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

Office for Victims of Crime

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

OVC accomplishes its mission by:

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

Office for Victims of Crime Resource Center

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

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

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

Office for Victims of Crime Training and Technical Assistance Center

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

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

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Table of Organization

Acknowledgments

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The original training was the result of the efforts of sexual assault advocates and Sexual Assault Nurse Examiners (SANEs) across the United States who have dedicated their careers to improving the system response to sexual assault survivors. In particular, it is the result of the efforts of the staff of the Sexual Assault Resource Service (SARS) in Minneapolis, Minnesota, and the Santa Fe Rape Crisis Center (SFRCC) in Santa Fe, New Mexico. It is based upon what was learned from these experts as a result of their efforts.

The original authors were Linda E. Ledray, Ph.D., RN, SANE-A, FAAN, SARS Director; Sharon Moscinski, M.A., LMHC, advocate, SFRCC; and Carla Ferrucci, Executive Director, Minnesota Coalition Against Sexual Assault.

This training was revised in 2014 by Dana DeHart, Ph.D., Assistant Dean for Research at the University of South Carolina's College of Social Work. James Hopper, Ph.D., Clinical Instructor of Psychology at Cambridge Health Alliance and Harvard Medical School; and Stacy Malone, JD and Lindy Aldrich, JD, Victim Rights Law Center, served as subject matter experts for new modules on neurobiology and the brain, male sexual assault, and campus sexual assault,

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

Module 1: Introductions and Overview

Purpose

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

Lessons

1. Introductions and Expectations
2. Overview of the Training
3. Creating a Common Language

Learning Objective

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

Participant Worksheets

No worksheets are required.

1. Introductions and Expectations

Participants have the opportunity introduce themselves by answering the following questions:

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

2. Overview of the Training

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

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

This training will draw on the experience and viewpoints of you, the participants. It will be dynamic and interactive and result in skills that participants will use as advocates/counselors who work with sexual assault victims/survivors.

Your Participant Manual is organized into modules; in addition to being information resources, it contains outlines and learning objectives for each module, instructions for participating in activities and some space for notes. The manual is yours to keep.

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

3. Creating a Common Language

Sexual assault service providers deal with both male and female sexual assault victims. In most cases, gender-neutral plural pronouns such as "they" and "them" are used throughout this training to refer to victims.

However, because most victims of sexual assault are female, female pronouns are occasionally used. Similarly, most advocates/counselors are women, so female pronouns are sometimes used to refer to those filling the advocate role. In the module dealing with male sexual assault, we will of course address all victims/survivors as males.

There are many different definitions of sex-related crimes. These definitions vary across states as well as federal agencies. Below are three definitions of sexual assault or sexual violence.

From the National Institutes of Justice: *Sexual assault* covers a wide range of unwanted behaviors—up to but not including penetration—that are attempted or completed against a victim's will or when a victim cannot consent because of age, disability, or the influence of alcohol or drugs. Sexual assault may involve actual or threatened physical force, use of weapons, coercion, intimidation, or pressure and may include:

- Intentional touching of the victim's genitals, anus, groin, or breasts.
- Voyeurism.
- Exposure to exhibitionism.
- Undesired exposure to pornography.
- Public display of images that were taken in a private context or when the victim was unaware.

From the Centers for Disease Control and Prevention (CDC): *Sexual violence* is any sexual act that is perpetrated against someone's will. This includes:

- A completed sex act (also called "rape"). The CDC's definition of a completed sex act is consistent with the Federal Bureau of Investigation's (FBI 2013) definition of rape as "penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim."
- An attempted (but not completed sex act).
- Abusive sexual contact. The CDC defines this as "intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse."

- Noncontact sexual abuse. The CDC notes that this does not include physical contact of a sexual nature, but rather includes voyeurism, exhibitionism, unwanted exposure to pornography, sexual harassment, threats of sexual violence, or taking nude photographs without the individual's consent or of a person unable to consent or refuse.

From the U.S. Department of Justice (DOJ): *Sexual assault* is "any type of sexual contact or behavior that occurs without the explicit consent of the recipient." Falling under the definition of sexual assault are sexual activities such as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape."

Thus, sexual assault is a broad term that includes a range of acts. In this training, we will typically use the term *sexual assault* as defined by DOJ, but will sometimes use terms such as *rape* and *sexual violence*. To find out more about how sexual assault is defined legally in states across the U.S., see The Laws in Your State published by the Rape, Abuse & Incest National Network (2014).

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

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

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

Training by Request
An OVC Program

Sexual Assault Advocate/Counselor Training

Welcome

OVC

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Training by Request
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Module 1
Introductions and Overview

OVC

OVCTTAC

Learning Objective

Training by Request

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

Introductions

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

  _____.

1-4

Training Goal

To provide advocates/counselors who work with victims/survivors of sexual assault with the skills necessary to provide competent, effective crisis intervention services.

1-5

Housekeeping

- Restrooms
- Breaks
- Cell phones off or on vibrate
- Participant Manual

1-6

Ground Rules And Parking Lot

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

1-7

Use of the Pronouns *She* or *He*

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

1-8

Definitions

- There are many different definitions of sex-related crimes.
- These definitions vary across states as well as federal agencies.
- Sexual assault is a broad term that includes a range of acts.
- In this training, we will typically use the term *sexual assault*, but will sometimes use terms such as *rape* and *sexual violence*.

1-9

Victim vs. Survivor

Individuals determine when the shift from victim to survivor occurs. In this training:

- V*ictim* of sexual assault will be used when discussing the emergency department response and early impact.
- *Survivor* will be used in later periods of recovery to recognize that this is indeed the goal for individuals with whom advocates will work.

1-10

Review of Learning Objective

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

1-11

End of Module 1

Questions? Comments?

1-12

Module 2: What is Sexual Assault Advocacy/Counseling?

Purpose

This module is intended to help you understand your role and responsibilities as an advocate, and the roles of others with whom you will work.

Lessons

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

Learning Objectives

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

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

Participant Worksheet

- Worksheet 2.1, Confidentiality Scenarios

1. Basic Tenets of Advocacy

One of the things that advocacy does is provide victims with information about their options so they can make educated choices (Ledray 1999; Ledray, O'Brien, and Chasson 2011). Advocacy encourages victims to ultimately advocate for themselves while giving them a voice when they are too weak to speak. Advocacy should be trauma-specific, addressing the immediate traumatic event, coping with the event, safety issues, risk of harm to self or others, and other presenting problems.

Crisis intervention should focus on organizing information about the individual and event to develop an action plan and connect the individual to appropriate supports. Supports may including longer term supports for pre-existing life problems such as an abusive relationship, substance abuse, mental health problems, or financial troubles, as these affect recovery and are thus important. It is important to know when to make referrals and which community resources are appropriate for followup counseling (Roberts 2002).

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

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

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

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

2. Overview of Sexual Assault Response Teams (SARTs) and Sexual Assault Nurse Examiners (SANEs)

No single agency can meet all of the needs of the sexual assault survivor. Sexual assault services, medical professionals, law enforcement, and prosecutors have recognized the benefits of collaborating in their work with sexual assault survivors.

In addition to learning to work effectively with victims of sexual assault, advocates must learn to work cooperatively and effectively with those with whom they will collaborate.

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

An empirical review of the effectiveness of SARTs found that these teams improve multidisciplinary relationships among responders; improve legal outcomes such as victim participation in the case, types of evidence collected, and likelihood of arrest and charges; and render victims' help-seeking experiences less traumatic.

However, SARTS do not appear to impact conviction rates or sentence length among those who are charged, and challenges remain in negotiating the SART's multidisciplinary collaborative relationships, addressing conflicting professional goals, and navigating confidentiality limitations across agencies (Greeson and Campbell 2013).

SART membership varies depending on the community and the needs of a particular sexual assault survivor. At a minimum, it should include the sexual assault advocate, medical personnel, law enforcement, prosecutor, and crime laboratory specialist. It may also include domestic violence victim advocates, clergy, and other social service agency personnel.

In some communities, a core group of SART members may respond together in the emergency department, or they may simply work cooperatively to meet the needs of sexual assault survivors and their families/significant others.

The medical professional who participates in a SART is often a SANE. SANEs are specially trained nurses who provide 24-hour-a-day, first-response medical care and crisis intervention to specified emergency departments, medical clinics, community agencies, or independent SANE facilities (Campbell et al. 2005).

SANEs are trained to complete a medical-legal examination of sexual assault victims, taking into account specific medical and emotional needs of the victims, as well as the importance of properly collecting forensic evidence that can be used in legal proceedings.

The SANE concept has been shown to be an effective model for providing better evidence collection and a more sensitive initial medical response to sexual assault victims (Ledray, O'Brien, and Chasson 2011).

A review of medical, legal, and community outcomes of SANE programs found them to be effective in promoting psychological recovery of survivors, providing comprehensive trauma-related medical care, documenting evidence accurately and completely, improving prosecution by providing better forensics and expert testimony, and creating community change by bringing multiple service providers together (Campbell et al. 2005).

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

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

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

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

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

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

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

3. Roles of the Advocate

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

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

Advocates may also provide walk-in crisis intervention; individual, ongoing supportive counseling; or support-group facilitation. However, these roles are less common for volunteers and will not be addressed in-depth in this training.

4. Maintaining Confidentiality

It is important to maintain confidentiality because it is the victim's right, it gives the victim more control and the ability to make informed decisions about whom to tell, and promotes safety of disclosure.

Advocates have a responsibility to maintain confidentiality, to the limits of the law, about each and every case with which they are involved.

Sexual assault may represent a loss of control over one's body and over the ability to choose with whom to be sexual. It is extremely important that the victim be able to retain control after the assault to the greatest extent possible. Deciding who will know about the sexual assault is an important part of regaining control. Maintaining confidentiality is one way to help the victim regain control over who does and does not know that the sexual assault occurred.

Only when victims know the limits of the confidentiality can they make a safe, educated choice about what to tell the advocate, SANE, or counselor.

Sexual assault advocates/counselors in many states have gone to great lengths to get state legislation passed to ensure that their conversations with sexual assault victims are completely confidential and that they cannot be subpoenaed to testify even if the case goes to court.

Advocates must know the limits of confidentiality for sexual assault advocates in their state and communicate these to victims before the victims disclose information (Ledray, O'Brien, and Chasson 2011).

Confidentiality is sometimes restricted based on organizational affiliation, position title, and other factors. For a state-by-state listing of confidentiality restrictions, see The Laws in Your State by the Rape, Abuse & Incest National Network at https://rainn.org/public-policy/laws-in-your-state.

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

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

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

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

The activity offers the opportunity to explore confidentiality scenarios.

Confidentiality means:

- Not talking to the media about the case without the victim's permission.
- Not using the victim's name when discussing the case with coworkers.
- Not discussing cases with your family.
- Not talking about cases on an elevator or in a public place.
- Not using any details of cases, even anonymously, for training purposes.

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

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An OVC Program

Module 2
What Is Sexual Assault Advocacy/Counseling?

OVC
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Learning Objectives

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

Tenets of Advocacy

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

SARTs and SANEs

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

2-4

Sexual Assault Response Teams (SARTs)

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

2-5

SART Membership Varies

- At minimum, sexual assault advocate, medical personnel, law enforcement, prosecutor, and crime laboratory specialist.
- May also include domestic violence victim advocates, clergy, and other social service agency personnel.

2-6

Sexual Assault Nurse Examiners (SANEs)

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

Need for SANEs

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

Teamwork

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

Roles of the Advocate

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

Roles of the Advocate

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

Confidentiality

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

Confidentiality

Issues differ for advocates and SANEs.

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

Ensure the victim knows limits to confidentiality.

2-13

Activity

Law Review

Worksheet 2.1, Appendix A, and Appendix B

- Review the appendices:
  - Background on VAWA 2005, VAWA 2013 and Forensic Compliance
  - HIPAA Privacy Guidelines and Sexual Assault Crisis Centers
- Complete the worksheet.

2-14

Maintaining Confidentiality Means . . .

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

2-15

Review of Learning Objectives

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

End of Module 2

Questions? Comments?

Module 3: Realities of Sexual Assault

Purpose

This module includes an examination of the realities of sexual assault, allowing a deeper understanding of the issues.

Lessons

1. Incidence and Prevalence of Sexual Assault
2. Myths and Facts About Rape and Sexual Assault

Learning Objectives

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

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

Participant Worksheets

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

1. Incidence and Prevalence of Sexual Assault

The activity will help familiarize you with the incidence and prevalence of sexual assault in the United States. The following statistics are from the 2014 National Crime Victims' Rights Week Resource Guide.

The questions and answers from the activity appear at the end of the module.

2. Myths and Facts About Rape and Sexual Assault

The activity explores myths and facts about rape and sexual assault.

Incidence and Prevalence of Sexual Assault in the United States

Source: 2014 National Crime Victims' Rights Week Resource Guide

Q: Approximately how many victims age 12 or older experienced rape or sexual assault in 2011?

A: Victims age 12 or older experienced a total of 243,800 rapes or sexual assaults.

Q: In 2011, what percentage of rape or sexual assault victims were female?

A: In 2011, 85.7 percent of rape or sexual assault victims were female.

Q: In 2011, what percentage of female rape or sexual assault victims were assaulted by a stranger?

A: In 2011, 28 percent of all rapes or sexual assaults were committed by a stranger, 48 percent by a friend or acquaintance, and 19 percent by intimate partners.

Q: In 2011, what percentage of all rapes and sexual assaults were reported to law enforcement?

A: In 2011, 27 percent of all rapes and sexual assaults were reported to law enforcement.

Q: In 2011, forcible rapes accounted for what percentage of violent crimes reported to law enforcement?

A: In 2011, forcible rapes accounted for 7 percent of violent crimes reported to law enforcement.

Q: The Department of Defense published a report on sexual assault in the military in 2012. In that year, how many sexual assaults were reported by military Service Members?

A: In 2011, military service members reported 3,374 sexual assaults, representing a 6 percent increase from 2011.

Q: In 2011, approximately what percentage of reported forcible rape cases were cleared by law enforcement?

A: In 2011, 41.2 percent of reported forcible rapes were cleared by law enforcement.

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Module 3
Realities of Sexual Assault

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Learning Objectives

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

Sexual Assault

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

Activity

Friendly Competition
Worksheet 3.1

3-4

Q: Approximately how many victims age 12 or older experienced rape or sexual assault in 2011? Was it approximately:

A. 57,000
B. 102,000
C. 188,000
D. 243,800

3-5

Q: Approximately how many victims age 12 or older experienced rape or sexual assault in 2011? Was it approximately:

A. 57,000
B. 102,000
C. 188,000
D. 243,800

3-6

Q: In 2011, what percentage of rape or sexual assault victims were female? Was it approximately:

A. 55%
B. 67%
C. 86%
D. 97%

3-7

Q: In 2011, what percentage of rape or sexual assault victims were female? Was it approximately:

A. 55%
B. 67%
C. 86%
D. 97%

3-8

Q: In 2011, what percentage of female rape or sexual assault victims were assaulted by a stranger? Was it approximately:

A. 12%
B. 28%
C. 36%
D. 55%

3-9

Q: In 2011, what percentage of female rape or sexual assault victims were assaulted by a stranger? Was it approximately:

A. 12%
B. 28%
C. 36%
D. 55%

Q: In 2011, what percentage of all rapes and sexual assaults were reported to law enforcement? Was it approximately:

A. 15%
B. 27%
C. 48%
D. 70%

Q: In 2011, what percentage of all rapes and sexual assaults were reported to law enforcement? Was it approximately:

A. 15%
B. 27%
C. 48%
D. 70%

Q: In 2011, forcible rapes accounted for what percentage of violent crimes reported to law enforcement? Was it approximately:

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

Q: In 2011, forcible rapes accounted for what percentage of violent crimes reported to law enforcement? Was it approximately:

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

Q: The Department of Defense published a report on sexual assault in the military in 2012. In that year, how many sexual assaults were reported by military Service Members?

A. 573
B. 1,802
C. 3,374
D. 10,575

Q: The Department of Defense published a report on sexual assault in the military in 2012. In that year, how many sexual assaults were reported by military Service Members?

A. 573
B. 1,802
C. 3,374
D. 10,575

3-16

Q: In 2011, approximately what percentage of reported forcible rape cases were cleared by law enforcement? Was it approximately:

A. 21%
B. 33%
C. 41%
D. 50%

3-17

Q: In 2011, approximately what percentage of reported forcible rape cases were cleared by law enforcement? Was it approximately:

A. 21%
B. 33%
C. 41%
D. 50%

3-18

Activity

Myth or Fact?
Worksheet 3.2

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

3-19

Myth:

Rape is most often perpetrated by a stranger.

3-20

Myth:

Rape is most often perpetrated by a stranger.

Fact:

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

3-21

Myth:

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

3-22

Myth:

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

Fact:

Legal definitions of sexual assault vary from state to state. For the purposes of this training, rape is the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

3-23

Myth:

People cannot be raped by their partners.

3-24

Myth:

People cannot be raped by their partners.

Fact:

People are raped by their partners.

3-25

Myth:

Prostitutes cannot be raped.

3-26

Myth:

Prostitutes cannot be raped.

Fact:

Prostitutes can be and often are raped by "johns" and by "pimps."

3-27

Myth:

Child molesters are all dirty old men.

3-28

Myth:

Child molesters are all dirty old men.

Fact:

These offenders tend to be juveniles or young adults under the age of 30 (Douglas and Finkelhor 2005).

3-29

Myth:

The “stranger” represents the greatest threat to children.

3-30

Myth:

The “stranger” represents the greatest threat to children.

Fact:

Studies show about one-fourth of child victims are victimized by family members, and another 60% are abused by persons known to the child. Only 14% are victimized by strangers (Snyder 2000).

Myth:

Rape only happens to young women.

Myth:

Rape only happens to young women.

Fact:

Elderly individuals can be and are raped.

Myth:

Rape can't happen in same-gender relationships.

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.

Myth:

Men cannot be sexually assaulted.

Fact:

Although men are less likely to report, 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.

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.

Review of Learning Objectives

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

3-40

End of Module 3

Questions? Comments?

3-41

Module 4: The Neurobiology of Trauma and Sexual Assault

Purpose

This module introduces the basic elements of neurobiology and the parts of the brain affected by traumatic situations such as sexual assault. You also will learn about types of drastic survival reflexes and the relationship between assault and memory.

Lessons

1. Brain Circuitry
2. Reactions in Traumatic Situations
3. Drastic Survival Reflexes During Sexual Assault
4. Roles of Brain Circuitries in Trauma, Memory, and Healing

Learning Objectives

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

- Describe the components of the brain related to trauma.
- Explain common ways the brain is affected during and after sexual assault.
- Recognize common ways a traumatic experience may affect a victim's behavior.
- Assist victims in understanding the neurobiology of trauma, when appropriate.

Participant Worksheets

- Worksheet 4.1, Response Scenarios Case Studies
- Worksheet 4.2, How Would You Respond?

1. Brain Circuitry

Sexual violence such as rape and sexual assault is almost always traumatic for victims. The effects of trauma on the brain can be devastating. Most of us do not really understand what happens in the brain when an individual has been the victim of trauma, such as sexual assault.

In this module, we will present an overview of what happens in the brain in a trauma situation. The brain is a truly complex organ, far too complex to cover in detail in this training. You will not need to memorize brain structures or processes. You *will*, however, be introduced to some basic brain circuitries and structures and how they come into play when a traumatic experience occurs.

Some mental health professionals, agencies, or entities may or may not agree with models of the neurobiology of trauma as scientific knowledge, models, and theories are rarely unanimously accepted.

In this module, we will cover several areas of the brain and its circuitry to give you an overview of neurobiology and trauma. As a victim service provider, you should understand some of the basics of how trauma can affect the emotions and behavior of victims of crime. Topics are:

- The prefrontal cortex of the brain – one very important brain region that we will keep coming back to.
- Key circuitries in the brain affected by trauma.
- Emotional and brain responses when confronted with a traumatic situation.
- Traumatic events and memory.
- How victim service providers can use their knowledge of neurobiology to better assist crime victims.

The area in the slide covered by the yellow oval is called the prefrontal cortex.

This part of our brain allows us to control, or at least guide, what happens in evolutionarily older brain regions, especially the parts of the brain responsible for emotions, fear, and stress.

The prefrontal cortex, more than anything else, is the part of the brain that makes us human. The prefrontal cortex helps us hold thoughts and memories in mind. It also helps us manage our emotions and reflect on our behavior.

The prefrontal cortex carries out many important functions in situations that are not traumatic or extremely stressful. It permits higher functioning and allows us to control – or at least to manage – what happens in other brain regions, such as the fear circuitry, much of which we call the "emotional part of the brain" or the "emotional brain."

The prefrontal cortex can directly and indirectly influence the amygdala (uh-MIG-dah-luh), hypothalamus, and other brain regions involved in emotions, stress reactions, and reflexive and impulsive behaviors.

Under normal conditions, the prefrontal cortex allows us to focus our attention where we choose, and do what we choose – consistent with our goals and values – and to do so deliberately. It allows us to do things that we can be mostly conscious of, like reflecting on our emotional reactions or deliberately directing our attention inward, as well outward.

However, the prefrontal cortex can become impaired or even shut down in traumatic situations like sexual assault.

The brain is made up of many circuitries – connected brain areas that work together to perform specific tasks. Some areas may be far away from each other in the brain, but they are connected by fibers that send information in one or both directions. Scientists know much about brain regions and how they interact with each other, both to produce fear and to regulate it. The amygdala is an important part of the brain and the fear circuitry. We will talk more about the amygdala later.

- The fear circuitry plays a huge role in trauma and posttraumatic stress, as in the case of most victims of sexual assault.

- Fear is located in multiple brain areas, not just one brain area.

- The circuitry of fear operates automatically and mostly outside of awareness. Our brains can detect a reminder of a trauma and generate an emotional response and fear behaviors before we know what has happened – and sometimes without us even knowing that our response was triggered by a trauma reminder. For example, the perpetrator of a sexual assault may have worn a yellow sweater during the attack, creating fear in the victim whenever she sees anyone wearing a yellow sweater. She may not even know what caused the fear.

Although most trainings on the neurobiology of trauma focus on fear, the brain circuitry of seeking is extremely important too.

Whenever there is something we fear and want to avoid, we also seek some kind of escape. Often it is a quick fix that does not really solve our problems. This is why you may have encountered victims of sexual assault who have substance abuse problems. Addictions are very common in traumatized people.

When we sense fear, anxiety, sadness, or any unwanted experiences, we want to avoid whatever is threatening. Our brains seek escape.

Seeking, in this sense, does not necessarily refer to craving or attachment, just escape.

As with the fear circuitry, elements of seeking circuitry are not located in just one brain area. And again, scientists know much about the brain regions involved and how they interact with each other, both to produce seeking and to regulate it.

The circuitry of seeking operates automatically and mostly outside of awareness. Our brains can respond to an unwanted feeling or experience and generate seeking behaviors, including addictive ones, sometimes without us realizing we have developed an addictive habit. At the same time, assault victims, no matter how badly they have been harmed, still seek to uphold their values and goals, even if their suffering and symptoms make it difficult.

This upholding of values and goals is something very important about the brain's seeking circuitry that is often overlooked. Not only does it seek addictive escapes, but it also seeks the very best in life and human nature. Everything that we seek – whether it's alcohol, drugs, sex, money, praise, promotions, or upholding our highest values and goals – involves the brain's seeking circuitry.

If people strive to be the best version of themselves and to achieve their goals, but they cannot (including due to the impacts of trauma), they become demoralized.

For example, for those in the military, the values of the military and the ideal of being a "good soldier" are extremely important. Or consider a mother or father for whom being a good parent is a cherished value. Imagine that PTSD symptoms are getting in the way of the ability to do one's job well or to parent effectively.

Whatever our values, we can't help but continually ask ourselves – and even judge ourselves – based on how close or far we are from our ideals and goals, and whether we feel like we're moving toward or away from them. When the answers are "far away" or "moving away" from our deepest values, then we can become discouraged, demoralized, and depressed. This is something that many traumatized people struggle with.

Another circuity relates to satisfaction. It overlaps and interacts with the seeking circuitry. The satisfaction circuitry:

- Produces the feeling of satisfaction when we get what we seek.
- Also central to feeling:
  - Soothed and safe in one's body.
  - Connected to other people.
  - Accepting of difficult experiences (not resigned).
  - Not surprisingly, given what most people know about opiate drugs as powerful pain relievers, as well as the "blissed out" high people get from heroin – a powerful synthetic opiate – this circuitry involves opioid chemicals.

In this slide of the satisfaction circuitry, the purple dots correspond to places where opioid receptors associated with satisfaction are found in the brain. It is difficult to study opioids in the brain, so the satisfaction circuitry is not as well understood as the seeking circuitry. But its existence is well established and new research continues to be done.

Again, this circuitry gives us the feeling of satisfaction that comes with getting what we seek – at least when it is actually satisfying.

It also is critical to feelings of connection between parents and children, and feelings of satisfaction and connection between people in general. It is central to experiences of feeling soothed and safe in our bodies, which are so important for healing from trauma.

The final circuitry we will discuss is called the embodiment circuitry. It includes an area called the insular cortex, or insula, which is beneath other cortical areas. This is an extremely important brain region.

The insular cortex gets sensory data from *all* body systems. If we direct our attention to the feeling of what is happening in our body, the insular cortex is the region that can pass that information on to our prefrontal cortex, where we can notice, reflect upon, and come to understand and accept what is happening in our body. Consequently, this circuitry is a key to healing from trauma, depression, addiction, and many other problems.

The insula receives information about what is happening in the body, including when people are experiencing emotions.

- It allows us to know what it feels like to be in our body, moment to moment.
- It also can help survivors heal from trauma, depression, addiction, and many other problems (covered later in the training).
- The insula lets us be an embodied self – that is, to experience ourselves as a self in a body, and for our subjective experience to be grounded in our bodily sensations. This is different than being "lost in our head," overly focused on thoughts but cut off from our body experiences; and different from experiencing our body as an *object* that looks good or bad, that does what we want or doesn't, or that we try to change – by working out, for example.
- The embodiment circuitry can come into play when the victim of a sexual assault has a drastic survival reflex during the attack.
- Most traumatized people, even though their brain and body are having intense fear and anxiety reactions, are not paying attention to their bodies or doing things to calm and sooth them. Instead, they have confusing thoughts about what the trauma means for them and their life, and what the effects, including those reactions, mean in terms of the kind of person they are.

In short, most traumatized people are not making good use of the insula to help themselves heal.

Although you do not need to be an expert in neurobiology, you'll be better able to understand what a victim needs after a sexual assault if you understand the circuitries of the brain that are related to seeking, satisfaction, and embodiment.

2. Reactions in Traumatic Situations

The amygdala is one of the most important regions of the brain during a traumatic event.

Notice how the arrows from the amygdala to other brain regions are the largest arrows. That means the amygdala has the most central and powerful role in coordinating the brain's responses during traumatic experiences.

Scientists know a lot about how the amygdala controls the brain in traumatic situations, that during traumatic experiences there is a loss of prefrontal cortex regulation and most of the brain's reactions happen automatically and outside our awareness.

The fear circuitry (especially the amygdala) causes several things to happen, including:

- Loss of prefrontal regulation: Chemicals from the brain stem impair (and may shut down) the prefrontal cortex.
- Bottom-up attention: Attention is automatically captured by anything perceived as dangerous or threatening, or as needed for survival.
- Emotional reflexes**:** Reflexes are automatic and include freeze, flight, or fight responses, as well as bodily responses like your heart pounding quickly.

Where did your attention go when this picture popped up?

It was your amygdala, not your prefrontal cortex, that automatically put your attention on the knife. That is what happens during a sexual assault. From the moment the fear kicks in, the fear circuitry, not the prefrontal cortex, is mostly or entirely determining where attention goes.

Attention can latch onto things that, in the moment, the fear circuitry determined were critical to survival. For example, during an attack, a victim might focus on a picture on the wall or a crack in the ceiling to escape from the awful sensations. Later, looking back on the assault, the victim and others – including loved ones, investigators, prosecutors, judges and juries – might not understand why the victim was focused on something inconsequential.

The point is we have no right to second-guess what the fear circuitry focused attention on in the midst of the assault, thus what is encoded into memory. That is just how human brains are wired to respond to being attacked or assaulted, based on hundreds of millions of years of evolution in mammals and the species from which they evolved.

All of this lets us to do things we could not do under ordinary circumstances – so we can survive what we perceive as a life-threatening experience such as encountering a predator.

"Fight or flight" is misleading and gets in the way of understanding how human brains are wired to respond to being assaulted.

That phrase seems to indicate that if someone is "brave," "a real man," or "a true soldier" he or she would react to assault by fighting back, and that only cowards try to escape. But that is simply not how our brains evolved or how they are wired.

We evolved to freeze first, then flee. Even if humans do fight when attacked by a predator, it is not because they want to win the fight; they just want to escape. We evolved knowing that if we fight a big predator that has menacing jaws and sharp teeth or claws we are going to lose. The same applies when the predator is human and carries a gun or knife or other threat.

Sometimes an assault victim may fight back, like a "cornered animal," in a sustained way against a more powerful and/or armed perpetrator. But that is extremely unusual.

It is very important that sexual assault victims and those who work with them understand this, because victims often feel ashamed that they did not fight back. Even otherwise supportive family members and friends may not understand, and may have incorrect expectations for how the victim should have responded – or how they would have responded had it happened to them.

Freeze reaction usually happens at the beginning of a trauma, and is usually brief.

Signs of a freeze reaction in a victim include:

- Brief response, when the victim perceives danger.
- Being highly alert.
- Having a heightened attentional state that is receptive to a wide array of information in the external environment.
- Not moving, because that could provoke or worsen attack, and because that would absorb brain resources that initially need to be focused on assessing the situation.
- Readiness to suddenly burst into action.

3. Drastic Survival Reflexes During Sexual Assault

During the initial freeze response or at any time during an assault, the prefrontal cortex will be affected, impairing rational thought processes. It is the brain's fear circuitry that may automatically determine that escape is impossible. The victim is attempting to escape and survive when there is no apparent (physical) escape.

Looking back later, the victim and others – that is, their prefrontal cortexes – may recognize that escape was possible (e.g., through an open door). But what matters is what the fear circuitry concluded at the time.

When this happens – that escape is **perceived** as impossible – the fear circuitry can trigger some drastic "survival reflexes." Victim service providers should be aware of these survival reflexes in victims because they can affect how the victim sees him or herself after the assault.

One of these automatic survival reflexes over which the victim has no control is dissociation. Dissociation involves disconnections of awareness from emotions and even sensations in one's body. It includes experiences such as feeling like you are unreal, or the situation is unreal, feeling like you're in a fog or a movie, or feeling like you're disconnected from your body.

The quotation is a from a research participant, describing her dissociative experience when reminded of an assault she experienced years before:

"It was silence, looking at her through a glass wall,
so it couldn't affect me, couldn't touch me."

There is currently little data on the biology of dissociation during trauma, although there are a few brain imaging studies on dissociative responses to trauma reminders, i.e., reminders of the trauma that generate an emotional response and fear behaviors.

However, there is definitely evidence that dissociation involves altered functioning of the embodiment circuitry and/or disconnection between the embodiment circuitry and the prefrontal cortex. And this fits with many victims' experiences of lacking awareness of bodily sensations of physical contact involved in the sexual assault and/or bodily sensations associated with emotions the assault is triggering.

When a victim experiences dissociation during a traumatic event, he or she may feel:

- "Spaced out," as if they were not part of what happened.
- Disconnected from their emotions and their body – as though in a dream or a fog, or watching a movie.
- "On autopilot," such that the victim goes through the motions without feeling any sense of control or choice, and only later realizes that they did things they never consciously intended or decided to do. This can mean participating in sex acts, not because the victim choose to, let alone consented or wanted to, but because she or he was in a terrified dissociative state.

Dissociation is a common response to repeated sexual abuse in children, especially when the perpetrator is someone close to the child, and it can become a more habitual response that carries over to all kinds of stressful situation – including sexual assault in adulthood.

But even someone who had no prior history of child abuse may dissociate during a physical or sexual assault as an adult.

Dissociation, especially dissociative autopilot, can be a huge source of shame and confusion to victims. They may be upset with themselves for not resisting and even actively participating in unwanted and terrible sexual acts.

Loved ones, investigators and others my misinterpret dissociative autopilot as consent and willing participation, and perpetrators and defense attorneys may point to such behavior as evidence that there was consent and no assault when nothing could be further from the truth.

Remember, it is critical for you to help victims who dissociated during an assault to understand that this is a brain-based, automatic, survival reflex.

Another survival reflex is tonic immobility. Tonic immobility is a brain-based response that is over 300 million years old. It is found in birds, sharks, and mammals, including humans. The chicken shown here is in a state of tonic immobility, after being restrained by a person. See how rigid its legs and neck are? If someone were to hit its feet or head, they would barely move.

Tonic immobility is different from freezing, in which movement is possible but not engaged in while assessing the situation and avoiding an even more dangerous attack.

With tonic immobility, the victim is actually paralyzed, unable to move and unable to speak or cry out – even if he or she wants to.

Like dissociation, with which it may overlap, tonic immobility happens when escape is or appears impossible. Tonic immobility is understood as a last-ditch, most extreme version of "shutting down" in the face of overwhelming threat or trauma.

An estimated 10-50 percent of victims experience tonic immobility to some extent in both sexual and nonsexual assaults.

The onset of tonic immobility is sudden, usually after a failed struggle; the immobility also terminates suddenly. This reflex response can last from seconds to hours. It does not impair alertness or memory encoding.

Tonic immobility can also overlap with dissociation and may include:

- Trembling or shaking.
- Stiff, rigid muscles.
- Feeling cold.
- Feeling numb to pain.
- Fixed or unfocused staring or intermittent eye closure

Collapsed immobility is another reflex, but it is different from tonic immobility and dissociation. Collapsed immobility results from a massive input to the heart from the parasympathetic branch of the autonomic nervous system, which causes extreme decreases in heart rate and blood pressure, which in turn can cause faintness, sleepiness, or even loss of consciousness.

Consistent with the name, collapsed immobility causes muscle tone to be lost and the body goes limp. If you were to pick up the possum in this picture, the body would be limp and floppy, not rigid like an animal in a state of tonic immobility (Kozlowski et al. in press 2015; Baldwin 2013).

Collapsed immobility often is accompanied by the experience of mental defeat – feeling totally overwhelmed and helpless. It can be triggered by seeing blood, a skin puncture, a knife, or other sharp objects.

Evidence suggests that collapsed immobility is more likely in those who faint while having blood drawn, and like blood phobia, the evidence suggests it is more likely to occur in women than in men.

Also, a significant percentage of animals resort to tonic immobility or collapsed immobility when attacked by a predator. Collapsed immobility is not as common as tonic immobility, but it is not uncommon, either.

Like tonic immobility, collapsed immobility can be a source of confusion and shame in victims, who look back at what happened and think they should have escaped or fought back. It can be disturbing to family members and friends, as well as investigators, prosecutors, judges, and juries. Their confusion can lead to doubt, blaming, and even shaming of victims.

So again, it is extremely important that sexual assault victims who have had these reactions during assault, and those who work with them, understand that these are normal, brain-based responses rooted in hundreds of millions of years of evolution; it is how human brains are wired (Kozlowski et al. in press 2015; Baldwin 2013).

You and the victims you work with are often told by other people that a victim's reported behaviors during the assault "don't make sense."

These are four major responses that lead people – not only friends, family members and partners, but police investigators, prosecutors, judges and juries – to doubt that the victim was actually sexually assaulted.

- Did not resist.
- Made no attempt to escape.
- Did not scream.
- Was an "active participant."

Defense attorneys try to use these brain-based trauma responses to undermine the credibility of the victim, by describing such responses as "evidence of consent."

Sadly, victims themselves often view these same responses as evidence that they were cowardly or weak in their response to the assault.

However, these responses make perfect sense if you understand the neurobiology of trauma responses during assault. As an advocate who has learned that these are completely normal brain-based responses – responses that have been studied by researchers and given names such as dissociation, tonic immobility and collapsed immobility – you can help victims to understand and feel validated in their experiences.

You can teach victims that these are normal, brain-based responses well understood by people who research and work with sexual assault victims. Understanding these brain-based responses may have huge positive effects on victims and their experiences with friends, family members, law enforcement, and the legal system.

Look at the differences in response and brain activity between most perpetrators and most sexual assault victims, who experience intense distress and fear during the assault.

In the typical perpetrator, the prefrontal cortex is in control, definitely more in control than the emotional brain – even if the perpetrator is acting compulsively. So the perpetrator is thinking clearly and able to carry out a planned sexual assault and to use their prefrontal cortex to direct and modify assaultive behaviors that are practiced, even habitual.

For the victim, the fear circuitry has kicked in, and the victim is terrified and overwhelmed. Thoughts are driven by the perpetrator's actions. Behaviors are controlled by emotional reflexes – and sometimes partly by habitual responses to aggression and domination first developed in childhood.

The activity explores survival reflexes.

4. Roles of Brain Circuitries in Trauma, Memory, and Healing

What happens to memory during a traumatic situation? Why are some sexual assault victims unable to recall what happened, or why do they remember some things and not others?

During trauma, the brain releases high amounts of stress chemicals. The amygdala is also very active, so there is strong encoding of emotional and sensory memories. The prefrontal cortex is impaired, including the language production area (Joels et al. 2012).

The function of the hippocampus also is altered, resulting in the following effects:

- The context of the assault and the elements of the event are poorly woven into a whole.
- The sequence of events is poorly encoded.
- Emotional memories however, are well encoded, especially for experiences surrounding the onset of fear/terror (e.g., when the victim realized she or he was being or going to be sexually assaulted).

  (Joels et al. 2012)

What we pay attention to largely determines what gets encoded into memory. During states of intense fear and distress, in which the prefrontal cortex is impaired and attention is determined by the fear circuitry, "bottom-up" attention latches onto specific stimuli. When this happens, there is much less encoding of more complex contextual information, such as how objects are arrayed in a room, or how events are sequenced over time (Joels et al. 2012).

Knowing this can help advocates and victims understand why assault memories are often fragmented and missing information about how a room was configured or the exact sequence in which things occurred. Even though the victim and others (including investigators, attorneys, judges, and juries) may believe the victim "would have to" remember how certain things were arrayed in space and time, in the midst of a traumatic assault the victim simply was not noticing or encoding such information.

For all these reasons, memories of sexual assault tend to be fragmentary images, sounds, and body and other sensations, as well as strong emotions like disgust and horror.

Traumatic memories have few peripheral details (because those were things given little attention or memory encoding resources), little or no time sequence information, and little or no words or narrative, especially soon after the trauma and early in recovery.

Exactly how are traumatic memories encoded? And how does the brain affect the kinds of memories assault victims have later, including when meeting with investigators and prosecutors and testifying in court?

Remember, during a sexual assault the fear circuitry takes control of the brain's response. The fear circuitry impairs the prefrontal cortex and releases stress hormones that impact the body and brain.

The combination of fear circuitry control and prefrontal cortex impairment leads to bottom-up attention, i.e., attention that is automatically captured or focused on those aspects of the experience that the fear circuitry perceives as dangerous, threatening, or essential to survival and coping.

Fear circuitry and the stress hormones change the way the hippocampus functions. Importantly, the hippocampus is a key structure for encoding memories. It weaves together details and contextual and time information. During a traumatic experience, the hippocampus is altered in ways that decrease the encoding of most of what is happening, especially contextual and time information (Schwabe et al. 2012; Joels et al. 2012).

The focus on danger from bottom-up attention and the altered hippocampus cause the victim's memories to be fragmentary. The memories that are retrieved can be unpredictable, incomplete, and disorganized. However, some aspects are often recalled accurately, such as the onset of fear, central details, survival reflexes, and other "islands of memory" (Schwabe et al. 2012; Joels et al. 2012).

In these "islands of memory," the micro islands contain fragmentary sensations, and the larger islands contain key periods of memory during the assault. These key periods include when fear kicks in, typically right before, during, and after the onset of the assault.

For that initial phase, contextual and time sequence information may be very well encoded (sometimes even especially so, if it seemed like everything was happening in slow motion).

These islands also contain memories that were part of the survival reflexes – freezing, dissociation, tonic immobility and collapsed immobility – or the shift from one reflexive state into another one; for example, moving from dissociation into collapsed immobility just before becoming dizzy or passing out.

In addition to the assault itself, alcohol and drug usage can affect an assault victim's memory.

A low to moderate dose or level of intoxication impairs the ability of the victim to encode the context of the situation, but it does not impair the victim's coding of sensation.

A high dose or level of intoxication impairs both context and sensations, and in a severe blackout, no information is encoded at all. The victim remembers nothing (Bisby et al. 2009, Bisby et al. 2010).

The state of the brain at the time of remembering affects which encoded aspects of the memory will be retrieved. For example, if a victim feels unsafe and judged, for example, by a police investigator who doesn't understand the impacts of sexual assault and doesn't believe the victim, then he or she may not be able to use their prefrontal cortex to understand questions and retrieve the memories the investigator wants.

On the other hand, if the victim is feeling traumatized by remembering and/or by the investigator, this may trigger the automatic retrieval, in a bottom-up way, of fragmentary sensations and emotions that are nearly as intense as the assault itself.

Even under the best of conditions, someone who has been assaulted is likely to have a hard time putting the fragments that they can remember into words, let alone into a coherent story.

To make things even more complex, someone may remember in a dissociated way – which can be how they experienced the original trauma, or a response to remembering it this time – and that involves its own impairments and problems.

For example, the more dissociated someone is the less activated their embodiment circuitry tends to be, and the less the memory feels real, true, or valid to them. And this can be contagious: If someone is talking about a terrible trauma but it sounds like they are reading a grocery list, it can cause the listener – including a victim advocate, police investigator, prosecutor, judge, or jury member – to doubt the reality of what happened and the credibility of the victim.

In short, the state of the brain during remembering is going to powerfully shape the remembering experience, and this can have very significant consequences – especially if people involved do not understand that these are normal experiences and behaviors caused by how the brain responds to trauma.

Because the language areas of the brain are impaired or shut down during trauma, the memory may have few words, or no narrative or "story" associated with it – at least at first, before the victim begins healing from the trauma and is able to add words and tell it as a story, however incomplete.

Traumatic memories are often associated with powerful emotions with little or no language. Therefore, when victims of sexual assault try to remember the trauma, they often have trouble. However, those memories can pop up later, when they do not expect them or want them.

Also, because of the associative nature of memory and the strength of associations made during a trauma, all kinds of things can get linked to the trauma. Thick eyebrows like the perpetrator's, an angry or threatening tone of voice, maybe walls the color of those in the room where the assault took place – all can trigger remembering, including the emotional reflexes linked to it.

In short, life can become a minefield of potential trauma memory triggers.

When you have some knowledge about just how profoundly neurobiology contributes to a victim's trauma, you'll have a much better understanding of why victims of sexual assault respond the way they do – why their memories are fragmented or incomplete, why they may have appeared to "cooperate" during the assault, or why other behaviors that might at first seem to "make no sense" are actually normal (or at least not rare) brain-based responses.

You will understand why victims need to feel safe talking about such experiences and to be understood as having responses and memories that totally make sense.

Your empathy for the victims will empower them. Victims that feel safe are more cooperative, more able to remember, and more willing to report. Your deeper understanding of the experiences of victims will also make it easier for you to determine the victims' physical and psychological needs, and to assist them in court and in meetings with the prosecutor if they do choose to report.

The activity explores responses to survival reflexes.

Training by Request
An OVC Program

Module 4
The Neurobiology of Trauma and Sexual Assault

OVC
OVCTTAC

Learning Objectives

- Describe the basic components of the brain related to trauma.
- Explain common ways the brain is affected during and after sexual assault.
- Recognize common ways a traumatic experience may affect a victim's behavior.
- Assist victims in understanding the neurobiology of trauma, when appropriate.

The Brain…

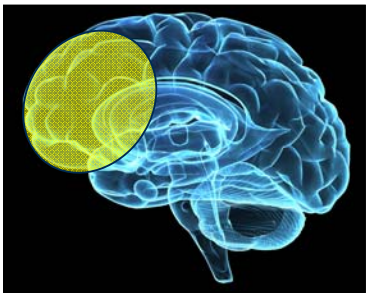
Disclaimer

Please note that some mental health professionals, agencies, or entities may or may not agree with models of the neurobiology of trauma as scientific knowledge, models, and theories are rarely unanimously accepted.

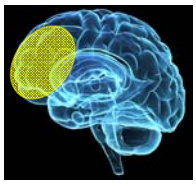
Module Overview

- The prefrontal cortex of the brain.
- Key circuitries in the brain affected by trauma.
- Emotional and brain responses when confronted with a traumatic situation.
- Traumatic events and memory.
- How knowledge of neurobiology can assist crime victims.

The Prefrontal Cortex



The Prefrontal Cortex



- Holds thoughts and memories in mind.
- Helps us manage emotions and reflect on behavior.
- Helps manage other brain regions.
- Allows us to focus our attention where we choose, and do what we choose, consistent with our goals and values.
- Becomes impaired in traumatic situations.

4-7

Fear Circuitry

- Plays a huge role in trauma and PTSD.
- Located in multiple brain areas.
- Operates automatically and mostly outside awareness.

4-8

Seeking Circuitry

- Seeks escape from fear, anxiety, sadness, and any unwanted experiences.
- May be “quick fixes” that don’t solve the problem and may lead to addiction.
- Also enables victims to seek to uphold their values.

4-9

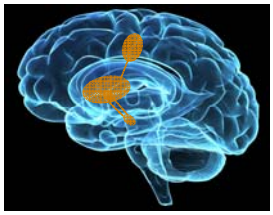
Satisfaction Circuitry

- Produces feeling of satisfaction when we get what we seek.
- Central to feeling safe, soothed, and connected to others.
- Produces opioids involved in feelings of satisfaction, connection, etc.

4-10

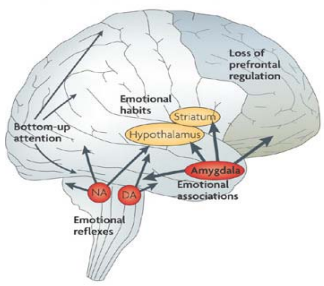
Embodiment Circuitry

- Includes the insular cortex (insula).
- Receives sensory data from all body systems.
- Key to healing from trauma.
- Allows us to know what it feels like to be in our body.



4-11

Traumatic Situations: Amygdala Control



Source of diagram: Arnsten 2009, *Nature Reviews Neuroscience,* 410

4-12

In Traumatic (and High-Stress) Situations…

- Loss of prefrontal regulation: Chemicals from the brain stem impair (and may shut down) the prefrontal cortex.
- Bottom-up attention: Attention is automatically captured by anything perceived as dangerous or threatening, or as necessary for survival.
- Emotional reflexes: Reflexes are automatic and include freeze, flight, or fight responses, as well as bodily responses like your heart pounding quickly.

4-13

The Amygdala and Attention

4-14

Survival Reflexes in the Body

Pupils dilate

Heart beats faster

Blood pressure increases

Blood flow to muscles increases

Breathing rate increases

4-15

"Fight or Flight" is Misleading

- Our brains are not wired this way.
- We evolved to freeze first, then flee.
- And fighting is only in the service of fleeing, unless there is no other option.
- It's important that assault victims understand this because many will be ashamed they did not fight back.

4-16

Freeze, Flight or Fight – Primary Purpose

Freeze:

- Brief response, when danger is perceived.
- Highly alert.
- Not moving.
- Ready to suddenly burst into action.

4-17

Drastic Survival Reflexes

- Occur when escape is – or appears – impossible.
- Attempting to escape and survive when there is no (physical) escape.
- Automatic survival reflexes.

4-18

Dissociation – Drastic Survival Reflex

"It was silence, looking at her
through a glass wall,
so it couldn't affect me, couldn't touch me."

Dissociation – Drastic Survival Reflex

- Victim feels:
  - "Spaced out."
  - Disconnected.
  - "On autopilot."
- These are common responses to sexual abuse in children, although it can happen to anyone.

Dissociation – Drastic Survival Reflex

Explain to victims that these are brain-based, automatic survival reflexes.

Tonic Immobility – Drastic Survival Reflex

- Freezing = Alert and immobile, but able to move.
- Tonic immobility = Paralysis, can't move or speak.
- Caused by extreme fear, physical contact with perpetrator, restraint, perception of inescapability.
- An estimated 10-50 percent of victims experience tonic immobility.

4-22

Tonic Immobility – Drastic Survival Reflex

- Sudden onset and termination.
- Lasts from seconds to hours.
- Does not impair alertness or memory.

4-23

Tonic Immobility – Drastic Survival Reflex

Can overlap with dissociation and may include:

- Trembling or shaking.
- Rigid muscles.
- Feeling of cold.
- Numbness to pain
- Unfocused staring or intermittent eye closure.

4-24

Collapsed Immobility – Drastic Survival Reflex

Heart gets massive parasympathetic input, resulting in…

- Extreme decreases in heart rate and blood pressure.
- Faintness, “sleepiness” or loss of consciousness.
- Loss of muscle tone.

Kozlowski et al. in press 2015; Baldwin 2013

Collapsed Immobility – Drastic Survival Reflex

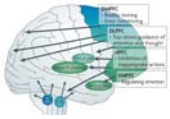
- Often accompanies mental defeat.
- Can be triggered by seeing blood, a skin puncture, a knife.
- More likely in women.
- Can be a source of shame in victims.
- These are normal, brain-based responses.

Kozlowski et al. in press 2015; Baldwin 2013

Brain-Based “Counter-Intuitive Behaviors”

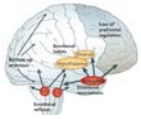
- Did not resist.
- No attempt to escape.
- Did not scream.
- “Active participant."

Brains During Most Sexual Assaults



Perpetrator

- Not stressed
- **Prefrontal cortex in control**
- Thinking and behavior:
  - Planned
  - Practiced
  - Habitual



Victim

- Terrified, overwhelmed
- **Fear circuitry in control**
- Attention and thoughts driven by perpetrator actions
- Behavior controlled by emotional reflexes and habits from childhood (including abuse)

Activity

Response Scenarios Case Studies

Worksheet 4.1

- Work in groups.
- Review the case studies and answer the questions.
- Report out to the large group.

The Brain During Trauma

- Brain releases high stress chemicals.
- High amygdala activity.
- Strong encoding of emotional and sensory memories.
- Prefrontal cortex is impaired, including language production area.

Joels et al. 2012

The Brain During Trauma

Hippocampus functioning altered:

- Elements and context poorly woven into whole.
- Sequence of events poorly encoded.
- Well-encoded emotional memories, especially for experiences surrounding fear/terror onset.

Joels et al. 2012

4-31

Attention, Trauma, and Memory

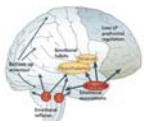
- Mostly bottom-up attention.
- Fear circuitry focused on what seems most important to survival and coping.
- Central details are encoded.
- Stimulus information is encoded much more than contextual information.

Joels et al. 2012

4-32

What Gets Encoded Into Memory

- Fragments of experience “burned in.”
- “Islands of memory.”
- Few peripheral details.
- Little or no time-sequence information.
- Little or no words or narrative.

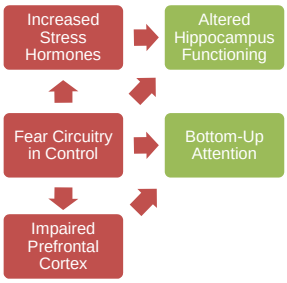


4-33

What Gets Encoded Into Memory

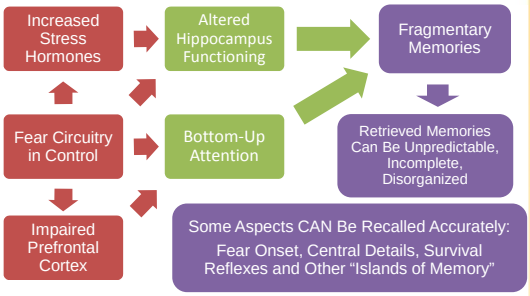
Schwabe et al. 2012; Joels et al. 2012.

What Gets Encoded Into Memory



Schwabe et al. 2012; Joels et al. 2012.

What Gets Encoded Into Memory



Schwabe et al. 2012; Joels et al. 2012.

"Islands of Memory"

- Micro-islands – Fragmentary sensations
- Larger islands – Key periods within assault
- When fear kicked in, right before and after
- Survival reflexes – Indicators of non-consent:
  - Freezing
  - Dissociation
  - Tonic immobility
  - Collapsed immobility

4-37

Alcohol, Drugs, and Memory

- Low to moderate dose/intoxication:
  - Impairs context encoding (hippocampus).
  - Does not impair encoding of sensations.
  - Resembles effect of fear/trauma.
- High dose/intoxication:
  - Impairs hippocampus-mediated encoding and consolidation of both context and sensations.
  - In a severe "black out," nothing gets encoded.

LeDoux 1996, Bisby et al. 2009, Bisby et al. 2010, 280

4-38

Remembering the Experience

- State of the brain when trying to remember affects what can be retrieved and put into words.
- If victims feel unsafe when questioned, they may not be able to use their prefrontal cortex to understand the questions and retrieve certain memories.
- If victims feel traumatized by questioning, this may trigger the bottom-up retrieval of fragmentary sensations and emotions that are nearly as intense as the assault itself.

4-39

Remembering the Experience

- Remember: The survivor may have been dissociated at the time of the assault, and when they remember it later.
- Or the survivor can alternate between dissociated and emotionally upset remembrances, for example, from one meeting or investigative interview to the next.

4-40

Life as a Minefield of Potential Trauma Triggers

Assault Memory

4-41

A Better Understanding

"I'm going to help this victim feel safe, in control, competent and cared for."

↘ Empathy for victim, empowerment of victim.

↘ Victim feels safer, is more cooperative, more able to remember, more willing to report.

← Victim advocate more easily determines victims' physical and psychological needs.

↖ Victim advocate provides better support for victim in court and during meetings with prosecutors.

↗

4-42

Activity

How Would You Respond?

Worksheet 4.2

- Work in groups.
- Review the worksheet and answer the questions.
- Report out to the large group.

4-43

Review of Learning Objectives

- Describe the basic components of the brain related to trauma.
- Explain common ways the brain is affected during and after sexual assault.
- Recognize common ways a traumatic experience may affect a victim's behavior.
- Assist victims in understanding the neurobiology of trauma, when appropriate.

4-44

End of Module 4

Questions? Comments?

4-45

Module 5: Impact of Sexual Assault

Purpose

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

Lessons

1. Physical Impact of Sexual Assault
2. Psychological Impact of Sexual Assault
3. Impact on Partners, Family, and Close Friends
4. Individual Factors Affecting Reactions to Sexual Assault

Learning Objectives

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

- Describe the physical and psychological impact of sexual assault.
- Describe the impact of sexual assault on partners, family, and close friends.

Participant Worksheets

- Worksheet 5.1, STI Scenario
- Worksheet 5.2, Physical and Psychological Impact Scenario

1. Physical Impact of Sexual Assault

The activity addresses the far-reaching impact of sexual assault.

Nongenital Physical Injury

The typical assumption is that rape victims experience physical injury during a rape. A recent review of research on injuries from rape indicates that it is difficult to show how often rape-related injuries occur given wide variation in research methodology, clinical setting, and training of medical staff identifying nongenital and genital injuries.

Across studies, the average prevalence of general bodily injury was about half of victims, prevalence of genital injury was about one-third of victims, with nearly 40 percent of victims having no injuries. However, these prevalence rates varied widely across studies, with some studies finding considerably fewer injuries, and some finding injuries among the vast majority of victims. Injuries also vary in severity and location around the genital area (Sommers 2007).

Numerous factors may relate to whether a victim of rape experiences injury. Some might assume that victims will fight back and be injured as a result. Based on data from the National Crime Victimization Survey, researchers indicate that most self-protective actions undertaken by rape victims appear to reduce the risk of rape completion and do not significantly affect the risk of additional injuries (Tark and Kleck 2014).

Relationship to the perpetrator may also impact rates of injury. Some research indicates that rapes committed by spouses or boyfriends are characterized by more coercion and injury than those committed by other known assailants or by strangers (Logan et al. 2007; Stermac et al. 2006), consistent with the idea that some sexual violence is part of a continuum of intimate partner violence.

Although some studies have found differences in levels of nongenital injury for male victims versus female victims or older victims versus younger victims, research findings have been conflicting, and further research is needed to clarify nature and degree of difference (Del Bove et al. 2005; Kimerling et al. 2002; Petrak and Claydon 1996; Stermac et al. 2004). However, further research is needed to determine whether such findings are consistently identified across studies.

Genital Trauma

Some rape victims sustain significant genital trauma, others have only minor genital trauma or none at all. Colposcopic (magnified) examination has been helpful to visualize vaginal abrasions, bruises, and tears that may be too minute to see with the naked eye (Frank 1996; Slaughter and Brown 1992).

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

In a review of visual rape evidence used in legal contexts, researchers have noted that tools such as the colposcope can document more and greater numbers of injuries and may be useful in distinguishing between consensual and nonconsensual sex.

The researchers held focus groups with SANEs, however, and noted high levels of concern that physical injuries may be absent, and that those observed through microvisualization may be explained away as resulting from consensual activity. SANEs also expressed concern that visual documentation may be dehumanizing for victims,

SANEs also acknowledged that the legal context overemphasizes physical injury as evidence that an assault occurred (White and Du Mont 2009).

Although use of colposcopy has been controversial due to the argument that injury does not differentiate between nonconsensual and consensual activity, theorists argue that visualization is an invaluable tool that provides information both for clinical judgment and is part of the patient's right to evidence-based medicine (Brennan 2006). Thus, preparation for cases should document as thoroughly as possible using technologies available (Brennan 2006; White and Du Mont, 2009).

Sexually Transmitted Infections (STIs)

About two-thirds of sexual assault victims who seek medical attention have concerns about sexually transmitted infections and HIV (Zinzow et al. 2012a). The National Protocol for Sexual Assault Medical Forensic Examinations (OVW 2013) recommends that all medical facilities offer rape victims medications to prevent contracting STIs.

The risk for contracting HIV from a sexual assault is less than 1 percent, but trichomonas, gonorrhea, chlamydia, and bacterial vaginosis are relatively prevalent. Although post-assault presence does not necessarily mean that the STI resulted from the assault, the exam provides an opportunity to treat the infection (CDC 2011).

Post-exposure prophylaxis (PEP) should be considered for victims at high risk of contracting HIV. The decision to offer PEP should be based on the risk of the rape combined with HIV prevalence in the specific geographic area.

Rape is considered high-risk if it involves rectal contact or vaginal contact with tearing, or existing vaginal STIs that have caused ulcerations or open sores disrupting the integrity of the vaginal mucosa. It also is considered high-risk if the victim knows or suspects that the assailant is an IV-drug user, HIV-positive, or bisexual (Ledray 2006).

Even if the survivor does not ask questions about HIV during the initial exam, the SANE or medical professional should, in a matter-of-fact manner, provide information about risk, testing, PEP, and safe-sex options, which allows the victim to make decisions based on facts, not fear (Ledray 1999). When used, it should be started within 72 hours of exposure. Its use is often reserved for high-risk cases because of the high cost and the serious side effects of the treatment (Simpson 2001).

The activity presents group process scenarios.

Pregnancy

Rape victims of reproductive age often fear becoming pregnant as a result of a rape. The actual risk is around 5 percent (Holmes et al. 1996; Gottschall and Gottschall 2003). Most SANE programs and medical facilities offer emergency contraception to women at risk of becoming pregnant, provided they are seen within 5 days of the rape and have a negative pregnancy test in the emergency department.

Oral contraceptives such as Ovral are still used in some areas; however, Plan B (levonorgestrel) is more commonly used today for emergency contraception. Plan B was developed specifically to prevent pregnancy after unprotected intercourse. It is believed to act as emergency contraception by preventing ovulation or fertilization by altering tubal transport of sperm and/or ova. It also may inhibit implantation by altering the lining of the uterus.

This treatment is not 100 percent effective in preventing pregnancy. A review of 10 studies found an overall effectiveness rate of at least 75 percent. This statistic does not mean that 25 percent will become pregnant; rather, if 100 women have intercourse in the middle 2 weeks of their cycle, approximately eight would become pregnant without post-coital interception. With interception, only two (a reduction of 75 percent) of the 100 would become pregnant (American College of Obstetricians and Gynecologists 2002).

General Health Risk

Rape, like other types of sexual assault, not only affects victims' health directly and immediately; there is convincing evidence that it also can have a significant and chronic impact on their general health for years to come (Frazier and Ledray 2011). Stress appears to suppress the immune system and increase susceptibility to disease (Cohen and Williamson 1991).

Stress such as a sexual assault also may result in injurious behaviors, such as substance abuse or eating disorders (Felitti 1991; Golding 1994; Messman-Moore and Garrigus 2007). Survivors of sexual assault also may experience chronic back and facial pain, chest pain, shortness of breath, insomnia and fatigue, heart palpitations, cardiac arrhythmia, nausea, vomiting, diarrhea, bloatedness, and abdominal pain (Golding 1994, 1996).

Sexual Dysfunction

Not surprisingly, studies have found that sexual dysfunction is a common reaction and often a chronic problem after rape. Mentioned repeatedly in the literature are avoidance, loss of interest in sex, loss of pleasure from sex, painful intercourse, and fear of sex (Abel and Rouleau 1995; Frazier and Borgidia1997; Ledray 1998).

In a review of studies exploring sexual problems following sexual assault, researchers found that frequency of sexual contact decreases after the assault, satisfaction and pleasure in sexual activities diminishes for some victims for at least 1 year post assault, and some victims develop sexual problems that persist for years after the assault (Van Berlo 2000).

Survivors of rape also may experience painful menstruation, excessive menstrual bleeding, menstrual irregularity, and genital burning (Golding 1996). Recent research on young female rape victims points to pelvic floor dysfunction as a possible mediator between rape and symptoms of sexual or reproductive dysfunction; this indicates that treatment strategies for physical dysfunction might be included in treatments for trauma exposure (Postma et al. 2013).

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

Increased risky sexual behavior among victims may stem from factors such as the psychological distress associated with sexual assault (Campbell and Lewandowski 1997) or reproductive coercion (forcing a woman to become pregnant) by relationship partners (Miller et al. 2011). Increased sexual activity with multiple partners may further increase exposure to disease (Ledray 1994).

Substance Abuse

Individuals are clearly more vulnerable to assault when intoxicated. A recent study of college women found that nearly a third of women experienced alcohol- or drug-related sexual assault or rape, and 5 percent experienced forcible sexual assault or rape.

The vast majority of the drug- and alcohol-related assaults involved voluntary (self-induced) incapacitation and alcohol use, with only 15 percent representing involuntary incapacitation (Lawyer et al. 2010).

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

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

In a national sample of 3,006 female survivors, both alcohol and drug use significantly increased after a sexual assault, even for women with no prior drug or alcohol use or abuse history (Kilpatrick, Acierno, Resnick, Saunders, and Best 1997). This study also found that women who were already using drugs and alcohol to cope were more likely to have a history of prior sexual abuse. Similarly, a study that followed female survivors of child sexual abuse over time found problem drinking was predicted by childhood victimization (Najdowski, Ullman, and Filipas 2009).

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

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

2. Psychological Impact of Sexual Assault

Researchers agree that sexual assault victims experience more psychological distress than do victims of other crimes. Compared to nonvictim control groups, rape and sexual abuse victims consistently report more symptoms of anxiety, fear, depression, and posttraumatic stress disorder (PTSD) (Frazier and Borgida 1997; Trickett et al. 2011).

The activity explores the psychological impact of sexual assault.

Anxiety

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

Fear

Death is the most common fear during the assault, with continued generalized fear after the assault a very common response to sexual assault (Dupre, Hampton, Morrison, and Meeks 1993; Ledray 1994). While evidence of the type and duration of fear varies, up to 83 percent of victims report some type of fear following a sexual assault (Frazier and Borgida 1997).

Girelli et al. (1986) found that the subjective distress of fear of injury or death during rape was more significant than the actual violence in predicting severe post-rape fear and anxiety. Thus, it is important to recognize that the threat of violence alone can be psychologically devastating (Goodman, Koss, and Russo 1993).

Depression

Depression is one of the most commonly mentioned long-term responses to rape (Abel and Rouleau 1995; Frazier and Borgida 1997; Ledray 1994). Compared to nonvictims, depression is more than three times as prevalent among victims of forcible rape and twice as prevalent among victims of drug-facilitated or incapacitated rape (Zinzow et al., 2012b). As with anxiety, symptoms of depression also overlap with those of PTSD. Such overlapping symptoms include:

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

Suicidal Ideation

While the number of suicides following a sexual assault is considered low, suicidal ideation (i.e., thoughts about suicide) is a significant issue. One study found 39 percent of rape victims reported a subsequent suicide attempt (Ackard and Neumark-Sztainer 2002).

In other studies, between 33 and 50 percent of victims reported that they considered suicide at some point after the rape (Ullman 2004; Ullman and Brecklin 2002). In a study of female survivors of sexual assault, researchers found that women at the most risk for suicidal ideation were younger, ethnic minority, or bisexual. Those with more traumas and drug use enacted more suicide attempts (Ullman, Najdowski, and Filipas 2009).

Self-Blame and Shame

A number of studies have identified posttraumatic guilt, self-blame, and shame as a common response following sexual assault, and one that is linked to PTSD, more depression, and poor adjustment post-rape (Vidal and Petrak 2007; Frazier 1990; Ledray 1999). One study compared college students' retrospective reports of different emotions during and after sexual assault. While emotions such as fear peaked during the trauma, other emotions such as shame, guilt, anger, and sadness often increased after the trauma (Amstadter and Vernon 2008).

Posttraumatic Stress Disorder (PTSD)

The definition of posttraumatic stress disorder is:

> "A psychiatric disorder that can occur in people who have experienced (directly or indirectly) or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or other violent personal assault" (American Psychiatric Association 2014).

The National Women's Study, an epidemiological survey of 4008 women, found the lifetime prevalence of PTSD resulting from rape and sexual assault to be 32 percent and 30.8 percent respectively, compared with a prevalence of 9.4 percent caused by non-crime-related trauma such as a car accident (Kilpatrick, Amstadter, Resnick, and Ruggiero 2007).

One study found 78 percent of rape victims met the criteria for PTSD at 2 weeks; 63 percent at 2 months; 58 percent at 6 months; and 48 percent at 1 year (Frazier, Conlon, and Glaser 2001). Sexual assault also has been identified as the most common cause of PTSD in women (Frans, Rimmo, Aberg, and Fredrickson 2005).

Symptoms of PTSD fall into four categories (APA 2014):

1. Intrusive symptoms such as repeated, involuntary memories, distressing dreams, or flashbacks of the traumatic event.

2. Avoidance of reminders such as people, places, activities, objects, and situations that bring on distressing memories.

3. Negative thoughts and feelings such as persistent and distorted beliefs about oneself and others (e.g., fear, shame, anger), diminished interest in activities, or feeling detached.

4. Arousal and reactivity symptoms such as angry outbursts, reckless behavior, problems concentrating, or sleep problems.

In 2013, the American Psychiatric Association made several key changes to criteria for PTSD, moving the disorder from classification as an anxiety disorder to a new chapter on Trauma- and Stressor-Related Disorders in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5).

Other changes in the criteria include explicitly including sexual assault as a traumatic event, and deleting criteria regarding the individual's response to the event (e.g., fear, horror), as this has been shown to have no utility in predicting onset of PTSD. The disturbance must continue for more than a month to be classified as PTSD (APA 2014).

The severity of PTSD symptoms in sexual assault survivors is associated with the victim's trauma history, perceived life threat during the assault, feelings of self-blame for the assault, avoidance coping, and negative social reactions from others (Ullman 2007).

Campbell, Patterson, Adams, Diegel, and Coats (2008) found more positive psychological outcomes among victims seen by SANEs who "empowered" them by providing health care, support, and resources; treating them with respect and dignity; believing them; helping them regain control; and respecting their decisions. These factors are important for the advocate or counselor to consider when making initial referrals for followup, and when attempting to contact the survivor for followup.

The activity explores the physical and psychological impact of sexual assault.

3. Impact on Partners, Family, and Close Friends

Family members and those close to the victim have been recognized as secondary or indirect victims (Koss and Harvey 1991; Ledray 1994). As a result, they, too, often suffer many of the same initial and long-term symptoms of distress experienced by the sexual assault survivor, including shock and disbelief, fear, anxiety, a sense of helplessness, depression, and anger.

Or, they may blame the victim for the assault. This type of blame is often a misdirected attempt to deal with their own feelings of guilt and self-blame for not protecting their loved one somehow and not preventing the assault (Ledray 1994).

A study of over 100 secondary victims of rape, including family members, partners, and friends, found that these persons suffered significant levels of trauma, with about one-quarter experiencing PTSD. They also reported difficulty in supporting the victims due to insecurities in how to help, refusal by the victim in receiving help, reactions of the victim, and own feelings about the assault.

Many reported that their relationship with the victim was affected by the assault, with about one-quarter feeling closer to the victim and another quarter reporting that the relationship had gotten worse for some period of time after the assault.

Family and friends may become overly protective, further limiting the victim's activities. In a large study on reactions to sexual assault disclosure among college women, researchers found social reactions that attempted to control the survivor's decisions were associated with greater symptomology for PTSD, depression, and anxiety. This may impede the survivor's perception of being in control of the recovery process.

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

4. Individual Factors That Affect Reactions to Sexual Assault

Sexual assault is traumatic for all victims; however, individual factors can have an impact on the nature and extent of the trauma. These include gender and sexual orientation, age, disability, race, culture, refugee and immigration status, and past experiences of victimization.

Part of being a conscientious victim service provider is the ability to be flexible and to remember that each person will react to assault differently.

Training by Request
An OVC Program

Module 5
Impact of Sexual Assault

OVC
OVCTTAC

Learning Objectives

- Describe the physical and psychological impact of sexual assault.
- Describe the impact of sexual assault on partners, family, and close friends.

Activity

Brainstorm –
Potential Physical Impact of Sexual Assault

Nongenital Physical Injury

- It is difficult to show how often rape-related injuries occur.
- Most self-protective actions undertaken by rape victims do not significantly affect the risk of additional injuries.
- Less common in stranger rape.
- Further research is needed.

Identified Genital Trauma

- Rates of identified genital injury vary from significant to no injury.
- Colposcopic (magnified) examination may be useful in distinguishing between consensual and nonconsensual sex.
- Visualization is an invaluable tool that is part of the patient's right to evidence-based medicine.

Sexually Transmitted Infections (STIs)

- Concern about STIs is one key difference between victims who seek medical care and those who do not.
- Risk of contracting HIV is low.
- Risk of contracting other diseases is relatively prevalent.
- Allow victims to make decisions based on facts, not fear.

Activity

Group Process Scenario I

Worksheet 5.1

STI Scenario:

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

5-7

Pregnancy

- The actual risk is around 5%.
- Medical facilities offer emergency contraception.

5-8

General Health Risk

- Sexual assault affects a victim's health directly and immediately.
- It also can have a significant and chronic impact on their general health for years.
- Stress appears to suppress the immune system.
- Injurious behaviors and health problems sometimes occur after sexual assault.

5-9

Sexual Dysfunction

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

- Avoidance of sex.
- Loss of interest, loss of pleasure in sex.
- Painful intercourse and periods.
- Risky sexual behaviors.

5-10

Substance Abuse

- Individuals are clearly more vulnerable to assault when intoxicated.
- The most frequently used drug to facilitate a sexual assault is alcohol.
- Alcohol and drug use by female survivors significantly increased after sexual assault.
- Sexual abuse plays a role in substance abuse.
- Rape victims are more likely to develop substance abuse problems.

5-11

Activity

Brainstorm –
Potential Psychological Impact of Sexual Assault

5-12

Anxiety

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

5-13

Fear

- Death is the most common fear during the assault.
- Continued generalized fear occurs after the assault.
- The threat of violence alone can be psychologically devastating.

5-14

Depression

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

5-15

Suicidal Ideation Studies

- Studies indicate suicide ideation after sexual assault is a significant issue.
- Women at the most risk for suicidal ideation were younger, ethnic minority, or bisexual victims.
- Victims with more traumas and drug use enacted more suicide attempts.

5-16

Self-Blame and Shame

- Posttraumatic guilt, self-blame, and shame are a common response following sexual assault.
- Emotions such as fear may increase during the trauma, but other emotions such as shame, guilt, anger, and sadness often increased after the trauma.

5-17

Posttraumatic Stress Disorder (PTSD)

"A psychiatric disorder that can occur in people who have experienced (directly or indirectly) or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war/combat, or rape or other violent personal assault."

APA 2014

5-18

PTSD Symptoms

- Intrusive symptoms
- Avoidance of reminders
- Negative thoughts and feelings
- Arousal and reactivity symptoms

APA 2014

5-19

Severity of PTSD Symptoms

- Associated with trauma history, perceived life threat during the assault, feelings of self-blame, avoidance coping, and negative social reactions from others.
- SANEs empower victims through health care, support, treating them with respect and dignity, believing them, helping them regain control; and respecting their decisions.

5-20

Activity

Group Process Scenario II

Worksheet 5.2

Physical and 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.

5-21

Impact on Partners, Family, Close Friends

- Secondary or indirect victims.
- Often suffer many of the same initial and long-term symptoms.
- May suffer from PTSD.
- May have difficulty supporting the victim.
- Relationship with the victim is affected.

5-22

Individual Factors

- Gender and sexual orientation
- Age
- Disability
- Race
- Culture
- Refugee and immigration status
- Past experiences of victimization

Remember that each person will react to assault differently.

5-23

Review of Learning Objectives

- Describe the physical and psychological impact of sexual assault.
- Describe the impact of sexual assault on partners, family, and close friends.

5-24

End of Module 5

Questions? Comments?

Module 6: Campus Sexual Assault

Purpose

The purpose of this module is to discuss statistics on the prevalence of sexual assault on school and university campuses, and to identify the resources available to these victims.

Lessons

1. Prevalence of Campus Sexual Assault
2. Laws and Recommendations That Apply to Campus Sexual Assault
3. Case Studies
4. Resources

Learning Objectives

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

- Cite key statistics on campus sexual assault.
- Describe the laws that apply to sexual assault on campus.
- Identify resources available to victims of campus sexual assault.

Participant Worksheets

- Worksheet 6.1, Campus Sexual Assault Case Studies

1. Prevalence of Campus Sexual Assault

Victims of sexual assault can be found in any community, and incidents on educational campuses are extremely common. Regardless of the situation in which the violence occurs – at a party, within a dormitory, after consuming alcohol – rape and other types of sexual assault are criminal acts. In this module, we will take a look at the victims and the prevalence of sexual assault on campus.

One group of individuals that is often believed to be at higher risk for sexual assault is college students. In 2007, the National Institute of Justice (NIJ) published the Campus Sexual Assault (CSA) Study, which is a study of various types of sexual assault experienced by university students. The study can be found at: www.ncjrs.gov/pdffiles1/nij/grants/221153.pdf.

The researchers interviewed 5,466 women and 1,375 men. Among their findings:

- 13.7 percent of undergraduate women had been victims of at least one completed sexual assault since entering college.
- 4.7 percent were victims of physically forced sexual assault, with 3.4 percent experiencing forced rape.
- 7.8 percent of women were sexually assaulted when they were incapacitated after voluntarily consuming drugs and/or alcohol (i.e., they were victims of alcohol- and/or other drug-enabled sexual assault).
- 0.6 percent were sexually assaulted when they were incapacitated after having been given a drug without their knowledge.

Self-reported rates of sexual assault victimization and perpetration among males were very low.

Researchers also studied the types of sexual assault and the risks involved:

Physically Forced Sexual Assault

- Substance abuse did not appear to play a part in the likelihood of a woman being victimized in a physically forced sexual assault. However, the number of sexual partners women had since entering college did appear to increase the risk of forced sexual assault while in college.
- In addition, women who had been threatened/humiliated and/or physically hurt by a dating partner since entering college had just over seven times the odds of experiencing forced sexual assault since entering college.
- The study also revealed that the longer a woman remained in college, the more likely she was to experience physically forced sexual assault since entering college. However, freshmen and sophomores were more likely to be victims than juniors and seniors.

Incapacitated Sexual Assault

A rather different set of risk factors was associated with incapacitated sexual assault. Substance abuse was significantly associated with the likelihood of experiencing incapacitated sexual assault.

- The frequency with which women reported being drunk during sex also increased the odds of being a victim of incapacitated sexual assault.
- Having been given a drug without one's knowledge or consent increased the odds of being a victim of incapacitated assault.
- Women who were humiliated or hurt by a dating partner had just over two times the odds of being a victim of incapacitated sexual assault since entering college, compared to other women.
- As seen in the analysis of physically forced sexual assaults, the more years a woman has been in college, the greater the odds that she experienced incapacitated assault.

Victims of forced sexual assault before college were at higher risk of experiencing both types of sexual assault since entering college. The same was true for victims of incapacitated sexual assault.

In fact, women who experienced both types of prior victimizations had almost eight times the odds of experienced both physically forced and incapacitated sexual assault during college, compared to other women.

2. Laws and Recommendations That Apply to Campus Sexual Assault

There are a number of laws that govern sexual assault. The three that we'll discuss here are:

1. Title IX
2. Clery Act
3. VAWA Amendments (commonly referred to as Campus SaVE)

1. Title IX

What is it and how does it apply?

- Title IX is a civil rights statute.
- This law applies to all schools who participate in federal financial aid programs (but excludes some parochial schools or schools that receive only private funding).

- Its general purpose is to provide for fairness in education. Sexual assault impedes a victim's access to education, and therefore a school must apply Title IX when there is a complaint of sexual assault.
- The law is enforced by the U.S. Department of Education, Office for Civil Rights.
- Retaliation against those who complain is strictly prohibited.

What are the basic requirements of Title IX?

- Educational institutions must publish a notice of nondiscrimination.
- The institution must designate an employee to coordinate Title IX compliance with the following responsibilities:
  - Disseminate notice of nondiscrimination.
  - Identify and address systemic patterns of discrimination.
  - Educate parties about the policy and answer procedural questions about the logistics of the disciplinary process.
  - Oversee the investigation of a complaint.
- The educational institution must adopt and publish grievance procedures. Some would include:
  - How long should the investigation take?
    - The process should be "reasonably prompt." In 2014, the U.S. Department of Education issued a Dear Colleague Letter (DCL) on student-on-student sexual harassment and sexual assault. The DCL explains a school's responsibility to respond promptly and effectively to sexual violence against students in accordance with the requirements of Title IX, and recommends 60 days as a general guideline for the length of a typical investigation.
  - What is the standard of proof?
    - Preponderance of the evidence. ("It is more likely than not that the accused student is 'responsible' for the alleged sexual assault.")
  - Can a school use both a formal and an informal grievance process?
    - Yes, but mediation should not be used to resolve a sexual assault complaint. Also, the parties must be notified that they have the right to end the informal process at any time and begin the formal process.

2. Clery Act

What is it and how does it apply?

- The Jeanne Clery Disclosure of Campus Security and Campus Crime Statistics Act requires schools to maintain and disclose campus crime statistics and security information.
- This Act applies to all schools who participate in federal financial aid programs.
- It is enforced by the U.S. Department of Education.

What are the basic requirements of the Clery Act?

- An educational institution must maintain crime statistics that occurred:
  - On campus.
  - In institution residential facilities.
  - In noncampus buildings.
  - On public property.
- The institution's police department or security departments are required to maintain a public log of all crimes reported to them, or those of which they are made aware.
  - The log is required to have the most recent 60 days' worth of information.
  - Each entry in the log must contain the nature, date, time, and general location of each crime and disposition of the complaint, if known.
  - Information in the log older than 60 days must be made available within 2 business days.
  - Crime logs must be kept for 7 years, 3 years following the publication of the last annual security report.

3. VAWA Amendments (Campus SaVE)

- VAWA Amendments are part of the reauthorization of the Violence Against Women Act/Amended the Clery Act
- SaVE requires that incidents of domestic violence, dating violence, sexual assault, and stalking be disclosed in annual campus crime statistic reports.
- Students or employees reporting victimization will be provided with their written rights to:

- Be assisted by campus authorities if reporting a crime to law enforcement.
- Change academic, living, transportation, or working situations to avoid a hostile environment.
- Obtain or enforce a no-contact directive or restraining order.
- Have a clear description of their institution's disciplinary process and know the range of possible sanctions.
- Receive contact information about existing counseling, health, mental health, victim advocacy, legal assistance, and other services available, both on campus and in the community.

- Institutional disciplinary procedures covering domestic violence, dating violence, sexual assault, and stalking must:
  - Provide a prompt, fair, and impartial investigation and resolution which are conducted by officials receiving annual training on domestic violence, sexual assault, and stalking.
  - Permit both parties to have others present during an institutional disciplinary proceeding and any related meeting, including an advisor of their choice.
  - Provide both parties with written outcomes of all disciplinary proceedings at the same time.
- Education programs shall include:
  - Primary prevention and awareness programs for all incoming students and new employees.
  - Safe and positive options for bystander intervention.
  - Information on risk reduction to recognize warning signs of abusive behavior.
  - Ongoing prevention and awareness programs for students and faculty.

Title IX also covers the obligations of the college campus in regard to its relationship to local law enforcement.

- It is not sufficient that the local police investigate the sexual assault; the school's Title IX investigation is different from any law enforcement investigation, and a law enforcement investigation does not relieve the school of its independent Title IX obligation to conduct an "adequate, reliable, and impartial investigation of complaints."

- Title IX does not usually require schools to notify local police if a sexual assault is reported. Generally, the decision to file a criminal complaint will be up to the victim. "Title IX does not require a school to report alleged incidents of sexual assault to law enforcement, but a school may have reporting obligations under state, local, or other federal laws."

- Even if the police determine that there is insufficient evidence to proceed criminally, a school may still find an accused student "responsible." In other words, there could be sexual harassment under Title IX even if there is insufficient evidence of a criminal violation. This is due to the lower burden of proof than the "preponderance of the evidence."

- Local police may ask the victim's school to wait on the Title IX investigation but only for 7-10 days. After that, a school must start its Title IX investigation.

In January 2014, President Obama created the Task Force To Protect Students From Sexual Assault. The purpose of the Task Force was to provide colleges and universities with recommendations on preventing and responding to sexual assault.

The Task Force was also to identify efforts to hold educational institutions accountable when they fall short in addressing sexual assault on their campuses. The Task Force issued a report which offers guidance to educational institutions on how to begin combating campus sexual assault and improve compliance with Title IX, the law that prevents discrimination by sex in programs within educational institutions.

The Task Force set out specific steps to begin addressing the problem:

1) Identify the problem using climate surveys.

2) Implement preventive programs and strategies, and research new ideas and solutions.

3) Implement effective response programs.

4) Increase transparency and improve enforcement.

As a result of the study, the Department of Education is likely to ramp up efforts to identify and correct Title IX violations. The report concluded that educational institutions continue not to do enough to prevent sexual assaults on their campuses, and that schools should reinforce education and awareness programs.

While the report indicates a preference for honoring a victim's request for confidentiality, Title IX and the Clery Act impose investigatory and reporting obligations that may conflict with this preference. Schools are advised to attempt to honor requests for confidentiality while refraining from compromising any investigation. As victim service providers understand, this balance is not always easy to maintain.

3. Case Studies

The activities explore campus sexual assault case studies.

4. Resources

Although many campus assaults are handled on campus, community and system-based victim service providers do see these victims. There are a number of steps victim service providers can take to help them. For example:

- Provide resources following the assault.
- Negotiate with the school for/with the victim to:
  - Honor a stay-away order.
  - Take a class as an independent study.
  - Change dining halls or relocate to another dorm with a kitchenette.
- Provide advocacy during a disciplinary process.
- Help the victim file a Title IX complaint with the Office for Civil Rights, U.S. Department of Education.
- Provide support and resources if the victim wants to report to law enforcement (local or campus).
- Help the victim navigate the college process and/or the criminal justice process.

Victim service providers should also be aware of the resources that are found on most campuses. These include:

- Advocacy.
- Medical.
- Mental health.
- Academic counseling.
- Accommodations/interim measures for victims to be safe.
- Title IX Coordinator.

Even if victims of campus violence have access to resources on campus, they may want to use off-campus services for a number of reasons. Make sure that victims have access to:

- Sexual Assault Nurse Examiner (SANE).
- Local rape crisis center.
- Hospital visit.

Finally, if you are on campus, find out what resources there are off campus, and consider the following questions:

- Can off-campus services offer training to campus administrators?
- Are they part of a Sexual Assault Response Team (SART)?
- Are their services known and accessible to students?

Training by Request
An OVC Program

Module 6
Campus Sexual Assault

OVC
OVCTTAC

Learning Objectives

- Cite key statistics on campus sexual assault.
- Describe the laws that apply to sexual assault on campus.
- Identify resources available to victims of campus sexual assault.

Victims of Campus Sexual Assault

According to the Campus Sexual Assault Study:

- 13.7% of undergraduate women have been victims of at least one completed sexual assault.
- 4.7% were victims of physically forced sexual assault.
- 7.8% were sexually assaulted when incapacitated after voluntarily consuming drugs/alcohol.
- 0.6% were sexually assaulted when incapacitated after given drugs/alcohol without their knowledge.

Physically Forced Sexual Assault Factors

- Number of sexual partners
- Previously threatened/hurt by dating partner
- Length of time in college
- Years in college

6-4

Incapacitated Sexual Assault Factors

- Voluntary substance abuse
- Substance abuse without knowledge/consent
- Previously threatened/hurt by dating partner
- Length of time in college

6-5

Primary Laws

1. Title IX
2. Clery Act
3. VAWA Amendments (commonly referred to as Campus SaVE)

6-6

Title IX

- Civil rights statute.
- Applies to all schools who participate in federal financial aid programs.
- Provides for fairness in education.
- Enforced by the U.S. Department of Education, Office for Civil Rights.
- Retaliation is strictly prohibited.

Title IX Basic Requirements

- Publish a notice of nondiscrimination.
- Designate an employee to coordinate Title IX compliance.
- Adopt and publish grievance procedures.

Clery Act

- The Jeanne Clery Disclosure of Campus Security and Campus Crime Statistics Act requires schools to maintain and disclose campus crime statistics and security information.
- Applies to all schools who participate in federal financial aid programs.
- Enforced by the U.S. Department of Education.

Clery Act Basic Requirements

- Maintain crime statistics.
- Maintain a public log of all crimes reported to them, or those of which they are made aware.

6-10

VAWA Amendments (Campus SaVE)

- Part of the reauthorization of Violence Against Women Act/Amended the Clery Act.
- SaVE requires that incidents of domestic violence, dating violence, sexual assault, and stalking be disclosed in annual campus crime statistic reports.
- Students or employees reporting victimization will be provided with their written rights.

6-11

VAWA Amendments (Campus SaVE), continued

- Requires institutional disciplinary procedures covering domestic violence, dating violence, sexual assault, and stalking.
- Education programs.

6-12

Title IX, Campus Obligations, and Local Law Enforcement

- It is not sufficient that the local police investigate the sexual assault; a school's Title IX obligations are different.
- Title IX does not usually require schools to notify local law enforcement; generally, reporting is up to the victim.
- If the police determine that there is insufficient evidence to proceed criminally, a school may still find an accused student "responsible."
- Local police may ask the victim's school to wait on the Title IX investigation for 7-10 days.

Task Force to Protect Students from Sexual Assault

- Provides colleges and universities with recommendations for preventing and responding to sexual assault.
- Identifies efforts to hold educational institutions accountable for addressing sexual assault on campus.
- Offers guidance to educational institutions on how to combat campus sexual assault and improve compliance with Title IX.

Task Force Recommendations

- Identify the problem using climate surveys.
- Implement preventive programs and strategies; research new ideas and solutions.
- Implement effective response programs.
- Increase transparency and improve enforcement.

Confidentiality

- Task Force report recommends honoring victim confidentiality.
- Title IX and Clery Act may impose investigatory and reporting obligations that may conflict with a victim's request.
- Schools are advised to honor confidentiality requests while not compromising investigations – a balance that may be difficult to maintain.

6-16

Activity

Campus Sexual Assault Case Studies

Worksheet 6.1

#1: The Perpetrator Leaves School

- Working in groups, read Case Study #1.
- Discuss and answers questions on the worksheet.
- Discuss with the large group.

6-17

Activity

1. Is this incident considered sexual harassment under Title IX?
2. If the perpetrator already withdrew, isn't that enough?
3. Is the taunting by classmates considered sexual harassment as defined by Title IX?

6-18

Activity

4. Does Title IX permit the victim to receive accommodations? What accommodations might the victim need?
5. What written information, if any, should the school be providing to the victim?
6. Should this be disclosed in the annual crime statistics under the Clery Act?

6-19

Activity

Campus Sexual Assault Case Studies

Worksheet 6.1

#2: Full Hearing

- Working in groups, read Case Study #2.
- Discuss and answers questions on the worksheet.
- Discuss with the large group.

6-20

Activity

1. What is the disciplinary process?
2. Where can I find the disciplinary process explained?
3. In a disciplinary process, what is the panel trying to decide?

6-21

Resources for Campus Sexual Assault

What can advocates do to help campus sexual assault victims?

- Provide resources following the assault.
- Negotiate with the school for/with the victim.
- Provide advocacy during a disciplinary process
- Help the victim file a Title IX complaint.
- Provide support and resources if the victim wants to report to law enforcement.
- Help the victim navigate the process.

6-22

Resources for Campus Sexual Assault, continued

What resources are available on campus?

- Advocacy
- Medical
- Mental health
- Academic counseling
- Accommodations/interim measures for victims to be safe
- Title IX Coordinator

6-23

Resources for Campus Sexual Assault, continued

What resources are available off campus?

- Sexual Assault Nurse Examiner (SANE)
- Local rape crisis center
- Hospital visit

6-24

Resources for Campus Sexual Assault, continued

Do you have a relationship with the off-campus resources?

- Can they offer training to campus administrators?
- Are they part of a Sexual Assault Response Team (SART)?
- Are their services known and accessible to students?

6-25

Review of Learning Objectives

- Cite key statistics on campus sexual assault.
- Describe the laws that apply to sexual assault on campus.
- Identify resources available to victims of campus sexual assault.

6-26

End of Module 6

Questions? Comments?

6-27

Module 7: Effects of Sexual Assault on Males

Purpose

The purpose of this module is to examine common myths of male sexual assault; discuss some basic statistics; examine how male biology, emotions, and socialization affect male response to sexual assault; and discuss how victim service providers can provide support to male victims of sexual assault.

Lessons

1. Myth or Fact?
2. Gender Socialization
3. Assisting Male Survivors of Sexual Assault

Learning Objectives

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

- Distinguish fact from myth regarding male sexual assault.
- Discuss gender socialization.
- Describe the effects of sexual assault on males.
- Discuss how to assist males who have been victims of sexual assault.

Participant Worksheet

- Worksheet 7.1, Themes and Beliefs Related to Male Sexual Assault

1. Myth or Fact?

The activity explores some of the myths about male sexual assault.

2. Gender Socialization

Because female sexual assault is more commonly reported than male sexual assault, you may never work with a male victim. However, if you do, you need to understand how – and why – males have some reactions that are very different from those of females.

Gender socialization is the process of learning the social expectations and attitudes associated with one's sex. Gender socialization can shape emotional impacts and how males and females experience, understand, and respond to them. The socialization of gender begins as soon as a baby is born and continues for the rest of his or her life.

As infants, males are more emotionally reactive and expressive than females. They are more easily startled, excited, frustrated, and distressed. Compared to female infants, they also cry sooner and more often.

By the age of 6 or 7, most of the important lessons in male socialization have been learned. By middle school, boys are less aware, less expressive, and less empathic toward others and themselves. They have been pervasively and deeply conditioned to respond in these ways.

Boys learn expected gender roles, including how to suppress, hide, deny, and feel ashamed of vulnerable emotions from parents, peers, teachers and coaches, the media, and role models. For example, researchers have found that parents – without even realizing they are doing it – talk less about emotional experiences in their conversations with boys than they do with girls.

Most young males have probably heard, more than once, "Don't act like a girl," "Act like a man!" and "Man up!" Males, particularly during childhood, suffer negative consequences if they do things that don't conform to masculine gender stereotypes. Females are supposed to be more feeling, more expressive, and more people-oriented, which are certainly positive human qualities.

Homophobia, in this sense a fear of being perceived as gay, is said to be perhaps the greatest pressure boys face while growing up and is considered the ultimate weapon in reinforcing rigid sex-role conformity (Friedman 1989).

Rigid gender and sex-role stereotypes make it harder for males to establish meaningful and intimate relationships with other men and women. They also set up boys and girls for male-female relationships based on male superiority, preventing equality and true intimacy (Neisen 1990).

Being so pervasively and deeply conditioned to suppress experiences and expressions of emotional vulnerability not only limits males' capacities for emotional maturity and intimacy, but also makes it harder for them to acknowledge, seek help, and heal from the impacts of sexual assault.

Victim advocates who understand these realities can be much more empathic toward males who have been sexually assaulted. They will have more appreciation of how sexual victimization can affect males differently from their female victims. They can be more accepting of males' tendencies to suppress and deny emotional and other impacts, and more accepting of the ways males may be emotionally disconnected and "difficult to engage" or work with.

With this knowledge, victim advocates will be better able to provide opportunities for males to reflect upon – and start freeing themselves from – the ways that masculine gender socialization has shaped their responses to being sexually assaulted and their capacities to heal and seek justice.

It's important to understand that gender is a moral dimension of identity. Morality isn't just about what we do, but *who were are.* Morality is about good ways to be a father or a mother, a friend, a victim advocate, a boy or girl, a man or woman.

Even if we don't reflect on it or put it into words, we can't help but constantly evaluate ourselves in terms of how close or far we are from our ideal visions of how we should be. We often can't help but feel that we're moving toward or away from our images of how we should be.

These evaluations – whether automatic and outside of awareness, or consciously thought about – have significant emotional effects on us. They can lead to happiness or sadness, pride or shame, hope or despair.

Thus, all of the messages and conditioning that boys and men receive about how boys and "real men" should be, about what qualities and behaviors make boys and men admirable or respectable *as boys and men*, focus on the good ways of being male. These are moral messages.

As victim advocates, it can be very helpful to keep this in mind. Doing so can reduce frustration with and judgments toward males who have trouble thinking and talking about what happened, how it has affected them, and what is involved in healing.

Male identity – at least as boys and men are conditioned to understand and embody it as a *moral* aspect of identity – involves particular kinds of thoughts, experiences, and behaviors.

Key thoughts about masculinity that inform conventional male identity include beliefs about masculinity, self, and relationships. "I have to be a real man," "real men never cry," "real men never look weak," "a real man never lets a woman push him around," and "a real man never lets anyone get away with disrespecting him."

Core experiences that make up the conventional masculine identity include having less awareness and empathy toward vulnerable feelings like sadness and shame, both within oneself and others.

They also include experiencing fear and vulnerability of any kind as bad and unsafe, while in comparison anger is experienced as good and safe. Feelings of anger are often experienced as powerful, protective, and central to what it means to be male.

Finally, the male identity is based on behaving in certain stereotypical ways. Being dominant and aggressive toward others, both male and female, is seen as very masculine. Indeed, the conventional masculine identity requires men to actively suppress the experience and expression of vulnerable emotions, and many conventionally male behaviors – including becoming angry and aggressive toward anyone who disrespects or attempts to dominate them, laughing and joking when one is actually experiencing significant emotional or physical pain – are largely about just that, suppressing the experience and expression of vulnerability.

Tragically, many aspects of this conventional masculine identity make men more likely to commit physical and sexual violence against others, especially girls and women. At the same time, taking on this masculine identity impairs and impedes boys' and men's abilities to recover from being sexually assaulted.

Social and cultural conditioning of how males relate to their emotions are so strong in our society that they are hard to overcome. Simply having different thoughts and beliefs, including feminist ones, is not enough to overcome that conditioning. Essentially, such conditioning rewires the brain and deeply ingrains habits for relating to emotions, especially vulnerable ones.

Overcoming that conditioning takes lots of effort and discipline, not only about what one thinks, but about how one habitually relates to emotions. We are all susceptible to cultural norms and social mores.

For males, this conditioning results in less emotional awareness, expressiveness, and empathy toward vulnerable emotions. It makes them likely to fear, hide, deny, and feel shame and contempt for feelings such as sadness, helplessness, and fear.

It's very difficult to overcome – though it's certainly possible with the right supports and disciplined efforts.

Sexual assault totally contradicts male identity. The victim no longer feels strong or in control – let alone invincible. He may feel "weak," like he was a coward to "let it happen," and ashamed that he was unable to defend himself.

In other words, his identification with the traits of his male identity, ingrained in him since birth, can be shattered. The victim does not know how to deal with the overwhelming vulnerable emotions evoked by the assault because he has always been told it's not OK for a male to be vulnerable, and he hasn't been taught constructive and effective ways of experiencing and dealing with such vulnerability.

All of this is a result of social conditioning, the expectation that he "be a man," and how these have deeply shaped his thinking, experience, behavior, and perception of manhood (Lisak 1994).

3. Assisting Male Survivors of Sexual Assault

Social conditioning has a great deal to do with why males don't seek help. Females often don't seek help either. But for males, it's "unmanly" to be victimized, or even need help – let alone ask for it.

Men may find it difficult to discuss the victimization for fear of being judged as weak or vulnerable, and "not a real man." And again, they have not been socialized to share vulnerable feelings, so it's very difficult to seek assistance or to know what to say even when they try.

In an article published in the *Journal of Traumatic Stress*, Dr. David Lisak (1994) reports on interviews he conducted with males who had experienced sexual abuse or assault.

Some of the themes and beliefs expressed by the men he interviewed included lack of public awareness and acceptance of male victims, and the theme of the unmanliness of being a victim, needing and seeking help, and talking about and sharing feelings.

Men who have been sexually assaulted often have common questions or comments that relate to three themes:

- Legitimacy – the inability of a victim to acknowledge that he was sexuality assaulted and that the crime had affected him, or the inability to see men as victims.
- Masculinity – the difficulty reconciling the fact that "real men" do not acknowledge and certainly do not express their own pain, vulnerability, or feelings of helplessness.
- Homosexuality – a victim's confusion about his sexuality or sexual orientation, or fear of homosexuality.

The activity addresses themes and beliefs related to male sexual assault.

For all the reasons we've discussed, men who are sexually assaulted are highly unlikely to report their victimization or to seek medical or mental health services. Because reporting is infrequent, services for male survivors of sexual assault have not been as prevalent as those for women.

There are few resources specifically designed for sexually assaulted men. The ones that do exist often fail to address homophobia and sexism. Or, they fail to challenge stereotypical notions of the male gender role that perpetuate shame and feelings of inadequacy and guilt.

Furthermore, services rarely recognize the specific needs of gay or transgendered individuals who have been sexually assaulted (Munro 2000). It is not surprising, then, that male sexual assault may be severely under-reported. (Tewksbury 2007).

Generating awareness of male sexual assault among advocates, victim service providers, and counselors is the first step toward developing reliable and useful services for male sexual assault victims. Support services need to be available that are knowledgeable and understanding of the specific needs of male victims, whether they are straight, gay, or transgendered.

Understanding Victim Behaviors

Because an assault so totally contradicts what males are supposed to experience and how they're supposed to be, normal masculinity gender identity may no longer be an option for some victims.

One way for victim service providers to understand how sexual assault affects males is in terms of a choice that is forced upon victims after the assault. Men who survive sexual assault may not put much reflection into this choice, but they do end up choosing by the ways they think and behave after sexual assault. The choices often take three paths:

Option A: Hyper-masculinity. One choice is to become hyper-masculine, to attempt to prove to oneself and everyone else that he not only is a "real man" but super-masculine. Insecurity and fear drive this choice, as well as the constant internal pressure to live up to this extreme version of masculinity.

Many men on this path are not aware of having made such a choice, in part because it would be too frightening to admit, even to themselves, that they feel a need to overcome the impacts of the sexual victimization they experienced.

Tragically, males who make this choice and head down this path are often at increased risk to victimize others – emotionally, physically, and/or sexually. Some who have been on this path sometimes tire of its hardships, or are helped to see the harm it is causing themselves and others.

Option B: Non-masculinity. Other men who have been sexually assaulted make another choice: simply to give up on being what society has defined as "real men," and resign themselves to a non-masculine identity. This can be accompanied by feelings of failure, defeat, depression, and demoralization.

And it literally is a demoralization for these men, because they have been, as many male victims of sexual assault have said, "robbed" of their masculinity and the moral foundation it had contributed to.

Option C: Healthy masculinity. Some men make yet another choice: to question and challenge masculine gender norms, and work to create an alternative masculine identity that is more positive and healthy than the stereotypical version. Simply reporting the crime and working with a victim advocate can be examples of such resistance and challenge, and you can acknowledge the strength and courage it takes for him to do so.

This choice is usually very consciously made, at least at some point along the way, although it may take man a while to arrive at it.

A victim also may choose this option if he is revictimized, or if someone he loves has been assaulted, which can bring an opportunity for openness to assistance from mental health professionals and victim advocates.

Providing Assistance

If you are working with a man who has already made one of these choices, it will determine how you relate to him. As a victim service provider, you may be able to help him reflect on whether and how he has made such choices, maybe without realizing he has done so; or whether he feels the need to make such choices now.

For men who have chosen the hyper-masculine or non-masculine options, a victim service provider can acknowledge how the sexual assault has forced them to make choices about their masculine identity and behavior, choices they may have made with little or no conscious deliberation.

The victim service provider can let them know that it's possible to develop an identity that includes human qualities conventionally ascribed only to males or females. Other men who've been sexually assaulted have done just that, and become stronger and more complete human beings.

Victim advocates also can tell victims that other males have had similar reactions, at least at first, and that it is totally normal and understandable.

For men who choose the healthy masculinity option, and who are ready to hear this and are receptive, confirm that it "totally makes sense" that he would have these questions and concerns given how he, like all boys and men, has always gotten the messages that "real men" can't be sexually victimized, that sexual contact with males either means you're gay or happened because you're gay, and other messages.

Acknowledge his courage for facing what he has been through and seeking help, in spite of social conditioning that makes it difficult to do so.

Recognize that he has reservoirs of strength to work through the process and overcome what has happened.

Depending on how the victim responds to your comments, or if he offers to engage in reflecting on how masculine gender socialization has shaped his understanding of what happened, you might help him sort out what actually makes sense, as opposed to what he's been taught all his life.

At some point in such a conversation, if he feels safe having it, you might point out that his questions and concerns are based in myths about males and sexual assault, and offer factual information that contradicts those myths.

It's important that you help him sort these things out for himself, and as much as possible arrive at these realizations on his own, with your support, rather than simply telling him what's myth and what's fact. As you would with anyone, take your cues from the victim you are working with.

You might also discuss the following topics with male victims, if they seem to be open to the discussion and it is appropriate to the situation.

Negative reactions: Be aware that others may have negative reactions to the crime. For example, male victims of female perpetrators may minimize the seriousness of their feelings about their assault due to a belief that they were supposed to "enjoy" it. Or, that gay and bisexual victims of male perpetrators may receive particularly blaming or homophobic reactions. Negative reactions from others serve to reinforce the victim's own negative attributions about the assault, and also serve as secondary victimization (Williams 1984).

Sexual aspects: Many men focus on the sexual aspect of the assault and not the totality. They may overlook the fact that they were coerced, had an unequal relationship with the perpetrator, and may have been emotionally abused. Helping them understand all aspects of the assault helps to reduce guilt and self-blame.

Effects on relationships: Many men do not consider how the crime may have affected their relationships. They may have viewed coping strategies as weaknesses rather than protective measures. Reminding the victim that the assault affects others – their partners, their families – helps to reduce tendencies to minimize the assault.

However, sometimes reactions from friends, families, and partners can be very negative (Walker et al. 2005). Disbelief and the partner's own grief may interfere with the support the victim needs.

Social conditioning: Help the victim understand that the messages they received at home and from society about being male can affect how they feel about the assault. You can help the victim examine how these messages left them vulnerable to feeling ashamed, and viewing the crime as negatively affecting their masculinity.

Permission to feel and to have needs. Many men have never let themselves cry or feel bad about the assault. Also, if a man's emotional needs were rebuffed as a child, he may feel that his needs are not important, and that other men are not supportive.

Men need to have opportunities to receive support from other men, and to affirm their male identity. Encouraging and supporting men in expressing their feelings can be valuable, especially if the victim chooses to go to group therapy with other male survivors.

Sexuality: Men who have been sexually assaulted need to explore their beliefs and problems with sexuality as it relates to the assault. Ambivalence and confusion may be an important part of the healing process for both gay and straight men. Be open about homosexuality, bisexuality, and straight sexuality.

In short, you can give victims support, encouragement, and hope.

Regardless of the path a male survivor chooses after an assault, he may display emotional responses that will negatively affect his ability to heal.

A male survivor's reaction to sexual assault may be very different from a female's. Men suffer distress and depression as women do, but a male survivor of sexual assault may be more likely to attempt to self-medicate with alcohol and drugs, show more anger and hostility to others (including support systems), withdraw from social contacts, display some form of posttraumatic stress disorder, or demonstrate confusion and sexual anxiety or dysfunction.

Do not hesitate to refer a male survivor to counseling or therapy if you feel it is necessary.

If you believe the victim should receive therapy, you can recommend individual or group approaches. Some therapists believe that individual therapy may be best suited to the initial stages of treatment, and that group therapy is the most useful approach for healing and change. Males may become isolated after they are sexually assaulted, and most have a profound need to connect with other men, and to explore how they have been affected.

As an advocate or victim service provider, you should be prepared to recognize these emotions and offer the appropriate assistance or referrals.

Additional Considerations

However well-intentioned or helpful to some men, identity labels can be harmful. Words like "victim" and "survivor" can feel wrong and scare people away – especially males who've been sexually assaulted.

Taking on the identity of "sexual assault victim," "sexual assault survivor," or "male survivor" can be limiting. It can create and solidify images of oneself as largely defined by, and/or forever damaged by, the experience.

Men who have had these experiences should be supported in finding their own language to describe what happened and understand its implications for their identity. Those of us attempting to help them can avoid identity labels and use "person-first" language. For example, we can refer to a sexual assault victim as "a person who's had an experience," or similar language.

Some males will feel safer with a female advocate than a male. This depends on factors such as whether the assault was perpetrated by a male or a female, and relationships with male and female parents.

In addition, gender socialization may condition males to seek support and comfort from females more than males because females are seen as being more nurturing, and emotional intimacy with a male advocate may trigger homophobic fears.

Conventional masculine values often are obstacles to males seeking help and benefiting from the help available to them. They may believe that being sexually abused or assaulted means they were cowards and they were weak. They may believe that seeking help is an act of cowardice and weakness because they haven't been able to "handle it themselves" like a "real man" would.

But victim advocates and mental health service providers can skillfully leverage and harness those same values to support boys and men. You can help a male who has been sexually victimized re-conceptualize his experiences, especially of seeking help and pursuing healing and recovery, as totally consistent with masculine values and his identity as a male.

Also, make sure your facility is welcoming to men. Have materials and information on assault that are designed exclusively for men. Ensure that all advocates understand the differences in working with male and female victims of sexual assault.

Training by Request
An OVC Program

Module 7
Effects of Sexual Assault on Males

OVC
OVCTTAC

Learning Objectives

- Distinguish fact from myth regarding male sexual assault.
- Discuss gender socialization.
- Describe the effects of sexual assault on males.
- Discuss how to assist males who have been victims of sexual assault.

Activity

What Do You Know About Male Sexual Assault?

- Read the slide.
- Decide if the statement is a myth or a fact.
- Raise your hand if you think the statement is a myth.

Myth or Fact?

If a man becomes sexually aroused during assault, he wants or enjoys it.

7-4

The Facts

A man may have liked the attention he was getting, or may have gotten sexually aroused. He may even have wanted some of the attention or sexual contact.

But that does not mean that he wanted or liked being assaulted.

7-5

Myth of Fact?

Sexual assault is less harmful to males than to females.

7-6

The Facts

Sexual assault harms males and females in ways that are similar and different, but equally harmful.

7-7

Myth or Fact?

If a female sexually assaults a male, he was "lucky." And if he doesn't feel that way, there's something wrong with him.

7-8

The Facts

Girls and women can and do sexually assault both boys and men.

Sexual abuse of a male by a female is not "luck" – it is exploitation and it is harmful, especially to boys who are more vulnerable and susceptible to manipulation by an adult female than an adult male.

7-9

Myth or Fact?

Most men who sexually assault boys and men are gay.

7-10

The Facts

Boys and men can be sexually assaulted by straight, gay, or bisexual men. The majority of those who do are straight/heterosexual.

Sexual assault is not related to the sexual orientation of the abusive person.

7-11

Myth or Fact?

Males assaulted by other males must have attracted the assault because they are gay or look gay. Or they become gay as a result.

7-12

The Facts

Whether a male is gay, straight, or bisexual, his sexual orientation is neither the cause nor the result of sexual assault.

If we focus on the *violence* of sexual assault rather than the *sexual* aspects of the interaction, it is easier to understand that sexual assault has nothing to do with a male's sexual orientation.

7-13

Gender Socialization

- The process of learning the social expectations and attitudes associated with one's sex.
- Can shape emotional impacts and how males and females respond.
- Begins as soon as a baby is born and continues throughout his or her life.

7-14

Male Biology and Emotions

As infants, males are more emotionally reactive and expressive than females:

- Startle more easily.
- Excite more quickly.
- Less frustration tolerance.
- Distressed more quickly.
- Cry sooner and more often.

7-15

Gender Socialization of Vulnerable Emotions

By middle of grade school boys are:

- Less aware,
- Less expressive,
- Less empathic – toward others and themselves

Zilbergeld 1992

7-16

Where Gender Socialization Comes From

Males and females are conditioned by different experiences and behaviors:

- How parents respond to their emotions.
- Responses from peers, games they play.
- Responses from teachers, coaches,
- Media messages and role models.

7-17

Criticized for “Non-Masculine” Behavior

Act like a man

Boys don’t cry

Man up!

Don’t be such a wimp

Don’t act so gay

That’s so *girly*

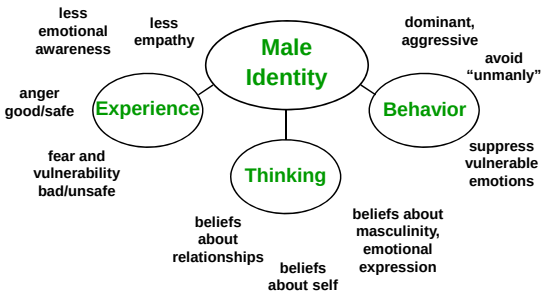
7-18

Moral Values and Gender Identity

- Moral values: Good ways to be who you are.
- We can't help but evaluate ourselves:
  - "How *close or far* am I from how I should be?"
  - "Am I moving *toward or away* from my ideal self?"
- Gender is moral, fundamental to identity.

7-19

Male Identity: Emotions and Values



7-20

Conditioning and Male Identity

- Thoughts and beliefs are important, but not the core.
- Conditioning goes deeper than what males think or choose.
- It wires and re-wires the brain.
- Less emotional awareness, expressiveness, and empathy = patterns of brain functioning.

7-21

Sexual Assault Totally Contradicts Male Identity

- No longer feels strong or in control.
- Identification with the traits of his male identity, ingrained since birth, can be shattered.
- Does not know how to deal with the overwhelming vulnerable emotions.

7-22

Why Males Don't Report Sexual Assault

- Social conditioning.
- Judgment as weak or "not a real man."
- Lack of public awareness.
- Needing and seeking help.
- Talking about and sharing feelings.

7-23

Three Themes

Men who have been sexually assaulted often have common questions or comments that relate to three themes:

- Legitimacy
- Masculinity
- Homosexuality

7-24

Activity

Themes and Beliefs Related to Male Sexual Assault

Worksheet 7.1

- Work individually to write at least one response for each statement.
- Report out to the large group.

7-25

Infrequency of Reporting

- Reporting is less prevalent for males than for females.
- Infrequency of reporting means fewer resources for men.

7-26

Infrequency of Reporting

Existing resources often:

- Do not address homophobia and sexism.
- Fail to challenge stereotypical notions of male gender roles
- Rarely recognize the specific needs of gay or transgendered victims.

7-27

Forced Choice

Option A: Hyper-masculine.
A “real man.” Insecurity and fear drive this choice.

Option B: Non-masculine.
Robbed of a masculine identity. Characterized by feelings of failure, defeat, depression, and demoralization.

Option C: Healthy masculinity.
Challenge masculine norms, create own identity that is more positive and healthy than the stereotype.

7-28

Providing Assistance

Option A Hyper-masculine
Option B Non-masculine

- Acknowledge how the sexual assault has forced him to make choices, which may not be made consciously.
- Explain that other males have had similar reactions.
- Let him know he can develop a more positive, healthier identity.
- Explain that other male survivors of sexual assault have done that.

7-29

Providing Assistance

Option C: Healthy Masculine

- Answer any questions and confirm his concerns are based on gender socialization.
- Acknowledge his courage for facing what he has been through and seeking help.
- Recognize that he has reservoirs of strength to work through the process.

7-30

Providing Assistance

- Help him engage in reflection and sort out what makes sense, vs. what he has been taught.
- Point out that most questions and concerns are based in myths about males and sexual assault.
- Offer factual information.
- Let the victim sort this information out for himself.
- Take your cues from the victim.

7-31

Topics To Discuss With Male Survivors

- Negative reactions from others.
- Totality of the assault, not just the sexual aspects.
- Effects on relationships.
- Social conditioning.
- Permission to feel and to have needs.
- Sexuality issues.

7-32

Negative Emotions

- Distress and depression.
- Self-medication.
- Anger and hostility.
- Withdrawal from social contacts.
- Some form of posttraumatic stress disorder.
- Confusion.
- Sexual anxiety or dysfunction.

7-33

Referrals

- Recommend therapy if you think it would be beneficial.
- Individual therapy is sometimes best suited for initial treatment.
- Group therapy is often best for healing and change.

7-34

Caution: Identity Labels Can Be Harmful

- Identity labels can be limiting.
- Men who've had these experiences should be supported in finding their own language.
- Avoid identity labels and use "person-first" language; for example, "a person who's had an experience."

7-35

Male vs. Female Advocates

- Some males will feel safer with a female advocate than a male.
- Gender socialization may condition males to seek support and comfort from females.
- Conventional masculine values are often obstacles to males seeking help.

7-36

Male vs. Female Advocates

Make sure your facility and staff:

- Welcome males.
- Have information on sexual assault specific to men.
- Understand the differences between male and female sexual assault.

7-37

Review of Learning Objectives

- Distinguish fact from myth regarding male sexual assault.
- Discuss gender socialization.
- Describe the effects of sexual assault on males.
- Discuss how to assist males who have been victims of sexual assault.

7-38

End of Module 7

Questions? Comments?

7-39

Module 8: Procedures in Common Advocacy Situations

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

Lessons

1. Responding to a Crisis Call Reporting a Recent Sexual Assault
2. The Medical-Forensic Exam
3. Law Enforcement Statement Accompaniment
4. Courtroom Accompaniment
5. Drug-Facilitated Sexual Assault

Learning Objectives

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

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

Participant Worksheets

- Worksheet 8.1, Medical-Forensic Exam Case Study
- Worksheet 8.2, Drug-Facilitated Sexual Assault

1. Responding to a Crisis Call Reporting a Recent Sexual Assault

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

- **Identify immediate concerns.** Assess the reason for the call.

- **Establish safety.** Ask where the perpetrator is, and where the victim is. Take appropriate steps to establish safety.

- **Explain services.** Explain the medical, support, and legal services available to the caller. Explain the importance of a medical-forensic exam, and the option of reporting the assault to law enforcement.

  Also explain to the victim that the sooner the medical exam is conducted, the more effective the treatment may be and the more evidence may be found. While the victim can certainly take more time to decide to get a medical exam and to report to law enforcement, the delay may affect credibility.

- **Arrange transportation.** If the caller wants to have a medical-forensic exam, discuss transportation. Callers may arrange their own transportation, or they can be transported in an ambulance or by law enforcement. Explain their options.

- **Discuss evidence.** Explain that victims should not shower, bathe, douche, change clothes, or brush their teeth. If they need to urinate and drugs or alcohol are involved, victims should collect the urine in a clean jar with a lid and bring it with them to the medical facility. Let victims know the local guidelines for evidence collection (e.g., 72/96/120 hours after the assault); however, also emphasize that the sooner the exam is completed, the more likely it is that evidence can be found.

- **Address practical issues.** Discuss any practical issues the victim needs to address, such as childcare or other responsibilities.

- **Arrange a time to meet.** If you will be meeting the victim at the emergency department, it is best to arrange a time to meet. If possible, the advocate should be there first. Discuss how to identify each other.

- **Activate other first responders.** Depending on the needs and wishes of the caller, and procedures in their area, advocates may need to activate other first responders.

2. Medical-Forensic Exam Accompaniment

Rape victims should receive a medical-forensic exam within 72/96/120 hours after the assault or longer (Linden 2011); time will vary depending upon local policy. The exam should be conducted as early as possible, since evidence is quickly lost. While DNA evidence has been collected 5-7 days after an assault, the likelihood significantly diminishes after 48 hours that the DNA can be linked to a suspect.

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

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

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

The activity is a medical-forensic exam case study.

A SANE is a specially trained nurse who will provide crisis intervention and support, and normalize the victim's response, just as you would. You and the SANE should reinforce each other. Having the support of two people in the emergency department can be invaluable for the victim.

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

An advocate or victim service provider must NEVER be involved in evidence collection.

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

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

3. Law Enforcement Statement Accompaniment

In addition to being present during the initial police report, you may accompany the rape victim to the investigator's office at a later time when an official statement is given. There, provide support and encouragement during what may be an intimidating experience and help the victim understand why certain questions are asked.

As with the SANE exam, you should not interrupt the law enforcement interview. Sit quietly during the interview and remember that you are there to support the victim, and to address any concerns when the interview is completed.

As an advocate, you function formally as members of the "response team," whether officially a SART or a community response team, or informally as members of separate community agencies. The "team" includes the law enforcement officer or investigator. Remember, you are *not advocating for the victim against the police.*

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

It is important that victims tell the complete truth about what happened, even if it is embarrassing, they were doing something they were told not to do, or they were engaged in an illegal activity, such as underage drinking or smoking marijuana. Victims need to know that this information will likely come out anyway.

Tell victims that if they lie about any part of the assault history, their credibility will be questioned, which could jeopardize the entire legal case.

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

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

In smaller communities, the investigator conducting the interview may be the same police officer who took the victim's initial statement; however, in larger municipalities, it will be someone from a separate department.

The investigator will usually ask the victim to verbally go through the statement in specific detail, with the investigator asking additional questions for clarification. Recording varies from area to area; the entire process may be video or audio recorded. The statement will usually be transcribed, and the victim will review and sign the transcript. This becomes the official account of the sexual assault.

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

Once the statement has been completed, you can talk with the investigator in private and ask about areas of concern. This will help you to better explain the process to the victim.

For example, if the investigator asked why the victim was walking through a downtown area alone at 1:00 a.m. and the tone of voice sounded accusatory, you can explain to the victim that such was not the intent: the investigator likely needed to know why the victim was in a particular area. If you still feel uncomfortable after talking with the investigator, you should report the situation to your supervisor the next day.

4. Courtroom Accompaniment

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

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

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

If the prosecutor decides not to charge the offender in a case, offering to go with the victim to the prosecutor’s office to discuss the reasons why may be as important as accompanying the victim to trial.

If the assailant is found guilty by trial, the victim may want you, as well as the victim’s family and friends, to go to the sentencing and provide support when the victim reads the victim impact statement, if a statement is to be read. Victim impact statements allow victims the chance to make prepared remarks to the judge indicating how the sexual assault has affected their lives. This impact is taken into consideration by the judge when determining the sentence. Victims often express a sense of empowerment after having made such a statement.

The activity explores some of the “dos and don’ts” of law enforcement statement accompaniment or courtroom accompaniment.

5. Drug-Facilitated Sexual Assault (DFSA)

For the activity, please use the drug-facilitated sexual assault material that follows.

Drug-Related Sexual Assault

Using drugs to make a woman more vulnerable to sexual assault is nothing new; alcohol has been used for this purpose for centuries and is still the most common substance used to facilitate sexual assault, involved in an estimated 75 percent of sexual assaults (Garriott and Mozayani 2001). Research on college women indicates that alcohol was used in nearly every assault, including forcible rape, incapacitated assaults, and drug-facilitated assaults (Lawyer et al. 2010).

What is different today is that inexpensive legal and illegal drugs are readily available that not only sedate the woman, facilitating the assault at the time, but also have an amnesic-like effect so that the victim has little or no memory of the sexual assault when it is over. These drugs may be referred to as drug-facilitated sexual assault (DFSA) drugs, and their presence is quickly spreading. These newer, memory-erasing drugs were first identified as a problem in the United States in the late 1980s and rapidly spread across the country during the 1990s. While drugs used to facilitate sexual assault are most often given to the potential victim without her knowledge – slipped into her drink, for instance – they also may be taken willingly by victims who are not fully aware of the effects, as is likely the situation at Rave parties where "Ecstasy," GHB and its derivatives, and other legal and illegal drugs are readily available.

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

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

- Alcohol
- Antihistamines
- Benzodiazepines, including flunitrazepam (Rohypnol)
- Alprazolam (Xanax)
- Diazepam (Valium)
- Midazolam (Versed)
- Clonazepam (Klonopin)
- Temazepam (Restoril)
- Zolpidem tartrate (Ambien)

- MDMA/Ecstasy
- GHB (Gamma Hydroxybutyric acid) and its precursors
- GBL (Gamma Butyrolactone) sold as a dietary supplement (Blue Nitro and Renewtrient)
- Tranquilizers (Ketamine)

Lawyer et al. (2010) found that about 30 percent of college women reported a drug-related sexual assault, while only 5 percent reported forcible rape. The vast majority of drug-related assaults involved alcohol and voluntary incapacitation (i.e., the victim willingly consumed the alcohol). Marijuana also was frequently used prior to drug-related assaults, followed by drugs such as Rohypnol, MDMA, GHB, and Ketamine, respectively. Rohypnol, MDMA, and GHB tended to be associated with involuntary incapacitation.

Related Federal Law

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

It also provides for a sentence of up to 20 years for the distribution and import of flunitrazepam into the United States. Congress passed another law, the Hillory J. Farias and Samantha Reid Date-Rape Drug Prohibition Act of 2000, which President Bill Clinton signed into law in 2000 (H.R. 2130). Among other mandates, this legislation made GHB a Schedule I controlled substance. The first prosecution under this law occurred in Miami within 2 weeks of its passage: A man on Florida's sexual predator list was charged with buying enough chemicals over the Internet to make 100,000 doses of the newly outlawed GHB.

Signs of Possible Drug-Facilitated Sexual Assault

To help a possible victim decide if a drug test should be done, you must be aware of the signs of drug use. They include:

- The victim has a history of being out drinking, having just one or two drinks (too few to account for the high level of "intoxication"), then a moment when she recognized feeling strange, then suddenly "very drunk." She may have still looked normal and, while a little unsteady on her feet, may have been able to walk out of the bar with her assailant.
- The victim becomes very "intoxicated" very rapidly – within 5 to 15 minutes – especially after accepting a drink from someone or drinking one she left unattended.

- The victim wakes up 8 or more hours later, uncertain but believing she may have been raped because she has vaginal soreness or is naked. Or, she wakes up with a strange man and has no or a very spotty memory of what happened.
- The victim was told she was given "Roaches," "Roofies," "Mexican Valium," "R-2," "easy lay," or GHB.
- The victim has a history of feeling or being told that she suddenly appeared drunk, drowsy, dizzy, and/or confused, with impaired motor skills, impaired judgment, and amnesia.
- The victim experiences "cameo appearances" in which she remembers waking up, possibly seeing the assailant with her, but being unable to move and passing out again. These memories may be associated with pain or a loud noise.
- The victim is high school or college age, since GHB and Rohypnol abuse is more common within these populations.

What To Do

Whenever you suspect that a drug was used to incapacitate a victim within the previous 72 hours, ask the victim not to void and to go immediately to a local hospital for a sexual assault forensic exam. If she must void, have her save her first voided urine in a clean container with a tight lid.

This urine will most likely contain metabolites of the drug she was given, which can be used to identify the drug. These metabolites are excreted from her system with each subsequent voiding, making it less likely that they will remain in sufficient quantity to be identified.

The victim should bring this urine to the hospital and give it to the SANE or other medical personnel conducting her forensic exam.

What the SANE Will Do

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

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

With so many other similar derivatives, this limited testing may give a false negative. Most laboratories do not have the ability to test for the drugs used to facilitate sexual assault, although

more are developing the capacity. Because a complete drug screen is necessary, private laboratory tests may cost in excess of $850.

Urine is used instead of blood because Rohypnol, GHB, and other commonly used drugs metabolize out of the bloodstream very quickly. Detection depends upon the dosage given and the procedures used by the laboratory in its analysis. Using current techniques, GHB and Rohypnol can be identified up to 72 hours after ingestion. Identification is more likely when the sample is collected earlier within these time frames (DrugForce Screening 2014).

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

Who Will Have Access to the Results?

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

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

While a urine, blood, or hair specimen obtained from the victim after a suspected DFSA is clearly the best evidence to lead to an arrest and conviction, the shortcomings inherent in today's techniques mean that positive specimens are often unobtainable.

However, there is still valuable evidence that the SANE can obtain to help the investigation and help the victim determine whether or not she was drugged and raped.

Impact on the Victim

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

Training by Request
An OVC Program

Module 8
Procedures in Common Advocacy Situations

OVC
OVCTTAC

Learning Objectives

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

Responding to a Crisis Call

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

Responding to a Crisis Call, continued

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

8-4

Medical-Forensic Exam Timeframe

Within 72/96/120 hours (or longer; advocates must know local policy).

Exceptions:

- Hostage situations.
- Force resulting in injury.
- Ejaculation without cleanup.

8-5

Medical-Forensic Exam: Yes or No?

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

8-6

Medical-Forensic Exam: Yes or No?

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

8-7

Activity

Medical-Forensic Exam
Case Study
Worksheet 8.1

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

8-8

Accessing Support

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

8-9

Advocates and SANEs

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

8-10

Dealing With Emergency Department Delays

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

8-11

Dealing With Conflicts or Problems

Never try to "fix" any issues with the SART yourself. Report any problems to your supervisor.

8-12

Law Enforcement Statement Accompaniment

- You are there to support the victim,
- Do not interrupt any part of the interview; you can address any concerns when the interview is completed.
- Law enforcement is part of your team.
- It is important that victims tell the complete truth.

8-13

Law Enforcement Statement Accompaniment

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

8-14

If You Have Concerns During the Statement

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

8-15

Courtroom Accompaniment

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

8-16

Support During a Case

If the prosecutor decides not to charge the case:

- Go with the victim to the prosecutor's office to discuss the reasons why.

If the assailant is found guilty by trial:

- The victim may want you to go with them to the sentencing and provide support.
- The victim impact statement is taken into consideration by the judge when determining the sentence.

8-17

Activity

Dos and Don'ts

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

8-18

Activity

Information Search and "Red Flags"
Worksheet 8.2

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

8-19

Learning Objectives

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

8-20

End of Module 8

Questions? Comments?

8-21

Module 9: Recovery Education and Skills Training

Purpose

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

Lessons

1. The REST Approach
2. Crisis Intervention
3. Education
4. Supportive Counseling and Other Therapies

Learning Objective

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

Participant Worksheet

- Worksheet 9.1, Role Play—Kendra and Laura

1. The REST Approach

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

- Crisis Intervention
- Education
- Supportive Counseling
- Skills Training

2. Crisis Intervention

Crisis intervention, either on the phone or face-to-face, 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 providing crisis intervention, advocates and victim service providers play a number of important roles, including:

- Supporting survivors in whatever way they need support.
- Normalizing their reactions to the trauma.
- Helping them prioritize and solve concerns.
- Ensuring that they are treated respectfully.
- Supporting their significant other(s).
- Providing crisis education, referrals, and followup contact as well as future legal advocacy, if necessary.

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

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

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

Victims often blame themselves for the sexual assault, 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.

Subsequently, it is very important for you to avoid placing blame on the victim, or appearing to place blame. Victims who blame themselves become more depressed, with post-rape adjustment worse than for victims who do not blame themselves.

Examples of positive statements:

- Healing happens.
- You will get better.

The activity is an opportunity to brainstorm about initial concerns during the crisis period.

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

- Deciding to report to the police.
- Concerns about the use of alcohol or drugs to facilitate the sexual assault.
- Deciding if they are ready to label the forced sex “rape,” and if so, what it means.
- Fears for their immediate safety.
- Deciding whom to tell and how to tell them.
- Confidentiality issues.
- Deciding where to go after the exam.
- Deciding if they will have an evidence kit exam.
- Fears of media involvement.

- Suicidal thoughts.
- Fear of contracting an STI, even HIV.
- Fear of becoming pregnant from the rape.
- Shame, self-blame, and embarrassment.

Effective crisis intervention requires establishing a therapeutic relationship with victims. These relationships are characterized by:

- Acceptance.
- Empathy.
- Support.

Conveying Acceptance

1. Nonverbally:
    - Maintain a calm facial expression.
    - Nod.
    - Lean in toward the victim.
    - Touch the victim on a hand or shoulder.
2. Verbally:
    - Restate what the victim has said.
    - Use the victim's language.
    - Allow and encourage victims to express their feelings.
3. By what you do:
    - Listen attentively.
    - Take time to be with victims and allow them to proceed at their own pace.

Conveying Empathy

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

Demonstrating Support

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

3. Education

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

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

Avoidance may be a common response to sexual assault but the literature clearly shows that, as a coping strategy, it is ineffective in facilitating recovery (Ullman et al. 2007).

Victims need to know this. The first step is to help them recognize avoidant coping strategies they may be using. One reason sexual assault victims do not want to report the crime is because they want to avoid thinking or talking about it, or dealing with it in any way, including participation in the legal process.

In order for victims to recover, they must learn not to avoid the cognitive and behavioral effects of the crime. The first step is to help victims understand that the painful process of facing their thoughts, fears, and anxieties is necessary. Other well-meaning individuals in their lives may actually be encouraging avoidance.

It is best to face these feelings and fears, because not thinking about the trauma does not make the memories go away. These memories will recur. If ignored, memories often come back and affect victims through nightmares, flashbacks, phobias, and other ways.

By facing these memories, the victim can get used to them and lessen or eliminate their power over the emotional response. Victims can then see or hear things that remind them of the trauma without experiencing the intense anxiety and fear. If victims expose themselves to memories or images of the feared situation long enough, their fears will decrease.

Encouraging victims to recount the traumatic event in detail is important, as is your response to their recounting. They may fear that if they tell you or anyone the gruesome details of the event, they will be seen as soiled, dirty, unworthy – much as they may now be feeling about themselves. However, never force victims to recount the event if they choose not to.

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

4. Supportive Counseling and Other Therapies

Supportive counseling is crisis-specific and includes respectfully listening to victims express their feelings as they become ready to do so, then demonstrating empathy and concern while providing information.

It is important to reassure survivors that their responses are normal, that they are not crazy and will recover (Ledray 1994). Supportive counseling encourages survivors to face their fears in realistically safe situations as soon as possible, and to discuss openly their concerns while the counselor acknowledges that any resistance to doing so is normal and understandable (Frazier and Ledray 2011).

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

Supportive counseling has been shown to improve symptoms of PTSD, anxiety, and fear among survivors of sexual assault. Yet, in a review of empirical research on rape treatment outcomes, Vickerman and Margolin (2009) found cognitive behavioral interventions lead to better outcomes than supportive counseling.

Among the most promising approaches are specialized techniques such as stress inoculation training, prolonged exposure therapy, cognitive processing therapy, and eye movement desensitization. All of these treatments are shown to have effects on PTSD, and possibly effects on depression, anxiety, fear, and other factors.

- Stress inoculation training includes psychoeducation to normalize fear and avoidance behaviors along with guided exposure to rape-related phobias.

- Prolonged exposure therapy includes psychoeducation, breathing training, and exposure via retelling of the rape event to address fear and avoidance.

- Cognitive processing therapy includes psychoeducation, exposure through writing assignments describing the rape and its meaning, and cognitive restructuring to accommodate information related to the trauma into pre-existing belief and memory structures.

- Eye movement desensitization involves exposure to a scene that represents the entire rape trauma, accompanied by the therapist moving his/her finger back and forth; this dual attention to the scene and the finger is hypothesized to help process the memory and reduce anxiety related to the scene. This therapy, in particular, requires further study to determine its efficacy.

Despite these successes, even the strongest interventions were limited in success for one-third of women (Vickerman and Margolin 2009). Also, only persons who have undergone proper training should implement these specialized interventions.

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

- When clothing is kept as evidence, finding clothes for the victim to wear home after the medical-forensic exam.

- Getting a shower/cleaning up after the evidentiary exam.

- Explaining the police report process; what it involves and means.

- Obtaining an order for protection.

- Finding a safe place to stay.

- Changing the door locks.

- Notifying victim credit card offices/bank of a theft.

- Obtaining emergency funds for food and housing.

- Locating or picking up the victim's children.

- Locating a pet or ensuring that it is fed.

- Providing or finding childcare.

- Addressing court issues and concerns.

- Arranging transportation home and to appointments.

- Obtaining telephone (or voice mail) 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 sexual assault and meet the demands of the criminal justice system. Many programs have special funds that can be used for such services and resources.

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

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

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

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

The activity is a role play addressing crisis intervention.

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

You should make a referral when victims are:

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

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

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

Criteria for suicide risk include:

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

Use the SLAP acronym to remember these criteria:

S = Statement of suicidal intent

L = Lethal

A = Access

P = Plan

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

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

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

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

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

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

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

- Drugs or alcohol was involved in the sexual assault.
- The victim comes to a counseling session intoxicated.
- The victim reports additional or increased substance use.
- The victim is concerned about her own substance use.
- The victim reports that friends or family are concerned about substance use.

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

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

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

Training by Request
An OVC Program

Module 9
Recovery Education and Skills Training

OVC
OVCTTAC

Learning Objective

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

Recovery Education and Skills Training (REST)

- Crisis Intervention
- Education
- Supportive Counseling
- Skills Training

Crisis Intervention

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

9-4

You Can:

- Support survivors in whatever way they need support.
- Normalize their reactions to the trauma.
- Help them prioritize and solve concerns.
- Ensure that they are treated respectfully.
- Support their significant other(s).
- Provide crisis education, referrals, and followup.

9-5

When To Begin?

Crisis intervention should begin as soon as possible, preferably within the first few hours after the sexual assault

9-6

Avoid Blame

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

9-7

Positive Statements

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

9-8

Activity

Brainstorm –
Initial Concerns During Crisis Period

9-9

Crisis Issues

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

9-10

Crisis Issues, continued

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

9-11

Supportive Relationship Characterized by…

- Acceptance
- Empathy
- Support

9-12

Acceptance Conveyed…

Nonverbally:

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

9-13

Acceptance Conveyed…

Verbally:

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

9-14

Acceptance Conveyed…

By what you do:

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

9-15

Empathy Conveyed by…

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

9-16

Support Demonstrated by…

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

9-17

Support Demonstrated by…

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

9-18

Destigmatizing Rape

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

9-19

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.

9-20

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.

9-21

Telling the Victim's Account

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

9-22

Supportive Counseling

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

9-23

Practical Concerns

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

9-24

Practical Concerns, continued

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

Practical Concerns, continued

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

Victim Needs To Know…

They are not alone.

When and who to call for help.

Explain Your Role

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

9-28

Activity

Role Plays – Kendra and Laura
Worksheet 9.1

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

9-29

When To Refer Out

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

9-30

Referral Should Be Made When a Victim is…

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

Suicide Risk

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

Psychosis

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

Concern About Substance Abuse

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

9-34

When To Ask for Assistance

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

9-35

Review of Learning Objective

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

9-36

End of Module 9

Questions? Comments?

Module 10: Compassion Fatigue and Self-Care

Purpose

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

Lessons

1. What is Compassion Fatigue?
2. Effects of Compassion Fatigue and Related Phenomena
3. Maintaining Healthy Boundaries
4. Strategies for Self-Care

Learning Objectives

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

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

Participant Worksheets

- Worksheet 10.1, Maintaining Healthy Boundaries
- Worksheet 10.2, Personal Self-Care Plan

1. What Is Compassion Fatigue?

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

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

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

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

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

Compassion fatigue is a syndrome that includes changes similar to those experienced by survivors. The American Bar Association (2014) defines compassion fatigue as the "cumulative physical, emotional, and psychological effect of exposure to traumatic stories or events when working in a helping capacity, combined with the strain and stress of everyday life. Symptoms of compassion fatigue can be similar to vicarious trauma, secondary traumatic stress, and burnout.

Vicarious trauma describes a cognitive shift in beliefs about one's self or one's world view about issues such as safety, trust, or control. For instance, hearing about a particularly horrendous event might compromise one's trust or shatter one's faith in humanity (Newell and MacNeil 2010).

Secondary traumatic stress (STS) describes symptoms of traumatic stress that result from bearing witness to another person's trauma via the empathetic relationship with that individual. Thus, the focus here is not on the effects on cognitions, but rather on symptomology such as anxiety and intrusive thoughts (Newell and MacNeil 2010). Just as PTSD is a normal reaction to an abnormal event, STS is a normal reaction to the stressful and sometimes traumatizing work with survivors (Rosenbloom, Pratt, and Pearlman 1995).

Like compassion fatigue, vicarious trauma and secondary traumatic stress are specifically related to working with trauma survivors. Vicarious trauma and secondary traumatic stress can occur after a single instance of exposure. (Newell and MacNeil 2010).

Burnout relates more to the service setting and working conditions, while compassion fatigue includes traumatic stress symptoms. Burnout can occur in any stressful work environment, and develops over time.

Burnout is physical, emotional, psychological, or spiritual exhaustion resulting from chronic exposure to vulnerable or suffering populations in any social service setting; burnout has dimensions of emotional exhaustion, depersonalization or cynicism and detachment toward victims and situations, and reduced sense of personal accomplishment (Newell and MacNeil 2010).

For instance, a mental health worker might experience burnout in relation to unmanageably large caseloads and mentally exhausting work. Although these individuals may become tired, drained, and unmotivated, they are not inclined to begin wondering if people are basically good or evil, or if the world is safe, both of which may happen to those repeatedly exposed to violence.

Mary Jo Barrett, director of training and consultation at the Center for Contextual Change, lectures widely on compassion fatigue. She differentiates between compassion fatigue, vicarious trauma, secondary traumatic stress, and burnout. Understanding each of these conditions better prepares advocates to identify and cope with the issues.

While the nuances of these various phenomena may be difficult to remember, the important thing to keep in mind is that in this field of work you are especially at risk for changes in your world view, emotional and physical exhaustion, feelings of detachment or cynicism, and symptoms of traumatic stress. These can occur from as little as a single exposure or can build up after cumulative exposure.

If you begin to experience these symptoms but do not understand why, the symptoms begin to consume all of your energy. You may see fear where there is no fear, or feel crazy or unlike yourself. Therefore, self-care is important to prevent from impairing your work and life.

With emotional and spiritual energy reservoirs drained, advocates no longer have the vital energy to offer to victims or to themselves, and they begin to suffer from compassion fatigue.

2. Effects of Compassion Fatigue and Related Phenomena

Compassion fatigue and other similar phenomena can disrupt your frame of reference (identity, worldview, and spirituality), self-capacities (eating, sleeping, exercising, hobbies, and relationships with friends and partners), and ego resources (the ability to self-monitor) (McCann and Pearlman 1990).

Disruptions in Frame of Reference

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

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

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

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

Another type of disruption reported by trauma workers is the intrusion of sexually traumatic images while engaging in sexual activity (Maltz 1992). This is a distressing example of how images from your professional life can blur into the intimacies of your private life.

One way to deal with this intrusion is to explain the cause of your distress to your partner (without revealing any details that would betray confidentiality) and focus on processing your own feelings and need to reconnect (Pearlman 1995).

Disruptions in Self-Capacities

Engaging empathically with victim after victim can be draining, and one response is to shut down emotionally (Pearlman 1995). As a result, you may tend to refuse social engagements or activities as a way of storing up energy to cope with the demands of your job. You may find yourself answering your phone less or making excuses to stay home.

This coping mechanism is particularly maladaptive because you limit your life while simultaneously severing yourself from some of the most effective ways to restore your energy. Connection is an antidote to violence and helps caregivers maintain the optimism and hope that victims rely on for their own healing.

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

Disruptions in Ego Resources

Ego resources refer to being able to effectively meet your psychological needs and manage interpersonal relationships. These resources include self-examination, intelligence, willpower, sense of humor, empathy, and the ability to set and keep boundaries, all of which can be affected by working with issues of sexual assault (Pearlman 1995).

Regarding your overall functioning, these disruptions are arguably the most insidious. When your ability to step back and assess your choices and behaviors becomes impaired, it is difficult to even recognize that you have a problem or no longer feel fulfilled and balanced.

Costs of Working With Survivors

The consequences of working with survivors are pervasive and real. Those who suffer from compassion fatigue and other such phenomena may find it increasingly difficult to attend to victims and survivors with an empathetic, hopeful, and compassionate response. Once affected, advocates may dread going to work and taking calls, become irritable, and appear to shut down or distance themselves when interacting with survivors.

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

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

Yet, working with a higher percentage of sexual assault survivors was not correlated with job burnout or the negative effects associated with depression.

They concluded this was likely because many caregivers also reported the work's positive aspects which they found rewarding, including being able to help people in crisis move toward recovery.

In a more recent study (Baird and Jenkins 2003) of 101 trauma counselors, researchers found that while younger workers experienced slightly more burnout, more experienced trauma workers reported both more emotional exhaustion and more sense of personal accomplishment.

McCann and Pearlman (1990) suggest that you can remain connected to survivors and protect yourself emotionally by remaining conscious of the broader context. For example, while survivors are telling their accounts of sexual assault, keep remembering that they have survived, are now connected to caring people and helpful resources, and that healing can and does happen.

Compassion fatigue and its variations, the terms of which are often used interchangeably in the literature, pose a problem to caregivers, yet our profession has only recently begun to talk about it. We still work in a culture where it is largely unacceptable to talk about feeling exhausted or overwhelmed, or not connecting with victims. However, if you are good at advocacy and victim services work, it is very difficult not to get compassion fatigue or these related occupational hazards.

The only way to avoid these consequences of working with survivors is to not care, which is hardly an option. The only way to continue caring is to pay attention to how you are being affected by your work, prioritize your own self-care, and do whatever you need to do to keep refilling your goblet again and again.

3. Maintaining Healthy Boundaries

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

The activity explores healthy boundaries.

4. Strategies for Self-Care

Caregivers generally know what to do to help themselves feel healthy, but they are often too tired to do it. Once you understand compassion fatigue and related phenomena, you must recognize that taking care of yourself is both your right and your responsibility and you must commit to replenishing yourself.

Part of self-care is self-compassion; that is, being caring and compassionate towards yourself in the face of hardship or perceived inadequacy. Self-compassion is taking a balanced approach to your negative experiences so that painful feelings are neither suppressed nor exaggerated (Neff, Kirkpatrick, and Rude 2006).

Advocate supervisors also must support their staff in doing the things that staff need to do to keep themselves healthy. Supervisors need to set a good example by making self-care a priority in their own lives as well.

The alternative is to continue doing victim services work at an impaired level or leaving the field entirely, neither of which serves survivors or advocates. You should figure out what depletes you, then automatically do something to replenish that energy.

Effective self-care means raising your awareness of how well you are/are not eating, sleeping, exercising, socializing, enjoying life, spending time with family, and participating in the hobbies and activities you love, then taking measures to make your own needs a priority.

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

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

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

- Difficult, new, or unusual cases.
- Cases involving compassion fatigue, vicarious trauma, and secondary traumatic stress.
- Cases with boundary issues.
- Cases in which you meet with the victim more than once a week or 12 total sessions.

The activity addresses self-care planning.

Training by Request
An OVC Program

Module 10
Compassion Fatigue and Self-Care

OVC
OVCTTAC

Learning Objectives

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

Compassion Fatigue

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

Survivors as Advocates

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

Compassion Fatigue

"…the cumulative physical, emotional, and psychological effect of exposure to traumatic stories or events when working in a helping capacity, combined with the strain and stress of everyday life."

American Bar Association 2014

Vicarious Trauma

Vicarious trauma is a cognitive shift in beliefs about one's self or one's world view about issues such as safety, trust, or control.

For example, hearing about a particularly horrible event might compromise one's trust or faith in humanity.

Newell and MacNeil 2010

Secondary Traumatic Stress

Secondary traumatic stress (STS) results from bearing witness to another person's trauma via an empathetic relationship, often resulting in anxiety and intrusive thoughts. However, STS is a normal reaction to the stressful and sometimes traumatizing work with survivors.

STS may occur independently or co-occur with vicarious trauma.

Newell and MacNeil 2010
Rosenbloom, Pratt, and Pearlman 1995

10-7

Burnout

Burnout is a physical, emotional, psychological, or spiritual exhaustion resulting from chronic exposure to vulnerable or suffering populations. Burnout can include emotional exhaustion, depersonalization or cynicism and detachment, as well as a reduced sense of personal accomplishment.

Newell and MacNeil 2010

10-8

Conditions Affecting Advocates

Condition	Who is Affected	Exposure
Compassion Fatigue	Those who work with trauma survivors	Develops over multiple exposures to traumatic stories
Vicarious Trauma	Those who work with trauma survivors	May develop from exposure to one or more instances.
Secondary Traumatic Stress	Those who work with trauma survivors	May develop from exposure to one or more instances.
Burnout	Anyone in a stressful work environment	Develops over time

10-9

Disruptions in Frame of Reference

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

10-10

Disruptions in Self-Capacities

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

10-11

Disruptions in Ego Resources

Disruption of your abilities to effectively meet your psychological needs and manage interpersonal relationships.

10-12

Costs of Working With Survivors

- Increasingly difficult to attend to survivors with empathy, hope, and compassion.
- Caregivers and supervisors must be aware of this possibility and recognize early symptoms.
- Remain connected to survivors and protect yourself emotionally by remaining conscious of the broader context.

10-13

Costs of Compassion Fatigue

Caregivers often work in a culture where it is largely unacceptable to talk about feeling exhausted, overwhelmed, or not connecting with victims.

Pay attention to how you are affected by your work and prioritize your own self-care.

10-14

Activity

Boundaries Checklist
Worksheet 10.1

10-15

Strategies for Self-Care

- Commit to replenishing yourself.
- Practice self-compassion.
- The alternative is to continue doing advocacy at an impaired level or leave the field.
- Be aware of how well you are functioning.
- Meet with your supervisor.

10-16

Meet With a Supervisor

- Difficult, new, or unusual cases.
- Cases involving vicarious trauma.
- Cases with boundary issues.
- Cases in which you are meeting with the victim frequently.

10-17

Activity

Self-Care Planning
Worksheet 10.2

10-18

Review of Learning Objectives

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

End of Module 10

Questions? Comments?

Module 11: Wrap-Up and Evaluation

Purpose

This module allows you to reflect on the training, prepare checklists for assisting victims of sexual assault, and provide feedback on your training experience.

Lessons

1. Wrap-Up
2. Evaluation

Learning Objective

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

Participant Worksheet

- Worksheet 11.1, Checklist for Working With Victims of Sexual Assault

1. Wrap-Up

The activity is an opportunity to review the training and come up with some personalized reminders to help you more effectively work with victims of sexual assault.

2. Evaluation (15 minutes)

Please complete an evaluation.

Thank you for making the commitment to attend the training, and for your hard work and insights.

Training by Request
An OVC Program

Module 11
Wrap-Up and Evaluation

OVC
OVCTTAC

Learning Objective

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

Activity

Checklist for Working With Victims of Sexual Assault
Worksheet 11.1

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

Evaluations

11-4

Thank you for your time,
commitment, and insight.

11-5

Information and Tools for Program Managers

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

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

Sample Advocate Recruiting and Application Materials

Sample Inquiry Letter

Dear Prospective Advocate,

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

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

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

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

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

Sincerely,

Advocacy Supervisor

Sample Job Description

The Role of the Volunteer Advocate

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

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

Qualifications for Women and Men

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

Training

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

Sample Written Application

Date_____

Name_____

Address _____

Phone: Home_____ Work _____

Date of Birth _____ Social Security Number _____

How did you hear about our program? _____

Current Employer/School _____

Address _____

Phone: _____

Emergency Contact_____

Address _____

Phone: Home_____ Work _____

References

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

Name_____

Address _____

Phone: Home_____ Work _____

Relationship _____

Name_____

Address _____

Phone: Home_____ Work _____

Relationship _____

Name_____

Address _____

Phone: Home_____ Work _____

Relationship _____

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

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

Volunteer Advocate Confidentiality Contract

Responsibilities of the Volunteer Advocate

1. Maintaining strict confidentiality with each case so as to protect the privacy of all clients served.

2. Attending all parts of the initial advocacy training.

3. Attending a monthly advocate team meeting, including in-service presentations, and contacting team leader or program coordinator if unable to attend. Arrangements for scheduling must be made prior to the meeting if absence is inevitable; otherwise, the team leader will schedule the advocate and the advocate will be responsible for filling those shifts.

4. Making a minimum *1-year* commitment to the program.

5. Being on call, from home or by a pager, according to a monthly prearranged schedule.

6. Being completely drug- and alcohol-free while on shift or backing up a shift.

7. Calling the answering service at the beginning of your shift to verify your phone number, updating as needed.

8. Providing information, referrals or emotional support over the phone to any hotline caller, and responding to the SANE Unit or St. Vincent's Hospital to assist survivors of sexual or domestic violence.

9. *Never* entering into a professional relationship with a SFRCC client/hotline caller (e.g., as a massage therapist, dog groomer, business consultant, etc.).

10. *Never* going to a victim's home or the scene of the alleged crime without having a police escort and contacting a team leader or the program supervisor.

11. Reporting a brief description of each case to the office staff *at the beginning of the next working day.*

12. Providing a written report with details of each case *within 48 hours* of the call.

13. Reporting any incident of child sexual abuse (age 17 or under) or alleged/suspected child abuse to the CYFD office and law enforcement *immediately* after receiving a disclosure. By law, this report must be filed.

14. Consulting with office staff before maintaining ongoing involvement in any case.

15. Doing followup on cases when appropriate, and providing information regarding that followup to the program supervisor.

Responsibilities of the Rape Crisis Center Staff

1. Providing an initial, intensive, 40-hour training for advocates as well as followup training and supervision in specific areas to enhance their job performance, as appropriate.

2. Providing debriefing and supervision to advocates in the office and via phone calls during and after the immediate crisis in which they are involved, as appropriate.

3. Providing support services to advocates in the areas of information, referral, backup advocacy, and short-term personal counseling pertaining to their role as an advocate.

4. Providing evaluations pertaining to an advocate's role performance at the request of the advocate or the SFRCC supervisor.

5. Other responsibilities of the SFRCC, as agreed.

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

Date _____

Advocate in Training _____

Advocate Supervisor _____

Advocate Interview

Applicant:

Interviewer:

Date of Interview:

Duration of Interview:

Why do you want to volunteer at the SFRCC?

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

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

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

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

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

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

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

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

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

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

Sample Reference Letter

(Date)

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

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

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

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

Thank you for your cooperation!

In community spirit,

Advocacy Program Supervisor

Sample Personal Reference Questionnaire

Volunteer Applicant: _____

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

Low Average High

1 2 3 4 5

1. Dependability (follows through with commitments) 1 2 3 4 5
2. Reliability in accepting responsibility 1 2 3 4 5
3. Evidence of good judgment in daily relations 1 2 3 4 5
4. Personal ethics 1 2 3 4 5
5. Flexibility (adapts to changes, accepts people with different values and lifestyles)

   1 2 3 4 5
6. Stability in applicant's life 1 2 3 4 5
7. Gets along well with others 1 2 3 4 5
8. How long have you known the applicant and in what capacity?

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

Additional comments:

Signature _____ Date _____

Sample Critical Item Suicide Potential Assessment

Hennepin County Medical Center, Minneapolis, MN

Primary Risk Factors

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

1. Attempt

(+) Present (-) Absent

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

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

(+) Present (-) Absent

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

Secondary Risk Factors

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

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

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

Major contributing Demographic Characteristics

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

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

Implementing Institutionalized Change to Prevent Compassion Fatigue

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

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

- **Institute policies that require advocates/counselors to discuss upsetting material and cases.** One helpful measure is for agencies to provide regular staff meetings that include case reviews, debriefing and mutual support, especially for the more distressing cases (Arndt 1988; Alexander, Chesnay, Marshall, Campbell, Johnson and Wright 1989; Eubert 1989; Tobias 1990; Holloway and Swan 1993; Tempelton 1993; Ledray 1998). It may even be necessary to utilize staff support groups (Eubert 1989) or refer staff to a counselor or psychologist for additional emotional support (Holloway and Swan 1993).

- **Ensure that sufficient staff is available to share the workload.** It is essential to keep the number of hours worked and overall stress at a manageable level for each employee (Ledray 1998). It may be necessary to discourage staff from taking back-to-back on-call shifts, especially during busy weekend periods. It may be helpful to have a predetermined number of shifts for which each staff member is responsible each month to ensure that a few are not being overburdened.

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

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

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

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

What Can Agencies and Organizations Do?

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

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

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

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

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

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

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

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

Ten Strategies to Help Prevent Compassion Fatigue

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

1. Create an atmosphere in which reactions to traumatic material are considered normal and inevitable, and where employees are supported and validated.

2. Encourage staff to not work overtime. Creating a position that cannot be filled in the number of paid hours is a setup for compassion fatigue. If an employee exhibits satisfactory job performance, it is ultimately the agency's responsibility to ensure that they complete their duties during their paid hours or change the job description to make this possible.

3. Schedule regular, full-staff meetings with periodic facilitated meetings to process reactions resulting from exposure to traumatic material, assess compassion fatigue, brainstorm successful self-care strategies, and discuss the future visions and successes of employees.

4. Enforce a work ethic that encourages staff to take full lunch breaks away from their desks.

5. Provide generous amounts of paid time off to allow for self-care, validate the difficulty of the work, and compensate for the lower pay typically offered at social service agencies.

6. Afford professional development money and time to allow employees to attend conferences, learn new intervention tools, and get "recharged."

7. Emphasize the importance of self-care. Make sure employees regularly have full days off with no on-call duties. Inquire about self-care strategies in all volunteer/ employee interviews.

8. Plan periodic picnics, retreats, nature walks, group lunches, or other agencywide activities.

9. Select a health plan that offers good mental health coverage.

10. Include as part of the agency's mission statement the awareness of and commitment to the prevention of compassion fatigue among employees.

The Importance of Program Evaluation

Why Evaluate?

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

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

Formal and Informal Evaluation Strategies

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

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

- Process evaluation.
- Outcome evaluation.

Each type of evaluation may be accomplished formally or informally.

Process Evaluation

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

- Sexual assault victims are surveyed and asked if it is helpful to have the advocate come to the emergency department (ED) automatically or if they believe they should be asked if they want her paged.

- Sexual assault victims are asked if it is helpful to bring up the issue of HIV in the ED or if it would be better to wait until a later time.

- Followup telephone surveys are conducted 2 months after the assault to see if the victims took advantage of referral information provided to them by the advocate.

- Calls are placed 2 months after the assault to rape victims who did not come in for counseling. They are assessed for symptoms of PTSD and asked if they are interested in coming in for counseling at this time.

- With counseling visits scheduled, the follow-through rate can then be compiled.

- Victims are surveyed 2 weeks after their ED visit and asked about their satisfaction with the care provided by the police, hospital medical staff, the SANE and the advocate.

- SANEs complete data sheets in the ED on every client seen, providing the following information:

- The time between the victim's arrival at the ED and the SANE's arrival.

- If no police report was made prior to the SANE's arrival, whether the SANE was able to resolve the client's fears and if a report was eventually made.

Outcome Evaluation

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

The immediate outcome of service may include:

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

The short-term outcome of service may include:

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

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

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

Data Collection and Analysis

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

Evaluation Utilization

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

Steps of Program Evaluation Planning

1. List the RCC program's primary goals and activities.

2. Identify problem areas, questions or concerns.

3. Identify outcomes of individuals or groups who make use of RCC services.

4. Formulate evaluation question(s).

5. Identify the types of information needed to answer the question(s).

6. Identify where the information is currently available or how to obtain it.

7. Decide who will obtain the information and over what timeframe.

8. Decide how the information obtained will be used.

Evolution of Program Evaluation

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

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

History and Development of Rape Crisis Centers

History of Rape Crisis Advocacy

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

Radical feminists in New York organized the first public speak-out on rape in 1971 (Herman 1992). These feminists recognized rape as much more than the result of the uncontrollable sexual drive of oversexed men. Sex was recognized as a weapon that men used against women. The political and control aspects of sexual assault were stressed, they being a way for men to maintain power and control over women by keeping them out of traditional male establishments such as bars, and keeping them dependent upon men for protection (Brownmiller 1975). In her landmark book on sexual assault, *Against Our Will: Men, Women, and Rape* (1975), Susan Brownmiller traced the origins of rape and rape laws as a means for men, not women, to obtain restitution for damage to their property, their women. Tracing the history of rape laws, she found that the term "rape" comes from Raptus, a Latin term which refers to the theft of property.

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

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

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

- Restrict, through the implementation of "Rape Shield Laws," the use of the victim's previous sexual history to discredit her in court. (While this is indeed a major improvement, one that significantly limits the content of the victim's sexual history now admissible into court, it has not totally eliminated it. For example, if sperm from another person is present in the medical-forensic exam findings, that is admissible, as is any past consensual sexual contact with the accused.)

- Change the definition of consent to recognize the difference between consent and submission (when the victim did not physically resist due to fear); to recognize the difference between consent and lack of consent (when the victim was asleep or passed out); and to include the use of force or "coercion."

- Exclude the need for there to be a witness to the rape in order to prove that it was indeed rape.

- Increase the statutory rape age from 10 to 12 years of age in most states. (The 1990s have seen an even more aggressive prosecution of statutory rape as an attempt to reduce teenage pregnancy.)

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

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

History of Rape Crisis Centers

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

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

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

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

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

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

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

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

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

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

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

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

1. Rectifying imbalances.

2. Helping survivors by funding services.

3. Providing resources and grants for education and training for police, prosecutors, judges and victim advocates.

4. Requiring treatment equal to that of men under the law by strengthening old laws and creating new ones (Biden 1993).

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

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

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

When Advocacy Programs Rely on Volunteers

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

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

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

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

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

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

What You Can Do

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

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

Appendix A

Background on VAWA 2005, VAWA 2013 and Forensic Compliance

EVAWI
End Violence Against Women International

Background on VAWA 2005, VAWA 2013 and Forensic Compliance

What is VAWA 2005?

In 2005, the Violence Against Women Act (VAWA) was reauthorized with several landmark changes particularly affecting the response of law enforcement agencies and health care facilities to victims of sexual assault. This act, often referred to as "VAWA 2005," specifies that states and territories may not "require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam, reimbursed for charges incurred on account of such an exam, or both." In other words, VAWA 2005 was designed to ensure that victims of sexual assault have access to a forensic medical exam free of charge or with full reimbursement regardless of whether they report the crime to police or otherwise cooperate with the criminal justice system.

All states and territories must now certify (as of January 5, 2009) that they are in compliance with these requirements in order to remain eligible for STOP Grant funds from the Office on Violence Against Women (OVW). Yet communities face considerable challenges in designing a protocol for the initial response to a sexual assault disclosure, as well as addressing questions regarding payment for the medical forensic examination, mandatory reporting to law enforcement, storage and transportation of evidence, case tracking and retrieval, processing of evidence, and the potential for evidence-based prosecution (i.e., without the victim's cooperation). For many states and territories, the changes that are required in public policy and daily practice have been described as "monumental." Some of these questions are addressed in the "Frequently Asked Questions" document published by OVW found here.

All states and territories must now certify (as of January 5, 2009) that they are in compliance with these requirements in order to remain eligible for STOP Grant funds from the Office on Violence Against Women (OVW).

What is VAWA 2013?

VAWA 2013 is the most recent authorization of the Violence Against Women Act. This act, often referred to as "VAWA 2013," retains all of the forensic compliance provisions from 2005 with two important changes. First, **VAWA 2013 clarified that victims cannot be required to pay any out-of-pocket costs to obtain a medical forensic exam.** Under VAWA 2005, jurisdictions were allowed to bill victims for the cost of the exam as long as they were fully reimbursed. However, this option was eliminated in VAWA 2013. Also, in a critical advance, VAWA 2013 states that a governmental entity (such as a U.S. state, territory, or tribal government) will only be eligible for STOP grant funding if it coordinates with regional health care providers to **notify victims of sexual assault of the availability of rape exams at no cost to the victims.** This new provision has the potential to create a sea change in public awareness.

What is Forensic Compliance?

Forensic compliance refers to two specific provisions that first appeared in the 2005 reauthorization (and remain in place under the most recent reauthorization of VAWA 2013) regarding medical forensic exams for victims of sexual assault. These provisions read as follows:

> *Nothing in this section shall be construed to permit a State, Indian tribal government, or territorial government to require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a medical forensic exam, reimbursement for charges incurred on account of such an exam or both (42 U.S.C.A §3796gg-4(d)(1)(2005)).*

Thus there are two dictates associated with forensic compliance. VAWA legislation states that victims of sexual assault must be provided with access to a medical forensic examination:

1. Free of charge, and
2. Without requiring them to cooperate with law enforcement or participate in the criminal justice system.

All states, territories and Indian tribal governments were required to certify compliance with VAWA 2005 by January 5, 2009 in order to continue receiving STOP funding. They must remain in compliance to retain their ongoing eligibility for STOP funds.

EVAWI's Forensic Compliance Project

In May of 2009, EVAWI was awarded a grant from the **Office on Violence Against Women (OVW)** U.S.
Department of Justice, to provide technical assistance for professionals implementing a community response system that is compliant with the forensic medical examination requirements of the **Violence Against Women Act of 2005, 42 U.S.C. § 3796gg-4(d)**. The grant has been renewed several times, and we are currently funded to continue this project through 2016.

As part of this project, we develop and disseminate a number of resources for professionals to adapt for use in their own communities. These resources include a community self-assessment tool and sample policies, protocols, forms, and other documents to help implement VAWA forensic compliance. We also offer detailed answers to Frequently Asked Questions. To submit a technical assistance request, please use the online portal on our home page.

This project is supported by Grant No. 2013-TA-AX-K045 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed on this website and all posted materials are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

http://www.evawintl.org/PAGEID2/Forensic-Compliance/Background

Appendix B

HIPAA Privacy Guidelines and Sexual Assault Crisis Centers

HIPAA Privacy Guidelines and Sexual Assault Crisis Centers

Table of Contents

Contacts

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www.oag.state.tx.us

For more information concerning HIPAA, please refer to www.oag.state.tx.us or www.taasa.org.

HIPAA Fact Sheet #1

HIPAA Privacy Guidelines And Their Impact On Sexual Assault Programs

Recently, questions have arisen regarding the application of the Health Insurance Portability and Accountability Act ("HIPAA") to sexual assault programs. Specifically, some programs are concerned that the Privacy Rule may limit their ability to provide advocacy services to survivors of sexual assault. This fact sheet is designed to help sexual assault programs determine whether they are required to comply with the Privacy Rule.

Similarly, some hospital personnel may have concerns about whether they can continue to notify local sexual assault programs when a survivor is in the emergency room and about whether, once an advocate is in the emergency room, the hospital personnel can disclose private health information about the survivor to the advocate. Two separate facts sheets–*HIPAA Privacy Guidelines and Notifying Crisis Centers* and *HIPAA Privacy Guidelines and Victim Advocates in the Emergency Room*–deal with those issues.

Q: Who is Required to Comply with HIPAA?

COVERED ENTITIES. The Privacy Rule sets out practices that certain entities must implement to comply with HIPAA. Those entities are referred to in the Privacy Rule as "covered entities." There are three types of covered entities: (1) health plans; (2) health care clearinghouses; and (3) health care providers. A health plan provides or pays the cost of medical care. Health plans include, for purposes of HIPAA, insurance companies and health maintenance organizations. The second type of covered entity–a health care clearinghouse–processes or aids the processing of health information received from another entity. Included in this category are billing services and repricing companies. The final type of covered entity is a health care provider. A health care provider is "a provider of services, a provider of medical or health services, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business," *and* - who transmits health information in electronic form in connection with certain transactions. Hospitals and physicians are health care providers for purposes of the Privacy Rule.

Q: Is a Sexual Assault Program a Covered Entity?

MAYBE. Sexual assault programs are neither "health plans" nor "health care clearinghouses." However, a program may be considered a "health care provider," and thus a covered entity. To be considered a health care provider, a program must do all of the following: (1) furnish, bill, or receive payment for health care or health care services in the normal course of business; (2) conduct covered transactions; and (3) transmit those transactions in electronic form.

(1) Furnish, Bill, or Receive Payment for Health Care or Health Care Services in the Normal Course of Business:

To be eligible for Office of the Attorney General funding, a sexual assault program must provide the following basic services: a 24-hour hotline; crisis intervention; advocacy and accompaniment to medical facilities, law enforcement offices and prosecutor's offices; community and professional education; and volunteer training. Some of these services may be considered counseling, which is a health care service. Thus, sexual assault programs may "furnish . . . health care services in the normal course of business" to survivors of sexual assault as contemplated in the Privacy Rule.

(2) Conduct Covered Transactions:

The provision of health care services is not enough to bring sexual assault programs within the definition of "health care provider," and thus within scope of the Privacy Rule's regulation of covered entities; advocates, as providers, also must conduct covered transactions. Covered transactions are as follows:

1. health care claims transaction;
2. eligibility for a health plan transaction;
3. referral certification and authorization transaction;
4. health care claim status transaction;

5. enrollment and disenrollment in health care plan transaction;
6. health care payment and remittance advice transaction;
7. health care premium payment transaction;
8. coordination of benefits transaction.

(3) Transmit those Transactions in Electronic Form:

Finally, to be considered a covered entity heath care provider, a sexual assault program must electronically transmit any information in connection with these transactions. Programs that bill insurance companies and Medicaid or Medicare for their services are the most likely of all sexual assault programs to fall into the health care provider category.

The following link to the U.S. Department of Health and Human Services, Civil Rights Office website includes interactive tools that may help a sexual assault program identify whether it is a covered entity.

http://www.cms.hhs.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp

If a program determines it is a covered entity, it must comply with the Privacy Rule. The regulations containing the Privacy Rule can be found at Volume 45, Code of Federal Regulations, sections 160 and 164.

Q: What is a Business Associate?

The Privacy Rule also contemplates the transmission of protected health information from covered entities to their business associates. Before a covered entity may share protected health information with its business associates, the covered entity must enter into a written agreement with its business associate assuring that the business associate will appropriately safeguard the information. To be considered a "business associate" of a covered entity under HIPAA, an entity must do one of two things: (1) provide specific services to a covered entity; or (2) act on the covered entity's behalf.

Q: Is a Sexual Assault Program a Business Associate of a Covered Entity?

NO. Sexual assault programs do not provide any of the services specifically enumerated under HIPAA to covered entities. Furthermore, programs do not act on a covered entity's behalf. Instead, they act on the behalf of survivors. Because sexual assault programs are not considered "business associates" of health care providers, covered entities are not bound to enter into business associate agreements with sexual assault programs. Nevertheless, a program may determine that entering into an agreement to protect information with providers is in the program's and a survivor's best interests. The U.S. Department of Health and Human Services, Office for Civil Rights has provided a sample business associate agreement on its website. You can access that sample at the following web address:

http://www.hhs.gov/ocr/hipaa/contractprov.html

HIPAA Fact Sheet #2

HIPAA Privacy Guidelines And Notifying Crisis Centers

There has been a great deal of publicity recently about the new privacy rules governing patient health information under the federal Health Insurance Portability and Accountability Act ("HIPAA"). The HIPAA privacy rules went into effect April 14, 2003, and many hospitals are still struggling to understand the new law. In particular, some hospital emergency rooms ("ER") may have concerns about whether they can still notify the local crisis center when a sexual assault survivor is in the ER, and what information they can reveal, if any, about the survivor.

Some hospital personnel may have concerns about how HIPAA affects the whole concept of victim advocates in the emergency rooms. That issue is dealt with in a separate fact sheet, *HIPAA Privacy Guidelines and Victim Advocates in the ER.*

Q: Can a hospital notify a sexual assault program that a survivor is in transport to, or is currently present in, an emergency room?

YES. A hospital may notify the program of a survivor's presence in the ER. The hospital may do so as long as it provides only "de-identified information" to the program. At a minimum, the hospital can tell the crisis center the following information about the survivor:

1. Gender;
2. Ethnic or racial background;
3. Age, if the survivor is 89 or less (if the survivor is older than 89, use the term "elderly"); and
4. Primary language

We encourage you to make arrangements to receive such information from your local hospital as soon as possible. An agreement between the hospital and your program will not only facilitate the exchange of such information between the hospital and your program, but will also ensure that the survivor receives the best possible service and care.

Q: What type of information is a hospital prohibited from sharing without patient authorization?

HIPAA was drafted by Congress to protect patient privacy while still allowing a hospital to do what is necessary to give the patient the proper care. Despite the initial cautiousness of some hospitals, HIPAA allows hospitals to release a patient's protected health information *after it has been made anonymous or, in other words, de-identified.* Once the following identifiers have been removed, a hospital may share freely a patient's health information:

1. Names;
2. Address, including city, county, and zip code;
3. All dates that could be used to identify the patient, like a birthday or admission/discharge dates, and ages for patients over 89;
4. Phone numbers;
5. Fax numbers;
6. E-mail addresses;
7. Social security numbers;
8. Health record numbers;
9. Account numbers;
10. Certificate/license numbers;
11. License plate numbers, vehicle identifiers, and serial numbers;
12. Device identifiers and serial numbers;
13. URL address;
14. Internet Protocol address numbers;
15. Biometric identifiers, including finger and voice prints;
16. Full face photographs; and
17. Any other unique identifying number, except one created by the hospital or health care provider to re-identify the patient's information.

Q: Our local hospital is still insisting that HIPAA prevents them from calling us when they get sexual assault survivors in the ER. What can I do?

You can set up a meeting with the hospital employee responsible for HIPAA compliance. (HIPAA requires the hospital to have someone in charge of privacy policies and procedures.) TAASA and OAG staff can help you get ready for this meeting. You may provide copies of these fact sheets to the hospital employee at your meeting.

Q: Does HIPAA affect how our crisis center works with law enforcement?

NO. HIPAA only applies to information held by hospitals and other health care providers. Law enforcement is free to work with the crisis center, especially in an active criminal investigation. If your local hospital is being uncooperative, ask local law enforcement to call the crisis center before the survivor arrives at the hospital.

Q: What can the advocate expect upon arrival at the ER?

The hospital may require the survivor to fill out a form to authorize disclosure of personal health information to the advocate. The HIPAA authorization form included in this packet has been prepared to allow you to handle this situation. For further details, please consult the fact sheet on *HIPAA Privacy Guidelines and Victim Advocates in the ER*.

HIPAA Fact Sheet #3

HIPAA Privacy Guidelines and Victim Advocates in the Emergency Room

There has been a great deal of publicity recently about the new privacy rules governing patient health information under the federal Health Insurance Portability and Accountability Act ("HIPAA"), which went into effect April 14, 2003. Some hospitals have interpreted HIPAA to conflict with Texas law guaranteeing a survivor's right to **have** an advocate in the emergency room ("ER"). In response to these concerns, TAASA and the Office of the Attorney General have created an authorization form designed to educate survivors about their rights while addressing the legal concerns of hospital personnel.

Some hospital personnel may also have concerns about whether they can still notify the local crisis center when a sexual assault survivor is in the ER. That issue is addressed in a separate fact sheet, *HIPAA Privacy Guidelines and Notifying Crisis Centers*.

Q: At what point will I need this form: when I first get to the ER, when I first meet the survivor, etc.?

It depends on the hospital, and possibly on the person you encounter in the ER. The authorization form contains a check list at the top, which gives survivors a choice among three options:

1. meet the advocate immediately;
2. share contact information for future services; or
3. have no contact with the crisis center.

In general, once you have arrived at the ER and the survivor has asked for you to come in, you should not have problems getting access to the survivor. If the hospital staff is reluctant, you can provide to them the authorization form, and the survivor can use the form to communicate her wishes. However, it is more often the case that hospital personnel are concerned about sharing the survivor's contact information with the advocate. When appropriate, an advocate can just ask the survivor for the information. In other circumstances it may be more appropriate to get the survivor's contact information from hospital personnel, and in that case the hospital may well require the authorization form.

Q: Is it a good idea to meet with our local hospitals ahead of time to discuss this?

YES, absolutely. You can meet with hospital staff on these HIPAA issues and agree on a set policy, so that ER personnel will have a clearer understanding of how to handle these situations. We have also provided a legal memorandum on HIPAA disclosures that will assist you with your local hospitals.

Q: Can we take the authorization form and customize it for our center?

YES, to some extent. The privacy rule requires the authorization form to contain specific information; the provided form meets the Privacy Rule's requirements. Deleting or changing anything on the form may render it unenforceable. You may, however, personalize the form with your center's name and address, put the form on your center's letterhead, or add the name and address of your local hospital.

Q: What if the hospital has its own authorization form, and wants us to use that instead?

As long as the hospital's form does not put any additional burdens on the survivor, the sexual assault program, or create other problems, you may use that form. The authorization form we have provided contains ALL the information required by state and federal law, and is designed specifically to educate survivors about their right to have an advocate with them in the ER. If you use another form, you will also have to specify what information you need from the survivor, e.g., contact information for follow-up visits with the survivor, etc.

Authorization Form

USING THE HIPAA AUTHORIZATION FORM

The Health Insurance Portability and Accountability Act ("HIPAA") Authorization Form we have provided is designed to help you gain access to survivors and their health information with ease. We encourage you to arrange to meet with your local hospital's HIPAA compliance officer to discuss your mutual expectations regarding the exchange of survivors' health information. At this meeting, we recommend that you present the HIPAA compliance officer with a copy of the HIPAA Authorization Form. Explain to the privacy officer that the authorization frees the hospital to disclose health information about the survivor to an advocate without violating the Privacy Rule. Ask the privacy officer to make arrangements with emergency room ("ER") personnel to present the authorization to all survivors once they arrive in the ER. Assuming the survivor authorizes the disclosure of her health information to an advocate, the hospital can immediately contact a sexual assault advocate and explain the survivor's circumstances.

The HIPAA compliance officer may propose that you use the hospital's authorization form rather than the one we have provided. The authorization form we have provided meets the standards imposed by the HIPAA Privacy Rule. As long as the hospital's form does not impose additional burdens on the survivor or the advocate, you may agree to use that form.

If your local hospital refuses to present survivors of sexual assault with the authorization form upon their arrival in the ER, you may make arrangements similar to those suggested above with local law enforcement. Or, the advocate may carry the authorization form with her, and present it in person to the survivor. It is important for the advocate to ensure she has a completed authorization form before the survivor leaves the hospital. The survivor herself can fill out the form, or the advocate may fill it out for her, and the survivor or a minor survivor's parent, guardian, or authorized representative must sign the form for it to be valid and enforceable.

If you have any questions about how to use the form, or would like clarification on its meaning, please do not hesitate to call one of the contacts we have provided you.

Appendix C

The Neurobiology of Trauma Responses

These responses are provided to help you answer a victim's frequently asked questions from a neurobiological perspective. In order to effectively use these answers, please take the victim's individual needs and circumstances into consideration PRIOR to using these responses.

Why didn't I fight back?

You can respond with:

During an assault, the emotional part of your brain takes over. Reflexes are automatic and normal.

Followed by:

There are a few common reflex responses that the brain can fall back on during an assault situation. For example, you may "freeze," space out, become paralyzed and unable to move, collapse, and even faint. Some people also panic and try to resist, but perpetrators expect this and often can easily counter the resistance.

Why can't I just get over it?

You can respond with:

There could be many reasons for that and all of them are completely normal. It's based on how human brains respond to sexual assault, especially in situations where there are many other stressful things going on.

Followed by:

Traumatic memories are usually quite different from normal memories. They tend to be strongly "encoded" or recorded into the brain – even if you only remember pieces of what you felt and saw. Many people continue to struggle with the memories, as well as things like anxiety, depression, trust, fears of intimacy, and shame, especially if they have not had the support they need and deserve.

Why do I sometimes feel like it's happening all over again?

You can respond with:

Traumatic memories are usually different from normal memories. They are strongly recorded in the brain because of the stress chemicals that are released during the trauma. Even if your memory is incomplete and you only remember pieces of what you felt and went through, it can feel like scenes of a movie playing in your head.

Followed by:

These "movie scenes," which can contain really traumatic sensations and emotions, can get triggered by things and situations that we don't expect or we can't control. So sometimes, no matter how much you try to avoid the traumatic memories, they can come up without warning and they can feel almost or just as intense as when the assault was actually happening.

Why do I sometimes feel like it's happening all over again? (alternate response)

You can also state:

You may feel like it's happening all over again because your body will react to the triggers the same way it reacted to the assault as it was happening. For many people, working with a trained professional who specializes in trauma can help reduce and stop these feelings.

Why am I so easily startled? (i.e., Why am I so jumpy?)

You can respond with:

Sexual assaults and other trauma affect the part of the brain that controls the "startle response." This part of the brain is linked to anxiety and the effects can be lasting. But the "startle response" can be reversed too.

Followed by:

Anything you can do to develop a sense of safety in your body and an awareness of your emotions may help to reduce how jumpy you feel. You can try to achieve this by using exercise, yoga, and meditation, but be careful with "mindfulness" meditation because it can bring up memories and feelings that are difficult to manage without other skills. Also, many people choose to seek help from a trained professional to help them reduce and eliminate this "startle response."

I've tried counseling before but it didn't help. So what do I do now?

First, try to obtain more information about their previous experience(s) with counseling. Use questions such as:

Can you tell me a little more about your past experience with a counselor?

Would you mind telling me a little more about your past counseling experience so that I can provide you with other resources that may be helpful to you?

Then, based on the victim's answers, you may state:

There are a variety of treatments that can help sexual assault survivors heal. Also, some therapists are more effective than others. Some clinicians are simply a better match for some clients than others.

Followed by:

I encourage you to not to give up on finding the help you deserve. There are professionals who can help you.

Ask about their experiences with and attitudes toward exercise, yoga, and meditation. Then provide them with suggestions such as:

Many sexual assault survivors have found exercise/yoga/meditation very helpful, especially when they are trying to develop a sense of safety and comfort with their bodies. These techniques can affect a specific brain region that allows you to be more aware of your bodily experiences. That awareness can be used to support your healing process.

Why am I drinking or using drugs? (i.e., addiction issues)

First, it's important to ask why they think they are drinking and using drugs as it may or may not be related to their sexual assault trauma.

Then, you can build on their experience to respond appropriately. Here are some sample responses, worded from a neurobiological perspective:

Whenever the brain is having unwanted and unpleasant experiences, it can't help but seek relief and escape from those experiences. There is actually a "seeking circuitry" of the brain. This circuitry seeks things that are healthy and fulfilling. But, it can also seek "quick fixes" that are unhealthy and potentially addictive.

When people are really hurting, and they don't have or can't make use of support and help from others, their seeking circuitry can get caught up in using substances to get relief.

Alcohol and different drugs have specific effects on the brain. Some of those effects offset symptoms such as depression and anxiety. So, it is very common for traumatized sexual assault survivors to "self-medicate" with alcohol and drugs so they can find relief, even if it's only temporary and leads to other problems.

Why am I self-harming?

You can respond with:

Research has found that self-harming behaviors can function in two basic ways:

> *Relieving emotional pain by releasing soothing chemicals in the brain.*
>
> *Producing a feeling of being alive and real when someone has been emotionally numb and disconnected from others and the world.*

Followed by:

Self-harming behaviors can also be a way for people to punish themselves or a way to express feelings of self-hate. These feelings are common in people who have experienced a great deal of trauma.

Why did I feel like I couldn't move?

You can respond with:

There is actually a term that describes what you experienced – "tonic immobility." It basically means that you couldn't move – even though you weren't technically paralyzed.

This reflexive response can happen when someone is unable, or they believe they are unable, to escape an assault. It's a response that appeared millions of years ago in evolution, and all mammals can have that type of response.

Followed by:

The fact that you couldn't move does not mean that _____ (insert whatever is most applicable to the survivor's experience such as: that you did anything wrong; that you wanted to have sex; that you are weak; that you deserved what happened because you didn't fight back). It's just that your brain went into extreme survival mode. This mode is designed to prevent the perpetrator from becoming even more violent.

Why do I feel numb and disconnected from other people?

You can respond with:

Feeling connected to other people, including those we love, requires being able to feel emotions. It requires us to feel positive emotions of happiness, love, and caring. Feeling connected also requires us to feel motivated to connect with others. A traumatic experience can change the brain areas that enable you to feel these types of emotions.

Followed by:

So, in other words, traumatic experiences can affect your ability to connect with others or to have positive and loving feelings. These "numbing" symptoms are common for trauma survivors.

How do I explain what I have been through and how it has affected me to my family, friends, and loved ones who have not experienced trauma?

Please note: There are no easy answers to this question, given all the variables that may be present, including the beliefs, attitudes, and emotional capacities of the people the survivor wants to disclose their information to.

In terms of brain-based explanations, you can state:

Research has shown that what you experienced during the sexual assault, and how you responded at the time, is all based in normal brain processes that occur during traumatic situations.

Research has shown that traumatic experiences can have lasting effects on many brain regions. These regions are connected to emotions, mood, anxiety, and how you relate to others. Yet, research also shows that therapy, supportive relationships, and a variety of other things can help people heal from trauma.

Are there any differences between the effects of trauma on a woman's brain versus a man's brain?

You can respond with:

There is some preliminary research suggesting differences, but nothing well established yet.

Followed by:

Everything we think, feel, and do involves activity in the brain regions that allow us to have those experiences and do those things.

However, in most cases, there are no significant differences in brain function. Instead, there are differences in how certain brain functions are used. For example, women are more likely to suffer from depression and men are more likely to suffer from addictions. Also, women tend to be more aware of their emotions than men.

How do I reconnect with who I am as a healthy and happy person – with playfulness, productiveness, and love? (i.e., who the survivor wants to be)

You can respond with:

Losing connection with these positive potentials is a normal effect of trauma on human brains. Trauma can greatly affect the brain's circuitry for seeking positive experiences and the "satisfaction circuitry" that allows us to experience enjoyment and satisfaction in life.

Followed by:

When people don't expect to enjoy things they used to before experiencing trauma, they think to themselves, "When I feel better, then I'll get back into the things I used to enjoy." But then they don't feel better and remain stuck. Research has shown that if people go ahead and do enjoyable and fun things, even if they don't enjoy them at first, eventually the brain's circuitries of seeking and satisfaction – as well connecting with others – will become more active and get back on track again.

Therapy and other activities may be necessary.

Why am I eating and/or sleeping too much or too little?

You can respond with:

Sexual assault and other traumas affect brain circuitries directly involved in the regulation of sleep and eating behaviors. Trauma also affects circuitries involved in depression and anxiety and both of these affect sleep and eating.

Followed by:

When depressed, it is common to have little appetite and to sleep too much or too little. Severe anxiety can make it very difficult to sleep, and sometimes the brain turns to food and eating, which can be very soothing and calming, as a brief escape from the anxiety.

The brain also has a remarkable ability to change and heal itself, especially with the right support and help from others. There are a variety of effective methods for bringing one's sleeping and eating back into normal and healthy ranges, and a qualified professional can help you learn and maintain healthy sleeping and eating habits.

Many traumatized people find that successful efforts to get their sleeping and eating back on a healthy track have huge positive effects on their symptoms of depression and anxiety.

Why has this assault affected me so much?

You can respond with:

Sexual assault, like any kind of major traumatic experience, can have huge effects on a variety of brain systems, especially those involved in fear, anxiety, depression, and addiction; as well as those required for healthy and normal functioning of memory, emotions, and various thought processes.

Followed by:

If a person has experienced a number of traumatic experiences and ongoing trauma and stress (like multiple deployments), their work and personal lives can be affected.

Why the assault has affected you so much as an individual, unique human being, is a bigger question than I could ever answer in a call/chat like this. But there are trained and experienced professionals who can help you answer that question for yourself. They can help you heal and recover from the assault and from other traumas in your life, so they will affect you less and less in the future.

Why am I just now remembering what happened?

You can respond with:

It is common for victims of sexual assault to go through a time with little memory of what happened, only to recall later.

A great deal of research has found that the human brain is capable of preventing unwanted memories or parts of unwanted memories from coming into awareness – sometimes for long periods of time; not only months or years, but even decades in some cases.

Followed by:

In the aftermath of a sexual assault or other trauma, it's totally normal to try not to remember or think about it. If, and when, the memories eventually come back into awareness, it's usually because something happens that, for that person, at that time, triggers recall or "recovery" of those memories.

For some, it's having another traumatic experience that brings the same feelings of helplessness, powerlessness, violation, shame, etc. For others, it's when someone important in their life has a similar experience.

I'm not sure why it's happening for you, or why it's happening now. But I do want you to know that there are qualified professionals who can help you find your own answer to this question. They can help you find and develop the resources you need to deal with the memories and experiences that have come back.

Source:

U.S. Department of Defense Sexual Assault Prevention and Response Office. 2012. SafeHelpline training: The neurobiology of trauma. Retrieved from: www.SafeHelpline.org.

Appendix D

Applying the Neurobiology of Trauma to Your Work: Steps for Working With Victims

Step 1:

- Make sure you have established rapport and trust with the victim.
- This process typically takes place at the beginning of the session where you are validating the victim's experience, learning about the victim's needs, and building mutual trust.

Step 2:

- After rapport is built and the victim has expressed feelings resulting from neurobiological effects, you might say:
  - **Option 1:** *It's understandable that you feel this way. Many people who have experienced sexual assault have the same feelings. If you would like, I can provide you with some basic information about why our brains and bodies react that way.*
  - **Option 2:** *It is very common for people to _____ when they are being assaulted. If you would like, and if you are open to it, I can provide you with some more information about this.*
  - **Option 3:** *It sounds like _____ has been difficult for you. It is very common for people who have been sexually assaulted to feel/think this way. If you are okay with it, I can provide you with some background information about why our bodies and brain react that way.*

Step 3:

- If they ***do*** consent to discussing the neurobiology of trauma:
  - You may proceed to use the neurobiology of trauma responses (Appendix C, The Neurobiology of Trauma Responses).
- If they ***do not*** consent to discussing the neurobiology of trauma:
  - Please refrain from using the neurobiology of trauma responses.
  - Instead, provide the victim with emotional support and other resources, as applicable.

Step 4:

- If the victim wants to read/obtain additional information and/or resources related to the neurobiology of trauma, you can respond with:
  - Are resources to help with _____ something that you may be interested in? If so, I have a few referrals that I can provide you (Appendix E, Additional Resources).

Step 5:

- If the victim wants additional information that is *beyond* the scope of the information that is included in this training and the provided responses, you may refer them to the additional resources listed in Appendix E, or to state and community resources that work with victims of sexual assault.

Source:

U.S. Department of Defense Sexual Assault Prevention and Response Office (SAPRO). 2012. SafeHelpline staff training: The neurobiology of trauma. Retrieved from: www.SafeHelpline.org.

Appendix E

Additional Resources

This appendix contains resources that may help a victim to heal brain-based consequences of trauma. Some of these listed resources and services may not be available in the crime victim's region or country. The victim may contact local providers to find out what services and support are available in their area. The victim also may refer to the listed Web sites and written materials if they are interested in learning more about the neurobiology of trauma.

Mental Health Services Locator

This locator provides you with comprehensive information about mental health services and resources and is useful for professionals, consumers, their families, and the public.
http://store.samhsa.gov/mhlocator

Healthcare Center Directory

The U.S. Department of Health and Human Services maintains a Healthcare Center Directory. This directory lists federally funded health centers that provide a variety of services even if the recipient does not have health insurance. Users pay a co-payment based on their income. These health centers can provide: preventive care, treatment when you are sick, prenatal care, immunizations and checkups for children, dental care, prescription drugs and mental health, and substance abuse care as well.

- Telephone Number: 1-877-464-4772 or 1-877-897-9910 (TTY)
- Web site: http://findahealthcenter.hrsa.gov/Search_HCC.aspx
- Hours of Operation: Monday through Friday, 9 a.m. –5:30 p.m. ET (except federal holidays)

Web Sites

- The Sidran Institute

The Sidran Institute is a national organization offering services to help people understand, recover from, and treat traumatic stress (including PTSD), dissociative disorders, and co-occurring issues such as addictions, self-injury, and suicidal behaviors. The Institute also provides resources for loved ones of trauma survivors.
www.sidran.org/index.cfm

- Rape, Assault and Incest National Network (RAINN)

RAINN provides support for sexual assault victims and their loved ones through two hotlines at 800.656.HOPE, and at www.rainn.org. Callers will be directed to a rape crisis center in or near their area. RAINN operates in partnership with more than 1,100 local rape crisis centers across the country and operates the DoD Safe Helpline for the Department of Defense.

RAINN also carries out programs to prevent sexual violence, help victims, and ensure that rapists are brought to justice.
www.rainn.org

- National Sexual Violence Resource Center (NSVRC)

The NSVRC collects and disseminates a wide range of resources on sexual violence including statistics, research, position statements, statutes, training curricula, prevention initiatives, and program information. With these resources, the NSVRC assists coalitions, advocates, and others interested in understanding and eliminating sexual violence. The NSVRC does not provide direct services to sexual assault victims, but rather supports those who do, such as coalitions; rape crisis centers; national, state and local agencies; and allied programs. The NSVRC refers requests for direct victim services to the appropriate state coalition and/or to a local program conveniently located to the caller.
www.NSVRC.org

Written Materials:

Growing Beyond Survival: A Self-Help Toolkit for Managing Traumatic Stress, by Elizabeth G. Vermilyea (2007)

Trauma and Recovery: The Aftermath of Violence - from Domestic Abuse to Political Terror, by Judith Herman (1997)

The Post-Traumatic Stress Disorder Sourcebook: A Guide to Healing, Recovery, and Growth, by Glenn Schiraldi (2009)

The PTSD Workbook: Simple, Effective Techniques for Overcoming Traumatic Stress Symptoms, by Mary Beth Williams and Soili Poijula (2002)

A Woman's Addiction Workbook: Your Guide to In-Depth Healing, by Lisa M. Najavits (2002)

Beyond Addiction: How Science and Kindness Help People Change, by Jeffrey Foote and colleagues (2014)

Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems, by Victoria M. Follette and Jacqueline Pistorello (2007)

Overcoming Trauma through Yoga: Reclaiming Your Body, by David Emerson and Elizabeth Hopper (2011)

When Anger Hurts: Quieting the Storm Within, 2nd Edition, by Matthew McKay Ph.D., Peter D. Rogers, and Judith McKay (2003)

References

Abbott, P. 1997. "Same sex assault." *Minnesota Coalition Against Sexual Assault Training Manual*. Coalition Against Sexual Assault. Minneapolis, MN

Abel, G., and J. Rouleau. 1995. "Sexual abuses." *Psychiatric Clinics of North America.* 18: 139–153.

Ackard, D. and D. Neumark-Sztainer. 2002. "Date violence and date rape among adolescents: Associations with disordered eating behaviors and psychological health." *Child Abuse and Neglect* 26(5): 455–473.

Adams, R., J. Boscarino, and C. Figley, C. 2006. "Compassion fatigue and psychological distress among social workers: A validation study." *American Journal of Orthopsychiatry*.

Aiello, D. 1986. "Issues and concerns confronting disabled assault victims: Strategies for treatment and prevention." *Sexuality & Disability* 7(3–4): 96–101.

Aiken, M. 1993. "False allegation: A concept in the context of rape." *Journal of Psychosocial Nursing* 31: 15–20.

Alexander, J., M. Chesnay, E. Marshall, A. Campbell, S. Johnson, and R. Wright. 1989. "Research note: Parallel reactions in rape victims and rape researchers." *Violence and Victims* 4: 57–62.

American Bar Association. Retrieved from: www.americanbar.org/groups/lawyer_assistance/resources/compassion_fatigue.html

American College of Obstetricians and Gynecologists. August 2002. *ACOG Practice Bulletin,* Number 25. "Emergency oral contraception." In *International Journal of Gynaecology and Obstetrics* 78(2): 191–198. (Original work published 2001.)

American Psychiatric Association. 2013. *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, D.C.: American Psychiatric Association.

Andrews, A., and L. Veronen. 1993. "Sexual assault and people with disabilities." *Journal of Social Work and Human Sexuality* 8: 137–159.

Amstadter, A. and L. Vernon. 2008. "Emotional reactions during and after trauma: A comparison of trauma types. *Journal of Aggression, Maltreatment and Trauma* 16(4): 391–408.

Arndt, S. 1988. "Nurses help Santa Cruz sexual assault survivors." *California Nurse* 84(8): 4–5.

Baird, S. and S. Jenkins. 2003. "Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims* 18(1): 71–86.

Baldwin, D. V. 2013. "Primitive mechanisms of trauma response: An evolutionary perspective on trauma-related disorders." *Neuroscience and Biobehavioral Reviews* 37: 1549–1566.

Bureau of Justice Statistics. "Rates of rape/sexual assaults, robberies, aggravated assaults, and simple assaults, 1993-2011." Generated using the NCVS Victimization Analysis Tool, accessed September 24, 2013, www.bjs.gov/index.cfm?ty=nvat

Beck, A., A. Rush, B. Shaw, and J. Emery. 1979. *Cognitive therapy of depression*. New York: Guilford Press.

Becker, G. 1997. *The gift of fear*. New York: Little, Brown.

Bell, K. 1995. "Tulsa sexual assault nurse examiners program." *Oklahoma Nurse* 16 July, August, September.

Benbow, S., and P. Haddad. 1993. "Sexual abuse of the elderly mentally ill." *Postgraduate Medical Journal* 69: 803–807.

Berkman, A. 1986. "Professional responsibility: Confronting sexual abuse of people with disabilities." *Sexuality & Disability* 7(3–4): 89–95.

Biden, J. 1993. "Violence against women: The Congressional response." *American Psychologist* 48: 1059–1061.

Bisby, J., C. Brewin, J. Leitz, and H. Curran. 2009. "Acute effects of alcohol on the development of intrusive memories." *Psychopharmacology* 204: 655.

Bisby, J., J. King, C. Brewin, N. Burgess, and H. Curran. 2010. "Acute effects of alcohol on intrusive memory development and viewpoint dependence in spatial memory support a dual representation model." *Biological Psychiatry* 68: 280.

Brener, N., P. McMahon, C. Warren, K. Douglas. 1999. "Forced sexual intercourse and associated health-risk behaviors among female college students." *Journal of Consulting and Clinical Psychology* 67(2); 252–259.

Brennan, P. 2006. "The medical and ethical aspects of photography in the sexual assault examination: Why does it offend?" *Journal of Clinical Forensic Medicine* 13(4): 194-202.

Brownmiller, S. 1975. *Against our will: Men, women, and rape*. New York: Simon and Schuster.

Brownmiller, S. 1985. *Femininity*. New York: Random House.

Bureau of Justice Statistics Selected Findings. "Female Victims of Violence", revised 10/23/09. Retrieved September 16, 2010 from: http://bjs.ojp.usdoj.gov/content/pub/pdf/fvv.pdf

Campbell, R., D. Patterson, A. Adams, R. Diegel, and S. Coats. 2008. "A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients' psychological well-being." *Journal of Forensic Nursing* 4(1):19–28.

Campbell, R., S. Townsend, S. Long, K. Kinnison, E. Pulley, S. Adames, and S. Wasco. 2005. "Organizational characteristics of Sexual Assault Nurse Examiner programs: Results from the National Survey Project." *Journal of Forensic Nursing* 1(2):57–64, 88.

Campbell, R., T. Self, and C. Ahrens. 2004. "The impact of rape on womens' sexual health risk behavior." *Health Psychology* 23:76–74.

Campbell, C. and L. Lewandowski. 1997. "Mental and physical health effects of intimate partner violence in women and children." *Psychiatric Clinics of North America* 20: 353–374.

Centers for Disease Control and Prevention. 2010. "2010 STD treatment guidelines." Retrieved from: www.cdc.gov/std/treatment/2010/sexual-assault.htm

Cohen, S., and G. Williamson. 1991. "Stress and infectious disease in humans." *Psychological Bulletin* 109: 5–24.

Coxell, A. and M. King. 1996. "Male victims of rape and sexual abuse." *Sexual and Marital Therapy* 11: 297–308.

Del Bove, G., L. Stermac, and D. Bainbridge. 2005. "Comparisons of sexual assault among older and younger women." *Journal of Elder Abuse and Neglect* 17(3).

Department of Veterans Affairs. Retrieved from: www.ptsd.va.gov/professional/pages/dsm5_criteria_ptsd.asp

Diamond, D., A. Campbell, C. Park, J. Halonen, and P. Zoladz. 2007. "The temporal dynamics model of emotional memory processing: A synthesis on the neurobiological basis of stress-induced amnesia, flashbulb and traumatic memories, and the Yerkes-Dodson law." *Neural Plasticity*, 60803. (www.ncbi.nlm.nih.gov/pmc/articles/PMC1906714/pdf/NP2007-60803.pdf)

DiNitto, D. 1986. "After rape: Who should examine rape survivors?" *American Journal of Nursing* 86: 538–540.

Donnelly, D. and S. Kenyon. 1996. "Honey, we don't do men: Gender stereotypes and the provision of services to sexually assaulted males." *Journal of Interpersonal Violence* 11: 441–448.

Douglas, E. and D. Finkelhor. 2005. "Childhood sexual abuse fact sheet." Retrieved from: www.unh.edu/ccrc/factsheet/pdf/CSA-FS20.pdf

Draguns, J.G. 1996. "Ethnocultural considerations in treatment of PTSD: Therapy and service delivery." *In* A. Marsella, M. Friedman, E. Gerrity, and R. Scurfi eld (Eds.), *Ethnocultural aspects of posttraumatic stress disorder: Issues, research, and clinical applications*: 459–482. Washington, D.C.: American Psychological Association.

DrugForce Screening. "Drug facts." Retrieved from: www.drugforcescreening.com/drugfacts.htm

Duncan, D. 1990. "Prevalence of sexual assault victimization among heterosexual and gay/lesbian university students." *Psychological Reports* 66: 65–66.

Dupre, A., H. Hampton, H. Morrison, and R. Meeks. 1993. "Sexual assault." *Obstetric and Gynecological Survey* 28: 640–648.

Alexander, J., M. Chesnay, E. Marshall, A. Campbell, S. Johnson, and R. Wright. 1989. "Research note: Parallel reactions in rape victims and rape researchers." *Violence and Victims* 4: 57–62.

Evans-Campbell, T., T. Lindhorst, B. Huang, and K. Walters. 2006. "Interpersonal violence in the lives of urban Americal Indian and Alaskan Native women: Implications for health, mental health, and help-seeking." *American Journal of Public Health* 67(3): 362–366.

Federal Bureau of Investigation. 2012. *Crime in the United States, 2011.* Washington, D.C.: U.S. Department of Justice.

Federal Bureau of Investigation. 2013. *Frequently asked questions*. Retrieved from: www.fbi.gov/about-us/cjis/ucr/recent-program-updates/new-rape-definition-frequently-asked-questions

Felitti, V. 1991. "Long-term medical consequences of incest, rape and molestation." *Southern Medical Journal* 84: 328–331.

Figley, C. 1989. *Helping traumatized families*. San Francisco: Jossey-Bass.

———. 1995. "Compassion fatigue: Toward a new understanding of the costs of caring." *In* B. Hundnall Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators*: 3–28. Lutherville, MD: Sidran Press.

———. 2012. *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* London, UK: Routledge.

Finkelhor, D. 2009. "The prevention of childhood sexual abuse." *The Future of Children* 19(2): 169–194. Order (CV192).

———. 1997. "Trauma and women: Course, predictors, and treatment." *Journal of Clinical Psychiatry* 5 (Supplement 9): 25–29.

Frank, C. 1996. "The new way to catch rapists." *Redbook* December: 104–105, 118, 120.

Frank, E., and P. Anderson. 1987. "Psychiatric disorders in rape victims: Past history and current symptomatology." *Comprehensive Psychiatry* 28: 77–82.

Frans, O., P. Rimmo, L. Aberg, and M. Fredrikson. 2005. "Trauma exposure and post-traumatic stress disorder in the general population." *Acta Psychiatrica Scandinavica* 111(4):291–299.

Frazier, P. 1990. "Victim attributions and post-rape trauma." *Journal of Personality and Social Psychology* 59: 298–304.

Frazier, P. 1993. **"**The prosecution of rapists." *CURA Reporter* 23**:** 1–6.

Frazier, P., and E. Borgida. 1997. "The scientific status of research on rape trauma syndrome." In D. Faigman, D. Kaye, M. Saks, and J. Sanders (Eds.). *Modern scientific evidence: The law and*

science of expert testimony. St. Paul, MN: West.

Frazier, P., A. Conlon, and T. Glaser. 2001. "Positive and negative life changes following sexual assault." *Journal of Consulting and Clinical Psychology* 69:1048–1055.

Frazier, P., T. Harlow, L. Schauben, and C. Byrne. 1993. *Predictors of post-rape trauma*. Paper presented at the July meeting of the American Psychological Association, Toronto, Canada.

Frazier, P. and L. Ledray. "Victim impact and recovery: chapter 9, pp. 179–204, in Ledray, L., A. Burgess, and A. and Giardino. 2011. *Medical response to adult sexual assault: A resource for clinicians and related professionals,* St. Louis: STM Learning.

Friedman, J. 1989. "The impact of homophobia on male sexual development." *SIECUS Report*, May–June: 8–9.

Garnets, L., G. Herek, and B. Levy. 1990. "Violence and victimization of lesbians and gay men: Mental health consequences." *Journal of Interpersonal Violence* 5: 336–383.

Garriott, J. and A. Mozayani. 2001. "Ethanol." *In* M. LeBeau and A. Mozaynai (Eds.), *Drug-facilitated sexual assault: A forensic handbook*: 73–88. San Diego: Academic Press.

Garry, M. and E. Loftus. 1994. **"**Pseudomemories without hypnosis." *International Journal of Clinical and Experimental Hypnosis* 42: 363–378.

Gidycz, C., C. Coble, L. Latham, and M. Layman. 1993. "Relation of a sexual assault experience in adulthood to prior victimization experiences: A prospective analysis." *Psychology of Women Quarterly* 17: 151–168.

Gidycz, C. and M. Koss. 1989. "The impact of adolescent sexual victimization: Standardized measures of anxiety, depression, and behavioral deviancy." *Violence and Victims* 4: 139–149.

Gidycz, C. and M. Koss. 1991. "Predictors of long-term sexual assault trauma among a national sample of victimized college women." *Violence and Victims* 6: 175–190.

Girelli, S., P. Resick, S. Marhoefer-Dvorak, and C. Hutter. 1986. "Subjective distress and violence during rape: Their effects on long-term fear." *Violence and Victims* 1: 35–46.

Golding, J. 1994. "Sexual assault history and physical health in randomly selected Los Angeles women." *Health Psychology* 13: 130–138.

Golding, J. 1996. "Sexual assault history and women's reproductive and sexual health." *Psychology of Women Quarterly* Vol. 20 Issue 1 101-121.

Goodman, L., M. Koss, and N. Russo. 1993. "Violence against women: Physical and mental health effects. Part 1: Research findings." *Applied & Preventive Psychology* 2: 79–89.

Gottsschall, J. and T. Gotttschall. 2003. "Are per-incident rape-pregnancy rates higher than per-incident consensual pregnancy rates?" *Human Nature* Volume 14 Issue 1.

Greeson, M and R. Campbell. 2013. "Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation." *Trauma, Violence, and Abuse* 14(2):83–95.

Groth, A. and A. Burgess. 1980. "Male rape: Offenders and victims." *Psychiatry* 137: 806–810.

Groth, A. 1990. *Men who rape: The psychology of the offender.* New York: Plenum Press.

Herman, J. 1992. *Trauma and recovery.* New York: Basic Books.

Holloway, M. and A. Swan. 1993. "A and E management of sexual assault." *Nursing Standard* 7: 31–35.

Holmes, M., H. Resnick, D. Kilpatrick, and C. Best. 1996. "Rape-related pregnancy: Estimates and descriptive characteristics from a national sample of women." *American Journal of Obstetrics and Gynecology* 175: 320–324.

Horn, B. J. 1999. "History of PCAR: Humble beginnings to statewide voice, 1975 to 1997." *PCAR contract manual*. Pittsburgh: Pennsylvania Coalition Against Rape (PCAR).

Horvath, M. and J. Brown. 2007. "Alcohol as a drug of choice: Is drug-assisted rape a misnomer?" *Psychology, Crime & Law* 13 (5): 417–429.

Joels, M., R. Sarabdjitsingh, and H. Karst. 2012. "Unraveling the time domains of corticosteroid hormone influences on brain activity: Rapid, slow, and chronic modes." *Pharmacological Reviews* 64(4): 901-938.

Keane, T., J. Fairbank, J. Caddell, and T. Zimering. 1989. "Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans." *Behavioral Therapy* 20: 245–260.

Kiffe, B. 1996. "Perceptions: Responsibility attributions of rape victims." (Doctoral dissertation, Augsburg College, Minneapolis, MN).

Kilpatrick, D. and R. Aciemo. 2003. "Mental health needs of crime victims: Epidemiology and outcomes." *Journal of Traumatic Stress*: 1612.

Kilpatrick, D., R. Acierno, H. Resnick, B. Saunders, and C. Best. 1997. "A two-year longitudinal analysis of the relationship between violent assault and substance use in women." *Journal of Consulting and Clinical Psychology* 65: 834–847.

Kilpatrick, D., A. Amstadter, H. Resnick, and K. Ruggiero. 2009. "Rape-related PTSD: Issues and interventions." *Psychiatric Times* 24, 50–58.

Kilpatrick, D., C. Best, B. Saunders, and L. Veronen. 1988. "Rape in marriage and in dating relationships: How bad is it for mental health?" *Annals of the New York Academy of Sciences* 528: 335–344.

Kilpatrick, D., C. Best, L. Veronen, A. Amick, L. Villeponteaux, and G. Ruff. 1985. "Mental health correlates of criminal victimization: A random community survey." *Journal of Consulting and Clinical Psychology* 53: 866–873.

Kilpatrick, D., B. Saunders, A. Amick-McMullan, C. Best, L. Veronen, and H. Resnick. 1989. "Victim and crime factors associated with the development of crime-related post-traumatic stress disorder." *Behavior Therapy* 20: 199–214.

Kilpatrick, D., B. Saunders, L. Veronen, C. Best, and J. Von. 1987. "Criminal victimization: Lifetime prevalence, reporting to police, and psychological impact." *Crime and Delinquency* 33: 479–489.

Kimerling, R. and S. Calhoun. 1994. "Somatic symptoms, social support and treatment seeking among sexual assault victims." *Journal of Consulting and Clinical Psychology* 62: 333–340.

Kimerling, R., P. Ouimette, and J. Wolfe (Eds.). 2002. *Gender and PTSD*. New York, NY: Guildford Press. Need all authors

King, M. 1992. "Male sexual assault in the community." *In* M. King and G. Mezey (Eds.) *Male victims of sexual assault*: 1–12. Oxford: Oxford University Press, Medical Publications.

King, M. and E. Woollett. 1997. "Sexually assaulted males: 115 men consulting a counseling service." *Archives of Sexual Behavior* 26: 579–588.

Koss, M. and M. Harvey. 1991. *The rape victim: Clinical and community interventions* (2nd ed.) Newbury Park, CA: Sage Publications.

Kozlowska, K. (in press/2015). "Fear and the defense cascade: Clinical implications and management." *Harvard Review of Psychiatry.*

Lang, A., C. Rodgers, C. Loffaye, L. Satz, T. Dresselhaus, and M. Stein. 2003. "Sexual trauma, post-traumatic stress disorder, and health behavior." *Behavior Medicine* 28:150–158.

Lawyer, S., H. Resnick, V. Bakanic, T. Burkette, and D. Kilpatrick. 2010. "Forcible, drug-facilitated, and incapacitated rape and sexual assault among undergraduate women." *Journal of American College Health* 58(5): 453–460.

Ledray, L. 1982. "Counseling victims of rape: Their needs and a new treatment approach." *In* H. Scheider (Ed.), *The victim in international perspective*: 358– 374. Berlin: Walter de Gruyter.

———. 1991. "Sexual assault and sexually transmitted disease: The issues and concerns." *In* A. W. Burgess (Ed.), *Rape and sexual assault III: A research handbook:* 181–193. New York: Garland.

———. 1992a. "The sexual assault nurse clinician: Minneapolis' 15 years experience." *Journal of Emergency Nursing* 18: 217–221.

———. 1992b. "The sexual assault examination: Overview and lessons learned in one

program." *Journal of Emergency Nursing* 18: 223–232.

———. 1994. "Rape or self injury?" *Journal of Emergency Nursing* 20: 88–90.

———. 1994. "Responding to the needs of rape victims." *In* A. W. Burgess (Ed.), *Community health nursing: Issues and topics:* 169–189. Norwalk, CT: Appleton and Lange.

———. 1996. "The sexual assault resource service: A new model of care." *Minnesota Medicine* 79(3): 43–45.

———. 1998. "Sexual assault: Clinical issues: SANE development and operation guide." *Journal of Emergency Nursing* 24: 197–198.

_____. 1999. *Sexual assault nurse examiner (SANE) development and operation guide.* Washington, D.C.: U.S. Department of Justice, Office of Victims of Crime.

———. 2006. *Sexual assault nurse examiner (SANE) development and operation Guide*. Washington, D.C.: U.S. Department of Justice, Office of Victims of Crime.

———. 2009. "Alcohol and sexual assault: What can/should we do in the emergency department?" *Journal of Forensic Nursing* 4(2): 91.

Ledray, L. and S. Arndt. 1994. "Examining the sexual assault victim: A new model for nursing care." *Journal of Psychosocial Nursing* 32: 7–12.

Ledray, L.E., P. Frazier, and J. Peters. 2007. *SART model final report*. Washington, D.C.:U.S. Department of Justice, Office of Justice Programs.

Ledray, L., S. Lund, and T. Kiresuk. 1986. "Impact of rape on victims and families: Treatment and research considerations." *In* I. Martinson, and D. Kjervik (Eds.), *Women in health and illness* (2nd ed.): 197–217. Philadelphia: W. B. Saunders.

Ledray, L., C. O'Brien, and S. Chasson. "Sexual assault response team operation," Chapter 12, in Ledray, L., A. Burgess, and A. Giargina, A. 2011. *Medical response to sexual assault: A resource for clinicians & other professionals*, STM Learning, Saint Louis.

Leininger, M. 1995. *Transcultural nursing: Concepts, theories, research and practice* (2nd ed.). New York: McGraw-Hill.

Lenehan, G. 1991. "A SANE way to care for rape victims." *Journal of Emergency Nursing* 17: 1–2.

Linden, J. 2012. "Care of the adult patient after sexual assault." *New England Journal of Medicine.* Retrieved from: www.nejm.org/doi/pdf/10.1056/NEJMcp1102869

Lipscomb, G., D. Muram, P. Speck, and M. Mercer. 1992. "Male victims of sexual assault." *Journal of the American Medical Association* 267(22): 3064–3066.

Lisak, D. 1994. "The psychological impact of sexual abuse: Content analysis of interviews with male survivors." *Journal of Traumatic Stress, 7*, 525–548.

Logan, T., J. Cole, and A. Capillo. 2007. "Differential characteristics of intimate partner, acquaintance, and stranger rape survivors examined by a sexual assault nurse examiner (SANE)." *Journal of Interpersonal Violence* Volume 22 No. 8, 1066–1076.

Lynch, V. 1993. "Forensic nursing: Diversity in education and practice." *Journal of Psychosocial Nursing* 132: 7–44.

Maltz, W. 2002. "Treating the sexual intimacy concerns of sexual abuse survivors." *Sexual and Relationship Therapy* 17(4), 321–327.

Marsella, A., M. Friedman, E. Gerrity, and R. Scurfield. 1996. *Ethnocultural aspects of post-traumatic stress disorder*. Washington, D.C.: American Psychological Association.

Martin, P. 1990. "Rethinking feminist organizations." *Gender and Society* 4: 182–206.

McCann, L. and L. Pearlman. 1990. "Vicarious taumatization: A framework for understanding the psychological effects of working with victims." *Journal of Traumatic Stress* 3: 131–149.

Messman-Moore, T. and A. Garrigus. 2007. "Association of child abuse and eating disorder symptomatology: The importance of multiple forms of abuse and revictimization." *Journal of Aggression, Maltreatment & Trauma* 14(3): 51 to 72.

Mezey, G. and M. King. 1992. *Male victims of sexual assault*. New York: Oxford Medical Publications.

Miller, E., M. Decker, H. LcCauley, D. Tancredi, R. Levenson, J. Waldman, P. Schoenwalk, and J. Silverman. 2011. "A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion." *Contraception* 83(3): 274–280.

Mitchell, M. 1991. "A family approach and network implications of therapy for victims of violence as applied in a case of rape." *Journal of Family Psychotherapy* 2: 1–12.

Munro, K. 2000. The treatment needs of sexually abused men: The role of sexism and homophobia in denial. *Toronto Psychotherapy and Online Counseling*. Retrieved from: C:\Users\19637\Desktop\NEW MALE SA\The Treatment Needs of Sexually Abused Men KaliMunro_com.mht

National Crime Victims' Right Week Resource Guide. 2014. Retrieved from: http://ovc.ncjrs.gov/ncvrw2014/pdf/FullGuide.pdf

Neff, J. 1989. "Editor's notes." *Journal of Emergency Nursing* May/June: 15: 3.

Neff, K., K. Kirkpatrick, and S. Rude. 2006. "Self-compassion and adaptive psychological functioning, Elsevier Inc. Retrieved from: www.reedelsevier.com, doi:10.1016/j.jrp.2006.03.004.

Patterson, D., R. Campbell, and S.M. Townsend. 2006. "Sexual assault nurse examiner (SANE) program goals and patient care practices." *Journal of Nursing Scholarship*, 38:2, 180–186.

Postma, R., I. Bicanic, and H. van der Vaart. 2013. "Pelvic floor muscle problems mediate sexual problems in young adult rape victims." *Journal of Sexual Medicine* 10(8): 1978–1987.

Rape, Abuse & Incest National Network. 2014. *The Laws in Your State*. Retrieved from: https://rainn.org/public-policy/laws-in-your-state .

Read, K. 2005. "Population-based study of police reported sexual assaults in Baltimore, Maryland." *American Journal of Emergency Medicine* 23(3): 273–278.

Resnick, H., R. Acinero, D. Kilpatrick, and M. Holmes. 2005. "Description of an early intervention to prevent substance abuse and psychopathology in recent rape victims." *Behavior Modification* 29(1): 156–188.

Roberts, A. Spring 2002. "Assessment, crisis intervention, and trauma treatment: The integrative ACT intervention model." *Brief Treatment and Crisis Intervention* 2:1.

Rosenbloom, D., A. Pratt, and L. Pearlman. 1995. "Helpers' responses to trauma work: understanding and intervening in an organization*." In* B. Hundnall Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators*: 65–79. Lutherville, MD: Sidran Press.

Sacks, M. and J. Sanders. 2009. *Modern scientific evidence: The law and science of expert testimony*: 414–435. St. Paul, MN: West Publishing.

Sandrick, K. 1996. "Tightening the chain of evidence." *Hospitals and Health Networks, Inside Track (Medicine and Law)* June 5: 29–30.

Schauben, L., and P. Frazier. 1995. "Vicarious traumatization: The effects on female counselors of working with sexual violence survivors." *Psychology of Women Quarterly* 19: 49–54.

Schaufeli, W.B. and A.B. Bakker. 2004. "Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study." *Journal of Organizational Behavior*, 25, 293–313, DOI: 10.1002/job.248

Schwabe, L., M. Joels, B. Roozendaal, O. Wolf, and M. Oitzl. 2012. "Stress effects on memory: An update and integration." *Neuroscience Biobehavior Review*: 1740

Simpson, M. 2001. "Complications of sexual assault: Sexually transmitted infections and pregnancy." In Ledray, L., A. Burgess, A. Giardina, A. 2011. *Medical response to adult sexual assault: A resource for clinicians and related professionals.* St Louis, MO: STM Learning.

Slaughter, L. and C. Brown. 1992. "Colposcopy to establish physical findings in rape victims." *American Journal of Obstetrics and Gynecology* 176: 83–86.

Snyder, H. 2000. "Sexual assault of young children as reported to law enforcement: victim,

incident, and offender characteristics." Washington, D.C: Bureau of Justice Statistics, U.S. Department of Justice.

Sommers, M. July 2007. "Defining patterns of genital injury from sexual assault. A review." *Trauma, Violence, & Abuse*. Philadelphia, PA: Pennsylvania School of Nursing.

Speck, P. and M. Aiken. 1995. "Twenty years of community nursing service." *Tennessee Nurse Focus* 15: 17–18.

Stermac, L., P. Sheridan, A. Davidson, and S. Dunn. 1996. "Sexual assault of adult males." *Journal of Interpersonal Violence* 11: 52–64.

Stermac, P., G. Del Bove, and M. Addison. 2004. "Stranger and acquaintance sexual assault of adult males." *Journal of Interpersonal Violence* 19(8): 901–915.

Tark, J. and G. Kleck. 2014. "Resisting rape: The effects of victim self protection on rape completion and injury." *Violence Against Women* 20(3): 270–292.

Tewskbury, R. 2007. "Effects of sexual assaults on men: Physical, mental and sexual consequences." International Journal of Men's Health 6(1): 22-35.

Thomas, M. and H. Zachritz. 1993. "Tulsa sexual assault nurse examiners (SANE) program." *Journal of the Oklahoma State Medical Association* 86: 284–286.

Tjaden, P. and N. Thoennes. 2006. "Extent, nature, and consequences of rape victimization: findings from the national crime victim survey." NIJ Special Report, Washington, D.C. Retrieved from: www.ncjrs.gov/pdffiles1/nij/210346.pdf

Tobias, G. 1990. "Rape examinations by GPs." *The Practitioner* 234: 874–877.

Trickett, P., J. Noll, and F. Putnam. 2011. "The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study." *Development and Psychopathy* 23(2):453–476.

Ullman, S. 2004. "Sexual assault victimization and suicide behavior in women: A review of the literature." *Aggression and Violent Behavior* 9(4): 331–351.

Ullman, S. 2007. "Mental health services seeking in sexual assault victims." *Women & Therapy* 30: 61–84.

Ullman S. and L. Brecklin. 2002. "Sexual assault history and suicide behavior in a national sample of women." *Suicide and Life-Threatening Behavior*. 32: 117–130.

Ullman, S., C. Najdowski, and H. Filipas. 2009. "Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors." *Journal of Child Sexual Abuse* 18(4): 367–385.

Upchurch, D., and Y. Kusunoki. 2004. "Associations between forced sex, sexual and protective practices, and sexually transmitted diseases among a national sample of adolescent girls." *Women's Health Issues* 14(3): 75–84.

U.S. Department of Justice, Office on Violence Against Women. 2013. A national protocol for sexual assault medical forensic examinations—Adults/adolescents. 2nd ed. www.ncjrs.gov/pdffiles1/ovw/241903.pdf.

Van Berlo, W. 2000. "Problems with sexuality after sexual assault." *Annual Review of Sex Research* 235–257.

Vickerman, K. and G. Margolin. 2010. "Rape treatment outcome research: Empirical findings and state of the literature." *Clinical Psychology Review* 29(5), 431–448.

Vidal, M. and J. Petrak. 2007. "Shame and adult sexual assault: A study with a group of female survivors recruited from an East London population. *Sexual and Relationship Therapy* 22(2).

Walker, J., J. Archer, and M. Davies. 2005. "Effects of rape on male survivors: A descriptive analysis." *Archives of Sexual Behavior* 34, 69−80.

White, D. and J. Du Mont. 2009. "Visualizing sexual assault: An exploration of the use of optical technologies in the medico-legal context." Retrieved from: www.ncbi.nlm.nih.gov/pubmed/18952339

Williams, L. 1984. "The classic rape: When do victims report?" *Social Problems* 31(4): 459-467.

Yorker, B. 1996. "Nurses in Georgia care for survivors of sexual assault." *Georgia Nursing* 56: 5–6.

Young, M. 1993. "Supportive counseling and advocacy." *NOVA Newsletter* 16: 1–13.

Zilbergeld, B. 1992. *The new male sexuality*. New York, NY: Bantam Books.

Zinzow, H., H. Resnick, S. Barr, C. Danielson, and D. Kilpatrick. 2012a. "Receipt of post-rape medical care in a national sample of female victims." *American Journal of Preventive Medicine* 43(2) 183–187.

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_____

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 2014 National Crime Victims' Rights Week Resource Guide.

Q: Approximately how many victims age 12 or older experienced rape or sexual assault in 2011? Was it approximately:

A. 57,000

B. 102,000

C. 188,000

D. 243,800

Answer:

Q: In 2011, what percentage of rape or sexual assault victims were female? Was it approximately:

A. 55 percent

B. 67 percent

C. 86 percent

D. 97 percent

Answer:

Q: In 2011, what percentage of female rape or sexual assault victims were assaulted by a stranger? Was it approximately:

A. 12 percent

B. 28 percent

C. 36 percent

D. 55 percent

Answer:

Q: In 2011, what percentage of all rapes and sexual assaults were reported to law enforcement? Was it approximately:

A. 15 percent

B. 27 percent

C. 48 percent

D. 70 percent

Answer:

Q: In 2011, forcible rapes accounted for what percentage of violent crimes reported to law enforcement? Was it approximately:

A. 3 percent

B. 7 percent

C. 12 percent

D. 18 percent

Answer:

Q: The Department of Defense published a report on sexual assault in the military in 2012. In that year, how many sexual assaults were reported by military Service Members?

A. 573

B. 1,802

C. 3,374

D. 10,575

Answer:

Q: In 2011, approximately what percentage of reported forcible rape cases were cleared by law enforcement? Was it approximately:

A. 21 percent

B. 33 percent

C. 41 percent

D. 50 percent

Answer:

Worksheet 3.2

Myths and Facts About Rape and Sexual Assault

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 sexual assault vary from state to state. For the purposes of this training, rape is the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

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: Data on perpetrators of sexual offenses against children indicates that these offenders tend to be juveniles or young adults under the age of 30 (Douglas and Finkelhor 2005).

Myth: The "stranger" represents the greatest threat to children.

Fact: Among child victims of sexual abuse coming to law enforcement attention, about one-fourth are victimized by family members, and another 60 percent are abused by persons known to the child. Only 14 percent are victimized by strangers (Snyder 2000).

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.

Worksheet 4.1

Response Scenarios Case Studies

Scenario 1:

Kevin is 12 years old, and has been bullied and sexually assaulted by several boys from school. He and his mother, Karen, visit you. The police have arrested the assailants and Kevin wants to find out will happen next.

Kevin is very quiet during your conversation. When his mother asks Kevin to describe what happened, you encourage Kevin to only say what he feels comfortable talking about.

Kevin responds, "I didn't feel anything. It was kind of like it was happening to someone else. Like I was in a movie or something. It was weird, it was like I didn't care."

Even though you make it clear it's not necessary, Kevin wants to tell you a little about the assault. But he does so in a very calm and detached way. When Kevin momentarily leaves the room, Karen confides to you that she is worried about Kevin, because although he seems okay, he won't leave her side. He is afraid to be alone and says he only feels safe with her.

More than once, Karen says, Kevin has said "I don't feel right anymore." I don't feel like myself."

1. **What survival reflex did Kevin experience?**

2. **What effects did the assault have on Kevin? Which of the key brain circuitries discussed in this training were involved?**

Scenario 2:

Bella is a single mother with three children. She works cleaning homes and was on her way to deposit a large sum of cash into her account when she was robbed and sexually molested. The perpetrator threatened her with a gun, took all her money, and fondled her roughly under her clothing before leaving.

Bella visits you to find out how to obtain money for living expenses and rent. She says the police cannot help because she was so focused on the gun she could not give a good description of the perpetrator. She tells you that when the perpetrator approached her with a gun, "That was all I could focus on – that gun."

Bella explains that she is from Colombia, and has seen much violence. She is very afraid of guns. "I was so scared I just stood there while he put his hands under my clothing and took my purse. I tried to scream but he had his hand over my mouth. I could feel my heart beating really fast. As soon as he was done I took off. I didn't know I could move that fast."

She is greatly troubled by the loss of money, more so than the sexual assault. Bella begins to cry. She blames herself for losing the money, and now she has no idea how she will provide for her children.

1. **Describe Bella's emotional, physical, and attentional responses to the assault, based on the class discussion.**

2. **Describe how Bella's memory may have been affected by the crime.**

Scenario 3:

When Gabrielle's rapist is brought to trial, she comes to you for information about the criminal justice process. As you are speaking with her, Gabrielle tells you she is afraid of testifying because of the way she responded during the crime. She says she was paralyzed with fear during the assault. "I just *knew* I was going to die," she says. "I tried to scream and wanted to defend myself, but I couldn't. I couldn't even *move.* I was just *stiff."*

She tells you that the police asked her repeatedly why she didn't fight back or resist. She feels ashamed that she wasn't able to fend off the attacker.

Because Gabrielle wants you to hear her story, you don't interrupt her. But as she continues, it's obvious that she's confused about some key facts and the sequence of events, and as she gets increasingly upset she has greater difficult describing what happened. You realize that Gabrielle may be experiencing some of the same emotions that were present during the rape.

1. **What survival reflex did Gabrielle experience?**

2. **What effect did the rape have on Gabrielle's memory? What parts of the brain were involved?**

Worksheet 4.2

How Would You Respond?

1. Why didn't I fight back?
2. Why can't I just get over it?
3. Why do I sometimes feel like it's happening all over again?
4. I've tried counseling before but it didn't help. So what do I do now?
5. Why am I drinking or using drugs? Why am I self-harming?
6. Why did I feel like I couldn't move?
7. Why do I feel numb and disconnected from other people?
8. How do I explain what I have been through and how it's affected me, to my family, friends, and loved ones who have not experienced trauma?
9. Are there any differences between the effects of trauma on a woman's brain versus a man's brain?
10. How do I reconnect with who I am as a healthy and happy person – with playfulness, productiveness, and love? (i.e., who the survivor wants to be)
11. Why am I eating and/or sleeping too much or too little?
12. Why has this assault affected me so much?
13. Why am I just now remembering what happened?

Worksheet 5.1

STI Scenario

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

What can you tell the caller?

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Worksheet 5.2

Physical and 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 physical and psychological effects of assault that this caller might be experiencing?

_____

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_____

Worksheet 6.1

Campus Sexual Assault Case Studies

Case Study #1, The Perpetrator Leaves School

A female student is sexually assaulted after class by a male football player in a classroom. The assault takes place in October. The victim needs to complete the class to graduate. The victim reports the assault to the university.

The football player immediately withdraws from the university. The victim is unable to use the dining hall and the gym because she runs into other members of the football team, who make sexually harassing comments and gestures. Additionally, she is having difficulty entering the classroom where the assault occurred and as a result, is failing the course. The professor has refused to make any accommodations.

Questions

1. Is this incident considered sexual harassment under Title IX?

2. If the perpetrator already withdrew, isn't that enough?

3. Is the taunting by classmates considered sexual harassment as defined by Title IX?

4. Does Title IX permit the victim to receive accommodations? What accommodations might the victim need?

5. What written information, if any, should the school be providing to the victim?

Notes:

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_____

Case Study #2, Full Hearing

A female student is sexually assaulted after class by a male football player in a classroom. The assault takes place in October. The victim needs to complete the class to graduate. The victim reports the assault to the university.

The football player denies the incident ever happened. The victim is unable to use the dining hall and the gym because she runs into the perpetrator and other members of the football team, who make harassing comments and gestures. Additionally, she is having difficulty entering the classroom where the assault occurred and as a result, is failing the course.

After being offered all of her options, the victim chooses to proceed through the campus disciplinary process, but does not want to have to sit in the same room as the perpetrator.

Questions

1. What is the disciplinary process?

2. Where can I find the disciplinary process explained?

3. In a disciplinary process, what is the panel trying to decide?

Notes:

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Worksheet 7.1

Themes and Beliefs Related to Male Sexual Assault

Legitimacy

- "Men can't be sexual assault victims."

- "No one will believe me."

Masculinity

- "I can't be a real man if I let this happen to me."

- "My manhood has been destroyed, stolen from me."

Homosexuality

- "Do I look gay?" "Am I gay?"

- "Homosexuality is perverted."

- "Did it happen because I'm gay/bisexual?"

Adapted from Lisak 1994.

Worksheet 8.1

Medical-Forensic 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.

1. What is the first thing you do when you arrive at the hospital?

2. Pamela wants to know what to expect during the examination. What do you tell her?

3. 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?

4. 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?

5. If you are not with Pamela while she is undergoing a medical-forensic exam, what else can you do to help?

6. If you are in the room with Pamela while she is undergoing a medical-forensic 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?

7. You disagree with the tone of the law enforcement officer while he is interviewing Pamela. What do you do?

8. 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 8.2

Drug-Facilitated Sexual Assault

Using the information Module 8, Lesson 5 in the Participant Manual, answer the following questions about drug-facilitated sexual assault.

1. What drug is most commonly used to facilitate rape?

2. Aside from the drug referenced in the previous question, what are two other drugs that also are used as facilitators of rape?

3. What special factors contribute to underreporting of drug-facilitated sexual assault?

4. Why is urine collection important if drug-facilitated sexual assault is suspected?

5. What will the SANE do if drug-facilitated sexual assault is suspected?

Worksheet 9.1

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-forensic 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 10.1

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 10.2

Personal Self-Care Plan

Create 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 11.1

Checklist for Working With Victims of Sexual Assault

Think back over this training and identify areas that might be a challenge for you. Create your own 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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___

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