

Sexual Assault Advocate/ Counselor Training

Instructor Manual

*OVC Can Help You
Put the Pieces Together*



OVCTTAC

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The Office of Justice Programs (OJP), headed by Acting Assistant Attorney General Mary Lou Leary, provides federal leadership in developing the Nation's capacity to prevent and control crime, administer justice, and assist victims. OJP has seven components: the Bureau of Justice Assistance; the Bureau of Justice Statistics; the National Institute of Justice; the Office of Juvenile Justice and Delinquency Prevention; the Office for Victims of Crime; the Community Capacity Development Office, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. More information about OJP can be found at <http://www.ojp.gov>.

Office for Victims of Crime

The Office for Victims of Crime (OVC) was created by the U.S. Department of Justice in 1983 and formally established by Congress in 1988 through an amendment to the Victims of Crime Act of 1984. OVC's mission is to enhance the Nation's capacity to assist victims of crime and to provide leadership in changing attitudes, policies, and practices to promote justice and healing for all victims of crime.

OVC accomplishes its mission by:

- Administering the Crime Victims Fund
- Supporting direct services
- Providing training programs
- Sponsoring demonstration and evaluation projects with national and international impact
- Publishing and disseminating materials that highlight promising practices that can be replicated worldwide
- Sponsoring fellowships and clinical internships

Office for Victims of Crime Resource Center

The Office for Victims of Crime Resource Center (OVCRC) is your information clearinghouse for emerging victim issues.

As a component of the National Criminal Justice Reference Service—a federally funded resource offering justice and substance abuse information to support research, policy, and program development worldwide—OVCRC offers access to a vast criminal justice resource library and top information specialists to answer your questions. Staff can offer statistics and referrals, discuss publications, compile information packages, and search for additional resources using OVCRC's extensive network of victim advocates and organizations.

OVCRC also offers easy access to OVC and other victim-related publications through an online ordering system and an electronic newsletter. To learn more about OVCRC and its products and online services, visit www.ovc.gov/ovcres/welcome.html or call 1-800-851-3420 (TTY 1-877-712-9279).

Office for Victims of Crime Training and Technical Assistance Center

For victim service providers, the Office for Victims of Crime Training and Technical Assistance Center (OVC TTAC) is the portal to a broad range of resources. OVC TTAC extends training and technical assistance to victim service providers, allied professionals, volunteers, advocates, and victim/witness coordinators. The training and technical assistance are designed to enhance participants' skills and improve the quality and efficiency of the services they deliver.

OVC TTAC also provides a broad range of comprehensive resources for victim service providers. These resources include needs assessment, resource development and delivery, education and outreach, and evaluation. OVC TTAC is committed to helping the Nation's victim service community build its capacity to respond to the increasingly complex needs of victims of crime.

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Acknowledgments

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This manual is the result of the efforts of sexual assault advocates and Sexual Assault Nurse Examiners (SANEs) across the United States who have dedicated their careers to improving the system response to sexual assault survivors. In particular, it is the result of the efforts of the staff of the Sexual Assault Resource Service (SARS) in Minneapolis, Minnesota, and the Santa Fe Rape Crisis Center (SFRCC) in Santa Fe, New Mexico. It is based upon what was learned from these experts as a result of their efforts. It is provided by OVC to you to allow you, the first responders of tomorrow, to continue this effort of improving our system and our response to sexual assault survivors.

The manual was written after an exhaustive review of the literature and existing training materials. The authors were Linda E. Ledray, Ph.D., RN, SANE-A, FAAN, SARS Director; Sharon Moscinski, M.A., LMHC, advocate, SFRCC; and Carla Ferrucci, Executive Director, Minnesota Coalition Against Sexual Assault.

The opinions, findings, and conclusions expressed in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Instructor Overview

Training Goal

The goal of this training is to help sexual assault advocates/counselors build the basic skills necessary to provide competent, effective crisis intervention services to sexual assault victims/survivors. The participants will learn information and skills related to:

- The realities of sexual violence.
- The impact of sexual assault.
- The needs of specific populations.
- Advocacy roles and requirements.
- Working as part of a Sexual Assault Response Team (SART).
- Responding to victims/survivors during a crisis.
- Preventing “compassion fatigue.”

The training is aimed at first responders and focuses heavily on crisis intervention, rather than long-term counseling. The training does not include instruction in group counseling techniques, as it is the consensus of the staff and advisory committee who developed this training that such techniques require advanced training and experience, and are beyond the scope of this basic program.

Target Audience

This training is designed primarily for sexual assault advocates/counselors who are volunteers or staff at rape crisis centers. The training will be relevant to new staff and volunteers, as well as people with many years of experience. However, the emphasis on understanding the realities, impact, and effects of sexual assault also may make the training useful for nurses, including Sexual Assault Nurse Examiners (SANEs), physicians, law enforcement officers, and professional counselors who do not have specific sexual assault training. For example, most university-based counselor training programs include little information specific to the needs of sexual assault survivors. This training can augment those programs.

To be most effective and to best use the participatory techniques in the training, enrollment should be limited to 25 participants.

Instructor Requirements

Instructors for this course should have:

- In-depth knowledge of sexual assault advocacy/counseling.
- Practical experience as a sexual assault advocate/counselor.
- Experience conducting training, particularly interactive (instead of lecture-based) programs.

If you are a subject matter expert but a novice instructor, it is highly recommended that you practice each section of this manual before the training and refer to a resource such as *The Instant Trainer: Quick Tips on How to Teach Others What You Know* by Leslie Charles and Chris Clarke-Epstein for tips on successful training.

Length of the Training

Over the course of 2 days, this training will provide a comprehensive introduction to sexual assault advocacy.

Training Approach

The training design is based on the principles of adult learning and interactive training. Adults learn best when:

- Training focuses on building skills rather than just transferring information.
- They are involved in meaningful activities to practice new skills.
- They can draw on and apply their own knowledge and experience to the training.
- They see the relevance to their jobs and their lives of what they are learning.

The training also incorporates a variety of methods and activities to appeal to visual learners (those who learn best by seeing), auditory learners (those who learn best by hearing), and kinesthetic learners (those who learn best by moving and doing).

Using This Instructor Manual

This Instructor Manual is a template to help instructors prepare for instruction and guide the delivery of the training. It details the information to be discussed and how to introduce, conduct, and process group activities. It also contains a copy of all visuals used in the training.

Each instructor should draw on her or his own knowledge and expertise to enrich the training and provide relevant examples and illustrations, while maintaining the integrity of the training design. To successfully conduct this training, you should become very familiar with all concepts and processing notes in this manual, as well as those in the Participant Manual.

Module 1: Introductions and Overview

Module 2: What Is Sexual Assault Advocacy/Counseling?

Module 3: Realities of Sexual Assault

Module 4: Impact of Sexual Assault

Module 5: Procedures in Common Advocacy Situations

Module 6: Recovery Education and Skills Training

Module 7: Compassion Fatigue and Self-Care

Module 8: Wrap-Up and Evaluation

There is also an Appendix of Information and Tools for Program Managers, and References. At the beginning of each module, an outline includes specific learning objectives, worksheets, any special equipment or materials, preparation instructions, and notification of the time required to complete the module. There is a timed sequence for all information and activities within the module, which will help participants achieve the learning objectives for each module.

Icons

There are several icons that appear frequently throughout the Instructor Manual:



with directive “Show Visual” indicates that a PowerPoint slide is to be shown.



indicates that an activity is to be conducted.

Activities are included in each module to provide participants with opportunities to apply or process information that has been presented, to enhance skill-building, and to underline the transfer of knowledge and skills to the participant’s job following the training. Each activity includes steps to follow and time estimates to conduct the activity.



indicates that the worksheet used in the activity that follows is to be collected after the activity, as part of the CEU award process. Worksheets are to be returned to the room monitor.

Using the Visuals

The visuals for this training provide you with an outline that can be used to guide the training and activities in each module. The visuals include “talking points” for use during lectures, as well as cues for you to conduct an activity, ask for questions from the participants, or transition to the next module.

As mentioned above, the directive “**Show Visual**” followed by a number appears throughout the Instructor Manual. The module number is included in the footer of each visual. This allows you to determine, at a glance, both the module number and the number of the particular visual within that module.

Equipment and Materials

The following equipment and materials are used consistently throughout the training:

- Instructor Manual (provided by OVC).
- Participant Manual (provided by OVC).
- PowerPoint presentation (and electronic templates) on flash drives (provided by OVC).
- Laptop PC with Microsoft Windows 7 and PowerPoint 2007 or later, LCD projector, and screen or blank wall space for projection.
- Tear sheet pad, easel, and tape.
- Multicolored, thick markers for use with tear sheets. (Dark colors should be used so participants can see the writing on the tear sheets. Red, orange, and yellow can be difficult to see at long distances.)
- Name tents (for each participant and instructor).
- Pens (one per participant).
- Highlighters (one per participant).
- Sticky notes.

Additionally, if a module requires specific equipment and materials, they are listed in the outline that precedes each module and also are included in the summary table in this Overview.

Worksheets

Most modules include worksheets that are used by participants during activities in a module. The worksheets are found behind a tab at the end of the Instructor and Participant Manuals, and are labeled sequentially by module (e.g., Worksheet 2.3 is the third worksheet in Module 2; Worksheet 5.2 is the second worksheet in Module 5). Refer to worksheets by number and title.

Handouts

There are handouts in two modules.

Module 2 uses **Handout 2.1, VAWA 2005 Reauthorization Forensic Compliance Mandates; and Handout 2.2, Victims of Sexual Assault HIPAA Privacy Rule**. Copies of these handouts are in the Participant Manual, behind the tab labeled Handouts.

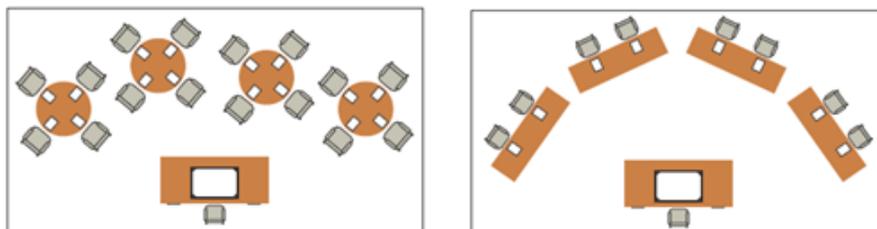
Module 3 uses **Handout 3.1, Sexual Assault Quiz** for participants, and **Handout 3.2, Sexual Assault Quiz With Answers** for instructors. You will pass out and give the quiz at the end of Module 3. Copies of the quiz are provided in your training materials.

Participant Manual

The participants will receive a comprehensive training manual that includes the agenda, articles and supporting text that complement each module, copies of the PowerPoint slides with room to take notes, and copies of worksheets participants will use during activities.

Room Preparation and Layout

If at all possible, try to avoid a traditional classroom-style layout in the training room. This type of layout makes it more difficult for participants to see and hear the instructor and the audiovisual equipment, and to interact with each other. Instead, try to organize the room so participants are seated in a series of small groups. This arrangement encourages discussion and participation. Remember that you will need a small table at the front of the room for your training supplies, as well as a larger table for supplementary materials for participants.



Advance Preparation for Training Delivery

In addition to studying and preparing for each module, instructors should be sure to visit the training room before training begins. Picture the layout of the training room, including the location of furniture and audiovisual equipment, and determine if you need any additional tables or chairs. Make sure all electrical outlets are functioning and check to see if there are shades on the windows to control any glare that could interfere with audiovisual presentations. Test all the equipment to be sure it is functioning properly.

INSTRUCTOR MANUAL
Sexual Assault Advocate/Counselor Training

Worksheets, Equipment/Materials, Preparation

Module	Worksheets/Handouts	Equipment/ Materials	Preparation	Worksheets To Turn In
1	None	None	<p>Instructor:</p> <ul style="list-style-type: none"> ▪ Have Visual 1-1 on the screen as participants enter the room. ▪ Place a Participant Manual, pen, and name tent at each seat. ▪ Prepare tear sheet with ground rules. See Instructor Manual for examples. 	
2	<ul style="list-style-type: none"> ▪ Handout 2.1, VAWA 2005 Reauthorization Forensic Compliance Mandates ▪ Handout 2.2, Victims of Sexual Assault HIPAA Privacy Rule ▪ Worksheet 2.1, Confidentiality Scenarios 	<ul style="list-style-type: none"> ▪ State sexual assault statutes for each state represented. 	<p>Instructor:</p> <ul style="list-style-type: none"> ▪ In preparation for the “Law Review” activity, prepare a written review of Handout 2.1, VAWA 2005 Reauthorization Forensic Compliance Mandates and Handout 2.2, Victims of Sexual Assault HIPAA Privacy Rule. ▪ Prepare any state disclosure laws related to mandatory reporting and confidentiality that you wish to present. See Instructor Manual for details. ▪ Review the Worksheet 2.1, Confidentiality Scenarios. Be sure you are aware of the appropriate way to respond to each scenario according to your state’s laws and organization/agency protocols. ▪ There is a sample of a volunteer confidentiality contract in the Appendix; participants can adapt it for use in their own organizations. 	<p>Visual 2-14: Collect Worksheet 2.1 at the end of the activity.</p>

INSTRUCTOR MANUAL
Sexual Assault Advocate/Counselor Training

Module	Worksheets/Handouts	Equipment/ Materials	Preparation	Worksheets To Turn In
3	<ul style="list-style-type: none"> ▪ Handout 3.1, Sexual Assault Quiz ▪ Handout 3.2, Sexual Assault Quiz With Answers ▪ Worksheet 3.1, Incidence and Prevalence of Sexual Assault ▪ Worksheet 3.2, Myths and Facts About Rape 	<ul style="list-style-type: none"> ▪ Large sticky notes or index cards (two per participant). 	<p>Instructor:</p> <ul style="list-style-type: none"> ▪ Prepare tear sheets and index cards/sticky notes for “Myths and Facts about Rape” lesson and “Myth or Fact?” activity. See Instructor Manual for details. <p>OVC TTAC:</p> <ul style="list-style-type: none"> ▪ Prepare copies of Handout 3.1, one for each participant. 	
4	<ul style="list-style-type: none"> ▪ Worksheet 4.1, STI Scenario ▪ Worksheet 4.2, Psychological Impact Scenario ▪ Worksheet 4.3, Participant Presentations 	None	<p>Instructor:</p> <ul style="list-style-type: none"> ▪ Carefully review the group process scenarios and be prepared to present an “ideal” response. As protocol, facilities, and resources vary from community to community, the response should be based on existing procedures at your center. ▪ Prepare sheets of paper (standard 8.5" x 11" will work well) with one of the following characteristics written on each sheet. Depending on the size of the training, you may choose 5 to 10 of the characteristics for the “Participant Presentation” activity. <ul style="list-style-type: none"> ♦ A man. ♦ A lesbian or gay person. ♦ A person with a developmental disability, such as very low IQ. ♦ A person with a physical disability. ♦ A person over 65. ♦ A person with a mental illness. ♦ A person from a culture that differs from yours. ♦ A person who is a survivor of childhood sexual abuse. 	<p>Visual 4-25: Collect Worksheet 4.3 at the end of the activity.</p>

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Sexual Assault Advocate/Counselor Training

Module	Worksheets/Handouts	Equipment/ Materials	Preparation	Worksheets To Turn In
			<ul style="list-style-type: none"> ♦ An adolescent. ♦ A person who is a survivor of a same-gender assault. 	
5	<ul style="list-style-type: none"> ▪ Worksheet 5.1, Medical-Evidentiary Exam Case Study ▪ Worksheet 5.2, Drug-Facilitated Sexual Assault 	<ul style="list-style-type: none"> ▪ Red paper or index cards (three pieces of paper or cards for five groups) for the Information Search and “Red Flag” activity. 	<p>Instructor:</p> <ul style="list-style-type: none"> ▪ Carefully review the medical-evidentiary exam case study described in this module. You also may wish to tailor it to reflect any particular processes or procedures in your area. ▪ You should be aware of whether or not a system-based advocacy program exists in your local police department or prosecutor’s office. See details in the Instructor Manual. <p>OVC TTAC:</p> <ul style="list-style-type: none"> ▪ Prepare red paper or red index cards (approximately 3" x 4") for the “Information Search and ‘Red Flags’” activity. 	
6	<ul style="list-style-type: none"> ▪ Worksheet 6.1, Role Play—Kendra and Laura 	None	<p>Instructor:</p> <ul style="list-style-type: none"> ▪ Carefully review the role plays in this module and make notes to yourself regarding some “ideal” responses to each. ▪ Carefully review the Suicide Risk section. See Instructor Manual for details. 	
7	<ul style="list-style-type: none"> ▪ Worksheet 7.1, Maintaining Healthy Boundaries ▪ Worksheet 7.2, Personal Self-Care Plan 	None	None	
8	<ul style="list-style-type: none"> ▪ Worksheet 8.1, The Effective Advocate Checklist 	None	None	

Module 1: Introductions and Overview

Time Required

30 minutes

Purpose

This module includes introductions of the instructor and participants, an overview of what participants can expect during the training, and a discussion of terms that will be used during the training.

Lessons

1. Introductions and Expectations (10 minutes)
2. Overview of the Training (10 minutes)
3. Creating a Common Language (10 minutes)

Learning Objective

By the end of this module, participants will be able to determine when to use the terms *rape*, *sexual assault*, *sexual abuse*, *victim*, and *survivor* during the training.

Participant Worksheets

No worksheets are required for this module.

Equipment and Materials

No special equipment or materials are required.

Preparation

- Open the PowerPoint presentation on the PC; have **Visual 1-1** on the screen as participants enter the room.
- Place a Participant Manual, pen, and name tent at each seat.
- Write the following ground rules on a tear sheet:
 - Arrive on time and attend the entire training.
 - Be respectful of other participants and the instructor.
 - Participate in each activity to the best of your abilities.
 - Ask questions, pose scenarios, and make suggestions that will help you to learn.
 - Turn cell phones off or to vibrate.

Leave some room for participants to add their own ground rules. Tape this sheet of paper to the wall, with the writing facing the wall. When you review the ground rules, turn the paper around so the writing is visible.

 **Show Visual 1-1.**

Greet participants as they walk into the room. **Ask** them to choose a seat and write their name on a name tent.

To begin the training, **welcome** the participants to the training and **introduce** yourself. **Tell** participants your name, relevant experience, and why you are facilitating this training.

 **Show Visual 1-2.**

Introduce the module.

 **Show Visual 1-3.**

Review the purpose and learning objective for this module.

By the end of this module, participants will be able to determine when to use the terms *rape*, *sexual assault*, *sexual abuse*, *victim*, and *survivor* during the training.

1. Introductions and Expectations (10 minutes)

 **Show Visual 1-4.**

Ask participants to introduce themselves by answering the following questions:

- What is your name?
- What, if any, experience do you have working with sexual assault victims/survivors?
- What is your motivation for doing this work?
- One thing you really want to learn in this training is _____.

Go around the room so everyone has a chance to share their answers with the group.

Record participants' answers to the last item on the tear sheet. As you fill the sheets with answers, you may wish to mount them on the wall with masking tape.

Explain that you will return to the information on the tear sheets in a few minutes.

2. Overview of the Training (10 minutes)



Show Visual 1-5.

Paraphrase:

The goal of this training is to provide sexual assault advocates/counselors with the skills necessary to provide competent, effective crisis intervention services to sexual assault victims/survivors.

The skills taught in this training are techniques that can be used to support recovery from sexual assault. The training focuses heavily on skills for first responders, and will not deal with advanced counseling techniques. Specific techniques such as eye movement desensitization and reprocessing (EMDR) or hypnosis will be referenced, but not explored in depth. Such techniques require more advanced training and experience, and are beyond the scope of this basic program.

Explain that this training will draw on the experience and viewpoints of the participants. It will be dynamic and interactive and result in skills that participants will use as sexual assault advocates/counselors.

Refer to the tear sheet where you recorded participants' expectations. **Compare** the expectations to the goal of the training and the skills the participants will learn. **Point out** which of their expectations will be met and which ones fall beyond the scope of this training.



Show Visual 1-6.

Address any housekeeping issues that participants will need to know during the training. **Tell** participants where the restrooms are located. **Ask** participants to refrain (as much as possible) from leaving the training except during designated breaks, and to keep cell phones off or on vibrate.

Tell participants that you are committed to starting and ending on time, and providing breaks as scheduled. If any alterations to the schedule are required, you will propose them to the group and come to a consensus.

Call participants' attention to the Participant Manual. **Explain** that the manuals are organized into modules; in addition to being information resources, they contain outlines and learning objectives for each module, instructions for participating in activities and some space for notes. **Explain** that you will refer to the Participant Manual throughout the training. **Encourage** participants to take notes, draw diagrams, or highlight information throughout the training.



Show Visual 1-7.

Share the ground rules for the training. During the training, all participants are expected to:

- Arrive on time and attend the entire training.
- Be respectful of other participants and the instructor(s).
- Participate in each activity to the best of their abilities.
- Ask questions, pose scenarios, and make suggestions that will help them learn.
- Turn cell phones off or to vibrate.

Ask participants for suggestions for additional ground rules. As the group agrees upon suggestions, **add** them to the prepared tear sheet hanging on the wall.

Explain to participants that the information in this training is based on a complete review of the scientific literature on sexual assault; the advice, recommendations, and vast experience of experts in the area of sexual assault counseling; and information provided by more than 30 rape crisis centers across the United States that shared the information they rely upon for local advocate training.

3. Creating a Common Language (10 minutes)



Show Visual 1-8.

Discuss the usage of *personal pronouns* in this training.

Rape crisis centers deal with both male and female sexual assault and abuse victims. In most cases, gender neutral plural pronouns such as “they” and “them” are used throughout this training to refer to victims.

However, because most victims of sexual assault are female, female pronouns are occasionally used. Similarly, most advocates/counselors are women, so female pronouns are sometimes used to refer to the advocate role.



Show Visual 1-9.

Paraphrase:

The legal definitions of rape, sexual assault, and sexual abuse vary from state to state. In this training, *rape* and *sexual assault* will be used interchangeably to refer to any contact between two or more people without consent, involving the sexual organs of one person or more, regardless of sex or marital status, with or without penetration, and with or without resulting physical injury. It may involve vaginal, oral, and/or anal contact.



Show Visual 1-10.

Paraphrase:

Sexual abuse will be used when the victim is a child and the perpetrator is a relative, caretaker, or person with authority over the child (e.g., a teacher, coach, babysitter).



Show Visual 1-11.

Paraphrase:

It is difficult for anyone other than individuals themselves to determine when the shift from *victim* to *survivor* occurs. Some people feel they are survivors from the moment they escape from the assailant(s). They may prefer the term *survivor* even in the emergency department.

Other individuals use *survivors* to mean people who have made significant progress toward regaining control of their lives and recovering from the experience. These individuals may resent being called survivors too soon, preferring instead that advocates recognize that they were victimized because, in the early stages, they feel like victims, not survivors.

At the request of individuals who do not feel they immediately move to survivor status, the term *victim* of rape rather than *survivor* will be used when discussing the emergency department response and early impact. When discussing the later periods of recovery, *survivor* will be used to recognize that, even if the shift has not yet been made from feelings of victim status to feelings of having survived, this is indeed the goal for individuals with whom advocates will work.



Show Visual 1-12.

Review the learning objective and **ensure** that it was met.

By the end of this module, participants will be able to determine when to use the terms *rape*, *sexual assault*, *sexual abuse*, *victim*, and *survivor* during the training.



Show Visual 1-13.

Ask if there are any final questions or comments before moving to the next module.

Sexual Assault Advocate/Counselor Training

Welcome!

OVC Can Help You Put the Pieces Together



JUSTICE FOR VICTIMS
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Module 1

Introductions and Overview

OVC Can Help You Put the Pieces Together



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Learning Objective

- ❖ **Determine when to use the terms *rape, sexual assault, sexual abuse, victim* and *survivor* during the training.**

Introductions

- ❖ **What is your name?**
- ❖ **What, if any, experience do you have working with sexual assault victims/survivors?**
- ❖ **What is your motivation for doing this work?**
- ❖ **One thing you really want to learn in this training is**
_____.

Training Goal

To provide sexual assault advocates/counselors the basic skills necessary to provide competent, effective services to sexual assault victims/survivors.

Housekeeping

Restrooms

Breaks

Cell phones off or on vibrate

Participant Manual

Ground Rules

- ❖ **Arrive on time and attend the entire training.**
- ❖ **Be respectful of other participants and the instructor(s).**
- ❖ **Participate in each activity to the best of your abilities.**
- ❖ **Ask questions, pose scenarios, and make suggestions that will help you to learn.**
- ❖ **Turn cell phones off or to vibrate.**

Use of the Pronouns *She* or *He*

- ❖ **Gender neutral plural pronouns will be used as much as possible – they or them.**
- ❖ **Female pronouns will be used to refer to the victim, as the majority of victims are female.**

Rape and Sexual Assault

In this training, the terms will be used interchangeably.

- ❖ **Any contact between two or more people, without consent.**
- ❖ **Sexual organs of one person or more.**
- ❖ **Regardless of sex or marital status.**
- ❖ **With or without penetration.**
- ❖ **With or without physical injury.**
- ❖ **Vaginal, oral, or anal contact.**

Sexual Abuse

In this training, the term will be used when:

- ❖ Victim is a child.**
- ❖ Perpetrator is a relative, caretaker, or person with authority over the child.**

Victim and Survivor

Individuals determine when the shift from victim to survivor occurs.

- ❖ Some may feel they are a survivor from the moment they escape the assailant.**
- ❖ When the survivor has made progress recovering from the experience.**
- ❖ Some need recognition they were victimized.**

Review of Learning Objective

- ❖ **Determine when to use the terms *rape, sexual assault, sexual abuse, victim* and *survivor* during the training.**

End of Module 1

Questions? Comments?



Module 2: What is Sexual Assault Advocacy/Counseling?

Time Required

1 hour, 15 minutes

Purpose

This module is intended to help participants understand their roles and responsibilities as advocates, and the roles of others with whom they will work.

Lessons

1. Basic Tenets of Advocacy (5 minutes)
2. Overview of Sexual Assault Response Teams (SARTs) and Sexual Assault Nurse Examiners (SANEs) (20 minutes)
3. Roles of the Advocate (10 minutes)
4. Maintaining Confidentiality (40 minutes)

Learning Objectives

By the end of this module, participants will be able to:

- Describe the composition of a SART.
- Identify the major roles of an advocate.
- Make appropriate decisions based on state reporting laws.

Handouts

- Handout 2.1, VAWA 2005 Reauthorization Forensic Compliance Mandates
- Handout 2.2, Victims of Sexual Assault HIPAA Privacy Rule

Participant Worksheet

- Worksheet 2.1, Confidentiality Scenarios

Equipment and Materials

- State sexual assault statutes for each state represented.

Preparation

- In preparation for the “Law Review” activity, prepare a written review of **Handout 2.1, VAWA 2005 Reauthorization Forensic Compliance Mandates** and **Handout 2.2, Victims of Sexual Assault HIPAA Privacy Rule**.
- Prepare any state disclosure laws related to mandatory reporting and confidentiality that you wish to present. It is not necessary to include exact legal language; however, be very clear about what your state’s laws are and how these laws and regulations affect the work of advocates. Specifically, you need to understand when you are mandated to report based upon your state laws and when reporting to law enforcement without the victim’s consent could be considered a breach of confidentiality.
- Review the **Worksheet 2.1, Confidentiality Scenarios**. Be sure you are aware of the appropriate way to respond to each scenario according to your state’s laws and organization/agency protocols.
- There is a sample of a volunteer confidentiality contract in the Appendix; participants can adapt it for use in their own organizations.



Show Visual 2-1.

Introduce the module.



Show Visual 2-2.

Review the purpose and learning objectives for this module.

By the end of this module, participants will be able to

- Describe the composition of a SART.
- Identify the major roles of an advocate.
- Make appropriate decisions based on state reporting laws.

1. Basic Tenets of Advocacy (5 minutes)



Show Visual 2-3.

Paraphrase:

One of the things that advocacy does is provide victims with information about their options so they can make educated choices (Ledray 1999; Ledray, O'Brien, and Chasson 2011). Advocacy encourages victims to ultimately advocate for themselves while giving them a voice when they are too weak to speak. Advocacy should be trauma-specific, addressing only the current sexual assault and any consequences or issues that arise as a result of that crime (Young 1993). Young cautions not to ignore preexisting life problems; rather, address them in descending order only after the more pressing criminal issues are addressed. Issues such as an abusive relationship, substance abuse, mental health problems, or financial troubles affect recovery and are thus issues for the advocate. It is important to know when to make referrals and which community resources are appropriate for follow-up counseling (Young 1993).

Whatever the scenario, the overriding tenet of advocacy is to listen and believe. The healing power of this is extraordinary. Survivors do not need to prove they are suffering to win support; advocates give unconditional support while safeguarding the individual's right to be treated with respect, whatever the circumstance.

The unfortunate reality is that an advocate may be the only person who believes a victim without question, comment, or blame, which makes the words, “I believe you,” and the corollary, “It wasn’t your fault,” that much more powerful. The rare case when a survivor is dishonest is relatively unimportant. Clearly, the survivor is suffering on some level and has most likely been victimized in some way. Having the wool pulled over our eyes on that rare occasion is a small price to pay for extending the healing power of unconditional belief that has helped so many survivors.

Another advocacy maxim is neither to investigate nor judge. Asking questions so the account makes sense can jeopardize the advocate’s relationship with the survivor. Leave the investigation to the investigators. This means no note-taking while the survivor talks about the assault. Keeping one’s hands free nonverbally communicates to the survivor that the advocate is not interested in “taking” anything (including a report) but rather is present as a trusted ally. Advocates are the only first responders who have no other responsibilities and no pressing agenda.

In addition to these basic tenets, participants must keep the word “teamwork” in mind. As advocates, they will work with other professionals, from law enforcement officers to medical professionals, to meet the needs of sexual assault victims.

2. Overview of Sexual Assault Response Teams and Sexual Assault Nurse Examiners (20 minutes)



Show Visual 2-4.

Ask the participants to volunteer any information they know about SARTs and SANEs. **Write** key responses on the tear sheet, then **proceed** with a brief lecture based on the information below. When preparing your lecture, keep in mind that this section is intended to provide an overview of SARTs and SANEs. Procedures for working with SARTs and SANEs are examined in detail in Module 5, Procedures in Common Advocacy Situations, and to a lesser extent in Module 6, Recovery Education and Skills Training.



Show Visual 2-5.

Paraphrase:

No single agency can meet all of the needs of the sexual assault survivor. Rape crisis centers, medical professionals, law enforcement, and prosecutors have recognized the benefits of collaborating in their work with sexual assault survivors. In addition to learning to work effectively with victims of sexual assault, advocates must learn to work cooperatively and effectively with those with whom they will collaborate.

In many communities, the group of individuals from different agencies who work with rape survivors is referred to as the SART. Demonstrated to be an effective model for providing better services to sexual assault victims, the SART concept includes crisis intervention and long-term counseling, investigation, and evidence collection, and a more sensitive initial medical response to rape victims (Ledray 1999; Ledray, O'Brien, and Chasson 2011).



Show Visual 2-6.

Paraphrase:

SART membership varies depending on the community and the needs of a particular rape survivor. At a minimum, it should include the rape crisis advocate, medical personnel, law enforcement, prosecutor, and crime laboratory specialist. It may also include domestic violence victim advocates, clergy, and other social service agency personnel. In some communities, a core group of SART members may respond together in the emergency department, or they may simply work cooperatively to meet the needs of sexual assault survivors and their families/significant others.



Show Visual 2-7.

Paraphrase:

The medical professional who participates in a SART is often a SANE. SANEs are specially trained nurses who are on call to specified emergency departments, medical clinics, community agencies, or independent SANE facilities.

SANEs are trained to complete a medical-legal examination of rape victims, taking into account specific medical and emotional needs of the victims, as well as the importance of properly collecting forensic evidence that can be used in legal proceedings. The SANE concept has been shown to be an effective model for providing better evidence collection and a more sensitive initial medical response to rape victims (Ledray, O'Brien, and Chasson 2011).



Show Visual 2-8.

Paraphrase:

Medical professionals developed the first SANE programs in the mid-1970s after recognizing the need for better care for sexual assault victims in the emergency department.

Previously, when rape victims came to the emergency department for care, they often had to wait as long as 4 to 12 hours in a busy public area, their wounds considered less serious than those of other trauma victims, as they competed unsuccessfully for staff time with the critically ill or injured (Halloway and Swan 1993; Sandrick 1996; Speck and Aiken 1995). Often, they were not allowed to eat, drink, or urinate while they waited, for fear of destroying evidence (Thomas and Zachritz 1993).

Doctors and nurses were often insufficiently trained to do medical-legal exams, and many lacked the ability to provide expert witness testimony as well (Lynch 1993). Even trained staff often failed to complete a sufficient number of exams to maintain any level of proficiency (Lenehan 1991; Tobias 1990; Yorker 1996). When the victim's medical needs were met, emotional needs all too often got overlooked (Speck and Aiken 1995) or even worse, the survivor was blamed for the rape by the emergency department staff (Kiffe 1996).

There are many published and anecdotal reports of physicians being reluctant to do the exam. Many factors contributed to this, including their lack of training and experience in forensic evidence collection (Bell 1995; Lynch 1993; Speck and Aiken 1995); the time-consuming nature of the evidentiary exam in a busy emergency department with many other medically urgent patients (DiNitto 1986; Frank 1996); and the potential of being subpoenaed and taken away from the emergency department to be questioned by a sometimes hostile defense attorney while testifying in court (DiNitto 1986; Frank 1996; Speck and Aiken 1995; Thomas and Zachritz 1993).

As a result, documentation of evidence could be rushed, inadequate, or incomplete (Frank 1996). Many physicians simply refused to do the exam (DiNitto 1986).



Show Visual 2-9.

Explain that advocates must work cooperatively with other members of a SART or, if there is no formal SART in their community, with other first responders. Strategies and considerations for working effectively with SART members will be explored throughout this training. As participants practice their skills throughout the training, they will be asked to define their own roles and the roles of other SART members.

Tell participants that rape crisis centers, advocacy, specialized training, and teamwork have greatly improved the quality of care for rape victims. Advocates have provided and continue to provide a range of services to address the needs of victims and their families/significant others. The next section will examine in detail the various roles of the advocate.

3. Roles of the Advocate (10 minutes)



Show Visual 2-10.

Paraphrase:

Advocates most commonly provide any or all of the following services:

- Crisis telephone line staffing, which involves giving victims of rape immediate support and information about what to do after an assault.
- Medical-evidentiary exam response, during which an advocate's primary functions are to provide the victim with information about options, answer questions, provide support and crisis intervention, and advocate on the victim's behalf with the medical personnel providing care.
- Law enforcement statement accompaniment, which involves the advocate accompanying the rape victim to an investigator's office to give an official statement of the assault.
- Courtroom accompaniment, which involves accompanying the victim to attorney appointments, as well as to the courtroom.
- Family/significant other supportive counseling, which involves providing information and support to family members or significant others.



Show Visual 2-11.

Tell participants that procedures for each of these roles will be examined more closely later in this training. **Explain** that advocates may also provide walk-in crisis intervention; individual, ongoing supportive counseling; or support group facilitation. However, these roles are less common for volunteers and will not be addressed in-depth in this training.

Point out that participants can find more information about the roles of an advocate in the Appendix.

4. Maintaining Confidentiality (40 minutes)



Show Visual 2-12.

Paraphrase:

It is important to maintain confidentiality because it is the victim's right, it gives the victim control and the ability to make decisions about whom to tell, and it makes disclosure safe. Advocates have a responsibility to maintain confidentiality, to the limits of the law, about each and every case with which they are involved. A sexual assault is a loss of control over one's body and over the ability to choose with whom to be sexual. It is extremely important that the victim be able to retain control after the assault to the greatest extent possible. Deciding who will know about the rape is an important part of regaining control. Maintaining confidentiality is one way to help the victim regain control over who does and does not know that the rape occurred.



Show Visual 2-13.

Paraphrase:

Only when victims know the limits of the confidentiality can they make a safe, educated choice about what to tell the advocate, SANE, or counselor. Rape crisis centers in many states have gone to great lengths to get state legislation passed to ensure that their conversations with sexual assault victims are completely confidential and that they cannot be subpoenaed to testify even if the case goes to court. Advocates must know the limits of confidentiality for rape crisis advocates in their state and communicate these to victims before the victims disclose information (Ledray, O'Brien, and Chasson 2011).

Explain that SANEs, on the other hand, are collecting evidence and expect that everything the victim tells them can be admitted into evidence and used in court. In other medical examinations, HIPAA requires the medical personnel to maintain all health-related information confidential.

Paraphrase:

However, because this is a medical-legal exam, the SANE will ask the victim to sign a release of information giving them permission to release all of the information gathered during this particular medical visit to law enforcement. The record of the visit and any physical evidence collected is an important part of the evidence that may be used in the investigation and prosecution of the reported sexual assault.

This release **ONLY** applies to health information collected in this particular visit. It **DOES NOT** apply to any other health records. The SANE is responsible for obtaining the consent and informing the victim about this lack of confidentiality.

One advantage of the SANE medical role is that the SANE can testify to things the victim says during the medical forensic examination. For example, if the victim tells the SANE information that establishes the sexual contact was forced, the SANE can testify to this in the courtroom as a medical exception to the hearsay rule, even if it was not an “excited utterance.”



Show Visual 2-14.

Instructor Note:



Following the activity, collect **Worksheet 2.1** and give to the room monitor.

Introduce the activity.



Activity: Law Review (30 minutes)

- 1. Refer participants to Handout 2.1, VAWA 2005 Reauthorization Forensic Compliance Mandates and Handout 2.2, Victims of Sexual Assault HIPAA Privacy Rule, found in the Participant Manual; and any state disclosure laws that you prepared earlier.**
- 2. Ask participants to follow along with the handouts as you review them.**
- 3. When the review is complete, refer participants to Worksheet 2.1, Confidentiality Scenarios, in the Participant Manual, which provides scenarios dealing with confidentiality. Ask participants to put their unique ID number on the worksheet.**
- 4. Ask participants to make choices based on their understanding of their state’s laws.**
- 5. Review the correct answers, and discuss anything that may still be ambiguous under their state’s laws.**
- 6. Remind participants to put their unique ID number on their worksheets. Collect worksheets and give to the room monitor.**



Show Visual 2-15.

Explain that maintaining confidentiality means:

- Not talking to the media about the case without the victim’s permission.
- Not using the victim’s name when discussing the case with coworkers.
- Not discussing cases with your family.

- Not talking about cases on an elevator or in a public place.
- Not using any details of cases, even anonymously, for training purposes.

Especially in a small community, it is all too easy to breach client confidentiality unknowingly.



Show Visual 2-16.

Review the learning objectives and **ensure** that these were met.

By the end of this module, participants will be able to

- Describe the composition of a SART.
- Identify the major roles of an advocate.
- Make appropriate decisions based on state reporting laws.



Show Visual 2-17.

Ask if there are any final questions or comments before moving to the next module.

Module 2

What Is Sexual Assault Advocacy/Counseling?

OVC Can Help You Put the Pieces Together



OVCTTAC

Learning Objectives

- ❖ **Describe the composition of a SART.**
- ❖ **Identify the major roles of an advocate.**
- ❖ **Make appropriate decisions based on state reporting laws.**

Tenets of Advocacy

- ❖ **Provide information about choices.**
- ❖ **Trauma-specific.**
- ❖ **Listen and believe.**
- ❖ **Neither investigate nor judge.**
- ❖ **Teamwork.**

SARTs and SANEs

What do you know about about Sexual Assault Response Teams (SARTs) and Sexual Assault Nurse Examiners (SANEs)?

Sexual Assault Response Teams (SARTs)

- ❖ **Group of individuals from different agencies who work with rape victims.**
- ❖ **Effective model.**
- ❖ **Crisis intervention and long-term counseling.**
- ❖ **Investigation and evidence collection.**
- ❖ **More sensitive medical response to rape victims.**

SART Membership Varies

- ❖ **At minimum, rape crisis advocate, SANE, law enforcement, prosecutor, and crime laboratory specialist.**
- ❖ **May also include domestic violence victim advocates, clergy, and other social service agency personnel.**

Sexual Assault Nurse Examiners (SANEs)

- ❖ **Medical professionals who participate in a SART.**
- ❖ **Specially trained nurses.**
- ❖ **Trained to complete a medical-legal exam of rape victims.**
- ❖ **Better evidence collection and more sensitive initial medical response.**

Need for SANEs

- ❖ **Long waits.**
- ❖ **Could not eat, drink, or urinate while waiting.**
- ❖ **Insufficient training.**
- ❖ **Improper evidence collection.**
- ❖ **Proper exams are time-consuming.**
- ❖ **Medical professionals fear subpoenas.**

Teamwork

- ❖ **Rape crisis centers, advocacy, specialized training, and teamwork have greatly improved the quality of care for rape victims.**
- ❖ **Be clear about roles.**
- ❖ **Be respectful of roles.**

Roles of the Advocate

- ❖ **Crisis telephone line.**
- ❖ **Medical-evidentiary exam response.**
- ❖ **Law enforcement statement accompaniment.**
- ❖ **Courtroom accompaniment.**
- ❖ **Family/significant other supportive counseling.**

Roles of the Advocate

- ❖ **Walk-in crisis intervention.**
- ❖ **Individual, ongoing supportive counseling.**
- ❖ **Support group facilitation.**

Confidentiality

- ❖ **It is the victim's right.**
- ❖ **It gives the victim control.**
- ❖ **It makes disclosure safe.**

Confidentiality

- ❖ **Issues differ for advocates and SANEs.**
 - **Rape crisis centers in many states have lobbied for legislation so advocates can't be subpoenaed; advocates must know limits of confidentiality.**
 - **SANEs expect that everything the victim says can be admitted into evidence.**
- ❖ **Ensure the victim knows limits to confidentiality.**

Activity

Law Review

Worksheet 2.1

- ❖ **Review the handouts:
2.1, VAWA 2005 Reauthorization Forensic
Compliance; and
2.2, Victims of Sexual Assault HIPAA Privacy Rule.**
- ❖ **Complete the worksheet.**
- ❖ **Turn in your worksheet.**

Maintaining Confidentiality Means . . .

- ❖ **Not talking to the media.**
- ❖ **Not using the victim's name when discussing with coworkers.**
- ❖ **Not discussing cases with your family.**
- ❖ **Not talking about cases on an elevator or in a public place.**
- ❖ **Not using any details of cases for training purposes.**

Review of Learning Objectives

- ❖ **Describe the composition of a SART.**
- ❖ **Identify the major roles of an advocate.**
- ❖ **Make appropriate decisions based on state reporting laws.**

End of Module 2

Questions? Comments?



Module 3: Realities of Sexual Assault

Time Required

45 minutes

Purpose

This module includes an examination of the realities of sexual assault, allowing participants to deepen their understanding of the issues.

Lessons

1. Incidence and Prevalence of Sexual Assault (20 minutes)
2. Myths and Facts About Rape (25 minutes)

Learning Objectives

By the end of this module, participants will be able to

- Correctly answer at least two questions about the incidence and prevalence of sexual assault in the United States.
- Identify at least one factor contributing to underreporting of rape.
- List at least two myths and two facts about rape.

Handouts

- Handout 3.1, Sexual Assault Quiz, one per participant
- Handout 3.2, Sexual Assault Quiz With Answers

Participant Worksheets

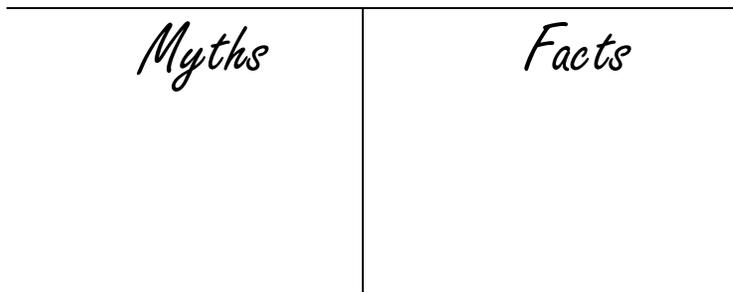
- Worksheet 3.1, Incidence and Prevalence of Sexual Assault
- Worksheet 3.2, Myths and Facts About Rape

Equipment and Materials

- Large sticky notes or index cards (two per participant).

Preparation

- On a tear sheet, write “Myths and Facts About Rape” across the top in large letters. Underneath, draw a line down the center, forming two columns. At the top of the left column, write “Myths.” At the top of the right column, write “Facts.” Tape this sheet to the wall, with the writing facing the wall. When you begin the “Myth or Fact?” activity, turn the paper around so the writing is visible.



- If you are using index cards instead of large sticky notes, tear off short pieces of masking tape (two per participant) and attach them lightly to the wall by the paper; the participants will use the tape to attach their cards to the appropriate column, as described in the activity.
- Prepare copies of Handout 3.1, one for each participant.



Show Visual 3-1.

Introduce the module.



Show Visual 3-2.

Review the purpose and learning objectives for this module.

By the end of this module, participants will be able to

- Correctly answer at least two questions about the incidence and prevalence of sexual assault in the United States.
- Identify at least one factor contributing to underreporting of rape.
- List at least two myths and two facts about rape.

1. Incidence and Prevalence of Sexual Assault (20 minutes)



Show Visual 3-3.

Introduce the module by asking participants how familiar they are with the incidence and prevalence of sexual assault in the United States.



Show Visual 3-4.

Introduce the activity.



Activity: Friendly Competition (15 minutes)

- 1. The participants will work in groups in a friendly competition as you proceed through a series of questions and answers. Divide participants into groups of four or five. Ask for a volunteer to act as scorekeeper.**
- 2. Ask participants to close the Participant Manual during this activity. Each of the questions below appears on a visual, with the correct answer to the question on the next visual. Show each visual and pose the question to the group.**
- 3. As you show each visual, ask participants to call out the correct answer. Allow sufficient time for several participants to respond in case they disagree on the correct answer.**

4. *After several responses, show the correct answer on the following slide. (The answers are also duplicated below.)*
5. *The participant who was the first to call out the correct answer will receive one point for their table group. The scorekeeper will keep track of group points.*
6. *Keep posing questions to the groups until all questions are answered.*
7. *The table group that answers the most questions correctly is declared the winner.*



Show Visual 3-5.

Instructor Note:

The questions that appear on the following PowerPoint visuals also are in the Participant Manual. Allow participants to try to respond before showing the answer on the following PowerPoint visual. Participants can write answers and notes in the Participant Manual, using **Worksheet 3.1, Incidence and Prevalence of Sexual Assault**.

Tell participants that the following statistics are from the 2012 National Crime Victims' Rights Week Resource Guide.

Q: Approximately how many victims age 12 or older experienced rape or sexual assault in 2010? Was it approximately:

- A. 57,000
- B. 102,000
- C. 188,000
- D. 212,000



Show Visual 3-6.

A: Victims age 12 or older experienced a total of 188,380 rapes or sexual assaults.



Show Visual 3-7.

Q: In 2010, what percentage of rape or sexual assault victims were female? Was it approximately:

- A. 55 percent
- B. 67 percent
- C. 81 percent
- D. 92 percent



Show Visual 3-8.

A: In 2010, 91.9 percent of rape or sexual assault victims were female.



Show Visual 3-9.

Q: In 2010, what percentage of female rape or sexual assault victims were assaulted by a stranger? Was it approximately:

- A. 12 percent
- B. 25 percent
- C. 36 percent
- D. 55 percent



Show Visual 3-10.

A: In 2010, 25 percent of all rapes or sexual assaults were committed by a stranger, 48 percent by a friend or acquaintance, and 17 percent by intimate partners.



Show Visual 3-11.

Q: In 2010, what percentage of all rapes and sexual assaults were reported to law enforcement? Was it approximately:

- A. 20 percent
- B. 30 percent
- C. 50 percent
- D. 70 percent



Show Visual 3-12.

A: In 2010, 49.6 percent of all rapes and sexual assaults were reported to law enforcement.



Show Visual 3-13.

Instructor Note:

Until January 2012, the FBI's Uniform Crime Report definition of forcible rape included penetration with the use of physical force, threat of force, or resulting in physical injury. The new definition of rape is the penetration, no matter how slight, of the vagina or anus with any body part, or oral penetration by a sex organ of another person without the consent of the victim.

The revised definition includes any gender of victim or perpetrator, and includes instances in which the victim is incapable of giving consent because of temporary or permanent mental or physical incapacity, including due to the influence of drugs or alcohol or because of age.

Q: In 2010, forcible rapes accounted for what percentage of violent crimes reported to law enforcement? Was it approximately:

- A. 3 percent
- B. 7 percent
- C. 12 percent
- D. 18 percent



Show Visual 3-14.

A: In 2010, forcible rapes accounted for 6.8 percent of violent crimes reported to law enforcement.



Show Visual 3-15.

Q: Has the forcible rape arrest rate increased or decreased in the past 20 years?



Show Visual 3-16.

A: The forcible rape arrest rate decreased 56 percent between 1991 and 2009, after peaking in the years from 1984 to 1991.



Show Visual 3-17.

Q: In 2010, approximately what percentage of reported forcible rape cases were cleared by law enforcement? Was it approximately:

- A. 20 percent
- B. 30 percent
- C. 40 percent
- D. 50 percent



Show Visual 3-18.

A: In 2010, 40.3 percent of reported forcible rapes were cleared, usually by arrest, by law enforcement.

Ask participants to take 10 minutes to write down the correct answers on the worksheet to each of the questions you discussed. **Tell** them you will be distributing a quiz, which they will answer and submit anonymously, at the end of this module. **Be explicit** about the fact that the quiz will not be graded and is not a form of censure; it is simply a tool to help you determine if the participants are learning the material.

Tell participants that the answers to each question can be found in the Participant Manual.

2. Myths and Facts About Rape (25 minutes)

Tell participants the group is now going to discuss myths and facts about rape.



Show Visual 3-19.

Introduce the activity.

Instructor Note:

Ask participants to close the Participant Manual so they will not have easy access to facts about rape.

 **Activity: Myth or Fact? (25 minutes)**

1. *Tape the prepared tear sheet labeled “Myths and Facts About Rape” to the wall.*
2. *Ask participants to close their manuals.*
3. *Distribute two index cards to each participant. Ask participants to take 2–3 minutes to write either a myth or a fact about rape on each index card. When they finish, they should tape their index cards on either the “Myth” side of the chart or the “Fact” side. The cards are anonymous, so participants should not worry if they are unsure of the statements they write on their cards.*
4. *When the participants have placed all of their cards on the chart, review the myths and facts by reading each one aloud. It is possible that some of the cards under the “Fact” side might actually be myths, and vice versa. Move the cards to the correct side.*
5. *After you read each card, ask participants to determine if the card is in the right place. If not, provide accurate information about the statement and move the card to the other column. If the following statements are not mentioned, review them with the participants.*
6. *Read the myths aloud and ask participants to state the facts. Provide hints and information as needed.*
7. *When you have reviewed the myths and facts, refer participants to Worksheet 3.2, Myths and Facts About Rape, in the Participant Manual, which includes a list of the myths and facts discussed below, as well as space for notes about additional myths and facts that may have been raised by the participants.*

Present myths and facts about rape.

 **Show Visual 3-20.**

Myth: Rape is most often perpetrated by a stranger.

 **Show Visual 3-21.**

Fact: Victims are more likely to be raped by someone they know.

 **Show Visual 3-22.**

Myth: If there was no penetration by a penis, then there was no rape.



Show Visual 3-23.

Fact: Legal definitions of rape vary from state to state. For the purposes of this training, rape constitutes penetration with a penis, fingers, and/or foreign objects, or when there was unwanted touching of the sexual body parts without penetration.



Show Visual 3-24.

Myth: People cannot be raped by their partners.



Show Visual 3-25.

Fact: Individuals are raped by their partners. Rape is often used as a tool to control one of the partners in a relationship in which the offender batters the victim, or where one partner feels entitled to sex despite the other person's wants or needs.

However, spousal and partner rape may be treated differently than other forms of rape in a jurisdiction's laws. For example, there may be a shorter reporting period or a requirement of use of weapons or force to commit the rape.



Show Visual 3-26.

Myth: Prostitutes cannot be raped.



Show Visual 3-27.

Fact: Prostitutes can be and often are raped by "johns," the customers who solicit sex from them, and by "pimps," the men who often control the prostitute's money and territory by supposedly offering protection. Often these pimps control women by ensuring or introducing drug usage, and with physical threats or force.



Show Visual 3-28.

Myth: Child molesters are all dirty old men.



Show Visual 3-29.

Fact: In recent surveys of child molesters, 80 percent were found to have committed their first offense before the age of 30.



Show Visual 3-30.

Myth: The “stranger” represents the greatest threat to children.



Show Visual 3-31.

Fact: Studies show that among children ages 6 to 11, 53 percent of perpetrators were acquaintances. Among adolescents ages 12 to 17, 66 percent of perpetrators were acquaintances. Strangers were the least likely perpetrators of sexual assault against children in cases reported to law enforcement: Only 3 percent of victims ages 5 and under, 5 percent of 6 to 11 year olds, and 10 percent of teen victims were sexually assaulted by strangers (Finkelhor 2009).

Often, a perpetrator will spend time “grooming” the child and his or her family by doing favors and providing assistance emotionally and physically for family members. This is done to win the family’s trust, which makes it harder for them to believe the child and decreases suspicion of the perpetrator.



Show Visual 3-32.

Myth: Rape only happens to young women.



Show Visual 3-33.

Fact: Elderly individuals can be and are raped. Because of such myths, elderly victims often do not come forward when they are sexually assaulted. There is a high level of shame and fear that they have lost the ability to care for themselves. In addition, the perpetrator could be someone who comes into the victim’s home to provide care. These victims may fear for their lives or that their care will be taken away.



Show Visual 3-34.

Myth: Rape can’t happen in same-gender relationships.



Show Visual 3-35.

Fact: Rape can occur in same-gender relationships as well as in heterosexual relationships.

 **Show Visual 3-36.**

Myth: Men cannot be raped.

 **Show Visual 3-37.**

Fact: Although men are less likely to report because of societal pressures, men can be and are raped by other men and by women.

 **Show Visual 3-38.**

Myth: If a woman drinks with a man, goes home with him, or wears skimpy clothing, it is her fault if she is raped.

 **Show Visual 3-39.**

Fact: It is never her fault. No one asks or deserves to be raped. Rape is a violent attack and a crime in which the perpetrator controls the victim.

 **Show Visual 3-40.**

Introduce the activity.

 **Activity: Sexual Assault Quiz (10 minutes)**

- 1. Allow participants 5 minutes to use their manuals to review the information in this module.**
- 2. Distribute Handout 3.1, Sexual Assault Quiz to participants. Answers to the quiz are found on Handout 3.2, Sexual Assault Quiz With Answers.**
- 3. Remind participants that the quizzes are anonymous and will help you determine if there are areas that need to be reviewed.**
- 4. Do not allow participants to refer to their manuals when taking the quiz. Allow no more than 5 minutes for the participants to answer the questions.**
- 5. Collect the quizzes and put them aside.**
- 6. Tell participants you plan to review participants' answers during the break.**

Instructor Note:

If most of the participants were unable to correctly answer at least two questions about the incidence and prevalence of sexual assault in the United States, and identify at least one factor contributing to underreporting of rape, conduct a brief review of any areas of confusion after the break.



Show Visual 3-41.

Review the learning objectives and **ensure** that these were met.

By the end of this module, participants will be able to

- Correctly answer at least two questions about the incidence and prevalence of sexual assault in the United States.
- Identify at least one factor contributing to underreporting of rape.
- List at least two myths and two facts about rape.



Show Visual 3-42.

Ask if there are any final questions or comments.

Module 3

Realities of Sexual Assault

OVC Can Help You Put the Pieces Together



OVCTTAC

Learning Objectives

- ❖ **Correctly answer at least two questions about the incidence and prevalence of sexual assault in the United States.**
- ❖ **Identify at least one factor contributing to underreporting of rape.**
- ❖ **List at least two myths and two facts about rape.**

Sexual Assault

How much do you know about the incidence and prevalence of sexual assault in the United States?

Activity

Friendly Competition



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Q: Approximately how many victims age 12 or older experienced rape or sexual assault in 2010?

- A. 57,000**
- B. 102,000**
- C. 188,000**
- D. 212,000**

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Q: Approximately how many victims age 12 or older experienced rape or sexual assault in 2010?

A: 188,380 victims age 12 or older experienced rape or sexual assault in 2010.

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Q: In 2010, approximately what percentage of rape or sexual assault victims were female?

- A. 55%**
- B. 67%**
- C. 81%**
- D. 92%**

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Q: In 2010, approximately what percentage of rape or sexual assault victims were female?

A: In 2010, 91.9% of rape or sexual assault victims were female.

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Q: In 2010, approximately what percentage of female rape or sexual assault victims were assaulted by a stranger?

- A. 12%**
- B. 25%**
- C. 36%**
- D. 55%**

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green, set against a light blue background.

Q: In 2010, approximately what percentage of female rape or sexual assault victims were assaulted by a stranger?

A: In 2010, 25% of all rapes or sexual assaults were committed by a stranger, 48% by a friend or acquaintance, and 17% by intimate partners.

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Q: In 2010, approximately what percentage of all rapes and sexual assaults were reported to law enforcement?

- A. 20%**
- B. 30%**
- C. 50%**
- D. 70%**

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Q: In 2010, approximately what percentage of all rapes and sexual assaults were reported to law enforcement?

A: In 2010, 49.6% of all rapes and sexual assaults were reported to law enforcement.

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Q: In 2010, forcible rapes accounted for approximately what percentage of violent crimes reported to law enforcement?

- A. 3%**
- B. 7%**
- C. 12%**
- D. 18%**

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Q: In 2010, forcible rapes accounted for approximately what percentage of violent crimes reported to law enforcement?

A: In 2010, forcible rapes accounted for 6.8% of violent crimes reported to law enforcement.

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Q: Has the forcible rape arrest rate increased or decreased in the past 20 years?

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Q: Has the forcible rape arrest rate increased or decreased in the past 20 years?

A: The forcible rape arrest rate decreased 56% between 1991 and 2009, after peaking in the years from 1984 to 1991.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green.

Q: In 2010, approximately what percentage of reported forcible rape cases were cleared by law enforcement?

- A. 20%**
- B. 30%**
- C. 40%**
- D. 50%**

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are arranged in a way that suggests a larger image or concept being pieced together.

Q: In 2010, approximately what percentage of reported forcible rape cases were cleared by law enforcement?

A: In 2010, 40.3% of reported forcible rapes were cleared, usually by arrest, by law enforcement.

Activity

Myth or Fact?

Worksheet 3.2

- ❖ **Without looking at the worksheet, write a myth or fact about rape on each card.**
- ❖ **Tape cards to the Myth or Facts column of the tear sheet.**
- ❖ **Refer to the worksheet for the debrief.**

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Myth:

Rape is most often perpetrated by a stranger.

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Myth:

Rape is most often perpetrated by a stranger.

Fact:

Victims are more likely to be raped by someone they know.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and overlap, creating a textured effect. The background of the slide is a solid blue color.

Myth:

**If there was no penetration by a penis,
then there was no rape.**



Myth:

If there was no penetration by a penis, then there was no rape.

Fact:

Legal definitions of rape vary from state to state. For this training, rape constitutes penetration with a penis, fingers, and/or foreign objects, or unwanted touching of the sexual body parts without penetration.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and overlap, creating a textured effect. The background of the bar is a light blue gradient.

Myth:

People cannot be raped by their partners.

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Myth:

People cannot be raped by their partners.

Fact:

People are raped by their partners.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and overlap, creating a textured effect. The background of the bar is a light blue gradient.

Myth:

Prostitutes cannot be raped.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and overlap, creating a textured, mosaic-like effect.

Myth:

Prostitutes cannot be raped.

Fact:

Prostitutes can be and often are raped by “johns” and by “pimps.”

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and overlap, creating a textured effect. The background of the bar is a light blue gradient.

Myth:

Child molesters are all dirty old men.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and some are missing, creating a textured, abstract look.

Myth:

Child molesters are all dirty old men.

Fact:

In recent surveys of child molesters, 80% were found to have committed their first offense before the age of 30.

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Myth:

The “stranger” represents the greatest threat to children.

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Myth:

The “stranger” represents the greatest threat to children.

Fact:

Studies show among children ages 6–17, 53% to 66% of offenders are acquaintances.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and overlap, creating a textured effect. The background of the bar is a light blue gradient.

Myth:

Rape only happens to young women.

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Myth:

Rape only happens to young women.

Fact:

Elderly individuals can be and are raped.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are arranged in a way that suggests they are being assembled or are part of a larger whole.

Myth:

Rape can't happen in same-gender relationships.

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Myth:

Rape can't happen in same-gender relationships.

Fact:

Rape can occur in same-gender relationships as well as in heterosexual relationships.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and overlap, creating a textured effect.

Myth:

Men cannot be raped.

A vertical decorative bar on the left side of the slide, featuring a pattern of interlocking puzzle pieces in various shades of blue and green. The pieces are arranged in a way that they appear to be falling or cascading down from the top.

Myth:

Men cannot be raped.

Fact:

Although men are less likely to report, men can be and are raped by other men and by women.

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are scattered and overlap, creating a textured effect. The background of the slide is a solid blue color.

Myth:

If a woman drinks with a man, goes home with him, or wears skimpy clothing, it is her fault if she is raped.

A vertical decorative bar on the left side of the slide, featuring a pattern of interlocking puzzle pieces in various shades of blue and green. The pieces are arranged in a way that they seem to be falling or stacked, with some pieces missing at the bottom.

Myth:

If a woman drinks with a man, goes home with him, or wears skimpy clothing, it is her fault if she is raped.

Fact:

It is never her fault. No one asks or deserves to be raped. Rape is a violent attack and a crime in which the perpetrator controls the victim.

Activity

Sexual Assault Quiz

Review of Learning Objectives

- ❖ **Correctly answer at least two questions about the incidence and prevalence of sexual assault in the United States.**
- ❖ **Identify at least one factor contributing to underreporting of rape.**
- ❖ **List at least two myths and two facts about rape.**

End of Module 3

Questions? Comments?



Module 4: Impact of Sexual Assault

Time Required

3 hours

Purpose

This module explores the physical and emotional impact of sexual assault.

Lessons

1. Physical Impact of Sexual Assault (30 minutes)
2. Psychological Impact of Sexual Assault (25 minutes)
3. Impact on Partners, Family, and Close Friends (5 minutes)
4. Individual Factors Affecting Reactions to Rape (2 hours)

Learning Objectives

By the end of this module, participants will be able to:

- Assess the physical and psychological impact of sexual assault.
- Describe the potential impact of rape on people with a range of particular characteristics.

Participant Worksheets

- Worksheet 4.1, STI Scenario
- Worksheet 4.2, Psychological Impact Scenario
- Worksheet 4.3, Participant Presentations

Equipment and Materials

No special equipment or materials are required.

Preparation

- Carefully review the group process scenarios and be prepared to present an “ideal” response. As protocol, facilities, and resources vary from community to community, the response should be based on existing procedures at your center.
- Prepare sheets of paper (standard 8.5" x 11" will work well) with one of the following characteristics written on each sheet. Depending on the size of the training, you may choose 5 to 10 of the characteristics for the “Participant Presentation” activity.
 1. A man.
 2. A lesbian or gay person.
 3. A person with a developmental disability, such as very low IQ.
 4. A person with a physical disability.
 5. A person over 65.
 6. A person with a mental illness.
 7. A person from a culture that differs from yours.
 8. A person who is a survivor of childhood sexual abuse.
 9. An adolescent.
 10. A person who is a survivor of a same-gender assault.



Show Visual 4-1.

Introduce the module.



Show Visual 4-2.

Review the purpose and learning objectives for this module.

By the end of this module, participants will be able to:

- Assess the physical and psychological impact of sexual assault.
- Describe the potential impact of rape on people with a range of particular characteristics.

1. Physical Impact of Sexual Assault (30 minutes)

Tell participants that, in order to best meet the needs of rape victims, they must first understand the far-reaching impact of rape.



Show Visual 4-3.

Introduce the activity.



Activity: Brainstorm – Potential Physical Impact of Sexual Assault (5 minutes)

- 1. Ask participants to close their manuals for this activity. Explain that the group is going to brainstorm a list of some of the potential physical impacts of sexual assault. Ask a volunteer to be a note taker.**
- 2. As participants come up with suggestions, say “yes” or “no” depending on whether the suggestion is or is not a likely physical impact of sexual assault. The note taker should write down all of the “yes” answers on the tear sheet.**
- 3. When participants have offered all of their suggestions, tell them that you are now going to explore the physical results of sexual assault in greater detail.**

Nongenital Physical Injury



Show Visual 4-4.

Paraphrase:

The typical assumption is that rape victims experience physical injury during a rape. It also is assumed they will fight back and be injured as a result. In reality, that is not commonly the case. The literature indicates that physical injury resulting from sexual assault is relatively rare, and even minor injury occurs in only about one-third of reported rapes.

As discussed earlier, injury is more common in stranger rapes than in rapes by someone the victim knows intimately (Ledray 2010). Injury is often related to age. Victims under 20 and over 49 years of age are more likely to be injured (Read 2005).

Male victims appear to be injured more often than female victims. In one study of 351 rape victims, the rate of physical injury for male rape victims was found to be 40 percent, compared with 26 percent for female victims (Petraak and Claydon 1995). The SANE program in Minneapolis, between June 2006 and June 2007, found that 27 male rape victims were seen, representing 5 percent of all victims during that period. This is higher than the 2006 National Crime Victim Survey that found 2.8 percent of men reported sexual assault (Tjaden and Thoennes 2009).

The male victims at the Minneapolis program were physically injured 53 percent of the time, compared to 27 percent of the female victims (Ledray, unpublished data). It is important to consider that the injury may have motivated males, hesitant to disclose to law enforcement, to come to a medical facility for treatment.

Far less data exist on lesbian, gay, bisexual and transgender, and bisexual victimization; however, available literature suggests similar rates of injuries for lesbian, gay, bisexual, and transgender adolescents and adults.

Genital Trauma



Show Visual 4-5.

Paraphrase:

Few rape victims sustain significant genital trauma as a result of the sexual assault. Colposcopic (magnified) examination has been helpful to visualize vaginal abrasions, bruises, and tears that may be too minute to see with the naked eye (Frank 1996; Slaughter and Brown 1992).

These minor injuries, the result of tightened pelvic muscles and the lack of pelvic tilt and lubrication during forced penetration, usually heal completely within 48 to 72 hours. With colposcopic examination, genital trauma has been identified in up to 87 percent of cases (Slaughter and Brown 1992).

The colposcope is used less today, however, as the pictures of the tears taken with the colposcope are very rarely used in court, and the minute injuries they help identify can also be the result of consenting sexual contact (Slaughter and Brown 1992). Photographic documentation of major injury, visible with the naked eye, is still important and may be used in court; however, SANEs today will more likely document this trauma with a digital camera. Since rape victims often fear vaginal trauma, it is important that they seek a medical examination and that the extent of the trauma, or lack thereof, is documented and explained to them for reassurance (Ledray 2006).

Sexually Transmitted Infections (STIs)



Show Visual 4-6.

Paraphrase:

While one study found that 36 percent of the rape victims coming to the emergency department stated that their primary reason for coming was concern about having contracted an STI (Ledray 1991), the actual risk is rather low. It is still important that victims get medical treatment to prevent the STIs that can be easily prevented. In addition to the serious psychological implications, such as fear of contracting an STI, this can prevent medical complications (i.e., the victim actually does contract an STI) as well (Simpson 2011).

The U.S. Centers for Disease Control and Prevention (CDC) estimates that the risk of rape victims contracting gonorrhea is 6 to 12 percent, chlamydia 4 to 17 percent, syphilis 0.5 to 3 percent, and HIV less than 1 percent. The specific STI risk varies from community to community. Since the National Protocol for Sexual Assault Medical Forensic Examinations (OVW 2004) recommends that all medical facilities offer sexual assault victims medications to prevent them from contracting STIs, the rates can be expected to be very low today (Ledray 2006).

Since the early 1980s, HIV has been a concern for rape survivors, even though the actual risk appears very low. The first case in which seroconversion—the process of going from HIV-negative to HIV-positive—was suspected as the result of a rape occurred in 1989 (Murphy, Harris, and Forester 1989). Claydon, Murphy, Osborne, Kitchen, Smith, and Harris (1991) reported four more cases in which the researchers believe a rape resulted in a subsequent HIV seroconversion. While these numbers are extremely low considering the number of rapes that occur, the effect on the individual victim is, of course, significant.

Post exposure prophylaxis (PEP) should be considered for victims at high risk, such as male-on-male assaults. When used, it should be started within 72 hours of exposure. It is not widely used today, however, because of the high cost and the serious side effects that result in few of the patients completing the treatment when started (Simpson 2011).



Show Visual 4-7.

Paraphrase:

Even if the survivor did not inquire about HIV in the emergency department, studies have shown that HIV exposure became a concern of the survivor or sexual partner within 2 weeks. Based on the rape survivors' recommendations, the researchers propose that, even if the survivor does not ask questions about HIV during the initial exam, the SANE or medical professional should, in a matter-of-fact manner, provide information about their risk, testing, prevention (PEP), and safe-sex options, which allows the victim to make decisions based on facts, not fear (Ledray 1999).

The best way to deal with the issue of HIV is complicated and controversial. Rates of infection vary from state to state and community to community, as does the actual risk of infection. The decision to offer prophylactic treatment should be based on the risk of the rape combined with HIV prevalence in the specific geographic area. A rape is considered high-risk if it involves rectal contact or vaginal contact with tearing, or existing vaginal STIs that have caused ulcerations or open sores disrupting the integrity of the vaginal mucosa. It also is considered high-risk if the victim knows or suspects that the assailant is an IV-drug user, HIV-positive, or bisexual (Ledray 2006).

The risk of HIV exposure after sexual contact is, overall, reported to be less than other routes of exposure, such as needle sticks, needle sharing, mother to infant, or blood transfusions. While the actual risk varies from study to study, if the assailant is known to be HIV-positive, the risk of HIV from sexual contact may be similar to that with a needle stick (Royce, Sena, Cates, and Cohen 1997).

Nine out of ten SANE programs interviewed across the U.S. recognized the importance of meeting the health needs of rape victims and identified providing high-quality medical care as their number one priority (Patterson, Campbell, and Townsend 2006). This includes addressing the issues of physical injury; STI risk evaluation and prevention, including HIV; and pregnancy risk evaluation and prevention (Ledray 2006).



Show Visual 4-8.

Introduce the Group Process Scenario

Instructor Note:

Group process scenarios are good exercises to enhance participants' understanding of specific issues, and to warm up for formal role plays. This group process scenario will help you to determine whether the participants are learning the material. If you do not get appropriate suggestions in response to the scenario from a range of participants, you may need to review the information. After suggestions are offered, summarize the ideas and model an appropriate response, or reinstruct on the issue as necessary.

Read the STI scenario below to the group and ask the participants to offer ideas on how to handle the situation. **Tell** participants they may use **Worksheet 4.1, STI Scenario**, in the Participant Manual, for their notes.

STI Scenario: A caller who was sexually assaulted the night before is concerned about STIs, including HIV/AIDS.

What can you tell the caller?

Pregnancy



Show Visual 4-9.

Paraphrase:

Rape victims of reproductive age often fear becoming pregnant as a result of a rape. The actual risk is the same as that from any one-time sexual encounter: an estimated 2 to 4 percent (Yuzpe, Smith, and Rademaker 1982). Most SANE programs and medical facilities offer emergency contraception to women at risk of becoming pregnant, provided they are seen within 5 days of the rape and have a negative pregnancy test in the emergency department.

Oral contraceptives such as Ovral are still used in some areas; however, the drug of choice today is Plan B (levonorgestrel) for emergency contraception. This treatment is not 100 percent effective in preventing pregnancy. A review of 10 studies found an overall effectiveness rate of at least 75 percent, which does not mean that 25 percent will become pregnant; rather, if 100 women have intercourse in the middle 2 weeks of their cycle, approximately eight would become pregnant without post-coital interception. With interception, only two (a reduction of 75 percent) of the 100 would become pregnant (American College of Obstetricians and Gynecologists 2002).

Plan B (levonorgestrel) was developed specifically to prevent pregnancy after unprotected intercourse. It is believed to act as emergency contraception by preventing ovulation or fertilization by altering tubal transport of sperm and/or ova. It also may inhibit implantation by altering the lining of the uterus.

General Health Risk



Show Visual 4-10.

Paraphrase:

Sexual assault not only affects victims' health directly and immediately; there is convincing evidence that it also can have a significant and chronic impact on their general health for years to come (Frazier and Ledray 2011). Stress appears to suppress the immune system and increase susceptibility to disease (Cohen and Williamson 1991). Stress such as a sexual assault also may result in injurious behaviors, such as substance abuse or eating disorders (Felitti 1991; Golding 1994).

Increased sexual activity with multiple partners sometimes follows rape which, in a formerly inactive adolescent for example, may result in increased exposure to disease (Ledray 1994). In addition, interpreting a sexual assault as a threat to one's body may lead to increased attention to subtle symptoms and heightened concern about health integrity (Cohen and Williamson 1991). Another possibility is interpreting emotional reactions to the assault as physical disease symptoms (Koss, Woodruff, and Koss 1990).

Psychological Symptoms Perceived as Physical



Show Visual 4-11.

Paraphrase:

Rape victims may seek physical versus mental health care following a sexual assault because it is less stigmatizing. Physical symptoms are perceived as more salient than psychological distress (Kimerling and Calhoun 1994). In their sample of 115 sexual assault victims, Kimerling and Calhoun found that 73 percent sought out medical services during the first year after a sexual assault, while only 19 percent pursued mental health services of any kind.

Low levels of social support were associated with higher use of medical services, and higher levels of social support resulted in better actual physical health and health perception. The victims reporting physical symptoms most often identified gynecological problems and sexual dysfunctions. The victims of more severe or multiple crimes were the most likely to seek medical care. The researchers, too, suggest that disease resistance may be compromised by the stress of victimization.

Walker, Katon, Hansom, Harrop-Griffith, Holm, Jones, Hickok, and Russo (1995) found that women with chronic pelvic pain were significantly more likely than women without it to be survivors of sexual abuse. The chronic pain groups also were more likely to be depressed and have substance abuse problems, phobias, and sexual dysfunction.

Koss, Koss, and Woodruff (1991) found that the single most powerful predictor of total annual visits to a physician and outpatient costs was severity of victimization, exceeding the predictive power of age, ethnicity, self-reported symptoms, and actual injury. They also found that rape victims were twice as likely to seek the help of a physician than nonvictims, with visits increasing 56 percent in victim groups compared to 2 percent in nonvictim groups.

Sexual Dysfunction



Show Visual 4-12.

Paraphrase:

Not surprisingly, studies have found that sexual dysfunction is a common reaction and often a chronic problem after a sexual assault. This may include a periodic or constant loss of sexual desire, inability to become sexually aroused, slow arousal, pelvic pain associated with sexual activity, a lack of sexual enjoyment, inability to achieve orgasm, fear of sex, avoidance of sex, intrusive thoughts of the assault during sex, vaginismus, or abstinence. Mentioned repeatedly in the literature are avoidance, loss of interest in sex, loss of pleasure from sex, painful intercourse, and fear of sex (Abel and Rouleau 1995; Frazier and Borgida 1997; Ledray 1998).

It is also well documented that sexual assault victims engage in risky sexual behaviors, such as more sexual partners and more current sexual partners as a result of the rape (Upchurch and Kusunoki 2004). This has been found to be true in large national samples of adolescent who were victims of a sexual assault (Upchurch and Kusunoki 2004), college women who were victimized (Brenner, McMahon, Warren, and Douglas 1999), Native American victims (Evans-Campbell, Lindhorst, Huang, and Walters 2006), and military women who were sexually assaulted (Lang, Rodgers, Loffaye, Satz, Dresselhaus, and Stein 2003).

This area still has not received the attention it deserves, considering the extent of the problem and the opportunity to prevent significant long-term health problems that may result. In one of the earliest reports on the impact of rape, Burgess and Holmstrom (1979) found that 71 percent of the rape victims they interviewed 6 years after the assault still avoided sexual contact and were less sexually active. In a study of 100 women, 61 percent of the women who were sexually abused, compared to 31 percent of a control group, experienced some form of sexual dysfunction 2 to 4 years after the assault (Chapman 1989).

The researchers stress that while rape victims may become sexually active again within months of the assault, they may still not enjoy sex years later. Celibacy or acting out sexually, including more frequent sexual activity with more partners, less condom use, and more alcohol use, are a common response and may be coping strategies (Campbell, Self, and Ahrens 2004). Counselors run the risk of delegitimizing assault-related sexual problems by not recognizing both the sexual and aggressive components of rape.

Substance Abuse



Show Visual 4-13.

Paraphrase:

Professionals working with sexual assault victims indicate that from 20 percent to more than 50 percent of rape victims across studies were under the influence of alcohol at the time of the assault (OVC 2005). Individuals are clearly more vulnerable to assault when intoxicated.

In a study conducted at the Sexual Assault Resource Service (SARS) in Minneapolis, 55 percent of rape victims (N=130) self-reported using alcohol at the time of the rape. Sixty percent of these reported the alcohol use was voluntary (Ledray, Frazier, and Peters 2007). While drug-facilitated sexual assault (DFSA) has received considerable attention because of the use of “designer” memory-erasing drugs, it is important to remember that the most-used drug to facilitate a sexual assault continues to be alcohol (OVC 2005).

It also is important to remember that rape can be facilitated by the use of drugs or alcohol, and it also can result in substance abuse in an attempt to dull the memory and avoid thinking about the rape (Ledray 2006).

In a national sample of 3,006 female survivors, both alcohol and drug use significantly increased after a sexual assault, even for women with no prior drug or alcohol use or abuse history (Kilpatrick, Acierno, Resnick, Saunders, and Best 1997). This study also found that women who were already using drugs and alcohol to cope at the first measurement point were more likely to have a history of prior sexual abuse.

The researchers concluded that sexual abuse plays a significant role in initiating and maintaining substance abuse in women, with younger women being even more at risk. In a more recent study, these same researchers reported that victims of rape are 13.4 times more likely to develop two or more alcohol-related problems and 26 times more likely to have two or more serious drug-related problems (Kilpatrick 2003).

Risk behavior is a factor in the lesbian, gay, bisexual, and transgender community as well. According to a 2009 study of LGBT high school students by the CDC, adolescent lesbian, gay, and bisexual students are significantly more likely to engage in health-risk behaviors than heterosexual individuals of the same age.

There is the opportunity to intervene during this crisis period to prevent future substance abuse and emotional disturbance among victims of sexual assault. There is considerable support for the implementation of brief intervention models in similar populations that could readily be adapted to sexual assault victims (Resnick, Acinero, Kilpatrick, and Holmes 2005; Ledray 2009).

2. Psychological Impact of Sexual Assault (25 minutes)



Show Visual 4-14.

Paraphrase:

Researchers agree that rape victims experience more psychological distress than do victims of other crimes. Compared to nonvictim control groups, rape victims consistently report more symptoms of anxiety, fear, depression, and posttraumatic stress disorder (PTSD) (Frazier and Borgida 1997).



Show Visual 4-15.

Introduce the activity.



Activity: Brainstorm – Potential Psychological Impact of Sexual Assault (5 minutes)

- 1. Ask participants to close their manuals for this activity. Explain that the group is going to brainstorm a list of some of the potential psychological impacts of sexual assault. Ask for a volunteer to be a note taker.**
- 2. As participants come up with suggestions, say “yes” or “no” depending on whether the suggestion is or isn’t a likely psychological impact of sexual assault. The note taker should write down all of the “yes” answers on the tear sheet.**
- 3. When participants have offered all of their suggestions, tell them that you are now going to explore the psychological impacts of sexual assault in greater detail.**

Anxiety



Show Visual 4-16.

Paraphrase:

Rape victims are consistently found to be more anxious than nonvictims during the first year after a rape (Frazier, Harlow, Schauben, and Byrne 1993). In one study, 82 percent of rape victims met the DSM criteria for generalized anxiety disorder (GAD), compared with 32 percent of nonvictims (Frank and Anderson 1987).

Fear



Show Visual 4-17.

Paraphrase:

Death is the most common fear during the assault, with continued generalized fear after the assault a very common response to rape (Dupre, Hampton, Morrison, and Meeks 1993; Ledray 1994). Post-rape fear can be specifically related to factors associated with the sexual assault or widely generalized to include fear of all men (Ledray 1994). Since fear is subjective, it is generally evaluated using self-report measures.

While evidence of the type and duration of fear varies, up to 83 percent of victims report some type of fear following a sexual assault (Frazier and Borgida 1997). Girelli et al. (1986) found that the subjective distress of fear of injury or death during rape was more significant than the actual violence in predicting severe post-rape fear and anxiety. Thus, it is important to recognize that the threat of violence alone can be psychologically devastating (Goodman, Koss, and Russo 1993).

Depression



Show Visual 4-18.

Paraphrase:

Depression is one of the most commonly mentioned long-term responses to rape (Abel and Rouleau 1995; Frazier and Borgida 1997; Ledray 1994). As with anxiety, symptoms of depression also overlap with those of PTSD. Such overlapping symptoms include:

- Weight loss or gain.
- Sleep disturbance.
- Feelings of worthlessness.
- Diminished interest in pleasurable activities.
- Inability to concentrate.
- Depressed mood.
- Suicidal thoughts.

Suicidal Ideation



Show Visual 4-19.

Paraphrase:

While the number of suicides following a rape is considered low, suicidal ideation (i.e., thoughts about suicide) is a significant issue. One study found up to 20 percent of rape victims may attempt suicide (Kilpatrick et al. 1985), and a more recent study found 39 percent of rape victims reported a subsequent suicide attempt (Ackard and Neumark-Sztainer 2002). Many more rape victims—33 to 50 percent—report that they considered suicide at some point after the rape (Ullman 2004; Ullman and Brecklin 2002). During the immediate post-rape period, rape victims are nine times more likely than nonvictims to attempt suicide (Kilpatrick, Saunders, Veronen, Best, and Von 1987).

Self-Blame and Shame



Show Visual 4-20.

Paraphrase:

A number of studies have identified posttraumatic guilt, self-blame, and shame as a common response following sexual assault, and one that is linked PTSD, more depression, and poor adjustment post-rape (Vidal and Petrak 2007; Frazier 1990; Ledray 1999).

Posttraumatic Stress Disorder

Paraphrase:

One-third to one-half of victims who have experienced a sexual assault that meets the legal definition of rape, without requiring participants to label the experience rape, met the criteria for PTSD at some point in their lives. They, too, are more likely to meet the PTSD criteria than nonrape victims. One study found 78 percent of rape victims met the criteria for PTSD at 2 weeks; 63 percent at 2 months; 58 percent at 6 months; and 48 percent at 1 year (Frazier, Conlon, and Glaser 2001).

Sexual assault also is more likely to result in PTSD than exposure to other types of traumatic events. For example, the National Women's Study, an epidemiological survey of 4008 women, found the lifetime prevalence of PTSD resulting from rape and sexual assault to be 32 percent and 30.8 percent respectively, compared with a prevalence of 9.4 percent caused by non-crime-related trauma such as a car accident (Kilpatrick, Amstadter, Resnick, and Ruggiero 2007).

It appears that the more severe forms of sexual assault result in more severe symptoms of distress, and that women who report a sexual assault to the police or other authorities report higher PTSD rates (Rothbaum et al. 1992). Sexual assault also has been identified as the most common cause of PTSD in women (Frans, Rimmo, Aberg, and Fredrickson 2005).



Show Visual 4-21.

Paraphrase:

The basic elements of a PTSD diagnosis are:

- Exposure to a traumatic event.
- Re-experiencing the trauma (flashbacks or intrusive memories).
- Symptoms of avoidance and numbing (attempts to avoid thoughts or situations that remind the survivor of the traumatic event, inability to recall certain aspects of the traumatic event, or feeling disconnected from others).
- Symptoms of increased arousal (exaggerated startle response, feeling easily irritated, constant fear of danger, or physiological response when exposed to similar events).
- Symptoms must be present for at least 1 month and must cause clinically significant distress or impairment (American Psychological Association 1994).

Factors Associated with Higher Levels of Post-Rape Trauma



Show Visual 4-22.

Paraphrase:

Pre-assault, assault, and post-assault factors all play a role in recovery, although studies present a conflicting picture of them (Resick 1993). Resick concluded from her review of available studies that the victim's psychological functioning before the rape and during the assault accounted for some of the variance. The degree of actual violence may not be as significant as the victim's perception of the threat of danger.

Significant factors associated with more severe and prolonged post-rape trauma include prior sexual victimization; the use of avoidant coping strategies; self-blame; prior mental health history, especially depression; a history of substance abuse (Resnick, Acinero, Kilpatrick, and Holmes 2005; Ledray 2009), and lack of social support following the sexual assault (Resick 1993).

Campbell, Patterson, Adams, Diegel, and Coats (2008) found more positive psychological outcomes among victims seen by SANEs who "empowered" them by providing health care, support, and resources; treating them with respect and dignity; believing them; helping them regain control; and respecting their decisions.

These factors are important for the advocate or counselor to consider when making initial referrals for followup, and when attempting to contact the survivor for followup.



Show Visual 4-23.

Introduce the Group Process Scenario: Psychological Impact Scenario.

Read the STI scenario below to the group and ask the participants to offer ideas on how to handle the situation. **Tell** participants they may use **Worksheet 4.2, Psychological Impact Scenario**, in the Participant Manual, for their notes.

Psychological Impact Scenario:

A caller who was sexually assaulted 6 months ago is experiencing sleeplessness, weight gain, and trouble concentrating. She is experiencing recurrent pelvic pain, but her doctor hasn't been able to find a physical cause.

What are some of the psychological effects of assault that this caller might be experiencing?

3. Impact on Partners, Family, and Close Friends (5 minutes)



Show Visual 4-24.

Paraphrase:

Family members and those close to the victim have been recognized as secondary or indirect victims (Koss and Harvey 1991; Ledray 1994). As a result, they, too, often suffer many of the same initial and long-term symptoms of distress experienced by the rape survivor, including shock and disbelief, fear, anxiety, a sense of helplessness, depression, and anger. Understandably, female partners, friends, and family members are more likely to become fearful than are males (Davis, Taylor, and Bench 1995).

Family and friends may become overly protective, further limiting the victim's activities. Or, they may blame the victim for the assault. This type of blame is often a misdirected attempt to deal with their own feelings of guilt and self-blame for not protecting their loved one somehow and not preventing the assault (Ledray 1994).

It also may be a misdirected way of preserving their own sense of safety and security by blaming the victim for a characteristic or behavior that they can convince themselves they would never have or do. They are thus able to maintain a sense of their ability to prevent the same thing from happening to them. The more similar they are to the victim, the more they may need to find something about the victim to blame in order to maintain their own sense of safety and security (Ledray 1994).

A partner's, friend's, or family member's high stress does not necessarily correlate with the level of distress the victim is experiencing. Nor does it necessarily interfere with the ability of the significant other to support the victim. It is, however, associated with unsupportive behaviors such as egocentric behavior, emotional withdrawal, and blaming the victim (Davis, Taylor, and Bench 1995).

It is common for the victim to become angry with family members who are themselves upset ("It didn't happen to them, so they have no right to be so upset"). This is especially true when family members appear more upset than the victim. Victims may also take out their anger about the rape on family members (Ledray 1994; Mitchell 1991). If the family is not prepared and does not understand the motivation behind this behavior, they may reject the victim, and victims may lose their social support when they need it most.

4. Individual Factors That Affect Reactions to Rape (2 hours)

Paraphrase:

Sexual assault is traumatic for all victims; however, individual factors can have an impact on the nature and extent of the trauma. These include gender, age, disability, race, culture, and refugee and immigration status. This section will look at information from studies of a range of factors and their impact on victims. It is important that participants use this information as a general guide, not to stereotype how they expect victims to react.

Emphasize that part of being a good first responder is the ability to be flexible and to remember that each person will react to assault differently.



Show Visual 4-25.

Instructor Note:



Following the activity, collect **Worksheet 4.3** and give to the room monitor.

Introduce the activity.



Activity: Participant Presentations (2 hours)

- 1. Tape the prepared sheets of paper around the room, each of which contains one of the descriptions described under “Preparation” at the beginning of this module.*
- 2. Explain that each sheet of paper contains a brief description of a victim of sexual assault. Each victim has a specific characteristic that might impact his or her reactions to rape, as well as his or her needs after a rape.*
- 3. Ask participants to move around the room and read each description. Each participant should then stand next to the sheet of paper that describes a victim with a characteristic that is particularly interesting to the participant or with which the participant might find it challenging to work.*
- 4. The participants should form a group with the others who are standing next to the same sheet of paper. Ideally, there should be at least two people in each group. However, a participant can choose to work alone if no one else has chosen the same characteristic.*

5. *Tell participants they are now going to participate in a group project to closely examine the specific characteristic they chose. Refer participants to Worksheet 4.3, Participant Presentations, in the Participant Manual. Ask participants to put their unique ID number on the worksheet.*
6. *Tell each group that these pages contain information about how different characteristics or factors might affect individual reactions to rape, as well as strategies for handling these reactions. Tell participants they should find the pages in the worksheet that discuss the specific characteristics they chose to examine. They will have about 15 minutes to read their assigned pages.*
7. *Each group will then work together for about 20 minutes to prepare a 10-minute presentation that addresses the questions provided on the worksheet. These questions encourage participants to think about strategies for working effectively with people with the characteristics they are examining.*
8. *The presentations might be panel discussions, illustrative role plays, etc. Allow participants to use tear sheets, markers, and masking tape as needed to prepare their presentations. Each member of the group should be included in preparing and delivering their presentation.*
9. *While they are preparing their presentations, encourage participants to request clarification from other members of their group and from you, if necessary. Remind participants to address the questions on the worksheet and to focus their presentations on issues an advocate would need to be aware of when dealing with a person who has the characteristics they have studied. For example, if a group studies male victims of rape, their presentation would address the specific issues an advocate would need to keep in mind when working with male victims.*
10. *When the groups give their presentations, the audience should be allowed to ask questions. You also should prompt each group to discuss anything of importance that was not included in their presentation.*
11. *After all groups have presented, remind participants to put their unique ID number on their worksheets. Collect worksheets and give to the room monitor.*

Debrief the activity by thanking the groups for their work.



Show Visual 4-26.

Review the learning objectives and **ensure** that these were met.

By the end of this module, participants will be able to:

- Assess the physical and psychological impact of sexual assault.
- Describe the potential impact of rape on people with a range of particular characteristics.



Show Visual 4-27.

Ask if there are any final questions or comments before moving to the next module.

Module 4

Impact of Sexual Assault

OVC Can Help You Put the Pieces Together



OVCTTAC

Learning Objectives

- ❖ **Assess the physical and psychological impact of sexual assault.**
- ❖ **Describe the potential impact of rape on people with a range of particular characteristics.**

Activity

Brainstorm – Potential Physical Impact of Sexual Assault

Nongenital Physical Injury

- ❖ **Physical injury resulting from sexual assault is relatively rare.**
- ❖ **It is more common in stranger rapes.**
- ❖ **Victims under age 20 and over age 49 are more likely to sustain injury.**
- ❖ **Male victims who report are injured more often than female victims.**

Genital Trauma

- ❖ **Few rape victims sustain significant genital trauma.**
- ❖ **Colposcopic (magnified) examination is helpful to visualize injuries too minute to see with the naked eye.**

Sexually Transmitted Infections (STIs)

- ❖ **Concern is often high, but actual risk is low.**
- ❖ **HIV is a concern of victims or sexual partners.**

Sexually Transmitted Infections (STIs)

- ❖ **Medical professionals should provide information.**
- ❖ **Rape victims are at a lower HIV risk than through other routes of exposure: needle sticks, needle sharing, mother-to-infant, or blood transfusions.**

Group Process Scenario: STIs

Worksheet 4.1

A caller who was sexually assaulted the night before is concerned about STIs, including HIV/AIDS.

What can you tell the caller?

Pregnancy

- ❖ **The actual risk is the same as that from any one-time sexual encounter: an estimated 2 to 4%.**
- ❖ **Medical facilities offer emergency contraception.**



General Health Risk

- ❖ **Sexual assault affects a victim's health directly and immediately.**
- ❖ **It also can have a significant and chronic impact on their general health for years to come.**
- ❖ **Stress appears to suppress the immune system.**
- ❖ **Increased sexual activity with multiple partners sometimes follows rape.**

Psychological Symptoms Perceived as Physical

- ❖ **Victims may seek physical versus mental health care.**
- ❖ **Low levels of social support are associated with higher use of medical services.**
- ❖ **Most common symptoms are gynecological problems and sexual dysfunctions.**
- ❖ **Victims of more severe crimes and multiple crimes are most likely to seek medical care.**

Sexual Dysfunction

Sexual dysfunction is a common reaction and often a chronic problem. This may include:

- ❖ **Loss of sexual desire.**
- ❖ **Inability to become sexually aroused.**
- ❖ **Pelvic pain.**
- ❖ **Lack of sexual enjoyment.**
- ❖ **Fear or avoidance of sex.**

Substance Abuse

Survey:

- ❖ **Substance abuse increased after a sexual assault.**
- ❖ **Sexual abuse plays a role in substance abuse.**
- ❖ **Rape victims are more likely to develop substance abuse problems.**

Psychological Impact

Researchers agree that victims of rape experience more psychological distress than victims of other crimes.

Activity

Brainstorm – Potential Psychological Impact of Sexual Assault

Anxiety

- ❖ **Rape victims are more anxious than nonvictims.**
- ❖ **82% of rape victims met criteria for Generalized Anxiety Disorder (GAD).**

Fear

- ❖ **Death is the most common fear during the assault.**
- ❖ **Continued generalized fear occurs after the assault.**

Depression

- ❖ **Weight loss or gain.**
- ❖ **Sleep disturbance.**
- ❖ **Feelings of worthlessness.**
- ❖ **Less interest in pleasurable activities.**
- ❖ **Inability to concentrate.**
- ❖ **Depressed mood.**
- ❖ **Suicidal thoughts.**

Suicidal Ideation

- ❖ **Completed suicides following a rape are considered low, but suicidal ideation is a significant issue.**
- ❖ **During immediate post-rape period, rape victims are nine times more likely than nonvictims to attempt suicide.**

Self-Blame and Shame

- ❖ **Common response.**
- ❖ **Associated with more depression and poor adjustment post-rape.**

Posttraumatic Stress Disorder (PTSD)

- ❖ **Exposure to a traumatic event.**
- ❖ **Re-experiencing the trauma.**
- ❖ **Symptoms of avoidance and numbing.**
- ❖ **Symptoms of increased arousal.**
- ❖ **Symptoms must be present for at least 1 month and cause clinically significant distress.**

Factors Associated With Higher Levels of Post-Rape Trauma

- ❖ **Victim's perception of the threat of danger.**
- ❖ **Prior sexual victimization.**
- ❖ **Use of avoidant coping strategies.**
- ❖ **Self-blame.**
- ❖ **Prior mental health history.**
- ❖ **History of substance abuse.**
- ❖ **Lack of social support following the sexual assault.**

Group Process Scenario: Psychological Impact

Worksheet 4.2

A caller who was sexually assaulted 6 months ago is experiencing sleeplessness, weight gain, and trouble concentrating. She has recurrent pelvic pain, but her doctor hasn't been able to find a physical cause.

What are some of the psychological effects of assault that this caller might be experiencing?

Impact on Partners, Family, Close Friends

- ❖ **Secondary or indirect victims.**
- ❖ **Often suffer many of the same initial and long-term symptoms.**
- ❖ **Over-protection or blame.**
- ❖ **High stress associated with unsupportive behaviors (emotional withdrawal, blaming).**

Activity

Participant Presentations

Worksheet 4.3

- ❖ **Select a characteristic of interest to you.**
- ❖ **Review the worksheet, answer the questions, and prepare a presentation illustrating working effectively with people with the characteristic.**
- ❖ **Present to the large group.**
- ❖ **Turn in your worksheet.**

Review of Learning Objectives

- ❖ **Assess the physical and psychological impact of sexual assault.**
- ❖ **Describe the potential impact of rape on people with a range of particular characteristics.**

End of Module 4

Questions? Comments?



Module 5: Procedures in Common Advocacy Situations

Time Required

2 hours, 45 minutes

Purpose

This module is intended to provide a more detailed look at procedures in common advocacy situations. It also will examine drug-facilitated sexual assault.

Lessons

1. Responding to a Crisis Call Reporting Recent Sexual Assault (15 minutes)
2. The Medical-Evidentiary Exam (1 hour)
3. Law Enforcement Statement Accompaniment (15 minutes)
4. Courtroom Accompaniment (35 minutes)
5. Drug-Facilitated Sexual Assault (40 minutes)

Learning Objectives

By the end of this module, participants will be able to:

- Respond appropriately to a caller on a crisis line who is reporting a recent sexual assault.
- Identify correct procedures during a medical-evidentiary exam.
- Create a list of “dos and don’ts” for law enforcement statement accompaniment and courtroom accompaniment.
- Differentiate the roles of advocates, SANEs, and other SART members.
- Identify special procedures and “red flags” for dealing with drug-facilitated sexual assault.

Participant Worksheets

- Worksheet 5.1, Medical-Evidentiary Exam Case Study
- Worksheet 5.2, Drug-Facilitated Sexual Assault

Equipment and Materials

- Red paper or index cards (three pieces of paper or cards for each of five groups). The red paper or index cards will be used in “Information Search and ‘Red Flags’” activity.

Preparation

- Carefully review the medical-evidentiary exam case study described in this module.
- You should be aware of whether or not a system-based advocacy program exists in your local police department or prosecutor’s office. If it does, you also should be aware of how this affects the role of the advocates in your training, particularly during law enforcement statement accompaniment and courtroom accompaniment. These roles should be clear to everyone involved in order to best serve the needs of the victim.
- Cut red paper or red index cards into small pieces (approximately 3" x 4") for the “Information Search and ‘Red Flags’” activity.



Show Visual 5-1.

Introduce the module.



Show Visual 5-2.

Review the purpose and learning objectives for this module.

By the end of this module, participants will be able to:

- Respond appropriately to a caller on a crisis line who is reporting a recent sexual assault.
- Identify correct procedures during a medical-evidentiary exam.
- Create a list of “dos and don’ts” for law enforcement statement accompaniment and courtroom accompaniment.
- Differentiate the roles of advocates, SANEs, and other SART members.
- Identify special procedures and “red flags” for dealing with drug-facilitated sexual assault.

1. Responding to a Crisis Call Reporting Recent Sexual Assault (15 minutes)



Show Visual 5-3.

Paraphrase:

One of the most common situations to which an advocate will respond is a crisis call reporting recent sexual assault. Many victims call rape crisis lines before they seek medical attention or involve law enforcement. Though specific procedures will vary from center to center, the following should be generally addressed with any crisis caller seeking assistance following sexual assault.

- **Identify immediate concerns.** Assess the reason for the call.
- **Establish safety.** Advocates will need to ask where the perpetrator is, and where the victim is. Take appropriate steps to establish safety.

- **Explain services.** Explain the medical, support, and legal services available to the caller. Explain the importance of a medical-evidentiary exam, and the option of reporting the assault to law enforcement. Explain to the victim that the sooner the medical exam is conducted the more effective the treatment may be and the more evidence may be found. While the victim can certainly take more time to decide to get a medical exam and to report to law enforcement, the delay may affect credibility.
- **Arrange transportation.** If the caller wants to have a medical-evidentiary exam, discuss transportation. Callers may arrange their own transportation, or they can be transported in an ambulance or by law enforcement. Explain their options.



Show Visual 5-4.

- **Discuss evidence.** Explain that victims should not shower, bathe, douche, change clothes, or brush their teeth. If they need to urinate and drugs or alcohol are involved, victims should collect the urine in a clean jar with a lid and bring it with them to the medical facility. Let victims know the local guidelines for evidence collection (e.g., 72/96/120 hours after the assault); however, also emphasize that the sooner the exam is completed the more likely it is that evidence can be found.
- **Address practical issues.** Discuss any practical issues the victim needs to address, such as childcare or other responsibilities.
- **Arrange a time to meet.** If an advocate will be meeting the victim at the emergency department, it is best to arrange a time to meet. If possible, the advocate should be there first. Discuss how to identify each other.
- **Activate other first responders.** Depending on the needs and wishes of the caller, and procedures in their area, advocates may need to activate other first responders.

Ask participants for any questions about these issues.

2. Medical-Evidentiary Exam Accompaniment (1 hour)



Show Visual 5-5.

Paraphrase:

Rape victims should receive a medical-evidentiary exam within 72/96/120 hours after the assault or longer. (The time will vary depending upon local policy.) The exam should be conducted as early as possible, since evidence is quickly lost. While DNA evidence has been collected 5-7 days after an assault, the likelihood significantly diminishes after 48 hours that the DNA can be linked to a suspect.

This timeframe also is important in terms of receiving medication to prevent pregnancy and some STIs. Emergency contraception can be provided for up to 5 days after unprotected sex, but the sooner it is given the more effective it will be in preventing a pregnancy. HIV post-exposure prophylaxis must be started within 72 hours of the unprotected sexual contact, but it too is more effective the sooner it is started.

In some situations, a medical-evidentiary exam is appropriate more than 72/96/120 hours after the assault; again, this may vary depending upon local policy. Examples include:

- **Hostage situations.** Victims who have been held hostage are more likely to have injuries or forensic evidence on their bodies. This evidence can be collected and used for prosecution.
- **Force resulting in injury.** These injuries should be treated and could be used as evidence.
- **Ejaculation without cleanup.** A medical-evidentiary exam also is appropriate after 72/96/120 hours if there is ejaculation without cleanup. Again, the ejaculate can be collected and used as evidence.



Show Visual 5-6.

Introduce the Medical-Evidentiary Exam.

Read the descriptions below and on the visuals, and **ask** participants to determine whether a medical-evidentiary exam should be done.

- Sharon reported an assault that occurred 12 hours ago; there was no penetration or apparent injury.
- Jane reported an oral sexual assault that occurred 24 hours ago.



Show Visual 5-7.

- Thomas reported a rape and robbery that occurred 5 hours ago.
- Maria reported a rape by two strangers that occurred 2 weeks ago.



Show Visual 5-8.

Introduce the activity.



Activity: Medical-Evidentiary Exam Case Study (45 minutes)

- 1. Divide participants into groups of four or five. Tell the participants they will be working in small groups to study some detailed procedures related to medical-evidentiary exams, and they will then answer some questions based on a case study of a typical exam.*
- 2. The groups should spend 10 to 15 minutes reading, discussing, and clarifying the information about procedures during a medical-evidentiary exam on Worksheet 5.1, Medical-Evidentiary Exam Case Study, in the Participant Manual. They should then use this information to answer the questions based on the case. The group should brainstorm together for an additional 10 to 15 minutes in order to answer the questions.*
- 3. Ask for each group to report in turn. For example, ask Group 1 to provide a response to the first question, Group 2 to provide a response to the second question, and so on. Fill in anything the groups missed. Correct the groups' responses as necessary.*

Debrief the activity by **reviewing and paraphrasing** the following information, which reinforces the appropriate roles of advocates and other SART members during the medical-evidentiary exam.



Show Visual 5-9.

Paraphrase:

The advocate and SANE should be called to the emergency department automatically; victims should not be asked if they want them to be called.



Show Visual 5-10.

Paraphrase:

The SANE and the advocate might do some of the same things, but this does not diminish their roles. A SANE is a specially trained nurse who will provide crisis intervention and support, and normalize the victim's response, just as an advocate will. They should reinforce each other, remembering that having the support of two people in the emergency department can be invaluable for the victim.

However, a SANE should not be described as an advocate, and an advocate must be very aware of what a SANE does. While the advocate should be present when the SANE conducts the patient history of the assault, it's important that the advocate not participate in the interview or take notes. The advocate is there solely to support the victim. Any concerns or questions from the advocate should be addressed after the SANE completes the patient history.

Remind participants that an advocate must NEVER be involved in evidence collection.



Show Visual 5-11.

Paraphrase:

Even when there is a SANE program, the victim may need to wait up to an hour in the emergency department because the department is so busy. If there is no SANE program, the wait can be even longer. If the victim is waiting for a SANE to arrive, it may be helpful to explain the SANE's role. If there are consistent delays and no reason is given, you should report this to your supervisor, who can speak to the emergency department or the SANE supervisor.



Show Visual 5-12.

Paraphrase:

Never try to “fix” any issues with the SART yourself. Report any problems to your supervisor and allow them to address any issues.

3. Law Enforcement Statement Accompaniment (15 minutes)



Show Visual 5-13.

Explain that in addition to being present during the initial police report, the advocate usually offers to accompany the rape victim to the investigator's office at a later time when an official statement is given. There, the advocate provides support and encouragement during what may be an intimidating experience and helps the victim understand why certain questions are asked.

Paraphrase:

As with the SANE exam, you should not interrupt the law enforcement interview. Sit quietly during the interview and remember that you are there to support the victim, and to address any concerns when the interview is completed. Advocates function formally as members of the “response team,” whether officially a SART or a community response team, or informally as members of separate community agencies. The “team” includes the law enforcement officer or investigator; *advocates are not advocating for the victim against the police.*

It is essential for advocates to have good working relationships with their police departments and sex crimes investigative units. Call the officer who will be taking the victim's statement to check the time and place, and let the officer know that you will be accompanying the victim. Ask if there is anything in particular you can do to prepare the victim.

It is important that victims tell the complete truth about what happened, even if it is embarrassing, they were doing something they were told not to do, or they were engaged in an illegal activity, such as underage drinking or smoking marijuana. Victims need to know that this information will likely come out anyway. Tell victims that if they lie about any part of the assault history, their credibility will be questioned, which could jeopardize the entire legal case.

It is important that the advocate know if the victim will be charged with illegal activities in connection with the rape, or as is the case in most jurisdictions, since the rape is the more serious crime it will be the focus, and the advocate can reassure victims that they can fully disclose without risk of being charged with a crime.

If you have developed a trusting relationship with the investigator, you should be able to stay in the room while the victim is interviewed. If that is not possible, you should wait outside.



Show Visual 5-14.

In smaller communities, the investigator conducting the interview may be the same police officer who took the victim's initial statement; however, in larger municipalities, it will be someone from a separate department. The investigator will usually ask the victim to verbally go through the statement in specific detail, with the investigator asking additional questions for clarification. Recording varies from area to area: The entire process may be video- or audio-recorded or, once the victim is comfortable, a complete statement will then be recorded. The statement will usually be transcribed, and the victim will review and sign the transcript. This becomes the official account of the sexual assault.



Show Visual 5-15.

Paraphrase:

Advocates should not participate in the interview nor interfere in any way. Even if you do not understand the rationale behind a line of questioning, you must not inquire about it during the statement.

Once the statement has been completed, you can talk with the investigator in private and ask about areas of concern. This will help you to better explain the process to the victim. For example, if the investigator asked why the victim was walking through a downtown area alone at 1:00 a.m. and the tone of voice sounded accusatory, you can explain to the victim that such was not the intent: the investigator likely needed to know why the victim was in a particular area. If you still feel uncomfortable after talking with the investigator, you should report the situation to your supervisor the next day.

4. Courtroom Accompaniment (35 minutes)



Show Visual 5-16.

Paraphrase:

The advocate typically offers to accompany the victim to any attorney appointments as well as to the courtroom. In some areas, a separate, specialized advocacy program may be available to do this. Whatever the scenario, the goal is to familiarize victims with the process and the courtroom, including where they will sit and what they will be asked to do. If possible, have victims visit an empty courtroom or watch a criminal case at trial.

If cases are plea bargained, it also is important to work with victims so they can express their opinions. In a plea bargain or plea agreement, the assailant usually agrees to plead guilty to a lesser charge in return for a lighter sentence. While the ultimate decision rests with the prosecutor, many prosecutors will discuss their options with the victim before making the final decision.

The advantage of a plea bargain to victims is that they do not have to testify in court and they are certain of a conviction. In most areas, many more plea agreements occur than cases that go to trial. Most of these arrangements are accepted at the last minute; often the day the trial is scheduled to begin.



Show Visual 5-17.

Paraphrase:

If the prosecutor decides not to charge the offender in a case, offering to go with the victim to the prosecutor's office to discuss the reasons why may be as important as accompanying the victim to trial. If the assailant is found guilty by trial, the victim may want you, as well as the victim's family and friends, to go to the sentencing and provide support when the victim reads the victim impact statement, if a statement is to be read. Victim impact statements allow victims the chance to make prepared remarks to the judge indicating how the sexual assault has affected their lives. This impact is taken into consideration by the judge when determining the sentence. Victims often express a sense of empowerment after having made such a statement.



Show Visual 5-18.

Introduce the activity.



Activity: “Dos and Don’ts” Demonstrations (25 minutes)

- 1. Divide participants into groups of four or five.*
- 2. Refer them to Lessons 3 and 4, which were just covered, in the Participant Manual. Each group should spend no more than 5 minutes designing a 1-minute demonstration that illustrates one or more “dos or don’ts” related to law enforcement statement accompaniment or courtroom accompaniment.*
- 3. Encourage participants to use tear sheets, markers, and masking tape as needed to plan and prepare their presentations. Make sure at least one group is addressing an issue described in each paragraph in the sections on law enforcement statement accompaniment and courtroom accompaniment.*
- 4. Groups will then conduct their demonstrations; you should correct or augment, as needed, the information they present.*

5. Drug-Facilitated Sexual Assault (DFSA) (40 minutes)



Show Visual 5-19.

Introduce the activity.



Activity: Information Search and “Red Flags” (40 minutes)

- 1. Divide participants into small groups of four or five. Refer participants to Worksheet 5.2, Drug-Facilitated Sexual Assault, in the Participant Manual.*
- 2. Ask participants to use Lesson 5 in the Participant Manual to locate information about drug-facilitated sexual assault in order to answer the questions on the worksheet. Allow about 20 minutes for participants to review the material and answer the questions.*
- 3. Review the answers as a group.*
- 4. Distribute three pieces of red paper or three red index cards to each group. Tell participants they are going to come up with their own “red flags” that might indicate a sexual assault was drug-facilitated.*

- 5. Ask the groups to write one issue on each of the three “red flags” (pieces of red paper/index cards) they received. Allow about 5 minutes. Review the answers and “red flags” as a class. Augment or clarify the information as required.**

Instructor Note:

Participants will use the following information to complete the preceding activity. You need not review this information if participants cover it in the activity.

Drug-Related Sexual Assault

Using drugs to make a woman more vulnerable to sexual assault is nothing new; alcohol has been used for this purpose for centuries and is still the most common substance used to facilitate sexual assault, involved in an estimated 75 percent of sexual assaults (Garriott and Mazayani 2001). What is different today is that inexpensive legal and illegal drugs are readily available that not only sedate the woman, facilitating the assault at the time, but also have an amnesic-like effect so that the victim has little or no memory of the rape when it is over. These drugs are commonly referred to as drug-facilitated sexual assault (DFSA) drugs, and their presence is quickly spreading.

These newer, memory-erasing drugs were first identified as a problem in the United States in the late 1980s and rapidly spread across the country during the 1990s. While drugs used to facilitate sexual assault are most often given to the potential victim without her knowledge – slipped into her drink, for instance – they also may be taken willingly by victims who are not fully aware of the effects, as is likely the situation at RAVE parties where “Ecstasy,” GHB and its derivatives, and other legal and illegal drugs are readily available.

Uncertain of what has happened to her, and possibly blaming herself for underage drinking or illegal drug use, the DFSA victim is unlikely to report to law enforcement. When a report is made, it is often significantly delayed, making detection and investigation a challenge. As a result, this crime is seldom prosecuted, and conviction rates are believed to be substantially lower than for non-DFSA.

Drugs currently used to facilitate sexual assault include but are not limited to the following:

- Alcohol
- Antihistamines
- Benzodiazepines, including flunitrazepam (Rohypnol)
- Alprazolam (Xanax)
- Diazepam (Valium)

- Midazolam (Versed)
- Clonazepam (Klonopin)
- Temazepam (Restoril)
- Zolpidem tartrate (Ambien)
- MDMA/Ecstasy
- GHB (Gamma Hydroxybutyric acid) and its precursors
- GBL (Gamma Butyrolactone) sold as a dietary supplement (Blue Nitro and Renewtrient)
- Tranquilizers (Ketamine)

It is difficult to confirm most cases of DFSA because of significant underreporting, long delays before reporting, and multiple-drug testing problems, so the true extent of its prevalence remains vague. Data are now being collected to more accurately identify the number of suspected and confirmed DFSA cases nationally.

Related Federal Law

Hoping to facilitate prosecution and limit the widespread, illegal import and abuse of these drugs, Congress passed the Drug-Induced Rape Prevention and Punishment Act of 1996. An amendment to the Controlled Substance Act, it imposes up to a 20-year prison term for anyone who gives a controlled substance to another person without that person's knowledge with the intent of committing a sexual assault.

It also provides for a sentence of up to 20 years for the distribution and import of flunitrazepam into the United States. The law also required the federal Drug Enforcement Agency (DEA) to study the reclassification of Rohypnol from a Schedule IV to a Schedule I drug to provide for closer controls, and instructed the Attorney General to create educational materials for police departments (H.R. 4137).

Congress passed another law, the "Hillary J. Farias and Samantha Reid Date-Rape Drug Prohibition Act of 2000," which President Bill Clinton signed into law in 2000 (H.R. 2130). Among other mandates, this legislation made GHB a Schedule I controlled substance. The first prosecution under this law occurred in Miami within 2 weeks of its passage: A man on Florida's sexual predator list was charged with buying enough chemicals over the Internet to make 100,000 doses of the newly outlawed GHB.

Signs of Possible Drug-Facilitated Sexual Assault

To help a possible victim decide if a drug screen is indicated, you must be aware of the signs of drug use.

- The victim has a history of being out drinking, having just one or two drinks (too few to account for the high level of “intoxication”), then a moment when she recognized feeling strange, then suddenly “very drunk.” She may have still looked normal and, while a little unsteady on her feet, may have been able to walk out of the bar with her assailant.
- The victim becomes very “intoxicated” very rapidly—within 5 to 15 minutes—especially after accepting a drink from someone or drinking one she left unattended.
- The victim wakes up 8 or more hours later, uncertain but believing she may have been raped because she has vaginal soreness or is naked. Or, she wakes up with a strange man and has no or a very spotty memory of what happened.
- The victim was told she was given “Roaches,” “Roofies,” “Mexican Valium,” “R-2,” “easy lay,” or GHB.
- The victim has a history of feeling or being told that she suddenly appeared drunk, drowsy, dizzy, and/or confused, with impaired motor skills, impaired judgment, and amnesia.
- The victim experiences “cameo appearances” in which she remembers waking up, possibly seeing the assailant with her, but being unable to move and passing out again. These memories may be associated with pain or a loud noise.
- The victim is high school or college age, since GHB and Rohypnol abuse is more common within these populations.

What To Do

Whenever you suspect that a drug was used to incapacitate a victim within the previous 72 hours, ask the victim to not void and to go immediately to a local hospital for a sexual assault evidentiary exam. If she must void, have her save her first voided urine in a clean container with a tight lid. This urine will most likely contain metabolites of the drug she was given, which can be used to identify the drug. These metabolites are excreted from her system with each subsequent voiding, making it less likely that they will remain in sufficient quantity to be identified. The victim should bring this urine to the hospital and give it to the SANE or other medical personnel conducting her evidentiary exam.

What the SANE Will Do

With the victim's informed consent, the SANE will obtain blood and the first voided urine, maintaining chain-of-custody. She will inform the victim about any limitations in confidentiality, whether she can be identified only by a number, and what drugs will be tested for.

Because of the wide range of drugs used to facilitate sexual assault, a complete drug screen should be done and the urine or blood tested for more than just one or two substances. SANEs keep current on local testing options to determine the best resource. Options may include the state crime laboratory or a private laboratory. When specimens are sent to state crime labs in many states, too often they are tested solely for GHB or flunitrazepam.

With so many other similar derivatives, this limited testing may give a false negative. Most laboratories do not have the ability to test for the drugs used to facilitate sexual assault, although more are developing the capacity. Because a complete drug screen is necessary, private laboratory tests may cost in excess of \$850.

Urine is used instead of blood because Rohypnol, GHB, and other commonly used drugs metabolize out of the bloodstream very quickly. Detection depends upon the dosage given and the procedures used by the laboratory in its analysis. Using current techniques, GHB can be identified up to 12 hours after ingestion and Rohypnol up to 36 hours. Identification is more likely when the sample is collected 8 hours after ingestion for GHB and 24 hours for Rohypnol.

The SANE also will take specimens to identify the presence of sperm or seminal fluid and will look for trauma. These too will help the victim determine if her suspicions of rape are valid.

Who Will Have Access to the Results?

It is always important to consider who will have access to the results of drug tests. Will access be limited to the legal system? In the case of an adolescent, will the parents be informed? What about the medical insurer or school? Will the victim be informed of the results of her drug screen? If so, who will report the information to the victim? The answers depend on who is ordering testing and where it is conducted.

The SANE program that collects the specimens should have access to the results. This feedback helps determine whether an appropriate clinical symptom picture and history are being used to determine when DFSA testing should be completed. A policy and procedure must be in place so the victim can access this information when deciding if she is willing to consent to testing.

While a urine, blood, or hair specimen obtained from the victim after a suspected DFSA is clearly the best evidence to lead to an arrest and conviction, the shortcomings inherent in today's techniques mean that positive specimens are often unobtainable. However, there is still valuable evidence that the SANE can obtain to help the investigation and help the victim determine whether or not she was drugged and raped.

Impact on the Victim

When drugs are used to facilitate a sexual assault, most victims never know for certain if they were raped or by whom. While recovery patterns vary greatly, some of these victims have considerable difficulty with the uncertainty, especially when the potential rape involved someone they know and may have trusted. Some victims recover and move on rapidly; others do not.



Show Visual 5-20.

Review the learning objectives and **ensure** that these were met.

By the end of this module, participants will be able to:

- Respond appropriately to a caller on a crisis line who is reporting a recent sexual assault.
- Identify correct procedures during a medical-evidentiary exam.
- Create a list of “dos and don’ts” for law enforcement statement accompaniment and courtroom accompaniment.
- Differentiate the roles of advocates, SANEs, and other SART members.
- Identify special procedures and “red flags” for dealing with drug-facilitated sexual assault.



Show Visual 5-21.

Ask if there are any final questions or comments before moving to the next module.

Module 5

Procedures in Common Advocacy Situations

OVC Can Help You Put the Pieces Together



OVCTTAC

Learning Objectives

- ❖ **Respond appropriately to a caller on a crisis line who is reporting a recent sexual assault.**
- ❖ **Identify correct procedures during a medical-evidentiary exam.**
- ❖ **Create a list of “dos and don’ts” for law enforcement statement accompaniment and courtroom accompaniment.**
- ❖ **Differentiate the roles of advocates, SANEs, and other SART members.**
- ❖ **Identify special procedures and “red flags” for dealing with drug-facilitated sexual assault.**

Responding to a Crisis Call

- ❖ **Identify immediate concerns.**
- ❖ **Establish safety.**
- ❖ **Explain services.**
- ❖ **Arrange transportation.**

Responding to a Crisis Call

- ❖ **Discuss evidence.**
- ❖ **Address practical issues.**
- ❖ **Arrange a time to meet.**
- ❖ **Activate other first responders.**

Medical-Evidentiary Exam

- ❖ **Within 72/96/120 hours (or longer; advocates must know local policy).**
- ❖ **Exceptions:**
 - **Hostage situations.**
 - **Force resulting in injury.**
 - **Ejaculation without cleanup.**

Medical-Evidentiary Exam: Yes or No?

- ❖ **Sharon reported an assault that occurred 12 hours ago; there was no penetration or apparent injury.**
- ❖ **Jane reported an oral sexual assault that occurred 24 hours ago.**

Medical-Evidentiary Exam: Yes or No?

- ❖ **Thomas reported a rape and robbery that occurred 5 hours ago.**
- ❖ **Maria reported a rape by two strangers that occurred 2 weeks ago.**



Activity

Medical-Evidentiary Exam Case Study

Worksheet 5.1

- ❖ **Working in groups, read and discuss the worksheet, then answer the questions.**
- ❖ **Report to the large group.**

Accessing Support

The advocate and, if available, the SANE should be called to the emergency department automatically, not at the victim's request.

Advocates and SANEs

- ❖ **May do some of the same things during crisis intervention, but the roles are distinct.**
- ❖ **Reinforce each other; the victim hears the same things (it's not your fault, your reaction is normal, etc.) from two people, helping to normalize the victim's reaction.**
- ❖ **Advocate should never be involved in evidence collection.**

Dealing With Emergency Department Delays

- ❖ **Up to 1 hour delay is common, even when there is a SANE program.**
- ❖ **If the victim is waiting for the SANE to arrive, it may be helpful to explain the SANE's role.**
- ❖ **Report consistent, unexplained delays to the advocate supervisor, who can speak to the emergency room supervisor or SANE supervisor.**

Dealing With Conflicts or Problems

**Report any problems to the
advocate supervisor.**



Law Enforcement Statement Accompaniment

- ❖ **Law enforcement is part of your team.**
- ❖ **You may stay in the room or wait outside.**
- ❖ **The investigator usually asks the victim to verbally go through their statement in detail.**

Law Enforcement Statement Accompaniment

- ❖ **The investigator will ask questions for clarification.**
- ❖ **Recording varies from area to area.**
- ❖ **Statement will usually be transcribed.**
- ❖ **The victim reviews and signs; this becomes their official account of the sexual assault.**



If You Have Concerns During the Statement

- ❖ **Never interfere with the statement.**
- ❖ **Hold all comments or questions until after the statement is complete.**
- ❖ **Talk with the officer alone.**
- ❖ **Talk with the victim, allowing the victim to voice their feelings about the statement.**

Courtroom Accompaniment

- ❖ You may accompany the victim to attorney appointments as well as the courtroom.
- ❖ The goal is to familiarize the victim with the process and the courtroom.
- ❖ If the case is plea bargained, work with the victim so they can express their opinion.
 - Many prosecutors will discuss options with victims.



Support During a Case

- ❖ **If the prosecutor decides not to charge the case:**
 - **Go with the victim to the prosecutor's office to discuss the reasons why.**
- ❖ **If the assailant is found guilty by trial:**
 - **The victim may want you to go with them to the sentencing and provide support.**

Activity

Dos and Don'ts

- ❖ **In groups, design a 1-minute presentation on dos and don'ts for law enforcement statement or courtroom accompaniment.**
- ❖ **Present to the large group.**

Activity

Information Search and “Red Flags”

Worksheet 5.2

- ❖ In small groups, use your manual to complete the worksheet.
- ❖ Write on your “red flags” possible indications of drug-facilitated sexual assault.
- ❖ Review in the large group.



Review of Learning Objectives

- ❖ Respond appropriately to a caller on a crisis line who is reporting a recent sexual assault.
- ❖ Identify correct procedures during a medical-evidentiary exam.
- ❖ Create a list of “dos and don’ts” for law enforcement statement accompaniment and courtroom accompaniment.
- ❖ Differentiate the roles of advocates, SANEs, and other SART members.
- ❖ Identify special procedures and “red flags” for dealing with drug-facilitated sexual assault.

End of Module 5

Questions? Comments?



Module 6: Recovery Education and Skills Training

Time Required

1 hour, 40 minutes

Purpose

This module provides a “toolkit” of techniques to support recovery from sexual assault.

Lessons

1. The REST Approach (1 minute)
2. Crisis Intervention (30 minutes)
3. Education (10 minutes)
4. Supportive Counseling (1 hour)

Learning Objective

By the end of this module, participants will be able to use crisis intervention, education, and supportive counseling skills to assist sexual assault victims.

Participant Worksheet

- Worksheet 6.1, Role Play—Kendra and Laura

Equipment and Materials

No special equipment or materials are required.

Preparation

- Carefully review the role plays in this module and make notes to yourself regarding some “ideal” responses to each. Protocol, facilities, and resources vary from community to community. With this in mind, this manual provides the scenario for each role play, but it does not provide a step-by-step response to the scenarios. You should be prepared to offer “ideal” responses to each scenario.
- Suicide risk is discussed in this module. Procedures for evaluating suicide risk vary greatly from center to center. Carefully review this section.



Show Visual 6-1.

Introduce the module.



Show Visual 6-2.

Review the purpose and learning objective for this module.

By the end of this module, participants will be able to use crisis intervention, education, and supportive counseling skills to assist sexual assault victims.

1. The REST Approach (1 minute)



Show Visual 6-3.

Paraphrase:

This module will explore counseling approaches demonstrated to be some of the most effective means of bringing about recovery. This combination of methods is referred to as Recovery Education and Skills Training (REST). This title distinguishes the approach from therapy. It also emphasizes that advocates will be learning how to give victims the information and skills they need to help themselves. The primary components of REST are:

- Crisis Intervention
- Education
- Supportive Counseling
- Skills Training

2. Crisis Intervention (30 minutes)



Show Visual 6-4.

Paraphrase:

Crisis intervention attempts to deal quickly with an immediate problem. Often referred to as emotional first aid designed to stop emotional bleeding; management, not resolution, is the goal.

When providing crisis intervention either on the phone or face to face, advocates play a number of important roles, including supporting survivors however they need support; normalizing their reactions to the trauma; helping them prioritize and solve concerns; ensuring that they are treated respectfully; supporting their significant other(s); and providing crisis education, referrals, and followup contact as well as future legal advocacy, if necessary.



Show Visual 6-5.

Paraphrase:

When should crisis intervention begin? Crisis intervention should begin as soon as possible, preferably within the first few hours after the sexual assault. This can be done when the advocate meets the victim at the emergency department. It also can occur over the crisis telephone line when a recent rape victim calls trying to decide if a rape actually occurred, and to ask what to do next. It can likewise happen on a walk-in basis at the rape crisis center.

Crisis intervention theory generally suggests that the first 72 hours after a sexual assault represent the crisis period. Treatment begun during this period of emotional disequilibrium often prevents secondary trauma and facilitates healing.

Since rape victims often do not want to think or talk about the rape because it is so painful, it is important to offer counseling rather than wait for them to ask. They can always refuse help when it is offered, and their refusal should be respected; however, advocates should be sure to let them know that they can always call later. It is normal not to want to talk about the sexual assault.



Show Visual 6-6.

Paraphrase:

Victims often blame themselves for the rape, possibly because they did something to make themselves more vulnerable. Because of this, they may be overly sensitive to possible blame by others, especially during the initial crisis period. Sadly, victims are often blamed by those closest to them. Sometimes this is done consciously and, other times, innocent but perhaps poorly phrased comments are interpreted by the victim to imply blame.

Subsequently, it is very important for advocates to avoid blame or the appearance of blame. Victims who blame themselves become more depressed, with post-rape adjustment worse than for victims who do not blame themselves.



Show Visual 6-7.

Provide examples of positive statements:

- Healing happens.
- You will get better.

Ask participants for other examples.



Show Visual 6-8.

Introduce the activity.



Activity: Brainstorm—Initial Concerns During Crisis Period (5 minutes)

- 1. Ask participants to close their manuals for this activity. Explain that the group is going to brainstorm a list of some of the initial concerns a victim might have during the crisis period. Ask a volunteer to be a note taker.**
- 2. As participants come up with suggestions, say “yes” or “no” depending on whether the suggestion is or isn’t likely to be a concern. The note taker should write down all of the “yes” answers on the tear sheet.**
- 3. When participants have offered all of their suggestions, add any of the following issues that were not raised by the participants.**



Show Visual 6-9.

Paraphrase:

When working with a victim during the initial crisis period, you may need to help the victim address such issues as:

- Deciding to report to the police.
- Concerns about the use of alcohol or drugs to facilitate the rape.
- Deciding if they are ready to label the forced sex “rape,” and if so, what it means.
- Fears for their immediate safety.

- Deciding whom to tell and how to tell them.
- Confidentiality issues.



Show Visual 6-10.

- Deciding where to go after the exam.
- Deciding if they will have an evidence kit exam.
- Fears of media involvement.
- Suicidal thoughts.
- Fear of contracting an STI, even HIV.
- Fear of becoming pregnant from the rape.
- Shame, self-blame, and embarrassment.



Show Visual 6-11.

Discuss how to establish a supportive relationship. **Tell** participants that effective crisis intervention requires establishing a therapeutic relationship with victims. These relationships are characterized by:

- Acceptance.
- Empathy.
- Support.



Show Visual 6-12.

Ask: How can you convey acceptance?

1. Nonverbally:

- Maintaining a calm facial expression.
- Nodding.
- Leaning in toward the victim.
- Touching the victim on a hand or shoulder.



Show Visual 6-13.

2. Verbally:

- Restating what the victim has said.
- Using the victim's language.
- Allowing and encouraging victims to express their feelings.



Show Visual 6-14.

3. By what you do:

- Listening attentively.
- Taking time to be with victims and allow them to proceed at their own pace.



Show Visual 6-15.

Ask: How can you convey empathy?

- Letting the victim know that you want to understand the situation from the victim's point of view.
- Restating the feelings the victim is expressing in their own words, acknowledging that whatever the feelings, they are normal.



Show Visuals 6-16 and 6-17.

Ask: How can you demonstrate support?

- Getting victims something to eat or drink (after the oral evidentiary exam is completed, if the rape was oral).
- Reassuring victims that the sexual assault was not their fault.
- Reassuring victims that whatever they did was "right" because they survived.
- Being sure the victim has a safe ride home.
- Providing the victim with information and resources to take care of practical problems and immediate needs, such as changing door locks, getting an Order for Protection, or applying for crime victim reparation funds.

3. Education (10 minutes)

Tell participants that education about sexual assault, and common reactions to it, can help victims recover.



Show Visual 6-18.

Paraphrase:

There is still a stigma attached to victims of sexual assault that blames or shames them and suggests that, in some way, the rape was their fault. To reduce this stigma, you must promote a view of rape as a criminal act committed against the individuals who are victims of this crime, and separate blame from vulnerability.



Show Visual 6-19.

Paraphrase:

You can normalize the response to rape by providing information about what victims might feel in the days, weeks, even months ahead. Talk with victims about typical responses before they occur; for instance, letting them know that it is normal to get upset when discussing the rape months and even years later. Whatever they feel, they are not the first to feel this.



Show Visual 6-20.

Discuss how to recognize avoidance.

Avoidance may be a common response to rape but the literature clearly shows that, as a coping strategy, it is ineffective in facilitating recovery. Victims need to know this. The first step is to help them recognize avoidant coping strategies they may be using. One reason rape victims do not want to report a rape is because they want to avoid thinking or talking about it, or dealing with it in any way, including participation in the legal process.

Cognitive and behavioral avoidance must be overcome for recovery to occur. The first step is to help victims understand that the painful process of facing their thoughts, fears and anxieties is necessary. Other well-meaning individuals in their lives may actually be encouraging avoidance. It is best to face these feelings and fears, because not thinking about the trauma does not make the memories go away. These memories will recur. If ignored, memories often come back and affect victims through nightmares, flashbacks, phobias, and other ways. By facing these memories, the victim can get used to them and lessen or eliminate their power over the emotional response. Victims can then see or hear things that remind them of the trauma without experiencing the intense anxiety and fear. If victims expose themselves to memories or images of the feared situation long enough, their fears will decrease.



Show Visual 6-21.

Paraphrase:

Encouraging victims to recount the traumatic event in detail is important, as is your response to their recounting. They may fear that if they tell you or anyone the gruesome details of the event, they will be seen as soiled, dirty, unworthy—much like they may now be feeling about themselves.

Thus, it is essential to show acceptance and reassure victims that, while they may have suffered a horrible, hurtful, and humiliating trauma, it in no way changes their worth as human beings. It is important to let the victims know that rape was a crime committed against them, which says a lot about the assailant's character but nothing about theirs, and that you will do all you can to help the victim recover and get on with life.

4. Supportive Counseling (1 hour)



Show Visual 6-22.

Paraphrase:

Supportive counseling is crisis-specific and includes respectfully listening to victims express their feelings as they become ready to do so, then demonstrating empathy and concern while providing information. It is important to reassure survivors that their responses are normal, that they are not crazy and will recover (Ledray 1994). Supportive counseling encourages survivors to face their fears in realistically safe situations as soon as possible, and to openly discuss their concerns while the counselor acknowledges that any resistance to doing so is normal and understandable (Frazier and Ledray 2011).

Supportive counseling also includes meeting the victim's practical needs related to the assault. Victims continually say that emotional support is of negligible benefit if their practical needs go unmet (Young 1993). Ledray (1996) recognizes that when these practical concerns are seen by survivors as pressing, they may need to be resolved before survivors can deal with the sexual assault.



Show Visuals 6-23 through 6-25.

Explain that during the crisis period and beyond it is important to help with practical problems such as:

- When clothing is kept as evidence, finding clothes for the victim to wear home after the evidentiary exam.
- Getting a shower/cleaning up after the rape exam.
- Explaining the police report process; what it involves and means.
- Obtaining an Order for Protection.
- Finding a safe place to stay.
- Changing the door locks.
- Notifying victim credit card offices/bank of a theft.
- Obtaining emergency funds for food and housing.
- Locating or picking up the victim's children.
- Locating a pet or ensuring that it is fed.
- Providing or finding child care.
- Addressing court issues and concerns.
- Arranging transportation home and to appointments.
- Obtaining telephone (or voicemail) service.
- Making referrals to appropriate medical or community agencies for followup services.
- Dealing with the media.

Add that these or other concerns may need to be resolved before the victim can focus on the rape and meet the demands of the criminal justice system. Many programs have special funds that can be used for such services and resources.



Show Visual 6-26.

Paraphrase:

It is crucial that victims know they are not alone; others are there to provide support. Tell victims what kind of support you can and cannot provide, and how to access additional services. The victim needs to know when and who to call for help.

Also explain to the victim that advocacy does not mean that you will make decisions for them; rather, you will provide the victim with the information and resources they need to make informed decisions. Advocacy also means providing support whether or not the victim decides to report the rape.



Show Visual 6-27.

Paraphrase:

What is the advocate's role now and in the future? Rape victims often form special bonds with the first people who respond to their needs. If you will be available to work with the victim in the future, let the victim know how to reach you, the hours you will be available, and whom to call in your absence. If you will not be available, let the victim know how your program operates and what services others can provide.

Providing support also means letting victims know that symptoms will improve. They will recover; they will not always feel as they do now. The advocate's goal should be to help survivors feel more in control when they leave than when they arrived.



Show Visual 6-28.

Introduce the activity.



Activity: Role Plays—Kendra and Laura (30 minutes)

- 1. Direct participants to Worksheet 6.1, Role Play—Kendra and Laura, in the Participant Manual. Ask them to work in pairs and role play the crisis intervention scenarios, practicing methods of demonstrating acceptance, empathy, and support in each situation.**
- 2. Ask participants to refrain from any improvisation that strays significantly from the provided simulation. Reassure the participants that making a “mistake” is fine; role plays are designed to enhance skills and correct weaknesses when there are no consequences.**
- 3. If the participants are stuck or say something inappropriate, they should not go out of character. Such scenarios are not uncommon, and advocates need to learn how to recover and reestablish rapport. Should advocates require assistance, they must, just as they would in the actual situation, gather all pertinent questions, contact their backup (the instructor) for answers or advice, and return to the victim with the appropriate answers or referrals.**

4. *Ask participants to start with the “Kendra” role play. Each pair should conduct the role play twice so that both have the opportunity to play the advocate. While participants are conducting the role play, walk around the room and listen. Offer suggestions or model “ideal” interventions as required. Allow about 10 minutes for the “Kendra” role play.*
5. *Debrief the “Kendra” role play by asking participants to share their thoughts about the experience. They also might want to identify their strengths and weaknesses and brainstorm alternative approaches with the group.*
6. *After debriefing, ask participants to conduct the “Laura” role play. Again, each pair should conduct the role play twice so that both have the opportunity to play the advocate. While participants are conducting the role play, walk around the room and listen. Offer suggestions or model “ideal” interventions as required. Allow about 10 minutes for the “Laura” role play.*

Debrief the role play by **asking** participants to share their thoughts about the experience. They also might want to identify their strengths and weaknesses and brainstorm alternative approaches with the group.



Show Visual 6-29.

Discuss when to refer out.

People working in a counseling capacity must, for the clients’ sake, know their limits. When you work with a victim of sexual assault, you should be aware of signs that the victim may need professional, in-depth counseling, which is probably more than you or a rape crisis center can provide. Referring survivors to mental health professionals for additional evaluation and treatment reveals your strength and good judgment, not a deficiency.



Show Visual 6-30.

Paraphrase:

A referral should be made when victims are:

- Actively suicidal.
- Actively psychotic.
- Unable to function in their social or occupational roles for more than a few days.

- Exhibiting persistent phobias.
- Actively abusing one or more substances.
- Interested in resolving long-term personal issues.

If you suspect any of the above but is uncertain, insist that the victim see a professional counselor who is capable of making an assessment.



Show Visual 6-31.

Paraphrase:

Whenever you suspect that a victim might be suicidal, further evaluation by a mental health or medical professional must be completed. Tell victims why you are concerned, and explain that you have a responsibility to see that the victim gets further evaluation. This evaluation protects the victim's physical health and also provides legal protection for you.

Criteria for suicide risk include:

- Stating suicidal intent.
- Choice of a lethal method.
- Access to the method.
- A plan of action.

Use the SLAP acronym to remember these criteria:

S = Statement of suicidal intent

L = Lethal

A = Access

P = Plan

Paraphrase:

If these criteria are present, you must seek professional help immediately on the victim's behalf. If the victim will not cooperate, inform the victim that you have an obligation to call 911 and ask the police to transport the victim to an emergency mental health assessment center for evaluation, even if this is against the victim's will.



Show Visual 6-32.

Introduce a discussion of psychosis.

Paraphrase:

If you suspect that a victim is psychotic, you will need to determine if the victim is oriented to person, place, and time. You can do this by asking the victim the following questions:

- “What is your name?”
- “Do you know where you are right now?”
- “What time is it? What day of the week? What is today’s date?”

If you think the victim is hearing voices, ask the victim if they are hearing voices that you or others might not be able to hear. Confusion can be caused by a number of factors—such as head trauma, or alcohol or drug intoxication—other than psychosis.

Whatever the cause, you must refer victims who appear to be psychotic to a professional who can definitively determine their ability to care for themselves. If victims are incapable of taking care of themselves and could legally be considered capable of self-harm, they need professional assessment.

If you are meeting the victim somewhere other than a medical facility where such assessment is available onsite, it may be necessary to have the police place a transportation hold on the victim so they can be taken to a medical or psychiatric facility for further evaluation. If the victim will go willingly with a responsible adult who is willing to assume responsibility, a hold is unnecessary.



Show Visual 6-33.

Discuss evaluating substance abuse.

Paraphrase:

Advocates should be concerned about potential substance abuse and consider professional evaluation if:

- Drugs or alcohol were involved in the sexual assault.
- The victim comes to a counseling session intoxicated.
- The victim reports additional or increased substance use.

- The victim is concerned about their own substance use.
- The victim reports that friends or family are concerned about substance use.



Show Visual 6-34.

Paraphrase:

There are other instances in which you should ask for assistance or refer a client, particularly situations in which you feel you are unable to provide the necessary support. Circumstances that may fit into this category include:

- Assault circumstances too similar to the advocate's own.
- Personality clash with the victim or the victim's family.
- Victim's needs are beyond the advocate's ability level.
- Difficulty maintaining healthy boundaries.

Emphasize that no single approach works for everyone. Advocates generally provide information about options, allowing victims to choose those with which they feel comfortable.

Tell participants that the Participant Manual includes information on skills training techniques and counseling approaches used to support recovery from sexual assault. With specialized training, advocates may use some of these techniques themselves. More advanced techniques should generally be practiced only by qualified counselors. However, advocates may wish to be acquainted with them in order to understand some of the options available to help support recovery.



Show Visual 6-35.

Review the learning objective and **ensure** that it was met.

By the end of this module, participants will be able to use crisis intervention, education, and supportive counseling skills to assist sexual assault victims.



Show Visual 6-36.

Ask if there are any final questions or comments before moving to the next module.

Module 6

Recovery Education and Skills Training

OVC Can Help You Put the Pieces Together



OVCTTAC

Learning Objective

- ❖ **Use crisis intervention, education, and supportive counseling skills to assist sexual assault victims.**

Recovery Education and Skills Training (REST)

- ❖ **Crisis Intervention**
- ❖ **Education**
- ❖ **Supportive Counseling**
- ❖ **Skills Training**

Crisis Intervention

- ❖ **Emotional first-aid designed to stop emotional bleeding.**
- ❖ **Management, not resolution.**
- ❖ **Phone or face-to-face.**



When Should Crisis Intervention Begin?

As soon as possible, preferably within the first few hours after the sexual assault

Avoid Blame

- ❖ **The victim may be especially sensitive.**
- ❖ **Avoid blame or the appearance of blame.**
- ❖ **Victims who blame themselves become more depressed, with post-rape adjustment worse than for victims who do not blame themselves.**

Positive Statements

- ❖ **Healing happens.**
- ❖ **You will get better.**
- ❖ **Others?**

Activity

Brainstorm – Initial Concerns During Crisis Period

Crisis Issues

- ❖ **Deciding to report to the police.**
- ❖ **Concerns about the use of rape drugs.**
- ❖ **Deciding if they are ready to label the forced sex “rape.”**
- ❖ **Fears for their immediate safety.**
- ❖ **Deciding whom to tell and how to tell them.**
- ❖ **Confidentiality issues.**

Crisis Issues

- ❖ **Deciding where to go after the exam.**
- ❖ **Deciding if they will have evidence kit exam.**
- ❖ **Fears of media involvement.**
- ❖ **Suicidal thoughts.**
- ❖ **Fear of contracting an STI, even HIV.**
- ❖ **Fear of becoming pregnant from the rape.**
- ❖ **Shame, self-blame, and embarrassment.**

Supportive Relationship Characterized by...



- ❖ **Acceptance**
- ❖ **Empathy**
- ❖ **Support**

Acceptance Conveyed...

Nonverbally:

- ❖ **Maintaining a calm facial expression.**
- ❖ **Nodding.**
- ❖ **Leaning in toward the victim.**
- ❖ **Touching the victim on the hand or shoulder.**

Acceptance Conveyed...

Verbally:

- ❖ **Restating what the victim has said.**
- ❖ **Using the victim's language.**
- ❖ **Allowing and encouraging expression of feelings.**

Acceptance Conveyed...

By what you do:

- ❖ **Listening attentively.**
- ❖ **Taking time to be with the victim and proceed at their own pace.**

Empathy Conveyed by...

- ❖ **Letting the victim know that you want to understand the situation from the victim's point of view.**
- ❖ **Restating the feelings the victim is expressing in their own words.**

Support Demonstrated by...

- ❖ **Getting victims something to eat or drink.**
- ❖ **Reassuring victims that the rape was not their fault.**
- ❖ **Reassuring victims that whatever they did was “right” because they survived.**

Support Demonstrated by...

- ❖ **Being sure the victim has a safe ride home.**
- ❖ **Providing the victim with information and resources to take care of practical problems and immediate needs.**

Destigmatizing Rape

- ❖ **Promote a view of rape as a criminal act.**
- ❖ **Separate blame from vulnerability.**

Normalizing the Victim's Response

- ❖ **Provide information about what victims might feel.**
- ❖ **Talk about typical responses before they occur.**
- ❖ **Whatever they feel, they are not the first.**

Recognizing Avoidance

- ❖ **Identify avoidant coping strategies, such as not talking about the rape.**
- ❖ **Help victims understand why the painful process of facing their thoughts, fears, and anxieties is necessary.**
- ❖ **If ignored, memories come back.**

Telling the Victim's Account

- ❖ **Recounting the traumatic event in detail is important, as is your reaction.**
- ❖ **It's important to let the victims know that rape was a crime committed against them.**

Supportive Counseling

- ❖ **Realize it is crisis-specific.**
- ❖ **Respectfully listen to victims.**
- ❖ **Meet the victim's practical needs.**

Supportive Counseling

- ❖ **When clothing is kept as evidence, finding clothes for the victim to wear home after the evidentiary exam.**
- ❖ **Getting a shower/cleaning up after the rape exam.**
- ❖ **Explaining the police report process; what it involves and means.**

Supportive Counseling

- ❖ **Obtaining an Order for Protection.**
- ❖ **Finding a safe place to stay.**
- ❖ **Changing the door locks.**
- ❖ **Notifying credit card offices/bank of any theft.**
- ❖ **Obtaining emergency funds for food and housing.**
- ❖ **Locating or picking up the victim's children.**
- ❖ **Locating a pet or ensuring that it is fed.**

Supportive Counseling

- ❖ **Providing or finding child care.**
- ❖ **Addressing court issues and concerns.**
- ❖ **Arranging transportation home and to appointments.**
- ❖ **Getting telephone or voice mail service.**
- ❖ **Making referrals to appropriate medical and other community agencies for followup services.**
- ❖ **Dealing with the media.**

Victim Needs To Know

- ❖ **They are not alone.**
- ❖ **When and who to call for help.**



Explain Your Role

Victims often form special bonds with the first people who respond to their needs.

Activity

Role Plays – Kendra and Laura

Worksheet 6.1

- ❖ In pairs, role play the Kendra scenario on the worksheet. The advocate should try to demonstrate acceptance, empathy, and support.
- ❖ Switch roles so each person plays both roles.
- ❖ Repeat with the Laura scenario.

When To Refer Out

- ❖ **Be aware of signs that the victim may need professional, in-depth counseling.**
- ❖ **Referring survivors is a sign of strength, not weakness.**

Referral Should Be Made When a Victim is...

- ❖ **Actively suicidal.**
- ❖ **Actively psychotic.**
- ❖ **Can't function in their occupational or social role for more than a few days.**
- ❖ **Exhibiting persistent phobias.**
- ❖ **Actively abusing substances.**
- ❖ **Interested in resolving long-term issues.**

Suicide Risk

- ❖ **S = Statement of suicidal intent**
- ❖ **L = Lethal**
- ❖ **A = Access**
- ❖ **P = Plan**

Psychosis

- ❖ **“What is your name?”**
- ❖ **“Do you know where you are right now?”**
- ❖ **“What time is it? What day of the week? What is today’s date?”**

Concern About Substance Abuse

- ❖ **Drugs were involved in the sexual assault.**
- ❖ **Victim comes to a counseling session intoxicated.**
- ❖ **Victim reports additional substance use.**
- ❖ **The victim is concerned about their own substance use.**
- ❖ **The victim reports that friends or family are concerned about their own substance use.**

When To Ask for Assistance

- ❖ **Assault circumstances too similar to your own.**
- ❖ **Personality clash with the victim or the victim's family.**
- ❖ **Victim's needs are beyond your ability level.**
- ❖ **Difficulty maintaining healthy boundaries.**

Review of Learning Objective

- ❖ **Use crisis intervention, education, and supportive counseling skills to assist sexual assault victims.**

End of Module 6

Questions? Comments?



Module 7: Compassion Fatigue and Self-Care

Time Required

1 hour

Purpose

This module is intended to help participants understand the impact of compassion fatigue on advocates and the importance of self-care.

Lessons

1. What is Compassion Fatigue? (10 minutes)
2. Effects of Compassion Fatigue (10 minutes)
3. Maintaining Healthy Boundaries (15 minutes)
4. Strategies for Self-Care (25 minutes)

Learning Objectives

By the end of this module, participants will be able to:

- Identify actions and behaviors that violate healthy boundaries.
- Develop a personalized self-care plan to prevent compassion fatigue.

Participant Worksheets

- Worksheet 7.1, Maintaining Healthy Boundaries
- Worksheet 7.2, Personal Self-Care Plan

Equipment and Materials

No special equipment or materials are required.

Preparation

No special preparation required for this module.



Show Visual 7-1.

Introduce the module.



Show Visual 7-2.

Review the purpose and learning objectives for this module.

By the end of this module, participants will be able to:

- Identify actions and behaviors that violate healthy boundaries.
- Develop a personalized self-care plan to prevent compassion fatigue.

1. What Is Compassion Fatigue? (10 minutes)

Tell participants that when Judith Herman, author of the highly acclaimed book *Trauma and Recovery*, spoke at a conference on child sexual abuse in 1998, she described the volunteers who staffed the health stations during Vietnam peace marches. The volunteers thought they were there to help if someone got injured, but when the marchers started getting tear-gassed and coming to the health stations, the health workers got doses of tear gas as well.



Show Visual 7-3.

Paraphrase:

Like these volunteers, advocates get doses of the trauma while helping trauma survivors heal. This work, however, is not without substantial meaning and reward. McCann and Pearlman (1990) point out that, by engaging empathetically with survivors to help them resolve the aftermath of violence and trauma, advocates open themselves to deep transformation that encompasses personal growth, a deeper connection with individuals and the human experience, and a greater awareness of and appreciation for all aspects of life.



Show Visual 7-4.

Paraphrase:

Some people have a tremendous capacity for empathy because of their own past victimization. Survivors often become particularly sensitive to the fears and concerns of victims, the inadequacies of victim services, or the magnitude of victim needs, all of which may contribute to a desire to become involved in victim services.

Survivors of sexual assault may have had a positive experience with the system and now want to offer other victims the same compassionate care. Alternatively, they may have had a very disappointing experience and want to prevent others from having the same experience.

Every victimization and recovery is different. Experience may or may not give a survivor greater empathy for other victims. Each survivor reacts differently; advocates cannot expect someone else to react as they did or to have the same needs and concerns. Survivors may have continuing unresolved issues such as anger, depression, fear, and difficulty trusting others. It will be very hard to help others deal with issues that they have not resolved.



Show Visual 7-5.

The darker side of this work, however, includes changes that are similar to those experienced by survivors. Compassion fatigue is defined as the enduring negative psychological consequence of caregivers' exposure to the traumatic experiences of victims in their care (Schauben and Frazier 1995).



Show Visual 7-6.

Paraphrase:

There are various subtleties of compassion fatigue in current literature. Mary Jo Barrett, director of training and consultation at the Center for Contextual Change, lectures widely on compassion fatigue. She differentiates between compassion fatigue, burnout, secondary posttraumatic stress, and vicarious traumatization. Understanding each of these better prepares advocates to identify and cope with the issues.

Explain that according to Barrett, all individuals have energy in five different compartments: intellectual, physical, emotional, spiritual, and sexual. When your work depletes these energy reserves, especially your emotional and spiritual energies, the result is compassion fatigue. Advocates working with sexual violence issues are likely to be depleted of sexual energy as well.

Ask participants to visualize themselves as a goblet of energy that gets depleted drop by drop. Clients rely on advocates' energy for their healing; however, if advocates neglect their own needs too long and do not replenish their goblets, they run dry. With emotional and spiritual energy reservoirs drained, advocates no longer have the vital energy to offer their clients or themselves, and they begin to suffer from compassion fatigue.

Burnout



Show Visuals 7-7 and 7-8.

Paraphrase:

Burnout is the depletion of physical and intellectual energy that happens when you are overworked, stressed, and involved in demanding situations over a long period of time. As a result, you may feel tired, rundown, overwhelmed, and irritable.

Burnout also has been associated with a reduced sense of personal accomplishment and with discouragement as an employee (Maslach and Jackson 1981).

Burnout can happen concurrently with the emotional, spiritual, and sexual energy depletion indicative of compassion fatigue. This occurs in mental health workers who have unmanageably large caseloads, for instance. Individuals also may experience burnout in other professions, such as technical or business fields; however, they generally do not have their emotional and spiritual energy challenged or used up.

Although these individuals may become tired, drained, and unmotivated, they are not inclined to begin wondering if people are basically good or evil, or if the world is safe, both of which may happen to those repeatedly exposed to violence.

Secondary Posttraumatic Stress (SPTS)



Show Visual 7-9.

Paraphrase:

SPTS is a specific form of compassion fatigue that occurs when we get symptoms of posttraumatic stress disorder (PTSD), including sleep disturbances, nightmares, intrusive thoughts, flashbacks of clients' stories, exaggerated startle response, irritability, withdrawal from others, feelings of increased vulnerability, and emotional reactions such as fear and anxiety.

As someone who works with victims of sexual violence, you are susceptible to SPTS because you are repeatedly exposed to traumatic events and you accumulate traumatic memories which affect your physiological reactions and view of the world. Just as PTSD is a normal reaction to an abnormal event, SPTS is a normal reaction to the stressful and sometimes traumatizing work with survivors (Rosenbloom, Pratt, and Pearlman 1995).

Advocates and trauma therapists are especially at risk, as are people who are close to the survivor. If you begin to experience these symptoms but do not understand why, the symptoms begin to consume all of your energy. You may see fear where there is no fear, feel crazy or unlike yourself. SPTS is cumulative; symptoms increase over time. Therefore, self-care is important to prevent SPTS from impairing your work and life.

Vicarious Traumatization (VT)



Show Visual 7-10.

Paraphrase:

In contrast to the cumulative nature of compassion fatigue, burnout, and SPTS, vicarious traumatization can emerge suddenly. It happens when you are actually traumatized during your job; for example, you have a traumatic reaction upon hearing a survivor's account of the assault that is particularly painful to you, or you witness violence or its immediate aftermath.

2. Effects of Compassion Fatigue (10 minutes)

Paraphrase:

Compassion fatigue disrupts your frame of reference (identity, worldview, and spirituality), self-capacities (eating, sleeping, exercising, hobbies, and relationships with friends and partners), and ego resources (the ability to self-monitor) as outlined on the following pages (McCann and Pearlman 1990).

Disruptions in Frame of Reference



Show Visual 7-11.

Paraphrase:

Compassion fatigue can shake the foundation of your basic identity. As a result of working with trauma survivors, you will likely experience disruptions in your sense of who you are as a woman/man, activist, partner, caregiver, and mother/father, or how you customarily characterize yourself (Pearlman 1995).

Such disruptions occur when your identity becomes too aligned with your work. You may find yourself putting in too many hours, taking more calls than you can handle, and believing that your work is a mission that takes priority over all of your other needs.

Compassion fatigue also can disrupt your worldview, including your moral principles and life philosophy (Pearlman 1995). Repeated exposure to violence and suffering can cause you to question your beliefs about the world and its inhabitants, whether random acts of violence are inevitable, or if justice exists.

You may begin to feel unsafe and vulnerable, checking the backseat of your car or feeling unusually afraid at home. Spirituality—defined here as your sense of meaning and hope, appreciation of a larger humanity, and sense of connection with a higher power—may be challenged by your work with trauma survivors (Pearlman 1995). You may struggle to maintain your faith and trust, belief in a higher power, and sense of cosmic meaning and goodness.

Another type of disruption reported by trauma workers is the intrusion of sexually traumatic images while engaging in sexual activity (Maltz 1992). This is a distressing example of how images from your professional life can blur into the intimacies of your private life. One way to deal with this intrusion is to explain the cause of your distress to your partner (without revealing any details that would betray confidentiality) and focus on processing your own feelings and need to reconnect (Pearlman 1995).

Disruptions in Self-Capacities



Show Visual 7-12.

Paraphrase:

Engaging empathically with client after client can be draining, and one response is to shut down emotionally (Pearlman 1995). As a result, you may tend to refuse social engagements or activities as a way of storing up energy to cope with the demands of your job. You may find yourself answering your phone less or making excuses to stay home. This coping mechanism is particularly maladaptive because you limit your life while simultaneously severing yourself from some of the most effective ways to restore your energy. Connection is an antidote to violence and helps caregivers maintain the optimism and hope that clients rely on for their own healing.

You also may notice disruptions in self-care habits. Your eating habits may steadily worsen, and your consumption of caffeine, alcohol, or nicotine increase. Sleep disturbances are common, as are changes in sexual appetite. Compassion fatigue may affect your overall motivation, and you may see the hobbies you once enjoyed become a thing of the past.

Disruptions in Ego Resources



Show Visual 7-13.

Paraphrase:

Ego resources refer to being able to effectively meet your psychological needs and manage interpersonal relationships. These resources include self-examination, intelligence, willpower, sense of humor, empathy, and the ability to set and keep boundaries, all of which can be affected by working with issues of sexual violence (Pearlman 1995). Regarding your overall functioning, these disruptions are arguably the most insidious. When your ability to step back and assess your choices and behaviors becomes impaired, it is difficult to even recognize that you have a problem or no longer feel fulfilled and balanced.

Costs of Compassion Fatigue



Show Visual 7-14.

Paraphrase:

The consequences of compassion fatigue are pervasive and real. Those who suffer from it find it increasingly difficult to attend to survivors with an empathetic, hopeful, and compassionate response. Once affected, advocates may dread going to work and taking calls, become irritable, and appear to shut down or distance themselves when interacting with survivors. In the worst circumstances, compassion fatigue can result in caregivers changing roles from the caregiver to the victim.

Both caregivers and supervisors must be aware of this possibility and recognize early symptoms, such as feeling used or unappreciated by the system or the survivors they serve.

It is important to remember the rewards of advocacy even when considering its possible drawbacks. In a study of both sexual assault counselors and those who work with a wide variety of populations, Schauben and Frazier (1995) found that counselors' disruption in their belief about the safety of the world and the goodness of others, PTSD symptoms, and self-reported compassion fatigue were associated with the percentage of sexual assault survivors in an individual's caseload.

Yet, working with a higher percentage of rape survivors was not correlated with job burnout or the negative effects associated with depression. They concluded this was likely because many caregivers also reported the work's positive aspects which they found rewarding, including being able to help people in crisis move toward recovery. In this light, McCann and Pearlman (1990) suggest that you can remain connected to survivors and protect yourself emotionally by remaining conscious of the broader context. For example, while survivors are telling their accounts of sexual violence, keep remembering that they have survived, are now connected to caring people and helpful resources, and that healing can and does happen.



Show Visual 7-15.

Paraphrase:

Compassion fatigue and its variations, the terms of which are often used interchangeably in the literature, pose a problem to caregivers, yet our profession has only recently begun to talk about it. We still work in a culture where it is largely unacceptable to talk about feeling exhausted or overwhelmed or not connecting with clients.

However, if you are good at advocacy work, it is very difficult not to get compassion fatigue; it is an occupational hazard. The only way to avoid it is to not care, which is hardly an option. The only way to continue caring is to pay attention to how you are being affected by your work, prioritize your own self-care, and do whatever you need to do to keep refilling your goblet again and again.

3. Maintaining Healthy Boundaries (15 minutes)

Paraphrase:

It is essential that advocates maintain healthy boundaries with the survivors with whom they work. This means being willing and able to set limits on what advocates will do for victims and when advocates will be available. Being a good advocate does not mean doing anything asked at any time; rather, it requires being able to distinguish between appropriate and inappropriate client requests. There are times when it is perfectly legitimate not to meet the requests of the victim and to put our own needs ahead of those of the victims.



Show Visual 7-16.

Introduce the activity.



Activity: Boundaries Checklist (10 minutes)

Ask participants to turn to Worksheet 7.1, Maintaining Healthy Boundaries, in the Participant Manual, and to complete the checklist related to boundaries. Briefly review which of these actions are inappropriate, and why.

4. Strategies for Self-Care (25 minutes)



Show Visual 7-17.

Paraphrase:

Caregivers generally know what to do to help themselves feel healthy, but they are often too tired to do it. Once advocates understand compassion fatigue, however, they must recognize that taking care of themselves is both their right and their responsibility and they must commit to replenishing themselves. Advocate supervisors also must support their staff in doing the things that staff need to do to keep themselves healthy. Supervisors need to set a good example by making self-care a priority in their own lives as well.

The alternative is to continue doing advocacy at an impaired level or leaving the field entirely, neither of which serves survivors or advocates. Advocates should figure out what depletes them, then automatically do something to replenish that energy. Effective self-care means raising their awareness of how well they are/are not eating, sleeping, exercising, socializing, enjoying life, spending time with family, and participating in the hobbies and activities they love, then taking measures to make their own needs a priority.

As much as it is normal for a rape survivor to experience symptoms of distress because of the assault, so it is for the advocate. It does not mean you are doing anything wrong, or that you are unfit for this work. It means you need to recognize the impact and take measures to take care of yourself, reducing your distress by whatever means you can reasonably achieve.

Paraphrase:

It is crucial that advocates have a supervisor for their clinical work with whom they meet regularly to discuss cases. The frequency of these meetings will depend upon the amount of time the advocates work, the number of cases they see and their level of experience. Supervision once a month is probably the minimum for maintaining consistency. Less experienced advocates/counselors should schedule more frequent meetings.

Refer participants to *Ten Strategies to Help Prevent Compassion Fatigue* in the Appendix.



Show Visual 7-18.

Discuss what might happen when an advocate meets with a supervisor.

When meeting with a supervisor, advocates will want to discuss:

- Difficult, new, or unusual cases.
- Cases involving vicarious trauma.
- Cases with boundary issues.
- Cases in which they meet with the victim more than once a week, or 12 total sessions.



Show Visual 7-19.

Introduce the activity.



Activity: Self-Care Planning (10 minutes)

Self-care plans are unique to each individual, so it is important that participants create their own. Instruct participants to turn to Worksheet 7.2, Personal Self-Care Plan, in the Participant Manual to create a personalized plan to help prevent compassion fatigue. Allow 10 minutes for this activity.



Show Visual 7-20.

Review the learning objectives and **ensure** that these were met.

By the end of this module, participants will be able to:

- Identify actions and behaviors that violate healthy boundaries.
- Develop a personalized self-care plan to prevent compassion fatigue.



Show Visual 7-21.

Ask if there are any final questions or comments before moving to the next module.

Module 7

Compassion Fatigue

and Self-Care

OVC Can Help You Put the Pieces Together



OVCTTAC

Learning Objectives

- ❖ **Identify actions and behaviors that violate healthy boundaries.**
- ❖ **Develop a personalized self-care plan to prevent compassion fatigue.**

Compassion Fatigue

- ❖ **Advocates get doses of the trauma while helping survivors to heal.**
- ❖ **Work also provides meaning and reward.**

Survivors as Advocates

- ❖ **Often become particularly sensitive to fears and concerns of victims, and the magnitude of their needs.**
- ❖ **May have had a positive or disappointing experience with the system.**
- ❖ **May seek to continue healing.**
- ❖ **May or may not have greater empathy.**
- ❖ **Wounds may reopen.**

Compassion Fatigue Defined

Compassion fatigue is a psychological consequence of caregivers' continual exposure to the traumatic experiences of victims, without sufficient relief for themselves.

~Schauben and Frazier, 1995

Compassion Fatigue

- ❖ **Mary Jo Barrett differentiates between compassion fatigue, burnout, secondary posttraumatic stress, and vicarious traumatization.**
- ❖ **Intellectual, physical, emotional, spiritual, and sexual energy gets depleted.**

Burnout

- ❖ **Depletion of physical and intellectual energy.**
- ❖ **Happens when overworked, stressed, and involved in demanding situations over a long period of time.**

Burnout

- ❖ **May feel tired, rundown, overwhelmed, and irritable.**
- ❖ **Reduced sense of personal accomplishment and discouragement as an employee/volunteer.**



Secondary Posttraumatic Stress (SPTS)

- ❖ **Specific form of compassion fatigue.**
- ❖ **Occurs when we get symptoms of posttraumatic stress disorder (PTSD).**
- ❖ **Susceptible to SPTS when repeatedly exposed to traumatic events.**

Vicarious Traumatization (VT)

- ❖ **Can emerge suddenly.**
- ❖ **Happens when you are actually traumatized during your job.**

Disruptions in Frame of Reference

- ❖ **Likely to experience disruptions in your sense of who you are.**
- ❖ **Disrupted worldview.**
- ❖ **Spirituality challenged.**
- ❖ **Intrusion of sexually traumatic images.**

Disruptions in Self-Capacities

- ❖ **Shut down emotionally.**
- ❖ **Refuse social engagements or activities.**
- ❖ **Disruptions in self-care habits.**

Disruptions in Ego Resources

Disruption of inner abilities to self-monitor to effectively meet your psychological needs and manage interpersonal relationships.

Costs of Compassion Fatigue

- ❖ **Increasingly difficult to attend to survivors with empathy, hope, and compassion.**
- ❖ **Results in caregivers changing roles from caregiver to victim.**

Costs of Compassion Fatigue

- ❖ **Caregivers often work in a culture where it is largely unacceptable to talk about feeling exhausted, overwhelmed or not connecting with clients.**
- ❖ **Pay attention to how you are affected by your work and prioritize your own self-care.**

Activity

Boundaries Checklist *Worksheet 7.1*

Strategies for Self-Care

- ❖ **Commit to replenishing yourself.**
- ❖ **The alternative is to continue doing advocacy at an impaired level or leave the field.**
- ❖ **Be aware of how well you are eating, sleeping, exercising, socializing, enjoying life, spending time with family, and participating in the hobbies and activities you love.**

Meet With a Supervisor

- ❖ **Difficult, new, or unusual cases.**
- ❖ **Cases involving vicarious trauma.**
- ❖ **Cases with boundary issues.**
- ❖ **Cases in which you are meeting with the victim more than once a week or 12 total sessions.**

Activity

Self-Care Planning Worksheet 7.2



Review of Learning Objectives

- ❖ **Identify actions and behaviors that violate healthy boundaries.**
- ❖ **Develop a personalized self-care plan to prevent compassion fatigue.**

End of Module 7

Questions? Comments?



Module 8: Wrap-Up and Evaluation

Time Required

30 minutes

Purpose

This module will allow participants to reflect on the training, prepare checklists for their use as advocates, and provide feedback on their training experience.

Lessons

1. Wrap-Up (15 minutes)
2. Evaluation (15 minutes)

Learning Objective

By the end of this module, participants will be able to design a personalized checklist to assist them during their advocacy work.

Participant Worksheet

- Worksheet 8.1, The Effective Advocate Checklist

Equipment and Materials

No special equipment or materials are required.

Preparation

No special preparation is required.



Show Visual 8-1.

Introduce the module.



Show Visual 8-2.

Review the purpose and learning objective for this module.

By the end of this module, participants will be able to design a personalized checklist to assist them during their advocacy work.

1. Wrap-Up (15 minutes)

Wrap up the training by asking for final questions about anything covered in the training. Tell participants that the next activity will allow them to review the training and come up with some personalized reminders to help them be effective advocates.



Show Visual 8-3.

Introduce the activity.



Activity: *The Effective Advocate Checklist (10 minutes)*

- 1. Ask participants to spend 10 minutes designing their own personalized Effective Advocate checklist. These checklists allow participants to develop reminders to apply their new knowledge and skills once they are “on the job” as advocates.***
- 2. Participants should review their manuals and notes, thinking about areas where they feel they excelled and areas that are a challenge to them.***
- 3. They should then use the Effective Advocate template to design their own checklists. The template is Worksheet 8.1, The Effective Advocate Checklist, found in the Participant Manual.***

2. Evaluation (15 minutes)



Show Visual 8-4.

Refer participants to the evaluation forms in the Participant Manual, and **ask** that they complete them. **Designate** an area for participants to drop off their forms on their way out of the room; this helps to ensure anonymity and encourages participants to be frank in their assessment of the training.



Show Visual 8-5.

Thank participants for making the commitment to attend the training and for taking the first steps to becoming effective advocates. **Congratulate** them on their success.

Module 8

Wrap-Up and Evaluation

OVC Can Help You Put the Pieces Together



OVCTTAC

Learning Objective

- ❖ **Design a personalized checklist to assist you during your advocacy work.**

Activity

The Effective Advocate Checklist Worksheet 8.1

Use your manual and notes to design a personalized checklist on the worksheet that you can take back to your job.

Evaluations

A vertical decorative bar on the left side of the slide, featuring a pattern of puzzle pieces in various shades of blue and green. The pieces are arranged in a way that suggests they are being assembled or are part of a larger whole.

Thank you
for your time, commitment,
and insight.

Appendix: Information and Tools for Program Managers

This appendix contains administrative tools and suggestions for sexual assault advocate/counselor program managers. The following are included:

- A complete set of sample advocate recruiting and application materials from the Santa Fe Rape Crisis Center.
- A sample suicide assessment form from Hennepin County Medical Center in Minneapolis, MN.
- Strategies for implementing institutionalized change to prevent compassion fatigue and burnout among staff and volunteer advocates/counselors.
- A discussion of the importance of evaluation, whether you are establishing, maintaining, or expanding an advocacy program.
- A summary of the history and development of rape crisis centers, with a brief discussion of the pros and cons of using volunteer advocates.

Sample Advocate Recruiting and Application Materials

Sample Inquiry Letter

Dear Prospective Advocate,

Thank you for your interest in the Santa Fe Rape Crisis Center (SFRCC) Advocacy Program. Enclosed you will find general information about the Advocacy Program, a training schedule, and an application.

The next volunteer training, a 40-hour intensive, will begin on [DATE] (exact dates and times are included on the attached schedule). The training will include presentations on such topics as sexual assault, child sexual abuse, crisis intervention techniques, post-traumatic stress disorder (PTSD), handling suicide calls, crisis call procedures, advocate self-care, grief and healing, domestic violence and domestic violence crisis intervention, role plays, and diversity training. Participants in the training include the Sexual Assault Nurse Examiner's (SANE) Initiative, District Attorney's Office and its Domestic Violence Unit, Esperanza, Victim/Witness Assistance Program, New Mexico State Crime Lab and Child Protective Services, as well as our professional clinical and administrative staff.

Our training is a time-intensive but rewarding experience that will prepare you to effectively assist and advocate for survivors of sexual and domestic violence. Once you have completed the initial training, the time commitment to the Advocacy Program becomes much more manageable, consisting of one monthly meeting (held from 6 to 8 p.m. on the third Tuesday of each month), and four hotline shifts per month, which can be done from home or by digital pager.

Volunteering with the SFRCC Advocacy Program is not only a way to help those in crisis; it is an opportunity to join a helping community of dynamic people. Advocates are invited to participate in regular group activities, from hiking trips to potlucks. The work is hard, but the rewards are many, including the chance to make wonderful friends.

To begin the application process, please complete the enclosed forms; then call me to schedule an interview. Thank you again for your interest in volunteering at the SFRCC. I look forward to welcoming you into our Advocate community.

Sincerely,

Advocacy Supervisor

Sample Job Description

The Role of the Volunteer Advocate

Advocates at the SFRCC staff our 24-hour hotline from their homes, taking a minimum of four shifts per month. In addition, advocates also provide crisis advocacy services at the SANE Unit at St. Vincent's Hospital to assist survivors of recent sexual assault. The overall role of the advocate is to provide information and resources, normalize callers in crisis, and give unbiased emotional support to survivors of sexual assault and their families.

Volunteer advocates are the backbone of our agency and provide a round-the-clock safety net for those in crisis. Through training and ongoing education, our volunteers enhance innate skills and learn new ones to offer professional and compassionate crisis intervention services for the Northern New Mexican community.

Qualifications for Women and Men

1. 21 years of age or older.
2. Resident of Santa Fe County for at least six months.
3. Settled in a job and/or home situation.
4. Has a car in good working condition.
5. Able to respond in person at the hospital.
6. Has a telephone.
7. Has no current personal upheavals to obstruct work with victims.
8. Willing to participate in medical or legal advocacy.

Training

Volunteers for the Advocacy Program are required to attend a 40-hour comprehensive training, which is scheduled on evenings and weekends to accommodate most work schedules. The training thoroughly prepares volunteers to handle crisis calls and assist survivors of recent sexual assault and domestic violence at St. Vincent's Hospital. Moreover, it covers facts and information specific to the diverse and unique population of Northern New Mexico. Required monthly meetings featuring debriefing sessions and educational in-services keep advocates up-to-date on new developments and provide ongoing support for this challenging role.

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Sample Written Application

Date _____

Name _____

Address _____

Phone: Home _____ Work _____

Date of Birth _____ Social Security Number _____

How did you hear about our program? _____

Current Employer/School _____

Address _____

Phone: _____

Emergency Contact _____

Address _____

Phone: Home _____ Work _____

References

We will use the employer listed above as a reference. Please list three additional references we may contact, giving COMPLETE and CURRENT addresses and phone numbers since we conduct reference checks by mail.

Name _____

Address _____

Phone: Home _____ Work _____

Relationship _____

Name _____

Address _____

Phone: Home _____ Work _____

Relationship _____

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Name _____

Address _____

Phone: Home _____ Work _____

Relationship _____

Please answer the following questions as completely as possible. Feel free to include extra pages if you need additional space.

1. Briefly describe your employment background.
2. Please describe your educational background and training.
3. List any special skills and/or interests you would be willing to share with the center (computer skills, graphic design skills, artistic skills, fundraising, etc.).
4. What are your reasons for wanting to volunteer with SFRCC?
5. What do you think you can offer to SFRCC as an advocate?
6. Please describe your own history with sexual violence, harassment, or domestic violence, if any.
7. Working closely with issues of sexual abuse and domestic violence can be stressful. Describe the types of support available to you.
8. Do you speak Spanish? Any Native American languages? Any other languages?
9. Are you able to commit to attending team meetings and/or in-service meetings on the third Tuesday evening of each month from 6:00 p.m. to 8:00 p.m.?
10. Are you able to commit to this position for a minimum period of 1 year?
11. What do you hope to get for yourself from this experience?
12. Is there anything else you would like us to know about you?

Volunteer Advocate Confidentiality Contract

Responsibilities of the Volunteer Advocate

1. Maintaining strict confidentiality with each case so as to protect the privacy of all clients served.
2. Attending all parts of the initial advocacy training.
3. Attending a monthly advocate team meeting, including in-service presentations, and contacting team leader or program coordinator if unable to attend. Arrangements for scheduling must be made prior to the meeting if absence is inevitable; otherwise, the team leader will schedule the advocate and the advocate will be responsible for filling those shifts.
4. Making a minimum *1-year* commitment to the program.
5. Being on call, from home or by a pager, according to a monthly prearranged schedule.
6. Being completely drug- and alcohol-free while on shift or backing up a shift.
7. Calling the answering service at the beginning of your shift to verify your phone number, updating as needed.
8. Providing information, referrals or emotional support over the phone to any hotline caller, and responding to the SANE Unit or St. Vincent's Hospital to assist survivors of sexual or domestic violence.
9. *Never* entering into a professional relationship with a SFRCC client/hotline caller (e.g., as a massage therapist, dog groomer, business consultant, etc.).
10. *Never* going to a victim's home or the scene of the alleged crime without having a police escort and contacting a team leader or the program supervisor.
11. Reporting a brief description of each case to the office staff *at the beginning of the next working day*.
12. Providing a written report with details of each case *within 48 hours* of the call.
13. Reporting any incident of child sexual abuse (age 17 or under) or alleged/suspected child abuse to the CYFD office and law enforcement *immediately* after receiving a disclosure. By law, this report must be filed.
14. Consulting with office staff before maintaining ongoing involvement in any case.
15. Doing followup on cases when appropriate, and providing information regarding that followup to the program supervisor.

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Responsibilities of the Rape Crisis Center Staff

1. Providing an initial, intensive, 40-hour training for advocates as well as followup training and supervision in specific areas to enhance their job performance, as appropriate.
2. Providing debriefing and supervision to advocates in the office and via phone calls during and after the immediate crisis in which they are involved, as appropriate.
3. Providing support services to advocates in the areas of information, referral, backup advocacy, and short-term personal counseling pertaining to their role as an advocate.
4. Providing evaluations pertaining to an advocate's role performance at the request of the advocate or the SFRCC supervisor.
5. Other responsibilities of the SFRCC, as agreed.

I understand and agree to accept the responsibilities outlined above. I understand that *CONFIDENTIALITY* is the primary task of all advocates; therefore, I will use only the office staff and advocate staff for consultation on cases. I understand if I break any part of this contract, my services with the SFRCC will be terminated.

Date _____

Advocate in Training _____

Advocate Supervisor _____

Advocate Interview

Applicant:

Interviewer:

Date of Interview:

Duration of Interview:

Why do you want to volunteer at the SFRCC?

What experience do you have helping others (formally or informally)?

What do you hope to get for yourself from this experience?

Can you identify any issues in your life that might make this work difficult for you (e.g., history of sexual and/or domestic violence, depression, drug/alcohol use, self-harm, trauma, etc.)? If you are a survivor of sexual and/or domestic violence, how have you dealt with your own history of sexual/domestic violence?

If a crisis call triggered personal issues or if you ever felt upset after taking a crisis call, how would you seek support? Would you be willing to utilize counseling?

Tell me about drug and alcohol abuse in your life. Could you commit to remaining drug/alcohol-free while on shift?

Tell me about stress in your life. How do you cope with it? How busy are you?

What is the level of stability in your life? Have you experienced any major changes (i.e., a move, change in career or significant relationship, loss, etc.)?

Are you able to commit to the SFRCC for a minimum period of 1 year and attend a mandatory monthly meeting held on a Tuesday night?

Are you willing to comply with New Mexico state law and report any/all incidences of sexual violence or abuse perpetrated on a minor, if you have identifying information?

Is there anything else about yourself you would like us to know?

Sample Reference Letter

(Date)

(Name) has applied to serve as a volunteer advocate at the Santa Fe Rape Crisis Center. This applicant has given us your name as a reference.

A volunteer advocate at the Santa Fe Rape Crisis Center is someone who donates their time each month to our advocacy program. Advocates staff our 24-hour crisis line on evenings, weekends, and holidays, and assist survivors of recent sexual assault or domestic violence at the local emergency department or at the Sexual Assault Nurse Examiner's Unit. Some of the qualities we look for in our volunteer applicants are honesty, integrity, reliability, balance, compassion and commitment. The contribution our volunteers make to our organization and the services they provide to survivors of violence and their families are both critical and invaluable; therefore, we believe it is essential for us to have an accurate sense of each individual applicant.

Please provide us with any insights that will help us determine the suitability of this applicant for a volunteer position with the Santa Fe Rape Crisis Center Advocacy Program. Your comments would be most helpful in our evaluation process. It is important that you give as honest and complete a summary of your impressions as possible.

Enclosed is a questionnaire to be completed by you. Again, feel free to include any additional comments. A self-addressed stamped envelope has been included for your convenience.

Thank you for your cooperation!

In community spirit,

Advocacy Program Supervisor

Sample Personal Reference Questionnaire

Volunteer Applicant: _____

Please circle the number in the scale ranging from high to low which reflects your opinion of this prospective volunteer. Indicate your general impression in each area. How does this person impress you in each of these areas? Few people will fall in the highest or lowest categories. Use these extremes to indicate a significant impression about this person.

Low Average High

1 2 3 4 5

1. Dependability (follows through with commitments) 1 2 3 4 5
2. Reliability in accepting responsibility 1 2 3 4 5
3. Evidence of good judgment in daily relations 1 2 3 4 5
4. Personal ethics 1 2 3 4 5
5. Flexibility (adapts to changes, accepts people with different values and lifestyles)
1 2 3 4 5
6. Stability in applicant's life 1 2 3 4 5
7. Gets along well with others 1 2 3 4 5
8. How long have you known the applicant and in what capacity?

Do you think this person is suitable to be a volunteer at the Santa Fe Rape Crisis Center?

Additional comments:

Signature _____ Date _____

Sample Critical Item Suicide Potential Assessment

Hennepin County Medical Center, Minneapolis, MN

Primary Risk Factors

Current (obtain consultation from psychiatrist or another staff member if ANY ONE factor is present)

1. Attempt

(+) Present (-) Absent

- Suicide attempt with lethal method (firearms, hanging/strangulation, jumping from high places).
- Suicide attempt resulting in moderate to severe lesions/toxicity.
- Suicide attempt with low rescue-ability (no known communication regarding the attempt, discovery unlikely because of chosen location and timing, no one nearby or in contact, active precaution to prevent discovery).
- Suicide attempt with subsequent expressed regret that it was not completed AND continued expressed desire to commit suicide OR unwillingness to accept treatment.

2. Intent (includes suicidal thoughts, preoccupation, plans, threats and impulses, whether communicated by the client directly or by another person based on observation of the client)

(+) Present (-) Absent

- Suicidal intent to commit suicide imminently.
- Suicidal intent with a lethal method selected and readily available.
- Suicidal intent AND preparations made for death (writing a testament or a suicide note, giving away possessions, making certain business or insurance arrangements).
- Suicidal intent with time and place planned AND foreseeable opportunity to commit suicide.
- Presence of acute command hallucinations to kill self whether or not there expressed suicidal intent.
- Suicidal intent with CURRENT ACTIVE psychosis, especially major affective disorder or schizophrenia.
- Suicidal intent or other objective indicators of elevated suicide risk but mental condition or lack of cooperation preclude adequate assessment.

Secondary Risk Factors

Mediating (obtain consultation from psychiatrist or another staff member if, in addition to some indication of increased risk, seven out of thirteen factors are present)

(+) Present (-) Absent (0) Unknown

- Recent separation or divorce.
- Recent death of significant other.
- Recent loss of job or severe financial setback.
- Other significant loss/stress/life changes interpreted by client as aggravating (victimization, threat of criminal prosecution, unwanted pregnancy, discovery of severe illness, etc.).
- Social isolation.
- Current or past major mental illness.
- Current or past chemical dependency/abuse.
- History of suicide attempt(s).
- History of family suicide (include recent suicide by close friend).
- Current or past difficulties with impulse control or antisocial behavior.
- Significant depression (whether clinically diagnosable or not), especially if accompanied by guilt, worthlessness, or helplessness.
- Expressed hopelessness.
- Rigidity (difficulty with adaptation to life changes).

Major contributing Demographic Characteristics

Not to be included in the ratings, but considered in the overall assessment of suicide risk.

- Male (especially older, white male).
- Living alone.
- Single, divorced, separated, or widowed.
- Unemployed.
- Chronic financial difficulties.

Implementing Institutionalized Change to Prevent Compassion Fatigue

Caregivers and social service agencies have a professional duty to raise overall consciousness and take action to help prevent compassion fatigue. Figley (1995) notes that we know enough to realize that compassion fatigue is an occupational hazard for caregivers, be they family, friends, counselors, or advocates. Recognizing this, Figley stresses that practicing professionals have a special obligation to prepare people in the field for these hazards. What often stands in the way, however, is the work ethic of some social service agencies, which tends to contribute to compassion fatigue. In some agencies, the cultural norm involves regularly working overtime, being on call during time off, not taking lunch breaks and vacations, and not receiving supervision to debrief difficult calls. Employees who complain about symptoms indicative of compassion fatigue may be viewed as a liability, even though such symptoms in no way indicate that the individual is not suited for trauma work. Implicit in this culture is the message that the work of the agency and welfare of survivors is more important than the personal lives and individual needs of the trauma workers. Such a culture needs to become as advocate/counselor-centered as it is client-centered. Doing so results in both a healthier staff and a healthier advocacy field, as experienced advocates are less likely to leave the field or become embittered and less effective in their role.

Research highlighting some of the most effective ways for institutions to reduce the effects of compassion fatigue includes the following:

- **Institute policies that require advocates/counselors to discuss upsetting material and cases.** One helpful measure is for agencies to provide regular staff meetings that include case reviews, debriefing and mutual support, especially for the more distressing cases (Arndt 1988; Alexander, Chesnay, Marshall, Campbell, Johnson and Wright 1989; Eubert 1989; Tobias 1990; Holloway and Swan 1993; Tempelton 1993; Ledray 1998). It may even be necessary to utilize staff support groups (Eubert 1989) or refer staff to a counselor or psychologist for additional emotional support (Holloway and Swan 1993).
- **Ensure that sufficient staff is available to share the workload.** It is essential to keep the number of hours worked and overall stress at a manageable level for each employee (Ledray 1998). It may be necessary to discourage staff from taking back-to-back on-call shifts, especially during busy weekend periods. It may be helpful to have a predetermined number of shifts for which each staff member is responsible each month to ensure that a few are not being overburdened.

Most centers find that advocates are less effective in providing support for the second and especially the third survivor with whom they deal in one on-call period. It is important to closely monitor the number of survivors seen during a typical on-call period. For example, if staff routinely take 24 hours on-call at a time, and more than one survivor is more than rarely seen during that time, it may be necessary to shorten the on-call shifts to 12-hour periods.

- **Experiment with various methods of avoiding compassion fatigue without sacrificing clinical effectiveness.** For example, agencies can put equal emphasis on the rewarding aspects of working with trauma survivors. Figley suggests focusing on how you are helping survivors transform sadness, desperation, and despair into hope, joy, and a new sense of meaning in life. Such transformation also is possible for trauma workers themselves who are suffering from compassion fatigue.

As an organizational model, the Traumatic Stress Institute (TSI) patently recognizes that trauma workers will be affected by their work and has pioneered ways to institutionalize policies to prevent compassion fatigue. TSI sets aside 1 hour each week for the entire clinical staff to express and process feelings raised by exposure to traumatic material, while observing a high level of confidentiality and respect for clients.

Trauma workers who experience traumatic reactions are not shamed or isolated in any way; rather, they are offered support and hope, and their reactions are both validated and normalized. In addition, TSI encourages employees to take adequate vacations and time off for illness and to continue their education. They also are offered health plans with good mental health coverage (Rosenbloom, Pratt, and Pearlman 1995). Moreover, TSI emphasizes the importance of every clinician receiving supervision, regardless of licensure status. This is particularly noteworthy because all too often advocates are not given proper supervision, if any, because they are not formally part of the agency's clinical team. Supervision is imperative, not only for the staff advocate coordinator, but for all paid and volunteer advocates as well. Research conducted by McCann and Pearlman (1990) shows that trauma therapists rated discussing cases with colleagues the most helpful antidote to compassion fatigue, above spending time with family or friends or taking vacations.

What Can Agencies and Organizations Do?

Changing an agency culture that is largely ignorant of compassion fatigue takes time. Administrators need to understand that they have an ethical obligation to protect employees from the occupational hazards of trauma work as much as possible. The prevention of compassion fatigue must be a strategic priority.

Reducing the negative impact of trauma work begins with careful screening of the individuals wanting to do the work. Only staff and volunteers with healthy boundaries and good personal support systems will be able to work directly with this population and remain centered. Others should be discouraged from direct victim contact and steered toward other roles. Program directors who understand the impact of working with sexual assault survivors are better equipped to develop strategies to reduce costly distress and turnover.

The program director should set an example of taking care of oneself and preventing compassion fatigue. Establish personal limits and maintain strong boundaries, such as not giving victims home phone or personal pager numbers and not being available to clients when not in the office or on-call (Ledray 1998). Encourage outside interests for

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yourself and your staff, especially activities that provide a physical release and healthy life balance. Hobbies reduce stress, especially those that allow for complete disengagement from work and a sense of completion of a task or goal.

Program directors do well to monitor caregivers who step over appropriate boundaries. An advocate who goes beyond providing information and suggesting options, and begins making decisions for survivors is fostering dependence and becoming a “rescuer.” For example, the advocate should not write or “draft” the victim impact statement to spare the survivor the pain of recalling the trauma (Young 1993). While it may appear emotionally difficult, this is a beneficial part of the victim’s recovery process.

Caregivers require ongoing supervision and debriefing. To meet this requirement, the Santa Fe Rape Crisis Center (SFRCC), for instance, provides clinical supervision to the staff advocacy coordinator and holds mandatory two-hour monthly meetings for all volunteer advocates. The first hour is devoted to small-group debriefings led by an experienced team leader. Group debriefings provide an opportunity to assess the skills and coping strategies of each advocate while educating other advocates on unique ways to handle calls.

Since unstructured debriefing can unnecessarily focus on accounts of sexual violence that can in themselves be traumatizing, Moscinski and Pratt (2000) developed a debriefing protocol that helps advocates process their personal reactions to their trauma exposure while minimizing the amount of traumatic material other group members hear. Guiding volunteers away from details protects clients’ confidentiality as well. Each debriefing takes 3 to 10 minutes and is interrupted only to guide the advocate back to the model. Moscinski and Pratt’s debriefing protocol covers the following:

- Brief overview—two-sentence maximum—of the account. (No details are permitted in order to protect confidentiality, ensure that the group is not retraumatized, and prevent the advocate from hiding behind the account to avoid emotional reactions.)
- What did you feel confident doing?
- What was the hardest part?
- What did you do to take care of yourself during and after the call?
- Do you have any procedural questions or new information to share with the group?
- Do you need anything from the group?

Ten Strategies to Help Prevent Compassion Fatigue

Many agencies are already raising general awareness of compassion fatigue and implementing strategies to prevent it. The following list highlights the most effective strategies.

1. Create an atmosphere in which reactions to traumatic material are considered normal and inevitable, and where employees are supported and validated.
2. Encourage staff to not work overtime. Creating a position that cannot be filled in the number of paid hours is a setup for compassion fatigue. If an employee exhibits satisfactory job performance, it is ultimately the agency's responsibility to ensure that they complete their duties during their paid hours or change the job description to make this possible.
3. Schedule regular, full-staff meetings with periodic facilitated meetings to process reactions resulting from exposure to traumatic material, assess compassion fatigue, brainstorm successful self-care strategies, and discuss the future visions and successes of employees.
4. Enforce a work ethic that encourages staff to take full lunch breaks away from their desks.
5. Provide generous amounts of paid time off to allow for self-care, validate the difficulty of the work, and compensate for the lower pay typically offered at social service agencies.
6. Afford professional development money and time to allow employees to attend conferences, learn new intervention tools, and get "recharged."
7. Emphasize the importance of self-care. Make sure employees regularly have full days off with no on-call duties. Inquire about self-care strategies in all volunteer/ employee interviews.
8. Plan periodic picnics, retreats, nature walks, group lunches, or other agencywide activities.
9. Select a health plan that offers good mental health coverage.
10. Include as part of the agency's mission statement the awareness of and commitment to the prevention of compassion fatigue among employees.

The Importance of Program Evaluation

Why Evaluate?

Evaluation allows for a systematic assessment of program strengths and limitations in order to improve the service delivery process and outcomes. Linking program process or performance with participant outcomes helps staff evaluate their progress and modify the program as appropriate. Information obtained through program evaluation can be used by administrators or funders to make decisions about future program goals, strategies, and options. For example, information such as the average number of “hot calls” made each month or year by advocates can be used to determine whether more volunteers should be trained.

Ongoing program evaluation must be an integral part of every rape crisis center (RCC). Program evaluation helps staff and volunteers learn what they do well, what goals they are accomplishing, and where they could improve to better fulfill other objectives. Evaluation is not effective as a one-time activity completed for “outside” purposes, such as those imposed by a funding source. To be effective, evaluation must be an ongoing tool employed to answer internal questions posed by program staff.

Formal and Informal Evaluation Strategies

Program evaluation may take the shape of formal evaluation or may involve informal data collection strategies. While either approach may accomplish many of the same functions, formal evaluation projects tend to employ more rigorous methods using larger groups and over longer periods of time. Moreover, formal evaluations tend to use standardized tools whose reliability and validity are established, or they establish these prior to the implementation of the formal evaluation.

There are two types of program evaluation relevant to our purposes:

- Process evaluation.
- Outcome evaluation.

Each type of evaluation may be accomplished formally or informally.

Process Evaluation

This type of evaluation focuses on how program services are delivered.

Examples include:

- Sexual assault victims are surveyed and asked if it is helpful to have the advocate come to the emergency department (ED) automatically or if they believe they should be asked if they want her paged.
- Sexual assault victims are asked if it is helpful to bring up the issue of HIV in the ED or if it would be better to wait until a later time.
- Followup telephone surveys are conducted 2 months after the assault to see if the victims took advantage of referral information provided to them by the advocate.
- Calls are placed 2 months after the assault to rape victims who did not come in for counseling. They are assessed for symptoms of PTSD and asked if they are interested in coming in for counseling at this time.
- With counseling visits scheduled, the follow-through rate can then be compiled.
- Victims are surveyed 2 weeks after their ED visit and asked about their satisfaction with the care provided by the police, hospital medical staff, the SANE and the advocate.
- SANEs complete data sheets in the ED on every client seen, providing the following information:
 - The time between the victim's arrival at the ED and the SANE's arrival.
 - If no police report was made prior to the SANE's arrival, whether the SANE was able to resolve the client's fears and if a report was eventually made.

Outcome Evaluation

Outcome evaluation focuses on the results of the service delivered to the targeted individuals or groups. It is important when designing an outcome evaluation to identify the target audience, then to explicitly state what knowledge, attitude, behavior, belief, or symptoms are expected to change as a result of the intervention. With sexual assault, for instance, it may be the reduction of symptoms of PTSD. Results evaluated may be immediate, short-term, or long-term.

The immediate outcome of service may include:

- If victims who did not initially want to report the rape decide to do so after talking with an advocate.
- If victims decide to take STD- and pregnancy-prevention medication.
- Peer review of courtroom testimony.

The short-term outcome of service may include:

- The first few weeks or months after the assault.
- Case presentations and peer reviews.

Evaluations of client outcomes 1 year after the rape and beyond are generally considered long-term. The longer the time period between the initial contact and the evaluation followup, the more difficult it will be to locate former victims; thus, a smaller sample can be expected, which may or may not be representative since rape victims who cannot be located may be better or worse off. Examples include:

- One-year anniversary telephone calls or mailed questionnaires assessing symptoms of PTSD in clients seen for counseling and those not seen.
- Courtroom outcomes of SANE and non-SANE cases in the area; for instance, the proportion of guilty verdicts in the SANE cases versus non-SANE cases.
- Client satisfaction questionnaires completed 1 year after the rape that ask for their feedback after going through the judicial or legal system.
- Yearly meetings with other community agencies to evaluate their satisfaction with the RCC program.
- Community sexual assault felony charge rates and prosecution rates of SANE and non-SANE cases.

Data Collection and Analysis

Evaluation data may be collected using standardized tests with established reliability and validity. It also may be collected using informal questionnaires developed specifically for RCC program evaluation. The data provided may be a simple count, an average or a percentage of cases, or it may involve sophisticated statistical analysis. Often, graphical representation of group or individual values is extremely helpful in understanding results.

Evaluation Utilization

In addition to answering questions raised by RCC staff and volunteers and ultimately improving RCC services, evaluation findings are useful in other ways. Findings may be used to convince funding sources to finance new program components or continue funding effective programs. Community leaders who support the RCC program may want access to the results to justify their ongoing support and to obtain the additional support of their colleagues. The media may be interested in the results. Other programs will likely be interested as they implement programs in their communities. Even if the results are negative or show where the program needs improvement, providing data to community organizations helps build the credibility and trust of the community and of potential clients. When community organizations decide which programs they are going to support, they expect to see documentation of program effectiveness.

Steps of Program Evaluation Planning

1. List the RCC program's primary goals and activities.
2. Identify problem areas, questions or concerns.
3. Identify outcomes of individuals or groups who make use of RCC services.
4. Formulate evaluation question(s).
5. Identify the types of information needed to answer the question(s).
6. Identify where the information is currently available or how to obtain it.
7. Decide who will obtain the information and over what timeframe.
8. Decide how the information obtained will be used.

Evolution of Program Evaluation

As the RCC evolves, the type and intensity of the evaluation will evolve. New programs stand to benefit the most from effective process evaluation. Informal, simple process evaluation of immediate or short-term impact will help staff evaluate program policies and procedures and make early decisions about changes in service delivery.

More established programs may elect to implement a more elaborate victim-and system-outcome evaluation that includes both short-term and long-term components. RCCs may benefit from the expertise often found at nearby universities. Sometimes a graduate student in evaluation or a related field may be able to integrate their thesis with the evaluation of the RCC. Local evaluation consultants also may be solicited to assist the program, at times offering their services pro bono. The RCC director, staff and volunteers may participate in creating the evaluation questions and deciding which outcomes are appropriate for their own program.

History and Development of Rape Crisis Centers

History of Rape Crisis Advocacy

Even though rape has likely occurred for as long as humanity has existed (Brownmiller 1975), only since the early 1970s has there been a concerted effort to better understand the issue and meet the needs of survivors. The women's movement of the 1970s created the first groundswell of information on sexual abuse and brought the extent of the problem to the forefront of public awareness. Feminists across the country organized and sought to make social changes to improve women's individual and collective status, living conditions, opportunities, power and self-esteem (Martin 1990).

Radical feminists in New York organized the first public speak-out on rape in 1971 (Herman 1991). These feminists recognized rape as much more than the result of the uncontrollable sexual drive of oversexed men. Sex was recognized as a weapon that men used against women. The political and control aspects of sexual assault were stressed, they being a way for men to maintain power and control over women by keeping them out of traditional male establishments such as bars, and keeping them dependent upon men for protection (Brownmiller 1975). In her landmark book on sexual assault, *Against Our Will: Men, Women, and Rape* (1975), Susan Brownmiller traced the origins of rape and rape laws as a means for men, not women, to obtain restitution for damage to their property, their women. Tracing the history of rape laws, she found that the term "rape" comes from Raptus, a Latin term which refers to the theft of property.

In the 1960s, definitions of rape became more gender-neutral, recognizing rape as a violent crime, not just a crime of sex. During the 1960s many states' sexual assault laws still contained the marital exception clauses, and the victim's past sexual history was admissible into court under rules of discovery. This was very traumatic to victims, who were forced to defend their sexual pasts while being made to look bad in public courtrooms (Dupre, Hampton, Morrison, and Meeks 1993).

In the mid-1970s the National Organization for Women (NOW) initiated legislative reform in the United States. Within a decade, all 50 states changed laws to facilitate prosecution and encourage women who had been silenced for generations to come forward and report the crime of rape. As Dupre, Hampton, Morrison, and Meeks report, as a result of pressure from feminist organizations, most states had, by 1980, revised their rape laws to:

- Remove the spousal exceptions, dating back to the 17th-century British "doctrine of irreversible consent," where Lord Hale proclaimed a man cannot be guilty of rape committed on his lawful wife because by their mutual matrimonial consent, the wife had given herself to her husband and was thus his possession.

- Restrict, through the implementation of “Rape Shield Laws,” the use of the victim’s previous sexual history to discredit her in court. (While this is indeed a major improvement, one that significantly limits the content of the victim’s sexual history now admissible into court, it has not totally eliminated it. For example, if sperm from another person is present in the evidentiary exam findings, that is admissible, as is any past consensual sexual contact with the accused.)
- Change the definition of consent to recognize the difference between consent and submission (when the victim did not physically resist due to fear); to recognize the difference between consent and lack of consent (when the victim was asleep or passed out); and to include the use of force or “coercion.”
- Exclude the need for there to be a witness to the rape in order to prove that it was indeed rape.
- Increase the statutory rape age from 10 to 12 years of age in most states. (The 1990s have seen an even more aggressive prosecution of statutory rape as an attempt to reduce teenage pregnancy.)

In 1976, the Pennsylvania Coalition Against Rape (PCAR), founded just 1 year earlier, secured passage of the first recodification of their state rape laws since 1939. In addition to many of the above changes, they eliminated the 90-day statute of limitations and the judicial instructions that the jury bear in mind a victim’s emotional involvement and credibility in a rape trial (Horn 1999).

Also in 1975, the creation of the National Center for the Prevention and Control of Rape at the National Institute of Mental Health resulted in an explosion of research on the previously ignored topic of sexual assault. Millions of dollars were made available to fund not only studies on the impact of sexual assault, but also to research demonstration treatment projects to provide improved medical and psychosocial care to sexual assault survivors. Women were sought out as the agents of inquiry, not just as its objects, and as a result, most of the principal investigators on studies funded by this new center were women (Herman 1992).

History of Rape Crisis Centers

In response to the increased awareness of rape, women worked in small, grassroots feminist collectives to develop the first rape crisis centers (RCCs) (Koss and Harvey 1991). Nearly all of the first RCCs were staffed on a volunteer basis by dedicated individuals who took the lead in developing these centers (Collins and Whalen 1989; Edlis 1993). In the early 1970s, many RCCs were radical feminist organizations, considered such because, as Collins and Whalen recognized, the goal initially was not reform, but total transformation of ideologies, power relationships, and the existing social structure. They were feminist because they were organized by women seeking to change the existing power structure with its “male voices being heard first and more often than female voices” (Fried 1994). They also recognized that their first goal had to be to establish a female-based power structure within their own organizations, because if they

could not effect a power change within the RCCs, they would not be able to stop rape in society (Fried 1994).

In these early years, organizational conflict within RCCs sometimes interfered with their ability to work in a unified way toward social change. This conflict was often the result of group members' differing goals. RCCs needed to learn to help these subgroups negotiate more effectively and with less confrontation in order to establish mutual goals on which they could work cooperatively to achieve. Or, RCCs had to accommodate this diversity by forming subgroups that could work independently on their own goals (Fried 1994).

Some RCCs were formed by both men and women who organized to meet a community need. In 1972, men and women in Boulder, Colorado, founded Humans Against Rape and Molestation. Outrage at a rape/homicide in the community initially brought them together. Their primary goals were to make their community safer by stopping rape and to assist victims. The Boulder RCC is still an active community agency.

As more RCCs developed, representatives came together to form state coalitions. As previously mentioned, 10 RCCs in Pennsylvania joined forces in 1975 to form the PCAR. They immediately began to make dramatic changes in their state's social and legal institutions and laws. PCAR worked collaboratively with local hospitals in 1978 to develop a treatment protocol for rape victims seen at local emergency rooms, and they developed a police training manual in 1981. PCAR continues to serve as a national role model for RCCs and state coalitions. One major contribution was their effort to help establish the National Coalition Against Sexual Assault in 1976. All of this was accomplished by a volunteer staff working out of donated office space. The first paid positions at PCAR were not funded until 1978.

By 1979, there were more than 1,000 RCCs across the United States. As the activities of PCAR demonstrated, RCCs were already beginning to shift from a radical feminist ideology to more liberal, reformism beliefs and cooperative working relationships with established social agencies (Edlis 1993).

Thanks to both organizational evolution and the availability of funding to hire staff, the rape crisis movement has become professionalized and institutionalized. Between 1979 and the mid-1980s, significant change in existing RCCs reinforced this move away from radicalism. This included obtaining state and federal funding to hire professional and paraprofessional staff, some of whom were selected for their expertise in administration or lobbying. These RCCs recognized that, to continue to receive this funding for salaries, the goals of the RCCs would need to appeal to legislators.

APPENDIX
Sexual Assault Advocate/Counselor Training

Wanting to be recognized for their expertise in providing counseling for sexual assault survivors, RCCs also began to stress credentials and certify volunteers. Traditional funding sources also required RCCs to adopt traditional hierarchical organizational structures with advisory boards who hired executive directors (Collins and Whalen 1989). Most RCCs are now funded by traditional sources such as the state, the U.S. Department of Health and Human Services, and the United Way (Black and DiNitto 1994).

Throughout the 1980s, RCCs gradually changed from a helping model dependent on volunteer staff to a stratified, counselor-client model with paid professional and paraprofessional staff. As state and federal money became available for direct services for other crime victims, RCCs across the country capitalized on this funding by expanding their victim populations to include families of homicide victims and victims of physical assault and robbery. The emphasis moved from reform to service delivery, and the complexion of the staff changed to include more white, middle-class women (Collins and Whalen 1989).

The next step was to better understand the impact of sexual assault and the treatment needs of rape victims. Scientific research on this impact and on evaluation of sexual assault programs began to meet this need (Burgess and Holmstrom 1974; Ledray and Chaignot 1981). While early feminist organizations initially stressed the power, humiliation, and control aspects of rape and minimized the sexual dimension, researchers and women working in RCCs have since recognized that rape also is sexual. While the penis is certainly used as a weapon, and gaining dominance and control over the woman is often a goal (Brownmiller 1985), if a man did not want sex, he could just beat up a woman. Rape is about sex, too (Fried 1994).

RCCs also recognized legislation as a means of dealing with many victim concerns, rectifying the imbalance of power and implementing social change from the top down. During the late 1970s and into the 1980s, RCC staff and volunteers focused on changing the laws pertaining to violence against women. It was RCCs working with legislators to remove the marital exclusion clause that resulted in the ability to prosecute abusive spouses and challenged traditional ideas about the institution of marriage and a woman's role within it (Collins and Whalen 1989). Passage of rape counselor confidentiality statutes in the early 1980s granted privileged communication status to certified rape crisis counselors in their contact with sexual assault victims. They no longer needed to fear being called into court to testify, with their statements possibly used against the victims they were there to serve. This privilege was not easily won, however. In 1980, Anne Pride, then director of Pittsburgh Action Against Rape (PAAR), was held in contempt of court after refusing to give a client's RCC record to the defense attorney in a rape trial. A mistrial was declared, and the issue of the confidentiality of RCC counseling records went to the Pennsylvania Supreme Court. In 1981, the Court ruled on *Commonwealth vs. PAAR* limiting the release of victim-related counseling information to the defense. In 1983, Women Organized Against Rape continued the legal battle against the confidentiality statute and won (Horn 1999).

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Sen. Joseph Biden, D-DE, was a strong, effective leader in changing legislation. The Privacy Protection Act of 1978 attempted to focus the attention in the courtroom on the defendant's conduct (the rape) by excluding the victim's past sexual history from the courtroom (Biden 1993). The Violence Prevention Service Act of 1984 created a special restitution fund with criminals paying fines to compensate victims. Rape and domestic abuse victims received priority for compensation (Biden 1993). Sen. Biden first introduced the Violence Against Women Act (VAWA) in 1990, and it was signed into law September 13, 1994, as Title IV of the Violent Crime Control and Law Enforcement Act of 1994. This bill made \$800 million available for training and program development over a six-year period, with \$26 million earmarked for the first year. The aim of VAWA was to deal with violence against women by:

1. Rectifying imbalances.
2. Helping survivors by funding services.
3. Providing resources and grants for education and training for police, prosecutors, judges and victim advocates.
4. Requiring treatment equal to that of men under the law by strengthening old laws and creating new ones (Biden 1993).

The impact of VAWA and other funding sources was widely felt by RCCs across the country. For the first time, funding was readily available for expenses and honorariums, which allowed communities to bring in experts to train paraprofessionals and professionals in their area, improving local victim care. RCCs also used this newly available funding to hire staff and introduce sexual assault advocates into county attorneys' offices and police departments (Fried 1994). Some RCCs remain social-movement organizations dedicated to broad social change from outside the existing social structure; others are working to make change from within. Transforming gender roles is a long-term process, and the institutional development of RCCs is an important part of this social evolution (Fried 1994).

Once RCCs were established to provide support to rape victims, the focus of attention became the injustice and victim blame still present within the criminal justice system and at hospitals. Rape crisis advocates, concerned for how victims were treated by police and hospital personnel, went to police stations to support victims during police interrogations (Edlis 1993) and to hospitals during the rape exam. In many communities this led to an adversarial relationship and conflict between strongly feminist rape crisis advocates and the establishment as represented by the police, medical personnel, and states' attorneys. This was counterproductive to communication and education, and hampered the progress of cases through the criminal justice system. In some communities the situation still has not been rectified, especially in the attitudes and relationship between the police and rape crisis advocates.

The emphasis in most RCCs today is on collaboration and cooperation rather than confrontation with other community agencies (Collins and Whalen 1989). This move to a collegial position within the existing social service structure has made RCCs more accepted and effective in providing training to other community organizations, such as the police, prosecutors, medical facilities, and schools. Most RCC staff today function effectively with these organizations as a member of the Sexual Assault Response Team (SART). Many state RCC coalitions are even taking the lead in obtaining funding to provide training and consultation to medical personnel to develop and implement Sexual Assault Nurse Examiner (SANE) programs (Ledray 1999), much like the RCCs took a leadership role in the 1970s and 1980s in sensitization training and protocol development (Horn 1999). Their motivation comes from the recognition that the SANE model is an effective way to bridge the remaining gap in services for rape victims by providing comprehensive medical care and forensic evidence collection.

When Advocacy Programs Rely on Volunteers

Throughout the nation, advocacy programs have traditionally relied on volunteers to staff crisis lines and ensure round-the-clock service. This has many advantages. In general, using volunteers saves money. In addition, educating civilians about sexual violence and crisis intervention gives communities more individuals who are educated to help friends and family who have been sexually assaulted. They also are in a position to dispel myths and prejudice through their knowledge and understanding of the dynamics of sexual violence. The influence of such individuals persists even when they are no longer advocates, and can help create positive social change long-term.

Arguably, however, volunteer advocacy programs are becoming dinosaurs among the ever-improving crisis response models. As SART teams become increasingly professional, volunteer advocates have become unequal in their training and status. Volunteers cannot be expected to have the same level of reliability and proficiency as paid professionals. Nor can they share the same level of collegiality. Compared to the proficiency, reliability and collegiality shared by SANEs and law enforcement professionals, advocates are in danger of becoming the “weakest link.”

Relying on volunteer advocates also creates a gap in the continuum of care. Volunteers cannot guarantee off-shift availability and may not be able to do thorough followup contact, short-term case management, or legal advocacy. Since volunteer advocates are prohibited from giving out their personal phone numbers, contacting survivors becomes difficult, with most advocates unable to perform the aggressive followup many survivors need in order to receive counseling immediately post-trauma, when the window of opportunity to prevent dysfunctional coping mechanisms and begin healing is most promising. If this responsibility then falls on the program coordinator, survivors have to reconnect all over again with a new person. Not surprisingly, many survivors “fall through the cracks.” This situation could be prevented if advocates were paid and had an expanded job description that included thorough followup for all recent survivors, short-term case management and counseling, ongoing medical and legal advocacy, regular office hours, and frequent on-call shifts to guarantee proficiency and consistent interaction with other first responders.

There is little research on rape crisis advocacy nationwide. For example, what percentage of survivors receive ongoing counseling immediately post-trauma? Is the prognosis of these clients more promising? What factors make it more likely that recent survivors will use support services? How can advocates make such utilization more likely? Which crisis counseling models used by advocates are most effective to prevent PTSD? Do regular check-in calls help survivors feel more supported? What training components are essential for advocates to feel competent in their role?

Since advocacy coordinators are usually busy training and supervising volunteers, and because advocacy does not have the professional cachet and credentials as other disciplines, there is a notable lack of research in the field. This is reflected as well in the lack of a professional journal featuring innovations, research and successes in the rape crisis advocacy movement.

Since their inception, RCCs have relied on volunteers. Such grassroots energy is typically generated and harnessed to effect positive social change. In the rape crisis movement, it is instead used to maintain an institutionalized status quo. This is a systemic problem because many agencies have no choice but to do so for financial reasons. Relying on volunteers, however, may jeopardize the existence of advocacy altogether. And the absence of advocates to provide agenda-free, nonjudgmental emotional support and followup case management for survivors and their families would be a tragic loss.

What You Can Do

The reality is that everything is changing except advocates ourselves. Most SANE programs provide 24-hour coverage with a small number of proficient, paid personnel; advocacy programs are challenged to do the same. Advocates need to compile examples of programs around the country that rely on paid staff and find the funding to do so. Any information evaluating the effectiveness of such programs is invaluable.

If you are involved in an innovative advocacy program, please e-mail Linda Ledray at mistyhillranch@aol.com with a brief program description and contact information, and someone will be in touch for more details. Together, advocates can make systemic changes to ensure that our crucial services remain available for survivors in need of our long-term compassion, presence, assistance, and support.

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Violence Against Women Act (VAWA) 2005 Reauthorization Forensic Compliance Mandates

Brief Overview

“Nothing in this section shall be construed to permit a State, Indian tribal government, or territorial government to require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursement for charges incurred on account of such an exam, or both.”

42 USCA S. 3796gg-4 (d) (1)

- Generally described as a two-prong approach to compliance:
 - 1) Ensuring victims of sexual assault are afforded forensic medical examinations *without* requiring cooperation with law enforcement and/or participation in the criminal justice system; and,
 - 2) States ensure that victims do not have any out of pocket expenses associated with the provision of the sexual assault forensic examination.
- Although the VAWA 2005 reauthorization mandates that States certify that they meet the forensic requirements, it does not articulate to States the method of compliance. Therefore States differ greatly in their approach to compliance. “Anonymous reporting”, “Blind reporting” or “Jane Doe reporting” are only examples of ways in which States can meet the forensic compliance mandate.
- A Blind or Anonymous system generally means that law enforcement is involved on some level – in many cases driven by the need to accept the evidence for storage. Therefore, this often translates to a police report generated to continue the chain of custody and establish a place holder, if you will, for the evidence to be stored (and tracked) within the local (or state) law enforcement agency. The “type” of police report (sexual assault, rape, miscellaneous, etc.) may vary greatly.
- The term “Jane Doe”, however, has a different connotation – especially with law enforcement. When using the terminology “Jane Doe” with law enforcement, it conjures up the image of the same terminology used when responding to “Jane Doe” homicides.

Officers may assume that both a police report and an investigation need to be initiated (which is not the case).

- States and territories must ensure that victims are not responsible for any portion of the sexual assault forensic examination regardless of what funds they choose to use for payment of those exams. Further guidance regarding the parameters pertaining to funding of exams can be found in OVW's Frequently Asked Questions (pages 22-25): http://www.ovw.usdoj.gov/docs/FAQ_FINAL_nov_21_07.pdf
- The forensic compliance mandates are applicable for teens and adults (see page 25: http://www.ovw.usdoj.gov/docs/FAQ_FINAL_nov_21_07.pdf). However, states and territories are to adhere to their respective state mandatory reporting laws. For example, cases that are classified as "child abuse" are still subject to mandatory reporting laws of the state or territory.
- Many states have developed statewide planning forums to identify victim-centered multi-disciplinary strategies to meeting the compliance mandates. To assess what statewide planning efforts are ongoing within your own state, contact your state STOP Administrator. Contact information for all STOP Administrators is available at: http://www.ovw.usdoj.gov/docs/admin_contact_list.pdf
- Further information may be obtained through the U.S. Department of Justice, Office on Violence Against: <http://www.ovw.usdoj.gov/index.html>.
- The Office on Violence Against Women has designated the Maryland Coalition Against Sexual Assault (MCASA) as the national technical assistance provider on this issue. MCASA is charged with providing technical assistance to States as they work toward implementing changes within their policies and procedures to ensure that they are in compliance. Further information regarding the national technical assistance project can be found at: www.mcasa.org.
- States and territories will need to certify that they are in compliance with the mandates by January 5, 2009. The certification applies to practices throughout all states and territories and is not limited to STOP grantees.



VICTIMS OF SEXUAL ASSAULT

HIPAA Privacy ♦ December 2005

TMA Privacy Office Guidance

Records Management ♦ FOIA ♦ DUAs ♦ HIPAA Compliance ♦ Privacy Act/System of Records ♦ PIAs



Purpose

The purpose of this paper is to clarify the policy and procedures on the disclosure of Protected Health Information (PHI) of sexual assault victims and to ensure that the Military Health Systems (MHS) apply appropriate safeguards, as set by the DoD Health Information Privacy Regulation (DoD 6025.18-R) and the Health Insurance Portability Act (HIPAA) of 1996, to prevent any use or disclosure of PHI that would be in violation of HIPAA.

DoD Health Information Privacy Regulation (DoD 6025.18-R, C7.6.3, C7.6.5 & C7.3) and HIPAA (45 CFR 164.512(c),(f)(3,5)) establish the requirement for the disclosure of PHI of sexual assault victims.

Policy

A Covered Entity (CE) may disclose the PHI of a victim of sexual abuse to law enforcement officials when the victim authorizes such disclosure or when certain exceptions, as set by the DoD Health Information Privacy Regulation, Federal or State Law, are applicable.

Guidance

A CE may disclose PHI, in response to a law enforcement official's request for such information, about an individual who is suspected to be a victim of a crime, other than disclosures for public health activities or disclosures about victims of abuse, neglect, or domestic violence, when:

1. The individual agrees to the disclosure;
2. The provider is unable to obtain the individual's agreement because of incapacity or other emergency circumstance if:
 - a. The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred and such information is intended to be used against the victim.
 - b. The law enforcement official represents that such immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and
 - c. The disclosure is in the best interests of the individual as determined by the provider, in the exercise of professional judgment.

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VICTIMS OF SEXUAL ASSAULT

HIPAA Privacy ♦ December 2005

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Records Management ♦ FOIA ♦ DUAs ♦ HIPAA Compliance ♦ Privacy Act/System of Records ♦ PIAs



The CE may disclose to a law enforcement official PHI that he/she believes in good faith constitutes evidence of criminal conduct that occurred on the premises of the provider.

Disclosures under this provision require the individual to be promptly informed that a disclosure has been or shall be made. All disclosures are to be accounted for using the Protection Health Information Management Tool (PHIMT) which has been provided to the Military Health System by TRICARE Management Activity. The PHIMT will be used to track disclosures, document complaints, requests for amendments and authorizations, and restrictions to PHI.

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TMA Privacy Office 5111 Leesburg Pike, Suite 810 Falls Church, VA 22041

Handout 3.1

Sexual Assault Quiz

1. The forcible rape arrest rate has decreased in the past 20 years.
True False
2. In 2010, forcible rapes accounted for less than 1 percent of violent crimes reported to law enforcement.
True False
3. More than 250,000 victims age 12 and older experienced rape or sexual assault in 2010.
True False
4. About half of all rapes and sexual assaults were reported to law enforcement in 2010.
True False
5. About 60 percent of reported forcible rapes were cleared by law enforcement in 2010.
True False
6. Most female rape or sexual assault victims are assaulted by strangers.
True False
7. In 2010, over 90 percent of rape or sexual assault victims were female.
True False

HANDOUTS
Sexual Assault Advocate/Counselor Training

Handout 3.2

Sexual Assault Quiz With Answers

1. The forcible rape arrest rate has decreased in the past 20 years.

True False

2. In 2010, forcible rapes accounted for less than 1 percent of violent crimes reported to law enforcement.

True **False**

3. More than 250,000 victims age 12 and older experienced rape or sexual assault in 2010.

True **False**

4. About half of all rapes and sexual assaults were reported to law enforcement in 2010.

True False

5. About 60 percent of reported forcible rapes were cleared by law enforcement in 2010.

True **False**

6. Most female rape or sexual assault victims are assaulted by strangers.

True **False**

7. In 2010, over 90 percent of rape or sexual assault victims were female.

True False

HANDOUTS
Sexual Assault Advocate/Counselor Training

Unique ID Number _____

Worksheet 2.1

Confidentiality Scenarios

1. A 14-year-old tells you that she was raped by her 32-year-old neighbor.

- Keep confidential.
- Report to the police.
- Report to child protection.
- Ask a supervisor/other professional to evaluate further.
- Other _____

2. You receive a call from a 16-year-old victim, who says she was raped several weeks ago. You then receive a call from her mother, who is very worried about her daughter and suspects what has happened. She wants you to tell her what is going on.

- Keep confidential.
- Report to the police.
- Report to child protection.
- Ask a supervisor/other professional to evaluate further.
- Other _____

3. During a crisis call, a victim expresses suicidal thoughts.

- Keep confidential.
- Report to the police.
- Report to child or adult protection.
- Ask a supervisor/other professional to evaluate further.
- Other _____

4. A 14-year-old victim was raped by a 16-year-old neighbor and does not want to report.

- Keep confidential.
- Report to the police.
- Report to child protection.
- Ask a supervisor/other professional to evaluate further.
- Other _____

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5. Your friend starts to date someone new. Through your work as an advocate, you have information that makes you suspect that this person is a perpetrator of several acquaintance rapes in your community.

- Keep confidential.
- Report to the police.
- Report to child protection.
- Ask a supervisor/other professional to evaluate further.
- Other _____

6. A mother calls and says her boyfriend is sexually abusing her 9-year-old daughter.

- Keep confidential.
- Report to the police.
- Report to child protection.
- Ask a supervisor/other professional to evaluate further.
- Other _____

7. A 72-year-old woman calls from a nursing home. She is clearly confused. She tells you she was sexually assaulted last night by a man who came into her room. She does not want you to call the police, but wants to talk.

- Keep confidential.
- Report to the police.
- Report to adult protection.
- Ask a supervisor/other professional to evaluate further.
- Other _____

Worksheet 3.1

Incidence and Prevalence of Sexual Assault

The following statistics are from the 2012 National Crime Victims' Rights Week Resource Guide.

Q: Approximately how many victims age 12 or older experienced rape or sexual assault in 2010?

A:

Q: In 2010, approximately what percentage of rape or sexual assault victims were female?

A:

Q: In 2010, what percentage of female rape or sexual assault victims were assaulted by a stranger? A friend or acquaintance? An intimate partner?

A:

Q: In 2010, approximately what percentage of all rapes and sexual assaults were reported to law enforcement?

A:

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Q: In 2010, forcible rapes accounted for approximately what percentage of violent crimes reported to law enforcement?

A:

Q: Has the forcible rape arrest rate increased or decreased in the past 20 years?

A:

Q: In 2010, approximately what percentage of reported forcible rape cases were cleared by law enforcement?

A:

Worksheet 3.2

Myths and Facts About Rape

Myth: Rape is most often perpetrated by a stranger.

Fact: Victims are more likely to be raped by someone they know.

Myth: If there was no penetration by a penis, then there was no rape.

Fact: Legal definitions of rape vary from state to state. For the purposes of this training, rape constitutes penetration with a penis, fingers and/or foreign objects, or when there was unwanted touching of the sexual body parts without penetration.

Myth: People cannot be raped by their partners.

Fact: Individuals are raped by their partners. Rape is often used as a tool to control one of the partners in a relationship in which the offender batters the victim, or where one partner feels entitled to sex despite the other person's wants or needs.

However, spousal and partner rape may be treated differently than other forms of rape in a jurisdiction's laws. For example, there may be a shorter reporting period or a requirement of use of weapons or force to commit the rape.

Myth: Prostitutes cannot be raped.

Fact: Prostitutes can be and often are raped by "johns," the customers who solicit sex from them, and by "pimps," the men who often control the prostitute's money and territory by supposedly offering protection. Often these pimps control women by ensuring or introducing drug usage, and with physical threats or force.

Myth: Child molesters are all dirty old men.

Fact: In recent surveys of child molesters, 80 percent were found to have committed their first offense before the age of 30.

Myth: The "stranger" represents the greatest threat to children.

Fact: Studies show that among children ages 6 to 11, 53 percent of perpetrators were acquaintances. Among adolescents ages 12 to 17, 66 percent of perpetrators were acquaintances. Strangers were the least likely perpetrators of sexual assault against children in cases reported to law enforcement: Only 3 percent of victims ages 5 and under, 5 percent of 6 to 11 year olds, and 10 percent of teen victims were sexually assaulted by strangers (Finkelhor 2009).

Often, a perpetrator will spend time "grooming" the child and his or her family by doing favors and providing assistance emotionally and physically for family members. This is done to win the family's trust, which makes it harder for them to believe the child and decreases suspicion of the perpetrator.

Myth: Rape only happens to young women.

Fact: Elderly individuals can be and are raped. Because of such myths, elderly victims often do not come forward when they are sexually assaulted. There is a high level of shame and fear that they have lost the ability to care for themselves. In addition, the perpetrator could be someone who comes into the victim's home to provide care. These victims may fear for their lives or that their care will be taken away.

Myth: Rape can't happen in same-gender relationships.

Fact: Rape can occur in same-gender relationships as well as in heterosexual relationships.

Myth: Men cannot be raped.

Fact: Although men are less likely to report because of societal pressures, men can be and are raped by other men and by women.

Myth: If a woman drinks with a man, goes home with him, or wears skimpy clothing, it is her fault if she is raped.

Fact: It is never her fault. No one asks or deserves to be raped. Rape is a violent attack and a crime in which the perpetrator controls the victim.

Make your own notes below about other myths and facts about rape.

Worksheet 4.1

STI Scenario

A caller who was sexually assaulted the night before is concerned about STIs, including HIV/AIDS.

What can you tell the caller?

Worksheet 4.2

Psychological Impact Scenario

A caller who was sexually assaulted 6 months ago is experiencing sleeplessness, weight gain, and trouble concentrating. She is experiencing recurrent pelvic pain, but her doctor hasn't been able to find a physical cause.

What are some of the psychological effects of assault that this caller might be experiencing?

Unique ID number _____

Worksheet 4.3

Participant Presentations

When preparing your presentation, please address the following questions. These questions encourage you to think about strategies for working effectively with a person with the particular characteristic you are examining. Focus your presentation on issues an advocate would need to be aware of when dealing with this hypothetical person.

Begin your presentation by noting the page numbers you studied so that other participants can follow along during your presentation.

Name at least two assumptions often made about this person after a sexual assault.

How might these assumptions impact the way in which advocates, law enforcement, medical professionals, or friends and family interact with this person?

Given the information you have read, what steps might you take to better respond to this person's needs during a crisis?

What are at least two things that advocates must know when working with this person after a sexual assault?

Worksheet 4.3, continued

1. Male Victims

A. Dynamics and Prevalence of Male Rape

As with the rape of women, the rape of men is not a crime of sexual motivation but rather one of aggression (Groth and Burgess 1980). Sexual assault treatment centers report that 5.7 to 10 percent of their clientele are males (King and Woollett 1997; Koss and Harvey 1991; Libscomb, Muram, Speck, and Mercer 1992). Male rape is generally thought to be more underreported than female rape (Dion 1997; Rentoul and Appleboom 1997). Data from the National Institute of Mental Health indicate that an estimated 90 percent of male survivors never report their rape to the police or hospitals, and 70 percent never tell anyone about the rape, not even friends or family (Dion 1997). Only 2 of 22 male sexual assault victims studied by Mezey and King (1989) had reported their sexual assault to the police. The remaining 20 cited fear of rejection, disbelief, and stigmatization as their reasons for not reporting. Most men never consider that they could be raped; therefore, when it happens to them, it can be devastating and stigmatizing. Male rape victims are less likely to report than women because of the extreme embarrassment they typically experience and because they fear being misunderstood as being homosexual. For this reason, community education and crisis intervention that serve to correct misconceptions about male rape are of critical importance.

The incidence of male rape is difficult to estimate. A survey of 336 agencies that respond to the needs of sexual assault victims found that just over half of these agencies serve male victims (Isley and Gehrenbeck-Shim 1997). The majority of men seen for sexual assault were white (85 percent) and heterosexual (81 percent). Most of the assaults occurred between the ages of 16 and 30 (86 percent) and involved a threat to the victim's safety through physical force (60 percent) or physical threat (68 percent), or occurred while the victim was intoxicated (40 percent). Slightly less than half of the assaults involved weapons. Most of the offenders were known to their victims (69 percent), and nearly 60 percent of the assaults involved only one offender. The rapists were generally male (94 percent), white (78 percent), and perceived by the victim to be heterosexual (90 percent).

After the assault, 1 in 5 of the male victims sought medical treatment; however, only 23 percent of these men revealed the sexual nature of the assault to medical personnel. Less than 15 percent reported the sexual assault to the police, and less than 2 percent of these assaults were reported in the media. Post-assault symptom data were available on 1,679 male victims, showing:

- Depression, 92 percent
- Shame, 89 percent
- Self-blame, 89 percent
- Increased anger and rage, 78 percent

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- Flashbacks, 69 percent
- Increased use of alcohol/drugs, 68 percent
- Preoccupation with assault memories, 66 percent
- Guilt, 66 percent
- Increased interpersonal problems, 63 percent
- Nightmares, 59 percent
- Social isolation, 58 percent
- Disruption in family life, 56 percent
- Sexual dysfunction, 51 percent
- Suicidal ideation, 46 percent
- Suicide attempt, 35 percent
- Confusion over sexual identity, 31 percent
- Fear of being perceived as gay, 1 percent

In a review of several studies of male rape victims, Frazier (1993) reports that 50 to 83 percent of male victims were raped by only one assailant, most victims knew their assailant, weapons were used in 9 to 25 percent of assaults, victims were threatened in 26 to 100 percent of the assaults, male victims were injured in 25 to 60 percent of the assaults, and most sexual assaults of males did not involve drugs or alcohol. Rates of weapon use, stranger assault, and injury were greater in studies of men who reported to emergency departments than in studies of men who were sampled in community clinics or who responded to newspaper ads. These findings may indicate that men are more likely to report a sexual assault in the context of seeking treatment for other injuries. It is important to train police and emergency personnel to ask men who report having been robbed or who present for treatment of physical injuries if they were sexually assaulted in any way.

In another study, Frazier (1993) reviewed the emergency department records of 74 male and 1,380 female victims of sexual assault who received care from SANEs. Most victims in this study reported the assault to the police (89 percent of men and 91 percent of women). One-fourth of both male and female victims reported a history of prior incest. More than 75 percent of male and female victims stated that they feared for their lives during the assault; however, 58 percent of women versus 40 percent of men reported being harmed during the assault. Male victims were significantly more likely to have been raped by more than one assailant, and only 48 percent of males and 46 percent of females reported being raped by an acquaintance.

Worksheet 4.3, continued

Most studies confirm that male sexual assault victims are less likely than female victims to sustain physical injuries (Calhoun and Atkeson 1991). King (1992) put forth that submitting to a sexual assault might be inexplicable or shameful to male survivors.

B. Erection and Ejaculation During Sexual Assault

In a study of 115 men with a history of sexual assault, King and Woollett (1997) report that 18 percent of the victims experienced ejaculation during the assault. Having an erection or ejaculating during a sexual assault can upset and confuse a victim. Many people (including significant others, police, juries, judges, and attorneys) share the false belief that a man cannot obtain an erection if he is frightened or anxious. This is not true.

In a review of sexual response literature, Coxell and King (1996) surmised that the physiological mechanism of any emotional response (whether anger, fear, or pain) may be one of sexual response. They point to evidence that high levels of physiological arousal can lead to involuntary erection and ejaculation. Masters (1986) also documents male victims' ability to experience erection and ejaculation during sexual victimization. Donnelly and Kenyon (1996) have shown that when a man is rectally raped, pressure on the prostate can produce an erection and even ejaculation.

When victims have a sexual response to an assault, they often feel as though their body has betrayed them. Victims benefit from hearing that this is a common physiological response. It may help to reassure them that their response was out of their control, much as tears are a normal physiological response to a sliced onion being held under their nose. They would cry regardless of their determination not to. After being sexually assaulted by another man, heterosexual men may struggle with issues surrounding sexual orientation and preference. Gay men may feel they were targeted because of their orientation or preference. Fear and confusion can be allayed by explaining that the sexual response is a physiological reaction to pressure on the prostate or to fear, anxiety, or pain.

C. Sexual Preference/Orientation of Rapists

Victim gender is not an indicator of the offender's sexual orientation or preference. In a study of convicted male sex offenders who raped men, Groth (1990) found that, at the time of their offense, all the men were actively engaged in consenting sexual encounters or relationships, with 9 percent reporting that those encounters were almost exclusively with other men and 32 percent reporting sexual activity with both men and women. In Groth's study, 27 percent of the convicted sex offenders reported that they confined their consenting sexual activity to women. Half of them were married.

D. PTSD in Male Survivors

Male victims of sexual assault experience posttraumatic stress reactions similar to those observed among female victims, with fear being most commonly reported, followed by depression or thoughts of suicide, anger, somatic problems, sexual dysfunction, and disturbances in peer relationships (Coxell and King 1996; Frazier 1993; Koss and Harvey 1991). In a study comparing male victims to female victims seen in the emergency department, Frazier (1993) found that males experience slightly more depression and hostility immediately after the assault than females.

Men need the same level of crisis intervention and followup care as women; however, males may be less likely than females to seek and receive support from family and friends. Like women, men need to be able to recount the sexual assault in a safe and supportive environment. Calhoun and Atkeson (1991) point out that male victims may not profit as much as women from social support, most likely because society emphasizes self-reliance in our socialization of men. The ability of male victims to seek support will vary according to the level of stigmatization they feel, the number of supportive relationships they have, the circumstances of the rape, and the sensitivity of care they receive in the emergency department or rape crisis center. Men may experience difficulty recognizing and expressing emotions other than those of anger and aggression, and may need particular help doing so in a healthy way.

E. Responding to Male Victims

Advocates/counselors serve male victims well by taking time to listen to their experiences, what they were feeling as it happened, and their immediate concerns.

In a study to determine the preferred gender for the advocate, it was found that half of female rape victims prefer to be seen by a woman while half have no preference. Of the male victims, however, 100 percent indicated that they felt more comfortable speaking with a woman immediately after the assault (Ledray 1994). It is helpful to describe common reactions men have after being sexually assaulted and to stress that men do get raped regardless of who they are, what they were doing, or how they look. Men may worry that they appear too effeminate and that this caused the assault. Gay men may wonder if the offender assaulted them because of their sexual orientation and, as a result, may struggle with self-blame. All men need to be reassured that their sexual orientation, appearance, and sexual preference had nothing to do with their being raped. Men are susceptible to the same techniques by which rapists gain control over female victims (the use of weapons, entrapment, intimidation, threats, and coercion).

One important function of the immediate crisis response is to help the victim decide whom he wants to tell. While support is critical, some within the victim's circle may respond in a way that further damages his concept of self. Helping family and friends understand the dynamics of male rape also is essential to the victim's recovery.

Worksheet 4.3, continued

The most important thing significant others can do for male victims is to believe them and try to understand what they are experiencing. Coming to grips with the fact that any man could be raped is threatening to many people who find comfort in believing that men can always protect themselves and others.

The majority of people also will need to be informed that, like female rape, male rape is not about sex but domination. As Dion (1997) points out, ironically, although males are the offenders in both cases, the fathers of female survivors often fear that sexual assault will cause their daughters to turn away from men, whereas fathers of male survivors seem to fear that their sons will turn toward men for sexual gratification.

F. Men Raped by Women

While reports of men being raped by women are rare, men who have been raped by women suffer similar feelings of helplessness, fear, and anxiety as do women who have been raped by men. Men, however, need more guidance in considering how friends and family members may react. Many men will react to a man who tells them he was raped by one or more women by laughing and saying, “Why doesn’t that ever happen to me?”

The victim is left with his intense fear and anxiety invalidated, which can lead to feelings of self-doubt, isolation, stigmatization, and depression. The rate of post-assault sexual dysfunction is high for men who have been raped by women (Coxell and King 1996; Masters 1986). Men raped by women also will need an evidentiary exam. Forensic evidence collection focuses on the presence of the assailant’s DNA in vaginal secretions, saliva or hair on his body or clothing, and inspection for and documentation of injuries.

2. Gay and Lesbian Victims

A. Prevalence of Sexual Assault for Gay Men and Lesbian Women

The rate of sexual assault for gay men and lesbian women has been found to be higher than the rate of sexual assault for heterosexual men and women. In a study of 412 university students, Duncan (1990) found the percentage of gay men reporting a history of sexual assault to be three times the percentage of heterosexual men (approximately 12 percent compared to 4 percent). Similarly, the percentage of lesbian women who reported a history of sexual assault was close to two times that of heterosexual women (approximately 31 percent compared to 18 percent). As with all people who have been sexually assaulted, the degree to which a person who is gay or lesbian will be able to recover from a sexual assault depends on the amount of support he or she receives.

Recovery for gay and lesbian victims also is affected by the amount of discrimination they experience from the community around them, including the advocates, health care workers, and legal professionals charged with their care after the assault.

B. Filing a Police Report May Force “Outing”

People who are gay or lesbian and have not “come out” to their family, friends, or employer may have an intense fear of reporting a sexual assault. They may fear that their cooperation with the prosecution may lead to a disclosure of their sexual orientation, which could endanger their child custody, “out” their partners if the investigation reveals their identity, result in the loss of their job, and prompt negative reactions or rejection by family members, friends, or coworkers. Advocates/counselors play an essential role in helping victims weigh the pros and cons of reporting. Accurate information about what the person can expect in the reporting and prosecution process is invaluable.

The fact that a victim is gay or lesbian does not necessarily mean that they will have more trouble recovering from the rape than a heterosexual victim, although they might. People who are well integrated into the gay and lesbian community may be better equipped to deal with the sexual assault. Their strength may stem from their coming out process, an increased sense of community, and the constant consideration of hate and bias crimes and how to heal from them. However, for gay and lesbian victims of sexual assault who are publicly open about their sexual preference, fear of disclosure can still be a major issue because it represents a further loss of control. Even when the assault was not a bias or hate crime, it often feels as though it was, and may result in increased anxiety, deep personal doubt, negative self- image, and depression (Miller 1997).

C. Adolescents Struggling With Sexual Identity

At particular risk are adolescents who live in families or communities where homosexuality is not accepted and who are beginning to feel attracted to people of the same gender, yet they have no supportive connections in the gay and lesbian community. Being raped by someone of the same gender and considering the ramifications of reporting can produce extreme anxiety for adolescents.

The advocate needs to understand that the adolescent’s sexual identity is unfolding, and that using labels such as “gay” or “lesbian” may be premature and threatening. It is less threatening to talk about attractions and interests. Asking, for example, “Are you attracted to males, females, or both?” is preferable to “Are you gay, lesbian, or bisexual?”

Worksheet 4.3, continued

Only half of males who have homosexual experiences involving ejaculation during their teen years go on to identify as gay (Miller 1997). Advocates must pay special attention to helping youth who have experienced same-gender assaults understand the ramifications of reporting. They will need referral information for supportive services as they sort through reactions to the assault and continue to explore issues of sexual identity.

D. Dynamics for Lesbians

Lesbian survivors of sexual assault by men often experience a unique constellation of concerns. Of all sexually active adults, lesbians constitute the lowest risk group for sexually transmitted diseases and may not be aware of current STI risks from heterosexual exposure. Also, they have not had to worry about pregnancy and will need careful counseling about pregnancy risk and prophylaxis.

For women who have not had sex with a man, vaginal penetration can be painful, both physically and emotionally. Lesbian women oftentimes report sexual dysfunction after a rape, which can be confusing as they ponder why the experience of violence with a man has carried over to their nurturing sexual relationship with a woman. Like others, lesbians often wonder if the rape was their fault, but it also may bring up a deep-seated sexual confusion as the woman questions if she somehow wanted the assault to happen and whether it occurred because of how she looks. Confusion about her decision not to resist or about a physical response to the rape can raise doubts in the victim's mind about her complicity or sexuality (Garnets, Herek, and Levy 1990). Many lesbians feel intense shame at having been violated and forced to have sex with a man. This adds an extra dimension beyond that experienced by straight female or gay male rape survivors. Common emotional reactions include a sense of isolation, vulnerability, punishment, and paranoia ("Did he pick me because of how I look?").

Lesbians who are unaccustomed to feeling dependent on or vulnerable around men may find their sense of safety, independence, and well-being greatly disrupted by a sexual assault that is a result of male rage at their sexual preference (Garnets, Herek, and Levy 1990). It is important that advocates have accurate information about lesbianism and anti-lesbian crime so that they can provide sensitive, appropriate care to lesbians who have been sexually assaulted. It may be difficult for a lesbian who has been raped to open up to male physicians, police officers, etc. Her lack of openness may be construed as being uncooperative or hostile. The presence of an understanding, accepting advocate in the post-assault period can be considerably helpful. For victims in relationships, including the significant other and recognizing the deep emotional bond is important to their recovery (Orzek 1988).

3. People With Developmental Disabilities

For the purpose of clarity in this training, the term “disability” is used despite some discomfort with it. It is preferable to think that all people are “differently abled” and to concentrate on our similarities. However, differences in physical appearance and cognitive ability affect the way victims react and are treated during and after a sexual assault. Moreover, a sexual assault can severely exacerbate the physical aspects of a disability and the emotional aspects of coping with it. It is important to appreciate each individual’s uniqueness and strive to understand the survivor’s view of any cognitive, emotional, or physical differences they may have. The goal is to concentrate on similarities among people rather than differences, and to recognize abilities as well as disabilities.

To disability activists, disability is the direct result of attitudinal, institutional, environmental, and legal barriers that limit a person’s ability to fully participate because of his or her impairment (Fine and Asch 1983; Neve 1996; Oliver 1990). When victims with disabilities are not served by the medical, legal, and advocacy systems, it may be more indicative of the system’s disability than the victims’. Effective victim service organizations establish relationships with organizations serving people with disabilities and ensure that they are represented at the decisionmaking level. They also place accessible information where women with disabilities frequent (Neve 1994).

A. Developmental Disabilities

Many people confuse the terms “developmental disability,” “developmental delays,” and “mental retardation.” These are three distinct concepts that, technically, should not be used interchangeably. When responding to people who have been sexually assaulted, it is necessary to understand the distinctions.

The term “developmental disability” is an umbrella term under which “mental retardation” falls. According to Federal Law PL 95-602, developmental disability is “a severe chronic disability of a person attributable to a physical or mental impairment or combination of physical and mental impairment, manifested before 22 years of age, and likely to continue indefinitely; resulting in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency that reflects the person’s need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services of lifelong or extended duration that are individually planned and coordinated” (Schor 1987). Developmental disability can include conditions such as spina bifida, cystic fibrosis, and cerebral palsy, which may carry physical function and movement impairments in people with normal or above normal intelligence.

Worksheet 4.3, continued

The term “developmental delay” is used to describe a child who is not progressing, growing, or developing at expected rates or levels for physical or environmental reasons (USF Division of Child Development and Neurology 1997). The term encompasses many children who also have developmental disabilities that are permanent, but also those who lack appropriate stimulation in their environment. With adequate stimulation and nurturing, the delay may disappear.

Finally, “mental retardation” refers to mental ability and self-help skills significantly below the average level for an individual’s age. According to the American Association on Mental Retardation, an individual is considered to have mental retardation if:

- Their intellectual functioning (IQ) is below 70-75.
- They experience significant limitations in two or more adaptive skill areas.
- The condition is present before the age of 18.

In referring to people who meet these criteria, some prefer to use the terms “cognitive impairment,” “intellectual disability,” or “cognitive disability” rather than “mental retardation.” Other people use the broader term “developmental disability.”

In this training, the term “cognitive disability” will be used rather than “mental retardation” except when referencing clinical diagnoses or the work of others.

Cognitive disability affects not only cognitive processing but also daily functioning; it is not IQ alone. Such functioning also is influenced by the amount of nurturing, support, and quality education a person receives. For example, even though an IQ of 65 is considered close to the upper cutoff for mild mental retardation, two people with the same IQ could function at very different levels. One with an IQ of 65 who grew up in a family where they were loved, challenged, taught, and not overly protected could be in the community living independently, holding down a job, and engaged in a loving relationship. Another person with the same IQ but a more limited childhood environment or background of trauma could be in a residential treatment facility, unemployed, and struggling with interpersonal relationships. By definition, mental retardation begins in childhood. If an injury or illness permanently affects cognitive and social functioning in a person over age 18, the impairment is termed dementia or encephalopathy (USF Division of Child Development and Neurology 1997). Mental retardation has many causes, only some of which also have physical characteristics such as Down’s Syndrome.

Many people mistakenly believe that you can tell if someone has a diagnosis of mental retardation by looking at them. Advocates/counselors must realize there are several syndromes, such as Noonans and Turners, which cause some physical characteristics similar to many who have Down’s Syndrome, but people with these syndromes have no cognitive impairment.

On the other hand, several constellations of learning disabilities can cause a person to fall into the diagnosis of mental retardation, although they have absolutely no physical characteristics. Take, for example, a “normal” -looking and -sounding 17-year-old whose behavior makes you wonder why she did what she did. Yet, as you come to know her, you learn that she has a constellation of learning disabilities that render her unable to understand other people’s motives or to identify potentially dangerous situations.

When working with victims, it is essential that advocates/counselors do not stereotype cognitive functioning based on physical appearance, but rather develop the ability to assess every victim’s capacity to think abstractly and make informed decisions. People with cognitive disabilities often lack the abstract reasoning skills to contemplate other people’s motives, perceive a situation’s risk, and understand the outcomes of their actions. Because this inability to think abstractly affects victims’ risk and reactions to rape in unique ways, working with people with cognitive disabilities will be covered in a separate section that also addresses people with dementia and adolescents.

B. Sexual Assault Rates for People With Disabilities

It is estimated that only 1 in 30 cases of sexual abuse/assault of persons with disabilities is reported, compared to 1 in 5 cases in the general population (Tharinger 1990). The actual occurrence of assault in people with disabilities is difficult to determine in that typical prevalence (ever assaulted in their lifetime) and incidence (assaulted within the last year) studies use telephone interviews with randomly selected households from the general population. These studies fail to reach people with cognitive disabilities, those with communication disorders, and those living in institutions (Andrews and Veronen 1993).

Agency data is equally flawed. Agencies that work with people with disabilities seldom ask about sexual victimization, and agencies that work with victims of sexual assault omit identification of disabilities from their records (Andrews and Veronen 1993). A review of assault rates indicates that 68 to 83 percent of people with developmental disabilities will be sexually assaulted in their lifetime, which represents a 50 percent higher rate than the rest of the population (Neve 1996; Pease and Frantz 1994). Reviewing data on sexual assaults of people with developmental disabilities, Pease and Frantz point out that 30 percent are assaulted by family members, 30 percent by friends or acquaintances, and 27 percent by service providers, with the likelihood of the latter increasing as the severity of disability increases.

People with cognitive disabilities or difficulty communicating are at especially high risk for sexual abuse and assault. They are more likely to be revictimized by the same person, and more than half of them never seek assistance from legal or treatment services (Pease and Frantz 1994). Sex offenders deter physical and verbal resistance by seductively offering attention, affection, rewards, and bribes in exchange for sexual contact, backing these by threatening loss of residential security, family disruption, humiliation, or physical or emotional harm if the victim tells anyone (Andrews and Veronen 1993).

Worksheet 4.3, continued

Reporting often involves a loss of independence; if a person is enjoying a sense of independence in a group home or is living on their own, reporting an ongoing assault by a caretaker or someone who lives in their building poses the threat of being reinstitutionalized or moved back home with their family (Berkman 1986). When someone who is cared for by a state-licensed agency is sexually assaulted by a person from that agency, a criminal report may be filed by the victim; however, the SANE, as a mandated reporter, will need to ensure that the state licensing agency receives a report of the abuse to investigate misconduct and/or failure to protect. Some states have vulnerable adult protection agencies that serve as contact points for such reports.

C. Prevention Education for People With Disabilities

One of the factors that keeps people with developmental disabilities at a greater risk for sexual assault is the lack of quality educational curricula covering the nature of sexual assault and how people can assert themselves to establish and maintain self-protective sexual boundaries. Even though 99 percent of assaults of people with disabilities involve offenders known to the survivor, most self-protection curricula are geared toward stranger rape (Seattle Rape Relief 1997). A significantly complex level of social skill is required to repel exploitative sexual behavior in its early stages, before it becomes aggressive. Without specific, appropriate training in handling such situations, the victim may feel discomfort, guilt, and powerlessness when the offender becomes aggressive (Andrews and Veronen 1993). There is some literature that suggests that offenders target people with disabilities because they believe there to be less risk of discovery (Andrews and Veronen 1993).

D. Helping Family Members Help Victims

The rape of someone with a disability, particularly a young person with a developmental disability, can cause extreme distress for family members who have been in the role of protector and caretaker. They may feel guilty for allowing the person too much independence and be compelled to step in to make sure this never happens again. It is crucial at this time to support family members as they weigh their need to protect with the victim's need to regain her sense of confidence, safety, trust, and independence. Immediately placing the person in a more protective environment disrupts the victim's healing by shattering the belief that the world is generally a safe place, that people can usually be trusted, and that the person is able to live independently.

Families can be reassured that their desire to protect is normal. Anyone whose loved one has been raped reacts the same way. Overwhelmed by the pain of what happened, they want to keep their loved one in a protective bubble. The victim, however, would then be left with the traumatic stress of the assault combined with grief over their loss of independence, which will bring to the surface and magnify any sense of loss and grief over the disability. The victim and her family need to hear that anyone can be raped, and that there is nothing we can do to absolutely prevent it from happening. They do, however, have control over their healing process, and the advocate/counselor will be there to guide and support them in that process. Providing families with helpful words and phrases (we're so sorry this happened to you; you didn't deserve it; you're going to be okay, etc.) will benefit them.

E. People With Cognitive Disabilities

The overarching ethical dilemma facing members of the SART in responding to people with cognitive disabilities is protecting them from sexual abuse and exploitation while still enabling fulfillment and expression of their sexuality (Tharinger, Horton, and Millea 1990). The trend to fully integrate people with cognitive disabilities into the community has resulted in many vulnerable people working in minimum wage jobs during evening or night hours. Their coworkers often have drug, alcohol, or untreated emotional problems. Group homes are frequently located in high-crime areas, and persons with disabilities must rely on such risky transportation as buses, taxis, and rides from coworkers (Andrews and Veronen 1993). As a special class, persons with cognitive disabilities are entitled to special legal protection from abuse and neglect, comparable to that for children and for the elderly (Tharinger, Horton, and Millea 1990).

Approximately 1 percent of the U.S. population (slightly over 2 million people) have cognitive disabilities (Tharinger, Horton, and Millea 1990). About 87 percent of them will be only mildly affected, acquiring new information and skills only a little more slowly than the average person. The remaining 13 percent, whose IQs are usually below 50, will experience serious limitations in functioning (ARC 1998). The effects of cognitive disabilities vary greatly from person to person, just as abilities vary considerably among people who do not have disabilities (ARC 1998). The ability to function and the level of disability depend on intelligence plus social skills, communication skills, personal independence, self-confidence, daily living skills, and self-sufficiency. The trajectory of sexual development and sexual interest is the same for people with mild cognitive disability as for people without any cognitive disability. However, people with cognitive disabilities oftentimes have fewer opportunities to explore their sexual curiosity and to understand their sexuality (Tharinger et al. 1990).

Worksheet 4.3, continued

Young people with cognitive disabilities are at especially high risk for sexual abuse. Elkins (1986) describes them as having a tendency to be passive, obedient, and affectionate. Youth with cognitive disabilities are aware of cultural norms surrounding coupling and dating. They watch the same TV programs as all youth and have the same desires to fit in, to be valued and accepted, and to be intimate. This places them at risk and makes them especially vulnerable to coercion, since many will do almost anything they believe or are told will help them to fit in with the “normal” crowd. Their emotional and social insecurities raise their vulnerabilities. Having the same sexual drives and development as the general population, and being confronted with a similar variety of sexual stimuli, they respond in the same way; however, their impaired abstract reasoning skills prevent them from perceiving danger and understanding the possible motives of others.

F. Factors Affecting Disclosure of Sexual Assault

Tharinger, Horton, and Millea (1990) present reasons why victims with mental retardation may not want to disclose that they were sexually assaulted, including not wanting to be stigmatized as “vulnerable,” having difficulty communicating, not knowing who to tell, feeling guilty and responsible, being coerced, fearing that they will not be believed, and being willing to put up with the abuse in order to be liked/feel normal/receive rewards. For these reasons, there is oftentimes a delay in reporting.

If made comfortable by an investigation style that follows developmentally sensitive procedures, victims with cognitive disabilities can usually provide reliable evidence leading to the prosecution of offenders. Investigators may need to be reminded that people with cognitive disabilities usually have no impairments in memory. Accounts of what they remember are reliable.

When severe cognitive disabilities exist, the ability to communicate that abuse occurred is often limited. Behavioral and emotional signs of sexual abuse/assault are important evidentiary aspects; however, they are not as conclusive as physical evidence. A cluster or pattern of indicators is sought rather than a single sign.

G. Counseling Victims With Cognitive Disabilities

People with cognitive disabilities need post-assault counseling support as much and possibly more than victims without such disabilities. The following guidelines may help advocates/counselors when responding to sexual assault victims with cognitive disabilities. In the immediate post-assault period:

- Reassure the victim that she is not in any trouble and didn't do anything wrong. Use kind words and gentle actions. Use simple instructions that are easy to remember.
- Allow time to process. A few days off from work or school may be called for so the victim can process what happened and do so with counselors and support people rather than people at work, school, or on the street.
- Assist the victim in deciding whom to tell. Anticipatory guidance is helpful. She will think everybody knows. Tell her, "You may think people know about this, but they don't. No one will know unless you tell them."
- Ask the victim who she trusts and who has helped her in the past when something bad happened to her. For example, "You say Ann has always been a help to you. You trust Ann. It's okay to talk to Ann about what happened. But you might not want to tell the people at your bus stop."
- Help significant others understand the importance of not blaming and of providing positive feedback. Tell them they will need to exaggerate their positive comments and avoid criticism. Victims will pay more attention to negative comments than to positive ones. Help significant others and caregivers understand that the immediate post-assault period is not the time for safety lectures.
- Followup supportive counseling is recommended as with all victims, and may need to include family, significant others, and caretakers.
- Assess for depression.

H. Ability to Consent

When responding to victims of sexual assault, issues often arise surrounding the victim's ability to consent to sexual contact, investigative interviewing, counseling, and medical treatment. Some people lack the cognitive capacity to consent and are considered more vulnerable to sexual abuse and assault. The concept of legal consent is fundamental to protection. It is generally defined to encompass three elements (Andrews and Veronen 1993; Tharinger, Horton and Millea 1990):

1. Having the capacity or aptitude to acquire knowledge and become informed about the nature of an activity.
2. Being informed: Being able to realize the risks and benefits associated with the decision to be made, and the ability to choose a course of action after considering the information.
3. Voluntary behavior: The lack of coercion or force through the entire decisionmaking process.

Worksheet 4.3, continued

Many people erroneously confuse the concept of a vulnerable adult with someone who lacks the cognitive capacity to consent to sexual contact. This is not always the case and can lead to infringing on the rights of people to express themselves sexually. A vulnerable adult is defined by the following criteria (Minnesota Department of Human Services 1997):

- An adult (age 18 or older) who has some type of physical, mental, or emotional impairment.
- The impairment necessitates that regular assistance or service be provided by a caregiver.
- Because of the impairment, the individual cannot protect himself or herself from maltreatment or harm.

The definition and protection of vulnerable adults vary from state to state. It is essential to know what the mandatory reporting guidelines are in your state.

The first step in assessing a person's ability to provide consent involves listening to the victim to determine what the sexual encounter in question meant to her or him. When a person who is vulnerable has been used by someone they liked and trusted, coming to terms with the fact that they were exploited involves not only mourning the loss of that relationship, but also facing their vulnerability and the potential loss of freedom and trust from family and caregivers. Coming to terms with this vulnerability is often a difficult, painful process that takes considerable time and support.

Each state defines ability to consent to sexual contact in their criminal sexual conduct statutes. Ability to consent is influenced by abstract reasoning skills, drug and alcohol intoxication, medications, thought disorders, mood disorders, and the relationship of the offender to the victim (Dexheimer Pharris 1998). Advocates must know the legal parameters of ability to consent to sexual contact in their state. Factors that place a person at increased risk for sexual abuse include dependence on others, social isolation, lack of cognitive ability to fully contemplate and understand the motives of the offender, and lack of education regarding sexuality and abuse prevention.

In determining decisionmaking competence, two very important ethical values are balanced: protecting and promoting the individual's well-being, and respecting the individual's self-determination (Buchanan and Brock 1989). A first consideration is discerning whether or not the person is her own guardian and whether she functions independently in the community. In cases where the person has been deemed legally unable to provide informed consent, it may be necessary to contact a legal guardian to obtain consent to do an evidentiary exam.

If a legal guardian is unavailable, the SANE usually proceeds with evidence collection, acting in what she perceives to be the victim's best interest, and then informs the legal guardian as soon as that person becomes available.

Exams are never done against a person's will. The reason for the exam is explained in terms that victims understand, and their consent is obtained regardless of legal ability to provide informed consent.

People with limited abstract reasoning skills need help in determining whom to tell about the assault and whom they do not want to know about it. Oftentimes, upon returning home or to school or work, people with cognitive disabilities and adolescents freely disclose details of the assault and become revictimized by the attention of those around them. The advocate can assist the survivor by talking through how different people will react, who needs to know, how much to share with whom, and what the possible ramifications are of sharing information. For victims who are unable to imagine other people's possible reactions and who are very verbal, it may be best to encourage a few days off from school or work so they can process their feelings and reactions with family, staff, or counselors rather than with people at work, school, or on the bus.

In considering whether to share information about the assault with other professionals in the victim's life, the advocate weighs the person's well-being with her right to confidential care and need to be in control of who is told. When staff from group homes or other social service agencies are present, it is important to honor the victim's right to confidentiality and discuss with her which information can be shared. Confidentiality should not be broken except when there is a clear need to involve another caring person to protect the victim from additional harm.

4. People With Physical Disabilities

People with physical disabilities also may be at greater risk for sexual assault, especially if they depend on others for personal care. When the offender is someone who is supposed to be in a helping relationship, concerns arise about a loss of services and independence. Victims are left with fear and anxiety over the potential of harm from people on whom they rely for assistance and support, and should be able to trust. This can lead to overwhelming feelings of vulnerability, stigmatization, and depression. When people with physical disabilities are sexually assaulted, they often experience compounded feelings of isolation, powerlessness, low self-esteem, and a sense of being different (Neve 1996).

After having been sexually assaulted, people with physical disabilities respond emotionally in all the same ways as able-bodied victims. They may, however, need to talk through the role they believe their disability played in making them more vulnerable to the assault.

Worksheet 4.3, continued

The advocate/counselor can listen to the victim's concerns and recollections of the experience. Victims benefit from reviewing how force, threats, and coercion are a part of rape, and being reminded that even strong, able-bodied men sometimes cannot get out of the situation and are raped.

Understanding these differences, the advocate has a very important role to play in ensuring the survivor's needs are appropriately met.

In the rush of an emergency response to sexual assault, medical and legal personnel may miss important aspects of the victim's experience. The following examples demonstrate ways in which advocates can work with the medical and legal systems to ensure that victims are properly understood, assessed, and treated immediately after the assault (Stuart and Stuart 1981):

- The advocate can make sure that appropriate interpreters are available to Deaf or hard-of-hearing victims so they can understand everything that is going on around them.
- A blind person may not be able to positively identify her assailant through standard visual means such as a lineup, but her ability to do so is still intact. The system needs to recognize the accuracy of verbal identification: When one sense is impaired, the other sensory systems become more acutely accurate.
- Anxiety almost always exacerbates speech impairments, so victims with such a condition need patient, reassuring questioning. Repeating what the victim has said assures her that her words were correctly understood and frees her from having to start at the beginning each time. If a certain word cannot be understood after several repetitions, asking her to spell it out may be helpful.
- Emotional trauma affects blood sugar levels. For people with diabetes, this can make them appear intoxicated when they are really in a state of medical emergency. People with cerebral palsy also are misjudged as drunk at times. Advocates can ask victims if they are diabetic or what kind of assistance they need, then see to it that their needs are met. It is important that advocates/counselors make no assumptions about the person's ability or disability and instead ask as many questions as necessary (Aiello 1986).

The victim should have total control over what is done to her and should direct any assistance that is provided. (For example, if a person whose body is paralyzed needs to be moved, she should direct who does what in moving her; if a person usually catheterizes herself, the hospital personnel should be encouraged to allow her to do so in the emergency department.) Caregivers must realize that a person with a disability is confronted with the complex interplay of not only the victimization episode, but their disabling condition and the barriers posed by agencies providing services (Aiello 1986).

A. People Who Are Deaf or Hard-of-Hearing

Much post-assault care involves an exchange of information (telling the account of the assault, discussing feelings, discerning whether to file a police report, explaining the evidentiary exam, teaching about common symptoms of rape-related PTSD, sharing means of coping, etc.), so people who are Deaf and hard-of-hearing require sensitive, appropriate care. Deaf is defined as a hearing loss of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication, and gestures. “Hard-of-hearing” is defined as a hearing loss resulting in a functional loss, but not to the extent that the individual must depend primarily upon visual communications (Schumacher and Hung Lee 1997). Deaf and hard-of-hearing people are further handicapped by the limited number of services that provide sign language interpreters. Advocacy programs must have a way to communicate with people whose primary means of communication is signing. The program also should provide access to a TTY/TDD (teletypewriter/telecommunications device) for Deaf and hard-of-hearing people to call.

The following guidelines for caring for people who are Deaf and hard-of-hearing were compiled by Kathy Schumacher, edited by May Hung Lee and published in the Minnesota Coalition Against Sexual Assault Training Manual (1997).

If a Deaf or hard-of-hearing woman seeks services, she will have the same basic needs and fears as a hearing woman. She needs to feel welcome. Motion her to follow you to a quiet office. Tell her your name. Write it down on paper if she does not seem to understand. Ask if she would like an interpreter and which kind (there are sign language interpreters as well as oral interpreters). At her request, let her know (on paper, if necessary) that you will call for an interpreter.

- It is important to have the Deaf and hard-of-hearing woman’s attention before speaking. Since she cannot hear the usual call for attention, she may need a tap on the shoulder, a wave of the hand, or other visual signals.
- If she is wearing a hearing aid, do not assume she will have good hearing.
- Never ask if she can read lips and use it as a means of communication. Stress affects a person’s ability to attend to details, and even under optimal conditions lip reading provides about 30 percent accuracy in interpretation, which is not acceptable in a post-assault situation.
- Whether she independently indicates that she can read lips or not, body language and gestures help with communication. Write down anything she has trouble understanding. Be sensitive to the fact that she is closely observing your body language and will pick up on your frustration. Try to relax and to help her relax.
- Do not speak to a Deaf and hard-of-hearing person with your back (and thus, her face) to a light, window, or mirror. Have the light in your face, not hers.

Worksheet 4.3, continued

- Every Deaf and hard-of-hearing person communicates in a different way. Some speak; others use American Sign Language (ASL); and others use a combination of sign language, finger spelling, and speech. Some people use body language and facial gestures.
- Just as each individual has a speaking style, grammar usage, vocabulary, and favorite idioms and clichés, Deaf and hard-of-hearing people have individualized ways of speaking in sign language.
- Often, enlisting a sign language interpreter will be your only way to communicate effectively with someone whose primary language is ASL, which is not the same as English. The interpreter is trained to recognize and use similar signs as the Deaf and hard-of-hearing person.

Examples of ASL written out would be: Movie last night. Wow good. Should see you. Laugh roll. (Translated: “The movie I saw last night was very good. You should see it. I laughed so hard I was almost falling on the floor.”) Or: Home many problems. Not good my house. Want out finish trouble. (Translated: “There are a lot of problems at home. My house is not a pleasant place right now. If my husband/boyfriend/partner leaves, the trouble may stop.”). To someone familiar with sign language, this manner of expression is quite clear. To someone who is not, however, word for word interpretation is not always understandable.

- Maintaining eye contact with the Deaf person helps convey the feeling of direct communication. If the interpreter is present, continue to talk directly to the Deaf person. Do not use phrases such as “Tell her that. . .” Speak directly to her.
- People with some hearing loss find it is hard to hear in the presence of background noise, so be sure to move away from such noise.
- If she does not understand, change the wording. Use other expressions to get the same point across. Do not repeat the same phrase over and over.
- Ask her to let you know what to do to better enable her to understand you. Her hearing ability will vary with rooms, background noise, fatigue, and other factors.

B. People With Visual Impairments

People with impaired vision usually do not need assistance in familiar surroundings but do when they are at the hospital or clinic being examined, the police station filing a center for receiving advocacy counseling, the district attorney’s office, and in the courtroom.

- Talk about everything being done around them and provide verbal orientation to the surroundings.
- Before you touch them, explain that you will be touching them, how, and why.
- When moving from one room to another, offer your arm to grasp above the elbow for guidance. Verbally point out obstructions. Always tell them when you are leaving the room. If the survivor has a guide dog, do not be diverted by it or ask about the dog's reaction to the assault; this distracts blame from where it belongs, with the rapist (Erb 1996).

C. Providing Barrier-Free Services

There are a number of ways in which victim service agencies can assure availability of care to persons with disabilities, including (Andrews and Veronen 1993):

- Public awareness activities that target people with disabilities.
- 24-hour availability of appropriate transportation, interpreters, communication assistance, and public transportation for emergency intervention.
- Physical accessibility of all facilities.
- Designated personnel who are trained to respond to victims with disabilities at survivor services agencies.
- Designated personnel trained to monitor risk reduction and respond to victims at agencies serving people with disabilities.
- Adaptive services by medical practitioners, psychotherapists, and others so special needs are met (for example, home-based crisis and recovery counseling).

5. Older Victims

National statistics for victims of rape over age 50 vary from 4 to 7 percent (Tyra 1993). For victims 65 years of age or older, Department of Justice statistics show the 1990 reported rape rate to be 10 per 100,000 versus 41 per 100,000 in the general population (Tyra 1993). The effects of assault on older victims are well documented. Victims over age 50 are more likely to suffer physical injuries (Muram, Miller, and Cutler 1992; Ramin, Satin, Stone, and Wendel 1992). The physical, financial, and psychosocial costs of rape are perceived as more severe by older victims (Andrews and Veronen 1993).

Worksheet 4.3, continued

Older victims experience more pain, soreness, and exhaustion, and are at increased risk for STIs. The assault may exacerbate chronic conditions already present, such as high blood pressure, arthritis, gastrointestinal upset, urinary tract disturbances, heart disease, diabetes, and dementia. Older victims of sexual assault also are more likely to suffer genital trauma. In a study comparing 129 post-menopausal women over age 50 with 129 women ages 14 to 49, all of whom had been sexually assaulted, Ramin, Satin, Stone, and Wendel found that the older women came to the emergency department sooner after the assault, had significantly more genital trauma (43 percent versus 18 percent), were more likely to need surgical repair of vaginal lacerations (5 percent versus 0 percent), and had suffered less nongenital trauma (49 percent versus 66 percent). Another study done by Muram, Miller, and Cutler (1992) compared 53 women age 55 and over to the same number of women ages 18 to 45. They found that the two groups differed in the following areas: The older women were more likely to have been the victim of a previous sexual assault (25 percent versus 9 percent), whereas, in their most recent assault, they experienced fewer instances of genital injury (13 percent versus 51 percent) and required less surgical repair (6 percent versus 28 percent). Moreover, they were less likely than the younger women to have been raped in their own home (36 percent versus 72 percent) or raped by a stranger (57 percent versus 79 percent).

A. Men Who Rape Older Women

Studies show that, for men who raped older women, these women represent authority figures against whom they wanted revenge (Tyra 1993). These rapes were more likely to be brutal and involve more severe psychopathological processes (Pollack 1988). Groth (1978) reported on a sample of 30 sex offenders who selected victims over age 50, and found these rapes to be exceptionally violent and more an issue of hostility than sexual on his interviews with male rapists, Groth also suggested that the sexual assault of older women was even more underreported than sexual assault in general.

B. Sexual Assault in Extended Care Facilities

People with impaired cognitive functioning or who live in a group living situation or long-term care facility are especially vulnerable to sexual assault. Their risk increases as a result of communication and physical impairments and isolation from family and friends, which result in a reduced ability to protect themselves from sexual assault and to disclose it, should it occur. Rape often goes undetected in health care facilities because health care professionals overlook the signs. Those working in facilities with large populations of older women need to be educated about the symptoms of sexual assault and how staff should respond when an assault is suspected. Health care facilities should have a policy in place for responding to allegations of sexual assault. When an assault occurs, the appropriate governmental adult protection agency must be notified.

They, in turn, must report the incident to the state regulatory agency, which conducts an investigation into failure to meet standards of practice. This investigation does not replace the law enforcement investigation for criminal sexual conduct.

When someone who is cared for by a state-licensed agency is sexually assaulted by a person from that agency, a criminal report may be filed by the victim; however, the SANE or advocate may be mandated reporters, in which case they need to ensure that the appropriate agency received a report of the abuse to investigate misconduct and/or failure to protect.

C. Traditional Beliefs Affect Reporting and Recovery

Even though research shows there is no upper age limit to sexual activity and that a significant proportion of older people remain sexually interested and active, sexuality in later life is often seen as a taboo topic (Benbow and Haddad 1993). Because of the era in which older victims were raised, they may experience difficulty and embarrassment talking about sexual matters. Sodomy and oral copulation may be especially traumatic to older women, yet they may be reluctant to mention it. Asking specific questions is often necessary to open the door for the survivor to talk. Older people may be more likely to hold traditional beliefs and misconceptions of rape, which may limit or slow their recovery. People age 70 and over grew up in a time when sexual involvement outside of marriage was regarded negatively, so much so that some unmarried women were placed in institutions if they became pregnant. Rape was seen as a sexual crime in which the woman was to blame for inciting her assailant (Benbow and Haddad 1993). Older victims need to hear that they did not do anything to bring this on, and that any embarrassment or shame belongs to their assailant.

D. Exacerbation of Grief and Loss

Older victims may experience exacerbated grief and loss related to their sense of diminished physical capability and increased sense of vulnerability. While still attending to the victim's grief and loss, advocates/counselors can remind them that all victims experience these feelings and that even healthy young men get raped.

Some older people may be quite isolated, having lost members of their support systems to death or relocation. If a partner or friend recently died, that person's absence will be more acutely felt as the rape intensifies the victim's loneliness.

On the positive side, other older people may have extended systems of support who will be outraged at the victimization of an elder and shower the victim with helpful emotional and physical assistance.

Worksheet 4.3, continued

E. Older Women Raped in Their Homes

With the vast majority of older women who are raped, the rape occurred in their own home by a stranger who gained access. Many of these women need to move in order to regain their emotional sense of security. For someone who has lived most of her life in one place, who loves her home and/or whose children have an emotional attachment to the house, a move can cause great turmoil and grief. Victims benefit from assistance in making sound decisions about what is best for them. If they decide to stay in their home, they can get help in developing a plan to reclaim their home as a safe place, and one where they are not constantly reminded of the assault. It may involve improving security, rearranging furniture, changing decor, reclaiming the space with a gathering of good friends, etc. Women on fixed incomes may need financial assistance to make such changes. Crime victim reparation boards are an excellent resource in most communities.

Such assistance, however, must be balanced with the woman's need to be in control of her own recovery and to preserve her sense of dignity, which has been threatened by the assault. From a practical perspective, she may need assistance replacing broken locks and stolen items, especially credit cards; repairing broken windows and doors; and collecting emergency funds on which to live. The advocate can stress that, as a victim, she should not have to pay the price of the assailant's actions; she deserves assistance.

Transportation to followup medical visits, counseling sessions, groups, and court dates also may be an issue. Victims who are isolated in their homes may benefit greatly from home visits. Well-meaning relatives may wish to place an elderly family member who has been raped in a care facility, which greatly limits the victim's independence. The advocate can help older victims and family members make plans that maximize the person's autonomy yet assure her safety.

F. People With Dementia

People with dementia, or loss of intellectual functioning, pose a significant challenge to members of the SART. Their level of orientation and attachment to reality affects how they perceive an assault and how they heal from the trauma, as well as their ability to communicate what happened and when. When you first meet someone in an acute state of trauma, it is difficult to determine if disorientation and confusion are normal for that person or if it is the result of traumatic stress. A sexual assault is very disorienting, even to people who do not have cognitive impairments. The effects of trauma often mimic dementia (forgetfulness, being jumpy, disorientation, etc.). Conversely, caretakers of people with dementia oftentimes misinterpret symptoms of posttraumatic stress disorder (PTSD). When someone is exhibiting disorganized or agitated behavior and showing signs of PTSD such as intense fear, helplessness or horror, these symptoms are often overlooked as normal confusion or anxiety related to the dementia (McCartney and Severson 1997).

When dementia is suspected in a person who has been sexually assaulted, it is helpful to consult someone who knows the victim well to see if the thought processing and behavior being observed are normal for this person. Ask caregivers about the person's behavior and orientation under less stressful conditions. When a caregiver, social worker, or family member is not present after the assault, try to assess the victim's ability to understand what is going on and their ability to give informed consent for any treatment. Medical professionals use several screening tools to detect the presence of dementia, establishing whether the person is oriented to person, time, and place, and whether they can carry out any kind of abstract reasoning skills. After someone is sexually assaulted, it would be an additional assault to start asking her these sorts of questions. However, some of the routine questions that need to be asked give an adequate picture into the level at which the person is functioning. The advocate will get a good sense of the victim's level of orientation by listening to answers to questions about where the person lives, when and where the assault occurred, who the person usually turns to for support, how the victim thinks specific support people might react, etc.

G. Can People With Dementia Have Consensual Sex?

Caregivers are faced with ethical questions when there has been sexual contact with someone who is clearly disoriented to person, time, and place. Can someone who has dementia engage in an intimate sexual relationship? Who decides what is healthy sexual contact and what constitutes sexual abuse? Benbow and Haddad (1993) draw on the work of Lichtenberg and Strezepek (1990) in attempting to provide a framework to answer these questions. They propose three guidelines for assessing the competency of a person with dementia to engage in an intimate relationship:

- The person's awareness of the relationship.
- Their ability to avoid exploitation.
- Their awareness of possible risks.

Benbow and Haddad propose that these guidelines be applied sensitively and flexibly, and that the concept of substituted judgment be used (what would that individual have chosen to do had they been capable of making a choice?). The employment of substituted judgment requires that the decision be made with thorough knowledge of who the person is and what their value system was before becoming disoriented. Sexual abuse of older people with dementia quite likely occurs more often than statistics suggest, but is neither observed nor reported by the victim. The key to assessing the extent of trauma in people who are disoriented or who are unable to verbally communicate lies in observing behavioral and affective changes. People who have been traumatized will show clusters of intrusive symptoms, avoidance symptoms, and hyperarousal symptoms. It is well known that people with dementia can remember significant events and information. Memory of a traumatic event is multifaceted, with multiple cognitive and affective connections. In people with dementia, the emotional meaning of an experience may be retained when the cognitive meaning is gone (McCartney and Severson 1997).

Worksheet 4.3, continued

Post-assault support of victims with dementia involves caregivers. The focus is on noncognitive interventions, such as providing a safe, calm environment; approaching from in front of the victim and speaking in a soft, nonthreatening voice; touching only in a gentle manner; avoiding any situations that mimic the assault situation; and paying attention to what calms the victim and makes her feel safe.

6. People With Mental Illness or Personality, Mood, and Anxiety Disorders

Four million people in the U.S. are diagnosed as severely mentally ill. If it seems that there are more people with mental illness these days it's because, over the past 20 years, the trend has been to de-institutionalize people and move toward community-based treatment (Malloy 1998). People with severe mental illness are at higher risk for sexual assault (Goodman, Dutton, and Harris 1997). Victims often feel powerless and have trust issues related to past treatment by the legal and medical systems. Advocates/counselors must be aware of the stigma of mental illness and take time to establish communication and a trusting relationship.

People with severe mental illness usually have psychological symptoms that are worse in the post-assault crisis period than in their day-to-day living. For instance, someone who was depressed and anxious before a rape may become severely depressed or anxious afterwards. Someone who was suspicious of others or paranoid will likely be much more so after a rape. The goal of initial post-assault interaction, then, is to establish a safe environment, treat the person with respect, listen with understanding and establish trust. Advocates must remember they are seeing this person when she is under extreme stress.

Goodman, Dutton, and Harris (1997) report that 11 recent studies of women with mental illness have shown rates of childhood physical abuse ranging from 35 to 51 percent, childhood sexual abuse from 20 to 54 percent, adult physical abuse from 42 to 64 percent, and adult sexual assault from 21 to 38 percent. Homeless women with severe mental illness are believed to have much higher rates of abuse and assault.

A. Understanding Psychiatric Diagnoses

Given the high incidence of sexual assault in people who have clinical diagnoses of mental disorders, it is helpful to have a working knowledge of these diagnoses. The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association 1994) describes the following categories of mental disorders that might affect a person's experience of sexual assault.

- **Bipolar Disorder.** Characterized by extreme mood swings. The person may be manic, have a lot of energy, display “wild behavior,” have racing thoughts, need less sleep and be overconfident, then have normal energy and feelings followed by feelings of depression. These periods may last for days or months.
- **Depression.** Characterized by difficulty deriving pleasure from life, irritability, sleeping a lot or hardly at all, a lack of energy, feelings of worthlessness and thoughts of death and suicide. The causes of depression and bipolar disorder are thought to be a biological illness, chemical imbalance in the brain, heredity, stress, or other factors.
- **Schizophrenic Disorders.** A group of disorders marked by unusual thoughts, actions, and emotions. People with schizophrenia often cannot get along with others, and may be unable to take care of themselves. They may not make sense when talking and may have strong fears, hallucinations (experiences of visions or voices), obsessions, and delusions (false beliefs). They often withdraw from everyday life. The causes are thought to be a chemical or hormonal imbalance, genetic abnormalities of the brain, infections, and other factors.
- **Anxiety Disorders.** Consist of fear or anxiety that is severe and lasting. They include general anxiety (tension or irritability that lasts a month or more), phobias (strong fears about an object, place, or situation), panic attacks (sudden fear or terror that causes heart flutters, dizziness, sweating, etc.), and obsessive-compulsive disorders (thoughts, images, or actions that are constantly repeated). Many factors are possible causes of anxiety disorders, including the brain’s inability to control anxiety chemically.
- **Personality Disorders.** These include antisocial personality disorder (pervasive pattern of disregard for and violation of the rights of others beginning by age 15) and borderline personality disorder (unstable relationships, self-image, affect, and marked impulsivity beginning by early adulthood). Personality disorders have a strong association to severe and persistent childhood abuse and neglect.
- **Dissociative Disorders.** Dissociative amnesia is characterized by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be ordinary forgetfulness. Dissociative identity disorder (formerly multiple personality disorder) is characterized by the presence of two or more distinct identities that recurrently take control of the individual’s behavior. Depersonalization disorder is characterized by a persistent or recurrent feeling of being detached from one’s mental processes or body, yet still being able to determine what is or is not real. Dissociative disorders have a strong association with childhood trauma.

Worksheet 4.3, continued

B. Responding to Anxious, Irritable, Disoriented People

When working with someone who is extremely anxious, irritable, or disoriented, the following actions may help de-escalate the situation (Malloy 1998):

- Strive to understand what the experience means to them.
- Use a calm, reassuring tone of voice.
- Provide a quiet, well-lit, safe environment.
- Give an agitated/psychotic patient more personal space than normal.
- Give one direction or make one request at a time.
- Use simple language; repeat proper names instead of using pronouns.
- Speak to the person at their level of comprehension.
- Pace your questions to their responses.
- Reassure the person that they will be safe, then take steps to make certain they will be.
- Maintain eye contact as is culturally appropriate.
- Correct misconceptions.

7. Cross-Cultural Considerations, Refugees, and Immigrants

A. When Cultures Blame or Stigmatize Victims

If a female victim comes from a culture that blames the victim for the rape or does not consider her able to marry once raped, she may deny rape occurred. If married, she may reasonably fear that her husband will blame her and/or reject her if she admits to being raped. Both male and female victims may admit to a physical assault, especially if there are injuries to explain; however, they may deny any sexual contact even when asked directly. This will be problematic to the SANE, the police, and the prosecutor. Valuable evidence will have been lost, and the victim's credibility as a witness will be jeopardized. To facilitate a truthful disclosure early, the victim must be interviewed in privacy and a trusting relationship developed.

Women from non-Western cultures may not seek treatment immediately following a rape, instead waiting until an injury, pregnancy, or sexually transmitted disease forces them to seek medical care. This is true even though they are found to be nearly twice as likely to be raped as women in Western cultures (Howard 1988). Because the consequences of rape within their cultural context are so grave, these women may be in extreme emotional crisis and suicidal. Understanding the meaning of rape in the victim's culture and knowing appropriate, culturally sensitive referral sources is crucial. Strict confidentiality must be maintained, even from family members and staff from the victim's culture (Mollica and Son 1989). The social stigma of people within the victim's community knowing about the assault can be so powerful that it may prevent her from telling what actually happened and getting needed care. The victim needs to have control over whether a professional interpreter is used and, if the interpreter is from his or her community, which one is brought in. Although it is always essential to explain the person's legal right to confidential care, many people from war-torn countries do not believe promises of confidentiality, no matter how confidentiality is explained, because of the extensive use of informants in their home countries. They may even be reluctant to confide in close friends.

B. Working With Interpreters

Employing highly skilled, professional interpreters is an essential component of providing comprehensive services to non-English speaking victims of sexual assault. Interpreter services need to be planned in advance for immigrant groups residing in the area of service. Family members or friends should never be used as interpreters in providing care and collecting evidence. Likewise, followup counseling involves discussing very personal information, and survivors have a right to professional services that allow them to express themselves and fully participate in the healing process. Many programs use the interpreter services of local medical and legal agencies. It is not sufficient to use a bilingual staff person to interpret. Professional interpreters not only speak both languages, but also are trained in how to make a person's message clear and can be held accountable for confidentiality and accurate, unbiased interpretation of what has been said.

Providing interpreter services is legally mandated. The Department of Health and Human Services considers lack of interpretation to be a form of discrimination. Title VI of the Civil Rights Act of 1964 (601 78 Stat 252 942 USC 2000d) states that "no person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

The following guidelines adapted from the Center for Cross-Cultural Health's handbook, *Caring Across Cultures: The Provider's Guide to Cross-Cultural Health Care* (1997), outline important principles in working with interpreters:

Worksheet 4.3, continued

- Briefly meet with the interpreter before the interview to explain the situation and the type of questioning and educating you will be doing. Attend to any personal issues the interpreter may have regarding sexual assault. Discuss how the interaction will proceed and where the interpreter should sit.
- When speaking, address yourself to the victim, not the interpreter. Maintain eye contact with the victim, not the interpreter as appropriate.
- Don't say anything you don't want the victim to hear. Expect everything to be translated. Realize that what may be said in a few words in one language may require lengthy paraphrasing in another.
- Speak clearly in a normal voice and at a pace that's not too fast. Stop at comfortable intervals for the interpreter so she can translate what you are saying accurately and completely. A general rule of thumb is one long sentence or three or four short ones.
- Avoid jargon and technical terms. You may need to repeat what you have said in different words if your message is not understood.
- Meet with the interpreter afterwards to assess how things went and to see if she is satisfied with the accuracy of the information passed along. Attend to any traumatization she may be experiencing from having translated the story of the sexual assault.
- In situations where an interpreter for the victim's language is not available or when the available interpreter is a member of the victim's community and she prefers a stranger, phone medical interpreter services can be accessed. Such services are expensive, however, and nonverbal cues cannot be picked up.

C. Providing Culturally Congruent Care

The way people react to and recover from sexual assault is largely determined by the culture(s) in which they live. An essential part of advocacy/counselor training involves developing competence in providing culturally congruent care. "Culture" does not simply refer to ethnic origin or race; rather, it implies all of the groups and subgroups that surround and support individuals. Culture refers to the learned, shared, and transmitted knowledge of values, beliefs, norms, and ways of life of a particular group. These guide an individual or group in its thinking, decisions, and actions (Leininger 1995). Subculture is closely related to culture and refers to a group that deviates in certain areas from the dominant culture in values, beliefs, norms, moral codes, and ways of living with some distinctive features of its own.

PARTICIPANT WORKSHEETS
Sexual Assault Advocate/Counselor Training

In order to provide culturally congruent care and to be of the greatest assistance, advocates/counselors need the ability to acquire essential knowledge about cultures and subcultures in their service area, and to assess the degree to which each individual ascribes to cultural values and mores governing sexual assault and recovery from trauma. There is a temptation to use a cookbook approach to caring for people from various cultural backgrounds by listing how each individual culture sees sexual assault. While broadly informative, this approach carries the danger of stereotyping individuals and not responding in a way that is comfortable or helpful to them. Advocates/counselors do know the potential differences and similarities between their own culture(s) and the culture(s) of the people they serve. The following process is recommended:

- Analyze your own beliefs and values about your culture and your beliefs about other cultures. Formal cultural assessment guides can assist in this process (Center for Cross-Cultural Health 1997).
- Get to know the cultures represented in your service area. Formal cultural guidebooks provide an overview of different cultures (Geissler 1993; Lipson, Dibble, and Minarik 1996), but it is best to meet with members of that cultural community who know how sexual assault is responded to within their culture. Listen to their experiences and beliefs surrounding rape, reporting, and recovery. Optimally, you will form a partnership to best serve people from that community. Representatives from all subgroups in the community should be equally represented within all service organizations.
- Become proficient in conducting cultural assessments whereby you assess where each individual is in terms of their unique set of values, beliefs, and lifestyle. This also involves an awareness that clients may belong to subcultures or groups such as gay, lesbian, transgender, and bisexual communities; a subculture of homeless people; the Deaf community; and so on. A good sense of the person's cultural influences can be gained by asking, "How will the people who are important to you react to this assault?" and exploring the meaning of the rape and significant others' reactions to the survivor.
- Listen to how the survivor perceives the ramifications of reporting or not reporting, telling others, etc. In some communities, an adolescent girl who is vaginally raped may be ostracized from the community or no longer considered a good marriage prospect. The limits of confidentiality within the legal system should be thoroughly explained. The advocate must listen to how the young woman feels, what she thinks might happen, and what she wants to do. Victims of color may be reluctant to further stigmatize people of their race, for instance. Many women who have been raped by men from their own racial group face intense conflict by wanting to hold the assailant accountable yet not wanting to send another man of her race to jail. If victims perceive the legal system as racist and untrustworthy, they may fear sending an innocent man to jail for their assailant's crime (White 1994; Wilson 1994). Advocates must be aware of and sensitive to such community dynamics.

Worksheet 4.3, continued

- Be aware of culturally appropriate referral sources for followup care, and develop partnerships with them. In order to meet the myriad needs of sexual assault victims, coalitions should be formed with the various cultural groups in your service area. Get a list of counselors from the cultural group. Culture shapes the way we frame traumatic experiences and how we heal from them. For example, Southeast Asians influenced by Buddhism may believe in “determinism,” which results in the philosophical acceptance of difficult life situations as having a purpose beyond the control or understanding of mortals. Thus, they may reach for a larger lesson to be learned from the experience and not be so overwhelmed by feelings of guilt and shame, instead dealing with the painful situation by using tolerance, denial, or stoicism (Kanuha 1997).

Other cultures may have a specific ritual for healing posttraumatic stress, such as the Navajo Enemy Way ceremony. In this ritual, the family and tribe accept responsibility for the impact of trauma on young returning warriors. A healing ceremony facilitates the processing of war trauma and reintegration into the peacetime community (Marsella, Friedman, Gerrity, and Scurfield 1996). Other Native rituals, such as smudging and sweats, also serve to purify victims from the effects of sexual assault.

Draguns (1996) points out that cultures vary in their intervention of PTSD in the following ways:

- Use of interpretations and their rationale and basis.
- Extent and nature of verbal interaction between client and therapist.
- Role of verbal communication.
- Role differentiation between client and therapist.
- Respective weights of physical, somatic, and psychological distress.
- Role of ritual in psychotherapy.
- Use of metaphor, imagery, myth, and storytelling.
- Nature of relationship between therapist and client.

D. Refugees and Immigrants

Refugees have left their native countries to seek asylum in the United States because it was too dangerous to stay in their homelands. Immigrants chose to come to the United States. In recent years, many men and women came to this country from Southeast Asia, South America, Central America, Northern Africa, and Bosnia as a result of war.

Refugees and new immigrants are especially vulnerable to victimization, more so if they do not have legal residency. Sexual predators assume that people who are undocumented will not report an assault to the legal authorities for fear of being deported.

E. Sexual Torture History

When people who have a history of having been sexually tortured are raped, they not only experience the trauma of the rape but also are vulnerable to a traumatic re-experiencing of the sexual torture. While exact numbers are not available, a review of studies of the prevalence of sexual torture in refugee populations shows rates of 20 to 80 percent (Mollia and Son 1989). In many countries that employ the use of torture to control populations, it often takes place in a room that looks much like an exam room and in the presence of a doctor or nurse. For this reason, being in a closed exam room or near medical personnel after a rape may be anxiety-producing. Likewise, the sex crime investigation interview mimics the interrogation process of the torture that resulted in severe physical and emotional pain. Members of the SART should be aware of this possible history and realize that, because of the devastating nature of the torture experience and its emotional impact, most torture survivors will not readily admit to a history of torture. Extra care must be taken to assure the refugee rape survivor that they do not have to do anything they do not want to do and, if something hurts or a discussion becomes too painful, to let the examiner or investigator know and they will stop. Being in control is essential for people with traumatic histories. Victims need to know why examiners and investigators are doing what they are doing and asking what they are asking. Encourage the survivor to keep her eyes open during the pelvic exam to reduce the likelihood of flashbacks to the torture experience.

Torture survivors who have been raped need to hear that they have sustained no permanent physical damage and that their bodies will heal, if indeed this is the case. As with incest survivors, torture survivors need additional support.

8. Survivors of Childhood Sexual Abuse

When survivors of childhood sexual abuse have been raped, they often strongly re-experience the trauma of their childhood abuse. To what extent will depend on the nature and frequency of the abuse, whether they were believed and rescued from it, and whether the survivor's parents or other adults reacted in a nonhysterical, helpful manner (Ledray 1994). Survivors' reactions depend on the amount of stress and support they have at the time of the assault, and the extent to which the current rape resembles the childhood abuse.

Worksheet 4.3, continued

Followup counseling for people who have been sexually abused as children involves healing from the present rape as well as exploring how the dynamics and trauma of childhood abuse have resurfaced. Issues of self-blame and feelings that they will never get away from abusers dominate the victims' reactions (Ledray 1994). The recovery process becomes multifaceted. Survivor support groups can be effectively combined with individual counseling to aid recovery.

If a person has experienced childhood incest, which is childhood sexual abuse by a close family member, she or he may have a reaction such as self-injury or traumatic re-experiencing of incest. These special reactions are discussed below.

A. Self-injury

Self-injury incest victims, while constituting an extremely small percentage of those who report being raped, are a special subcategory that may make false reports (Ledray 1994). Some victims of incest who have not resolved their childhood trauma may injure themselves and report having been raped in an attempt to relieve their distress and get help. They may have actually re-experienced a painful incest experience in its totality while they were alone, which can be terrifying, exhausting, and overwhelming. This usually occurs during times of stress for the victim, such as following the first disclosure of incest or the recent loss of a supportive loved one, or at the beginning of a new intimate relationship. The SART team must be alert to clues indicating false reports and recognize them as calls for help.

When injury has been self-inflicted, the survivor will usually describe the assailant too vaguely for the described circumstances of the assault. For example, she may describe an assault that involved prolonged torture, yet not be able to even remotely describe the assailant's general height, weight, skin color, voice, smell, distinguishing features, or clothing.

Other characteristics that may indicate self-injury include reports of stalking or of receiving notes telling the survivor how beautiful or terrible she is; superficial cuts or scratches of the neck, inner thigh or inner arm at an angle consistent with the survivor's handedness; an unusual event reported as part of the rape, such as dirt and leaves in the vagina; unusual patterned injuries such as superficial straight patterned cuts intersecting the nipples described as occurring during a struggle; and multiple similar rape reports.

The survivor also may report a history of incest that resembles the current trauma she or he is reporting (Ledray 1994).

Considering the fact that an assault may have been self-inflicted can be uncomfortable for advocates. It helps to remember that, in this person's mental and emotional experience, the assault really happened. When they come to the rape crisis center or the emergency department, they need to be treated with respect. It is the role of the law enforcement officer to determine what actually did or did not happen; the advocate supports the victim in her recovery regardless. The pain she is feeling is real. The crisis intervention she needs is the same as someone who experienced the reported event at the hands of another person. It is quite likely that the victim did in fact experience what she is reporting, maybe many times when she was younger, but no one was there to help her. Comments that focus on what the person is feeling rather than what actually happened are helpful, such as, "What you are telling me sounds terrifying," or, "You must feel really scared."

Helping people who self-injure may be challenging because of their reluctance to follow through with counseling and because survivors who self-inflict injury are usually angry, volatile, and exhibit severe mood shifts with little control over their anger (Ledray 1994). However, the help they get in this crisis may enable them to begin to heal once and for all. Rarely in the emergency situation do people admit that their injuries were self-inflicted. A complete forensic exam should be done by the SANE, and the survivor's injuries assessed and treated. Objective evidence is collected. As with all victims, it is important not to push police notification with those who are uncomfortable reporting. The police will need to establish quickly whether the case is unfounded, which involves a process that can be very disturbing to a survivor in crisis. A mental health referral should be made to a therapist skilled in working with incest survivors. The objective evidence collected by the SANE may be invaluable to the counselor and survivor in the post-crisis period. This evidence will enable the survivor to face what actually happened and eventually discover healthy ways of recognizing and dealing with the pain of past sexual abuse.

B. Traumatic Re-Experiencing of Incest

A person may come to the emergency department reporting a rape after a traumatic re-experiencing of a painful incest experience during a sexual encounter with someone who thought the sex was consensual. The survivor withdrew and dissociated from the partner, was unable to stop the encounter, and emotionally re-experienced the incest. While this experience leaves the victim with acute traumatic stress related to sexual assault, the experience may not meet the legal criteria for rape and be deemed an unfounded case. In these situations, the presence of an advocate to provide support before and after police investigative interviews is essential.

Worksheet 4.3, continued

9. Adolescents

Thirty-two percent of rape victims are between the ages of 11 and 17, and 22 percent are between 18 and 24 years of age (National Victim Center 1992). Survey data of middle and high school students reveal that 12 percent of males and 18 percent of females report a history of unwanted sexual activity, with the majority of episodes occurring between the ages of 13 and 16 (American Academy of Pediatricians 1994). Adolescents respond to sexual assault differently than adults. Muram, Hostetler, Jones, and Speck (1995) found that adolescents are much more likely to delay reporting a sexual assault beyond 24 hours and to have been assaulted in a situation involving drugs and alcohol. They also are significantly less likely than adults to have been injured or to have had a weapon used against them (Muram et al. 1995). This data suggests that sex offenders can more easily coerce an adolescent to submit to sexual contact without using a weapon or injuring them.

A. Minor Consent to Sexual Contact and Medical Care

Adolescents are more vulnerable to social pressure and more likely to draw on denial as their first defense mechanism. For this reason, most states have passed statutory rape laws that make it illegal for people more than a few years older than an adolescent to have sex with them, with the victim's consent not admissible as a legal defense. Statutory rape laws are based on the belief that until a person reaches a certain age, they are legally incapable of consenting to sexual intercourse under certain stressful conditions.

Most states have statutes allowing adolescents to consent for their own care after a sexual assault; however, minor consent laws vary from state to state and advocates should be aware of the laws in their service area.

10. Same-Gender Assaults

A. Same-Gender Stranger Assaults

It is important for advocates to understand the dynamics involved in same-gender assaults. The term "homosexual assault," which is often used in the literature, is not accurate in that the majority of the perpetrators and victims of same-gender sexual assaults are not "homosexual."

The majority of same-gender stranger assaults involve men, usually heterosexual men. When the victim is gay or perceived to be gay and the perpetrator attempts to humiliate or demean him, the assault may be part of a hate or bias crime involving power and control over the victim. Stermac, Sheridan, Davidson, and Dunn (1996) state that antigay violence, or gay bashing, involves ostensibly heterosexual men and men who are conflicted about their sexuality, committing sexual offenses against adult males as a means of symbolically defeating unresolved feelings about their own sexuality.

B. Same-Gender Acquaintance Assaults

The majority of same-gender acquaintance assaults occur as part of a pattern of domestic abuse in same-gender relationships. The rate of same-gender domestic abuse mirrors that of the heterosexual population: about 30 percent (Abbott 1997). It is important for advocates to sort through their own feelings regarding homosexual relationships so that all survivors are treated with dignity, respect, and compassion. All people who have been abused by their partners report the same range of feelings of fear, anger, guilt, depression, and anxiety over their living situation (Abbott 1997).

C. Female Same-Gender Sexual Assault

Although female same-gender assault is rare, it does occur. Women who are forced to have sex with other women experience the same emotional reactions as do women who are forced to have sex with men. They also may go through a process of questioning their sexuality if they are heterosexual or, if they are lesbian or bisexual, experience an increased sense of vulnerability. A post-assault forensic exam is important and may involve the collection of hair, saliva, or vaginal secretions from the victim's body and clothing, as well as inspection for and documentation of injuries.

D. PTSD in Same-Gender Sexual Assault

Both gay and heterosexual victims of same-gender sexual assault are at high risk for depression, hostility, sexual dysfunction, and suicidal thoughts or actions (Coxell and King 1996; Frazier 1993; Koss and Harvey 1991). After being sexually assaulted by someone of the same gender, gay men and lesbian women often feel even more stigmatized and vulnerable, and heterosexual men and women may go through a process of questioning their own sexuality (Abbott 1997).

Worksheet 5.1

Medical-Evidentiary Exam Case Study

You are a victim advocate and have been called to the hospital to assist Pamela, 19, who was raped at a party. Pamela went straight home after the assault. She told her mother what happened. Pamela's mother and father have brought her straight to the hospital. Pamela's father is very angry about the assault and is frustrated that Pamela was at the party. Her mother does not want to leave Pamela alone. Pamela has decided to report to law enforcement, and two officers arrive shortly after you.

What is the first thing you do when you arrive at the hospital?

Pamela wants to know what to expect during the examination. What do you tell her?

While you are waiting with Pamela before the examination, Pamela says she is warm and asks if you will hold her sweater and scarf, which she was wearing during the assault. What do you say? Why?

Who should be in the room with Pamela while the SANE conducts a medical-legal assault history? While the SANE conducts the physical exam? While Pamela speaks to law enforcement?

If you are not with Pamela while she is undergoing a medical-evidentiary exam, what else can you do to help?

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If you are in the room with Pamela while she is undergoing a medical-evidentiary exam, what should you do with the evidence if the SANE/medical professional needs to leave the room? What about after the SANE/medical professional has finished?

You disagree with the tone of the law enforcement officer while he is interviewing Pamela. What do you do?

What kinds of notes should you take during and after your time with Pamela? What issues should be considered when deciding what to write down?

Worksheet 5.2

Drug-Facilitated Sexual Assault

Using the information in the Participant Manual, answer the following questions about drug-facilitated sexual assault.

What drug is most commonly used to facilitate rape?

Aside from the drug referenced in the previous question, what are two other drugs that also are used as facilitators of rape?

What special factors contribute to underreporting of drug-facilitated sexual assault?

Why is urine collection important if drug-facilitated sexual assault is suspected?

What will the SANE do if drug-facilitated sexual assault is suspected?

Worksheet 6.1

Role Play – Kendra and Laura

Role Play: Kendra

Kendra has been raped in her apartment by her date. She has called the rape crisis center and spoken to an advocate, who is now meeting Kendra in the emergency department.

Notes to “Kendra”

You are traumatized and overwhelmed and have difficulty understanding too much information at once. You are interested in receiving a medical-evidentiary exam and medication to prevent pregnancy and sexually transmitted infections, but you do not think you want to make a police report. You haven’t told anyone else about the assault; you want to talk about the experience, but you feel ashamed.

Tips for the Advocate

Kendra is frightened. Your job is to provide support and information. Remember, if someone is acutely traumatized, they may not be able to retain large amounts of information; use your judgment in deciding what and how much is important. Practice verbal and nonverbal ways to demonstrate acceptance, empathy, and support. Normalize Kendra’s response to the rape.

Debrief

When you were the advocate, what information did you give Kendra? What techniques did you use to demonstrate acceptance, empathy, and support?

What did you do well? What would you like to do better?

When you were Kendra, what did the advocate do well? What might she have done differently?

Role Play: Laura

Laura, now 25, was molested by a close friend of the family on several occasions when she was 11. When she finally disclosed the fact, her family met the information with silence, and encouraged her to forget that it ever happened. Laura is periodically overwhelmed with unresolved feelings about the abuse; she is often anxious and/or depressed. She is now in a relationship with a loving, wonderful man of whom she sometimes feels undeserving. She is scared she will lose him because she is so “messed up,” and this has prompted her to call the rape crisis center.

Notes to “Laura”

You love your partner and very much want the relationship to work. You respond well to reassurance, and are interested in options and referral sources; however, your financial situation does not make it possible to receive any high-cost services.

Tips for the Advocate

In a crisis call, try to identify the strength, support, and positive coping mechanisms the caller already possesses. In this case, Laura’s healthy reflexes include her reaching out to get help and her desire to preserve and enjoy her relationship, which provides healthy motivation to deal with past wounding. Address Laura’s immediate feelings of confusion. Practice active listening by restating what Laura says and using her language. Offer hope, because there is always hope. Provide Laura with referrals for individual and couples counseling.

Debrief

When you were the advocate, what information did you give Laura? What techniques did you use to demonstrate acceptance, empathy, and support?

What did you do well? What would you like to do better?

When you were Laura, what did the advocate do well? What could she have done differently?

Worksheet 7.1

Maintaining Healthy Boundaries

Check all of the following that you believe you would be justified doing under certain circumstances.

- Giving a victim your home telephone number or personal pager number.
- Giving a victim a ride to her doctor/counselor.
- Babysitting for a victim while she is at the doctor.
- Letting a frightened victim spend the night at your home.
- Giving food to a hungry victim.
- Lending a victim cab money.
- Taking a homeless victim into your home.
- Leaving a family gathering to meet a distraught victim who insists that you are the only person who can help her, even though you are not officially on call.
- Encouraging a victim to take medications to prevent a pregnancy.
- Telling a victim's parents about the rape on her behalf.
- Giving a fearful victim a ride home from the emergency department.
- Not taking a call for a fellow staff person even though it is important for her to have the time off.
- Discussing the specifics of a case with a friend.

Worksheet 7.2

Personal Self-Care Plan

Spend the next 15 minutes creating a personalized self-care plan that you will use during your advocacy work. The plan might address self-care activities on a personal, professional, and organizational level. Identify at least three strategies for self-care, how often you plan to engage in that activity, and when specifically you plan to start.

Worksheet 8.1

The Effective Advocate Checklist

Think back over this training and identify areas that might be a challenge for you. Create your own Effective Advocate checklist to help remind you of solutions to each of these areas.

For example, if you have a tendency to take on too much, you might remember to...

___ *Ask for help from your supervisor.*

If you are apprehensive about the first time you work with a rape victim, you might remember to...

___ *Restate what the victim has said.*

___ *Use the victim's language.*

I will remember to...

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