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Development of a Sexual Assault Support Group for Female Rape Victims

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Abstract

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MS, Walden University, 2015

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Project Study Submitted in Partial Fulfillment

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Doctor of Nursing Practice

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Abstract

Survivors of sexual assault struggle to cope with subsequent psychological disturbances. The project facility was a rural hospital in the southwestern United States in which postasault care was initially provided, but survivors later returned to the emergency department. Support groups can be a powerful tool to alleviate long-term consequences of assault by helping individuals cope and improving socialization. This project used the social-ecological theory to explore whether a sexual assault support group would impact the progress of survivors toward improved social interaction, improved socialization, and decreased psychological disturbance. The purpose of the quality improvement (QI) project was the development of a sexual assault support group, based on the International Association of Forensic Nurses guideline to improve and expand health care services for survivors of sexual assault. The QI development was accomplished in conjunction with a team of local experts consisting of law enforcement, social worker, nurse, victims advocate and, a victim of sexual assault, who provided process evaluation regarding their satisfaction with the planning process through the completion of an anonymous, 10-question, Likert-type survey. A descriptive analysis of the data provided information that positively supported the development of the project. Project deliverables included the developed QI, a plan for later implementation, and plans for outcome evaluation through measurement of socialization, psychological disturbances, and emergency department visits. This project has the potential to achieve positive social change through improved quality of life for survivors of sexual assault

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Dedication

I dedicate this project to the women who have suffered a sexual assault and has fought back to defy societal odds. Those who are struggling and those who need help in coping with the stresses of sexual victimization. Additional, all those who give willingly of themselves to support victims of sexual assault.

Acknowledgments

My husband and son have been a tower of strength throughout my educational journey. Upon graduating with my Masters, they pushed me into pursuing my doctoral studies. Reminding me of the dangers of delaying when it comes to adult learning. I cannot forget the nights my husband sleeps on the sofa as a means of supporting me while I sit at my desk doing schoolwork. Although he would go out to work and is tired, he never fails to prepare a hot meal while I study. To my son, for being patient and for the times I could not attend a tennis match because I am writing a paper, thank you for your understanding. I would like to thank my Chair; Dr. Cassandra Taylor, committee member Dr. Dana Leach and all Instructors at Walden University, who supported and guided me on my journey throughout the course.

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Section 1: Nature of the Project

Introduction

Sexual assault is the act of sexual conduct or behavior without the consent of the recipient (United States Department of Justice 2016). Since 2005, sexual assault nurse examiners (SANE), at a rural hospital in West Texas, in the community of interest, performed more than 1,600 sexual assault exams, 912 for adults and 692 for children. However, the reports of sexual abuse are underreported (Bunting, 2014), as up to 91% of abused persons do not report the abuse (Busech-Armendariz, Olaya Kerwick, Wachter, & Sulley, 2015). From January to May of 2017, there were 85 exams in this West Texas hospital.

Sexual assault may lead to multiple physically, psychologically, and socially adverse effects in victims. Notable physical effects are unwanted pregnancies, sexually transmitted diseases, chronic gastrointestinal disorders, headaches, chronic pain, obesity, and gynecological complications such as genital injuries and cervical cancer (CDC, 2016). The vast array of social issues includes isolation, poor boundary identification, and lack of trust. However, the more gripping effect of the abuse is one that is not easily seen, that is the psychological effect.

Amongst these silent effects are post-traumatic stress disorder, anxiety, depression, shame, suicide ideation and attempts, decreased self-worth, and disinterest in sex (Centers for Disease Control and Prevention [CDC], 2016). A plethora of high risks behavior such as substance abuse, criminal acts, promiscuity, and eating disorders can also be seen in rape victims. Not only is the victim's health at risk, but the nation's

healthcare costs are negatively affected. Billions of dollars are spent each year in the United States to address the issues associated with rape. In 2011, the estimated cost of care per rape victim was $151,423 (National Alliance to End Sexual Violence [NAESV], 2011). Additionally, the psychological issues faced by these victims cannot be resolved until proper treatment is established (CDC, 2016). Despite the high prevalence of assault and multitude of victims, no support group exists in the area to assist these victims in coping or recapturing their lives. In this project, I developed and planned a sexual assault support group, including the policies and procedures for the group. The support group resulting from this project has the potential to facilitate positive social change by promoting improved coping among survivors and reducing their post-assault complications, thus improving their quality of life and reducing costs to society.

Problem Statement

There is a high prevalence of sexual assault in the community, yet no support group exists to assist the victims. Over 6.3 million Texans have been affected by sexual assault (Busch-Armendariz, 2015). Rape is a crime not only against the individual but also against families and society. Sexual assault has many consequences including sexually transmitted infections and clinically diagnosable illnesses such as post-traumatic stress disorder (PTSD), substance abuse disorders, significant depression, and other mental health issues (Chen & Ullman, 2016). Women who have been abused sexually have a greater prevalence of long-term health concerns such as physical disabilities, breathing problems, and mental health conditions including depression and anxiety (Santaularia, 2014). Multiple victims of sexual assault received forensic examinations at

the project facility followed by referral to other agencies for continued or follow-up care. Although the SANE has no further contact with the victims regarding the assaults, some of these victims are later seen in the emergency department on multiple occasions for issues such as drug use, anxiety, and PTSD. One identifiable problem is that there is an increase in the number of sexual assault victims returning to the emergency room with problems such as anxiety, depression, drug use, suicidal ideations or attempts, self-mutilation, and associated symptoms. Additionally, some victims are re-victimized and have returned for another SANE exam. Resources for sexual assault victims in the area are limited, and the project hospital is the only non-profit hospital serving twenty-two counties.

Sexual promiscuity, substance abuse, and other at-risk behaviors are commonplace among victims, thus increasing the prevalence of sexually transmitted diseases in this population (Fry, McCoy, & Swales, 2012). The primary community of interest has a population of 117,000 people, and the surrounding counties have a combined population of close to 53,000. In 2017, there have been more than 250 reported cases of sexual abuse that were seen by a SANE. The cost to both State and local government, to address these problems is significant. The SANE exam can cost up to thousands of dollars in addition to costs for follow-up care and time lost from work. Busch-Armendariz et al. (2011) reported that sexual assault crimes cost the state of Texas up to $8 A positive correlation between sexual aggression and suicide have been seen by researchers (Fry, McCoy, & Swales, 2012). Additionally, women who were sexually abused as children were more likely to develop a major depressive disorder, and to

attempt or commit suicide (Saaniva et al., 2011). Tomasula, (2012), identified a high prevalence of attempted suicide in students who were raped versus students who were not sexually assaulted. Chen and Ullman (2014) revealed the connections between sexual abuse and abuse of drugs and alcohol. This rural community does not have the tools available to assist victims with mechanisms to cope with the ramifications of the abuse in order to recapture their lives.

Purpose

Support groups provide a safe environment for victims to process their abuse and to transition from the trauma to recovery. Support groups play a pivotal role in enabling the survivors to develop trust and healthy relationships in and out of the group by sharing of common experiences, thereby decreasing feelings of isolation. Some survivors report the positive influence of support group in helping them gain the courage to feel stronger and obtain a sense of self (Abercrombie, 2012). Although not a substitute for individual counseling, support groups complement the counseling process, allowing victims to re-establish trust, build support networks, and develop healthy relationships in a safe, cathartic environment, which lessens psychological and emotional effects that would otherwise interfere with activities of daily life (Abercrombie, 2012).

Rape is not just a national problem, but affects people globally. The U.K. National Guidelines on the Management of Adult and Adolescent Complainants of Sexual Assault (British Association for Sexual Health & HIV [BASHH], 2011), includes recommendations for support of sexually abused patients. Patients with psychological problems related to the abuse who are having ongoing psychological issues following the

assault with continued difficulties should be referred to an health advisor, counselor, or other medical personnel for counseling or psychological treatment (BASHH, 2011). The guidelines further recommend that providing support to all persons who have been sexually assaulted may play an integral part in their recovery (BASHH, 2011). Prior to this project, no support group was available at the project site despite evidence that demonstrates the value of a support group. The gap in practice, therefore, is that there was no support group available in this rural community. Having a support group will not only fill the gap but will play a pivotal role in the healing process.

The International Association of Forensic Nursing (IAFN,2016) protocol highlights the value of offering ongoing support, counseling, and community referrals to victims of sexual assault. The purpose of this quality improvement project was to use evidence-based practice guidelines to develop a sexual assault support group for rape victims. The organizational level practice-focused question I developed to address the issue was: In women who have been sexually assaulted and receiving care at a rural West Texas hospital, how does adding a local sexual assault support group to care provision impact the progress toward improved social interaction, and decreased psychological disturbances such as PTSD symptoms as measured six months post-implementation, when compared to the current standard of care no support group?

The goal is to improve social interactions, improve socialization, and decrease psychological disturbances such as PTSD in adult female victims of sexual assault. Support groups bring together individuals who are facing similar issues—whether these

matters are illness, relationship problems, or major life changes—to mitigate their suffering (Ferreira Santos et al., 2012). Victims in this rural community have prolonged recovery from the trauma, including issues with normal socialization and resolving psychological problems. A support group in this rural community will, therefore, be an asset to its people.

Nature of the Doctoral Project

I analyzed practice guidelines on the management of sexual assault to identify evidence relevant to the development of the support group (BASHH, 2011). Further, I conducted a review of scholarly articles on sexual assault and its impact on the patient, which assisted in formulating a plan of action to help these victims of sexual abuse through a support group. Information regarding state sexual assaults provided details on the impact of sexual abuse on the patient. The IAFN, the World Health Organization (WHO), and the CDC provided a wealth of information including recommendations that I used to design the support group.

I assembled a team of experts including SANEs, law enforcement representatives, victim support workers, and healthcare providers to provide feedback regarding the planning phase for the support group. I discussed the plan with team members to garner their feedback and to identify further strategies for the program's development. I then revised the plan to incorporate their feedback. Another meeting followed, where the revised plan was discussed and finalized. Their input served as an additional source of evidence of need for the support group. I then proceeded to develop the mission and vision of the support group.

Significance of the Project

Stakeholders to this project include victims of sexual assault, SANEs, those working in law enforcement, victim support workers, victims' advocates, organizations in support of victims (such as the child advocacy center and the Noah project), nurses, and social workers. The rape crisis center will also play a crucial role in the support group as a referral agency for members of the support group who developed a crisis during a support session. The child advocacy centers in the surrounding communities will play a pivotal role in offering training for facilitators and referrals of patients to the support group. The child advocacy center also provides counselors and trainers that may be used as group facilitators. Additionally, the Noah project is an organization in the community that provides services to battered women, including those who have been sexually abused. The organization will be available to provide a home for those victims who were fearful of seeking the support they needed because of being involved in a volatile relationship. In addition, the Noah project assists women in regaining their self-esteem by helping them in finding a part-time job to assist in meeting their basic needs.

The rape crisis center plays a crucial role in providing support for women who are observed to be needing additional help not provided by the support group. A patient who is seen with a complaint of sexual abuse is cared for by the SANE, who often develops a rapport to put the patient at ease. A general physical assessment is performed by a physician to ascertain if other medical issues are present and to evaluate if the patient is safe to undergo the forensic examination. Police officers are stakeholders because they are the ones who may have the first encounter with the victim. Educating the officers on

the importance of a SANE and the value of a support group may help with providing the care needed by the patients. Each of these stakeholders can play a role in an interdisciplinary team working together to assist patients in reconnecting with their former way of life.

Although not all assaults present the same, there is always a nurse present providing care. This quality improvement doctoral project is significant to the field of nursing as it addresses an issue that is of high public health significance. Nurses are sometimes the first who interact with patients following the abuse. The nurse must ensure that a physical assessment is done to rule out other serious medical issues, as sexual assault is sometimes associated with other trauma such as strangulation or insertion of a foreign body in the orifices. Insertion of a foreign body to the vagina may not be seen but can easily result in internal bleeding and subsequent death. The nurse takes a detailed history from the patient and performs a physical assessment, which often reveals the trauma. Such extreme physical trauma can result in the patient having difficulty forming a healthy social relationship, or the development of a psychological break such as is evident in PTSD.

Acute care provided after sexual assault is short-lived, and the patients must go home to deal with the aftereffects of the trauma. A support group has the potential to achieve positive social change through reduction of complications following sexual assault in women between the ages of 18 and 65 years old. Women who are sexually abused may be reluctant in seeking out help. Living with the trauma results in development of anxiety and other psychological complications (Walsh & Bruce, 2014).

Supporting victims of sexual abuse can help with their recovery (Wilson & Scarpa, 2014). Additionally, group therapy plays an integral role in patient rehabilitation and the prevention of isolation through improved interpersonal relationships (Brown, Reyes, Brown, & Gonzenbach, 2013). Providing the support needed is a crucial part of minimizing further psychological setbacks and improving social outcomes (Rahm, Renck, & Ringsberg, 2013). The implication for positive social change are considerable given that rape victims can develop coping skills to address socialization issues, drastically minimizing the chances of developing psychological and psychiatric illnesses and reducing the amount of money spent in caring for the numerous complications associated with sexual trauma.

Summary

Sexual assault can lead to multiple physically, psychologically, and socially adverse effects in victims. Although patients are seen and examined by a sexual assault nurse at the rural hospital in the southwestern United States, they continue to have issues with coping and socialization. The rural hospital does not have the tools necessary to assist the community in dealing with the ramifications of the abuse. There is a high prevalence of sexual assault in the community, yet no support group exists to assist the victims. The identified gap in practice therefore, is that there is no support group available in this rural community. Having a support group may play a pivotal role in the healing process. The purpose of this quality improvement project was to use evidence-based practice guidelines to develop a sexual assault support group to assist victims of sexual trauma. The goal of the project is to improve social interactions, improve

socialization, and decrease psychological disturbances such as PTSD in adult female victims of sexual assault.

Section 2: Background and Context

Introduction

The practice problem I addressed is the lack of a sexual assault support group in the community, despite evidence that such a group would be beneficial. The purpose of this quality improvement project was to use evidence-based practice guidelines to develop a sexual assault support group for rape victims. The goal of the project is to improve social interactions, improve socialization, and decrease psychological disturbances such as PTSD in adult female victims of sexual assault. The support group will assist victims of sexual assault in dealing with social interactions and problem-solving, thereby preventing the cycle of abuse (see Brown, Reyes, Brown, & Gonzenbach, 2013)

Another significant aspect of support groups is that they minimize isolation. Although not a substitute for individual counseling, they complement counseling, allow victims to re-establish trust, build support networks and develop healthy relationships, and provide safe environments for cathartic release that can assist in lessening psychological and emotional effects interfering with activities of daily life (see Abercrombie, 2012). Despite the wide array of benefits of a support group, in this rural community hospital in the southwestern United States, there is no support group for the victims of sexual assault. Support groups bring together people facing similar issues—whether these matters are illness, relationship problems, or major life changes—to mitigate their suffering (Ferreira Santos et al., 2012). A support group in this rural community will, therefore, be an asset to its people.

In this project, I addressed the gap by using evidence-based guidelines and literature to develop plans for a support group in the rural community hospital setting for women between the ages of 18 and 65 years old who have been sexually assaulted. In the following section, I discussed the model that was used to guide the development of this quality improvement (QI) project, the relevance of the project to the nursing practice, background, and context as well as information about the DNP student.

Social Ecological Theory

I developed this QI project using the social ecological theory. The theory was developed in the field of psychology but has also been used in nursing. The model guides the translation of theory to practice by addressing various levels of social and societal norms and behaviors related to socioeconomic, political, environmental, behavioral, and psychological areas (Whittemore, Melkus, & Grey, 2004). The model originated with Bronfenbrenner (1999), who described the evolving relationship between children and their environments during their growth and development.

Community psychology emerged in the early 1960s when psychologists recognized that more than one-to-one therapy was needed to assist patients. Psychological help was then offered to individuals and groups in the community setting; however, more was needed. Thus, the ecological model was developed on the theory that changes in behavior can occur with changes in environment or social and organizational relationships (Visser, 2007).

The core principles of the social ecological theory have been used to develop guidelines for designing and evaluating community health programs (Stokols, 1996).

The theory provides a clear outline of the various aspects of situations that influence the individual's reaction to problems. The five elements of the theory consist of an intrapersonal, interpersonal, institutional, community, and, public policies; which I will discuss further in this paper (Whittemore et al., 2004).

Assessing the beliefs of the victims and relating those beliefs to social norms plays a fundamental role in the development of a support group. In this project, the social ecological theory played a vital role when addressing sexual revictimization. Researchers have found that individuals who experience multiple interpersonal traumas have significantly higher psychological distress (Pittenger, Huit, & Hansen, 2016). The theory was used by Douglas (2015), in predicting other forms of abuse in children. Although I focused on adults in this project, I refer to some children cases as, most adult victims are abused as children. Thus, it is important to include the social ecological theory. The CDC (2015), has used the model to understand the reason for violence toward children so that preventative strategies could be developed.

Relevance to Nursing Practice

According to the NAESV (2011), criminal violence costs the United States $450 billion each year. Rape is the most expensive, costing around $127 billion annually, or about $151,423 per rape victim. The American Association of Colleges of Nursing (AACN, 2006) DNP Essentials Competency 6 speaks to the collaboration of various professionals for improving patient and population health outcomes. This QI project aligns with the competency given its focus on helping victims of sexual assault to reintegrate with society. In a comprehensive literature review, Pittenger, Huit, and

Hansen, (2016), discussed the impact of sexual assault on the survivor; including the consequences of PTSD and revictimization. Patients who were sexually victimize needed support to continue functioning in society. Having a sexual assault support group reduced the number of hospital visits, the number of suicides, revictimization, and future abuse from individuals who were once abused (see Pittenger, Huit, & Hansen, 2016). Basile et al. (2016), found that support groups also played a pivotal role in improving outcomes for survivors and mitigating long-term negative health consequences. I reviewed evidence on how to care for and support victims of sexual assault and identified three distinct stages. One of these stages involves victim-centered services. These types of services focus on providing support to victims based on their needs and circumstances. The approach is in line with the evidence indicating the need for and importance of support to this vulnerable population.

Trauma histories also influence women's recovery after sexual assault. Ullman, Peter-Hagene, and Relyea, (2014), gathered data from 1863 women from varying backgrounds who were sexually assaulted and had complications of PTSD and/or depression to determine the relationship between the attack and the symptoms. The sample was divided into two groups, with 658 of the women received some counseling post sexual assault and 1188 received no therapy. Results demonstrated a significant association between a history of assault and later PTSD or depression. The women who received counseling had better adaptive skills than those not receiving therapy, indicating that emotional treatment may reduce complications associated with sexual abuse.

Sexual assault of children is often perpetrated by family members who have easy access to children who are dependent on the perpetrator for their survival. While some child victims overcome their tremendous fear and report the abuse, others do not take that step until reaching adulthood. Consequently, research concerning childhood assault provides relevant information that can assist in the development of policies and protocols for adult support groups. In a 2-year population-based study, Bunting (2014), analyzed patterns of abuse and outcomes among 2194 sexually abused children. Only about 19% of the sexual abuse was reported, possibly because other victims are unaware of the resources available in their communities. To bring about an awareness and minimize the various complications of sexual assault, a support group may play a fundamental role in assisting these victims.

Dworkin and Schumacher, (2016), in their systematic review of the role of early intervention following sexual assault, described how the attitudes of various members of society impact the patient who has been sexually assaulted and how the interactions can result in post-traumatic syndrome up to a year following the assault. Positive interactions with others in formal or informal relationships were shown to play a key role in minimizing the long-term effects such as PTSD, making them crucial to the patients' long-term recovery.

Numerous researchers have outlined the deleterious effects of sexual assault and the impact of support on the affected population. The facilitation of a sexual assault support group provides a comprehensive level of non-medical care that complements the medical treatment offered by the hospital (see Basile et al., 2016). The IAFN and the

United State Department of Justice provide valuable evidence in their protocol of the need for support for those who have been sexually victimized. Persons who have been sexually abused are provided with an advocate at the time of their examination as well as throughout their ordeal with law enforcement and the court system when necessary. One of the guiding principles from the IAFN is the provision of a person-centered approach to care, in which the individual will be provided information regarding community resources of needed support. A victim-centered approach is also used to address the victim's needs, improve their outcomes, and minimize the chances of the patient developing long-term psychological and or behavioral consequences. The gamut of psychological effects of sexual trauma does not end after the abuse. The evidence-based victim-centered approach includes formal services such as support groups, crisis intervention, medical and legal advocacy, and access to community resources that improve survivor outcomes and mitigate long-term negative health problems. IAFN has identified a need to improve and expand health care services for survivors of sexual assault.

In a research paper done by Campbell, (2016), to determine the design and need for support for victims of sexual abuse; a comprehensive survey was carried out concerning the needs of a New Zealand community regarding sexual assault. Campbell noted that the number of reports of sexual assault in the community and of victims seeking support following rape was significantly high, with 4056 reported cases of sexual abuse identified in 2014. Persons who were raped presented with numerous health problems following the abuse. The researcher identified the numerous impacts of rape

and how a support group assists in minimizing the psychological trauma experienced by the victims by helping victims gain control over their bodies and the decision-making process. Support groups also assist victims by preventing or reducing isolation and giving them a sense of belonging while providing mutual support through meeting with others who understand the experience and can offer suggestions for coping. Additionally, support groups can assist the victims to gain acceptance, empathy, and encouragement from others. Campbell thus showed a positive correlation between support groups and advocacy in attenuating the effects of sexual trauma.

Victims who endure sexual assault experience a gamut of emotions that is sometimes not understood by the victim themselves or their healthcare providers (Bonugli, Brackley, Williams, & Lesser, 2010). Price, Davidson, Ruggiero, Acierno, and Resnick, (2014), examined the attitudes of 266 female sexual assault victims toward seeking psychological support for distress related to their sexual assault. Depression was shown to be a factor associated with seeking help, and seeking help was associated with experiencing relief of negative symptoms.

Other factors such as the stigma of the assault, culture, and racism, may prevent the patient from seeking needed help from a formal institution. However, knowing that there is a group that they can attend without the pressure of revealing their assault as well as having a group of individuals' who have experienced a similar trauma, can help the patient to know that they are not alone. Bryant-Davis et al., (2015), in their yearlong study, examined the differences in the use of religious and social support and how each benefitted 252 African-American sexual assault victims. In a previous study, researchers

established through a survey that African American women were more likely to have reduced symptoms of PTSD if they use a support group. A follow-up was done 1 year later to gain an understanding of the impact of social support versus religious support in helping the survivor to cope. The authors defined social support as a component of support from either formal or informal source. Formal support includes law enforcement, medical support, and mental health providers, whereas informal support includes family, significant others, and neighbors. The result was that there was a strong correlation between high levels of social support and the prevention of PTSD.

Brown (2013), m contended that there is an oversimplification of trauma and that these victims need support to help them heal. Group treatment plays a pivotal role in the healing process because it contributes to the empowerment of the survivors. Brown studied 31 female incest survivors using two scales to determine the efficacy of group therapy. Participants were assessed initially and 12 weeks later to ensure enough time was given for changes to be apparent. Participants showed improvement in several scores following the group therapy. Included in the group treatment was support for the victims to explore their feelings and connect their thoughts to the source of the problem thoughts. In addition, victims were supported by group members with similar thoughts and feelings. Participants' hope and confidence improved as their therapy progressed.

Rahm (2013), investigated how participants in self-help groups benefited from the support and their reason for joining the group. 87 adult females with a median age of 35 and with a history of childhood sexual abuse were studied. The participants were at high risk for PTSD, based on results obtained from the SCL-90-R measure (The Swedish

normalizing constant, standardization and validation of the symptom rating scale). The women lacked social support and were vulnerable to various mental health problems. Data were collected over a period of five years from 18 self-help groups, demonstrating that 86% of the participants stated their reasons for joining the group was to meet other women with similar issues whom they could talk with and who would understand what they were going through. The participants further reported that the support group played a key role in their mental health through reduction of psychological symptoms.

Stappenbeck, Hassija, Zimmerman, & Kaysen (2015), conducted a study on a random sample of 11544 undergraduate students, including 264 who had a history of sexual assault. Data collected for 2494 days revealed that women who were sexually abused and had problems with coping resorted to drinking alcohol. Moreover, women who were sexually assaulted and received no social support consumed more alcohol than those who had. Those with less coping control had an increase in the number of drinks consumed by 9% for every 1-point increase in sexual assault-related distress. Clinicians are encouraged to assist these vulnerable women in identifying elevated levels of distress and seeking social support to reduce drinking on those high-risk days.

There are numerous reactions to a rape victim when they speak up about the assault, leading some victims to internalize their pain. Schönbucher, Maier, Mohler-Kuo, Schnyder, & Landolt (2014), conducted a qualitative study of 26 adolescents who were sexually assaulted, to gain an understanding of their views of support. The participants revealed that although they received parental support in some instances, the support from their peers was more beneficial in preventing psychological symptoms. One participant

was grateful for the support and found the support group to be an avenue where 11 years after the assault he could discuss the trauma and start the healing process. Other victims were challenged by their parents' response specifically if the abuse was by a partner or family member.

Practice guidelines (BASHH, 2011), based on a review of research related to the care of the patient who has been sexually traumatized recommend confidentiality, legal framework, sexual assault referral centers and psychosocial support, to name a few. The guideline recommendations include offering emotional support to anyone who has been sexually assaulted. Having a support group is crucial to closing the gap of no support group in the community.

Local Background and Context

Current practice in caring for patients in the project facility involves a SANE exam and the administration of prophylaxis medication. The patient is then sent home and advised that if they are experiencing other issues to visit the local health center or their primary care physician. During the SANE exam, an advocate from the Regional Victims' Crisis Center (RVCC) is available. The advocate discusses their role and informs the patient that if they need further assistance, they can be contacted. A business card is then given to the patient.

The project site is a not for profit 522 beds community hospital that has a Sexual Assault Nurse Examiner (SANE) program serving 22 counties. It is the only hospital in this rural community and surrounding areas that offers this program. The mission statement of the hospital is to provide care that is Christlike and care of a high quality

irrespective if patients are funded or unfunded. In 2014, there was a 143% increase in the number of cases attended to by the SANEs. In 2017, over two hundred and fifty exams were performed. Unfortunately, the problem does not seem to be improving. The increase in the number of assaults means either an increase in the victim pool or repeated offenses on the same victim. Very little is known about the outcome of the patients after the incidence. SANEs who work in the emergency department reported seeing some of the victims visiting the hospital for problems that are likely to be related to the rape trauma. For example, there is an increased incidence of "self-mutilation," prostitution, and drug overdose in the victims. All these problems were suspected as being effects of sexual assault and supports the purpose of this project to develop a support group for these survivors.

Numerous organizations exist that provide some form of care for these vulnerable individuals. The RVCC is a nonprofit organization that provides advocates for assaulted victims. These advocates are trained counselors who assist with filling out documents for reimbursement for hospital visits, locate safe places for victims following the attack, accompany victims to follow up appointments and offer 24-hour crisis availability.

Another organization that plays a pivotal role in helping victims of sexual assault is the child advocacy center (CAC). Although the focus of the project is a support group for adult females, the CAC plays an integral role in helping children who are abused. It is imperative to remember also, that the children who are abused, later are the ones presenting with psychological issues and suicidal ideations (see Fry, McCoy, & Swales, 2012; Ullman, Peter-Hagene, & Relyea, 2014). The CAC also provides sponsorship to

other local organizations working towards helping victims of abuse. The goals of the QI project are to assist victims of abuse in dealing with social interaction and problem-solving to improve the utilization a support group to improve social interaction and socialization, and, decrease the development of psychological disturbances such as PTSD in adult female victims of sexual assault. The mission of the CAC is to prevent child abuse. Both the CAC and RVCC are working in line with the QI project as the development of the support group not only offer additional support to the victims but in addition to formal counseling and treatment can prevent the survivors of assault from becoming abusers thereby reducing the devastating impact that abuse has on society.

Having an opportunity to conduct the project at the hospital will aid in assisting those in need of support following sexual assault. Also, staff members have voiced the need for support as they have been victims of abuse. The project site and population have a need for this project as it will provide interventions that address the gap in the practice of no support group.

Definition of Terms

Support group: A group of people with common experiences or concerns who provide each other with encouragement, comfort, and advice (Rahm, Renck, & Ringsberg, 2013).

Sexual Assault: Sexual conduct or behavior without the consent of the recipient (United States Department of Justice, 2016)

Effects of Sexual Assault: longstanding psychological and emotional problems affecting the victim and others directly involved with the victims (The Sloan, 2016).

SANE: Sexual Assault Nurse Examiner are registered nurses who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse (IAFN, 2017)

RVCC: An advocate who supports the patient/victim and help them to cope with the current situation. These advocates also accompany the patient to appointments relating to the assault and provide some assistance with financial reimbursement (Regional Victims Crisis Center, 2015).

In addition to the definitions, the state of Texas recognizes the impact of sexual assault on the community. Senators authored the bill "the Justice for All Reauthorization Act of 2013" (Congress.Gov, 2013). The bill that was approved by the Senate committee helps in providing law enforcement with necessary resources to protect victims of sexual abuse (Congress.Gov, 2013).

Role of the DNP Student

In my current position, I wear three hats. I am a clinical educator, clinical coordinator, and an assistant manager. I am also a SANE. Wearing those many hats provided me with the opportunity to identify issues or problems in the work setting that may need to be addressed. As a leader I can play a key role in the development of the organization through understanding and development of goals, using persuasion and communication to share the vision and values of the organization. Logic is also needed when dealing with others (Marker, 2010). Making any change in an institution is a mammoth task. Having an in-depth knowledge of the problem and possible solution is imperative if the change to the organization is to be effective.

In training to become a SANE, I was precepted by other SANEs, including the coordinator of the SANE program; as a result, I was able to observe patients and their coping mechanisms, when dealing with issues of sexual assault. Also, I could witness, firsthand the consequence of sexual abuse on the survivor. Another factor is that I have a personal interest in sexual abuse and, have personally seen the short and long-term effects of sexual assault when the individual does not receive counseling recognizing the number of patients returning to the hospital with varying psychological complaints following the initial sexual assault. I took the opportunity to speak with the coordinator, and a collaborative decision was made, following discussion with the SANE coordinator that there was a great need for a support group for survivors of sexual assault. The idea was initially explored, and then developed and presented to the hospital administration for approval. The hope is that an avenue can be created where victims of sexual abuse can meet and receive support in a non-judgmental environment thus enhancing the care of patients who are victims of sexual assault.

One potential bias that I may have is that I am a victim of sexual abuse. I was assaulted for over a decade before escaping the situation. My assault was kept in secret. As a result, I did not receive the counseling or support that was deemed necessary to alleviate some of the psychological issues associated with the abuse. However, I believe that my previous experience adds strength to my project. Input from a multidisciplinary team provided guidance from an objective point-of-view during this project, which helped to minimize the effect of individual bias.

Role of the Project Team

The development of this project meant working with others to achieve the goal and fulfill the purpose of the project. A collaboration of various members of the multidisciplinary team were drawn from the facility's established team that routinely meets twice per month. The result of the literature review, and the proposed draft of plans for the support group were presented to the team for their feedback and suggestions. The team was encouraged to ask questions, clarify points and define the appropriateness of the information presented.

Team members include nurses who interact with survivors and are often the ones who answer relevant medical questions. The facility social worker gave the team expertise into resources and aid from a community perspective. The hospital counselor helped the team to understand the process of referral for follow up counseling. Law enforcement provided the team with knowledge of the legal process and victim rights.

The team of experts also included counselors from local agencies such as Noah Project, provided insight into counseling options outside of the project facility. A rape victim who has received the benefits of a support group and one who has not received the benefits of a support group were included as they provided valuable insights into the needs of the group participants. These survivors were recruited for the team based on their history of being sexually assaulted, and their willingness to participate in the project.

Summary

There are several effects of sexual assault for which a sexual assault support group may provide a substantial improvement when used with other treatment programs. Literature was presented that demonstrates that support groups have improved outcomes in sexual assault survivors.

This section of the project looked at the theoretical concepts relevant to guide narrowing the gap in practice. The following part of the project will re-evaluate the problem focused question and discuss various sources of evidence to be employed in the development of the project.

Section 3: Collection and Analysis of Evidence

Introduction

There is a high prevalence of sexual assault in the project community, yet no support group exists to assist the victims. Over 6.3 million Texans have been affected by sexual assault (Busch-Armendariz, 2015). Rape is a crime not only against the individual but also against families and society. The purpose of this QI project was to develop a sexual assault support group assist victims of sexual trauma, with the goal to improve social interaction and socialization, and decrease psychological disturbances such as PTSD in adult female victims.

Sexual assault can have long-term effects on psychological well-being, increase the risk for later sexual violence, and lead to other problem behaviors (Basile et al., 2016). There is a positive correlation between sexual aggression and suicide. Following SANE exams at the rural hospital, some victims have been referred to other agencies for continued or follow-up care. Although the SANE has no further contact with the victim regarding the assault, some of these victims are later seen in the emergency department on multiple occasions for issues such as drug use, anxiety, PTSD.

Support groups provide a safe environment for victims to process their abuse and to transition from the trauma to recovery. Support groups play a pivotal role in enabling the survivors to develop trust and healthy relationships in and out of the group. Through the sharing of common experiences, some survivors report the positive influence of support group in helping them gain the courage to feel stronger and obtain a sense of self. The articles I reviewed showed the benefits of support groups to victims of sexual

assault. In this section, I present the practice question, discuss sources of evidence I reviewed and analyzed to determine the relevance of the doctoral project, and offer a summary of the findings.

Practice Focused Question

The identifiable problem is that there is a high prevalence of sexual assault in the community, yet no support group exists to assist the victims. Over 6.3 million Texans have been affected by sexual assault (Busch-Armendariz, 2015). Increased numbers of sexual assault victims return to the emergency department with problems such as anxiety, depression, drug use, suicidal ideation or attempts, self-mutilation, and symptoms of PTSD. The practice focused question was: In women who have been sexually assaulted and receiving care at a rural hospital in the southwestern United States, how does adding a local sexual assault support group to care provision impact the progress toward improved social interaction, and decreased psychological disturbances such as PTSD symptoms as measured six months post-implementation, when compared to the current standard of care no support group?

The purpose of the project was to use evidence-based practice guidelines to develop a sexual assault support group to assist victims of sexual trauma. The purpose is relevant because it is only through the development of the group that the answer to the question can be ascertained.

Sources of Evidence

Sources of evidence for this QI project included input from experts in sexual assault, and literature explaining sexual assault and the effects following the trauma. To gather materials for the literature review, I searched CINAHL and Medline databases. Key search terms included *rape, sexual assault, sexual abuse, sexual violence, sexual assault support group, support group,* and *rape trauma*. I collected evidence from peer reviewed scholarly journals, the United States Department of Justice, the CDC website, and the IAFN website. I limited database searchers to peer reviewed materials published between 2010-2017 that were relevant to females over the age of 18 years and below the age of 65 years.

Other sources of evidence included feedback from stakeholders or involved parties such as SANES, law-enforcement, advocates, and emergency room nurses. I developed a draft of the support group plan and presented it to the team members. Included in the draft was the background of the problem, the group objectives, plan of approach, estimated costs, suggested meeting venue, how often the group will meet and the resources that will be offered. I also developed and presented policies for the group and a memorandum of understanding (MOU) for group members (see Appendix G). The MOU explains that the medical record of the participants will be accessed within 1 year following their participation in the support group to evaluate the benefits of the group. I presented topics for support group discussion to the project team members for their approval.

The project team met on a biweekly basis, and I presented and the team discussed first draft at the initial meeting. Feedback and input garnered were used in revising the draft, which I then submitted to the team for revision and approval at the second meeting. The project team developed the sexual assault support group plan and associated documents.

The format of the support group meetings will be a 30-minute educational session where topics such as healthy boundaries, blame game, plan of action, after the abuse, and guilt and shame can be discussed under the guidance of group facilitators. The group facilitators are counselors from the RVCC, nurses from the hospital, and a social worker. Following the session, participants will be dispersed into small groups for further discussion, with a facilitator for each group.

Although this project was limited to planning the program only, I developed implementation and evaluation plans to be used when the facility decides to start the program. Screening tools used to determine PTSD, anxiety, depression, and social isolation such as the Clinician-Administered PTSD Scale or the self-administered questionnaire scale (Foa, Cashman, Jaycox, & Perry, 1997; Weathers, Blake, & Schnurr, 2015) were evaluated by the team during planning. Upon complete development of the program, project deliverables were handed over to the facility. These deliverables included all materials needed for the support group, a workbook for group participants (see Appendix H), an implementation plan, and a plan for program evaluation. There are several workbooks available for purchase designed to help victims of sexual assault recover. I have suggested that the support group use the workbook *Resurrection After*

Rape. A copy of the workbook will be presented as a deliverable for stakeholders to review and make a decision.

Analysis and Synthesis

I summatively measured outcomes of the planning process for this project using a survey of the stakeholders regarding their satisfaction with my project leadership (see Appendix A).

Summary

In this project, I developed a sexual assault support group to assist victims of rape trauma in coping with the effects of the abuse. The literature I reviewed revealed the various issues that may occur because of the act and how a support group can be beneficial in helping to alleviating some of the complications or long-term effects of sexual assault. The victimization that stays with the patients long after the abuse ended is significant. In Section 4, I discuss the findings, implications, and limitations of the project. Further, I offer recommendations to address the gap in practice, and discuss the contribution of the doctoral team and the strength of the project.

Section 4: Findings and Recommendations

Introduction

In the rural Texas community there is a high prevalence of sexual assault, yet no support group exists to assist the victims. Over 6.3 million Texans have been affected by sexual assault (Busch-Armendariz, 2015). Rape is a crime not only against the individual but also against families and society. The purpose of this QI project was to develop a sexual assault support group with the goal of improving social interaction and socialization, and decreasing psychological disturbances such as PTSD in adult female victims of sexual assault. In 2017, there were more than 200 SANE exams performed.

Sexual assault can have long-term effects on psychological well-being and increase the risk for later sexual violence and other problem behaviors (Basile et al., 2016). A positive correlation is seen between sexual aggression and suicide. Support groups provide a safe environment for victims to process their abuse and to transition from the trauma to recovery. Support groups play a pivotal role in enabling the survivors to develop trust and healthy relationships in and out of the group. Through the sharing experiences, some survivors report the positive influence of support groups in helping them gain the courage to feel stronger and obtain a sense of self. The gap in practice I addressed is that there is no support group available in this rural community. Having a support group will fill the gap and play a pivotal role in the healing process for these women. The question I developed to address that gap was: In women who have been sexually assaulted and receiving care at a rural West Texas hospital, how does adding a local sexual assault support group to care provision impact the progress toward improved

social interaction, and decreased psychological disturbances such as PTSD symptoms as measured six months post-implementation, when compared to the current standard of care no support group?

The collection of the evidence and analysis from the project team provided vital input toward the solution of the practice-focused question. The multidisciplinary project team members provided expert feedback that included recommendations for moving forward with the development of the support group, educational sessions to inform the public on the need for the support group, and training for facilitators of the support group.

Findings and Implications

The goal of the project is to improve social interaction, improve socialization, and decrease psychological disturbances such as PTSD in adult female victims of sexual assault. The support group will assist victims of sexual assault in dealing with social interactions and problem-solving, thereby preventing the cycle of abuse (see Brown et al., 2013). At the initial meeting, I presented a summary of the literature review and ideas of what to involve in the support group in an initial draft to the planning team who reviewed and discussed the current impact of sexual abuse on women in society. Specifically, I provided an outline of the problem of sexual assault and its impact on society and identify the gap in the practice. The multidisciplinary team deliberated and agreed that there was a need for a support group for sexual assault victims. Some example of questions explored by the team during their first meeting were: Based on the literature presented to you, how useful would a support group be to the stated population? What other strategies, if any, could be employed to assist this vulnerable population? Based on

your professional opinion, is there anything you believe needs to be added to the plan that would benefit victims of sexual abuse? Will the victims attend the support group? What measures will be put in place to ensure that victims are made aware of the support group and how will they be protected from the public? The project team provided feedback relevant to the success of the program. I incorporated this feedback into the plan, and presented a revised plan at a second meeting for further discussion and approval.

The project team carried out a project evaluation (see Appendix A). Ten questionnaires were given out, and seven were completed (70%). Three participants left the study for personal reasons as outlined. Of the seven that were completed, 100% of the respondents answered all questions. Eighty percent of the respondents strongly agreed that the problems were made clear at the onset of the meeting, and 20% agreed that the problems were made clear. Ninety percent of the respondent strongly agreed that the goals were appropriate and 10 % agreed. One hundred percent of the respondent strongly agreed that my leadership style was effective. All respondents agreed that the meetings were timely, organized, and productive. The respondents all agreed that their input was valued during the process.

Unanticipated Findings

During the meetings, the team suggested that a support group would be beneficial not only to the female population or those older than 18 years old, but also for those younger than 18 because there have been extensive reports in the press of child sexual abuse and victimization. It was suggested that a group be considered for children and

teenagers as well as males and transgender individuals. Although my initial focus was on females over the age of 18 years, it would be prudent to focus on other vulnerable populations. However, having a mixed group with both adults and children or males and females may not be as productive as having separate groups and would, therefore, not be practical. Also, being a new venture, it may be difficult to find individuals who are willing to participate mainly if the offender is of the same gender as a member of the group. The consensus was to maintain the focus on adult females, but consider future development of support groups to meet the needs of other vulnerable individuals in the community.

Implications of the Findings

The support group is needed in this West Texas community, now more than ever. This QI project will set precedence for future support groups in surrounding rural areas. Guidelines developed for this project may also be used in the development of future projects, preventing the re-inventing of the figurative wheel.

I considered several factors when developing the support group, one of which is the reduction of cost both State and Local Government and, the organization from money spent on caring for the complications associated with sexual assault. I used an evidence-based approach to develop the group that assists in preventing or minimizing complications of rape. Frontline staff, victims, law-enforcement, and advocates will all be made aware of the program and how to access and recommend individuals to the services of the support group. The community has a pivotal role in the success of the support group, which will empower community members.

The project facility will play a crucial role in implementation and evaluation of the support group program to determine its success and to identify areas needing improvement to care for this vulnerable population. The support group is the first of its kind to be proposed and developed in this rural community. The project facility serves several counties, which may increase the number of participants seeking services from the hospital where this project will be implemented. These surrounding communities may be able to adapt the methods and develop similar groups to assist their community members. The project does not exist in a vacuum and may act as a catalyst for future evidence-based sexual assault support groups in surrounding rural communities and larger cities. The goal of the support group is to decrease participants' psychological symptoms, which will benefit the healthcare system through reduction in the number of patients visiting the emergency room for sexual assault-related complications.

Positive Social Change

The introduction of the sexual assault support group in the community will have a significant impact on healthcare and the victims' psychological well-being. Rape victims have several outcomes if the assault is not addressed efficiently, which range from sexual promiscuity, suicidal ideation, anxiety, depression, and PTSD, to social isolation. Sexual promiscuity has the potential to lead to the development of sexually transmitted infections from unsafe sexual practices. The support group will empower these individuals, thereby minimizing the risk to society while also reducing the strain on and costs to the healthcare and legal systems. Rape victims may be socially challenged, but

the support group will provide the necessary interaction and support to help reduce the incidence of social isolation (see Ullman, Peter-Hagene, & Relyea, 2014)

Recommendations

The development of a sexual assault support group in the rural community the project facility will address the gap in the practice of no support group in this rural community and play a pivotal role in the healing process. I designed the support group to serve women 18 years and older, but based on discussions with the project team, I may develop a future proposal for a support group for teenagers in the community.

Included in the project deliverables was an intake form outlining basic rules and criteria for joining the group as well as a questionnaire to ensure that group participants are obtaining the services most suitable for their needs (see Appendix B and C). The project team discussed group rules and meeting outlines. In order to determine that participants are at the proper place to get the care needed, they will be prescreened using tools used to determine PTSD, anxiety, depression, and social isolation such as the Clinician-Administered PTSD Scale or the self-administered questionnaire scale (National Center for PTSD, 2015; see Appendix F) prior to the initial meeting. The initial meeting will establish ground rules and boundaries in the group (see Appendix D). Provisions will be made for individuals to fill out intake forms at the initial meeting. Participants who opt to fill out intake forms at the initial meeting will do so with a facilitator away from other group members to ensure that the individual meets criteria for the group. All intake forms will be reviewed by the facilitators, and candidates who are selected to attend the group will be contacted via their preferred means of

communication. Those not selected will be contacted with an explanation and likely resources applicable to their needs. During the first 30 minutes of subsequent group meetings education sessions will offer information to help the victims to cope with every-day challenges (see Appendix D). A break-away session with a facilitator will follow the education session. Each facilitator will have no more than eight members in a group to ensure that everyone is getting the attention needed for success. A workbook will be provided for the participants (Appendix H). These will be self-paced, and the facilitators will discuss them with each participant according to their comfort level. Sessions will be held twice per month for 90 minutes to 2 hours each session with a complete cycle being eight sessions. A crisis hotline and mental health partnership will be established in the event any group participant is having trouble during a group session.

The project team worked on developing the plans for the sexual assault support group, and although limited to planning only, implementation and evaluation plans were developed for the facility should it decide to implement the program. To get the group up and running, there will be a 4- to 6-week recruitment process where members will be recruited by means of a flyer (Appendix E). These flyers will be given to rape victims who visit the hospital for a sexual assault exam, and those who attend local counseling services. Further, the flyers will be placed in churches, local colleges, and public businesses upon obtaining verbal consents from the owners. Prospective members will call the number listed on the flyer to obtain an intake form and questionnaire (Appendix B and C) that can be filled out immediately and returned to a facilitator, who will be a counselor, or mailed in to the meeting site. Education programs may need to be

developed to sensitize the public about the need for a support group and what is involved for individuals to participate in the group. Rape victims often blame themselves; attending a support group that provides positive healing educational session might be encouraging to participants.

Following the eight sessions, I will re-evaluate the participants to determine the impact of the group on these individuals. Participants will be asked by the facilitators to, participate in a post screening that will assist in identifying improvement in social interaction and socialization, and decrease in the development of psychological disturbances such as PTSD, anxiety, and social isolation. Evaluation will include the use of the electronic record to track emergency room visits of all sexual assaulted victims and a comparison made with those patients involved in the support group 1 year prior to the start of the group to their current state.

Contributions of the Doctoral Project Team

The project team or the team of experts contributed to the development of the support group. The valuable feedback provided and their insight helped the DNP student with the process of addressing the gap in practice. The project team was vital to the project as they facilitated a multidisciplinary approach. Included in the team were a social worker, SANES, emergency room staff, victim advocates, counselors, and law enforcement. Some pointed suggestions made by the team are not to go unnoticed. The social worker in the team provided information on housing and support that may be needed if the group member is finding it challenging to attend the meetings. The social worker also provided valuable insight on community challenges that may be a hindrance

to victims joining the group and how these issues can be addressed. Additionally, resources that may be tapped into, to assist the victims were discussed from the social workers perspective. These insights assist in facilitating the development of a more person-centered approach when recruiting members for the group. For example, some women may be concerned about who will look after their children while they are at the group; the information provided by the group member helped to include the need for a babysitter in the planning budget (see Appendix I) or to seek volunteers who will babysit during the time.

Revenue is required to start a program of this nature. The source of the funding will be from contributions, donations, fundraisings and volunteer services. The budget will outline the source of financing from donations, volunteers and, fundraising. The implementation site will provide a place for meetings, and the volunteers will offer their time to facilitate the group and in some instance, babysit when applicable.

The counselors and victims advocate in the group provided information on what to expect from a group member. Their input was crucial in the development of the intake form as they provide information on acceptable behaviors for group members and reasons why it is crucial to pre-screen candidates. Information obtained from the members on the reason for pre-screening include providing safety for other members of the group by preventing individuals with at-risk behaviors who may be better suited for another type of mental health assistance from being at the group. Although, there may be a place at the group for these once their acute issues have been resolved.

The Victims' advocates offered feedback on the dangers of having individuals attending the group at a vulnerable stage. The consensus was that some of these victims might be using drugs as a means of coping (Santaularia et al., 2014), and as such may be disruptive at meetings. Thus, there may be a need to provide other services for these prior to offering the support group. The law enforcement provided nurses with information that is prudent to the protection of both the patients and the volunteers. The project team also discussed the need for public education and support groups for other ages, however; these may be addressed in future projects.

Plans to extend the project include the development of additional support groups as well as taking it out to other areas. The community of interest serves several counties. The plan is to outreach to these neighboring communities and provides education about the services. There may be a fear of attending a support group in a small community but going to a neighboring town not far from home and you are not likely to be seen may be more practical for some participant

Strength and Limitation of the Project

Several positives were identified during the development of the project. Firstly, there was the benefit to the target population, that of having a support system dedicated to helping them cope with the effects of their abuse. Policies and procedures were developed as well as questionnaires and intake forms to identify suitable candidates for the support group. The project site and the other key members at the potential implementation site provides a rich avenue of support as the stakeholders at the facility were very supportive, offering to implement the project and to utilize the campus as a

meeting place for the support group. The support obtained from members of the project site was phenomenal. It was there that the needed guidance was received to help see this project through; as everyone was in tune with the project and, seeking out ways to assist. It is through their efforts and guidance that this project was initiated. The idea was conceived as a discussion and a passion that was held dear; however, the vision was moved forward through the support of the team.

This project was strengthened through input from SANEs and assault survivors. SANEs are often the first ones to talk with the victims and can understand what the victims need to help them recover from the trauma. Assault survivors have experienced the pain and emotions that often weigh on victims, along with the measures that work to help with the transition from victim to survivor. That knowledge plays an essential role in the development of critical areas of the project to ensure its success. Victims will likely be more willing to come forward to seek help knowing that the individual offering the help understands what they are experiencing.

The project was limited to planning only and as such; the outcome cannot be ascertained. However, during the planning phase, several issues arose that proved to be challenging. Three members of the project team left the group; one relocated to another city as her husband had to leave as a result of his job. Another member changed job and expressed that finding the time to learn her new role and be a part of the project team is challenging and so she decided to leave the group and focused on her primary job. The third member that departed the group got pregnant and had a few complications with her pregnancy and decided as this is her first pregnancy, she would like to spend more time

with her husband and learning how to be a mother. The loss of those three members was significant as they played a pivotal role in the group and was there at the beginning when the idea for the development of the support group was conceived. In fact, one member voiced that she was sexually abused and that a support group helped her to cope to the point where she is now able to have a healthy relationship and is now happily married. It was this member that was willing to offer her experience and ideas on the plans toward making the group a success. Team members who are survivors of sexual abuse sometimes found it difficult to not bring personal feelings into the equation and make decisions based on emotions. However, the remaining members of the project team provided the support needed for the personal experiences of survivors to strengthen the project results.

Section 5: Dissemination Plan

In this project, I focused on the development of a sexual assault support group for women. Having such a service is irrelevant if no one is aware the service exists. Thus, the information will be taken to the organization leadership, nurses and other stakeholders. The format for dissemination will be an oral presentation at meetings and workshops. The organization board of trustee has monthly meetings where proposals are presented for their approval. I will present the dissemination plan using a visual aid presentation, will outline what the group will look like when implemented, and will allow time for questions and feedback:

Additionally, I will present the information at the monthly nursing division and nursing council meeting in the form of a question and answer forum. Information about the support group and what it entails will first be presented, and the audience will have the opportunity to ask questions. To ensure that all relevant areas are covered, I will take a poll prior to the dissemination process on possible questions individuals would like answered about the development of a support group. Subsequently, a group of questions will be developed and placed in a jar. During the meeting, the jar will be passed around for individuals to pick a question. Following the reading of the question, I will answer the questions to help familiarize the staff with the group process and remove all ambiguities.

Finally, I will present an educational session about the support group and its potential benefits to the frontline nursing staff. The frontline nurses are usually the first to see the patients, and sometimes the first to hear the victim's outcry. Particularly in the

emergency room, these nurses may see the victims returning to the hospital on several occasions for various complaints that may be related to the assault. Therefore, providing information specifically for this group and allowing them time to ask questions on what a support group in action looks like and what it will mean for the team may be pivotal to the success of the group.

Dissemination to the Broader Nursing Profession

The third essential of the AACN (2006) speaks of DNP nurses as scholar-practitioners who utilizes evidence-based practice to improve the care of their patients. I developed this project using available evidence to promote an improvement in victims who have been sexually victimized. The sharing of the results or findings is necessary if the project is to be beneficial to the target population. Additionally, the core competencies of the doctoral nurse provide guidance relating to the expectations of scholar-practitioners. Another of those essentials is related to health policy and advocacy (AACN, 2006). The development and promotion of the support group serves as a form of advocacy for patients who have been sexually victimized. Prospective candidates such as those who visit the hospital for a SANE exam must be made aware of the services relating to the support group and information can be shared through community forums.

Another means of sharing the information regarding the support group is by publishing in a journal such as the *International Association of Forensic Nursing Journal*, or the pediatric journals, as well as presenting the findings at the IAFN conference. The print and visual media may also be used to send information to a broader group of people.

Analysis of Self

As a Scholar-Practitioner

Essential 3 of the AACN (2006) identifies the DNP nurse as a scholar-practitioner who uses evidence-based practice to improve patient care. Nursing scholarship takes several paths, including but not limited to academia, education, or clinical improvement (Slyer & Levin, 2012). Through scholarship, DNPs evaluate current practice, formulate questions, and use evidence to answer those questions (Slyer & Levin, 2012), as I have demonstrated in the development of the evidence-based project to provide a support group for women in the rural community. Additionally, Essential 5 speaks to health care policy and advocacy; as a scholar-practitioner, it is imperative that the needs of the victims be advocated. Policies need to be developed to impact the delivery of care to all involved. One example may be in determining individuals who are accepted in the support group. Care must be taken that victims are being treated fairly and that care is ethically sound so that individuals do not feel they are being discriminated against. Adherence to these essentials supports me as a scholar-practitioner.

As a Project Manager

The development of the sexual assault support group has been a journey, beginning when the idea was first conceived and proceeding to materialization. The need for a support group for sexual assault victims is not new. However, the timing is now for the development of this evidence-based project, as it will pave the way for similar projects in the counties served by the community of interest and beyond. The project will serve to empower the victims of sexual abuse by providing them the necessary tools to

prevent the stated complications such as anxiety, depression, PTSD, and suicidal ideation, and to improve socialization (see Fry, McCoy, & Swales, 2012; Kim, Wildeman, Jonson-Reid, & Drake, 2017).

Summary

The problem identified was the need for a support group for victims of sexual assault. Because there was no support group in the community, victims were seen frequenting the emergency department for issues identified as complications associated with rape. Providing a support group to offer guidance and help in alleviating social anxiety plays a pivotal role in the healing process of survivors. The goal of the project was to improve social interaction and socialization and decrease the development of psychological disturbances such as PTSD in adult female victims of sexual assault by assisting victims of sexual assault in dealing with social interactions and problem-solving (see Brown et al., 2013). The project committee played a crucial role in reviewing the literature and offering suggestions on strategies to make the group a success. The group also evaluated my leadership technique and provided valuable feedback. The support group will fill the identified gap in practice.

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Appendix A: Project Team Process Evaluation

Problem: There is a high prevalence of sexual assault in the community, yet no support group exists to assist the victims

Purpose: The utilization of evidence-based practice guidelines in the development of a sexual assault support group to assist victims of sexual trauma.

Goal: To improve social interaction and socialization, and, decrease the development of psychological disturbances such as PTSD in adult female victims of sexual assault

Objective: To close the gap in practice of no support group

Scale: SD=Strongly Disagree D=Disagree U=Uncertain A=Agree SA=Strongly Agree

1=SD 2=D 3=UC 4=A SA=5

Q1 Was the problem made clear to you in the beginning? ___ ___ ___ ___ ___

Q2 Did the DNP student analyze and synthesize the evidence-based literature for the team? ___ ___ ___ ___ ___

Q3 Was the stated program goal appropriate? ___ ___ ___ ___ ___

Q4 Was the stated project objective met? ___ ___ ___ ___ ___

Q5 How would you rate the DNP student's leadership throughout the process? ___ ___ ___ ___ ___

Q6 Were meeting agendas sent out in a timely manner? ___ ___ ___ ___ ___

Q7 Were meeting minutes submitted in a timely manner? ___ ___ ___ ___ ___

Q8 Were meetings held to the allotted time frame? ___ ___ ___ ___ ___

Q9 Would you consider the meetings productive? ___ ___ ___ ___ ___

Q10 Do you feel that you had input into the process? ___ ___ ___ ___ ___

Q11 Please comment on areas where you feel the DNP student excelled or might learn from your advice/suggestions

Appendix B: Sexual Assault Support Group Intake Form

Sexual Assault Support Group

Thank you for your interest in this group therapy experience designed to assist sexual abuse survivors on their healing journey. Group therapy can be exciting, challenging, and transformational. Group will typically consist of a psychoeducational portion regarding a topic surrounding sexual abuse, and will then transition into small group time led by a facilitator. You will be provided with a workbook (appendix H) during the individual group time, this is self-paced, and members are encouraged to work on it throughout the week and bring insights to share during group. Please read carefully about what it means to be a group member, and fill out the information honestly and accurately as possible. After completing the paperwork, please turn it into the stated address. A counselor will then contact you to schedule an individual interview to ensure that the group can meet your needs. Incomplete questionnaires will not be considered for group membership. It may be necessary for a counselor or facilitator to make appropriate referrals or schedule a personal consultation with a group participant about their progress and continuation in the group.

Expectations of being a group member:

Confidentiality- is essential in group therapy as members need to speak freely. What is being said must remain in the group. There is no guarantee that all members will adhere to the confidentiality clause even with continual stress on its importance. One way to maintain confidentiality is by not socializing outside of the group, or discussing group occurrences with others outside of the group. By law, professional confidence may

include communication which involves the committing of a crime, the endangering of a life of a client or someone else, or cases of child abuse. In these instances, it is the legal obligation of the counselor/facilitator to notify authorities.

Members should make their best efforts to be present and on time for all meetings. If a member wants to leave the group, this should be communicated to the facilitator and the other members. It is essential to communicate your thoughts, feelings, & reactions to each other in a way that is kind and honest.

Members might be required to be in individual counseling concurrent to group work; Members are also encouraged to find alternative self-care activities during group therapy, such as but not limited to: exercise, journaling, religious activities, hobbies or recreational activities

Members must be respectful of each other and the group experience, be willing to share aspects of self with the group and to listen and respond to others when they share. Strive to be open and non-judgmental of other member's growth process. Avoid the temptation to "give advice" to other members. Learn to set limits, so if you feel that you do not want to share your thoughts and feelings at a particular time, it is ok to say "no."

Basic Information

Name: Age: Gender: Male/Female

Community Resources

Group participation is limited, and even participants might find that their needs require additional assistance. Below are some other contacts you might find beneficial.

Informed Consent

I have read and understood all the potential benefits and limitations of group therapy. I agree to participate in sessions and to the therapeutic process.

Name & Date

Appendix C: Intake Questionnaire

This questionnaire is to help you learn more about how you can benefit from group therapy and how the group can assist you. There are no right or wrong answers. Please answer as honestly and clearly as you can.

1) Have you had previous counseling of any type? Yes No

   If yes, what type?

2) What if anything, are you most afraid of about group therapy?

3) If you could change something about yourself as a result of group therapy, what would you change?

4) What do you hope to achieve from group therapy?

5) What might prevent you from achieving your goals?

6) What would help you to feel comfortable and safe during group?

7) What do you already have in place for a support system?

8) Is there anything you have not told us that you believe might be helpful?

Health & Interpersonal Relationships:

1) Please list any prior or current medical conditions, previous diagnoses, and/or surgeries:

_____

_____

_____

2) Please list any pain or medical issues you have not yet sought treatment for:

_____

_____

3) Check any of the following you are dealing with or have dealt with in the last year:

Excessive arguments

Physical fights with partner or others

Separation/Divorce

Feeling too dependent on others

Shyness/Not being assertive

Not enjoying or desiring close relationships

Unstable relationships

Lack of control of my anger

Feeling empty and bored/Mood changes quickly

Constantly need reassurance or approval

Avoid social activities

Feeling Abandoned/Isolated/Lonely

Lack of identity

Difficulty trusting others

Do you have friends? None Few Many

4) Are you feeling suicidal? No Yes, with thoughts only Yes, with plan

Have you ever attempted suicide? No Yes If yes, when?

Appendix D: Sexual Assault Support Group

Proposed Agenda

Type of Meeting: Support Group

Meeting Facilitator:

Invitees:

- Registration
- Group Introductions
- Support group overview
- Establish group rules
- Educational session
- Introduction to the workbook
- Activities with facilitator
- Activities with facilitator
- Activities with facilitator
- Regroup
- Check out session
- Reflections
- questions
- Adjournment

Session One

1. Welcome
2. Introduction real names or nicknames.
3. Introduce to workbook
4. Activity sessions

Introduction to group

Brainstorm ground rules with participants (what do you think the rules for a group such as this one should include?)

- Confidentiality
- Attendance
- Not bringing outside people
- Drug and alcohol use
- Safety considerations
- Respectful communication
- Use of technology during sessions

Meeting Format

- Check in/ each person encouraged to answer a brief prompt question for example; state one positive thing that happened in your life in the past week.
- Education session

- Activities
- Self-care activity (activities to help participants cope)
- Check out/what you learn what you are looking forward to next session

Review of topics for discussion

- Handout with topic for each session
- Have a box or envelope where participants can write questions or request topics they would like discussed

Example of a meeting discussion regarding "rape triggers"

Have participants list things that they may consider to be triggers? (Facilitator need to normalize these triggers and let the participants know that the group discussion may cause emotional reactions)

If there are triggers, causing the participants to feel overwhelmed, a facilitator can take the individual to a quiet area until they are calm. The individual may choose to rejoin the group or end your session for the day. That does not make them a failure.

Closing: Knowing you are not alone, and that others care about you, believe in you and want to support you is something we want to offer to each member of this support group. Your participation will help you to gain strength, knowledge and skills as well as to be empowered to help others.

You are amazing. You are brave and we are proud of you. One more thing before you go; I would like each of you to share something you brainstormed at the beginning of the

session, this may be helpful to others as they may find hope and encouragement from your words.

Next session we will review the workbook (see appendix H), and answer questions. Note that the following weeks will be more intense. I want you to think about someone in your life you can always count on and that person will be your lifeline. Think also, about makes you uncomfortable? There will be discussion on sexual abuse/rape as the weeks progress, feel free to talk to a facilitator if you are becoming overwhelmed.

Appendix E: Sexual Assault Support Group Flyer

Sexual Assault Support Group

Meets every 1st and third Thursday of the month

6-7:30 p.m.

Local Hospital

Room 2360

This support group welcomes victims of sexual assault and abuse.

For more information

Call: 325-262-7983

Appendix F: Excerpts of the Clinician Administered PTSD Scale

CAPS-5 Past Month

Instructions:

Standard administration and scoring of the CAPS-5 are essential for producing reliable and valid scores and diagnostic decisions. The CAPS-5 should be administered only by qualified interviewers who have formal training in structured clinical interviewing and differential diagnosis, a thorough understanding of the conceptual basis of PTSD and its various symptoms, and detailed knowledge of the features and conventions of the CAPS-5 itself.

Administration

1. Identify an index traumatic event to serve as the basis for symptom inquiry. Administer the Life Events Checklist and Criterion A inquiry provided on p. 5, or use some other structured, evidence-based method. The index event may involve either a single incident (e.g., "the accident") or multiple, closely related incidents (e.g., "the worst parts of your combat experiences").
2. Read prompts verbatim, one at a time, and in the order presented, EXCEPT:
   a. Use the respondent's own words for labeling the index event or describing specific symptoms.
   b. Rephrase standard prompts to acknowledge previously reported information, but return to verbatim phrasing as soon as possible. For example, inquiry for item 20 might begin: "You already mentioned having problem sleeping. What kinds of problems?"
   c. If you don't have sufficient information after exhausting all standard prompts, follow up ad lib. In this situation, repeating the initial prompt often helps refocus the respondent.
   d. As needed, ask for specific examples or direct the respondent to elaborate even when such prompts are not provided explicitly.
3. In general, DO NOT suggest responses. If a respondent has pronounced difficulty understanding a prompt it may be necessary to offer a brief example to clarify and illustrate. However, this should be done rarely and only after the respondent has been given ample opportunity to answer spontaneously.
4. DO NOT read rating scale anchors to the respondent. They are intended only for you, the interviewer, because appropriate use requires clinical judgment and a thorough understanding of CAPS-5 scoring conventions.
5. Move through the interview as efficiently as possible to minimize respondent burden. Some useful strategies:
   a. Be thoroughly familiar with the CAPS-5 so that prompts flow smoothly.
   b. Ask the fewest number of prompts needed to obtain sufficient information to support a valid rating.
   c. Minimize note-taking and write while the respondent is talking to avoid long pauses.

Scoring

1. As with previous versions of the CAPS, CAPS-5 symptom severity ratings are based on symptom frequency and intensity, except for items 8 (amnesia) and 12 (diminished interest), which are based on amount and intensity. However, CAPS-5 items are rated with a single severity score, in contrast to previous versions of the CAPS which required separate frequency and intensity scores for each item that were either summed to create a symptom severity score or combined in various scoring rules to create a dichotomous (present/absent) symptom score. Thus, on the CAPS-5 the clinician combines information about frequency and intensity before making a single severity rating. Depending on the item, frequency is rated as either the number of occurrences (how often in the past month) or percent of time (how much of the time in the past month). Intensity is rated on a four-point ordinal scale with ratings of *Minimal, Clearly Present, Pronounced*, and *Extreme*. Intensity and severity are related but distinct. Intensity refers to the strength of a typical occurrence of a symptom. Severity refers to the total symptom load over a given time period, and is a combination of intensity and frequency. This is similar to the quantity/frequency assessment approach to alcohol consumption. In general, intensity rating anchors correspond to severity scale anchors described below and should be interpreted and used in the same way, except that severity ratings require joint consideration of intensity and frequency. Thus, before taking frequency into account, an intensity rating of *Minimal* corresponds to a severity rating of *Mild / subthreshold*, Clearly Present corresponds with *Moderate / threshold*, Pronounced corresponds with *Severe / markedly elevated*, and Extreme corresponds with *Extreme / incapacitating*.

2. The five-point CAPS-5 symptom severity rating scale is used for all symptoms. Rating scale anchors should be interpreted and used as follows:

   0 ***Absent*** The respondent denied the problem or the respondent's report doesn't fit the *DSM-5* symptom criterion.

   1 ***Mild / subthreshold*** The respondent described a problem that is consistent with the symptom criterion but isn't severe enough to be considered clinically significant. The problem doesn't satisfy the *DSM-5* symptom criterion and thus doesn't count toward a PTSD diagnosis.

   2 ***Moderate / threshold*** The respondent described a clinically significant problem. The problem satisfies the *DSM-5* symptom criterion and thus counts toward a PTSD diagnosis. The problem would be a target for intervention. This rating requires a minimum frequency of *2 X month* or *some of the time (20-30%)* PLUS a minimum intensity of *Clearly Present*.

   3 ***Severe / markedly elevated*** The respondent described a problem that is well above threshold. The problem is difficult to manage and at times overwhelming, and would be a prominent target for intervention. This rating requires a minimum frequency of *2 X week* or *much of the time (50-60%)* PLUS a minimum intensity of *Pronounced*.

   4 ***Extreme / incapacitating*** The respondent described a dramatic symptom, far above threshold. The problem is pervasive, unmanageable, and overwhelming, and would be a high-priority target for intervention.

3. In general, make a given severity rating only if the minimum frequency and intensity for that rating are both met. However, you may exercise clinical judgment in making a given severity rating if the reported frequency is somewhat lower than required, but the intensity is higher. For example, you may make a severity rating of *Moderate / threshold* if a symptom occurs 1 X month (instead of the required 2 X month) as long as intensity is rated *Pronounced or Extreme* (instead of the required *Clearly Present*). Similarly, you may make a severity rating of *Severe / markedly elevated* if a symptom occurs 1 X week (instead of the required 2 X week) as long as the intensity is rated *Extreme* (instead of the required *Pronounced*). If you are unable to decide between two severity ratings, make the lower rating.

4. You need to establish that a symptom not only meets the *DSM-5* criterion phenomenologically, but is also functionally related to the index traumatic event, i.e., started or got worse as a result of the event. CAPS-5 items 1-8 and 10 (reexperiencing, effortful avoidance, amnesia, and blame) are inherently linked to the event. Evaluate the remaining items for trauma-relatedness (TR) using the TR inquiry and rating scale. The three TR ratings are:

   a. ***Definite*** = the symptom can clearly be attributed to the index trauma, because (1) there is an obvious change from the pre-trauma level of functioning and/or (2) the respondent makes the attribution to the index trauma with confidence.

   b. ***Probable*** = the symptom is likely related to the index trauma, but an unequivocal connection can't be made. Situations in which this rating would be given include the following: (1) there seems to be a change from the pre-trauma level of functioning, but it isn't as clear and explicit as it would be for a *Definite*; (2) the respondent attributes a causal link between the symptom and the index trauma, but with less confidence than for a rating of *Definite*; (3) there appears to be a functional relationship between the symptom and inherently trauma-linked symptoms such as reexperiencing symptoms (e.g., numbing or withdrawal increases when reexperiencing increases).

   c. ***Unlikely*** = the symptom can be attributed to a cause other than the index trauma because (1) there is an obvious functional link with this other cause and/or (2) the respondent makes a confident attribution to this other cause and denies a link to the index trauma. Because it can be difficult to rule out a functional link between a symptom and the index trauma, a rating of *Unlikely* should be used only when the available evidence strongly points to a cause other than the index trauma. NOTE: Symptoms with a TR rating of *Unlikely* should not be counted toward a PTSD diagnosis or included in the total CAPS-5 symptom severity score.

5. **CAPS-5 total symptom severity score** is calculated by summing severity scores for items 1-20. NOTE: Severity scores for the two dissociation items (29 and 30) should NOT be included in the calculation of the total CAPS-5 severity score.

6. **CAPS-5 symptom cluster severity scores** are calculated by summing the individual item severity scores for symptoms contained in a given *DSM-5* cluster. Thus, the Criterion B (reexperiencing) severity score is the sum of the individual severity scores for items 1-5; the Criterion C (avoidance) severity score is the sum of items 6 and 7; the Criterion D (negative alterations in cognitions and mood) severity score is the sum of items 8-14; and the Criterion E (hyperarousal) severity score is the sum of items 15-20. A symptom cluster score may also be calculated for dissociation by summing items 29 and 30.

7. **PTSD diagnostic status** is determined by first dichotomizing individual symptoms as *Present* or *Absent*, then following the *DSM-5* diagnostic rule. A symptom is considered present only if the corresponding item severity score is rated 2=*Moderate / threshold* or higher. Items 9 and 11-20 have the additional requirement of a trauma-relatedness rating of *Definite* or *Probable*. Otherwise a symptom is considered absent. The *DSM-5* diagnostic rule requires the presence of least one Criterion B symptom, one Criterion C symptom, two Criterion D symptoms, and two Criterion E symptoms. In addition, Criteria F and G must be met. Criterion F requires that the disturbance has lasted at least one month. Criterion G requires that the disturbance cause either clinically significant distress or functional impairment, as indicated by a rating of 2=*Moderate* or higher on items 23-25.

CAPS-5 SUMMARY SHEET

Name:_____ ID#:_____ Interviewer:_____ Study: _____ Date:_____

A. Exposure to actual or threatened death, serious injury, or sexual violence	
Criterion A met?	0 = NO 1= YES

B. Intrusion symptoms (need 1 for diagnosis)	Past Month	
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(1) B1 – Intrusive memories		0 = NO 1= YES
(2) B2 – Distressing dreams		0 = NO 1= YES
(3) B3 – Dissociative reactions		0 = NO 1= YES
(4) B4 – Cued psychological distress		0 = NO 1= YES
(5) B5 – Cued physiological reactions		0 = NO 1= YES
B subtotals	*B Sev =*	*#B Sx =*

C. Avoidance symptoms (need 1 for diagnosis)	Past Month	
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(6) C1 – Avoidance of memories, thoughts, feelings		0 = NO 1= YES
(7) C2 – Avoidance of external reminders		0 = NO 1= YES
C subtotals	*C Sev =*	*#C Sx =*

D. Cognitions and mood symptoms (need 2 for diagnosis)	Past Month	
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(8) D1 – Inability to recall important aspect of event		0 = NO 1= YES
(9) D2 – Exaggerated negative beliefs or expectations		0 = NO 1= YES
(10) D3 – Distorted cognitions leading to blame		0 = NO 1= YES
(11) D4 – Persistent negative emotional state		0 = NO 1= YES
(12) D5 – Diminished interest or participation in activities		0 = NO 1= YES
(13) D6 – Detachment or estrangement from others		0 = NO 1= YES
(14) D7 – Persistent inability to experience positive emotions		0 = NO 1= YES
D subtotals	*D Sev =*	*#D Sx =*

E. Arousal and reactivity symptoms (need 2 for diagnosis)	Past Month

E. Arousal and reactivity symptoms (need 2 for diagnosis)		Past Month
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(15) E1 – Irritable behavior and angry outbursts		0 = NO 1= YES
(16) E2 – Reckless or self-destructive behavior		0 = NO 1= YES
(17) E3 – Hypervigilance		0 = NO 1= YES
(18) E4 – Exaggerated startle response		0 = NO 1= YES
(19) E5 – Problems with concentration		0 = NO 1= YES
(20) E6 – Sleep disturbance		0 = NO 1= YES
E subtotals	*E Sev =*	*#E Sx =*

PTSD totals	**Past Month**	
Totals	*Total Sev*	*Total # Sx*
Sum of subtotals (B+C+D+E)		

F. Duration of disturbance	**Current**
(22) Duration of disturbance ≥ 1 month?	0 = NO 1= YES

G. Distress or impairment (need 1 for diagnosis)	**Past Month**	
Criterion	*Sev*	*Cx (Sev ≥ 2)?*
(23) Subjective distress		0 = NO 1= YES
(24) Impairment in social functioning		0 = NO 1= YES
(25) Impairment in occupational functioning		0 = NO 1= YES
G subtotals	*G Sev =*	*#G Cx =*

Global ratings	**Past Month**
(26) Global validity	
(27) Global severity	
(28) Global improvement	

Dissociative symptoms (need 1 for subtype)	**Past Month**	
Symptom	*Sev*	*Sx (Sev ≥ 2)?*
(29) 1 – Depersonalization		0 = NO 1= YES
(30) 2 – Derealization		0 = NO 1= YES
Dissociative subtotals	*Diss Sev* =	*#Diss Sx* =

PTSD diagnosis	**Past Month**
PTSD PRESENT – ALL CRITERIA (A-G) MET?	0 = NO 1= YES
With dissociative symptoms	0 = NO 1= YES
(21) With delayed onset (≥ 6 months)	0 = NO 1= YES

Appendix G: Memorandum of Understanding

Memorandum of Understanding

This memorandum of understanding (MOU) is entered into by and between the following entities: _____ (sexual assault victim/group member), and the Sexual Assault Support Group.

The group member agrees to have their record evaluated one year after completion of the group and, a comparison made between them and victims of sexual assault who did not attend a support group. The group member acknowledges that information obtained from their medical record will be treated in the same manner as all health records, ensuring their privacy. Also, no information regarding the medical history will be shared for any commercial purposes.

The group member and the support group agrees to be bound to every statement made in this document. The group members understand that their record will only be evaluated for comparison purpose to identify long-term benefits of the support group.

The group member and the support group understands that at any time the group member can withdraw their agreement in writing.

This memorandum shall take effect upon the group member signing the document and will remain in place unless either party terminates the agreement in writing.

Signatures

Support Group Representative	Support Group Member
_____	_____
Signature/Date	Signature/Date

Appendix H: Resurrection After Rape: Opening letter and table of contents

Resurrection After Rape

By

Matt Atkinson

Complimentary Free Edition

Dear Reader,

Thank you for choosing Resurrection After Rape as your guide through the healing process. This book was a labor of love, and was written not to make money or gain status, but with a sincere desire to help and uplift others. This book has been endorsed by several State Coalitions Against Sexual Assault, by several psychologists, treatment centers, and by some universities, which now use this as a course textbook.

A word of caution: this is a very challenging, difficult book to work through. I am often affectionately teased by my readers about the times they have hurled the book in frustration, calling it "that damned book" and referring to me as "the jerk who wrote it!" They tell me this with fondness, though, to humorously describe their own initial response to the book. Without exception, the feedback continues: "…but when I really started to work hard at it, this book really worked!" My online discussion group has over 280 members, and almost daily one of them shares the same testimonial: "this was the hardest book of all the ones I tried, but it was the one that helped me the most" and, "the parts that made me the angriest at first are now my favorite parts."

Do not rely on any book as the sole source of support if you are in crisis; trained and qualified in-person support is essential in some circumstances.

Work through this with your therapist, and don't give up. Recovery is not a straight course, but a zig-zag pattern of success, relapse, despair, and more success. If sometimes you struggle, if you falter, you are normal. More than you know.

Sincerely, Matt

Appendix I: Sexual Assault Support Group Proposed Budget

The estimated cost for the group is as follows

Proposed Budget for the meeting **Expenditure**	**March**	**April**	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**TOTAL**
Conference Room ($100/meeting)	200	200	200	200	200	200	200	200	200	200	2000
Personnel ($25/hrx4)	100	100	100	100	100	100	100	100	100	100	1000
Refreshments	100	100	100	150	150	150	150	150	150	150	1350
Participant Books (100@$25)	2500	0	0	0	0	0					2500
Facilitator books (8@$25)	200	0	0	0	0	0					200
Materials/handouts	100	0	0	0	100	0			100		300
Tokens/100	0	0	50	0	0	0	50				100
Marketing 6 weeks of advertisement (200/week)											1200
Grand Total											8600