



Service satisfaction and utilization among sexual assault survivors seeking assistance at the Rape Trauma Service in Reykjavik Iceland

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**Lokaverkefni til cand.psych gráðu
Sálfræðideild
Heilbrigðisvíssindasvið**



HÁSKÓLI ÍSLANDS

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Lokaverkefni til cand.psych gráðu í sálfræði

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Abstract

Sexual violence is a serious public health problem that has resulted in the establishment of professional, multidisciplinary service centers for victims in most of the Nordic countries. In Iceland a Rape Trauma Service (RTS) was established in 1993. The RTS is a multidisciplinary service clinic that provides free comprehensive and immediate 24 hour service to all sexually victimized adolescents and adults. In addition to acute medical, forensic, legal and psychological services the clinic offers follow-up psychological services due to the potential severe psychological consequences of sexual assault. According to research a big proportion of sexual assault survivors do not utilize the available service after trauma, even though the trauma can have very serious consequences for the survivor, the most common one being PTSD. The purpose of this study was to examine survivors' views of the RTS services and in particular the follow-up psychological services, as well as reasons for not accepting psychological services. Furthermore, the goal was to examine the relationship between the initial post assault psychological symptoms (depressive symptoms, posttraumatic stress symptoms) and service utilization as well as survivors' views of the RTS services and service. The participants of the study were 91 female survivors who had sought the RTS services in the years 2010 to 2014 and agreed to participate in a service satisfaction survey. Three levels of follow-up psychological services at the RTS were defined: psychological first aid, follow-up psychosocial support and cognitive processing therapy (CPT). The results indicated that most survivors were happy with the RTS services and would recommend it to others. The most common reason given for not accepting or utilizing the follow-up psychological services were e.g. "I wasn't ready to face what happened" and "The service was too far away from my home" which were categorized as avoidance. Those participants who utilized the follow-up psychological service described a desire for more psychology sessions after finishing treatment. No relationship was found between service utilization and age, initial depressive symptoms, and survivor's views of

the RTS. A significant relationship was found between posttrauma symptoms and service utilization indicating that participants with higher initial posttrauma symptoms utilized more psychological services. Consistent with prior studies it seems important to inform participants of the counterproductive avoidance that can follow trauma, as well as consider offering more therapy or follow-up sessions to increase service satisfaction.

According to the World Health Organization sexual violence is defined as

... any sexual act, attempt to obtain a sexual act, or other act directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part or object (World Health Organization, 2011).

Also when someone is unable to give consent due to being mentally incapacitated, while drugged, asleep or intoxicated it is considered sexual violence (World Health Organization, 2012). There exist many more similar definitions for sexual violence some of which are more narrow or broad.

Sexual abuse can have serious psychological consequences for the survivor, for example depression, substance abuse/dependence, anxiety disorders, eating and, sexual disorders (Burnam et al., 1988; Faravelli, Giugni, Salvatori & Valdo, 2004; Resnick & Kilpatrick, 1993). The most frequently reported psychological consequence is posttraumatic stress disorder (PTSD) (Faravelli, Giugni, Salvatori & Valdo, 2004; Resick, Monson & Chard, 2014; Resnick & Kilpatrick, 1993). Up to half of rape survivors are diagnosed with PTSD (American Psychiatric Association, 2013; Kilpatrick et al., 2003) and they are more than 80% more likely to develop symptoms of other mental disorders than those without PTSD (American Psychiatric Association, 2013). PTSD is defined by the American Psychiatric Association (2013) as a development of characteristic symptoms following exposure to a traumatic event. The characteristic symptoms group together in four clusters which are intrusive symptoms associated with the traumatic event, persistent avoidance of anything that triggers memory of the event, negative alterations in cognition and mood, and marked alterations in arousal and reactivity. The symptoms must be present for at least a month after

the traumatic event and cause clinically significant interference and/or distress in important aspects of functioning to be diagnosed as PTSD (American Psychiatry Association, 2013).

PTSD has been defined as a disorder of non-recovery of trauma symptoms and National Institute for Health and Care Excellence (NICE guidelines) advice watchful waiting during the first month following a traumatic event (National Institute for Health and Care Excellence, 2005). Studies show that half of all trauma survivors recover in the first three months following the trauma without formal treatment and a good indicator for whether a person will recover naturally is the magnitude of the immediate post-assault trauma symptoms (National Institute for Health and Care Excellence, 2005). When a person's trauma symptoms don't diminish within the first month after the traumatic event PTSD may be developing and assistance of formal psychological treatment may be needed (American Psychiatric Association, 2013). However natural recovery can still happen up to two or three years after the event (National Institute for Health and Care Excellence, 2005). According to the guidelines provided by the National Institute for Health and Care Excellence (NICE, 2005) either trauma focused cognitive behavioral therapy (CBT) or eye movement desensitization and reprocessing (EMDR) should be offered as a first line of treatment after PTSD has been diagnosed.

In order to meet the needs of survivors, multidisciplinary acute service centers have been established. In 1986 the first Nordic multidisciplinary service center was opened in Oslo, Norway. Following Norway the Rape Trauma Service (RTS) was opened in Landspítali – The National University Hospital of Iceland in 1993. The RTS is a multidisciplinary service clinic that provides free comprehensive and immediate 24 hour service to all sexually assaulted adolescents and adults in the population. It offers rape survivors the services of a variety of professionals that are trained in the care of rape survivors. The survivor is offered medical examination, forensic medical exam, medical follow-up, a phone call or an

appointment(s) with a psychologist, and a lawyer. Survivors under the age of 18 are referred to services at Barnahús, a service center for children under the age of 18 that have been sexually abused. Before the RTS was founded the survivor had to seek professional services in different locations, with the RTS the services have become much more accessible for the survivor. Since the RTS opened in 1993 and through the year 2015 the RTS has received 2585 visits by sexual assault survivors seeking the services offered by the clinic.

Despite its importance very few studies have examined the service utilization of these centers and survivors views of the services. A study by Nesvold, Worm, Vala and Agnarsdóttir (2005) compared the open multidisciplinary centers in Oslo and Reykjavik versus the forensic medical examination that was only available to victims that reported the assault to the police in Copenhagen and Helsinki on the victims' frequency to seek help and report to the assault to the police. The results were that the open multidisciplinary centers had the highest attendance rates and reports to the police. In particular the results showed that Iceland had the highest attendance rates and reports to the police when the figures were related to the population at risk (Nesvold et al., 2005)

As was mentioned earlier there is a variety of services by multiple professionals that are available to the survivors at the RTS, it is up to the survivors which services they accept. A research by Sveinsdóttir (2012) rape survivors' psychological service utilization at the RTS in Landspítali was recorded. Her results were that of the 501 survivors during the years 2007 to 2010 only 367 survivors accepted to receive a phone call from a psychologist, 86 survivors refused the phone call, and the remaining 48 survivors received some service other than the RTS provided. Of those 367 survivors that accepted to phone call only 141 received crisis counseling by a psychologist within the RTS, 47 survivors were referred to psychological service outside the RTS, 102 survivors were referred to some other service than the RTS provided, and 77 survivors refused the services of a psychologists (Sveinsdóttir, 2012). Of

those 141 survivors that accepted the phone call from the RTS psychologists 73 were given psychological treatment for PTSD at the RTS. Of those 73 that received treatment 26 terminated the treatment without finishing the treatment and recovering from the PTSD symptoms according the psychologists' reports (Jónasdóttir, 2013; Sveinsdóttir, 2012).

Despite services being available and the severity of the consequences of sexual violence, it is estimated that only a quarter of survivors of rape seek acute service centers following assault and only a proportion of those seeking help continue to utilize the recommended follow-up services despite ongoing post-assault trauma symptoms (Price, Davidson, Ruggiero, Acierno, & Resnick, 2014). The literature does not always come to an agreement on what is likely to increase or decrease survivors' service utilization after sexual abuse. According to research PTSD symptoms are usually considered an indicator of using RTS services (Amstadter, McCauley, Ruggiero, Resnick, & Kilpatrick, 2008; Amstadter et al., 2010; Elhai, North, & Frueh, 2005; Starzynski, Ullman, Townsend, Long, & Long, 2007; Ullman, & Brecklin, 2002). Although not all studies have found this connection. Results in a study by Price et al. (2014) indicated that one day depression predicted service utilization better than PTSD after sexual assault. A study by Jónasdóttir (2013) found that survivors with more PTSD symptoms were more likely to terminate treatment thus having negative impact on service utilization. The literature mostly agrees on that survivors are more likely to accept RTS services when they are in fear of sexually transmitted diseases, pregnancy and want to press charges against the abuser (Holmes, Resnick, & Frampton, 1998; Nesvold et al., 2005; Resnick et al., 2000). There is inconsistency regarding whether alcohol and drug use effects service utilization. According to Price et al. (2014) survivors with alcoholic/drug addiction before the sexual abuse occurred were four times more likely to seek help than other survivors. In contrast Sveinsdóttir (2012) found no such indication in her research on survivors after sexual assault. According to studies by Guðbjartsdóttir (2013) and Jónasdóttir

(2013) survivors who had willingly consumed alcohol or drugs previously to the sexual abuse were less likely to seek help. Furthermore Price et al. concluded that an indicator of whether survivors would seek help was if they had received any psychological service before the trauma occurred. If the assault was stereotypical in nature, that is, if the assault happened unexpectedly and the perpetrator was a stranger the survivor is more likely to seek and accept RTS services. If however the survivor is married to the perpetrator or knows him or her the survivor is less likely to accept the event as assault and then again less likely to seek the RTS services (Mahony, 1999; Ullman & Filipas, 2001). It is not clear in the literature whether age has affect or not on service utilization. According to Ullman and Brecklin (2002) and Starzynski (2007) older survivors are more likely to seek help and accept service after sexual abuse rather than younger survivors. In contrast to those studies Guðbjartsdóttir (2013), Nesvold (2008) and Sveinsdóttir (2012) all found indication that younger aged survivors were more likely to accept RTS services than older survivors. Other variables have been found to show indication to increase service utilization such as being employed, being a student and being homosexual or bisexual (Guðbjartsdóttir, 2013; Starzynski et al., 2007). It is not clear what predicts service utilization after sexual abuse since the literature does have some contradicting results but likely predictors are survivors' depressive symptoms, fear of diseases and pregnancies, connection to the abuser, former psychological service, plans to press charges against the abuser, the severity of the assault, employment, and sexuality. However, the impact of survivors' age, posttrauma symptoms, and alcohol and drug addiction, have been shown to have some contradicting results.

A small research by Eriksen et al. (2002) interviewed women about their experience at the rape service center (RSC). Their research revealed that the women who sought the RSC were happy with the services they received and in particular with the nurses that they were assigned. They noted that the women appreciated when the nurses respected them as whole

persons, in offering them food and water and being concerned for their comfort in general. They also noted that being touched in a supportive manner was very comforting to them and made going through a forensic examination a much more durable experience (Eriksen et al., 2002). Another study by Welch (2010) on patient satisfaction in emergency departments revealed that what correlated most with patient satisfaction were timeliness of care, empathy, technical competence, information dispensation, and pain management.

The goal of the present study was to examine service utilization when seeking help at the RTS following sexual assault in the years 2010 through 2014. Also, this study examined survivors' attitudes towards the RTS and the follow-up psychological services offered at the RTS. Reasons for not accepting post assault follow-up psychological services and the reasons for early termination from therapy were also examined. It was hypothesized that there would be a correlation between survivors' age and whether survivors accepted follow-up psychological services and whether they completed treatment. It was hypothesized that younger age would have a positive correlation with accepting and completing service. It was also hypothesized that more initial depressive and posttraumatic stress symptoms would positively correlate with higher levels of service utilized, and that more satisfaction with the follow-up psychological services would be positively correlated with the more utilized levels of service.

Method

Participants

Participants were 91 sexual assault survivors that sought the services of the RTS in Landspítali in the years 2010 through 2014 and answered the service utilization survey fully or partially. Of the 444 survivors that had sought the services at the RTS, 212 were reachable through the phone. Of the 194 individuals who accepted to receive the survey via mail 91 answered the survey (48.2%). The participant age span was 18 – 60 with the mean age 25.7 and 6.8 as standard deviation. All participants were female.

Research design

This study was both a prospective and retrospective cohort study without a comparison group. Information for the study was obtained from the medical history of the participants that was documented during their service at the RTS in the years 2010 through 2014 and from a survey sent out to all participants who agreed to participate in 2015 and 2016 (see appendix I).

Measures

This study collected information about each survivor who sought the RTS services thru the years 2010 to 2014. Information was gathered from a nurse's report, doctor's report, psychologist's report, and a survey that was sent out to the participants. The survivors that came to the RTS thru the years 2010 to 2012 received and answered the survey in April 2015 and the survivors who came through the RTS during the years 2013 through 2014 received and answered the survey in April 2016. Information that the survivors gave at the RTS was coded on a standardized form which can be seen in appendix II.

Medical records.

The RTS nurses, doctors and forensic examiners gathered detailed information regarding the event, the severity of the event according to the NorVold Abuse Questionnaire, prior trauma history, the survivor's current mental state and performed a medical, gynecological and forensic exam. With these records as data source a checklist was designed to help gather information systematically. All RTS medical records from 1 January 2010 through 31 December 2014 were coded this way. All coding was done by four graduate students and one RTS psychologist and the inter-rater reliability was satisfactory.

NorVold

Severity of sexual violence was assessed using the categorization of the NorVold Abuse Questionnaire's (NorAQ). The questionnaire divides sexual violence into three categories ranging from mild sexual abuse to severe sexual abuse: *Mild* (touch of other body parts than genitals in a sexual way used for perpetrator's sexual satisfaction and/or sexual humiliation), *moderate* (touch of genitals or body used for perpetrator's sexual satisfaction) and *severe* (some form of penetration or attempted penetration; penis, other part of the body or an object into vagina, rectum or mouth) (Swahnberg & Wijma, 2003).

Psychologist report and levels of psychological service.

In the psychologist's report it was noted how many times the psychologist met with a survivor and what was the purpose of the sessions and whether or not the survivor completed or dropped out of therapy. The post-assault follow-up psychological service was categorized into three groups in regards to time interval from the assault. The first level of service was psychological first aid which was given to survivors within six weeks of the assault. The second level of service was follow-up psychosocial support without formal treatment. The

session was defined as follow-up psychosocial support if six or more weeks had passed since the assault. The third and highest level of service was cognitive processing therapy (CPT). Most survivors had already received psychological first-aid before receiving this highest level of service. CPT was only applicable a month after the trauma and if the survivor had been diagnosed with PTSD. The report also had the initial scores of a survivors PTSD, depressive and anxiety symptoms they were experiencing. The same method of coding was used for the psychologist reports as was done with the medical records.

PTSD Symptoms Scale-Self Report (PSS-SR)

To measure initial posttrauma symptoms during the sessions with a psychologist at the RTS the PTSD Symptoms Scale-Self Report was used (Foa et al., 1993). The PSS-SR is a self-report scale designed to measure the severity of trauma symptoms. The scale has 17 items and is a 4 point Likert-scale (scoring from 0-3), where higher scores indicate more severe trauma symptoms. The scale has three clusters; re-experiencing (items 1-5), avoidance and numbing (items 6-12) and arousal (items 13-17). A total score of 14 or higher indicates likelihood of PTSD. Psychometric research of the scale demonstrates good internal- and test-retest reliability and moderate internal validity (Foa et al., 1993)

Becks Depression Index (BDI-II)

To measure initial depressive symptoms during the sessions with a psychologist at the RTS Becks Depression Index was used (Beck, Steer and Brown, 1996). BDI-II is a self-report scale designed to measure the severity of depression symptoms of the two preceding weeks. The scale has 21 items and is a 4 point Likert-scale (scoring from 0-3), where higher score indicates more severe depression symptoms (Beck et al., 1996). Multiple studies on the original edition have shown good psychometrical qualities of the scale (Beck et al., 1996) and study of the Icelandic translation indicates that these qualities are maintained in the version

and that a cutoff score of 21 is the best criteria to determine between those with and without depression (Arnarsson, Ólason, Smári & Sigurðsson, 2008).

General service satisfaction.

General service views were evaluated with the question: “How satisfied were you with the service you received at RTS?”. Participants were asked to base their answer on a five point Likert scale: Very unhappy, somewhat unhappy, neither unhappy nor happy, somewhat happy and very happy.

Satisfaction of the psychological service.

Psychological service views were evaluated using the question: “In general how happy or unhappy were you with the psychological service you received at the RTS?”. The answers were assessed using a five point Likert scale: Very unhappy, somewhat unhappy, neither unhappy nor happy, somewhat happy and very happy. The usefulness of the psychology sessions were evaluated with the question “How useful/useless do you think your sessions were at dealing with the sexual assault?”. The answers were again on a five point Likert scale: Very useless, somewhat useless, neither useless nor useful, somewhat useful and very useful. Participants also had the choice to give open feedback on two questions regarding the RTS psychological services: “What in your opinion was the most helpful to you in regards to the RTS psychological services?” and “What do you think is missing in the RTS psychological service?”.

Service utilization of the psychological services and reasons for drop out.

Participants were asked to give an account of what kind of service they accepted at the RTS. Furthermore, participants were asked why they did not complete treatment after having accepted psychological service. If applicable the survey also asked participants to give the

reasons for not accepting any psychological services. The participants answered these questions with mostly standardized answers. Answers to the question that asked why a participant did not complete treatment after having already accepted the service were: “I didn’t believe that the service would help coping with the trauma”, “I wasn’t ready to face what happened” and “Emotional reasons”. There was also the option to answer this question with an open answer. Answers to the question that asked why a participant did not accept any psychological service at the RTS were: “I did not think I needed it”, “I didn’t believe that the service would help coping with the trauma”, “I wasn’t ready to face what happened”, “Emotional reasons”, “Physical health”, “The service was too far away from my home”, “I had a hard time getting to the location (e.g. I had no car etc.)”, “I couldn’t find the time (e.g. because of work, children, too busy etc.)” and there was an option for open answers as well.

Problems with the data.

The RTS reports are not equally precise. It can depend on the working staff how precise they are with their information gathering and the survivors may withhold some information. There was no way of knowing whether missing information was unknown or just not registered by the staff. Missing information and the category unknown are therefore merged together.

Procedure

This research is a part of a larger study, which is conducted by a cooperation group on behalf of Landspítali Háskólasjúkrahús and University of Iceland. The ethics committee of Landspítali gave permission for the research (admission nr. 2.2015) and notified The Data Protection Authority (Persónuvernd). The medical reports from the RTS doctors and nurses were read and documented, the nature of the psychological sessions and the assessments of the survivors depressive and posttrauma symptoms were found in the psychologists’ reports and documented. All this information was read and documented into a specially designed

forms (see appendix II). The forms were coded and anonymized when entered into the statistical program SPSS. Phone calls were made by psychologists of the RTS to all of the participants in the periods of 13.-17. April 2015 and 1.-20. April 2016 depending on when they sought the RTS, and those who answered and agreed to participate were sent a link to the online survey and information about the goals of the survey via e-mail or postal service (see appendix III). The survey asked about the survivors views of the RTS service in general and the psychological service in particular. The survey was administered in April 2015 and April 2016. The information from the online survey was also coded and grouped together with preexisting data of each participant. All participants had to give their informed consent before completing the survey. Two e-mails were sent to remind those who accepted to participate to fill out the survey. All participants were familiarized with their right to refuse to participate at any time in the survey.

Statistics

The statistical program SPSS was used to process the data. One-way ANOVA and Chi-Square tests were used to assess the relationships between the variables.

Results

The nature of arrivals at the RTS

Most survivors were 25 years old or younger (62.2%). The current age distribution of the participants can be seen in table 1 below.

Table 1. RTS survivors age distribution

| Age | Frequency | Percent |
|--------------|-----------|---------|
| 18 – 25 | 58 | 63.7% |
| 26 – 35 | 26 | 28.6% |
| 36 – 45 | 5 | 5.5% |
| 46 and older | 2 | 2.2% |

Most survivors (70%) came to the RTS following a severe sexual assault, some came after moderate sexual assault (7.8%) and the remaining survivors' reason for arrival was unknown. Around 70% of the survivors came to the RTS within 24 hours of the assault. According to RTS medical reports most survivors or 73.6% come to the RTS accompanied by someone, whether it is the police, a friend or a family member. Of the survivors that come to the RTS 44% reported to having experienced a prior trauma history. Of those survivors that have experienced prior trauma 22% have experienced rape or attempted rape before and 8.8% have been the victims of childhood sexual abuse. Only 2.2% disclose to have been to the RTS before regarding another case of sexual assault.

Service utilization and satisfaction

Results from the service utilization survey indicate that more survivors were happy with the RTS service than not. In particular, majority of participants (48.9%) were either somewhat happy or very happy with the overall service but almost one third (28.4%) were either somewhat or very unhappy with the service. Great majority of participants were either somewhat happy or very happy or impartial with RTS facilities but 14.3% thought that the

reception and facilities were somewhat bad or very bad. The survivors' answers are displayed in figures 1 and 2 respectively.

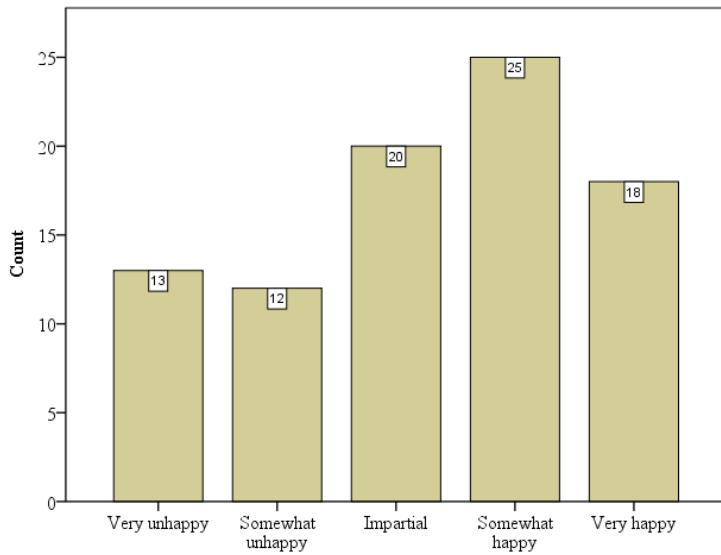


Figure 1. Survivors' views on the quality of service at the RTS.

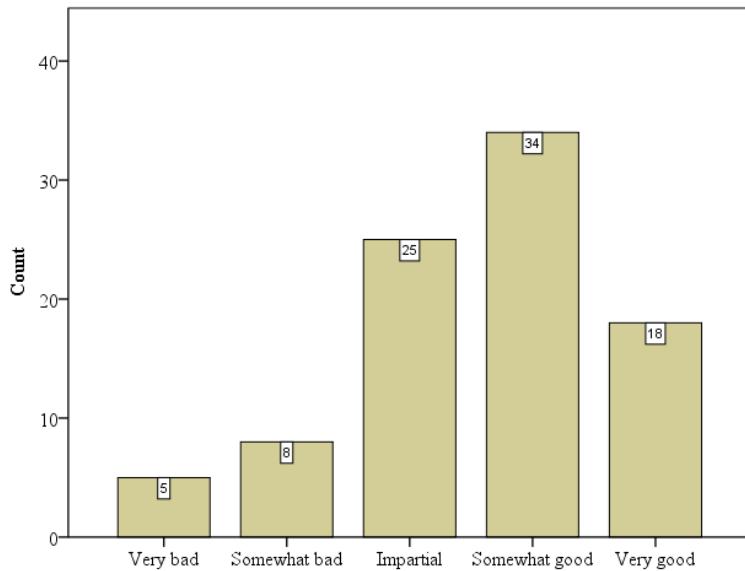


Figure 2. Survivors' views of the RTS facilities.

Participants were asked the open ended question "What do you think is missing in the RTS service?" which 33 answered. The most common complaint, which 19 participants complained about was the lack of warmth and understanding from the ER and RTS staff as well as lack of professionalism when dealing with sexual assault survivors. Also, ten participants complained about the waiting room and facilities. Participants thought it was not acceptable to have to wait with other ER patients in the same

waiting room and they thought the RTS exam room to be unwelcoming. Some participants (n=4) complained about wanting to talk to a psychologist straight away when arriving at the RTS and five participants wanted better psychological service and more follow-up from the RTS staff. Majority of the participants answered that they were either somewhat likely or very likely to refer a friend in a similar situation to the RTS, three were impartial and one thought it very unlikely (see figure 3). Only 27 participants answered this particular question.

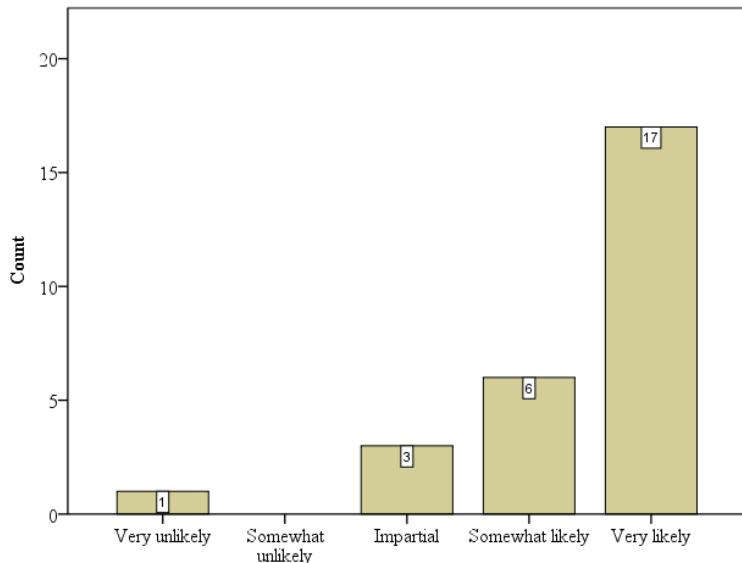


Figure 3. How likely survivors are to refer a friend to the RTS.

Psychological utilization

Survivors have the choice to receive a phone call from a psychologist a few days after arriving at the RTS. A large majority of the survivors accepted this service level or 77 of them (84.6%). Of those who accepted the offer of being contacted by a psychologist, 45 survivors met with the psychologist (49.5%). The level of service participants received is displayed in figure 4. Psychological first aid was considered first level of service, follow-up psychosocial support following psychological first aid considered second level of service and cognitive processing therapy as third level of service. Nine participants received follow-up service without first receiving psychosocial support because they accepted the service at least six weeks after the traumatic event, those participants fell in to the second level of service.

Three participants received CPT without first receiving either psychological first aid or follow-up psychosocial support. Of the 45 participants who utilized the psychological services 13 stopped treatment on or after the first level of treatment and 16 stopped treatment on or after the second level of treatment.

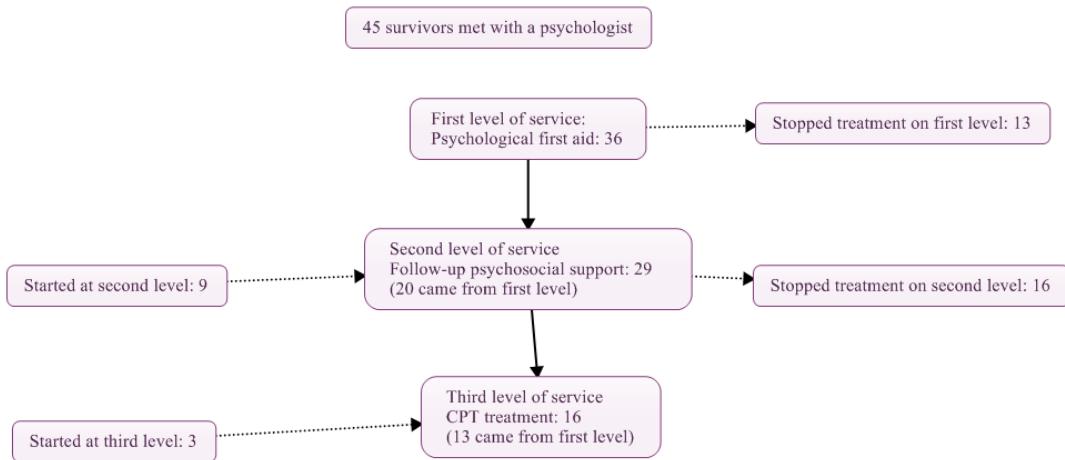


Figure 4. The levels of psychological service participants received at the RTS.

Results from the service utilization survey indicate that most survivors (71.4%, figure 5) were happy with the psychological service and thought it helped them cope with the trauma (71.4%, figure 6). However six participants were somewhat or very unhappy with the psychological service (see figure 5) and four participants thought the service to be somewhat or very useless.

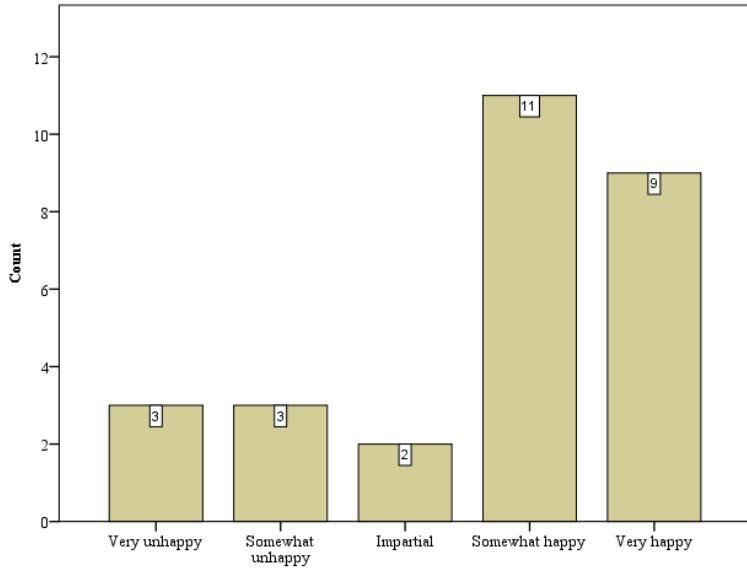


Figure 5. Survivors' views on the psychological service at the RTS.

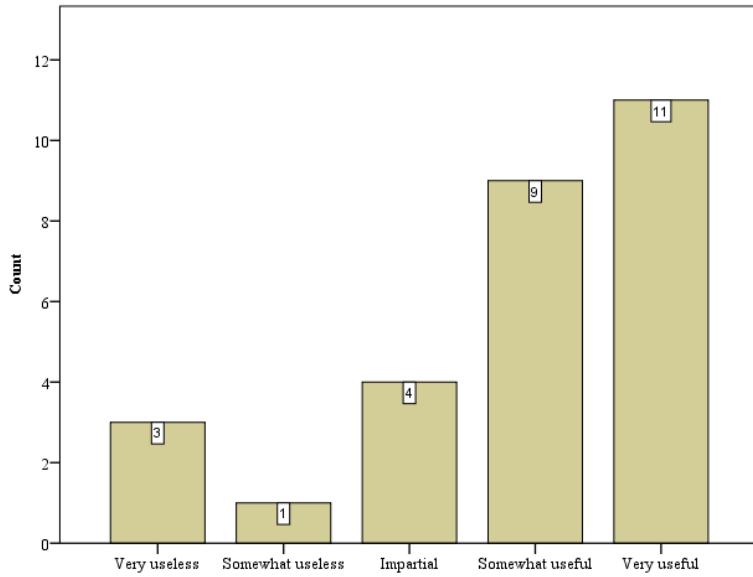


Figure 6. Survivor's views of the usefulness of the psychological service at the RTS.

The reasons given in the service utilization survey for not meeting with the RTS psychologist are listed in table 2. Of the 36 participants that did not receive psychological follow-up service participants 26 answered this question in the survey. Participants were asked two open ended questions regarding the RTS psychological service. These questions were “What did you think was the most helpful element of the RTS psychological service?” and “What do you think is lacking in the RTS psychological service (something you would have wanted help with)?” Of all the participants that agreed to take the survey 19 participants answered the

former question and 12 the latter. Of those who answered five participants said that the most helpful element was to talk to someone impartial and five said that getting a proper diagnosis and treatment was most helpful. Other five said that having their feelings normalized was the best element and other two said that the flexibility and availability. The most common answers to what was lacking in the RTS psychological services five participants wanted more therapy sessions and/or follow-up sessions and three complained about the timing that the service was offered. Of those who answered the survey almost 19% of participants were not interested in services. 11.5% did not realize the service was available to them but 42% were referred elsewhere, of which 8.8% were referred to Barnahús and the remaining 33.5% were referred to unknown services.

Table 2. Reasons for not meeting with an RTS psychologist.

| Reasons | Frequency | Percentage |
|---|-----------|------------|
| I didn't want the service of the RTS psychologist | 5 | 19.2% |
| I was referred elsewhere | 11 | 42.3% |
| I didn't realize the service was available to me | 3 | 11.5% |
| I don't remember why | 6 | 23.1% |
| I wasn't ready at the time | 1 | 3.8% |

Participants were asked to list reasons for declining follow-up psychological services of the RTS and 12 answered this question in the survey and could give multiple answers. Almost all the answers (n=11) gave reasons that could be interpreted as avoidance (e.g. it was too hard to get to the location of the service or I didn't believe they I was ready). Half of those who answered declined psychological services because of emotional reasons such as shame, self-blame, anxiety and sadness. Two participants thought that they didn't need the service or thought that the service would be of no use to them and other two were already meeting with psychologists and one had other issues that were more pressing to deal with at the time. Some participants don't remember their answers or if they were offered the service.

Reasons for not completing psychological treatment

About half of the survivors who accepted treatment (n=21, 23.1%) discontinued psychological treatment in coordination with the psychologist. Some participants refused treatment after it had already begun (n=6, 6.6%) or stopped showing up for appointments (n=15, 6.6%), the reasons for terminating treatment for the remaining survivors is unknown. Only eight participants gave answers for terminating treatment. Three said “I didn’t believe that the service would help coping with the trauma”, three said “I wasn’t ready to face what happened” and two said “Emotional reasons (e.g. anxiety, shame, self-blame, sadness).

Age and the utilization of the psychological service

A one-way ANOVA was used to assess whether survivors’ age would be different depending on whether or not they utilized the psychological service following the sexual assault. The one-way ANOVA, $F(1, 80) = 1.22$, $MSE = 58.12$, $p = 0.27$, did not show statistically significant difference between the age of those who utilized the psychological service and those who didn’t. The mean age and standard deviation for those who didn’t receive treatment was $M = 22$, $SD = 7.5$ and for those who received treatment was $M = 23.7$, $SD = 6.4$. Furthermore, no significant difference was found between survivors who completed psychological treatment or dropped out, $F(1, 40) = 0.73$, $MSE = 27.52$, $p = 0.40$ in regards to age. The mean age for those who didn’t complete treatment was $M = 22.7$ with $SD = 4.4$ and the mean age for those who completed treatment was $M = 24.3$ and $SD = 7.5$.

Depressive symptoms and the highest level of utilization of the psychological service

A Chi-Square test was used to examine the relationship between depressive symptoms at the first assessment and the highest level of service utilized by participants. A cut-off score of 21 was used to categorize the participants (Arnarson et al., 2008). The number of participants

that scored above the cut-off score at the initial depressive symptoms assessment were 25. No significant difference was found between survivors who utilized higher levels of service, $F(1) = 5.32, p = 0.07$, and those who did not.

Trauma symptoms and the highest level of utilization of the psychological service

A one-way ANOVA was used to assess whether survivors' trauma symptoms at the first assessment would be different depending on the highest level of service utilized. The one-way ANOVA, $F(2, 40) = 3.40$, $MSE = 306.6, p = 0.04$, showed significant difference between the groups. A Bonferroni post-hoc test was used to evaluate where the difference between the groups was. The results showed a significant difference between participants in follow-up psychosocial support and those in CPT, $t(31) = 2.47, p = 0.054$. However the results did not show a significant difference between participants in psychological first aid only and follow-up psychological support, $t(31) = 0.29, p = 1.00$, or between participants in psychological first aid only and CPT, $t(31) = 1.85, p = 0.22$. The means and standard deviations for these three groups were as follows: *Psychological first aid M = 26.8 and SD = 10*, *Follow-up psychosocial support M = 25.7 and SD = 11.5*, and *CPT M = 33.9 and SD = 6.3*.

Participants views of the service and the highest level of utilization of the psychological service

A one-way ANOVA was used to assess whether survivors' views would differ depending on the highest level of psychological service they utilized. Results did not show a difference between participants views of the service and levels of utilization of the psychological service, $F(2, 40) = 0.78$, $MSE = 1.69, p = 0.47$. The means and standard deviations for the different levels of service were as follows: *Psychological first aid M = 3.0 and SD = 1.7*, *Follow-up psychosocial support M = 2.7 and SD = 1.2*, and *CPT M = 3.4 and SD = 1.5*.

Results of a one-way ANOVA assessing whether participants views of the RTS reception and facilities would differ depending on their highest level of utilization of the psychological service did not show a difference, $F(2, 42) = 0.46$, $MSE = 0.66$, $p = 0.63$. The means and standard deviations for the different levels of service were as follows: *Psychosocial first aid* $M = 3.85$ and $SD = 1.4$, *Follow-up psychosocial support* $M = 2.47$ and $SD = 0.94$, and *CPT* $M = 2.47$ and $SD = 1.25$.

A one-way ANOVA was used to assess whether survivors' views of the RTS psychological service would differ depending on the highest levels of psychological service they utilized. Results did not show a difference between participants views of the psychological service and levels of utilization of the psychological service, $F(2, 16) = 0.55$, $MSE = 1.21$, $p = 0.59$. The means and standard deviations for the different levels of service were as follows: *Psychological first aid* $M = 3.3$ and $SD = 1.2$, *Follow-up psychosocial support* $M = 3.4$ and $SD = 4.1$, and *CPT* $M = 4.1$ and $SD = 1.4$.

A one-way ANOVA was used to assess whether survivors' views of the usefulness of the RTS psychological service would differ depending on the highest level of psychological service they utilized. Results did not show a difference between participants views of the usefulness of the psychological service and the levels of utilization of the psychological service $F(2, 16) = 0.74$, $MSE = 1.30$, $p = 0.49$. The means and standard deviations for the different levels of service were as follows: *Psychological first aid* $M = 3.7$ and $SD = 0.6$, *Follow-up psychosocial support* $M = 3.4$ and $SD = 1.7$, and *CPT* $M = 4.2$ and $SD = 1.1$.

Discussion

The main purpose of this study was to examine the RTS service utilization and views from those who were offered the services, in particular the psychological service, for the years 2010 to 2014. The goal was also to examine the relationship between survivors' age and their post-trauma follow-up psychological service, as well as examining the relationship between the levels of psychological service and initial depressive symptoms, initial trauma symptoms and survivors views of the service.

No relationship was identified between age and psychological utilization. The literature is inconclusive on the effect age has on psychological service utilization. In the current study majority of participants were between 18 and 25. It is possible that for this age group survivors' age may not have an impact on their utilization. Further examination is needed to determine the relationship between age and service utilization.

According to Price et al. (2014) one day depression predicted service utilization after assault better than PTSD. The results in this study do not comply with that assumption. Depressive symptoms at first assessment did not associate with the utilized levels of service, however the depressive symptoms in this study was assessed later than by Price et al. where the assessment was conducted as a 1 day following the assault. In the current study the assessment was conducted in most cases at the first psychological session which was conducted a few days up to a week after the assault. The more trauma symptoms survivors had at first assessment was associated with higher levels of psychological service utilized by the survivor. That is, if survivors had many initial posttrauma symptoms then they most likely went on to utilize a higher level of psychological service than a survivor who exhibited less posttrauma symptoms. That is consistent with the literature as PTSD is commonly linked with more psychological service utilization. According to research PTSD symptoms are usually considered an indicator of using posttrauma psychological services (Amstadter,

McCauley, Ruggiero, Resnick, & Kilpatrick, 2008; Amstadter et al., 2010; Elhai, North, & Frueh, 2005; Starzynski, Ullman, Townsend, Long, & Long, 2007; Ullman, & Brecklin, 2002). These results are also consistent with studies that show that a good indicator for whether a person will recover naturally is the magnitude of the immediate post-assault trauma symptoms and a survivor should only receive a formal CPT treatment after being diagnosed with PTSD (National Institute for Health and Care Excellence, 2005). If a survivor had sub threshold PTSD symptoms follow-up psychosocial support was administered.

Only one survey participant claimed he would be very unlikely to recommend the RTS to a friend after a form of sexual assault, all other participants were somewhat likely, very likely or neither likely nor unlikely to recommend the RTS to a friend. Most survivors were very happy or somewhat happy with the service they received at the RTS according to the survey and an even bigger proportion thought the RTS facilities were somewhat good or very good. However, almost a third of the survivors were somewhat or very unhappy with the service at the RTS. Based on the current study few important factors could be addressed to improve service satisfaction. In Particular, it seems important to offer the survivors service very shortly after they arrive at the RTS and make sure that they don't have to wait with other ER patients as the survivors are very often in an emotional shock and discomfort. Offering survivors services right away or offer them to wait in a more private location may increase the comfort level of the survivor. Also, it might increase survivors' satisfaction if the staff at the ER and RTS received more training in how to approach sexual assault survivors and make them feel safe

Only a small proportion accepted the follow-up psychological services. Of those who accepted the service almost a third of the participants (28.3%) utilized only the psychological first aid, and almost equal proportions received follow-up psychosocial support and CPT treatment (35.0% and 37.0%). This small acceptance rate of service is consistent with other

studies (Price, et al., 2014). As the survey indicated some survivors already had psychological service and therefore did not seek the RTS service and others didn't know the service was available to them at all. Some survivors gave reason for refusing the follow-up psychological service that can be categorized as trauma related avoidance behavior, for example refusing treatment when it is offered or not showing up for treatment session because that would force the survivor to think and talk about the trauma.

The most common answers to what survivors thought was most helpful about the psychological service was to talk to someone impartial about their experiences, and to get an appropriate mental diagnosis and then the following treatment. The most common complaint about the RTS psychological service was that survivors wanted more sessions and follow-up after the treatment ended. The reasons for dropping out of therapy were also trauma related avoidance and dissatisfaction with the service.

From these results it can be assumed that most survivors are satisfied with the RTS post-assault follow-up psychological services. However not all survivors seem to realize that the RTS offers psychological service. To increase the service utilization among survivors the RTS might consider some ways to make survivors more aware of the service available to them. Also in order to increase psychological service utilization it seems important to help survivors realize that avoidance is a common trauma symptom and appears for example in avoiding treatment and talking about the trauma and that avoidance does the survivor more harm than good in coping with the trauma. As well as making sure the survivors know that the psychological service will be available to them later on even though they are not ready to accept it at the time it is offered. Perhaps some other form of therapy might be needed for example an online therapy since some survivors drop out of service due to dissatisfaction with the service. To increase overall satisfaction with the psychological service more follow-up after treatment might be needed.

The limitations of this study are that the results were produced with a small sample and need to be replicated with a bigger one and not enough statistical power to make a linear regression analysis. Also the data gathered in the service utilization survey was retrospective and survivors views might have altered since the event and some survivors couldn't give answers to the questions because such long time had passes since they utilized the services.

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Appendix I.

Spurningalisti um þjónustunýtingu, lýðfræðilegar upplýsingar og heilsuhegðun

Spurningar um þjónustunýtingu Neyðarmóttökunnar:

1. Hver vísaði þér á Neyðarmóttökuna? Vinsamlegast merktu við allt sem við á.

- | | |
|-----------------------------|---------------------------------------|
| 1. <input type="checkbox"/> | Móðir |
| 2. <input type="checkbox"/> | Faðir |
| 3. <input type="checkbox"/> | Vinur/vinkona |
| 4. <input type="checkbox"/> | Maki |
| 5. <input type="checkbox"/> | Ættingi |
| 6. <input type="checkbox"/> | Lögregla |
| 7. <input type="checkbox"/> | Heilbrigðisstarfsmaður |
| 8. <input type="checkbox"/> | Prestur |
| 9. <input type="checkbox"/> | Annar. Vinsamlegast tilgreinið: _____ |

2. Hvaða aðstoð og/eða þjónustu varstu að leita eftir þegar þú leitaðir á Neyðarmóttökuna?

Vinsamlegast merktu við allt sem við á.

- | | |
|-----------------------------|---------------------------------------|
| 1. <input type="checkbox"/> | Læknis-/réttarlæknisskoðun |
| 2. <input type="checkbox"/> | Hjúkrunarþjónustu |
| 3. <input type="checkbox"/> | Lögfræðipjónustu (réttargæslumaður) |
| 4. <input type="checkbox"/> | Sálfræðipjónustu |
| 5. <input type="checkbox"/> | Stuðningi og ráðgjöf |
| 6. <input type="checkbox"/> | Vissi það ekki |
| 7. <input type="checkbox"/> | Annað. Vinsamlegast tilgreinið: _____ |

3. Hvaða fagaðila hittir þú hjá Neyðarmóttökunni? Vinsamlegast merktu við allt sem við á.

- | | |
|-----------------------------|----------------------------|
| 1. <input type="checkbox"/> | Hjúkrunarfræðing |
| 2. <input type="checkbox"/> | Lækni |
| 3. <input type="checkbox"/> | Lögfræðing/réttargæslumann |
| 4. <input type="checkbox"/> | Sálfræðing |

4. Ef þú hittir ekki sálfræðing hjá Neyðarmóttökunni, hver heldur þú að hafi verið ástæðan?

Vinsamlegast merktu við allt sem við á.

- | | |
|-----------------------------|---|
| 1. <input type="checkbox"/> | Vildi ekki þjónustu sálfræðings Neyðarmóttökunnar |
| 2. <input type="checkbox"/> | Var vísað annað |
| 3. <input type="checkbox"/> | Var hjá sálfræðingi/í meðferð annars staðar |
| 4. <input type="checkbox"/> | Annað. Vinsamlegast skýrið: _____ |

5. Ef þú þáðir ekki sálfræðipjónustu Neyðarmóttökunnar, af hverju heldur þú að það hafi verið? Vinsamlegast merktu við allt sem við á.

- | | |
|-----------------------------|---|
| 1. <input type="checkbox"/> | Fannst ég ekki þurfa á henni að halda |
| 2. <input type="checkbox"/> | Trúði ekki að aðstoðin myndi hjálpa mér við að takast á við kynferðisofbeldið |
| 3. <input type="checkbox"/> | Var ekki tilbúin/n til að takast á við það sem gerðist á þeim tíma sem mér var boðin þjónusta |
| 4. <input type="checkbox"/> | Tilfinningalegar ástæður (t.d. kvíði, skömm, sjálfsásökun, depurð) |
| 5. <input type="checkbox"/> | Líkamleg heilsa |
| 6. <input type="checkbox"/> | Þjónustan var of langt í burtu frá heimili mínu |
| 7. <input type="checkbox"/> | Átti erfitt með að koma mér á staðinn (t.d. hafði ekki bíl, enginn gat keyrt mig) |
| 8. <input type="checkbox"/> | Átti erfitt með að komast frá t.d. vegna vinnu, umönnun barna, of upptekin/n við annað, o.fl. |
| 9. <input type="checkbox"/> | Annað. Vinsamlegast skýrið: _____ |

6. Hve ánægð/ur eða óánægð/ur varstu með þá þjónustu sem þú fékkst á Neyðarmóttökunni?

- | | |
|---------|------------------|
| 1. ____ | Mjög óánægð/ur |
| 2. ____ | Nokkuð óánægð/ur |
| 3. ____ | Hlutlaus |
| 4. ____ | Nokkuð ánægð/ur |
| 5. ____ | Mjög ánægð/ur |

7. Hve góð/slæm fannst þér aðkoman og aðstaðan á Neyðarmóttökunni (t.d. móttakan á bráðamóttöku, biðherbergi, aðstaða Neyðarmóttöku)?

- | | |
|---------|-------------|
| 1. ____ | Mjög góð |
| 2. ____ | Nokkuð góð |
| 3. ____ | Hlutlaust |
| 4. ____ | Nokkuð slæm |
| 5. ____ | Mjög slæm |

7a. Hvað fannst þér vanta upp á þjónustu Neyðarmóttökunnar almennt?

Spurningar um Sálfræðiþjónustu Neyðarmóttökunnar

Ef þú hlaust einhver viðtöl við sálfræðing vinsamlegast svaraðu eftirfarandi.

Ef þú hlaust ekki viðtöl hjá sálfræðingi vinsamlegast svaraðu næst spurningu 16.

8. Á heildina litið hve ánægð/ur eða óánægð/ur varstu með þá sálfræðiþjónustu sem þú fékkst á Neyðarmóttökunni?

- | | |
|---------|------------------|
| 1. ____ | Mjög óánægð/ur |
| 2. ____ | Nokkuð óánægð/ur |
| 3. ____ | Hlutlaus |
| 4. ____ | Nokkuð ánægð/ur |
| 5. ____ | Mjög ánægð/ur |

9. Hve gagnleg/ógagnleg fannst þér viðtöl hjá sálfræðingi vera við að takast á við kynferðisofbeldið?

- | | |
|---------|-----------------|
| 1. ____ | Mjög ógagnleg |
| 2. ____ | Nokkuð ógagnleg |
| 3. ____ | Hlutlaus |
| 4. ____ | Nokkuð gagnleg |
| 5. ____ | Mjög gagnleg |

10. Hverjar voru ástæður þess að sálfræðipjónustu lauk?

1. _____ Mér leið betur, þurfti ekki meiri þjónustu
2. _____ Ég vildi ekki meiri þjónustu
3. _____ Mér var vísað í aðra þjónustu
4. _____ Annað. Vinsamlegast tilgreinið: _____

11. Ef þú hættir í viðtolum hjá sálfræðingi áður en þér leið betur, hverja telur þú ástæðuna vera?

1. _____ Trúði ekki að aðstoðin myndi hjálpa mér við að takast á við kynferðisofbeldið
2. _____ Var ekki tilbúin/n til að takast á við það sem gerðist
3. _____ Tilfinningalegar ástæður (t.d. kvíði, skömm, sjálfsásökun, depurð)
4. _____ Líkamleg heilsa
5. _____ Þjónustan var of langt í burtu frá heimili mínu
6. _____ Átti erfitt með að koma mér á staðinn (t.d. hafði ekki bíl, enginn gat keyrt mig)
7. _____ Átti erfitt með að komast frá vegna t.d. vinnu, umönnun barna, of upptekin við annað, o.fl.
8. _____ Annað. Vinsamlegast tilgreinið: _____

12. Við lok sálfræðipjónustu, hversu bætt var líðan þín frá upphafi þjónustu?

1. _____ 0%
2. _____ 10%
3. _____ 20%
4. _____ 30%
5. _____ 40%
6. _____ 50%
7. _____ 60%
8. _____ 70%
9. _____ 80%
10. _____ 90%
11. _____ 100%

13. Hversu líkleg/ur eða ólíkleg/ur ert þú til að mæla með sálfræðipjónustu Neyðarmóttökunnar við vin sem lenti í svipuðum atburði?

1. _____ Mjög ólíkleg/ur
2. _____ Nokkuð ólíkleg/ur
3. _____ Hlutlaus
4. _____ Nokkuð líkleg/ur
5. _____ Mjög líkleg/ur

14. Hvað fannst þér hjálplegast við sálfræðipjónustu Neyðarmóttökunnar?

15. Hvað fannst þér vanta upp á hjá sálfræðipjónustu Neyðarmóttökunnar (hefðir viljað fá aðstoð við)?

Spurningar um þjónustunýtingu utan Neyðarmóttökunnar:

16. Hefur þú leitað til eftirfarandi fagaðila vegna tilfinningalegra vandamála sem þú upplifðir út af kynferðisofbeldinu?

| | |
|--------------------|---|
| Til heimilislæknis | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. <input type="checkbox"/> Aldrei á síðustu 12 mánuðum 2. <input type="checkbox"/> 1-2 sinnum 3. <input type="checkbox"/> 3-4 sinnum 4. <input type="checkbox"/> 5-10 sinnum 5. <input type="checkbox"/> Oftar en 10 sinnum |
| Til geðlæknis | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. <input type="checkbox"/> Aldrei á síðustu 12 mánuðum 2. <input type="checkbox"/> 1-2 sinnum 3. <input type="checkbox"/> 3-4 sinnum 4. <input type="checkbox"/> 5-10 sinnum 5. <input type="checkbox"/> Oftar en 10 sinnum |
| Til sálfræðings | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. <input type="checkbox"/> Aldrei á síðustu 12 mánuðum 2. <input type="checkbox"/> 1-2 sinnum 3. <input type="checkbox"/> 3-4 sinnum 4. <input type="checkbox"/> 5-10 sinnum 5. <input type="checkbox"/> Oftar en 10 sinnum |
| Til félagsráðgjafa | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. <input type="checkbox"/> Aldrei á síðustu 12 mánuðum 2. <input type="checkbox"/> 1-2 sinnum 3. <input type="checkbox"/> 3-4 sinnum 4. <input type="checkbox"/> 5-10 sinnum 5. <input type="checkbox"/> Oftar en 10 sinnum |

| | |
|-------------------------------------|---|
| Til áfengis- og vímuefnaráðgjafa | 1. ____ (já) 2. ____ (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. ____ Aldrei á síðustu 12 mánuðum 2. ____ 1-2 sinnum 3. ____ 3-4 sinnum 4. ____ 5-10 sinnum 5. ____ Oftar en 10 sinnum |
| Til kvensjúkdómá�æknis | 1. ____ (já) 2. ____ (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. ____ Aldrei á síðustu 12 mánuðum 2. ____ 1-2 sinnum 3. ____ 3-4 sinnum 4. ____ 5-10 sinnum 5. ____ Oftar en 10 sinnum |
| Til læknis með aðra sérgrein | 1. ____ (já) 2. ____ (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. ____ Aldrei á síðustu 12 mánuðum 2. ____ 1-2 sinnum 3. ____ 3-4 sinnum 4. ____ 5-10 sinnum 5. ____ Oftar en 10 sinnum |
| Til hjúkrunarfæðings | 1. ____ (já) 2. ____ (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. ____ Aldrei á síðustu 12 mánuðum 2. ____ 1-2 sinnum 3. ____ 3-4 sinnum 4. ____ 5-10 sinnum 5. ____ Oftar en 10 sinnum |
| Til sjúkra- eða iðjuþjálfa | 1. ____ (já) 2. ____ (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. ____ Aldrei á síðustu 12 mánuðum 2. ____ 1-2 sinnum 3. ____ 3-4 sinnum 4. ____ 5-10 sinnum 5. ____ Oftar en 10 sinnum |

| | |
|---|---|
| Til námsráðgjafa eða kennara | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. <input type="checkbox"/> Aldrei á síðustu 12 mánuðum 2. <input type="checkbox"/> 1-2 sinnum 3. <input type="checkbox"/> 3-4 sinnum 4. <input type="checkbox"/> 5-10 sinnum 5. <input type="checkbox"/> Oftar en 10 sinnum |
| Til prests | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. <input type="checkbox"/> Aldrei á síðustu 12 mánuðum 2. <input type="checkbox"/> 1-2 sinnum 3. <input type="checkbox"/> 3-4 sinnum 4. <input type="checkbox"/> 5-10 sinnum 5. <input type="checkbox"/> Oftar en 10 sinnum |
| Til annars en ofangreindra | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| | Ef já, hve oft sl. 12 mánuði? 1. <input type="checkbox"/> Aldrei á síðustu 12 mánuðum 2. <input type="checkbox"/> 1-2 sinnum 3. <input type="checkbox"/> 3-4 sinnum 4. <input type="checkbox"/> 5-10 sinnum 5. <input type="checkbox"/> Oftar en 10 sinnum |
| 17. Var aðstoðin sem þú fékkst hjá fagaðila/-aðilum utan Neyðarmóttöku hjálpleg við að leysa þau tilfinningalegu vandamál sem þú upplifðir? | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| 18. Hefur þú leitað til einhverra samtaka (t.d. AA, Al-anon, Stígamóta, Geðverndar, Rauða Krossins, Hugarafls) vegna tilfinningalegra vandamála sem þú upplifðir út af kynferðisofbeldinu? | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| 19. Hefur þú einhvern tímann notað óhefðbundnar lækningar (t.d. nudd, höfuðbeina- og spjaldhryggsmeðferð, nálastungur, kírópraktor, heilun, hugleiðslu) vegna tilfinningalegra vandamála sem þú upplifðir út af kynferðisofbeldinu? | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |
| 20. Hefur þú einhvern tímann verið lögð/lagður inn á sjúkrahús af geðrænum ástæðum (t.d. þunglyndis, kvíða, sjálf skaðandi hegðunar eða of mikillar neyslu áfengis eða vímuefna) sem þú upplifðir út af | 1. <input type="checkbox"/> (já) 2. <input type="checkbox"/> (nei) |

kynferðisofbeldinu?

Spurningalisti um lýðfræðilegar upplýsingar og heilsuhegðun

Lýðfræðilegar upplýsingar, heilsuhegðun og heilsufar:

21. Hver er hjúskaparstaða þín:

1. ____ Gift/ur
2. ____ Einhleyp/ur
3. ____ Í föstu sambandi
4. ____ Í sambúð
5. ____ Fráskilin/n
6. ____ Ekkja/ekkill

22. Hvaða námi hefur þú lokið? (*Merktu við hæstu gráðu sem þú hefur lokið*)

1. ____ Hætti í skyldunámi
2. ____ Skyldunámi (*t.d. grunnskólaprófi, landsprófi, gagnfræðiprófi*)
3. ____ Starfsnámi, iðnnámi, bóklegu framhaldsnámi (*t.d. stúdentsprófi, samvinnuskólaprófi, verslunarprófi, vélfræðingar, skipstjórnarnámi*)
4. ____ Sérskólanámi á eða við háskólastig (*t.d. iðnfræði- eða tækninámi*)
5. ____ Háskólanámi (*þá ára eða lengra*)
6. ____ Annað. Vinsamlegast tilgreinið: _____

23. Áttu barn/börn?

1. ____ Nei
2. ____ Já. Ef já, hve mörg _____

24. Hvað gerir þú? (*Starf, nám, orlof, annað*)

1. ____ Í fullu starfi
2. ____ Í hlutastarfi
3. ____ Atvinnulaus/í leit að vinnu
4. ____ Öryrki/frá vinnu vegna veikinda
5. ____ Námsmaður
6. ____ Í fæðingarorlofi
7. ____ Heimavinnandi
8. ____ Á eftirlaunum
9. ____ Annað. Vinsamlegast tilgreinið: _____

25. Hvernig metur þú fjárhagss töðu þína?

1. ____ Mjög góða
2. ____ Góða
3. ____ Þokkalega (*endar ná saman*)
4. ____ Slæma
5. ____ Mjög slæma (*miklar skuldir eða gjaldprot*)

26. Að þínu mati, hve góð er heilsa þín miðað við aldur?

1. ____ Mjög góð
2. ____ Góð
3. ____ Í meðallagi

4. ____ Slæm
 5. ____ Mjög slæm

Spurningar um áfengisdrykkju síðastliðna 3 mánuði*

| | Nei | Já |
|--|------------|-----------|
| 27. Drekkur þú stundum áfenga drykki eins og bjór, léttvín eða aðra áfenga drykki? | | |
| Ef nei, þá skaltu svara spurningu 34 næst. | | |
| 28. Hefur þér einhvern tíma fundist að þú þyrftir að draga úr drykkjunni? | | |
| 29. Hefur fólk gert þér gramt í geði með því að setja út á drykkju þína? | | |
| 30. Hefur þér einhvern tíma liðið illa eða haft sektarkennd vegna drykkju þinnar? | | |
| 31. Hefur þú einhvern tíma fengið þér áfengi að morgni til að laga taugakerfið eða losa þig við timburmenn? | | |

| | Fjöldi drykkja |
|--|-----------------------|
| 32. Hversu margta drykki drekkur þú á viku að meðaltali? (einn drykkur er einn einfaldur, einn bjór, eða eitt léttvínsglas) | |
| 33. Hver er mesti fjöldi drykkja sem þú hefur drukkið á einum degi á síðasta ári? | |

Eftirfarandi spurningar fjalla um mögulega notkun efna annarra en áfengis, þ.e. önnur vímuefn eða lyfseðilsskyld lyf, síðastliðna 3 mánuði. Lyf/vímuefni vísa til þess að nota lyf ávísað af lækni eða fengin frá öðrum. Efnin sem um ræði eru t.d. kannabis, róandi lyf, svefnlyf, kókaín, örvarið lyf, ofskynjunarlyf, eða sterkt verkjalyf (eins og morfín og parkódín forte).

Lestu hverja staðhæfingu vandlega og taktu afstöðu til þess hvort þú svarir játandi eða neitandi. Merktu svo við viðeigandi svarmöguleika.

| | Nei | Já |
|---|------------|-----------|
| 34. Hefurðu notað lyf og/eða vímuefni í öðrum tilgangi en til lækninga? | | |
| 35. Hefur þér einhvern tíma fundist að þú þyrftir að draga úr lyfja/vímuefnaneyslu þinni? | | |
| 36. Hefur fólk gert þér gramt í geði með því að setja út á lyfja/vímuefnaneyslu þína ? | | |
| 37. Hefur þér einhvern tíma liðið illa eða haft sektarkennd vegna lyfja/vímuefnaneyslu þinnar? | | |
| 38. Hefur þú einhvern tíma fengið þér lyf/ vímuefni að morgni til að laga taugakerfið eða losa þig við timburmenn? | | |

*CAGE questionnaire (Ewing 1984) og CAGE-AID (Brown & Rounds, 1995)

PCL-5 (modified)*

Leiðbeiningar: Hér að neðan er listi yfir vandamál sem fólk upplifir stundum eftir mjög streituvaldandi reynslu. Vinsamlega lestu vandlega yfir hvert vandamál og dragðu hring utan um tölu til hægri til að gefa til kynna hversu mikið hvert vandamál hefur truflað þig síðastliðinn mánuð.

| Síðastliðinn mánuð, hversu mikið truflaði eftirsarandi þig: | Ekki neitt | Litið | Miðlungs | Töluvert | Mjög mikið |
|---|-------------------|--------------|-----------------|-----------------|-------------------|
| 1. Endurteknar, truflandi og óvelkomnar minningar um hina streituvaldandi reynslu? | 0 | 1 | 2 | 3 | 4 |
| 2. Endurteknir truflandi draumar um hina streituvaldandi reynslu? | 0 | 1 | 2 | 3 | 4 |
| 3. Skyndilega liðið eða hegðað þér eins og streituvaldandi reynslan sé raunverulega að gerast aftur (eins og þú sérst að endurupplifa hana)? | 0 | 1 | 2 | 3 | 4 |
| 4. Komast í mikið uppnám þegar eitthvað minnti þig á hina streituvaldandi reynslu? | 0 | 1 | 2 | 3 | 4 |
| 5. Fá sterk líkamleg viðbrögð þegar eitthvað minnti þig á streituvaldandi reynsluna (t.d. hraður hjartsláttur, öndunarferfiðleikar, svitna)? | 0 | 1 | 2 | 3 | 4 |
| 6. Forðast minningar, hugsanir og tilfinningar tengdar streituvaldandi reynslunni? | 0 | 1 | 2 | 3 | 4 |
| 7. Forðast ytri áminningar um hina streituvaldandi reynslu (t.d. fólk, staði, samtöl, athafnir, hluti eða aðstæður)? | 0 | 1 | 2 | 3 | 4 |
| 8. Eiga í erfiðleikum með að muna mikilvæga hluta streituvaldandi reynslunnar? | 0 | 1 | 2 | 3 | 4 |
| 9. Hafa sterk neikvæð viðhorf um sjálfa/n þig, annað fólk eða heiminn (t.d. hugsanir eins og: Ég er slæm/ur, það er eitthvað alvarlegt að mér, engum er treystandi, heimurinn er hættulegur)? | 0 | 1 | 2 | 3 | 4 |
| 10. Ásaka sjálfa/n þig eða einhvern annan um hina streituvaldandi reynslu eða það sem gerðist í kjölfar hennar? | 0 | 1 | 2 | 3 | 4 |
| 11. Hafa sterkar neikvæðar tilfinningar eins og ótta, hrylling, reiði, sektarkennd eða skömm? | 0 | 1 | 2 | 3 | 4 |
| 12. Missa áhuga á athöfnum sem þú áður hafðir gaman af? | 0 | 1 | 2 | 3 | 4 |
| 13. Finnast þú vera fjarlæg/ur eða úr tengslum við annað fólk? | 0 | 1 | 2 | 3 | 4 |
| 14. Eiga í erfiðleikum með að upplifa jákvæðar tilfinningar (t.d. að vera ófær um að finna hamingju eða væntumþykju gagnvart fólk) sem er þér nákomið? | 0 | 1 | 2 | 3 | 4 |
| 15. Pirringur, reiðikost og árásargjörn hegðun. | 0 | 1 | 2 | 3 | 4 |
| 16. Taka of oft áhættu eða gera hluti sem gætu valdið þér skaða? | 0 | 1 | 2 | 3 | 4 |
| 17. Vera ofurárvökul/l eða vakandi fyrir umhverfinu eða á verði? | 0 | 1 | 2 | 3 | 4 |
| 18. Vera viðbrigðin/n eða bregða auðveldlega? | 0 | 1 | 2 | 3 | 4 |
| 19. Eiga erfitt með einbeitingu? | 0 | 1 | 2 | 3 | 4 |
| 20. Vandi við að sofna eða sofa? | 0 | 1 | 2 | 3 | 4 |
| 21. Finnast eins og áætlanir eða framtíðardraumar þínir muni ekki rætast (t.d. að þú munir ekki eiga farsælan starfsferil, eignast maka, börn eða lifa lengi). | 0 | 1 | 2 | 3 | 4 |

**Posttraumatic stress disorder checklist for DSM-5 (PCL-5). Weathers, Litz, Keane, Palmieri, Marx og Schnurr (2013).*
Þýðendur: Berglind Guðmundsdóttir, Ingunn Hansdóttir, Agnes B. Tryggvadóttir, Guðlaug Friðgeirs dóttir (2015).

PCL-5 (modified) (frh.)*

Hafa vandamálin sem þú merktir við hér að ofan truflað
einhverja af eftirfarandi þáttum í lífi þínu **SÍÐASTLIÐINN** **Já** **Nei**
MÁNUÐ?

Settu hring utan um **J** ef svarið er Já en **N** ef svarið er Nei.

- | | | |
|---|---|---|
| a. Vinnan | J | N |
| b. Húsverk og heimilisskyldur | J | N |
| c. Sambönd við vini | J | N |
| d. Skemmtanir eða áhugamál | J | N |
| e. Nám og heimalærdómur | J | N |
| f. Sambönd við fjölskyldu | J | N |
| g. Kynlíf | J | N |
| h. Almenna ánægju með lífið | J | N |
| i. Almenna getu til að takast á við lífið í heild sinni | J | N |

**Posttraumatic stress disorder checklist for DSM-5 (PCL-5).*
Weathers, Litz, Keane, Palmieri, Marx og Schnurr (2013).
Þýðendur: Berglind Guðmundsdóttir, Ingunn Hansdóttir, Agnes B. Tryggvadóttir, Guðlaug Friðgeirs dóttir (2015).

Svefnleysiskvarði*

1. Vinsamlega flokkaðu núverandi (sl. mánuð) **ALVARLEIKA** svefnvanda þíns.

| | Enginn | Lítill | Miðlungs | Mikill | Mjög mikill |
|--------------------------------------|--------|--------|----------|--------|-------------|
| a) Erfiðleikar með að sofna: | 0 | 1 | 2 | 3 | 4 |
| b) Erfiðleikar með samfelldan svefn: | 0 | 1 | 2 | 3 | 4 |
| c) Að vakna of snemma: | 0 | 1 | 2 | 3 | 4 |

2. Hversu **ánægð(ur)/óánægð(ur)** ert þú með núverandi svefnmynstur þitt?

| Mjög ánægð(ur) | 0 | 1 | 2 | 3 | Mjög óánægð(ur) | 4 |
|----------------|---|---|---|---|-----------------|---|
|----------------|---|---|---|---|-----------------|---|

3. Að hve miklu leyti telur þú svefnvandann **TRUFLA** dagleg störf þín (t.d dagþreyta, getu til að sinna vinnu/daglegum skyldum, einbeitingu, minni, skap og svo frv.)

| Alls ekki truflandi | Lítið | Eitthvað | Mikið | Mjög mikið truflandi |
|---------------------|-------|----------|-------|----------------------|
| 0 | 1 | 2 | 3 | 4 |

4. Telur þú aðra **TAKA EFTIR** því að svefnvandi þinn skerði lífsgæði þín?

| Alls ekki neitt | Lítillega | Eitthvað | Mikið | Mjög mikið |
|-----------------|-----------|----------|-------|------------|
| 0 | 1 | 2 | 3 | 4 |

5. Hversu miklar **ÁHYGGJUR** hefur þú af núverandi svefnvanda þínum?

| Alls engar | Litlar | Einhverjar | Miklar | Mjög miklar |
|------------|--------|------------|--------|-------------|
| 0 | 1 | 2 | 3 | 4 |

**Insomnia Severity Index (ISI)*. Morin, Belleville, Bélanger og Ivers (2011).
Þýðendur: Gunnhildur Marteinsdóttir og Nína Guðmundsdóttir (2014).

DASS21

Depression Anxiety Stress Scale*

Lestu hverju fullyrðingu og dragðu hring um tölu 0, 1, 2 eða 3 sem segir til um hve vel hver fullyrðing átti við í þínu tilviki **síðustu vikuna**. Það eru engin rétt eða röng svör. Eyddu ekki of miklum tíma í að velta fyrir þér hverri fullyrðingu.

0 = Átti alls ekki við mig

1 = Átti við mig að einhverju leyti eða stundum

2 = Átti tölувart vel við mig eða drjúgan hluta vikunnar

3 = Átti mjög vel við mig eða mest allan tímann

| | | | | |
|---|---|---|---|---|
| 1 Mér fannst erfitt að slappa af. | 0 | 1 | 2 | 3 |
| 2 Ég fann fyrir munnpurki. | 0 | 1 | 2 | 3 |
| 3 Ég virtist alls ekki geta fundið fyrir neinum góðum tilfinningum. | 0 | 1 | 2 | 3 |
| 4 Ég átti í erfiðleikum með að anda (t.d. allt of hröð öndun, mæði án líkamlegrar áreynslu). | 0 | 1 | 2 | 3 |
| 5 Ég gat ekki byrjað á neinu. | 0 | 1 | 2 | 3 |
| 6 Ég hafði tilhneigingu til að bregðast of harkalega við aðstæðum. | 0 | 1 | 2 | 3 |
| 7 Mér fannst ég vera óstyrk(ur) (t.d. að fæturnir væru að gefa sig). | 0 | 1 | 2 | 3 |
| 8 Mér fannst ég eyða mikilli andlegri orku. | 0 | 1 | 2 | 3 |
| 9 Ég hafði áhyggjur af aðstæðum þar sem ég fengi hræðslukast (panik) og gerði mig að fífla. | 0 | 1 | 2 | 3 |
| 10 Mér fannst ég ekki geta hlakkað til neins. | 0 | 1 | 2 | 3 |
| 11 Ég komst auðveldlega í uppnám. | 0 | 1 | 2 | 3 |
| 12 Mér fannst erfitt að ná mér niður. | 0 | 1 | 2 | 3 |
| 13 Ég var hrygg/hryggur og þunglynd(ur). | 0 | 1 | 2 | 3 |
| 14 Ég þoldi ekki þegar eitthvað kom í veg fyrir að ég héldi áfram við það sem ég var að gera. | 0 | 1 | 2 | 3 |
| 15 Mér fannst ég nánast gripin(n) skelfingu. | 0 | 1 | 2 | 3 |
| 16 Ég gat ekki fengið brennandi áhuga á neinu. | 0 | 1 | 2 | 3 |
| 17 Mér fannst ég nánast einskis virði. | 0 | 1 | 2 | 3 |
| 18 Mér fannst ég frekar hörundsár. | 0 | 1 | 2 | 3 |
| 19 Ég varð var við hjartsláttinn í mér þó ég hefði ekki reynt á mig (t.d. hraðari hjartsláttur, hjartað slepti úr slagi). | 0 | 1 | 2 | 3 |
| 20 Ég fann fyrir ótta án nokkurrar skynsamlegrar ástæðu. | 0 | 1 | 2 | 3 |
| 21 Mér fannst lífið varla þess virði að lifa því. | 0 | 1 | 2 | 3 |

* DASS-21: Lovibond og Lovibond (1995). Þýðandi: Pétur Tyrfingsson

Spurningalisti um félagslegan stuðning (MSPSS)*

Vinsamlegast lestu staðhæfingarnar hér að neðan vandlega og skráðu númer þess valmöguleika sem best á við um skoðun þína á staðhæfingunni fyrir framan hana. Það eru engin rétt eða röng svör.

| 1 Fullkomlega ósam mála | 2 Mjög ósam mála | 3 Frekar ósam mála | 4 Hlutlaus | 5 Frekar sammála | 6 Mjög sammála | 7 Fullkomlega sammála |
|-------------------------------|------------------------|--------------------------|---------------|------------------------|----------------------|-----------------------------|
|-------------------------------|------------------------|--------------------------|---------------|------------------------|----------------------|-----------------------------|

- _____ 1. Tiltekin manneskja er til staðar fyrir mig þegar ég þarfna st hennar.
_____ 2. Ég get deilt gleði minni og sorg með tiltekinni manneskju.
_____ 3. Fjölskylda mír reynir virkilega að hjálpa mér.
_____ 4. Ég fæ þá tilfinningalegu aðstoð og stuðning sem ég þarfna frá fjölskyldu minni.
_____ 5. Ég get leitað til tiltekinnar manneskju þegar ég þarfna hugunar.
_____ 6. Vinir mírir reyna virkilega að hjálpa mér.
_____ 7. Ég get reitt mig á vini mína þegar hlutirnir ganga illa.
_____ 8. Ég get rætt vandamál mír við fjölskyldu mína.
_____ 9. Ég á vini sem ég get deilt með gleði minni og sorg.
_____ 10. Tiltekinni manneskju í lífi mínu er umhugað um tilfinningar mínar.
_____ 11. Fjölskyldan mír er fús til að aðstoða mig við ákvarðanatöku.
_____ 12. Ég get rætt vandamál mír við vini mína.

* Multidimensional Scale of Perceived Social Support, MSPSS:
Zimet, Dahlem, Zimet og Farley (1988).
Þýðandi: Berglind Guðmundsdóttir

Appendix 2.

Agnes Björg Tryggvadóttir, Berglind
 Guðmundsdóttri, Ingunn Hansdóttir og Eyrún
 Jónsdóttir

Páttakandi nr.: _____ Dagsetning brots: _____ Dagsetning komu: _____

Um komu á Neyðarmóttóku

| | | | | |
|-------------------|---------------------|--|---------------------------------|--|
| 1. Mánuður | 2. Vikudagur | 3.a Tímasetning árásar | 4. Tími frá árás að komu | 5. Kom á NM... |
| 1. Janúar | 1. Mánudagur | 1. Morgni dags (08-12) | 1. 0-6 klst | 1. Ein/n |
| 2. Febrúar | 2. Priðjudagur | 2. Eftir hádegi (12-16) | 2. 6-12 klst | 2. Í fylgd |
| 3. Mars | 3. Miðvikudagur | 3. Síðdegis (16-20) | 3. 13-24 klst | 3. Upplýsingar vantar |
| 4. Apríl | 4. Fimmtudagur | 4. Að kvöldlagi (20-00) | 4. 25-48 klst | |
| 5. Maí | 5. Föstudagur | 5. Snemma nætur (00-04) | 5. 49-72 klst | |
| 6. Júní | 6. Laugardagur | 6. Seinni hluta nætur/Árla morguns (04-08) | 6. 3-4 sólarhringar | |
| 7. Júlí | 7. Sunnudagur | 7. Að næturlagi (00-08) | 7. 4-5 sólarhringar | |
| 8. Ágúst | | 8. Upplýsingar vantar | 8. 5-7 sólarhringar | |
| 9. September | | | 9. 1-2 vikur | |
| 10. Október | | | 10. 2-4 vikur | |
| 11. Nóvember | | | 11. 4 vikur – 3 mánuðir | |
| 12. Desember | | | 12. 3 – 6 mánuðir | |
| | | | 13. 6 mánuðir – 1 ár | |
| | | | 14. Meira en 1 ár | |
| | | | 15. Upplýsingar vantar | |
| | | | | a. Ef í fylgd, með hverjum? (Merkja við allt sem við á) |
| | | | | 1. Móður |
| | | | | 2. Föður |
| | | | | 3. Vini/Vinkonu |
| | | | | 4. Maka |
| | | | | 5. Ættingja |
| | | | | 6. Lögreglu |
| | | | | 7. Sjúkrabíl |
| | | | | 8. Öðrum |
| | | | | b. Hverjum: _____ |

Um þolanda

| | | |
|---|--|--|
| 6. Aldur: _____ 1. | 9. Fyrri áföll 1. Já 2. Nei 3. Upplýsingar vantar a. Ef já, hvers konar áfall? 1. Nauðgun/nauðgunartilraun 2. Kynferðisleg misnotkun 3. Líkamlegt ofbeldi 4. Heimilisofbeldi (búið við ofbeldi, vitni af) 5. Annars konar áfall (t.d. slys, dauðsfall, skilnaður) 6. Upplýsingar vantar b. Ef 12a er 1, varð þolandi þunguð í kjölfar fyrri nauðgunar? 1. Já 2. Nei 3. Upplýsingar vantar c. Ef já, fóstureyðing eftir fyrri nauðgun? 1. Já 2. Nei 3. Upplýsingar vantar | 10. Leitað áður til NM 1. Já 2. Nei 3. Upplýsingar vantar |
| 7. Kyn 1. Karl 2. Kona | | 11. Greind fötlun hjá þolanda 1. Já 2. Nei 3. Upplýsingar vantar a. Hver er fötlunin? 1. Proskaskerðing 2. Líkamleg fötlun 3. Langvarandi líkamlegur sjúkdómur 4. Upplýsingar vantar |
| 8. Þjóðerni þolanda 1. Íslenskt 2. Annað: a. Land: _____ | | |

| | | |
|---|---|--|
| 12. Starf 1. Full starf 2. Hlutastarf 3. Heimavinnandi 4. Öryrki 5. Námsmaður 6. Í námi og hlutastarfí 7. Atvinnulaus 8. Annað a. Hvað: _____ 9. Upplýsingar vantar | 14. Saga um geðræn vandamál 1. Já 2. Nei 3. Upplýsingar vantar 15. Saga um áfengisvanda/-meðferð 1. Já 2. Nei 3. Upplýsingar vantar 16. Saga um vímuefnavanda/-meðferð 1. Já 2. Nei 3. Upplýsingar vantar 17. Fyrri meðferð hjá sálfræðingi eða geðlækni 1. Já 2. Nei 3. Upplýsingar vantar 18. Mansal 1. Já 2. Nei 3. Upplýsingar vantar | 22. Tengsl þolanda við geranda (Merkja tengsl við alla gerendur ef margir) 1. Ókunnug/ur 2. Kannast við (<24 klst) 3. Kunningi 4. Vinur/vinkona 5. Faðir/móðir 6. Systkin 7. Blóðskylđur (aðrir en foreldrar/systkin) 8. Tengd/ur (s.s. fósturfaðir/móðir, stjúpfaðir/móðir, mákur/mágkona) 9. Kærasti/a 10. Maki (eiginmaður/kona, samþýlismaður/kona) 11. Fyrverandi maki 12. Yfirboðari (s.s. kennari, læknir, prestur, yfirmaður) 13. Samstarfsmaður/kona 14. skólafelagi 15. upplýsingar vantar |
| 13. Hjúskaparstaða 1. Gift/ur 2. Einhleyp/ur 3. Í föstu sambandi 4. Í sambúð 5. Fráskilin/n 6. Ekkja/ekkill 7. Upplýsingar vantar | 19. Vændi 1. Já 2. Nei 3. Upplýsingar vantar 20. Nýtur félagslegrar þjónustu 1. Já 2. Nei 3. Upplýsingar vantar 21. Pekkt neyslusaga foreldra/fjölskyldu 1. Já 2. Nei 3. Upplýsingar vantar | 52 15. Upplýsingar vantar |

| | | | | | |
|--|--|---|--|--|---|
| 3. Kyn 1. Karl 2. Kona 3. Upplýsingar vantar | 24. Þjóðerni 1. Íslenskt 2. Erlent a. Ef erlent, skrá land: | 25. Framdi gerandi sjálfsvíg? 1. Já 2. Nei | 26. Fjöldi gerenda 1. 1 2. 2 3. 3-4 4. 5 eða fleiri | a. Virkir gerendur 1. 1 2. 2 3. 3-4 4. 5 eða fleiri | b. Áhorfendur 1. 1 2. 2 3. 3-4 4. 5 eða fleiri |
| 27. Hvar var brotið framið? 1. Á Íslandi 2. Erlendis | | 28. Vettvangur árásar 1. Heima hjá þolanda 2. Heima hjá geranda 3. Á öðru heimili 4. Á vinnustað 5. Í bíl 6. Á götu í miðbæ Reykjavíkur 7. Á víðavangi 8. Á útihátið 9. Á skemmtistað 10. Fyrir utan skemmtistað 11. Annars staðar a. Hvar: _____ 12. Upplýsingar vantar | | Hvers konar kynferðisofbeldi varð polandi fyrir? | |
| a. Ef Ísland, hvar á landinu? 1. Höfuðborgarsvæðinu 2. Reykjanesinu 3. Vesturlandi 4. Vestfjörðum 5. Suðurlandi 6. Austurlandi 7. Norðurlandi 8. Upplýsingar vantar | | | | 31. Kynmök um leggöng 1. Já 2. Nei 3. Upplýsingar vantar | |
| i. Ef á Höfuðborgarsvæðinu, þá nánar hvar? 1. Miðbæ Reykjavíkur 2. Annars staðar í Reykjavík 3. Seltjarnarnesi 4. Kópavogi 5. Garðabæ 6. Hafnarfirði 7. Álfanesi 8. Mosfellsbæ 9. Kjalarnesi 10. Upplýsingar vantar | | | | 32. Kynmök um endaþarm 1. Já 2. Nei 3. Upplýsingar vantar | |
| b. Ef erlendis, hver var ástæða dvalar erlendis? 1. Ferðamaður 2. Námsmaður 3. Au-pair 4. Skiptinemi 5. Atvinna 6. Annað i. Hvað: _____ | | | | 33. Kynfæri polanda sugin 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | 29. Aðdragandi árásar 1. Óvænt áras 2. Innbrot 3. Stefnumót 4. Tengdist skemmtun 5. Samskipti á undan önnur en skemmtun 6. Annað a. Hvað: _____ 7. Óvist | | 34. Polandi neydd/ur til að sjúga kynfæri geranda 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | Ef 5. hvernig samskipti? | | 35. Sáðlát 1. Já 2. Nei 3. Ekki vitað | |
| | | 29.b Í persónu 1. Já 2. Nei 3. Ekki vitað | | 36. Aðskotahlutur í leggöng eða endaþarm 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | 29.c Netsamskipti (e-mail, msn) 1. Já 2. Nei 3. Ekki vitað | | 37. Fingur settur í leggöng eða endaþarm 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | 29.d Símasamskipti (símtöl, sms) 1. Já 2. Nei 3. Ekki vitað | | 38. Snerting með getnaðarlim án innþreingingar 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | 30. Myndataka af polanda 1. Já 2. Nei 3. Annað | | 39. Káfað á kynfærum 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | | | 40. Káfað á brjóstum 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | | | 41. Káfað á rassi 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | | | 42. Smokkur notaður 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | | | 43.a Nauðgunartilraun 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | | | 44. Annað 1. Já 2. Nei 3. Upplýsingar vantar | |
| | | | | 45. Alvarleiki kynferðisofbeldis (skv. NorVold) 1. Vægt – engin kynfærasnerting 2. Vægt – tilfinningalegt eða kynferðislegt 3. Miðlungs - kynfærasnerting 4. Alvarlegt – innþreinging 5. Umhlíðar vantar | |

| | | |
|--|---|--|
| 46. Líkamlegt ofbeldi 1. Já 2. Nei 3. Upplýsingar vantar | 55. Hrint 1. Já 2. Nei 3. Upplýsingar vantar | 63. Líkamlegir áverkar 1. Engir áverkar |
| 47. Haldið 1. Já 2. Nei 3. Upplýsingar vantar | 56. Sparkað 1. Já 2. Nei 3. Upplýsingar vantar | 2. Minniháttar áverkar (ekki þörf á frekari læknisaðstoð, t.d., mar, roði, eymslí, rispur) |
| 48. Hindruð för 1. Já 2. Nei 3. Upplýsingar vantar | 57. Notar vopn/áhald 1. Já 2. Nei 3. Upplýsingar vantar | 3. Meðal áverkar (þörf fyrir læknisaðstoð en ekki þörf á innlögn, t.d., grunnur um beinbrot, grunnir skurðir, víðtæk eymslí á kynfærum) |
| 49. Bundið/handjárn 1. Já 2. Nei 3. Upplýsingar vantar | 58. Bitið, rispað, stungið (m. áhaldi/vopni) 1. Já 2. Nei 3. Upplýsingar vantar | 4. Alvarlegir áverkar (innlögn á sjúkrahús, ekki þörf á skurðaðgerð, t.d. alvarlegir áverkar á kynfærum, beinbrot, höfuðáverkar, útbreitt mar) |
| 50. Lokað inni 1. Já 2. Nei 3. Upplýsingar vantar | 59. Kverkatak 1. Já 2. Nei 3. Upplýsingar vantar | |
| 51. Föt rifin, skemmd 1. Já 2. Nei 3. Upplýsingar vantar | 60. Beinbrot 1. Já 2. Nei 3. Upplýsingar vantar | |
| 52. Rispað, klórað (með nöglum) 1. Já 2. Nei 3. Upplýsingar vantar | 61. Bruni 1. Já 2. Nei 3. Upplýsingar vantar | |
| 53. Slegið með flötum lófa 1. Já 2. Nei 3. Upplýsingar vantar | 62. Annað 1. Já 2. Nei 3. Upplýsingar vantar | |
| 54. Hnefahögg 1. Já 2. Nei 3. Upplýsingar vantar | a. Ef já, hvað: _____ | |

| | | |
|--|--|--|
| 64. Hótun 1. Já 2. Nei 3. Upplýsingar vantar | 74. Afengisneysla polanda 1. Já 2. Nei 3. Upplýsingar vantar | 77. Vímuefnaneysla polanda 1. Já 2. Nei 3. Upplýsingar vantar |
| Ef já, hvernig hótun? | | |
| 65. Hótun með sms 1. Já 2. Nei | a. Ef já, hvert var vitundarástand polanda? 1. Áfengisdá 2. Of drukkin/n til að vita hvað var að gerast 3. Of drukkin/n til að stjórna eigin hegðun 4. Undir áhrifum en með fulla vitund 5. Ekkert af ofangreindu 6. Upplýsingar vantar | a. Ef já, vitundarástand polanda 1. Vímuefnadá 2. Of mikil víma til að vita hvað hún/hann væri að gera 3. Of mikil víma til að stjórna eigin hegðun 4. Undir áhrifum en með fulla vitund 5. Ekkert af ofangreindu 6. Upplýsingar vantar |
| 66. Hótun með síma 1. Já 2. Nei | | |
| 67. Hótun gegnum netið (e-mail, msn) 1. Já 2. Nei | | |
| 68. Hótun í eigin persónu 1. Já 2. Nei | | |
| 69. Annað 1. Já 2. Nei | | |
| a. Ef já, hvað: _____ | | |
| Ef hótun í eigin persónu, hvernig? | 75. Ef misneyting vegna áfengisneyslu, eðli neyslu? 1. Sjálfviljug áfengisneysla 2. Þvinguð áfengisneysla 3. Áfengi halddið að viðkomandi 4. Upplýsingar vantar | 78. Ef misneyting vegna vímuefnaneyslu, hvers eðlis var neyslan? 1. Sjálfviljug vímuefnaneysla 2. Þvinguð vímuefnaneysla 3. Vímuefnum halddið að viðkomandi 4. Upplýsingar vantar |
| 70. Hótun með líkamlegu látbragði 1. Já 2. Nei | | |
| 71. Hótun með vopnum 1. Já 2. Nei | | |
| 72. Hótun með orðum 1. Já 2. Nei | 76. Misneyting vegna fötlunar 1. Misneyting v/líkamlegs sjúkdóms 2. Misneyting v/andlegs sjúkdóms 3. Á ekki við 4. Upplýsingar vantar | 79. Grunur um lyfjabyrlun 1. Já 2. Nei |
| 73. Annað 1. Já 2. Nei | | |
| a. Ef já, hvað: _____ | | 80. Pungun í kjölfar nauðgunar 1. Já 2. Nei 3. Upplýsingar vantar |
| | a. Ef já, fóstureyðing í kjölfar nauðgunar 1. Já 2. Nei 3. Upplýsingar vantar | |

Pjónusta á Neyðarmóttöku

| | | |
|---|---|--|
| Vitundarástand við komu á NM 81. Vímuáhrif 1. Já 2. Nei 3. Upplýsingar vantar | Pjónustunýting á NM | 94. Samtal við réttargæslumann (lögfræðing) 1. Já 2. Nei 3. Upplýsingar vantar |
| | 88. Læknisskoðun/meðferð 1. Já 2. Nei 3. Upplýsingar vantar | |
| 82. Man lítið/ekkert 1. Já 2. Nei 3. Upplýsingar vantar | 89. Réttarlæknisskoðun 1. Já 2. Nei 3. Upplýsingar vantar | 95. Sjálfsvígshugsanir eftir atburð 1. Já 2. Nei 3. Ekki vitað |
| | 90. Áverkaskýrsla/komuskýrsla á slysa- og bráðamóttöku 1. Já 2. Nei 3. Upplýsingar vantar | |
| 83. Tjáir sig um smáatriði árásar 1. Já 2. Nei 3. Upplýsingar vantar | | 96. Sjálfsskaði eftir atburð 1. Já 2. Nei 3. Ekki vitað |
| | | |
| 84. Skýr frásögn 1. Já 2. Nei 3. Upplýsingar vantar | 91. Innlögn á gæsludeild/sjúkradeild 1. Já 2. Nei 3. Upplýsingar vantar | 97. Sjálfsvígstilraun/ir eftir atburð 1. Já 2. Nei 3. Ekki vitað |
| | | |
| 85. Samhengislaus frásögn 1. Já 2. Nei 3. Upplýsingar vantar | | |
| 86. Í sjálfsvígshugleiðingum 1. Já 2. Nei 3. Upplýsingar vantar | 92. Samtal við hjúkrunarfræðing 1. Já 2. Nei 3. Upplýsingar vantar | 98. Mál tilkynnt Barnaverndarnefnd? 1. Já 2. Nei 3. Á ekki við 4. Uppl. vantar |
| 87. Annað 1. Já 2. Nei 3. Upplýsingar vantar | 93. Vísad til sálfræðings 1. Já 2. Nei 3. Upplýsingar vantar | |
| a. Ef já, hvað: _____ | | |

Pjónusta á Neyðarmóttöku, frh.

| | | |
|---|---|---|
| 99. Polanda vísað til annarra fagaðila: 1. Já 2. Nei 3. Upplýsingar vantar | Kærur/Málsmeðferð 100. Kærði polandi? 1. Já 2. Nei 3. Upplýsingar vantar | 101. Hver var dómur Héraðsdóms? 1. Sakfelling 2. Sýkna 3. Dómur ekki fallinn 4. Upplýsingar vantar |
| 99.a Ef já, hvert? 1. Geðdeild LSH i. Ef já, bráðainnlogn? 1. Já 2. Nei 3. Ekki vitað 2. Stígamót 3. Kvennaathvarf 4. SÁA/Teigur LSH/Stuðlar 5. Barnahús 6. Annar aðili a. Ef já, hvaða: _____ 7. Upplýsingar vantar | 100a. Ef já, hver var meðferð málsins hjá lögreglu? 1. Kæra afturkölluð 2. Mál fellt niður hjá lögreglu 3. Mál sent frá lögreglu 4. Mál enn í vinnslu 5. Upplýsingar vantar | 102. Hver var dómur Hæstaréttar? 1. Sakfelling 2. Sýkna 3. Dómur ekki fallinn 4. Upplýsingar vantar |
| | 100b. Ef mál sent frá lögreglu, ákærði saksóknari? 1. Já 2. Nei – mál fellt niður 3. Mál enn í vinnslu 4. Upplýsingar vantar | 103. Fékk polandi miskabætur? 1. Já 2. Nei 3. Mál enn í vinnslu 4. Upplýsingar vantar |
| | | 104. Aukalega um kærur: a. Sakargögn sótt dags: _____ b. Sakargögnum hent dags: _____ c. Mál sent frá RLR dags: _____ d. Læknir kom fyrir rétt dags: _____ e. Hjúkrunarfræðingur kom fyrir rétt dags: _____ f. Ráðgjafi kom fyrir rétt dags: _____ |
| 105. Sálfræðileg meðferð 1. Já 2. Nei 3. Upplýsingar vantar | | |
| 106. Ef já, hjá hverjum? _____ | | |
| 107. Ef já, fjöldi viðtala: _____ | | |
| a. Hlaut áfallahjálp 1. Já 2. Nei. Ef já, fjöldi viðtala _____ | | |
| b. Hlaut eftirfylgd án formlegar meðferðar? 1. Já 2. Nei. Ef já, fjöldi viðtala _____ | | |
| c. Hlaut sálfræðilega meðferð umfram áfallahjálp og eftirfylgd? 1. Já 2. Nei. Ef já, fjöldi viðtala _____ | | |
| d. Lauk meðferð? 1. Já 2. Nei. Ef nei, ástæða lok meðferðar: e.1) Hætti að mæta? 1. Já 2. Nei. e.2) Af þakkaði þjónustu eftir að meðferð byrjaði? 1. Já 2. Nei. | | |
| Tímabil meðferðar?: f.1) dags. upphaf _____ f.2) dags. lok meðferðar _____ | | |
| 108) Spurningalistar já ____ nei ____ | | |
| Fjöldi skipta _____ | | |
| <i>Ef já hvaða, spurningalistar:</i> | | |
| 108a) PDS/PSS-SR fj. Skipta _____ | | |
| 108b) IES fj. skipta _____ | | |
| 108c) BDI (BDI-II) fj. skipta _____ | | |
| 108d) BAI fj. skipta _____ | | |

108e) Ef já: fylla út skorin:

| Dags. þegar listi fylltur út | PSS-SR heildarskor (undirkvarðar) | BDI-II heildarskor | BAI heildarskor |
|------------------------------|-----------------------------------|--------------------|-----------------|
| | | | |
| | | | |
| | | | |
| | | | |

Appendix III



Pjónustunýting og líðan þolenda kynferðislegs ofbeldis sem leitað hafa til Neyðarmóttöku LSH

Kæri viðtakandi,

Nýlega fékkst þú símtal þar sem falast var eftir þáttöku þinni í rannsókn á pjónustunýtingu og líðan þolenda kynferðislegs ofbeldis sem leitað hafa til Neyðarmóttöku LSH. Eins og rætt var um í símtalinu færð þú hér sent upplýsingabréf sem útlistar framkvæmd og tilgang rannsóknarinnar sem og vefslóð til að nálgast spurningalistana sem við óskum eftir að þú svarir.

Tilgangur og markmið rannsóknar

Kynferðisofbeldi getur haft víðtækjar og alvarlegar afleiðingar á heilsu þolenda og valdið t.d. truflun á starfsgetu og verulegri skerðingu á lífsgæðum. Mikilvæg þjónusta fyrir þolendur var sett á laggirnar árið 1993 en hingað til hefur lítið verið kannað hvort þessi þjónusta mæti þörfum þolanda og hver afdrif þolanda eru.

Tilgangur þessarar rannsóknar er að kanna hvernig þjónustan nýttist þeim sem leituðu á Neyðarmóttökuna á árunum 2010 til 2014, hvernig þeim líkaði þjónustan og þá sérstaklega hvað þeim fannst vanta upp á þjónustuna. Þá er tilgangur rannsóknarinnar einnig að kanna afdrif þolenda, hvernig staða þeirra er með tilliti til streitueinkenna og aðlögunar almennt eftir að hafa leitað eftir þjónustu á Neyðarmóttökunni.

Von okkar er sú að með þáttöku þinni muni skilningur batna og innsýn aukast inn í hvaða þættir þjónustu Neyðarmóttökunnar nýtast þolendum best, hvernig má bæta þjónustuna og hvað er hægt að gera til að aðstoða þolendur betur við að takast á við aðlögun eftir kynferðisofbeldi. Þátttaka þín er því mikils metin.

Rannsóknin ber heitið „**Pjónustunýting og líðan þolenda kynferðislegs ofbeldis sem leitað hafa til Neyðarmóttöku LSH**“ og er unnin af samstarfshópi á vegum Landspítala Háskólasjúkrahúss og Háskóla Íslands.

Ábyrgðaraðili rannsóknarinnar

Nafn: Dr. Berglind Guðmundsdóttir

Starfsheiti: Yfirsálfraðingur Landspítala

Aðsetur: Geðsvið, Hringbraut, 101 Reykjavík

Sími: 543-9292

Netfang: berggudm@landspitali.is

Aðrir rannsakendur/rannsóknarhópurinn:

Dr. Ingunn Hansdóttir, lektor við sálfræðideild Háskóla Íslands,
Agnes Björg Tryggvadóttir, sálfræðingur við Neyðarmóttöku Landspítala,

Eyrún Jónsdóttir, hjúkrunarfræðingur og verkefnastjóri við Neyðarmóttöku Landspítala, Guðlaug Friðgeirs dóttir, Cand.psych. nemandi við Sálfræðideild Háskóla Íslands og Auður Friðriksdóttir, Cand.psych. nemandi við Sálfræðideild Háskóla Íslands

Upplýsingar sem þáttakandi gefur í rannsókninni

Þú ert vinsamlegast beðin(n) um að taka þátt í rannsókninni með því að veita leyfi til að vinna úr gögnum í sjúkraskrá sem skráðar voru þegar þú leitaðir á Neyðarmóttöku á árabilinu 2010-2014.

Þau gögn sem munu verða notuð varða þá þjónustu sem þú hlaust og þína líðan við komu eða nánar tiltekið: lýðfræðilegar upplýsingar, upplýsingar um kynferðisbrotið, hvaða meðferðaraðilar veittu þjónustu, og hvers konar þjónustu. Ef þú fylltir út spurningalistu hjá sálfræðingi, þá er óskað eftir upplýsingum um niðurstöður spurningalistar (áfallastreitueinkenni, kvíða- og þunglyndiseinkenni).

Einnig biðjum við þig um að meta stöðu þína í dag með því að svara fimm spurningalistum. Fyrsti spurningalistinn kannar þjónustunýtingu og ánægju/óánægju með þá þjónustu sem þú hlaust hjá Neyðarmóttökunni, aðra þjónustunýtingu í kjölfar kynferðisofbeldisins, lýðfræðilegar upplýsingar og heilsuhegðun. Þá eru fjórir spurningalistar notaðir til að kanna einkenni áfallastreitu, þunglyndi og kvíða, svefn og félagslegan stuðning.

Þáttaka í rannsókninni tekur um 30 mínútur.

Ef þú samþykkir þáttöku þá hakar þú við reit því til staðfestingar og getur hafið þáttöku. Við mælum með að þú geymir þetta kynningarbréf og eigir afrit af staðfestingu þinni á þáttöku.

Trúnaður og öryggi gagna:

Öll rannsóknargögn verða varðveitt leyndarmerkt með rannsóknarnúmeri á öruggum stað á meðan á úrvinnslu þeirra stendur og unnin án persónuauðkenna. Leitað verður eftir upplýstu samþykki þeirra þáttakenda sem veita upplýsingar í þágu rannsóknarinnar. Þetta er í samræmi við lög nr. 77/2000 um persónuvernd og meðferð persónuupplýsinga.

Greiningarlykill sem tengir rannsóknarnúmer og kennitölu þáttakanda er geymdur aðskilinn frá rannsóknargögnum í læstum skáp hjá ábyrgðarmanni, Dr. Berglindi Guðmundsdóttur, meðan á rannsókn stendur. Auk þess verður greiningarlykill sem tengir rannsóknarnúmer og tölvupóstfang. Greiningarlyklar gera kleift að tengja upplýsingar úr sjúkraskrá við spurningalistagögn. Þessum greiningarlykli verður eytt að rannsókn lokinni. Eingöngu rannsakendur munu nýta rannsóknargögnin og fimm árum eftir að rannsókn lýkur verður rannsóknargögnunum eytt.

Áviningur og áhætta/óþægindi fyrir þáttakendur:

Helsti áviningur rannsóknarinnar er mögulega að auka skilning og innsýn í hvaða þættir þjónustu Neyðarmóttökunnar nýast þolendum best, hvernig megi bæta þjónustuna og hvað er hægt að gera til að aðstoða þolendur betur við að takast á við aðlögun eftir kynferðisofbeldi. Einnig geta fengist mikilvægar upplýsingar um afdrif og stöðu þeirra sem leitað hafa til Neyðarmóttökunnar sem gefur vísbendingar um þjónustuþörf þolenda kynferðisofbeldis til lengri tíma litið.

Rannsóknin er ekki talin fela í sér áhættu fyrir þáttakendur aðra en þá að valda hugsanlega óþægindum við að svara spurningum um líðan í dag. Í þeim tilfellum getur þáttakandi fengið eitt viðtal hjá:

Svanhvít Björgvinsdóttur, sálfræðingi hjá sálfræðibjónustu Landspítalans (s. 543-1116).

Þú verður ekki beðin/n um að rifja upp liðna atburði þar sem stuðst verður við þær upplýsingar sem þú veittir við fyrstu komu til Neyðarmóttökunnar.

Réttur þátttakenda

Þér ber engin skylda til þess að taka þátt í rannsókninni. Þú getur hætt þáttöku hvenær sem er, án útskýringa og án eftirmála. Það að hafna þáttöku eða hætta við þáttöku mun ekki hafa áhrif á þá þjónustu sem þér stendur til boða á Landspítala. Þér er að sjálfsögðu heimilt að sleppa því að svara einstökum spurningum og spurningalistum í heild sinni, en tekið er fram að útfylltir spurningalistar gefa mestar upplýsingar og gagnast því rannsókninni best.

Birting á niðurstöðum

Fyrirhugað er að birta niðurstöður rannsóknarinnar í fagtímariti, erlendis eða innanlands. Öll gögn og niðurstöður verða ópersónugreinanleg. Niðurstöður verða birtar í Cand. psych. ritgerðum Guðlaugar Friðgeirs dóttur og Auðar Friðriksdóttur.

Rannsóknin er unnin með samþykki Siðanefndar Landspítalans.

Óskir þú eftir nánari skýringum á rannsókninni eða þáttöku þinni í henni mun Dr. Berglind Guðmundsdóttir veita nánari upplýsingar í síma 543-9292.

Ef þú hefur spurningar um rétt þinn sem þátttakandi í þessari vísindarannsókn eða vilt hætta þáttöku í henni getur þú snúið þér til Siðanefndar, Eiríksgötu 34, Landspítala Hringbraut 101 Reykjavík, sími 543-1000.

Þátttaka þín er mikils metin.

Með fyrirfram þökk fyrir þáttökuna.

Berglind Guðmundsdóttir ábyrgðarmaður (s: 543-9292)

Ef þú hefur spurningar um rétt þinn sem þátttakandi í vísindarannsókn eða vilt hætta þátttöku í rannsókninni getur þú snúið þér til Siðanefndar Landspítala, Eirbergi, Eiríksgötu 34, 101 Reykjavík. Sími: 543-1000, tölvupóstfang: sidanefnd@landspitali.is



Samþykkisýfirlýsing vegna þáttöku í vísindarannsókn

Pjónustunýting og líðan þolenda kynferðislegs ofbeldis sem leitað hafa til Neyðarmóttöku LSH

Ég undirrituð/aður staðfesti með undirskrift minni vilja minn til þáttöku í ofannefndri rannsókn og að ég hafi kynnt mér meðfylgjandi upplýsingablað og fengið viðunandi svör við spurningum mínum.

Tilgangur þessarar rannsóknar er að kanna hvernig þjónustan nýttist þeim sem leituðu á Neyðarmóttökuna á árunum 2010 til 2014, hvernig þeim líkaði þjónustan og þá sérstaklega hvað þeim fannst vanta upp á þjónustuna. Þá er tilgangur rannsóknarinnar einnig að kanna afdrif þolenda, hvernig staða þeirra er með tilliti til streitueinkenna, og aðlögunar almennt eftir að hafa leitað eftir þjónustu á Neyðarmóttökunni.

1. Ég samþykki að veita rannsakendum aðgang að upplýsingum sem ég veitti við fyrstu komu mína til Neyðarmóttökunnar á tímabilinu 2010-2014 sem varða þá þjónustu sem ég hlaut og mína líðan við komu.
2. Ég samþykki að veita rannsakendum aðgang að upplýsingum í sjúkraská um sálfræðiþjónustu og niðurstöður sálfræðilegra prófa hafi slík þjónusta verið veitt eða slík próf lögð fyrir vegna sálfræðimeðferðar tengd fyrstu komu minni á Neyðarmóttöku
3. Ég samþykki að svara fimm spurningalistum um stöðu mína í dag. Fyrsti spurningalistinn kannar þjónustunýtingu og ánægju/óánægju með þá þjónustu sem ég hlaut hjá Neyðarmóttökunni, aðra þjónustunýtingu í kjölfar kynferðisofbeldisins, lýðfræðilegar upplýsingar og heilsuhegðun. Auk fjögurra spurningalista sem meta einkenni áfallastreitu, þunglyndis og kvíða, svefn og félagslegan stuðning.

Mér er ljóst að engar greiðslur eru í boði vegna rannsóknarinnar.

Mér er ljóst að þáttakendum er frjálst að hafna þáttöku á hvaða stigi sem er, án skyringa og án afleiðinga fyrir aðra meðferð auk þess að frjálst er að neita að svara einstökum spurningum. Upplýst samþykki mitt um þáttöku felst í því að ég krossa í reitinn hér að neðan og jafngildir það undirskrift minni.

Ég samþykki að taka þátt í rannsókninni sem ég hef fengið nægar upplýsingar um.