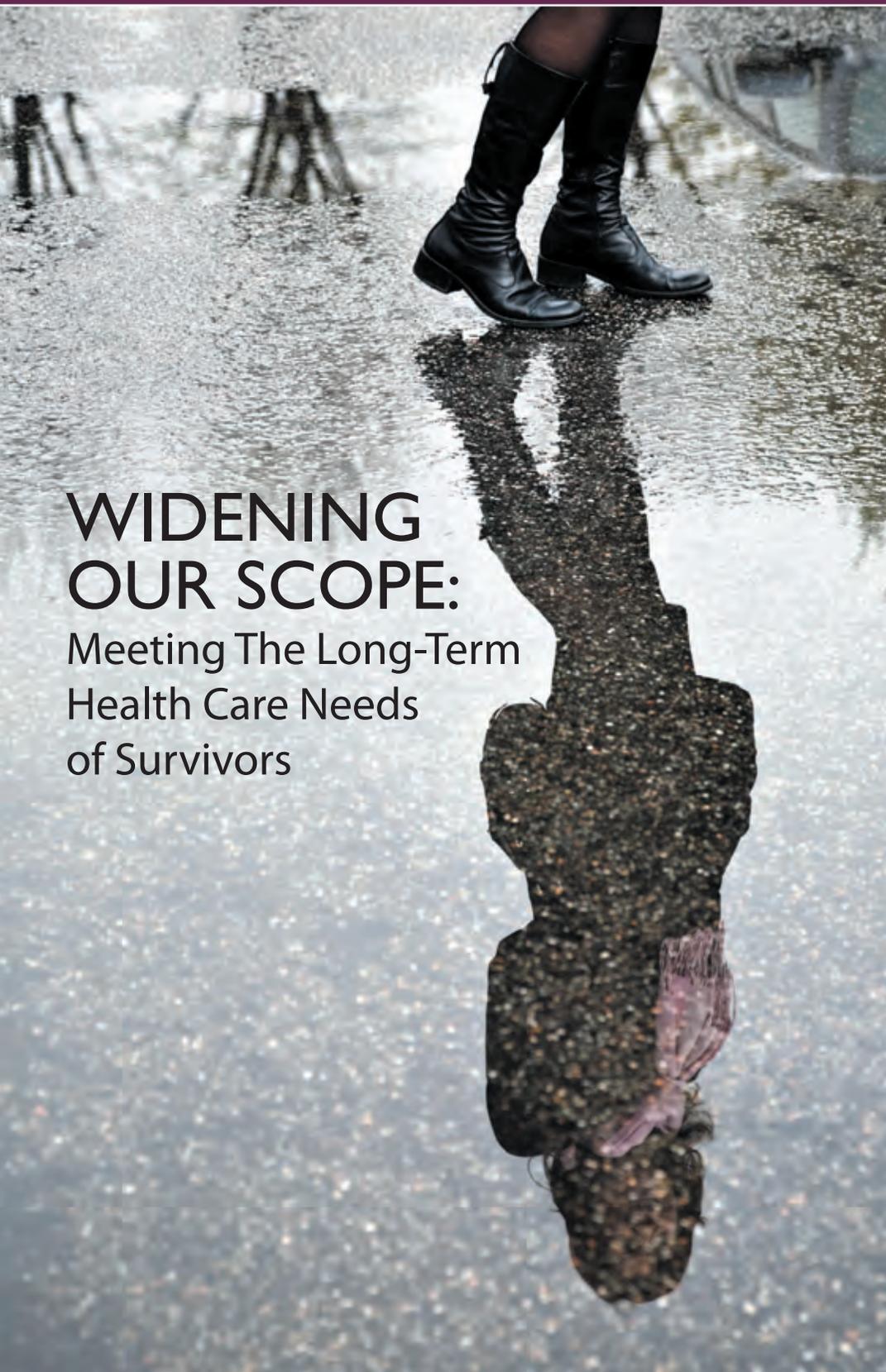


Connections

A Biannual Publication of
Washington Coalition of
Sexual Assault Programs

Volume XII

WINTER 2009



WIDENING OUR SCOPE:

Meeting The Long-Term
Health Care Needs
of Survivors

The Road to Recovery:
Mental Health Needs of Sexual
Abuse and Assault Survivors

In the Years After:
A Look at Survivors'
Long-Term Physical Health Needs

A Holistic View
Of Long-Term Recovery

Navigating the Crime Victims
Compensation Program

Rape Victim's Choice:
Risk AIDS or Health Insurance?

Women Servicemembers
Face Sexual Assaults and
Inadequate Health Care

Beyond the Forensic Exam:
Consider These Resources
for Survivors

How Advocates Can Address
The Long-Term Health Care
Needs of Survivors

LETTER FROM THE EDITOR

Trisha Smith, Advocacy Specialist

As we approach the year 2010, health care is a hot topic. It seems you cannot read a newspaper, check out a blog, watch TV, or even eat dinner with your family without it coming forward as a matter of debate. There is great hope that change is brewing. As we evaluate our current health care system and avenues to access its resources, we need to ask, "Are survivors' needs being met?"

Included in this issue of *Connections* are two recent news stories that highlight specific barriers survivors face when trying to obtain much-needed long-term care. *Rape Victim's Choice: Risk AIDS or Health Insurance?* discusses the many different ways survivors are being denied the care they need by the private insurance industry. *Women Servicemembers Face Sexual Assaults and Inadequate Health Care* speaks to the lack of protections and care options for women in the military who have been sexually victimized at disturbingly high rates. In this time of flux, we all have the opportunity to make change, on both an individual and a societal level. As we move forward, we can consider modifications in services to survivors as well as more sweeping policy changes.

The long-term medical and mental health needs of survivors, as discussed in this issue, are critical and complex. We have included practical resources to assist advocates and other professionals working in the sexual assault field to expand their skills and awareness. We have also included a thought-provoking article about the possible benefits of a holistic health paradigm for healing trauma.

Advocates sometimes feel at a loss about how to effectively help people who are dealing with long-term consequences of abuse or assault, as we are neither therapists nor physicians. An additional goal of this publication is to help advocates challenge their view of medical advocacy. Advocates have a vital role in supporting survivors in the emergency medical setting during the post-assault exam procedure. The advocate serves as a support person, resource provider, and educator. It is inspiring to think about these skill sets being applied outside of the emergency room. Offering this expertise in various settings would provide meaningful help to many survivors who are

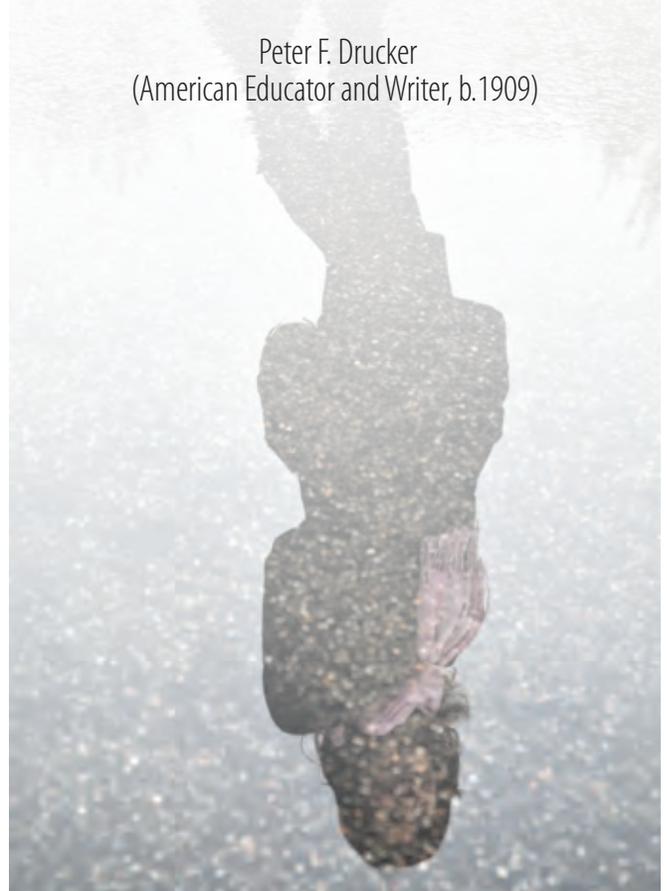
interacting with the medical system. This extension of the advocacy role affords advocates the opportunity to become even greater allies, enhancing our ability to provide effective systems advocacy and collaboration with other service providers.

It is important to note that the information presented in this publication was developed with the incredible strength and resilience of survivors in the forefront of our hearts and minds. Ensuring survivors have access to quality care and support throughout their life span is an essential duty. It is equally important to take the time to recognize and celebrate the many healthy, strong, thriving survivors out there today.

Jennifer Y. Levy-Peck, Program Management Specialist, served as co-editor for this issue of Connections.

"Follow effective action with quiet reflection.
From the quiet reflection will come
even more effective action."

Peter F. Drucker
(American Educator and Writer, b.1909)





**WIDENING OUR SCOPE:
Meeting The Long-Term
Health Care Needs
of Survivors**

*The Mission of the
Washington Coalition
of Sexual Assault
Programs is to unite
agencies engaged in
the elimination of
sexual violence
through education,
advocacy, victim
services and
social change.*

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THE ROAD TO RECOVERY:

Mental Health Needs of Sexual Abuse and Assault Survivors

Jennifer Y. Levy-Peck, Program Management Specialist

Jennifer Y. Levy-Peck, Ph.D., is WCSAP's Program Management Specialist. Dr. Levy-Peck is also a clinical psychologist who has provided treatment for a wide range of sexual abuse and assault survivors over the years.

Overview

Sexual abuse and assault survivors suffer from a wide variety of mental health issues, and many of these individuals need mental health services immediately following the assault, or over the long term, or both. The mental health consequences of sexual abuse and assault are well documented. Survivors of all ages manifest psychological symptoms related to sexual victimization. In considering the psychological effects of abuse and assault, it is important to recognize that many survivors are remarkably resilient. Not all survivors need mental health treatment, but for those who do, having access to services can make a life-changing difference.

Survivors of all ages manifest psychological symptoms related to sexual victimization.

Consequences of Child Sexual Abuse

Children who have been sexually abused are more likely than others to experience posttraumatic stress disorder (PTSD), depression, problems at school, and behavioral problems. Adolescents who have been abused may experience suicidal thoughts and behaviors, substance abuse disorders, long-term depression, aggressive or sexually inappropriate behaviors, and eating disorders. Indirect mental health consequences may result from the stress associated with higher rates of teen pregnancy and sexually transmitted diseases among child sexual abuse (CSA) survivors.

Children who have been sexually abused are more likely than others to experience posttraumatic stress disorder (PTSD), depression, problems at school, and behavioral problems.



Research on nonclinical samples shows that the mental health consequences of CSA are widespread. A recent community study of adolescents revealed that those who had experienced CSA demonstrated markedly increased psychological distress compared to their nonabused peers (Newcomb, Munoz, & Carmona, 2009). In addition, a large-scale population-based study (Kendler, Bulik, Silberg, Hettema, Myers, & Prescott, 2000) found that women who had been sexually abused were at significantly higher risk for psychological and substance abuse disorders than those who had not been victimized. Another large-scale epidemiological study showed an elevated risk of developing eight different psychiatric disorders in individuals with CSA histories (Scott, 1992).

Consequences of Adult Sexual Assault

The mental health impact of adult sexual assault is also substantial. The Department of Veterans Affairs discovered that 20% of female veterans who sought health care services had experienced military sexual trauma, and they were diagnosed with PTSD at a rate eight times as high as those women who had not been victimized (Munsey, 2009). Because “violence against women is predominantly intimate partner violence,” with nearly 62% of sexual assaults being perpetrated by an intimate partner (Tjaden & Thoennes, 2000), many female sexual assault survivors have complex ongoing relationship issues that make short-term crisis management an inadequate response to their problems.

20% of female veterans who sought health care services had experienced military sexual trauma, and they were diagnosed with PTSD at a rate eight times as high as those women who had not been victimized.

The Range and Complexity of Mental Health Needs

Children, adolescents, and adults who have been sexually victimized need access to mental health services. In addition, “secondary survivors” such as nonoffending parents and caregivers or partners of survivors may often benefit from psychotherapy in order to help them to support the survivor, and also to manage their own pain and distress. Mental health treatment may need to be offered in stages, such as crisis counseling, treatment to manage the immediate

aftereffects of the trauma, and follow-up treatment to help survivors as they deal with the long-term effects or with the exacerbation of life stresses caused by prior victimization.

The need for “intervention by stages” may be clearer if we follow a hypothetical case. Jodie was sexually victimized from age five to age 12 by an uncle (her mother’s brother). When she finally disclosed the abuse at age 12, she was seen first by a crisis counselor at a local mental health center, and then she participated in 14 sessions of individual psychotherapy aimed at helping her to deal with her feelings of shame, betrayal, disgust, and depression. Her parents also were offered several counseling sessions to help them understand what had happened to Jodie and how to support her in her recovery.

Jodie’s mother, Ann, became quite depressed because her own parents and siblings refused to believe that Jodie had been abused and they ostracized Ann and the rest of her immediate family. Ann eventually needed short-term inpatient treatment for depression and then participated in an outpatient therapeutic group for six months. Two years after the initial disclosure, Jodie’s younger brother, Jason, revealed that he too had been abused by the uncle, although his abuse was shorter-term and less severe than Jodie’s. Jason saw a therapist a couple of times but was unwilling to talk about what had happened and seemed to be doing okay, so his parents did not press the issue.

Jodie seemed to do well after her course of treatment, but when she turned sixteen she became involved with her first serious boyfriend and this triggered feelings of shame and disgust. She was able to return to her original therapist and went through another four months of psychotherapy. Jason began drinking and using drugs. After getting into some serious trouble, he was court-ordered into an intensive outpatient treatment program, where he finally began dealing with his feelings about the abuse. Jodie became pregnant shortly after she married at age 19, and her pregnancy and the birth of her baby were very difficult for her because of the aftermath of the abuse. She started taking antidepressant medication and once again sought psychotherapy for a few months.

Mental health treatment may need to be offered in stages. . . to help survivors as they deal with the long-term effects or with the exacerbation of life stresses caused by prior victimization.

This is just a “snapshot” of how a family *might* be involved with mental health services for a few years after the disclosure of CSA. It could reasonably be anticipated that any of the family members in this scenario would have additional mental health needs as the years go by. While not all of their psychological concerns emanate exclusively from the abuse, the abuse complicates normal life transitions and creates increased distress and thus a need for more frequent or longer-duration services. Mental health needs become even more complex when we take into account the possibility that a single individual may be victimized on multiple occasions and by multiple perpetrators.

Appropriate Mental Health Treatment for Survivors

There is a movement toward Evidence-Based Treatment (EBT) for survivors. Access to clinicians with a high level of training and sophistication about psychotherapy for survivors varies widely because of economic, geographic, attitudinal, and political variables. For children who have been sexually abused, the two treatment modalities with the most research support are Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Parent Child Interaction Therapy (PCIT). While these treatment modalities are not appropriate for every child survivor and family member, they have been shown to be more effective than other treatments in helping most children overcome the trauma of abuse.

The National Child Traumatic Stress Network has identified several levels of barriers (from resistance by individual clinicians to a lack of funding by institutions) that have resulted in the limited dissemination of EBT in children’s mental health services. Some examples would be the lack of investment in advanced training for care providers, third party payers’ reluctance to cover therapy sessions aimed at parents and caregivers rather than the child alone (which are part of the protocol for these treatments), and the difficulty of obtaining crime victim compensation that will finance the 12 to 25 sessions required in some cases. The Network’s report, *Closing the Quality Chasm In Child Abuse Treatment* (2004), provides insight into the large-scale systemic change that needs to occur so that all child survivors and their families may be offered the most effective possible psychotherapeutic treatment.

Adults who are sexually assaulted also need appropriate high-quality mental health services. In addition to crisis counseling and individual trauma-focused psychotherapy, other modalities may support

the healing process. For example, psychoeducational support groups have been shown to be useful for many survivors. A mental health professional may facilitate or co-facilitate such a group, or may supervise group facilitators. Because sexual assault affects the partners and family members of victims, couples’ therapy or family therapy is sometimes appropriate. Psychotropic

Mental health needs become even more complex when we take into account the possibility that a single individual may be victimized on multiple occasions and by multiple perpetrators.

medications may be useful in managing some of the symptoms experienced by certain survivors, in conjunction with psychotherapy. Substance abuse treatment is necessary for some individuals, since numerous studies have demonstrated high rates of substance abuse among those who have been sexually victimized.

Issues in Mental Health Service Delivery

One issue for both adult and child services is the need for coordination by mental health professionals with other service providers, such as advocates, school personnel, and lawyers. Such coordination may be a vital part of effective therapy, but there may be no easy way for mental health providers to be compensated for these types of professional activities.

Effective psychological treatment for abuse and assault survivors requires changes in the current health care delivery system.

Effective psychological treatment for abuse and assault survivors requires changes in the current health care delivery system. Most private insurance companies limit the number of treatment sessions and the range of treatment modalities so that survivors may not be able to receive evidence-based therapy even if it is available in their area. There are recent reports of individuals who state that their mental health treatment claims have been denied because of a history of abuse or assault (Ivory & Sebert, 2009). Residents of rural areas, survivors with limited English proficiency, homeless individuals, and those who believe in the stigma of receiving psychological help may face substantial barriers to mental health treatment.

According to the Agency for Healthcare Research and Quality (2003), "little is known about who and how many health professionals have received training or education in the examination and treatment of victims of sexual assault or other forms of abuse, nor the content, duration and scientific basis for the training." There are not enough mental health professionals who have the specific training and experience necessary to meet the complex needs of individuals and families who have been affected by sexual assault. Some innovative training methods, such as a free web-based course on Trauma Focused Cognitive Behavioral Therapy, seek to remedy this situation, but the dissemination of state-of-the-art treatment is uneven, to say the least.



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Recommendations

Recommendations for improving mental health services available to survivors include:

- ✓ more research to identify a variety of effective treatment approaches
- ✓ assessment of training needs for mental health professionals and development of training programs to fill any gaps
- ✓ extension of financial benefits to cover all appropriate treatment modalities
- ✓ recognition of the complex and sometimes long-term treatment needs of survivors
- ✓ development of innovative strategies to overcome barriers to obtaining appropriate mental health services

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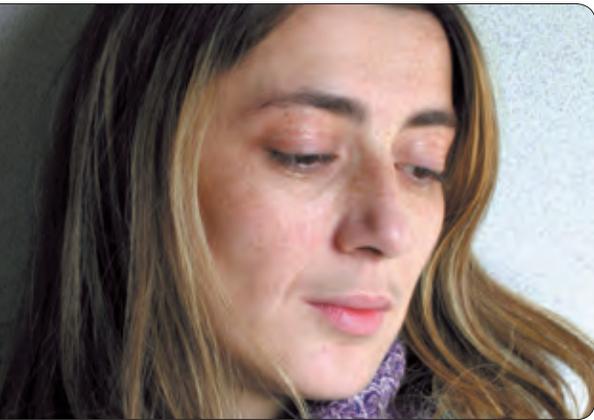
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IN THE YEARS AFTER:

A Look at Survivors' Long-Term Physical Health Needs

Trisha Smith, Advocacy Specialist

Trisha Smith, Advocacy Specialist for the Washington Coalition of Sexual Assault Programs, had the privilege of speaking with David McCollum, MD, about the long-term physical health effects of sexual violence. Dr. McCollum is one of the co-founders of the Academy on Violence and Abuse (AVA), an organization whose mission is to “advance health education and research on the prevention, recognition, and treatment of the health effects of violence and abuse.” He is currently working as an emergency physician at Ridgeview Medical Center in Waconia, MN.



Overview

As medical professionals, advocates, and survivors, we often fail to recognize the long-term physical effects of sexual violence. There are a number of reasons for this omission. To begin with, the physical effects often take time to present themselves and usually show no direct correlation to the sexual violence itself. Additionally, research focusing on the effects of violence and abuse on long-term physical health is still fairly new within the medical arena. Therefore the majority of medical practitioners do not discuss past sexual trauma with their patients, nor do they recognize this as a possible root cause for their patients' physical maladies. However, more and more research now shows that sexual trauma manifests itself in our

As medical professionals, advocates, and survivors, we often fail to recognize the long-term physical effects of sexual violence.

bodies in countless ways. There is no denying that there are serious medical consequences of exposure to sexual violence that may last long after the initial trauma (Dolezal, McCollum, & Callahan, 2009).

Dr. McCollum first started to take note of the number of patients he saw with histories of violence, abuse, and neglect when he opened his family practice in 1980. Once he began to recognize how many patients shared these experiences, he began to see the effects of past victimization on their diminished health and overall well-being. As Dr. McCollum began to dig deeper, learning more from his patients and talking with other medical professionals, the connection of exposure to violence and abuse with consequent long-term health issues became overwhelmingly evident.

What Are the Physical Effects?

The information that Dr. McCollum shared made sense, in that experiencing a trauma such as sexual violence affects us in ways that are not always apparent or easy to identify. This observation resonates as logical and truthful, yet becomes hard to recognize when there is such a wide range of maladies that can develop. Research suggests that "prolonged exposure to stress hormones released by the body in response to violence or abuse affect the regulation of the nervous system, as well as the immune, endocrine, or other organ systems" (Dolezal, McCollum, & Callahan, 2009).

Individuals may show a variety of responses to the mental and physical pain associated with sexual assault and abuse. The body can process and respond to trauma via gastrointestinal issues, chronic fatigue, headaches, environmental sensitivities, heart palpitations, and many other seemingly unrelated physical maladies. While the array of medical ailments is overwhelming, it clearly supports the need for access to ongoing health care throughout the recovery process.

An additional consideration is that survivors may also be engaging in behaviors that may put them at a higher risk for medical issues, for example "smoking, alcohol and drug use, and poor eating and exercise habits" (Dolezal, McCollum, & Callahan, 2009). As we analyze the physical effects, it is clear that the psychological impact of an act of sexual assault is a

... the connection of exposure to violence and abuse with consequent long-term health issues became overwhelmingly evident.

Sexual assault advocates are very likely to be working with a large population of people plagued by various physical ailments or chronic illnesses.

It can be very powerful to let survivors know that their physical distress is not their fault, that they didn't ask for it, and that it can get better.

significant factor in the physical responses. This is a helpful reiteration of the need for a medical response that addresses both physical and mental health concerns.

Sexual assault advocates are very likely to be working with a large population of people plagued by various physical ailments or chronic illnesses. This can be a tremendous stressor in a survivor's life. Not only can it impede one's ability to focus on recovery from sexual assault, it brings forth other life stressors such as financial considerations and the need for access to appropriate care. Knowing the medical resources as well as the options for financial assistance available within the community can be a key support mechanism for advocates and other professionals to assist survivors.

Treatment for Survivors

One of the most important steps in treating an illness that is rooted in response to a trauma is to recognize the need to reorient the brain by focusing on emotional recovery in tandem with physical treatment. This is a long-term process, and Dr. McCollum identifies advocates as key players in helping people see their way through it. Sharing stories of success, validating that recovery is hard work, and normalizing frustrations will help clients to stay engaged in the treatment process. So much of advocacy is about validating clients' experiences, and this is no exception. In Dr. McCollum's practice, he has seen great improvements in his ability to work effectively with people by taking the time to simply acknowledge that the violence they have experienced has been damaging to their health.

It can be very powerful to let survivors know that their physical distress is not their fault, that they

didn't ask for it, and that it can get better. A medical concern is stressful in and of itself, and may become even more stressful when patients are left without an understanding or explanation of why they are suffering. This may ring especially true for individuals who are seeking medical care and yet are not seeing any improvement in their condition. Discussing ways clients can get the medical attention they need while also addressing the core issue of sexual trauma will help them to develop their own road map to recovery.

Dr. McCollum expressed a need for medical practitioners to stop looking at violence and abuse as just a criminal justice or social service issue. Medical providers need to feel comfortable in asking their patients about both past and present sexual assaults. Dr. McCollum found that the more he asked the question, the more he heard the answer "yes." As he states, you can ask in a way that is comfortable for both the doctor and the patient. One doesn't have to broach the subject so abruptly as "Have you ever been raped?" These questions can be asked in a manner that is conversational and contained within a broader context. For example, "Can you tell me a little bit about your relationship? Do you feel supported in your partnership? What happens when your partner wants to have sex and you don't?" When a clinician develops a better understanding of the dynamics involved and the stressors that this person is dealing with on a daily basis, he or she can more appropriately treat their medical needs. Taking time and building rapport will help facilitate these dialogues with more comfort and ease.

When we think of medical advocacy, it is generally in relation to medical forensic exams that take place immediately after an assault. When we think of medical

treatment for those who have been victimized, it is generally in relation to the injuries that occur directly from an assault. Realizing the intense impact that the long-term physical effects of trauma such as sexual assault may have on a person requires us to rethink our response.

Where Do We Go From Here?

Advocates are notoriously good at being vocal about the needs of their clients, and this is one more area where survivors need the support of advocates. The science around the effects of violence and abuse is still new to many medical practitioners, and may not be communicated to their patients. Offering this information, validation, and support to survivors will help them feel confident in getting their own needs met in the medical world. Being proactive in generating dialogue about what the physical aftermath of sexual violence really looks like will help people recognize these connections. The hope is that this will develop into a more holistic medical response to survivors of sexual abuse.

“The health care system spends many billions of dollars each year treating consequences of this exposure [to violence and abuse] – too often without addressing the underlying causes” (Dolezal, McCollum, & Callahan, 2009). While most physicians would state they don’t have the time it takes to build this rapport and address these issues with their patients, Dr. McCollum believes otherwise. Addressing a patient’s needs more appropriately during the first few visits may result in more beneficial treatment, thus saving time, energy, and medical costs. This is an effective way to offer treatment without encouraging dependency on the medical system.

The Academy on Violence and Abuse has the following recommendations:

- ✓ **Fund** further large-scale studies on the fiscal impact of violence and abuse
- ✓ **Identify** evidence-based practices that better address violence and abuse exposure
- ✓ **Establish** guidelines for treatment and management of patients
- ✓ **Identify** appropriate prevention components for health care providers

Resources:

Please explore the Academy on Violence and Abuse’s website for more information and resources
www.avahealth.org

A Guide for Developing Tools to Assess for Sexual Assault Within the Context of Domestic Violence is a resource with examples of screening questions. Available online:
<http://www.wcsap.org/pdf/developingtools.pdf>

Know More Say More: Reproductive Health Consequences of Violence and Sexual Coercion
<http://www.endabuse.org/content/features/detail/817/>

Getting it Right! A practical guide to evaluating and improving health services for women victims and survivors of sexual violence
http://www.ipas.org/Publications/asset_upload_file523_4350.pdf

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A HOLISTIC VIEW

Of Long-Term Recovery

J. David Forbes, MD, ABIHM

David Forbes is the current President of the American Holistic Medical Association. He is the founder and director of Nashville Integrated Medicine (www.Nashvilleintegratedmedicine.com). Dr. Forbes' current practice focuses on combining standard Western medicine with gentler and more natural approaches to healing, with a particular passion and emphasis on PEER therapy (Primary Emotional Energy Recovery), a process that provides a completely safe and unconditionally loving environment for the healing of deeper emotional wounds. Dr. Forbes' work also encompasses energy work and meditation training, development of intuitive skills, and cultivation of our internal spiritual energy as a guide in the healing process.

This article, excerpted from a previous article about group work entitled *Safety in Numbers*, explains how physical and emotional healing are inextricably intertwined. Survivors of sexual abuse and assault may want to explore holistic health models to address their recovery needs.

It is this stuck energy, surprisingly, not the original "wound," that is the trauma.

In my practice I do a significant amount of work in emotional process healing. I find that the number one issue in transformative healing of old emotional material is safety. Techniques don't heal, love and safety do. Many modalities are fine tools for doing deeper healing work provided that there is adequate safety involved. Conversely, even the best modality will have minimal and superficial results with an unsafe practitioner or environment.

Safety means that people will be able to reveal their deeper suffering without receiving shame, criticism, analysis, unsolicited advice, or any other adverse emotional consequence. In other words, they will receive real unconditional love. Deeper emotional healing work requires descent into the body, and descent into the mystery of the body requires relaxation and trust. In fact, *relaxation of the body* and *trust* are the very same thing, the same mechanism. The depth of descent and the degree of transformation of the wounded place are directly correlated with the degree of safety present.

The reason safety is so important is that old wounds are essentially about the *lack* of safety. There's a saying in the type of emotional process work that I practice: *The wound is not the trauma*. Wounds are a given. Life is wounding. There's constant loss, various forms of pain and insults, culminating in the ultimate wound, death. But, the trauma we carry from the past is not actually from the wound, it's from the *lack of safety that was present around the wound at the time it occurred and thereafter*. When we don't feel safe, we shut the feeling mechanism down, disconnect from that part of ourselves, and flee, mostly up into our heads. In doing this we shut off a natural arc: the experience of emotion, its organic flow through the body, and its discharge in a healthy, safe way. Just like leaving a chemical reaction in suspended animation, these truncated emotions spin and churn, creating both havoc with the body and problems in our present-day lives. It is this stuck energy, surprisingly, not the original "wound," that is the trauma.

Recent neurobiological studies on PTSD have begun to elucidate a biochemical picture congruent

with this model, showing that memories of painful events don't form instantly but congeal over time. The laying down of the memory in the "hard drive" of the brain seems to be mediated by stress hormones that go into high gear in the time following traumatic events, slowly cementing the painful long-term effects. Commensurate with this, a state of self-disconnected fear develops in which we cease to be in loving, compassionate relationship to a part of ourselves. Healing occurs when there is enough safe, unconditionally loving space for us to feel through our deepest places of suffering. It has been demonstrated through these studies that an atmosphere of love and safety, taken in at a deep level, can actually heal the visible EEG damage from trauma that is seen on brain scans.

When a person descends to do transformative work, two things need to happen. They need to be able to clear out the energy, completely and honestly. They also need to receive loving response and witness. The essence of the trauma is an old internal equation that *to feel=pain*. When the response is different, this equation is undone at a deep bodily level.

When we cultivate safety with others, we internalize it into our bodies. We then can carry that out into the world and be different people. We are affected less and less by the patterns of others. We become more loving, compassionate and tolerant because we have taken in love, compassion and tolerance. We can see another's distress for what it is because we recognize ourselves in it. Only then can real transformation occur, and only then can we truly be of service to others.

Author's Note: I am deeply indebted to the work, ideas and mentoring of Dan Jones and John Lee, co-founders of PEER (Primary Emotional Energy Recovery). Their words and teachings are intertwined with mine throughout this article.



...an atmosphere of love and safety, taken in at a deep level, can actually heal the visible EEG damage from trauma that is seen on brain scans.

➔ NAVIGATING

the Crime Victims Compensation Program

Q & A

Trisha Smith, Advocacy Specialist

Trisha Smith, WCSAP Advocacy Specialist, had the opportunity to connect with two Crime Victims Compensation Program (CVC) staff members: Janice Deal, Policy and Outreach Coordinator, and Maty Brimmer, Claims Unit Supervisor, to discuss the different options survivors have in accessing long-term health care services with CVC benefits.

Crime Victims Compensation (CVC) is a program that is most often associated with payment for medical forensic exams following a sexual assault. However, this program has much to offer, and it may be a great resource for people affected by the mental and physical effects of sexual abuse or assault. As CVC states, “the goal of this program is to work to reduce the financial impact of violent crime on eligible families, working in partnership with victim-assistance communities.”

Who is eligible?

Before referring someone to CVC, it is important to make sure that he or she meets the requirements for the program. The program does require some involvement with the criminal justice system, which may be a barrier for some survivors. However, it may be helpful for survivors to hear that the benefits are not tied in any way to the outcome of a case nor to what is done with the report of the crime.

Please note that survivors do not need to fill out an application to cover the cost of a SANE exam; this is automatically covered by the CVC program. Applications for benefits relate only to support services needed beyond the scope of the medical forensic exam.

➔ The application steps are:

1. File a police report.
2. Fill out the [Application for Benefits - Crime Victims \(F800042000\)](#) form (available online at www.CrimeVictims.Lni.wa.gov). This form is also available from [Victim Witness offices](#), health care providers, and community sexual assault programs.
3. Provide all information requested, then sign and date the form. Incomplete information could delay the decision on your claim.
4. You should hear within 60 days after we receive your application. You can call 800-762-3716 to check the status of your application.

Once the necessary information has been gathered, the CVC claims manager reviews the file and makes eligibility determinations. Once a claim has been approved for benefits, the claims manager is also responsible for authorizing appropriate treatment, managing and monitoring activity, and ensuring treatment is related to the crime and is curative in nature.

➔ The primary eligibility requirements are:

- The crime must have occurred in Washington State. The only exception to this is if a Washington State resident was the victim of a crime in another state that does not have a crime victim compensation program.
- The crime must be a gross misdemeanor or a felony. This is something that the claims manager can help you to assess; the evidence required by CVC is much less stringent than that of the criminal justice system and is not affected by a plea bargain or lack of prosecution or conviction.
- A report to law enforcement needs to be made within one year of the crime, or within one year of when it could be reasonably reported. Whether or not law enforcement moves forward with the report will not affect the client's CVC eligibility. The determination of what is reasonable is considered case by case.
- Application for benefits through CVC must happen within two years of the police report or two years after the client's 18th birthday (if the parent or guardian did not file on his or her behalf). This time frame can be extended up to five years with good cause.
- Applicant must be willing to provide reasonable cooperation with law enforcement; this will vary based on the situation.
- The victim cannot be incarcerated at the time of the claim.
- CVC is a payer of last resort, meaning any private insurance or public benefit programs in which the victim is enrolled will have to be billed before CVC can make any payments. If the victim has no public or private health care coverage, this is a moot point.

(For more specifics on eligibility requirements please contact Crime Victims Compensation.)





What is covered?

CVC can cover a wide array of services that are connected to an assault. This discussion focuses on the potential long-term health care needs of survivors.

What does justification of a claim look like?

For example, when thinking about the long-term physical health effects of sexual trauma, will CVC cover payment for treatment of migraines or a chronic illness thought to be brought on by the assault?

The approval of a specific condition, such as migraines, is based on the information provided to the claims manager by the medical provider. In order for CVC to approve coverage for this type of treatment, the provider must supply a statement that the migraines (for example) were caused by the crime. CVC relies on medical professionals to be the experts in this area. However, it would be normal for CVC to question the relationship of this condition because the connection to the assault is not immediately apparent. This does not mean the benefit will be denied, but CVC may need additional information from the medical provider. The medical provider should ensure that his or her statement clearly ties the health issue being treated to the assault that occurred.

What if the client disagrees with the medical provider's assessment?

If a claim has been denied, or the person wishes to consult with another provider, that is an appropriate next step. Individuals can then present any additional information to their CVC claims manager.

In regard to access to mental health treatment, how many sessions can a person receive under CVC benefits?

Does CVC stipulate a specific dollar amount or a length of treatment time that will be covered?

There is no predetermined number of sessions that will be covered. CVC requires providers to submit periodic reports. These reports are reviewed for some measures of progress. CVC cannot cover treatment that would be considered maintenance; their benefits are focused on helping those in the acute phase of trauma. Additionally, they have to ensure that the treatment that is being provided is related to the event, which is based on the reports supplied by the provider. There is a financial cap for all areas of service; however, according to the CVC staff interviewed, it has not been an issue in previous claims.

If someone has been seeing a therapist for months and no change is noted, the claims manager would question whether this treatment was the best match for the survivor. The next step would be to look at changing therapists or treatment options. In a sense, it is CVC's responsibility to verify that the treatment that the provider is offering is helping victims with their recovery. However, there is a solid understanding that the course of treatment may vary, especially for young clients.





Can benefits be used years after an assault, years after filing a claim?

Yes, once a claim is filed, a survivor may be eligible to re-open it in the future. CVC staff recommend filing a claim as soon as possible, even if the victim doesn't plan to use the benefits right away. It is generally easier to complete all the documentation needed to process a claim soon after the assault. In other words, it is much easier to open a claim early than it is to file one year later.

It is not unusual for a claim to be re-opened several times, according to CVC. This is most common when working with youth. CVC recognizes and validates that any survivor may be triggered by various life stressors and may need to access support services throughout his or her life span.

Are there any restrictions on types of therapy that will be covered, what providers may be used, or any specific diagnoses that will be covered?

The main concern here is that the treatment being offered is related to the criminal event. Any medical or mental health provider needs to be a licensed health care provider in Washington State and must be willing to accept CVC payments. Survivors should address the compensation issue directly with their providers. There is additional information for providers on the CVC website.

When you say “report” from providers, what does that look like?

Any provider who receives CVC payments is required to report regularly to the client's claims manager on the treatment that is being provided and on any progress to date. The claims managers prefer the report to be focused on these two areas. CVC does have the legal right to a client file (case notes) but does not see this as best practice. The program recognizes most therapists would have a conflict in sharing such information and they do not need that level of information to process a claim.

Will CVC cover substance abuse treatment?

It is a possibility, if one can connect the substance abuse to the event. If the client had a history of substance abuse prior to the event, he or she would most likely not be eligible; however this would be considered case by case.

What support options are there for secondary victims?

There are options for secondary victims specific to sexual assault cases when the secondary victim is an immediate family member. Immediate family members include parents, spouses, children, siblings, grandparents, and any member of the same household who assumes duties associated with being a family member. CVC does require that the treatment focuses on how the secondary victim is helping the primary victim to recover and heal.



Does CVC maintain a referral list?

On the CVC website, there is a list of providers who have registered with CVC, but that doesn't guarantee that they will take the payment. Survivors should still confirm each provider's willingness to take CVC compensation prior to beginning treatment.

Have you received any reports from people having difficulty finding therapists or medical providers that take CVC?

In 2005 CVC had to lower their reimbursement levels, which resulted in the loss of some providers. Providers who accept CVC payments are agreeing to a fee schedule developed by CVC. The program is concerned about access to providers, and they are interested in hearing from survivors who may be having difficulty finding providers that accept CVC payments. Survivors who have encountered this problem are encouraged to call the CVC hotline (1-800-762-3716).

Would someone have to pay any fees upfront to access services?

There should be no out-of-pocket costs for clients. All bills should go to their primary insurer (if any) and then to CVC directly.

Have there been any changes to CVC as budgets get cut?

As stated above, the reimbursement levels have been lowered, which has resulted in the loss of some providers. There is the potential for cuts to the program and no one can be sure what will happen this next legislative session. Advocates should feel free to contact CVC with any questions that come up.

What is the advocate's role in this process?

The CVC program states that "without advocates, this program would not be as successful. Advocates are one of the key elements to getting the information out there and connecting resources to the people that need them." The CVC staff would like advocates to keep asking "lots and lots" of questions, as this provides valuable feedback.

Many claims managers find that clients working with an advocate are better able to handle the multi-step application process for benefits. Depending on the client's comfort level, the claims manager can work directly with the advocate or directly with the client. Doing this type of work over the phone can be very difficult; having an advocate sitting with the client and offering support and clarification throughout the conversation can make the application process much smoother. Advocates can be instrumental in helping those who have been victimized to complete their application process and get connected to this resource.

Final Thoughts:

CVC applies treatment guidelines on an individual basis for each separate claim, as no two cases are alike. Such variability will most likely resonate with CSAP staff, as most of our work is tailored to individual clients. This also allows the claims manager flexibility with cases as long as they meet the requirements of a) treatment focused on issues related to the event and b) treatment with documented progress. As a survivor or as an advocate, don't be afraid to ask questions and get more information about a claim.

CVC is governed by various state laws and items in the Washington Administrative Code. If you would like any additional information on this topic, or anything else covered in this article, please don't hesitate to contact trisha@wcsap.org.

Contact Information for CVC:

Toll Free Phone Number: 1-800-762-3716

Website: www.CrimeVictims.Lni.wa.gov

Fax: 360-902-5333

Mailing Address:

PO Box 44520

Olympia, WA 98504-4520

RAPE VICTIM'S CHOICE: Risk AIDS or Health Insurance?

Danielle Ivory, Staff Reporter
Huffington Post Investigative Fund

Christina Turner feared that she might have been sexually assaulted after two men slipped her a knockout drug. She thought she was taking proper precautions when her doctor prescribed a month's worth of anti-AIDS medicine.

Only later did she learn that she had made herself all but uninsurable.

Turner had let the men buy her drinks at a bar in Fort Lauderdale. The next thing she knew, she said, she was lying on a roadside with cuts and bruises that indicated she had been raped. She never developed an HIV infection. But months later, when she lost her health insurance and sought new coverage, she ran into a problem.

Turner, 45, who used to be a health insurance underwriter herself, said the insurance companies examined her health records. Even after she explained the assault, the insurers would not sell her a policy because the HIV medication raised too many health questions. They told her they might reconsider in three or more years if she could prove that she was still AIDS-free.

Stories of how victims of sexual assault can get tangled in the health insurance system have been one result of the Huffington Post Investigative Fund's citizen journalism project, which is calling on readers to provide information and anecdotes about the inner workings of the insurance industry. The project aims to uncover details and data that can inform the larger debate over how to fix the nation's health care system. As the Investigative Fund reported in September, health insurance companies are not required to make public their records on how often claims are denied and for what reasons.

Some women have contacted the Investigative Fund to say they were deemed ineligible for health insurance because they had a pre-existing condition as a result of a rape, such as posttraumatic stress disorder or a sexually transmitted disease. Other patients and therapists wrote in with allegations that insurers are routinely denying long-term mental health care to women who have been sexually assaulted.

Danielle Ivory, Staff Reporter for the Huffington Post Investigative Fund, raised an important issue with the original online publication of this story. She formerly was a multimedia producer and reporter for the American News Project. She has been a Senior Fellow and Research Director at Bill Moyers Journal and the Schumann Center for Media and Democracy. This article is excerpted from the original article and is reproduced with the kind permission of the Huffington Post Investigative Fund (<http://huffpostfund.org>).

Only later did she learn that she had made herself all but uninsurable.



As the Investigative Fund reported in September, health insurance companies are not required to make public their records on how often claims are denied and for what reasons.

Susan Pisano, spokeswoman for the health insurance industry's largest trade group, America's Health Insurance Plans, said insurers do not discriminate against victims of sexual assault and ordinarily would not even know if a patient had been raped.

"These issues you are bringing up, they deserve to be brought up," said Pisano. "People who have experienced rape and sexual assault are victims and we want them to be in a system where everyone is covered."

Turner's story about HIV drugs is not unusual, said Cindy Holtzman, an insurance agent and expert in medical billing at Medical Refund Service, Inc. of Marietta, Georgia. Insurers generally categorize HIV-positive people as having a pre-existing condition and deny them coverage. Holtzman said that health insurance companies also consistently decline coverage for anyone who has taken anti-HIV drugs, even if they test negative for the virus. "It's basically an automatic no," she said.

Pisano, of the insurance trade group, said: "If you put down on a form that you are or were taking anti-HIV drugs at any time, they [the insurance companies] are going to understand that you are or were in treatment for HIV, period," she said. "That could be a factor in determining whether you get coverage."

Some doctors and nurses said that the industry's policy is not medically sound. "The chance of a

"What are we supposed to tell women now? Well, I guess you have a choice - you can risk your health insurance or you can risk AIDS. Go ahead and choose."

Women International. "What are we supposed to tell women now? Well, I guess you have a choice - you can risk your health insurance or you can risk AIDS. Go ahead and choose."

Turner, now a life and casualty insurance agent, said she went without health coverage for three years after the attack. She second-guesses her decision to take the HIV drugs. "I'm going to be penalized my whole life because of this," she said.

Several women told the Investigative Fund that after being sexually assaulted they had been denied care or ruled ineligible for health insurance because of what were deemed pre-existing conditions stemming from their assaults—particularly posttraumatic stress disorder, or PTSD.

A 38-year-old woman in Ithaca, New York, said she was raped last year and then penalized by insurers because in giving her medical history she mentioned an assault she suffered in college 17 years earlier. The woman, Kimberly Fallon, told a nurse about the previous attack and months later, her doctor's office sent her a bill for treatment. She said she was informed by a nurse and, later, the hospital's billing department that her health insurance company, Blue Cross Blue Shield, not only had declined payment for the rape exam, but also would not pay for therapy or medication for trauma because she "had been raped before."

Fallon says she now has trouble getting coverage for gynecological exams. To avoid the hassle of fighting



rape victim actually contracting AIDS is very low. It doesn't make any sense to use that as a calculus for determining who gets health insurance," said Dr. Alex Schafir, faculty instructor at Providence St. Vincent Hospital in Portland, Oregon.

Nurses who deal with sexual assault cases say the industry's policy creates a significant problem for those treating women who have been assaulted. "It's difficult enough to make sure that rape victims take the drugs," said Diana Faugno, a forensic nurse in California and board director of End Violence Against

“Insurance discrimination against rape victims will only further discourage them from coming forward to law enforcement and seeking medical help.”

with her insurance company, she goes to Planned Parenthood instead and pays out of pocket.

A New Mexico woman told the Investigative Fund she was denied coverage at several health insurance companies because she had suffered from PTSD after being attacked and raped in 2003. She did not want to disclose her name because she feared that she would lose her group health insurance if she went on the record as a rape victim. “I remember just feeling infuriated,” she said.

“I think it’s important to point out that health plans are not denying coverage based on the fact that someone was raped,” said Pisano of the insurance trade group. “But PTSD could be a factor in denied coverage.”

“That might not be a discriminatory action, but it certainly would seem to have a discriminatory impact,” said Sandra Park, staff attorney at the Women’s Rights Project at the American Civil Liberties Union. “Insurance discrimination against rape victims will only further discourage them from coming forward to law enforcement and seeking medical help.”

Even when patients have coverage, there are fundamental disagreements between insurance companies and doctors about what mental health treatment is medically necessary. The Investigative Fund spoke with doctors, psychologists, and licensed clinical social workers around the country who work regularly with victims of sexual assault. They said that their patients have been experiencing an increase in

delays and denials, particularly for talk therapy.

“There’s a lot of anger about this in the medical community,” said Dr. George Shapiro-Weiss, a psychiatrist in Middletown, Connecticut. “You don’t realize what an Alice in Wonderland web this has become.”

“A lot of my patients are being told that their treatment isn’t medically necessary,” said Keri Nola, an Orlando, Florida, psychologist, who said about 75 percent of her patients are victims of sexual violence.

Several therapists cited problems with managed care companies that specialize in mental health. Such firms generally work under contract with health insurers to hold down costs while still authorizing appropriate care.

Some therapists and patients said the managed care companies have cut off necessary treatment for sexual assault victims in the name of cost containment. “The companies are peppering them with questions about their symptoms, and about their histories, and asking, ‘Well, are you sure you really need therapy?’” said Jeffrey Axelbank, a New Jersey psychologist. “For someone who has been traumatized, it can feel like another trauma, and it makes the therapy less effective.”

Pisano, of the insurance association, said it was not fair to draw a larger pattern from such anecdotal evidence. “These situations are evaluated on a person-by-person basis,” she said. “There is nothing routine about this.”

Jim Wrich, a Madison, Wisconsin, consultant who helps employers evaluate the companies that manage their mental health care, said his work has made him wary of the industry. “This is absolutely routine - these denials,” Wrich said. “The default position is to reject care.”

<http://huffpostfund.org>

 creative commons

Resources:

For the original story and links to related stories:

<http://huffpostfund.org/stories/2009/10/rape-victims-choice-risk-aids-or-health-insurance>

To watch a video about a rape survivor’s attempt to obtain mental health services:

http://www.youtube.com/watch?v=wDDHScYy5PY&feature=player_embedded



WOMEN SERVICEMEMBERS

Face Sexual Assaults and Inadequate Health Care

One in three female servicemembers are sexually assaulted at least once during their enlistment.

This article is excerpted from a transcript of an interview that aired on November 11, 2009 between **Amy Goodman** of *Democracy Now!* and **Anuradha Bhagwati**, Executive Director of Service Women's Action Network, an advocacy group for women veterans. She is a former captain in the United States Marine Corps. It is reprinted with the kind permission of *Democracy Now!* (www.democracynow.org).

If the staff themselves are not trained in what military sexual trauma is. . . you're really subjecting a woman to the high possibility of further trauma.

AMY GOODMAN: Unfortunately, health insurance is just one of many serious problems vets face. Veterans account for up to a quarter of all homeless in the country. Up to one in five veterans of the wars in Iraq and Afghanistan suffer posttraumatic stress disorder. Vets face suicide rates double the national average.

Meanwhile, the rate of sexual assault within the military also exceeds that of the general population. A Pentagon report earlier this year found one in three female service members are sexually assaulted at least once during their enlistment. Sixty-three percent of nearly 3,000 cases reported last year were rapes or aggravated assaults. Despite what some have called an epidemic of military sexual trauma, the delivery of health care to women veterans remains grossly inadequate.

AMY GOODMAN: Start off by talking about the issues women face.

ANURADHA BHAGWATI: Alright. Well, one of the things that a lot of people don't realize is women make up 15 percent of today's military, so about one in seven soldiers are female. And the face of war has completely changed because of the conflicts in Iraq and Afghanistan. Women are being used on the so-called front lines every single day. And it's completely unprecedented. The Department of Defense did not expect this, going into these wars, that women would be virtually fully integrated into the military on the ground. And so, congressional policy hasn't yet caught up with what's playing out in these conflicts.

AMY GOODMAN: And here at home, the whole—the figures that I just laid out about what happens to women in the military, the level of assault, I mean, that is just astounding. Lay out what the figures are.

ANURADHA BHAGWATI: Right, it is astounding. Approximately one in three women are sexually assaulted. And I would say virtually every woman experiences some form of sexual harassment in the military. I think it's underreported, in part because women themselves are so ingrained and indoctrinated to sort of cope in an all-male environment, which is, on a daily basis, extremely abusive, whether that's verbally or physically, that, you know, in order to survive, say, a four-year tour in the military, you do have to put on a suit of armor that allows you to simply get by from day to day, you know, dealing with kind of the systemic, you know, verbal harassment, you know, pornography in the barracks, this type of thing.

And so, you know, that kind of trauma that results from, again, several years of what's likely verbal harassment and quite possibly sexual assault can lead to posttraumatic stress disorder, major depression, anxiety disorder, all of which are extremely debilitating conditions. So women who are coming out of the military, whether or not they've actually been in combat, been deployed overseas, are likely to suffer from various sorts of trauma. And, you know, any time a soldier experiences trauma, they're more likely to need help from an institution or a nonprofit coming out.

And the VA is completely—the Department of Veterans Affairs is completely overwhelmed, with veterans, in general, but again, they weren't prepared for this surge of women veterans coming back from these two conflicts, you know, that they are under-resourced in terms of female counselors, female mental health professionals, female physicians. And for women who have experienced trauma, it is often necessary that they be treated by female health professionals. You know, to walk into a VA hospital having been sexually harassed or sexually assaulted, it can be a nightmare for a woman veteran. You know, she is likely to not come back at all.

AMY GOODMAN: Why a nightmare?

ANURADHA BHAGWATI: Well, it's an all-male environment, which women veterans are used to, but a lot of the patients can harass, you know, their fellow women patients. The staff members—you know, depending on what hospital you go into, because some VA hospitals are—do treat women fairly well. The ones that I've been to do not treat women well. It's really hit or miss. So you're sort of—you're taking a risk by using VA facilities if you're a woman.

You know, if you have a child, there's no guarantee of childcare. You may have to travel several hours to reach a VA hospital.

But, you know, if the staff themselves are not trained in what military sexual trauma is, what the ramifications and consequences of sexual trauma is, what that looks like, the likelihood of having experienced it if you're a woman in the military, you know, you're really subjecting a woman to the high possibility of further trauma.

AMY GOODMAN: Anuradha Bhagwati, you testified before the House twice—the House Committee on Veterans' Affairs, Subcommittee on Disability Assistance and Memorial Affairs—last July. Talk about the examples that you used to illustrate what happens in the VA.

ANURADHA BHAGWATI: Sure. A lot of these units are not equipped to deal with women, so what you often find is that women are being forced to share facilities with male patients. So, in this particular example, an Iraq veteran was going through an extreme episode of PTSD, was feeling suicidal, and so she checked herself into a California VA hospital and was forced to share bathroom facilities with men, was forced to share a facility with a peeping tom, was told by a nurse practitioner that she had to eat with men or she wouldn't be able to eat at all, she wouldn't be given any food.

And that kind of treatment is all too common. You know, there's a real lack of privacy. You know, the VA is looking at having private female clinics in every single hospital, but that's—you know, that's years down the road. It's really up to individual VA managers to make that happen on the ground.

AMY GOODMAN: You also described to the House subcommittee a woman veteran from Afghanistan, single mom who was raped in theater [where the war is taking place].

ANURADHA BHAGWATI: Yes. I mean, that's also extremely common. You know, there were about 3,000 reported sexual assaults last year, which is an extremely low estimate. I mean, those were reported, which means that women and men who had experienced sexual assault went through the formal procedures to tell their chain of command. It's—

AMY GOODMAN: Say that number again. How many a year?

ANURADHA BHAGWATI: It was just over 2,900.

AMY GOODMAN: That's like nine a day?

ANURADHA BHAGWATI: Something like that. And what we believe is that it's about half of what is actually occurring. There are several reports that indicate that actual assaults are much higher. To actually report an instance of sexual harassment or sexual assault takes a great deal of courage, but not just courage, a lot of luck. It depends on your commander. It depends on your command climate. It depends on whether they're actually going to support you. And it's very likely that your commander will not just not support you, but further punish you or allow further harassment of you by the men and women in your command. So, you know, you're taking a lot of risk by reporting either sexual harassment or assault. Oftentimes you end up being the victim again. And you cannot transfer out of your unit just like that. You can't quit your job.

AMY GOODMAN: And the story of the woman who was raped in theater coming back to a VA facility for treatment?

... there were about 3,000 reported sexual assaults last year, which is an extremely low estimate. I mean, those were reported, which means that women and men who had experienced sexual assault went through the formal procedures to tell their chain of command.

ANURADHA BHAGWATI: Yes, I mean, that's one of many examples. You know, SWAN, Service Women's Action Network, the organization I direct, we have clients—we have legal services, pro bono legal services, for women veterans and male veterans who are victims of sexual assault. And it's very common for veterans who have experienced sexual assault or sexual harassment to just refuse to use the VA after a bad experience. Women under-utilize the VA, to begin with, whether or not they've been sexually traumatized in the military. There is, you know, a male bias in the VA, whether that's the actual hospitals or the benefits administration. For women, it appears that there is a male bias, especially when it comes to MST [military sexual trauma] claims. And we're actually working on pushing legislation through Congress right now.

AMY GOODMAN: Your final recommendations?

ANURADHA BHAGWATI: You know, trauma from military experience is extremely common. When you've been hurt by the military, you're less likely to trust the VA. It's extremely important that nonprofits who are serving veterans get the support that they need and that the civilian-veteran partnerships that are out there also get the funding that they need, because, you know, our government is not doing its job right now. We need to pick up the slack for them.

AMY GOODMAN: So you're recommending the support of nonprofits. What else, when it comes to veterans?

ANURADHA BHAGWATI: It's important to educate everyone involved in serving the normal local population that there are veterans here. They have very specific needs from military service, and unless we address those needs, we're going to see more indigence, more unemployment, more homelessness.

It's extremely important that nonprofits who are serving veterans get the support that they need. . .

Related Links

[Service Women's Action Network](http://www.servicewomen.org)
www.servicewomen.org

To see the full video version of this interview:

http://www.democracynow.org/2009/11/11/sexual_assaults_inadequate_healthcare_among_spate

**Department of Defense Task Force
On Sexual Assault
Submits Findings, Recommendations**

<http://www.defenselink.mil/releases/release.aspx?releaseid=13165>



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BEYOND THE FORENSIC EXAM

Consider These Resources for Survivors



- » Follow-up medical care for STI and HIV testing and treatment, and for Hepatitis B vaccine administration
- » Psychotherapy for survivors and secondary survivors - individual, group, family, or couples
- » Psychoeducational support groups
- » Developmental screening for children
- » Parenting classes to learn to respond appropriately to child behavior problems
- » Advocacy to assist with access to financial support for health care, such as the Crime Victims Compensation Program
- » Gynecological care to repair injuries
- » Obstetric care with extra support for pregnancy and postpartum issues triggered by abuse
- » Sex therapy to assist in overcoming sexual problems resulting from abuse
- » Accompaniment by an advocate to stressful medical appointments such as dentist or gynecological appointments
- » Dental care by a dentist skilled in managing anxiety and posttraumatic reactions (for children and adults)
- » Holistic health care that takes mind-body connections into account
- » Bodywork such as massage therapy to heal trauma-related suffering
- » Medical care for chronic illnesses that are exacerbated by stress and may be related to abuse histories
- » Substance abuse treatment
- » Alcoholics Anonymous, Al-Anon (for family members), Ala-Teen (for teens affected by a family member's alcoholism), Narcotics Anonymous
- » Pain management programs to deal with increased rates of chronic pain
- » Dietician involvement in eating disorder care or nutritional support
- » Medical social work to help clients find appropriate care or payment resources
- » Inpatient mental health, substance abuse, or eating disorder treatment
- » Culturally and spiritually appropriate healing rituals



**Do you know where to locate these resources in your community?
What else might survivors need?**

HOW ADVOCATES CAN ADDRESS The Long-Term Health Care Needs of Survivors

- 1.** Recognize that stress and trauma can contribute to a wide variety of long-term physical and emotional ailments.
- 2.** Identify providers in your community who provide sensitive, culturally relevant, knowledgeable medical and mental health care.
- 3.** Learn about challenges survivors face so you can provide adequate support. For example, pregnancy and the postpartum period are often very difficult for sexual abuse survivors.
- 4.** Educate survivors about the general connections between sexual abuse or assault and long-term consequences. Do not attempt to make the connection for or about a specific survivor – “Your migraines are probably caused by your abuse history.” This is inaccurate and is overstepping the advocacy role.
- 5.** Familiarize yourself with resource information, such as details about the Crime Victims Compensation Program and children’s health care initiatives.
- 6.** Inform local health care providers about these issues and communicate with them to increase their capacity to respond to survivors’ long-term needs.
- 7.** Work with survivors to consider the practical implications of addressing health care issues. For example, a client may need to carefully consider the health care insurance offered by potential employers when making job choices.
- 8.** Advocate on a local, statewide, and national level for adequate and appropriate care, financial support, and research to address the long-term recovery needs of survivors.

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*For information about becoming a member of WCSAP,
please e-mail us at wcsap@wcsap.org, or call (360) 754-7583.*

www.wcsap.org