

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?



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**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.

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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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