

Module 6: Recovery Education and Skills Training

Purpose

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

Lessons

- The REST Approach.
- Crisis Intervention.
- Education.
- Supportive Counseling.

Learning Objectives

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

The REST Approach

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

- Crisis intervention.
- Education.
- Supportive counseling.
- Skills training.

Crisis Intervention

Crisis intervention is arguably the advocate's most important role. Crisis intervention attempts to deal quickly with an immediate problem; it often is referred to as emotional first-aid designed to stop emotional bleeding. Management, not resolution, is the goal. When performing crisis intervention either on the phone or face-to-face, advocates play a number of important roles, including supporting the survivor however she needs support, normalizing her reactions to the trauma, helping her prioritize and solve concerns, ensuring that she is treated respectfully, supporting her significant other(s), and providing crisis education, referrals, and followup contact as well as future legal advocacy, if necessary.

When Should Crisis Intervention Begin?

Crisis intervention should begin as soon as possible, preferably within the first few hours after the sexual assault. This can be done when the advocate meets the victim at the emergency department. It also can occur over the crisis telephone line when a recent rape victim calls trying to decide if she was raped and to ask what she should do next. It can likewise happen on a walk-in basis at the rape crisis center. Crisis intervention theory generally suggests that the first 72 hours after a sexual assault represent the crisis period. Treatment begun during this period of emotional disequilibrium

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

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

Self-blame was once thought to be self-protective; one theory was it helped victims feel safe in the future. If they took responsibility for the rape by attributing it to something they did, then they could feel more in control, reasoning that they could prevent tragedy by not behaving that way again. In the 1980s, it was even thought that perhaps self-blame should be encouraged.

While this theory seems reasonable intuitively, researchers nonetheless found that victims who blame themselves do not recover faster, but rather become more depressed, with post-rape adjustment worse than for victims who do not blame themselves (Frazier, 1990). Consequently, it is very important to avoid blaming, or even the appearance of blaming, the victim.

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

- Deciding whether to report the rape to the police.
- Concerns about the use of drugs to facilitate sexual assault.
- Deciding if she is ready to label forced sex “rape” and, if she does, what that means to her.
- Fears for her immediate safety.
- Deciding who to tell and how to tell them.
- Confidentiality.
- Deciding where to go after the exam.

- Deciding if she will have a medical-evidentiary exam.
- Fears of media involvement.
- Suicidal thoughts.
- Fear of contracting a sexually transmitted infection (including HIV).
- Fear of becoming pregnant from the rape.
- Shame, self-blame, and embarrassment.

Labeling Forced Sex “Rape”

Rape victims are hesitant to report when they are uncertain if they have indeed been raped. Many things contribute to this uncertainty. When drugs are used with or without their knowledge, victims may have only vague, scattered memories of the events. There are other times when rape victims may not label forced sex a “sexual assault.” If she did not fight back or try to run away, she may blame herself and not label the assault “rape.” She also may blame herself if she willingly kissed the assailant or had previous consensual contact.

Disclosure

Disclosure is an important element of crisis intervention and the first step toward recovery. As Goodman, Koss, and Russo (1993) report, many sexual assault victims never have disclosed the sexual assault to anyone, and many more have yet to label the forced sex “rape.” They may have unexplained somatic symptoms or general depression but remain unaware of the underlying reasons; thus, it is important for medical and mental health professionals to learn to screen for sexual assault. Often, victims do not disclose the rape because they do not want to talk about it; the memories are too painful (Ledray, 1994).

Deciding Who To Tell

Victims need to decide early on who they will tell about the assault and how. This can be more complex and difficult than one might expect, and the factors will vary significantly, depending on the individual. For instance, the adolescent victim who was raped

doing something her parents told her not to do, or perhaps that was even illegal, may be afraid to tell her parents or to report to the police. She will need help working through these initial fears and concerns before she is able to come forth, and she may need support when she discloses. Remember, there is no guarantee her worst fears will not be realized. Some women endure the pain of a sexual assault for years, telling no one or only their closest friends. As a result, they do not get the help they need to heal and instead continue to suffer in silence.

Little data are available on where rape victims who do tell someone about the rape go for support. Because it is well documented that most rape victims never report and many do not disclose the rape, it follows that most rape victims do not get the help they need and deserve.

The low success rates of attempts to follow up with rape victims who were seen in hospital emergency departments have been well documented and are of great concern (Herbert, Grams, and Berkowitz, 1992; Ledray, 1994). In a study of 294 rape victims seen in one emergency department, nearly half—46 percent—could not be reached 24 to 48 hours after their initial visit. After 1 month, 81 percent were unreachable (Herbert, Grams, and Berkowitz, 1992). The researchers caution that good, supportive intervention must be provided in the emergency department because so few victims are available for followup.

In another study of 447 rape victims (Golding et al., 1989), 65 percent reported telling someone about the assault, three quarters of whom found the person with whom they spoke helpful. Of those who told someone, 59 percent talked to a friend, 16 percent to a mental health professional, 10 percent to the police, 9 percent to a physician, 4 percent to their priest or minister, and 2 percent to a rape crisis center advocate. Victims who were the most emotionally distressed were more likely to report to the police and a physician. Though the study showed a low percentage of rape victims confiding in an advocate, the helpfulness of the support they received ranked higher than any of the other five confidants.

These data support Minden's (1989) assertion that you do not have to be a professional counselor to care effectively for rape victims. While sexual assault victims certainly have special needs, and experience and training are necessary when working with them, factors other than expert counseling ability play a significant role.

Ledray (1994) learned that sexual assault victims found it very helpful to have a caring sexual assault counselor in the room during the evidentiary exam, even when the counselor said nothing after introducing herself, but sat quietly by the survivor's side during the exam. Ledray speculated that the sexual assault counselor communicated her empathy and concern nonverbally, and that it was reassuring and helpful for the survivor to know that someone was with her who cared; it did not matter what that someone did or did not say.

Additional Referrals

It also is important to become familiar with community resources such as domestic violence shelters, locksmiths who will change locks in the middle of the night for a reasonable fee, and substance abuse programs that are sensitive to the needs of sexual assault survivors. Your organization already should have this information; if not, you may want to recommend that a resource list be developed and made available.

Establishing a Supportive Relationship

Effective crisis intervention requires establishment of a supportive relationship with the victim. These relationships are characterized by

- Acceptance.
- Empathy.
- Support.

Acceptance can be conveyed

- Nonverbally
 - Maintaining a calm facial expression.
 - Nodding your head.
 - Leaning in toward the victim.
 - Touching the victim on her hand or shoulder.
- Verbally
 - Restating what the victim has said.

- Using the victim's language.
- Allowing and encouraging her to express her feelings.
- By what you do
 - Lack of verbal or nonverbal withdrawal.
 - Listening attentively.
 - Taking time to be with the victim and proceed at her pace.

Empathy can be conveyed by

- Letting her know that you want to understand the situation from her point of view; even if you have been raped, too, you understand that every experience is different.
- Restating the feelings she is expressing in your own words, acknowledging that whatever her feelings, they are normal.

Support can be demonstrated by

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

Education

Destigmatizing Rape

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

Normalizing the Victim's Response

We can normalize the response to rape by providing information about what victims might feel in the days, weeks, even months ahead. We should talk with victims about typical responses before they occur; for instance, letting them know that it is normal to get upset when discussing the rape months and even years later. Rape victims often have feelings or do things after a rape that seem odd, bizarre, or crazy, even to them. Many of these are measures they take to make themselves feel safer, such as carrying a knife in their purse, only sleeping facing the bedroom door, or sleeping with a chair propped against the door. Others are the result of rape-related fears. For instance, if the man who raped them had a beard or wore a red shirt, they may be unreasonably afraid of all men with beards or those wearing red shirts. They may be afraid to go out of their house alone or to stay home alone, and they may be unable to sleep at night.

It is essential to reassure them that whatever they feel, they are not the first; others have felt the same way or have taken the same or similar measures to feel safe. These feelings and behaviors will not last forever; they are a normal response to a traumatic event. It is okay for them to do pretty much whatever they need to do to feel safer the first few days and weeks. Providing information that normalizes victims' responses and symptoms soon after the assault may reduce or prevent depression, anxiety, and PTSD by preventing the development of potentially damaging negative thoughts (Ledray, 1994; Resick and Mechanic, 1995).

Recognizing Avoidance

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

Cognitive and behavioral avoidance must be overcome for recovery to occur. The first step is to help victims understand why the painful process of facing their thoughts, fears, and anxieties is necessary. Other well-meaning individuals in their lives may actually

encourage avoidance. It is best to face these feelings and fears, because not thinking about the trauma does not make the memories go away. These memories will recur. If ignored, memories often come back and affect victims through nightmares, flashbacks, phobias, and other problems. By facing these memories, the victim can get used to them and lessen or eliminate their power over her emotional response. Victims then can see or hear things that remind them of the trauma without experiencing intense anxiety and fear. If victims expose themselves to memories or images of the feared situation long enough, their fears will decrease.

Telling Her Story

We now know that recounting the trauma in detail is one of the most effective treatment methods identified (Foa, 1997). Even victims who do disclose the rape initially may have been discouraged from talking about the details of the assault by well-meaning family and friends.

One of the most widespread beliefs held by otherwise well-informed Sexual Assault Response Team (SART) members is that retelling the account of the assault should be avoided because it is painful for victims and retraumatizes them. While research has yet to be conducted on the long-term impact of immediate and detailed disclosure, it appears that having victims recall the assault in detail may evoke a deep emotional response, including bursting into tears, which may benefit their eventual recovery. In fact, with further research we may find that it should be encouraged, not only because it is important for law enforcement, but initial research indicates that it is one of the most effective treatment approaches available (Foa, 1997; Foa and Rothbaum, 1990).

Encouraging victims to recount the traumatic event in detail is important, as is your response to their recounting. They may fear that if they tell you or anyone the gruesome details of the event, you will see them as soiled, dirty, unworthy—the way they may now be feeling about themselves. Thus, it is essential to show acceptance and reassure victims that, while they may have suffered a horrible, hurtful, and humiliating trauma, it in no way changes their worth as human beings. It is important to let victims know that rape was a crime committed against them, which says a lot about the assailant's character but nothing about theirs, and that advocates will do all we can to help them recover and get on with their lives.

Supportive Counseling

Supportive counseling is crisis specific and includes respectfully listening to victims express their feelings as they become ready to do so, then demonstrating empathy and concern while providing information. It is important to reassure survivors that their responses are normal, they are not crazy, and they will recover (Ledray, 1994; Ruckman 1992). Supportive counseling encourages survivors to face their fears in realistically safe situations as soon as possible and to openly discuss their concerns while the counselor acknowledges that any resistance to doing so is normal and understandable (Ledray, 1994).

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

During the crisis period and beyond it is important to help the victim with practical problems such as

- Getting her something to eat or drink after the oral evidentiary exam is completed (if the rape was oral).
- Finding clothes for her to wear home after the evidentiary exam when her clothing is kept as evidence.
- Getting a shower/cleaning up after the rape exam.
- Explaining the police report process; what it involves and means.
- Obtaining an order for protection.
- Finding a safe place to stay.
- Changing her locks.
- Notifying her credit card offices/bank of a theft.
- Obtaining emergency funds for food and housing.
- Locating or picking up her children.
- Locating a pet or ensuring that it is fed.

- Providing or finding childcare.
- Addressing court issues and concerns.
- Arranging transportation home and to appointments.
- Obtaining telephone (or voicemail) service.
- Making referrals to appropriate medical or community agencies for followup services.
- Dealing with the media.

These or other concerns may need to be resolved before the victim can focus on the rape and comply with the demands made upon her by the criminal justice system. Many programs have special funds that can be used for such services and resources.

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

Advocacy does not mean you will make decisions for her; rather, you will provide her with the information and resources she needs to make informed decisions. It also means providing support, whether or not the victim decides to report the rape.

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

Providing support also means letting her know that you fully expect her symptoms to improve. She will recover; she will not always feel as she does now. Your goal should be to help the victim feel more in control when she leaves than when she arrived.

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 have not 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, she 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, age 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 wounds. 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?

When To Refer Out

Those working in an advocacy or counseling capacity must, for the victims' sake, know their limits. When you first begin working with a victim of sexual assault and throughout your relationship, be aware of signs that she may need professional, indepth counseling, which is probably more than you or your rape crisis center can provide. Referring survivors to mental health professionals for additional evaluation and treatment reveals your strength and good judgement, not a deficiency.

A referral should be made when a victim is

- Actively suicidal.
- Actively psychotic.
- Unable to function in her social or occupational role for more than a few days.
- Exhibiting persistent phobias.
- Actively abusing one or more substances.
- Interested in resolving long-term issues.

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

An actively suicidal victim who refuses to make a verbal contract not to hurt herself requires a referral for immediate evaluation and may, for her own protection, need emergency hospitalization. The same may apply if she is unaware of who or where she is or what day it is. A victim experiencing hallucinations, delusions, or fears that significantly interfere with her functioning also needs to be referred to a professional and may need medication. While it is normal and often advisable for the sexual assault survivor to take a few days or even weeks off from work or school, if she is still unable to return, consider referring her to a professional counselor.

Evaluating Suicide Risk

Whenever you suspect a victim might be suicidal, you must tell her why you are concerned and explain that you have a responsibility to evaluate her further, for her own protection as well as for your legal protection. Evaluation criteria include

- **S** = She states *suicidal* intent.
- **L** = She has chosen a *lethal* method.
- **A** = She has *access* to the method.
- **P** = She has a *plan* of action.

If these criteria are all present, seek professional help on her behalf immediately. If the victim will not cooperate, inform her that advocates have an obligation to call 911 and ask the police to transport victims to an emergency mental health assessment center for evaluation, even if this is against her will. Some rape crisis centers may have a more detailed form, often called a Critical Item Suicide Potential Assessment (CISPA), to help assess suicide risk.

Suicide Risk Scenario

A caller who was sexually assaulted and decided to press charges is apprehensive about the upcoming trial. She sounds despondent, has access to medication, and expresses interest in using the medication to “drift away.” What should the counselor do?

Psychosis

If you suspect that a victim is psychotic, you will want to determine if she is oriented to person, place, and time. Do this by asking her

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

If you think she is hearing voices, ask her if she is hearing voices that you or others might not be able to hear. Confusion can be

caused by a number of factors—such as drug intoxication—other than psychosis. Whatever the cause, she needs to be referred to a professional who can definitively determine her ability to care for herself. If she is incapable of taking care of herself and could legally be considered a “danger to herself,” she needs professional assessment. If you are meeting with her somewhere other than a medical facility where such assessment is available onsite, it may be necessary to have the police place a transportation hold on her so she can be taken to a medical or psychiatric facility for evaluation. If she goes willingly with an adult who agrees to assume responsibility, a hold is unnecessary.

Evaluating Substance Abuse

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

- The victim was using drugs at the time of the sexual assault.
- She comes to a counseling session intoxicated.
- She reports additional substance use.
- She is concerned about her substance use.
- She reports that friends or family are concerned about her substance use.

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

- Assault circumstances are too similar to your own.
- Personality clashes exist between you and the victim or her family.
- The victim's needs are beyond your ability level.
- You are having difficulty maintaining healthy boundaries.

When Is the Victim Considered Recovered?

Certain signs indicate that a victim has recovered and is now a survivor. Koss and Harvey (1991) suggest that recovery involves

- **Control over the memory process.** The individual can choose to recall the events without having intrusive thoughts, frightening dreams, or troubling flashbacks.
- **Integration of memory and feeling.** The victim shows appropriate affect when remembering things.
- **Affect tolerance.** Feelings are no longer overwhelming. They can be recognized and endured without the individual becoming overwhelmed.
- **Symptom mastery.** Symptoms of depression, anxiety, fear, and sexual dysfunction have receded and are tolerable.
- **Attachment.** The individual has reconnected with others, is less isolated, and is once again able to trust.
- **Meaning.** The individual has assigned some tolerable meaning to the trauma.

Skills Training

This section provides information on skills that are effective in helping sexual assault victims recover. In some centers, advocates may participate in specialized training to use some of these techniques to help victims recover. Reading the information contained in this section is not sufficient preparation for practicing these techniques.

Artistic Expression

Victims may express what they are feeling through artistic means such as working with clay, watercolors, finger painting, oil painting, or another medium of choice. There will be great differences in victims' ability to freely express their feelings about the assault or their resulting life through art. Explore with them artistic venues they may have tried in the past and let them decide if this option works for them. Many communities have art shows at the local rape crisis center to display victims' work.

Assertiveness Training

Assertiveness training involves helping victims identify potentially dangerous situations and giving them the skills to make themselves

less vulnerable to these dangers. Assertiveness training can be simple: for example, not smiling at strangers who approach the victim on the street, or not approaching a stranger in a car who asks for directions.

Many rape crisis centers hold seminars discussing ways rape victims can be more assertive in their daily lives. Assertiveness gives them more control over their lives and decreases their vulnerability to many forms of abuse.

Breathing Control

When people experience fearful situations, they respond by breathing very rapidly. Their pulse quickens and they may begin to sweat. This is the usual physiological response to fear or excitement. When rape victims are taught to recognize these signs and control them, they learn to control their responses and to change their physiological experience of fear.

Victims must learn to concentrate on their breathing immediately when they first feel afraid, taking slow, deep breaths, as opposed to the shallow, rapid breaths they are likely taking. It is also helpful to breathe through the abdomen versus the chest.

To teach this, have victims put their hand on their stomachs and breathe in so they can feel the abdomen rise and fall with each breath. Have them fill and empty the lungs fully with each breath. As they do this, have victims count slowly to themselves, “One-one thousand, two-one thousand, three-one thousand,” trying to breathe even more slowly with each breath.

Covert Modeling

Covert modeling is similar to role playing, which we discuss later, except it is done in the victim's imagination. Using this technique, victims are asked to imagine, one by one, the steps necessary to accomplish a desired outcome and then to imagine how they will feel when the outcome is achieved. It is like planning a mental map of what they must do to achieve a goal.

Deep Muscle Relaxation

Fear and anxiety often result in muscle tension, which leads to pain and fear of physical illness. This can result in unnecessary medical

visits, exploratory procedures, and pain and suffering for the victim as well as unnecessary high costs to our health care system. Recognizing the location of this tension early and teaching victims skills such as deep muscle relaxation to relieve it may help prevent further pain and suffering.

One way to relax is to get in a comfortable position, then systematically move through each muscle group, tensing the muscle, then relaxing it. This is usually begun at the head, moving to the toes. Soft music may facilitate the relaxation process. As you do this, identify areas where there appears to be additional tension that does not easily respond. Many audiotapes are available to help learn and practice deep relaxation. Some people have specific places in their body that become tense when they are under stress. For many rape victims, this is the abdomen.

Exposure Desensitization

Fear often is a learned response and can be unlearned. As discussed earlier, exposure to events that cause irrational fear can reduce anxiety and allow survivors to function again in their day-to-day activities. Exposure desensitization can occur in the victim's imagination or in vivo (in reality). To use desensitization

- Have victims make a list of feared situations.
- Work with victims to distinguish between situations on the list that are actually dangerous and should be avoided and those that in reality are not dangerous. Eliminate the truly dangerous situations from the list. It is inappropriate, of course, to desensitize a victim to a truly dangerous situation. For example, walking down an alley alone at 2 a.m. would probably be truly dangerous and hence should be eliminated from the list. When there are truly dangerous situations on the list that victims cannot avoid, help them decide how they can make the situation less risky. For example, a victim may have no choice but to take a bus home from work at 1 a.m. and walk home from the bus stop. Carrying a whistle or mace or taking a self-defense course may make her less vulnerable in this situation.
- Rank the remaining items, putting the least feared at the top. It may be necessary to help victims identify less fearful intermediate steps. For instance, if a feared situation on one

victim's list is "to go out of the house," you may want to have separate items such as

- Afraid to go out of the house with someone during the day.
- Afraid to go out of the house alone during the day.
- Afraid to go out with someone after dark.
- Afraid to walk to my car alone after dark with someone watching from the house.
- Afraid to walk to my car alone at dark with no one watching.
- Teach victims breath control and deep muscle relaxation as described earlier in this module.
- Pick the least feared item and either have victims relax and imagine themselves doing that activity, or actually have them face the feared situation as "homework" while remaining relaxed.

It is important that victims work slowly down from the top of their lists. Each intermediate feared situation should become relatively comfortable before moving to the next level. It is critical that victims not place themselves in situations where they experience such intense fear and anxiety that it reinforces the fear experience.

Guided Self-Dialogue

Guided self-dialogue is a technique that teaches victims to focus on the internal dialogue they have with themselves and to use this to overcome fears and anxieties. Once identified, irrational thoughts can be replaced by rational ones. Because the victim's irrational thoughts often are the source of anxiety, they stay calm by concentrating on rational thoughts.

The first step is identifying irrational, untrue, and negative self-dialogue, which tends to increase fear and produce anxiety. The next step is to identify rational, positive, goal-directed dialogue. Koss and Harvey (1991) suggest that this positive self-dialogue is created in four categories:

- Preparing for the stressor: "I will be able to testify in court because I'll have my advocate there and I can look at her and just tell the truth."

- Confronting and handling the stressor: “The noises I hear at night are normal house noises. All the windows and doors are locked and my dog is sleeping soundly beside the bed. He would wake up if this were a real danger.”
- Coping with feelings of being overwhelmed: “I can do this. I just have to relax, take a deep breath, and take one manageable step at a time.”
- Reinforcing self-statements: “I can do this. If I get afraid I will just _____.”

Journaling

Keeping a journal does not mean the victim must write everything she feels every day. Some victims, especially teens, are afraid to keep a journal because they fear their confidentiality will be violated and someone—a parent, roommate, and so forth—will read the journal. If there is nowhere to keep such a journal safely, they will be unable to be sufficiently honest to make the exercise worthwhile.

Victims often find that putting their thoughts and feelings down on paper helps them clarify what they are really feeling regarding their fears, hopes, and goals. Journaling is also a way to track their progress and see that recovery is indeed occurring.

Poetry

Some victims find a release in writing about their experience and feelings in the form of poetry or prose. Many communities offer adult education classes that teach these skills. Attending such a class can help bring about reengagement in activities with other people as well.

Rational Thinking

This skill teaches victims how their thoughts affect their emotional reactions to events. Irrational, negative thoughts can lead to fear, anxiety, and withdrawal from friends and the world around them. When rational thoughts are substituted, fear and anxiety decrease or are eliminated, and the victim once again is able to engage.

Steps to rational thinking include:

1. Identify an everyday situation that has caused fear or anxiety since the assault.
2. Identify automatic thinking about the situation that caused the victim to become upset.
3. Test the rationality/irrationality of the automatic thinking by weighing the evidence for and against the thought.
4. If the evidence does not support the thought, it can be discarded.
5. The discarded explanation can be replaced by rational thinking, or reformulated.

Role Playing

Role playing gives sexual assault survivors an opportunity to practice the skills they are learning. For instance, if a victim is afraid her mother will be angry with her or blame her for the rape, the survivor can practice possible responses with another person playing the part of her mother. She also can switch roles with the other actor and play her mother. When the other person repeats her “part,” the daughter can see how she might come across to her mother and how she would respond in her mother’s shoes.

Sometimes role playing can be done with an empty chair representing a role rather than an actual person. The survivor can play both roles by changing chairs.

Self-Defense Training

Self-defense training can increase victims’ sense of safety and security, providing actual physical defense skills and helping victims regain a sense of control.

Thought Stopping

Thought stopping is a useful method for getting victims to stop repeating negative thoughts to themselves and thus reinforcing negative beliefs. It teaches them that they have control over their thoughts as well as how to exercise this control.

In this process, a victim is asked to identify and record the negative thoughts they have on a repeated basis; for instance, “The assault is my fault because I asked him to come to my apartment “ or “I’ll never recover.” The client is asked to think the bothersome thought for 35 to 45 seconds, then quit when the care provider says “Stop” in a loud voice. The process is repeated several times, after which victims are encouraged to silently verbalize “Stop” themselves. As soon as they begin to think the bothersome thoughts, clients are instructed to tell themselves to “Stop.”

Advanced Counseling Techniques

This information describes techniques that may be used in your center. These techniques are generally practiced by trained counselors. However, advocates may wish to be acquainted with them to understand some of the options available to help support recovery.

Cognitive Behavioral Therapy

Initially developed by Beck for treating depression, cognitive therapy is based on the theory that people become depressed because of distorted and maladaptive cognitions (Beck et al., 1979). Depression being one of the primary long-term symptoms identified in sexual assault victims, cognitive behavioral therapy (CBT) has been used extensively in this population. Cognitive behavioral interventions rely heavily on exposure methods to reduce fear, anxiety, and other symptoms of post-traumatic stress disorder (PTSD). Many variations of CBT have been used and evaluated for their efficacy in bringing about recovery after rape, including brief CBT, cognitive processing therapy, and stress inoculation training.

Before initiating one of these methods, it is important to screen victims to determine the best means of treatment. Clients in crisis may be too fragile to treat with exposure methods and may need stabilization before treatment. Some clients may be at risk for decompensation, even suicide (Resick and Mechanic, 1995). It is always important to screen sexual assault victims for potential suicide risk, regardless of how much time has passed since the rape (Ledray, 1998; Resick and Mechanic, 1995).

Brief Cognitive Behavioral Therapy

In an attempt to reduce treatment costs and recognize time constraints, brief models using cognitive behavioral techniques have been developed and tested. One example is brief cognitive behavioral therapy, also referred to as brief behavioral intervention (Foa et al., 1991). This limited therapy may involve as few as 4 to 8 hours of clinical contact, including education about typical reactions to rape together with a discussion and training in a few coping skills, such as self-assertion, thought stopping, and relaxation. In a study evaluating this abbreviated treatment model, Foa, Hearst-Ikeda, and Perry (1995) found that 2 months after the rape, the victims who received brief therapy experienced significantly fewer PTSD symptoms, with only 10 percent meeting the PTSD criteria compared with 70 percent of the no-treatment controls. The brief therapy group also was significantly less depressed 5½ months after the rape; however, they did not differ significantly on rates of PTSD.

Cognitive Processing Therapy

Because of the cognitive nature of many of the PTSD symptoms that sexual assault survivors experience, Resick developed a treatment package with a more cognitive orientation. Cognitive processing therapy (CPT) consists of exposure to the traumatic memories, training to challenge these cognitions, and systematically addressing topics specific to rape, such as safety, trust, power, self-esteem, and intimacy, using modules developed for this purpose (Resick and Mechanic, 1995). The goal of this model is to alleviate PTSD and depression by helping survivors fully process the trauma, accept that the event happened, and adapt existing goals to include new information. Resick and Mechanic emphasize the importance of identifying whether the victim is incompletely processing the rape or experiencing faulty logic (for example, “I caused the rape because I was drinking”). CPT is designed to be completed in 12 therapy sessions. Initial studies indicate that CPT significantly reduced PTSD and depression in rape victims, who were compared with a wait-list control group, and that improvements were maintained through a 6-month followup.

Exposure Therapy

Several varieties of exposure therapy have been successfully employed to help sexual assault survivors. Often, the first step that should occur as soon as possible is to have the client verbally recount the traumatic experience. Avoidance only results in greater anxiety and a slower recovery (Muran and DiGiuseppe, 1994). Rothbaum and Foa (1992) suggest that clients be encouraged to tell their stories in their own words during the first couple of sessions, retelling their stories as many as four times during a session. Then, during the third session, they should be encouraged to tell their stories in very specific detail “as if it were happening now.” This recounting is taped, and clients are expected to listen to it daily between sessions. Usually, clients are taught deep breathing to promote relaxation during the process. Clients in exposure therapy also are encouraged to do things they have avoided because such activities arouse anxiety, such as going to parties and clubs with friends.

When comparing exposure therapy with stress inoculation training (SIT), which is discussed later in this module, Foa (1990) found that while both groups were improved at 3 months, survivors receiving exposure therapy continued to improve beyond 3 months, suggesting that exposure therapy may be more beneficial in long-term recovery. However, it should be noted that for the purposes of this study, exposure elements normally included in SIT were eliminated. It is possible that the results would have differed had these elements of SIT been retained.

Prolonged Exposure

In the prolonged exposure treatment model, survivors are audiotaped recounting the sexual assault in the first person to promote emotional engagement. They then are asked to listen to the tape at home between sessions. A type of cognitive behavioral therapy, this method is effective because survivors face their fears in a safe environment. It is especially effective for clients with pervasive anxiety and avoidance and those who dislike feeling a loss of control (Foa, 1997). Foa cautions that this form of therapy should not be used with actively psychotic clients; or those who have severe dissociative symptoms, such as multiple personality disorder, now referred to as dissociative identity disorder (DID); or those who have substance abuse issues.

In Vivo Desensitization

Using this method, survivors usually list situations that cause them fear and anxiety. Truly unsafe situations are distinguished from safe situations; the latter group then is ranked from the least to the most fear- and anxiety-producing situation. Survivors are taught deep-breathing relaxation and assisted in progressively facing the feared situations in their environments. They learn to refrain from moving on to a more-feared situation until they feel relatively comfortable confronting the less-feared situation (Ledray, 1994).

Imaginal Desensitization

This method is similar to in vivo desensitization except that instead of progressively facing the feared situations in real life, clients do so in their imagination and in the safety of their counselor's office or their own home (Ledray, 1994). Imagery, which has been successfully used in the treatment of sexual assault survivors, can be an effective catalyst to maneuver past fear and guilt to repressed emotions (Siegel and Romig, 1988). While family and friends, police, advocates, medical personnel, and counselors have historically wanted to avoid asking victims to repeat their stories over and over again—first to the police, then to the nurse or physician, then to the advocate, and then to the counselor—research now shows that having survivors recount the traumatic event in detail is one of the most effective treatment approaches available (Foa, 1997). Quite the opposite of being avoided, it should be facilitated and encouraged. Well-meaning families and friends may discourage the victim from describing the rape in detail during the crisis period because of the apparent emotional trauma that results and because it can be uncomfortable for them to hear. They may believe it is in the victim's best interest to forget about it and get on with her life; however, research now makes it clear that complete imaginal exposure can extinguish symptoms of PTSD (Foa, 1997; Muran and DiGiuseppe, 1994).

Guided Imagery

Similar to imaginal desensitization, guided imagery is effective in reducing fear and guilt while assessing repressed emotions (Siegel and Romig, 1988). After teaching clients relaxation techniques, counselors have them sit relaxed, with their eyes closed, and

picture a feared image, such as the face of their assailant. They are asked to feel and express the emotions this image evokes while sitting relaxed.

Guided imagery also is taught as a coping skill for survivors to use to help relax and gain control over their feelings on difficult days. In such situations, survivors are taught to relax and imagine themselves in their favorite setting, such as the beach or the mountains (Ledray, 1994).

Flooding

Flooding is basically the same as prolonged exposure. It is imaginal or in vivo desensitization, or exposure to feared cues, and has been highly successful in treating anxiety in Vietnam War veterans (Keane et al., 1989). Using this technique, rape victims are asked to recall the rape in great detail in the first person. This recounting is taped, and survivors are expected to listen to the tape at least once a day between counseling sessions. While an effective technique for reducing anxiety to feared objects in other populations, it is criticized for a number of shortcomings when used with rape victims. This technique can be adversarial initially, creating the potential for a high treatment dropout rate as a result. It fails to address irrational cognitions or to develop coping skills.

Hypnosis

Hypnosis is an altered state of awareness that can be useful in reviving suppressed memories in rape victims (Lohyn, 1993; Siegel and Romig, 1988; Smith, 1991, 1995). It is, however, very controversial because it may result in the suggestion of pseudo-memories of sexual abuse that are not accurate and may damage a court case (Garry and Loftus, 1994; Levitt, 1990). When recommended for treatment, it should not begin until after any legal case is settled (Ledray, 1998).

Stress Inoculation Training

An effective type of cognitive behavioral therapy for sexual assault survivors, SIT was originally developed in the 1970s by Meichenbaum (1985) and adapted by Kilpatrick, Veronen, and Resick (1979) for use with sexual assault survivors. This treatment

model provides survivors with training in a variety of coping strategies; survivors then select the ones they believe will help them overcome their fears and anxieties. The goal is to promote a sense of control in survivors so they can better function in stressful situations. Anxiety is not eliminated but is managed across both situations and stimuli (Resick, 1990).

With this model, survivors usually meet for 12 weekly 90-minute sessions with a counselor. SIT consists of three phases: education, skills building, and application. In the education phase, survivors learn about common reactions to rape and how these fears and symptoms develop. This initial phase also covers the difference between physical, behavioral, and cognitive responses and how they interact. Taught next are a variety of coping strategies to control fear and anxieties.

Survivors receive tapes for practicing the skills at home between sessions. These skills include progressive deep muscle relaxation, deep breathing, role playing, preparation for stressors, controlled breathing, cognitive restructuring, thought stopping, guided self-dialogue, and covert modeling, in which the survivor imagines an anxiety-producing situation, then envisions herself confronting it successfully using the coping skills learned (Foa, 1997; Kilpatrick, Veronen, and Resick, 1982; Muran and DiGiuseppe, 1994). Given the typical time constraints of counseling, a more realistic goal may be to teach only some of the coping skills (Muran and DiGiuseppe, 1994).

SIT has been found to be highly effective in providing victims with skills to control their fears and anxieties (Foa, 1997; Muran and DiGiuseppe, 1994). In a controlled study, Resick and colleagues (1988) compared supportive counseling to SIT and assertiveness training. All were found to be equally effective in reducing fear, anxiety, and depression while improving self-esteem.

Foa and colleagues (1991) compared SIT to supportive counseling and prolonged exposure. They found that all three produced improvement on all measures of PTSD, depression, general distress, and anxiety immediately and on followup. SIT, however, produced significantly more improvement in decreasing PTSD symptoms than did supportive counseling or a wait-list control group. At followup, prolonged exposure was superior in reducing PTSD symptoms. It is also notable that the victims in the

supportive counseling condition were not allowed to talk about their assault. Whenever assault issues arose in counseling, they were redirected to other topics.

Goal Attainment Scaling

Initially developed by Kiresuk and Sherman (1968) as a program evaluation tool, goal attainment scaling (GAS) has been demonstrated to have a treatment facilitation effect (Ledray, Lund, and Kiresuk, 1986). The process of developing goals and determining realistic strategies to achieve them is believed to significantly benefit clients. The survivor gains additional control and experiences positive results toward goal achievement (Ledray, 1988). Today, GAS is more widely used as a counseling tool than program evaluation. When used for counseling, the client determines her goals using the Guide to Goals (GTG).

In a 1-year controlled study of 98 rape victims that used standardized outcome measures, GAS was found to have a significant treatment effect. Ledray (1994) found that survivors using GAS recovered faster and were less depressed, anxious, and angry. They made behavioral changes in the desired direction as rapidly as 2 days after the assault, with the results becoming statistically significant by 3 weeks. In combination with supportive counseling, GAS users did even better, even though the results did not reach statistical significance. This study also resulted in the development of a self-guided GTG specific to the needs of the sexual assault victim (Ledray, 1994).

Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR), or eye movement desensitization (EMD), initially described by Shapiro (1993), has attracted attention recently for use in treating PTSD in sexual assault victims. Its popularity results from its ease of training and the rapid relief it provides, as well as its proponents' assertions that its effects are long-term and that it affects a wide range of symptoms (Shapiro and Forest, 1997). It is reported to be a rapidly effective method of desensitization that can be used in place of muscle relaxation (Wolpe and Abrams, 1991). You must be a licensed counselor in any field to attend the initial 20 eye

movement desensitization and reprocessing trainings. As Shapiro (1993) describes, this method involves the production of saccadic, or rapid, rhythmic eye movements by having a client maintain an image of an anxiety-provoking stimulus, such as her assailant's face, while visually tracking the lateral movement of the clinician's finger 12 to 14 inches from the client's face while her head is immobilized. A set consists of 12 to 24 lateral back-and-forth movements. Sets are repeated until anxiety is reduced or the scene becomes difficult for the client to visualize. One to three individual memories can be treated in a single session. To date, Shapiro is uncertain of the underlying mechanism of this technique, as it was not developed from a theoretical perspective. Nonetheless, she does not feel this detracts from its usefulness. She discovered the technique by accident when she noticed that her saccadic eye movements decreased her own anxiety as she recalled a traumatic incident. Shapiro also cautions that specialized and intensive training is necessary to achieve the highest success rates.

In a case study, Wolpe and Abrams (1991) report that after four sets per visualization, anxiety was significantly reduced and the rape victim had difficulty visualizing the traumatic image. They also report reduced anxiety in vivo after the treatment. In a review of eye movement desensitization used with 22 rape survivors and Vietnam War veterans whose symptoms lasted many years and had yet to be successfully treated, Shapiro (1993) reports that significant results were seen in reducing anxiety and improving their subjective cognitive assessment of distress in one desensitization session. During a followup interview 3 months later, subjects reported that these improvements remained unchanged.

Because EMDR includes imaginal exposure, Hyer and Brandsma (1997) compared EMDR with imaginal exposure and found that the imaginal exposure alone was as effective as EMDR. This suggests that it is the imaginal exposure component of EMDR that alleviates symptoms. In an analysis of 17 studies on the effectiveness of EMDR and the conceptual analysis of its mechanisms of action, Lohr and Tolin (1998) concluded that

- The effects of EMDR are limited largely or entirely to verbal reports.
- Eye movements appear to be unnecessary for improvement.
- Reported effects are consistent with nonspecific procedural artifacts.

They also concluded that, conceptually, EMDR is inconsistent with scientific findings concerning the role of eye movements. They caution that with any new or novel therapeutic model containing an exposure component, the developer must clearly demonstrate that the efficacy does not come entirely from the well-established exposure component.

Sample Suicide Potential Assessment Form

Primary Risk Factors

CURRENT (Consult a psychiatrist or another staff member if ANY ONE of the following factors is present):

1. **Attempt** (+) Present (-) Absent

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

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

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

Secondary Risk Factors

MEDIATING (Consult a psychiatrist or another staff member if, in addition to some indication of increased risk, 7 out of the following 13 factors are present):

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

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

Major Contributing Demographic Characteristics

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

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

Module 6 References

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Module 6: Recovery Education and Skills Training

Purpose

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

Module 6 Objective

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

Recovery Education and Skills Training

- Crisis Intervention.
- Education.
- Supportive Counseling.
- Skills Training.

Crisis Intervention

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

When Should Crisis Intervention Begin?

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

Avoid Blame

- The victim may be especially sensitive.
- Avoid blame or the appearance of blame.
- Victims who blame themselves become more depressed, experiencing a more difficult post-rape adjustment than victims who do not blame themselves.

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Brainstorm Activity

Crisis Issues



Module 6 7

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Crisis Issues

- Deciding whether to report to the police.
- Concerns about the use of rape drugs.
- Deciding if she is ready to label the forced sex "rape."
- Fears for her immediate safety.
- Deciding who to tell and how to tell them.
- Confidentiality issues.
- Deciding where to go after the exam.
- Deciding if she will have a medical-evidentiary exam.
- Fears of media involvement.
- Suicidal thoughts.
- Fear of contracting an STI, even HIV.
- Fear of becoming pregnant from the rape.
- Shame, self-blame, and embarrassment.



Module 6 8

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Supportive Relationship Characterized by

- Acceptance.
- Empathy.
- Support.



Module 6 9

Acceptance Conveyed Nonverbally

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

Acceptance Conveyed Verbally

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

Acceptance Conveyed by What You Do

- Lack of verbal or nonverbal withdrawal.
- Listening attentively.
- Taking time to be with the victim and proceeding at her own pace.

Empathy Conveyed by

- Letting her know that you want to understand the situation from her point of view.
- Restating the feelings she is expressing in your own words.

Support Demonstrated by

- Getting her something to eat or drink (after oral exam, if applicable).
- Reassuring her that the rape was not her fault.
- Reassuring her that whatever she did was "right" because she survived.
- Being sure she has a safe ride home.
- Providing her with information and resources to take care of practical problems and immediate needs.

Destigmatizing Rape

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

Normalizing the Victim's Response

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

Recognizing Avoidance

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

Giving Her Account of Events

- Recounting the traumatic event in detail is important, as is your reaction.
- Let the victims know that rape was a crime committed against them.

Supportive Counseling

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

Supportive Counseling

- Getting the victim something to eat or drink.
- When her clothing is kept as evidence, finding clothes for her to wear home after the evidentiary exam.
- Getting a shower/cleaning up after the rape exam.
- Explaining the police report process.
- Obtaining an order for protection.
- Finding a safe place to stay.
- Changing the locks on her doors.
- Notifying her credit card offices/bank of any theft.

Support and Advocacy

- Obtaining emergency funds for food and housing.
- Locating or picking up her children.
- Locating a pet or ensuring that it is fed.
- Providing or finding childcare.
- Addressing court issues and concerns.
- Arranging transportation home and to appointments.
- Obtaining telephone (or voicemail) service.
- Making referrals to appropriate medical and other community agencies for followup services.
- Dealing with the media.

Victim Needs To Know

- She is not alone.
- When and who to call for help.

Explain Your Role

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

Dyad Role Plays

Participant's materials,
pages VI-12 through VI-15

When To Refer Out

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

Referral Made When a Victim Is

- Actively suicidal.
- Actively psychotic.
- Unable to function in her social or occupational role for more than a few days.
- Exhibiting persistent phobias.
- Actively abusing one or more substances.
- Interested in resolving long-term issues.

Suicide Risk

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

Psychosis

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

Concerns About Substance Abuse

- Drugs were involved in the sexual assault.
- The victim reports additional substance use.
- The victim is concerned about her substance use.
- The victim reports that friends or family are concerned about her substance use.

When To Ask for Assistance

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

Module 6

Questions or comments?
