ISTSS Expert Consensus Guidelines in Action

Responding to Campus Sexual Assault

By Divya Kannan, PhD

As the number of college students diagnosed with serious mental illness has risen over the past decade, university health services are faced with the increasing demands of providing consistent care to a student body with reportedly more stress than the previous generation of students (Galatzer-Levy, Burton, & Bonanno, 2012; Mobray et al., 2006).

In the context of a competitive academic environment, students who have been sexually victimized and/or have experienced various forms of interpersonal violence are a particularly vulnerable group, at higher risk for mental health concerns and adjustment difficulties (Carey et al., 2015; Lawyer et al., 2010). A growing trend in the literature also indicates a positive link between sexual assault and suicide risk (Chang et al., 2015; Tomasula et al., 2012). Furthermore, prior exposure to interpersonal violence, including sexual assault, is not only associated with greater risk for later revictimization (Fisher, Cullen, & Turner, 2000), but may also associated with greater experience of psychological distress as a consequence of revictimization (Aosved, Long, & Voller, 2011).

A recent study (Carey et al., 2015) on prevalence rates of incapacitated rape (i.e., unwanted sexual contact or intercourse that occurs after the victim is too intoxicated or high to provide consent; Lawyer et al., 2010) and forcible rape among women college students (N = 483) indicated that prior to college, 15.4 percent of the students had experienced either attempted or completed forcible rape and 17.5 percent had experienced attempted or completed incapacitated assault. Furthermore, 11.4 percent and 8.5 percent of female freshman students in this study reported an attempted or completed rape in the fall and spring semesters, respectively, a trend consistent with other findings (Read et al., 2011). A review of the literature on how campus services are utilized by students who have been

victimized, indicated that physical and mental health services were the most sought out services by students (Sabina & Ho, 2014).

The trends reflected in the literature were also evident across clinicians 'caseloads at the Vanderbilt Psychological & Counseling Center and the national campus climate around sexual assault was additional impetus in recognizing the need to develop a protocol that addresses the needs of students who have been assaulted and who may have extensive trauma histories. A study on rates of exposure to traumatic events (Read et al., 2011) indicated that approximately 9 percent of incoming freshman (N = 3014) met the diagnostic criteria for Post-Traumatic Stress Disorder and 7 percent reported experiencing sexual assault.

This protocol was developed due to the need for planning care around the rapidly emergent needs of students who presented with increased acuity and frequency with reported experiences of sexual assault often complicated by a history of prior abuse. The protocol helps clinicians in matching students to a treatment plan based on their level of need, with those students at a higher level of need being more likely to remain connected with services on campus. In addition to sexual assault, traumatic events have included although are not restricted to childhood abuse or neglect, grief and loss, and motor-vehicle accidents. Due to the need to provide evidence-based care for a rapidly growing number of students, a needs-assessment of mental health services alongside a literature review was conducted over a 6-month period by members of the trauma team at the center based on the expert consensus treatment guidelines for the treatment of complex PTSD (Cloitre et al., 2012) disseminated by the International Society for Traumatic Stress Studies (ISTSS).

Cloitre and colleagues indicated that 84 percent of expert clinicians surveyed in their study endorsed a phase-based or sequenced approach as a first line treatment for complex PTSD. Treatment for trauma at the Vanderbilt counseling center was conceptualized within this framework, with the ultimate goal of improving the functioning of students so that they may be able to successfully graduate (Turchick & Hassija, 2014).

A significant factor within university settings is that mental health concerns are conceptualized and addressed from a developmental lens, and so goals within each phase of treatment are conceptualized accordingly. Conceptualization of sexual assault within the protocol was broadly organized into acute/single-incident and complex/multiple-incidents of assault. Acute concerns were defined as single incidents of attempted and/or completed sexual assault/violence while complex trauma concerns often have included ongoing or repeated acts of interpersonal violence. The protocol describes three main phases of treatment, and while each phase contains unique goals, there is overlap between the phases as treatment does not always follow a linear and sequential format.

Phase 1 of treatment within the protocol includes identification and assessment of symptoms and functioning, safety and stabilization needs, couched within a developmental and biopsychosocial case formulation to inform treatment. Phase 2 involves skills building and trauma processing, which includes improving students' ability to regulate their behaviors and emotions, while also moving towards focusing on the review and reappraisal of traumatic memories, thoughts, and beliefs. Goals include enhancing students' ability to regulate their emotions and strengthen their competencies and resources to cope with traumatic experiences (ISTSS complex PTSD guidelines, 2012). Phase 3 involves the consolidation of treatment gains to facilitate the transition from the end of treatment to re-engagement with other aspects of student life or to prepare students for their lives after graduation.

Therefore, within this phase approach, treatments selected have focused on strengthening students' skills in multiple areas, targeted by therapies such as cognitive processing therapy and exposure-based therapies, primarily used as individual treatments, and skills based interventions that utilize models such as seeking safety (Najavitz, 2009) and dialectical behavior therapy within a group format. Because isolation and shame can be a consequence of sexual trauma in particular, group therapies offer students the chance to reconnect with others who may have gone through similar experiences and can offer one

another support (Kahn & Aaronson, 2007). The protocol implemented at the PCC is described below and is based on the ISTSS guidelines for best practice in the treatment of complex trauma. While this description is not exhaustive, the main components are highlighted.

Developmental Approach to Assessment to Address Risk and Acuity

Assessment of self-harm and risk (e.g., suicidality, cutting) is a significant part of Phase 1 of the protocol to help both the clinician and client to work on therapy goals safely within the context of their emotional, behavioral, academic and social functioning. Some of the parameters for assessment of sexual trauma in the protocol includes the type of sexual trauma (complex vs. acute); diagnostic considerations (e.g., risk for PTSD, bipolar disorder); type of treatment (e.g., psychiatric medication, skills-based therapies, treatment for substance use); timeline (e.g., abuse that occurred at a developmentally sensitive time in childhood); causation (sexual assault within a relationship vs. a random incident); and prognosis (immediate and long-term impact of sexual assault on recovery and coping resources within the individual).

Using this developmental approach to assessment allows the clinician to explore where traumatic experiences may have been the most severe or had the most impact and helps the clinician with identifying risk factors and vulnerabilities across multiple domains of functioning. Additionally, this approach may help to elicit time periods when good coping was used or when healthy support systems were accessed. Identifying disruptions in pivotal developmental tasks (e.g., sexual identity, attachment patterns, trust in adults) can inform phase 2 of the protocol to target specific areas of dysregulation or exacerbation in symptoms or functioning.

Connection and Safety Within the Therapeutic Relationship

Within the protocol, establishing a sense of trust and safety in the therapeutic relationship is a pivotal task in working with survivors of sexual assault. This task could take anywhere from

a few sessions to a few months, or longer to establish this goal. Within the protocol, conceptualization of the therapy process includes the awareness that some clients could remain in Phase 1 of the protocol for the duration of their time on campus and interaction with the counseling center.

So, for some individuals impacted by sexual assault, trusting the campus community and the treatment centers and resources available could be the most challenging task. Because interpersonal trauma can cause changes in relationships with others and increase difficulties with trust, intimacy, and control, this beginning phase of the relationship with the clinician and the larger campus community is a necessary focus of this phase of the protocol.

Acute Care Team

To address single incident traumas around sexual assault, the counseling center implemented a core team of professionals to include medical professionals as well as psychologists and counselors to provide immediate psychological care for students in the acute phase of an assault. The acute care team (ACT) was designed as a brief and systemic model of care as the benefits of supportive and targeted skills-based interventions following a traumatic event can lead to an increase in an individual's sense of safety and symptom stability (Lawyer et al. 2010). Components of treatment include grounding skills; psychoeducation about PTSD and acute stress reactions; assistance in navigating the disclosure of sexual assault; and integration of campus-wide resources. Students' who present with acute incidents of assault will be assessed and tracked in their mental health outcomes based on trauma and depression symptoms to evaluate the impact of this intervention and to guide treatment planning. Future directions for research are to conduct a systematic review of the literature that identify other brief models of care for sexual assault/violence and utilize the results of the review towards evaluating the efficacy of the proposed model of care at the Vanderbilt PCC.

Tip: The Biofeedback team at the PCC serves as an adjunct modality to the treatment of trauma and is helpful in this phase of the protocol in the absence of any dissociative symptoms associated with sexual trauma. Literature on using biofeedback for the treatment of anxiety and PTSD (Polak et al., 2015) suggests the utility of using biofeedback to hasten the reduction of PTSD symptoms).

Developing Regulatory Capacities to Prepare for Trauma Work

The primary goal within this phase is to begin working on skills to help students regulate difficult emotions and manage their symptoms while also adhering to social norms within which problematic behaviors could occur (e.g., binge drinking, increased sexual freedom). The need for working on these skills can often present itself as a crisis that may indicate the need for hospitalization or a temporary medical withdrawal from school. It is understood that assessment of crisis situations could be an ongoing task at any phase of the protocol. This is primarily due to the possibility of dealing with triggers in the environment at different times of the year, changes in clients' levels of functioning, and the potential vulnerability of repeated exposure to sexual assault or other traumatic experiences.

At the PCC, the seeking safety group helps provide a safe and supportive therapeutic space where students can learn skills to manage triggers and PTSD symptoms, better understand the impact of sexual assault across multiple areas of functioning, and respond to stress in healthy ways. Dialectical behavioral group therapy helps to address mood dysregulation and provides skills to manage mood, tolerate distress in safe ways, and to build self-regulatory capacities. Additionally, individual therapists who refer their clients to these groups aim to structure their work so that learning and growth in individual therapy can intersect with the clients' group therapy experience.

Creating New Meaning Through Processing Traumatic Memories

Readiness for trauma processing is discussed with the client and assessed based on the skills building that the client has engaged in through group and individual interventions.

Trauma processing focuses directly on the review and reappraisal of trauma-related memories and structured approaches to treatment have been adapted to the university counseling setting. A strong therapeutic relationship is the foundation for this work so that memories relates to assault can be explored within a safe context.

The primary purpose of this part of the protocol is to help the client develop new understandings of traumatic experiences and for the client to experience the assault while staying connected to their emotions vs. experiencing it in a dissociated manner. Exposure-based therapies and cognitive processing therapy is often used in Phase 2 to reduce avoidance based coping and to work towards the goal of integrating traumatic experiences into the clients self-narrative. Processing of sexual assault may include identifying defenses and coping mechanisms, identifying cognitive stuck points, and re-processing memories related to assault. Progress in this phase should lead to a symptom decrease and an increase in the client's sense of efficacy.

Tip: While the client may not be motivated for these changes in the context of a challenging academic environment, the clinician can model consistency and stability to their work by addressing ambivalence, going at the client's pace, yet also returning to treatment goals and emphasizing a team approach in working with the client. The PCC holds a weekly case conference which focuses on complex cases to help the entire team think through treatment challenges as well as provide support to clinicians as they work with difficult cases. An interdisciplinary team ensures that diverse viewpoints are being considered and best-practice decisions can be made for the welfare of students.

Maintenance Goals for Ongoing Care and Support

The third phase of the protocol deals with maintenance of gains and consideration of resources outside of traditional psychotherapy. Internal referrals within the center as well as referrals to external campus resources or the community are considered and may be appropriate at different phases of the protocol.

For instance, students with co-occurring concerns such as substance use are often referred to BASICS (Brief Alcohol and Screening for College Students) or other alcohol and drug intervention/programs available on campus or in the community. Additionally, frequent referrals for students also struggling with eating disorders to the campus health center as well as to the eating disorder specialty team at the PCC are often sought out.

Referrals for medication management to target symptoms related to decreased concentration, sleep problems, and nightmares, have been helpful for students to begin to feel more in control of their environment and to be able to fulfil their academic roles, particularly for those students who are returning after a medical withdrawal from school. Maintenance of gains may include once a month check-ins for medication and therapy, brief psychotherapy sessions, or a referral to a process group.

Tip: Relapse or resurgence of PTSD symptoms is common and should be viewed as part of the conceptualization of complex trauma. Education around the nature of PTSD that some triggers may cause “flare-ups” in symptoms and that the client may need a few “booster sessions” focused on coping with triggers. It is useful to discuss this with clients so that they may develop more of an acceptance based mindset around dealing with triggers rather than viewing it as a failure of treatment.

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