

# RAPE CRISIS VOLUNTEER TRAINING MANUAL

Published by:  
Ohio Alliance to End  
Sexual Violence

*For Volunteer Rape  
Crisis Advocates in  
Ohio*

## **Volunteer Training Manual For Rape Crisis Programs in Ohio**



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## **Rape Crisis Program Volunteers**

Many rape crisis programs in the United States, including Ohio, utilize trained volunteers in providing support to survivors of sexual violence. The work of volunteers may include speaking with survivors on the hotline, accompanying survivors to the hospital for forensic exams and treatment, and supporting survivors at various stages of the criminal justice process. Additionally, rape crisis programs often utilize volunteers to assist with program projects, public awareness events, and general office duties. The Ohio Alliance to End Sexual Violence (OAESV) recognizes the importance of volunteers within rape crisis programs, as well as the importance of ensuring that volunteers receive appropriate training.

## **About this manual**

The *Rape Crisis Volunteer Training Manual* was created by OAESV as a tool for rape crisis programs throughout Ohio to utilize in training Volunteer Advocates. It was created to complement the Staff/Volunteer Training Standard in the *Core Standards for Rape Crisis Programs in Ohio*, and is intended to assist programs in providing 40 hours of comprehensive training. (To access the full Standards document, please visit <http://www.oaesv.org/ohio-core-rape-crisis-standards-2013/>). This manual is not intended to replace existing training curricula in local programs, but rather to better equip programs that do not have such curricula, or to supplement existing curricula as needed.

The *Rape Crisis Volunteer Training Manual* includes the following components:

- Basic information and suggested additional reading on specific topics related to sexual violence
- Questions for personal reflection regarding specific aspects of advocacy
- Role-play scenarios for practicing advocacy skills
- Evaluation materials

The *Rape Crisis Volunteer Training Manual* is designed to be flexible in its utilization. It includes numerous specific topics that can be taught in short increments of time, thus enabling a variety of scheduling structures. Additionally, OAESV recognizes that not all rape crisis volunteers perform all the functions included in the manual; therefore it is designed to easily include elements that are most relevant to each program, and exclude elements that are not relevant.

## **Acknowledgements**

This manual utilizes handouts and materials created by the Sexual Assault Response Network of Central Ohio (SARNCO). Sources for other materials and information are cited where appropriate.

**Please direct any questions or comments about this manual to:  
Ohio Alliance to End Sexual Violence, 216-658-1381 or [info@oaesv.org](mailto:info@oaesv.org)**

## Standard for Volunteer Training

Below is the Standard for Staff/Volunteer Training from the *Core Standards for Rape Crisis Programs*:

Staff/Volunteer Training	
<b>Definition</b>	Educating staff and volunteers about the dynamics of sexual violence and equipping them with the skills to provide appropriate, client-centered, empathic support for survivors/co-survivors. Basic training topics include: discussion of myths v. facts; types of sexual violence; crisis intervention; law enforcement/criminal justice system overview; sexual assault exam information; meeting the needs of diverse populations; and supporting survivors with varying abilities
<b>Goal</b>	To equip staff and volunteers with the knowledge and skills necessary to become effective advocates for survivors/co-survivors of sexual violence
<b>Duration</b>	40 hours for volunteers; duration for new staff members may vary
<b>Qualifications</b>	<p>At a minimum, Staff/Volunteer Training includes:</p> <ul style="list-style-type: none"> <li>• Volunteers must receive a minimum of 40 hours of sexual assault/abuse training following the Ohio Standards</li> <li>• Volunteers must complete an application, be interviewed by staff using a standardized list of questions, pass a background check, and possess the necessary auto insurance coverage, as well as other program or agency-specific requirements (e.g., TB test)</li> <li>• The Program must have written guidelines, policies, and procedures for staff and volunteers, including: <ul style="list-style-type: none"> <li>○ Protocols for documentation of crisis contacts</li> <li>○ Protocols for when and how volunteers should contact a volunteer coordinator/staff member</li> <li>○ Protocols for referring clients elsewhere (e.g., suicidal ideation)</li> <li>○ Protocols for ensuring survivors receive information and referrals (e.g., Victims Compensation, VINE)</li> </ul> </li> <li>• The Program should establish record-keeping protocols, including: <ul style="list-style-type: none"> <li>○ Protocols for how to track the number of client contacts (phone and in-person) and how to dispose of confidential information</li> <li>○ A roster of all volunteer names/contact information on file</li> <li>○ Number of volunteer hours and types of assistance provided per volunteer</li> </ul> </li> <li>• Volunteers do not need to be licensed mental health providers; if an advocate is a licensed mental health provider, they do not serve in their professional capacity when acting as an advocate <ul style="list-style-type: none"> <li>○ All staff and volunteers must sign a confidentiality statement and the Program must keep it on file</li> </ul> </li> </ul>

## TABLE OF CONTENTS

Title/Subject	Page
<b>SECTION 1: INTRODUCTION &amp; ORIENTATION</b>	6
A. Training overview: goals & expectations	7
B. Creating a shared language	8
C. Importance of self-care during training	9
<b>SECTION 2: OVERVIEW OF RAPE CRISIS ADVOCACY</b>	10
A. Brief history of rape crisis advocacy	11
B. Defining the Volunteer Advocate	12
C. Importance of confidentiality	13
<b>SECTION 3: REALITIES OF SEXUAL VIOLENCE</b>	14
A. Sexual violence statistics	15
B. Myths & facts about sexual violence	16
C. Dynamics of sexual violence	17
D. Rape culture	18
<b>SECTION 4: IMPACT OF SEXUAL VIOLENCE</b>	19
A. Mental health & neurobiological impact	20
B. Emotional impact	24
C. Behavioral & interpersonal impact	25
D. Physical impact	27
E. Spiritual impact	28
F. Economic impact	28
G. Impact on loved ones/co-survivors	29
<b>SECTION 5: CRISIS COUNSELING &amp; ACTIVE LISTENING</b>	31
A. Common concerns of survivors	32
B. Importance of empathy	33
C. Crisis counseling & active listening skills	34
<b>SECTION 6: HOTLINE ADVOCACY</b>	39
A. Supporting survivors on the phone	40
B. Boundaries, limitations, & safety on the phone	42
C. Assessing for suicidal ideation/threats	44
<b>SECTION 7: HOSPITAL ADVOCACY</b>	45
A. Forensic exam process	46
B. Supporting the survivor through the exam process	49
C. Challenges in the hospital setting	51
<b>SECTION 8: CRIMINAL JUSTICE/LEGAL ADVOCACY</b>	52
A. Overview of criminal justice system	53
B. Supporting survivors in the criminal justice system	54
C. Civil legal needs of survivors	55

## TABLE OF CONTENTS (continued)

Title/Subject	Page
<b>SECTION 9: CULTURAL COMPETENCY</b>	56
A. Defining & practicing cultural competency	57
B. Accessibility for survivors	59
<b>SECTION 10: SPECIAL POPULATIONS &amp; ISSUES</b>	60
A. Drug-facilitated sexual assault	61
B. Male survivors	62
C. Child & adolescent survivors	63
D. Elderly survivors	64
E. Incarcerated survivors	64
F. Domestic violence & human trafficking	65
<b>SECTION 11: DOCUMENTATION &amp; POLICIES</b>	66
A. Documentation of survivor services & volunteer hours	67
B. Local program policies	68
<b>SECTION 12: VICARIOUS TRAUMA &amp; SELF-CARE</b>	69
A. Vicarious trauma in rape crisis work	70
B. Self-care for advocates	71
<b>SECTION 13: ADDITIONAL MATERIALS</b>	72
A. Role play scenarios	73
B. Self-reflection worksheet	75
C. Training Manual Evaluation	76

*“Never doubt that a small group of committed citizens can change the world; indeed, it’s the only thing that ever does.”*

*Margaret Mead*

**SECTION 1:**

**INTRODUCTION & ORIENTATION**

## A. TRAINING OVERVIEW: GOALS & EXPECTATIONS

Welcome to the training course for new Volunteer Advocates! We're glad you're here and that you're committed to supporting survivors of sexual violence in your community. We hope you find this training to be both informative and inspiring, and that as a result of the training, you feel equipped to effectively serve as a Volunteer Advocate.

### Training goals

The purpose of providing a thorough training for you as a new Volunteer Advocate is to equip you with the information and skills necessary to effectively serve survivors of sexual violence. All advocates require ongoing support and education in order to be effective in advocating for survivors. This training is intended to be a thorough starting point from which to learn advocacy skills.

The goal of this training is to equip you with:

- Knowledge about the dynamics and impact of sexual violence
- Understanding of the needs and concerns of survivors
- Skills for active listening and effective advocacy
- Knowledge about advocating for survivors in a variety of contexts
- Skills for self-care while serving as a Volunteer Advocate

### Training expectations

As with most experiences in life, what you get out of this training will depend in part on what you put into it. You should expect that your trainer(s) will be respectful of your questions, concerns, ideas, and perspectives. To receive the greatest benefit from this training, you should plan to:

- Arrive on time for each session and attend the entire session
- Be respectful of others in the class, including fellow participants, trainer(s) and any outside presenters
- Actively participate in discussions, activities and exercises throughout the training
- Ask questions and make suggestions that will help you to grasp concepts
- Share any concerns you have about your role as a Volunteer Advocate – chances are good that other participants have the same concerns



**What are some personal goals you have for this training?**

**What made you decide to become a Volunteer Advocate?**

*Note: This question mark symbol and corresponding questions will be utilized throughout this manual in order to help you apply specific concepts to your individual learning. The answers do not have to be shared with others; however, they may at times be useful for group discussions.*

## B. CREATING A SHARED LANGUAGE

There are numerous words and unique terminology used in the field of victim advocacy in general, and in rape crisis advocacy in particular. Some of those words and terms are defined here for the purpose of creating a shared language for your training class and for your work as a Volunteer Advocate.

### **Sexual violence/sexual assault/rape**

In Ohio, the terms “sexual violence” and “sexual assault” do not exist in state law, whereas “rape” is a felony crime defined by the Ohio Revised Code. The Centers for Disease Control defines sexual violence as any sexual act perpetrated against someone’s will. It encompasses a range of offenses, all of which involve victims who do not consent, or who are unable to consent or refuse to allow the act.\* The terms sexual violence, sexual assault, and rape will all be used in this manual.

### **Victim/survivor**

The term “victim” is rooted in the criminal justice system and refers to the status of an individual based on the commission of a crime against them. The term “survivor” is thought to be a more progressive term, emphasizing the individual’s literal survival of the crime and/or the individual’s determination to recover from the crime. If it is necessary to utilize a descriptor when working with a particular individual, it is best to allow the individual to decide the appropriate descriptor. For the purposes of this manual, the term “survivor” will be used almost exclusively.

### **Secondary victim/co-survivor/loved one**

Friends and family members of survivors are also impacted by sexual violence. The term “secondary victim” refers to the status of a friend or family member being “secondarily victimized” by the crime another suffered. The term “co-survivor” implies a supportive status in which the survivor and the friend/family member are working toward recovery. “Loved one” simply refers to anyone in the survivor’s life who is important to the survivor and shares some level of intimacy. The term “loved one” will most commonly be used in this manual.

### **Gender-based pronouns**

Sexual violence has traditionally been thought of as a crime primarily committed by males and suffered by females. We know that males can be both perpetrators and survivors, as can females. Additionally, transgender survivors and other individuals may or may not identify as “he” or “she.” The use of gender-based pronouns are used in this manual for the purposes of establishing clarity and flow in syntax, and is not intended to exclude or invalidate the identities or experiences of any individual.

\*For the full definition of sexual violence from the Centers for Disease Control, read here:

<http://www.cdc.gov/violenceprevention/sexualviolence/definitions.html>

## C. IMPORTANCE OF SELF-CARE DURING TRAINING

### Impact of training

While this training is intended to be informative and inspiring to participants, it is to be expected that learning intensive concepts about sexual violence and advocacy may cause unsettling feelings in the short-term. Your sense of safety and your view of individuals and society may be challenged by this training, which is normal. Conversely, it is also quite possible that concepts learned in this training may empower you and increase your sense of safety and efficacy. Be sure to discuss any concerns you have with your trainer(s) at any point during the training, and be sure to ask questions throughout the training that will address any fears or questions you may have.

If you are a survivor of sexual violence, it is possible that parts of this training may trigger you. Detailed information about the psychological and physiological impact of sexual violence will be discussed, and case examples will be utilized in applying concepts to practice, which may or may not be upsetting for you. It might also be empowering. It is important that you are open and honest with your trainer(s) and/or supervisor about how the training is impacting you, and how you can best be supported.

### About self-care

Self-care is the consistent, intentional practice of monitoring how advocacy/training is impacting you as a Volunteer Advocate, and practicing basic skills and techniques for minimizing any negative impact. It is normal for a new Volunteer Advocate to become engrossed in the training material and to strive for the greatest amount of skill and competence as possible. It is important, however, that balance is maintained between this training and other activities and responsibilities in your daily life. That sense of balance will promote enrichment and efficacy in your work as a Volunteer Advocate.

Some general self-care tips during training:

- Read only the materials that are assigned for any particular session; do not read ahead
- Note how your body reacts to different concepts of training (pulse, agitation, butterflies in your stomach, sense of anxiety or excitement, etc.); note how these reactions change over time or when discussing new topics
- Engage in activities during your personal time that are healthy and fulfilling
- Ask questions and share your “gut reaction” to stories or concepts discussed in training



**How do you like to unwind after a busy or stressful day?**

**How do you know if you're feeling stressed or bothered by something?**

**What activities do you enjoy in your free time?**

**SECTION 2:**

**OVERVIEW OF RAPE CRISIS ADVOCACY**

## A. BRIEF HISTORY OF RAPE CRISIS ADVOCACY

Sexual violence is a form of oppression that is used to silence, divide and further marginalize oppressed groups. Such groups include females in general, females of color in particular, individuals with physical, cognitive, or developmental disabilities, and individuals who identify as LGBTQ. The history of the rape crisis movement in the U.S. closely mirrors the anti-oppression movement, particularly the oppression of women of color. During slavery, the rape of African-American women by white men was both common and legal. After slavery, physical and sexual violence were used to terrorize and keep African-Americans from gaining political or civil rights. The Reconstruction Period following the Civil War was especially violent, when mobs of white men, including the Ku Klux Klan, gang-raped black women and murdered black men. Propaganda was spread that black men were likely to rape white women; meanwhile, the rape of black women was not even considered a crime.

Black women were among the first to testify before Congress as to the epidemic of rape they were experiencing. Sojourner Truth was the first woman to connect black oppression with women's oppression. The 1870's saw the earliest organized efforts to address rape and lynching in the U.S., and most such efforts were led by African-American survivors. Their courageous efforts in the face of intense hatred and violence led to the formation of the Black Women's Club movement of the 1890's and laid the groundwork for later establishment of national organizations, including the National Coalition Against Domestic Violence.

The rape crisis movement experienced its next significant wave of activity in the 1960's and 1970's on the heels of the Civil Rights Movement. In the mid-1970's, national organizing efforts brought attention to the imprisonment of several black women who fought and killed their rapists. The earliest rape crisis centers were established in 1972 in politically active towns, and were largely staffed by volunteer-survivors. By the late-1970s, the first "Take Back the Night" marches were held, and women of color continued joining the movement; however, white women had assumed many leadership positions within rape crisis centers, and the emphasis on racism and oppression began to wane.

In the years since, rape crisis centers have become more formalized and widespread, and they have received government and other funding that has fluctuated; however, this progress poses its own challenges. The movement has largely shifted from a political-activist perspective to a public health perspective. As the movement continues on, emerging and existing issues will need to be addressed, including the need for consistent, deliberate inclusion of the intersectionality of racism, oppression, and sexual violence in our work.

Summarized from: *History of the Rape Crisis Movement* by Gillian Greensite

Read the full document: <http://www.calcasa.org/blog/history-rape-crisis-movement>

## B. DEFINING THE VOLUNTEER ADVOCATE

### About rape crisis advocacy

Rape crisis advocates (both paid and volunteer) are unique in the field of victim services and within the overall response to sexual violence. While different programs utilize Volunteer Advocates for different functions, all Volunteer Advocates approach rape crisis advocacy from the same philosophical basis, namely believing and empowering survivors and providing nonjudgmental support and advocacy. As the term “rape crisis” implies, Volunteer Advocates typically support survivors during the crisis period, which could be immediately after the assault, or at any point that the survivor experiences a crisis that prompts her/him to seek support.

All Volunteer Advocates approach advocacy:

- Believing all survivors, regardless of the circumstances of the assault/abuse
- Providing unbiased information to survivors about their options and resources
- Empowering survivors to make their own decisions and supporting them in those decisions
- Connecting survivors with resources that will encourage and support their recovery

Volunteer Advocates do NOT:

- Question, judge or investigate the crime or the circumstances surrounding it
- Provide therapeutic counseling services, medical advice, or legal advice
- Persuade or coerce a survivor into any particular course of action
- Provide services to survivors long-term

### Other roles within sexual violence response

*Law Enforcement:* take statements, gather facts and investigate crime

*Sexual Assault Nurse Examiner:* impartially collect evidence and document presence/absence of injury

*Hospital Personnel:* assess, diagnose, and treat physical ailments, disease, and/or injury

*Prosecutor:* present the facts of the criminal case before a judge, grand jury, and/or jury

*Mental Health Professional:* provide scheduled, therapeutic counseling services

One way to think of the response to sexual violence is that all other professionals who respond to sexual violence are either doing something to, or taking something from, the survivor. Advocates are the only ones who are there to be *with* the survivor. Advocates are unique and critically important.

Read more about the efficacy of Rape Crisis Advocates:

[http://psychology.msu.edu/vaw/core\\_faculty/rebecca\\_campbell/Articles/Campbell%20\(2005\).pdf](http://psychology.msu.edu/vaw/core_faculty/rebecca_campbell/Articles/Campbell%20(2005).pdf)



**Is anything about the role of a Volunteer Advocate surprising to you?**

**What are some advantages of being an Advocate, as opposed to another professional?**

**What are some disadvantages of being an Advocate?**

## C. IMPORTANCE OF CONFIDENTIALITY

Confidentiality is of paramount importance to an advocate's work with survivors. In order for survivors to share intimate thoughts, feelings, and/or details about the assault, they must have an assurance that what they share will not be exposed or shared with anyone else, unless they give permission to share it. Confidentiality is a matter of ethics and is a standard of best practice.

Confidentiality is also a requirement. Each rape crisis program should have a policy regarding confidentiality, in accordance with federal and state law, funding requirements, and best practice standards. (Your program's staff will explain the policy and how it applies to your role as a Volunteer Advocate). Confidentiality is required by all major state and federal funders of rape crisis services in Ohio, including the federal Violence Against Women Act (VAWA).<sup>\*</sup> Failure to comply with confidentiality requirements could result in loss of funding and other repercussions for the program.

Generally speaking, confidentiality is an easy policy for advocates to follow. It can sometimes be tempting to breach confidentiality in daily life, such as when your family or friends read about a particular case in the news and ask you about it, or if a neighbor or someone with whom you live sees you leave and return from a hospital call and asks you about it. Rape crisis work can at times be intense, upsetting, and rewarding, which are all emotions and reactions we would normally be inclined to share with loved ones. You can share these things with your supervisor in the confidential environment of your local rape crisis program, but you cannot share details of cases with loved ones, even if they promise not to share it. The privacy of survivors must always be preserved.

### **How confidentiality is applied to rape crisis work**

No identifying information about a survivor can be shared with anyone unless the survivor has given consent to share it. Identifying information includes the survivor's name, age, date of birth, address, phone number, email, family names or contact information, and details of the assault/abuse or treatment/services sought by the survivor. If the survivor grants consent to share any information, the advocate should obtain (preferably in writing) consent that includes exactly the information the survivor does (or does not) want to be shared and exactly with whom to share (or not share) it.

There may be times when breach of confidentiality is required or necessary. Your trainer or supervisor will discuss these circumstances with you and how you should respond in your role as a Volunteer Advocate. Generally speaking, it is always wise to err on the side of caution by maintaining confidentiality. If you are unsure about what to do in a particular situation, consult with your supervisor prior to breaching confidentiality.

<sup>\*</sup>For more information about the Violence Against Women Act and confidentiality, read here:

[http://www.lsc.gov/sites/lsc.gov/files/LSC/pdfs/10.%20%20Appendix%20IX-2%20%20CH%203%20SA Confidentiality Final.pdf](http://www.lsc.gov/sites/lsc.gov/files/LSC/pdfs/10.%20%20Appendix%20IX-2%20%20CH%203%20SA%20Confidentiality%20Final.pdf)

**SECTION 3:**

**REALITIES OF SEXUAL VIOLENCE**

## A. SEXUAL VIOLENCE STATISTICS

Sexual violence is a crime that impacts a significant number of people worldwide, including the U.S. Statistics regarding the prevalence of sexual violence are readily available, but vary widely depending on their source and how that source defines sexual violence and specific sex offenses.

Differing definitions of sexual violence:

- Centers for Disease Control: <http://www.cdc.gov/violenceprevention/sexualviolence/definitions.html>
- FBI: <http://www.fbi.gov/about-us/cjis/ucr/recent-program-updates/new-rape-definition-frequently-asked-questions>
- Ohio Revised Code: <http://www.oaesv.org/wp-content/uploads/2012/12/Legal-Definitions-Fact-Sheet.pdf>

What we know about sexual violence in general:

- It is a widespread crime suffered worldwide by individuals of all ages, races, ethnicities, socioeconomic statuses, gender identities, sexual orientations, and geographic locations
- It is suffered disproportionately by women of color, individuals with disabilities, and individuals who identify as LGBTQ
- It is one of the most underreported crimes
- It is associated with numerous negative health and economic outcomes for survivors

A sampling of statistics about sexual violence:

- Nearly 1 in 5 women in the U.S. has been the victim of rape in her lifetime; nearly half of all women have experienced sexual violence other than rape; 1 in 71 men in the U.S. has been the victim of rape in his lifetime; 1 in 5 has experienced sexual violence other than rape (National Intimate Partner & Sexual Violence Survey: <http://www.cdc.gov/violenceprevention/nisvs/>)
- 42% of female survivors experienced their first completed rape prior to age 18; 28% of male survivors were first raped prior to age 11 (Centers for Disease Control)
- 1 in 4 girls and 1 in 6 boys are sexually victimized before age 18 (Adverse Childhood Experiences Study: <http://www.cdc.gov/ace/prevalence.htm>)
- In Ohio in 2011, 61% of reported rapes were committed against juveniles; the average age of victimization was 15 (Ohio Incident-Based Reporting System)
- Approximately 63% of sexual assaults are never reported to law enforcement (Read more: [http://nsvrc.org/sites/default/files/publications\\_nsvrc\\_factsheet\\_media-packet\\_crime-reports-sexual-violence.pdf](http://nsvrc.org/sites/default/files/publications_nsvrc_factsheet_media-packet_crime-reports-sexual-violence.pdf))



**How are statistics useful in understanding sexual violence?**

**How are statistics limiting?**

**Which statistic above do you find most surprising or troubling? Why?**

## B. MYTHS & FACTS ABOUT SEXUAL VIOLENCE

There are numerous myths about sexual violence that exist in our society, the impact of which is both individual and cultural. Sexual violence is a form of oppression and a crime of power and control. Most myths about sexual violence are rooted in and perpetuated by this oppression, and are a direct extension of the rape culture which exists in our society. Some myths are rooted in our psychological need to protect ourselves from harm and to distance ourselves from those who have been victimized.

Below are a few of the most common myths (and their countering facts) about sexual violence in our society. As you study this list, consider how each myth perpetuates oppression and control. Also consider how each myth might impact someone who has experienced sexual violence.

MYTH	FACT
Most rapes are committed in dark alleys by strangers.	The majority of rapists are known to the survivor and assaults often occur in locations familiar to the survivor and/or rapist.
Rape is motivated by uncontrollable sexual desire.	Rape is a violent crime of power and control in which sex is used as a weapon to harm and humiliate.
If the survivor was dressed provocatively or intoxicated or high, it's her/his fault.	It is never the survivor's fault, no matter what s/he was or was not doing or wearing. No one ever asks for or deserves to be raped.
Women often lie about being raped.	Very few reported rapes are false – about 4% - which is consistent with the false reporting rate for most other felony crimes.
If the survivor didn't resist or struggle, then it wasn't rape.	There are many reasons a survivor may not (or cannot) resist, including fear, being overpowered, or being incapacitated.
Only gay men rape other men.	Most males who rape other males identify as heterosexual. Rape is about power and control, not sexual desire or orientation.
Rape cannot happen in same-gender relationships.	Males can rape other males, and females can rape other females, whether in an intimate relationship, acquaintances, or strangers.
Prostitutes can't be raped; someone engaging in risky sexual behavior is to blame if s/he is raped.	Regardless of a person's sexual history or behavior, if s/he did not consent, it is rape. An individual can be raped by someone with whom s/he had prior consensual sexual contact.
Rape by an acquaintance is not as serious as rape by a stranger.	Any form of sexual violence, regardless of who it is committed by, is serious and traumatic. Non-stranger rape often causes the survivor to question her/his judgment of others and sense of trust.
Survivors of rape are (or should be) upset/hysterical and have physical injuries.	Most survivors do not have obvious signs of injury, and survivors can react in a variety of ways, all of which are normal.
A wife cannot be raped by her husband.	While some states do not legally recognize marital rape, a married person can be raped by his/her spouse. It's about consent.

## C. DYNAMICS OF SEXUAL VIOLENCE

Understanding the dynamics of sexual violence involves striving to understand the motivations and characteristics of those who commit this violence. Historically, research has been limited to incarcerated male sex offenders. Since the majority of rapes are never reported, most sex offenders are never identified, making it difficult to study them. Research on incarcerated male sex offenders has identified and characterized them into three types:

1. **Power rapist:** motivated by the need to control and dominate his victim, and inversely, to avoid being controlled by his victim
2. **Anger rapist:** motivated by resentment and a general hostility toward women
3. **Sadistic rapist:** motivated by sexual gratification he experiences by inflicting pain on his victim; contrary to television and movie portrayals, this typology is extremely rare

Beginning in the 1980's, social science researchers began to systematically expose the reality of interpersonal violence in America by researching and documenting the true prevalence of both sexual and domestic violence. These efforts revealed three fundamental realities: Most interpersonal violence is perpetrated by individuals who are known to the survivor; most of this violence is never reported to authorities; and most perpetrators of this violence are never prosecuted.

More recent research has deliberately looked at non-incarcerated sex offenders. Researchers discovered that it was possible to study these men because they did not view themselves as rapists. They believe that rapists are knife-wielding strangers who attack in ski masks. Since their behavior doesn't match that description, they don't believe that their behavior qualifies as rape. This research has found that many of the motivational factors in incarcerated sex offenders apply equally to undetected rapists. When compared to men who do not rape, these undetected rapists are measurably angrier at women, more motivated by the need to dominate and control women, more impulsive and dis-inhibited in their behavior, more hyper-masculine in their beliefs and attitudes, less empathic and more antisocial.

These undetected rapists:

- Are extremely adept at identifying "likely" victims and testing prospective victims' boundaries
- Plan and premeditate their crimes using sophisticated strategies to isolate and groom victims
- Use only as much violence/force as is necessary to terrify and coerce their victims into submission; use psychological tactics backed up by physical force, almost never using weapons
- Deliberately use alcohol to render victims more vulnerable to attack or even unconscious

Summarized from: *Understanding the Predatory Behavior of Sexual Violence* by David Lisak, Ph.D.

Full document: <http://www.middlebury.edu/media/view/240951/original/PredatoryNature.pdf>

## D. RAPE CULTURE

As previously discussed, sexual violence is a form of oppression in which sex is used as a weapon to control, humiliate, and intimidate those on whom that violence is committed. In modern American society, it may be difficult to believe or accept that a culture supporting rape still exists, but it arguably does. Many aspects of “rape culture” are so much a part of our social structure and discourse that we don’t always recognize them as contributing to the problem of sexual violence. As a result, sexual violence is normalized, tolerated, excused, and thus also encouraged.

In the broadest context, rape culture affects every woman. “The rape of one woman is a degradation, terror, and intimidation to all women” (Marshall University Women’s Center). Most women live in fear of rape and are taught from an early age to be fearful of it and thus alter their behavior to avoid it. This fear serves to keep females subordinate to males, and being taught to avoid rape puts the responsibility for the crime on women. If a woman is raped, she is blamed directly and/or indirectly by a society that has taught her that it’s her responsibility to keep rape from happening to her.

There are many examples of rape culture in our society. Below are a few examples:

- Widespread, consistent glamorization of sexual violence committed against women and girls in popular media and the entertainment industry
- Objectification of women and girls in entertainment, advertising, and the media
- Adherence to rigid gender norms and stereotypes that support hyper-masculinity and discourage the equality and sexual freedom of females and individuals who identify as LGBTQ
- Tolerance of sexually explicit jokes, sexual harassment, demeaning sexual comments, etc.
- Excusing sexually violent or coercive behavior of males (“boys will be boys”), while blaming females for “tempting” males or placing themselves in a position to be victimized
- Choosing not to believe survivors or refusing to take accusations of sexual violence seriously
- Teaching women and girls to avoid being raped, rather than teaching men and boys not to rape

Rape culture affects everyone in our society, and everyone has a role in combatting it. Each of us can choose not to laugh at sexist jokes, not to purchase or consume sexually violent entertainment, and to speak up when acts of sexual violence are excused and individual survivors are blamed or otherwise not supported. In short, when we see something, we should do something. When we hear something, we should say something.



**What are some other examples of rape culture that you can think of?**

**Within this past week, name two examples of rape culture you have seen/witnessed.**

**What can you do (or have you done) when confronted with elements of rape culture?**

**SECTION 4:**

**IMPACT OF SEXUAL VIOLENCE**

## A. MENTAL HEALTH & NEUROBIOLOGICAL IMPACT

### **Sexual violence is a trauma**

Sexual violence is a crisis, a traumatic experience that impacts the survivor physically, mentally and emotionally. Other traumatic experiences we commonly hear about include combat conditions, natural disasters, terrorist attacks, and accidents. Any event that falls outside the realm of normal experience for an individual can be traumatic. What makes a particular experience traumatic is that it causes the survivor to feel that her/his life and well-being are directly threatened and s/he has little or no control over the event. Such an event overwhelms the brain's capacity to cope the way it would in ordinary stressful situations in life. The extent to which a person feels threatened and unable to exercise control over the event determines how traumatic that event is to that person. For example, an attempted rape can be as traumatic for one person as a completed rape is for another person. The trauma of sexual violence is uniquely challenging for survivors in that it involves the violation of one's most personal space, it likely is committed by someone the survivor knows, trusts, or even loves, and society tends to blame survivors for their own victimization.

### **Rape Trauma Syndrome**

The reaction to sexual violence is as unique as each individual survivor and is influenced by numerous factors, such as the survivor's history of experiencing other traumatic events, the survivor's current mental health, and the survivor's support system. There is no right or wrong way for a survivor to feel or react after experiencing sexual violence, nor is there a normal timeline for recovery.

"Rape Trauma Syndrome" is not a diagnosable condition, but rather a theoretical framework for understanding the mental and emotional response to sexual violence. It describes a general process of response and recovery, but is meant to be fluid in its application to individual survivors. For example, not all survivors move through this process sequentially, nor is there a predictable pace. It is intended to help survivors, their loved ones, and professionals/service providers to better understand the emotions and behaviors survivors experience and express over time.

**Acute Stage:** This stage typically lasts from a few days to a few weeks after the traumatic event and is characterized by intense physical, mental, and emotional symptoms. In the immediate aftermath of the trauma, the body and mind of the survivor are still reeling and are struggling to return to a sense of balance and normalcy. Some survivors are very expressive (crying, yelling), while others are very reserved (calm, in shock). Both reactions are normal responses to trauma, as is fluctuation between the two. It is also normal for some survivors to react by laughing/giggling, particularly if that is the survivor's normal response to being nervous or overwhelmed. The survivor may shake or tremble, and may have difficulty concentrating on tasks and/or have difficulty with comprehension.

***Underground Stage:*** It is intolerable for the body and mind to continue to operate in the intensity described in the Acute Stage and so the survivor strives to return to normal, everyday life. This stage can last from a few days or weeks to decades or even the rest of the survivor's life. In this stage, the survivor will often go to great lengths to distance her/himself from the trauma and any reminders of it. This might involve making subtle or profound changes to one's routine or surroundings. It is common to deny the trauma, or to think and speak of it as if it's "no big deal." It is also common for survivors to analyze or talk incessantly about the trauma, in order to normalize it. Meanwhile, the survivor is likely experiencing internal turmoil, such as nightmares and self-blame. Loved ones of the survivor may express confusion or concern about the survivor's actions or emotions during this stage. The survivor has in essence embraced a "new normal" in order to function in the aftermath of the trauma.

***Reorganization Stage:*** This stage often begins if/when the survivor experiences memories or sensations of the trauma and a return of intense emotions described in the Acute Stage. These are usually triggered by something that may or may not be directly related to the past trauma, including experiencing a sensory reminder of the trauma (sight, sound or smell), or experiencing a major life transition, such as getting married, having a child, or the child reaching the age the survivor was when s/he was assaulted. Some survivors in this stage feel a need to examine the impact the trauma has had on their lives, while others are not able or willing to examine the impact of the trauma. For some survivors, this stage results in reaching a sense of resolution, where the trauma is understood and integrated within the context of the survivor's full life and experience. This can occur with or without formal assistance. Other survivors may return to the Underground Stage.

## **Post-traumatic Stress Disorder**

Post-traumatic stress disorder (PTSD) is a mental health condition suffered by many individuals who have experienced one or more traumatic events, including sexual violence. Not everyone who has experienced a traumatic event develops PTSD. About one-third of sexual assault survivors do. A survivor may experience PTSD at any point following a traumatic event, even many years later. Many of the symptoms of PTSD are also common in rape trauma syndrome, but PTSD is diagnosed when specific symptoms are present, persist for a prolonged period, and/or are interfering with the survivor's ability to function normally.

PTSD is generally characterized by the presence of three types of symptoms:

- ***Intrusive memories:*** These include flashbacks and disturbing thoughts or dreams about the event. Flashbacks are intense, terrifying recollections of the event, such that the survivor actually feels as if the event is happening again.
- ***Avoidance and emotional numbing:*** This may include avoiding things that could elicit memories of the trauma, avoiding activities that used to be enjoyable, feeling emotionally disconnected, feeling hopeless about the future, having difficulty with memory and concentration, and having difficulty maintaining close relationships.

- *Anxiety and emotional arousal:* This may include irritability or anger; overwhelming guilt or shame; difficulty sleeping; seeing or hearing things that aren't there; being easily startled or frightened; and engaging in self-destructive behavior.

Only a licensed mental health professional can diagnose and treat PTSD. Treatment includes mental health counseling, medication, or a combination of the two. Mental health counseling methods to treat PTSD and/or to address the emotional, mental health, and neurobiological impact of trauma include (but are not limited to) Cognitive-Behavioral Therapy, Eye Movement Desensitization and Reprocessing (EMDR), and Somatic Experiencing ©. For more information about mental health treatment and best practices, visit here: <http://www.oaesv.org/mental-health-providers/>

## **Neurobiological impact**

The response to sexual violence, like other traumatic experiences, has traditionally been thought of primarily in psychological terms, but we also know that survivors experience higher rates of chronic health conditions over time when compared with those who have not been traumatized. Recent advances in neuroscience have helped to explain why this is.

When threatened, human beings (like animals) are hard-wired to address the threat by fighting (*fight*), running (*flight*) or “playing dead” (*freeze*). How the survivor reacts is involuntary; it is an instantaneous determination made by the survivor’s brain based on the nature and context of the threat. The brain determines which response is most likely to enable the survivor to *literally survive* the threat. Powerful hormones flood the survivor’s body preparing her/him to exercise the fight/flight/freeze response. A person is traumatized when that response is thwarted or overwhelmed (i.e. the survivor is overpowered and unable to neutralize or escape the threat. The survivor may literally survive the assault, but s/he doesn’t know while it’s happening whether or not s/he will survive). When this happens, the tremendous amount of energy summoned for the fight/flight/freeze response is unable to be exercised or released, causing it to become trapped in the nervous system and body tissues of the survivor. The brain and body are, in essence, confined to a constant state of vigilance. If that energy is not enabled to be released following the trauma, it can contribute to numerous chronic health conditions and ailments over time, including hypertension (high blood pressure), headaches, fibromyalgia, and other conditions. For this reason, rape crisis and therapeutic services should consider both the emotional and physical impact of sexual violence when working with survivors.

## **Neurobiological impact: helping survivors**

One of the most important things advocates can do to support survivors of sexual violence is to help them to understand why they are feeling the way they are feeling, how they can expect to feel in the days and weeks to come, and the resources that are available to help them recover. Many survivors feel that they are “going crazy” in the aftermath of the trauma. By explaining the survivor’s response

to the assault, advocates can help to alleviate the confusion, shame, and fear that the survivor (and her/his loved ones) may be feeling. Individuals in crisis cannot absorb detailed information, but they *can* absorb and will benefit from knowing that what they are experiencing is a normal reaction to an abnormal life experience.

In addition to addressing the survivor's unique questions, needs and concerns (to be discussed elsewhere in this manual), advocates can support survivors in the following general ways:

- **Promote a sense of safety:** Provided that the survivor is not in danger when you are speaking with them, help them to identify and orient to the safety of their surroundings, such as the room they are in, the building/home they are in, the people with them or nearby, etc. Help them to describe what about their surroundings makes them feel safe (space, distance, light, sounds, colors, textures, temperature, etc.), and what "safe" feels like (calm, comforted, contained, warm, etc.). Remind them frequently that the assault is over, that they are alive and they are safe now. By helping survivors to identify the experience and feeling of safety, they will be better equipped and empowered in their recovery process.
- **Promote the body's needs:** Survivors are frequently discouraged from expressing intense emotions or from physically trembling/shaking in the aftermath of sexual assault. These things can be frightening, distracting, or confusing for survivors to experience and for loved ones and service providers to witness; however, emoting and trembling are *natural, healthy responses* to the trauma of the assault. Explaining this and gently encouraging the survivor to experience these reactions in a safe, supportive environment will promote their recovery. Advocates should also educate loved ones of the survivor, so that they are more comfortable allowing the survivor to experience/express these emotions and movements as they arise.

For more information on neurobiology of trauma and how it impacts survivors, watch this webinar, *Neurobiology of Sexual Assault* by Rebecca Campbell, Ph.D.: <http://www.nsvrc.org/elearning/20044>



**When you feel safe and secure, what are your surroundings like?**

**When you are feeling safe and secure, what emotions and sensations do you feel?**

**How do these emotions and sensations differ when you are feeling insecure or unsafe?**

In your free time, practice orienting to your surroundings – taking in the details of where you are and what is happening around you – and take notice of how your surroundings make you feel (your pulse and breathing, how your stomach feels, any tension in your muscles, any sensations that are especially pleasant and/or unpleasant, etc.). Suspend judgment about yourself and your body as you do this. Simply be with yourself as you are in the moment. Practicing this regularly will not only enable you to help survivors orient to their surroundings and sense of safety, but it will also enable you to feel more secure and empowered while working with survivors.

## B. EMOTIONAL IMPACT

Not surprisingly, the experience of sexual violence elicits emotional responses in survivors. Those emotions are appropriate responses to the survivor's specific experience and reaction to the trauma. How a particular survivor reacts, both emotionally and behaviorally, is unique to each individual survivor, her/his experience of the traumatic event and the circumstances surrounding the trauma, as well as her/his support system. While some emotional processes are generally more helpful than others to the survivor's recovery process, there is no right or wrong way for a survivor to feel or react.

Common emotions survivors of sexual violence feel at one or more points in their recovery process:

- **Fear:** Many survivors feel a sense of fear of varying intensity, which can come from the terrifying experience of the assault itself, from feeling that their attacker may assault them again or even kill them, from the intensity of sensations and emotions they are experiencing, from not being able to trust others/the world, from feeling that loved ones will not believe or accept them, and many other things.
- **Sadness/grief:** Survivors may feel a sense of sadness about what they've experienced and/or a sense of loss – of their “old self,” a sense of safety, a sense of trusting others, etc.
- **Anger:** Survivors may feel a sense of anger ranging from mild resentment to rage. They have been subjected to a horrible crime, which is unjust, unfair, and undeserved. Some survivors correctly blame their attackers for the crime and its resulting impact, while other survivors blame themselves for “allowing/causing it to happen,” or “not stopping it.”
- **Shame:** Many survivors feel a sense of shame surrounding the assault, even if they believe and accept that they are not to blame. This sense of shame comes in part from the pervasive societal stigma associated with this crime, and in part from the intensely personal nature of the assault – nudity, sex acts, etc. that the survivor may or may not consider shameful.

The experience of these (and other) emotions can be exhibited in a variety of ways. Again, each response is unique to the survivor, and there is no right or wrong way to experience or exhibit emotions. Additionally, how a survivor reacts does not indicate how traumatic the assault was:

- **Emotive/expressive:** Some survivors may be outwardly expressive with their emotions (crying, screaming, cursing, etc.). This may or may not be accompanied by shaking/trembling. Some survivors may also express their emotions in what seem to be unconventional ways, such as laughing or giggling.
- **Controlled/unexpressive:** Some survivors may be very controlled in expressing emotions, appearing calm/collected. This, too, may or may not be accompanied by shaking/trembling.
- **Numb/detached:** Some survivors may have difficulty expressing emotion or they may be unable to express emotion at all. They may exhibit a “deer in the headlights” body language.
- **Varied response:** An individual survivor may exhibit any one or all of the above expressions, or fluctuate between them.

## C. BEHAVIORAL & INTERPERSONAL IMPACT

### **Behavioral impact**

Survivors of sexual violence exhibit varying short-term and long-term behaviors as they recover from the assault/abuse, and each individual survivor's response is unique. These behaviors can be a means by which the survivor attempts to exert control and mastery over her/his life in the aftermath of the trauma. They can also be a means by which the survivor attempts to escape or "numb" the negative emotions, memories, and sensations associated with the trauma. While behaviors are traditionally thought to be actions or a set of actions that are voluntary in nature, the motivating factors behind certain behaviors for survivors are based on psychological or neurobiological needs, influenced by their unique histories, personalities, cultural experience, health, and surrounding support systems.

The unhealthy or harmful nature of certain behaviors can be outweighed in some survivors by the need to feel in control and/or to escape traumatic feelings. For this reason, advocates and service providers should be careful not to question or judge too harshly the behaviors of survivors. Medical and mental health professionals should also be intentional in screening for a history of violence or abuse among patients with chronic medical conditions and substance abuse disorders.

Behaviors that some survivors exhibit include:

- Changing physical appearance, home, job, running away, etc. in order to distance themselves from reminders of the assault and/or negative reactions of those around them
- Self-protective behaviors, such as installing an alarm system or additional locks, getting a dog, carrying a weapon, taking a self-defense course, etc.
- Using substances such as alcohol, tobacco, or other drugs in order to numb negative feelings and sensations and/or heighten positive feelings and sensations
- Engaging in high-risk sexual behavior, such as unprotected sex, having multiple sexual partners, having sex early in life, trading sex for food, money, other items, etc.
- Withdrawing from social or intimate relationships, or becoming more dependent upon others
- Specific eating behaviors, such as bingeing, fasting, vomiting, abusing diet pills, etc.
- Self-harming behavior, such as cutting, burning or bruising one's own body

### **Substance abuse and sexual violence**

Substance abuse and sexual violence are inter-related in that each makes the other more likely. Those who abuse substances are more likely to be sexually victimized by perpetrators who facilitate or exploit the substance abuse; and those who have been sexually victimized are more likely to abuse substances. Many women who undergo treatment for chemical dependency have a history of sexual assault or abuse. Using substances can cause traumatic memories and feelings to surface, and can also numb those feelings. Substance abuse is often associated with feelings of secrecy and shame, which

can intensify these same feelings about the trauma. Additionally, continued substance abuse is associated with a loss of control over using, which can exacerbate the sense of powerlessness and helplessness associated with the trauma. Trauma and substance abuse together can lead to a downward spiral of using more to cope with symptoms, which then makes one more vulnerable to additional trauma. Successful treatment of drug/alcohol abuse in survivors should take into consideration the underlying trauma history of survivors.

## **Self-harm and sexual violence**

When survivors harm themselves, they may do so for a variety of reasons that are directly related to emotional pain associated with the trauma of sexual violence. These reasons may include:

- Release anxiety or internal tension
- Cope with repeated nightmares or memories of the trauma
- Provide a physical representation of feelings the survivor is unable to express
- Help to end feeling numb, to “feel something” again
- Witness the capacity for healing (as the physical wound heals)
- Feel in control
- Cope with difficult or stressful situations



**Why might a survivor engage in risky sexual behavior, as opposed to avoiding sex?  
How might it be especially difficult for a survivor to stop using a substance?  
What might be other reasons a survivor would engage in self-harming behavior?**

## **Interpersonal impact**

The experience of sexual violence often impacts the survivor’s relationships and interactions with others, including intimate partners, family members, friends, classmates, coworkers, and acquaintances. The survivor’s sense of safety and trust has most likely been impacted by the assault, potentially resulting in feelings of confusion, fear and mistrust of relationships in general. The survivor’s interest in and comfort with physical and sexual intimacy may be impacted, which in turn may impact the survivor’s relationship with an intimate partner. If the survivor was assaulted by someone with whom they are close, the resulting social and interpersonal impact can be complex and especially difficult.

For survivors whose loved ones know about the assault/abuse, they may worry about what their loved ones now think of them, they may be concerned about the integrity of the relationship, and/or they may be dealing with/managing their loved ones’ own varied reactions to the assault. For survivors whose loved ones do not know about the assault, they may face the challenge of privately/secretly navigating their complex feelings and reactions to the trauma within the context of their daily lives and relationships, which may or may not be complicated by choosing to report the assault to the police.

## D. PHYSICAL IMPACT

### **Injury from the assault/abuse**

It is typically assumed that most survivors of sexual violence experience physical injury during the assault, whether from the perpetrator inflicting injury and/or from the survivor resisting or fighting. In reality, serious physical injury from sexual assault is relatively rare and minor injury (scrapes, bruises) occur in only about a third of assaults. Minor genital injury is common in completed rapes of female survivors, including vaginal abrasions or tears and cervical bruising. These injuries are due to a lack of pelvic tilt and vaginal lubrication from forced penetration. These injuries, while certainly painful, typically heal completely within 48 to 72 hours. Forced anal penetration in male or female survivors can likewise result in anal/rectal bruising or tearing. In cases of forced oral penetration, injury may include bruising or tearing of the lips and abrasions or bruising to the roof and/or back of the mouth.

### **Sexually transmitted infections & pregnancy**

Acquiring sexually transmitted infections (STIs) from sexual assault is a common concern of survivors; however, the actual risk of contracting an STI is rather low. The Centers for Disease Control and Prevention (CDC) estimates that the risk of rape survivors contracting gonorrhea is between 6% and 12%; chlamydia 4% to 17%; syphilis 0.5% to 3%; and HIV less than 1%. The specific risk of contracting an STI varies from one community to the next, depending on the rates of STI infection in a particular community. The risk is higher if the assault involved rectal contact, vaginal contact with tearing, or if the survivor has an existing STI that has caused ulcerations or open sores. The risk is also higher if the assailant is an IV-drug user or is HIV-positive. About 1-5% of rapes result in pregnancy. While this percentage is low, pregnancy is a concern of many female survivors. Sexual Assault Nurse Examiners (SANEs) and other medical professionals should be able to provide thorough, impartial information about risks, testing, and treatment options for potential exposure to STIs, as well as information regarding the risk of pregnancy from rape.

### **General physical impact and health risk**

Many survivors experience physical symptoms, both immediately following the assault and as they recover over time. These may include muscle soreness, body aches/pains, upset stomach or bowels, headache, fatigue, difficulty with or changes in sleeping, appetite changes, and other ailments. Long-term, survivors are more susceptible to chronic physical and mental health conditions, including hypertension, heart disease, diabetes, depression, and anxiety. Most survivors who seek services from a healthcare professional do so because of one or more secondary physical ailments, not because of the trauma itself. For this reason, trauma-informed care practices are important in healthcare.

Read here for more information on trauma-informed care: <http://www.samhsa.gov/nctic/trauma.asp>

## E. SPIRITUAL IMPACT

Survivors of sexual violence are individuals who have their own unique cultural norms, religious and spiritual beliefs and practices, and individual and community identities. All of these impact the survivor's response to and recovery from the assault. How survivors and their loved ones identify, understand, and respond to sexual violence can vary widely. It is impossible for advocates to know all there is to know about these factors as they apply to individual survivors; however, it is possible and essential for advocates to approach these issues with openness and respect. Survivors may espouse certain cultural or religious beliefs with which you the advocate may or may not agree. It's important to remember that while advocates have valuable information to share about the trauma of and recovery from sexual violence, survivors are the experts on their own lives, including their own cultural, religious, and spiritual identities and beliefs.

The experience of sexual violence can impact the religious/spiritual beliefs and worldview of survivors in various ways. Why sexual violence/violent people exist, why the assault or abuse happened to them, and what it means to their life are questions many survivors ask, outwardly and/or internally. A survivor's personal belief system can be helpful and/or hurtful in that survivor's individual recovery process, as can representatives of the survivor's faith community.

Suggested reading on the subject of religion, spirituality and sexual violence:

[http://www.vawnet.org/Assoc\\_Files\\_VAWnet/AR\\_VAWReligion.pdf](http://www.vawnet.org/Assoc_Files_VAWnet/AR_VAWReligion.pdf)

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3155866/>

<http://www.nova.edu/ssss/QR/QR15-3/knapik.pdf>

## F. ECONOMIC IMPACT

The crime of sexual violence is financially costly both to individual survivors and to the country. It is estimated that crime victimization in general costs the U.S. at least \$450 billion annually, which includes costs associated with the criminal justice system, rape crisis services, mental health services, and healthcare, in addition to lost productivity from survivors. Rape is the costliest of all crimes to its victims, with total estimated costs related to adult sexual assault at \$127 billion annually. The experience of sexual assault results in lost productivity, lost income, and higher healthcare costs for survivors when compared with those who haven't suffered sexual assault. Individuals victimized in adolescence experience a lifetime net income loss of over \$241,000.

More information on the economic impact of sexual violence:

<http://www.nsvrc.org/sites/default/files/CostsConsequencesSV.pdf>

## G. IMPACT ON LOVED ONES/CO-SURVIVORS

Loved ones of survivors, which can include family, friends and other close acquaintances, are also impacted by sexual violence. Loved ones may experience many of the same thoughts, concerns, questions, and feelings that survivors experience. For some, the assault/abuse of their loved one can actually be experienced as traumatic.

Some common reactions of loved ones include:

- **Anger:** A loved one experiencing anger regarding the assault/abuse may express that anger directly or indirectly at the perpetrator, at the survivor, at him/herself, at agencies/systems, at others, or a combination of these. A loved one's anger is sometimes manifested in the loved one demanding justice or trying to force or coerce the survivor into pressing charges.
- **Sadness:** Loved ones may experience sadness or grief regarding the assault/abuse, its impact on the survivor, and its impact on themselves.
- **Helplessness:** When we love or care about someone, we tend to want to "fix" anything that may be wrong where that person is concerned. Not being able to "make it better" or to "make it go away" can be difficult for loved ones. This sense of helplessness can be exacerbated by numerous individual, familial, and cultural factors.
- **Blame:** When a loved one has suffered an injustice like sexual violence, it is natural to look for someone to blame. Sometimes loved ones correctly blame the perpetrator. Other times, they may blame the survivor (questioning her/his actions or behavior surrounding the assault). And sometimes, loved ones blame themselves for not protecting the survivor.
- **Denial/disbelief:** Sometimes loved ones may have difficulty believing that the assault/abuse happened, particularly if the perpetrator is someone they know and trust. This can be manifested in actual disbelief of the survivor wherein the loved one directly or indirectly asserts that the survivor is lying. Disbelief can also be manifested in a self-protective denial that such a crime could be committed against someone they love and/or that someone they know and trust could do such a thing. In this case, it's not that the loved one truly disbelieves the survivor; rather, it's that the loved one has difficulty accepting the reality of it.
- **Apathy:** Sometimes loved ones may be apathetic or uncaring toward the survivor. This can be a self-protective response, in that allowing oneself to feel the impact of the crime is too much to handle. Unfortunately, sometimes individual, family, and social dynamics are such that "loved ones" simply do not care about the survivor, even in the aftermath of crime.
- **Overprotective:** Some loved ones may become overprotective of the survivor following the assault/abuse, which is especially common in loved ones who feel a sense of responsibility for not protecting the survivor from the assault in the first place. While the loved one's intent may be to protect the survivor from future harm, the loved one's behavior may be experienced by the survivor as controlling, smothering, and/or as a form of punishment.

## **Loved ones who are survivors**

It is common in rape crisis advocacy to encounter loved ones who are themselves survivors of sexual violence. Some loved ones disclose this information to the advocate, while others do not. For loved ones who have their own personal history of sexual violence, the impact of the current assault/abuse of the survivor can be varied and complex. It is not at all uncommon for the survivor's victimization to trigger thoughts and feelings in a loved one regarding their own past victimization, even if the context and circumstances of the assault/abuse are very different. The experience of trauma and recovery from it are influenced by many factors, including exposure to or knowledge of the trauma of others. Loved ones who have a personal history of sexual violence may have greater understanding and empathy for the survivor, but they may also have greater difficulty supporting the survivor due to their own reaction to the trauma. If the survivor is unaware of the loved one's past victimization, the loved one may feel an added pressure to conceal their own traumatic reactions in order to maintain their privacy and best support the survivor.

## **Supporting loved ones**

The most important thing for advocates to remember when working with loved ones/co-survivors is that they, too, are impacted by the crime and they are in need of support. It is easy to concentrate solely on the needs of the survivor, but loved ones have their own questions, concerns, and needs. Crisis and advocacy services provided by rape crisis programs should always be available to loved ones of survivors. Some loved ones also benefit from professional counseling services and support groups, when and where those services are available in their communities.

Loved ones are most likely part of the survivor's ongoing support system, which means they are critical in providing long-term support to the survivor as s/he recovers. For this reason, loved ones need information, education, and support as they endeavor to help the survivor recover. Many loved ones want to do what's right (and are afraid of doing what's wrong) when it comes to supporting the survivor. Advocates can provide invaluable information to empower loved ones in ways that also support the empowerment of the survivor.

For specific information about how loved ones can support survivors, read here:

[http://www.oaesv.org/wp-content/uploads/2013/03/Survivor-Series\\_Supporting-a-Loved-One.pdf](http://www.oaesv.org/wp-content/uploads/2013/03/Survivor-Series_Supporting-a-Loved-One.pdf)



**How might a parent react to the rape of their child?**

**How might a friend's reaction be the same or different from a family member's?**

**What potential reaction of a loved one would you find most difficult to work with? Why?**

**SECTION 5:**

**CRISIS COUNSELING & ACTIVE LISTENING**

## A. COMMON CONCERNS OF SURVIVORS

While each individual survivor and her/his victimization experience are unique, there are numerous concerns that most survivors have in the aftermath of sexual violence. Some or all of these concerns, in addition to others, may be expressed directly or indirectly by the survivor, or not at all.

Common concerns of survivors include:

- **Not being believed:** This is one of the most common concerns of survivors, in part because survivors *are* frequently dismissed or not believed. For a survivor to receive the message of “I don’t believe you,” whether it is expressly stated or implied, can be devastating.
- **Being blamed:** This is also one of the most common concerns of survivors, in part because survivors *are* frequently blamed for their own victimization. Many survivors struggle with self-blame, which is exacerbated by actual or perceived blame by others.
- **Safety/re-victimization:** Survivors may have difficulty feeling safe in the aftermath of sexual violence. It is common for perpetrators to attach a threat of some kind to the assault (“If you tell, I’ll kill you...hurt someone you love...hurt your pet... no one will believe you” ...etc.).
- **Exposure:** Survivors often feel a sense of embarrassment or shame following the assault, and they may fear being exposed within their families, social circles, and/or publicly. If the survivor reports the crime to law enforcement or goes to the hospital for an exam, s/he may fear that her/his name and details of the assault will appear in the media.
- **Physical health:** Many survivors are concerned about exposure to STIs, pregnancy, and/or other physical effects of the assault. Some survivors feel (or fear) that their body is now broken or permanently changed as a result of the assault.
- **Mental health:** Similarly, many survivors worry about their mental and emotional health in response to the assault. Some may express fears that they are “going crazy” or that they will never feel like themselves again.
- **Relationships with others:** Survivors are often concerned about how the assault and their recovery from it will impact their relationships with others, including intimate partners, family members, friends, classmates, coworkers, etc. Survivors often fear that they will be seen or treated differently because of the assault. These concerns are often compounded when the perpetrator is someone within the survivor’s family or social circle.

Survivors who were victimized weeks, months or years ago may have some of these same concerns, but they may shift or be expressed in different ways. For example: a survivor who is unable to become pregnant may be concerned that past victimization has damaged her body or otherwise impacted her ability to conceive; a survivor who never told his parents about a past assault may worry about how a disclosure after the fact will impact them; and a survivor who was raped years ago may be confused as to why she is suddenly now experiencing nightmares and thoughts about the rape.

## B. IMPORTANCE OF EMPATHY

### **Defining empathy**

Empathy is a concept that is of paramount importance to victim advocacy and to helping professions in general. It is not to be confused with *sympathy*, which is the act of objectively feeling sorry for someone or feeling badly about their situation. Empathy is an active approach to relating to someone that is attentive, supportive, and engaged. Empathy is a willingness to see, hear, and feel things from the perspective of the other person. It is impossible to duplicate in ourselves exactly what another person has experienced, or to take upon ourselves another's entire thought process and emotional experience. That is not something we would want to do even if we could. To be empathic means to share, understand, be aware of, and be sensitive to the thoughts, feelings and experiences of another. It is a way of being more than it is a communication skill.

### **Empathy with survivors**

Empathy is important when working with survivors for a number of important reasons. Survivors often feel scared, confused and alone. They often feel that no one could understand what they are going through, which causes them to feel reluctant to share themselves with others. It is true that no one, including a rape crisis advocate, can know exactly what the survivor is experiencing, but approaching the survivor with empathy will enable a willingness and capacity to understand where the survivor is coming from. The presence of an empathic, engaged, nonjudgmental advocate can be invaluable and transformative in the survivor's ability to feel safe, supported, and empowered to recover.

General guidelines for exercising empathy with survivors:

- When working with a survivor, that survivor is the most important person and your conversation with her/him is the most important thing; all of your attention should be there.
- Your biases, beliefs and judgments of people, ideas, and circumstances must be set aside as much as possible. We all have certain biases, which is to be expected, but the survivor is the expert on her/his life, not you.
- Listen to everything the survivor says and how s/he says it, allowing the information to be fully heard and considered before forming a response.

### **Empathy and self-care**

Empathy requires openness to the survivor's traumatic experience, which inevitably means that you the advocate will feel an impact from what you see and hear. Empathy is best thought of as an art-form wherein all advocates must learn to temporarily hold these traumatic elements without absorbing them or becoming overwhelmed by them. Thoughtfully sharing/processing your cases with your supervisor will help you to fully release these traumatic elements more easily over time.

## C. CRISIS COUNSELING & ACTIVE LISTENING SKILLS

In addition to employing empathy and active listening skills (discussed on the next page), there are a few “ground rules” that will help facilitate effective communication with survivors:

- **Expect the unexpected:** As a function of our socialization and our individual biases, we may come to our work as advocates with preconceived notions of who survivors are, what they look like, how they act, what they believe, and what they need. Rarely are those notions confirmed by reality. When answering the phone, entering a hospital exam room, or otherwise engaging with a survivor, expect nothing and be prepared for anything.
- **Establish safety:** Survivors are more likely to participate in and benefit from conversation with you if they feel safe. Safety can be established by explaining your role (including confidentiality) and by helping the survivor to orient to a sense of safety in her/his surroundings (the room/building, the people surrounding her/him, what feels safe or unsafe, etc.).
- **Enable individual expression:** As has previously been stated, individual survivors express their feelings and emotions in different ways (expressively, controlled, or varying between these). It’s important for you the advocate to be comfortable allowing survivors to express themselves however they need to in the moment. For example, you should not “get the survivor to cry” or try to get the survivor to stop crying or shaking. Instead, your body language, tone of voice, and relational style should be such that survivors feel comfortable being themselves around you.
- **Meet survivors where they are:** Survivors interact with us at various points in their recovery process, and at varied moments within their individual emotional and thought processes. Engage the survivor in discussion that reflects what s/he wants and needs to talk about in the moment, whatever that may be. There will be opportunities to expand the conversation in time, but in the beginning, start at the survivor’s starting point and follow her/his lead.
- **Believe in what you do:** Most of us would not be advocates if we did not believe that what we do is important and worthwhile. No advocate ever has all the answers or knows the perfect thing to say from one moment to the next. But having a purpose and a humble sense of confidence in your abilities will enable effective communication and will transfer to the survivor in ways that facilitate hope and empowerment.

### Essential messages for all survivors

There are important messages that all survivors should hear from you the advocate. These messages are applicable regardless of who the survivor is or what their circumstances are. Individuals in crisis only retain about 10% of what is said to them. Survivors have consistently stated that hearing the following basic messages from advocates was impactful and beneficial to them. These messages are not meant to be stated bluntly at the beginning of every conversation; rather, they should be weaved into the conversation in ways that feel natural, appropriate, and impactful.

1. **“I believe you.”** This simple phrase can mean the world to a survivor. Regardless of the circumstances of the case, advocates must approach every survivor believing her/him. There are sometimes cases/stories that you the advocate will question in your mind (i.e. something doesn’t add up or it seems like the survivor might not be truthful). It is okay to question things internally, but you must always outwardly conduct yourself as if you believe the survivor.
2. **“It’s not your fault.”** Blame from others and/or self-blame from the survivor are common. Reminding the survivor who truly is and is not to blame for the assault can help empower the survivor in her/his recovery. When stating this, some survivors may react by saying, “I know that!” Other survivors may disagree with you (“but if I had only done this...if I hadn’t done that”). If a survivor is adamant about being responsible for the assault, do not engage in an argument. Self-blame, while destructive in the long-term, can be a self-protective defensive mechanism in the short-term.
3. **“You’re not alone. Support is available.”** Survivors can feel isolated, as though no one could understand how they feel. It’s important to let survivors know that although their experience is unique, important, and significant, many people experience sexual violence and recovery is possible. This sense of hope is critical to the survivor’s recovery. When determining the survivor’s unique needs and concerns, you will be able to provide specific support (personally or via resources) that will let them know that they have support in their recovery.
4. **“You are safe now.”** Assuming that the survivor is, in fact, physically safe when you are interacting with her/him, this is an important message to relay. The brain of a traumatized person needs to know that the trauma is now over and that the survivor is safe. This phrase is not intended to soothe an emotionally expressive survivor; rather, it is intended to help the survivor orient to a sense of safety and control over her/his immediate environment.

## **Active listening skills**

The following active listening skills will enable effective communication with survivors. You will notice that these skills do not feel natural in terms of the way we normally relate to others. Keep in mind that crisis counseling is not the same as ordinary conversation. The purpose of our communication with survivors is to support them in their recovery from the trauma of sexual violence. We are not engaging in a mutually-beneficial, social relationship. It’s all about what the survivor needs.

- **Open-ended questions:** These are questions (or phrases) that elicit more than a “yes” or “no” response from the survivor. These questions will allow the survivor to provide more of an expanded answer, with information the advocate can use to further the conversation. Note that sometimes, closed-ended questions can be useful, such as when asking for basic information (i.e. “Do you have a safe place to stay tonight?”) or when the survivor is feeling overwhelmed or uncomfortable providing a more expanded response.

- **Encouraging phrases:** Saying things like “Um-hmm,” “I see,” or “I’m with you” can show survivors that you are there and that you’re listening. This is especially useful when speaking with a survivor on the phone, when the survivor cannot see your attentive body language.
- **Reflection:** When utilizing reflection, the advocate focuses on expressed and unexpressed feelings, rather than on content. This helps to facilitate the survivor’s self-awareness. One way to employ reflection is to respond by saying, “It sounds like you’re frustrated by...” or “I’m hearing that you’re worried about...” The emphasis is on the frustration and the worry, rather than on the context of what the survivor is frustrated or worried about.
- **Paraphrasing:** Differently from reflection, paraphrasing means relaying in your own words the content portion (facts, events, people, etc.) of what the survivor just said. This shows the survivor that you understand and are interested in what s/he is saying. It also gives the survivor the opportunity to correct you or to elaborate if you have misunderstood something. Paraphrasing can begin with statements such as, “So, what you’re saying is...”
- **Probing:** This encourages the survivor to talk more concretely about a feeling or a thought. For example, you might say, “What happens when you feel panicky?” or “Tell me more about that.” It does not mean prying for details, as if nosy. (It’s important to note that while some details of the assault may be necessary in order to support the survivor, advocates do not need to know all the details or the full story, nor should we ever ask a survivor to supply that to us).
- **Ownership:** This allows the survivor to articulate what s/he thinks or feels about something. For example, you might ask, “How do YOU feel about that?” or “What do YOU think about that?” This can be especially useful when working with survivors who feel disempowered by those around them.
- **Focusing:** Sometimes survivors provide a lot of information, which may be scattered with specific feelings, concepts or needs embedded throughout. It can be helpful to focus the survivor on one point, or a few points, that are of greatest need or concern at the moment. For example you might say, “Of all that you’ve shared me with, what are you most concerned about right now?” or “How much relief would you feel if this issue were resolved right now?”
- **Silence:** Silence is often the most challenging listening skill for advocates, as we naturally want to interact with survivors. Silence can be extremely important for survivors in a number of ways. Sometimes survivors need to gather their thoughts and their strength to be able to tell you something very distressing or important to them. If you interrupt that silence, the moment can be lost and they might never be able to share that important thing with you. Silence also sends the message to the survivor that you are comfortable with the pace and flow of the interaction (i.e. you don’t “need” to talk if s/he doesn’t want to). Finally, silence puts ownership of the interaction on the survivor – s/he is in control, not you. If you the advocate are feeling especially uncomfortable with silence, it may be useful to reflect that tension (“It’s hard to know what to say” or “Take all the time you need”).

- **Body language/non-verbal behavior:** Much of our trust of and comfort with others is based on body language. This can be as important (if not more important) than the words we say. Your body language with a survivor should be attentive, but relaxed; comfortable, but not casual. Distractions should be minimized as much as possible. Use your natural voice and give all your attention to the survivor, without making her/him feel as though you are scrutinizing their every word and movement.

For additional, important information on active listening skills, concrete examples, and guidance for working with survivors of various styles of expression, read here:

<http://www.oaesv.org/wp-content/uploads/2013/05/Listening-Skills.docx>

## **Self-disclosure**

In our work with survivors, it is natural and appropriate that we share some of ourselves in order to establish a sense of trust and rapport. Survivors often bare their most private and intimate thoughts, feelings, and experiences with us. While we as advocates should not share detailed information about our personal lives, it's appropriate to share non-intimate aspects of our lives and personalities in order to facilitate a comfortable interaction. What we share of ourselves should be brief and limited to this purpose. We never want the survivor to feel distracted by what we share, or to feel that they need to stop talking, refrain from sharing something, or take care of us.

Some survivors may ask you the advocate if you have ever been raped or abused. This can be an uncomfortable question to be asked, but it's one that you must prepare for in your work as an advocate. Generally speaking, survivors ask this question not because they actually want to know and hear about your personal history; rather, they want to know if you are able to hear them and to be present with them and their pain. Survivors often feel alone and isolated, and they may assume that only another survivor would be able to understand and relate to them. This is not true. Having empathy and exercising it responsibly and effectively is the key to relating to others, which is not dependent upon our specific knowledge or personal experience with another's circumstances. How you choose to answer this question is up to you, in accordance with your program's policy or preference. Generally speaking, the best response is one that both lets the survivor know you can handle the interaction and that puts the focus back onto her/him. Examples: "No, I haven't been raped, but I care very much about those who have and I'm here to support you" or "Yes, I have been raped, but I'm here for you and what you need."



**Think about a time in your life when you've needed emotional support in a difficult or painful situation. What responses from others were helpful? Which were not? How did these responses make you feel?**

## **How to start and stop**

Sometimes the most difficult part of interacting with a survivor is in knowing how to start that interaction, and when and how to stop. There are ways of starting and stopping that are unique to the context of your interaction (i.e. in-person versus on the phone), which will be discussed elsewhere in this manual. A simple and appropriate starting point in any context is to introduce yourself by first name, the name of the program/agency you're with, and a very brief description of your role. To start the conversation, you may simply ask if there's anything the survivor would like to ask, say, or talk about. When to end the conversation will depend on numerous cues, such as events surrounding the survivor (exam in the hospital, e.g.), fatigue on the part of the survivor, and/or a recycling or rehashing of things that have already been discussed. Ways of ending the interaction include: ensuring the survivor has any needed resources; making arrangements for follow-up contact, if appropriate; and reminding the survivor that they may contact your program for on-going support.

## **Abusive survivors**

Sometimes survivors are angry about the violence they have suffered and they may project that anger onto specific people or onto anyone in their path, including advocates. Loved ones of survivors may also react in this way. Do not become offended by this, or defensive. Keep in mind that the survivor is most likely not upset with you; however, if the survivor is abusive toward you (repeatedly insulting you, calling you names, threatening you, etc.), you should not tolerate this. Calmly let the survivor know that while they have every right to be upset, their abusive behavior toward you is not appropriate and will not be tolerated. If the survivor continues the abusive behavior, you should discontinue the interaction and notify a supervisor.

## **Follow-up with survivors**

If you the advocate will be providing follow-up contact with survivors, it's important to follow your program's specific guidelines as to how/where, when, and how frequently follow-up is to occur. Generally speaking, follow-up should occur at a time that is mutually convenient for you and the survivor. Remember that you are a volunteer and your obligations and activities outside your role as an advocate should remain separate and be preserved to every extent possible. If it appears that a survivor needs more extensive follow-up than what you are permitted or able to provide, you should speak with your supervisor so that the appropriate arrangements can be made.

## **If the survivor is someone you know**

Hopefully you will never encounter a loved one or acquaintance as the survivor while serving in your capacity as an advocate; however, should this occur, your role would transition from advocate to co-survivor. You should notify your supervisor right away, so that another advocate can take your place and you can concentrate on your own needs and/or on supporting your loved one within the context of your relationship with her/him.

**SECTION 6:**

**HOTLINE ADVOCACY**

## A. SUPPORTING SURVIVORS ON THE PHONE

Providing support to survivors on the telephone presents unique opportunities and challenges. Not being able to see the survivor and having little or no information about the survivor's presenting problem or need forces the advocate to truly be prepared for anything. While active listening skills are employed the same in phone interactions as in face-to-face interactions, they become especially important while on the phone, where body language cues cannot be seen or assessed.

**Important Note:** *Some rape crisis advocates answer a general crisis hotline serving all individuals in the community (not just survivors of sexual violence). If this applies to you, it's important that you receive additional training from your agency on how to respond to individuals presenting various crises, with various mental health issues, and those who are suicidal. Even if the hotline in your agency serves sexual assault survivors specifically, it is possible that individuals with very complex mental health needs will call. While this manual includes useful information for phone-based advocacy, it is not adequate in preparing any advocate to respond to a general crisis hotline.*

### Tips for phone-based advocacy

The following general tips will facilitate effective communication with survivors via phone:

- **Assess for safety:** Since you will have very little, if any, information about the survivor, it's important to assess for safety. It's appropriate to ask the survivor if they are physically safe right now and if it's safe for them to talk. (Information about advocating for survivors who are not safe is found on the next page).
- **Praise for reaching out:** While it may seem unnecessary or even awkward, it's often helpful to tell a survivor that you're glad they called. Doing so demonstrates to the survivor that you are there for them and that you want to support them.
- **Start where they are:** As has previously been stated, it's important to start where the survivor is, with their unique questions or concerns in the moment. A good way to facilitate this is by asking the survivor, "What prompted you to call today/right now?"
- **Listen to nuances:** While speaking with a survivor on the phone, it's important to pay careful attention to the survivor's tone of voice, inflections in speech, and other emotive cues (such as breathing patterns/sighing, pauses in speech, having a shaky voice, etc.). These cues will help guide the active listening skills you employ (including silence), and it will help you to ascertain when the survivor might be struggling or in need of a break.



**Beyond the words they use, how can you tell when someone is happy, sad, or excited?  
What does your voice sound like when you're scared or nervous?  
How might talking on the phone be easier for a survivor than talking in person?**

## **If the survivor is not safe/may not be safe**

### **Assessing the survivor's physical safety:**

If the survivor is not in a safe location or if the threat of the perpetrator returning is present, brainstorm possible options with the survivor by:

- Asking if the survivor feels comfortable calling 911, or if they would like for you to call. Ask the survivor if s/he would like for you to call law enforcement if the perpetrator returns or if the call is disconnected. If so, collect identifying information immediately.
- If at home, asking the survivor if there is a neighbor's house that s/he could go to and then call the hotline back.
- Asking the survivor if there is a friend or family member's house s/he could go to and then call the hotline back, or (depending on safety concerns) if a friend or family member could come and stay with the survivor.

### **Assess the survivor's medical condition:**

Ask the survivor if s/he is hurt and needs immediate medical attention. Some survivors may not be aware of how badly injured they are, so it is imperative that you ask direct questions. For example, you should ask the survivor if s/he is bleeding, is dizzy, feels light-headed, etc. This is especially important if the survivor has been strangled (which s/he may or may not remember). If the need for immediate medical attention exists, brainstorm possible options with the caller by:

- Asking the survivor if s/he feels comfortable calling 911, or if s/he would like for you to call. Try to obtain identifying information in the event that the call is disconnected.
- If at home, asking if the survivor has a neighbor, friend, or family member who could transport her/him to the hospital.

Your program staff should have policies in place regarding when and how to contact emergency services while working with survivors on the phone. Documentation of such calls is important. Your program staff will discuss protocol around documentation.

## **Handling abusive callers**

Abusive callers are an unfortunate reality for crisis hotlines everywhere. These callers use hotlines for a variety of inappropriate reasons, including for sexual gratification. Some are motivated by spite, while others have complex mental and emotional problems. No matter how well-insulated the hotline or well-trained or experienced the advocate, abusive callers still sometimes get through and can cause the advocate to feel violated and ineffective. Your program should have policies in place about dealing with abusive callers.

For information about chronic and abusive callers, and how best to handle them, please read here:

<http://www.oaesv.org/wp-content/uploads/2013/05/Management-of-Chronic-and-Abusive-Calls.docx>

## B. BOUNDARIES, LIMITATIONS & SAFETY ON THE PHONE

Your safety as a Volunteer Advocate must be considered in every context, including on the phone. Because we believe all survivors and want to support them, it is difficult to accept that any survivor could pose a threat to our safety as individuals or to our work as advocates. Most survivors feel the same way about us, that we are always and only trustworthy and caring. For these reasons, it is imperative that boundaries be established and maintained in our work as advocates. When interacting with a survivor on the phone, it may at times be tempting for you the advocate to feel a false sense of safety by virtue of being physically isolated from the survivor. This sense of safety can at times lead to a desire or willingness to stretch boundaries, but it is essential not to let your guard down in this way. Adhering to boundaries will not only protect you as an advocate and the survivors with whom you interact, but it will also make those interactions more authentic, meaningful and effective.

### Healthy boundaries and limitations:

In all our interactions with survivors, it's useful and helpful to remember that we are not the survivor's friend, parent, or therapist. While we certainly exude warmth, caring and support with survivors, we do not (and should not) endeavor to become to the survivor anything other than what we are.

- **Know your role:** It's important for advocates to always know their role and to be prepared to explain it. Knowing your role means knowing what you are (and are not) capable of doing or permitted to do. If your role is ever unclear, seek clarification from your supervisor.
- **Stay within your role:** We may have good intentions in wanting to stretch our boundaries with a particular survivor – sometimes you might “click” with a certain survivor or feel that you alone are uniquely able to address her/his needs. Sometimes, survivors encourage this by saying, “No one gets me like you,” “only you can help me,” or “can't you do [this] for me?” This can flatter you and tempt you to be the survivor's only resource and lifeline. Always remember, however, that our role is a supportive one. To step outside of that role is to confuse the survivor, potentially damage or discourage her/his recovery, and to compromise the integrity of our role as advocates and the agency for which we volunteer.
- **Be wise and watchful:** Working within the role of an advocate means that you will learn to interpret cues from survivors, intuitive things that will guide you in your interactions. This same intuition should be consulted in situations where survivors may be taking advantage of you or coercing you into stretching your boundaries. If you sense that something is not right, whether in-person or on the phone, don't be afraid to follow your instincts, assess whether or not a boundary has been violated, and respond accordingly. Do not hesitate to discuss this with your supervisor, as s/he has likely encountered this numerous times in her/his work.



**Have you ever been manipulated into doing something you wouldn't ordinarily do?  
When did you realize you were being manipulated? How did it make you feel?  
How did you respond?**

## **Safety while working with survivors on the phone**

Certain safety precautions should be practiced when working with survivors on the phone, whether on the hotline or via a follow-up call. These precautions include:

- **Preserve your privacy:** Do not share personally identifiable information with a survivor, such as your full name, personal contact information (phone number, address, email address, social media account), location, etc. Also do not share personal information about other Volunteer Advocates or staff members of the program. Some survivors are emotionally needy and will exploit you if they have your contact information. Some survivors, their loved ones, or even perpetrators can pose a threat to you if they are able to locate you or contact you on your own time. Even if a survivor seems completely safe and trustworthy, still preserve your privacy.
- **Use caller I.D. blocking:** If possible, always call a survivor from your program's office or hotline phone. If you must call a survivor from your home or from a location away from the program, use caller I.D. blocking by dialing \*67 before dialing the survivor's phone number. This will cause your call to appear as "blocked" or "private" on the survivor's phone. (When possible, it is best to alert survivors of this ahead of time, so they know to expect a call that is unidentifiable by caller I.D.). You should never text a survivor from your phone.
- **Follow protocol for repeat/abusive callers:** If you are working on the hotline, your program staff should inform you of any repeat or abusive callers, how to identify them, and what to do if they call. Follow your program's protocol regarding such callers. If you are following-up with a survivor you've previously spoken to and that survivor becomes abusive, terminate the call, document it, and speak with your supervisor about next steps.
- **Make safe arrangements:** The survivor may need to go to the hospital, a police station, your rape crisis program, or another agency in the community for specific services. The information you provide should promote the safety of the survivor and of professionals in those locations. For example, you should adhere to office hours, protocols for contacting certain agencies, and safe transportation options for the survivor. Your program should have a policy regarding the transportation of survivors by advocates. For safety reasons, it is highly recommended that Volunteer Advocates never transport survivors for any reason.
- **Document calls appropriately:** Proper documentation is an important part of advocacy. Among other things, it ensures that the correct protocol was followed with a particular survivor, which is especially important when working with difficult or challenging survivors. Proper documentation protects you the advocate, your program, and survivors.
- **Seek supervision:** Regular supervision is an important part of your work as a Volunteer Advocate. Supervision is especially important when dealing with complex, confusing, or potentially unsafe situations. If you are unsure about the safety or appropriateness of a particular course of action, always seek supervision first.

## C. ASSESSING FOR SUICIDAL IDEATION/THREATS

When providing support to survivors of sexual violence, it is possible that you may encounter a survivor who is suicidal. While suicide is most certainly a frightening and upsetting topic for most of us, we must be willing to ask about it and talk about it directly and comfortably with survivors. We always want to prevent survivors from killing themselves, but in doing so, we do not want to judge them because of their suicidal intention. Most suicidal people do not truly want to kill themselves; rather, they need help in managing what has become unmanageable.

You must assess for suicidal ideation if survivors say anything that even remotely suggests that they are contemplating suicide. They may make direct statements, such as “I want to kill myself,” “I wish I were dead,” or “You’ll read about me tomorrow.” They may also make indirect statements, such as “I can’t go on living like this,” “My family would be better off without me,” or “I just want it all to end.”

When assessing for suicidal intention, be direct. Ask, “*Are you thinking of hurting or killing yourself?*” If the answer is “yes,” “maybe,” or “sometimes,” then explore exactly what the survivor is thinking of doing or has already planned to do. Specifically, you need to determine the following:

- **Plan:** Does the survivor have a plan for how they are going to kill themselves? How well-thought out and detailed is that plan? Do they know when, where, and how?
- **Intent:** How serious is the survivor about executing their plan? Is it “well, sometimes I think about doing it,” or is it, “I’m planning on doing it tonight”?
- **Means:** Does the survivor have the means by which to carry out the plan? For example, if the survivor is planning on taking a bottle of pills, is there an actual bottle of pills accessible?\*
- **Prior Attempt:** Has the survivor attempted suicide in the past? Has someone close to the survivor attempted or completed suicide? An affirmative answer to either makes it more likely that the survivor will attempt suicide.

\*Keep in mind that if a survivor is intoxicated, s/he is at greater risk of attempting suicide, even if s/he does not have a well thought-out plan, intent, or history of suicidal attempts.

The response you provide will depend on your assessment of the above factors. If the survivor has a well-formulated plan, means, intent, history of suicide attempts, and/or is intoxicated, s/he may need immediate intervention (911, law enforcement, or emergency crisis management). Your program should have a protocol in place for how to handle this situation, who to call, and what supervision is required. If the survivor is not in immediate danger of killing her/himself, then crisis counseling and active listening can be employed. It is always useful to ask the survivor what prompted her/him to call right now, today. Start there and determine the survivor’s needs, identifying specific resources and supports that will encourage the survivor’s sense of agency and empowerment.

For more detailed information about warning signs of suicide and intervention tactics, read here: <http://www.oaesv.org/wp-content/uploads/2013/05/Suicide-Warning-Signs-Intervention.docx>

**SECTION 7:**

**HOSPITAL ADVOCACY**

## A. FORENSIC EXAM PROCESS

Forensic examinations (a.k.a. “rape kits”) are examinations of a survivor of sexual violence performed in a hospital emergency department or sexual assault clinic, the purpose of which is to collect evidence of the crime and document injury for potential prosecution of the crime in the criminal justice system. Rape kits are not available in private physicians’ offices, in Urgent Care facilities, or other outpatient health facilities. All hospital emergency departments are required to perform rape kit examinations on survivors who meet the criteria and request it. Ideally, a specially-trained Sexual Assault Nurse Examiner (SANE) or Sexual Assault Forensic Examiner (SAFE) should perform the exam; however, when a SANE or SAFE is not available, the exam must still be made available to the survivor. Whoever performs the exam can later be called to testify in court about the exam process.

In order to obtain a rape kit examination, the survivor must submit to the exam no later than 96 hours after the assault was committed. Exceptions to this time limitation can be made, such as if the survivor was held captive and thus unable to be examined within 96 hours. Survivors must consent to the exam (i.e. they cannot be forced to submit to the exam); however, exceptions to this can also be made, such as if the survivor is unconscious/incapacitated and it is determined that evidence of the crime will deteriorate or be lost by waiting for the survivor to regain the ability to consent. Survivors who are minors do not need the consent or permission of a parent/guardian to have an exam, nor can they be forced to submit to an exam by a parent/guardian.

There are many advantages of obtaining a forensic exam following sexual assault/abuse:

- It is the only means by which to collect and document evidence that is deemed permissible in the criminal justice system.
- It preserves evidence of the crime without obligating the survivor to pursue prosecution.
- The exam includes assessment of injury and prophylactic treatment for exposure to STIs.
- The exam and treatment for STIs are free of charge to the survivor.
- The survivor can obtain the exam anonymously (i.e. without identifying him/herself by name).
- In communities that offer rape crisis advocacy services, advocates are often available to survivors during the exam process, facilitating emotional support and recovery resources.

Some potential disadvantages of obtaining a forensic exam:

- It can be experienced as prolonged, invasive, and traumatizing by some survivors.
- Although the survivor is not required to participate in the criminal justice system, the crime will still be reported to law enforcement by the Sexual Assault Nurse Examiner (SANE).
- If the survivor requires additional testing or treatment beyond the scope of the exam, s/he or her/his insurance will be charged for the cost of those additional services.

## **Protocol and components of the forensic exam process**

The purpose of a rape kit examination is to collect evidence of sexual assault/abuse, and to document any injury. Whether performed by a SANE/SAFE or a physician, the exam is performed objectively (i.e. the examiner is not “on the survivor’s side”) and cannot in itself prove or disprove the truth of a crime.

When a survivor comes to the emergency department and identifies her/himself as a survivor of sexual assault, the hospital will admit the survivor to the department, ideally taking the survivor immediately to a private exam room. The survivor should be made aware of the option of the rape kit exam and asked if s/he would like to submit to the exam. If rape crisis services are available in the community, the survivor should also be asked if s/he wishes an advocate to be contacted. Prior to the exam, the survivor is instructed not to eat or drink, smoke, shower/bathe, or use the restroom, as these activities can destroy evidence.

In communities/hospitals where a SANE/SAFE is available, the SANE/SAFE may or may not be onsite. It is possible that the survivor may have to wait for the examiner to arrive. Once the examiner arrives, the exam process is explained to the survivor and, assuming the survivor wishes to undergo the exam, the survivor signs one or more consent forms. Although completing all elements of the exam is recommended, the survivor retains complete control over the process. If the survivor wants to stop the exam at any point, or if there is a specific part of the exam the survivor does not want to complete, her/his wishes will be respected fully.

Specific components of a rape kit exam include:

- Questions about the survivor’s recent activity, such as when s/he last ate/drank, bathed, used the restroom, and engaged in consensual sexual activity (this is asked in case more than one source of DNA is found from the survivor’s body), use of a condom during the assault, and any penetration that occurred (anal, vaginal, and/or oral); and female survivors will also be asked about menstruation or current use of tampons
- Detailed account of everything the survivor can recall about the assault, which is stated by the survivor and written down by the examiner
- A DNA “standard” from the survivor; that is, a sample of the survivor’s blood, hair, saliva or skin cells used for comparison purposes when testing other sources of DNA obtained from the exam
- Swabs of all areas of the body impacted by the assault, including areas that were kissed, licked, bitten, or touched by the perpetrator; this may include swabs from inside the mouth
- Scrapings from beneath the fingernails of the survivor and/or collection of any debris or foliage present on or about the survivor’s body
- Photograph of the survivor’s face (for identification purposes) and photographs of any visible injury on the survivor’s body (cuts, scrapes, bruises, abrasions, burns, etc.). These photographs may or may not be taken with a known object (a coin, e.g.) or a measuring implement (ruler,

- e.g.) to provide a reference as to the size of the injury
- Collection of the survivor's undergarments and/or outer clothing; it is unlikely that these items will be returned to the survivor after testing, although it is possible
- Vaginal and/or anal examination, including photographs of injury and swabs of fluid or skin cells from the perpetrator

The exact components of a rape kit will depend on the specific circumstances of the crime. For example, if the survivor was not vaginally penetrated, she likely will not have a vaginal exam. If a survivor does not remember all or part of the assault, s/he will likely be encouraged to submit to the full exam. If intoxication/incapacitation due to alcohol or other drugs is suspected, the survivor has the option of submitting to a Drug-Facilitated Sexual Assault Kit, which consists of taking a sample of the survivor's blood to be examined off-site for the presence of substances.

Following the exam, the SANE/SAFE or physician will provide prophylactic treatment for exposure to STIs (if appropriate and desired) and discuss options and recommendations for follow-up medical care. If the survivor requires additional tests or treatments, those will usually be done following the exam, unless they are needed to preserve the survivor's life. The survivor is permitted to leave the hospital once s/he has received discharge instructions from the attending physician.

For complete information about the rape kit process, read here:

<http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/hprp/sexual%20assault/adultprotocol2011.ashx>

### **Storing and processing the rape kit**

The rape kit itself is a sealed cardboard box that contains all the evidence collected from the exam. (Clothing may be too large or bulky to fit into the box; evidence bags are available for this purpose). Each individual piece of evidence collected by the examiner has its own container within the rape kit. Each of these containers is sealed, signed/initialed, dated and timed by the examiner. A carbon copy of the written statement and documentation is included in the kit. When all parts of the exam are complete and all pieces of evidence are collected, the cardboard box is closed, sealed with a special evidence sticker, signed/initialed, dated, and timed by the examiner.

The examiner will contact the police department in the jurisdiction where the crime occurred. A police officer or detective from that police department should come to the hospital to collect the rape kit from the examiner. The officer/detective will sign the evidence sticker on the rape kit box and s/he will retain legal custody of the kit. The officer/detective often wants to speak with the survivor in the hospital. This does not, however, obligate the survivor to make a report or participate in the criminal justice system. Although efforts have improved to test/analyze more rape kits, most kits are kept in storage at the police department until/unless the case proceeds through the criminal justice system. It can take weeks or even months for a kit to be analyzed.

## **B. SUPPORTING THE SURVIVOR THROUGH THE EXAM PROCESS**

Having the presence of an advocate during the exam process can be of tremendous comfort and support to the survivor. This process can be stressful, in that it requires the survivor to be in the emergency department, to endure an invasive exam, and to answer difficult and personal questions. All of this occurs after the survivor has suffered a traumatic crime, which is tremendously difficult in itself. Most forensic examiners are kind and sensitive to the survivor's situation and needs; however, examiners must remain objective. The advocate is uniquely valuable during the exam in that the advocate is there to support the survivor, not to "do something" to her/him.

When entering the hospital/beginning your interaction with the survivor:

- Introduce yourself to the survivor, the examiner, and any loved ones of the survivor (provided that they know why the survivor is there), and briefly explain your role.
- Ask the survivor if s/he is okay with you being in the room. Some survivors don't want anyone but the examiner in the room with them.
- If you arrive before the examiner, it can be helpful to explain the exam process in general terms. You do not need to be specific, but rather provide an overview of the purpose of the exam and what the survivor can expect. Offer to stay with the survivor, or to step out of the room, according to her/his wishes.
- If loved ones are at the hospital, it is generally helpful to provide support to them outside of the room while the exam is going on. (It's helpful if a second advocate is available for this purpose). The survivor can choose to have anyone s/he wants in the room (including loved ones), but it's often easier for the survivor to be forthcoming about details of the assault with the examiner if loved ones aren't in the room.
- There is no need to ask the survivor about the assault or to talk about it any detail, unless the survivor wants to. The survivor will be asked to talk about the assault with the examiner.
- Remember to allow the survivor to express emotions however is best for her/him, and to allow her/him to tremble or shake. These are normal bodily reactions to trauma and should not be interrupted. Provide encouragement and support to the survivor as s/he experiences this.

During the exam process:

- The exam can be scary and intimidating for the survivor, which may exacerbate her/his reactions to the trauma itself. At all points during your interaction with the survivor in the hospital, it's important to help the survivor to feel safe by reminding her/him that the assault is over and s/he is safe now, and by helping her/him to orient to the safety and stability of her/his surroundings (the room/building, the blanket, you, etc.).
- It's important to allow the examiner to do what s/he needs to do, and to not interrupt the examiner or survivor while the survivor is telling details of the assault. It's appropriate,

however, to offer encouragement to survivor at this time.

- Make every effort to preserve the survivor's privacy during the exam. This can be done by stepping behind the curtain while the survivor undresses and staying at the head of the exam table/bed while the examiner performs the vaginal/anal exam; or by leaving the room.
- Sometimes survivors find physical touch from the advocate to be comforting, such as holding their hand during the vaginal/anal exam, or putting your hand on their shoulder to offer comfort and support. Always ask a survivor before touching her/him, as unexpected touch can be experienced as unwelcome, invasive, or controlling.
- When the examiner opens the actual rape kit box, s/he cannot (or should not) let it leave her/his sight, in order to preserve the chain of custody and integrity of the evidence collected. This being the case, the examiner may ask you the advocate to retrieve a supply s/he may need from outside the room in order to complete the exam.

After the exam is over:

- Once the exam is over, the survivor is free to shower/bathe, use the restroom, and eat/drink. Help the survivor obtain whatever s/he wants or needs in order to feel clean and comfortable. This might include finding toiletries and clothes for the survivor to change into, and obtaining food from the hospital's cafeteria/food service or a vending machine.
- The survivor has the option of taking prophylactic antibiotics to prevent against bacterial-based STIs. The examiner or attending physician should discuss with the survivor the need for such treatment and any risks associated with it. Similarly, the examiner or attending physician should discuss with the survivor any follow-up medical care or treatment, including emergency contraception.
- While the survivor is waiting for medication or to be discharged is an excellent time to discuss any questions, concerns, or needs the survivor may have. (Hospitals can sometimes be slow in dispensing medication or discharging patients). It can be helpful to share with the survivor how s/he can expect to feel in the next few days (i.e. rape trauma syndrome), discuss any resources that might be helpful, assess for the survivor's safety and support when s/he leaves the hospital, and provide additional support to loved ones who may be present.

Note: Emergency contraception (i.e. the "morning after pill") is medication that a female can take to prevent becoming pregnant immediately after unprotected intercourse or rape. Survivors, medical personnel, advocates and other service providers can have strong feelings about emergency contraception. Only medical professionals can and should provide guidance about the morning-after pill, its uses, effectiveness, and risks. It's important for you not to share your opinions about emergency contraception, or to question or judge a survivor's opinion. The survivor should be able to decide for herself what is best for her in all forms of medical care and treatment.

## C. CHALLENGES IN THE HOSPITAL SETTING

### **The hospital environment**

Emergency departments exist to treat serious or life-threatening illness and injury. As such, you the advocate can expect to see, hear and even smell things in the emergency department which may be upsetting or uncomfortable. It's important to be in tune with yourself, to know the things that push your buttons, turn your stomach, or otherwise make you uneasy. Practice how you might manage your response to these things should you encounter them. Be sure to discuss these with your supervisor.

### **The survivor**

When interacting with the survivor, you may encounter unexpected, upsetting and/or uncomfortable things about her/him. Survivors may have physical injuries (with or without the presence of blood); they may be intoxicated; they may need to vomit; they may have an illness; they may have a disability; they may have body odor or body lice; they may have scars or physical deformities; and they may have body piercings or tattoos. While every effort is made on the part of the advocate to preserve the survivor's privacy, it is possible that you may see the survivor in various states of undress. Some survivors wish to conceal their bodies in the presence of others, while some survivors are comfortable being naked in front of others. Regardless of the physical state or behavior of the survivor, you must approach each survivor with an open mind and a willingness to support her/him.

### **The exam process**

During the exam, the examiner may need to take a sample of the survivor's blood, which may or may not include the use of a syringe. The survivor will be asked by the examiner to recount the assault in as much detail as possible, so you may hear graphic details about the crime. Finally, parts of the exam may be painful for the survivor (such as the vaginal exam), causing the survivor to cry or even scream. All of these things may be disturbing or upsetting for you to witness, which is to be expected. Just remember that the survivor needs your calm support and reassurance. Be sure to later share with your supervisor anything that is especially upsetting for you.

### **Service providers and loved ones**

Most service providers are professional and treat survivors with respect. Unfortunately, you will sometimes encounter service providers in any profession (hospital staff, examiners, or law enforcement) who are rude or insensitive to the survivor. You must always remain calm and professional in your role as an advocate; however, it may be appropriate to intervene on behalf of the survivor if a service provider is especially rude or insensitive. Your supervisor will let you know what is expected in such circumstances. Similarly, loved ones can be insensitive or cause distress to the survivor. It is usually not helpful to confront loved ones in the survivor's presence. It is most effective to speak privately with the loved one to discuss more productive ways they can support the survivor.

**SECTION 8:**

**CRIMINAL JUSTICE/LEGAL ADVOCACY**

## A. OVERVIEW OF THE CRIMINAL JUSTICE SYSTEM

The criminal justice system can be confusing for survivors and their loved ones. This is due in part to the fact that the criminal justice system is complex in many ways. There are many components to our justice system, which are interrelated and depend on the timing and outcome of other components. The definitions and applications of the law are complex and confusing even to some professionals who are familiar with the system.

The confusion that survivors may experience is also due to the misrepresentation of the criminal justice system in popular media. For example, many television crime dramas depict the system as swiftly-moving and highly likely to result in a conviction, with the defendant being sentenced to lengthy periods of confinement. In reality, the justice system (particularly as it relates to sexual violence) is very different. The system typically moves slowly, with some rape cases taking a year or longer to adjudicate. Additionally, rape cases must progress through multiple stages in the process, and unfortunately, very few make it to trial. Finally, many perpetrators who are convicted do not receive lengthy sentences.

When working with a survivor who is unsure about reporting the crime to the police, or when working with a survivor who is currently participating in the justice system, it is helpful to inform the survivor and her/his loved ones about the realities of the criminal justice system and what to expect.

Questions that may be helpful to ask survivors include:

- If you participate in the justice system, what do you want the outcome to be?
- If that outcome is not realized, how might that impact you and your recovery?
- If you choose not to participate in the criminal justice system, how might that impact you and your recovery over time?
- What support do you need in making this decision or in navigating the system?

### **Additional Reading**

Read the following resources for specific information about the criminal justice process:

- Legal definitions: <http://www.oaesv.org/wp-content/uploads/2012/12/Legal-Definitions-Fact-Sheet.pdf>
- Factsheet on the criminal justice process: <http://www.oaesv.org/wp-content/uploads/2012/12/Criminal-Justice-Fact-Sheet-for-Survivors.pdf>
- Fundamentals of victim rights: <https://law.lclark.edu/live/files/11823-fundamentals-of-victims-rights-a-summary-of-12>
- Information about protection orders: [http://www.supremecourt.ohio.gov/JCS/domesticViolence/protection\\_forms/stalkingForms/default.asp](http://www.supremecourt.ohio.gov/JCS/domesticViolence/protection_forms/stalkingForms/default.asp)

## B. SUPPORTING SURVIVORS IN THE CRIMINAL JUSTICE SYSTEM

### Roles within the criminal justice system

Supporting survivors in the criminal justice system requires an understanding of the different roles within the system and how they impact/interact with survivors:

- **Law Enforcement:** Police officers and detectives are responsible for gathering facts and investigating crime. They are objective (i.e. not representing or “on the side” of the survivor or perpetrator). While law enforcement professionals should understand trauma, victimization, and the needs of survivors, they are not advocates or support professionals. They are information-gatherers and fact-finders. Communication between law enforcement and survivors is not privileged or confidential (i.e. not legally protected private communication).
- **Prosecutors:** Prosecutors, both at the municipal and county levels, are responsible for prosecuting the offender. While they obviously pursue a criminal conviction or guilty plea for the offender, they represent the State of Ohio, not the survivor. Communication between survivors and prosecutors is not privileged or confidential, and prosecutors cannot personally represent survivors in matters outside the criminal case.
- **Victim/witness advocates:** Most victim/witness advocates are part of the Prosecutor’s Office. Their role is to provide information about the process and support to the survivor while s/he is participating in the process. Communication between the victim/witness advocate is not privileged and may or may not be confidential.
- **Judges:** Judges are responsible for interpreting the law as it applies to individual cases. Judges at the municipal level decide in preliminary hearings whether or not a case will proceed to the next step. Judges at the common pleas level can decide the outcome of a case at trial if the defendant agrees to a bench trial.
- **Rape crisis advocates:** As an advocate, you cannot dispense legal advice to a survivor, but you may provide emotional support and information about the process to a survivor at any point in her/his participation in the system, or any point in her/his recovery process. Communication between survivors and advocates is not privileged in Ohio, but it is confidential.

### Tips for working within the criminal justice system

Supporting survivors in the criminal justice system will be more effective by doing the following:

- **Preserve confidentiality:** Do not discuss the details of the survivor’s case or your interaction with her/him, with anyone in the criminal justice system.
- **Be professional:** Despite various depictions of the process on television, the criminal justice system requires professionalism on the part of all who participate in it. This means dressing appropriately, following rules/protocol, and interacting respectfully with others.
- **Be an advocate:** Check in frequently with the survivor to address questions, concerns, and needs. With the survivor’s consent, advocate for those needs on her/his behalf with others.

## C. CIVIL LEGAL NEEDS OF SURVIVORS

There are numerous legal issues impacting survivors of sexual violence that extend beyond the scope of the criminal justice system. Consult with your supervisor as to your role in advocating for these needs among survivors in your program:

- **Privacy:** Many survivors of sexual violence have concerns about the privacy of and access to their personal information, as well as information/documentation regarding their victimization. Federal law protects personal health information contained in medical records, and in mental health records from licensed counselors and social workers. Rape Crisis records are confidential, but can be subpoenaed in court. Police and court records are generally public record, however survivors can petition to have their identifying information concealed.
- **Ongoing Safety:** Some survivors of sexual violence have concerns regarding their ongoing safety from the perpetrator and/or acquaintances or associates of the perpetrator. In addition to making safety arrangements surrounding housing and employment, survivors can obtain a variety of court orders designed to protect them.
- **Employment:** Due to the trauma of sexual violence, some survivors may have difficulty concentrating at work and interacting with colleagues and customers/clients. Survivors may also need to miss work due to stress, to attend court proceedings, or to attend medical or mental health appointments. Employers should work with survivors regarding time off, reasonable accommodations, and safety while at work. If the perpetrator is a colleague or supervisor of the survivor, the employer must make accommodations to protect the survivor.
- **Education:** Schools and campuses throughout the U.S. must abide by laws and policies establishing student safety, and to respond appropriately when students are victimized.
- **Housing:** The availability of safe, affordable housing for survivors of sexual violence is critically important. Some survivors are unable to pay rent after their victimization, they want to move in order to facilitate healing from the trauma, or they need to move in order to feel safe. The 2013 reauthorization of the Violence Against Women Act extended housing protection rights to survivors of non-intimate partner violence within nine categories of public housing assistance.
- **Immigration:** Immigrant women are frequently targeted for violence and abuse. Perpetrators often exploit language barriers and the legal status of immigrant women in order to harm them. Survivors of sexual violence have rights as crime victims, regardless of their documentation status. U-Visas and T-Visas are potential remedies for undocumented survivors.
- **Financial Assistance:** The ability to meet basic needs is often impacted by the experience of sexual violence. Additionally, some survivors face financial hardship in the aftermath of violence due to the inability to work. Still other survivors seek financial compensation to address the impact of the crime on their lives.

**SECTION 9:**

**CULTURAL COMPETENCY**

## A. DEFINING & PRACTICING CULTURAL COMPETENCY

The U.S. Department of Health and Human Services, Office of Minority Health, defines cultural competence this way: “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.” Cultural competence is not “tolerance” or “political correctness.” It is a commitment to learning from, having and demonstrating respect for, and accepting all individuals as unique, important human beings whose individuality and experiences are equally as valid as our own. No person can fully understand another person’s experience in life; that is not what cultural competency requires of us. It is the constant willingness to learn from another, to allow that individual to always be the expert on her/his life and for us to conduct ourselves as individuals, advocates, and organizations accordingly.

Cultural competence is important in our work as advocates for several reasons:

- Sexual violence is not limited to any one cultural group or community. It impacts individuals from all over the world, each of whom has their own unique histories and experiences.
- As advocates in a crisis setting, we have a limited opportunity to provide support to the survivors we encounter, and the quality of that support can impact the survivor’s recovery process going forward. As such, we must eliminate, to every extent possible, barriers in understanding and accessibility that would hinder our ability to provide that support.
- A survivor’s individual, cultural and community identities impact her/his recovery process in multiple ways. These should be embraced by advocates, not avoided or feared.

A starting point for employing cultural competency in your work with survivors is to understand that every survivor is unique, including survivors from groups or communities that survivors self-identify with and/or that society labels them as being members of. You must be willing to set aside assumptions and stereotypes, so that the individual survivor receives the support s/he deserves.

For an explanation of fundamental cultural differences, read here: <http://www.oaesv.org/wp-content/uploads/2013/05/Six-Fundamental-Patterns-of-Cultural-Differences.docx>

For suggestions on working with survivors in a culturally competent manner, read here: <http://www.oaesv.org/wp-content/uploads/2013/05/Diversity-Awareness-and-Sensitivity-Working-with-Survivors.docx>

## **Additional Reading**

To assist you in understanding the needs and experiences of survivors and how best to support them, please read the information contained via the links provided below. Not all communities are represented in this manual. You are encouraged to seek additional information and resources regarding the specific needs of survivors in your community.

### **Latino/Latina and Immigrant survivors of sexual violence**

- Factsheet on Latinas and sexual violence: [www.ovc.gov/pubs/existeayuda/tools/pdf/factsheet\\_eng.pdf](http://www.ovc.gov/pubs/existeayuda/tools/pdf/factsheet_eng.pdf)
- Working with survivors in Latino communities: [http://www.janedoe.org/site/assets/docs/Curriculum\\_SSSA\\_2012/09\\_Working\\_with\\_Survivors\\_in\\_Latino\\_Communities.pdf](http://www.janedoe.org/site/assets/docs/Curriculum_SSSA_2012/09_Working_with_Survivors_in_Latino_Communities.pdf)
- Immigrant survivors of sexual violence: <http://www.vawnet.org/special-collections/SVImmigrant.php>

### **LGBTQI survivors of sexual violence**

- Sexual violence in LGBTQI communities: <http://www.vawnet.org/special-collections/SVLGBTIQ.php>
- Culturally competent service to LGBT survivors: [http://new.vawnet.org/Assoc\\_Files\\_VAWnet/AR\\_LGBTSexualViolence.pdf](http://new.vawnet.org/Assoc_Files_VAWnet/AR_LGBTSexualViolence.pdf)
- Frequently asked questions about LGBTQI language: [http://www.pcar.org/sites/default/files/FAQ%20Lesbian,%20Gay,%20Bisexual,%20Transgender,%20Queer%20or%20Questioning%20\(LGBTQ\)%20Language.pdf](http://www.pcar.org/sites/default/files/FAQ%20Lesbian,%20Gay,%20Bisexual,%20Transgender,%20Queer%20or%20Questioning%20(LGBTQ)%20Language.pdf)
- Understanding the transgender community: [http://www.pcar.org/sites/default/files/TAB\\_2007\\_Summer\\_Understanding\\_Transgendered\\_Community.pdf](http://www.pcar.org/sites/default/files/TAB_2007_Summer_Understanding_Transgendered_Community.pdf)

### **Deaf and hard of hearing survivors of sexual violence**

- Violence in the lives of the Deaf or Hard of Hearing: <http://www.vawnet.org/special-collections/Deaf.php>
- Understanding Deaf culture: [http://www.accessingsafety.org/index.php/main/main\\_menu/understanding\\_deaf\\_culture](http://www.accessingsafety.org/index.php/main/main_menu/understanding_deaf_culture)

### **Survivors of sexual violence with physical or cognitive disabilities**

- Intellectual disabilities and sexual violence: <http://www.thearc.org/document.doc?id=3657>
- FAQs about serving survivors with disabilities: <http://www.safeplace.org/page.aspx?pid=319>
- Sexual abuse of women with disabilities: [http://www.vawnet.org/applied-research-papers/print-document.php?doc\\_id=416](http://www.vawnet.org/applied-research-papers/print-document.php?doc_id=416)

## B. ACCESSIBILITY FOR SURVIVORS

At the heart of any advocacy relationship is the ability of the survivor and the advocate to come together and to communicate. Individuals who are fluent in English, have little difficulty with cognition, or who are hearing, possess the privilege of being able to access services and to immediately communicate with service providers. For survivors with limited English proficiency (LEP), survivors with cognitive disabilities, and survivors who are Deaf or hard of hearing, the ability to come together and communicate is often challenged. When barriers to access and communication exist in any context, it is frustrating and limiting for those in need of services. When a survivor of sexual violence is unable to access the services they need, that survivor faces the added burden of navigating the difficult aftermath of trauma within a service structure that may or may not be adequately equipped to assist them. Simply put, all survivors deserve access to advocacy, support, and resources for recovery.

When making reasonable accommodations for survivors to access advocacy services, it is always best to ask the survivor which accommodations are most comfortable and effective for her/him. This might include a particular interpreter, a particular hospital, a particular place to meet for follow-up counseling services, etc. Always start with the survivor's preference, and work from there.

Your program should be able to demonstrate the following adherence to accessibility:

- Compliance with requirements of the Americans with Disabilities Act
- Utilization of language interpreting services
- Utilization of American Sign Language (ASL) interpreting services, via contracts with interpreters in the community
- Advocating for interpreting services for survivors in hospitals, police stations and courts
- To every extent possible, providing program materials in different languages, and that are sensitive to visually impaired survivors, as well as survivors with cognitive disabilities
- Existence of collaborative partnerships with organizations in the community that provide services to individuals with varying abilities

For information about rights and resources for survivors, read here: <http://www.oaesv.org/wp-content/uploads/2012/12/Rights-Resources-Fact-Sheet-for-Advocates.pdf>

For information on ensuring access for LEP survivors, read here: <http://www.icdv.idaho.gov/conference/handouts/2013/Ensuring-Access-to-Services-Survivors-with-LEP.pdf>



**What barriers to rape crisis services do you see in your community?**  
**What can you do to remove those barriers?**

**SECTION 10:**

**SPECIAL POPULATIONS & ISSUES**

## A. DRUG-FACILITATED SEXUAL ASSAULT

Many perpetrators of sexual violence utilize alcohol or other drugs in facilitating the commission of their crimes. They may seek out/wait for intoxication in a survivor, or they may facilitate the intoxication of the survivor (buying her/him drinks, slipping a substance in a drink, e.g.). These perpetrators exploit the ways in which intoxication renders the survivor vulnerable or even incapacitated. The survivor is more easily manipulated and violated, while s/he is also less likely to remember what happened or to report the crime. Additionally, many substances metabolize quickly and are excreted from the body before testing is able to detect the substance's presence in the survivor's body. All these factors make the assault easier for the perpetrator to commit and get away with. While the entertainment industry frequently depicts drug-facilitated sexual assault as something committed primarily by strangers in bars or college-age men at campus parties, it is just as frequently committed by someone the survivor trusts, in a location the survivor trusts or feels safe.

There are many substances that can be exploited by perpetrators in incapacitating and violating survivors. These include substances we typically think about with sexual assault, such as GHB or Rohypnol (i.e. "roofies" or the "date rape drug"), which can cause unconsciousness, muscle paralysis, and memory loss similar to anesthesia. Alcohol is by far the most common substance used in committing sexual assault, but there are also many readily-available substances that perpetrators exploit. These include over-the-counter and prescription medications, which can produce many of the same effects of "date rape drugs" when ingested alone, in combination with each other, or in combination with alcohol. What makes this especially dangerous is that combining certain substances can lead to serious health problems or even death.

If a survivor cannot remember much of the assault, if s/he doesn't know how s/he arrived at a particular location, and/or if s/he feels light-headed, unusually physically sluggish, disoriented or confused, it is possible that s/he may have been drugged. It's important for survivors in this case to be examined at a hospital quickly, or at a clinic or doctor's office, to be assessed for health risk. As part of the rape kit examination, survivors have the option of submitting to a drug-facilitated sexual assault kit, which involves taking a sample of the survivor's blood to be analyzed at an off-site laboratory. The forensic examiner, along with the survivor, will determine if such a kit is appropriate.

Finally, survivors who were intoxicated when they were assaulted often experience self-blame, as well as blame from others (i.e. "What did you expect would happen?"). Additionally, underage survivors who were intoxicated may fear getting in trouble with the law, with parents, etc. These survivors need a lot of support from advocates to feel believed, validated and empowered in their recovery.

For more information about drug-facilitated sexual assault, read here: <http://www.oaesv.org/wp-content/uploads/2013/05/Drug-Facilitated-Sexual-Assault.docx>

## B. MALE SURVIVORS

Sexual violence has traditionally been thought of as a crime committed primarily against females. While it is true that a greater proportion of females are sexually victimized than males, a significant proportion of males are nonetheless victimized. The reporting rate for male survivors is lower than that of female survivors, so the true scope of male victimization is difficult to determine. Additionally, the stigma attached to the experience of rape or abuse is often greater for male survivors.

Common concerns, stereotypes, and issues regarding male sexual victimization (summarized from information available from MaleSurvivor at <http://www.malesurvivor.org/myths.html>):

- **Sexual orientation:** It is commonly believed that males who are sexually assaulted or abused early in life are more likely to become homosexual later in life. Sexual orientation is a complex issue. While sexually abusive or exploitative experiences can create confusion for some survivors, it is unlikely that early sexual experiences directly influence or “cause” a survivor’s sexual orientation. Likewise, it is commonly believed that males who sexually assault other males are homosexual. While homosexual males can certainly sexually offend, the reality is that most male sex offenders are heterosexual and/or pedophilic.
- **Arousal during assault:** Some male survivors experience physical arousal and even orgasm while being assaulted, which can cause confusion and added distress. The male body can respond to stimulation even in abusive or traumatic circumstances, and it does not mean the survivor subconsciously enjoyed or was an active participant in the assault/abuse.
- **Traumatic response:** It is sometimes believed that rape or abuse experienced by a male is not as traumatic as rape or abuse experienced by a female. Additionally, it is commonly believed that males who are victimized by females should be happy about the experience. In reality, male survivors experience confusion, pain, and betrayal just as female survivors do. Male survivors often have the added burden of being expected to fight off an attacker/abuser and being able to “get over it” or “tough it out” more easily after the crime.
- **Becoming abusers:** There is an unfortunate assumption by some in society that males who are sexually abused earlier in life will become sexual offenders later in life. While it is true that many sex offenders have histories of sexual abuse, most survivors do NOT become offenders.

In advocating for male survivors (as with all survivors), it’s important they know that you believe them, that it’s not their fault, that their experience is significant and legitimate, and that resources for recovery are available.

For information on resources for male survivors: <http://www.oaesv.org/wp-content/uploads/2013/02/Male-Survivors.pdf>

## C. CHILD & ADOLESCENT SURVIVORS

### ***Child Sexual Abuse***

Child sexual abuse is a problem of epidemic proportions in our world and in the U.S. The impact of child sexual abuse is far-reaching, affecting the long-term physical, mental and emotional health of survivors. Families and communities are also impacted, particularly when the abuse is ignored or otherwise not addressed. Sexual abuse of children exists silently and often in plain sight, with signs of it largely ignored or dismissed by adults. Perpetrators, whether from within the child's family or from outside the family, often live, work and participate in community activities among others who may or may not realize the child is being abused. It is critical that if a child discloses abuse to us, that we believe him/her and secure the resources and support the child needs to be safe and to recover.

Additional reading:

- Facts about child sexual abuse: [http://nctsn.org/nctsn\\_assets/pdfs/caring/ChildSexualAbuseFactSheet.pdf](http://nctsn.org/nctsn_assets/pdfs/caring/ChildSexualAbuseFactSheet.pdf)
- Common behaviors of sexual abuse survivors: <http://www.pcar.org/blog/common-victim-behaviors-survivors-sexual-abuse>

### ***Adolescent Survivors***

Adolescents are among the most vulnerable individuals to sexual assault or abuse due to a number of factors, including their inexperience, natural risk-taking and socialization behaviors, desire to demonstrate independence and individuality, and required submission to authority figures. It is not these factors that cause sexual violence in adolescents; rather, it is that perpetrators seek and exploit these vulnerabilities. Adolescents who are sexually victimized experience higher incidences of mental and emotional problems, due in part to the impact of trauma on their rapidly-developing and changing neurobiological processes. Adolescent survivors need to be believed and provided continual support that engenders autonomy and empowerment.

Additional reading:

- For more information about child and adolescent sexual assault: <http://www.oaesv.org/wp-content/uploads/2013/05/Child-and-Adolescent-Sexual-Assault-Overview.docx>
- For more information about adolescent sexual assault: [http://www.wcasa.org/file\\_open.php?id=9](http://www.wcasa.org/file_open.php?id=9)

### ***Mandated Reporting***

In Ohio, some individuals are required by law to report sexual assault or abuse of minors to law enforcement or child protective services. Your supervisor/program staff will inform you of your reporting requirements as a volunteer.

## D. ELDERLY SURVIVORS

Sexual violence is traditionally thought of as a crime primarily suffered by younger individuals, but people of any age can be victimized. We do not normally think about perpetration of rape or sexual abuse against the elderly, primarily because we've been socialized to believe the myths that rape is about sex and sexual desire, and that elderly individuals are not sexual beings. Those who sexually assault or abuse the elderly exploit vulnerabilities in physical or mental health, and/or they have access to the elderly person or her/his family. Elderly survivors are more likely than younger survivors to sustain serious physical and genital injury from sexual violence. They may also experience a greater sense of shame. Unfortunately, elderly survivors are often not believed, particularly if their memory or cognition is impaired. Additionally, elderly survivors are often disempowered in their own recovery by family members or caregivers who may restrict or altogether strip the survivors of their independence.

In advocating for elderly survivors, it's important to believe them and to empower them as much as possible in their recovery and in their criminal justice options. While loved ones certainly need and deserve support, it's important to focus your attention on the survivor and what s/he wants and needs. For information on signs of elder abuse and reporting elder abuse, read:

<http://www.proseniors.org/PDFDocs/Probate/APS.pdf>

For more information on sexual violence later in life, read:

[http://www.nsvrc.org/sites/default/files/publication\\_SVlaterlife\\_FS.pdf](http://www.nsvrc.org/sites/default/files/publication_SVlaterlife_FS.pdf)

## E. INCARCERATED SURVIVORS

Sexual assault in U.S. confinement facilities is common, including in jails, juvenile detention facilities, and adult prisons. Perpetrators include other inmates and facility/corrections staff members. Sexual assault is most often committed as a means of exerting dominance over a particular inmate and/or as a means of establishing a hierarchy of power within the particular facility. Survivors are often reluctant to report sexual violence for fear of not being believed and/or fear of retaliation.

In 2003, the Prison Rape Elimination Act (PREA) was signed into law, the intention of which was to systematically address sexual violence in U.S. confinement facilities. In May 2012, the U.S. Department of Justice released National PREA Standards, among them that confinement facilities must collaborate with community rape crisis centers in providing advocacy and support for incarcerated survivors. In August 2013, all confinement facilities were required to demonstrate compliance with PREA Standards. Your supervisor or program staff will inform you as to your role (if any) in providing advocacy services to incarcerated survivors.

For more information about PREA and sexual violence in detention facilities:

<http://www.oaesv.org/wp-content/uploads/2013/05/PREA-Supporting-Inmate-Survivors.docx>

## F. DOMESTIC VIOLENCE & HUMAN TRAFFICKING

Domestic violence impacts a quarter of all women at some point in their lives. Domestic violence is the intentional intimidation or abuse of a person by an intimate partner, and/or intimidation or abuse of multiple individuals by someone in the home or family. Domestic violence has serious and far-reaching effects on individual survivors, families and households. Perpetrators often use psychological manipulation to isolate survivors physically, emotionally and socially, such that survivors are forced to depend on the perpetrator for shelter, food, money, medicine, etc. Women who are abused by an intimate partner are frequently criticized for not leaving, or for returning to an abuser, but they are almost always physically, psychologically, and/or economically dependent on the abuser. Leaving an abuser is also dangerous, sometimes resulting in serious injury or even death for the abused. Sexual assault or abuse is often part of domestic violence. Perpetrators use sexual violence as a means of intimidating, humiliating and terrifying the survivor. Additionally, some perpetrators commit reproductive coercion, which may include forcing the survivor to bear children; hiding, controlling, or otherwise sabotaging birth control; and/or forcing the survivor to have an abortion.

When providing advocacy and support to a survivor of domestic violence who was raped by her/his intimate partner or household member, expect that s/he may be reluctant to agree to leave the abuser and/or that s/he may agree to leave without an intention of actually leaving. It takes a tremendous amount of support and planning before a survivor may feel safe and comfortable leaving an abuser. As an advocate, you should provide safety options, such as staying at a shelter and/or developing a safety plan. If you are providing support to a domestic violence survivor in the hospital, it's possible that s/he may have more physical injury than what is typically seen. In some cases, her/his abuser might be present at the hospital.

Human trafficking involves similar manipulation, control and abuse as domestic violence. Human trafficking is a modern-day form of slavery impacting every country in the world, in which individuals of all ages are captured or lured into servitude, where they are forced to work for little or no pay, and/or forced into prostitution. Survivors are subjected to psychological manipulation, intimidation, fear, and abuse, and are forced to rely on their abusers for basic living needs (shelter, food, water, medicine, etc.). Survivors are often physically isolated from families, communities, or geographic locations that are familiar, making safe escape incredibly difficult.

For more information about domestic violence:

[http://www.ncadv.org/files/DomesticViolenceFactSheet\(National\).pdf](http://www.ncadv.org/files/DomesticViolenceFactSheet(National).pdf)

For more information on safety planning: <http://www.oaesv.org/wp-content/uploads/2013/05/Safety-Planning.docx>

For more information about human trafficking and supporting survivors: <http://www.oaesv.org/wp-content/uploads/2013/05/Identifying-and-Interacting-with-VictimSurvivors-of-Human-Trafficking.docx>

**SECTION 11:**

**DOCUMENTATION & POLICIES**

## A. DOCUMENTATION

### **Documenting survivor services**

Rape crisis programs that receive federal or state funding are required to document the number and type of services provided to survivors, in addition to some demographic data. Any additional information collected and retained depends on the policies of individual programs. For quality assurance and liability purposes, some documentation of services provided to survivors is important. For example, documentation of services provided to a specific survivor over time will help program staff to ensure that the appropriate services and resources were provided to the survivor in a timely and appropriate manner.

Rape crisis program records are considered confidential, which means they generally cannot be shared with anyone unless the survivor grants permission to share it; however, because rape crisis communications are not privileged in Ohio, records can be subpoenaed by a court of law. For this reason, programs are advised to refrain from recording any information that could be discriminatory against a survivor in court (i.e. anything that would paint the survivor in a bad light). Such things might include drug use or other criminal activity on the part of the survivor when the assault occurred.

If you the advocate will be documenting your interaction with survivors, it is important to follow your program's documentation policy carefully. Documentation should be recorded and submitted in a professional manner. For example, documentation should always be neat, legible, concise, reflective of the services actually provided, and avoiding jargon or inappropriate language. Any notes taken about cases should not be kept with the formal documentation. For example, sometimes advocates find it helpful to take notes about a particular survivor or case, in order to facilitate the most effective service delivery possible; however, such notes can contain detailed information about the survivor or the case that could result in a breach of confidentiality or harm to the survivor's case. You are encouraged to seek clarification from your supervisor if you have any questions or concerns about your program's documentation policy and your documentation responsibilities.

### **Documenting volunteer hours**

Rape crisis programs who receive federal or state funding are required to maintain records of the total number of hours that volunteers contribute to the program. Typically, volunteer time is recorded monthly and is verified by the volunteer with a signature. Your willingness to give of your time and talents is invaluable. It's not only important for your program to keep track of how many hours you contribute to the program and serving survivors, but it's also worthwhile and rewarding for you to know this as well. Advocating for survivors is about quality and impact, and part of that impact is the amount of time you give of yourself in service to others.

## B. LOCAL PROGRAM POLICIES

Policies in any organization exist to define the roles, responsibilities, and procedures for everyone working or volunteering in the organization, and for everything that happens (or could happen) there. We normally think of policies as onerous documents full of “legalese,” which they certainly can be. But they are also extremely important in helping employees and volunteers feel informed and competent, and in helping clients to know that they will receive safe, professional, and competent services.

Each organization is different, and individual programs within organizations often have their own set of policies and procedures. Additionally, the roles, responsibilities and expectations of volunteers may differ from employees in subtle or significant ways. For this reason, the more specific a program’s policies, the more informed and effective everyone will feel.

Ideally, your program should have a policy for each of the following elements. If there is not a policy for each element, it doesn’t mean the program is ill-prepared; however, as an informed volunteer, you have the right to know any and all of these things.

- **Requirements to be a volunteer:** What personal characteristics must you possess in order to be a volunteer? This may include age, ability to drive, ability to commit to a certain number of hours, absence of criminal history, etc.
- **Roles and responsibilities:** Exactly what role(s) will you be performing for the program, and when and how are they to be performed? Examples may include face-to-face contact with survivors in hospitals, police stations, courts, or at the program’s facility. It might also include speaking with survivors via phone, and/or providing follow-up contact with survivors.
- **Time commitment:** How many hours are you expected to contribute per week or month? Does this include being on-call and/or actually interacting with survivors? What happens if you are unable to meet the commitment in a given week or month?
- **Supervision and evaluation:** What kind of supervision is required in your work as a volunteer? This may include time, frequency and duration of supervision, what is shared in supervision, and a particular individual with whom to meet. Can you seek additional supervision if needed, and if so, when and how should that occur? How frequently and in what manner will your performance be measured, assessed, or evaluated?
- **Self-care and continuing education:** How does the program monitor your self-care? Are you permitted to take a break or leave of absence if needed? Is self-care included in your supervision? Is continuing education required or encouraged, and if so, when and how frequently are continuing education opportunities offered?



**Which of the above policy categories are most important to you? Why?**  
**What additional policies (if any) would be helpful to you?**

**SECTION 12:**

**VICARIOUS TRAUMA & SELF-CARE**

## A. VICARIOUS TRAUMA IN RAPE CRISIS WORK

It is impossible not to be impacted by providing advocacy and support to survivors of sexual violence. As advocates, we see and hear difficult and disturbing details of traumatic events while providing empathic support to survivors of those events. How deeply we are impacted by our work depends on many factors, including the frequency and type of exposure to trauma material; the training, supervision and support we receive; our own histories of sexual violence or other trauma; personal stress; our own support systems; and the balance we are able to maintain between our work and our personal lives. All of these elements can move and shift over time, in positive and negative ways.

### Vicarious trauma

Vicarious trauma is defined as a cumulative process by which an advocate's inner experience is negatively transformed by exposure to trauma material and empathic engagement with trauma survivors. Repeated exposure to trauma material can alter the way an advocate perceives her/himself, others, and the world. Unlike burnout or countertransference (defined below), vicarious trauma is a direct reaction to trauma work and impacts every facet of the advocate's life.

- **Burnout** is general psychological stress that results from working with difficult clients or within difficult systems. It can be caused by overwork, a sense of unfairness, lack of control, insufficient reward, and/or a lack of support. When the stress is unrelieved, it can lead to emotional exhaustion, frustration, feelings of inadequacy, and apathy towards one's job and clients (Maslach, 1982; Leiter & Maslach, 2005). Burnout can happen in any profession/field.
- **Countertransference** is the attributing to the survivor, by the advocate, traits and behaviors of past and present significant others or events in the advocate's own life. The advocate's emotional reaction to a survivor is a result of the advocate's personal life experiences. If advocates relate to survivors empathically, then countertransference is inevitable and necessary; acknowledging it is usually enough to alleviate it (James, 2008; Pearlman & Saakvitne, 1995; Figley, 1995).

### Symptoms of vicarious trauma

The signs or symptoms of vicarious trauma can closely mirror the physical, emotional and behavioral reactions survivors of sexual violence have to the assault/abuse. When our work as advocates consistently impacts our lives in negative ways, then we are likely experiencing vicarious trauma. Preventing and responding to vicarious trauma requires dedication to self-care.



**In what ways might you be at risk of experiencing vicarious trauma?**

**In what ways might you be resilient to experiencing vicarious trauma?**

## B. SELF-CARE FOR ADVOCATES

Self-care is the consistent, intentional practice of monitoring how advocacy/rape crisis work is impacting you as a Volunteer Advocate, and practicing basic skills and techniques for minimizing any negative impact. Helpful tips in the successful practice of self-care include:

### **Self-awareness**

Being in tune with your thoughts, feelings, beliefs, and body sensations is an important part of understanding how advocacy impacts you. Self-awareness is not easy for everyone, but it is a skill that can be learned and applied to many contexts in life. Examples of self-awareness include:

- **Sensory reactions:** When working with a survivor, take notice of how your body is reacting to the things you see and hear, or how your body feels once your contact with the survivor is over. Pay attention to things like your pulse, breathing, muscle tension, energy/tension in your stomach, chest, arms, legs, etc. As best you can, note how your body reacts differently to different survivors or traumatic details. Over time, you will be able to discern which things elicit a reaction in your system and thus require greater attention.
- **Orienting:** When you feel signs of stress in your system in response to a survivor or her/his traumatic material, take a moment to orient to your surroundings. This can be something as simple as making a conscious note of the details of the room you're in (size, depth, furnishings, light, temperature, colors, etc.). Doing this will encourage your system to feel grounded in the safety and security of your surroundings in the present moment, rather than drifting to disturbing images of the trauma material from the survivor.

### **Supervision and support**

Being able to share details about your advocacy experiences, and how you feel about them, is incredibly important. Since confidentiality is essential in your role as an advocate, you cannot share these things in any depth with loved ones. Your program should prioritize supportive supervision so that you have a built-in structure for support and guidance. The supervisory relationship should be such that you feel safe and comfortable in sharing *any* thoughts, feelings, triumphs, and concerns you have about your work as a volunteer.

Additional Reading:

- Self-care and trauma work: [http://www.nsvrc.org/sites/default/files/Publication\\_NSVRC\\_Overview\\_Self-Care.pdf](http://www.nsvrc.org/sites/default/files/Publication_NSVRC_Overview_Self-Care.pdf)
- Tools for watching movies and television shows: <http://www.oaesv.org/wp-content/uploads/2013/05/Tools-for-Watching-Movies-and-Television-Shows.docx>
- Self-care assessment worksheet: [http://www.ecu.edu/cs-dhs/rehb/upload/Wellness\\_Assessment.pdf](http://www.ecu.edu/cs-dhs/rehb/upload/Wellness_Assessment.pdf)

**SECTION 13:**

**ADDITIONAL MATERIALS**

## A. ROLE PLAY SCENARIOS

### Hotline/phone call scenarios

- A twenty-year-old male calls and says that he is considering suicide. He was raped six months ago by a stranger. He constantly feels afraid and has cut himself off from all of his friends. He doesn't work and can't leave his home anymore. He did try counseling right after it happened but it didn't seem to help very much. He feels bad all the time and just wants the pain to stop.
- A drag performer thinks she may have been sexually assaulted at a bar yesterday-- she doesn't remember anything after her first drink until she woke up the following morning.
- A particular survivor uses the hotline a lot. In the past she has spoken with the hotline supervisor and he has set a limit with her. He told her that she could only call the hotline once a day. Today has been a difficult day for her, so this is actually the third time she has called in. The hotline worker on before you actually ended the call with her and said she would have to wait until tomorrow to call back. She wants to talk to someone now, though, and is hoping you won't hang up on her.
- An elderly woman in her sixties calls in. When she was in her twenties she was raped by a friend of the family. She never reported the crime, nor did she tell anyone about it. Up until the last two weeks she didn't even think about it. Recently, however, she has been having terrible flashbacks and is finding it hard to get through the day. She is calling because she wants the flashbacks to stop.
- The caller is a female prostitute who was sexually assaulted last night by a client. She is afraid of speaking with a detective, who might make an arrest for prostitution. The survivor agreed to have vaginal sex with the client, but the client forced anal penetration. She is concerned about getting HIV/AIDS because no condom was used.
- A man calls because his girlfriend just disclosed that she was raped during a party. He does not feel that it was rape because she admitted that she had been drinking and dancing. He feels that she is just trying to make excuses for "cheating" on him.
- A woman in her 30s calls because she was raped two days ago and doesn't know what to do. She hasn't told anyone what happened to her because she feels like it's her fault. She went to her date's apartment and wanted to have sex with him, but then he started acting weird. When she changed her mind, he raped her. She hasn't gone to a hospital.
- A lesbian reports that her new girlfriend does not respect her boundaries. She states that a cousin molested her as a child, and her girlfriend's behavior has caused her to have "issues" again. Mid-way into the call she begins sobbing and becomes very quiet.
- A male caller states that he is confused about his sexual identity. He had a recent sexual encounter with a man. He tells you he was really aroused by the experience, and wants to talk about it in explicit detail.

## Hospital/in-person scenarios

- A survivor is at the hospital in the middle of having evidence collected. She has been at the hospital for several hours and the exam is taking a long time. She tells you that she wants to stop the exam and just go home.
- A 16-year-old survivor is alone and does not have her parents present. She tells you that she is afraid to contact her parents to tell them what happened, but the nurse insists she must have parental consent before the hospital can treat her.
- The parents of the survivor are having a difficult time after what just happened to their daughter. They blame themselves for their daughter's assault and say that they should not have allowed her to attend her friend's birthday party.
- The survivor is a gay man, raped by male partner (of 1 year) earlier today. He presented to the emergency room complaining of rectal pain and while talking with the nurse disclosed the assault. He is unsure about speaking with law enforcement and having evidence collected. He is also concerned about having ejaculated during the assault, and worries others won't believe this was rape.
- You arrive at the hospital for a face-to-face advocacy request and let the front desk/triage know who you are and why you are there. They ask you to have a seat in the waiting room. Twenty-five minutes later you are still waiting and have not spoken with any hospital staff.
- A survivor at the hospital is giving information to the nurse about her medical history and assault history. She informs you that her husband threatened to divorce her if she was raped. She is shaking and extremely nervous about having the exam done, and talks about how angry her husband is and how she should just go home and not make him angrier.
- An elderly survivor was assaulted by a staff member at the nursing home he resides at. He is at the hospital to have an evidence collection kit completed. He is cooperative but not interested in discussing the assault, but would rather speak to you about TV shows, your family, or anything else that comes to mind.
- A mother is at the hospital with her 9 year old child, who was sexually assaulted by her father (the grandfather). She is extremely upset because she was also perpetrated on by him as a child and she blames herself for the assault.
- The survivor was sexually assaulted by her boyfriend yesterday. She reluctantly decided to speak with the detective and is now regretting that decision because of the types of questions he asked, which implied disbelief. She wants this detective to be reprimanded for his hostile line of questioning but is afraid this will negatively impact the case.



**Which of the above scenarios makes you especially nervous? Why?**

**What other situations/circumstances would you like more information about?**

## B. SELF-REFLECTION WORKSHEET

Congratulations! You've completed a training course that we hope you've found to be informative and inspiring. We wish you all the best in your experience as an advocate for survivors of sexual violence. This worksheet is not an evaluation or test; rather, it is intended for your own self-reflection about the training you've received and your goals and desires for your work as an advocate. Although this completed worksheet may be useful for group discussion, your answers do not need to be shared. Record your answers on a separate sheet of paper, in as much detail as is comfortable for you.

1. Coming into this training, what hopes and desires did you have about becoming an advocate? Were those hopes and desires encouraged or discouraged by the training? How so?
2. What most excites you about becoming an advocate? What most concerns you? What fears, if any, do you have about interacting with a survivor the first time?
3. How has this training impacted your feelings about sexual violence? How has it impacted your feelings about your own safety and the safety of others?
4. If you are a survivor of sexual violence, how (if at all) has this training impacted your healing? If you know someone who is a survivor, how has this training impacted your understanding of their healing process?
5. Do your friends and loved ones know that you have trained to become an advocate? If so, what kind of response have they had (support, concern, questions about it, etc.)? If your friends and loved ones do not know, what impact does their not knowing have on you?
6. If there's one thing you wish the world (or just your community) could know from what you've learned in training, what would it be and why?
7. How has this training affected your educational or career goals, if at all? How has it affected your opinion of or experience with volunteerism/community service?
8. A year from now, what do you hope to be able to say about your experiences as an advocate? How, if at all, might you feel differently than you do now (more confident, e.g.)?

## C. TRAINING MANUAL EVALUATION

It is important to the Ohio Alliance to End Sexual Violence (OAESV) that the materials we produce are accurate, informative, and relevant to rape crisis programs. The following evaluation asks you to provide feedback about the content of the training manual only (not about the actual training you received; your trainer(s) will provide a separate evaluation form for that). Your feedback will be used by OAESV in revising the manual and producing additional print and online training resources. Please return the completed evaluation to your trainer(s). Thank you for your candid feedback!

Please rate the statements below, based on the following scale:

1 = Completely disagree      2 = Disagree      3 = Neutral      4 = Agree      5 = Completely Agree

1. The content of the manual is clear and easy to understand: \_\_\_\_\_
2. The content is accurate, timely and up-to-date: \_\_\_\_\_
3. The content for each topic is thorough: \_\_\_\_\_
4. The topics covered are important for advocacy with survivors: \_\_\_\_\_
5. The content is relevant to my specific role within my program: \_\_\_\_\_
6. I would recommend this manual to others for advocacy training: \_\_\_\_\_

What topics/information would you recommend be added to the manual?

What topics/information would you recommend be removed or changed?

Overall, how helpful was this manual in your training to become a Volunteer Advocate?

Please comment on any aspect of the training manual: