Creation of a Medical Student Training to Improve Comfort Providing Trauma-Informed Care to Sexual Assault Survivors

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Abstract

Introduction: Sexual violence is a significant public health concern in the United States, affecting as many as one in two women and one in four men. However, few medical schools offer education on trauma-informed communication with patients who disclose sexual assault (SA). The goal of this training was to provide medical students with an understanding of how to empathically respond to SA disclosures, collect pertinent medical information while avoiding retraumatization, and empower patients to feel in control of their care. Methods: One hundred forty-nine second-year medical students at Rush Medical College attended a 1-hour didactic lecture discussing the needs of SA survivors followed by small-group sessions during which they practiced trauma-informed communication skills. Students completed anonymous pre- and postsession surveys featuring nine Likert-scale questions that assessed comfort level providing trauma-informed care. Results: Of the 149 attendees, 88 (59%) completed matched pre- and posttraining surveys that demonstrated significant improvement in all assessed metrics of trauma-informed care, including comfort collecting information, empowering survivors, and responding to and normalizing patients’ concerns. Two weeks after completing the training, all 149 students also correctly answered a free-response question testing retention of key training takeaways on their Sexuality and Reproduction final exam. Discussion: The training significantly improved medical student comfort in providing trauma-informed care across all collected metrics. The training can be feasibly reproduced at other institutions so that future physicians across specialties can provide trauma-informed care, ideally improving the acute and chronic health outcomes that disproportionately affect SA survivors.

Keywords
Sexual Assault, Sexual Violence, Sex Offenses, Trauma-Informed Care, Trauma-Sensitive Care, Role-Plays, Role-Playing

Educational Objectives
By the end of this activity, learners will be able to:

1. Respond appropriately to disclosures of sexual assault in health care settings with attention to appropriate and inappropriate language.
2. Report increased comfort validating patients’ emotions and normalizing distress following a sexual assault.
3. Collect pertinent medical history without asking unnecessary and/or retraumatizing questions.
4. Communicate medical care options in a trauma-informed manner that reinforces patient autonomy.

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Introduction
Sexual assault (SA) is a pervasive public health crisis affecting individuals of all genders and ages. In the United States, almost half of women and a quarter of men experience a form of SA or sexual violence in their lifetime, including completed or attempted rape, sexual coercion, or unwanted sexual contact.1 Despite various efforts to decrease the rate of SA, data from the United States Department of Justice show that the rate of reported SA continues to increase every year.2 These distressingly high values nonetheless underestimate the true occurrence of SA, which is broadly underreported due to stigma, fear of reprisal, and survivors’ doubts that reporting an assault would be of any benefit.3 Following an assault, SA survivors suffer disproportionately high rates of mental health problems, including depression, anxiety, substance misuse, posttraumatic stress disorder, and suicidality. Given the profound impact of SA, physicians across all disciplines should receive training in trauma-informed care, a set of best practices
used to promote survivor comfort and agency during care provision.5

Physician trainees are rarely taught trauma-informed care or educated on the concerns of SA survivors. While some US-based medical schools incorporate education on intimate partner violence,6 there is no consistent didactic focus on SA. For example, the Association of American Medical Colleges (AAMC), which regularly publishes data on medical school curricular content and desired student competencies, does not report on medical school SA education or student aptitude in caring for survivors.7 A national survey of family medicine residencies in 2010 demonstrated that only 67% of programs included training on rape and 42% on working with survivors of SA.8 Limited contemporary data on the inclusion of trauma-informed care training in medical schools or residency programs of other specialties further highlight educational gaps.

We developed this training to equip medical students with increased comfort providing trauma-informed care to SA survivors in order to improve physical and mental health outcomes in this patient population. While some institutions have developed and implemented similar trainings in their medical school curricula,9,10 our training incorporated several unique features, including skilled SA advocates/counselors to assist with facilitating small-group activities, an emphasis on communication skills involved in trauma-informed care, and role-play simulations of SA patient encounters to practice communication skills in real time. The training also included written materials with key takeaways that students could utilize and reference throughout their careers.

**Methods**

**Curriculum Context**

We piloted the training for second-year medical students at Rush Medical College in 2018 and used student feedback to make minor curricular adjustments. We then administered the revised 3-hour training, complete with pre- and posttraining surveys, to 149 second-year Rush medical students in 2019 during their Sexuality and Reproduction block. The training was developed as a collaboration between students, physicians, and the Sexual Assault Nurse Examiner (SANE) Coordinator of the Office of the Illinois Attorney General. Rush’s Institutional Review Board granted the study exempt status on June 26, 2019 (project number 18091406).

**Curriculum Components**

The training featured the following materials:

- Didactic lecture slideshow (Appendix A).
- Facilitation guide (Appendix B).
- Video from the Crime Victims Treatment Center: One in Six (Appendix C).11
- Student worksheet (Appendix D).
- Tool kit (Appendix E).12
- Role-play scenarios for students (Appendix F).
- Scene information for actors/facilitators (Appendix G).
- Pre- and postraining evaluation surveys (Appendix H).

**Materials**

The training utilized a lecture hall with a computer, PowerPoint, internet access, and a projector. The training also required ample classroom space and printed materials for completing small-group discussions, role-play sessions, and worksheets.

**Personnel**

The training featured one lecturer, who delivered the didactic presentation on SA, and classroom physician facilitators, who led the group discussions and role-play activities. The lecturer and facilitators had previous experience working with SA survivors in clinical contexts. Several SA counselors from Resilience, a Chicago-based SA survivor advocacy group, played the role of survivors during role-play encounters and helped facilitate subsequent debriefs. All SA counselors previously had undergone 60 hours of state-mandated training in addition to clinical experience working with SA survivors in emergency departments.

**Student Preparation and Safety Measures**

Considering the sensitive topic of this training, we took various precautions to prepare students for the sessions. Prior to the first training component (the didactic lecture), we sent an email providing all second-year medical students with a detailed description of the upcoming classes as well as access to training materials and resources for psychosocial support. Specifically, students had access to the didactic lecture slideshow (Appendix A), student worksheet (Appendix D), and role-play scenarios (Appendix F) prior to attending the workshop so that they could familiarize themselves with all SA scenarios. Our goal was to avoid subjecting students to potentially triggering content without providing them with advance warning. We gave students the contact information of their classroom facilitators and encouraged them to reach out with any questions. We also provided students with the contact information of the university counseling center. Finally, we notified students that they could
Part 1: Didactic Lecture

The SANE Coordinator of the Office of the Illinois Attorney General created and delivered a 1-hour in-person didactic lecture (Appendix A). The lecture provided background information on the definition and effects of SA as well as important considerations for physicians caring for SA survivors. Specifically, it included information on the neurobiology of trauma, trauma-informed communication, medical needs of survivors, and medical documentation. All students attended the didactic lecture 1 week prior to the small-group workshop component.

Part 2: Small-Group Activities

Using videos, worksheets, class discussions, and role-plays, this 2-hour session focused on practicing skills essential to caring for SA survivors. This portion of the training also featured trained SA counselors, who utilized their experience caring for survivors to explain trauma-informed practices and shed light on the perspectives of SA survivors navigating the health care system.

We first divided students into groups of around 18 and assigned each group a physician facilitator with experience leading second-year classes. We provided facilitators with a comprehensive facilitation guide (Appendix B), which instructed them to lead their small groups through the following activities:

**Part 2A:** Students watched a 5-minute video (Appendix C) demonstrating a positive interaction between a survivor and a physician. Crime Victims Treatment Center, the SA survivor advocacy organization that created the video, granted us permission to include it in our training as well as in the appendices of this publication to assist with future trainings.

**Part 2B:** Students completed a worksheet (Appendix D) in groups of four to five. The worksheet featured seven open-ended questions on appropriate language to use when communicating with SA survivors. We provided sample answers in the facilitation guide (Appendix B) and instructed the class to discuss the activity and review both student and sample answers when ready.

**Part 2C:** Facilitators provided students with tool kits (Appendix E) consisting of communication dos and don'ts to provide additional preparation for the subsequent role-plays.

**Part 2D:** Students participated in three brief role-play sessions (Appendix F) written to represent diverse patients with varying concerns related to SA. Each role-play included a patient scenario, specific patient concerns, and general prompts for medical students. SA counselors used the scene information for role-play actors/facilitators (Appendix G) for guidance while acting as the survivors during the role-plays. We conducted all role-plays using a popcorn-style format, meaning the SA counselors playing the role of the survivors remained at the front of the room while students took turns voluntarily responding to the survivors’ statements. The goal of this format was to simulate a conversation with survivors using role-plays due to their efficacy in improving communication skills. To counter initial student hesitation to participate, we employed popcorn-style role-plays to diffuse responsibility among students and minimize stress or shyness over engaging in sensitive role-play content. Classroom physician facilitators and SA counselors debriefed with the class after each activity and regularly gauged student comfort levels. Debriefs often included the following discussion questions:

1. What do you think the medical student/health provider did well?
2. How could the medical student/health provider improve?
3. What examples of trauma-informed communication did you like?
4. What examples of trauma-informed communication would you add or suggest for next time?
5. Do you have any other questions or comments about the activity?

Facilitators and SA counselors also provided feedback on the role-play performances and shared their insights on working with SA survivors during the debriefs.

Student Assessment and Statistical Evaluation

We tested students for self-reported comfort in working with SA survivors by providing them with identical pre- and posttraining paper evaluation surveys (Appendix H) immediately before the introductory didactic lecture and following the conclusion of the small-group activities 1 week later. To ensure anonymity, we assigned each pretraining survey a unique identification number and instructed students to record that same number on posttraining surveys for data matching. The surveys featured nine questions that assessed student comfort with various aspects of trauma-informed care on a 5-point Likert scale (1 = very uncomfortable, 5 = very comfortable). After students completed all components of the training, we also provided them with a standardized institutional postsession satisfaction survey, a regular practice after all Rush educational activities.

To assess short-term learning retention and comfort working with SA survivors, we included one manually graded free-response question on the medical students’ Sexuality and Reproduction
final examination, which occurred 2 weeks after the completion of the training. The question prompt was “Give two examples of what to avoid saying to a survivor of sexual assault.”

Results
One hundred forty-nine second-year medical students at Rush Medical College participated in our training during the fall of 2019. Of these students, 88 (59%) completed paired pre- and posttraining evaluation surveys. We compared the pre- and posttraining Likert scores of matched survey responses using the McNemar-Bowker test of symmetry (Table 1). We calculated the median and interquartile range for the composite pre- and posttraining survey scores for each student. We then found the difference between the composite pre- and posttraining scores using the Wilcoxon signed rank test (Table 2). We did not include unpaired survey responses in the analyses.

Survey analyses demonstrated a statistically significant increase in self-reported comfort in each of the nine assessed communication skills regarding trauma-informed care \((p = .0001)\) as well as in the composite results of all nine survey questions \((p = .0001)\). See Table 1 for more details.

Out of 89 students (60%) who completed the Rush institutional postsession satisfaction survey, 86 (97%) agreed or strongly agreed that the overall quality of the workshop was excellent. Eighty-one (93%) agreed or strongly agreed that the quality of the self-study materials was excellent, and 79 (92%) agreed or strongly agreed that the session activities were excellent.

We grouped qualitative feedback from the Rush institutional satisfaction survey into three primary categories. The first category included comments discussing how students appreciated receiving trauma-informed care training for SA survivors, practicing communication skills in role-play sessions, and obtaining real-time feedback. Students reported that they enjoyed debriefing and discussing each activity, which provided an additional opportunity to explore the subject matter. The second category focused on the utility that SA counselors brought to the sessions. Students appreciated that these counselors answered student questions and discussed their own experiences working with survivors. The final category of comments focused on the size of breakout groups during the role-play sessions, emphasizing that small groups were helpful in ensuring the role-plays did not intimidate students.

On their Sexuality and Reproduction final exam, all 149 students correctly answered the training-based exam question by successfully providing two examples of phrases to avoid saying to survivors.

Discussion
Given the alarming prevalence of SA, physicians require specialized education in trauma-informed care to facilitate patients’ paths toward healing. We designed this training through a collaboration between experts in the field of sexual violence, Rush Medical College faculty, and students to address gaps in medical student education regarding working with SA survivors. Composed of a class lecture and small-group activities, the training emphasized active student participation to promote trauma-informed communication techniques. The training successfully increased student comfort in communicating with SA survivors as measured by pre- and postsession surveys. Considering its positive results, Rush Medical College incorporated this training session as a fixed component of the second-year medical student curriculum.

| Survey Question                                                                 | Pre-/Posttraining Percentages | \(p^a\) |
|--------------------------------------------------------------------------------|-------------------------------|---------|
| Responding to sexual assault disclosures.                                      | Very Comfortable: 1/17        | .0001   |
|                                                                                  | Slightly Comfortable: 5/16    |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |
| Normalizing distress regarding assault.                                        | Very Comfortable: 25/5        | .0001   |
|                                                                                  | Slightly Comfortable: 37/11   |         |
|                                                                                  | Neither Uncomfortable: 33/17  |         |
|                                                                                  | Slightly Uncomfortable: 25/53 |         |
|                                                                                  | Very Uncomfortable: 3/0       |         |
| Addressing emotions regarding assault.                                         | Very Comfortable: 5/16        | .0001   |
|                                                                                  | Slightly Comfortable: 25/53   |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |
| Collecting pertinent history without asking unnecessary, retraumatizing questions. | Very Comfortable: 5/16        | .0001   |
|                                                                                  | Slightly Comfortable: 25/53   |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |
| Communicating medical options in trauma-informed manners.                      | Very Comfortable: 5/16        | .0001   |
|                                                                                  | Slightly Comfortable: 25/53   |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |
| Helping survivors feel in control of their care.                               | Very Comfortable: 5/16        | .0001   |
|                                                                                  | Slightly Comfortable: 25/53   |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |
| Understanding what to say/what not to say to survivors.                        | Very Comfortable: 5/16        | .0001   |
|                                                                                  | Slightly Comfortable: 25/53   |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |
| Empowering patients through affirmation.                                       | Very Comfortable: 5/16        | .0001   |
|                                                                                  | Slightly Comfortable: 25/53   |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |
| Comfort working with survivors overall.                                        | Very Comfortable: 5/16        | .0001   |
|                                                                                  | Slightly Comfortable: 25/53   |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |
| Sum of questions (overall).                                                     | Very Comfortable: 1/17        | .0001   |
|                                                                                  | Slightly Comfortable: 5/16    |         |
|                                                                                  | Neither Uncomfortable: 31/46  |         |
|                                                                                  | Slightly Uncomfortable: 49/34 |         |
|                                                                                  | Very Uncomfortable: 71/30     |         |

\(p^a\) is based on the McNemar-Bowker test of symmetry.
Results of the Likert-scale questions from pre- and posttraining surveys showed significant improvement in comfort addressing, responding to, normalizing, and understanding patient concerns as well as comfort collecting information from, communicating with, empowering, and overall working with SA survivors. All second-year medical students exposed to the training also responded correctly to the Sexuality and Reproduction final exam question that evaluated short-term retention of trauma-informed communication skills 2 weeks after the training had been administered. Qualitative feedback from the institutional postsession survey revealed high student satisfaction with the self-study materials, training organization, and facilitation by medical professionals and SA counselors.

Positive results from our training echoed those of previous US-based medical school trainings demonstrating that focused educational sessions were successful in teaching trauma-informed care to medical students.⁹,¹⁰ For example, 32 medical students from the Boston University School of Medicine reported increased comfort and medical knowledge regarding caring for SA survivors after viewing a series of online modules focused on the initial medical management of SA survivors.¹⁰ The Warren Alpert Medical School also developed and administered a 3-hour lecture on trauma-informed physical examinations for SA survivors followed by breakout sessions with standardized patients, improving knowledge of trauma-informed exam techniques among 148 first-year medical students.⁹ Our training, however, differed from previous ones in that it primarily focused on the communication aspect of trauma-informed care rather than medical management or physical exam maneuvers. We took this approach because trauma-informed communication is critical to learn and translatable across medical specialties.

Our training also highlighted the diversity of SA survivors and the increased risk of SA in the LGBTQ community¹⁵ by featuring case scenarios of a transgender woman survivor and of a gay man survivor. Finally, we incorporated role-play scenarios featuring SA counselors so that students could practice communication and receive feedback from experts in real time. We included the role-plays due to their effectiveness in improving empathy scores.¹⁶

Strengths of our training included the involvement of subject experts such as the SANE Coordinator of the Office of the Illinois Attorney General, who created and presented the didactic lecture, and SA counselors from the local nonprofit organization Resilience, who assisted small-group sessions by participating in the role-plays, providing students with feedback, and answering questions about working with survivors. The incorporation of SA counselors enhanced interprofessional collaboration, and their involvement met criteria for the Accreditation Council for Graduate Medical Education’s system-based practice competency¹⁷ and the AAMC entrustable professional activity.¹⁸ The training also incorporated multimedia, including a lecture, videos, worksheets, and role-play sessions, to foster student engagement and accommodate different learning styles. Our patient scenarios reflected a range of genders, situations, and patient concerns, enhancing the external validity of the workshop.

There were several limitations to our study. First, not all second-year medical students who underwent the training completed paired pre- and posttraining surveys. Second, other institutions may struggle to find SA counselors to assist with the training. While we strongly recommend partnering with local advocacy organizations, if this is not feasible, faculty with experience treating SA survivors should facilitate the sessions using trained standardized patients to complete the role-plays. Third, due to last-minute cancellations by facilitators, we combined several small-group sessions during the role-plays, resulting in some groups of 30-35 students. Select students in larger groups reported feeling intimidated during the role-plays due to concerns of misspeaking in front of their peers. While some discomfort may be unavoidable when discussing SA, we are confident that student participation, comfort levels, and satisfaction will increase when role-plays are conducted in smaller cohorts, as originally intended. Directions for future research include studying long-term retention of knowledge and comfort providing trauma-informed care to SA survivors, educating residents on working with SA survivors, and special considerations for survivors who are undocumented, living with disabilities, and/or do not speak English as a first language.

Our training exposed students to trauma-informed communication skills specific to interacting with SA survivors and successfully increased medical student comfort levels using these techniques. This training is crucial as all medical professionals are likely to treat SA survivors at some point in their careers. Although trauma-informed care is always relevant, it is especially pertinent during a public health crisis like the COVID-19 pandemic, when victims may be quarantined at home.
with their abusers and are at increased risk for intimate partner violence and SA. Our training can be feasibly replicated at other institutions to increase student exposure to trauma-informed care practices. Through our shared data and programming, we advocate for increased national medical student training in trauma-informed care by providing the tools to make it possible.

Appendices
A. Didactic Lecture.pptx
B. Facilitation Guide.docx
C. Crime Victims Treatment Center Video.mp4
D. Student Worksheet.docx
E. Tool Kit.docx
F. Student Role-Play Scenarios.docx
G. Actor & Facilitator Scene Information.docx
H. Pre- & Posttraining Evaluation.docx

All appendices are peer reviewed as integral parts of the Original Publication.

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Informed Consent
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Prior Presentations
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Ethical Approval
The Rush University Medical Center Institutional Review Board approved this study.

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