically made and as part of a more in-depth assessment, a woman is screened for other experiences of violence (Street & Bell, 2007).

There has also been some research on the prevalence of sexual, physical and emotional violence of women attending Women, Infants and Children (WIC) Centers (Kershner et al., 1998). Although assessing violence at this type of site would be another opportunity to widen the scope of screening, there are also immediate problems, such as concerns about privacy, confidentiality and lack of trust between women and the staff at WIC sites. But, Kershner et al. (1998) highlight the need to screen where women actually go—expanding on the idea of offering help where women already go to social services.

What Type of Screening: Universal or Case Review

Because of what some administrators perceive as time constraints, some health care services screen on a case review basis. This means that only women who providers suspect of being victims of violence would be screened. Women, for example, who present with physical and/or sexual symptoms, or who raise "red flags" because of their symptoms or presentation would be asked about violence. While this might save minutes overall, it is a subjective screening method and misses the mark in terms of casting the widest net.

Using one's judgment as to who to screen would allow providers to consciously and unconsciously decide who "looks" like a victim. (One scenario would be for a provider to believe that they themselves could never be a victim of violence and therefore only screen women who she/he sees as **not** like them). This type of inquiry would statistically eliminate most women who are victims of past or present day violence from being screened. Using this model, a health care site might decide that all women over the age of 50 do not need to be screened for sexual violence, nor women under the age of 15. Each site might therefore make their own protocols, eliminating populations that have experienced violence or who are at risk for becoming victims. It might also cause women who are then screened to feel targeted and defensive. There is no scientific basis for screening in this manner. Physicians would not screen certain women for breast cancer and not others. That would be unethical and termed a medical error. Screening all women for violence eliminates such problems as individual patients feeling singled-out, bias in screening and nonstandardized protocols.

Gaps in the Research

Although there is some research on domestic violence that has included questions about sexual violence, there is still a great need for developing and implementing a research agenda about sexual violence screening. The existing literature provides an opportunity to learn from the research that has been done on domestic violence screening and to develop a research agenda that asks important questions specifically related to sexual violence. These questions include:

- Do women and providers feel differently being asked/asking about sexual violence versus other types of violence?
- Are there more and less appropriate places and times to ask about sexual violence?
- What specific barriers are there for survivors regarding disclosing sexual violence?
- What is the gap between women saying they would disclose violence to providers and actually doing so when providers screen them?
- For women who have been sexually assaulted in the recent past, what would they

want in terms of an intervention(s) after they disclose?

- What are the critical components to training that assist providers in learning how to ask patients about the "taboo" topic of sexual violence?
- Are there ways to define sexual violence that would allow the screening to be brief but also clear to both the person asking and the person answering?

Suggestions for a Research and Program Agenda

Recipient of Screening and Services

It is important to ask women how they wish to be asked about sexual violence and what would help them to disclose violence, and also what words and behaviors should not be used when asking about violence. We need knowledge of the best way to ask women about sexual assault so that we can screen women in a way that is clear, concise, valid and reliable. It is also important to include women of different cultures and backgrounds in these discussions and understand whether women from various cultures need to be screened differently. We know from research that their may be cultural differences in the meanings of sexual assault and in the association of sexual assault with unexplained reproductive and sexual symptoms (Golding, 1996). This is also true for adolescents in terms of possibly needing different screens for this age group.

We need to know more about what survivors of violence want in the way of resources. Because the majority of survivors of violence do not use hotlines or rape crisis services, we need to find out what services they would want and use. What needs to be done to make the services more accessible? We need to test offering on-site referral resources in order to follow whether survivors follow-up on referrals, control the quality of the care survivors receive, study the effectiveness of multiple types of interventions and make it easier for survivors to reach services. There is also a need for pilot studies at health care sites that screen adolescents and adult men for sexual violence.

Health Care Systems

We need to look for already implemented high quality screening and research models and replicate them. Implementing a successful screening program requires a systemic, multi-component approach. For example, in piloting a new screening program for domestic violence, McCaw, Berman, Syme and Hunkeler (2001) reported that a successful implementation was characterized by a health care setting that was fully supportive, training for staff, posters and brochures in waiting and exam rooms to indicate awareness of violence issues and the safety of disclosing them, chart review to monitor compliance and report back to medical staff, and a back-up person or team that can respond or consult when positive case identifications are made.

If there are programs that have not been evaluated, this must be added to the agenda of the screening program. When possible, we must also find out how these successful screening programs received institutional buy-in, and what else has helped these programs to work. We also need to research various models of screening in order to develop models that work, are cost effective and are adaptable to different types of sites. We need to research barriers that stop institutions from implementing sexual violence screening and referral programs and work with them on overcoming these barriers.

It is also critical to develop and test health care outcome measures that could be used as basic and reachable outcome measures for screening programs. Lastly, we need to look at screening for sexual violence and how it affects health care usage, the quality of survivors' lives and health care savings.

Sexual Violence Screening Tools

Often screening for violence is not standardized. Instead, with broad outlines, providers ask their own idiosyncratic questions about violence. Validity is a main concern, as the lack of uniformity of screening questions may mean that some women are carefully and thoughtfully screened by their providers while other women are not clear about the meaning of the questions that are being asked or questions are asked in such a way that the provider is prompting a "no" response. Although there is

some resistance to using and asking standardized questions about sexual violence, a lack of standardized screening tools brings up concerns about the reliability of the screening. The objective of standardization would be to develop the best questions that could successfully reach the largest numbers of survivors. Questions need to be tested for sensitivity and specificity. They also need to be translatable into different languages and useable with translators.

Programmatic Concerns

We need to develop step-by- step program models that can be used in the implementation of successful screening programs. As part of this, there needs to be research in order to develop different program models that can be used by a variety of site**s,** depending upon their organizational capacity, staff level, finances and resource level.

Within the program modules, standardized sensitizations and training curriculums need to be developed and tested, which will then clarify the quality and quantity of trainings that staff in health care institutions receive. But training is only one component of a program, as training by itself does not work. A program model includes developing and implementing clear policies and protocols as guidelines within screening and referral programs. Forms should be clear, relatively easy to fill out and read. Forms and prompts for screening and rescreeening are additional components of programs that can be tested and distributed.

Collaboration

It is important that researchers, advocates, and practitioners work together to develop the most effective components of screening and referral programs. Rape crisis advocates should be involved in the design, development and implementation of screening programs at health care sites, and also collaborate with academic researchers and individuals with programmatic expertise. Rape crisis advocates can also collaborate with local health care sites to work with government funded health care facilities to implement programs and to develop credible research and programmatic agendas that will attract funders. Advocates can also collaborate with groups outside the U.S. and study the programs that have been developed for possible replication in the U.S.

Evaluation

Lastly, it is crucial that we build in monitoring and evaluation from the beginning of any program. This has been a" missing link" in the screening field. Indicators of success need to be developed before the program is implemented. Evaluation is necessary in order to test what types of interventions help women, and monitoring can assure continuous quality of care and raise awareness of program flaws. Monitoring would be done on a continuous basis, looking at screening practices, levels of disclosures and fluctuations in both. Awareness of what is going on within a program would offer more information as to what is working, what needs improvement, and what needs revision or updating.

Conclusion

As there has so far been more of a focus on screening women for domestic violence, there is more of a library of research on the different aspects of this type of screening along with information on how to integrate this into health care. There are already screening tools, training manuals and monitoring guidelines**.** This knowledge is crucial in caring for survivors of domestic violence and designing, developing and implementing strong screening and service programs. But there is a critical gap in the level of knowledge we have about sexual violence in this context. However, there is also the opportunity to learn from the successes and challenges of domestic violence screening efforts when advocating for, designing, developing and implementing sexual violence screening and service programs. The work on screening for sexual violence can enlarge the field and gather advocates who understand the importance of screening women for all types of violence. What we have already learned can assist us in developing better quality and stronger programs, conduct research in areas of the field that answer important questions, and develop critical standards for monitoring and evaluation of these programs that can then be integrated into health care systems.

If the mental and physical health of survivors of sexual violence in the U.S. is to improve, health care services need to continue to find out what the underlying sources of morbidity are and focus time and energy on assisting women with the underlying "real problems" in their lives. We need to assist girls and women in letting go of the shame of silence and isolation about their experiences of sexual violence. One of the ways to do this is to no longer weigh them with the burden of finding a person to tell or a place to get help. We need to offer comprehensive screening, referrals, and resources at the health care facilities where women already go. Screening should not be something that is only offered at certain sites or to certain women, but needs to be a clear part of all women's health care.

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In Brief:
Screening for Sexual Violence: Gaps in Research and Recommendations for Change

Data show that the majority of completed and attempted sexual assaults against women are *not* reported to the police. In addition, resources that may be thought of as refuges for survivors, such as rape crisis centers, are often not accessed by them. In fact, most women who are victims of childhood or adult sexual violence do not go to hospitals, do not tell their families, and are hesitant to speak to their friends about it.

But survivors of sexual violence do make frequent visits to health care services. Often these women go to health care providers because they are experiencing the physical and psychological effects of sexual violence, which can manifest as headaches, gastrointestinal distress and/or the physical effects of the violence such as Pelvic Inflammatory Disease (PID) and Sexually Transmitted Infections (STI's) or Human Immunodeficiency Virus (HIV).

It is clear that health care visits are the gateway to care for many survivors of sexual violence and that providers could be central in improving the outcomes of survivors of violence if they screened, educated and referred their patients. The American Medical Association, the World Health Organization, American College of Obstetricians and Gynecologists (ACOG**),** American Academy of Pediatricians, and the American Nurses Association are amongst the health care groups who recommend that providers screen their women patients for violence. ACOG specifically recommends that obstetricians/gynecologists screen women at each visit and include inquiry about sexual violence.

Yet often when providers do screen their female patients for violence, the focus of the screening is on assessing women for domestic violence. This type of screen usually covers physical, emotional/psychological and possibly financial abuse of a woman by her partner, but not sexual violence. But research shows an overlap between types of violence, so that women who are beaten by their partners are often also the victims of sexual violence as well (and visa versa).

There is a critical gap in the level of knowledge we have about sexual violence in this context. The existing domestic violence research gives us the opportunity to learn from the research and to develop a research agenda that asks important questions specifically related to sexual violence. This future agenda includes questions about: inclusive and effective screening tools; types of referrals survivors need; the development and testing of health care outcome measures; development and implementation of program models that work within the health care system, are cost effective and are adaptable to different types of sites; and how screening for sexual violence affects health care usage, the quality of survivors' lives and health care savings.

We need to focus on identifying and assisting survivors of sexual violence, and help them to let go of the shame of silence and isolation related to their experiences of sexual violence. One way to do this is to no longer weigh them with the burden of finding a person to tell or a place to get help. We need to offer comprehensive care and services where women already go, and make sexual violence screening a clear and integrated part of women's health care.

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