

Sexual Assault Advocate Training Manual

Revised November 2016



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NOTES:

HE VS SHE, HIM VS HER

In this manual, you will find that that when pronouns or other gender-specific terms are used, victims of sexual assault are referred to as female and perpetrators as male. Are all victims of sexual assault women? Are all perpetrators of sexual assault men? Of course the answer to both these questions is 'No.' However, the majority of victims are female and the majority of perpetrators are men, so for the purpose of simplified language, this manual will utilize female pronouns when referring to victims and male pronouns when referring to men.

VICTIM VS. SURVIVOR

The terms "victim" and "survivor" are often used interchangeably to describe an individual who has experienced sexual assault. For the advocacy purposes of this curriculum, the term "survivor" will be utilized in recognition that every person who lives through a sexual assault is a survivor. The word 'victim' will be utilized at times, typically to refer to a survivor in the immediate aftermath of the assault.

DISCLAIMER

While we strive to keep our training materials up to date, Texas laws regarding sexual assault and crime victims' rights change periodically. Therefore, our Sexual Assault Advocate Training Manual may not reflect recent legislative changes. For this reason, we recommend reviewing the following statutes for updated information surrounding sexual assault advocacy and victims' rights:

Victims' rights during a forensic exam or law enforcement interview:

- [Right to a Sexual Assault Program Advocate](#)
- [Right to a Forensic Medical Examination](#)

Rights of crime victims:

- [Code of Criminal Procedure: Chapter 56A Rights of Crime Victims](#)

Confidentiality protections and exceptions:

- [Confidential Communication between a sexual assault program and a survivor](#)

To look up or review additional laws related to victim rights or sexual assault, please refer to the Texas Constitution and Statutes website: <https://statutes.capitol.texas.gov>.

If you have any questions or need further assistance, please contact us at advocacy@taasa.org.

CONTRIBUTORS

The developers of this publication would like to acknowledge all those who have contributed to current and previous versions of this training manual

This is the Seventh Revision of this manual. In earlier versions, contributors used varied compositional styles (e.g., the use of personal pronouns or the way they cited references). This version preserved some of those differences when they did not interfere with the most important goal clarity.

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Section 1:

DYNAMICS OF SEXUAL ASSAULT

Sexual assault is any type of sexual contact or behavior that occurs without the explicit consent of the recipient.¹

Understanding the many different forms of sexual assault is important. Advocates, and survivors themselves, often have an incomplete understanding of what sexual assault encompasses which includes cultural inaccuracies about what is a 'real' sexual assault. Of course a 'real' sexual assault is far more than the stereotypical stranger climbing through a bedroom window or jumping out of the bushes. While ambush style stranger sexual assault occurs, it is far less common than the sexual assault committed by someone known to the victim whose trust is taken advantage of and betrayed. The ability to understand and acknowledge your own biases will strengthen your ability to provide non-judgmental support to survivors.

Survivors also carry many of these same misunderstandings about sexual assault which may lead them to wonder if what happened to them was a 'real' sexual assault. This can influence their willingness to seek assistance at a rape crisis center or report the assault to law enforcement. This is reflected in the low reporting rates among sexual assault victims. Many survivors are concerned that they won't be believed, are embarrassed or ashamed about their actions or role in the assault, or think that it is a private matter. Survivors who take the step of seeking outside assistance should be praised for their courage.

One of the most critical factors to remember and emphasize is that sexual assault is always the responsibility of the offender/perpetrator. Sexual assault is an abuse of power against someone who is vulnerable. The survivor did not cause the assault to happen. It does not matter what the victim was wearing, where they were, what they were doing or who they were with. No matter what type of sexual assault, it is the perpetrator who made a decision to commit a sexual act without the victim's consent and the perpetrator is the one who should be held responsible.

¹ Definition used by the U.S. Department of Justice, Office on Violence Against Women. Available here: <http://www.justice.gov/ovw/sexual-assault>

Note: The term 'sexual assault' has specific legal definitions in Texas statute which are more closely aligned with the word 'rape' and includes penetration. This manual and this section, specifically, use sexual assault as a broader umbrella term for sexual violence in its many forms.

FORMS OF SEXUAL ASSAULT/ABUSE

Non-Stranger Rape (acquaintance rape) is sexual assault by someone known to the victim. Most sexual assault survivors are victims of acquaintance rape. The offender can be anyone from a casual acquaintance to a relative or boyfriend. Acquaintance rape occurs between persons who may or may not have had a previous sexual history and who may or may not have expectations of a sexual interaction.² In one of the first studies of its kind, Mary Koss³ found that more than 3/4 of the rapes reported in this country are committed by someone known to the victim: current or former spouse, boyfriend/girlfriend, relative, friend, friend of a friend, brief acquaintance, date, neighbor or fellow worker. The 2010 Summary Report on the National Intimate Partner and Sexual Violence Survey, the most recent report on the prevalence of sexual violence issued by the National Center for Injury Prevention and Control and the Centers for Disease Control and Prevention (CDC), found that just over half (51.1%) of women reported being raped by an intimate partner and 40.8% reported being raped by an acquaintance. In the case of male victims, greater than half (52.4%) reported being raped by an acquaintance. The most recent data for the state of Texas found 70% of sexual assault victims knew or were related to, their perpetrator (Busch-Armendariz et al., 2015). The common factors which may lead to an acquaintance rape (social gender norms/roles/ expectations, male entitlement, consent etc.) can occur within numerous types of relationships, even among those who are well-known most trusted.

Date rape is, by definition, sexual assault that occurs while on a date or between persons who expect to have (or already have had) an intimate relationship (Wegner et al., 2014). In one study of 204 men from a large urban community, 63% of men reported obtaining unwanted sex (committing rape) at least once with a steady dating partner, spouse, or

Most research, including the Wegner et al, 2014 study noted here, regarding perpetrators of sexual assault do not ask men to admit if they have committed 'rape' or 'sexual assault.' Instead, researchers have developed a variety of questions detailing specific behaviors which describe rape and sexual assault, but without using those words. For example, participants in a study might be asked to indicate if they have ever: "had oral sex with someone or had someone perform oral sex on me without their consent by showing displeasure, criticizing their sexuality or attractiveness, getting angry but not using physical force after they said they didn't want to."

Not only are these types of questions more likely to illicit positive responses from participants, but they provide the opportunity to learn about the different types of rape and sexual assault.

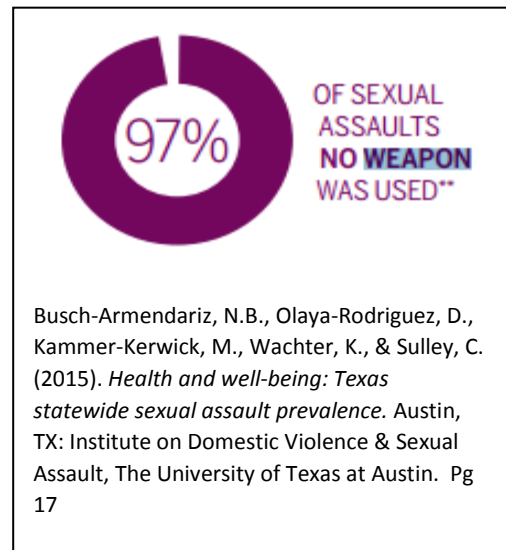
² Wegner R., Pierce, J., and Abbey, A. (2014). Relationship type and sexual precedence: Their associations with characteristics of sexual assault perpetrators and incidents. *Violence Against Women*, 20(11), 1360-1382.

³ Koss, M.P. (1988). *Hidden Rape: Sexual Aggression and Victimization in a National Sample in Higher Education*. In A.W. Burgess (Ed.), *Rape and Sexual Assault II* (pp 3-26). New York: Garland.

former spouse (Wegner et al., 2014). The date rapist frequently uses the least amount of physical force necessary and rarely use lethal weapons⁴ relying instead on verbal coercion, guilt tactics, emotional manipulation, and intoxicating substances. Wegner et al. (2014) found perpetrators in committed or long-term relationships that included prior sexual contact with the victim were more likely to use displeasure, pressure, made their partner feel guilty, continually argued, and/or threatened to end the relationship as their primary tactics in the rape. Whereas perpetrators in causal relationships where there was no previous sexual contact with the victim were more inclined to use an intoxicating substance as their primary tactic.

THE ROOTS AND EXTENT OF ACQUAINTANCE/DATE RAPE

In our society, many males and females have been taught half-truths about the other sex. Males are taught to "score" with women; they believe women say "no" but really mean "yes" and just need a little persuasion; that a partner who previously engaged in consensual sexual activity "owes" them sex (Wegner et al., 2014). On the other hand, females are taught that flirting is an innocent and harmless game that everyone plays. Yet women are also held responsible for being 'temptresses' and blamed if they are victimized. A number of behaviors (objectification of women, sexist jokes & behaviors, gender inequality, etc.) result from this type of social conditioning and all too frequently, the most extreme result is rape—a rape that both survivor and rapist may rationalize as being something less.



Survivors of sexual assault respond to the assault experience according to societal programming and must deal with cultural attitudes about sex and violence. Acts of sexual violence are often seen as a normal sexual behavior or at least justified. For example, in the following study, students age 14 to 18 were asked under which circumstances it was okay for a male to force sex on a female.

CIRCUMSTANCES:⁵

	Males agreeing	Females agreeing
She is going to have sex with him, then changes her mind	54%	31%
She has led him on	54%	26%
She gets him sexually excited	51%	42%
They have dated for a long time	43%	32%
She lets him touch her above the waist	39%	28%

⁴ Busch-Armendariz, N.B., Olaya-Rodriguez, D., Kammer-Kerwick, M., Wachter, K., and Sulley, C. (2015). *Health and well-being: Texas statewide sexual assault prevalence*. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas as Austin. Retrieved from <https://social-work.utexas.edu/cswr/institutes/idvsa>

⁵ Goodchilds, J.D., Zellman, G.L., Johnson, P.B., and Giarusso, R. (1988). Adolescents and Their Perceptions of Sexual Interactions. In A.W. Burgess (Ed.), *Rape and Sexual Assault II* (pp 245-270). New York: Garland.

The type of socialization that becomes apparent through studies like this illustrate how men and women label the incident something else besides rape, or at least believe the rape in some way, was justified. Similarly, in a 2000 study by the National Institute of Justice, Bureau of Justice Statistics⁶ even though even though the legal definition of rape fit the victimization experienced by women, the study found that in about half of the incidents, the women did not consider the incident rape.

Another pervasive myth about date rape is that the victim provoked it, owed it to their partner, or “led the perpetrator on.”⁷ This mistaken belief holds that women ask to be raped through their actions or dress. In fact, studies demonstrate that many perpetrators in date rape situations have expectations of sex even before the date begins. Perpetrators will create an environment in which the victim is made to be vulnerable (e.g., intoxicated or isolated from protective friends) enabling the perpetrator to assault the victim.

Another fallacy about acquaintance/date rape is that people agree to sexual intercourse, regret it and then call it rape. Much research has been devoted to the issue of false reporting and there have been attempts to precisely define the rates of false reporting. Most studies tend to converge with a range of 2% - 8% or 10% of rape reports being considered false, depending on which studies are being included.⁸ What has not been made clear traditionally in regards to false reporting is the distinction between a true false report (the crime of rape never occurred) and one which has been deemed unfounded or is not investigated at all, although the rape did occur. Lonsway describes how the only research into true false reports (crimes that were proven to have not occurred) shows that they almost always are stories of a stereotypical stranger rape involving a high degree of violence and a high level of physical resistance by the victim.

IMPACT OF ACQUAINTANCE/DATE RAPE ON SURVIVORS

The acquaintance rape survivor often suffers from an inability to trust as a result of the incident. The rape is a devastating act of betrayal because someone the victim trusted or maybe loved assaulted them. This betrayal of trust influences the immediate decision making process, “Who can I tell? Can anyone be trusted? Will anyone believe me?”

For a variety of reasons including societal attitudes, acquaintance rape survivors often do not report the crime or seek help from a rape crisis center.⁹ Survivors tend to feel ashamed, guilty, depressed and angry with themselves. The trust and integrity of a relationship has been shattered. They could blame themselves for the rape, feel a loss of control of their lives or betrayed by their own judgment. Survivors may find themselves in the position of having to face their rapist again, particularly in school

⁶ Crime and Victim Statistics, (2001). Bureau of Justice Statistics, U.S. Department of Justice [On-line], Available: <http://www.ojp.usdoj.gov/bjs/cvict.htm#summary>.

⁷ Wegner R., Pierce, J., and Abbey, A. (2014). Relationship type and sexual precedence: Their associations with characteristics of sexual assault perpetrators and incidents. *Violence Against Women*, 20(11), 1360-1382.

⁸ Lonsway, K.A. (2010). Trying to move the elephant in the living room: responding to the challenge of false rape reports. *Violence Against Women*, 16(12), 1356-1371.

⁹ Busch-Armendariz, N.B., Olaya-Rodriguez, D., Kammer-Kerwick, M., Wachter, K., and Sulley, C. (2015). Health and well-being: Texas statewide sexual assault prevalence. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas as Austin. Retrieved from <https://social-work.utexas.edu/cswr/institutes/idvsa>

or work settings. Since most acquaintance rapes are not reported to law enforcement agencies or rape crisis centers¹⁰, the survivor deals with these intense feelings alone.

TOP REASONS VICTIMS DID NOT REPORT TO LAW ENFORCEMENT	OTHER REASONS GIVEN
<ul style="list-style-type: none">• Did not define their experience as a crime.• Were too young to report their victimization to law enforcement.• Were too scared to report.• Chose to deal with the sexual assault themselves or ask friends or family for help.• Felt "stupid," ashamed, or embarrassed about what had happened to them.	<ul style="list-style-type: none">• Wanted to forget about it and move on with their lives.• Did not think they would be believed.• Were prevented from reporting it.• Thought that reporting it might jeopardize their employment.• Blamed themselves.• Worried about jeopardizing their immigration status.

Busch-Armendariz, N.B., Olaya-Rodriguez, D., Kammer-Kerwick, M., Wachter, K., & Sulley, C. (2015). Health and well-being: Texas statewide sexual assault prevalence. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas at Austin. Pg 37

As with all types of sexual assault, myths about this type of sexual assault are still prevalent. These myths are often a major factor in the fear and distrust of reporting. Others—and even the survivor—may perceive the assault as the fault of the victim. The myth that date rape is an act of passion, not violence, is a distortion that increases victim blaming.

The truth is, everyone has the right to control his/her own body and to make decisions about having sex. When survivors disclose feeling guilty, they are assuming responsibility for the assault and questioning their behavior in a desperate effort to answer the question, "Why did it happen?" They may have been told that they "were a tease" or "asked for it". The offender may apologize and deliver a long list of rationalizations. Shame and embarrassment show a fear of how others will respond; fear that others will categorize the assault not as it was – a rape – but according to societal programming and say it was "a bad night, not an assault/rape." Thus, there is reluctance to tell others.

The assault may also have a long-term physical and mental health impacts on the survivor.¹¹ Lack of support compounds the survivor's

The NISVS survey found that survivors – both men and women - of rape and other forms of intimate partner violence were more likely than those who did not experience rape to report headaches, chronic pain, difficulty with sleeping, activity limitations, poor physical and mental health. And women who experienced sexual violence were more likely to report asthma, IBS, and diabetes than women who did experience sexual violence.

Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

¹⁰ ibid

¹¹ Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 summary report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

emotional reactions. Denial of the emotional impact of the assault can occur. Without intervention, victims of acquaintance rape may develop lifestyles of being exploited and victimized. An acquaintance rape survivor may not realize that they have personal rights or control over their own body. An ability to trust others may result in losing the capacity for intimacy.

Acquaintance rape survivors may also have a hear of:

- retaliation, since they are known by the rapist (address, etc.);
- subsequent harassment;
- future harm;
- harassment by family and friends of rapist; and/or
- returning to normal routine (particularly if the rapist is part of this routine).

FAMILY REACTIONS

The data on family reactions to acquaintance rape are limited because relatively few families are given the chance to react to acquaintance rape. Because of pressures (based on society's attitudes and expected codes of conduct) on the survivor to keep the rape a secret, a minority of acquaintance rape survivors reveal the assault to their families.

The reasons victims give for not telling family members include.¹²

- The victim wishes to protect the family from upsetting news. Victims in this category felt that they could handle the rape, but family members could not.
- Value conflicts with the family led some victims to feel that the family would not understand because of their attitudes about rape, their religious orientation, or their disapproval of the survivor's lifestyle, thus blaming the survivor for the rape.
- The survivors wished to maintain their independence. Adolescents, dealing developmentally with establishing their own identity and eventual independence from the family, felt that telling parents would restrict their independence.
- Some survivors felt psychologically distant from their families.

Some adolescents were geographically distant from family members, usually away from home at school or living in another type of residence.

RAPE WITHIN MARRIAGE

Rape in marriage can be defined as any unwanted intercourse or penetration (vaginal, anal, oral) obtained by force, threat of force or when a spouse is unable to consent¹³. Researchers estimate that between 10-14% of married women experience rape within marriage.¹⁴ Unmarried, but co-habiting couples are included in this research as the dynamics of sexual violence in a long-term co-habiting relationship are understood to be similar to those of a married couple. Research on gay and lesbian

¹² Ageton, S.S. (1983). *Sexual Assault Among Adolescents*. Lexington, MA: D.C. Heath.

¹³ Bergen, R. K. (1996). *Wife rape: Understanding the response of survivors and service providers*. Thousand Oaks, CA: Sage.

¹⁴ Finkelhor, D., & Yllo K. (1985). *License to rape: Sexual abuse of wives*. New York: Holt, Rinehart, & Winston.

co-habiting partners is sparse, but gay men and women endure the same types of sexual abuse that exists within heterosexual relationships, with the added challenges of subtle and outright discrimination when seeking assistance.

Marital rape is nothing new. Throughout the history of most societies, it has been acceptable for husbands to force their wives to have sex against their will.¹⁵ Nineteenth century US lawmakers cited Sir Matthew Hale's *History of the Pleas of the Crown* (1736) that stated, 'marriage constitutes a blanket consent to sexual intimacy which the woman may revoke only by dissolving the marital relationship.' While as early as the 1850s the women's rights' movement argued for women to be able to set the terms of marital intercourse, it was not until 1977 that the spousal exemption was challenged in a US court.¹⁶

Currently, it is illegal in all 50 states for one spouse to rape the other spouse. Some states, including, Texas, have gender-neutral laws which apply to both spouses. Although Texas was relatively late in doing away with marital exemptions for rape (1994), the state is currently one of only twenty states to completely abolish all marital exemptions.¹⁷ The majority of states still include additional legal burdens on wives in charging husbands with sexual assault. By statute in Texas, marital rape is treated identically to other sexual assaults. A victim can make charges in the same manner as with other sexual assault cases.

IMPACT OF MARITAL RAPE ON THE SURVIVOR

Women who are raped by someone with whom they share a life, home, and family can experience profound psychological injuries. They are not only violated sexually, but their intimate relationship has been betrayed as well. This is perhaps the most private and personalized form of betrayal they could imagine.

Survivors of marital rape generally experience the acute fear of being assaulted again and again, a deep-seated mistrust in their chosen life-partners, self-doubt regarding their responsibility in the assault, etc. They commonly will suffer from residual effects years after an assault, even when in new relationships, such as an inability to trust, aversion to sex or intimacy, intense and sometimes unspecific anger towards people in general. These symptoms are aggravated by the fact that most people still see marital rape as somehow being less serious than other rape, consequently they may receive limited support from others.

When providing crisis intervention or advocacy for victims of domestic violence, remember to ask questions that address the possibility of their sexual, as well as physical victimization. This frequently cannot be determined by bluntly asking, "Have you been raped by your husband?" If their personal belief system does not include the possibility of husbands raping their wives they will not answer

¹⁵ Bergen, R. & Barnhill, E. (2011). *Marital Rape: New Research and Directions*. National Online Resources Center on Violence Against Women. Available at: http://www.vawnet.org/applied-research-papers/print-document.php?doc_id=248

¹⁶ Hasday, J. (2000) *Contest and Consent: A legal history of marital rape*. 88 California Law Review. 1373. Available at: <http://scholarship.law.berkeley.edu/californialawreview/vol88/iss5/2/>

¹⁷ State Law Chart. National Clearinghouse on Marital & Date Rape. Updated May 2005. http://ncmdr.org/state_law_chart.html

affirmatively, regardless of the circumstances. It makes sense to be more specific and use less-charged language in your initial intake, such as. “Has your husband ever made you have sex when you didn’t want to?” or “Has your husband ever held you down to make you submit to sex?” or “Has your husband ever made you do something sexually that you clearly did not want to engage in?” This may give you a more accurate picture of the actual victimization she may be experiencing and prepare you for how to best assist or refer your client.

Survivors of marital rape need on-going and unconditional support from advocates (and ideally their friends and family). Remember, they may not self-identify as a rape victim/survivor. It is not important whether or not they accept this label. Do not try to change a survivor’s religious beliefs or value system to reflect the legal definition of sexual assault or to bring her in line with your way of thinking. Advocates must be willing to assist all survivors with their issues, as they see them. Offer non-judging support and resources to marital rape victims, even if they do not recognize the full extent of their victimization.

STRANGER RAPE

For most people, their mental image of sexual assault is “a violent and unprovoked attack by a stranger.”¹⁸ The unknown man jumping out from behind a bush or climbing in a window is what most of society has been programmed to envision when thinking about sexual assault. Yet, while these types of assaults are very serious crimes, they make up a minority of total sexual assaults.

One of the first comprehensive studies ever conducted on sexual assault, Rape In America, found that only 22 percent of perpetrators of sexual assault are strangers to the victims.¹⁹ The Texas Department of Public Safety (DPS) publishes yearly data based on sexual assaults reported to law enforcement and in 2014, DPS reported that approximately 10% of reported sexual assaults were committed by a stranger.²⁰ While the DPS data includes only sexual assaults reported to law enforcement, it is more typical for survivors who are raped by a stranger, as opposed to someone known to them, to call the police.

There is no set formula for rape by a stranger. It does not just happen to beautiful women, late at night, on deserted streets or in the woods. The unsettling reality of stranger rape is that it happens during the day and at night, to people from all different backgrounds, and in a variety of settings. What’s difficult about this reality is that it means that no one can protect herself from being raped. Although you can avoid potentially dangerous situations and can be trained in self-defense techniques, you cannot conduct your life so as to guarantee you will not be raped. Another misconception about stranger rape is that it is random, is perpetrated by “crazy” people, and is the result of uncontrollable sexual urges. In fact, interviews with convicted stranger rapists have

¹⁸ Archambault, J. & Lindsay, S. (2001). Responding to Non-Stranger Sexual Assault in *Solving Crime and Disorder Problems – Current Issues, Police Strategies and Organizational Tactics*, editors: by Reuland, M., Brito, C. & Carroll, L., published by Police Executive Research Forum.

¹⁹ D. G. Kilpatrick, C. N. Edmunds, and A. Seymour, Rape in America: A Report to the Nation (Arlington, VA: National Victim Center, 1992).

²⁰ The Texas Crime Report for 2014. Chapter 7, Sexual Assault. Available at: <https://www.txdps.state.tx.us/crimereports/14/citCh7.pdf>

taught us that most stranger rapes are planned. In some cases the rapist may have observed his victim for some time. In other cases, the rapist plans to be ready when an opportunity presents itself or lures victims to their home or other place they control. Most perpetrators of stranger rape are just like the people we see on the street every day. Many have stable jobs, many have families, and most have access to consensual sex.²¹ All of this evidence supports the analysis that rape is an act of power and control, not a biological need for sexual gratification.

Considerations for Counselors (excerpted from CALCASA's *Support for Survivors: Training for sexual assault counselors*.²²)

There are some specific issues that may arise for survivors of stranger rape. One such issue is a heightened sense of fear. If the rape happened in the survivor's home, they may be afraid of returning there or of being alone. If the assault occurred on the street, they may avoid the area where the rape happened or the survivor may be fearful of going out at all. The seeming randomness of the assault may cause some survivors to become distrustful of all strangers, particularly those that remind them of the assailant. As long the perpetrator is not caught, the survivor may remain in an acute stage of crisis, fearing that the rapist will return and assault again.

The survivor of stranger rape may also experience trauma and confusion because she compares her experience to the myths she has been taught about rape and how to avoid it. She may feel that she "should have known better." She might also torment herself with "what if" scenarios about different ways she could have avoided the attack. Additionally, because she does not know the perpetrator and because it is commonly assumed that rapists are more likely to be diseased, she might also have increased concern about pregnancy, AIDS, and other sexually transmitted diseases.



SYSTEMIC RAPE DURING ARMED CONFLICT

Rape as weapon of war or the prerogative of the victorious soldiers over a conquered people is not a new phenomenon. Indeed, when war atrocities occur, rape is usually among them. Examples of rape during war are too numerous to list, but include acts by individual soldiers as well as groups of soldiers acting in concert. Today, rape is a criminal act of war under the international war laws, yet it is still commonplace in areas of war and hostility.

Picture Available from:
<https://journals.lib.unb.ca/index.php/MCR/article/view/17665/22310>

²¹ Beauregard, E., Proulx, J., Rossmo, K., LeClerc, B., Allaire, J. (2007). *Script Analysis of the Hunting Process of Serial Sex Offenders*. *Criminal Justice and Behavior*, Vol. 34, No. , 1069-1084.

²² California Coalition Against Sexual Assault. (1999). *Support for Survivors: Training for sexual assault counselors*. http://www.calcasa.org/wp-content/uploads/files/CALCASA-1999_Support-for-Survivors.pdf pg 48

Historically, a primary purpose of rape in war is to humiliate enemy males by despoiling their valued property. Men who have failed to protect their property are considered to be humiliated and weak. Sexual violence can also be used as a means of inflicting terror on a particular community or people and driving people out of their homes. Rape during war may also be oriented particularly towards forced impregnation as a form of ethnic cleansing. This has been evident most recently in Bosnia where it has been estimated that anywhere between 20,000 – 50,000 mostly Muslim women were raped by Serbian forces.²³ While women are more typically the victims of rape, men are also victimized as a way to assert dominance and cement victory. Rape is a crime of domination and war has everything to do with domination.²⁴

Not surprisingly, 'in wartime, perpetrating sexual violence – at least against the 'enemy' – becomes a more socially acceptable feature of (militarized) masculinity.'²⁵ The social norms that might limit rape during peace time are weak or absent during an armed conflict. Rape, particularly gang rape, may also be used to promote group cohesion and loyalty among soldiers. Those who might not rape individually do rape collectively and bonds men together in complicity.

International Response

UN Declarations on the protection of women and children in emergencies and armed conflicts date back to 1974. In 1994, through the Declaration on the Elimination of Violence Against Women, the UN recognized that women in conflict situations were particularly vulnerable to violence. Yet while sympathy for the suffering of women raped during an armed conflict has been typically high, little support came to survivors and even less often were soldiers, their armies or leaders held accountable. As an international community, some of this changed in the early 1990s as a result of publicized accounts of sexual violence committed in the former Yugoslavia.

Towards the end of 1992, the world was stunned by reports of sexual atrocities committed during the armed conflict in the former Yugoslavia. Newspaper headlines decried: "Serbian'rape camps': Evil Upon Evil" and "Serben vergewaltigen auf obersten Befehl" (Serbs rape on highest orders). The media reported that rape and other sexual atrocities were a deliberate and systematic part of the Bosnian Serb campaign for victory in the war. A perception was generated that detention camps had been set up specifically for the purpose of raping women, and that the policy of rape had been planned at the highest levels of the Bosnian Serb military structure. Strong and persistent demands for a decisive response to these outrages came from around the globe.¹

The publicizing of these war crimes resulted in the International Criminal Tribunal for the former Yugoslavia recognizing sexual violence as a war crime and a crime against humanity. In 1996 as a part

²³ Ibid

²⁴ Goldstein, J. S. (2003). *War and Gender: How Gender Shapes the War System and Vice Versa*. Cambridge University Press

²⁵ MIRANDA ALISON (2007). Wartime sexual violence: women's human rights and questions of masculinity. *Review of International Studies*, 33, pp 75-90 doi:10.1017/S0260210507007310

of the Tribunal and for the first time at the international level, women provided testimony regarding wartime rape.

Other notable steps by the UN include the 1993 Declaration on the Elimination of Violence Against Women, the 1994 the appointment of a Special Rapporteur on violence against women and in 1995, during the Fourth World Conference on Women, the effects of armed conflict on women was identified as one of 12 critical areas of concern requiring action by governments and the international community.

Considerations for Counselors

Survivors of wartime rape are not only survivors of rape, but also survivors of war. They may have lost or missing family members, they may have witnessed or experienced atrocities besides rape, they may be parenting children who are also suffering and, if relocated to the US, managing the transition to a new country with very few resources. The sexual assault may or may not be their highest concern. Besides an understanding of the broad scope of trauma, great care should be given to understand the cultural traditions of the survivor which may prove to be more beneficial to them than Western based 'talk' therapy. For example, in a group of rape survivors from Sierra Leone, the use of symbolic cleaning rituals for spiritual pollution ("noro") and ceremonial gestures of reconciliation resulted in improvement of mental health status.²⁶ Coordination with other available support services, particularly for refugees, should be emphasized.

UNWANTED SEXUAL ADVANCES OR SEXUAL HARASSMENT, INCLUDING DEMANDING SEX IN RETURN FOR FAVORS

Sexual harassment is any deliberate or repeated sexual behavior that is unwelcome to its recipient, as well as other sex-related behaviors that are hostile, offensive, or degrading.

Victim advocates are hearing from an increasing number of clients who have a primary complaint of sexual harassment. This is not necessarily because the incidence of sexual harassment is skyrocketing but rather because survivors of harassment have only recently been acknowledged as being victims of sexual abuse.

Limited resources and limited personnel at rape crisis centers have often necessitated that sexual harassment be a very low priority. Victims of sexual harassment frequently did not know that support and services were available for them through their local rape crisis center. Consequently, they did not call hotlines or visit outreach offices. Sexual harassment was most often dealt with as a secondary complaint or when it had escalated into rape. As individuals become more aware of their rights they may also feel entitled to services to help them cope with their ordeal. Sexual assault advocates should have a working knowledge about the dynamics of sexual harassment and an adequate grasp of what resources and remedies are available to its victims.

²⁶ Stark L. (2006). Cleansing the wounds of war: An examination of traditional healing, psychosocial health and reintegration in Sierra Leone. *Intervention*, 4(3), 206-218.

THERE ARE BASICALLY TWO TYPES OF SEXUAL HARASSMENT:

Quid Pro Quo occurs when sexual favors are openly or implicitly suggested as a condition of employment (e.g. "Have sex with me or you are fired," "If you want that promotion you'll have to sleep with me," etc.)

Hostile Environment occurs when sexual conduct that is unwelcome and sufficiently severe and pervasive to create a hostile working environment or hostile educational environment. This could include: sexual jokes, lewd posters, leering, inappropriate touching, rape, etc. In schools at any level of education, the U.S. Department of Education has advised that a single instance of sexual assault against a student is enough to constitute a hostile environment. For less severe examples, patterns are important; a single crude remark or request for a date would not qualify. This type of sexual harassment comprises 95 percent of total cases.

HOW COMMON IS SEXUAL HARASSMENT?

Statistics vary, however, most women will experience sexual harassment at least once during their academic or professional careers. Only about 5 percent of sexually harassed women will make a formal complaint and about 2 percent will seek outside action. Although sexual harassment is more commonly experienced by women, some men are the targets of sexual harassment as well. Their harassers may be male or female and the same legal remedies are available to them. Sexual harassment is so prevalent that the impact in the workplace or school is tremendous. The negative consequences of sexual harassment to the employee and the employer are well-documented. A person who is sexually harassed is likely to experience:

- emotional & physical consequences
- poor concentration at work
- stress on their personal relationships
- fear or anxiety
- debilitating depression
- sleep or weight problems
- alcohol or drug abuse

The costs associated with sexual harassment may be high to the employer or school also. These costs may include:

- staff turnover
- increased absenteeism
- tarnished company reputation
- increased pay outs for sick leave & medical benefits
- vulnerability to hostile confrontations
- legal & consultant costs

- lower staff productivity
- poor staff morale
- less teamwork

THE LAW

There are several sections of federal law that pertain to sexual harassment: Title VII, Title IX, and the Campus SaVE Act. Title VII of the 1964 Civil Rights Acts prohibits discrimination on the basis of race, color, religion, or gender. In 1977, the Supreme Court affirmed that sexual harassment is a form of sexual discrimination and is thereby covered under The Civil Rights Act. Title IX refers to the Education Amendments added to the Civil Rights Act in 1972. This prohibited sex discrimination in public schools and colleges that receive money from the federal government. In 2013, Congress enacted the Campus SaVE Act, which expanded and clarified schools' requirements in responding to sexual harassment. In a nutshell, Title VII will pertain to workplace sexual harassment and Title IX covers sexual harassment in schools. Rape crisis centers should have a copy/summary of these laws available at their center. This will provide useful information such as filing deadlines, etc.

To stay in compliance with the law, employers have three primary obligations when an employee makes an allegation of sexual harassment:

- To fully inform the complainant of their rights
- To fully and effectively investigate the alleged incident(s)
- To promptly and effectively remedy the situation. The law requires more than a request to stop the conduct.

To comply with federal requirements, schools must ensure several requirements are met, including:

- Notify students of their rights to report sexual victimizations to law enforcement, to obtain protective orders, to have existing protective orders enforced on campus, and to contact local advocacy, counseling, health, mental health, and legal assistance services.
- Notify students who report victimization of options to change academic, living, working, and transportation situations if reasonably available.
- Honor any lawful protective order or no-contact order.
- Disclose the range of possible sanctions that may be imposed on a perpetrator.
- Detail the procedures victimized students should follow if a sexual offense occurs.
- Summarize the school's disciplinary procedures, including complainants' right to prompt and equitable proceedings and the right of both complainants and respondents to be notified in writing of the outcome of a proceeding within 1 day of the decision.
- Ensure disciplinary proceedings are conducted by personnel trained on sexual assault and intimate partner violence, and that the preponderance of the evidence standard is used in such proceedings.

SUGGESTIONS FOR HANDLING SEXUAL HARASSMENT

- If safe and practical, talk to the harasser. Tell that person, in plain language, that the behavior must stop. This may also be handled through a letter rather than a direct conversation.
- Keep a log with specific dates, times, locations, possible witnesses, etc.

- Talk to a supervisor, formally or informally. If your direct supervisor is the harasser, go to the next level of management.
- Contact the Personnel Office or Human Resources Department. Large employers, have departments that are likely to have staff prepared to deal with sexual harassment allegations.
- File a formal complaint. If the problem cannot be resolved at a lower level it may become necessary to file a formal complaint through an internal procedure or with an outside source.
- When the sexual assault survivor is also a student, the sexual assault often is both a crime and sexual harassment. That means the survivor may have multiple remedies that can be pursued at once.

FORCED MARRIAGE OR COHABITATION, INCLUDING THE MARRIAGE OF CHILDREN

What is a forced marriage?

A forced marriage lacks the consent of one or both parties, and typically involves one or more elements of force, fraud or coercion.²⁷ Some types of coercion are obvious and easy to identify, including the use of physical or sexual violence, or refusing to let somebody leave a particular place or location until they accept the marriage. Other types of coercion are less obvious because they involve psychological and emotional pressure.²⁸ These types of coercion can include emotional blackmail and abuse, isolation, making threats and manipulating fears of being rejected by family or community.²⁹

How is this different from an arranged marriage?³⁰

In many cultures, it is customary for families to arrange meetings between their children in the hopes of fostering a voluntary relationship that will lead to a marriage. In such situations, the ultimate decision regarding whether to marry remains with the couple. In contrast, in a forced marriage, an individual is threatened and/or coerced by her family to enter into the marriage against her will and may suffer honor violence if she resists or refuses the marriage.

Do forced marriages occur in the US?

According to a survey conducted by the Tahirih Justice Center, approximately 3,000 known or suspected forced marriages occurred in the US over a two-year period. Cases were reported among families from 56 different countries of origin (including India, Pakistan, Bangladesh, Yemen, the Philippines, Afghanistan, Somalia and Mexico) and a varied religious backgrounds (including Muslim, Christian, Hindu, Sikh, Buddhist and Jewish).³¹

²⁷ American Bar Association (Commission on Domestic and Sexual Violence). Report to the House of Delegates. Available here: <http://carrcenter.hks.harvard.edu/files/carrcenter/files/abareportonforcedmarriageaug2014.pdf?m=1413563686>

²⁸ Attorney General's Department, Australia.

<http://www.ag.gov.au/CrimeAndCorruption/HumanTrafficking/Pages/ForcedMarriage.aspx>

²⁹ National Survey on Forced Marriage Among Immigrant Communities in the United States. (2011). Tahirih Justice Center. Available here: <http://www.tahirih.org/site/wp-content/uploads/2011/09/REPORT-TahirihSurvey-on-Forced-Marriage-in-Immigrant-Communities-in-the-United-States-September-2011.pdf>

³⁰ Ayann Hirsi Ali Foundation. <http://www.theahafoundation.org/forced-marriage/>

³¹ Tahirih Just Center Study. See above.

What legal protections are in place for victims of forced marriage?

Texas does not have a specific statute that criminalizes forcing someone into a marriage. While existing laws can be used to protect victims, they are not widely used. For example, assault, kidnapping and false imprisonment may all be involved in forced marriage and are prosecutable offenses. Yet, forced marriage prosecutions under these criminal statutes is rare and complicated since these statutes were not designed to protect parents from forcing their own children into marriage.

Civil protective orders are another legal option and offer victims a path to safety that does not include criminal consequences for family members. Yet current protective orders for sexual assault, domestic violence or stalking victims may not be expansive enough to include all forced marriage victims. Minors may also have increased difficulty in accessing protective orders, particularly if their parents are the offenders.

DENIAL OF THE RIGHT TO USE CONTRACEPTION OR TO ADOPT OTHER MEASURES TO PROTECT AGAINST SEXUALLY TRANSMITTED DISEASES³² and FORCED ABORTION

Reproductive coercion describes behavior used to pressure or coerce a woman into becoming pregnant or into continuing or ending a pregnancy against her will, through the use of manipulation, intimidation, threats, and/or actual acts of violence.³³ The denial of the right to use contraception and forced abortion are both forms of reproductive coercion.

The most common forms of reproductive coercion include:³⁴

- Birth Control Sabotage. Birth control sabotage is active interference with a partner's contraceptive methods. Examples include:
 - hiding, withholding, or destroying a partner's birth control pills
 - breaking or poking holes in a condom on purpose or removing a condom during sex in an attempt to promote pregnancy
 - not withdrawing when that was the agreed upon method of contraception
 - removing vaginal rings, contraceptive patches, or intrauterine devices (IUDs)

³² Committee on Healthcare for Underserved Women. (2013). *Reproductive and Sexual Coercion*. American College of Obstetricians and Gynecologists. <http://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co554.pdf?dmc=1&ts=20150901T1405024146>

³³ National Coalition Against Domestic Violence. *Reproductive coercion: Quick facts for domestic violence workers*. <http://www.ncadv.org/files/Quick%20Facts%20for%20Domestic%20Violence%20Workers.pdf>

³⁴Chamberlain, L., Levenson, R. (2012). *Addressing intimate partner violence, reproductive and sexual coercion: a guide for obstetric, gynecologic and reproductive health care settings*. 2nd ed. Washington, DC: American College of Obstetricians and gynecologists; San Francisco (CA): Futures Without Violence. Available at: http://www.acog.org/About_ACOG/ACOG_Departments/Health_Care_for_Underserved_Women/~/-/media/Departments/Violence%20Against%20Women/Reproguidelines.pdf

- Pregnancy Pressure and Coercion. Pregnancy pressure involves behaviors intended to pressure a female to become pregnant. Pregnancy coercion involves behaviors intended to pressure a female to continue or terminate a pregnancy. Examples include:
 - Threatening to hurt a partner who does not become pregnant
 - Forcing a female partner to carry a pregnancy to term against her wishes
 - Forcing a female partner to terminate a pregnancy when she does not want to
 - Injuring a female partner in a way that may cause a miscarriage

Adolescent and adult males may also experience reproductive coercion including behaviors designed to limit a male's decision making around becoming a parent. Research on the impact of reproductive coercion on men is needed to understand the prevalence and inform interventions for men who experience reproductive coercion.

There is a strong link between partner violence and unintended pregnancy as reproductive coercion is one of many types of violence that may be inflicted by an abuser. Abused women may have a limited ability to enact regular contraceptive use, resulting in unintended pregnancies for the woman.³⁵ Similar to other forms of controlling behavior in abusive relationships, partners interfere with women's birth control as a means to control them.³⁶

Over one-third of abused women in one study also reported lack of reproductive control.³⁷ In another study, of 53 females aged 15 to 20 years, one quarter reported that their abusive male partners were trying to get them pregnant through manipulation of condom use and sabotaged birth control.³⁸ In a study of 1,278 females age 16-29 at family planning clinics, 19% reported experiencing pregnancy pressure and 15% reported birth control sabotage.³⁹

Not surprisingly, women who are being forced or coerced into unprotected sex are at an increased risk of sexually transmitted infections (STIs). Some abusers intentionally expose a partner to a sexually transmitted infection (STI), including human immunodeficiency virus (HIV), as a means of control and domination.

Considerations for Counselors

Consider asking if your client is pregnant or planning to become pregnant. If not, does she feel safe using birth control? Does she feel like her partner pressures her to become pregnant? If she is pregnant, how does she feel about the pregnancy? How does her partner feel about the pregnancy?

VIOLENT ACTS AGAINST THE SEXUAL INTEGRITY OF WOMEN, INCLUDING FEMALE GENITAL MUTILATION AND OBLIGATORY INSPECTIONS FOR VIRGINITY

³⁵Miller, E., Decker, M.R., McCauley, J.L., Tancredi, D.J., Levenson, R.R., Waldman, J., et al. (2010) *Pregnancy Coercion, Intimate Partner Violence and Unintended Pregnancy*. *Contraception*; 81: 316-22. Available here: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2896047/>

³⁶Chamberlain, L., Levenson, R. (2012). See above.

³⁷Miller, E., Decker, M.R., McCauley, J.L., Tancredi, D.J., Levenson, R.R., Waldman, J., et al. (2010). See Above.

³⁸Miller, E., Decker, M.R., Reed, E., Raj, A., Hathaway, J.E., Silverman, J.G. (2007) Male Partner Pregnancy-Promoting behaviors and Adolescent Partner Violence: Findings from a qualitative study with adolescent females. *Ambul Pediatr*, 7:360-6. Available here: <http://www.ncbi.nlm.nih.gov/pubmed/17870644>

³⁹Miller, E., Decker, M.R., McCauley, J.L., Tancredi, D.J., Levenson, R.R., Waldman, J., et al. See above.

Female Genital Mutilation⁴⁰ (Excerpted from World Health Organization – Female Genital Mutilation Fact sheet, 2016)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths.

More than 200 million girls and women alive today have been cut in 30 countries in Africa, the Middle East and Asia where FGM is concentrated. More than half of those affected live in Indonesia, Egypt and Ethiopia. In countries such as Somalia, Guinea, Djibouti and Sierra Leone, it is estimated that more than 90% of females aged 15-49 have undergone FGM.⁴¹

FGM is recognized internationally as a violation of the human rights of girls and women.

Female genital mutilation is classified into 4 major types.

- **Type 1:** Often referred to as **clitoridectomy**, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- **Type 2:** Often referred to as **excision**, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).
- **Type 3:** Often referred to as **infibulation**, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
- **Type 4:** This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

Deinfibulation refers to the practice of cutting open the sealed vaginal opening in a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth.

FGM has no health benefits, and it harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. Generally speaking, risks increase with increasing severity of the procedure.

Immediate complications can include:

- severe pain

⁴⁰ World Health Organization. (2014). *Female genital mutilation fact sheet*. <http://www.who.int/mediacentre/factsheets/fs241/en/>

⁴¹ http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf

- excessive bleeding (hemorrhage)
- genital tissue swelling
- fever
- infections e.g., tetanus
- urinary problems
- wound healing problems
- injury to surrounding genital tissue
- shock
- death.

Long-term consequences can include:

- urinary problems (painful urination, urinary tract infections);
- vaginal problems (discharge, itching, bacterial vaginosis and other infections);
- menstrual problems (painful menstruations, difficulty in passing menstrual blood, etc.);
- scar tissue and keloid;
- sexual problems (pain during intercourse, decreased satisfaction, etc.);
- increased risk of childbirth complications (difficult delivery, excessive bleeding, caesarean section, need to resuscitate the baby, etc.) and newborn deaths;
- need for later surgeries: for example, the FGM procedure that seals or narrows a vaginal opening (type 3) needs to be cut open later to allow for sexual intercourse and childbirth (deinfibulation). Sometimes genital tissue is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing both immediate and long-term risks;
- psychological problems (depression, anxiety, post-traumatic stress disorder, low self-esteem, etc.).

The reasons why female genital mutilations are performed vary from one region to another as well as over time, and include a mix of sociocultural factors within families and communities. The most commonly cited reasons are:

- Where FGM is a social convention (social norm), the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice. In some communities, FGM is almost universally performed and unquestioned.
- FGM is often considered a necessary part of raising a girl, and a way to prepare her for adulthood and marriage.
- FGM is often motivated by beliefs about what is considered acceptable sexual behavior. It aims to ensure premarital virginity and marital fidelity. FGM is in many communities believed to reduce a woman's libido and therefore believed to help her resist extramarital sexual acts. When a vaginal opening is covered or narrowed (type 3), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage extramarital sexual intercourse among women with this type of FGM.
- Where it is believed that being cut increases marriageability, FGM is more likely to be carried out.

- FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are clean and beautiful after removal of body parts that are considered unclean, unfeminine or male.
- Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support.
- Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination.
- Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice.
- In most societies, where FGM is practiced, it is considered a cultural tradition, which is often used as an argument for its continuation.
- In some societies, recent adoption of the practice is linked to copying the traditions of neighboring groups. Sometimes it has started as part of a wider religious or traditional revival movement.

Inspections for Virginity⁴² (Excerpts from Stop Violence Against Women, A project of The Advocates for Human Rights)

To varying degrees, the virginity of a girl or woman is still considered a virtue in communities throughout the world. Virginity testing, the examination of the genitals as a way to determine sexual chastity, remains popular in communities that place a high premium on virginity for social, economic, and religious reasons. The equation of virginity to purity elevates the value and credibility of those deemed virgins, but diminishes the value and credibility of women who are not virgins.

Virginity tests take various forms, but none are scientifically valid. They are based on a commonly held but inaccurate belief that all women and girls who are virgins have intact hymens that bleed on first intercourse. Yet the status of the hymen has no correlation with previous penetration or sexual contact; it does not enable a determination of whether penetration of the hymen or vagina by a penis or any other object has occurred.⁴³ The World Health Organization in 2014 concluded ‘that that the invasive and degrading “virginity test” or the “two-finger” test” - still used in some countries to “prove” whether a woman or girl is a virgin - has “no scientific validity.”⁴⁴ Published and peer-reviewed medical literature establishes that virginity examinations have no scientific value.⁴⁵ Because of both the abuses and the unreliability of these tests, Human Rights Watch Director, Liesl Gertholtz stated, ‘Health authorities worldwide should end the practice of ‘virginity testing’ in all cases and prohibit health care workers from perpetuating this discriminatory and degrading practice.

Although virginity tests have no scientific validity, their results may have adverse legal and social consequences including: loss of access to school, exclusion from marriage, employment discrimination, and prosecutions of consensual sex between adults outside of marriage. At times virginity tests are used to help determine a woman’s morality and credibility when accused of

⁴² Stop Violence Against Women. *Virginity tests*. The Advocates for Human Rights. http://www.stopvaw.org/harmful_practices_virginity_tests

⁴³ Independent Forensic Expert Group, International Rehabilitation Council for Torture Victims. Statement on Virginity Testing. 2015 Available here: <http://doc.rct.dk/doc/TORT2015.1.5.pdf>

⁴⁴ <https://www.hrw.org/news/2014/12/01/un-who-condemns-virginity-tests>

⁴⁵ Frank M, Bauer H, Arican N, Fincanci S, Iacopino V. Virginity examinations in Turkey: Role of forensic physicians in controlling female sexuality. JAMA 1999, Aug; Vol. 282(5); 485-90.

unrelated crimes such as robbery or assault. Girls who fail these unreliable tests may be ostracized, labeled prostitutes, fined, or beaten by their parents.

The statistics on how many girls and women are 'tested' is unclear. However, and for whatever reason virginity testing is practiced, it constitutes a clear violation of women's and girls' right to privacy and bodily integrity.

FORCED PROSTITUTION AND TRAFFICKING OF PERSONS FOR THE PURPOSE OF SEXUAL EXPLOITATION

Sex trafficking, along with labor trafficking, is a form of human trafficking (slavery) that exists throughout the United States and globally.

When a person is coerced, forced or deceived into prostitution, that person is a victim of sex trafficking.⁴⁶ Sex trafficking occurs in a range of venues including fake massage businesses, via online ads or escort services, in residential brothels, on the street or at truck stops, or at hotels and motels.⁴⁷ Labor trafficking has been reported in door-to-door sales crews, restaurants, construction work, carnivals, farms, factories, health and beauty services as well as private homes.⁴⁸ All persons who recruit, harbor, transport or obtain a person for forced labor or sexual exploitation are committing the crime of human trafficking.

Victims are not typically snatched from their homes and sold into slavery, more often they are lured into trafficking by false promises of high-paying or exciting jobs, education, travel opportunities or romance. By the time the victim understands the promises were lies, the traffickers exert such physical and/or psychological control, that the victim believes they have no choice but to remain. Isolated from friends and family, ashamed and embarrassed, frightened of physical violence against themselves or their family members, fearful of being deported or imprisoned, and without money, passports or identification, victims often feel they have no escape.⁴⁹

Note: While sex trafficking victims are obviously victims of sexual violence, it should not be overlooked that sexual assault **by the traffickers** themselves against victims of sex trafficking and labor trafficking occurs as a means of exerting power and control over another person.

Sex Trafficking in the U.S.

Like sexual violence, and perhaps even more so, sex trafficking is a hidden and underreported crime. Any counts of reports, investigations or prosecutions should be understood to represent only a small portion of the actual total.

Trafficking victims in the US include more than foreign born individuals brought to the US illegally. US citizens are also trafficked and primarily include women and children who have experienced poverty, homelessness and abuse.

⁴⁶ U.S. Department of State. What is Modern Slavery? Available at: <http://www.state.gov/j/tip/what/index.htm>

⁴⁷ Polaris Project. Sex Trafficking. Available at: <https://polarisproject.org/sex-trafficking>

⁴⁸ Polaris Project. Labor Trafficking. Available here: <https://polarisproject.org/labor-trafficking>

⁴⁹ US Department of Health and Human Services. Office on Trafficking in Persons. What is Human Trafficking? Available here: <http://www.acf.hhs.gov/programs/endtrafficking/trafficking>

- In 2015, the National Human Trafficking Resource Center hotline, operated by Polaris, received 21,947 calls identifying 4,136 reported cases of sex trafficking in the US. 1,731 of those calls were from Texas representing 337 cases of sex trafficking.⁵⁰
- In 2015, the National Center for Missing & Exploited Children estimated that 1 in 5 runaways reported to them were likely sex trafficking victims.⁵¹

Sex Trafficking in Texas

In 2003, Texas passed one of the first state statutes on human trafficking in the nation. Since then, the Governor's Office, Office of the Attorney General and Health and Human Service Commission's Office for Immigrant and Refugee Affairs have all been heavily involved in addressing human trafficking. Locally, several metropolitan areas have well-developed coalitions to address and respond to the crime.

Legal protections for victims of trafficking include the T-visa, a three-year visa which allows the victim to apply for permanent resident status at the end of the three-year term. If certified by the Office of Refugee Resettlement as a victim of human trafficking, victims are eligible for comprehensive services and benefits much like any refugee being resettled in the US. Because of the complex nature of these cases and the varied needs of human trafficking victims, it is typical that multiple organizations are required to meet the needs of the victim. Often the organization in the community that primarily serves clients with similar needs (immigration and refugee services, domestic violence or rape crisis center) will take the lead in coordinating services including housing, medical assistance, legal assistance, mental health services and advocacy.

Recognizing human trafficking can be difficult. Survivors are often hidden in plain view. The following is a list of red flags for human trafficking. Learning these red flags is a key step to finding victims and helping them find the assistance they need. If human trafficking is suspected, call the National Human Trafficking Resource Center hotline at 1-888-373-7888.

Red Flags for Human Trafficking⁵²

Common Work and Living Conditions: The individual(s) in question

- Is not free to leave or come and go as he/she wishes
- Is under 18 and is providing commercial sex acts
- Is in the commercial sex industry and has a pimp / manager
- Is unpaid, paid very little, or paid only through tips
- Works excessively long and/or unusual hours
- Is not allowed breaks or suffers under unusual restrictions at work
- Owes a large debt and is unable to pay it off
- Was recruited through false promises concerning the nature and conditions of his/her work

⁵⁰ Trafficking Resource Center. Hotline Statistics. Available here: <https://traffickingresourcecenter.org/states>

⁵¹ National Center for Missing & Exploited Children. Child Sex Trafficking. Available here: <http://www.missingkids.org/1in5>

⁵² Polaris Project. Available here: <https://polarisproject.org/recognize-signs>

- High security measures exist in the work and/or living locations (e.g. opaque windows, boarded up windows, bars on windows, barbed wire, security cameras, etc.)

Poor Mental Health or Abnormal Behavior

- Is fearful, anxious, depressed, submissive, tense, or nervous/paranoid
- Exhibits unusually fearful or anxious behavior after bringing up law enforcement
- Avoids eye contact

Poor Physical Health

- Lacks health care
- Appears malnourished
- Shows signs of physical and/or sexual abuse, physical restraint, confinement, or torture

Lack of Control

- Has few or no personal possessions
- Is not in control of his/her own money, no financial records, or bank account
- Is not in control of his/her own identification documents (ID or passport)
- Is not allowed or able to speak for themselves (a third party may insist on being present and/or translating)

Other

- Claims of just visiting and inability to clarify where he/she is staying/address
- Lack of knowledge of whereabouts and/or do not know what city he/she is in
- Loss of sense of time
- Has numerous inconsistencies in his/her story

Considerations for Counselors

It is important to remember that survivors of human trafficking may not seek out or be directed to a rape crisis center if they've not been identified as having experienced sex trafficking, yet sexual violence may indeed have been a component of their abuse and exploitation. Educating community partners regarding this aspect of trafficking may be important to ensure survivors are able to access all pertinent services.

When a survivor of human trafficking does present at your agency, be aware that they may suffer from the effects of traumatic experiences, chronic substance abuse or physical and psychological attacks. Because of these injuries, it may be difficult to develop a strong working relationship. Minimization, denial and memory loss, which are symptoms of psychological trauma, may all be present. Identification and assistance with the survivors' self-reported most urgent needs should be prioritized.

STALKING

Stalking occurs when a person intentionally and knowingly engages in a behavior that is directed towards another person that would cause a reasonable individual to fear for his/her safety or the

safety of their immediate family. This could include: maintaining close visual or physical contact (e.g., following, spying, watching, etc.) or making overt or implied verbal or written threats to a person on at least two occasions (e.g., phone calls, letters, messages, e-mail, etc.).

Our best current estimates reflect that approximately 200,000 Americans are stalked at this time. One in twenty women will become stalking targets and about one in seventy-six men will as well. At least 80 percent of stalkers are men, primarily stalking women. Most are young to middle-aged, with above average intelligence. Almost three quarters of stalking victims are female; one quarter are males. An overwhelming majority of male stalking victims are being stalked by males.

There are two broad categories of stalkers. The most common type is the Simple Obsession Stalker. This stalker has had some kind of prior personal relationship with the victim. This accounts for about 75 percent to 80 percent of all stalkers. In summary, this is a person who cannot let go. The other type is the Love Obsession Stalker. There was no previous relationship between the victim and the stalker, except perhaps in the stalker's mind. This stalker has delusional thought patterns. He is inclined to live out his fantasies when the victim does not follow the script.

There are some common characteristics shared by many stalkers. These personality traits can be seen as warning signs of potential danger:

- Jealous in nature
- Obsessive and compulsive
- Falls in love at first sight
- Extremely manipulative
- Very self-centered or arrogant
- Not responsible for own actions or feelings
- Controlling
- Socially inadequate or awkward
- Feels he/she is always the victim of others
- Sneaky
- Will not take no for an answer
- Violent mood swings, especially between love & hate
- Often of above average intelligence
- Tremendous sense of entitlement
- Does not cope well with rejection
- Confuses their fantasies with the reality of the situation

Many stalkers are former intimate partners or casual dates of the victim and the threat of physical or sexual violence is often implied or clearly stated. For this reason, rape crisis centers and domestic violence shelters will often be called by stalking victims searching for assistance. Advocates will be most effective if they stay current on the anti-stalking laws and can adequately provide information to victims who are experiencing this unique brand of terrorism.

ANTI-STALKING LAW IN TEXAS

In March 1993, Texas' first anti-stalking law was passed. Unfortunately, the language of this law was later deemed unconstitutionally vague by higher courts. The very first bill signed into law during the following legislative session was a stricter version of the same anti-stalking legislation. The new anti-stalking law (Penal Code 42.072) became effective on January 28, 1997. Since the anti-stalking law of 1997, stalking has been incorporated into several areas of Texas law to provide further protections for victims of stalking. Stalking survivors are able to receive protective orders, utilize a pseudonym form to protect their identity in court documents, utilize the address confidentiality program and access crime victims' compensation to cover needed moving expenses. See Chapter 3 for more details on these and other legal remedies.

This law forbids the following actions by the stalker or other(s) who act on his/her behalf:

- On more than one occasion and pursuant to the same scheme or course of conduct directed at a specific person, following; placing a person under surveillance; making threats; restraining; confining; or engaging in behavior or threats that the actor knows or reasonably should know will cause the victim or member of the victim's family or household to fear bodily injury, death, or damage to his/her property.
- The first stalking conviction is a Class A misdemeanor, with a maximum penalty of one year in jail and a \$4000 fine. Any subsequent convictions are third degree felonies and can carry a penalty of up to a 10-year prison term and a \$10,000 fine.
- Stalking can be difficult to prove. The advocate can provide valuable information on developing safety plans for potential stalking victims, as well as helping a stalking victim build a prosecutable case. One method for building a stalking case is to keep a journal of stalking incidents, including dates, locations and witnesses.

CIVIL REMEDIES FOR STALKING VICTIMS

Texas law allows for a variety of civil legal remedies for stalking victims. These include applying for a protective order, terminating a lease, applying for the Address Confidentiality Program through the OAG, utilizing a pseudonym in court documents as well as having some moving expenses reimbursed through crime victims' compensation. For more information on these remedies see Ch. 3 System Response.

SAFETY PLAN FOR STALKING VICTIMS

Early intervention is always best, as waiting tends to intensify the obsession. There are certain pre-stalking behaviors that generally signal that there may be trouble ahead. At the first sign of discomfort, the potential stalking victim could try to clearly communicate his/her desire to sever all ties with the other person. When attempting to cut off all contact she may state directly what behaviors she has seen, how it makes her feel, and that she does not want to continue any type of relationship. This can be done in a non-accusatory fashion, firmly but with plenty of "I" statements.

On occasion, despite the clearest message of non-interest, a person will attempt to continue (or develop) a relationship with a disinterested party. This situation can run the gamut from annoying to extremely dangerous. The advocate should never try to minimize the potential risks for the victim. What may seem harmless or inconsequential at first glance may actually become very explosive in a

short span of time. Stalking victims should be encouraged to take the utmost caution concerning their personal safety.

Stalking victims can be offered detailed suggestions on residential, office and school security. This is true for measures concerning safety in their vehicles and other personal security information. A stalking victim may need to be extra sensitive suspicious to potential personal information getting in the wrong hands. Many police departments can offer safety plans to individuals who feel threatened in this manner. Additionally, there are websites that specifically cater to potential stalking victims and offer information and support in this area. Some stalking victims can benefit from protective orders. Fear of the criminal justice system will stop 20 percent to 30 percent of all stalkers. Other victims are in such grave danger that they resort to permanent relocation. There is detailed information available as to the most effective means of accomplishing this feat.

BUILDING A PROSECUTABLE CASE

There are ways that a victim can improve her/his chance of a prosecutable case of stalking. It generally involves meticulous documentation. This thorough paper-trail will assist law enforcement in presenting a solid case for possible prosecution. The following steps are concrete ways a victim can strengthen a case against a stalker:

- Have a thorough understanding of her state's anti-stalking law.
- Keep detailed records of all encounters.
- Keep a personal copy of all applicable police reports.
- Make sure all law enforcement jurisdictions in her area have copies of the reports.
- Report every incident, every time.
- Request that all police reports make reference to her prior reports.
- Keep all potential evidence, no matter how seemingly insignificant.
- Stay in constant contact with the detectives assigned to your case.
- Save all forms of communication.
- Use Caller ID or Call Trace (if available in your area).
- Ask anyone who has had contact with the stalker to provide documentation as well.
- Obtain a Protective Order.
- Videotape the stalker in the act (if safe to do so).
- Contact a victim's advocate group for support & assistance.

Stalking is a very dangerous and damaging type of victimization. It can leave the victim feeling extremely vulnerable and fearful, even without overt threats to her personal safety. It is best to treat all incidences of stalking seriously, regardless of how mundane the situation may seem in the beginning. Like other types of intimate violence, it has a tendency to escalate in frequency and severity.

SEXUAL EXPLOITATION BY HELPING PROFESSIONALS

Since the early 1970s, numerous studies in the U.S. have documented the prevalence of sexual contact between a variety of helping professionals and their clients/patients. An early study of physicians (psychiatrists, obstetrician/gynecologists, surgeons, internists, and general practitioners), showed 13 percent of those surveyed stated they had engaged in some form of erotic behavior with patients, which ranged from kissing to sexual intercourse (Sheldon H. Kardener, Marielle Fuller & Ivan N. Mensh, *A Survey of Physicians' Attitudes & Practices Regarding Erotic and Non-erotic Contact with Patients*, 130 Am. J. Psychiatry 1077 (1973)). Subsequent studies focused specifically on the sexual involvement of psychologists, psychotherapists, or other health care providers with their patients. In one survey of practicing therapists 70 percent reported they were aware of at least one patient who had been sexually involved with a previous therapist. Studies consistently report as many as 90 percent of patients who have had some sexual contact with a health care provider or other helping professional suffer some kind of damage, including sexual dysfunction, anxiety disorders, depression, increased risk of suicide, internalized feelings of guilt, shame, anger, confusion, worthlessness, and loss of trust. (Nanette Gartrell et al., *Psychiatrist-Patient Sexual Contact: Results of a Nat'l Survey, I. Prevalence*, 143, Am J. Psychiatry 1126 (1986); Kenneth Pope, *Therapist-Patient Sex Syndrome: A Guide for Attorneys*, in *Sexual Exploitation In Professional Relationships*, 45 (Glen O. Garbbard ed. 1989).



In spite of the prevalence of sexual exploitation of clients by professional helpers, the incidence of reporting such abuse is low, variously estimated at 4 to 8 percent of actual incidents. (Nanette Gartrell et al., *Reporting Practices of Psychiatrists Who Knew of Sexual Misconduct by Colleagues*, 57 Am. J. Orthopsychiatry, 287-293 (1987)). One reason for the low reporting rate is that clients often take several years to recognize the harm done to them. To address the specific needs of sexually exploited patients, some states have begun to extend the statute of limitations beyond those applicable in usual malpractice cases.

Sexual contact of any kind between a helping professional and a client/patient is universally regarded as unethical and, in every licensed profession, can be grounds for malpractice and possible loss of licensure. With increasing frequency, states are enacting legislation specifically targeted at the professional/client-patient relationship. In some states, sexual contact between a client and a helping professional is a criminal offense. Even in states where it is not a criminal offense, sexual exploitation of a client by any professional – physician, attorney, clergy, chiropractor, dentist or others – may constitute grounds for a lawsuit. In states where sexual contact with a patient is a felony offense, all but one (Maine) say that consent from the patient is not a legal defense.

Sexual exploitation of the professional-client relationship is so heinous because the relationship has a special characteristic: the professional has the duty of care, meaning that the professional's role is to protect the interests of that patient and to avoid doing anything that would harm the client or benefit the professional at the client's expense. The helping professional is, by definition, in a position of greater power and authority. Many professions consider their members to have a "fiduciary" relationship with clients and patients. Originating in estate law, the definition of "fiduciary" has extended to include any relationship in which one party places trust and confidence in the other,

more powerful party. The more powerful party is said to have “fiduciary duty” toward the less powerful party; therefore, any exploitation of a client is unethical, not only because it harms the client, but also because the professional is deemed to have violated his/her fiduciary duty.

Although exploitation can occur in any professional–client relationship, the relationship between client and therapist is perhaps the most susceptible because of the relationship's special characteristics. The client or patient is vulnerable and trusts the therapist to help her/him feel better. The therapeutic relationship is particularly intimate because the therapist hears the client's most private thoughts, feelings, and experiences. This intimacy lends itself to sexual acting out. According to the American Psychiatric Association, “The necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control.” (American Psychiatric Association, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, section 2.1, p.7A –17A (1985).

Additionally, the issue of transference can sometimes help to sexualize the therapy. Transference refers to the way in which clients transfer positive and negative feelings about others in their lives to the therapist. Transference occurs in all therapeutic relationships and is a necessary occurrence. The patient's positive transference enables a therapist to help the patient. However, difficulties arise when the therapist is unable to recognize the transference for what it is and counter-transfers his/her own feelings back to the client in a sexual manner.

A Minnesota court aptly described the situation:

- *The therapist must encourage the patient to express her transferred feelings, while rejecting her erotic advances; at the same time, he must explain to the patient that her feelings are not really for him, but that she is using him in a symbolic role to react to some other significant person in her life. In short, the therapist must both encourage transference and discourage certain aspects of it. This may be difficult to do and presents an occupational risk. The therapeutic alliance in this situation gives rise to a duty, imposed by professional standards of care as well as ethical standards of behavior, to refrain from a personal relationship with the patient, whether during or outside therapy sessions. This is because the personal relationship infects the therapy treatment, rendering it ineffective and even harmful (St. Paul Fire and Marine Ins. Co. v. Love, 459 N.W. 2nd 698, 701 Minn. 1990).*

Exploited patients tend to have three common characteristics. They frequently are vulnerable, female, and much younger than the therapist (Gary R. Schoener et al., *Psychotherapists' Sexual Involvement with Clients: Intervention and Prevention* (1989). The profile of therapists who sexually exploit include psychopathic repeat offenders, those in the midst of their own marital or mid-life difficulties, and those who feel lonely and vulnerable and gradually become more involved with a particular patient, first through minor non-sexual boundary violations and eventually through sexual contact (*Sexual Exploitation in Professional Relationships*, p. 83-87, Glen O. Gabbard, ed., 1989).

Sexually exploited clients have remedies in three categories: licensing board complaints, civil lawsuits, and criminal complaints.

Licensing standards vary considerably among states and professions. The most severe penalty is the loss of a license to practice, which does not necessarily mean the therapist can never practice again. The licensing authority is responsible for proving the case (Licensing Board vs. Therapist).

In *civil lawsuits*, the client must hire his/her own attorney and sue the therapist directly (Client vs. Therapist). The burden of proof is on the client. The applicable standard of proof is the preponderance of the evidence. The best outcome the client can hope for the court to order the therapist to pay the client a monetary award.

In *criminal proceedings*, the client does not bring the suit and does not have to hire an attorney; the state prosecutes (State vs. Therapist). The burden of proof is “proof beyond a reasonable doubt.” The best outcome for the client would be a criminal sanction (fines, probation, incarceration, or all of these) against the therapist.

With the victim of abuse by a therapist (or other helping professional), the advocate has the same role as with any other client, with the additional caveat that it is important to understand the special dynamics inherent in this kind of professional-client relationship and the potential ramifications of the betrayal for the victim.

PREVALENCE – SEXUAL ASSAULT STATISTICS

Determining the actual number of sexual assaults that occur is a challenge. Differing definitions of sexual assault and different measurement techniques result in different estimates. That said, with an understanding of definitions and research methods, it is possible to gain a reasonably good understanding of the pervasiveness of sexual assault. The prevalence of sexual assault has been estimated through several national surveys.

National

In 2011, the Center for Disease Control released a report detailing the findings of a large, methodologically rigorous research study on the prevalence and consequences of sexual assault, stalking, and intimate partner violence called the National Intimate Partner and Sexual Violence Survey (NIPSVS).⁵³

The study found:

- A lifetime sexual assault prevalence rate of 18.3% of women and 1.4% of men, meaning that almost 1 in 5 women and 1 in 71 men experiences rape in the span of their lifetime.
- 44.6% of women and 22.2% of men have experienced sexual violence other than rape in their lifetime (including being made to penetrate someone, sexual coercion, unwanted sexual contact, and unwanted non-contact sexual experiences).
- Most rapes are committed by intimate partners (51.1% for women), acquaintances (40.8% for women, 52.4% for men).

⁵³ Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., . . . Stevens, M. R. (2011). The national intimate partner and sexual violence survey: 2010 summary report. Atlanta, GA: National Center for

- 79.6% of female victims of rape experienced their first rape before age 25, 42.2% before the age of 18.
- 27.8% of male victims experienced their first rape by the age of 10.
- An estimated 1.3 million women were raped in the 12 months prior to the survey.

This research echoes the results of previous research which indicated that:

- About 20 million of 112 million women (18.0%) in the United States have been raped during their lifetime.⁵⁴

In order to understand the various statistics you might encounter, it's important to understand the major surveys that measure the prevalence of sexual violence.

The **National Crime Victimization Survey** (NCVS) is an annual, nationally representative survey administered to approximately 90,000 households, comprising nearly 160,000 persons in the US. Participants are individuals in the selected households, age 12 years old and older. Interviews are conducted every six months over a course of three years. During the interviews, individuals are asked about crime victimization that occurred to them since the last interview. This type of survey technique (asking people about victimization that occurred to them since they were last interviewed), results in a high level of reporting accuracy. According to this NCVS, in 2014 there were 284,350 rapes/sexual assaults, 34% of which were reported to police.⁵⁵

How you ask makes a difference.

The NIPSVS and the NCVS have very different estimates of sexual violence prevalence, 1.3 million/year vs ~300,000/year. Why? Because the two surveys ask about sexual violence in two different ways.

The NIPSVS uses behaviorally based questions. For example, the NIPSVS asks, 'Has someone ever used physical force or threats to physically harm you to make you have vaginal sex?' On the other hand, the NCVS asks participants more directly, 'Have you been forced or coerced to engage in unwanted sexual activity?'

The difference in the way these two questions ask about sexual assault leads to different types of response by participants. While the NCVS has been criticized over the wording choice of questions, they have been reluctant to change them as they have been asking these same questions for a number of years, producing informative trend data.

⁵⁴ Kilpatrick, Dean G., Ph.D., Heidi S. Resnick, Ph.D., Kenneth J. Ruggiero, Ph.D., Lauren M. Conoscenti, M.A., and Jenna McCauley, M.S., "Drug-Facilitated, Incapacitated, and Forcible Rape: A National Study," July 2007. (<https://www.ncjrs.gov/pdffiles1/nij/grants/219181.pdf>) (December 21, 2011)

⁵⁵ Truman, Jennifer L., Langton, Lynn . Aug 2015. Criminal Victimization, 2014. BJS Bulletin. NCJ 248973, Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics <http://www.bjs.gov/content/pub/pdf/cv14.pdf>

The **Uniform Crime Report (UCR)**, published each year by the Federal Bureau of Investigation, produces a fundamentally different type of number. Instead of estimating the number of total offenses based on a survey sample, the Uniform Crime Report is the number of actual reports made by crime victims to law enforcement in the U.S. In 2014, there were 84,041 rapes (legacy definition)/116,645 rapes (revised definition) reported to law enforcement.⁵⁶

Definitions are changing.

In 2013, the FBI changed the 80-year old definition of rape it was using in the UCR to be gender neutral, to include a wider variety of unwanted sexual acts, and to remove the word "forcible."

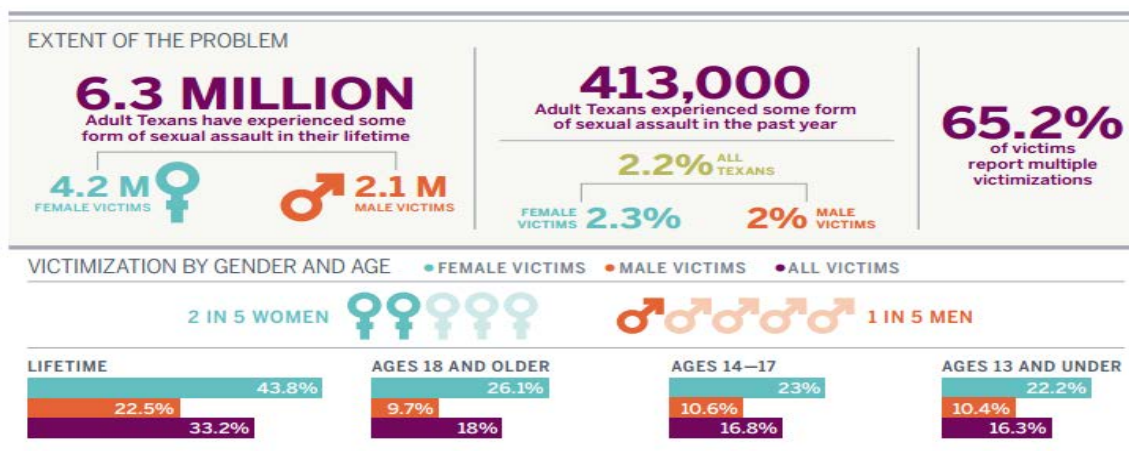
UCR legacy (old) UCR definition of rape: The carnal knowledge of a female forcibly and against her will.

UCR revised (current) definition of rape: Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

Texas⁵⁷

The Institute on Domestic Violence and Sexual Assault at UT-Austin conducted a prevalence study in 2015 called *Health and Well-Being: Texas Statewide Sexual Assault Prevalence*. This study included a representative sample of 1,203 adult Texans. Participants were chosen randomly from landline (60%) and mobile phone (40%) numbers. Telephone interviewers collected data using closed ended questions with a specific survey protocol. The study found:

- 6.3 million (4.2 million women and 2.1 million men) or 33.2% of adult Texans have experience some form of sexual assault in their lifetime.
- 413,000 (2.3% women and 2% men) or 2.2% of adult Texans experienced sexual assault in the year prior to the survey.
- 65.2% of victims reported multiple victimizations.
- Sexual assault affects all **genders**; however, women (2 in 5) are twice as likely to be sexually assaulted as men (1 in 5) in their lifetime.
- Women are more likely to experience sexual assault when they are 18 or older (26.1%), and men when they are ages 14 to 15 (10.6%).



⁵⁶ Crime in the U.S. 2014 <https://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2014/crime-in-the-u.s.-2014/tables/table-1>

⁵⁷ Busch-Armendariz, N.B., Olaya, D., Kerwick, M., Wachter, K. & Sulley C. (2015). Health and well-being: Texas statewide sexual assault prevalence. The University of Texas at Austin, Institute on Domestic Violence & Sexual Assault: Austin, Texas. Available at: <http://rapecrisis.com/wp-content/uploads/2015/09/TX-SA-Prevalence-Study-Final-Report-4-2015.pdf>

The Department of Public Safety publishes a Chapter on Sexual Assault each year in their *Crime in Texas*⁵⁸ report. This report is based on the number of reports to law enforcement of six different types of sexually violent offenses (Continuous Sexual Abuse of Young Child or Children, Indecency with a Child by Contact, Indecency with a Child by Exposure, Sexual Assault, Aggravated Sexual Assault, Sexual Performance by a Child). The report states:

- In 2014, there were 18,756 reported sexually violent incidents in Texas, a 5.1% change from 2013.
- 87% of victims were female, 13% were male.
- The majority of victims were 10-14 years old or 15-19 years old.

Sexual Assault Realities

Here are some of the realities about sexual assault. Understanding them will increase your ability to provide effective assistance to survivors and their families.

THE REALITIES	
Rape is not about sex. It is sexualized violence.	The major motive for sexual assault is power—to overpower and control another person. It is false that people who commit sexual assault do not have any other outlet for their sexual needs.
Someone's actions or dress cannot send a message "asking" for sexual assault.	The survivor's demeanor or apparel at the time of an assault is irrelevant. No one asks or wants to be attacked where they risk injury, sexually transmitted infections or pregnancy.
Rapists live, undetected, in our neighborhoods and communities.	If the accused appears and acts normal, it is very hard to believe he/she could have committed the crime. Our cultural is inclined to believe that only sick or insane people are sex offenders and that obtaining sex is the primary motive for sexual assault. Believing this may cause us to expect the offender to be somehow different or noticeable, which is not the case.

⁵⁸ Crime in Texas. Texas Department of Public Safety. Available at: http://www.txdps.state.tx.us/administration/crime_records/pages/crimestatistics.htm

<p>People are most often assaulted by someone they know and often trust.</p>	<p>Sexual assault by a stranger is not the norm. Around 50% of female survivors and 60% of male survivors are assaulted by an acquaintance or friend. Around 50% of female survivors and 30% of male survivors are assaulted by an intimate partner or family member.⁵⁹</p>
<p>Banning pornographic material will not stop sexual assault.</p>	<p>During the 80s and 90s, campaigns to limit or ban pornography included arguments that pornography, especially violent pornography, was linked to sexual assault. However, since then, correlational and experimental studies have been unable to consistently identify a relationship between pornography and sexual aggression. While it may be impossible to definitively draw a connection between pornography and sexual violence, it's clear that some pornography does objectify women, create a sexist, unrealistic standard for sexual encounters, and shows men committing violent acts against women; all of which support the rape culture that we currently live in. It is possible for pornography to bypass misogynistic storylines and depict more honest sex.</p>
<p>Women nor men secretly want to be sexually 'taken.'</p>	<p>Fiction, fantasy writing and TV dramas promote this idea. There is a big difference between fiction and real life. Even in a fantasy, the person fantasizing is in control; in a sexual assault, the survivor is not in control and fears being injured or killed.</p>
<p>Unfortunately, everyone is at risk of sexual assault.</p>	<p>Anyone may be sexually assaulted. Victims include infants, seniors, men, women, people of color, lesbians/gays/bisexual/trans/queer, people with disabilities and persons from every racial, ethnic, religious, economic and social background. In fact, many of these groups are at higher risk of sexual assault as they are more vulnerable due to their dependence on others for their basic needs or are targeted because they are different than the white, heterosexual norm.</p>

⁵⁹ Busch-Armendariz, N.B., Olaya, D., Kerwick, M., Wachter, K. & Sulley C. (2015). Health and well-being: Texas statewide sexual assault prevalence. The University of Texas at Austin, Institute on Domestic Violence & Sexual Assault: Austin, Texas. Available at: <http://rapecrisis.com/wp-content/uploads/2015/09/TX-SA-Prevalence-Study-Final-Report-4-2015.pdf> pg 20

It is OK for a person to say 'no' to sex, even if they have previously given consent or even during the middle of a sexual encounter.

If you wanted to take a friend's car for a drive, but then they change their mind, you should stop and give the keys back. That's true even if you have driven the car before and even if you were in the driver's seat with the engine on. When a person says, 'stop' then another person should stop.

GENDER SOCIALIZATION

Gender socialization is the process by which individuals incorporate the expectations, behaviors, attitudes and values that are culturally assigned according to one's gender into their own self-concept.

Socialization is a core component of our identity and behavior patterns. Socialization strongly influences a person's gender identity in society. Someone born female traditionally learns how to "act like a girl," and a male learns to "act like a man." Eventually, they internalize these teachings. They accept the behaviors, attitudes, and values of the culture as their own. Here are some troublesome attitudes widely held in modern society.

WHAT BOYS LEARN

- ♂ Boys may learn to view sexual activity as an end in itself, and a "relationship" as a means to that end.
- ♂ Boys tend to focus on the completion of sexual actions as opposed to the respectful process involved in consensual sexual intercourse or interplay.
- ♂ Boys learn a concept of ownership of females or "male sexual access rights" (Mahoney, 1980) that make them think they have a right to demand sexual "favors" from a girl.
- ♂ Boys learn it is their responsibility to verbally and/or nonverbally initiate every interaction with girls, from asking them for dates to any affectionate touching or sexual activity.
- ♂ Boys learn to see girls as "sexual objects," to be commented upon, discussed, and touched.

WHAT GIRLS LEARN

- ♀ Girls learn it is important to have a boyfriend.
- ♀ While girls learn a relationship entails more than just sexual interaction, they also learn that boys are probably more interested in sex than they are. So, some girls learn that by submitting easily they can trade sex for a relationship.
- ♀ Girls learn that boys may get angry if they do not get their way. Girls also learn that because of their anger, boys might end the relationship, circulate rumors about them, or hurt them physically.

To help prevent sexual assault, it is important to change, as much as possible, these causal patterns and values.

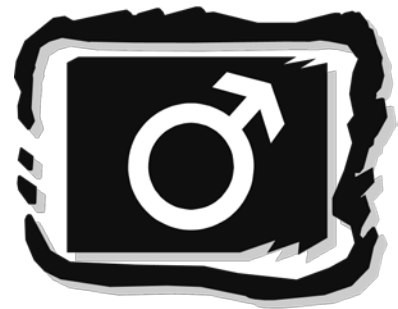
MALE SEXUAL ACCESS RIGHTS

It is "all right if a male holds down a female and physically forces her to engage in intercourse" under some conditions, according to some respondents in a study E.R. Mahoney at Western Washington University, during the winter of 1979-80. Mahoney discussed these results in terms of "male sexual access rights."

He said that many in our society believe men "have sexual access rights to females under varying conditions." This belief, he hypothesized, is supported by social conditioning and learning. Note that generalizations about male and female social conditions will not hold true for the entire population.

The concept of male sexual access rights simply reflects two things.

First, it reflects "normal" male sexual socialization, male sexual gender role learning—that is, how men learn to be males. And second, it shows that sexual assault is nothing more than those components of learning carried to varying extreme degrees. In other words, males learn they need sex, should seek sex, and are supposed to be the initiators. They learn that a good male is aggressive in many areas of life. Males learn that physical violence and physical force are acceptable forms of expression for them. Males learn that if they want something, whether it is a job, a promotion, or sex, they can get it one way or another. The point is to get it. They strive, they fight and they dig, whether working in a major corporation or a sexual relationship.



In relatively normal sex-role socialization, the three components of power, anger, and sexuality simply occupy various locations on a continuum. Power, anger and rape are simply parts of the traditional male role, taken to the extreme.

Males in this society learn they have the right to sexual access to females under certain conditions. For example, it is widely known that males can purchase sexual access through prostitutes and the commercial sex industry. This concept has been transformed into the idea of "noncommercial sex:" He spends a lot of money on her and then expects to be compensated with sex.

Four conditions are too often accepted as automatically granting males sexual access. The first is sexual arousal. In other words, males (and evidently numerous females) believe that if the male is sexually aroused, he is then granted the right to complete the arousal through sexual activity...even if that activity is forced. If he is "turned on and can't stop," if she has "led him on," or if she "gets him sexually excited," a fairly high percentage of the respondents believed it is okay for him to have forcible sex with her.

The second condition that seems to mandate sexual access rights is the woman's previous sexual activity. In studies of attribution of responsibility to rape survivors, it is very clear that if by occupation, innuendo, or behavior, the survivor has granted any kind of access rights, then she is perceived to

have granted all sexual access rights. Therefore, if a topless dancer becomes a rape survivor, the chances of her succeeding in any legal action are very slim.

The third condition exists if the woman is stoned or drunk. If she has given up her responsibility for the situation by losing control, she also gives up her right to refuse intercourse or to be selective about her role as sexual "gatekeeper" in this society.

The fourth condition exists if the woman grants a male any sexual access rights whatsoever. For example, if she lets him touch her above the waist, 36 percent of men and 12 percent of women responded that he is not in the wrong if he then forces her to have sex. If she granted him some access, she granted him all access.

One important idea in all of these cases is the concept of property, specifically the idea of women as sexual property. This idea has a long tradition throughout history and is one reason why it has been so difficult to convince people marital rape is even possible. In the study, 42 percent of males and 16 percent of females approved of sexual intercourse in long-term dating relationships. The farther the relationship moves from marriage, the less automatic is the sanctioning of sexual access rights. For example, if the couple is separated, the numbers drop to 21 percent and 5 percent, respectively; if divorced, 6 percent and zero.

Addressing the Real Problem

One of the ways prevention programs can be more effective is to sensitize people to the kinds of socialization discussed here. For example, some men's magazines, including some considered respectable, devote significant time to the idea that male sexual access to females is normal and expected. This attitude is such an integral part of our society that it is seen as humorous. Sensitization will help by changing the definition of relationships between men and women. Men and women need to understand that no human being is property to be possessed or used by another.

MALE SEXUAL ACCESS RIGHTS

It is sexual assault for a male to hold down a female and physically force her to engage in sexual intercourse under any condition(s).

- ♂ He spends a lot of money on her = No sexual access rights
- ♂ He is so turned on he (allegedly) cannot stop = No sexual access rights
- ♂ She has had sexual intercourse with others = No sexual access rights
- ♂ She is stoned or drunk = No sexual access rights
- ♂ She let him touch her above the waist = No sexual access rights
- ♂ She is going to have sex with him and then changes her mind = No sexual access rights

- ♫ They have dated for a long time = No sexual access rights
- ♫ She has led him on = No sexual access rights
- ♫ She gets him sexually excited = No sexual access rights
- ♫ She has had intercourse with him before = No sexual access rights
- ♫ They are married to each other = No sexual access rights
- ♫ They are separated from each other = No sexual access rights
- ♫ They are divorced from each other = No sexual access rights

SUBSTANCE-FACILITATED SEXUAL ASSAULT

The link between alcohol and sexual assault is a strong one. Research has shown that the use of alcohol is the single largest determining factor in a sexual assault. Alcohol use and sexual assault among teens and young adults is undisputedly entwined. Fifty percent of young men who perpetrated an acquaintance rape had been using alcohol (Abbey et al 2004). In addition, 68 percent of young women who were victims of acquaintance rape had also been drinking (Fisher et. al. (2003)). "Alcohol is the most related factor to sexual aggression" (Kerns 1996). This is not to say that the use of alcohol explains why sexual violence is so prevalent, but it does suggest that society needs a better understanding about the role of alcohol and the issue of consent, responsibility, and access.

ALCOHOL

The effects of alcohol on men and women can make a sexual assault more likely to occur. Men often see themselves as "more powerful, sexual, aggressive, and believe alcohol increases their sexuality and women's interest in having sex. In addition, many rapists use alcohol as a means to an end; purposefully getting a 'date' drunk and then raping her. Afterwards, the victim is viewed as being at least partially responsible for the attack. If the perpetrator was drinking as well, the alcohol makes an easy excuse for his behavior after the fact.

Women or men drinking alcohol are frequently seen as easier targets. On many levels, it reduces their ability to protect themselves. She/he may not realize the situation has become dangerous. Thinking is impaired and the victim may miss the danger signals. It is generally harder to avoid or handle conflict while intoxicated. It is harder to leave a disagreement or risky



circumstances while inebriated. Perceptions of others are not as clear. She/he may miss major indicators of a problem or miss clues to the perpetrators behavior/motives, etc. It is impossible to consent to sex when intoxicated. Additionally, the victim's ability to resist physically or verbally is seriously impaired.

Although alcohol or drug use increases one's vulnerability to sexual assault, advocates should be careful not to suggest that a survivor who has been drinking or using drugs is responsible for their own assault. The choice to victimize someone rests solely upon the abuser. Similarly, the use of drugs or alcohol does not lessen the responsibility of the offender for the assault.

DIMINISHED CAPACITY

Sexual activity by individuals who are impaired by drugs or alcohol can be a very tricky proposition. Questions frequently come up about consent issues when both/all parties are intoxicated. Be prepared to handle questions, comments, and challenges about the importance of consent and how alcohol compromises consensual sex. It is helpful to have a working understanding of diminished capacity. And it is imperative that the public, especially young people, know that there are not only moral implications, but also serious legal implications to having sex with someone who cannot consent because they are high or drunk.

The law is clear that certain individuals do not have the capacity to consent. They include, but are not limited to, anyone who is sleeping, drugged, passed out, unconscious, mentally incapacitated, etc. Young people should learn that if they are in doubt about the person's ability to give consent, even in the slightest, it is best for all parties concerned not to engage in sexual activity.

"DATE RAPE" DRUGS

Alcohol is the original date rape drug and it is not likely to be replaced any time in the near future. In fact, virtually any drug can be misused to serve the purpose of incapacitating an individual for the purpose of sexual victimization. "Date rape drugs" is a tag put on a few specific drugs that have shown their potential for helping facilitate a sexual assault. Because of the prevalence, availability, and potential for abuse of these drugs, we will discuss them in some detail. Please remember, however, that many other drugs may be substituted and have the same effects. A sexual assault that has been carried out by drugging a victim with Benadryl is no less serious than an assault where GHB was the drug of choice.

In recent years, offenders have used a variety of inexpensive, easy to obtain drugs to incapacitate and sexually victimize an individual. These drugs are often administered to the unsuspecting targeted person. Other times, the person ingests drugs voluntarily for recreational purposes and while incapacitated is sexually abused.

Texas, due to our shared border with Mexico which makes access to some drugs easier than in many other states, is a hotbed for drugs like Rohypnol and other benzodiazepines. To a lesser degree, there are other drugs with more limited access such as Ketamine.

Rohypnol (Roofies, Rope, Roach, Rib, Roches, Etc.)

This drug is illegal to sell, make, or possess in the USA. It is, however, legal in many countries, particularly in Europe and Latin America. Its legitimate purposes are primarily to treat insomnia and as a pre-anesthetic medication.

Effects (starts working 10-15 min. after ingestion, peaks 1-2 hrs. later, can last 8 hrs. Residual effects for 24 hrs.)

- dizziness/nausea
- disorientation
- drowsiness
- low blood pressure
- visual disturbances
- unconsciousness
- memory loss/amnesia
- skeletal-muscular relaxation (difficulty speaking or moving)

Additional factors which make this drug so popular are that it is tasteless, easy to get, inexpensive, dissolves quickly and is odorless. When mixed with alcohol, the drug effect is tripled. It remains in the victim's urine for 3 days or less. Drugs such as Valium, Librium, and Klonopin and other benzodiazepines, are often substituted for Rohypnol and the effects are very similar.

Gamma Hydroxy Butyrate And Its Analogs Gamma Butyrolactone And 1,4 Butanediol

This GHB is illegal to sell, make or possess (although possession in Texas is currently only a misdemeanor). It is legal in Europe where it is primarily used for treating narcolepsy, and in France as an anti-depressant. In addition, it has been used for alcohol withdrawal and Japanese and American bodybuilders have illegally used it to bulk up. When ingested, GHB's analogs, or chemical cousins, are quickly transformed into GHB with the same effects. These analogs can be found in products like fingernail polish remover and wheel cleaners. It is legal to possess these analogs.

Effects (starts working 5-15 min. after ingestion, lasts about 3 hr's.)

- extreme intoxication
- impaired judgment and decision making
- enhanced sexual feelings
- unconsciousness
- nausea/vomiting
- dizziness
- seizures
- respiratory arrest
- memory loss/amnesia

Additional factors: easy to obtain, easy to manufacture, inexpensive. Even small amounts of alcohol or antibiotics react with GHB and can cause overdose. Urine test must be taken in less than 12 hours.

OTHER POTENTIAL DATE RAPE DRUGS:

Ketamine (KIT KAT, Special K): legal for veterinarians to use as an anesthetic. It is in a class of drugs known as a Dissociative Anesthetic, which causes an out of body experience. Effects are similar to PCP and include:

- Vivid hallucinations and possibly extreme delirium
- memory loss/amnesia
- stroke and cardiac arrest
- cessation of breathing, brain damage and death
- poor coordination

What all these drugs have in common is the very real potential for being an aid in perpetuating a sexual assault scenario. These drugs are generally easy to get, inexpensive, fast-acting, incapacitating, and unfortunately share the quality of causing anterograde amnesia. This last factor alone makes drug-induced sexual assaults extremely damaging.

As difficult as it is for a survivor to remember the details of a sexual assault, it is even more devastating to the survivor to experience significant memory lapses. The survivor then uses his/her imagination to fill in the gaps and this can prove to be overwhelming.

Often the unknown is even worse than the realized victimization. These survivors are left with lingering doubts about details such as: the number of perpetrators, acts forced upon them, whether pictures or videos were taken, whether people witnessed the assault, fears that it will show up on the internet, etc. Advocates need to be very cautious that they do not unintentionally help the survivor fill in the gaps. This will be damaging to their emotional well-being, as well as to any potential legal action.

Realistically, prosecuting a substance-related sexual assault is even more difficult than other sexual assaults. This is especially true for victims who knowingly ingested drugs or alcohol. This lends itself very well to victim blaming. Other potential complications to prosecution include the memory loss that many drugged victims' experience. While the lack of specific details of the assault can be a challenge to the investigation, memory loss itself can be evidence of symptoms that are consistent with drugging which may support the investigation. Symptoms of drug and/or alcohol use, including memory loss should be noted and shared with investigators.

Keep in mind: the victim is likely to need a lot of reassurance and on-going support.

EFFECTS OF SEXUAL ASSAULT ON SURVIVORS

“A traumatic event or situation creates psychological trauma when it overwhelms the individual’s ability to cope... The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss.”

-Sidran Institute, Traumatic Stress Education and Advocacy

Trauma occurs when a person’s ability to cope with an event is overwhelmed. Typically, the event includes fear of death, bodily integrity or other great harm that the person is powerless to control. Events do not necessarily require physical harm in order to be considered traumatic. What makes an event traumatic is the person’s *experience* of the event.⁶⁰ Just a few examples of traumatic events are: sexual, physical, or verbal abuse, domestic violence, neglect, bullying, serious illness or surgery, car accident, natural disaster, urban violence, witnessing a traumatic event, or being a close friend or family member of someone who has experienced a traumatic event, or working closely with survivors of traumatic events (this is often called “vicarious trauma”). Certain factors (Risk factors) can increase a person’s vulnerability to trauma. These include: being under heavy stress or having experienced significant recent loss, and having previously been traumatized – particularly if the trauma occurred in childhood.⁶¹

What is important to remember is that what is traumatic for one person may not be traumatic for another person. It is the survivor’s experience which determines if an event was traumatic and this is why two people can experience the same event and have very different outcomes.⁶²

A traumatic event can be a one-time trauma (or “single-blow” like an accident or single rape) or it can be a repeated trauma (like combat or chronic abuse). Trauma can also be human-made or natural. Violent crimes such as sexual assaults are considered human-made and research shows that these types of traumas are often more difficult to absorb. *Interpersonal trauma* (domestic violence, child abuse, sexual assault by a known offender, etc.), or trauma that originates out of a close personal relationship is often one of the most difficult types of traumas to overcome because of the deep betrayal of trust.

“Trauma is defined by the experience of the survivor. Two people could undergo the same event and one person might be traumatized while the other person remained relatively unscathed. It is not possible to make blanket generalization such that “X is traumatic for all who go through it” or “Y event was not traumatic because no one was physically injured.” In addition, the specific aspects of an event that are traumatic will be

⁶⁰ HelpGuide.Org (2016) Emotional and Psychological Trauma: Symptoms, treatment, and recovery. Retrieved April 12, 2016 from <http://www.helpguide.org/articles/ptsd-trauma/emotional-and-psychological-trauma.htm>

⁶¹ HelpGuide.Org (2016) Emotional and Psychological Trauma: Symptoms, treatment, and recovery. Retrieved April 12, 2016 from <http://www.helpguide.org/articles/ptsd-trauma/emotional-and-psychological-trauma.htm>

⁶² Sidran.org (2016) What is Psychological Trauma? Retrieved April 13, 2016 from <http://www.sidran.org/resources/for-survivors-and-loved-ones/what-is-psychological-trauma/>

different from one individual to the next. You cannot assume that the details or meaning of an event, such as a violent assault or rape, that are most distressing for one person will be the same for another person."

-Sidran Institute, Traumatic Stress Education and Advocacy

The responses to trauma vary and there are no 'right' or 'wrong' responses, but many of the common responses are:⁶³

- Shock, denial, or disbelief
- anger, irritability, or mood swings
- guilt, shame, or self-blame
- feeling sad or hopeless
- confusion or difficulty concentrating
- anxiety or fear
- withdrawing socially
- feeling numb or disconnected

The effects of a trauma can be increased or reduced, by the post trauma response that a survivor receives. Some examples of responses which *increase* trauma (and decrease the chances of recovery) are those which lack empathy for the survivor, blame the victim, and minimize the effect or impact of the sexual assault/violence on the survivor's life. Some examples of responses which have the potential to *decrease* trauma (and therefore aide or increase the chances of recovery) are those where the survivor feels heard, was not blamed, and which provide emotional support for the survivor.

There are many effective treatments for trauma and it is often helpful for persons who have experienced a traumatic event to seek the help of a professional who is knowledgeable in treating trauma.

POST TRAUMATIC STRESS DISORDER

Post Traumatic Stress Disorder (PTSD) can be one of the most debilitating and disabling psychological conditions to be experienced after a sexual assault. The risk of developing PTSD is greater if the sexual violence occurred within the context of other interpersonal violence as opposed to the sexual assault occurring independent of a known relationship. But keep in mind that PTSD is a possible consequence of experiencing a traumatic event, and the degree to which someone is traumatized by an event varies considerably from person to person. Studies have consistently shown that survivors of rape and sexual violence are among the largest group of individuals to develop PTSD (ranging from 30% to 94% of survivors meeting the criteria for a PTSD diagnosis at some point after the assault). In addition, research has shown that experiencing sexual violence more strongly predicts the development of PTSD than exposure to any other trauma.⁶⁴

⁶³ HelpGuide.Org (2016) Emotional and Psychological Trauma: Symptoms, treatment, and recovery. Retrieved April 12, 2016 from <http://www.helpguide.org/articles/ptsd-trauma/emotional-and-psychological-trauma.htm>

⁶⁴ Jina, R. and Thomas, L. (2013). Health consequences of sexual violence against women. *Best Practices & Research Clinical Obstetrics and Gynecology*, 27(2013), 15-26.

A diagnosis of PTSD must be made by a licensed health care professional after a formal evaluation. Generally, the health care professional is looking for signs that the survivor is suffering significant distress or impairment and is:

- Persistently re-experience the event (nightmares, flashbacks, etc.)
- Persistently avoiding stimuli associated with the event
- Experiencing persistent symptoms of hyper arousal (e.g. exaggerated startle response)⁶⁵

One study on PTSD found that 94% of sexual assault survivors met the criteria to be diagnosed with PTSD 12 days after their assault and at just over 3 months, 47% of sexual assault survivors still met the criteria for a PTSD diagnosis. In another study, it was found that 51% of rape survivors developed PTSD at some point post-assault.⁶⁶

PTSD can be more difficult to treat when avoidance mechanisms become the primary coping tool of a survivor. This is because the avoidance itself makes treatment harder to obtain. The risk of developing PTSD seems to be elevated when there are cumulative exposures to traumatic events over the course of one's lifetime. In particular, childhood trauma – especially prolonged traumas like ongoing child abuse or neglect – seem to make a person more vulnerable to the development of PTSD, even after exposure to a traumatic event as an adult.

PHYSICAL EFFECTS OF SEXUAL ASSAULT/VIOLENCE

The physical effects of sexual assault/violence are characterized by those which are **immediate** and directly stem from the sexual assault and the longer term consequences which are seen on a more **chronic** basis. It should be noted that survivors suffering chronic physical consequences of an assault are more vulnerable to additional violence which only compounds and complicates their journey to long term physical and emotional well-being.

Immediate Physical Effects

Genital injuries are a potential immediate consequence of sexual assault/violence. Injuries to genitals are reported at wildly varying rates. The studies which have been conducted to look at genital injuries post sexual assault are generally not consistent in techniques or methods and therefore make accurate estimates very difficult. Some studies using only visual inspection of the genitals post assault have found rates of injury about 5%. While other studies using colposcopic techniques to examine genitals post assault have found rates of injury close to 87%.⁶⁷

It is not uncommon that various other physical injuries are seen in survivors of sexual assault/violence depending upon the nature and scope of the assault. These types of injuries may be bruises, cuts, abrasions, or lacerations across the body to broken bones, internal organ damage, hemorrhage, shock, strangulation-related injuries, and head injuries up to and including fatal injuries. The presence or

⁶⁵ Mason, F. and Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practices & Research Clinical Obstetrics and Gynaecology*, 27(2013), 27-37.

⁶⁶ Mason, F. and Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practices & Research Clinical Obstetrics and Gynaecology*, 27(2013), 27-37.

⁶⁷ Weaver, T.L. (2009). Impact of rape on female sexuality: Review of selected literature. *Clinical Obstetrics and Gynecology*, 52(4), 702-711.

absence of physical injuries however does not indicate the authenticity or credibility of a “real” sexual assault or incident of sexual violence. It is not unusual for a rapist to use only the amount of physical force necessary to complete the rape. Survivors are often surprised, shocked and terrified about the situation they find themselves, resulting in a ‘freeze’ response which results in very little physical resistance. This lack of physical injuries or signs of resistance should not be used to suggest that the assault did not occur, but rather verification of a common reaction (freezing) to a traumatic event.

Chronic Physical Effects

Research has documented some of the chronic long-term physical reactions to sexual assault/violence which include: chronic pain, gastrointestinal disorders, gynecological complications, nausea, diarrhea, migraines and other frequent headaches, sexually transmitted infections, urinary tract infections, chest pain, shortness of breath, insomnia, fatigue, asthma, back pain, chronic fibroids, chronic pelvic pain, genital irritation, fibromyalgia, irritable bowel syndrome, and cervical cancer.^{68 69}

Some research shows that survivors of sexual assault/violence experience higher rates of chronic medical conditions, utilize healthcare services at rates higher than average and access preventive health care services at rates lower than average.⁷⁰

Physical Consequences of Sexual Assault/Violence	
IMMEDIATE	CHRONIC
Bruises	Chronic Pain Syndrome
Cuts	Irritable Bowel Syndrome
Abrasions	Gastrointestinal Disorders
Lacerations	Gynecological Complications
Broken Bones	Fibromyalgia
Bleeding	Chronic Fatigue
Shock	HIV/AIDS
Concussion	
Wound Infections	
Urinary Tract Infections	
Back Pain	
Migraines & other Headaches	
Diarrhea	
Nausea	

Adapted from Jina, R. and Thomas, L. (2013). Health consequences of sexual violence against women. *Best Practices & Research Clinical Obstetrics and Gynecology*, 27(2013), 15-26.

⁶⁸ Center for Disease Control and Prevention. Atlanta, GA. Sexual Violence: Consequences. (2016). Retrieved February 2, 2016 from <http://www.cdc.gov/violenceprevention/sexualviolence/consequences.html>

⁶⁹ Weaver, T.L. (2009). Impact of rape on female sexuality: Review of selected literature. *Clinical Obstetrics and Gynecology*, 52(4), 702-711.

⁷⁰ Jina, R. and Thomas, L. (2013). Health consequences of sexual violence against women. *Best Practices & Research Clinical Obstetrics and Gynaecology*, 27(2013), 15-26.

SEXUALLY TRANSMITTED INFECTIONS

Sexual assault survivors may have a variety of health concerns following an assault. One such concern might be the risk of having contracted a **sexually transmitted disease/infection (STD/STI)**. STDs/STIs are infections that are passed from person to person via vaginal, oral, or rectal contact with an individual who is infected. These infections may be caused by a virus, bacteria, or a parasite. It is important to receive early treatment for any STD/STI in order to prevent further spread and to minimize the long-term consequences of an infection.⁷¹ Some of the most common STDs/STIs include: chlamydia, gonorrhea, Herpes Simplex Virus (HSV), Human Papillomavirus (HPV), Syphilis, HIV/AIDS, and Hepatitis A, B, and C. Hepatitis B and HIV/AIDS will be discussed in more detail later.

While the overall risk of contracting an STD/STI from a single sexual encounter is low, there are some risk factors which may increase the likelihood of transmission. Although all STDs/STIs can be transmitted orally, unprotected vaginal or anal sex is generally considered to be a higher risk for transmission. Sexual contact with an individual who has had multiple sexual partners and unprotected sex increases the risk of transmission. Having a history of STDs/STIs can make future transmission easier. Women are more likely than men to contract many STDs/STIs and adolescent females also seem to be at greater risk for STD/STI transmission due to the immature cells in their cervix.⁷² Some STDs/STIs can make a person seriously ill, leave them infertile, or can be fatal. Physical symptoms of an STD/STI can include: itching, pain during sex, spotting between periods, vaginal/penile discharge, burning during urination, or sores/bumps around the genitalia. Some special health problems for women caused by STDs/STIs include: pregnancy complications, pelvic inflammatory disease (PID), infertility, and a higher risk for cervical cancer. Unfortunately, many people do not show – or recognize – the signs of an STD/STI and are therefore untreated and more likely to spread the disease to others.

Sexual assault survivors should meet with a medical professional and receive treatment after an assault to prevent the potential transmission of STDs/STIs. The medical professional can discuss the risk of HIV/AIDS and, with the survivor, determine if preventative medication for HIV/AIDS is appropriate.

PREGNANCY

Another common concern of female sexual assault survivors who are of child bearing age is **pregnancy**. Studies vary with regard to the risk of pregnancy after a single instance of unprotected sexual intercourse, but estimates range from 2% to 10%. The risk of pregnancy will be the greatest right around the time of ovulation.

⁷¹ Mayo Clinic. Rochester, MN. Sexually Transmitted Diseases, Treatment. (2016). Retrieved January 27, 2016 from <http://www.mayoclinic.org/diseases-conditions/sexually-transmitted-diseases-stds/basics/treatment/con-20034128>

⁷² Mayo Clinic. Rochester, MN. Sexually Transmitted Diseases, Treatment. (2016). Retrieved January 27, 2016 from <http://www.mayoclinic.org/diseases-conditions/sexually-transmitted-diseases-stds/basics/risk-factors/con-20034128>

In 2012, the U.S. Department of Justice National Crime Victimization Survey reported 346,830 rapes. Rape Abuse Incest National Network (RAINN), utilizing an incidence of 5% for pregnancy after a single instance of unprotected sexual intercourse and the 346,830 number of rapes published by the Department of Justice, estimated that there were 17,342 pregnancies which were the result of rape in the year 2012.⁷³

Most SANE programs and medical facilities will offer emergency contraception to survivors who are at risk of becoming pregnant. If emergency contraception is not offered at the medical facility, it may be available over (or behind) the counter without a prescription at pharmacies. Emergency contraception is most effective (but not 100%) when taken as soon as possible after the sexual assault or unprotected sexual encounter although it may still be effective up to 5 days post assault. The effectiveness of all contraceptive methods decreases the more time that elapses between the exposure, or sexual assault, and the first dose of contraceptive. Nausea and vomiting are two of the most commonly reported side effects of emergency contraception.

PSYCHOLOGICAL/MENTAL EFFECTS OF SEXUAL ASSAULT/VIOLENCE

Similar to the physical effects of sexual assault/violence, psychological/mental effects are characterized by those which are **immediate** and those which are long-term or chronic **effects**. It is not uncommon for an immediate effect to transition into a chronic effect or to have previous traumas or mental health issues play a role in the severity or degree of these effects after experiencing sexual assault/violence. In some studies, psychological reactions to sexual assault/violence have peaked about 3 weeks after the assault/violence and remained elevated for one to two months before then gradually declining.⁷⁴

The Centers for Disease Control and Prevention (CDC) lists these common **immediate** psychological reactions to sexual assault/violence: shock, denial, fear, confusion, anxiety, withdrawal, shame and/or guilt, nervousness, distrust of others, emotional detachment, sleep disturbances, flashbacks, and mentally replaying the assault.⁷⁵ In the immediate aftermath of a sexual assault/violence there is no one emotional response which is universal to all victims/survivors. Victims/survivors can vary tremendously in their individual reactions to a sexual assault/violence. They can be quiet and withdrawn or tearful and anxious or some may minimize the event or even laugh – there is no right or wrong response.

⁷³ RAINN. Effects of Rape, Pregnancies resulting from rape. (2016). Retrieved February 25, 2016 from <https://rainn.org/get-information/statistics/sexual-assault-victims>

⁷⁴ Jina, R. and Thomas, L. (2013). Health consequences of sexual violence against women. *Best Practices & Research Clinical Obstetrics and Gynaecology*, 27(2013), 15-26.

⁷⁵ Center for Disease Control and Prevention. Atlanta, GA. Sexual Violence: Consequences. Retrieved February 2, 2016 from <http://www.cdc.gov/violenceprevention/sexualviolence/consequences.html>

The CDC has listed these common **chronic** psychological reactions to sexual assault/violence: depression, generalized anxiety, attempted or completed suicide, post-traumatic stress disorder, diminished interest in/avoidance of sex, and low self-esteem/self-blame.⁷⁶

Psychological Consequences of Sexual Assault/Violence		
IMMEDIATE		CHRONIC
Shock		Post Traumatic Stress Disorder (PTSD)
Denial	→	Depression
Quiet & Withdrawn		Self-Harming
Anxiety	→	Eating Disorders
Sleeping difficulties		Suicidal Tendencies
Increased anxiety	→	High-Risk Behaviors
Depression	→	
Anger		
Flashbacks		

Adapted from Jina, R. and Thomas, L. (2013). Health consequences of sexual violence against women. *Best Practices & Research Clinical Obstetrics and Gynaecology*, 27(2013), 15-26.

DEPRESSION

Depression is a serious psychological consequence of sexual assault/violence. It has been estimated that there are 350 million individuals across the world who suffer from some form of depression. Those who suffer from depression often experience depressed mood, loss of interest in things that used to be enjoyable, decreased energy, and a decrease in the engaging in enjoyable activities. People who are suffering from depression frequently experience some degree of anxiety as well and therefore may have difficulty sleeping or staying asleep, they may have a decreased appetite, may be unable to concentrate, and might feel guilty or have feelings of low self-worth.

Typically for a clinical diagnosis of depression these feelings/symptoms need to be present for at least two weeks and must be interfering in activities of daily living (such as school, work, and family). The World Health Organization has determined depression to be the leading cause of disability worldwide as well as a major contributor to the general burden of disease globally.⁷⁷ Recent studies on depression with survivors of sexual assault/violence have shown that PTSD and depression very

⁷⁶ Center for Disease Control and Prevention. Atlanta, GA. Sexual Violence: Consequences. Retrieved February 2, 2016 from <http://www.cdc.gov/violenceprevention/sexualviolence/consequences.html>

⁷⁷ World Health Organization, "Depression," Fact Sheet no. 369, 2016. Retrieved May 3, 2016 from: <http://www.who.int/mediacentre/factsheets/fs369/en/#>

frequently occur together and at the same rates - leading researchers to suspect that the depression seen following sexual violence may be a neurobiologically distinct subtype of depression.^{78 79}

Depression is categorized as mild, moderate, or severe, and can be unipolar (consisting of depressive episodes only) or bipolar (consisting of both manic and depressive episodes). There are effective treatments for depression and it is important to make sure that a depressed individual is connected with available resources.

SELF HARM/SELF INJURY

Any injury that a person inflicts upon themselves intentionally is considered **self-harm** or **self-injury**. The most frequent form of self-injury/self-harm is often found to be *cutting*. However, self-harm/self-injury can take many forms – burning, pulling out hair, picking at wounds to prevent healing, and in extreme forms can result in things like broken bones.⁸⁰ Beyond the usual forms of self-harm/self-injury, the Centers for Disease Control and Prevention (CDC) has stated that sexual violence is associated with several health-behavior related types of self-harm/self-injury behaviors. These include: engaging in unprotected sex, trading sex for food or money, choosing unhealthy sexual partners, smoking, drinking, using drugs, driving while under the influence, engaging in unhealthy eating behaviors (fasting, vomiting, overeating, etc.), engaging in criminal behavior, and the *failure* to engage in proactive health behaviors (e.g. wearing seatbelts, etc.).⁸¹

Self-harm/Self-Injury is frequently a sign of emotional distress. Emotions which are overwhelming to a person and beyond what they feel they are capable of managing can lead an individual to self-harm/self-injury as one method to cope with these emotions. People who engage in self-harming behaviors often feel significant shame and/or guilt associated with the behaviors and as a result the self-harm/self-injury is often done in private. Self-harm is different from suicidal ideation and suicidal behaviors. It is important to recognize that self-harm/self-injury is an indication of significant emotional distress and the lack of effective coping skills to deal with those emotions.⁸²

SUBSTANCE ABUSE

Substance abuse is often seen as drug (prescription or illicit) use or alcohol use that includes behaviors such as consuming hazardous quantities of the substance, impairment or loss of control, displays of dependence, and use that results in harm. Drug and alcohol use and abuse is seen more common among survivors of sexual assault/violence than among those who have not experienced this type of trauma. Women who have histories of experiencing sexual assault have elevated risks for developing problematic alcohol use. The development of Post Traumatic Stress Disorder (PTSD) appears to be a

⁷⁸ Au, T.M., Dickstein, B.D., Comer, J.S., Salters-Pedneault, K., and Litz, B.T. (2013). Co-occurring posttraumatic stress and depression symptoms after sexual assault: a latent profile analysis. *Journal of Affective Disorders*, 149(2013), 209-216.

⁷⁹ Vitriol, V., Cancino, A., Weil, K., Salgado, C., Asenjo, M.A., and Potthoff, S. (2014). Depression and psychological trauma: an overview integrating current research and specific evidence of studies in the treatment of depression in public mental health services in Chile. *Depression Research and Treatment*, 2014, 1-10.

⁸⁰ National Alliance on Mental Illness (NAMI), "Self-Harm", 2016. Retrieved May 6, 2016 from: <https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Self-harm>

⁸¹ Center for Disease Control and Prevention. Atlanta, GA. Sexual Violence: Consequences. Retrieved February 2, 2016 from: <http://www.cdc.gov/violenceprevention/sexualviolence/consequences.html>

⁸² National Alliance on Mental Illness (NAMI), "Self-Harm", 2016. Retrieved May 6, 2016 from: <https://www.nami.org/Learn-More/Mental-Health-Conditions/Related-Conditions/Self-harm>

main contributing factor in the development of substance abuse issues after experiencing trauma. When PTSD symptoms are present, substance use and abuse is used in an attempt to decrease the negative symptoms associated with PTSD – in effect, survivors are self-medicating.⁸³

Research has begun to show that the type of trauma experienced can impact the potential risk to abuse or use drugs or alcohol. Research indicates that survivors of interpersonal trauma (abuse by someone else) experience high levels of substance abuse disorders, especially alcohol abuse, and in particular by survivors of sexual assault.⁸⁴

“Interpersonal traumas are more likely to affect women’s trust in others, and their ability to rely on their social network to cope, which in turn increases their reliance on maladaptive coping strategies such as drinking.”

-Ullman, S.E., Relyea, M., Peter-Hagene, L., and Vasquez, A.L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors*, 38, 2219-2223.

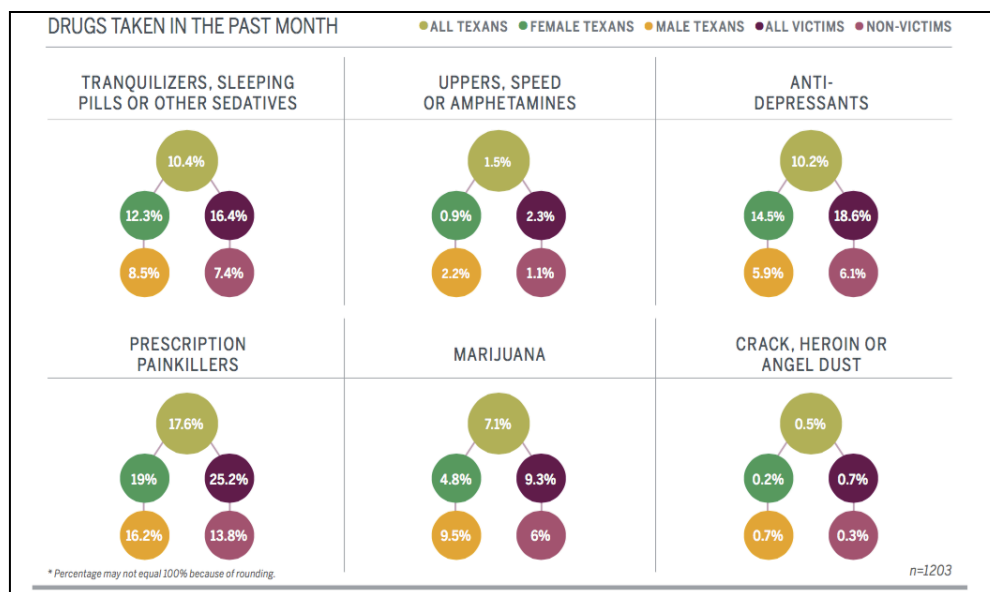
In addition, ongoing childhood sexual abuse is the type of interpersonal trauma which is associated with the very highest risk of substance abuse, even accounting for genetic predispositions to addiction.⁸⁵

A study by the Institute on Domestic Violence and Sexual Assault in 2015 stated that legal and illicit drug use was reported more frequently for victims including the use of sedatives/sleeping pills (16.4%), anti-depressants (18.6%) and prescription painkillers (25.2%) compared to non-victims (7.4%, 6.1% and 13.8% respectively).

⁸³ Ullman, S.E., Relyea, M., Peter-Hagene, L., and Vasquez, A.L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors*, 38, 2219-2223.

⁸⁴ Ullman, S.E., Relyea, M., Peter-Hagene, L., and Vasquez, A.L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors*, 38, 2219-2223.

⁸⁵ Delker, B.C. and Freyd, J.J. (2014). From betrayal to the bottle: investigating possible pathways from trauma to problematic substance use. *Journal of Traumatic Stress*, 27, 576-584.



Busch-Armentariz, N.B., Olaya-Rodriguez, D., Kammer-Kerwick, M., Wachter, K. & Sulley, C. (2015). Health and well-being: Texas statewide sexual assault prevalence. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas at Austin. Available here: <http://sites.utexas.edu/idvsa/>

BODY MEMORIES

The impact of trauma on the body is believed to create two types of memories – *implicit* and *explicit* memories. Explicit memories are those types of memories which one can readily ‘pull up’ or bring into conscious awareness. Implicit memories are also called ‘body memories.’ **Body Memories** are those types of traumatic events which a person might not necessarily remember the specific details for but when triggered with a specific sensory memory – an image, a certain smell, a feeling on the skin, etc. the body becomes “activated” and the person can *feel* as though they are reliving an event for which they did not have a conscious awareness.

The research involving body memories is grounded in three basic types of nervous systems: *enteric nervous system*, *sympathetic nervous system*, and *parasympathetic nervous system*. Someone who has experienced sexual assault/violence may find that their body responds in a way that they have no control over to a trigger that they may or may not have realized would generate a response within their body. This is what is most commonly referred to as a body memory.⁸⁶

EATING DISORDERS

Experiencing sexual assault/violence has been shown in multiple studies to have an impact on eating habits, in particular the development of eating disorders. Two of the most commonly studied eating disorders are *Anorexia Nervosa* and *Bulimia Nervosa*. Most research has focused on the impact of child sexual abuse and the subsequent development of eating disorders. The link between child sexual abuse and eating disorders is consistent and widely accepted. Newer research is looking into the connection between sexual violence experienced as an adult and subsequent development of eating

⁸⁶ Helsei, P.B. (2015) Witnessing the body’s response to trauma: resistance, ritual, and nervous system activation. *Pastoral Psychology*, 64(5), 681-693.

disorders. Bulimia Nervosa is the disorder which has been most commonly associated with child sexual abuse. The eating disorder most frequently being seen in studies with sexual assault/violence in adulthood is Anorexia Nervosa.⁸⁷ The fact that child sexual abuse victims are at greater risk for being victims of sexual assault/violence in adulthood and the convergence of multiple forms of violence makes understanding the link of experiencing sexual assault/violence in adulthood and the subsequent development of an eating disorder difficult to study.

Survivors of sexual assault/violence appear to be more likely to develop an eating disorder when they use avoidance techniques like thought suppression (to push away memories from their active consciousness). Avoidance and suppression seem to be a mechanisms that survivors utilize in an attempt to regulate their emotions. However, avoidance and suppression often result in a “rebound” effect whereby the thoughts can be *more* intrusive and more upsetting.⁸⁸ There are some experts in the field of eating disorders who argue that the development of an eating disorder comes about after experiencing sexual violence because these crimes can result in higher levels of anxiety, higher levels of depression, lower levels of self-esteem, increased levels of substance abuse, and higher levels of self-destructive behaviors – all of which can make an individual more prone to the development of an eating disorder.⁸⁹

The difference in the development of the specific type of eating disorders – with child sexual abuse survivors being much more prone to developing Bulimia Nervosa and adult sexual assault/violence survivors being more prone to development of Anorexia Nervosa - is believed to be related to the psycho-social stage of development of the individual. Anorexia Nervosa is an eating disorder characterized by restriction and Bulimia Nervosa is characterized by bingeing and purging and is seen as a more impulsive behavior. Children who are sexually abused generally tend to have difficulty in learning self-regulation and are thus seen as showing more impulsivity in their behaviors. Whereas those who experience sexual assault/violence in adulthood and have successfully achieved the developmental milestones of childhood will have already mastered the skill of self-regulation and do not tend to display as many impulsive behaviors. Rather, what is seen is that adults who experience sexual violence exhibit the controlling and restrictive behaviors of Anorexia Nervosa. The impact of trauma depends on when in the developmental life cycle is occurs and there do appear to be some periods which are more vulnerable than others as it relates to the development of an eating disorder. The most vulnerable periods seem to be childhood, especially early childhood, and late adolescence into early adulthood.⁹⁰

SLEEPING DISORDERS

There are more than 90 official **sleep disorders** which fall into two broad categories – *dysomnias* (including *insomnia* - the chronic inability to initiate and maintain sleep and *hypersomnia* - excessive sleepiness) and *parasomnias* (which occur or impact sleep directly but do not cause insomnia or

⁸⁷ Collins, B., Fischer, S., Stojek, M., and Becker, K. (2014). The relationship of thought suppression and recent rape to disordered eating in emerging adulthood. *Journal of Adolescence* 37(2014), 113-121.

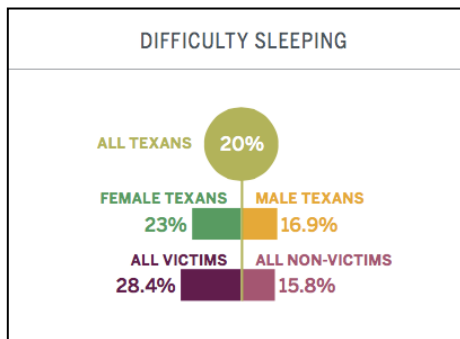
⁸⁸ Collins, B., Fischer, S., Stojek, M., and Becker, K. (2014). The relationship of thought suppression and recent rape to disordered eating in emerging adulthood. *Journal of Adolescence* 37(2014), 113-121.

⁸⁹ Conley, T.D. and Garza, M.R. (2011). Gender and sequelae of child versus adult onset of sexual victimization: body mass, binge eating, and promiscuity. *Journal of Applied Social Psychology*, 41(11), 2551-2572.

⁹⁰ Conley, T.D. and Garza, M.R. (2011). Gender and sequelae of child versus adult onset of sexual victimization: body mass, binge eating, and promiscuity. *Journal of Applied Social Psychology*, 41(11), 2551-2572.

sleepiness, e.g. sleepwalking). Estimates are that roughly 30-40% of the adult population experiences some problems with sleeping and insomnia is the most common of the sleep disorders affecting approximately 6-10% of the population. Sleep disorders impact physical health, mental health, increase the risk for PTSD, substance abuse, work accidents, and even car accidents, among others.⁹¹

Sleep disorders appear to be more common among those who have been victims of sexual violence than those who have not. The symptoms of sleep disorders which are most frequently reported by survivors of sexual violence are: nightmares, sleep paralysis, awakening at night, restless sleep, and tiredness. In research, sleep disorders have been reported by survivors of sexual violence/assault in the range of 20% to 100%, depending upon the nature of the study.⁹² In the most recent study on sexual assault in Texas done by the Institute on Domestic Violence and Sexual Assault at The University of Texas at Austin, 28.4% of victims reported having difficulty sleeping.⁹³



Busch-Armendariz, N.B., Olaya-Rodriguez, D., Kammer-Kerwick, M., Wachter, K. & Sulley, C. (2015). Health and well-being: Texas statewide sexual assault prevalence. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas at Austin.

FLASHBACKS

Scientific studies seem to suggest that **flashbacks** may be on the extreme end of a continuum of intrusive sensory-based memories experienced by those suffering from Post Traumatic Stress Disorder (PTSD). Involuntary and distressing sensory-based memories of trauma(s), called flashbacks, are a hallmark of PTSD.

'Flashbacks' [are] vivid, sensory-perceptual (predominately visual) emotional memories from a traumatic event that intrude involuntarily into consciousness. That is, a 'flashback' is 'a mental vision of a past experience.'

Bourne, C., MacKay, C.E., and Holmes, E.A. (2013). The neural basis of flashback formation: the impact of viewing trauma. *Psychological Medicine*, 43, 1521-1532.

Flashbacks can be a brief mental vision of a past traumatic experience to a full-blown intense event that causes dissociation. Scientists are learning more about flashbacks and how the brain functions during times of trauma and high stress. The *amygdala*, an area of the brain responsible for emotional processing, seems to be especially active when creating memories of traumatic events that are susceptible to becoming flashbacks. However, not all traumatic memories become flashbacks. Those memories which become flashbacks tend to be distinct moments within an event rather than the

⁹¹ Vandrey, R., Babson, K.A., Herrmann, E.S., and Bonn-Miller, M.O. (2014). Interactions between disordered sleep, post-traumatic stress disorder, and substance abuse disorders. *International Review of Psychiatry*, 26(2), 237-247.

⁹² Steine, I.M., Harvey, A.G., Krystal, J.H., Milde, A.M., Grønli, J., Bjorvatn, B., Nordhus, I.H., Eid, J., and Pallesen, S. (2012). Sleep disturbances in sexual abuse victims: a systematic review. *Sleep Medicine Reviews*, 16, 15-25.

⁹³ Busch-Armendariz, N.B., Olaya-Rodriguez, D., Kammer-Kerwick, M., Wachter, K. & Sulley, C. (2015). *Health and well-being: Texas statewide sexual assault prevalence*. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas at Austin.

entire event from start to finish. An intense emotional reaction to trauma appears to be one condition necessary for the creation of flashbacks but it is not the only requirement. Flashbacks can come from a trauma that was experienced firsthand or they can come from a trauma that was witnessed but not necessarily experienced. From an evolutionary standpoint flashbacks likely served a purpose to enhance memory for life-threatening events and could have offered a potential aide in survival.⁹⁴

SUICIDE

Unwanted sexual experiences are associated with an increased risk for suicide attempts and suicidal ideation.⁹⁵ *Suicidal Ideation* occurs when an individual is significantly preoccupied with or by suicidal thoughts. Suicidal ideation itself does not necessarily indicate that an individual will act on the thoughts, however, it is generally considered a significant risk factor for suicide attempts and for completed suicide. Suicidal ideation is also associated with other psychiatric conditions like depression and Post Traumatic Stress Disorder (PTSD) which may further serve to elevate a person's risk for suicide. Of those who attempt suicide, roughly 15% will go on to complete suicide – meaning that 85% will not complete suicide.⁹⁶

Suicide has been associated with sexual assault/violence in some studies at a rate as high as 14 times that of those who during a similar time period did not report sexual victimization.⁹⁷ Other research has shown that women with a history of experiencing sexual assault/violence were 6 times more likely to attempt suicide than those women without a history of sexual assault/violence. Larger studies on the entire U.S. population found that female adult survivors of sexual assault/violence showed increased suicidal ideation and suicide attempts compared to women who were not survivors of sexual assault/violence.

Men and women react differently to sexual assault/violence and they also attempt and complete suicide at very different rates. Historically men are 4 times more likely to complete suicide than women but women are 3 times more likely to attempt suicide than men.⁹⁸ In general the elevated risk for suicide may be due to the psychological effects of sexual assault/violence – the development of anxiety disorders, depression, and PTSD.

SOCIAL EFFECTS OF SEXUAL ASSAULT/VIOLENCE

Sexual assault/violence has an impact on social functioning for survivors. Most frequently this is seen in survivors having strained relationships with family, friends, and intimate partners. As a result of

⁹⁴ Bourne, C., MacKay, C.E., and Holmes, E.A. (2013). The neural basis of flashback formation: the impact of viewing trauma. *Psychological Medicine*, 43, 1521-1532.

⁹⁵ Bryan, C.J., McNaughton-Cassill, M., Osman, A., and Hernandez, A.M. (2013). The associations of physical and sexual assault with suicide risk in nonclinical military and undergraduate samples. *Suicide and Life-Threatening Behavior*, 43(2) 223-234.

⁹⁶ Gradus, J.L., Qin, P., Lincoln, A.K., et al (2012). Sexual victimization and completed suicide among Danish female adults. *Violence Against Women*, 18(5), 552-561.

⁹⁷ Gradus, J.L., Qin, P., Lincoln, A.K., et al. (2012). Sexual victimization and completed suicide among Danish female adults. *Violence Against Women*, 18(5), 552-561.

⁹⁸ Gradus, J.L., Qin, P., Lincoln, A.K., et al (2012). Sexual victimization and completed suicide among Danish female adults. *Violence Against Women*, 18(5), 552-561

these strained relationships they then often receive less emotional support from friends and family and have less frequent contact with friends and relatives and potentially become ostracized from family, friends, and/or the community.

SPIRITUAL OR RELIGIOUS EFFECTS

"If there is little community recognition of the impacts of sexual abuse on the spirituality of those who are abused within religious contexts, there is even less acknowledgement of there being spiritual consequences for those who are sexually abused in other settings."

-Crisp, B.R. (2012). The spiritual implications of sexual abuse: not just an issue for religious women? *Feminist Theology*, 20(2), 133-145.

Estimates in 2012 by the Pew Research Center showed that globally eight out of ten people are affiliated with some form of religious group. It is therefore important to consider the spiritual/religious impacts of sexual violence as well as the potential ways that spiritual or religious practices may be important to survivors in recovery post-assault.

Sexual violence does not need to occur within the context of a religious or spiritual setting to have spiritual or religious consequences for a survivor. Some make the distinction of *religiosity* being an affiliation with a formal religion or organized faith and *spirituality* as the personal practice of what an individual themselves deems sacred. In either situation, after experiencing sexual violence there can often be spiritual/religious implications.

"A faith crisis can result even when one does not hold the notion that the divine protects from all suffering and pain. Instead, this crisis occurs due to feeling abandoned by the divine while attempting to survive the after effects of the rape."

Messina-Dysert, G. (2012). Rape and spiritual death. *Feminist Theology*, 20(2), 120-132.

Following an episode of sexual violence individuals will frequently report that they have experienced something akin to a "spiritual death." For some survivors they feel that once the most sacred part of their physical body has been violated they are no longer whole and do not feel safe in society. Survivors often feel shameful about the assault and friends and family may not provide the type of reassurance, acceptance and support that is needed by the survivor which can contribute to spiritual and religious isolation, suffering, and pain.⁹⁹

In the aftermath of sexual violence, spiritual or religious coping can either be negative or positive. Examples of positive coping can include things like prayer for relief, seeking God (or a higher power) in a religious community, or belief that God (or a higher power) was present at the time of the assault. Negative coping might be the belief that God (or a higher power) 'allowed' the sexual assault to occur for some reason (e.g. punishment, the person wasn't good enough, had sinned, etc.), being rejected or

⁹⁹ Messina-Dysert, G. (2012). Rape and spiritual death. *Feminist Theology*, 20(2), 120-132.

shunned by a religious community, and feeling the need for forgiveness (self-blame). Positive religious or spiritual coping has been associated with higher levels of psychological well-being while negative religious or spiritual coping has been associated with higher levels of depression.¹⁰⁰

FINANCIAL

All of society pays an **economic cost** for sexual assault/violence. Some scholars have begun to refer to this tangible economic burden of sexual assault as a “rape tax.” In Texas, it has been estimated that sexual assaults cost the state \$8 billion annually. This works out to a “rape tax” of over \$300 per resident per year.¹⁰¹

While the economic burden of sexual assault affects everyone, no one is impacted more than the survivors themselves. Survivors may find that they are responsible for a variety of out-of-pocket expenses after a sexual assault while at the same time they find they have a decreased income. Many times survivors work fewer hours during pay cycles post-assault. This can be for various reasons such as attending medical evaluations and/or treatment, dealing with criminal justice processes, or simply being unable to feel/be productive in a work environment due to the mental health consequences of a sexual assault. Some survivors may even quit their jobs post-assault. Research has also found that it is not unusual for life-long earning potential to be impacted after a sexual assault.¹⁰²

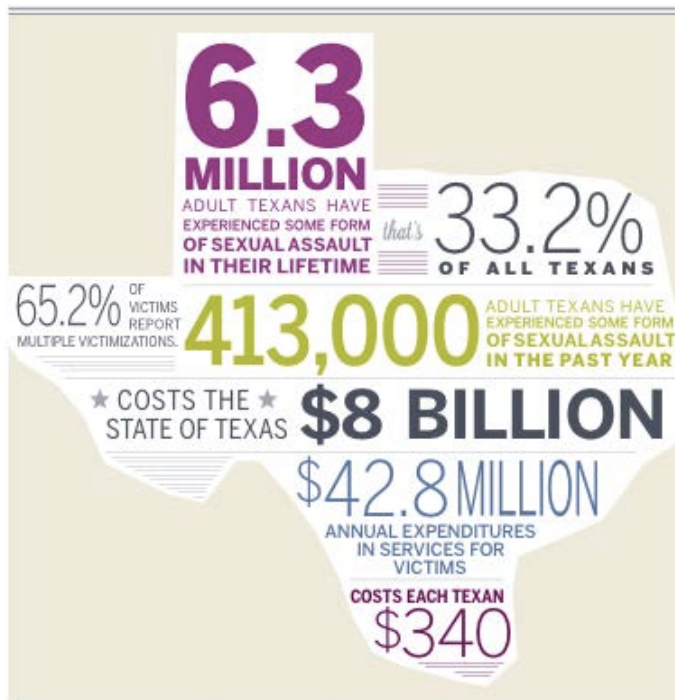
It is important to remember that the economic or financial impact of a sexual assault can have a compound and cumulative impact on the lives of survivors, but these impacts are particularly and disproportionately pronounced in those survivors who are already in low-wage or hourly jobs and those with few financial assets to being with.¹⁰³

¹⁰⁰ Bryant-Davis, T., & Wong, E.C. (2013). Faith to move mountains: religious coping, spirituality, and interpersonal trauma recovery. *American Psychologist*, 675-684.

¹⁰¹ Busch-Armendariz, N.B., Heffron, L.C., & Bohman, T. (2011). *Statewide Prevalence of Intimate Partner Violence in Texas*. Austin, TX: The Texas Council on Family Violence.

¹⁰² Loya, R.M. (2014). Rape as an economic crime: The impact of sexual violence on survivors' employment and economic well-being. *Journal of Interpersonal Violence*, 30(16), 1-21.

¹⁰³ Loya, R.M. (2015). A bridge to recovery: How assets affect sexual assault survivors' economic well-being. *SAGE Open*, 5(1), 1-13.



Busch-Armendariz, N.B., Olaya-Rodriguez, D., Kammer-Kerwick, M., Wachter, K. & Sulley, C. (2015). Health and well-being: Texas statewide sexual assault prevalence. Austin, TX: Institute on Domestic Violence & Sexual Assault, The University of Texas at Austin.

“They are in jobs where if they don’t show up, they don’t get paid. Maybe they can take two weeks off, but that means they’re not going to get paid those two weeks. So that pretty quickly affects someone’s ability to pay their rent and pay their utility bills and buy food and take care of their kids. And then that also affects them emotionally and their ability to continue to function. And I’ve seen a lot of clients in that position really sink into a depression, where even if they could go back to work, they weren’t in a position to go back to work. And unfortunately, I think those are the clients that are always in danger of becoming homeless and really just losing everything because they didn’t have that much to begin with.”

-Loya, R.M. (2014). Rape as an economic crime: The impact of sexual violence on survivors’ employment and economic well-being. *Journal of Interpersonal Violence*, 30(16), 1-21.

SEXUAL/INTIMATE HEALTH

*“Burgess and Holmstrom found 78% of their sample had been sexually active at the time of rape but, of these, 38% gave up sex for at least 6 months and 33% decreased their frequency of sexual activity after rape. Studies comparing sexual satisfaction of rape victims with non-victims **all** report that rape survivors experience less sexual satisfaction.”*

-Mason, F. and Lodrick, Z. (2013). Psychological consequences of sexual assault. *Best Practices & Research Clinical Obstetrics and Gynaecology*, 27(2013), 27-37.

Sexual violence/assault can impact intimate sexual functioning in a variety of ways. Some national studies have reported that approximately 40% of American women have some form of sexual dysfunction which is thought to be related to previous sexual victimization.

Research evaluating sexual dysfunction in both male and female populations have seen correlations between prior sexual victimization and varying degrees of sexual dysfunction – with those experiencing more severe forms of victimization reporting more extensive sexual difficulties.¹⁰⁴ In a 2009 study, rape was twice as common among individuals with sexual difficulties, compared to those in a comparison group.¹⁰⁵

Survivors of sexual assault and violence have reported various types of sexual dysfunctions/difficulties. They have reported being fearful of sex, having a lack of interest in sex, an inability to get and/or maintain an erection, inability to become lubricated, difficulty achieving orgasm, inhibited sexual arousal, painful vaginal intercourse, and not feeling sexually satisfied. Not all survivors of sexual assault/violence encounter difficulties with sexual intimacy. Those who do have been reported to either have used avoidant coping mechanisms (avoiding sex, numbing themselves to sexual acts, feeling as though they have no ability to assert themselves sexually and just ‘giving in’, etc.) or they engage in high risk behaviors (become sexually compulsive, have unprotected sex without knowing a partner’s sexual history, engage in sexual activity while under the influence of mood altering substances, etc.).¹⁰⁶

REVICITIMIZATION

Unfortunately, a sad reality is that the occurrence of sexual assault/violence increases the risk for future victimization. One might think that survivors of sexual assault/violence might have increased sensitivity to potentially dangerous situations and heightened awareness regarding sexual violence that might keep them safer. However, many of the possible effects of victimization (depression, PTSD, alcohol abuse, sleep disorders, strained social relationships, sexually risk taking) actually put survivors at higher risk for being assaulted again. In particular, survivors of child hood abuse, whose internal sense of what is safe and not safe may have never been allowed to fully develop, are at risk. This is not

¹⁰⁴ Turchik, J.A. (2014). Female sexual victimization among college students: assault severity, health risk behaviors, and sexual functioning. *Journal of Interpersonal Violence*, 29(13), 2439-2457.

¹⁰⁵ Weaver, T.L. (2009). Impact of rape on female sexuality: Review of selected literature. *Clinical Obstetrics and Gynecology*, 52(4), 702-711.

¹⁰⁶ Turchik, J.A. (2014). Female sexual victimization among college students: assault severity, health risk behaviors, and sexual functioning. *Journal of Interpersonal Violence*, 29(13), 2439-2457.

to say that re-victimization is a guarantee, simply that repeated victimization (*re-victimization*) across the lifespan is more common than previously thought and not something which should ever be seen as a discrediting factor in a disclosure of sexual assault/violence.¹⁰⁷

THE SURVIVOR PROFILE

There are countless examples of survivors of sexual assault. Carolyn Craven describes the subtle ways in which some survivors suffer:

While I may not believe that all men are potential rapists, in fact, I must act as though they are because there's no way I can tell, walking down the street, whether or not that man just walking up the street in a three-piece suit or in blue jeans and a work shirt is a rapist. Therefore, I have to treat all of them as though they are, because I can't tell them apart. All women have to do that.



So, in a sense, all women are victims. All men are victims, too, because they viewed with fear and suspicion. For years, researchers have studied the impact of society on sexual assault and have realized to some extent the culture's collective responsibility for rapists. But is it possible to gauge the impact of sexual assault on society?

How many tears? How many relationships uprooted? How many post-rape suicides? How many social myths and fallacies? How many cases thrown out of court? How many cases never heard in court? How many misdiagnosed conditions? How many weapons, security systems and other forms of self-protection? How many police sex crime personnel? How many workshops, special training seminars and books such as this one? How much rage? How many lives shaken or devastated?

So, who are the victims? We all are. We all hurt. We all fear. We all suspect. We all suffer. We all need support. Women, men, all of us, have become the victims.

MARIA

When Maria reached her car, she found her tire had been flattened. She was returning to her apartment when a man shoved her back into the elevator as she was getting out at her floor. Maria recognized him before he ripped off her glasses and held a knife to her throat. She remembered the man (Ralph Lenko) as the stranger who had approached her earlier at the apartment swimming pool. Lenko forced her from the elevator into a storage room. He cut Maria's throat slightly. Trying to pull

¹⁰⁷ Martin, S. and Macy, R. (2009). *Sexual Violence Against Women: Impact on High-Risk Health Behaviors and Reproductive Health*. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Retrieved February 2, 2016 from: http://www.vawnet.org/summary.php?doc_id=2034&find_type=web_desc_AR

the knife away, she cut two of her fingers. He shifted the knife to the back of her neck and cut her again.

The man then forced Maria from the storage room to her apartment where he blindfolded her. Lenko ordered her to disrobe down to her panties, pantyhose and shoes. She heard his zipper. He seated himself next to her on the sofa, yanked Maria to him, pushed her to her knees and forced his penis into her mouth. Maria nearly vomited. He told her to take off the rest of her clothes and ordered her to stand. He inserted his fingers into her vagina; then raped her.

Afterward he asked her if she had a boyfriend, saying, "You better not lie to me. I know everything about you. I know what time you leave work, and I know what time you get home." Then, as though wooing, "I have seen you from afar, and I admired you for a long time."

He then forced his penis into Maria's rectum. She had diarrhea and evacuated her bowels twice. Lenko continued insisting that she "satisfy" him. Despite Maria's gagging and vomiting, he resumed the oral copulation. He attempted to rape her again but did not ejaculate; so while wiping away the vomit, he again forced her to copulate orally.

The rapist finally decided to leave. On his way out, he threatened to kill Maria if she reported the rape to anyone. "It will be embarrassing for you only," he said.

A three year trial and appeal process began; the jury found Lenko guilty of forcible rape, sodomy, oral copulation, first-degree burglary (he took \$60 from Maria's wallet,) and kidnapping. The jury also found him guilty of causing great bodily injury (GBI), which automatically lengthened his minimum prison sentence.

Unfortunately, his sentence was reduced in the California Supreme Court of Appeals. The kidnapping conviction was cleansed because the distance from the elevator to Maria's apartment was said to be "not substantial," and the GBI charge was struck down. The court majority insisted that the lack of "visible injury, laceration or hematoma of the sexual organ or the anus" and the fact that Maria's knife wounds did not need suturing would not "permit" the court to hold the GBI conviction. Ralph Lenko could end up free after serving less than a year. **Maria is a victim.**

ANN

Ann walked into work with no suspicion of or inclination toward the ensuing events. She changed into working clothes and joined her coworkers in the foyer of the massage parlor.

Ann had been tricking for 4 of her 28 years. Employed for the past 2 years in New Mexico and Las Vegas, she moved to the West Coast in hope of entering law school full-time. She had taken this part-time job to pay her way.

As her peers huddled around the television watching a favorite soap opera, Ann sat on a corner couch studying contract law. A customer dressed in a gray suit stepped through the door in a hurry, as though he had just sprinted from his car.

"Close the door before I freeze my ass!" someone shouted from in front of the television. The customer glared in the direction of the TV and nearly turned on his heels to walk out. Then he noticed the young woman reading quietly in the corner.

The man approached Ann and made fumbling suggestions about going to her room for a "rum." The couple entered the sparse, windowless room. The trick stood uneasily for a moment, and then disrobed. He sat on the edge of the table and stared at the woman.

"How would you like it?" she asked, in attempt to play the familiar word game.

"How much will it cost me to fuck you from behind?" the customer mumbled. The game playing continued until they agreed on a price. Ann set her clothes on a chair and lay face down on the table as he instructed. The trick's behavior began changing as he paced about the small quarters. Ann was familiar with the rather bizarre actions of some clients, and this seemed like nothing alarming.

The man went to his clothes for a moment. Ann's back was to him as he returned to the table. She felt a cold piece of metal at her temple; he held a loaded blue magnum pistol. "Make a noise, scum, and I'll blast," he threatened.

Ann's coworkers, unaware of her plight, sat before the blaring television. The man forced the gun in and out of Ann's vagina; then forced her to copulate orally. Twice he struck her in the face with the butt of the pistol when he was unable to ejaculate. As he fled, his business card dropped from his loosened wallet.

Ann was taken to the hospital with multiple lacerations and wounds to the mons veneris, labia majora, perineum, vaginal vault, cervix, neck, and face. She was threatened with arrest for prostitution. No further investigation occurred. **Ann is a victim.**

SHELL

Dave, a 38-year-old magazine circulation director, came to the party with one thing in mind. His lover had left him only three days earlier because of Dave's violent outbursts. Now Dave mingled with the younger guests in a reserved manner, scanning the moving bodies as though counting magazine stacks.

Shell, an attractive 22-year-old employee of a telephone company, sat uncomfortably on a couch with three men who were begging for attention. Dave moved toward the couch and spoke quickly, yet firmly, to Shell, "Let's dance."

Shell, not amused by the antics of the trio, jumped up and headed toward the dance floor. The couple appeared awkward, as though they were dancing to entirely different songs. In the middle of the first song, Dave suddenly spun about, walked off the dance floor and headed out the door to his car. Shell, confused by Dave's turnabout, ran out after him.

"So, what's the matter? You don't like disco?" queried Shell. Dave stopped as he rounded the driveway of the large estate.

"I don't like loud music and boys who are forward. Besides, you don't want to dance with me. You just wanted to escape those flirts on the couch," cried Dave.

"You're right about those three, but give me a chance," Shell risked.

"I'll give you a chance," Dave blurted while revealing a snub-nosed revolver. "Do you like blood, dear?"

"Listen, I don't have a cent," Shell continued. "There's nothing you can take from me."

"Get in the car," Dave ordered. He forced Shell to drive the sports car into the hills. On the side of a dirt road, Shell was raped and left for dead – naked with a pen knife still twitching between his lower ribs.

Shell knew the decision to live or die required swift action. It was a long walk to the two-lane highway. Many people drove past the bleeding victim, ignoring Shell's pleas for help. It was not until Shell collapsed that a trucker pulled up to aid the assaulted man.

Since both Dave and Shell were males, Shell received less than sensitive treatment in the investigation phase. He never had contact with sex crimes detail. "Investigating gays assaulting gays doesn't fit in our job description," snarled the officer in charge of that department. **Shell is a victim.**

RUSSELL, JEREMY, CARL, THANE, SCOTT AND SUSAN

Every one of the boys in the family had gone through the ordeal except 13-year-old Russell. His brothers Jeremy, 14; Carl, 16; Thane, 17; and Scott, 18, had been forced at gunpoint by their father to engage in sexual relations with an 11-year-old cross-town girl named Susan.

The girl had been picked up as she played outside the home of a sitter and was taken to the abductor's home. The boys pleaded with their father to stop the torture. "I promised your mother I'd make you into men, and that's what I am going to do!" the man shouted. The boys knew their father would act on his drunken threat to shoot. In years past, Jeremy and Thane had been hospitalized with ice-pick puncture wounds. The boys lived in fear of their father; yet they had never reported his violent behavior.

Susan had withdrawn into unconsciousness by the time Russell was forced to undress. "She's dead, Father!" the boy cried. The man fired into the carpeted floor and demanded that the boy proceed.

As the other boys had done, Russell rubbed his flaccid penis against the girl's genitals, faking intercourse. The boys were then ordered from the room. The man fired, into his own head. **Susan, Russell, Jeremy, Carl, Thane and Scott are victims.**

JEFF

Mike could identify the prison's homosexual prostitutes, but their availability did not fulfill his need for power and dominance. "Fags who sell their services are less than useless to me. Showing him and the other guys that I can force my cock up his asshole isn't what I'm into. I'm looking for a gal-boy!"

That evening, Mike and a friend approached a young, rather frail convicted pot user named Jeff. "Grab this woman's ass!" Mike ordered his friend. They stuffed an old pair of underwear into Jeff's mouth, threw him from his bunk to the floor and bent him over a toilet seat.

After removing his pants, they forced dark machinery grease up his rectum with the aid of a metal pipe. After inserting the metal pipe, they pushed a rod through the pipe further up the canal. Jeff's muffled cries only heightened Mike's objective. Jeff was then raped anally over and over by three different men.

Fearing for his life, Jeff never told the prison staff what had taken place. Infection set in rapidly, and eventually a colostomy was required to save Jeff's life. Ironically, Mike's freedom came before Jeff's. **Jeff is a victim.**

SHARRON

It had been one week since Sharron and Randy had been separated... the longest the two had been away from one another in their eight year marriage.

Randy was staying at a friend's house six blocks away but drove by the house several times each night, watching shadows in the curtains. This evening he was not content to wait any longer. Sharron was asleep when her husband unlocked the front door. She jolted awake when she heard the wooden door slam shut and listened as the man's husky breathing moved toward the bedroom.

"Cut the drama," she shouted as Randy swung through the door.

"Why don't you want me to screw you anymore?" he snapped.

"You know this infection is painful, Randy. The doctor told me to stop for three weeks."

Randy climbed onto the bed and made attempts to pull the covers from Sharron. She resisted. "I told you I'm not interested in you sexually when I'm mad at you. Now just go back to your friend's house and leave me alone."

Randy reared back and slapped Sharron across the face, cutting her.

He jumped from the bed and opened the closet door. He grabbed a free coat hanger, flew back to the bed and forced the hanger over her head. With a quick twist, he yanked the hanger tight around Sharron's neck.

"Come on, bitch!" Holding the hanger tight, he undressed quickly. Randy raped Sharron while simultaneously mocking her cries.

"You...are...going...to...get...it...on!" **Sharron is a victim.**

WILMA, JEFFERSON, TANYA AND RANDOLPH

The family was excited about their move from Washington, D.C., to East Los Angeles. They had only been in their home two months when the unexpected event took place.

Wilma was walking home from adult school when a fellow student named Ben offered her a ride to her house. Because he seemed friendly enough and had impressed her with his knowledge of Los Angeles, she accepted, hoping to learn more about the new territory.

Ben said he needed gas and turned up an alley in a deserted industrial park. Half way up the alley he turned his van into an empty garage and revealed a stiletto blade. Ben asked Wilma if she knew what was coming next. She sat petrified. He raped Wilma, then drove her to the doorstep as if nothing had happened. As the door of the van slid closed behind her, she heard the man threaten, "Call the police and your kids will get to know my sharp friend here."

Tanya and Randolph were playing in the living room when the van pulled away. Wilma walked past the children and into the bedroom. Jefferson called to his wife from the kitchen but received no response. He found Wilma staring deep into the bedroom mirror.

Jefferson approached her and softly touched her shoulder. The woman suddenly began to scream and claw wildly at her husband. Randolph and Tanya stopped their play, ran to the room and found their father tightly holding their mother's wrists.

Wilma continued to scream at him to let her go. The children ran to their mother's aid, shouting at their father to let go. They tried to hug their mother, but she kicked at them. Jefferson took the children to their bedroom, where they sat on the edge of their beds, shaking in terror of the unknown. Wilma fell across her bed and pleaded with her husband to take her to the hospital. She refused to reveal the toll of the trauma.

A sitter was located quickly. The couple entered a hospital emergency department. As Wilma and Jefferson sat and waited, Jefferson's suspicions grew. Wilma was on the verge of convulsions. Jefferson asked his wife pointed questions, which she evaded. The hospital took note of the man's building rage.

Wilma was led in an examining room, where she curled into a ball like a child. "Don't tell the police," she cried. Lacking specialized training in post-rape trauma, the personnel were not adequately prepared for Wilma's plight. They suspected her reactions were due to a hallucinogenic drug overdose; so they immediately injected her with a major tranquilizer. Wilma soon lost consciousness.

Jefferson checked in with the sitter. The children had not slept. He could hear them crying in the background. The father felt too confused to speak with them. He hung up the phone and returned to his wife's bedside.

As morning approached, Wilma slowly awakened to her husband's tearful gaze. It took her nearly an hour to reveal the entire story. Jefferson was in a daze. He walked from Wilma's room, not hearing her plea for him to stay with her. Jefferson thought to himself, "How could this happen to me?"

Wilma returned home that night to frightened children and an ambivalent husband. Wilma shunned Tanya and Randolph. Jefferson's doubts grew, and his questions came hard and fast.

"Why were you talking to that man? Did you think of your kids before you let him give you a ride? That was a pretty revealing outfit you were wearing! What's the matter ... hadn't our sex been exciting enough for you? That'll teach you about going to school. Why didn't you just go to his apartment?"

The interrogation continued. Randolph and Tanya heard every word.

"Okay, so he had a knife. Where was the blade when he was taking off his pants? Did you ever try to run? Did you get the license plate number or did you even care? Do you think I'll ever have sex with you again now that someone else has had you?"

Jefferson ran from the house with a handful of clothes, shouting, "I'll kill the bastard!" The family car roared down the street with Jefferson in futile search. Wilma recoiled in self-blame and alcohol.

Jefferson did not return home for several weeks. He suffered from severe mood swings at work and self-medicated at his motel room. In anguish over his behavior, he was afraid to call home. He felt pain for his wife, yet was afraid to face her with his shame.

Randolph's grades plummeted, as he became preoccupied with bleak fantasies. Twice he was sent home from school for rough behavior with fellow students. Tanya regressed to bedwetting, nightmares, and thumb sucking. Her condition resembled autistic absorption.

Wilma's, reactive depression was complicated by her ensuing drinking. Her physical health and social functioning fell to a dangerously low point. She developed a skin disorder and musculoskeletal reaction in which emotional factors played a causative role.

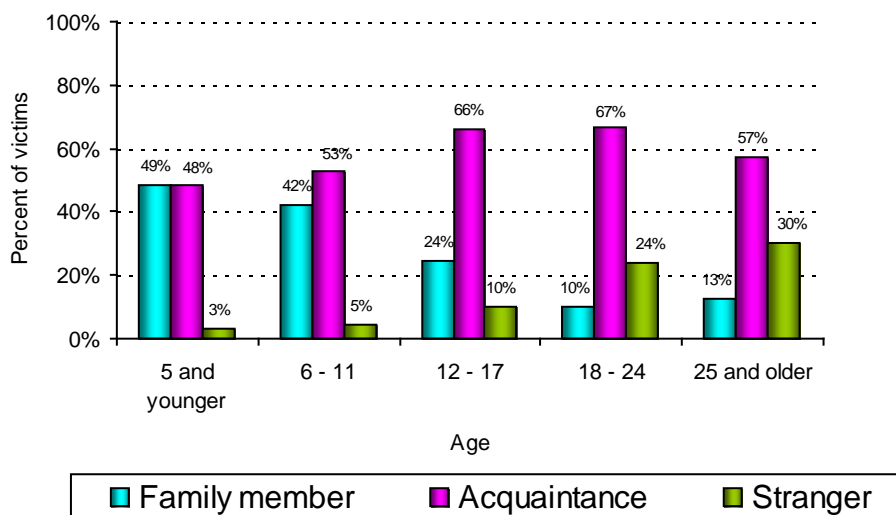
Jefferson eventually received individual counseling with a marriage and family therapist. This opened the door for family therapy. Communication levels were low. Once Jefferson moved back into the home, Wilma and he made some attempts to engage in sexual relations, but Wilma suffered from severe vaginismus during these attempts. It was nearly a year before Wilma felt safe leaving the house. She never returned to school. There are lasting scars. **Wilma, Jefferson, Tanya, and Randolph are victims.**

SEX OFFENDERS

Who are sex offenders, why do they offend, and how can they be stopped? Although there are no simple answers to these questions, this section will offer some data about sex offenders and why experts believe that individuals commit sex offenses.

One particularly important fact about sex offenders is that most are *known* to their victims. Only a small percentage of perpetrators are *unknown* (strangers) to their victims. The following chart details the relationship between victim and offender of reported sexual assaults. Generally, stranger sexual assaults are reported at higher rates than sexual assault perpetrated by acquaintances, especially family members. It should be expected that among all survivors, sexual assault by known perpetrators is even higher than this chart depicts.

Reporting Rates by Perpetrator Type



(Snyder, 2000)¹⁰⁸

In 2014, there were 11,466 reported rapes in Texas. Remember that the number of reported rates is far lower than the actual number of rapes that occur. Of those reports, 2,085 led to an arrest (i.e. about 5% of reported rapes result in an arrest). Of those arrested, 14 percent were juveniles (16 or under) and the remainder were adults; 95 percent were male, 75.8 percent were White, 23.7 percent were Black, 52 percent were Hispanic.¹⁰⁹

¹⁰⁸ Snyder, H. Sexual Assault of Young Children Reported to Law Enforcement: Victim, Incident and Offender Characteristics. BJS report, NCJ 182990, July 2000. Available here: <http://www.bjs.gov/content/pub/pdf/saycrlr.pdf>

¹⁰⁹ Crime in Texas (2014). Texas Department of Public Safety. Available here: <http://dps.texas.gov/crimereports/14/citCh3Add.pdf>

Around 10% of our prison population, nationwide, is comprised of sex offenders representing over 150,000 incarcerated individuals.¹¹⁰ Sometimes when people hear this large number of incarcerated sex offenders, they feel relieved because they are 'off the streets.' Yet most, if not all of these sex offenders will be released back into our communities.

One notable fact about sex offenders is that they are typically arrested and convicted on only one occurrence of sexual assault. Research has taught us that sex offenders often offend more than once. The following excerpt is from the Center for Sex Offender Management's curriculum *Understanding Sex Offenders: An Introductory Curriculum*.¹¹¹

In a very influential study by Abel and his colleagues, several hundred sex offenders were granted federal assurances of confidentiality so that they could disclose to the researchers their full sex offense histories without the possibility of that information being reported to law enforcement. On average, these offenders admitted to having many more victims and offenses than were known to the authorities. Another study by Freeman-Longo and Blanchard yielded strikingly similar results, with significantly greater numbers of undetected deviant sexual acts than what were indicated in the official records for these offenders. Something else that was very noteworthy in this particular study was that some rapists of adult women reported that they had also committed sex offenses against children, and some child sexual abusers reported that they had also perpetrated rapes against adult women. This is referred to as "crossover." In other words, beyond what we learn about the actual numbers of undetected offenses and victims, we might also learn that there are additional types of deviant or criminal sexual behavior and the types of victims may be different than what is documented in official records.

There are many more sex offenders and many more sex offenses than will ever be reported to law enforcement.

CHARACTERISTICS OF SEX OFFENDERS

It would be helpful if sex offenders were easy to identify, or we could predict who might be a sex offender based on personality characteristics, demographics or any other variable. Unfortunately, there is no such thing as a 'sex offender profile.' Sex offenders are young, old, from all different socioeconomic levels, they can be exceptionally bright, average or of limited intellectual abilities, and while some think they must be 'crazy' to commit a sex offense, the truth is that most sex offenders are not psychotic (or crazy). The only characteristic that is predictable is that most sex offenders are male.¹¹² While the label of 'sex offender' might imply that individuals in this group are alike, they are actually a very heterogeneous group, not uniquely different from the general public (other than the fact that they have sexually assaulted others).

¹¹⁰ Harrison, P.M. & Beck, A.J. *Prisoners in 2005*. BJS, NCJ 215092, November 2006. Available here: <http://www.bjs.gov/content/pub/pdf/p05.pdf>

¹¹¹ Center for Sex Offender Management. *Understanding Sex Offenders: An Introductory Curriculum*. Available here: <http://www.csom.org/train/etiology/download/download.htm>

¹¹² *ibid*

That said, researchers have found some evidence of some issues that seem to be common to at least a broad group of offenders. Not every sex offender will have each of these characteristics and some of these features may be present in the general population. Having these characteristics does not make someone a sex offender, but sex offenders seem to share many, or at least some, of the following features:¹¹³

Deviant sexual arousal, interests or preferences.

Researchers have found that some sex offenders are aroused by things that are considered to be outside the realm of appropriate sexual interest and behavior. These might include:

- Engaging in sexual contact with young children or adolescents
- Having sexual contact with others against their will
- Inflicting pain or humiliation on others
- Participating in or watching acts of physical aggression or violence
- Exposing oneself in a public setting
- Secretly watching others who are undressing, unclothed or engaging in sexual activities

Cognitive Distortions of Pro-Offending Attitudes

Sex offenders may tell themselves that their actions are not harmful and/or claim that the victim enjoyed it. Or they may tell themselves that women deserved to be treated in this way. By doing this, the sex offender gives themselves 'permission' to do something that would be wrong under other circumstances.

Social, Interpersonal, and Intimacy Deficits

Some sex offenders seem to have problems with effective communication, social isolation, social skills deficits or problems in intimate relationships. Researchers believe that these problems may play a role in the development of sexually abusive behavior.

Victim Empathy Deficits

Empathy means the ability to feel what another person may be feeling. Some sex offenders seem to lack the ability to be empathic. This characteristic is easy to see how it would play a role in how a sex offender is able to engage in sexually abusive behavior.

Poor Coping or Self-Management Skills

Some offenders have difficulty managing their emotions, or they may be highly impulsive. While these factors are common within the general population as well, emotional and behavioral self-regulation difficulties do seem to play some role in sex offending behavior.

Under-detected Deviant Sexual Behaviors

While this may be obvious, it's worth mentioning. A common characteristic of someone who may sexually abuse or assault someone is a history of sexually abusing and assaulting people. For many sex offenders, there is more than one victim.

¹¹³ Center for Sex Offender Management. *Understanding Sex Offenders: An Introductory Curriculum*. Available here: [http://www.csom.org/train/etiology/3/Etiology%20Curriculum%20Lecture%20Content%20-%20Characteristics%20\(Topic%203\).pdf](http://www.csom.org/train/etiology/3/Etiology%20Curriculum%20Lecture%20Content%20-%20Characteristics%20(Topic%203).pdf)

History of Maltreatment

There seems to be a relatively high amount of sex offenders that have a history of sexual or physical abuse. Certainly not all sex offenders were abused and there is no research that indicates that because someone was abused that it causes them to become a sex offender. There are many survivors of abuse who do not go on to commit sex offenses. But there does seem to be some relationship between being maltreated and later engaging in sex offending behaviors.

Sex Offender Subtypes

Sex offender subtypes can be helpful, particularly for those working to understand the motivations of sex offenders and potentially work with them or monitor them to avoid future victimizations. Once again, it is important to remember that while typologies can be helpful, sex offenders may not all fit as neatly into one type or another. In addition, crossover – the ability of a sex offender to fit into two or more categories or switch between categories, occurs.

One of the first classification models about sex offenders was developed by Dr. Nicholas Groth in 1979. It is important to recognize that Groth's typologies are based on research with incarcerated sex offenders and may not apply well to sex offenders overall. The system divided sex offenders into two groups: either child sexual abusers or rapists (adult). Child sexual abusers were then further classified as either 'fixated' or 'regressed' and rapists were further classified as either: anger rapists, power rapists or sadistic rapists.

Groth's Typologies:

Child Sexual Abusers

- **Fixated:** This group is made up of what we might commonly call pedophiles. Individuals whose sexual interests revolve around children. They tend to target young male children and will go through great efforts to 'groom' their victims.
- **Regressed:** This group is made up of individuals who typically select more appropriate sexual partners, but may turn to children for sexual contact as a means of coping or as a substitute for an appropriate partner. Their behaviors may be more situational and opportunistic.

Rapists

- **Anger Rapist:** This group is made up of individuals who commit rape as a means of expressing anger. They are physically aggressive and may cause considerable physical harms. These rapes may be more impulsive or situational and are generally preceded by some type of conflict or stressor.
- **Power Rapist:** This group is motivated by the need for power and to control their victim. These rapists may feel inadequate or insecure and use rape as a means of feeling powerful, strong or in control. These rapes may be more planned as the rapist may target someone who is vulnerable.
- **Sadistic Rapist:** This is the most dangerous type of offender in Groth's Typologies. The sadistic rapist gains pleasure – including sexual arousal – from inflicting pain on their

victims. These individuals are extremely abuse and may mutilate or kill their victims. There is considerable planning and victims may be targeted because of specific attributes.

To date, one of the most comprehensive typologies was developed by Knight and Prentky in 1990 at the Massachusetts Treatment Center.¹¹⁴ Like Groth's typologies, it divides sex offenders into either child molesters or rapist, but does contemplate the possibility of crossover.

Massachusetts Treatment Center (MTC) – Knight and Prentky

Child Sexual Abusers

- High fixation/high social competence
- High fixation/low social competence
- Low fixation/high social competence
- Low fixation/low social competence

Much like Groth's typologies, child sexual abusers are identified as either having a high fixation on children (fixated) or who have a 'low' fixation or more age appropriate sexual preferences. Individuals are further sub-divided based on their level of social competence.

- High contact/interpersonal
- High contact/narcissistic
- Low contact/low physical injury/non-sadistic
- Low contact/low physical injury/sadistic
- Low contact/high physical injury/non-sadistic
- Low contact/high physical injury/sadistic

The MTC system also consider the amount of access the offender has with children , if they are attempting to create a 'relationship' with the child, the degree of physical harm caused to the child and whether the offender is considered to be sadistic or not.

Rapists

- **Opportunistic.** These individuals commit rapes that are impulsive, unplanned and opportunistic. Physical violence is usually limited to the amount of force necessary to complete the assault.
- **Pervasively Angry.** These individuals have generalized anger and hostility issues. They are driven by anger and will use excessive force during the assault. They often have low social competence and a history of anti-social behavior.

¹¹⁴ Classifying Sexual Offenders: The Development and Corroboration of Taxonomic Models (From Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender, P 23-52, 1990, W L Marshall, et al, eds. -- See NCJ-125290). Abstract available here: <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=125291>

- **Sexual Gratification.** This group is made up of offenders who have extensive sexual fantasies or preoccupations which are incorporated into the assault. This group includes sadistic rapists.
- **Vindictive.** The vindictive rapist has strong anger towards women. Their offenses seek to humiliate and harm their victims.

Sex offender typologies are useful for understanding the motivations of sex offenders. They may help a survivor understand why they were attacked or why something happened during the assault. However, caution should be used when applying these subtypes as every sex offender, just as every victim, is unique in their own way.

Section 2: SYSTEM RESPONSE

TEXAS LEGAL DEFINITION OF SEXUAL ASSAULT

The legal definition of sexual assault can be found in the Texas Penal Code, Sec. 22.011. Without reiterating the statute, the offense can be described within its three basic components. The first component is that the accused purposefully ('intentionally and knowingly') committed the act. The second component is that the accused committed a specific act. For sexual assault, the act is described as:

- the penetration of the anus or sexual organ of the victim by any means,
- the penetration of the mouth of the victim by the sexual organ of the actor, or
- causing the sexual organ of one person to contact or penetrate the mouth, anus or sexual organ of another person.



Finally, the third component is that the act was committed without the consent of the victim. If the victim is a 16 years old or younger, and since children 16 and under are not legally able to consent to sexual acts, only the first two components (the intent and actually committing the act) are required.

The law includes specific instances when consent is CANNOT given. These include:

1. The victim submits because of physical force or violence
2. The victim submits because of threats of violence
3. The victim is unconscious or physically unable to resist
4. The victim has a mental disease/defect
5. The victim is unaware that the sexual assault is occurring
6. The victim has been drugged
7. The victim submits because of threats of violence to another person
8. The accused is a public servant who coerces the victim
9. The accused is a mental health provider and is exploiting the victim's emotional dependence
10. The accused is a clergyman and is exploiting the victim's emotional dependence

11. The accused is an employee at a facility where the victim is a resident (unless they are married)

A number of additional 'sexually assaultive' offenses also exist. Two of the most common are:

Aggravated Sexual Assault (Texas Penal Code, Sec. 22.021). A sexual assault rises to the level of aggravated sexual assault when the victim:

- sustains serious bodily injury
- if they are in fear of their or another person's life
- if they are under 14 years of age
- if they are disabled or elderly.

Indecency With a Child (Texas Penal Code, Sec. 21.11). This offense addresses the sexual abuse of a child that stops just short of sexual assault (penetration).

OVERVIEW OF THE CRIMINAL JUSTICE SYSTEM

BASIC OUTLINE

Defendant is charged with offense.

One of the Criminal Courts obtains jurisdiction of the case. Information as to the location of the case can be obtained by calling the District Clerk's office or the District Attorney's office, and giving the defendant's name. If one does not know the defendant's name, call the District Attorney's office any time after the Preliminary Initial Appearance.

1. **Preliminary Initial Appearance:** within 24 hours of arrest the defendant will appear before the judge or magistrate.
 - a. The Court will see that the defendant is represented by counsel. If indigent, the court will appoint an attorney.
 - b. The Court will make sure that the defendant understands the charge against him.
 - c. The Court will make a finding if there is probable cause to send the case to the Grand Jury.
 - d. Survivor will not be needed at this stage.
 - e. Survivor can ask the D.A. to request conditions on bond.
2. **Examining Trial:** Defendant may request examining trial; witnesses may need to be available. The D.A. attempts to circumvent this most of the time.
3. **Grand Jury:** If the Court finds probable cause, the case is sent to a 12-person grand jury.
 - a. This body sits for a 3-month term.

- b. The grand jury either issues a true bill (indictment) or a no bill usually within two weeks after preliminary initial appearance.
 - c. If a true bill, the case is sent back to the original court conducting the preliminary initial appearance giving the court jurisdiction over the case until disposition of the case is over.
 - d. Normally the survivor is not needed to testify at this stage; however, the grand jury may want to hear testimony.
 - e. The State of Texas is the charging party.
 - 1. D.A.'s office represents the State of Texas as a party to the case
 - 2. The survivor is considered a witness, not a party. The prosecutor is not the survivor's lawyer).
 - f. Court is assigned at random to dispose of case.
Bond is automatically set when defendant is charged.
Bond may either be raised or lowered. Conditions may also be set, such as no contact with survivor, etc.
4. **Arraignment**
- a. Usually waived; the defendant does not verbally enter a plea at this time.
 - b. This is a good time for the D.A. and the defense attorney to get together and discuss the case, usually for the first time, for several plea negotiations.
 - c. Survivor should notify the D.A. that he/she wants to be involved in the plea negotiations.
 - d. Case is usually reset a couple of weeks later for a non-issue reset.
 - e. Survivor is not needed at this stage.
5. **Non-issue Setting:** There may be several of these to accomplish plea bargaining and discovery.
- a. Again, a time for the state and defense to get together and discuss the merits of the case.
 - b. Survivor is not needed at this setting.
6. **Disposition Setting**
- a. Last reset date for discussion of the case.
 - b. If plea bargain is not reached, the case will be set for trial.
 - c. If plea agreement is made, the plea may be taken or reset.
 - d. Survivor is not needed at this setting.
7. **Plea**
- a. Defendant may plead guilty, not guilty or no contest.
 - b. Defendant may plead in exchange for the agreed punishment recommended by the State.
 - c. Defendant may plead to the Court without an agreement with the State.
 - i. The Court would order a pre-sentence investigation report before deciding upon the appropriate punishment.

- ii. The sentencing would be reset for approximately six weeks until receipt of the report.

8. Trial

- a. Defendant elects to have case tried by court judge or jury.
- b. If found guilty by a jury, the defendant also elects whether the judge or the jury would assess punishment.
- c. Procedure:
 - i. Jury selection
 - ii. State's case presented
 - iii. Defense's case presented
 - iv. Both sides rest and close
 - v. Judge charges the jury with the law
 - vi. Summation by the attorneys
 - vii. Deliberation

9. Punishment

- Class A Misdemeanor – Fine not to exceed \$4000.00 and/or less than 1 year in jail
- Class B Misdemeanor – Fine not to exceed \$2000.00 and/or less than 180 days in jail
- Class C Misdemeanor – Fine not to exceed \$500.00
- Capital Felony
 - (i) Capital Felony: a person adjudged guilty of a capital felony in a case in which the state seeks the death penalty shall be punished by imprisonment in the Texas Department of Corrections for life or by death. An individual adjudged guilty of a capital felony in a case in which the state does not seek the death penalty shall be punished by imprisonment in the institutional division for life.
 - (ii) In a capital felony trial in which the state seeks the death penalty, prospective jurors shall be informed that a sentence of life imprisonment or death is mandatory on conviction of a capital felony. In a capital felony trial in which the state does not seek the death penalty, prospective jurors shall be informed that the state is not seeking the death penalty and that a sentence of life imprisonment is mandatory on conviction of the capital felony.
- First Degree Felony Offense: 5 to 99 years, or life in the Texas Department of Corrections. Fine not to exceed \$10,000.
- Second Degree Felony Offense: 2 to 20 years in the Texas Department of Corrections. Fine not to exceed \$10,000.

- Third Degree Felony Offense: 2 to 10 years in the Texas Department of Corrections. Fine not to exceed \$10,000.
- State Jail Felony: 180 days to 2 years. Fine not to exceed \$10,000.
If the defendant has not been convicted of a felony before or has not received a felony probation, the Judge or jury may recommend probation on the term of years not exceeding 10 years. (Probation is supervised by the Court during the term assessed.)

10. **Sex Offender Registration/Notification** – Required for a person who has a reportable conviction or adjudication of a sexual offense under Chapter 62, Texas Code of Criminal Procedures.

Informs:

- Judicial System
- Community Supervision
- Juvenile Probation
- Texas Department of Criminal Justice
- Law Enforcement Agencies
- Schools-both public and private

11. **Victim Service**

- Victim Lounge.
- District Attorney Victim/Witness Program.
- Victim Assistance Program.

SUGGESTIONS FOR COURT ACCOMPANIMENT ADVOCATES

- Without speculation on the merits of the survivor's case, provide him/her with as much information as possible on the court system. It is much better to tell the survivor that you do not know the answer to a question than give incorrect information.
- Often the survivor is not as concerned about a particular legal aspect of their case, as they are afraid and frustrated by an unfamiliar set of circumstances or intimidated by the threats of the defendant. If the defendant threatens the witness she/he should contact the police and the victim witness office immediately.
- If the survivor does want to know about a particular problem in his/her case, call the victim witness office and the sexual assault coordinator will provide the information or will contact the prosecutor.
- Postponements are an inherent problem in the judicial system and the effect can be devastating to a witness. Regardless of the type of case, cases are given scheduling priority according to the amount of time the defendant is not in jail, and out on bond: how old the

case is in relation to the others on the court's docket (unless the case is given a priority setting).

- Some courts, especially the older ones, have more of a backlog than others do, which further aggravates the problem. Postponing the case is also a standard defense tactic because the more frustrated the witness gets; the less likely the witness is to appear when the trial finally does begin.
- Assure the survivor that the postponement is not due to a frailty in the case. The victim witness office can work with her/him to place he/she ON-CALL for court appearances in conjunction with the prosecutor. That is, they will not have to come to the courtroom until called when the case is certain to go to trial.
- The Texas Penal Code requires the defense to inform the court (out of the hearing of the jury) prior to asking any question of the survivor concerning specific instances, opinion evidence, or reputation evidence of prior sexual conduct. After this notice, the judge will hold an IN CAMERA hearing to determine whether the proposed evidence is admissible and the limitations of such questioning. If the witness is concerned, advise discussion with the prosecutor.
- The most common defenses in a sexual assault case are either identity or consent. In an identity defense, the defendant does not deny that the witness was sexually assaulted, but asserts that he/she did not do it. In a consent defense, the defendant will claim that he/she did have intercourse with survivor, but it was consensual.
- Assure the witness that the trial will be difficult to go through, but not impossible. Often it is beneficial to contact the victim witness office to find a scheduled trial for the witness to observe.
- Information on the Texas Crime Victims' Compensation Act is available through the victim witness office. The act provides payment of medical bills and counseling expenses for victims of violent crime less insurance benefits. For more information on Crime Victims' Compensation, you may contact the Crime Victims' Compensation Division at the Office of the Attorney General at 1-800-983-9933.
- Billing for the sexual assault forensic exam itself is covered under another statute. Other bills related to the collection of forensic evidence are paid by the law enforcement agency.
- Finally, you may be the first contact that the victim has. Your function is an invaluable one and much needed. Please feel free to call on the victim witness office to help you with any problems.

SUGGESTIONS FOR WITNESSES

- **Answer all questions directly**—Answer only the question that is asked. If you can answer with a "yes" or "no," do so. If you do not understand a question, **feel free to ask to have the question repeated or explained.**
- **Speak clearly and distinctly**—The juror farthest from you should be able to hear you.
- **Be attentive**—Remain alert at all times so that you can hear, understand, and give a proper response to each question. Avoid trying to "second guess" the questioner. The prosecutor will develop the case by your testimony and will object to any improper questioning by the defense during cross-examination.
- **Do not be afraid to tell the truth**- Do not guess or make up an answer. If asked little details you do not remember, it is best to say, "I don't remember."
- **Do not lose your temper**—Losing your temper during cross-examination may mean losing your credibility. Anger will lessen your recall ability and may cause you to make incorrect statements.
- **Dress conservatively and be courteous**—The jury knows nothing about you, except for the impression that you make with your testimony and with your appearance. Wear clothing that will not distract the judge or jury from your testimony.
- **Bring friends and family**—You will only be present in the courtroom for your testimony and the closing arguments. This is to ensure that the testimony of one witness will not influence that of another, and is called "invoking the rule." The support of friends and family is helpful at this time, although they cannot relate actual proceedings to you. A coordinator from the victim witness office or an advocate from the sexual assault program will also accompany you, if called.
- **Be aware that the defendant will be in the courtroom at all times and that you will be asked to identify him**—This is easier to deal with if you prepare beforehand. Remember that the defendant is on trial; you are not!
- **Take a positive attitude with you**—It is not a good idea to go into trial with revenge in mind as no amount of punishment for the defendant can atone for what you have gone through. By going through the ordeal of testifying you have shown a great deal of courage and concern for others by hopefully preventing this from happening to someone else.

BASIC LEGAL CONCEPTS

The following rights and privileges are accorded to those accused of crime by the Constitution and The Bill of Rights.

- **The defendant is innocent until proven guilty:** This concept is the foundation of our judicial system and influences every other legal principle.

- The defendant has the right to trial by jury: The Sixth Amendment to the Constitution guarantees that in all criminal proceedings, the accused shall enjoy the right to a speedy and public trial by an “impartial jury.”
- The defendant has a right to counsel: This is an inherent right of any defendant and the State must provide counsel if the defendant cannot secure his/her own.
- The burden of proof belongs to the state: The State has the burden of proof and must show BEYOND A REASONABLE DOUBT that the accused committed the act charged. This phrase means that a member of the jury must have no reasonable doubts about the defendant's guilt. If the juror does have a reasonable doubt, the juror must vote "Not Guilty."
- The defendant has a right to confront witnesses: The Sixth Amendment also guarantees that the accused shall be allowed to confront the witnesses against him. The defendant also has the right to cross examine any witnesses presented by the State. For this reason, the defendant will always be present in the courtroom, while the witness will be present only for her/his testimony.
- The defendant does not have to testify: The jury cannot deliberate the issue of whether or not the defendant testifies. The full burden of proof lies with the State and it must supply the evidence.

ELEMENTS OF A TRIAL

- **Pre-Trial Setting**—any court setting scheduled before a trial setting.
- **Non-Trial Setting**—any setting that is not a trial setting.
- **Motion Setting**—a requested setting by either the attorney for the defense or the state for the court to rule on a legal issue. Motions may be for continuances, suppression of evidence (such as prior sexual history or improperly taken confession), for speedy trial by the defendant, etc.

The trial is the most effective method that our society has devised to settle disputes among people. A trial is not a contest: there is not a winner or loser. A trial is a method of gathering facts and drawing a conclusion from those facts while operating under procedural code.

THE PROGRESS OF A TRIAL

- The defendant is read his charge by the judge and **pleads** "Not Guilty."

- The defense attorney and the prosecutor question prospective jurors and select those that will become jury members (**Voir Dire**).
- The prosecution, representing the State, makes the **opening statement** to the jury, outlining the case to be established.
- The **prosecution** calls its witnesses and offers evidence.
- The defense may **cross examine** the State's witnesses after the State has concluded the **direct examination**. The State may then take the witness on **re-direct examination** after the defense concludes the cross exam. The defense may take the State's witness on **re-cross examination** after the State concludes the re-direct exam, etc.
- When the state has concluded its case, or **rested**, the defense, representing the defendant, makes its **opening statement**, and puts on its evidence and witnesses.
- The prosecution and the defense then offer their **final arguments** to the jury. Usually, the witness may come back into the courtroom to hear this summation.
- The jury then retires to **deliberate** the guilt or innocence of the defendant.
- If the defendant is convicted by the jury then both the defense and the prosecution present in the **punishment** phase.
- Texas has a **bifurcated** trial system. That is, the trial is held in two stages: the guilt stage and the punishment stage.
- The jury must be unanimous in their decision. If the jury cannot come to a verdict, a **mistrial** results in the form of a **hung jury**.
- The case may also result in a **mistrial** if the judge so rules on a procedural error.
- If the defendant is found **not guilty** there will not be a retrial. The rule of **double jeopardy** prohibits the accused from being tried twice for the same offense (with some exceptions).
- The defendant may waive his right to a jury trial and go directly to the judge in a **bench trial**.
- If the defendant is found guilty some judges will order the probation department to complete a **pre-sentence investigation report, or "PSI,"** on the defendant before the judge will rule on punishment.

Portions of the above have been adapted from publications of the Chicago Women Against Rape. Chicago, Illinois.

DEFINING ADVOCACY

Advocacy is one of the five minimum services to be provided by every Texas rape crisis center. It is also at the heart of what rape crisis centers do and the way they do it. At its most basic level, advocacy means providing assistance on behalf of a survivor of sexual violence. This assistance must be victim-centered which means the expressed needs of the sexual assault survivor guides the advocate in the provision of advocacy. The following three steps can ensure that advocacy is being provided in a victim-centered manner.

1. Check in with the survivor to determine their needs
2. Inform the survivor of options and opportunities
3. With the survivor's consent, act on their behalf

Typical Activities that may be considered advocacy include:

- Attending exams, meetings, interviews and proceedings at hospitals, law enforcement offices, prosecutors' offices and courts with the survivor.
- Providing preparation for, and information about, what to expect of the examination, interview, meeting or proceeding.
- Explaining and clarifying options to survivor
- Assisting with immediate and basic needs such as transportation and clothing.
- Providing referrals as needed.
- Offering empathic, non-judgmental support and guidance, regardless of the choices a survivor makes.
- Providing information about Crime Victims' Compensation application and benefits and assisting with the application process.
- With the survivor's consent, following-up with the survivor according to agency policy and procedures.

VICTIMS' BILL OF RIGHTS

Texas law enumerates many rights concerning the treatment of and participation by crime victims in the criminal justice process. Certain rights apply specifically to sexual assault survivors, and others apply to all crime victims. Additionally, some rights apply automatically, whereas others only apply "upon request" by the victim. In cases involving minor victims, the rights may be invoked by the minor's parent or guardian.

Violations of these rights cannot give rise to financial liability on the part of an official or agency, but violations can often be enforced by requesting that the court issue an order to correct the violation.

Rights of Victims of Sexual Assault (Art. 56.021, Code of Criminal Procedure)

- The right to a forensic medical examination if, within 96 hours of the offense, the survivor presents at a health care facility emergency department and consents to the examination.

- If requested, the right to disclosure of information regarding any evidence collected during the investigation, unless disclosing the information would interfere with the investigation or prosecution, in which event the victim shall be informed of the estimated date the information can be disclosed.
- If requested, the right to a disclosure of information regarding the status of any analysis being performed on evidence collected during the investigation.
- If requested, the right to be notified (1) at the time evidence is submitted to a crime laboratory to process and analyze evidence collected during the investigation, (2) at the time a request is submitted to compare biological evidence with DNA profiles maintained in a DNA database, or (3) of the results of a comparison of biological evidence with DNA profiles maintained in a DNA database (unless disclosing those results would interfere with the investigation or prosecution).
- The right to request that a prosecutor file an application for a protective order on behalf of the victim.
- The right to be informed that the victim or the victim's parent or guardian may file an application for a protective order, the court in which the application may be filed, and that, on request of the victim or the victim's parent or guardian, a prosecutor may file the application on behalf of the victim.
- If the victim or victim's parent or guardian is present when the defendant is convicted or placed on deferred adjudication, the right to be informed about protective orders and, if the court has jurisdiction over applications for protective orders, the right to file an application for a protective order immediately following the defendant's conviction or placement on deferred adjudication.
- If requested, the right to counseling regarding HIV/AIDS infection.
- Testing of the victim for HIV/AIDS, HIV antibodies, or infection with any probable causative agent of AIDS.

Constitutional Rights of Crime Victims (Art 1, § 30, Texas Constitution)

- The right to be treated with fairness and with respect for the victim's dignity and privacy throughout the criminal justice process.
- The right to be reasonably protected from the accused throughout the criminal justice process.
- On request, the right to be notified of court proceedings.
- On request, the right to be present at all public court proceedings related to the offense, unless the victim is to testify and the court determines that the victim's testimony would be materially affected if the victim hears other testimony at the trial.
- On request, the right to confer with a representative of the prosecutor's office.
- On request, the right to restitution.
- On request, the right to information about the conviction, sentence, imprisonment, and release of the accused.

Rights of Crime Victims (Art. 56.02, Code of Criminal Procedure)

- The right to receive from law enforcement agencies adequate protection from harm and threats of harm arising from cooperation with prosecution efforts.
- The right to have the magistrate take the safety of the victim or his family into consideration as an element in fixing the amount of bail for the accused.
- If requested, the right to be informed by the prosecutor of relevant court proceedings, including appellate proceedings, and to be informed if those proceedings have been canceled or rescheduled.
- If requested, the right to be informed by an appellate court of decisions of the court, after the decisions are entered but before the decisions are made public.
- If requested, the right to be informed by a peace officer concerning the defendant's right to bail and the procedures in criminal investigations, and by the district attorney's office concerning the general procedures in the criminal justice system, including procedures in guilty plea negotiations and arrangements, restitution, and the appeals and parole process.
- The right to provide pertinent information to a probation department conducting a presentencing investigation concerning the impact of the offense on the victim and his family by testimony, written statement, or any other manner prior to any sentencing of the offender.
- The right to receive information regarding Crime Victims' Compensation, including eligibility, the costs that may be compensated, the amount of compensation, application procedures, and referral to available agencies for assistance.
- Upon request, the right to be informed of parole procedures, to participate in the parole process, to be notified of parole proceedings, to provide the Board of Pardons and Paroles for inclusion in the defendant's file information to be considered by the board prior to the defendant's parole, and to be notified of the defendant's release.
- If available, the right to a waiting area separate and secure from other witnesses before testifying in any proceeding. If not available, other safeguards should be taken to minimize the victim's contact with the offender and the offender's relatives and witnesses.
- The right to prompt return of property of the victim held by law enforcement or the prosecutor's office as evidence when the property is no longer required for that purpose.
- If requested, the right to have the prosecutor notify the victim's employer of the necessity of the victim's cooperation and testimony in a proceeding that may necessitate the absence of the victim from work for good cause.
- The right to request victim-offender mediation coordinated by the victim services division of the Texas Department of Criminal Justice.
- The right to be informed of the uses of a victim impact statement and the statement's purpose in the criminal justice system, to complete the victim impact statement, and to have the statement considered by the attorney representing the state and the judge before sentencing or before a plea bargain agreement is accepted and by the Board of Pardons and Paroles before an inmate is released on parole.
- For victims of assault or sexual assault who are younger than 17 years of age or whose cases involves family violence, the right to have the court consider the impact on the victim of a continuance requested by the defendant. If requested by the prosecutor or

defense counsel, the court shall state on the record the reason for granting or denying the continuance.

- If the offense is a capital felony, the right to receive by mail from the court a written explanation of defense-initiated victim outreach if the court has authorized expenditures for a defense-initiated victim outreach specialist, not be contacted by the victim outreach specialist unless the victim has consented in writing to the contact, and to designate a victim service provider to receive all communications from a victim outreach specialist acting on behalf of any person.

CRIME VICTIMS' COMPENSATION

A Resource For Victims

The Crime Victims' Compensation Act, passed in 1979, created the Crime Victims' Compensation Fund. The fund is supported by persons convicted of crime through payments of court costs and probation fees in amounts ranging from \$15 to \$45.



Costs That May Be Compensated

The Crime Victims' Compensation Fund can provide financial assistance for a variety of expenses related to a crime. For example, Crime Victims' Compensation can help pay:

- The medical bills associated with the injuries caused by sexual assault;
- The counseling expenses of an abused child or a sexual assault survivor, and assist with counseling for members of the victim's immediate family;
- Compensation for lost wages and loss of support payments in certain situations. CVC can assist victims and their families with travel expenses associated with medical treatment and court appearances associated with the crime. All expenses must be for items that fall within the general categories listed below and are necessary and related to the crime.
 - Reasonable medical, ambulance, prescription and rehabilitation expenses
 - Mental health counseling
 - Burial and funeral expenses
 - Lost wages and loss of support
 - Travel associated with seeking medical treatment, or attending and/or participating in the criminal justice process
 - Reasonable attorney fees for legal assistance in filing the crime victims' compensation application and in obtaining benefits, if the claim is approved
 - Reasonable costs associated with crime scene cleanup
 - Reasonable replacement costs for items such as clothing or bedding taken as evidence or made unusable as a result of the criminal investigation
 - Some moving costs if the assault or stalking occurred at victim's residence.
 - Reimbursement for property damage or loss is **NOT** an eligible expense.

Amount Of Compensation

- Total recovery may not exceed \$50,000 unless the injury is catastrophic.
- Individuals who suffer total and permanent disability as a result of their victimization may qualify for an additional award from \$25,000 - \$75,000 which may be used for expenses such as lost wages, prosthetics, rehabilitation and making a home wheelchair accessible.

Recoveries From Other Sources

The Crime Victims' Compensation Fund is regarded as "the payer of last resort." Other sources, such as health care insurance or Medicaid, must be considered first. The staff in the Crime Victims' Compensation Division will work with applicants to see that all available resources are coordinated to work in the best interests of the victim.

Who Is Eligible?

- Victims who suffer bodily injury, emotional harm or death as the result of a violent crime.
- U.S. residents who become victims of crime in Texas, and other Texas residents who become victims of crime in a state or country without a compensation program.
- Immediate family members of a victim and people who legally or voluntarily assume expenses related to the crime.
- Public safety professionals and citizens who are injured or killed as the result of intervening on the behalf of a victim or law enforcement.

To be eligible, the victim and/or claimant cannot share responsibility for the crime. The crime must be reported to a law enforcement agency and the victim must cooperate with criminal justice authorities. The only exception to this cooperation requirement is that sexual assault survivors who obtain forensic medical examinations without police involvement are eligible for reimbursement of emergency room costs without reporting to police (Article 56.54(k)(2), Texas Code of Criminal Procedure (effective September 1, 2015)).

How To Apply

Applications are available from hospitals, law enforcement agencies and prosecutors' offices. The Crime Victims' Compensation Division also provides applications, brochures and posters. For more information, contact:

Office of the Attorney General
Crime Victims' Compensation Division
P.O. Box 12198
Austin, TX 78711
1-800-983-9933

The Crime Victims' Compensation Division Staff are available to help victims and their families access this program. Applications are available in English and Spanish; the toll-free number is staffed by both English and Spanish speakers. Applications and information are also available from the CVC website: <http://www.oag.state.tx.us>

ADDRESS CONFIDENTIALITY PROGRAM

For added privacy protection, the Office of the Attorney General also administers the Address Confidentiality Program. (Texas Code of Criminal Procedure, Ch. 56, Subch. C) Survivors of sexual assault, family violence, and stalking are eligible to participate in the Address Confidentiality Program.

The Address Confidentiality Program is an important privacy tool for many survivors. Even with a pseudonym on all public records, criminal defendants have the constitutional right to know the survivor's true identity (the Sixth Amendment right to confront witnesses). However, defendants do not have the right to know where survivors live. That's where the Address Confidentiality Program comes in.

The OAG provides survivors with a PO box address to be used for all survivors' first class mail. Survivors can use the PO box address for virtually any public document or registration, including court records, driver's licenses, school registration, and service of process for court proceedings. The only uses that are prohibited are for utility providers and creditors. The PO box lasts 3 years, and survivors may apply for renewal.

Thus, although defendants will learn survivors' identities, the Address Confidentiality Program helps promote survivors' safety by keeping survivors' locations secret. To enroll, a survivor must:

1. Meet with a victim assistance counselor to discuss the Address Confidentiality Program;
2. File an application to participate in the program;
3. Designate the attorney general as agent to receive service of process on behalf of the survivor; and
4. Live at, or relocate to, an address that is unknown to the perpetrator.

(Texas Code of Criminal Procedure, Art. 56.82)

PSEUDONYM

In 1988, the state of Texas made available to sexual assault survivors the option of using a pseudonym. A survivor can fill out a form to choose a false name to be used on all legal and medical documents associated with the assault. Using a pseudonym may help shield the survivor from unwanted publicity. (If the case goes to court, though the pseudonym will still be used, there may be enough information, including photographs, to identify the survivor anyway). As of 2015, stalking victims may also use pseudonyms.

If a survivor chooses to use a pseudonym, all people and agencies involved in her/his case must receive a copy of the pseudonym form—the hospital emergency room and registration, the police or sheriff's office, Crime Victim's Compensation, her/his therapist, sexual assault programs, etc.

The intent of this legislation was to give survivors a choice in protecting their identity. For many victims, the greatest fear is that their name will appear in the press. It is intended that this option will encourage more survivors to file complaints and experience a sense of privacy when they do.

- Pseudonym forms are available from local sexual assault programs or the Office of the Attorney General—Sexual Assault Prevention and Crisis Services.
- Law enforcement agencies are encouraged to use the pseudonym form routinely and at first contact. If it is not proffered and the victim requests it later, all public records and court proceedings will need to be changed retroactively. The law was specifically designed to affect the General Offense Report since most news media obtain their information there first.
- The pseudonym can be used for children. It is not addressed as a requirement or prohibition in the bill.
- We suggest that the word "pseudonym" be used in place of the name on any public documents. Please advise survivors that the name they choose will follow them through the criminal justice system. Care should be taken in the choice. Also, the pseudo-address and phone number used should be that of the police department or sexual assault program or it should be left blank on the affected documents.
- A space is provided on the form for the survivor to give permission for release of information for specific purposes. This should help investigations, insurance payments and counseling referrals.
- Law enforcement should make an extra copy of the form to give to the victim.
- The form, or a copy of it, should follow the case file to court and probation or parole.
- All press releases or statements about a sexual assault case should include a disclaimer that a pseudonym is being used.
- A potential jury can be polled about whether or not they know the survivor by bringing her/him into the courtroom during voir dire (questioning of potential jury members).

Pseudonym forms for various types of crime victims can be found on the website of the Texas Attorney General: <https://www.texasattorneygeneral.gov/cvs/crime-victim-forms-applications>

The pseudonym form for sexual assault survivors can be found here: https://www.texasattorneygeneral.gov/files/cvs/pseudonym_sapcs.pdf

PSEUDONYM FOR SEXUAL ASSAULT SURVIVORS
All information will be kept confidential

Law Enforcement Agency:	Phone Number
Case # or Cause #:	Pseudonym *
Real Name	
Real Address	
Real Phone # (day)	(evening)
Alternate Contact Name	
Alternate Contact Phone # (day)	(evening)
* This name will be used in all public files to take the place of your real name. Your correct address and phone number will also be protected. (Texas Code of Criminal Procedure, Chapter 57B).	

RELEASE OF INFORMATION

To assist law enforcement with their investigation and obtain further assistance, I give permission for specific limited release of my real name, address, and phone number. By checking the following, my real information may be released to these specified agencies.

<input type="checkbox"/> Local advocacy program	<input type="checkbox"/> Local, State or Federal Attorney's Office
<input type="checkbox"/> Local, State, or Federal Law Enforcement Agency	<input type="checkbox"/> Medical Insurance Carrier
<input type="checkbox"/> Crime Victims' Compensation Program	<input type="checkbox"/> Local, State, or Federal restitution payment office

Survivor Signature (please use real name)

Date

Law Enforcement Officer Signature

Badge number

Date

The following program is available to you: _____

Advocacy Program name and phone number (to be filled in by officer)

For more information please contact:

The Office of the Attorney General
Crime Victim Services Division MC 011
PO Box 12548
Austin, TX 78711-2548

Phone: (512) 936-1200
Email: crimvictims@texasattorneygeneral.gov

Revised 07/12

CIVIL LEGAL REMEDIES

Sexual Assault Protective Orders (Ch. 7A, Code of Criminal Procedure)

Texas law provides for civil protective orders to limit or prohibit perpetrators' contact with survivors. Survivors of sexual assault or abuse, stalking, human trafficking, family violence, and dating violence may apply for protective orders. Minor survivors of any age may apply personally or have a parent or guardian apply on their behalves. A prosecutor can also file an application on behalf of any survivor.

Protective order applications are civil proceedings and completely separate from any criminal case. Survivors (called "applicants") do not have a criminal case, or even make a police report, in order to apply for a protective order. However, a violation of a protective order is a class A misdemeanor, and perpetrators (called "respondents") can be arrested immediately for most violations. Therefore, survivors should always contact police immediately if the perpetrator does anything to violate the order.

A sexual assault protective order can prohibit any or all of the following conduct:

- Communicating directly or indirectly with the applicant or any member of the applicant's family or household in a threatening or harassing manner
- Communicating in any manner with the applicant or any member of the applicant family or household except through the applicant's attorney
- Going to or near the residence, place of employment or business, or child-care facility or school of the applicant or any member of the applicant's family or household
- Engaging in conduct directed specifically toward the applicant or any member of the applicant's family or household, including following the person, that is reasonably likely to harass, annoy, alarm, abuse, torment, or embarrass the person
- Possessing a firearm, unless the alleged offender is a peace officer actively engaged in employment as a sworn, full-time paid employee of a state agency or political subdivision (Note: Even if the order does not expressly prohibit possession of a firearm, federal law prohibits possession of firearms by any person subject to protective order issued by a state court.)
- Any other action specified by the court that the court determines is necessary or appropriate to prevent or reduce the likelihood of future harm to the applicant or a member of the applicant's family or household

It is legally impossible for an applicant to violate a protective order issued for her or his own protection. Protective orders can only impose requirements on one party—the respondent. There is no such thing as a “mutual protective order,” and there are no legal grounds to arrest or punish an applicant for violating her own order.

Sexual assault protective orders can last for any amount of time that a judge determines, up to a lifetime order. If an order does not state a specific duration, the default duration is two years.

To obtain a protective order, a survivor must prove to a judge that there are “reasonable grounds to believe” she or he is the victim of sexual assault or abuse, stalking, or human trafficking. Unlike family violence and dating violence protective orders, there is no additional requirement that the survivor be subject to a threat of future violence.

The first step to obtain a protective order is to file an application. The application may be filed in any county or district court in the county where the applicant resides, in the county the respondent resides, or in any county where an element of the offense occurred. The application will ask for the applicant's identifying information and a description of what the respondent did to the applicant.

Based on the information in the application, if the judge believes there is a clear and present danger to the applicant or to a family member of the applicant, the judge can issue a temporary order called an “ex parte” order, which typically lasts two weeks. Regardless of whether an ex parte order is issued, the judge will schedule a full hearing. At the full hearing, both parties may present evidence, witnesses, and cross-examine opposing witnesses. The judge may also question the parties. Then, the judge will decide whether to issue an order, how long it will last, and what prohibitions to impose on the respondent.

Housing: Lease Termination (Sec. 91.0161, Property Code)

In some circumstances, Texas law allows survivors of sexual assault or abuse, domestic violence, stalking, or attempted offenses to break their leases early without a penalty. The requirements for survivors of sexual assault and abuse are as follows:

- The assault, abuse, or attempted assault or abuse occurred on the leased premises or in any dwelling on the leased premises within the past six months.
- The survivor provides 30 days' written notice to the landlord of the intent to terminate the lease pursuant to the sexual assault lease termination statute.
- The survivor provides the landlord with documentation of the assault, abuse, or attempted assault or abuse from one of the following sources:
 - A health care services provider who provided an examination,
 - A mental health services provider who provided an examination or evaluation,
 - A rape crisis center that provided services, or
 - A final sexual assault protective order.

Survivors who have experienced co-occurring domestic violence or stalking may be eligible to terminate a lease under multiple statutes. However, the requirements are different for survivors of domestic violence and stalking, so survivors should consult each statute to determine which is best for their circumstances.

You can obtain more information about Texas lease termination laws, including template Landlord Notice Letters in English and Spanish, by contacting the Texas Association Against Sexual Assault.

Housing: Anti-Discrimination Laws

The federal Violence Against Women Act (VAWA) provides several protections in the context of public and subsidized housing for survivors of sexual assault, domestic violence, and stalking. The following protections apply in virtually all HUD housing programs:

- **Eviction Protection:** Victims cannot be evicted from a covered housing program for any reason directly related to incidence of actual or threatened violence. Victims' housing assistance may not be terminated based on their status as victims unless there is an actual or imminent threat to other tenants or employees.
- **Admission Protection:** Victims cannot be denied admission to a covered program because of their status as victims.
- **Protective Orders:** Landlords, owners, and public housing administrations (PHAs) for covered programs must honor civil protective orders and other orders from family court or domestic violence judges regarding access to or control of the leased property.
- **Eviction of Perpetrator:** Landlords, owners, and PHAs for covered programs may evict or terminate assistance to a perpetrator while allowing the co-tenant who is a victim to stay. This is true even if the lease or Section 8 voucher is in the perpetrator's name and the victim is only listed as an occupant.
- **Transferral of Voucher:** Victims can transfer their Section 8 vouchers to new jurisdictions, even if moving would terminate their current leases.
- **Confidentiality:** PHAs, landlords, and property managers must maintain the confidentiality of any information or documents belonging to victims.

Immigration: U visas, T visas, and VAWA self-petitions

Federal immigration law provides three important mechanisms to help provide safety and justice to non-citizen victims of crime, including sexual assault survivors: U visas, T visas, and self-petitions under the Violence Against Women Act.

U and T visas are designed to encourage reporting by victims of violent crime who do not currently have legal immigration statuses by offering a path to temporary immigration status. In exchange for cooperating with the investigation and prosecution of the crime, an immigrant survivor is granted up to four years' temporary status and work eligibility. In addition, survivors can also obtain legal residency for certain family members, including children and spouses. Minor victims can obtain legal residency for their parents and siblings.

These tools help law enforcement detect crime and hold perpetrators accountable, because perpetrators frequently threaten their victims with reporting to immigration authorities and deportation in order to discourage reporting. U and T visas undermine this tactic by offering safety from deportation and the ability to keep victims' families together.

U Visa Eligibility Requirements:

- The victim has suffered "substantial physical or mental abuse" as a result of rape; torture; trafficking; incest; domestic violence; sexual assault; stalking; abusive sexual contact; prostitution; sexual exploitation; female genital mutilation; being held hostage; peonage; involuntary servitude; slave trade; kidnapping; abduction; unlawful criminal restraint; false imprisonment; blackmail; extortion; manslaughter; murder; felonious assault; witness tampering; obstruction of justice; perjury; or attempt, conspiracy, or solicitation to commit any of the above.
- The victim possesses information concerning the criminal activity, and
- The victim provides a certification from a law enforcement officer, prosecutor, judge, or other investigating authority that states the victim is, has been, or is likely to be helpful to the investigation or prosecution.

T Visa Eligibility Requirements:

- The applicant is a victim of "severe" trafficking involving:
 - Sex trafficking in which a commercial sex act was induced by force, fraud, or coercion, or in which the victim induced to perform such act was younger than 18, or
 - Using force, fraud, or coercion for the purpose of subjecting the survivor to involuntary servitude, peonage, debt bondage, or slavery, and
- The victim would encounter extreme hardship involving unusual and extreme harm if removed from the US.

VAWA Self-Petitions

Self-petitions under the Violence Against Women Act are designed to assist survivors of domestic violence and extreme cruelty whose legal residency in the US is tied to their marriage to a citizen or legal permanent resident.

Batterers often threaten to report their victims to immigration authorities for deportation, which discourages survivors from reporting and reinforces the batterer's control. VAWA enables survivors to "self-petition" for their own status—separate from the batterer—which eliminates the batterer's status as a power imbalance.

There are four requirements a survivor must prove in order to succeed in a self-petition:

1. The survivor has one of the following six relationships with a U.S. citizen or lawful permanent resident ("LPR"):
 - The spouse or child of a U.S. citizen or LPR
 - The spouse or child of a U.S. citizen or LPR who lost his or her immigration status within the past two years because of domestic violence
 - The former spouse of a U.S. citizen or LPR whose divorce took place in the past two years and was related to domestic violence
 - The spouse of a U.S. citizen or LPR who was a bigamist (and therefore they were never legally married, but the survivor married in good faith)
 - The spouse of a U.S. citizen who died within the past two years
 - The parent of an adult US citizen son or daughter (over the age of 21)
2. The survivor and perpetrator have lived together and married in good faith (meaning they were not married solely to obtain immigration status in the U.S.). They need not have resided together in the U.S.
3. The perpetrator has subjected the survivor to "battery or extreme cruelty" (the abuse generally does not have to have occurred in the U.S.)
4. The survivor has good moral character (based on criminal history).

There are many complex rules regarding these immigration remedies, and other areas of immigration law can complicate a survivor's case further. Survivors should always consult an immigration attorney before taking action regarding their immigration status. Often, seemingly minor details can have great repercussions on a survivor's immigration status.

EMPLOYMENT: TITLE VII, ADA, AND TEXAS LAW

Sexual Harassment

Like the education setting, when a sexual assault occurs at work or is committed against an employee by a co-worker or boss while on the job, it is considered a form of sexual harassment. Therefore, employees who have been sexually assaulted have a federal civil right to have the employer remedy the harassment and ensure the survivor is not deprived of her or his ability to continue working. Retaliating against an employee for reporting harassment, including taking a negative employment action, is also prohibited.

Just as required by Title IX in the educational setting, Title VII requires employers who learn of sexual harassment to promptly investigate the complaint and eliminate any hostile environment. Failure to do so can give rise to liability on the part of the employer, including compensatory damages, back pay if the employee was fired or lost income as a result of the employer's failure, punitive damages, court costs, or injunctive relief.

If an employer violates a survivor's rights under Title VII, the employee or a third party may make a complaint to the federal Equal Employment Opportunity Commission ("EEOC") within 180 days of the discriminatory act.

Other Federal Protections

In addition, survivors may have legal rights concerning their employment even if Title VII's sexual harassment protections do not apply. For example, the Americans with Disabilities Act ("ADA") prohibits negative employment actions based on an employee's actual or perceived disability. It also requires covered employers to provide "reasonable accommodations" to employees with disabilities to enable them to perform the basic duties of their jobs.

Each of these provisions may apply to an employee who has been sexually assaulted, even if the assault did not occur at work. For example, a survivor who suffers from post-traumatic stress following a rape may require an accommodation in the workplace or in the employee's work schedule in order to continue working. If the employee can document the PTSD diagnosis and requests the accommodation, the employer will likely be required to provide it. In addition, if an employer fires, demotes, harasses, or otherwise discriminates against the survivor because of the effects of PTSD, the employer has likely violated the survivor's rights under the ADA.

Texas law also provides for virtually identical protections as the ADA under the Texas Commission on Human Rights Act (TCHRA). As a result, most employees whose ADA rights have been violated also have the option to pursue a remedy under the TCHRA. To do so, employees should contact the Texas Workforce Commission.

Finally, in some circumstances Texas law makes unemployment insurance ("UI") benefits available to survivors if they are forced to leave their jobs as a result of the assault. In general, Texas workers are ineligible to receive UI benefits if they voluntarily quit their jobs. However, survivors who quit for

safety reasons following a sexual assault, domestic violence, or stalking are exempted from this requirement.

In order to receive UI benefits, a survivor should apply through the Texas Workforce Commission’s (“TWC”) online form and state that she or he quit as the “reason for no longer working.” When the TWC officer follows up for more information, the survivor will need to explain that the reason she or he quit was for safety reasons stemming from the assault and provide documentation of the assault. Acceptable forms of documentation include the following:

- A recently-issued protective order documenting sexual assault of the worker or a member of the worker’s family or household, or domestic violence or stalking against the worker
- A police record documenting the sexual assault against the worker or a member of the worker’s family or household, or family violence or stalking against the worker
- Medical documentation of the violence against the worker or against a member of the worker’s family or household

Economic Compensation vs. Other Accommodations in Legal Employment Remedies	
ECONOMIC COMPENSATION	OTHER ACCOMMODATIONS
<ul style="list-style-type: none"> • Title VII (back or front pay, damages, court costs) • Americans with Disabilities Act (back or front pay, damages, court costs) • Texas Commission on Human Rights Act (back or front pay, damages, court costs) • Unemployment Insurance • Civil Lawsuit for Damages 	<ul style="list-style-type: none"> • Family Medical Leave Act (leave from work) • Title VII (injunctive relief) • Americans with Disabilities Act (reasonable accommodations, other injunctive relief) • Texas Commission on Human Rights Act (reasonable accommodations, other injunctive relief)

Family Law & Termination of Rapists’ Parental Rights

When rape results in pregnancy, Texas law provides an avenue for survivors to terminate the parental rights of the rapist.

Under the Texas Family Code, a court may order the termination of a person’s parental rights if the court finds by clear and convincing evidence that the person has committed sexual assault,

aggravated sexual assault, incest, or continuous sexual abuse of a child, that the victim became pregnant as a result of that conduct, and that termination is in the best interests of the child.

For parties who were married or cohabiting for two years following a child's birth, the rapist must have been convicted of the offense in criminal court. The other requirements are the same.

Lawsuits for Monetary Damages

A person who has been harmed by the wrongful conduct of another can bring a lawsuit in the civil court system for a remedy. In most cases, that remedy is monetary damages (e.g., compensation for losses and pain and suffering, reimbursement of medical bills, etc.) In other civil cases, the legal remedy being sought is an order of protection or other type of restraining order.

The most distinctive characteristic of a civil lawsuit is the control the plaintiff has over the action. The plaintiff decides whether or not to bring the lawsuit whereas in a criminal case, the police can arrest someone for the crime whether the victim wishes the arrest to happen or not. The plaintiff chooses the attorney who will prosecute the case. In most cases, if the plaintiff is unhappy with the attorney representing him or her, the plaintiff can hire another attorney.

For some victims, the civil lawsuit is the only method of obtaining any remedy because the government does not prosecute the case or the defendant is acquitted in the criminal action. Sometimes, the defendant is acquitted in the criminal trial because the higher standard of proof (beyond a reasonable doubt) cannot be met, although the civil standard of proof (preponderance of the evidence) could be met. Sometimes, the government does not do a good job of prosecuting the offender and the victim brings a civil lawsuit in order to have an attorney chosen by the victim prosecute the case. For some victims, the goal is to establish the truth of what happened even if the defendant has no income or assets from which the judgment could be collected.



DECIDING TO FILE A CIVIL CLAIM

Whether or not to commence a civil lawsuit is an important decision for the victim. The process can invade the victim's privacy, cost money for lost time from work, attorneys' fees and litigation costs, force the victim to relive the painful memories repeatedly, and otherwise be painful and inconvenient for the victim. What many victims do not realize is that, during the discovery phase of civil litigation, the plaintiff and defendant are both entitled to compel the other to produce documents, evidence, answer questions, testify at pre-trial proceedings, etc. In some cases, confidential counseling records may become available to the offender and his or her attorney which is a horrifying prospect for most victims.

Any survivor who wishes to institute a civil claim should be well-established in supportive therapy before starting the action. It is not a good idea to start a lawsuit shortly after recovering memories of abuse or acknowledging the issue of abuse in your life.

Cases that are based solely upon her word against his are difficult. Cases with some outside corroboration are more feasible. Outside corroboration can consist of other victim evidence and also corroboration by expert mental health professionals. Expert psychologists and psychiatrists are qualified to evaluate a victim and her history in order to identify patterns of behavior and psychological and somatic (physical) complaints that are typical of victims of sexual assault.

No case can be feasible unless the perpetrator is lawsuit worthy. Theoretical cases with no hope of collecting damages are not handled well by our judicial system and only serve to further disappoint, invalidate and frustrate victims. Cases can be lost for legal reasons that have no bearing on the truth of the allegations or the merits of the claim. Lost cases only serve to further damage victims. Lost cases also send the wrong message to perpetrators. For these reasons most lawyers carefully screen victim recourse cases and only accept those with a good chance of success. When those cases are identified and successful claims are brought, victims can benefit from making their perpetrators financially and morally accountable.

ABUSE BY PROFESSIONALS

Offenders are sometimes in a professional position that they can exploit to gain access to or control victims. For example, members of the clergy, employers/supervisors, law enforcement officers, teachers, prison guards and others can all wield a great deal of power. If an organization that employs one of these professionals is aware or should have been aware of the sexual abuse, the organization could be held liable for the abuse and subject to a civil law suit.

Adult victims who have been exploited by medical professionals (i.e., doctors, therapists and psychiatrists) also have a civil remedy. It is fairly well-established that mishandling of the transference/counter-transference phenomenon that arises in therapy is malpractice that is covered by insurance. (*St. Paul Fire & Marine Ins. Co. v. Shernow*, 222 Conn. 823 (1992)).

SECURITY CASES

In some settings, adult victims may have remedies against property owners for failure to provide adequate security. For example, successful suits have been brought against parking lot and garage owners, hotels/motels, private owners of buildings open to the public and apartment building owners.

VICTIM IMPACT STATEMENTS

Texas law allows victims who have suffered personal injury as a result of a crime, including victims of sexual assault, kidnapping, aggravated robbery, and trafficking of persons, to submit a victim impact statement to the prosecutor's office. You can find all necessary forms in English and Spanish at the TDCJ website at https://www.tdcj.state.tx.us/publications/pubs_victim_impact_statement.html.

The victim impact statement serves two very important functions. First, it is the victim's best way to inform criminal justice officials about the full impact of the crime. Unlike the victim's in-court testimony, the victim impact statement can include information about the emotional, psychological, physical, and financial impact of the crime on the victim and the victim's family and household.

Providing this full picture of the crime's impact is important at the trial phase as well as during parole proceedings for years to come. At the trial phase, the prosecutor must consider the victim impact statement before offering the defendant a plea agreement, and, after the defendant is found guilty, the judge must consider the statement in determining an appropriate punishment. In fact, before accepting a plea agreement or imposing a sentence the law requires the judge to inquire whether a victim impact statement has been submitted and, if one has not, the victim has an opportunity to submit one before a punishment is imposed.

The second function of the victim impact statement is to ensure officials have accurate contact information for the victim, to be used for notifications regarding the defendant's appeals, parole proceedings, and eventual release from prison. The victim impact statement form includes a "Confidential Information Sheet," on which victims can provide their contact information. The Confidential Information Sheet is separated from the rest of the form, does not become part of the court record, and cannot be seen by the defendant and his or her counsel. However, it will remain on file with the Victim Services Division of the Texas Department of Criminal Justice so that the victim may be notified of parole proceedings and the defendant's release. Crime victims may submit the Confidential Information form to receive notifications without also submitting a victim impact statement during the trial.

SAVNS: STATEWIDE AUTOMATIC VICTIM NOTIFICATION SYSTEM

Many of the statutory and constitution rights of crime victims involve receiving notifications and staying informed about court proceedings. To help fulfill these rights, the Office of the Attorney General administers a free, automated telephone service.

Texas SAVNS gives victims of crime information and notifications about offender custody status and related court events. The service is available 24 hours for offender custody status and case information and offers the option of automatic notifications to registered users regarding changes to offender custody or case status.

Victims of crime can call 1-877-TX4-VINE toll-free from any location in Texas to use SAVNS. In addition, online access is available at www.vineline.com.

TITLE IX AND THE CLERY ACT

Sexual assault is a criminal offense, but when it occurs in an educational setting it is also considered a form of sexual harassment. That means a survivor who is a student has a federal civil right to have the

school remedy the harassment and ensure the survivor is not deprived of any educational programming or extracurricular activities.

Title IX applies to every school receiving federal funding—virtually every school district, high school, technical school, 2- and 4-year college, and university in the country. Each school must appoint a “Title IX coordinator” to oversee all the institution’s policies and responses to sexual harassment. The Title IX coordinator is typically the best resource for students to learn about their rights and options following any incident of sexual harassment, including a sexual assault.

Schools have a legal obligation to investigate sexual assault committed against their students as soon as they receive notice of it. However, students 18 or older who have not decided how they want to proceed can request that the Title IX coordinator keep their information confidential, and the law requires the school to honor that request unless doing so would create a public safety risk on campus. Alternatively, many schools have mental health professionals on campus who serve as confidential resources. For students younger than 18, Texas law mandates law enforcement reporting.

The school’s response to sexual assault under Title IX is separate from any criminal investigation and serves a different purpose. Therefore, the school may not wait to take action until a criminal case is closed, nor may it base its findings on those of law enforcement. Even if there is insufficient evidence to prosecute an assault as a crime, the school’s obligation to support and accommodate the survivor remains. In addition, there may be adequate evidence to discipline the perpetrator if he or she is a student, based on the lower administrative standard of evidence.

Each survivor’s needs and circumstances are different, so the school actions necessary to support survivors will vary from case to case. However, when schools receive notice of a sexual assault against a student, Title IX and the Clery Act require the school to inform the survivor of the following:

- The option to report, or not report, the assault to law enforcement, and to seek assistance from the school in reporting.
- The survivor’s rights to seek a civil protective order and the school’s responsibilities to enforce the order on campus.
- On-campus protective measures, including stay-away agreements, campus escorts, or modifying the survivor’s course schedule.
- Potential disciplinary actions against the perpetrator or third parties for further harassment or retaliation, and the procedures for pursuing disciplinary action.
- Assistance adding or dropping courses.
- Procedures for taking leaves of absence with accommodations for tuition or student loan payments, or for work-study credit.
- Options for modifying exam schedules.
- Options for housing relocation.
- Rights concerning confidentiality of student records and disciplinary records.

During any investigatory or disciplinary proceeding, the law requires both parties to be treated equitably, meaning, among other things, that the school may not make presumptions in favor of

either party and must provide equal information and opportunities to present evidence to both parties.

Survivors, advocates, or third parties can contact a school's Title IX coordinator for assistance resolving a hostile educational environment stemming from sexual assault, harassment, or retaliation for reporting. If a school fails to respond adequately, including by failing to support a survivor or violating its own policies, complaints should be made to the U.S. Department of Education Office for Civil Rights ("OCR"). The OCR regional office covering Texas is in Dallas and can be contacted at 214-661-9600 or OCR.Dallas@ed.gov. More information about legal requirements under Title IX and the Clery Act can be found at www.NotAlone.gov. In some circumstances, students may also bring individual lawsuits against schools for violating their rights under Title IX and the Clery Act.

Section 3:

PREVENTION

WHAT IS PRIMARY PREVENTION

In the simplest terms, primary prevention is about stopping sexual violence before it happens.

In practice, this means addressing the root causes of that violence rather than directly addressing the violence. This is distinct from efforts that seek to interrupt violence that's already in progress or to mitigate the situational factors that facilitate violence in a moment (i.e., risk reduction). That is, these risk reduction techniques, rather than addressing the causes of violence, are built to be responsive to what we know about the dynamics of sexual violence (e.g., the use of alcohol to facilitate sexual violence).

To illustrate the differences in these, consider the following approaches:

Approach 1: A college program teaches young girls to refuse drinks offered to them by strangers and to watch their friends' drinks at parties to avoid getting drugged and sexually assaulted.

Approach 2: A college program teaches young men in fraternities to stop their fraternity brothers from taking drunk women to their rooms.

Approach 3: A rape crisis center conducts presentations during high school assemblies to talk about the dynamics and prevalence of sexual assault and dating violence.

Approach 4: A high school program focuses on working with young men around gender role socialization, especially expectations for men to be dominant, express aggressive behaviors and attitudes (including sexually aggressive behaviors), and objectify women, and teaches them skills for engaging in healthy, equitable relationships.

One day a woman was having a picnic and reading a book on the side of a river. After spending hours relaxing in the quiet of the afternoon, she heard someone screaming for help. Turning around to look at the river, she noticed a person being swept downstream by the current. Fortunately, the picnicking woman was trained as a lifeguard, so she hopped into the water, caught the scared stranger, and pulled her to shore. The stranger was offered what was left of the picnic, and the two women sat by the shore talking about what had just happened. In a short time, cries for help were heard again. The first woman again jumped into the river to help this second woman being swept away with the current. This happened several more times before the first woman was completely exhausted. During the time between rescues, she trained the people she had rescued so that they could begin to help her pull people out of the river. Finally, she decided to leave the others behind and head upstream to see if she could figure out why all of these people were in the river.

The following chart compares the three approaches side-by-side.¹¹⁵

	Primary Prevention	Risk Reduction	Awareness & Outreach
Focus	Changing/addressing the underlying causes of sexual violence at the individual, relationship, community, and societal levels (<i>see section on ecological model for more information</i>)	Teaching individuals skills to reduce their risk of being victimized or to reduce the risk of someone else being victimized	Informing the community at-large and current or potential victims about the dynamics of violence and where to access services
Goal(s)	Eliminating and reducing factors that perpetuate sexual violence to keep it from happening in the first place Creating healthy norms and healthy communities	Thwarting an attack that is in progress Avoiding imminent attacks Avoiding potentially dangerous people or situations by changing individual behaviors	Increasing community knowledge about the dynamics and prevalence of sexual violence Reaching out to victims/survivors so that they will seek services
Example(s)	A comprehensive initiative that helps young people learn the skills to interrupt attitudes and behaviors that contribute to sexual violence and works to change school-wide norms about gender roles and bystander behaviors	Self-defense classes Project Watch Your Drink™ Yellow Dyno®	Presentations that talk about red flags for dating violence and/or dynamics of sexual violence

¹¹⁵ This chart is adapted from Curtis, M.J. & Love, T. (2008) *Tools for change: An introduction to the primary prevention of sexual violence*. Texas Association Against Sexual Assault: Austin, TX.

Based on this chart, we can see that the four approaches outlined above break down as follows:

Approach 1: Risk Reduction

Approach 2: Risk Reduction

Approach 3: Awareness/Outreach

Approach 4: Primary Prevention

In order to truly understand primary prevention, we must see sexual violence as more than an individual issue and also as more than a criminal justice issue. Instead, we must also see it as a social justice and a public health issue. Rather than addressing the behavior of potential victims, primary prevention asks us to look at the myriad factors that influence the person who committed the violent act. To understand those factors, it's helpful to familiarize ourselves with social justice and public health paradigms.

SOCIAL JUSTICE

A social justice analysis of sexual violence brings to light "rape as a cultural phenomenon, or stated more simply, rape as a predictable consequence of the power differential between men and women. ... The basic premise of this concept is that rape does not happen just because one individual chooses to rape another. Rape happens because there are attitudes and norms that allow it to happen."¹¹⁶ This culture, and the attitudes and norms that are supported by and perpetuate it, are often referred to as rape culture.

"What is rape culture? It is a complex set of beliefs that encourages male sexual aggression and supports violence against women. It is a society where violence is seen as sexy and sexuality as violent. In a rape culture, women perceive a continuum of threatened violence that ranges from sexual remarks to sexual touching to rape itself."¹¹⁷

Society is the water we are steeped in. Just as we pay very little attention to the air we breathe or even the process of breathing, most people spend relatively little time examining the culture we live in. When we start to examine the culture with a critical lens, many concerning aspects of it become apparent, and we are better able to understand a variety of social problems. This is true of trying to understand the cultural issues that are related to sexual violence.

¹¹⁶ L.Guy, (Fall 2006). Re-Visioning the Sexual Violence Continuum, Partners in Social Change, pp. 4-7.

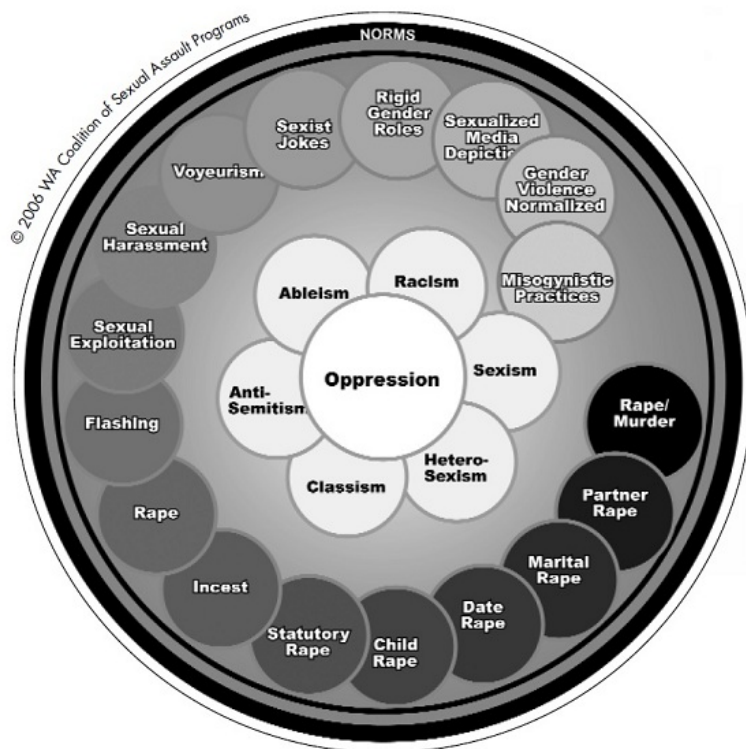
¹¹⁷ Buchwald, E., Fletcher, P.R., & Roth, M. (Eds.). (2005). *Transforming a rape culture* (Revised Ed.). Minneapolis, MN: Milkweed Editions, p. xi.

The term rape culture is meant to refer to all of the ways that our societal conditioning and cultural practices contribute to sexual violence, including practices that dismiss the severity of such violence or blame victims for it. Blogger Shannon Ridgeway points out that “[m]ore often than not, it’s situations in which sexual assault, rape, and general violence are ignored, trivialized, normalized, or made into jokes.”¹¹⁸ Rape culture is evident when victims are blamed for their assault or asked what they were wearing or questioned why they were with the person who ended up assaulting them.

Rape Culture

Media, especially advertisements, both perpetuate and reflect societal norms in a given culture. A quick glance at magazine covers in the checkout line of your local grocery store will tell you a striking story about our cultural conceptions of gender. Frequently, women are shown in submissive or suggestive poses that are meant to invite sexual attention. Men, on the other hand, are often shown fully facing the camera and in ways that are meant to highlight their strength (e.g., they will be shirtless so that you can see their muscles). We encounter these images (and their underlying messages) so frequently that we hardly question them much less notice them. Yet, we encounter them not just in magazine advertisements and covers but also in commercials, on billboards, etc.

In her attempts to define and understand rape culture, Lydia Guy, formerly of the Washington Coalition of Sexual Assault Programs, redesigned the spectrum of sexual violence to include the cultural issues that feed into violence. The image shows how she re-visioned it to include societal issues of oppression and the relatively normative cultural behaviors that are ultimately problematic.



¹¹⁸ <http://everydayfeminism.com/2014/03/examples-of-rape-culture/>

A social justice analysis of sexual violence highlights the ways complex identities and related power imbalances, some of which are illustrated in the image above, make people more or less vulnerable to violence (as either victims or perpetrators). The dehumanization that results from oppression combined with deep histories of viewing certain people as property permeates our daily lives and interactions. From this perspective, we acknowledge that intersecting oppressions (racism, sexism, homophobia, classism, ableism, and more) underlie the perpetration of violence, including sexual violence. Therefore, to prevent violence, we must address how those oppressions show up systemically, relationally, and individually.

COUNTERING RAPE CULTURE

Jada Pose

In 2014, Jada, a 16-year-old young woman who lived in Houston, went to a party, drank punch that was offered to her, passed out, and was sexually assaulted. She didn't realize she was assaulted until she saw images of herself on social media. As noted in an article published in *The Guardian*, other social media users started taking photographs of themselves in the same spread-eagled position in which Jada's unconscious, stripped body was pictured, and sharing them online using the hashtag #JadaPose. "Jada made a public response to these efforts to shame her. Moreover, to confront this, staff at TAASA started #jadacounterpose, a hashtag meant to show support for Jada and call out the victim-blaming that was happening in both traditional and social media. These images are example of the counter-messages.



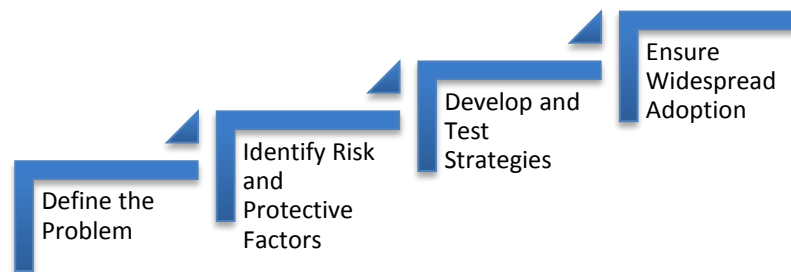
THE PUBLIC HEALTH MODEL

What does it say about sexual violence? How do we understand sexual violence as a public health issue?

The dedicated and tireless efforts of the women who started the anti-sexual violence movement ushered in criminal justice remedies for people who experienced violence and increased the potential (if not actual) sanctions against people who perpetrate violence. For many, this represented great strides in the movement. However, looking at the issue as a crime between people does not offer the critical insight needed to determine how to uproot that violence. Public health is a field usually associated with preventing and addressing the spread of diseases, epidemics that put our entire population at risk. Looking at sexual violence through a public health lens shows us that it, too, is an epidemic. Moreover, the public health lens allows us to see this violence as preventable by highlighting the constellation of factors underlying it. Some other core components of the public health model are explained below.

Steps of the Public Health Model

The public health model involves 4 basic steps for addressing a public health issue/problem (see figure below).



Defining the problem involves understanding the incidence, prevalence, and dynamics of sexual violence, including information about both victims and perpetrators. The scope and definition should be specific to a particular community, and the data should be community specific. Once the problem is well defined, **identifying risk and protective factors** from the community-specific data and data from the field at-large is possible. After the most salient and changeable factors are identified, we can **design and test strategies** that address the risk and protective factors within a community of interest. Through evaluation of our efforts, we can identify what works well and **ensure widespread adoption** of those strategies and the sharing of critical lessons learned through their development and testing.

Risk and Protective Factors

The public health model looks at problems in terms of risk and protective factors. In the simplest terms, risk factors are factors that increase the risk of something happening (e.g., contracting a disease) and protective factors are factors that protect against something happening. For more technical definitions from the CDC, see the callout box. Since the public health model deals most frequently with disease and injury (i.e., issues where there are not two human actors to consider), the application of the model to an issue like violence (where there are actions and contexts to consider for both victims and perpetrators) can feel a little clumsy at times. However, the theory behind it can lend a lot of insight to how we understand and ultimately work to end violence.

***Risk factors** are an attribute, situation, condition or environmental context that **increases the likelihood** of the occurrence of a health problem or behavior such as sexual violence.*

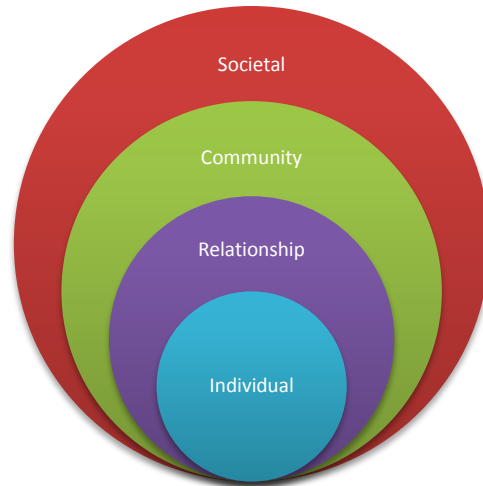
***Protective factors** are an attribute, situation, condition, or environmental context that works to **decrease the likelihood** of the occurrence of a health problem or behavior such as sexual violence.*

Centers for Disease Control and Prevention. (2008). Guidance Document for the Sexual Violence Prevention and Education Cooperative Agreement CE07-701 (Rape Prevention and Education).

THE ECOLOGICAL MODEL¹¹⁹

The ecological model (also called the socio-ecological model, social-ecological model, and SEM) is a method of describing how factors (both risk and protective) interact across spheres of influence. The four spheres of influence in the ecological model that is used to examine and explain sexual violence are societal, community, relationship, and individual. The idea behind the model is that factors in any one level influence and are influenced by factors in every other level. Also, the model helps us to see how certain factors play out across each level but in slightly different ways. As is seen in the diagram below, the individual level is considered to be the innermost level, which suggests that the outer levels have more influence on it than it does on them. The societal level is the outer ring and contains all of the other levels because all of the other levels exist in the context of societal norms and values.

¹¹⁹ For more information on the ecological model, see <http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html>



For the purposes of primary prevention, we are mostly concerned with risk factors for **perpetration** and not victimization. Since primary prevention is about stopping the behavior before it happens, we focus on understanding the root of the behavior on the part of the actor (i.e., the perpetrator).

Risk factors should not be considered to be causal factors of violence. The existence of one (or more) risk factors does not indicate that violence is inevitable; risk factors can be balanced out by protective factors. Moreover, individuals who have many risk factors might never commit sexual violence. We do know, however, that the existence of risk factors increases the likelihood of someone committing violence.

According to the CDC, the following are risk factors for sexual violence at each level of the SEM. ¹²⁰

Individual

- General aggressiveness and acceptance of violence
- Hostility towards women
- Adherence to traditional gender role norms
- Hyper-masculinity

Relationship

- Family environment characterized by physical violence and conflict
- Childhood history of physical, sexual, or emotional abuse
- Emotionally unsupportive family environment
- Association with sexually aggressive, hypermasculine, and delinquent peers

Community

- Poverty
- Lack of employment opportunities

¹²⁰ This is a selection of the full list of risk factors available at <http://www.cdc.gov/violenceprevention/sexualviolence/riskprotectivefactors.html>

- General tolerance of sexual violence within the community
- Weak community sanctions against sexual violence perpetrators

Societal

- Societal norms that support sexual violence
- Societal norms that support male superiority and sexual entitlement
- Societal norms that maintain women's inferiority and sexual submissiveness
- Weak laws and policies related to sexual violence and gender equity

Despite the significant research into risk factors for sexual violence, far less data exist around protective factors. The CDC identifies only a few of these potentially buffering factors, including the following:

- Parental use of reasoning to resolve family conflict
- Emotional health and connectedness
- Empathy and concern for how one’s actions affect others¹²¹

So, let’s look at example of how this might play out.

Jordan’s World¹²²



This is Jordan. He identifies as male. By the time Jordan is 9 years old, he believes that being a man means that he must be strong. He stops crying when something hurts him physically or emotionally. When he starts middle school, Jordan plays football because his dad wants him to play.



When boys on his football team make a bad pass, the coach tells them to stop “throwing like a girl.” These teammates also snap girls’ bras in the hallways, and call them names. By high school, all of Jordan’s teammates are talking about the girls in school, rating their looks and talking about how far they’ve gone sexually with various ones. They give each other advice on which girls are the “easiest” and which ones like to drink.

¹²¹ Same as above but for protective factors

¹²² All images are Creative Commons licensed for commercial use.



Even though the school has policies about sexual harassment, when the coach or other teacher's see the way Jordan's teammates treat the young girls in the school, they refuse to do anything about it. None of the policies are ever enforced, and the teachers seem to live by the code that boys will be boys.



The video games available to Jordan have sexually violent content, including storylines where players get more points for beating up women who are engaging in sex work. The images in advertisements and media often suggest that alcohol could or should be used to get women to have sex.

EFFECTIVE PREVENTION PROGRAMS

What do prevention programs need to look like in order to be most effective?

Comprehensive – Since, as discussed above, the levels of the SEM are all connected, the most effective way to prevent sexual violence is to work on connected risk factors at multiple levels with the same community. For example, in the example above about Jordan, the most obvious intervention that people move toward is to do individual-level work to change the attitudes and behavior of Jordan and his friends. However, those efforts can't be ultimately successful if Jordan and his friends are still surrounded by community and societal level risk factors that reinforce the old behaviors. ¹²³

Sufficient Dosage – The attitudes, behaviors, and norms that perpetuate sexual violence are deeply ingrained and also the result of years upon years of social conditioning. As such, they can't be shifted quickly. One-time presentations don't produce lasting changes in any of those areas and are not useful for long-term skill building. In order to instill a sustainable new behavior or new way of thinking, people must be repeatedly exposed to new messages or opportunities to practice behaviors. ¹²⁴

Promotion-Oriented – As part of addressing risk and protective factors, public health programs seek to promote the healthy attitudes and behaviors that are alternatives to the risky or unhealthy behaviors. Instead of focusing primarily on what is bad or wrong, the messaging and skill building focuses on what should be in place instead.

¹²³ This list is adapted from Nation, Crusto, Wandersman, Kumpfer, Seybolt, Morissey-Kan, & Davino. (2003). What works in prevention: Principles of effective prevention programs. *American Psychologist*, 56 (6/7), 449-446.

¹²⁴ Ibid

Population-Based - Public health interventions are also **population-based**, that is they focus on improving conditions for the majority of people rather than creating change individual by individual. This is in contrast to most risk reduction efforts that focus on making one person safer at a time. For primary prevention initiatives, the public health model breaks populations of interest out in the following ways¹²⁵:

- **Universal** interventions are those directed toward groups of people who are targeted for programming regardless of the presence of risk factors for perpetration of violence. The population might be defined by a geographic region or other shared characteristics.
- **Selected** interventions are geared toward people who are seen as being at “heightened risk” for perpetration.

PRIMARY PREVENTION IN TEXAS

What is Texas doing to prevent sexual violence?

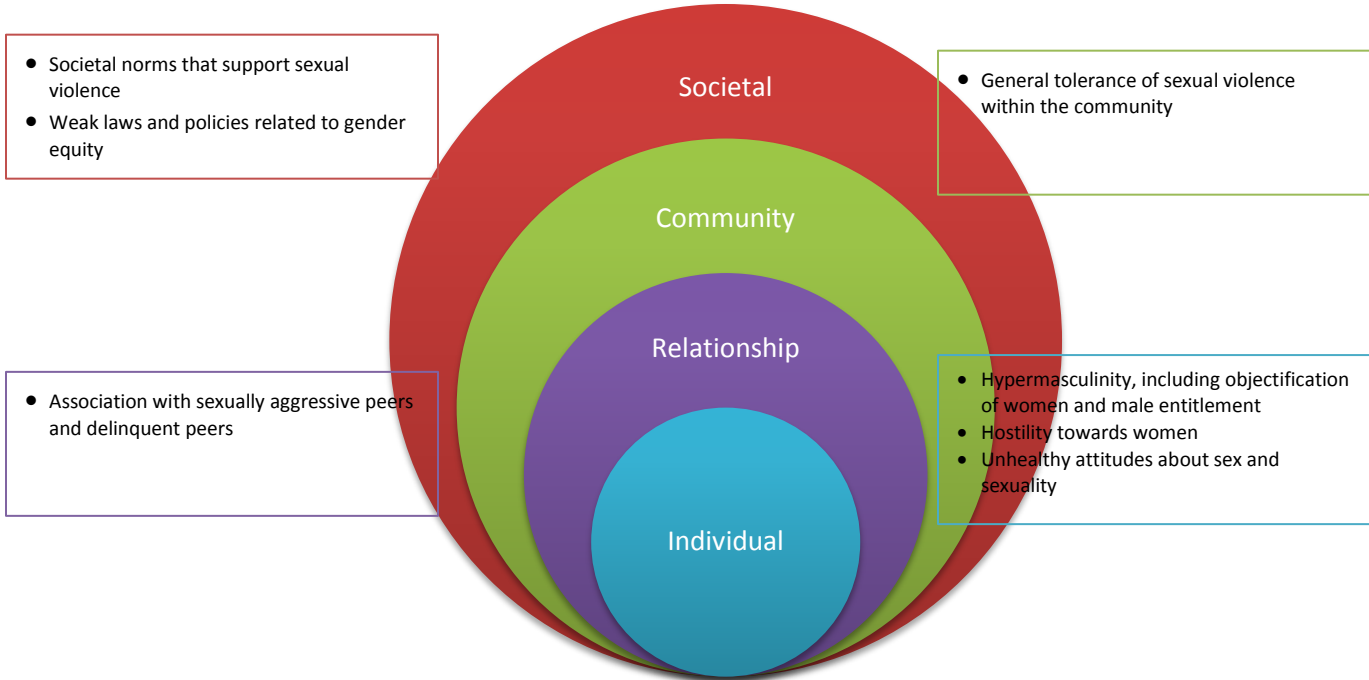
In 2007, the Office of the Attorney General, the Department of State Health Services, and TAASA convened a planning committee to guide Texas’ efforts to prevent sexual violence. The committee, called the Primary Prevention Planning Committee (PPPC), was charged with collecting data about the scope of and risk factors for sexual violence in Texas and developing a state plan to address the problem. The first version of the plan, *Preventing Sexual Violence in Texas: A Primary Prevention Approach*, was completed in 2010, and Texas rape crisis centers were offered assistance in its implementation. Although that plan was meant to be implemented until 2018, changes in both funding and guidelines, combined with feedback from the field about what was and wasn’t working, led the PPPC to amend the plan in 2015. The information below is a summary of the amendment that highlights the efforts Texas RCCs will engage in as they work to make Texas communities safer and healthier for all residents.

What is the change we seek to make in Texas?

In order to end sexual violence in Texas, the plan states that we first need to **reduce attitudes, behaviors, and norms supportive of sexual violence**. (This is the overarching goal of the efforts outlined in the state plan.)

The attitudes, behaviors, and norms of interest are the risk factors listed below and were chosen based on Texas-specific data.

¹²⁵ Beginning the dialogue



In addition to working to reduce or mitigate the protective factors above, the Texas plan also ask grantees to engage in efforts that will enhance the following protective factors:

- Gender equality
- Connectedness
- Conflict resolution
- Empathy

Who do we need to impact in order to reach the change we seek?

Prevention efforts driven by the Texas plan are directed at a selected population of 4th to 12th grade youth (or age equivalent if not in school) and college/university students. As the selected population, these are the people whose attitudes and behaviors we are most interested in impacting, in addition to impacting the norms that influence these age groups. Since this population is itself influenced by other people, programming can also be directed at influencers (e.g., parents and school personnel).

How will we achieve this change?

Since much of the funding that supports primary prevention work comes from the federal government, so too do some of the guidelines about how to go about the work of preventing violence. There are approved activities and community change strategies that each state can use to guide their efforts. For Texas, we use the following:

Approved Activities

- Educational seminars
- Training programs for professionals
- Preparation of informational materials
- Training programs for students and campus personnel designed to reduce the incidence of sexual assault at colleges and universities

Community Change Strategies

- Community mobilization
- Coalition building
- Policy education
- Social norms change

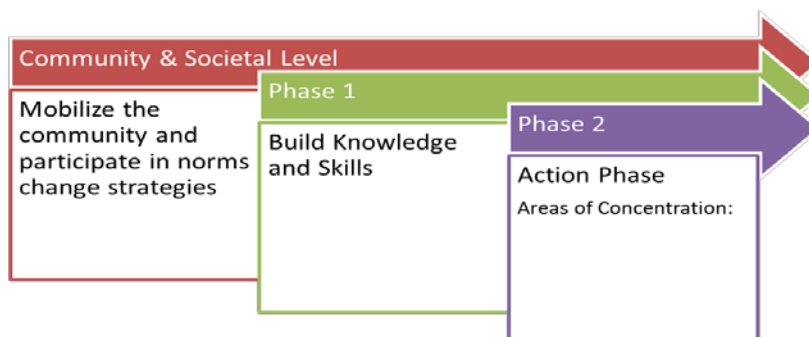
Guided by those activities, the PPC developed guidelines for prevention work in Texas. These efforts are divided into phases that build upon each other, leveraging initial impacts toward future change at the various levels of the social ecology.

Phase 1 – Build Knowledge and Skills

Phase 2 – Action Phase – Areas of Concentration: Bystander Intervention; Youth Development; Adult Influencers)

Ongoing - Community & Societal Level Interventions

The work should roll out in communities in line with the following image



The components of each phase are outlined in more detail below.

Phase 1

Outcomes
<ul style="list-style-type: none">• Increase participants' knowledge of gender socialization.• Decrease participants' acceptance of attitudes, statements, or behaviors that demean or degrade people based on gender.• Increase participants' intent to engage in healthy relationship behaviors.
Approach
<ul style="list-style-type: none">• Addressing certain components of gender socialization (hypermasculinity, hostility towards women, and unhealthy attitudes about sex and sexuality) that contribute to unhealthy interactions and set the environment for adversarial relationships that can lead to violence
Target audience
<ul style="list-style-type: none">• Young people• Adult influencers
Individual level programming
<ul style="list-style-type: none">• 1) explores dynamics of gender socialization• 2) examines the overall problematic impact of gender socialization and its impact on individual participants; and• 3) develops skills for healthy relationships ³
Relationship level programming
<ul style="list-style-type: none">• works with youth and/or youth influencers to model/promote healthy relationship skills.

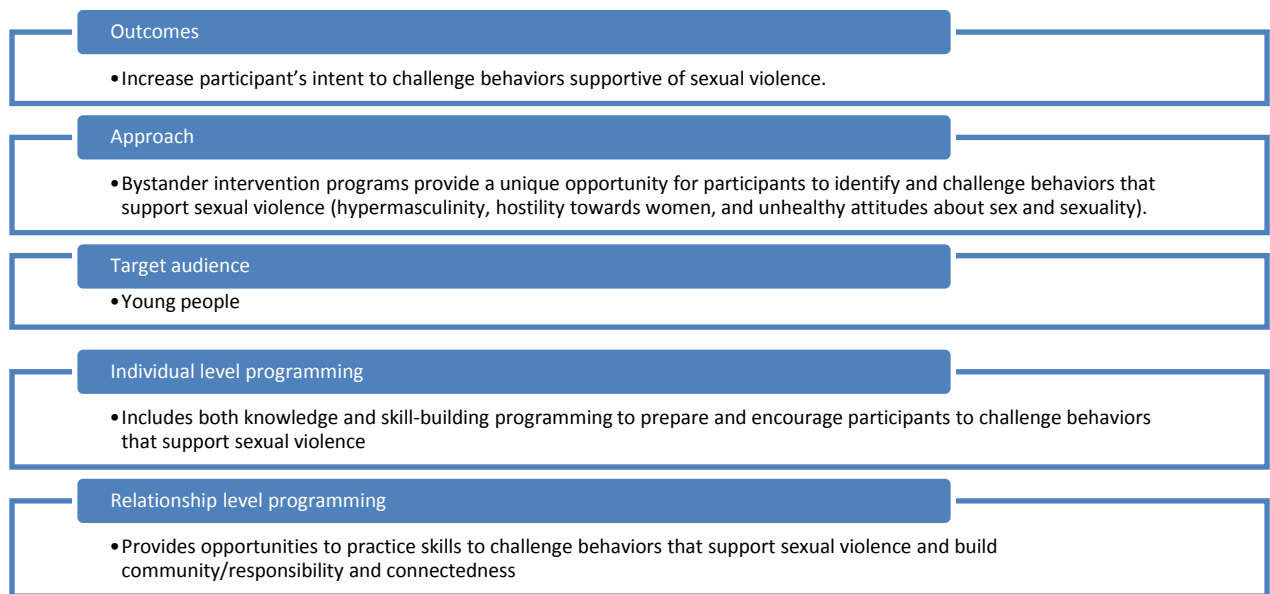
*For the purposes of the plan, healthy relationships are defined as relationships (romantic or otherwise) that are gender equitable, respectful and consensual.

Phase 2

Phase 2 offers 3 choices for building on the knowledge and skill acquisition from Phase 1. Those three choices are outlined below.

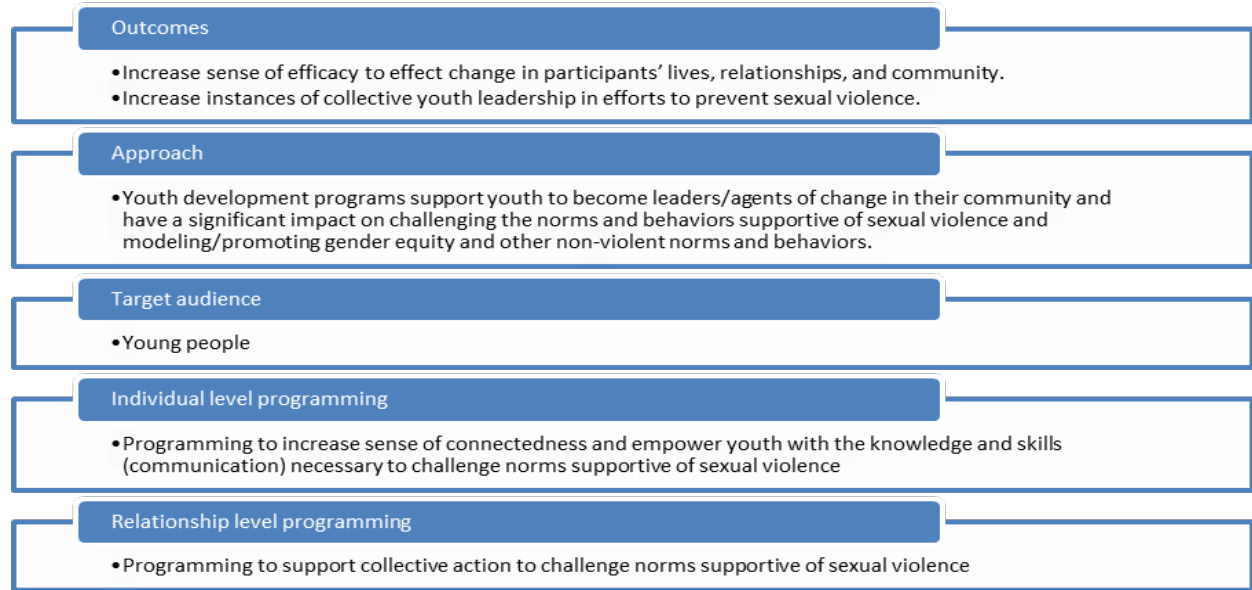
1) *Bystander Intervention*

Bystander intervention from a primary prevention standpoint involves intervening in the attitudes, behaviors, and norms that are supportive of sexual violence. For example, young people might be given the skills to interrupt sexist comments in the locker room or hallway of their school. This is contrasted with the kind of bystander intervention that focuses on intervening in situations that are already escalating into violence (e.g., stopping a friend at a party from taking advantage of a drunk person).



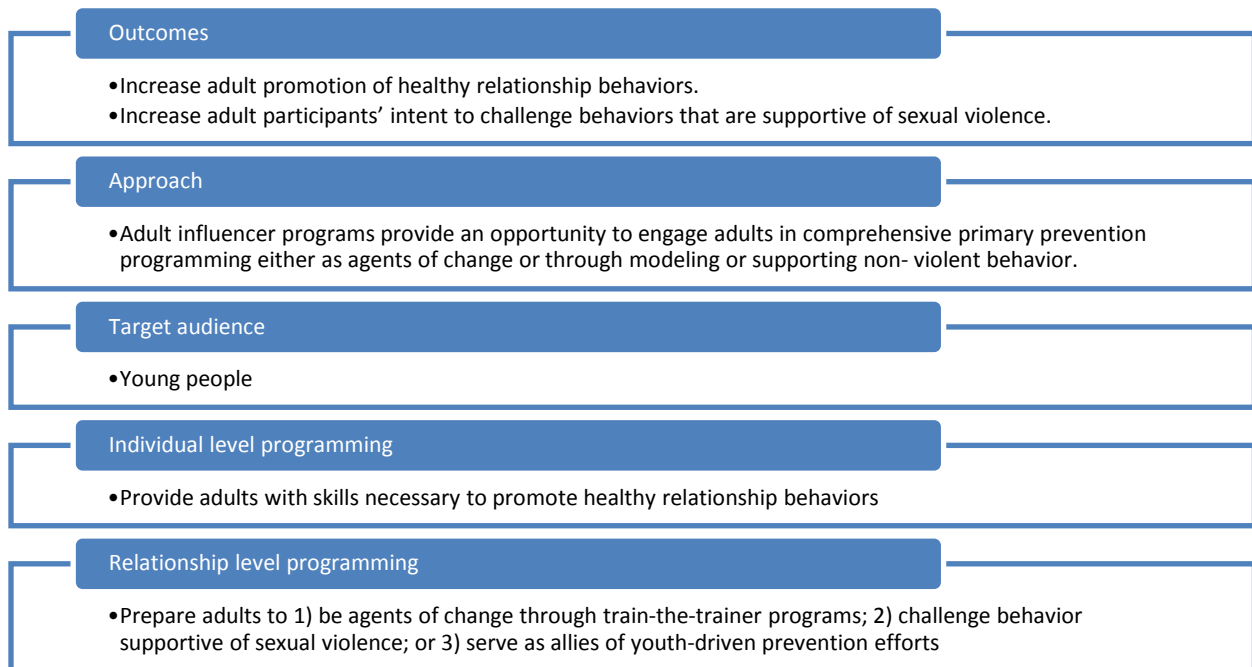
2) *Youth Development*

Young people can be important change agents in their communities as they work to challenge attitudes, behaviors, and norms that are supportive of sexual violence and to model healthy and equitable alternatives for their peers and community. This phase of programming seeks to equip young people with the skills and motivation to take collective action to address risk and protective factors for sexual violence. These actions might include getting involved in policy change work, organizing letter-writing campaigns, creating and implementing social media campaigns, and a variety of other efforts.



3) *Adult Influencers*

The work with adult influencers in Phase 2 is designed to build upon work done with adult influencers in Phase 1.



Community Level

As noted in the image above, the community- and societal-level work is ongoing and is meant to support the work that happens in Phases 1 and 2.

Outcomes

- Increase community investment in primary prevention programming.
- Increase number of primary prevention initiatives (e.g. policy changes, petitions, letter writing campaigns, community events, and social norms campaign).

Approach

- This programming is meant to change the environment of the targeted population. This type of programming is connected to both Phase 1 and 2 and should complement efforts at the individual and relationship level.

Programming

- Efforts will employ the use of the community change strategies (community mobilization, coalition building, social norms change, or policy education).

Societal Level

Outcomes

- Increase participation in social norms campaigns offered by the state level partners.

Approach

- This programming serves to engage individuals in conversations about gender role socialization and its impact on sexual violence and to promote the interrupting of sexist comments and behaviors.

Programming

- Programming includes promotion of TAASA's Break the Box Campaign or other national social norms campaigns. The state level partners will guide these efforts.

Break the Box Campaign

Break the Box is a media-based public awareness initiative aimed at ending sexual violence through education and action against gender inequality. The initiative consists of a short video, video discussion and activity guide, and posters that support the messaging in the video. In addition, Break the Box has a social media component through Causes – the world’s largest campaigning platform – where participants can view the video, take a pledge, share their stories, and get additional information about the prevalence of sexual violence in Texas.



CONCLUSION

In conclusion, sexual violence is preventable. This work requires strategic and comprehensive efforts to address the various issues that underlie and cause violence. Through addressing risk factors and promoting protective factors, we can create a safer, healthier Texas for all who live here.

Resources for Further Reading/Learning

Resource	Notes
<p><i>Tools for Change</i> (TAASA) (http://devsite.taasaconference.org/wp-content/uploads/2014/10/ToolsforChange_PrimaryPreventionofSA.pdf)</p>	<p>This is a comprehensive introduction to primary prevention practice and theory.</p>
<p><i>Primary Prevention: The Next Step in Sexual Violence Education</i> (Maine Coalition Against Sexual Assault) http://www.mecasa.org/images/pdfs/primary_prevention/primaryprevention-1-2015.pdf</p>	<p>This is an overview of public health theory and its application to the primary prevention of sexual violence.</p>
<p>PreventConnect www.preventconnect.org</p>	<p>PreventConnect, a project of the California Coalition Against Sexual Assault (CALCASA), offers various services and resources for people doing prevention work, including frequent webinars, blogs, podcasts, and eLearning module. They also moderate a very active listserv</p>
<p><i>Responding to Everyday Bigotry: Speak Up! Speak up Handbook</i> (from Teaching Tolerance) http://www.tolerance.org/sites/default/files/general/speak_up_handbook.pdf</p>	<p>A guidebook with suggestions for how to respond to everyday bigotry in different situations and settings, and with different people.</p>
<p>Sexual Violence Prevention: Beginning the Dialogue http://www.cdc.gov/violenceprevention/pdf/svprevention-a.pdf</p>	<p>This short document from the CDC gives a good overview of the application of the public health model to sexual violence. While some of the CDC's thinking about primary prevention of sexual violence has shifted since this document was published, it still offers good insight into how to think about sexual violence and its prevention through a public health lens. To explore how their thinking has shifted, check out their website.</p>

Section 4:

WORKING WITH SURVIVORS

CONFIDENTIALITY

Sexual assault is a loss of control over one's body and over the ability to choose with whom to be sexual. Deciding who will have information about the sexual assault is an important part of regaining control after an assault. Maintaining strict confidentiality is one way to help the victim control who does and does not know about the sexual assault.¹²⁶ Confidentiality is one of the most fundamental principle of providing services to survivors of sexual assault.

Survivors expect information shared with the advocate will not be shared with others inappropriately or without the survivors' knowledge or consent. That said, an advocate's confidentiality is not absolute, and it is essential that survivors be made aware of the exceptions. When an exception to confidentiality is made, the survivor should be notified of the disclosure, preferably in advance of the disclosure. In addition, the survivor's privacy should be protected to the extent possible when disclosure is required.

A sexual violence program should have policies and procedures to ensure that the confidentiality of any individuals seeking or receiving services is protected. Advocates should be aware that a sexual assault program that receives VAWA (Violence Against Women Act) or VOCA (Victims of Crime Act) grant money is required, as a part of the grant, to insure confidentiality for clients or be at risk of losing those funds. The client's informed, written, and time-limited consent must be obtained prior to sharing any information or records except in the case of a statutory requirement (mandatory CPS report) or court order (e.g., a valid subpoena).

Exceptions to confidentiality include:

- Occasions when a survivor poses a danger to themselves or others; the advocate has a duty to warn and protect.
- Occasions when a survivor requests information be released to appropriate third parties, providers, officials or agencies. In these cases, the survivor should sign a release specifying the information to be released and specifying the length of time for which the release applies.
- Occasions when a court orders a release of information (subpoena).

¹²⁶ OVC Sexual Assault Advocate/Counselor Training: Module 2-5. Available here: https://www.ovcttac.gov/downloads/SAACT/module2/SAACT-Jan-15-PM-Mod-2_508c_SJP_01132015.pdf

- Anytime the advocate is working under supervision, information can be shared with the supervisor as it relates to providing supervision.
- Occasions when a client discloses information about physical, emotional and/or sexual abuse of a child. This is a mandated report to CPS and required by law.
- Anytime a third party is present in the room.

Releases/Waiversⁱ

Before any person or agency can discuss details about a sexual assault case with another party, the survivor must sign a *release form*. This is necessary even to acknowledge whether the survivor has sought services with your agency at all. For example, if a detective wishes to ask you (as an advocate) questions about a survivor's case, you must secure a release from the survivor before you can disclose information.

Sometimes, advocates communicate with survivors on behalf of the survivor's attorney. In some circumstances this may allow the attorney-client privilege to cover client communications, which provides much stronger protection than ordinary advocate confidentiality. Whenever advocates work with survivors' attorneys, all parties should clearly understand the type of confidentiality protection that applies and its limits

Here are a few professionals who commonly seek survivor information and require a release before disclosure:

- police officers/detectives
- district attorneys
- victim/witness staff or volunteers
- friends and family members
- school personnel

Before releasing any information about a survivor, the survivor must provide written authorization. The authorization should specifically state:

- The purpose of the release of information
- The specific information that the survivor agrees can be released
- The person or entity to whom the information can be released
- The date on which the form was signed
- Clear time limits for the duration of the release of information which includes the date at which the consent for release of information terminates
- Language that clearly indicates that the consent for release of information may be revoked at any time.

ETHICS

Volunteer Vs. Professional

Sexual assault programs have long valued the ability of volunteer advocates to provide crisis intervention, assistance, and information to survivors of sexual assault and abuse. The sexual assault field originated as a “grassroots” movement with the philosophy that a professional license or academic degree was not necessary to provide basic emotional support to survivors. Volunteers who were well trained and sensitive to the issues could provide excellent service to survivors. Some volunteers are survivors of sexual assault and understand, through personal experience, the trauma of sexual assault and want to assist others who have been similarly victimized.

Most advocates enter the field with similar selfless motives. It is easy for the advocate to believe that a genuine desire to be of service to others cannot possibly cause harm. Although advocates may complete a certified training program, individual volunteers are not regulated by professional licensing agencies or governing bodies (unless the volunteer was a psychologist, social worker, nurse, attorney or similarly licensed professional before becoming a sexual assault advocate). Each profession that requires a license to practice also has a formal written standard of professional ethics, specific to that profession that the members of that profession must subscribe to, or risk losing the license to practice. Since volunteer advocates are not bound to the parameters of such formal written guidelines, it is easier to minimize or overlook the importance of ethical behavior applicable to the sexual assault field. Yet, even an innocent breach of ethical behavior can do unintended damage to a survivor, causing the client to feel re-victimized, or possibly impede the healing process and the criminal justice process.



Definition

Ethics: Rules of behavior based on ideas about what is morally good and bad. the discipline dealing with what is good and bad and with moral duty and obligation; a set of moral values; the principles of conduct governing an individual or a group.¹²⁷

The Importance Of Boundaries

To provide the best possible service to survivors, advocates must be familiar with and conscientiously model good ethical behavior. Essential to the practice of ethical behavior is a recognition and understanding of basic boundary issues. Maintaining appropriate boundaries and consistently and steadfastly behaving within the limits of the advocate/survivor relationship are essential to maintain the survivor's trust and sense of safety.

Often, survivors who are appreciative of the support of the advocate will want to extend the relationship beyond the advocate/survivor relationship into a friendship. It is the advocate's responsibility to maintain appropriate limits on the relationship gently. This can be accomplished by encouraging the survivor to develop a personal support system outside of the sexual assault

¹²⁷ Merriam-Webster. Available here: <http://www.merriam-webster.com/dictionary/ethic>

program. It is never appropriate to allow an advocate/survivor relationship to gradually blend into a friendship.

Although it is sometimes difficult to recognize, there is a power differential between the survivor and advocate. No matter how caring or well intentioned, the advocate is still in the role of the “expert” or “provider,” while the survivor is in the role of “recipient” or “consumer.” No matter how much it feels like a friendship between equals, it is inevitable that a survivor will rely on, lean on or give more credibility to the feelings, behavior, and values of the advocate. The survivor already had a significant violation of boundaries occur during the victimization; it is crucial that the advocate not engage in any behavior that may even subtly blur the boundaries of the relationship with the survivor.

Consistently practicing ethical behavior requires vigilance. The advocate must constantly monitor innuendoes, suggestions, offers, opportunities and all aspects of the relationship for signs it is losing its professional focus.

Innocent, but potentially damaging ethical violations might occur when/if:

- The survivor asks for the advocate’s home phone number or the advocate provides it.
- The survivor asks for personal information about the advocate or the advocate volunteers it
- The survivor offers the advocate goods or services, such as a discount at a survivor-owned business, or coupons for a dinner or similar entertainment to express appreciation for services rendered.
- The survivor or advocate extends an invitation to lunch, dinner, coffee, or other occasions purely social in nature.
- The advocate volunteers specifics of his/her own history of abuse.
- The advocate shares his/her own feelings about the insensitivity of the police, the callousness of the hospital staff or the frustration of working within a bureaucratic system.
- The advocate begins to support a course of action he/she believes is in the survivor’s best interest, rather than allowing the survivor to make his/her own choices.

Just as it is a principle of victim advocacy that the perpetrator is always responsible for the assault and the survivor is never responsible for being raped, it is a principle that the advocate is always responsible for maintaining appropriate advocate/survivor boundaries. The survivor is not responsible for monitoring the relationship to determine when boundaries are being crossed.

Basic Ethical Principles

In sexual assault work, another principle is that survivors are entitled to knowledgeable assistance, privacy, and respect. Every survivor has the right to self-determination, which means being allowed to make one’s own choices without criticism, opposition or judgment. This does not mean the advocate validates every choice a survivor makes, but the advocate consistently supports the survivor’s right to make her own choices. The advocate can serve the survivor best by objectively encouraging the survivor to explore the potential positive and negative consequences of decisions. Fairness and flexibility are hallmarks of ethical and effective advocacy. Fairness includes providing the same excellent service to all survivors, regardless of age, ethnicity, sexual orientation or lifestyle. It means apprising the survivor of all the options available, rather than just those the advocate favors.

Flexibility calls for the advocate to recognize when a particular approach is not helpful to a survivor and to be willing and able to modify it as needed.

An ethical advocate will always honor the survivor's right to informed consent, which means the advocate has the duty and responsibility to provide appropriate, timely and accurate information the survivor needs to make informed choices and decisions.

Survivors seeking services have the right to be informed about:

- The advocate's qualifications training, credentials and experience.
- The agency's philosophy of counseling. For example, if the agency is affiliated with a specific religious denomination that has prohibitions against certain behaviors or lifestyles, the survivor should be informed of this, before delivery of services.
- Confidentiality policy, including the limits and exceptions.
- The nature and limits of the counseling relationship.
- Anticipated duration of counseling including length and frequency of sessions. If the agency must limit services to a maximum of three or six months, the survivor should be informed of this in advance.
- The survivor's recourse if dissatisfied with the services provided.

Ethical Standards

These standards for advocates can provide guidance in current and pending situations.

- The highest level of ethics is required of all advocates.
- Being an advocate for survivors of sexual assault involves trust. Any attempt to realize personal gain through advocacy is inconsistent with the proper discharge of the advocate's duties with the program.
- Follow these general standards:
 - Do no harm.
 - Promote the good of the survivor.
 - Be fair to all parties involved.
 - Keep your word.
 - Maintain confidentiality of survivor disclosures and records (unless disclosure is required).
 - Foster and respect the survivor's right to information and to make decisions based on the information (e.g., informed consent).
 - Avoid conflicts of interest.
 - Avoid dual roles in relation to the survivor or his/her family.
 - Represent accurately your own abilities, authority and power.

- Advocates should seek the guidance and support of their supervisor in all areas of ethical concerns.

COMMUNICATION/ACTIVE LISTENING SKILLS

Communication requires both a speaker and a listener. While much emphasis is placed on speaking skills, including speech classes in schools and books on how to become an effective speaker, less emphasis is placed on the equally important skill of listening. Of course listening in this context is more than just the physical act of hearing and we will use the term 'active listening' to emphasize that fully attending to the speaker is required by this type of listening. Think of active listening like you might listen to music. You might have the music on in the background while you're doing something else. Or you might put on your headphones, close your eyes and give the music your undivided attention.

Actively listening to a person requires you to master certain behaviors – some verbal, some nonverbal – that signal your interest.

Nonverbal

- Maintain good eye contact
- Sit facing the speaker
- Sit up or lean in
- Put your phone away, turn off your computer

Verbal

- Use short words or sounds to encourage the speaker: 'right', 'mmm hmmm' and 'yep'
- Legitimize the speaker's feelings: 'that must have been hard for you'
- Paraphrase: 'So you spoke with your sister'
- Ask open-ended questions: 'How did that make you feel?' 'What are you going to do now?'

Becoming an active listener requires effort, but will increase your sensitivity to the needs of the speaker. As Paul Tournier, Swiss Psychiatrist and author expressed, "It is impossible to overemphasize the immense need humans have to be really listened to, to be taken seriously, to be understood."

As you become more skilled at active listening, you will learn to gently guide the conversation towards identifying problems and encouraging action to address those problems. Exactly when to start focusing on the problem may be different for different survivors. Some survivors may be very clear and articulate about their problem(s), some may need assistance in prioritizing which problem to address first, some problems are not solvable and the survivor may need strategies to cope. Whatever the specific problem, your job is to listen without judgement, provide information when possible and encouragement to the survivor.

Advocates can utilize active listening skills to build rapport, identify problems and encourage action to address problems. Below you will find examples of how active listening can be utilized to support a survivor.

Achieve a Relationship

- Listen with compassion to what the person is feeling and experiencing. "Am I understanding you correctly?"
- "Check out" what you understand them to be saying to see if you are on the same wavelength.
- Let them experience your warmth and concern. Be genuine.
- Allow them to tell you about the crisis or problem at hand, when it started, how it developed and how they feel about it.
- Let the survivor know you would like to work together to find something that can be done to help—preferably to help them to help themselves.

Isolate the Problem

- Help them to sort out the pieces of the problem they are facing.
- Help them in separating those parts about which something can be done from those about which nothing can be done.
- Encourage them to describe what has been tried. (This way you will not repeat those things that have not worked.)
- Encourage the survivor to describe or discover other possible options.
- Help them examine each option in terms of their probable consequences. "What will happen if...?"
- Help them to decide which of the various options they may want to try now.

Encourage Action

- Encourage the survivor to plan just how he/she might begin doing what he/she has decided to do; the plan should be realistic with achievable goals.
- Encourage commitment to self, beginning soon and at an agreed upon time.
- If you perceive resistance to action on the problem, help them discuss and resolve these feelings.
- Assure them that someone will be available as they try to act in a constructive way; support with realistic hope. Remember not to be judgmental if your expectations are not met as to the best course of action.
- Encourage step taking. (Avoid doing things for them if they can do it alone—this allows them control of situations.)
- Show support by telling them that as they begin to do things, however small, they may feel better, less depressed, more hopeful, etc.
- Help examine and discover resources to cope—interpersonal, inner, spiritual.

TRAUMA INFORMED CARE

Trauma Informed Care (TIC) is an evidence-based systematic and organizational approach to delivering victim-centered service that seeks to avoid re-victimization, emphasize safety for all involved, acknowledge the widespread prevalence of trauma, and understand the impact of trauma in the lives of those it affects. An agency providing trauma informed care considers all people – those the agency serves and those who work for the agency - and works to integrate knowledge about trauma into its policies and procedures. A key tenet of trauma informed care is that everyone experiences trauma in their lives - directly or indirectly. This exposure to trauma can come in many forms and is as true for the clients served as it is for the staff who care for them. In order for advocates/employees to be effective in their delivery of care to clients, they must first be working within a system that acknowledges their own history of trauma, that understands its impact in their lives, and that strives to provide them the same environment it does to the clients.

Trauma informed care has been shown to be effective in the delivery of services for many populations such as children exposed to violence, adolescents with behavioral issues, substance abusers with comorbid diagnoses, those with diagnosed mental illness, and homeless mothers among others. Trauma informed care is especially relevant for populations that have been marginalized or those which have been disproportionately affected by interpersonal violence related issues.

There are five core principles central to trauma informed care. These core concepts are: safety, trustworthiness, choice, collaboration, and empowerment. An agency operating from/with a trauma-informed care model asks the general question “What happened to you?” instead of what has been traditionally asked - “What is wrong with you?”

Both the criminal justice and victim services systems can inadvertently re-traumatize. Key triggers to re-traumatization include:

- Feeling a lack of control
- Experiencing unnecessary and unexpected changes
- Feeling threatened or attacked
- Feeling overly vulnerable or frightened
- Feeling shamed

Placing victims in a detention facility rather than a shelter, shelter night bed checks and nightly curfews, and last minute court date changes are typical aspects of a victim’s life when cooperating with a task force investigation, yet they can be simultaneously re-victimizing. It can be helpful to consider re-traumatization as a cause when a victim exhibits behavior that may seem unusual, inconsistent, or even aggressive.

Agencies implementing trauma informed care should develop policies and procedures that are consistent with the five core principles as they relate to both staff and clients. Agencies should also assess and train all staff within a system/organization on the impact of trauma not only on a client’s life, but also on staff and colleagues’ lives. This includes training support staff, janitorial staff, direct

service, administration, etc. Support staff may actually have more contact with and by extension, more opportunity to impact clients, than initially expected.

Trauma informed agencies should also actively monitor for signs of secondary trauma amongst staff/employees. Staff/employees in agencies may be traumatized by the constant exposure to the nature of the trauma-related work they do and the trauma that exists in the lives of the people they serve.

Trauma informed care is different from trauma-specific interventions which are designed to treat the after effects of trauma such as post-traumatic stress disorder or other trauma related symptoms, but do not necessarily take into account the larger systemic impact of trauma. Trauma specific interventions may address only one aspect of trauma whereas trauma-informed care takes a systems based approach and realizes that trauma can come from many places in peoples' lives. Trauma can be the result of a single event like a crime or natural disaster or it can be a systematic trauma resulting from oppression and poverty.

Agencies that operate from models of trauma informed care, provide not only physically welcoming and safe environments for clients but also strive to create an environment that allows staff to both feel physically and emotionally safe as well. This means that one takes into account the environment that greets a client as well as understanding the environment in which advocates are working. A trauma informed agency asks questions like: Does my client feel safe in this environment? Is it welcoming? Is this an emotionally safe area? In addition, they ask: Does staff feel physically safe? Does staff feel emotionally safe? A trauma informed agency asks not simply "can my client trust me/us?" but also "can staff trust one another?" If staff/advocates do not feel that they can trust one another or reach out collaboratively for assistance with cases then it is very difficult, if not impossible, to deliver truly trauma informed care to a client.

CULTURALLY COMPETENT CARE AND CULTURAL HUMILITY

Sexual violence knows no boundaries based on culture, race or ethnicity. Men, children and women from all communities are victimized and affected by sexual violence.

Historically, efforts to address cultural differences began in the '70s with a wave of diversity trainings focused primarily on workplace relations, cultural sensitivity, respect and "getting along." These were followed by cultural awareness and sensitivity trainings, which often included an unintentional over-emphasis on shared group characteristics of particular cultures in an effort to become competent in those cultures. Yet, true competence in another's culture is not possible without living in that culture. A focus on cultural humility, as a compliment to cultural competence, should liberate advocates from the expectations of being cultural experts and, instead, engage clients, inclusive of their cultural differences, in service delivery.

Each survivor brings their individual worlds and perspectives which are affected by their ethnicity, class, educational background, age, disability, sexual identity, etc. When being cultural humble, sexual assault advocate should keep in mind those histories and the social barriers related to them.

Advocates also should work to be aware of social distinctions, biases, and oppression in our society – and realize that her or his own values may affect the advocacy relationship.

Because of America's diverse population, every advocate should begin the lifelong work of striving towards cultural competence, while simultaneously maintaining cultural humility in recognition that true competence in all cultures is an unachievable goal. Every advocate, regardless of race, ethnic or economic background has work to do and each advocate is responsible for undertaking this process, which includes (but is not limited to) reading, getting to know people of other cultures, and gaining experiences of other cultures. As you become more culturally aware and competent, you accumulate experiences that give you the insight you need to do this work.

TIPS AND TOOLS FOR CULTURALLY COMPETENT ADVOCATES

Communication

1. Listen patiently, show interest and demonstrate empathy.
2. Be aware of confidentiality. Self-disclosures may be a concern to some survivors.
3. Validate the survivor's explanation of the crime and its repercussions.
4. Be flexible, alter an action plan to fit the survivor's cultural framework and negotiate a compromise, whenever possible.
5. Reassure the survivor that the best will be done to help him/her.
6. Practice effective cross-cultural communication which includes:
 - Awareness and sensitivity to non-verbal cues, body language, gender roles, and face-saving needs.
 - Ask for clarification and check for understanding. Often even though the same term is used, it may mean different things to the advocate and the survivor.
 - Keep it simple and jargon-free.
 - Recognize your own communication style and acknowledge when it may clash with the survivor's.
 - Know and manage your own hot buttons.

Relationship Building

1. Take time to build trust and rapport.
2. Build a relationship with the family and extended family, when appropriate.
3. Work within the survivor's system, or negotiate/compromise.

Self Awareness

1. Be aware of your own biases/stereotypes and put them aside.
2. Reduce ethnocentrism and respect the survivor's world view, even if it does not mesh with yours.
3. Recognize your limitations and ask for clarification and/or seek cultural informants to better your understanding.

Discerning Cultural Patterns

1. Recognize and work within cultural norms, when appropriate.
2. Elicit the survivor's concept of the crime, safety, grief and healing.
3. Acquire cultural knowledge, which will enable you to react positively to unfamiliar practices.
4. However, be careful not to stereotype. Treat each case uniquely.

CRISIS INTERVENTION

All people are subject to stress at different points in their lives; all people attempt to maintain a sense of balance. Yet there are times when the stress is so great that the person cannot maintain a sense of balance with the personal and environmental resources available to them. The crisis may be a threat, loss or other traumatic physical or emotional event (such as a sexual assault). At this point a person may not be able to function as usual and is in 'crisis.' A state of crisis is not an illness or weakness. It represents a struggle with a current life situation. The person in crisis may feel confused, overwhelmed or frightened. Typically, the crisis situation is time limited and within 8-10 weeks the person may reach a new balance (which can be better, the same, or worse than the pre-crisis functioning).

Crisis intervention is the immediate short-term assistance and support you can give to individuals in a crisis. Crisis Intervention may have several goals:

- To reduce the immediate impact of the crisis.
- To understand the precipitating circumstances.
- To help the person access healthy coping skills, capitalizing on strengths, support systems and resources in the community from which a base of reintegration may occur.
- To help the person move beyond the crisis so that she/he may get on with his/her life.

The first important thing to know about a crisis is that it is time limited. A crisis always pushes towards some sort of resolution (good or bad) and will usually run its course in about 8-10 weeks. During a crisis, a person's habits, coping patterns and defenses are suspended. It is during this time that the individual is most open to learning new coping skills effectively.

It is vitally important for the advocate to be nonjudgmental regarding the nature of an individual's crisis. Trauma and crisis are subjective experiences. What may seem to be a comparatively trivial matter to one person may cause extreme distress for another. For example, one person may go into a crisis and experience intense grief when a pet dies. For another individual, the cat's dying may be of little consequence. There are many factors that influence whether or not we will perceive an incident as traumatic. Past experiences, values and beliefs, emotional stability and support prior to the event are a few of the variables that influence the way we perceive the events in our lives.

It is extremely important to note that a person who is in crisis is experiencing a number of different feelings, two of which may be anxiety and confusion. Therefore, especially in the initial stages of a crisis, help the person get in touch with the feelings that they are experiencing before attempting to provide any information. In reality, there are a lot of places an individual can go to get information

that may or may not help. There are not, however, as many places where an individual can get help clarifying feelings about an event. This is important, as clarifying one's feelings will help in making a decision that will in turn lead to a resolution of the crisis.

FEELINGS THAT MAY BE EXPERIENCED BY SOMEONE IN CRISIS

- **Anxiety**—This is perhaps the most common feeling. Any substantial threat produces anxiety. Normal amounts of anxiety assist in mobilizing against the threat and may be appropriate and helpful. However, great anxiety may produce confusion, distortion, poor judgment, self-defeating behavior and/or questionable decisions. Anxiety may be the first emotion the advocate must learn to work with.
- **Powerlessness**—People work hard to develop and manage their own set of coping skills. Then, perhaps because of an external event or a conglomeration of unfamiliar emotions, they experience a sense of loss of control that may be overwhelming, bringing with it a feeling of powerlessness. This feeling of powerlessness, in turn, may bring with it a feeling of shame.
- **Shame**—Many people are taught to be competent and self-reliant, but during a crisis, a competent, self-reliant person's skills may fail them, leaving them feeling incompetent and dependent on others. This may produce feelings of shame, and may be closely related to feelings of powerlessness.
- **Anger**—There may be very little, some or a lot of anger. However, anger may often be hidden behind other expressions, sadness, for example. Anger may be directed at self, others, the listener or an event.
- **Ambivalence**—Feelings of confusion and uncertainty may emerge. As a result the person may struggle with issues brought on by the crisis. Some of these issues may be: self-reliance vs. relying upon others; controlling emotions vs. losing control; trusting others vs. total distrust of others.
- **Hopelessness**—Survivors may feel that they will never get beyond the present incapacitating feelings. They see no hope of ever recovering or moving beyond the crisis and may talk of ending their lives. Suicidal thoughts or tendencies may sometimes accompany this feeling. See the section below on Suicide Assessment.
- **Decreased Self-Image**—The individual may also feel a decrease in self-esteem. All these feelings in this list may combine and result in a decrease in self-esteem, leaving the person in crisis extremely vulnerable.

It is important that the advocate assure the survivor that there are no right or wrong feelings and that whatever he/she is feeling is okay. This may become difficult at times because the survivor may be experiencing a mixture of feelings. Feelings, especially anger, may be displaced and directed at the

advocate. The advocate should not be offended by this and thereby, act in a negative way. Remember, the survivor may be in a state of emotional confusion.

As an advocate you should not attempt or intend to overhaul the basic personality of the person in crisis. Instead, the advocate should help empower the survivor so that they may access existing or develop new problem-solving methods. Advocates may use the following steps to walk a survivor through a crisis.

1. Establish rapport and trust
2. Clarify the current situation
3. Discussion of plans and options, offering available information

Providing crisis intervention is a skill that every advocate can learn. Don't think that you can't help because you don't have all the answers, no one has all the answers. Sometimes figuring out solutions with the survivor is the best way to demonstrate your support and commitment to them. Building rapport and clarifying what the survivor needs are good first steps. Keep survivors in the "here and now." This will give you a clue as to what issues are most pressing and presently disrupting their lives and where to begin. Keep them focused on what they are feeling right now and begin the crisis intervention.¹²⁸

SUICIDE ASSESSMENT SKILLS

It has often been said that fear is the product of a lack of knowledge about the things that frighten us. Consequently, the more we understand something, the better we are able to deal with it in a positive manner. This maxim can be applied most appropriately to the phenomenon of suicide.

It is important to remember that our society still views suicide as a taboo subject, a topic which should be avoided like the plague. For many people, just the word suicide is enough to instill anxiety, uneasiness, helplessness, fear or even anger in the person who hears it or is faced with it.

As advocates, it is important to discern what personal emotions we attach to a suicide threat from a survivor. In several instances, our own feelings about suicide can get in the way of our being able to hear and cope with the survivor's very immediate needs. Additionally, it is a responsibility of the advocates to have an understanding of what constitutes a suicide threat and, more significantly, awareness that suicide is preventable. A suicidal threat on any level is a cry for help. The volunteer who is faced with such a threat has been given the opportunity to assist a person walk away from a suicidal crisis.

We need to consider some of the false notions we all entertain about suicide and concentrate on providing advocates with the knowledge they will need to most effectively handle suicidal situations.

¹²⁸ Compiled by Ben Komman, MSW, ACSW from Crisis Suicide Rescue, Inc. and Suicide and Crisis Center of Dallas.

STATISTICAL INFORMATION

The national suicide rate is approximately 13 completed suicides per 100,000 persons per year, which is 41,140 suicide deaths/year. This rate has been slowly increasing (in 1999, the suicide rate was 10.5 per 100,000, in 2004 the suicide rate was 11 per 100,000 and in 2009 the rate was 12 per 100,000¹²⁹). The rate of suicide attempts, although very difficult to substantiate, is calculated as almost twenty-five times the number of deaths by suicide. Suicide ranks as the tenth leading cause of death in the United States.¹³⁰

On average, there are 117 suicides per day. The highest suicide rate is among people ages 85 and older, the second highest occurs between those ages 45- 64 years of age. Younger groups have consistently lower suicide rates than middle-aged and older adults.¹³¹ Almost four times as many men complete the act for every female completion, although females make more suicide attempts. The risk of dying from suicide is almost double for the white population than for the black population. An individual who is suicidal is frequently thought of as "typical" when discussing a crisis intervention center, such as a rape crisis center, yet this type of encounter may be one of the most frightening to a new advocate.

Although suicide is a frightening subject to many of us, it is a familiar thought to many others. Because of this apparent contradiction, it is important that volunteers examine their own feelings about suicide. This will help avoid paralyzing fears when encountering the suicidal survivor. It should also be recognized that, when a suicidal person calls the hotline or talks with you face to face, they have involved you in their considerations about suicide. They are 'asking' for help including intervention as needed and if possible.

FACTORS CONTRIBUTING TO SUICIDE:

Although suicide has no age, gender, ethnic or socio-economic limits, there are a number of emotional states and perceptions that are common to most suicidal persons. The advocate must be aware of these and recognize them and, in order to help. These factors include:

- recent history of loss or threatened loss
- previous suicide attempts
- severe depression
- specificity of suicidal plan
- lethality of method
- disturbed or disrupted interpersonal or social relationships
- inability to communicate and be understood

¹²⁹ National Vital Statistics Reports. 2016 Available here: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

¹³⁰ National Vital Statistics Reports. 2016 Available here: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf

¹³¹ American Foundation for Suicide Prevention. www.afsp.org

Although suicide is "democratic," meaning that no particular group is immune to it, some sociological factors are also significant. The suicide rate among Whites is higher than among Blacks, except for the suicide rate of young Black males, which is increasing at an alarming rate. Men tend to complete suicide more, while women tend to attempt it more. Middle age and old age are the most common times for suicide, although the rate for young people is increasing. There does not seem to be any significant tendencies in religious, social, political or class factors, except in the motivational aspects between these groups.

SUICIDAL BEHAVIOR

- Impulsive suicide behavior usually follows anger, disappointment, or frustration. This emotional crisis is highly temporary but, in an impulsive person, can also be very dangerous.
- The feeling that life is no longer worth living may be the result of severe depression. Individuals may feel a sense of worthlessness about themselves and the external world.
- A very serious illness may lead to suicide as an escape from suffering for both the individual and their family.
- The communication of a suicide attempt may occur when a person has no real wish to die but desires a radical change in the behavior of those around them and uses a suicidal attempt to communicate this.

THE SUICIDAL CRISIS

A suicidal crisis is characterized by various behavioral and topical aspects. It is usually short in duration and works quickly toward some type of resolution. One significant aspect, however, is that most suicides occur within three months after the beginning of "improvement." The myth that once a person experiences a suicidal crisis, he will always be suicidal, is not true. Many people who overcome such a crisis will go on to lead happy and productive lives and are usually very grateful for having been "saved."

The potential suicide will almost invariably display warning signals in one form or another. Contrary to popular belief, people who are considering suicide will give many clues. People who consider suicide as a possible alternative may be ambivalent to some degree about their wish to die because they realize that they are gambling with life and death. This is one of the most important points to remember when talking with a suicidal survivor. If the person feels uncertain enough to call, they are giving you the chance to help.

Some of the clues resulting from the ambivalent state can be discerned from the person's behavior and the circumstances which surround their life. A serious change in a person's mood or behavior is an indication that all is not going well. This behavior can take the form of depression, intentional or circumstantial isolation or withdrawal, change in eating, sleeping or social habits or loss of interest in the external world. People may physically prepare for death by making a will, giving away possessions

or giving orders suggesting that they will not be around to see them carried out. Individuals who are suicidal may give many verbal signals that refer to this intention. For example:

"I'm so bored. I just can't go on."
"I don't want to be a burden."
"I can't stand it any longer."
"You won't have me to kick around much longer."

An advocate may encounter not only the individual contemplating suicide, but also a person concerned about someone else contemplating suicide or a person affected by someone who took their own life.

In order to deal with these situations in the most effective manner, the advocate must remember that it is not his/her responsibility to either psychoanalyze or discover the deep seated problems that either led to or caused the suicidal behavior. The problems involved in such behavior are usually based on experiences that have accumulated over a lifetime, sometimes resulting from a traumatic childhood or infancy.

It is, however, a function of the advocate to respond to immediate needs—to be supportive, to be reflective and understanding and most of all, to be accepting and nonjudgmental. There are ways in which to help:

- **Do Not Deny Feelings**—Accept statements about how the survivor is feeling as true and accurate. The desire to have another listen to and accept our feelings is strong and will help build rapport between the survivor and advocate.
- **Reflect and Clarify What You Hear**—The survivor may be in a highly confused and uncertain state and may desperately need clarity. A survivor might say, "Nothing ever works out for me." An appropriate response might be, "You feel like nothing works for you, so you are wondering why you should you keep trying."
- **Verbalize Suicidal Feelings**—Nothing can be scarier than that which is shrouded in a cloud of mystery and silence. Speaking about suicide to a person will NOT cause them to commit suicide. The advocate may be the only person who can understand and accept a person's wish to die. Direct statements are, therefore, the best. If someone is hinting of intentions to commit suicide because of fear or shame, the most effective response is to ask, "Are you thinking about suicide?" or "Are you thinking about hurting yourself?" Other direct questions that delve into the considered plan, method, etc., will also help in the assessment.

The most common feelings are those of hopelessness and helplessness. The caller is unable to see a future, especially a good future, and is convinced that there is nothing to be done to change the situation. These feelings can set up a vicious cycle of "There's nothing to look forward to, so why should I bother to do anything? It won't change anything anyway," and "I've never done anything right. I've always screwed up my life. It'll never be any different. What's the use of trying anymore?"

The caller may attempt to project this attitude onto the volunteer with a comment of, "You probably can't help me either." It is important that the volunteer not let this be dropped unanswered and be careful not to be unrealistic.

EVALUATING THE SUICIDE RISK

The following is a list of symptoms of a caller who is a potential suicide that will help you make your evaluation. They are not in special order and are not of equal weight, but the more of these symptoms a caller exhibits, the more likely it is that he/she is suicidal.

- **Means**—A suicidal tool is available (e.g., gun, sleeping pills, etc.). This factor carries double weight if the caller frequently mentions that he/she has the means and a well-defined plan.
- **Previous Attempt**—A recent study of suicide in Philadelphia showed that in 75 percent of accomplished suicides, there has been a previous attempt, and this is representative of most suicides.
- **Lack of Roots**—The further away from home, family connections and close friends a person gets, the more likely suicide becomes.
- **Withdrawal**—The suicidal person has often withdrawn from social contacts; they drop out of clubs, church, even jobs. They avoid old friends and can reasonably say, "I'm not needed."
- **Fear of Future**—"I know it's cowardly to think of suicide," they say, but actually they are thinking that if they can accomplish suicide, they will not have to fear the things that really worry them.
- **Financial Reversal**—Closely allied with fear of the future is anticipation of financial reversal. The realization is never as bad as the anticipation, but the potential suicide will avoid this impending financial crisis. It is the loss of status that hurts.
- **Feelings of Failure**—Despite any past successes, the person will dwell on failures—even small ones. He/She will say they are inefficient, forgetful, make mistakes that others notice, etc.
- **Bad Breaks**—Or they will bend in the opposite direction. They are always right and the others are always wrong. But they get all the bad breaks. This is a cover up for feelings of failure.
- **Revenge**—They may be seeking revenge, thinking, "You'll be sorry when I'm gone." This is a very dangerous attitude because it may give birth to homicide.

If a caller tells you that an overdose has been taken, etc., you should contact the police immediately, without asking the caller's permission. If possible, get an address and the caller's phone number and keep the caller on the phone while someone else calls the police. If you cannot get an address, call police, calmly explain what has happened and give them the caller's phone number if you have been able to obtain it. The police may be able match it with a cross directory to get the address.

NO-SUICIDE CONTRACTS

Your assessment will help you decide whether this person is a suicide risk. Is this enough information? A tool developed by Robert and Mary Goulding and Robert Dyrel, can help us further assess suicide potential by providing information about how at risk a person is, and for how long the client can be trusted not to kill themselves. This tool is called the "No-Suicide" Contract and is stated as follows:

"No matter what happens, I will not kill myself, accidentally or on purpose, at any time."

The client who is able to make this statement confidently and with congruent behavior is considered safe, although outpatient therapy may be needed to deal with underlying issues. Clients are encouraged to call the hotline if at any time they feel unable to uphold the contract. The client who refuses to repeat the contract in some way is considered to be at risk. Alterations of the contract frequently are made in three areas.

1. The most common alteration of the contract is made in relation to time. The client may state the contract and then add "for a week" or "two months" or "six months." This gives you a safety period within which you can work or refer the client. The client should be reevaluated for suicide potential well in advance of the time the contract expires. It is imperative that you record the date of the contract and renew it before it expires, or you have provided the client with free reign to commit suicide. If the client is only able to give you a time limit of one hour, this will provide you enough time to get the client to a safe environment. It is up to you to decide whether the time period stipulated is something with which you can work.
2. The second condition a client may make is the part of the statement, "No matter what." For example, the client may repeat the contract and add: "unless my husband leaves me, "if I get the job I want," "if my wife still loves me," "if my child behaves himself," etc. There are endless possibilities of an individual nature that the client may relate to you. It is important for you to tell the client that someone else is being allowed to control whether they live or die. This is another issue and requires further intervention. If possible, request that the client set a specific time limit on living, rather than relying on another individual's actions or responses. The time limit will then give you a definite period within which you and the client can work.
3. The third qualification is the part of the contract stating "I will not kill myself." The client may respond by saying: "I will not try to," "I probably won't," "I'd like to be able to," and

might not provide you with a concrete decision. Avoid accepting them! When a client uses one of these variations, counter with “but will you?” This forces the individual to reconsider and make a definite decision by either saying no or stating the time limit.

Suicide is a scary possibility. All too often we don’t speak of suicide for fear that mentioning it may somehow increase the likelihood of it occurring. In fact, the opposite is true. Much like sexual assault, speaking about it brings it into the light and decreases its occurrence.

SAFETY PLAN

Credit for this section is given to the Ministry of Public Safety and Solicitor General, Victim Services and Crime Prevention Division, January 2007, Sexual Assault: Victim Service Worker Handbook.

Your role in assisting a survivor in her safety planning is to help her identify the risks and to present her with possible strategies or options for reducing or eliminating these risks. It is important to understand that safety is a relative term and that women’s lives are complex and variable. A woman’s safety needs may change from day to day and from situation to situation.

If she has been sexually assaulted within a relationship or by someone else she knows, her safety planning will have a different focus than if she was assaulted by a stranger. In either case, however, safety planning around sexual assault should take into consideration protection from both offenders who are known to the woman and those who are not. In addition, safety planning should take into consideration the safety of any children.

It is important to look at risk factors that arise from the offender, as well as risk factors that arise because of the individual woman’s personal circumstances, which make accessing services and trusting the system more challenging. Racism, poverty, lack of education, language barriers, mental and physical disabilities, sexual orientation, and geography all place barriers in the way of effective safety planning. Many women from marginalized populations have experienced systemic discrimination as well as mistreatment at the hands of various government systems (for example, child apprehension), which may make them skeptical about your offers of assistance.

The Victims’ Rights Law Center has published an excellent guide to Safety Planning with victims of non-intimate partner sexual assault. Search for the *Safety Planning with Adult Sexual Assault Survivors: A Guide for Advocates and Attorneys* available at <http://www.victimrights.org/>.

BARRIERS TO REPORTING

Sexual assault continues to be a severely underreported crime. In a 2015 study by the Institute on Domestic Violence and Sexual Assault at the University of Texas, only 9.2% of victims reported their experience to the police.¹³²

The reasons that survivors do not report are numerous. Simply put, not all survivors find it necessary to report sexual assault to the criminal justice system in order to move forward from their experience. In fact, some feel that the criminal justice system re-victimizes them in its process. Some survivors find that the services provided by a rape crisis and recovery center or similar provider are the only services they feel comfortable pursuing.¹³³

Several research studies have been conducted to understand more specifically what motivates a survivor of sexual assault to report to law enforcement or not.

A survivor's relationship with the offender has a strong effect on the likelihood of reporting.¹³⁴

- When an offender is an intimate partner or former intimate partner, only 25 percent of sexual assaults are reported to the police.
- When an offender is a friend or acquaintance, only 18 to 40 percent of sexual assaults are reported.
- When an offender is a stranger, between 46 and 66 percent of sexual assaults are reported.

Beyond the relationship with the offender, survivors cite the following reasons for not reporting a sexual assault:¹³⁵

- Fear of reprisal
- Personal matter
- Reported to a different official
- Not important enough to respondent
- Belief that the police would not do anything to help
- Belief that the police could not do anything to help
- Did not want to get offender in trouble with law
- Did not want family to know
- Did not want others to know

¹³² Busch-Armendariz, B., Olaya-Rodriguez, and D. Kammer-Kerwick, M. (2015) *Health and Well-Being: Texas State Sexual Assault Prevalence Study*. Institute on Domestic Violence & Sexual Assault, University of Texas. <http://rapecrisis.com/wp-content/uploads/2015/09/TX-SA-Prevalence-Study-Final-Report-4-2015.pdf>

¹³³ Maryland Coalition Against Sexual Assault Fact Sheet. Available here: <http://www.umd.edu/ocrsm/files/Why-Is-Sexual-Assault-Under-Reported.pdf>

¹³⁴ U.S. Bureau of Justice Statistics, T. Hart and C. Rennison (2003). *Reporting Crime to the Police*. 1992-2000

¹³⁵ D. Kilpatrick et al., "Drug-facilitated, Incapacitated, and Forcible Rape: A National Study," 2007; U.S. Bureau of Justice Statistics, M. Planty and L. Langton, "Female Victims of Sexual Violence, 1994-2010," 2013; Wolitzky-Taylor et al, "Is Reporting of Rape on the Rise? A Comparison of Women with Reported Versus Unreported Rape Experiences in the National Women's Study-Replication", 2010

- Not enough proof
- Fear of the justice system
- Did not know how
- Feel the crime was not “serious enough”
- Fear of lack of evidence
- Unsure about perpetrator’s intent

Of the sexual violence crimes that were reported to police from 2005-2010, survivors gave the following reasons for making a report to law enforcement:¹³⁶

- 28% to protect the household or victim from further crimes by the offender
- 25% to stop the incident or prevent recurrence or escalation
- 21% to improve police surveillance or they believed they had a duty to do so
- 17% to catch/punish/prevent offender from reoffending
- 6% gave a different answer, or declined to cite one reason
- 3% did so to get help or recover loss

In addition, factors specific to the survivor may create an additional barrier to reporting. These factors may also create barriers to survivors seeking services at rape crisis centers.

Language. As our society evolves, a more ethnically, racially, and culturally diverse population emerges. The need for bilingual staff and qualified interpreters is being felt by all agencies that strive to better serve their communities.

Elderly. Elderly survivors of sexual abuse may think law enforcement would never believe someone their age would be a target for sexual abuse.

Adolescents. Because of assumed legal or parental consequences, adolescent victims may fear reporting the assault, especially if alcohol or illegal substances were involved. It is important for law enforcement to reassure teens that despite their potential poor choices, consent is still necessary before sexual activity is legal. It may also be helpful to offer teens your support when they talk to angry or disapproving parents.

Gender. Sexual assault of males continues to be underreported because of the stigma associated with this crime. The violent crimes of rape and sexual assault are minimized when people believe “real” men are never raped. Harmful sex-role stereotypes that create narrow definitions of masculinity make it particularly difficult for male survivors of sexual assault to report and seek help.

Lesbian, gay, bisexual, transgender and queer survivors frequently will not report an assault out of concern that their sexual orientation, rather than the crime, will become the focus. Physical injuries beyond the rape/sexual assault itself may be suffered by survivors of a hate-based attack. In seeking services or help, these survivors may not disclose the sexual assault and only report the physical

¹³⁶ Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Female Victims of Sexual Violence, 1994-2010 (2013). Available here: <http://www.bjs.gov/content/pub/pdf/fvsv9410.pdf>

assault. Survivors who are not open about their sexuality may fear that reporting and cooperating in prosecution may lead to disclosure.

Persons with disabilities may be:

- Less able to report or disclose the abuse
- At increased risk for abuse because of dependence on others for assistance or care.
- Reluctant to report instances of abuse out of fear of losing their vital linkage to major care providers or hard-earned independence.
- Not taken seriously when disclosing or reporting abuse. People with disabilities are targeted for victimization at a much higher rate than the general population. It is important to be patient and proactive when serving this community.

Residency Status Possible barriers for immigrant survivors:

- Fear of deportation.
- Distrust of the criminal justice system. For some, experiencing police corruption in their country of origin has made them distrustful and apprehensive of police in this country.
- Loyalty to own cultural group.
- For fear of being deported, many immigrants will not seek assistance through social services or report their victimization to law enforcement.
- Anti-immigrant climate

WORKING WITH SECONDARY VICTIMS

Significant Others

Those closest to the survivor are also effected by the assault and are called secondary victims. While many secondary victims seek to support survivors as much as possible, they may also need support themselves. How can those closest to a survivor do “the right thing?”

The divorce rate among sexual assault survivors is extremely high. Often the significant other has grown up with preconceived notions (myths) about rape and cannot comprehend the totality of the trauma and how that may surface in a relationship. When the survivor has post-rape sexual problems, the significant other may interpret unwillingness or inability to have a normal sexual relationship as rejection. Also, a sexual assault might bring other family problems to the surface. Advocates must address the problem of working with significant others of survivors. Significant others may stymie the process of healing if not information about what has happened.

The goal of crisis intervention with relatives and close friends is twofold;

First, to assist with their own feelings about sexual assault and the effect it might have in their relationship with the survivor; and to assist the family and friends in giving support to the survivor.

Sexual assault is an emotionally charged situation surrounding family and friends immediately after the rape. Some of the reactions you might expect from family and friends could include:

- distress for the survivor's physical health
- anger at the offender that might be taken out on the survivor
- anger that the survivor did not "fight harder"
- anger that the person had not been "careful" enough
- feelings of revenge on the offender
- feelings of guilt that they were not there to protect the survivor
- sense of loss for themselves, for the survivor, for the family

Listen to what the partner, father or other family members are saying. As they express their feelings they will be better able to help the survivor express theirs. Provide accurate information and encouragement—give them permission to react to this crisis, also. Friends and family may have a difficult time talking about sexual assault. The advocate can be a safe place to discuss their concerns and vent their feelings.

When you have had a chance to listen to what has been said, you can give the family some concrete information about what the sexual assault represents to the survivor. First, the significant other and family should know that the fear of not being believed, along with feelings of embarrassment, and shame will most likely be uppermost in the survivor's mind. Second, you should try to dispel myths about rape that the family may have grown up with (e.g., "If she didn't fight back, she must have wanted it", "If she was in a relationship with the offender it couldn't be rape", "If she was drinking than it was probably a misunderstanding.") The third thing you want to stress is that, since this is a mutual crisis, they should support one another. The family can support its loved one by providing a place to share feelings without condemnation and by assisting in mobilizing the survivor's coping skills. The survivor should be allowed, not forced to express her/his emotions.

Questions about how the survivor feels now and what bothers her/him the most are useful. They are not threatening and should allow her/him to talk about the most immediate concerns. Remember, too, the survivor wants to talk about other things. Often the sexual assault may leave them concentrating on other things and it is important to talk about these. Probably the most practical suggestion is that you communicate your own willingness to let the survivor talk. Because of your closeness to him/her, the survivor may be more sensitive to your feelings. If you are distressed, it may be impossible to talk to you. She/he may also try to protect you. In these and other cases, where he/she really will not be able to talk to you, encourage speaking with someone trusted. Remember that the sexual assault has brought up feelings of powerlessness. Encouraging him/her to talk to whom he/she wants, when he/she wants, is more helpful than feeling it is necessary to talk to you.

If the family has strong religious convictions, they might have trouble dealing with the sin aspect of the sexual assault. The survivor may feel as though she/he committed the sin. If the family agrees with or promotes this idea, the psychological ramifications could be tremendous.

The crisis is very much akin to the grieving process associated with the loss of a loved one. The survivor must be allowed to grieve – it will lead to eventual healing, and the healing of the family. If the family tries to get the survivor to forget it or deny it by shrouding the incident and feelings in silence, they only force her/him to bury it more deeply. This can cause problems for years afterward.

Overprotecting the wounded loved one can be just as harmful as denying the crime. If family/friends constantly try to insulate the survivor from hurt, they keep him/her from confronting feelings. Keeping the survivor in a cage and taking away car keys is not the answer, either. Survivors must live in this world when their “protectors” are no longer there. They must be allowed to regain control of all of their life.

Sometimes family members turn their feelings of inadequacy into self-recrimination – “If I had taken her, she wouldn’t have been assaulted.” Significant others must be made to realize that blaming themselves only increases their own anxiety. They could not know this would happen. When they blame themselves, it might cause further anxiety to the survivor because she/he does not want to be the cause of their hurt. One thing you might point out is that if they continue to concentrate on their own reactions, they cannot help the survivor.

The advocate’s key roles in intervention with the families and partners of survivors should be educational in nature.

- Explain the inherent maliciousness of the assault as a crime, helping family members to understand the ill intention of the perpetrator helps to put into context the responsibility of the perpetrator of the crime.
- Prepare the family for the predictable psychological and physiological consequences of the sexual assault.
- Explain to the family how to provide an accepting and safe environment into which the survivor can release troubling thoughts and feelings without fear of condemnation or critical response.
- Discuss any sexual indifference by a partner toward the survivor. Help the partner to identify the components of change in feelings and see the congruity of the feelings.
- Discuss sexual incompatibility or indifference before the assault. Encourage both partners to discuss this fact and not to blame the sexual assault for pre-existing problems.

HELPFUL INFORMATION FOR THE ADVOCATE

- **Don't** be openly critical (“You shouldn’t...” “You are angry and that’s bad.”) This can cause defensiveness and anger as well as cause the family to stop talking with you and thereby decrease useful venting and render you powerless to help.
- **Do** focus supportively on the partner’s injury – be aware and let her/him know you are aware that she/he has suffered a loss also.
- **Do** let them know that although it is like grief, it need not be permanently debilitating. He/She will never forget it, but they can go on.

- **Do** encourage significant others to support one another.
- **Do** give any information and support you can.
- **Do** let them know you care.
- **Do** offer a male counselor for male survivors or male family members if available and requested.

FOR SIGNIFICANT OTHERS ASSISTING THE SURVIVOR

- Let the survivor know you are willing to listen. Because of the nature of the crime, it is sometimes difficult to talk about it. Be a good listener. Allow him/her to “talk it out” if he/she wants to – to you or to someone else.
- Let him/her know you care and that it is important to you that he/she feel safe again.
- Allow him/her to make decisions and take control of his/her life at his/her own pace. The rapist just took that control away. You may help make decisions but do not overprotect.
- Be stable and secure for them. He/She will need reassurances that he/she is still the same person, not dirty or ruined.
- In general, a male survivor may be more controlled in his response to the crisis and less inclined to talk about it. Encourage him to talk, but do not force him. Be supportive. Be open when he wants to talk.
- Everyone reacts differently in a crisis situation. Try not to judge.

SPECIAL POPULATIONS

Introduction

Historically, rape and racism in this country have always been connected. Because racism and sexism are pervasive in our society, violence against people of color reflects both biases. According to a National Institute of Justice report (NIJ 1995), of 319 victim services programs in law enforcement agencies and prosecutors’ offices, about 65 percent of the victims were white, 22 percent were African-American, 8 percent were Latinos, and 5 percent were Asian, American Indian, or other ethnic group. Yet, minorities are disproportionately affected by crime. Even in 2000, males, African-Americans, Latinos, the poor, and residents of urban areas were the most vulnerable to crimes of violence according to the Bureau of Justice Statistics (2000). Harassment and violence reinforce the

power that one individual may assert over another solely by virtue of his/her status in society; status derived from race, class, gender or sexual orientation.

Cultural Groups

For people of color, the vulnerability caused by the constant threat of violence places them in a weakened status. Racist and sexist myths have continually stereotyped people of color within our society, thus perpetuating their victimization. African-American women are sometimes portrayed as primitive, promiscuous and domineering; Latinas as passionate, teasing and flirtatious; Asian American women as submissive sexual servants, mysterious and sinister; American Indians as subservient, savage and child-like; men of color as macho, lazy and womanizing. The exoticizing of women of color contributes to the myths that they are more willing to be abused and are easier to abuse. This same stereotyping consequently affects the credibility of both male and female persons of color who are sexual assault victims. This often leads to a failure to report the crime for fear that he/she will not be believed or supported by police, judges, the media, professors, administration, or even his or her family. Language barriers and failure to report crime to authorities were also cited as partial reasons for limited representation of certain groups. However, it is more than language problems that keep survivors of sexual assault from diverse backgrounds from reporting and accessing victim assistance services.

All survivors are individuals, with different reactions to being raped. But people of color have special concerns about sexual assault that come from their cultural upbringing and the problems of coping with racism in society. Although not all people of color share the same feelings, there are patterns that some people of color share.

Similar feelings shared by people of color

- A lack of trust in authorities and the legal system
- Less inclination to openly discuss feelings with a counselor or authorities
- Reluctance to report sexual assault
- Shame and taboo—each culture has taboos, and certain crimes can bring shame upon victims
- Fear of deportation
- Loyalty to own cultural group, especially if perpetrator is from same culture
- Concerns about what will happen if their families or communities find out about the sexual assault
- Prejudice by sexual assault service providers
- Cross cultural-communication. In addition to language barriers, there are many aspects of communication (verbal and non-verbal) that can either impede or facilitate service

delivery. Word meanings and gestures vary for different ethnic groups, which can contribute to misunderstandings or miscommunications.

- Conceptions of privacy. People of color may feel that certain types of crimes should be dealt with within a family or community. The most common examples of this are sexual assault and domestic violence.

The following sections will provide some information about various cultural groups. It is a challenge to find a balance of providing overarching information that will help an advocate learn about how to best serve a survivor from a particular culture without putting the survivor into a box that labels her as being one way or another based on her culture. There is a vast diversity and uniqueness within all cultural groups. Be aware of the temptation to make assumptions about a person based on their culture. These cultural biases, which we all have and must work to make ourselves aware of, can lead to misunderstandings regarding the survivor and her story.

While much of this section emphasizes differences between cultures, it should be remembered that there are also many similarities – because of the fact that we are all human. People have similar needs, wants, feelings, and ways of coping with problems. An advocate with good skills, empathy, and respect can use these to begin to see these similarities and develop culturally appropriate strategies for advocacy. The relationship that the advocate forms with the survivor depends on the counselor's ability to remove barriers and develop culturally appropriate relationships.

AFRICAN-AMERICANS

The term "African-American" refers to an ethnic group of Americans with total or partial ancestry from any origin of the native peoples of Sub-Saharan Africa. Some [African immigrants](#) generally do not self-identify as African-American and the majority of African immigrants identify with their own respective ethnicities. Also, some people from the [Caribbean](#), Central America, and [South America](#) and their descendants who originate from Sub-Saharan Africa may or may not self-identify with the term "African-American."

Sexual stereotyping of the African-American community, as well as other people of color, still persists today. Women of color are more hesitant to file charges due to being victims of all types of sexual assault, especially rape and child molestation. They are also less likely to be believed in court. Men of color, especially African-American men, have often been the scapegoat for sex crimes. Many more African-American men will be sentenced for longer periods of time than white men for the same crime.

The African-American Community's Response To Sexual Assault

African-Americans have been blocked from forming a constructive group identity. As a racial minority in the United States, African-Americans have been pressured to trust whites more so than themselves. They have had a value system imposed on them that forcefully undermines their self-esteem and very existence. The image of African-American women as long-suffering victims may help keep African-American women passive and confused about the assaults in our lives (White, 19). Many contradictory

messages may discourage women from seeking outside help when they are raped. African-American women have had to fight throughout history. They are survivors in the true sense of the word. As Evelyn White states "We are considered evil, but self-sacrificing; stupid, but conniving; domineering while at the same time obedient to our men; and sexually inhibited, yet promiscuous. Covered by what is considered our seductively rich, but repulsive brown skin, Black women are perceived as inviting but armored. Society finds it difficult to believe that we really need physical or emotional support like all women of all races."¹³⁷

African-American women have historically experienced increased objectification. Therefore, the African-American rape victim may feel a similar but greater level of helplessness, shame, guilt, failure, devaluing and unworthiness. As service providers, it is important to be culturally and ethnically aware, not prejudiced, but genuine in your desire to help and support African-American women. Service providers are also ethically responsible for assessing their own racist attitude. It must become important for us to document the number of incidents of sexual assaults in the African- American community. Advocates must be willing to read literature, participate in events, go out into the community, and accept theories from this culturally specific diverse population.

Advocacy Issues

White advocates conducting intervention with African-American survivors will need to overcome distrust by African-Americans of the white community and white authorities. Sexual assault programs are usually not considered part of the African-American community. African-American women may be hesitant to report sexual assaults to police, or to use available social services, because they suspect they will not be believed or taken seriously. They fear a lack of concern for their needs, and wonder if they will be accused of provoking the assault. Because authorities have traditionally ignored the needs of African-American women, they believe reporting will have no effect and no action will be taken to arrest the offender. Evelyn C. White states, "...we (black women) know that we cannot depend on the police, social workers or the criminal justice system to protect us from abuse or intervene on our behalf. They have, in fact, been some of the worst offenders in perpetuating and blatantly ignoring the violence in black communities."¹³⁸

If the assailant is white, the survivor may expect a lack of concern, or even retribution against her, by a primarily white criminal justice system. If the assailant is African-American, she may be reluctant to expose another African-American to the racist system, and she will be worried that the African-American community will view her as disloyal. According to White, "The traditional response of the black community to violence committed against its most vulnerable members—women and children -- has been silence. This silence does not stem from acceptance of violence as a Black cultural norm ... but rather from shame, fear and an understandable, but nonetheless detrimental, sense of racial loyalty."¹³⁹

¹³⁷ White, Evelyn C., Chain, Chain, Change: For Black Women in Abusive Relationships, Seal Press Feminist Publishers, 1995. Pg 20

¹³⁸ White, Evelyn C., Chain, Chain, Change: For Black Women in Abusive Relationships, Seal Press Feminist Publishers, 1995.

¹³⁹ *ibid*

For the African-American woman, feelings of powerlessness that come from being assaulted are greatly intensified because she may feel she lacks power in her everyday life. She may want to get past the emotional distress quickly and revert to her routine without giving herself adequate time for recovery. There may also be a need to deny long-term effects of sexual assault.

Many African-American women have access to a strong support system that includes family and the African-American community. To gain the trust of African-American women, sexual assault advocates may want to gain assistance from ministers or other service providers within the African-American community. Although African-American women often find support from their families and the community, the advocate should not automatically assume that these provide all the emotional support an African-American survivor needs when coping with a crisis, such as sexual assault. Every survivor may not have access to these safety nets.

A woman of color may also fear that revealing sexual assault to an advocate and/or the authorities will break up her family. The advocate has to be sensitive to these fears and be careful to not push the sexual assault survivor into taking actions that she might not be ready to handle. It is recommended to provide resources and information so that the African-American survivor can make an educated decision.

To avoid interacting based on stereotypes of African-Americans, advocates should examine their own feelings and attitudes about African-American women. Advocates should become aware of feelings that come from not belonging to a privileged class: feelings such as alienation, low self-esteem, anger, impotence, isolation and frustration. White advocates must admit racism exists, and must allow African-American women to discuss the problem openly. Advocates must confront racism in their own attitudes.

White sexual assault advocates must work to gain the confidence of African-American women survivors. Trust must be established, and strict confidentiality maintained.

If a family member sexually abuses a child in the home, child protection authorities will probably remove the child from the home, thereby breaking up the family. If the mother does not force the perpetrator to leave the home, authorities may perceive her as not protecting her children. Many families of color are unwilling or unable to choose between the welfare of the children and the family member, especially when reporting the assault will lead to the division of the family. This is one reason cases of child sexual abuse often go unreported in general and also by members of the African-American community.

It is important that advocates understand the sensitivity of why many African-American's in the community do not seek professional counseling or therapy. Sometimes, it is due to a stigma and sometimes it is due to financial reasons. Advocates should be prepared to provide resources regarding agencies in their community that provide free or low-cost assistance, as well as information on the benefits of receiving professional counseling and therapy. Knowing the specific culture, patterns of beliefs, and family dynamics will be crucial on how to direct African-Americans in the community who have been victimized directly and/or indirectly.

According to the 2010 Census, African-Americans make up 12.6% of the population in the United States.¹⁴⁰ Yet, according to the Federal Bureau of Prisons, African-Americans account for almost up to 40% of the prison population. Advocates should be educated and prepared on the Prison Rape Elimination Act (PREA), as well as educating the community on this Federal Act and where to give assistance if they or someone has been affected by rape in the prison system. Victim services and victim advocates should have programs in place to specifically assist this area of the population in the community. It is essential that re-victimization does not take place. Within the community, this topic is considered taboo in every aspect. It is imperative that victim advocates keep in mind the sensitivity of victims who have been victimized due to being incarcerated.

Faith in the African-American community is considered to be stronger than the United States population as whole. Within the faith-based community, specifically in the African-American community, sexual assault is often not addressed and even to the point of it being prohibited to address and/or discuss. There is a gap between services offered in the community at large and services offered through faith-based communities that can be bridged through advocacy. Many people, survivors and advocates, do not know what services are available within the faith-based community, the support that is available or the role that faith-based communities can play to help survivors (and their families) get the professional assistance they need. The faith-based community should not neglect, reject, or ignore the services that are provided through sexual assault programs; the same is true for advocates, they should not neglect, reject, or the faith-based services that might fill a critical role for the African-American survivor.

LATINOS

The term Latino identifies the large groups of people whose national and cultural origins, or those of their ancestors, are from Mexico, Central America, or Latin American. The term "Latina" is used for women of descent from these regions.

As well as individual differences, there is great diversity among Latinos in the wide variety of traditions from their original countries. While many Latinas may speak Spanish, there will be some language variation from country to country. There will be class and political differences, and varying degrees of assimilation into mainstream American culture.

When working with Latina survivors of sexual assault, it is important to be aware of stereotypes about persons of Latin or Spanish heritage. Typical misconceptions about them include: inherent laziness, lack of education, lack of intelligence, lack of sophistication, dependency, passivity, machismo, and sexual promiscuity. Recognizing and dispelling these racist attitudes are essential for the advocate.

¹⁴⁰ Rastogi, Sonya, Johnson, Tallese D., Hoeffel, Elizabeth M., and Drewery, Jr., Malcolm P., The Black Population: 2010 Census Briefs, U.S. Census Bureau, 2011.

Latina Survivors

The diversity of Latinos is reflected in such factors as income and education levels, lifestyles, family patterns, residency status, length of time in this country, and languages spoken. Despite great diversity, some general beliefs within the Latino culture may influence the Latina after a sexual assault. In the cultural and religious perspective of the Latina, human sexuality is generally confined to marriage and is considered a very private matter. The emphasis on virginity for a single woman and on monogamy in marriage is significant, and thus plays an important role in the Latina's foundation of self-respect and respect from others. A Latina survivor may react to an assault with additional shame, dishonor and loss of respect.

Within the Latino culture is a traditional view of female/male roles. This can contribute to the feelings of shame and loss of respect. Traditionally, Latinas have been seen in extremes, either as madonna or whore. The sexually active Latina is traditionally viewed as responsible if a sexual assault occurs. If the Latina is young and a virgin, she is considered less responsible but her prospects or chances to marry and reputation are at risk. In addition, the Latino culture is heavily influenced by the Catholic Church's teachings which emphasize a woman's virginity and purity of mind and body. Sometimes sexual assault is equated with the sexual act and may be seen as God's punishment for previous sin.

Social mores concerning sexuality make it difficult for a woman who has been assaulted to readily talk about the experience or to be assured and supported. In addition, Latinas may not readily seek help because many professionals do not offer bilingual/bicultural services. If the victim is undocumented there is the added fear of deportation. Thus, for the Latina, seeking assistance for a sexual assault may jeopardize her residency status, her job, her relationships with family and her community.

Guidelines that may be useful in working with Latina victims:

- Try not to stereotype Latina survivors. Understand that some elements of the traditional culture may lead to victimize the survivor further, as do Anglo-American societal myths and attitudes about Latinas. Anglo stereotypes abound concerning Latinas as uneducated, intellectually inferior, unsophisticated, overly dependent, and eager for sex.
- If at all possible, provide bilingual services. Fear of stereotypes may cause a Latina victim to claim to be bilingual, when in fact, she may be limited in the expression of feelings in English, her second language. Expressing feelings is always easier and more complete in a person's native language.
- Be sensitive to a Latina's residence status. It should not block the victim from obtaining sensitive assistance, or from holding an assailant accountable for a crime.
- Because of sexual mores concerning sexuality, it may be difficult for the Latina victim to discuss the specifics of the assault. In addition, words that adequately describe such acts and body parts may not be part of the routine vocabulary of the Latina whose primary language is not English. Professionals who understand the Latino language and culture are particularly helpful.
- Because of cultural and religious beliefs, the Latina victim may be prone to feeling self-blame and violated. It is important to help the victim and her family to understand rape as an act of violence.
- Latina survivors who do not believe in artificial birth control or abortion may have particular concerns about dealing with pregnancy resulting from assault.

- Professionals should be aware of referral resources, particularly bilingual/bicultural resources for the victim's different needs. These resources should be sensitive to the general needs of a sexual assault survivor and to the specific concerns resulting from traditional cultural values and language differences.

Advocating For The Latino Family

Family life is highly important to Latinos. "As in other traditional agricultural societies, family solidarity, subordination of women and respect for elders created a structure where large and extended families lived under patriarchal authority," write Angela Ginorio and Jane Reno. The family structure is hierarchical, with special respect given to the father. The mother is supposed to be obedient to her husband, and she receives respect from her children. "Older family members order the younger, and the men order the women. This establishes interpersonal patterns in the family around the dimensions of respect and obedience to elders and male dominance" (Ginorio and Reno, 1986). Extended families often exist, which include the nuclear family, relatives, long-standing friends, and relatives such as godparents.

Strict role identification is generally maintained in the Latino family. Boys are taught to respect and obey their parents but are allowed a high degree of freedom in lifestyle. "While the male role was defined in secular terms, the female role was closely tied to the values and traditions of the Catholic Church," write Ginorio and Reno (1986). "As females, the models presented to us were accepting, silent and constantly responsive to others' needs. We were told we were morally superior to and spiritually stronger than the male. Thus we must be mediators for him and represent him by our presence in the church and by our exemplary behavior. Any misbehavior by any family members reflects on the honor, pride and prestige of the male."

Girls are closely supervised by their families, who wish to protect the girls' innocence and virginity. Sex for Latina women, especially those who are Catholic, is discouraged, except for childbearing. Latina women often suffer extreme shame and guilt if they are raped. If she is an unmarried woman, she will be punished because she is no longer a virgin; if she is married, she will be humiliated because she has been abused by a man who is not her husband.

Because of the close family ties in Latino culture, the survivor's recovery process will be affected by her family's reactions to the sexual assault. The survivor may not gain the support of family members and the Latino community. It could be believed that she provoked the rape by not acting properly, or that she is being punished by God for some past impropriety. She may hesitate to tell her family or authorities. There may be fear that disclosing the abuse will be more harmful than the abuse itself, or that the family may seek retribution by attacking the assailant. It is important to respect the survivor's reluctance to disclose the rape. If the family does become involved, the advocate should try to understand its' reactions, even if the attitudes seem negative or old-fashioned.

If the survivor felt comfortable enough to disclose the rape to her family, the family should be included in any advocacy sessions. The survivor should be able to decide which family members she wants to include. Working with the entire family can help them understand the survivor's lack of complicity in the assault and the need for medical and emotional treatment.

Counseling And Religious Issues

Latinas are raised with the concept that sex outside marriage is wrong. The religion of the vast majority of Spanish-speaking people is Catholicism. "Because for so many women the (Catholic) Church has been the only avenue for participation and expression outside of the family, we have looked to the Church for leadership and support to help in establishing our identity as women...Sexism in the Church has often reinforced passivity and acceptance of male domination. The religious stance on sexuality, rape, abortion and birth control has not made it possible to openly and frankly confront these issues so central to women's lives, neither in the privacy of the family nor in the public forum of society" (Ginorio and Reno, 1986).

If the survivor becomes pregnant, there may be particularly great concern because of the Catholic sanction against abortion. The advocate must respect the victim's religious beliefs and should never pressure the survivor to have an abortion. Advocates must respect the victim's religious beliefs. The Catholic survivor may exhibit a fatalistic attitude about the assault, with an unwillingness to work at recovery. She may feel the rape was God's will, part of her own inalterable fate. The counselor should encourage the survivor to take responsibility for helping herself.

There may also be a high level of self-criticism and guilt because of the victim's religious beliefs. The advocate should determine whether consulting a sympathetic priest will help the Latina woman.

Other Advocacy Issue

If the survivor does not speak English well, and the advocate is not bilingual, there will be a language barrier. Even when the Latina woman speaks English, she may have difficulty with the English language. People tend to revert to their native language during periods of crisis, and a Spanish-speaking advocate should be provided to give more effective services. Even a Spanish speaking advocate may have difficulty communicating with a woman from a cultural background different from the advocate's own. The introduction of an interpreter into a session may also cause the survivor additional discomfort when revealing humiliating details of the rape. The advocate will have to be particularly sensitive at such times.

Latina survivors may not have the words to describe the sexual assault. Words used to describe sexual offenses might not exist in their language, or will be seen as too obscene to speak. Confusion may result as to the meanings of American expressions for sexual activity.

Some Latinas will not feel comfortable with the intimate, explicit questions asked by advocates. This discomfort may prevent them from reporting the assault.

If a Latina is not a naturalized citizen of the United States, she will probably have strong concerns about deportation and the problem of maintaining economic survival. This may discourage the survivor from reporting the rape to authorities. The perpetrator may be an individual who maintains power over the woman and her family directly because of her non-resident status (such as an employer, coyote or another family member). It is essential that the advocate provide support, even when charges against the assailant cannot be pursued.

Latinas, especially those classified as non-residents, may be particularly vulnerable to gang rape. Gang rape will also bring concern that disclosure will cause further, possibly more severe violence from gang members. The resulting fear can be especially disabling.

Expressing anger should be encouraged in Latinas as a legitimate reaction to sexual assault. Culturally, Latina women have been raised to contain their rage. Part of a survivor's recovery will hinge on her ability to express and cope with anger.

Referral to other community resources should show awareness of cultural differences. Bilingual services sensitive to issues of sexual assault, as well as to Latino culture, are critical and necessary. Because of a history of racism and discrimination towards Latino communities, advocates must work to gain the trust of Latina survivors. The advocate may be viewed as another representative of an oppressive system. Assure the survivor that everything discussed will be confidential.

Advocates should respect the Latina woman's religious views and cultural heritage, which stresses concepts such as honor and close family interaction. Respect and validation of cultural differences will assist in recovery. It is essential to remain nonjudgmental at all times.

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ASIAN AMERICANS AND PACIFIC ISLANDERS

There are wide cultural and language differences among people of Asian and Pacific Island descent. The largest Asian population in the United States is Chinese.

Asian refers to any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Native Hawaiian or Other Pacific Islander refers to any person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Asian Americans and Pacific Islanders (AAPI) vast and many-faceted heritage is present in one form or another across the entire nation: in old western mining camps, in China towns, Korea towns and little Manilas; in the legacies of the labor movement; and in the Asian architectural details that inspired Frank Lloyd Wright. Generation after generation, Asian Americans and Pacific Islanders have forged a proud legacy.¹⁴¹

Because of the uniqueness of cultures among Asian Americans and Pacific Islanders, as well as the diversity of experience between recent and second or third generation immigrants, plus the

¹⁴¹ National Park Services, Asian American and Pacific Islander Appreciation Month, 2015 Available here: <https://www.nps.gov/heritageinitiatives/pubs/AsAmBklt2.pdf>

differences in personality and circumstances, generalizations are impossible. However, awareness of the common myths about Asian Americans and Pacific Islanders and understanding some common cultural patterns may help in working with Asian Americans and Pacific Islanders who have been sexually assaulted.

Asian Americans and Pacific Islanders represent a large diversity of religious and spiritual practices, which may include Buddhism, Hinduism, Muslim, Catholicism and more. Religious traditions may have a strong influence on the Asian American and Pacific Islander's response to sexual assault. These strong spiritual or religious traditions may impact the survivor's decision making regarding medical care/interventions, involvement with law enforcement or seeking mental health care.

Traditional Asian American and Pacific Islanders values tend to socialize women into secondary roles to men. Their identities may be defined in terms of their husbands and family responsibilities. As a consequence, there is often a pattern of behavior characterized by deference to authority (males, elders), non-assertiveness, and self-effacement....these behaviors create a vulnerability which invites exploitation and manipulation. Assertive behaviors for women may seem threatening if presented in opposition to traditional responses.

Asian Americans and Pacific Islanders, particularly women, may suffer from racist beliefs that define them as passive and subservient. U.S. intervention in AAPI countries has brought about an attitude of superiority toward the AAPI community. Some people, accustomed to viewing Asian Americans and Pacific Islanders as enemies or prostitutes, perpetuate hatred toward Asian people in the United States. Domination, both military and sexual, is basic to stereotypes.

Common myths include the belief that Asian Americans and Pacific Islanders are rarely sexually assaulted, that they rarely use social service agencies or that they have adequate social service resources within their own communities. In reality, language, cultural barriers, lack of knowledge about resources, and reluctance to bring attention to themselves contribute to the low reporting rate and underutilization of established services.

In AAPI cultures, sexual assault may be viewed primarily as sexual in motivation, and sexuality itself may not be easily discussed. In addition, women may be held responsible for the assault. A woman's self-worth may be based on chastity, virginity and her ability to marry. Sexual assault may not only decrease self-worth, but may bring shame to the whole family. In some cultures, only marriage to the perpetrator of sexual assault removes the stigma for the woman.

When working with AAPI women, it is imperative to assure confidentiality if the woman is to express her feelings openly. While a professional of a different ethnic group may be viewed with suspicion and have language or cultural barriers, a professional of the same ethnic group may also be viewed with suspicion because of fear of gossip. The following guidelines might be helpful when working with AAPI survivor's:

- AAPI women, like other survivor's, may need to learn to understand that the sexual assault was an act of violence and was not their fault. It is helpful to emphasize the susceptibility of all women and the reasons men assault. While the Asian American and Pacific Islander

experiences the same emotional crisis as almost all other victims, she may be more likely to deny the assault. She may be unwilling to discuss the attack. In addition, her family may share her denial. Asian American and Pacific Islanders may be more likely to put family ahead of individual interests and less willing to discuss sexual incidents (Ohio Coalition 1991; "Cross Cultural Service Delivery," 1992; United States Commission on Civil Rights, 1992; Hamilton, 1989).

- Because of cultural mores, the process of getting information and helping the victim through the recovery process may be longer and present additional and unique challenges, e.g. some AAPI languages may not have words for body parts, particularly the genital areas. Be prepared for this and don't rush.
- An Asian American and Pacific Islander may view her post-assault need as limited to concrete practical procedures. The Asian American and Pacific Islander may not be interested in counseling services until she has built trust in the agency after receiving 'tangible' services. "Most Asians are taught to be task-oriented. Therapy sessions for Asians should therefore delineate goals, assign practical exercises, and should occur over a brief rather than extended period" (Ogawa, p. 274). Due to the stigma around mental health or other un-named reasons, some survivors may not ever want to access counseling. These survivors should be supported in their decision and assisted to identifying other ways to process/heal from the assault.
- Because of the societal shame following a sexual assault, the AAPI woman may be particularly susceptible to suicide ideation. It is very difficult for many AAPI women to tell their families about a sexual assault. Often, victims make plans to 'disappear' from their families and communities. Professionals should help victims make plans for how to approach or work with their families.

Unfortunately, it is possible that some AAPI woman will be disowned by her family or be battered by male relatives after a sexual assault. Make sure the victim has information regarding emergency shelters or an alternative plan if a shelter is not available.

- Married AAPI women who are raped are traditionally viewed as unfaithful to their husbands. If the Asian woman is single, her family may consider her no longer eligible for marriage since a great value may be placed on virginity. In some AAPI ethnic groups, sexual assault of married women automatically means divorce. It may be particularly difficult for AAPI husbands to comprehend that their wives are not responsible for the sexual assault. Her trauma will be increased by his inability to understand. It is important for professionals to understand this fear and be able to provide information about the woman's rights as an immigrant, as a refugee, and as a spouse regarding community property if needed.
- Non-AAPI professionals may find communicating with AAPI victims difficult because of the cultural tendency to be indirect. Special sensitivity to nonverbal signals is important. It is

essential that the advocate respect the confidentiality of the survivor, and be understanding of the shame felt by the survivor and, possibly, her family.

The Asian American And Pacific Islander Family

In Asian American and Pacific Islander's culture, the image of the family is usually regarded as more important than an individual's needs. A sexual assault may be viewed as a disaster that has befallen the entire family. The survivor may feel that she has dishonored the family by being a victim, or that she is humiliating them by disclosing the rape.

The family may deny a rape occurred and try to keep the assault a private matter, undisclosed to the extended family and the community. Relatives may accuse the survivor of provoking the sexual assault. The survivor may refuse to speak to the advocate or continue services after the initial disclosure, based on the family's reaction to the rape. Relatives may attempt to speak on the woman's behalf or may literally prevent her from seeking help.

If the Asian American and Pacific Islander does seek assistance, the advocate may want to talk with the survivor if there is a need for a family member or members to be included. The family member(s) might be a grandparent, parent, husband or other important figure in family or the survivor's life. Ultimately, the survivor should determine if the advocate will speak to or coordinate services with any of the survivor's family members.

Advocacy Issues

Common emotional reactions by survivors include fear of retaliation by the assailant, shame, guilt and the belief they are responsible for the sexual assault. However, the intensity and level felt by Asian Americans and Pacific Islanders may be worsened due to collectivism and the desire to 'save face.' There may be a feeling of loss of value or pride which is associated with extreme shame and disgrace. Recent immigrants to the United States may not report sexual assault, fearing that contacting the authorities will lead to deportation. They may also not know about sexual assault programs or how to find them.

Advocates who are not fluent in Asian or Pacific Island languages may have difficulty communicating with some Asian American or Pacific Islander clients. An interpreter sensitive to sexual assault issues will be vital in such cases. The advocate should remain aware that words describing sexual parts, functions or activities may not exist in the AAPI woman's language. Sex may not be freely spoken about in the AAPI culture, and the survivor may be reluctant to discuss the rape in explicit terms. The advocate should avoid using words the survivor does not use, because they may have negative implications in her understanding of English.

Because of the tendency to deny rape, providing strong assistance to the AAPI survivor during the initial session is critical. The advocate should discuss what the survivor can expect emotionally, common issues and distress faced by sexual assault victims, and written materials for further reference.

The AAPI survivor may come to the advocate seeking concrete, practical information about what she should do. Once getting legal or medical information, she may terminate the relationship. Legal

problems confronting the AAPI woman may concern divorce, or her rights as an immigrant, or custody of children. If the AAPI woman returns to the sexual assault program, the advocate may find that problems will be confronted slowly over an extended period of time.

An AAPI woman may view the advocate as an authority figure. The survivor may want the advocate to tell her what to do, she may not initially understand the concept of helping herself. Some Asian Americans and Pacific Islanders are accustomed to consulting with older, more experienced members of the community and may put the advocate in this role.

Respect and integrity are important in the AAPI community. When speaking to the survivor's family, the advocate should acknowledge and accept the authority of the elder spokesperson. Ask family members how they would like to be addressed, perhaps by a title or last name. Eye contact and touching should be done with discretion, as some AAPI survivors find these expressions too familiar and intimate.

Asian Americans and Pacific Islanders may use laughter to mask anxiety. If the survivor's family laughs, the advocate should not assume this demonstrates a lack of regard for the seriousness of the survivor's problem. Anger and distress are not easily displayed in AAPI culture.

Referral

Referral for long-term counseling may not be possible with some Asian Americans and Pacific Islanders. Individual mental health has little meaning in AAPI culture, where the function of the family as a whole is of primary concern. If the survivor does return for counseling, she may prefer an older woman as a counselor, preferably one who speaks her language, but is not a part of her community. If the survivor is Catholic, she might appreciate a referral to a sympathetic priest.

Summary

Asian and Pacific Islanders represent a large diversity of cultural practices, yet common threads are found amongst these cultures. While not true for every Asian or Pacific Islander, intense feelings of shame regarding the assault, concern for privacy and valuing the family before the individual may be encountered. The advocate would best serve the Asian or Pacific Islander by listening carefully to her expressed needs, offering information and options and remaining respectful of the survivor's culture.

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AMERICAN INDIAN

Cultural Traditions

The terms "Native American" and "American Indian" apply to the many tribes that inhabited the United States before Europeans came to this country. Because these tribes maintain vastly different

traditions and degrees of assimilation into mainstream American culture, the following information should be considered a generalization of many of the diverse characteristics of American Indians.

Extended families are common among American Indians, who respect the elderly and family traditions. American-Indian women may allow their children to be cared for by relatives. American Indians are expected to be self-reliant at an early age and able to care for younger children.

American Indians often have a frequent turnover of jobs and a casual attitude about time. Traditionally, American Indians do not value the accumulation of wealth as an end in itself, but enjoy sharing their possessions. There is little incentive to acquire a job and move up the ladder of success in the workplace. American Indians expect work to be valuable and enjoyable, but most of them do not have the education and experience to acquire fulfilling jobs in this country. A job may be taken to pay for immediate expenses, and the American-Indian employee will then quit when the money is made.

Time is viewed differently in the Native-American culture than it is in the regimented mainstream lifestyle. As a result, Native Americans are often late to appointments. The advocate should try not to be annoyed when a client is late, because the lateness is not a sign of disrespect or lack of interest.

American Indians have suffered from abuse, discrimination and racist misinformation including characterizations of them as savage, woman-hating, impoverished, simple-minded, drunken, childlike and weak. The results of the white man's subjugation of American Indians are particularly devastating.

Violence In Native-American Culture

American Indians are not easily assimilated into mainstream American culture. American Indians have the lowest per capita income, the highest unemployment rate, the lowest level of education, the worst health and housing conditions, and the highest suicide rate of any group in the United States.

The breakdown of the extended family and increasing alienation from traditional values have resulted in increased occurrences of child sexual assault, incest, rape and domestic violence.

A report by Phyllis Old Dog Cross in the periodical *Listening Post*, cited by Allen (1986) reports that rape, sexual assault and incest are becoming frequent on reservations. The report states that at least 80 percent of American-Indian women seen at a five-state regional psychiatric center experienced sexual assault. According to this report, "Sexual abuse at a young age is quite frequent and almost always involves a relative such as a father, brother, cousin, uncle or grandfather...the problem of alcohol is seen in about 90 percent of the cases."³

Advocacy Issues

People advocating for American Indians must work to understand the group's strong culture and tradition.

The advocate will have to work to gain the trust of the American Indian survivor, whose culture has been victimized for centuries. Patience and quiet presence will work better than aggressively pushing the survivor to disclose her feelings.

The advocate may find that an American Indian who has been sexually assaulted will distrust the advocate, medical personnel and other authorities. The survivor will expect to be treated poorly and with disrespect, and the advocate must assure her this will not occur.

The advocate should allow the survivor to set the pace of discussion and intervention. The Native-American woman might not wish to speak at all. Coping with sexual assault is a private struggle. Silence does not necessarily indicate the survivor does not appreciate the advocate's support. The advocate should never push the victim into conversation, because this may make her even more reticent.

Questions from the sexually assaulted woman should be answered, and medical and legal processes she will undergo explained. The advocate should not be authoritative but must gently help the woman search inside herself for the means of healing.

It may be difficult to maintain eye contact with an American-Indian person. This is probably a sign of respect on her part, since eye contact is believed to be powerful, and it is not given easily.

Written by: Becky Bradway, Staff, Illinois Coalition Against Sexual Assault, Springfield, Illinois, 1986.

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PERSONS WITH DIABILITIES

Children and adults with disabilities have the same rights as persons without disabilities to personal safety and a life free of sexual violence and abuse, yet sadly, individuals with disabilities are particularly vulnerable to sexual assault, sexual abuse, and other violent crimes. Sexual abuse or assault against persons with disabilities may include nonconsensual sexual touches, verbal propositions that are sexual in nature, exhibitionism, and any other forms of sexual exploitation. Any

sexual encounter between an individual with a disability and a paid service provider is considered sexual abuse.

Research has documented that people with disabilities experience violence and abuse at least twice as often as their peers without disabilities (Sobsey & Doe, 1991). Stimpson and Best (1991) suggest that more than 70 percent of women with a wide range of disabilities have been victims of violent sexual encounters at some time in their lives. Another study estimated that 83 percent of women and 32 percent of men with developmental disabilities experience sexual abuse during their lifetimes.

Sexual assault programs, law enforcement, and other helping professionals or family members sometimes do not help or reach out to people with disabilities because of stereotypes and myths. These include:

MYTHS	FACTS
Strangers are the most likely perpetrators so people with disabilities must be kept in protective environments such as state schools, state hospitals, nursing homes, and group homes.	Persons who live in congregate living facilities face an increased likelihood that they will be sexually abused. Strangers are sometimes perpetrators, but research has clearly documented that the most likely perpetrators are persons who have an established relationship with the individual with disabilities.
People with disabilities are asexual.	People with disabilities develop physiologically in a similar way to people without disabilities and have sexual urges, feelings, and reactions.
Males are generally at lower risk for sexual assault so males with disabilities are rarely sexually abused.	Boys and men with disabilities are sexually abused less often than females with disabilities, but studies have shown that males with disabilities encounter sexual abuse at a higher rate than males without disabilities.
People with cognitive disabilities are not affected by sexual abuse.	Persons with all types of disabilities including cognitive disabilities experience emotional trauma, physical injury, and social consequences of abuse.
People with disabilities cannot benefit from crisis intervention or counseling.	Individuals with disabilities have feelings and can heal and learn to empower themselves through crisis intervention and counseling services.

What Is A Disability?

There are an estimated 313,600 children and adults with developmental disabilities in Texas. A developmental disability is a mental or physical impairment or both that substantially limits functioning in at least three areas of daily living (receptive or expressive communication, mobility, learning, self-care, self-direction, economic self-sufficiency, and/or capacity for independent living). A developmental disability occurs before the age of 22 and is expected to last indefinitely. Some examples of developmental disabilities include, but are not limited to:

- Cerebral Palsy
- Mental Retardation
- Spina Bifida
- Muscular Dystrophy
- Downs Syndrome
- Autism
- Attention Deficit Disorder (ADD)
- Dyslexia or other learning disabilities

Persons who have developmental disabilities are less likely than those without disabilities to receive education related to sexuality or self-protection strategies. In working with survivors with developmental disabilities, it may be necessary to provide basic education related to personal safety, sexuality, and the right to say “no” to an unwanted touch.

Acquired disabilities may occur at any time during the lifespan either through an accident, as a result of a crime, a degenerative disease, and/or as a result of the aging process. Persons who acquire disabilities through an automobile, explosive, or other accident, viral infection, or as a result of battering or other crimes are more likely to have knowledge about their sexual anatomy, self-defense or self-protection strategies, and boundary issues especially if the disability was acquired during adulthood. Some examples of acquired disabilities include:

- head injury
- spinal cord injury
- back injury
- paralysis
- visual or hearing loss
- Acquired Immune Deficiency Syndrome (AIDS)/HIV
- diabetes
- Alzheimer’s disease
- cancer

Some individuals may be classified as having multiple disabilities including a combination of speech, hearing, physical, visual, cognitive, and/or psychiatric disabilities. Sensory impairments may include a speech or language disorder, visual impairment or blindness, or hearing impairment or deafness. Speech and language disorders refer to difficulties with communication. Some causes of speech and language disorders include hearing loss, neurological disorders, brain injury, mental retardation, drug abuse, or physical impairments.

Some individuals who are deaf or hearing impaired will either have complete or partial hearing loss. Persons who are deaf or hearing impaired will communicate in different ways. Some individuals utilize American Sign Language, finger-spelling, oral communication, speech communication, and/or written communication. Persons who are labeled as visually impaired or legally blind will have vision loss, but may have some sight. Individuals who are blind or visually impaired usually have a sense of awareness

about their environment, but may not have experience setting verbal or physical boundaries if they are approached too closely or touched inappropriately.

Some individuals have disabilities that may not be visually apparent. “Invisible disabilities” may be classified as developmental or acquired. Some examples of invisible disabilities include epilepsy (seizure disorders), traumatic brain injury, learning disabilities, diabetes, mental illness, and chronic fatigue syndrome.

Vulnerability Factors

Although all people are at risk of sexual violence, people with disabilities may face increased vulnerability factors to sexual assault or abuse that are related to their disability. A risk factor for sexual abuse against persons with disabilities stems from the fact that they must contend with the possibility of violence inflicted by caregivers or personal care attendants. Care providers frequently have close, personal, and frequent contact with people with disabilities. These relationships often resemble the intimate type of relationships many people have with partners.

The following are some vulnerability factors faced by individuals with physical, cognitive, sensory, and speech disabilities:

- Persons with physical disabilities may depend on others to meet some of their basic needs. Care providers may be involved in the most intimate and personal parts of the individual’s life (e.g., assistance with bathing, toileting, changing clothes, other hygiene-related tasks), which can increase the opportunity for sexually abusive acts. Persons with physical disabilities may be less likely to defend themselves or to escape sexually abusive situations.
- Persons with cognitive limitations may be overly trusting of others and easier to trick, bribe, or coerce. Individuals with cognitive disabilities may have an overwhelming desire to please others and participate in sexual activities even when the situation is exploitative or illegal. They may not understand the differences between physical and sexual touches. Persons with cognitive disabilities who are abused may not understand that the violation is not normal, especially in cases of sexual abuse. Many people with mental retardation and other disabilities (e.g., speech impairments) are unable to articulate verbally when sexual abuse or assault has occurred. Furthermore, even when they try to report abuse, individuals with disabilities are often not believed and have difficulty establishing credibility.
- Persons with cognitive disabilities have traditionally spent much time in settings in which they are taught to do as they are told. This increases their risk for sexual abuse. Many people with disabilities are taught in school and through other service providers and family members to be obedient, passive, and to control difficult behaviors. This compliance training teaches them to be good victims for sexual abuse. When people with disabilities are assertive or stand up for their rights, they may be punished.
- Persons who are deaf may have difficulty reporting due to barriers with communication including lack of interpreter and or other assistive devices such as telecommunication device for the deaf (TDD).

- Persons who have speech impairments may have limited vocabulary or communication skills which can pose barriers to disclosing sexual assault or abuse. They may be misunderstood or viewed as intoxicated or making a prank call when reporting sexual assault or abuse. Some people who have speech impairments utilize communication boards; however, many of these devices do not include vocabulary for reporting sexual assault or abuse.
- Many persons with disabilities tend to grow up without receiving sexuality education, abuse prevention information or self-defense training. They may lack knowledge about their bodies, healthy relationships, and how to protect themselves. Persons with disabilities may be touched so often and without permission that they may become conditioned to touch. This may lead to the individual having difficulty distinguishing between abusive and necessary touches.

Even when people with disabilities do report sexual abuse, they are often not believed. Due to societal attitudes, people with disabilities are generally viewed as non-sexual, lacking intelligence and not being credible witnesses to crimes. When a person with a disability does report sexual abuse, many times they are not believed due to beliefs that the individual is not sexually desirable. People with speech impairments and/or cognitive disabilities are also often considered incompetent witnesses.

Generally, social isolation is associated with higher risks for sexual abuse. People with disabilities have traditionally been oppressed through their segregation from the community and placement into congregate care residential facilities or settings (e.g., state schools, state hospitals, nursing homes, group homes, foster homes, sheltered employment workshop settings, etc.). In residential facilities, people with disabilities may lack access to telephones as well as family, social supports, police, lawyers, or advocates. Persons living in congregate residential facilities are more likely to be repeatedly sexually victimized and have multiple perpetrators.

Who Commits Sexual Assault Against People With Disabilities?

It may be hard to believe that someone would hurt a person who uses a wheelchair or someone who has any type of impairment. Persons who sexually offend against people with disabilities may be paid or volunteer caregivers, family members, intimate partners, disability service providers, friends, acquaintances, special transit bus drivers, or strangers. The most likely sexual predators though are persons who are known to the individual with a disability. Between 1977 and 1983, the Seattle Rape Relief Project found that 99 percent of victims with developmental disabilities were sexually assaulted by a relative or caregiver (Wisconsin Planning Council on Developmental Disabilities, 1991). Between 1995 and 1998, SafePlace (in Austin, Texas) found that at least 57 percent of sexual abuse survivors with disabilities who entered counseling at the agency had multiple perpetrators and 71 percent reported multiple incidents of sexual assault in their lifetime. In addition, 73 percent of clients with disabilities reported sexual victimization by friends, acquaintances, intimate partners, family members, and/or paid caregivers.

Tips For Working With Sexual Abuse Survivors With Disabilities

Persons with disabilities face increased risks to sexual assault or abuse and they deserve access to the same services as survivors without disabilities. The challenge for sexual assault centers is to find ways to make all services accessible to all people, regardless of their abilities or disabilities. **Crisis**

intervention can be an effective means of healing for sexual abuse survivors with disabilities.

Counseling can help the person with a disability deal with the effects of the abuse and help prevent subsequent victimization. People with disabilities are a very heterogeneous group. They will be very different from one another in skills and in needs. Assumptions should not be made about a person's abilities based on his or her appearance. Instead, the person should be asked what support they will need from you.

Referrals

It is important to keep in mind that the survivor with a disability may not self-refer for services. A survivor may not self-refer for a variety of reasons including: limited or lack of access to telephone, difficulties with communication, and unawareness of community resources such as a rape crisis center. It is important to remember that the survivor with a disability may not want services and the survivor's decision should be respected even if the referral source requests that the individual have intervention services. The referral source may have ideas about how intervention should proceed which may be in conflict with the needs of the survivor with a disability. It is important to follow the needs of the survivor rather than the suggested needs by the referral source when there is inconsistency between the two.

Tips for Communication:

- Survivors of sexual assault who have disabilities deal with similar challenges to mental health that all survivors must face. As an advocate, it is important to realize that communicating with a survivor who has a disability may require additional time.
- Start where the client chooses even if it does not seem relevant to sexual assault. Persons with disabilities tend to have people enter and leave their lives on a frequent basis. It may take extra time to build rapport and trust with a survivor with a disability.
- When communicating with an individual with a disability, listen and ask them to repeat if you do not understand them. Do not pretend that you understand if you do not. You might paraphrase what they are saying to ensure that you understand them correctly. Encourage the client with a disability to ask questions, ask if he or she understands, and be sure that he or she is with you before moving on. If the individual has difficulty expressing him or herself with words, you might try role plays, picture books, or art drawings to assist the person in expressing his or her feelings or the concept.
- When introduced to a person who has a disability, it is appropriate to offer to shake hands. People with limited hand use or who wear an artificial limb can usually shake hands.
- When meeting a person with a visual impairment, always identify yourself and others who may be with you. When conversing in a group, remember to identify the person to whom you are speaking. Describe materials such as videos or visual cues or materials that a person who is blind or visually impaired may not be able to see.
- If you offer assistance, wait until the offer is accepted. Then listen to or ask for instructions.
- Treat adults as adults regardless of their disability. Address people who have disabilities by their first names only when extending that same familiarity to all others. Never patronize people who use wheelchairs by patting them on the head or shoulder. Never treat adults as children nor refer to adults with disabilities as children.

- Leaning or hanging on a person's wheelchair or scooter is similar to leaning or hanging on a person and is generally considered annoying. The chair is part of the personal body space of the person who uses it.
- Listen attentively when you are talking with a person who has difficulty speaking. Be patient and wait for the person to finish, rather than correcting or speaking for the person. If necessary, ask short questions that require short answers, a nod or a shake of the head. Never pretend to understand if you are having difficulty doing so. Instead, repeat what you have understood and allow the person to respond. The response will clue in and guide your understanding.
- When speaking with a person in a wheelchair or a person who uses crutches, place yourself at eye level in front of the person to facilitate conversation. This will limit the possibility that the individual will strain his or her neck when conversing with you.
- To get the attention of a person who is hearing-impaired or deaf, tap the person on the shoulder or wave your hand. Look directly at the person and speak clearly, slowly and expressively to establish if the person can read your lips. Not all people who are deaf or hearing impaired can lip-read. For those who do lip-read, be sensitive to their needs by placing yourself facing the light source and keeping hands, cigarettes and food away from your mouth when speaking. When a sign language interpreter is utilized, speak directly to the person rather than the interpreter. When communicating with someone who is deaf or hearing impaired, it is better to utilize concrete examples rather than abstract concepts or euphemisms.
- When communicating with a person who has a cognitive impairment, present your ideas or questions in concrete rather than abstract terms. Use simple language and break complicated instructions or information into smaller parts. Keep sentences short and speak slowly and clearly. If the individual does not seem to understand you, repeat the information or ask in a different format.
- Relax. Do not be embarrassed if you happen to use accepted, common expressions such as "See you later," or "Did you hear about this," that seem to relate to the person's disability.
- Be patient and take time when giving or asking for information.
- Go slowly in getting information about the sexual assault incident(s). Remember that many people with disabilities have extremely limited knowledge of private parts, sexual activity, and have been told not to talk about sexuality.

Education as a Component of Counseling

Persons with disabilities may live in over-protective environments and may not be given opportunities to take risks or make decisions. Realize that the survivor with disabilities may have a limited vocabulary of feeling words and may need basic education about feelings. Describe what counseling is. Give them a list of available services.

Survivors with disabilities are frequently sexually re-victimized during their lifetime and may have limited knowledge about their body and/or self-protection. Accurate and appropriate sexuality education is rarely provided to individuals with disabilities, despite its critical role in preventing sexual abuse and in promoting healthy relationships. Clients with disabilities may need assurance that they

have the right to be safe. They also may need information on self-protection, how to know when a situation is dangerous, how to say no to an unwanted sexual touch, and the importance of telling someone if abuse occurs. Be aware that many persons with disabilities tend to be taught to be compliant, so teaching exceptions to compliance may be a confusing concept.

Reporting Sexual Abuse

A majority of suspected cases of sexual abuse against people with disabilities are not reported. Public citizens and professionals are mandated to report any suspected case of sexual or physical abuse, neglect, or exploitation against people with disabilities to the Texas Department of Family and Protective Services (DFPS). In 1998, there were approximately 52,000 cases of suspected abuse against older adults or people with disabilities reported to DFPS. Approximately 1 percent of these reports were of sexual violence and approximately 10 percent of the reports of sexual abuse were validated. All residents of the State of Texas are required by law to report any and all suspected abuse of any type of against persons with disabilities. Often, there is no medical evidence to substantiate sexual abuse, but this does not mean that abuse did not occur. It is recommended that volunteers inform their supervisor when making a report to DFPS. The telephone number to report suspected abuse, neglect, or exploitation of children or adults with disabilities is 1-800-252-5400. Reports can also be made online at www.txabusehotline.org.

First Language

Language is an important factor in the way that information is communicated. All people deserve the right to be treated with dignity and respect. People First Language is the recommendation that when referring to an individual, refer to the person first and then to the situation, condition or disability – if it is relevant.

Utilizing People First terminology represents a change in how language has been used as an identifier in the past. Sometimes though, people with disabilities and their families may refer to themselves in a way that would not be sensitive coming from a person without a disability. Do not correct their preferred way of referring to themselves or loved one with a disability.

Examples of People First Language	To Replace
People (or person) with disabilities	The disabled, handicapped, special, gimp, charity case
People (or person) who experience disabilities	Suffers from, afflicted, victim, special needs, diseased, poor, unfortunate
People (or person) who have a cognitive disability	Stupid, dumb
People (or person) who have mental retardation	Retard, retarded, mentally retarded

Person who has a physical disability	Crippled, wheelchair bound, confined to a wheelchair
Person who uses a wheelchair	Physically challenged, differently abled, ill, gimp
Person with a hearing, speech or vision impairment	The deaf, the blind, deaf and dumb

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ADOLESCENTS

One out of four girls and one out of seven to ten boys will be sexually assaulted by the time they are age 18. In many cases, the abuse will take place over a period of time by someone the survivor knows. However, many adolescents are also survivors of a one-time assault. This section is about those survivors.

Though all survivors share similar responses to sexual assault, some issues and reactions are specific to the adolescent survivor. It is important to keep in mind that adolescents differ from adults on three primary levels:

- Adolescents are still growing developmentally. Trauma may interfere with the completion of that specific phase.

- Along with their parents, adolescents are still defining the concept of autonomy and independence. Many adolescents fear their parents' response to their victimization will foster a loss of autonomy. Sometimes they are right.
- Peer pressure and peer identity strongly impact how adolescent survivors perceive themselves and what happened to them. It will also impact their commitment to a recovery program.

Sexual Assault: Effects On Adolescents

- **Self Blame:** Many peer attitudes contribute to the occurrence of sexual assault among adolescents. Adolescent males and females may have very different views on what is appropriate in a dating relationship, and many have incorporated myths in their ideas of appropriate dating behavior. Therefore, guilt and self-blame may be very prominent if the adolescent feels he/she has broken one of the rules under which the peer group operates. The adolescent may wonder about having flirted too much or dressing too provocatively.
- **Fear:** Adolescents may fear other acquaintances will find out and take sides. Most adolescent girls date boys who attend the same school they do. Many times when word gets out about the assault, students will take sides. Adolescent survivors may face ridicule, ostracism, even physical attacks.
- **Victim Blaming:** Adolescent survivors may be more likely than adults to be blamed for being raped. They may even be labeled delinquent and stigmatized because they were "asking for it."
- **Pregnancy:** Adolescent girls are less likely to be using any form of birth control at the time of the rape than adult women. Adolescents also are more likely to have anxiety about pregnancy but also deny the possibility of it. They are more likely ignorant about the symptoms of pregnancy and will have great difficulties making deciding what to do about a pregnancy.
- **Multiple Rapes:** An adolescent survivor may be more likely to be the victim of multiple rapes, not only because of the greater vulnerability of this age group, but also because she is more vulnerable to gang rape, especially if marked as a target after the rapist brags to others.
- **Power and Control:** Feelings of powerlessness, often experienced by rape survivors, may only increase in adolescents, who already have less power and control over their lives than adults do. Due to the exacerbated feelings of powerlessness, adolescent survivors may have a more difficult time exercising control in their lives. Thus, to escape feelings of fear, unpleasant associations, and/or harmful attitudes of others, adolescent survivors may run away from home, skip school or psychologically run away by dissociating.
- **Resources:** Adolescent survivors have fewer resources available. They may trust very few adults in their lives. Adolescents may have difficulties accessing resources or, due to distrust of adults, be slower to seek help.
- **Parents:** A major problem between many adolescents and their parents may be difficulty communicating including a reluctance to tell parents. Other problems may include:



- Parental over-reaction.
- Over protectiveness and restrictiveness.
- Parental anger.
- Rejection.
- Lack of attention.

Parents often experience anger at the assailant. Parents may demand prosecution or plan some retribution. If the adolescent disagrees, parents' anger can be turned against the adolescent. "If you don't want retribution, this must not have happened." Parents should be reminded of the peer pressure the adolescent may face, as well as the strong desire adolescents have for things to get back to normal. To participate in the criminal justice process keeps their lives from being as normal as their peers'.

Parents may also be more concerned about the adolescent's emotional and sexual development. There might be a great fear the survivor will hate men (or women) or sex. Parents should be assured the adolescent will take more cues from parents than anyone else. If parents constantly discuss the traumatization (even if they think the adolescent cannot hear it), the adolescent will focus on it, too. Frank discussion about normal sexual behavior and how it differs from rape will go a long way to minimize trauma in this area.

Parents may also unrealistically expect behavior to change after sexual assault. They misinterpret the adolescent's desire to go out with friends or on a date as evidence that rape produced no trauma. Parents may need to be reminded that adolescents have a great need to be like their peers. It is important for adolescents not to be different, so they may try hard not to show any trauma because then they would seem different.

Parents may also be more concerned about pregnancy and venereal disease. Adolescents have a wonderful ability to believe if they do not think about something bad, then it will not happen. This belief does not necessarily come from a position of irresponsibility but more from vestiges of childhood naiveté.

An adolescent often assumes that if parents know about the sexual assault, and especially the specifics of the assault, they will view their child as bad, dirty or irresponsible. An advocate's reassurances that this will not happen can be empty promises because the advocate has no idea what myths about rape and victims have been discussed in the home. Instead, advocates should discuss where any assumptions come from and, whenever possible, arrange to talk to the parents about the myths and facts about rape, before they talk with the adolescent.

Displaying a need to protect their parents, adolescents may refuse help or resist telling their parents for fear of hurting them. "You don't understand. My mother can't handle this kind of news." This sense of protection is real and is an expression of caring that may be based on facts. Ascertain why the parents cannot handle the news; then strategize ways to break the news in an empathetic fashion.

Tips For Counseling Adolescent Survivors

- Emphasize the sexual abuse/assault was not the adolescent's fault. The adolescent can sense disapproval from an adult so develop a nonjudgmental rapport. It is possible to disagree with adolescent behavior—but never act shocked by it.
- Beware of promising strict confidence. The advocate has a responsibility to make parents aware of dangerous behavior or circumstances. It is important for the advocate to tell the adolescent about plans to share information with parents when it is appropriate. Also, share the hope that all parties can work on the solution together.
- Do not assume the parent and the adolescent have the same concerns. Discuss each person's concerns separately and decide, with each person, ways to communicate those concerns to the other.
- To desensitize the survivor to assault, encourage the adolescent to verbalize and rework the experience. Actively inquire about feelings of blame and guilt. Help the adolescent to focus on feeling responses.
- Help parents accept and support their child's separate emotional reactions and needs.
- Remember the adolescent may not have developed enough coping skills to deal with the assault and may need extra guidance. Be mindful of issues involving power, and be sure not to make the adolescent's decisions. This is a great opportunity for the adolescent to discover she knows a great deal about taking care of himself; so this can be a very empowering experience.
- The family needs to be allowed to express emotions in a safe environment away from the adolescent. Offer that opportunity and gently provide facts about any myths or misconceptions they have.
- Trust may be one of the first issues to discuss with an adolescent. An abused or assaulted adolescent may have trust issues that need addressing before issues about the abuse can be handled. The adolescent needs to recognize the advocate knows about the potential mistrust of adults.
- Working with adolescents can be a wonderful experience. They are not small adults. They are young people still learning their way. Do not get in the way of that learning. Encourage them to learn more about themselves and the world around them. They can.

COLLEGE STUDENTS

College survivors of sexual assault/violence suffer many of the same or similar effects as other survivors. That said, there are some important and unique differences regarding sexual violence/assaults that occur on a college or university environment.

Sexual violence on college campuses is not a new phenomenon though it has in recent years garnered much national attention. On April 4, 2011 a major policy shift occurred when the U.S. Department of Education, Office of Civil Rights issued its "Dear Colleague Letter"¹⁴² to colleges and universities across the country. With this letter came proclamations for colleges and universities to address issues of

¹⁴²U.S. Department of Education. Office of Civil Rights. (2011). *Dear Colleague Letter*. Retrieved 8/8/16 from <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201104.html>

sexual harassment and sexual violence on their campuses and if they did not address the needs of survivors on their campuses and work to create climates free of sexual violence these institutions would risk losing federal funding.

It is not necessarily being on a college or university campus itself which elevates the risk for sexual assault, the age group is at heightened risk. The majority of college students on most major campuses in the United States fall within the age range identified by the CDC to be at highest risk for experiencing sexual assault, 18-24 years of age. This age group, 18–24 years, experiences an elevated risk of sexual violence regardless of their geographic location.

There are a couple of reasons hypothesized for this elevated risk in the literature. One of these reasons is the “hookup culture” which tends to be fairly prevalent on university campuses. In the “hookup culture” it is not necessary to have an established relationship with a partner before engaging in sexual behavior. There is also often no expectation of commitment after the sexual encounter. Another risk factor which may elevate the risk for sexual assault on a college or university campus is an affiliation with the Greek system (fraternities and sororities) as well participation in athletic programs. Lastly, excessive alcohol consumption is another factor which may increase the risk of sexual violence on university campuses.

Recently reported prevalence rates for sexual assault on college campuses in the United States show that about 20 percent (1 in 5) of students are sexually assaulted during their college careers. The risk of experiencing sexual assault during the college years does not seem to remain uniform over a four year college career. The period of greatest risk appears to occur during the first two years, with the greatest risk being the 1st semester of the 1st year.

There can be many issues and challenges facing the survivor of a college sexual assault. These may include:

- Loss of identity
- Loss of friends
- Potentially dropping out of academic programs
- Losing or setting back a future career
- Loss of freedom. Parents/guardians may respond by becoming overly protective or wanting their child to return home.
- Having to make the choice of withdrawing from classes or facing the offender
- Potentially having leave their current living situation
- Becoming a source of gossip
- Figuring out where to go for help if they decide to seek help
- If they were engaged in any activity that may have violated a student honor code will the university hold them accountable for that conduct and in essence “blame” them for their assault?
- Fear that the institution will show ‘institutional bias’ in their handling of the case. In these circumstances the institution takes into account the damage to the reputation of the university or college when making decisions regarding the assault.

These are just a few of the numerous challenges and questions that face a survivor of a college sexual assault.

One of the first issues a survivor of college sexual assault will face is whether or not to make an official report to their school. An official report will almost certainly trigger an investigation into the assault. If a university or college is made aware of sexual violence/assault they are mandated under Title IX to investigate. This may seem on the surface to be positive, however some argue that it removes the choice and power for deciding what happens with a case from the survivor.

Universities and collegiate systems are often confusing in their choices for adjudicating or processing cases of sexual violence. There can often be parallel courses of action that schools may have - a university student judicial review process might be one possibility but it is separate and distinct from the legal criminal justice process which happens external to the university. In addition to these two processes there can also be a title IX investigation. Some campuses may offer the option of reporting sexual assault anonymously but not every campus provides survivors with this option. If these different options/choices are confusing, imagine what it is like for survivors to navigate? College survivors are facing these confusing choices while often trying to keep up with their school work, maintain a sense of normalcy within their peer group, and process what has just happened and what the consequences will be for them if they choose to report.

For some survivors, generations of their family may have attended a particular institution or they may have dreamed their entire lives of one day being a student at a particular campus. There is often a sense of belonging to a community that is larger than oneself when a person joins a university campus – one becomes part of a ‘college family’. This type of environment comes with history, tradition, and culture which can be a great place to grow and develop, make friends and embark on a career, but when an individual is sexually assaulted and violated, institutions often become impersonal and bureaucratic and can fail to deliver the services and compassion a survivor needs.

When a university or college places the good of the institution (the reputation for instance) and people put the institutional needs ahead of the welfare and needs of the individual survivor, **institutional betrayal** occurs. Institutional betrayal can often compound the trauma a survivor experiences and may magnify the symptoms he/she has post assault.¹⁴³ For the survivor this can result in a number of things – a loss of identity, loss of peer groups, loss of career plans and loss of educational goals. For many survivors of sexual assault on university campuses the assault disrupts their academic careers, and sometimes even their professional careers. Many withdraw from college.¹⁴⁴

Colleges and Universities are like micro-societies where people interact, live, work, learn, and play in close proximity to one another. A student may share a dorm or class schedule with his/her offender. A survivor may see the person who assaulted them several times a week or even several times a day in a cafeteria, a lecture hall, a library, or another shared space. Survivors may find that in order to avoid

¹⁴³ Smith, C.P. & Freyd, J.J. (2013). Dangerous safe havens: Institutional betrayal exacerbates sexual trauma. *Journal of Traumatic Stress*, 26, 119-124.

¹⁴⁴ Lombardi, K. (2010). A lack of consequences for sexual assault. The center for Public Integrity. Retrieved 7/28/2016 from <http://www.publicintegrity.org/2010/02/24/4360/lack-consequences-sexual-assault>

interacting with an offender they must become withdrawn from friends, stop going to classes, reduce socializing - all in an effort to avoid contact. In short, the survivor is the one who frequently feels that they must isolate themselves. There are accommodations available to survivors of sexual violence but they can vary depending upon the institution and the survivor must disclose the assault in order to receive accommodations for most campuses. The quality of services for survivors and response to survivors of sexual violence on college campuses is wide and varied.

Summary

The recent national attention brought to the topic of college sexual assault has shined a spotlight on the epidemic of sexual assault on university and college campuses. Survivors of college sexual assault will share many of the same experiences of other survivors, i.e. guilt, shame, confusion. In addition, they may face challenges that are unique to the college setting, particularly judicial and administrative process unique to Universities.

ELDERLY

An elderly person is at risk for many types of abuse and may be particularly vulnerable to certain kinds of crime. Seniors may experience physical or psychological abuse, neglect, a lack of supervision, or sexual assault. Seniors may face an increased susceptibility to sexual abuse perpetrated by relatives, caregivers, acquaintances, and strangers. The older woman can be vulnerable to sexual assault because:

- He/She is generally predictable.
- He/She may be less able to physically defend him or herself.
- He/She is often more dependent on public transportation or favors from others for assistance.
- He/She is more likely to live alone than younger individuals.

The perception of their vulnerability can make seniors an easy target. The rate of sexual abuse for this age group remains lower than for many younger people; however, the incidences of abuse are likely to be much higher than is expected by the general public.

About 85 percent of senior victims are women. The remaining 15 percent are men. Well over 90 percent of the abusers are also male. The vast majority of senior female victims are abused by close family members and caregivers. The male victims are most likely to be abused by individuals who are identified as friends or housekeepers. Reporting among senior victims is very low. Factors such as loyalty to family, fear of retaliation, and revulsion to the crime keep many seniors from telling anyone what happened.

What Seniors Need From Advocates:

- non-judgmental emotional support
- protection from access by the abuser
- medical care
- legal remedies when appropriate and wanted

The concerns and experiences of a senior sexual assault victim may be somewhat different from that of their younger counterparts. Seniors commonly experience feelings of helplessness, fear of outside people finding out, physical trauma, overprotective families or a significant loss of freedom, confusion about how this could happen to them, and, ultimately, major lifestyle changes. Advocates should be sensitive to the special needs of an elderly survivor of sexual assault such as those that follow.

Special Considerations For Seniors Who Are Sexually Abused

- **Medical**—An elderly survivor may experience more pain, soreness, and exhaustion than a younger survivor suffering a similar assault. In addition to possible pelvic injury and venereal disease, the older survivor may easily sustain other soft tissue damage. Since bones tend to become brittle with age, broken bones are more likely. An assault may exacerbate existing chronic conditions, such as arthritis, high blood pressure, and heart conditions.
- **Psychological**—It is not absolutely clear whether or not the psychological impact on an older person differs from that of a younger one. There do seem to be indicators that a senior victim may have concerns different from other survivors based upon their unique life experiences and special needs, including:
 - Diminished ability to face the physical frailties associated with advanced years. Being injured or physically disabled may raise awareness of physical vulnerability, reduced resiliency, old age, and the imminence of death.
 - After being violated sexually, perhaps after years of voluntary sexual inactivity, sodomy and oral sex may be especially traumatic.
 - There is likely to be humiliation, fear, anger, and depression associated with the sexual assault. The first reactions of the older survivor are frequently embarrassment, shock, disbelief, and denial (just as in some younger survivors), as well as gratitude that it did not happen to someone younger (for example, “I’m glad it was me and not my granddaughter.”). The real impact of the sexual assault may come later. Fear, anger, and depression can be especially severe in cases of seniors who are isolated, live alone, and have little self-confidence. Most sexual abuse that affects seniors occurs in their home, so there may be a great reluctance to return home.

Crisis Advocacy

Be aware of the profound effect that sexual assault may have on an individual whose generation seldom mentioned the word “rape” or believe that it happened only to bad girls, or that women who are raped are ruined and somehow are to blame for the incident. Many survivors have the fear that others will find out but this may be even more pronounced concern with a senior survivor. This reluctance to share can result in an extremely limited support network, thus placing a greater responsibility on the advocate. Remember, maintaining reputation and respectability may be a major issue for this survivor.

Be sensitive to the fact that some older people distrust or are uncomfortable with a younger person. Younger advocates should be especially diligent in treating the senior survivor with the utmost respect. Do not refer to him/her by a first name unless he/she has specifically asked you to do so. Help her/him to rebuild a sense of dignity and self-respect that may have been damaged during the assault.

Follow the survivor's lead as far as language standards are concerned. She/he may be very uncomfortable talking about sex or using explicit terms. Be sensitive to this and always emphasize the violent (rather than sexual) aspects of the crime.

Older survivors may have disabilities that will be undetectable at first. Vision may be poor; they may be hard of hearing and seem not to understand what people are saying. They may be arthritic or very slow and deliberate in their step. Offer assistance but do not rush to maneuver them around.

Dementia is a condition of some elderly people which may result in a decreased ability to remember and cope with recent events, names, etc. In some individuals this will manifest itself in child-like behavior. It is not uncommon for a person with dementia to have moments of lucidity and be able to respond to questions in a very accurate manner; at other times, confusion will be the norm. A trauma such as sexual assault is likely to further erode their ability to think and function at an optimal level.

Older people may be very concerned over the lack of control they feel over their lives. Well-intentioned individuals in their support network may want to put them in a more controlled environment where they can be cared for by others. A senior who is filled with self-doubt and fear may accept this proposition, when they resisted such a move in the past. The senior survivor may also be very resistant to this step and feel like the sexual assault has impacted their freedom to the point that life is not worth living. The advocate can be instrumental in working with the entire family on this delicate issue. Always support the survivor in whatever choice she/he makes, regardless of how much pressure the family may put on you to support their agenda.

Logistical Problems

If the survivor was robbed, you may need to find a source of emergency funds. Reduced incomes of the elderly also may make any hardship much more difficult to endure. Be aware of the financial constraints and of potential monetary resources that may be available.

- If the survivor was living alone and the assault took place in the home, windows and doors may be broken and emergency shelter needed until these can be repaired.
- If assaulted by a caregiver, the survivor may need assistance in identifying alternative personnel to help meet their needs.
- An elderly survivor may have transportation problems, especially during the evening. Be sure that a way to the hospital, support groups, and other services.

Follow-Up

This is an essential step, especially if the survivor lives alone. Special care should be taken to ensure that there is contact with the appropriate resources so that over time routine activities may be resumed.

Dealing With Older Persons With Communication Impairments

The Police Executive Research Forum (PERF) developed excellent guidelines to help law enforcement accommodate elderly victims who may have communication impairments. These guidelines, listed below, have been slightly modified in order to be relevant to victim service providers.

- Because many older people have communication impairments, it is essential for service providers to develop skills that will optimize their effectiveness in interviewing victims, providing counseling or other support services, and offering information and referral assistance.
- Many older people have a partial hearing loss. This means that they can hear some sounds but not others. Most of the elderly with hearing loss do not learn sign language. Rather, they depend on lip reading, hearing aids, or other electronic devices to assist them.
- If a service provider suspects that an older person has a hearing loss, the service provider should ask the victim if he or she is having difficulty understanding (but not assume that the victim is having such difficulty). There are numerous methods and devices which can help when communicating with individuals who have hearing disabilities. Some communities have agencies (such as hearing societies or independent living resource centers) that can lend out special equipment or provide assistance with interviews. Victim service providers should determine if such services exist in their jurisdictions.
- Most people with hearing loss compensate for the loss by paying more attention to visual cues. For that reason, it is important that they can clearly see the speaker's lips, facial expressions, and hands.

Effective strategies for communicating with adults with hearing loss include the following:

Asking the person if she/he would prefer to use written communication or an interpreter.

- Arranging the room where communication will take place so that no speaker and listener are more than six feet apart, and everyone is completely visible.
- Positioning yourself directly in front of the person to whom you are speaking.
- Concentrating non-glaring light on the speaker's face for greater visibility of lip movements, facial expressions, and gestures.
- Not standing in front of a direct light source such as a window.

- Speaking to the person with hearing loss from a distance of no more than six feet, but no less than three feet.
- Establishing eye contact before you begin to speak.
- Speaking slightly louder than you normally would.
- Speaking clearly at your normal rate, but not too quickly.
- Using short, simple sentences. Keeping language concrete.
- Never speaking directly into the person's ear.
- Rephrasing the statement if the person does not appear to understand what is being said, rather than just repeating the same words.
- Refraining from over-articulating. Over-articulation distorts both the sound of the speech and the face, making visual cues more difficult for the elderly victim to understand.
- Including the person in all discussion about him or her.
- Avoiding smoking, chewing gum, or covering your mouth while you speak.
- Repeating key words and phrases. Asking the listener to repeat what you have said.
- Asking the victim to repeat or rephrase the response if you cannot understand the person's answer to your question.
- Using open-ended questions, not requiring a "yes" or "no" answer.
- Using visual aids whenever possible, such as drawings, diagrams, and brochures.
- Treating the elderly client with dignity and respect, and avoiding a condescending tone. (PERF 1993).

LGBT (LESBIAN, GAY, BISEXUAL, TRANSGENDER)

If the advocates' core beliefs will not allow affirming homosexuality, bisexuality and transgender individuals then working with this population can cause more harm than good, so you should facilitate such individuals transfer to an advocate or counselor who can be affirming. Survivors are already sufficiently fearful of being disbelieved or rejected by service providers, and they are quite sensitive to any such signs.

To be called gay or lesbian an individual must self-identify and prefer the same gender on many levels: sexually, emotionally, intellectually and physically. The bisexual label has been a cover for some gays unable to tolerate the homophobia of society and who found the label more acceptable than the homosexual one. However, many people who identify openly in this way are trying to acknowledge the fact that, no matter what their preference, their attractions both to men and to women are real and valid. Transgenderism refers to a range of individuals who are living as the opposite sex, (with or without surgical reassignment) cross-dressing for a period of time, or earning a living working in the dress of the opposite sex.

An assumption prevails that all people are heterosexual, and that heterosexuality is right, correct and normal. Based on this assumption, organizations, policies, and structures that only benefit and acknowledge heterosexuality and heterosexuals exclude and put down individuals of another sexual orientation. Forms, printed materials and language when on the phone or in person need to be gender neutral, which means not using a pronoun or sex-specific label unless the person gives one.

When people, regardless of sexual orientation, suffer sexual assault, common behavioral and somatic reactions include psychological distress that often leads people to question their own worth. When LGBT individuals are attacked, because they are perceived to be other than heterosexual, the consequences of victimization mix with those of societal heterosexism to create a unique set of challenges for the survivor to overcome. Perhaps most important is that the survivor's sexual orientation becomes directly linked to the heightened sense of vulnerability that follows victimization.

- **Incident:** Lesbians and gay men of color are at increased risk for attack because of their orientation. Gay men and transgender individuals also are targeted for sexual assault. Male-male sexual assault is largely an invisible problem in our society, it often is assumed to occur only in prisons, the military or other similar settings. As with sexual assault of females by males, male-male sexual assault is a crime of violence, often anti-gay violence, rather than a crime of sexuality. Another unique problem may be that lesbians may be directly targeted for sexual assault by anti-gay attackers or raped opportunistically (when the perpetrator of another crime inadvertently discovers his victim is a lesbian) to 'show them what they are missing.' For some lesbian women, the trauma of rape by a male is exacerbated because they have never have been with a man before.
- **Aftermath Issues:** The aftermath of victimization for gays and lesbians is affected by the survivor's stage in the coming out process. Those who are out have already faced a major threat to their self-esteem. Those who are still in the early stages of coming out will probably not have the social support and developed gay identity that can increase their psychological resilience and coping skills. A survivor lacking a positive interpretation, may have feelings especially vulnerable to others' influence, and they may accept feelings of helplessness, depression and low self-esteem. Survivors who are still not "out" may choose to avoid the public disclosure of their sexual orientation in such a potentially hostile setting as a police station, and thus not report the victimization.

Reactions by LGBT survivors to being sexually assaulted will most likely be similar to those experienced by heterosexual survivors. However, there are some additional specific issues with

lesbian/gay/bisexual/transgender survivors. For example, while many survivors are fearful of disclosing or reporting the assault, LGBT survivors have the added fear that their sexual orientation will be an issue. Many LGBT individuals have experienced discrimination or judgmental attitudes from family, friends, community members or service providers. The combination of disclosing the assault and disclosing sexual orientation at the same may deter many LGBT survivors from reporting. Survivors may feel they either have to remain silent and deny sexual orientation, which will foster shame and internalized homophobia, or disclose sexual orientation and risk discrimination or physical harm.

Working with gay/lesbian/bisexual/transgender survivors will require the service provider to confront personal interpretations and beliefs about this population. It is important for service providers to address their own issues of personal, social and cultural homophobia before trying to provide services to the group. To keep an advocate from re-victimizing the survivor because of the advocate's particular beliefs and prejudices an advocate uncomfortable working with this population should not work with them. Be aware during a period in the coming out process some gay men/lesbians will prefer receiving services from the gay community, with gay providers. So be willing to refer out and know of resources in the community for them.

Without cultural sensitivity to this community, it is virtually impossible to provide meaningful, supportive services. To gain some cultural sensitivity, service providers can seek out opportunities to educate themselves about gay/lesbian/bisexual and transgender culture and to participate in cultural activities. Lesbians and gay men are often less likely to be supported in their own communities than are heterosexual survivors of sexual assault so it is important to acknowledge the assault with survivors and tell them it is not less likely to have occurred because same-sex partners were involved. Also, encourage reporting the assault. The fear of reprisal/non-belief from law enforcement personnel may discourage the possibility of reporting.

Often survivors of gay/lesbian/bisexual/transgender sexual assault are not out to family members and/or are not supported by members of their community, which often times leads to internal conflict about what to do. Although the root of sexual assault against the LGBT community has more to do with societal perceptions and societal homophobia, survivors may somehow deem their assault as less important than straight-identified survivors. It is important to listen to them and validate their concerns, but also remind them of the importance of reporting and self-care. They may also need to be assured the assault is not something they should have expected to experience because of their identity or whom they choose to love.

Support the strengths and abilities of the survivor because the survivor is usually hyperaware of personal weaknesses. Focus on empowerment. It is often assumed that, contrary to heterosexual relationships in which there are usually clear power imbalances, there can be no power imbalances involving same-sex partners. Although there are no gender differences between partners, gays/lesbians may have less economic power and almost always have less social power than heterosexuals. Survivors do not need to be blamed or shamed. Many lesbians/gays have a heightened fear of abandonment/loss that may be attributed to feeling different and set apart as children, or losses experienced from disclosing their orientation to family members and friends.

All workers can serve as change agents by helping their agencies and other service providers be more responsive and affirming to gay/lesbian/bisexual and transgendered survivors of sexual assault.

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HUMAN TRAFFICKING VICTIMS

Credit for this section goes to the California Coalition Against Sexual Assault.¹⁴⁵

Sexual assault programs are in a unique position to identify and support trafficking survivors. Advocates are likely to encounter trafficking survivors, because they are often subjected to sexual assault, and will either seek out services from sexual assault programs or be referred for services. Traffickers use sexual violence as a primary tool of power and control against women and children regardless of what type of trafficking they are being used in. Sexual assault programs are often the first responders in cases of human trafficking, as well as partners in raising awareness around the issue of trafficking. In these cases, it is important to understand that while trafficking survivors have special needs, they are also survivors of sexual assault. Address their needs as sexual assault survivors, inform them of their options and work within the systems that can provide them with support. In addition, help provide them with the invaluable psychological support they need as a result of the ongoing trauma they have experienced.

Considerations for Counselors

- **Build trust with the survivor.** Often trafficking survivors do not know the systems they are now involved in and may come from countries where those systems cannot be trusted to protect people. Also, she may have been told by her trafficker that she will be arrested or deported if she tells anyone what is happening. Be aware that trusting you may be a big factor in her counseling.
- **She may not see herself as a victim.** Since she is not homeless or in need of social services, and believes that she has a paying job, she may not see herself as a victim. You may need to help her understand her rights, and educate her about what options are available.
- **Assure the survivor she is not to blame.** The perpetrators, sellers and buyers of trafficking survivors are responsible.
- **Place the blame where it belongs.** Guilt or self-blame is a frequent response to being used in the sex industry. Survivors sometimes worry that they could have done something to prevent this from happening to them. Since you work with other survivors of sexual assault, you are aware that traffickers, like rapists, target their victims.
- **Be aware of her loyalty to the trafficker.** Much like in domestic violence situations, trafficking victims may have developed a loyalty to the trafficker since he is her path to survival. She may have been forced to choose a lack of response to the crisis as a means of self preservation. When you are counseling a trafficking survivor make sure to pay attention to how she feels about her trafficker and work within that context.
- **Have linguistically and culturally appropriate interpreters available.** In small linguistically unique communities be sure that the interpreters used are not related to or known by the survivor. Use certified/trained interpreters if possible, not family members or other members of the survivor's community.

¹⁴⁵ Labertew, D., and Wong, K. *Supporting Survivors of Human Trafficking*. CALCASA. Available here: <http://www.calcasa.org/wp-content/uploads/2010/12/Survivors-of-Human-Trafficking.pdf>

- **Listen to her and know your own feelings about her experience.** As a means of survival, survivors in trafficking situations may appear to have “willingly” participated in behaviors or acts that might be difficult for us to understand. When someone is in a captive situation, survival is complicated and we must be aware of any judgments we have of those behaviors. Offer non-judgmental, non-blaming listening. Listen with compassion without asking questions that begin with why, or imply that she is responsible in any way for the abuse she has survived. Let her express her feelings in a time and manner and with language that is comfortable for her.
- **Counseling as a result of forced sex may not be her priority.** Her basic needs may take priority over her legal and emotional needs. Ask her how you can help keep her safe. Find out what she needs. She may need help with some very basic necessities; where to live, how to get food, transportation. You may need to help her obtain needed medications or other medical services, make copies of important documents, or any other help you feel you can provide.
- **Have resources available.** It is important to have resources available to provide to survivors who are trafficked. Identify local experts and have their information available for referral.

MILITARY MEMBERS

This section reflects information published by the US Department of Veterans Affairs¹⁴⁶ as well as the Battered Women’s Justice Project¹⁴⁷

Prevalence

Sexual assault is a pervasive problem in the United States, including in the Armed Forces. Public beliefs and attitudes about sexual assault lead to complacency and acceptance of a “rape culture” in the United States where rape is normalized, excused, tolerated, and even condoned. This acceptance creates an environment that makes it nearly impossible for sexual assault victims, in both the military and civilian systems, to obtain justice and discourages them from reporting and seeking help.

Both men and women are victims of sexual assault perpetrated by military service members. However, nearly 25% of women veterans who seek health care services from the Department of Veterans Affairs report experiencing at least one sexual assault while in the military compared to slightly more than 1% of male veterans. Women who enter the military at younger ages, those of enlisted rank, and those who experienced sexual assault prior to entering the military, appear to be at increased risk of sexual assault while in the military.

¹⁴⁶ Street, A., and Stafford, J. *Military Sexual Trauma: Issues in Caring for Veterans*. Available here: <http://www.ptsd.va.gov/professional/trauma/war/military-sexual-trauma.asp>

¹⁴⁷ Military Sexual Assault. Battered Women’s Justice Project. Available here: <http://www.bwjp.org/our-work/topics/military-sexual-assult.html>

Restricted and Unrestricted Reports

A sexual assault victim in the military may make a “restricted report” that allows disclosure to specified individuals (i.e., sexual assault response coordinator (SARC), sexual assault prevention and response victim advocate (SAPR VA), or healthcare personnel). The victim can receive medical treatment, including emergency care, counseling, and assignment of a SARC and SAPR VA, without triggering an official investigation. However, exceptions limit the ability to make a restricted report.

A victim may also make an “unrestricted report” without requesting confidentiality or restricted reporting. Under these circumstances, the victim’s report provided to healthcare personnel, the SARC, a SAPR VA, command authorities, or other persons is reported to law enforcement and may be used to initiate the official investigative process.

When an unrestricted report is made, the alleged offender’s commanding officer has a great deal of discretion about what action to take. He/she may take disciplinary, administrative, or legal action against the offender. He/she may also decide to administratively separate the service member from the military. As in the civilian system, many people feel that sexual assault offenders in the military are often not held accountable, which has the effect of minimizing, excusing, and condoning sexual assault and reinforcing sexist attitudes and behavior toward women.

The military can and sometimes does take disciplinary or legal action against sexual assault survivors for infractions committed related to the sexual assault (underage drinking, fraternization, adultery). In addition, survivors have been separated from the military for mental health or disciplinary reasons, and they have limited recourse when this occurs. This and other negative actions directed at survivors are often perceived as retaliation for reporting and can have devastating effects on the survivor’s sense of safety, trust, and well-being and lead to a complex array of problems that affect the survivor’s future significantly beyond leaving the military.

Special Considerations

While there is almost no empirical data comparing experiences of military sexual trauma with experiences of sexual harassment and assault that occur outside of military service, there is some anecdotal evidence that these experiences are unique and may be associated with qualitatively or quantitatively different psychological outcomes.

Sexual trauma that is associated with military service most often occurs in a setting where the victim lives and works. In most cases, this means that victims must continue to live and work closely with their perpetrators, often leading to an increased sense of feeling helpless, powerless, and at risk for additional victimization. In addition, sexual victimization that occurs in this setting often means that victims are relying on their perpetrators (or associates of the perpetrator) to provide for basic needs including medical and psychological care.

Similarly, because military sexual trauma occurs within the workplace, this form of victimization disrupts the career goals of many of its victims. Perpetrators may be peers or supervisors responsible for making decisions about work-related evaluations and promotions. In addition, victims may be forced to choose between continuing military careers during which they are forced to have frequent

contact with their perpetrators or sacrificing their career goals in order to protect themselves from future victimization.

Most military groups are characterized by high unit cohesion, particularly during combat. While this level of solidarity typically reflects a positive aspect of military service, the dynamics of cohesion may play a role in the negative psychological effects associated with sexual harassment and assault that occurs. Because organizational cohesion is so highly valued within the military environment, victims may fear that divulging any negative information about a fellow Service member may affect their relationships with their co-workers and peers.

As in civilian contexts, most victims of military sexual trauma do not make official reports to authorities about their experiences. When victims do reach out for help, how authorities respond can have a powerful impact on their post-trauma recovery. For example, receiving invalidating responses from legal, medical or other sources of formal help can often compound the mental health difficulties victims have after MST, increasing symptoms of depression, feelings of isolation, perceptions of self-blame and other problems. Also, negative reactions from formal sources of help may affect victims' willingness to seek out treatment or disclose their experiences to others, such as family and friends. This is problematic, as social support is the strong predictor of victims' recovery from trauma. In contrast, positive, supportive responses from formal and informal sources of support can help mitigate some of the potential consequences of military sexual assault by reducing a victim's sense of helplessness, isolation, self-blame and general distress. Positive responses from others can also provide tangible support such as a change in housing, workplace accommodations, financial support, transportation, or other support that can help alleviate some of the practical problems victims may encounter after sexual trauma.

Implications for Counseling

Given the range of sexual victimization experiences that Veterans report there are a wide range of emotional reactions reported by Veterans in response to these events. Even in the aftermath of severe forms of victimization, there is no one way that victims will respond.

Instead, the intensity, duration, and trajectory of psychological responses will all vary based on factors like the Veterans' previous trauma history, their appraisal of the traumatic event, and the quality of their support systems following the trauma. In addition, the victim's gender may play a role in the intensity of the post-trauma reactions.

While the types of psychological reactions experienced by men and women are often similar, the experience of sexual victimization may be even more stigmatizing for men than it is for women because these victimization experiences fall so far outside of the proscribed male gender role. Accordingly, men may experience more severe symptomatology than women, may be more likely to feel shame about their victimization, and may be less likely to seek professional help.

Studies of sexual assault among civilian populations identify posttraumatic stress disorder (PTSD) as a frequent outcome. Sexual assault victimization is associated with high lifetime rates of PTSD in both men (65%) and women (45.9%). Interestingly, these rates are higher than the rate reported by men

following combat exposure (38.8%). Major depressive disorder (MDD) is another common reaction following sexual assault, with research suggesting that almost a third of sexual assault victims have at least one period of MDD during their lives. Victims of sexual assault may also report increased substance use, perhaps as a means of managing other psychological symptoms.

Common emotional reactions include anger and shame, guilt or self-blame. Victims of sexual trauma may report problems in their interpersonal relationships, including difficulties with trust, difficulties engaging in social activities or sexual dysfunction. Male victims of sexual trauma may also express concern about their sexuality or their masculinity.

While the consequences of sexual assault can be severe and complex, there are treatments available that can significantly reduce psychological symptoms and improve a victim's quality of life. Although the literature examining the use of empirically-based treatments for the treatment of sexual trauma associated with military service remains small, there is a wealth of information available on the treatment of sexual assault in civilian populations that can be used to inform treatment of Veteran populations.

Interventions for sexual trauma often involve addressing immediate health and safety concerns (particularly in the case of an acute trauma), normalizing post-trauma reactions by providing education about trauma and psychological reactions to traumatic events, providing the victim with validation, supporting existing adaptive coping strategies and facilitating the development of new coping skills, like muscle relaxation or deep breathing.

ADULT SURVIVORS OF CHILDHOOD SEXUAL ASSAULT/INCEST

There are two categories into which adult survivors of childhood sexual assault fall: either they were victims of incest by a family member, (someone in a parental/authoritative role) or they were assaulted by a stranger. Whatever the case may be one thing is certain, survivors have a long and very difficult road to recovery ahead of them. This violation of one's most personal boundary, especially during the developmental stages of childhood, can have very long-lasting and devastating effects on the child's growth physically, emotionally and mentally. This is why many survivors have difficulty expressing any emotions except sadness or hopelessness.



In cases where the perpetrator was someone in a parental or authoritative role, the fact that this violation came from someone who was supposed to love, protect and/or nurture them can be a very frightening realization. Even to allow themselves to fully understand this means knowing how completely powerless they were. Thus, the survivor may try to bury every memory of the assault. It is a shame many survivors cannot bear.

To understand how prevalent the problem of childhood sexual assault is, advocates can examine the statistics. According to a report from the National Victim Center and Crime Victims Research and Treatment Center in 1992, six out of ten of all rape cases occurred before survivors reached the age of

18. More recent research in Texas indicates that, “the highest prevalence rate of sexual assault for women occurs when they are over 18; in contrast, men report higher sexual assault prevalence for ages 17 and under.”¹⁴⁸ It is imperative that advocates and counselors become familiar with childhood sexual assault issues as these clients will be accessing the sexual assault programs for services. In order to discuss the ramifications of childhood sexual assault on the adult survivor, advocates must have a thorough understanding of the issues involved. Although many of them run parallel to those of the survivor who is sexually assaulted as an adult, certain issues such as trust, self-esteem and forgiveness go even deeper.

The following is a brief synopsis of some of the issues facing adult survivors of childhood sexual assault:

- **Setting Limits/Boundaries**—Survivors who are sexually assaulted as children may have difficulty with setting limits and boundaries. Past experiences have given them little hope of ever having any control over what happens to them. During the recovery process there is a need to understand that they are no longer the child who was powerless to stop the abuse perpetrated on them by the adults in their lives. Not only do they have more power now, but they also have the right to control what happens to them. They have the right to choose their sexual partners and they have the right to make any other decisions that affect their lives.
- **Memories/Flashbacks**—Survivors may experience the constant and repetitious return of certain memories surrounding the assault. They can be very disruptive, constantly reminding the survivor of what happened. A flashback is the sudden occurrence of a visual image of the assault. It returns with all of the emotions and feelings experienced at that particular time and can be very frightening. Both the memories and flashbacks may have been triggered by a familiar face, place, certain sounds, smells, etc. The important thing is to assure the survivor that they are only pictures and recollections of what has already happened, not what is going to happen. The perpetrator(s) can no longer hurt them in that way.

Often, the mind will not allow a memory to surface until the survivor is at a place where they can deal with it. This could mean that they are at a place where they feel both emotionally and physically safe or they now have access to a support system when the memories become overwhelming. Once the survivor realizes that they have control over the memories and flashbacks, and that they can actually choose when to think about them, the memories lose their power and the survivor can get on with life.

- **Anger**—Although this is one of the most common issues that a survivor has to deal with following a sexual assault, it is also the most difficult emotion to get in touch with for the adult survivor of childhood sexual assault. The survivor has perhaps spent many years

¹⁴⁸ Busch-Armendariz, N.B., Olaya, D., Kerwick, M., Wachter, K. & Sulley C. (2015). Health and well-being: Texas statewide sexual assault prevalence. The University of Texas at Austin, Institute on Domestic Violence & Sexual Assault: Austin, Texas. Available at: <http://rapecrisis.com/wp-content/uploads/2015/09/TX-SA-Prevalence-Study-Final-Report-4-2015.pdf>

covering up real feelings and emotions. Their anger had little or no effect on the actions of the perpetrators in their lives, so they learned how to suppress their anger. Some survivors were too young to know that what was happening to them was wrong.

The healing process involves helping survivors get in touch with their feelings of anger. The anger felt toward the perpetrator(s), toward the adults who should have protected them, and the anger that arises from self-blame needs to be acknowledged and experienced. It involves helping survivors understand that they have the right to feel angry about what happened and that there is nothing wrong with expressing the anger in positive ways. Unexpressed anger leads to depression. Healthy expressions of anger free the survivor to move beyond it. Encourage the survivor to utilize activities such as: exercising, journaling, screaming, or punching pillows, thereby enabling the anger to move from the inside to the outside where it can be dealt with effectively. Remember, anger is an issue that is bound to come up sooner or later and it is only after working through the anger that the survivor is able to really let go and move on.

- **Grieving/Mourning**—Being abused as a child means experiencing the loss of many things. There is the loss of childhood experiences like being carefree, happy, nurtured, protected and unencumbered by serious things. How can a child be carefree when she/he is carrying a secret as big as being sexually assaulted by a family member? They do not dare let their guards down and experience happiness for fear of losing control. There is a loss of innocence.

Since incest involves parents, and/or other family members, there is a loss of trust. The very people who were supposed to nurture and protect the survivor were the abusers. There is a loss of a normal relationship with a parent, a loss of childhood memories and a loss of the right to choose their own sexual partner. The list goes on and on. However, now the time has come to name these losses, grieve over them and bury them once and for all. This may mean having some sort of ritual where they are finally put to rest. All losses need to be mourned, this helps to bring the grieving to closure.

- **Guilt, Shame & Blame**—Part of the healing process is reminding the survivor that a child can never be responsible for being sexually assaulted. All of the blame needs to be placed firmly where it belongs, with the perpetrator. Survivors need to understand that, although the perpetrators are their parents and/or others who were in positions of authority, they abused their positions of authority and should be held accountable.

Survivors often carry a lot of guilt either because they may have experienced some physical pleasure from the sexual abuse or because they did not try to stop it. It is important for the survivor to be told that although the body will respond to certain stimulations, it is up to the adult to know better and teach the child the difference. Children often actively seek the affection of an adult and will sometimes accept any show of affection as an affirmation that they are loved.

Although survivors may soon accept the fact that it was not their fault and that they did

not do anything to cause the abuse, it takes longer for the sense of shame to subside. Due to the myths about sexual assault, survivors are often blamed or disbelieved so much after making the decision to disclose their abuse, few want to come forward. Unfortunately, the secrecy continues to clothe the incident in shame. It is only in breaking the silence that the shame begins to dissipate. The more the survivor talks about the abuse, the less shameful it becomes and the more empowered survivors become to move forward in recovery.

- **Trust**—As discussed earlier, learning to trust again is very difficult for the adult survivor. The survivor of incest entered this world as an innocent child, but became the recipient of pain and suffering, shame and guilt at the hands of family members who used and abused them. In addition, they may have grown up in an unsafe environment where nothing was sacred. An adult in their lives was manipulative and abusive. They had no reason to believe that others in their lives would be any different, making them unwilling to take the risk of being deceived again.

If survivors cannot trust the people in their most immediate environment, how do they step out of that space to begin to trust others? This is the dilemma that the advocate must help the survivor to overcome. It is the fear of trusting others, of being hurt and experiencing that pain all over again. Survivors will sometimes go from one extreme to another, not trusting at all or trusting too much. This is where setting limits and boundaries becomes very important

Express to survivors that as adults they have the right to choose the people with whom they want to begin a relationship. They are no longer the children that had no control or power in their past relationships. Also, remind them that trust does not come automatically, it has to be earned. It is permissible for them to test the person with whom they want to develop a relationship by asking them to do small favors to see if they can be trusted. It is also permissible to go back to not trusting someone if that trust is violated. The important thing is for them to take one step at a time and allow themselves to take whatever time is needed to learn or regain the ability to trust.

- **Coping Skills**—People develop many different coping skills to help them deal with trauma. Some of them are healthy and some are not; however, all of them are very important because they enable the person to survive whatever they were going through. These were the skills that worked and often the survivor did not know any others to use. The role of the helper is to assist the survivor in recognizing those coping skills that are unhealthy and replacing them with healthier ones.

When examining past coping mechanisms it is important that survivors forgive themselves for any coping skills used that were unhealthy. Once again, these skills served a purpose and fulfilled a need at that time. For instance, they may have developed a habit of drinking excessively whenever any memories of the childhood sexual abuse arose. This behavior was repeated again and again and was a way for them to numb their feelings so they did not have to re-experience the pain that returns with the memories.

When survivors allow themselves to go through the feelings and emotions of a childhood sexual assault, help and healing comes much faster. They can do this in a safe environment where they can receive the support and information needed. For adult survivors, these coping mechanisms helped carry them through a painful childhood all the way into adulthood. It is important that they give themselves enough time to learn and develop new and healthier skills to cope in the future.

- **Self-Esteem/Isolation**—An adult survivor of childhood sexual assault may have a problem with issues of self-esteem. This is a result of hearing all the negative messages from their perpetrators while being abused, as well as feeling that they were somehow responsible. As soon as they realize that being abused was not their fault and that 100 percent of the responsibility for what happens belongs to the perpetrator, the more quickly they can move beyond this false perception of themselves. Those negative messages may have completely overshadowed any positive images they had of themselves.

Statements such as: "You are a bad girl," "You were a little tease," and "You made me do this to you," etc., reinforced the idea that they were to blame for what happened.

A child that grows up with the belief that somehow she/he caused a family member to sexually violate him/her, must now come to accept that a child can never be responsible for being sexually abused. He/She carries this burden for years; his/her self-image plummets, and it takes time and work to heal from the perpetrator's lies.

The recovery process begins by reaffirming their experience as a survivor of a very traumatic experience. They are not responsible for the abuse. They did not ask for it or cause it to happen in any way. Survivors need to know that their feelings and emotions are normal reactions to sexual abuse. They have the right to their feelings and to be able to express them in a healthy, safe environment. Also, no one has the right to tell them when they should or should not be over this. There are people who do care and agencies where they can go to receive the support and information they need. There is no time limit for the recovery process.

Survivors might begin taking care of themselves by first acknowledging and celebrating their successes, no matter how small. Looking back and remembering how other crises were dealt with in the past and comparing them to present coping skills, will enable survivors to see what progress has been made. Help them remember that, as an adult, they have more power and control over what happens to them. They also have the right to do what is best for them. They can set boundaries and say "**NO**," and they have the right to be respected for that "**NO**." Help survivors find ways of affirming how important they are. This could begin by making a list of ways to nurture themselves and referring to that list whenever there is the need to feel more relaxed, calm, cared for or centered.

- **Intimacy**—Intimacy is a close bond between two people, but survivors of childhood sexual assault may have a hard time establishing an intimate bond. Entering into a close

relationship with another person involves trust, respect, love and the ability to share. Survivors sometimes flee from intimacy; at other times, a survivor may hold on too tightly for fear of losing the relationship. Both reactions are a result of having been sexually abused as a child. In incest cases, the trust they so innocently gave was violated, their personal boundaries were not respected and they never felt the love and caring that comes from growing up in a healthy environment.

The advocate's role is to help the survivor understand that she/he can develop the skills necessary to learn how to be intimate with someone else. It just takes time. It is always risky to open up and allow oneself to enter into a relationship with another person. True, she/he may experience hurt or disappointment, however, it will not destroy him/her. She/he can assess what happened, learn from it and move on. No one can predict or control another person's behavior, however, survivors can develop skills that will better prepare them for entering new relationships. This is one of the goals of the healing work that needs to be done.

- **Sexuality**—The very nature of the assault has a tremendous impact on the survivor as far as sexuality issues are concerned. First of all, an adult who has been sexually assaulted as a child has to deal with the fact that their first initiation into sex came as a result of incest or rape, perhaps at an age when they could not even verbalize what was happening to him/her. Yet the body stored those painful memories for years. As a result, many survivors experience the return of body memories while engaged in a sexual activity with another person. This can be frightening, especially when the source of these memories is not readily available. It can also be frustrating as it may inhibit the survivor from participating in any type of sexual act with their partner.

SEXUALITY TRUTHS

Below are some sexuality truths that can be discussed with the survivor:

- Anyone has a right to say "NO" when he/she does not want to be touched or engage in sexual activity.
- People are not objects to be used or abused by other people. All individuals have rights.
- Men and women have equal responsibility during sexual activity.
- Women have the same sexual rights as men for self-experimentation and self-exploration.
- Women and men both have the same sexual right to be assertive.
- Women and men have the same freedoms to be sexually active and to receive pleasure from sex.

Help the survivor to understand that their partners and the perpetrator(s) are different people. The memories and flashbacks are just that, images of something that has already happened and not predictions of what is going to happen.

- **Forgiveness**—The important thing to know about forgiveness is that there is no rule that says that the survivor must forgive the perpetrator in order to heal and recover. This decision is entirely up to him/her. What is important is that the survivor understands that lack of forgiveness can become so encompassing that it grips them like a vise, bombarding them every moment with thoughts of ways to get revenge, is very damaging. It serves no purpose and can end up being very self-destructive. Anger is a valid reaction to the abuse; however, there are ways, as discussed earlier, of expressing it in a safe and non-threatening manner.

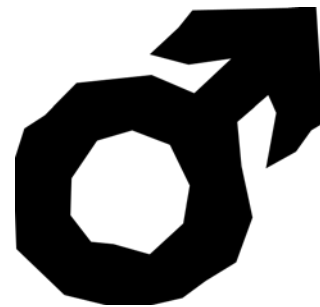
The survivor may decide that she/he is not ready to forgive the perpetrator. This is permissible as long as she/he does not allow the lack of forgiveness to become like a canker sore, eating away at him/her. Forgiveness for the survivor may mean just learning how to "let go." The key is for survivors, first of all, to forgive themselves.

MALE SURVIVORS

Prevalence

By far, the majority of survivors who seek the services of crisis centers are female. Similarly, the overwhelming majority of identified rapists and child molesters are male. For those who work with survivors, the evidence of violence by men against women is so pervasive that it is sometimes difficult to remember that males can also become victims of sexual assault. Yet, sexual violence perpetrated on males is far more common than most people realize.

Until the age of twelve, rates of sexual abuse of male and female children are approximately equal. It is estimated that one in six men (excluding the prison population) are sexually assaulted in their lifetime, although national studies variously estimate the rate of abuse at between 2.5 and 16 per cent (Mic Hunter, Abused Boys: The Neglected Victims of Sexual Abuse [Lexington, Mass.: Lexington Books, 1990]). In one study, one of every twenty-five male high school students and one of every fourteen male college students reported that he had been a victim of sexual abuse (Ibid). In spite of these estimates, most sexual abuse of children (both sexes) is never reported and most sources agree that reported cases represent only a fraction of the actual number of male victims, whether child or adult. As low as the rate of reporting is for female victims, it is even lower for male victims because "perhaps even more than women, the stigma of being sexually assaulted discourages men from reporting such events" (Groth and Birnbaum, Men Who Rape: The Psychology of the Offender [New York: Plenum, 1979]).



Characteristics

Sexual abuse of adolescent girls generally involves a family friend or relative whereas research indicates that adolescent boys are more likely to be abused by strangers or authority figures in an organization, such as school, youth group, athletic team, scouting or church-related groups. Girls are

more likely to be molested in the home whereas males are more likely to be molested outdoors, in remote areas and/or automobiles.

The sexual orientation of the rapist is generally identified as heterosexual and, in fact, homosexual men are far less likely than heterosexuals to engage in rape. According to several studies, more than 50 percent of rapists choose victims of either gender.

Sexual abuse of young males by older females is far less common, although in recent years, reports of sexual abuse by female perpetrators have increased. While the motivation of male abusers is more often related to the need for power and control or to attempt to humiliate the victim, motivations of female abusers may emanate from a variety of sources. The female abuser may be an older sister, cousin or baby-sitter who is in a position of power over the boy and seizes the opportunity to explore her own sexual curiosity. She can also be a mother, aunt, grandmother or other female relative or neighbor who is unable to get her emotional needs met by traditional means and turns to a younger male in an attempt to satisfy those needs.

While the characteristics of sexual abuse of males are similar to those for females during childhood, from adolescence onward, sexual assault of males takes on a more violent cast. For example, gang-rape is more common, multiple forms of sexual acts are likely to be demanded from and perpetrated on the victim, weapons are more likely to be used, and physical injury is more common and more severe.

Cultural Issues

Throughout our culture, rape is one of the most misunderstood of all violent crimes. When the victim is male, these misconceptions are dramatically compounded. In part, this is attributed to culturally pervasive stereotypes of males as strong, powerful and aggressive—stereotypes that contradict the general depiction of victims as powerless, weak and vulnerable. A male who admits to being sexually assaulted risks being thought of as “less male” by others as well as by the victim himself.

As a result, much sexual abuse of males is not defined as abuse. A common misconception is that “girls get raped, but boys get seduced – and love it.” (Anonymous client, Survivors and Friends, Bellevue, Wa.) The image of the macho male permeates American culture to such an extent that we assume males, even boys, are able to protect themselves and are less vulnerable to sexual assault than females.

A corollary to this myth is that, when males are sexually assaulted, they are less traumatized than females. While a few studies have suggested that males may be less negatively affected, the preponderance of evidence indicates the long-term effects are very damaging to both sexes. Boys who are sexually abused show the effects of the trauma in many areas of life: physical, emotional, sexual, social, behavioral and spiritual. Guilt, shame, anger, fear and loneliness are common after-effects, which often result in addictive behaviors. Sexual dysfunction such as premature ejaculation, sexual masochism, sadism, exhibitionism and impotence occur about five times more often in sexually abused males than in non-abused males.

Another common myth is that homosexual males perpetrate most sexual abuse of boys. Pedophiles who molest boys are not expressing a homosexual orientation any more than pedophiles who molest girls are practicing heterosexual behaviors (Fifth International Conference on Incest and Related Problems, Biel, Switzerland, Aug. 1991).

A related myth about male sexual abuse is that males who are victimized are or will become homosexual. This is particularly damaging to the survivor who, in addition to all of the other issues related to recovery, must also grapple with doubts about his own sexuality and, as a result, may be discouraged from reporting the abuse. The process by which one's sexual orientation develops is a complex one but most experts in the field of human sexuality do not believe that it is significantly impacted or shaped by early abuse experiences. For both boys and girls, one of the issues related to victimization is a tendency to question what caused the perpetrator to choose "me" rather than someone else as their victim. Early victimization, for both boys and girls, can lead to confusion about one's sexual identity and orientation. This is related to the confusion generated by premature sexual contact before one is developmentally ready, rather than innate characteristics of the victim's sexual identity.

Another misconception about male sexual abuse is that, once victimized, a male is likely to become a sexual predator himself who will go on to victimize others. Although most perpetrators do have histories of sexual abuse, it is not true that most victims go on to become perpetrators. The most significant factor that determines whether an abused male becomes a perpetrator seems to be whether or not he told about the abuse and was believed and supported by significant people in his life.

Implications For Counseling

Men respond to being sexually assaulted in much the same way that women do, however there are some primary counseling issues specific to male survivors. These include the following:

- **Psychological Issues**—Since men have generally not been socialized to believe that being sexually assaulted is in any way a remote possibility for them, the psychological impact on a male survivor can be even more severe than with female survivors. Being assaulted violates everything he has been taught about his own maleness or male identity. For most men, sexual assault is the ultimate humiliation. As a result, his sense of himself and his concept of reality is disrupted. This may include profound anxiety, depression, fearfulness and identity confusion. Withdrawal from interpersonal contact is likely to result and will heighten his sense of alienation. His relationship with a counselor is critical during this period.

Specific psychological problems may result from the assault. Counselors should be alert for the development of phobias specific to identifiable characteristics of the assault setting. Survivors are likely to show an increase in hypochondriacal (extreme depression or imaginary ailments) and stress-induced psycho-physiological reactions. The assault may also mobilize underlying paranoia and obsessive fear of bodily harm.

- **Sexual Identity Issues**—Men who have never felt any same-sex attractions may experience “homosexual panic,” fearing that the assault will make them become homosexual. A survivor may feel he is less of a man. While acknowledging these feelings, the counselor must consistently counter these ideas.

Men who have felt same-sex attractions are likely to believe that the assault was their own fault and that they are being punished and victimized because of these feelings. Extreme self-loathing and self-destructive behavior may result. The counselor must work to reduce this self-blaming.

Support Issues—It is very difficult for male sexual assault survivors to seek support from family and friends. Often, even if the survivor is willing or able to ask for support, the responses of others are often further damaging to his self-concept. The advocate can help the survivor decide who to talk to and arrange sessions with family members or collaterals when appropriate.

- **Relationship Issues**—The male victim’s primary relationships will almost certainly be disrupted by the assault and his reactions to it. The advocate must assess how best to assist him to maintain his relationships for the stability and support they can provide.
- **Emotional Issues**—It is extremely important for advocates to help male survivors work through the anger and hostility that could result from the assault. This is essential to help them rebuild their self-esteem and identity. Further, although research data to support the conclusion is sketchy, clinical evidence seems to indicate an increased probability of male survivors acting-out their anger in ways which later victimize others.
- **Safety Issues**—Other fears may result from the rape itself. Perhaps the assailant threatened the life of the survivor or his family to prevent the victim from making a report. Or perhaps the assailant coerced the survivor into silence through his position of power or authority. Survivors in institutions such as prisons or mental hospitals, the disabled and those receiving certain kinds of mental health counseling are particularly vulnerable to the coercion of authority figures.
- **Privacy Issues**—The survivor may also be uncomfortable with the need to report the details of his story so many times to so many different people during the reporting process. Or he may be unwilling to subject his family to the possibility of it becoming public information. Support and understanding on the part of family and friends and from medical and law enforcement personnel can greatly reduce the stress placed on survivors by these fears.

Reactions Of Family And Friends

The most important factor from the survivor’s point of view is to be believed. Lack of belief of the survivor’s story on the part of friends or family members is not only devastating to the survivor, but may cause irreparable damage to the relationship. It is very rare for people to make allegations about sexual assault that are untrue.

Because of the obsessive fear of homosexuality among many males in our society, some male friends and relatives may have a difficult time understanding that being a victim of rape is not related to a person's sexual preference. The survivor's sexual orientation does not cause the assault, and neither is there any evidence that an assault will have an effect on the future sexual preference of the survivor. Ironically, although males are the offenders in both cases, the fathers of female survivors often fear that sexual assault will cause their daughters to turn away from men, whereas fathers of male survivors seem to fear that their sons will turn toward men for sexual gratification.

Family and friends should try to remember that survivors of sexual assault may react very differently depending upon personality, life experience, the events surrounding the assault, and the reactions of significant others. Whatever the apparent reaction, survivors need time to heal; the trauma is often severe and may take months or years to resolve. Survivors may need not only emotional support, but also encouragement to take time to do whatever feels helpful to them to reduce feelings of stress. That may mean plenty of time alone with their favorite music, or enjoying natural surroundings, or it may mean plenty of supportive company. Allow the survivor to set the pace and determine his needs.

THE SEXUALLY ABUSED CHILD

Sexual abuse is defined in the Texas Family Code as any sexual conduct harmful to a child's mental, emotional or physical welfare as well as failure to make a reasonable effort to prevent sexual conduct with a child. A person who compels or encourages a child to engage in sexual conduct commits abuse, and it is against the law to make or possess child pornography, or to display such material to a child.



According to Planned Parenthood, child sexual abuse involves sexual contact—by force, trickery or bribery—where there is an imbalance in age, size power or knowledge. Contact can include fondling, obscene phone calls, exhibitionism, masturbation, intercourse, oral or anal sex, prostitution or pornography.

Sexual abuse may consist of a single incident or many acts over a long period of time. Boys and girls of any age can be victims of sexual abuse. The molester can be almost anyone, but most often is someone known to the child. The abuse may escalate over time, particularly if the abuser is a member of the child's own family. The child's non-abusing caregiver(s) may be unaware of the abuse or may be in a state of denial.

Child sexual abuse includes fondling, lewd or lascivious exposure or behavior, intercourse, sodomy, oral copulation, penetration of a genital or anal opening by a foreign object, child pornography, child prostitution, and any other sexual conduct harmful to a child's mental, emotional or physical welfare. These acts may be forced upon the child, or the child may be coaxed, seduced and persuaded to cooperate. The absence of force or coercion does not diminish the abusive nature of the conduct but, sadly, it may cause the child to feel responsible for what has occurred.

It is extremely difficult for a child to report sexual abuse. A very young child may not understand the abuse is not normal or accepted. More importantly, the abuser will do his or her best to keep the child from telling anyone about the abuse. The strategies for silencing a sexual abuse victim are as ruthless as they are varied. If the child depends upon and trusts the abuser, the offender may use the child's dependency and affection to extort a promise of secrecy. A more brutal perpetrator may threaten to harm and even kill the child or other family members or pets. Or the abuser may tell the child that the family will be broken up, the child blamed, or the child taken away from home if the secret becomes known. These are not altogether unrealistic fears for the child, unfortunately.

For many people, an allegation or disclosure of sexual abuse is indeed hard to accept. Many adults have a tendency to overlook, discount, minimize, explain away or simply disbelieve allegations of sexual abuse. This is particularly true when the perpetrator is a family member or an otherwise law-abiding, respectable and seemingly "nice," "normal" person.

Texas law (Texas Civil Statutes, Texas Family Code, Chapter 34, Sections 34.01 and 34.02, 1994) does require that any person who suspects child abuse must report it to either local/state law enforcement or the Texas Department of Protective and Regulatory Services (TDPRS) by calling 1-800-252-5400. The report may be made in writing, by telephone or in person. Those reporting an incident or participating in an investigation or court proceeding are immune from civil or criminal liability, unless that person acts in bad faith or malice. Medical and social services organizations are not exempt from this statute.

Physical Indicators Of Sexual Abuse

Sexual abuse may result in physical injury (though most often it does not). A child who is physically injured as a result of sexual abuse may display difficulty in sitting or walking, report pain when urinating or defecating, or complain of stomach aches. The child may report a discharge, pain or itching in the genital area. Injuries to a child's genitalia may or may not leave lasting marks; other physical evidence, such as semen, is certainly ephemeral. A child, therefore, needs to be examined as soon as possible if there is reason to suspect sexual abuse.

Specific Behavioral Indicators Of Sexual Abuse

A sexually abused child may make frequent expressions (e.g., verbal references, pictures, pretend games, etc.) of sexual activity between adults and children. Or the child may display more knowledge about sexual relations than someone that age likely would know. The child may masturbate inappropriately or compulsively. Behavior may be sexually suggestive or inappropriate or, conversely, the child may show infantile behavior or extreme fear of being alone with adults of a particular sex. A very strong indication that a child has been abused is that child's sexual victimization of other children.

Symptoms Of Emotional Injury

More generalized psychological impacts of sexual abuse include withdrawal, depression, sleeping and eating disorders, self-mutilation, phobias, and psychosomatic symptoms such as stomach aches and headaches. The child may develop school problems such as frequent absence or a sudden drop in grades. The child may exhibit either poor hygiene or excessive bathing. Older children may abuse alcohol or drugs, run away or adopt other self-destructive behaviors including suicide threats or attempts. Any or all of these behaviors can arise from causes other than sexual abuse. However, in

context, any one of them could be taken as a warning that some form of harmful sexual conduct has occurred or is still occurring.

Child Sexual Abuse Statistics

- In 1995, local child protective service agencies identified 126,000 children who were victims of either substantiated or indicated sexual abuse; of these, 75 percent were girls. Nearly 30 percent of child victims were ages 4–7. (Department of Health and Human Services, Administration for Children and Families, Child Maltreatment, 1995).
- Approximately one-third of all juvenile victims of sexual abuse cases are children younger than age 6. (Violence and the Family. Report of the American Psychological Association Presidential Task Force on Violence and the Family, 1996).
- According to the Justice Department, one of every two rape victims is under age 18; one in six is under age 12. (Child Rape Victims, US Department of Justice, 1992).
- While 9 out of 10 rape victims are women, victims also include men and boys. In 1995, among males age 12 and older, 32,130 were victims of rape, attempted rape or sexual assault. (National Crime Victimization Survey. Bureau of Justice Statistics, US Department of Justice, 1996).
- Teens 16–19 were 3.5 times more likely than the general population to be victims of rape, attempted rape or sexual assault. (National Crime Victimization Survey. Bureau of Justice Statistics, US Department of Justice, 1996).

SUBTITLE E. PROTECTION OF THE CHILD

CHAPTER 261. INVESTIGATION OF REPORT OF CHILD ABUSE OR NEGLECT

SUBCHAPTER A. GENERAL PROVISIONS

§ 261.001. Definitions

In this chapter:

(1) "Abuse" includes the following acts or omissions by a person:

- A. mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning;
- B. causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment in the child's growth, development, or psychological functioning;
- C. physical injury that results in substantial harm to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk of harm;

- D. failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child;
- E. sexual conduct harmful to a child's mental, emotional, or physical welfare;
- F. failure to make a reasonable effort to prevent sexual conduct harmful to a child;
- G. compelling or encouraging the child to engage in sexual conduct as defined by Section 43.01, Penal Code;
- H. causing, permitting, encouraging, engaging in, or allowing the photographing, filming, or depicting of the child if the person knew or should have known that the resulting photograph, film, or depiction of the child is obscene as defined by Section 43.21, Penal Code, or pornographic;
- I. the current use by a person of a controlled substance as defined by Chapter 481, Health and Safety Code, in a manner or to the extent that the use results in physical, mental, or emotional injury to a child; or
- J. causing, expressly permitting, or encouraging a child to use a controlled substance as defined by Chapter 481, Health and Safety Code;
- K. causing, permitting, encouraging, engaging in, or allowing a sexual performance by a child as defined by Section 43.25, Penal Code; or
- L. knowingly causing, permitting, encouraging, engaging in, or allowing a child to be trafficked in a manner punishable as an offense under Section 20A.02(a)(5), (6), (7), or (8), Penal Code, or the failure to make a reasonable effort to prevent a child from being trafficked in a manner punishable as an offense under any of those sections.

VICARIOUS TRAUMA AND SELF-CARE

VICARIOUS TRAUMA

...Those in the helping professions were often profoundly affected by their exposure to indirect trauma. Symptoms of post-traumatic stress can appear in some, even if they have not themselves been in danger or in the line of fire. They report experiencing intrusive images, nightmares and intense preoccupation with clients' stories, long after the encounters. Over time they may develop vicarious trauma – a shift in how they view the world: one terrible story (or thousands of them) may become deeply embedded in the soul, to the point where it changes their sense of safety and makes them more anxious or more fearful about specific situations. Vicarious trauma leads to a loss of innocence and interferes with our ability to enjoy daily living and connect with others.¹⁴⁹

It is helpful to explain what vicarious trauma is by first explaining what it is not. Two commonly confused conditions, "Compassion fatigue" and "burnout," are related, but not the same as vicarious trauma. Compassion fatigue refers to the emotional and physical exhaustion that develops over the course of a career when someone does not have ample opportunity to refuel and recharge. Compassion fatigue generally describes the loss of the ability to connect with clients as a result of

¹⁴⁹ Mathieu, F. (2014). Occupational hazards: compassion fatigue, vicarious trauma and burnout. *Canadian Nurse*, 110(5), 12-13.

having heard difficult stories that are similar, over and over. Compassion fatigue is not the same as vicarious trauma. Sometimes the term “burnout” can also be used when discussing issues surrounding vicarious trauma but burnout is also a distinct phenomenon. Burnout is the exhaustion and disconnected feeling that comes from feeling overwhelmed. Over a period of time the responsibility of helping one after another person in crisis can take its toll on the helper. The helper may find him or herself feeling over-stressed and as a result not being of much help to anyone. Burnout generally happens over time and can be improved with changing jobs or time off.

Secondary Trauma or Secondary Victimization are the terms most closely related to vicarious trauma. Vicarious trauma occurs when the ‘helping’ person is profoundly impacted by their work with traumatized individuals. The helper is traumatized and becomes the “secondary victim” of the original traumatic event. Professionals and volunteers in this field often find that the tragedies they are exposed to trigger memories and grief associated with losses and struggles in their own lives.

Vicarious Traumatization describes a transformation or fundamental shift in the advocate’s inner experience as a result of their empathic engagement with clients who are survivors of trauma. Vicarious traumatization is the result of an interplay between many things including an advocate’s personality, personal history, the social and cultural context within which the advocate operates, and the specific traumatic experience that a survivor has shared. One of the primary causes of traumatic stress is the feeling of powerlessness. This is true for the survivors we serve and it is also true for us. After working with survivors for some time, it is common to feel helpless to stop the violence, the suffering, or the intense pain that we witness. This feeling of powerlessness is linked to the traumatic reaction. Vicarious trauma disrupts how an advocate views themselves, others, and in general, how they view the world. It is important to remember that like all trauma, vicarious trauma impacts different people in different ways. Those who experience vicarious trauma often become preoccupied with the trauma that others have experienced. There are a number of signs and symptoms of vicarious trauma, and the following are just a few listed by The American Counseling Association:

- Becoming numb to the trauma in affected clients (avoiding talking or thinking about it)
- Being in a state of persistent arousal
- Difficulty falling or staying asleep or losing sleep over clients
- Worrying that one isn’t doing enough for clients
- Having difficulty talking about one’s own feelings
- Feeling hopeless regarding client-related work
- Diminished feeling of satisfaction
- Feeling trapped
- Having intrusive thoughts of clients’ trauma histories
- Developing outbursts of anger or becoming irritable
- Avoiding being alone
- Rejecting physical and emotional closeness
- Poor relationships and increased conflict
- Avoidance of working with clients with trauma
- Withdrawal and isolation

Vicarious trauma can impact a person's sense of safety, it can cause an increase in anxiety, and can make a person more fearful. It interferes with the ability to live life and connect with others and comes about as a result of being exposed to traumatic narratives combined with an over commitment or sense of responsibility to help those who have been traumatized. Vicarious traumatization does not require direct face-to-face encounters to occur – it has also been seen in those who work telephone and online counseling hotlines and were exposed to traumatic crisis calls. It might be easy to think of vicarious trauma as a “spreading” of trauma in the way that one thinks of a contagion being spread. Some people will be more susceptible and not everyone displays the exact same symptoms, but there are some commonalities in the exposure to trauma that will be seen in everyone – whether they are the person who directly experienced the trauma or they are the person who is providing help for a client and bearing witness to that client's trauma.

There are some factors which can contribute to an increased risk for vicarious traumatization such as having a personal history of trauma (especially in childhood), having caseloads with high percentages of clients with trauma histories, and being new to the field with fewer developed coping skills. Some of the factors which have been seen to help reduce the risk for vicarious traumatization are the good use of social supports and the use of positive coping strategies such as having supportive supervisors/mentors, being comfortable voicing concerns and anxieties, receiving training for working with clients who have experienced trauma, and practicing self-care which will be discussed in more detail in the next section.

Trauma affects not only those who themselves survive the trauma but it will also inevitably impact those who subsequently engage with that survivor as well. It is important for those who will be supporting any survivor to recognize the signs of vicarious trauma, to be given adequate training on the impact of trauma in the lives of survivors and how vicarious trauma occurs. It is also important that those who are working with survivors of trauma understand that vicarious trauma is a hazard of the work. They should be encouraged to mitigate it by seeking support within their organization and to not be afraid to seek help, ask for advice or collaboration on cases that are difficult – and they should not view asking for help or seeking support, in themselves or others, as a sign of weakness or an ‘inability to do the job.’

The flip side of vicarious trauma is compassion satisfaction or vicarious resilience. Despite the work being draining, it is equally satisfying and despite the trauma, there is a sense that one is able to have an impact on the world and make a difference. Compassion satisfaction or vicarious resilience can make the more challenging and difficult aspects of working with clients who have been traumatized easier to deal with. Fostering an environment where those who are working with clients know that their work is making a difference and receive gratitude from the organization is another possible way to buffer against the effects of vicarious traumatization.

SELF-CARE

Self-care is the active and intentional process of caring for one's physical, mental, emotional/spiritual health. Self-care is a regular practice of identification and reduction of stressors in one's life as well as the attempt to enhance overall well-being by achieving a balance across one's personal, social, and professional lives. Self-care is not something that happens to us. We must choose to engage in

behaviors, interact with others, and develop practices in our daily lives that not only allow for our current and overall health and well-being to be preserved, but to be enhanced. Continual and regular practice of self-care is necessary in order to minimize the stressors from working with those who have been traumatized (vicarious trauma) and to help maintain effective balance in our professional and personal lives.

The aim of self-care is not to simply identify or limit stressors in one's life but to enhance overall well-being. Specific self-care plans will vary from person to person as each individual will apply their self-care plans differently and will determine for themselves what domains they need to address. Each person will also find different activities or strategies to be beneficial. The important thing in self-care is to:

1. get to know yourself and what makes you feel stressed and what can be relaxing to you, AND
2. make a commitment to develop stress reduction skills in yourself, and encourage this in clients and colleagues, AND
3. come up with a plan of action, AND
4. act on this plan.

Self-care is a constant work in progress. Some questions to ask yourself when coming up with a self-care plan are:

- How do I cope with stress now? Are these good/helpful or negative/not helpful? One potential component of a self-care plan may be to decrease negative strategies and increase positive strategies.
- What do I do for self-care now? Are there any imbalances in the domains (i.e. physical, emotional/spiritual, mental, relationships)? Try and work towards achieving a balance in each domain.
- How do I maintain self-care? Are there currently any obstacles/barriers to my practicing self-care? Can I add any practices? How can I work around any obstacles/barriers? How will I stay on my plan?
- What is my emergency self-care plan? No one likes to think of emergencies but it is important to plan for a time when you may feel overwhelmed or may be facing a crisis.
- Can I make a commitment to myself? self-care is essential to your overall well-being and to your ability to give and to help others. You must first be healthy if you are to help others on their journey to become healthy. The success of self-care often depends on the level of commitment that one makes.
- Have I shared this plan with others? Who can I share my plan with?

The types of activities that can be considered self-care are varied. Some people may have more difficulties committing to certain domains like healthy eating or physical exercise and others may find it more challenging to take time for themselves. It is important to address the physical, mental, and emotional/spiritual sides of ourselves and to continue to maintain and foster the relationships with others. Being connected to others helps us to be resilient in times of stress. Developing activities which are grounding for us can help us to find ourselves in times when emotions may run high. Below is a template for a self-care plan which may help you think about self-care and the types of activities which you might engage in.

My Self-Care Plan

Name: _____

<i>Physical:</i>	<i>Mental:</i>
<i>Emotional:</i>	<i>Spiritual:</i>

Life Stressors:

Supportive Relationships

Techniques to Enhance Well-Being

My Goals

Part of your responsibility now that you are becoming an advocate is to keep yourself psychologically and physically healthy so that you can best serve the survivors that seek your help. Besides being aware of your own stress level, take steps to actively combat stress. Exercise regularly. Choose a type of exercise that you enjoy and do it regularly. Regular exercise acts as diversion to get your mind off stressful events. It also conditions your body to enable you to handle higher levels of stress.

Also allow yourself time to simply relax and get away from it all. Choose an activity that you enjoy doing that will help take your mind off of things. Meditation following exercise is a great practice in reducing stress. Watching T.V., playing cards, or simply reading may be important activities which will help revitalize and reenergize you and make you much more effective as an advocate.

You may not feel sympathetic to every survivor. You may not even like some survivors. Conversely, you may feel intense sadness and grieve for a survivor. We must not judge ourselves harshly for these reactions. Feelings are not always rational or within our control. We are, however, completely responsible for our behavior. We cannot become fixated on what we do and do not feel. We must focus our attention purposefully and direct our energy toward behaving in a compassionate and professional manner with every victim regardless of your feelings. Just as you do not attach judgment to clients, you must not attach judgment to the feelings that you, yourself, may experience.

Finally, you must make your own mental health a priority. You must know your limits, communicate about what you are feeling and learning as we experience these new situations, allow time for peace and relaxation, nurture intimate relationship with those who are important to you, seek opportunities to enjoy the things that lift your spirits and inspire you. You cannot give to others when you are empty.

SELF-PROTECTION

When speaking of self-protection, we must consider these facts:

- Sexual assaults are going to happen. An offender who wants to commit rape, eventually will find a victim.
- Many sexual assaults are unavoidable. Regardless of previous training and preparation, some people will face situations where the rape is going to occur.
- Rape victims DO NOT share any responsibility of the crime with the offender. The offender is 100 percent responsible for the rape.

With these facts in mind, self-protection can be viewed in three areas:

- Preventing the assault
- Avoiding the assault
- Surviving the assault

PREVENTION

True prevention work seeks not only to prevent oneself from being sexually assaulted, but to prevent the occurrence of sexual assault completely. This is accomplished by changing the current culture from one that produces rapists and tacitly supports rape (the rape culture) to a culture where rape would be an absurd notion and a non-occurrence.

The prevention of sexual assault is a lofty goal and is addressed in this manual in Chapter 3.

AVOIDANCE

The basic principle underlying avoidance and security measures is that the more difficult it is for a rapist to attack, the less likely it is that he will. There are no guarantees that he will not; it is simply a matter of increasing the odds in your favor.

The most widely known avoidance techniques are those associated with stranger sexual assault. They include things like not walking alone at night, locking your doors, and making sure friends or family know when to expect you home. While these are common sense safety measures, they do nothing to

protect you from the more likely perpetrator, the perpetrator who is acquainted with or known to the victim such as a neighbor, church leader, co-worker, teacher, or family friend.

Other widely known rape avoidance tips are the safety measures you might make when **dating**.

These may include:

- Find out as much as possible about your date, particularly if he is a blind date or someone you do not know well.
- Consider double-dating the first few times you go out with a male with whom you are not well acquainted.
- Know beforehand the exact plans for the evening and make sure a parent or a friend knows these plans and what time to expect you home.
- Communicate expectations by asking (do not guess) what your dates' or friends' desires are.
- Have ideas about the evening and communicate them clearly, verbally and non-verbally (body language). Be direct and do not hint.
- When appropriate, make and declare your choices about sex—what you will and will not do, what you expect from others, and say "yes" if you mean yes, "no" if you mean no.
- Be aware of your decreased ability to react under the influence of alcohol or drugs.
- Think carefully about leaving a party or a gathering with a male you do not know well- if you do leave with someone, be sure you tell another person you are leaving and with whom.
- Avoid out-of-the-way or secluded areas.
- Assert yourself when necessary; be firm and straightforward in your relationships.
- TRUST YOUR INSTINCTS- if a situation makes you uncomfortable, try to be calm and think of ways to remove yourself from the situation.
- Consider taking a self-defense course.

Assertive communication can play a role in rape avoidance. This requires relatively honest, clear and open communication between the sexes and we must begin with men and women talking to each other more frankly about sex, personal needs and limits. To be assertive means to express your ideas and needs clearly, to enforce your rights without violating someone else's, to disagree with others without putting them down personally, and to be direct and to speak up for yourself. An assertive statement is an honest expression of feelings, needs and rights said in your own words, a way of working out differences and having more honesty with others. The idea is not to win, but to work things out.

Unfortunately, the closer a perpetrator is to you, both physically and emotionally, the more challenging it will be to avoid a sexual assault. It is impossible to keep your guard up all the time, and when we are with people we know and trust, we let that guard down. Generally, letting your guard down with people you know and trust is safe, but perpetrators who are intent on assaulting or are opportunistic may take these moments and turn them to their advantage. These types of sexual assaults are the most difficult to avoid and often the most challenging to recover from as they represent both a sexual attack and a betrayal of trust.

Avoiding a sexual assault from a perpetrator who has the advantage of your trust is difficult. But remember, trust is on a continuum, you can trust someone a little or a lot and it's up to you to decide how much trust to give them. Consider that most sexual assaults occur when the victim is isolated and/or dependent on the perpetrator in some way. Your best weapon against rape may be your intuition. Be aware and alert—then trust your intuition. It is on your side. There are no guarantees and no rules you must follow, but if you do what feels right to you, your chances are very good.

RESISTANCE MEASURES

It is not always possible to avoid a rape situation. Even women who are careful to practice personal safety measures can be caught in a direct confrontation with a rapist. When confronted, many victims experience their body's natural fight, flight or freeze response. They may find themselves unable to speak or move, or they may find themselves flailing and unable to stop. These reactions are instinctual, lie deep within the brain and are meant to ensure survival. The rush of adrenaline that occurs during this response is what can make it difficult for many survivors to remember the assault in a linear way.

Some survivors are able to maintain their ability to think even during their body's survival responses, which allows them to consider resistance measures. It remains unknown what resistance measures would be most effective in every situation. If you are facing a rapist, you are the one who must choose what to do about it. In that situation, you know better than anyone else what your best choice is. Trust your intuitive feelings about what might work best in that situation.

Let your intuition be your guide. Usually your intuitive feeling about the best thing to do will be right. Remember that you did nothing to deserve this and surviving is the most important thing.

A word about self-defense training and carrying a gun:

Martial arts or self-defense training is helpful primarily because it increases a person's self-confidence and general physical condition. Martial arts training can increase your natural strength, quicken your responses and build up your own confidence in your abilities.

It cannot be emphasized too strongly that the aim of any self-defense strategy will be to escape from the situation. When speaking of self-defense, the goal is not winning a fight, or overpowering an attacker; it is about changing the situation to the extent that escape becomes possible. That may mean, in various situations, loosening his grip, getting him off balance, and/or distracting him or discouraging him (remember that a rapist is not looking for a fight, but for a victim).

There is also the question of whether a person should carry a weapon for their own defense. More and more people are choosing to do this. It is still a personal decision. For some, it is a moral issue, for some there is worry about possible accidents, especially if there are small children in the house. Whatever decision a person makes, it is important to understand that you cannot always depend on a weapon to save yourself from danger, and that if you choose to carry a weapon you should learn to use it and care for it correctly.

Summary

Remember that it is impossible to guarantee that you will never be sexually assaulted. There are common safety precautions that can be taken to help reduce the likelihood of an attack especially by a stranger or date. Yet many precautions will not protect you from an assault by someone who you know and trust. Your best weapon against rape may be your intuition.

VALUES, BELIEFS, AND BIASES THAT MAY IMPACT SERVICE DELIVERY

Unintentional revictimization – Revictimization may mean a couple of things. It can mean the survivor is sexually assaulted for a second (or third, or more) time. It can also mean the survivor experiences trauma from the response of family, friends and/or the ‘system’ that was meant to assist them. It is this second kind of revictimization, from the ‘helping’ professionals and advocates themselves that this section focuses on. This type of revictimization is sometimes called ‘secondary revictimization’ of the ‘second rape.’

Service providers that revictimize survivors often have the following characteristics:¹⁵⁰

- Belief in rape myths that blame the victim for the assault and which result in providers voicing doubt about the veracity of victims' accounts
- Neglecting to offer or outright denial of important services such as pregnancy testing, informing rape survivors about HIV-AIDS and other sexually transmitted diseases, and legal prosecution of the sexual assault
- The performance of services in ways that leave victims feeling "violated and re-raped" or which otherwise damage victims' psychological well being.

Unintentional victim-blaming¹⁵¹

“Even a victim service worker can fall into the trap of blaming the victim, especially if efforts to assist her have not been successful and the worker is feeling frustrated. Assaulted women, like all other people, are not perfect. You may find some of them unlikable. It may be tempting at times to believe that a woman’s choices are at least partly responsible for the assault. In order to provide effective assistance and emotional support to sexual assault survivors, you must examine your own values and beliefs.”

Values, beliefs, and biases

¹⁵⁰ Campbell, R., & Raja, S.R. (1999) *Secondary Victimization of Rape Victims: Insights from Mental Health Professionals Who Treat Survivors of Violence*. *Violence and Victims*, V. 14 (3). Summary available here: <https://mainweb-v.musc.edu/vawprevention/research/victimrape.shtml>

¹⁵¹ Sexual Assault: Victim Service Worker Handbook. Ministry of Public Safety and Solicitor General, Victim Services and Crime Prevention Division, January 2007. Available here: <http://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/victims-of-crime/vs-info-for-professionals/info-resources/victim-service-worker-sexual-assault.pdf>

Prejudices

- *Prejudice* is an attitude, opinion, or feeling formed about individuals or groups without adequate knowledge, thought, or reason.¹⁵²

Stereotypes

- A generalization, usually exaggerated or oversimplified and often offensive, that is used to describe or distinguish a group. Typically, the stereotype is a too-simple and therefore gives a distorted image of a group, such as "Football players are stupid" or "The English are cold and unfriendly people."

Discrimination

- *Discrimination*, a manifestation of oppression, is differential treatment that favors one group over another, including the denial or limitation of access to rights, goods, and privileges.¹⁵³

Judgments

- A judgment is a decision or opinion. Prejudices and stereotypes can negatively affect the judgments we make about others. For example, the stereotype that underemployed, African American men are more likely to be criminals, may lead you to making an inaccurate judgment about that person.

Oppression

- Oppression is a systematic phenomenon based on the values assigned to real or perceived differences between social groups. It involves institutional power, ideological domination, and the promulgation of the culture, logic system, and ideology of the oppressor group on the oppressed group. Derald Wing Sue and David Sue, *Counseling the Culturally Different: Theory and Practice* (1981).

-isms

- In a system of oppression, the dominant group gains the benefits, resources, and privileges of society at the expense of the oppressed group. Some of the many forms of oppression are racism, sexism, ageism, classism and heterosexism. The sexual assault advocate should be aware of various forms of oppression, for the "isms" are manifestations of the larger system and interconnected. For example, a survivor who is a lesbian of color may face discrimination because of both her race and her sexual orientation.

Values Clarification

The following exercise is provided as an example of a values clarification exercise. Values clarification exercises can be used to

¹⁵² Rita Hardiman and Bailey Jackson, "Social Oppression: An Operational System," in *Social Oppression and Diversity: Conceptual Framework* (Amherst, MA, 1982).

¹⁵³ *ibid*

- recognize that the issues surrounding sexual assault, sexual assault survivors and sex offenders are complex.
- recognize the varied beliefs, attitudes and opinions of others surrounding sexual assault issues.
- verbalize the reasoning behind opinions surrounding sexual assault issues, sexual assault survivors and sex offenders.
- identify an advocate's own beliefs and attitudes surrounding sexual assault, sexual assault survivors and sex offenders.

The object of the values clarification exercise is not to teach specific values, but to help advocates become aware of their own personally held values and of the way in which their values compared to others. It is hoped that, as this awareness increases, advocates will reconsider and perhaps modify poorly founded values while, at the same time, hold more confidently values which stand the test of review and comparison.

Materials: Flip Chart
Markers

I. Values Clarification

45 minutes

Materials: List of value statements (for facilitator only)

Signs that say: STONGLY AGREE
 AGREE
 DISAGREE
 STRONGLY DISAGREE

Masking tape
Paper
Pens or pencils

This exercise is designed to help participants clarify their opinions about different issues related to sexual assault. At the same time, it promotes sensitivity and respect for others' points of view.

Before starting the class, prepare signs with the following statements paste the signs in four corners of the room, across the blackboard or on a continuum along the floor or wall:

- STRONGLY AGREE
- AGREE
- DISAGREE
- STRONGLY DISAGREE

Begin this exercise by letting advocates know they are invited to participate in an opinion poll in which everyone will share their opinion, but will do so anonymously. Encourage them to be completely honest in their responses.

On a piece of paper, have students write their response – STRONGLY AGREE, AGREE, DISAGREE, STRONGLY DISAGREE—to the following statements:

After going through all the statements, ask the participants to crumple up their papers and invite them to “make a snowstorm” by tossing the papers around the room. Have them toss the papers at least three times, and remind them that if they happen to end up with their own paper, they should not announce that. (The idea here is to mix the papers up so no one knows who belongs to which paper.) Have fun! The paper they end up with after the last throw will become their ‘new’ opinion.

Have participants go to the corner of the room where the sign matching the response to the first statement on the paper they now hold is posted. Re-read the first statement. Invite participants to “own” the opinion on their paper (which may be different or the same as their own opinion) and to discuss it with others assembled under their sign. Remind them they are not to discuss their actual belief, but rather the one on their paper as if it were their own.

After a few minutes, invite one or two representatives from each group to share what they discussed. It may be a good idea to remind the group again that this is not the actual opinion of the person speaking, but rather the response that was on their paper. Repeat this process with each of the additional statements.

VALUES CLARIFICATION STATEMENTS

1. I love chocolate cake (warm up question)
 2. Victims of sexual assault should attend counseling.
 3. Sex offenders should have to serve a minimum of 10 years.
 4. Victims of sexual assault should have a SANE exam regardless if they want to prosecute.
 5. Perpetrators of sexual assault should be registered as sex offenders for life.
 6. Victims of sexual assault should be encouraged to report.
 7. It should be legal for a 14 year old and 18 year old to have sex.
 8. It is possible to completely recover from a sexual assault.
 9. Sex offenders can be cured.
 10. Sexual assault survivors do not lie.
 11. Men should be allowed to do hospital accompaniments.
- Bring the activity to a close by communicating that different people may have different attitudes and beliefs towards sexual assault.
 - Ask trainees how different values might affect one's approach to clients and how advocates can remain open to clients with differing values and beliefs.

Action Steps

The following is a list of values and beliefs that form the basis for effective work with survivors:¹⁵⁴

- No behavior of any survivor causes or justifies violence.
- No survivor ever deserves to be sexually assaulted.
- People do not ask to be sexual assaulted and do not get pleasure from being sexually assaulted.
- Different women experience different demands and expectations within their families and their communities. Your ability to provide effective support depends on your understanding of those demands and expectations, and your respect for each woman's experience.
- Many cultures value interdependence and cooperation among family members above independence and assertiveness. You need to be aware of your own attitudes about these values, and not project your particular values as the solution.

¹⁵⁴ Sexual Assault: Victim Service Worker Handbook. Ministry of Public Safety and Solicitor General, Victim Services and Crime Prevention Division, January 2007. Available here: <http://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/victims-of-crime/vs-info-for-professionals/info-resources/victim-service-worker-sexual-assault.pdf>

Section 5:

LOCAL PROGRAM INFORMATION

SEXUAL ASSAULT RESPONSE TEAMS

A Sexual Assault Response Team (SART) is a multi-disciplinary, interagency, sexual assault intervention system composed of public and private partners who form a team to employ a coordinated, collaborative response to sexual assault.¹⁵⁵

The SART model has become the standard for responding to victims of sexual assault. Models range from informal, cooperative partnerships to more formalized coordinated, multidisciplinary responses on local, regional, state, tribal, or territory levels. SARTs function in various ways and often provide a wide range of services.¹⁵⁶

Team Approach

SARTs are multi-disciplinary by definition. A collaborative, multi-disciplinary team that coordinates sexual assault response among all the key disciplines and agencies involved is the essential heart of SART. Given the multi-faceted nature of sexual assault and the range of institutions called into play by the crime, no one agency can do the job alone. Research suggests effective multi-disciplinary teams generate the best outcomes for each of the institutions involved, for the community, and for the victim.

Coordinated Response

Collaboration strengthens the response of individual agencies and unites them into a coordinated team approach. No one agency can successfully handle all aspects of a sexual assault. Each agency is important and has its strengths and limitations. Effective multi-disciplinary teams generate a stronger response and produce more effective outcomes for the victim and the criminal justice system. Coordinating the efforts of all the parties and agencies involved in sexual assault investigations may be the most important thing a jurisdiction can do to ensure that cases are handled, investigated and prosecuted expeditiously.¹⁵⁷

¹⁵⁵ Peterson, M., Green, W., & Allison, B. (2009) California SART Report: Taking Sexual Assault Response Team to the Next level. California Clinical Forensic Medical Training Center. http://www.calcasa.org/wp-content/uploads/2010/01/SART-Report_08.pdf

¹⁵⁶ Sexual Assault Response Team. Office for Victims of Crime. <http://ovc.ncjrs.gov/sartkit/about/about-sart-same.html>

¹⁵⁷ Maryland Coalition Against Sexual Assault's *Introduction to Sexual Assault Response Teams fact sheet* which was, in turn, taken and condensed from the California Coalition Against Sexual Assault's, California Sexual Assault Response Team (SART) Manual which was financially assisted through Grant Award Number RP98021578 from the California Office of Criminal Justice Planning (OCJP) and written by Marilyn Peterson, MSW, MPA.

Activities

In general, SARTs¹⁵⁸

- Support victims' rights.
- Commit to meeting victims' needs.
- Organize their service delivery to enhance evidence collection.
- Educate the community about available intervention and prevention services.

Benefits

Cases that involve SARTs¹⁵⁹

- Are reported more quickly.
- Have more evidence (in particular, DNA evidence).
- Are the strongest predictor that charges will be filed in sexual assault cases with adult female victims.
- Yield more evidence on average than cases in which no SANE or SART intervention occurs.
- Are more likely to lead to arrest than cases in which there is no intervention.
- Have personnel who keep victims better informed and engaged throughout the criminal justice process.

Core Members

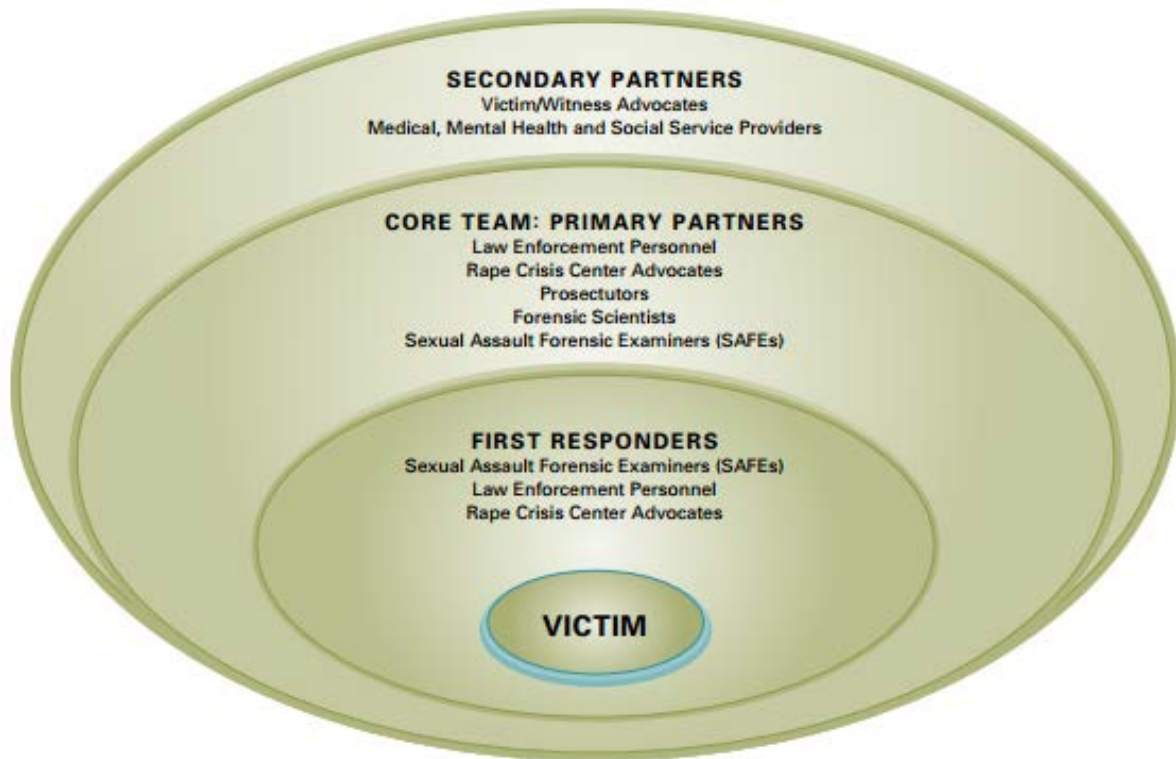
The fully multi-disciplinary SART can be visualized in four concentric circles with the victim at the center. The circle closest to the victim comprises first responders — law enforcement personnel, SAFEs, and rape crisis center advocates. First responders are a subset of the core SART or primary partners, which includes all five primary partners — first responders, plus forensic scientists and prosecutors.

The outermost circle, encompassing follow-up and ancillary services to the victim and the victim's important others, consists of secondary partners — victim/witness assistance, medical, mental health, and social service providers. This secondary set of partners — while not essential to basic SART operation — offers resources that, when well-integrated into the SART, promise to take SARTs to the next level by further enhancing recovery and justice for the sake of both victim and community.

At a minimum, the multi-disciplinary SART should consist of the five core, primary partners. Maximum effectiveness would likely require coordinated involvement with secondary partners as well.

¹⁵⁸ Sexual Assault Response Team. Office for Victims of Crime. <http://ovc.ncjrs.gov/sartkit/about/about-sart-same.html>

¹⁵⁹ Nugent-Borakove et al., *Testing the Efficacy of SANE/SART Programs: Do They Make a Difference in Sexual Assault Arrest & Prosecution Outcomes?*, 2006.



COMMUNITY-BASED ADVOCATES

Overview of community-based advocates

Community based advocates are typically employed by a non-profit organization whose mission includes assisting and/or empowering victims of sexual assault. The organization may be a stand-alone rape crisis center or it may be a dual domestic violence and rape crisis center program or the agency may provide services to many other types of individuals beyond sexual assault survivors. There is no set formula for what makes a community-based advocates, only that they are not employed by or acting on behalf of law enforcement, prosecutor's office or other agency whose mission is something other than assisting sexual assault survivors.

- Accompaniment under Code of Criminal Procedure, Article 56.045. The presence of a sexual assault advocate during a medical forensic exam is codified in Texas state law. In brief, state law provides survivors of sexual assault with the legal right to a rape crisis center advocate during the medical forensic exam. For more information, see Chapter 8: Role of an Advocate During the Sexual Assault Medical Forensic Examination.
- Confidential communications (Texas Government Code Section, 420.071). Texas law states that private conversations between a survivor and rape crisis center advocate are confidential. For more information, see Chapter 8.

Overview of services provided by sexual assault programs

A sexual assault program is defined in Texas statute as “any local public or private nonprofit corporation, independent of a law enforcement agency or prosecutor’s office, that is operated as an independent program or as part of municipal, county or state agency and that provides the minimum services to adult survivors of stranger and non-stranger sexual assault.”

- Minimum services. In order to be an official sexual assault program, an agency must provide the following five services. The Office of the Attorney General has published standards which defines and lists the required components of the service. Those Standards are provided at the end of this section.
 1. 24-hour crisis hotline
 2. Crisis Intervention
 3. Advocacy
 4. Accompaniment to hospitals, law enforcement offices, prosecutors’ offices, and courts
 5. Public Education

Other. Besides the minimum services, a sexual assault program may provide other services to sexual assault survivors. These may include: individual or group counseling, legal assistance, transitional housing, job training or a host of other services designed to support and empower survivors of sexual assault.

Importance of advocate presence during examination

Advocates play a key role during the medical forensic examination as the only individual present whose priorities are undivided and whose support for the survivor may continue past the time of the exam and into the unforeseeable future. SANEs, for example, may provide compassionate medical care and unbiased evidence collection, but their relationship with the survivor ends after the exam. Similarly, while law enforcement may be concerned with the well-being of the survivor, they also desire to investigate the assault to increase community safety. This admirable goal of community safety may lead them to pressing the survivor for information that he or she is not ready to share. The advocate is the only person who demands nothing from the survivor and can continue that relationship throughout the crisis and towards recovery.

Law enforcement's mission is to protect and serve the public, identify and apprehend perpetrators, investigate crimes, and prepare investigative reports. Their investigative objectives are to: determine if a sexual assault occurred; determine who is responsible; collect and preserve evidence; identify and apprehend suspect(s); arrest where probable cause exists; assist the State’s Attorney in the prosecution of cases; and provide testimony and evidence in court.

Health Care

- SANE. The role of the sexual assault nurse examiner is to provide compassionate medical care, conduct quality forensic sexual assault examinations and to provide exam findings to the law enforcement agency and/or District Attorney’s Office. SANEs offer victims prompt, compassionate care and comprehensive forensic evidence collection.

- Collaborating physicians and medical oversight. SANEs operate under the direction of a physician who provides general supervision as well as consultation on any medical issues. While the SANE may be ultimately responsible for the collection of forensic evidence and documentation of injuries, it is the physician who is ultimately responsible for the survivor's medical treatment.
- Health care agencies – Medical forensic exams are typically conducted in the *hospital* setting, but *community* or clinic based settings are growing more common. Community based health care allows for more prompt and focused attention on the survivor as opposed to a busy emergency room where the priorities of other patients sometimes must take precedence.

Forensic Scientist

- The crime laboratory analyzes and interprets evidence collected by medical and law enforcement personnel. Its objective is to provide information useful for identifying or eliminating persons suspected of committing the crime, and reconstruction of the events in question. *Some larger law enforcement departments have their own crime lab* and forensic scientists that test all of the evidence for that department. Smaller law enforcement departments generally utilize the *crime labs operated by the Texas Department of Public Safety*. At times, law enforcement departments and the Texas Department of Public Safety will contract out testing of evidence to a *private lab*. This is most often done when capacity at the lab is overwhelmed or when an urgent case requiring rapid or specialized testing is needed.

Prosecutors

- The role of the District Attorney is to prosecute violations of law. Cases are referred by the law enforcement agency in whose jurisdiction the crime occurred. Detectives investigate the case and submit a written report to the district attorney. The district attorney reviews the report and decides whether or not to file criminal charges. If charges are filed, the district attorney's office prosecutes the case on behalf of the state. The survivor will be called as a 'witness' to the crime. It is important to remember that the prosecutor is not the survivor's attorney, but rather the prosecutor is the state's attorney. The survivor may work closely with the prosecutor, but the survivor does not have the ability to decide if the case moves forward or stops.

ADDITIONAL TEAM MEMBERS

System advocates are typically employees of a law enforcement department or prosecutor's office. Their job, within the confines of the law enforcement department or prosecutor's office, is to provide information and support to crime victims. They cannot provide confidentiality to crime victims as they may be required to provide information that is important to an investigation or prosecution to the investigator or prosecutor.

Every law enforcement department in Texas is required to appoint a person as the **Crime Victim Liaison** who's job responsibilities include ensuring victims of crime are aware of their statutory rights

as crime victims. These rights include the rights granted by the Texas crime victims' bill of rights, receiving information about crime victims' compensation, the return of property that was used as evidence. Texas law also requires that a **Victim Assistance Coordinator** be appointed in each District Attorney's Office whose duty is to ensure that victims are afforded the rights granted to them by state law. In particular, the Victim Assistance Coordinator should ensure that they victim receives and is given the opportunity to submit a victim impact statement to be considered by the court during sentencing.

Pre-hospital providers. Emergency responders, such as paramedics or fire fighters, may be the first people who are able to provide assistance to a survivor after a sexual assault. These professionals typically have extensive training on providing emergency medical care to a survivor as well as working with traumatized persons. Their inclusion on a SART team may provide interesting opportunities for cross training regarding caring for a patient without destroying potential evidence.

Correctional staff. While increased focus on prison rape has occurred over the past 10 years, the issue is still often ignored. Inviting correctional staff into the SART team will provide opportunities to learn about providing sexual assault support services within the correctional framework and can be an opportunity for needed resources to these isolated survivors.

Culturally specific organization representative. Some survivors of sexual assault will reach out to culturally specific organizations first, before reaching out to a rape crisis center. This is not surprising as it is well understood that when persons are feeling vulnerable, unsure and in need of assistance they will reach out to others that they feel most comfortable with, even if that person or organization is not the 'expert.' Making connections with Asian, African American, LGBT and other culturally specific organizations will build bridges between your agencies and make it easier for survivors to receive the assistance they need.

Sex offender management professionals. While working with sex offender management professionals may seem counter intuitive, a common goal is shared by survivors, advocates and sex offender management professionals...that the sex offender will stop offending. Participation of the sex offender management professional on the SART may allow for sharing of information about current offender management practices.

Policy makers. Including policy makers on a SART is a good opportunity to build knowledge and trust between SART members and policy makers. When an issue arises that requires a policy solution, then the policy maker will have a built in knowledge base to work from. If a public policy issues arises for the policy maker, they will know what experts to turn to.

Child Advocacy Centers. The Child Advocacy Center will already be a part of a multi-disciplinary team whose members will be very similar to the SART, but when community issues regarding sexual assault at large are considered, the CAC can be a valuable member of a SART.

State public health services. Survivors of sexual assault are often seen in public health clinics across the state. In addition, public health clinics provide services for free or at reduced rates that many survivors of sexual assault may benefit from, e.g. STD testing and follow-up care. In addition, the

Department of Family and Protective Services (DFPS) is over Child Protective Services which investigates instances of child abuse, including sexual abuse, of children by caretakers. Likewise, the **Department of Aging and Disability Services** (DADS), is over Adult Protective services which investigates instances of abuse, including sexual abuse, against the elderly and disabled. Incorporating representatives from these organizations on your SART will provide an avenue for information as well as build bridges between these service organizations.

Schools and universities. Universities are hot spots for sexual assault and have received attention and scrutiny over the last several years. Schools and universities can be guilty of not addressing sexual violence on their campuses for fear of the negative public attention it may bring. Sadly, this resulted in survivors of sexual assault being re-victimized by these educational institutes. By coordinating with schools and universities, SART teams can help provide the resources needed to support survivors of sexual assault on campus.

SEXUAL ASSAULT PROGRAM POLICIES/PROTOCOLS FOR PROVIDING MINIMUM SERVICES

In 2016, the Office of the Attorney General began requiring specific standards for five minimum services as a requirement for grant funding. These minimum services are listed in Chapter 420 of the Texas Government Code and include:

- 24-Hour Crisis Hotline
- Crisis Intervention
- Advocacy
- Accompaniment to Hospitals, Law Enforcement Offices, Prosecutor's Offices and Courts
- Public Education

The intent of the standards is twofold:

1. To ensure that every survivor in the state of Texas has access to a minimum level of consistent services regardless of demographic characteristics or location in the state; and
2. To provide a formalized framework for describing and defining the components of each of the five minimum services that must be provided by sexual assault programs in Texas.

24 - HOUR CRISIS HOTLINE

- The SAP must maintain a 24 Hour Crisis Hotline for survivors of sexual violence to provide immediate, confidential, non-judgmental support, crisis intervention, information and referrals.
- A 24 Hour Crisis Hotline means a telephone line answered 24 hours a day, 7 days a week by trained Sexual Assault Program (SAP) staff/volunteers.
- The Hotline number must be accessible to the public via the SAP's website and in public directories that cover the SAP's service area, if available.

- Where advertised, the Hotline indicates 24 hour availability and specifies 'sexual assault' or indicates the hotline provides assistance to survivors of sexual assault.
- SAPs must ensure employees/volunteers provide 24 Hour Crisis Hotline services subject to confidential communication requirements in the Texas Government Code, Chapter 420, Subchapter D.
- Hotline calls must be answered immediately either by a SAP employee/volunteer or a 3rd party answering service and connected to a trained SAP employee/volunteer within 5 minutes. Hotlines must have at least one bypass feature in place to accommodate more than one call at a time (busy signal and call-waiting features do not satisfy the bypass feature). Bypass calls must be answered or returned by a trained SAP employee/volunteer within 15 minutes.
- SAP employees/volunteers providing 24 Hour Crisis Hotline services shall complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
- SAP employees/volunteers providing 24 Hour Crisis Hotline services must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexual violence.
- Hotlines must be equipped to respond to callers who are deaf, hearing impaired or with limited English proficiency.
- SAPs must maintain a current resource/referral list responsive to individuals affected by sexual violence.
- SAP employees/volunteers answering the Hotline must have the current resource/referral list in their possession.
- The SAP must regularly evaluate the 24 Hour Crisis Hotline and, as needed, make adjustments based on the findings.

CRISIS INTERVENTION

- SAPs must provide Crisis Intervention to survivors of sexual violence.
- Crisis Intervention means an immediate, supportive response in order to reduce acute distress, to begin stabilization, and to assist in determining next steps.
- Crisis Intervention must be provided by trained SAP employees/volunteers.
- The SAP must provide Crisis Intervention 24 hours/day, 7 days/week via the 24 Hour Crisis Hotline and via Accompaniment to Hospitals, Law Enforcement Offices, Prosecutor's Offices and Courts.
- SAPs must ensure employees/volunteers provide Crisis Intervention subject to confidential communication requirements in the Texas Government Code, Chapter 420, Subchapter D.
- The SAP must provide Crisis Intervention on a walk-in basis during the SAP's regular hours of operation.
- The SAP employee/volunteer providing Crisis Intervention must complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.

- SAP employees/volunteers providing Crisis Intervention must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexual violence.
- SAPs must maintain a current resource/referral list responsive to individuals affected by sexual violence.
- SAP employees/volunteers providing Crisis Intervention must have the current resource/referral list in their possession.
- The SAP must regularly evaluate Crisis Intervention services and, as needed, make adjustments based on the findings.

ACCOMPANIMENT TO HOSPITALS, LAW ENFORCEMENT OFFICES, PROSECUTORS' OFFICES, AND COURTS

- Sexual Assault Programs (SAPs) must provide Accompaniment to Hospitals, Law Enforcement Offices, Prosecutors' Offices and Courts.
- Accompaniment to Hospitals, Law Enforcement Offices, Prosecutors' Offices and Courts means in-person support, assistance and provision of information about crime victims' rights during the survivor's interaction with medical or criminal justice professionals at hospitals, law enforcement offices, prosecutors' offices, and courts. To qualify as an Accompaniment to a Hospital a minimum of 45 minutes must be spent with the survivor.
- Accompaniment to Hospitals, Law Enforcement Offices, Prosecutors' Offices and Courts must be provided by trained SAP employees/volunteers.
- The SAP must provide hospital Accompaniment services for survivors of sexual violence for a sexual assault medical forensic exam 24/hours day, 7 days/week.
- SAPs must ensure employees/volunteers provide Accompaniment subject to confidential communication requirements in the Texas Government Code, Chapter 420, Subchapter D.
- SAP employees/volunteers must provide Accompaniment services until they are no longer needed by the survivor.
- The SAP must dispatch an employee/volunteer to provide Accompaniment to a hospital within 15 minutes of receiving a request.
- The SAP must have a system in a place to accommodate multiple or overlapping requests for Accompaniment to a hospital.
- SAPs shall initiate, lead or be a key participant in a sexual assault response team. A sexual assault response team includes, at a minimum, the following core members who are first responders as identified in the Office for Victims Crime SART Toolkit: community-based advocates, law enforcement, and forensic medical examiners including sexual assault nurse examiners.
- SAP employees/volunteers providing Accompaniment must complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
- SAP employees/volunteers providing Accompaniment must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexual violence.

- The SAP must regularly evaluate Accompaniment services and, as needed, make adjustments based on the findings.

ADVOCACY

- Sexual Assault Programs (SAPs) must provide Advocacy to survivors of sexual violence.
- Advocacy means providing assistance on behalf of a survivor of sexual violence with third parties (e.g., schools, employers, law enforcement agencies, housing authorities, healthcare professionals, prosecutor's offices, CVC).
- Advocacy must be provided by trained SAP employees/volunteers.
- The SAP must provide Advocacy 24 hours/day, 7 days/week via the 24 Hour Crisis Hotline and via Accompaniment to Hospitals, Law Enforcement Offices, Prosecutor's Offices and Courts.
- The SAP must provide Advocacy on a walk-in basis during the SAP's regular hours of operation.
- SAP employees/volunteers must orient survivors of sexual violence to their constitutional and statutory rights and assist survivors in securing those rights.
- SAPs must ensure employees/volunteers provide Advocacy subject to confidential communication requirements in the Texas Government Code, Chapter 420, Subchapter D.
- SAPs shall initiate, lead or be a key participant in a sexual assault response team. A sexual assault response team includes at a minimum the following core members who are first responders as identified in the Office for Victims Crime SART Toolkit: community-based advocates, law enforcement, and forensic medical examiners including sexual assault nurse examiners.
- SAP employees/volunteers providing Advocacy must complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
- SAP employees/volunteers providing Advocacy must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexual violence.
- The SAP must regularly evaluate Advocacy services and, as needed, make adjustments based on the findings.

PUBLIC EDUCATION

- The Sexual Assault Program (SAP) must provide Public Education to increase knowledge of the dynamics of sexual violence, its causes and consequences, and of services available through the sexual assault program.
- Public Education means workshops, speaking engagements, and distribution of printed materials.
- SAP employees/volunteers must provide Crisis Intervention, information and referral to individuals making a sexual assault related outcry at Public Education events.
- SAP Public Education must use accurate information and statistics with citations.

- SAP Public Education must include efforts to identify survivors of sexual violence that might not otherwise be reached (i.e., underserved or marginalized populations) and refer them to services.
- Public Education must be culturally and developmentally appropriate to the audience.
- Public Education must be intentionally inclusive of underserved and marginalized populations.
- SAP employees/volunteers providing Public Education must complete training that meets the OAG's Sexual Assault Training Program Certification Requirements contained in the OAG's Sexual Assault Training Program Certification Guide.
- SAP employees/volunteers providing Public Education must be supervised by a SAP staff member with at least one year experience providing direct services to survivors of sexual violence or providing Public Education.
- The SAP must regularly evaluate Public Education and, as needed, make adjustments based on the findings.

Section 6:

MEDICAL FORENSIC EXAMINATIONS FOR THE COLLECTION OF EVIDENCE

The medical forensic exam is an examination of a sexual assault patient by a health care provider, ideally one who has specialized education and clinical experience, to treat and diagnose a victim of sexual assault while also collecting evidence of the crime.

The examination includes gathering information from the patient for the medical forensic history, documentation and care of injuries, collection of evidence, and evaluation and treatment for sexually transmitted Infections (STIs) and pregnancy prevention. The exam is referred to as the “forensic medical examination.”

The immediate collection of forensic evidence is extremely important in sexual assault cases. It can mean the difference between a conviction and a dismissal—or even failing to identify the perpetrator at all. Evidence a perpetrator leaves behind after a sexual assault is especially vulnerable to contamination or being washed away. An immediate sexual assault exam allows for the collection of corroborating evidence to support a victim’s allegations in the criminal justice system.

- While all emergency rooms are required to have medical professionals who are prepared to conduct a medical forensic exam, many communities have designated medical facilities or clinics with Sexual Assault Nurse Examiners (SANEs) on-call to provide the highest quality medical forensic exams. Research indicates there is “preliminary ‘proof’ that facilities with SANE programs provide for a substantial improvement over traditional hospital ED services.”¹⁶⁰ The Texas Department of State Health Services maintains a list of ‘designated’ hospitals for medical forensic exams in Texas. To view the list, go to: <https://www.dshs.state.tx.us/hfp/#assault> and scroll down to [Community Wide Designated Hospitals for Sexual Assault Survivors](#).

Traditionally, medical forensic exams were only provided to and conducted on sexual assault survivors who wanted to **report** the crime and pursue criminal charges. On the surface, this process made sense, why collect evidence if it was not going to be used in an investigation? Yet, survivors

¹⁶⁰ Campbell, R., Patterson, D. & Licty, L. (2005). The effectiveness of sexual assault nurse examiner (SANE) programs: A review of psychological, medical, legal, and community outcomes. *Trauma Violence Abuse*, vol 6, no 4, 313-329. <http://tva.sagepub.com/content/6/4/313.abstract>

often need time to prepare themselves before reporting since criminal investigations and prosecutions are often invasive and exhausting. Important evidence was lost.

Non-report sexual assault examinations balance the needs of the victim and the criminal justice system by allowing survivors to preserve important evidence to use against their attackers and still take the time they need to decide whether to report. If a sexual assault victim is not ready to get police involved, she or he still has the option to have a sexual assault examination conducted. No police report is required. Victims who are unsure about reporting their attack to authorities may seek more information about the reporting process from their local sexual assault prevention and assistance programs. These programs provide survivors with support, confidential services, and an advocate to accompany victims to the emergency room.

Any victim of sexual assault who does not wish to involve the police can receive a non-report exam, as long as she or he:

- is at least 18 years old,
- arrives at the medical facility within 96 hours (4 days) of the assault, and
- consents to the exam. If a child (anyone younger than 18) has been sexually assaulted, that MUST be reported to law enforcement under Texas' mandatory reporting laws.

The Department of Public Safety will store any evidence collected during a non-report sexual assault exam for two years from the time it is collected. If the survivor has not reported the assault at the end of two years DPS will destroy the evidence. DPS will also pay for the forensic portion of the exam. The non-reporting sexual assault survivor IS eligible for reimbursement of medical costs associated with the medical forensic exam (but only for the exam, not follow up treatment) through Crime Victims' Compensation.

EMERGENCY ROOM PROTOCOL

Few other criminal offenses require as extensive an examination and collection of evidence as a sexual assault. Additionally, except for an occasional assault case, no other crime collects as much evidence from a live person.

While a potentially fatal object (e.g., bullet, knife, etc.) may be removed from someone and taken to the forensic lab for analysis, that person is not required to submit to the same intrusive exam as a survivor of sexual assault. So, it is not unreasonable to assume that having your physically body gone over with a fine tooth comb, your blood and saliva samples taken, your fingernails scraped and every orifice that has already been violated swabbed with cotton on a stick can be a distressing experience.

Traditionally, the prosecution of adult and child sexual assault cases has been difficult. The survivor often is the only witness to the crime. The examination, collection of physical evidence and the documentation of physical injury may be necessary either to substantiate an allegation or to help strengthen a case for court. Evidence from the offender and the crime scene often may be found on the body and clothing of the survivor. When immediate medical attention is received, the chances increase that some type of injury or physical evidence may be found. Conversely, the chances of finding injury or physical evidence decrease in direct proportion to the length of time which elapses between the assault and the examination.



The examination and collection of physical evidence in sexual assault cases has fallen to physicians and nurses in hospital emergency rooms and pediatric units. The role of medical personnel in this process often can be the key to successful prosecution and can help to promote early emotional recovery for the survivor.

FACILITY & PERSONNEL

It is advantageous for all survivors of sexual assault to seek both medical treatment and evidence collection from a health care facility. Physicians who work primarily in private office-based facilities usually do not have evidence collection kits on hand and may not be as familiar as hospital-based physicians and nurse examiners with the specific medical and evidence collection procedures relevant to sexual assault survivors. Additionally, many private medical offices are not open on a 24-hour basis, and may not have equipment available to document injuries. However, Texas has many areas in which no hospital is available for 100–200 miles. If that is the case, the facility used **MUST** have adequate equipment available to collect evidence and treat the injuries incurred. The facility should be chosen in consultation with local law enforcement and the local sexual assault program.

The use of Sexual Assault Nurse Examiners (SANEs) to do the forensic examination and collection of evidence is encouraged as an alternative to a physician. SANEs are registered nurses who have completed special training in the forensic examination procedures and issues surrounding sexual assault.

Ideally, adults should be treated in medical facilities designated for such treatment. Children should be treated in a pediatrics unit, if available, because staff in these units are specially trained to treat them. The ideal situation for children is a local child advocacy center if your community has one. However, regardless of who examines and treats the survivor or where the examination occurs, he/she should be specially trained in the examination, recognition and collection of evidence and administering to the special needs of a sexual assault survivor. The Office of the Attorney General, Sexual Assault Prevention and Crisis Services Program can recommend training specifically for this purpose. (512) 936-1270.

PAYMENT

Texas law (Texas Code of Criminal Procedure, Art. 56.06) requires that the law enforcement jurisdiction investigating the reported sexual assault is responsible for the payment of medical examinations and collection of evidence in connection with the investigation or prosecution of a sexual assault. In cases when the survivor chooses to undergo a medical forensic examination without police involvement, the Texas Department of Public Safety is responsible for the cost of evidence collection (Texas Code of Criminal Procedure, Art. 56.065). In all cases, survivors may be billed for medical treatment separate from evidence collection, but Texas Crime Victims Compensation is available to reimburse those medical costs.

Medical facilities designated to provide sexual assault treatment should have 24-hour emergency ability with staff trained in sexual assault examinations. The local sexual assault program should be called in to serve as an advocate for the survivor. The ideal situation would also include the on-call availability of a specialty physician if needed for consultation and contingency plans for cases requiring photographs and bite mark impressions.

TRANSFER

At hospitals that are not designated or equipped to provide sexual assault examinations, arrangements can be made to transfer survivors to the nearest designated treatment facility, if the survivor wishes. Keep in mind that every transfer and examination of the survivor can destroy evidence. Whenever possible, attempts should be made to preserve evidence when examining, treating or transferring the survivor. However, if there are acute medical or psychological injuries which must be treated immediately, this should be done at the initial receiving facility. A copy of all records, including X-rays taken, should be transported with the survivor to the designated treatment facility. All medical facilities receiving federal funds including Medicare and Medicaid payments are prohibited from refusing treatment or transferring any survivor whose condition is not stable. (Consolidated Omnibus Budget Reconciliation Act [COBRA]; Sections 9121, 1888 (a)(1)(i), 1866(a)(1)(1), 1867; 1985.)

Transfer plans should be developed in conjunction with other treatment facilities in the immediate and surrounding community, and the list of designated medical facilities should then be provided to all local law enforcement agencies and sexual assault programs. This action will greatly reduce the amount of confusion and additional trauma incurred by those survivors who are initially taken or referred to a non-treatment facility and reduce the loss of valuable evidence.

In addition, as of September 1, 2013 all Texas emergency departments are required by law to have personnel equipped with at least basic training on forensic evidence collection and to provide medical forensic examinations. (Texas Health and Safety Code §§ 323.004-323.0045). According to the Texas Board of Nursing, all Registered Nurses who work in an Emergency or who may float into an Emergency room must complete a two hour Forensic Course which is available on-line. For the reasons described above, treatment by a certified sexual assault nurse examiner is encouraged whenever possible. However, if a survivor is unable or unwilling to travel to a facility with a SANE, the survivor has the legal right to decline a transfer and to obtain a medical forensic exam where she or he is.

MEDICAL INTAKE

The treatment of victims of sexual assault should be considered a medical emergency. Although many survivors may not have visible signs of physical injury, they will, at the very least, be suffering from emotional trauma. The Information Sheet for Sexual Assault Survivors, available here: <https://www.dshs.state.tx.us/hfp/docs/SexAssaultPatientEng.pdf>, should be provided to all survivors when they arrive at the emergency room.

A private location within the designated medical facility should be utilized for the preliminary consultation or admission with the survivor. This could be a room adjacent to the emergency department or a private office located nearby. In order to prevent others from hearing the conversation, it is recommended that this same type of privacy be provided for any follow-up law enforcement interview at the conclusion of the examination.

While the survivor is being treated at the designated medical facility, the responding officer should wait some place other than in the examining room. In some jurisdictions, police protocol calls for the officer who accompanies the survivor to the hospital to also conduct the follow-up investigation. Officers in these departments should remain at the hospital until the examination is complete (or return to the hospital if they need to patrol) before making arrangements to conduct the more in-depth interview with the survivor.

Over the past several years, many hospitals have developed coding plans, such as "Code R", "Code 5", or "SA" which they use when referring to a sexual assault case. This eliminates the needless embarrassment to survivors and/or their families of being identified in the public emergency or examining room setting as the 'rape' or 'sexual assault' survivor. Other methods can be devised to avoid inappropriate references to sexual assault cases, and designated medical facilities are encouraged to develop their own sensitive coding plans to ensure privacy.

General guidelines for the medical history include the following:

- The history collection conducted by the examiner must be held in a private setting which is free of outside interruptions.
- Consideration should be given to the possible need or request by the survivor or by the advocate on behalf of the survivor for an advocate in the room. The person conducting the examination is also required by law to offer the presence of an advocate to the survivor. (Texas Code of Criminal Procedure, Art. 56.045)

REPORTING

The examiner should be empathetic and understanding of the survivor's trauma, while at the same time efficient in collecting all information necessary for effective treatment.

The examiner should establish rapport as an ally of the survivor and try to cushion the survivor from pressures by family, friends, and other medical personnel.

The survivor should be asked only those questions necessary to discover information that will assist the examiner in making a plan of care, diagnosis and treatment of the survivor which includes evidence collection.

Texas law has affirmed that the privacy and choice for the survivor is of paramount importance, therefore, there is no law in Texas that requires an adult sexual assault survivor to report the assault, (other than some disabled or elderly persons). If no report is made, the survivor is still eligible for CVC reimbursement of medical costs arising from the initial ER visit, but no other expenses may be covered by CVC unless the survivor reports to police and cooperates with the investigation. Many hospitals have policies that direct emergency room staff to notify law enforcement whenever any person involved in criminal activity, as survivor or perpetrator, seeks treatment. If that is the case, adult sexual assault survivors shall be given the courtesy and choice of whether they wish to receive a medical forensic exam with or without making a police report. **A report to law enforcement CANNOT be required as a condition of receiving a medical forensic examination.**

When the survivor chooses not to report, sexual assault programs and law enforcement personnel might encourage the survivor to file an Information Report or Third Party Report. It is very important to the investigation of other cases that law enforcement have all available information even if the survivor does not choose to report the crime. In any event, the survivor should still receive medical treatment and the respectful and sensitive treatment accorded to those who do choose to report.

If the survivor does report the sexual assault, the law enforcement jurisdiction investigating the case is responsible for the cost of the examination to collect evidence. If the survivor does not report at the time of the examination, the Texas Department of Public Safety is responsible for the cost of evidence collection. Appropriate forms for submitting evidence from non-report exams and billing can be found here: <https://www.txdps.state.tx.us/CrimeLaboratory/NRSA.htm>

Texas law (Texas Family Code § 261.101) requires that any person who suspects child abuse must report it to either Texas Child Protective Services or the local or state law enforcement. The reports should be made by calling 1-800-252-5400 or online at www.txabusehotline.org. Those reporting the incident or participating in an investigation or court proceeding are immune from civil or criminal liability, unless that person acts in bad faith or malice. Medical and social services organizations are bound by this statute.

Cases involving minors who are abused by someone other than a caretaker fall under the same procedures as adult survivors.

SUPPORT PERSONNEL

The importance of having a support person available to sexual assault survivors cannot be over-emphasized. Whenever possible, one person should be assigned to be available throughout the medical and evidence collection procedure visit and preferably the entire system.

Well-trained support persons can provide the immediate crisis intervention necessary when survivors first enter the designated medical facility for treatment; they can assist hospital medical staff in explaining the necessity of medical and evidence collection procedures; and they can advise family members or friends of the survivor who may be at the hospital. A support person can also help provide counseling referrals and other information, such as the existence and availability of Crime Victim Compensation or other types of assistance, emphasize the importance of follow-up testing for possible venereal disease or other medical problems, and answer additional questions survivors may have following their medical evidence collection examinations. They are also able to provide support for the survivor throughout the criminal justice process.

As a result of the dedication of women and men involved in the issue of sexual assault, many hospitals have entered into working agreements with sexual assault programs. The Office of the Attorney General encourages all hospitals to incorporate the notification of sexual assault advocates into their treatment protocol just as they do law enforcement agencies. Early crisis intervention and support can help reduce re-victimization and start the survivor towards recovery.

PATIENT/SURVIVOR CONSENT

Obtaining a survivor's written consent prior to conducting a medical examination or administering treatment is standard medical practice. With the advent of evidence collection requirements and crisis intervention services, sexual assault survivors are expected to make a decision about consent to these procedures, as well.

Informed consent should be a continuing process that involves more than obtaining a signature on a form. When under stress, many survivors may not always understand or remember the reason for or significance of unfamiliar, embarrassing and sometimes intimidating procedures. Therefore, all procedures should be explained as thoroughly as possible, so that the survivor can understand what the attending medical personnel are doing and why.

Although much of the examination and evidence collection process can be explained by the designated medical facility support person or advocate, this function is ultimately the responsibility of the attending medical personnel.

When written consent is obtained, it should not be interpreted as a blank check for performing tests or pursuing questions. If a survivor expresses resistance or non-cooperation, the medical personnel should immediately discontinue that portion of the process and consider going back to it at a later time in the examination, if the survivor then agrees. In either event, the survivor should have the right to decline one or more tests or to decline to answer any question. Having a sense of control is an important part of the healing process for survivors, especially at the early stages of examination and initial interviewing.

It is important to remember that consent to have a support person or advocate present must be given by the survivor prior to the introduction of that person. Also, at any time throughout the treatment and evidence collection process, the survivor should be able to refuse further interaction with the designated support person and/or request that the support person leave.

Consent to conduct a medical examination and collect physical evidence should be obtained from parents/guardians of all children under the age of 18. However, Texas law provides that an examination may be done in cases of suspected child abuse or suicide prevention with the consent of the minor only, court order or on the opinion of the physician in emergencies. Examination may not be done if the child is 16 or older and refuses to consent or if consent is refused by a court order. (Texas Family Code § 32.005). Hospitals should follow their usual procedures for obtaining consent in extraordinary cases, e.g., for the severely injured or incoherent survivor.

SEXUAL ASSAULT EVIDENCE COLLECTION KIT (RAPE KIT)

The Texas Evidence Collection Protocol, as designated by Chapter 420, Government Code, requires sexual assault evidence collection kits to contain items to collect and preserve evidence of a sexual assault or other sex offense.

Required Kit Contents

- Crush-proof box
- white envelopes
- 3 frosted-ended glass slides with new/unused pap smear mailers
- 2 small narrow tooth combs
- purple-top blood tubes;
- 1 red- 10cc blood tube nail file or pick
- 4 swabs for each (Minimum swabs per area)
 - vaginal
 - oral
 - rectal
 - 2 body surface areas
 - TOTAL SWABS: 16
- 2 plain envelopes for any other evidence that needs to be included

Recommended Equipment

In addition to the sexual assault examination kit, the following equipment may be needed:

- urine specimen containers
- Wood's lamp – UV light
- large paper bags
- catheter marking pens
- manila envelopes (preferred)
- white table paper
- sterile water for irrigation

- disposable powder free gloves
- scissors
- forms
- sharpened lead pencil
- blood tubes
- scotch tape
- Colposcope
- sterile test tubes
- hemocult slide
- spot light
- GC culture media
- forced air dryer (fan driven)
- vaginal speculum (sm., med., lg.)
- chlamydia media ruler (with cm measurements)
- pipettes

Packaging

Kits can be made from materials readily available at most medical facilities or purchased commercially. If a kit is purchased commercially, the cost should be approximately \$20.00 each. Kits should be packaged in a crush proof box for transportation to the forensics lab.

In order to prevent the loss of hairs, fibers, or other trace evidence, clothing and other evidence specimens must be sealed in paper or cardboard containers because moisture remaining in the evidence items will be sealed in, making it possible for bacteria to quickly destroy biological fluid evidence. Unlike plastic, paper breathes, and allows moisture to escape. Biological evidence should never be packed in plastic. However, this does not mean that evidence may be packaged wet in paper. All items should be actively air-dried, without heat, before packaging.

Every item submitted to the forensic lab for analysis must be labeled as to site (e.g., vaginal, oral, rectal, penile, etc.), name of survivor, date and examiner's initials.

EVIDENTIARY AND MEDICAL EXAMINATIONS

A physical examination should be performed in all cases of sexual assault, regardless of the length of time which may have elapsed between the time of the assault and the examination.

Some survivors may ignore symptoms which would ordinarily indicate serious physical trauma, such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices. Also, there may be areas of tenderness which will later develop into bruises but which are not apparent at the time of initial examination.

If the assault occurred **within the 96 hours prior to the examination**, then an evidence collection kit should be used. The time line of 96 hours is not absolute. It is a guideline. Medical and law enforcement should evaluate each case after that time individually.

If it is determined that the assault took place more than **96 hours prior to the examination**, the use of an evidence collection kit may not be necessary. It is unlikely that trace evidence would still be present on the survivor. However, evidence may still be gathered by documenting any findings obtained during the medical examination (such as bruises or lacerations), photographs and bite mark impressions (if appropriate) and statements about the assault made by the survivor. These observations and findings should be documented on the report form.

When a medical forensic examination is performed, it is important that the medical and evidence collection procedures be integrated throughout. This coordination of medical and forensic procedures is crucial to the successful examination of sexual assault survivors.

For example, in order to minimize trauma, blood drawn for medical purposes, if indicated (pregnancy, syphilis, HIV) should be done at the same time as blood drawn for evidence collection purposes. However, please note that most Emergency Rooms will not test for sexually transmitted diseases due to the lack of follow-up capabilities of the Emergency Room. Most emergency rooms have protocols that treat the survivor prophylactically for sexually transmitted diseases and pregnancy. The survivor is usually given a list of clinics in which follow-up for HIV testing can be completed with proper follow up and counseling services. Also, when evidence specimens are collected from the oral, female sexual organ or anal orifices, cultures for sexually transmitted disease should be taken immediately following these collection procedures, when indicated.

Attending Personnel

The only people who should be with the adult survivor in the examining room are the examining medical personnel, any translator needed and, (with the consent of the survivor and attending medical personnel) a specially trained advocate. Every effort should be made to limit the number of people in attendance during the examination. Every person in the room can be considered a witness to the procedure and therefore called to testify in court.

It is not necessary for a law enforcement representative or child protective agency representative to observe evidence collection procedures to maintain the chain of evidence or custody. This is the function of the attending medical personnel.

Subjecting sexual assault survivors to the observation of law enforcement personnel during this process as well as having the law enforcement representative privy to the private communications between the survivor and the examining/support team is an invasion of the survivor's privacy and is an unnecessary practice.

Presence of Parent/Guardian

Since children many times will tell health professionals information they may not tell in the presence of parents or other adults, adolescents and older children should be encouraged to provide much of their own medical history, as appropriate. This interview should be conducted in a private area, and

information regarding sexual history (of both males and females), menstrual history and use of birth control should be recorded. Encourage the child to be interviewed alone (without parent or guardian) if it does not cause too much stress for the child.

The child and the child's parents/guardians should be informed about and prepared for the physical examination by the medical personnel. They should also be told what specific lab tests will be done, the purpose of each test and when the results will be available.

If a parent or guardian is present, the purpose of the interview should be explained in a straight-forward manner, and cooperation should be elicited to reassure the child that it is safe to talk with the interviewer. The parent/guardian should also be told that any facial expressions of shock, disbelief or disapproval or any verbal or physical signals to the child could impede the investigation.

Under no circumstances should the interview be held in the presence of a parent/guardian who is suspected of perpetrating the abuse.

Preserving the Integrity of Evidence

The custody of any evidence collection kit and the specimens it contains must be accounted for from the moment of collection until the moment it is introduced in court as evidence. This is necessary in order to maintain the legally necessary chain of evidence; sometimes called chain of custody, or chain of possession. **Therefore, the number of people who handle evidence should be minimized, and anyone who handles evidence items should label them with their initials, the date, source of the specimen, the name of the attending medical personnel and of the survivor. All outside containers should be sealed with an integrity seal.**

DNA Examination of Sexual Assault Evidence

Research in the last few years has revealed new options for identification in criminal investigations. The analysis of cellular biological materials for DNA (Deoxyribonucleic Acid) has greatly enhanced identification possibilities of criminals. DNA (chromosomal material) contains the genetic code of an individual and if sufficient quantity of DNA exists in a given sample, that individual may be identified by DNA comparisons (e.g., comparing blood from a suspect with blood left at a crime scene, etc.). This technique of identification can be helpful in a sexual assault investigation where the survivor cannot identify her/his assailant. DNA is found in blood, saliva, hair (containing hair root with root sheath), tissue and bone marrow.

DNA is also found in spermatozoa and can be readily used for identification of an individual provided sufficient sample is available. However, **a lack of spermatozoa is not conclusive evidence that an assault did not occur it only means that spermatozoa may have been destroyed after being deposited or that it may never have been present.** Offenders may use a prophylactic, have a low sperm count (frequent with heavy drug or alcohol use), ejaculate somewhere other than in an orifice or on the survivor's clothes or body, or penetration could have been by an object other than a penis. There could also have been a significant time delay between the assault and the collection of specimens. The survivor could have inadvertently cleaned or washed away the semen, or the specimens could have been collected improperly.

Throughout the examination, the attending medical personnel explains to the survivor why questions are being asked, why certain medical and evidentiary tests may need to be performed and what treatment, if any, may be necessary.

1. Vital signs and other initial information, such as the date and time of both the examination and the assault, are recorded.
2. A brief description of the details of the assault is recorded. This description includes any oral, rectal or vaginal penetration, whether the assailant penetrated the survivor with finger(s) or foreign object(s), whether any oral contact occurred, and whether ejaculation occurred (if known). The survivor's account of what happened is recorded accurately, briefly and in the survivor's own words.
3. Gynecological history information including menstrual history (last menstrual period, date and duration, menstrual cycle), pregnancy history (including evaluation of possible current pregnancy) and contraceptive history is evaluated and recorded. In survivors at risk for pregnancy, a pregnancy test is done to establish a baseline for possible pre-existing pregnancy.
4. During the general physical examination, all details of trauma are recorded, such as bruises, abrasions, lacerations, bite marks, blood or other secretions, with particular attention paid to the genital and rectal areas of both male and female survivors. Common sites and types of injury, even if not yet visible, include the breasts, the upper portion of the inner thighs, grab or restraining marks on the neck, side of the face, arms, wrists or legs, and injuries or soreness to the scalp area, back or buttocks as a result of being thrown against an object or onto the ground.

CLOTHING EVIDENCE

Frequently, clothing contains the most important evidence in a case of sexual assault. The reasons for this are as follows:

- Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hairs and fibers as well as debris from the crime scene. While foreign matter can be washed or worn off the body of the survivor, the same substances often can be found intact on clothing for a considerable length of time following the assault.
- Drainage of ejaculate from the vaginal or anal cavities may collect on the panties/underwear, especially with a child survivor. Although bacterial action and breakdown does occur in this environment, it happens at a slower rate than in the body cavities. After 3–6 hours, usable semen evidence, if present, is more likely to be found on the survivor's undergarment than on vaginal or anal swabs. For a child, undergarments are very important, and parents should be encouraged to bring in the child's underwear.

- Damaged or torn clothing may be significant. It may be evidence of force and can also provide laboratory standards for comparing trace evidence from the clothing of the survivor with trace evidence collected from the suspect and/or the crime scene. Any item of clothing worn during the assault or prior to the examination may need to be collected.

In the process of criminal activity, different garments may have contact with different surfaces and debris from both the crime scene and the assailant. Keeping the garments separate from one another permits the forensic scientist to reach certain pertinent conclusions regarding reconstruction of criminal actions. For example, if semen in the female survivor's underpants is accidentally transferred to her bra or scarf during packaging, the finding of semen on those garments might appear contradictory to the survivor's own testimony in court of exactly what events occurred in the assault.

Therefore, each garment should be properly labeled and placed separately in its own paper bag to prevent cross-contamination from occurring.

Prior to the full examination, great care must be taken by the attending medical personnel to determine if the survivor is wearing the same clothing she/he wore during or immediately following the assault. If so, the clothing should be examined for any apparent foreign materials, stains or damage. When the determination has been made by law enforcement personnel that items may contain possible evidence related to the assault, **with survivor consent** those items should be collected.

If it is determined that the survivor is not wearing the same clothing, the attending medical personnel should inquire as to the location of the original clothing, such as at the survivor's home or at the laundry for cleaning. **This information should then be given to the investigating officer so that arrangements can be made to retrieve the clothing before any potential evidence is destroyed.** If this clothing was worn before and/or during the assault, trace evidence may be found. Semen may also be found if the assailant ejaculated outside the survivor's body. Any briefs, trunks, sanitary napkins, panty liners, diapers or tampons worn by the survivor for the period of up to 24 hours after the assault should be obtained as they may contain semen or other evidence.

To minimize loss of evidence, the survivor disrobes over a white cloth or sheet of paper. If survivors cannot undress on their own, and because of their condition it is necessary to cut off items of clothing, the examiner does **not cut through** existing rips, tears, or stains. The white cloth or sheet of paper is then folded, placed in an envelope and placed in the evidence collection box. This ensures that even the tiniest particle of evidence that could have fallen while the survivor is disrobing is collected.

Any foreign materials found are collected and put into a small paper envelope, properly labeled and sealed with cellophane tape. If the survivor consents, the clothing is then collected and packaged.

SWABS AND SMEARS

Smears are made to allow the forensic analyst to test microscopically for the presence of spermatozoa. If they are present, the analyst will then proceed to use the swab(s) to identify the seminal plasma components and attempt to identify the donor population based on genetic markers.

Depending upon the type of sexual assault, sperm or sperm particles may be detected in the mouth, vagina and rectum. However, embarrassment, trauma or a lack of understanding of the nature of the assault may cause a survivor to be vague or mistaken about the type of sexual contact which actually occurred. Because of these reasons, and because there also can be leakage of semen from the vagina or penis onto the anus, even without rectal penetration, it is recommended that the survivor be encouraged to allow examination of all three orifices to determine the specimen collection indicated.

When taking swabs, the examiner takes special care not to contaminate the individual collections with secretions or matter from other areas, such as vaginal to rectal or penile to rectal. Such contamination may unnecessarily jeopardize future court proceedings.

If survivors must use bathroom facilities prior to the collection of these specimens, they should be instructed to do so in a bedpan so that any evidence can be collected from the discharge, if needed.

Oral/Collection Procedures

The oral smear can be as important as the vaginal or rectal smears. The purpose of this test is to recover spermatozoa/seminal fluid from recesses in the oral cavity where traces of spermatozoa could survive. This test should be done first, so that the survivor can rinse out her or his mouth as soon as possible. Such a practice will reduce a significant source of unnecessary survivor distress. Oral washings should be restricted to facilities where immediate laboratory analysis can be performed. If washings are utilized, the oral swabs and smears should be performed prior to the washings.

After the procedure is completed, the survivor rinses her/his mouth out with clear water. The survivor should not eat, drink or smoke for 30 minutes. At that time, the saliva sample will be taken to check for secretor status.

Vaginal/Collection Procedures

Vaginal/cervical specimens are collected on four cotton swabs by swabbing the vaginal vault and cervical cuff, but retained in two ways: one specimen is an air-dried smear on a frosted-end slide from the swabbing, the second is retained on the cotton swabs themselves.

The examiner checks for any contraceptive or sanitary device that may be left in the vagina. These are retained for evidence. If a sponge or diaphragm is removed before the prescribed time, morning after treatment should be considered. Any device that is removed should be air dried, packaged in an envelope and labeled as to contents, source, name, date and personnel.

In special cases a vaginal wash or aspirate will be used instead of cotton swabs. No more than 1 cc of normal saline/sterile water should be used if a vaginal wash/aspirate is used instead of swabs. The wash should then be placed on a cotton swab and air-dried. If the specimen is obtained in this way, it should be properly labeled as such and packaged in a cardboard tube as other specimens.

Note that under certain circumstances a semen-free vaginal swab may have to be collected from the survivor at a later time in order for the laboratory personnel to interpret genetic marker results in blood specimens. If this is the case, laboratory personnel will notify the appropriate medical personnel.

At the time of the vaginal exam, if a SANE nurse is performing the collection, her or she may or may not use a colposcope to help with the viewing of the vaginal tissue. This equipment is used regularly by SANE examiners due to its ability to magnify, green filter the tissue and take pictures of injuries. The colposcope allows the SANE to pick up on tiny lacerations found on the victim for evidence. Remember though a survivor can have no injuries on the vaginal tissue, this does not mean that the assault did not happen.

Immediately following this procedure, the pelvic examination should be performed and medical cultures taken, if indicated.

Penile/Collection Procedures

For the male survivor (both adult and child), the presence of saliva on the penis could indicate that oral-genital contact was made; the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal vault; and feces or lubricants might be found if rectal penetration occurred. Vaginal secretions cannot reliably be identified microscopically or chemically. However, attempts can be made to detect genetic markers foreign to the male survivor and consistent with the suspect.

The proper method of collecting a penile smear is to use two lightly moistened cotton swabs to thoroughly swab the external surface of the penile shaft and glands. All outer areas of the penis and scrotum where contact is suspected should be swabbed.

These swabs are not, however, for use in the medical diagnosis of a sexually transmitted disease; therefore, they are not to be used to swab inside the penile opening.

It is at this time that swabs should be made for detection of possible sexually transmitted disease, if indicated.

Anal/Collection Procedures

The examiner ensures contact is only with the rectum during the collection procedure. After preparing the slide from the swab, it is placed in the cardboard mailer, allowed to air dry, then labeled and sealed.

The colposcope may also be used for the anal exam for its magnification purposes and picture taking should the SANE feel that it is necessary to help document injuries for the evidence collection.

At this time, any additional examinations or tests involving the anus should be considered.

Other Dried Fluids/Collection Procedures

Saliva, blood and semen are the most common secretions deposited on the survivor by an offender. These secretions can be analyzed by laboratories to aid in the identification of the perpetrator.

It is important that the medical team ask the survivor where any bodily fluid deposits might be and examine the survivor's body for evidence of foreign matter. A swab should be taken for each secretion.

BITEMARK EVIDENCE

Bite marks may be found on survivors as a result of sexual assault and other violent crimes and should not be overlooked as important evidence. Bite mark impressions can be compared to the teeth of a suspect and can sometimes become as important, for identification purposes, as fingerprint evidence. The collection of saliva and the taking of photographs of the affected area are the minimum procedures which should be followed in cases where a bite mark is present.

Saliva, like semen, demonstrates blood group factors characteristic to the person they came from. Therefore, the collection of saliva from the bite mark should be made prior to the cleansing or dressing of a wound. If the skin is broken, swabbing of the actual punctures should be avoided when collecting dried saliva. Instead, just the area directly surrounding the bite marks should be swabbed.

It is important that photographs of bite marks be taken properly. It is recommended that a local law enforcement agency representative be contacted when the hospital protocol is developed, to provide the proper instructions on how to take photographs of bite mark evidence. A ruler should be used to document the size of the bite mark in the photograph.

If the exam is being performed by a SANE nurse, you will notice that the SANE will take pictures if Law Enforcement is not available or the exam is a non-report exam. Bite-marks, bruises and ligament marks are usually well documented with the Crimes Against Person's division from law enforcement and they usually want to obtain and document their own pictures for the case.

HAIR EVIDENCE

During an assault, hairs may be transferred from one individual to the person or clothing of the other or to the crime scene. Other hairs transferred during an assault are pulled out by friction or other means of forcible removal.

These hairs can be microscopically compared to known hair samples from both individuals to determine the origin. Head and pubic hairs are the only hairs on the body that have enough individual characteristics for this type of analysis. Hair characteristics are affected by many factors including stress, diet and hair care products. Time delay in the collection of hair samples of the survivor may adversely affect future comparisons.



Combings

Where there is evidence of semen or other matted material on pubic or head hair, collect it by clipping around the matted area and place the sample in a separate white paper envelope and label it matted hair sample from head (pubic) area. It is important to obtain the **survivor's permission** prior to cutting any significant amount of hair. If the sample cannot be cut, it may be collected in the same manner as other dried fluid. The swab is then placed in a small paper envelope and labeled as described above.

The top, back, front and sides of the survivor's head hair should be combed over a piece of paper to collect all loose hairs and fibers. Put the combings and the comb into a folded paper and place in an envelope marked head hair combings, complete the labeling information and then seal the envelope with tape.

A second comb is used to collect any loose hairs or fibers from the pubic area over a piece of paper or paper towel. **Survivors may prefer to do the combing themselves to reduce embarrassment and increase their sense of control.** Fold the pubic hair combings and the comb into the paper and place in a second envelope marked pubic hair combings. After the labeling information is completed the envelope is sealed with tape. Combing is done vigorously and thoroughly to lessen the chance that valuable evidence may be missed.

Pulled Standards

There is a division of opinion among professionals as to the value of hair comparison evidence to successful prosecution, as weighed against the discomfort of the survivor whose known hairs are collected. Each elected district attorney should make a determination whether comparison hair evidence should be collected and when it should be collected and inform their respective medical and law enforcement personnel accordingly.

If your jurisdiction chooses to collect pulled hair standards, care should be taken prior to collection to inform the survivor of the procedures which will be used and why it is being collected at that time. Every effort should be made to reduce the discomfort and stress of the examination to avoid further traumatizing the survivor. Evidence should never be taken without the informed consent of the survivor. If pulled hair standards are to be collected, the following procedures should be followed.

The combing of the survivor's head and pubic hair will remove any foreign hairs which then can be compared to pulled hairs from the survivor and the suspect. It is necessary that the pulled hairs possess roots for a complete and accurate comparison. These collection procedures can be performed by the survivor.

Additional hairs may be needed at a later time. The absence of pubic or head hairs should be noted.

If the survivor shaves his/her public area, wet to dry swabs are usually collected in the event that evidence is present in this area. The box is labeled as pubic area and placed in the collection box.

FINGERNAIL SCRAPINGS

The purpose of collecting fingernail scrapings is to collect potentially useful evidence of cross-transfer. During the course of a physical crime, the survivor will be in contact with the environment as well as with the assailant. Trace materials, such as skin, blood, hairs, soil and fibers (e.g., from upholstering, carpeting, blankets, etc.) can collect under the fingernails of the survivor.

The survivor is asked whether he/she scratched the offender's face, body or clothing. If so, or if fibers or other materials are observed under the survivor's fingernails, the nails are scraped, one hand at a time, using an orange stick, plastic pick, any appropriate hard pointed implement or a small cotton swab lightly moistened with sterile water to clean under the finger nails. This swab would need to be dried prior to packaging. This procedure is at the medical and law enforcement personnel's discretion.

This is a procedure that survivors may want to perform themselves, and they should be encouraged to do so. Scrapings are made for each hand over a separate piece of paper. The paper is folded and placed in small, individual envelopes along with the pick.

The examiner completes the labeling information for each envelope making certain to differentiate between left and right hand on the labels. The flaps are then sealed with tape.

WHOLE BLOOD SPECIMEN

Any semen found on the clothing or in the body cavities of the survivor is likely to be mixed with her/his body fluid (e.g., vaginal secretions, saliva, etc.). Therefore, a blood sample must be collected from the survivor to determine the contribution of her/his genetic markers to the mixture or unidentified stains.

Note that under certain rare circumstances a semen-free vaginal swab may have to be collected from the survivor at a later time in order for the laboratory personnel to interpret genetic marker results. This would entail the survivor abstaining from intercourse for one week then having a vaginal swab collected by a medical professional.

SALIVA or Buccal SPECIMENS

In the ABO analysis of secretion mixtures, such as semen and vaginal secretions, the ABO type of the survivor must be identified in order to evaluate properly the blood type of the other contributor. A dried sample of known saliva and the known liquid blood sample are used to determine the ABO secretor status of the survivor.

It is important that this specimen not be contaminated by outside elements. Therefore, the survivor should not smoke or have anything to eat or drink for at least 30 minutes prior to this procedure. For the comfort of the survivor, this part of the evidence collection is done first, so that the survivor can rinse out their mouth and drink water if need be.

Specimens can be collected by either swabs that are placed in the survivor's mouth, or the examiner can swab the mucosa on the inside of the survivor's cheek. If using the swabs that are placed in the mouth Survivors are reminded not to chew the swabs; moistening them for a few seconds is usually sufficient. Survivors are instructed to remove the swabs with their own fingers. **The swabs must not be removed by anyone other than the survivor unless a hemostat or a clean gloved hand is used, because the slightest contamination from another person's secretions may be detected by the forensic analyst.**

OTHER DOCUMENTATION

Body Diagrams

Photographs of sexual assault survivors **are not the only form of documentation**. Instead, a drawing of the human figure is used to show the location and size of the injury as well as a written description of the trauma. Outlines of adult, child and infant figures, contain genitalia for males and females, are included in all kits and will be utilized by the medical professional to document injuries.

Photographs

Photographs of extremely brutal injuries and of bite marks can prove quite beneficial in court; however, many times injuries, such as bruises, will become apparent only after several days. There is no guarantee that photographs will develop to show the actual severity of the injury. Once taken, photographs can be subpoenaed into evidence.

Therefore, any photographs which are taken should be limited to those instances where there is an opportunity to produce clear pictorial evidence of injury, such as bruises or lacerations. If photographs are taken, they should be done **only with the specific consent of the survivor**.

Further, **photographs should not be taken of the genital areas unless the survivor specifically gives permission for this procedure**. Again, drawings accompanied by accurate written descriptions can be as effective in court as photographs.

Finally, it is vital that a competent camera operator take all photographs, preferably of the same sex as the survivor, and that a ruler and color chart be used to indicate the size and nature of each injury. If the examiner is not the one taking the photographs, the examiner should remain in the room while the photographs are being taken.

Toxicology Blood/Urine Screen

Some hospital protocols include the routine procedure of testing for the presence of alcohol and other drugs in the systems of sexual assault survivors.

Blood/urine screens for determining toxicology are done in the following situations in cases of sexual assault:

- If the survivor or accompanying person (such as a family member, friend or police officer), states that the survivor was involuntarily drugged by the assailant(s),
- AND/OR if in the opinion of the attending medical personnel, the survivor's medical condition appears to warrant toxicology screening for optimal care.

Great care should be exercised to ensure that toxicology screens are not routine for survivors of sexual assault.

Routinely, if a urine is obtained in the emergency room, it is for pregnancy testing only. The labs in the emergency room are not sensitive enough to detect date rape drugs that may have been used prior/during the assault. If a survivor suspects that they were drugged a urine is obtained in a special cup and sent to the DPS lab with the evidence collection kit.

PROCEDURES FOR RELEASE OF EVIDENCE

Preliminary Procedures

When all evidence specimens have been collected, they are placed back into the kit, making certain that everything is properly labeled and sealed.

The original copy of the sexual assault forensic examination form is to be maintained at the facility where the exam was completed. The second copy is for the law enforcement officer to take and the third copy is included in the kit. All copies should be legible.

All required information is filled out on the top of the kit just prior to sealing it with red or orange evidence tape at the indicated area. The completed kit and clothing bags are kept together and stored in a safe area. Paper bags are placed next to but not inside the complete kit.

All medical and forensic specimens collected during the sexual assault examination must be kept separate in terms of collection and processing. Those required only for medical purposes should be kept and processed at the examining medical facility, and those required strictly for forensic analysis should be transferred by law enforcement with the evidence collection kit to the crime laboratory for interpretation.

Transportation of Evidence

Under no circumstances should survivors be allowed or expected to handle evidence after it has been collected. Only a law enforcement official or duly authorized agent should transfer physical evidence from hospitals to law enforcement departments or crime laboratories. In order to inhibit deterioration and assure the best possible test results, kits should be refrigerated immediately and kept so until transported.

Release of Evidence

Evidence collection items should not be released from a medical facility without the written authorization and consent of the informed adult survivor, or an authorized third party acting on the survivor's behalf if the survivor is unable to understand or execute the release. An authorization for release of information and evidence form should be completed, making certain that all items being transferred are checked off. Besides obtaining the signature on this form, signatures must be obtained from the medical facility staff person turning over the evidence as well as the law enforcement representative who picks up the evidence.

One copy of the release form should be kept at the medical facility and the other copy given to the law enforcement representative. This representative should also print and sign her or his name on the cover of the collection kit and bags of clothing and fill in the time of transfer.

Non-authorization of Release

Although most sexual assault survivors consent to have their evidence specimens released to law enforcement subsequent to the medical examination and evidence collection process, there may be a few instances when a survivor will not authorize such a release. Medical facilities and/or law

enforcement personnel should not react negatively to a survivor's initial decision not to release evidence. They should inform the survivor that the release of evidence is not a commitment to prosecute. Although the lack of authorization on the date of collection could later be questioned if the case goes to court, such reluctance can be explained easily and is not considered by prosecutors to be a serious problem.

If consent is not initially received, kits and clothing bags can be stored on a temporary basis in a locked, secure area. To retard spoilage, kits should be refrigerated for up to two weeks, if possible, before being destroyed. If refrigerated storage is not available, the evidence should remain sealed and be placed in a secure cool dry place. (Although some medical facilities have limited storage and/or refrigeration facilities, space should not present any major problem since the number of actual cases in which release is not authorized is very low). Hospital personnel and/or the survivor's advocate must inform survivor of the length of time the evidence will be held prior to destruction, thereby providing the survivor with an opportunity to reconsider authorization for release within a reasonable period of time after the initial hospital examination. It is the responsibility of the law enforcement agency to contact the survivor to inquire about any change of decision.

Although there have been instances where a parent or guardian, acting on behalf of the child, has refused to authorize the release of evidence to law enforcement, the actual incidence of this has been very low. Since child abuse must be reported, the parent/guardian does not have a choice in whether the evidence is released to the law enforcement agency.

POST-EXAMINATION INFORMATION

Information Brochures

The Office of the Attorney General has developed an informational brochure about sexual assault. These brochures can be helpful in explaining to survivors some of the common problems they may encounter, such as disturbances in sleeping or eating patterns, flashbacks of the attack, and post-traumatic stress syndrome. They also provide reassurance to the survivor that sexual assault survivors are not responsible for the assault. Copies of the brochure are available from the hospital, local sexual assault program or Office of the Attorney General, Sexual Assault Prevention and Crisis Services Division.

Arrangements should be made to provide a copy of such publications to sexual assault survivors and their families when they leave the hospital. Many kits come with this prepackaged.

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for sexual assault survivors. Before leaving the hospital, the medical facilities portion of the information booklet mentioned above should be completed. The type and dosage of any medication prescribed or administered should be recorded in the section provided.

Many medical facilities report that most sexual assault survivors do not return to the facility for these follow-up tests. Denial of the assault or of the need for follow-up testing, especially if no unusual

symptoms are experienced and inadequate information provided by many medical facilities concerning the necessity for follow-up treatment are common reasons for a failure to return.

Survivors should be encouraged to obtain follow-up tests, if needed or indicated, for possible pregnancy, sexually transmitted disease and urinary tract or other infections within four to six weeks after the initial hospital visit. It is vital that both written and verbal information be provided, including the locations of public health clinics or referrals to private physicians for medical follow-up. Most emergency rooms do not provide follow-up visits. Advocates can be helpful in explaining the need for the survivor to follow up with their primary doctor or a community resource/clinic for further testing if needed. Parents of children need to be reminded of the importance of following up with the child's pediatrician within a week for follow-up examination.

Another section of the booklet is used to record follow-up counseling information. While the survivor should be encouraged to seek follow-up counseling, the decision to do so must be voluntary. Some survivors may be reluctant to talk with a counselor; however, they are more likely to participate if counseling has been coordinated with the examination process.

Follow-up Contact

Any further contact with sexual assault survivors must be carried out in a very discreet manner. In an effort to avoid any breach of confidentiality or unnecessary embarrassment, it is recommended that survivors be asked, prior to leaving the medical facility, whether they may be contacted about follow-up services. If so, they should be asked to provide an appropriate mailing address and/or telephone number where they can be reached.

Clean-up/Change of Clothing

Many survivors would like to wash after the examination and evidence collection process. If possible, the medical facility should provide the basics required, such as mouth rinse, soap and a towel. Many crisis centers will provide a change of clothing and toiletries for the survivor to use after the examination.

If garments have been collected for evidence purposes and no additional clothing is available, arrangements should be made to insure that no survivor has to leave the hospital in an examination gown. In those instances, where police officers transport victims from their homes to the hospital, officers should be instructed to advise survivors to bring an additional set of clothing with them in the event any garments are collected. Some survivors may wish to have a family member or friend contacted to provide substitute clothing. When the survivor has no available personal clothing, necessary items could be supplied by volunteer organizations and/or the local sexual assault program. A list of agencies should be developed by the local task force.

This and other issues can be addressed by developing a community plan with local law enforcement agencies and sexual assault programs.

Transportation

Finally, transportation should be arranged when the survivor is ready to leave the hospital. In some cases this will be provided by a family member or friend who may have been called to the hospital for

support. In other cases, transportation can be provided by the local law enforcement agency as a community service or by the local advocacy agency.

ROLE OF THE SANE (SEXUAL ASSAULT NURSE EXAMINER)

Sexual Assault Nurse Examiners (SANE) are registered nurses who have completed specialized education and clinical preparation in the medical forensic care of the patient who has experienced sexual assault or abuse.¹⁶¹ The International Association of Forensic Nurses (IAFN), established in 1992, is the professional organization representing forensic nurses, including SANEs, around the world. In 1995, the American Nurses Association (ANA) formally recognized forensic nursing as a specialty area in the United States.

SANEs are on-call in emergency rooms, agencies, clinics, or independent SANE centers. SANEs must follow specific protocols concerning evidence collection and treatment and care of the victim. Although most SANE programs are located in health care facilities or hospital emergency departments, some can be found in sexual assault or rape crisis centers or even in private health care facilities or departments.¹⁶²

Generally, there are five goals of an examination by a SANE. These include "(a) documentation and care of injuries; (b) collection of medical-legal evidence, (c) evaluation of risk and prophylactic treatment of sexually transmitted diseases (STDs), (d) evaluation of risk and emergency pregnancy interception, and (e) crisis intervention."¹⁶³

By profession, SANEs are not victim advocates. SANEs support victims by providing caring, respectful, and efficient emergency medical-legal treatment. SANEs must remain as objective as possible in their evidence collection in order to maintain a high level of credibility in court for both themselves and the evidence they collect. Unbiased evidence collection is more likely to support positive outcomes for the survivor.

Victim support provided by SANEs is not a substitute for services offered by advocates. Advocates are in the unique position to be entirely on the side of the survivor and have training, experience, and access to program resources that allow them to address a wide range of victim needs during the emergency medical-legal process and beyond.¹⁶⁴

SANE programs and sexual assault crisis centers in the same locality may offer a few similar victim services during emergency medical-legal procedures, including crisis intervention or provision of

¹⁶¹ [SANE] *Sexual Assault Nurse Examiner* Fact Sheet. International Association of Forensic Nurses. http://c.ymcdn.com/sites/www.forensicnurses.org/resource/resmgr/About/SANE_Flyer_2014-FIN-PQ.pdf

¹⁶² Gaffney, D. (2002). Community-Based Sexual Assault Nurse Examiners: A New Role for the Visiting Nurses Association. *Violence Against Women*, 27, 3. (Joan Zorza, ed.)

¹⁶³ Ledray, L. (2001). Sexual Assault Nurse Examiner (SANE) Program. *Sourcebook on Violence Against Women* 243-44 (Claire M. Renzetti et al. eds.)

¹⁶⁴ Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims. (2001) *Office for Victims of Crime* https://www.ncjrs.gov/ovc_archives/bulletins/sane_4_2001/7.html

information about reporting options. Agency directors should work together to clearly delineate separate functions, eliminate duplication, and/or determine the appropriateness of collaboratively delivering some services.¹⁶⁵

PREGNANCY PREVENTION

If the medical team determines that the female survivor of child-bearing years is at high-risk for pregnancy, prophylactic treatment for pregnancy is discussed and offered. A thorough history is taken to determine the survivor's method of birth control and whether it was in use during the assault. Should the medical facility have a policy that is philosophically opposed to "morning after treatment," the survivor should still be alerted to her risk for pregnancy, informed of her options and referred to a pharmacy or facility that will provide follow-up care if she chooses it.

Emergency Contraception, Ovral, Preven, Plan B ("morning after pill")

Estimated Effectiveness: ranges from 52 to 94%. Effectiveness decreases with time. The sooner emergency contraception is begun the more likely it is to be effective.

Risks: Headaches, blurred vision, nausea, chest pain, abdominal pain and leg pain

Non-contraceptive Benefits: None

Convenience: Must start treatment within 72 hours after intercourse.

Availability: Over the counter, but not all pharmacies may stock emergency contraception.

www.arhp.org

SEXUALLY TRANSMITTED INFECTIONS

All survivors should be given information about the possibility of contracting sexually transmitted infections from the assault. Only a follow-up test at a later time will confirm any transmission. The survivor should be consoled with the fact that because a sexual assault has occurred does not necessarily result in the transmission of a disease or pregnancy. However, a follow-up exam and test six weeks after the assault should be encouraged. Prophylactic treatment for sexually transmitted diseases should be offered routinely at the time of the initial exam.

Sexual assault survivors are likely to have many health concerns following their assault. One common fear is of contracting a disease from their assailant. The risk of contracting a disease from a single sexual episode is relatively low, however, this does little to alleviate the fear of the survivor and the chance of getting a sexually transmitted disease is a clear possibility.

THE FACTS ABOUT SEXUALLY TRANSMITTED INFECTIONS (STIS)

¹⁶⁵ *ibid*

STIs are diseases that are passed during sexual contact. Some of the most common STIs include: chlamydia, syphilis, genital herpes, genital warts, gonorrhea, HIV/AIDS and hepatitis B. Hepatitis and HIV/AIDS will be discussed in detail, apart from the other diseases listed above.

Some STIs can make you seriously ill or even kill you. Women are more likely than men to contract STI. Some special health problems for women caused by STIs include: problem pregnancies, pelvic inflammatory disease and a higher risk for cervical cancer.

Some women exhibit physical symptoms of an STI such as: pain during sex, spotting between periods, unusual discharge or vaginal odor, burning during urination, or sores or bumps around the vagina or inner thighs. Unfortunately, many women do not show any sign of a STI and are therefore left untreated and likely to spread the disease to other partners. The Center for Disease Control (CDC) concludes that more than 20 million cases of sexually transmitted diseases are reported in the United States every year. The CDC offers the following summaries of various STIs.

CHLAMYDIA

Chlamydia is the most common bacterial sexually transmitted disease in the United States. The CDC in 2014, estimated that 1,441,789 infections annually were reported, primarily among adolescents and young adults. In women, untreated infections can progress to involve the upper reproductive tract and may result in serious complications. About 75 percent of women infected with chlamydia have few or no symptoms, and the infection may persist for as long as 15 months without testing and treatment. Without treatment, 20 percent to 40 percent of women with chlamydia may develop pelvic inflammatory disease (PID). An estimated 1 in 10 adolescent girls and 1 in 20 women of reproductive age are infected.

GONORRHEA

Gonorrhea is a common bacterial STI that can be treated with antibiotics. Adolescent females aged 15 to 19 have the highest rates of gonorrhea. The CDC in 2014, estimated 350,062 cases per 100,000 people. An estimated 50 percent of women with gonorrhea have no symptoms. Without early screening and treatment, 10 to 40 percent of women with gonorrhea will develop PID.

PELVIC INFLAMMATORY DISEASE (PID)

PID refers to upper reproductive tract infections in women, which often develop when STIs go untreated or are inadequately treated. Each year, PID and its complications affect more than 750,000 women. PID can cause chronic pelvic pain or harm to the reproductive organs. Permanent damage to the fallopian tubes can result from a single episode of PID and is even more common after a second or third episode. As much as 30 percent of infertility in women may be related to preventable complications of past STIs. One potentially fatal complication of PID is ectopic pregnancy, an abnormal condition that occurs when a fertilized egg implants in a location other than inside a woman's uterus—often in a fallopian tube.

HERPES SIMPLEX VIRUS (HSV)

Genital herpes is a disease caused by herpes simplex virus (HSV). The disease may recur periodically and has no cure. Scientists have estimated that about 30 million persons in the United States may have genital HSV infection. Most infected persons never recognize the symptoms of genital herpes; some will have symptoms shortly after infection and never again. A minority of those infected will have recurrent episodes of genital sores. Many cases of genital herpes are acquired from people who do not know they are infected or who had no symptoms at the time of sexual contact.

HUMAN PAPILLOMAVIRUS (HPV)

HPV is a virus that sometimes causes genital warts but in many cases infects people without causing noticeable symptoms. Concern about HPV has increased in recent years after several studies showed that HPV infection is associated with the development of cervical cancer. Approximately 25 types of HPV can infect the genital area. These types are divided into high risk and low risk groups based on whether they are associated with cancer. Infection with a high risk type of HPV is one risk factor for cervical cancer, which causes 4,500 deaths among women each year. No cure for HPV infection exists.

SYPHILIS

Syphilis is a bacterial infection that can be cured with antibiotics. In 2014, the CDC reported 19,999 cases per 100,000 people were reported. Rates among females were more than twice as high as rates among males in the 15 to 19 age group. African-American women have syphilis rates that are 7 times greater than the female population as a whole. More than 3000 cases of congenital syphilis were reported in 1993. Death of the fetus or newborn infant occurs in up to 40 percent of pregnant women who have untreated syphilis.

HEPATITIS

Hepatitis is generally identified as A, B, or C. Hepatitis B (HBV) is the most likely strain to be spread through sexual contact. Hepatitis B is one of the most common, serious infectious diseases in the world, however, it can be prevented with a safe and effective vaccine. Hepatitis B is 100 times more infectious than the AIDS virus. One out of 20 people in the United States has been infected with Hepatitis B. Each year 300,000 new people will become infected with HBV.

HBV is found in body fluids such as blood, semen and vaginal secretions. Hepatitis B is known as the "Silent Infection" because carriers of HBV may not become noticeably sick and may not realize they have the disease. Whether they have symptoms or not, they can pass the virus onto others. Hepatitis B

is so contagious that it is advised that you do not share personal items such as toothbrushes, nail clippers, pierced earrings, or razor with a carrier. **The ABCs of Viral HEPATITIS**

	HEPATITIS A (HAV)	HEPATITIS B (HBV)	HEPATITIS C (HCV)
What is it?	HAV is a virus that causes inflammation of the liver. It does not lead to chronic diseases.	HBV is a virus that causes inflammation of the liver. The virus can cause liver cell damage, leading to cirrhosis and cancer.	HCV is a virus that causes inflammation of the liver. This infection can lead to cirrhosis and cancer.
Incubation period (time from exposure to illness)	15 to 50 days. Average 30 days.	4 to 25 weeks. Average 8 to 12 weeks.	2 to 25 weeks. Average 7 to 9 weeks.
How is it spread?	Transmitted by fecal/oral route, through close person to person contact (changing diapers without good handwashing), anal-oral sex, or ingestion of contaminated food and water.	Contact with infected blood, seminal fluid, vaginal secretions, contaminated needles, including tattoo/body-piercing tools, infected mother to newborn, human bite, sexual contact.	Contact with infected blood, contaminated IV needles, razors and tattoo/body piercing tools, infected mother to newborn. NOT easily spread through sex.
Symptoms	May have none, especially young children. Symptoms may include light stools, dark urine, fatigue, fever and jaundice (yellow skin). Jaundice by age group < 6 yrs.: < 10% 6-14 yrs.: 40-50% > 14 yrs.: 70-80%	May have none, especially young children. Some persons have mild flu-like symptoms, dark urine, light stools, jaundice, fatigue and fever. Jaundice by age groups: < 5 yrs.: < 10% > 5 yrs.: 30-50%	It has symptoms, similar as with HBV. Between 30% with acute HCV develop symptoms and 20 to 30% develop jaundice.

Percent who develop chronic disease	None	Varies by age of onset of infection. < 5 yrs.: 30-90% > 5 yrs.: 2-10%	75%-85%
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HIV/AIDS

It is estimated that since 1981, 1.7 million people in the US have been infected with the Human Immunodeficiency Virus (HIV). Approximately 1 million people are living with the disease and it's estimated that 20% are unaware they are infected. Currently there are about 50,000 new infections each year and over 620,000 have died due to complications caused by the infection.

One of the most frightening problems associated with the epidemic is the possibility that the virus can be transmitted to a victim during an act of sexual assault. Victims of sexual assault often spend many years, or even a lifetime, trying to recover from such physical and psychological traumatization. Moreover, the trauma is magnified and prolonged by the fear of contracting HIV as a result of the attack.



HIV TESTING FOR DEFENDANTS

Over the past several years an increasing number of sexual assault survivors are requesting that perpetrators be tested for HIV/AIDS. Texas law allows for testing of adult defendants and juvenile respondents.

Article 21.31 of the Texas Code of Criminal Procedure grants the court the power to order, either on its own motion or on the request of the victim of the alleged offense, that an adult defendant, who has been indicted or waives indictment for an offense under Texas Penal Code §22.11(a)(1) indecency with a child by sexual contact, §22.0112 sexual assault, or §22.021 aggravated sexual assault, undergo a medical procedure or test to show or help show whether the defendant has a sexually transmitted diseases or has HIV or AIDS. The Texas Family Code §54.033 gives the court the same power with a juvenile who has been adjudicated and found to have committed an offense under the same Penal Code statutes. The test results may be disclosed to the survivor and the defendant or juvenile. However, time is of the essence as it relates to preventing HIV infection after an assault. Post exposure prophylaxis (PEP) medications need to be started within 72 hours. The sooner they are started the more likely they are to be effective, so treatment decisions will most often need to be made without information as to the assailants HIV status.

HIV POSTEXPOSURE PREVENTION

Post exposure prevention (PEP) is the use of antiretroviral medications as a prophylaxis (or prevention) to reduce a person's risk for acquiring HIV infection after an exposure.

One of the factors that makes HIV hard to cure is that it takes up residence inside immune cells and inserts its genetic material in to the genetic material of the host cell, such that it essentially becomes part of the host immune cells. The idea behind Pep is that there is a window of opportunity where the HIV virus is in the blood, but has not yet been incorporated in to host cells. At this state it can be blocked from integrating in to the immune cells, thereby preventing infection.

Unlike bacterial STDs (such as chlamydia and gonorrhea) which can be effectively cured weeks or months after the infection is acquired, HIV cannot be cured – only prevented. Because the goal is to prevent a newly acquired virus from establishing itself, PEP must start within 72 hours of possible exposure, and the sooner the better.

Using HIV medications to prevent HIV infection after exposure has been in practice for many years in a variety of settings including: Occupational exposures of health care workers, sexual or drug-related exposures, prevention of infection in newborns born to HIV positive mothers. The medications for PEP include 3 antiretrovirals, which may be 2 or 3 pills/day depending on which medications are chosen. Although there are potential side effects such as fatigue, nausea, diarrhea, these medications have been used to treat HIV for years and are generally safe and well tolerated. A basic workup will be done in the hospital and then most often the survivor will be scheduled for follow up with an HIV specialist ~ 1 week after starting the medication to ensure there are no serious troubles with the medications and to schedule follow up HIV testing which should be done at baseline, 1, 3, and 6 months in order to ensure infection hasn't occurred.

A common question from survivors trying to decide whether or not to take PEP is simply "do I need it?" or "what's my risk?". This is a difficult question to answer and impossible to fully quantify but there are variables that increase or decrease risk in a sexual assault which can be explained. Factors related to the assailant include, most importantly, their HIV status. If the HIV status of the assailant is unknown then are they known to engage in high risk behaviors such as injecting drugs or having sex with other men? If none of this is known then factors about the assault can be helpful in determining risk. Was a condom used? What type of contact was there? The highest risk would be an anal assault without a condom and the lowest risk would be an oral assault with a condom. However, the most important thing to remember is that each individual will have a different threshold for risk and while we can explain the variables that increase or decrease risk, what PEP involves, and the time sensitive nature of PEP, we should never tell a survivor that they should or should not chose to initiate PEP.

Centers For Disease Control And Prevention (Cdc) Recommended Use Of Pep:

- Occupational exposures of health care workers
- One isolated study states that using PEP was 81 percent effective in preventing HIV infection in health care workers.
- Perinatal transmission
- HIV antiretroviral treatment with pregnant HIV positive women and newborns has 98% success rate in preventing perinatal transmission.
- Unanticipated sexual or drug injection-related exposures to HIV

What Is The Probability Of Hiv Transmission From One Exposure?

- Blood transfusions-92.5%
- Intravenous needle exposure-0.63%-2.4%
- Needlestick- 0.13%
- Receptive penile-anal sexual exposure- 0.4%-3.38%
- Receptive vaginal exposure- 0.04%-0.55%
- Receptive oral sex- 0.00%-0.04%

PEP Treatment Protocol:

- Usually a combination of 3 antiretrovirals (ARVs)

Side Effects:

- The most common are nausea, headache, fatigue, vomiting, diarrhea and generally not feeling well. Most side effects are reversed when PEP is discontinued.
- Some drugs used may inhibit the metabolism of other drugs clients are taking and may make their use ineffective such as oral contraceptives.
- Due to side effects statistics for health care workers who start PEP treatment show that 30 to 50 percent discontinue treatment.
- Rates of effectiveness based on the number of hours PEP is started after possible HIV exposure: within one hour, 24 hours, or 72 hours. **Beyond 72 hours PEP is not considered as a preventive treatment, treatment is not 100% effective.**

Follow-up should include:

- Counseling
- Medical evaluation
- Postexposure HIV antibody testing—baseline, 6 weeks, 12 weeks, and 6 months
- Post exposure prophylaxis toxicity monitoring should include a complete blood count, renal & hepatic chemical function tests, and monitoring for anemia and hepatitis before initial treatment and 2 weeks later.

Cost of Medication & Treatment: \$600 to \$1000

- Who is going to provide and pay for treatment and follow up?
- How many victims have a primary care physician?
- If the victim has medical insurance, will the insurance cover HIV postexposure treatment?
- Is the victim eligible for assistance through Crime Victims' Compensation?

What is the medical status of the rape victim when he/she arrives in the emergency room and requests a rape exam?

- When was the rape reported?
- HIV status of the perpetrator?
- Number of exposures? Were there multiple exposures over an extended period of time?

Section 7:

RIGHTS AND RESPONSIBILITIES OF ADVOCATES

THE ROLE OF THE ADVOCATE DURING THE SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATION

When a survivor of sexual assault decides to have a medical forensic examination, several different systems are put into motion. One of these systems is, hopefully, advocacy services provided by a rape crisis center. The primary purpose of the advocate during the medical forensic exam is to provide support to the survivor. Unlike other professionals that the survivor may come into contact with during the exam, the advocate is the only one whose sole purpose is the care of the survivor. The advocate can be 100% victim centered and victim focused with no other competing priorities such as collecting evidence, treating injuries, or taking a police report. In addition, the advocate may continue this supportive relationship beyond the time of the exam and involvement with the criminal justice system into the weeks, months and sometimes years after the assault.

Before, during and for some time after the exam, the survivor is most likely experiencing acute trauma. Brain functioning will be affected and much of the information that is provided may not be absorbed well or completely. One of the most important things an advocate can do while the survivor is at the hospital or clinic is to make sure the survivor has and understands pertinent information before making any critical decisions. Hospitals, where most exams are conducted, can be intimidating places. Advocates can make sure that survivors don't get lost in the shuffle.

Texas law requires the person conducting the medical forensic exam give the survivor a choice if they would like a trained advocate. To be considered a 'trained advocate,' an advocate must have successfully completed a sexual assault training program certified by the Office of the Attorney General. Of course this legal requirement only applies if there are trained advocates in the community. If there is not rape crisis center, and thus no advocates, the law does not require one to be offered. If there is an advocate available, but they have not completed the required training, then the person conducting the medical forensic exam is under no legal obligation to make an offer of an advocate to the survivor.

If the survivor does not want an advocate to be called or does not want to speak with an advocate who may be present, then it goes without saying that the advocate should respect the survivor's

preference. Under these circumstances, the advocate may want to speak with family members or friends or simply leave some information in case the survivor would like to contact the rape crisis center later. It should go without saying, that the advocate should not impede any medical care of a patient, particularly emergency medical care.

The law is in place to ensure advocates can provide hospital accompaniment services to survivors who desire them. However, the law is nuanced in this area and only applies within very specific parameters. Please ensure you understand how the law is meant to work and consider calling TAASA for technical assistance if you are working in a community that does not currently welcome advocates in the room during the medical forensic exam.

Fortunately, in most Texas communities, especially where a Sexual Assault Response Team has been formed, hospitals call advocates from the rape crisis center as a matter of course, knowing that the advocate who arrives will be well trained and a valuable member of the team seeking to assist and support the survivor.

For reference, the statute is below (current as of March 1, 2016) in the left hand column. The right hand column provides information about statutory references.

<p>Art. 56.045. PRESENCE OF ADVOCATE OR REPRESENTATIVE DURING FORENSIC MEDICAL EXAMINATION.</p>	
<p>(a) Before conducting a forensic medical examination of a person who consents to such an examination for the collection of evidence for an alleged sexual assault, the physician or other medical services personnel conducting the examination shall offer the person the opportunity to have an advocate from a sexual assault program as defined by Section 420.003, Government Code, who has completed a sexual assault training program described by Section 420.011(b), Government Code, present with the person during the examination, if the advocate is available at the time of the examination.</p> <p>(b) The advocate may only provide the injured person with:</p> <p>(1) counseling and other support services; and</p>	<p>Section 420.003, Government Code provides the legal definition of a sexual assault program which is: <i>"Sexual assault program" means any local public or private nonprofit corporation, independent of a law enforcement agency or prosecutor's office, that is operated as an independent program or as part of a municipal, county, or state agency and that provides the minimum services to adult survivors of stranger and non-stranger sexual assault.</i></p> <p>The minimum services are:</p> <p>(A) a 24-hour crisis hotline;</p> <p>(B) crisis intervention;</p> <p>(C) public education;</p> <p>(D) advocacy; and</p> <p>(E) accompaniment to hospitals, law enforcement offices, prosecutors' offices, and courts.</p>
<p>(2) information regarding the rights of crime victims under Articles 56.02 and 56.021.</p>	<p>Section 420.011(b), Government Code authorizes the Office of the Attorney General to have a sexual assault training program certification program. The certification program is not described in statute. Information about</p>

<p>(c) Notwithstanding Subsection (a), the advocate and the sexual assault program providing the advocate may not delay or otherwise impede the screening or stabilization of an emergency medical condition.</p> <p>(d) The sexual assault program providing the advocate shall pay all costs associated with providing the advocate.</p> <p>(e) Any individual or entity, including a health care facility, that provides an advocate with access to a person consenting to an examination under Subsection (a) is not subject to civil or criminal liability for providing that access. In this subsection, "health care facility" includes a hospital licensed under Chapter 241, Health and Safety Code.</p> <p>(f) If a person alleging to have sustained injuries as the victim of a sexual assault was confined in a penal institution, as defined by Section 1.07, Penal Code, at the time of the alleged assault, the penal institution shall provide, at the person's request, a representative to be present with the person at any forensic medical examination conducted for the purpose of collecting and preserving evidence related to the investigation or prosecution of the alleged assault. The representative may only provide the injured person with counseling and other support services and with information regarding the rights of crime victims under Articles 56.02 and 56.021 and may not delay or otherwise impede the screening or stabilization of an emergency medical condition. The representative must be approved by the penal institution and must be a:</p> <ol style="list-style-type: none"> (1) psychologist; (2) sociologist; (3) chaplain; (4) social worker; (5) case manager; or 	<p>the certification program requirements can be found here: www.texasattorneygeneral.gov/cvs/sexual-assault-prevention-and-crisis-services</p>
	<p><i>Articles 56.02 and 56.021, Code of Criminal Procedure. These Articles provide the list of legal rights available to sexual assault survivors in Texas.</i></p>
	<p>By including hospitals licensed under Chapter 241, Health and Safety Code all Texas hospitals with an emergency room should be included in the requirement to call an advocate.</p>
	<p>Section 1.07, Penal Code provides the following definition for "Penal institution" <i>means a place designated by law for confinement of persons arrested for, charged with, or convicted of an offense.</i></p>

(6) volunteer who has completed a sexual assault training program described by Section 420.011(b), Government Code.	
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CONFIDENTIAL COMMUNICATIONS

Confidentiality is a cornerstone of advocacy services. Sexual assault programs and advocates recognize the very personal and private nature of information that may be shared by survivors. Survivors may have overwhelming feelings of shame and may be fearful of sharing information about their assault. Ensuring confidentiality provides survivors with a safe opportunity to share their fears and concerns and find the assistance they need. If advocacy services are truly victim-centered (i.e. placing the needs and desires of the sexual assault survivor first and foremost), than any information the survivor shares, as well as identifying information about the survivor, must remain confidential as long as the survivors wishes it to remain confidential. Respecting a survivor’s confidentiality places power with the survivor and facilitates empowerment.

Sexual assault programs and advocates should take all necessary steps to ensure confidentiality, unless authorized by the survivor to do otherwise. This confidentiality should not only include information that could identify a survivor, but also their personal history as well as details of their assault.

Exceptions to confidentiality can occur only under specific circumstances and are outlined below. Generally speaking, these include: mandated abuse reporting when there is reason to believe a child, disabled or elderly person is being abused, there is imminent danger to any person of serious injury or death, or there is a subpoena.

Following is Texas’s confidential communications statute that is applicable to sexual assault advocates. The left column is the text of the actual law and the right column is a layman’s interpretation.

<p>Sec. 420.071. CONFIDENTIAL COMMUNICATIONS. (a) A communication between an advocate and a survivor, or a person claiming to be a survivor, that is made in the course of providing sexual assault advocacy services to the survivor is confidential and may not be disclosed except as provided by this subchapter. (b) A record of the identity, personal history, or background information of a survivor or information</p>	<p>This section outlines the basic provisions of confidentiality between an advocate and a sexual assault survivor. This includes:</p> <ul style="list-style-type: none"> a) That communications between advocates and survivor IS confidential. b) Confidential information includes the identity, personal history as
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<p>concerning the victimization of a survivor that is created by or provided to an advocate or maintained by a sexual assault program is confidential and may not be disclosed except as provided by this subchapter.</p> <p>(c) A person who receives information from a confidential communication or record as described by this subchapter may not disclose the information except to the extent that disclosure is consistent with the authorized purposes for which the information was obtained.</p> <p>(d) This subchapter governs a confidential communication or record concerning a survivor regardless of when the survivor received the services of an advocate or sexual assault program.</p>	<p>well as victimization details of a survivor.</p> <p>c) Confidential information may not be disclosed, unless authorized.</p> <p>d) Confidentiality is required no matter how long ago the services were provided.</p>
<p>Sec. 420.072. EXCEPTIONS.</p> <p>(a) A communication, a record, or evidence that is confidential under this subchapter may be disclosed in court or in an administrative proceeding if:</p> <p>(1) the proceeding is brought by the survivor against an advocate or a sexual assault program or is a criminal proceeding or a certification revocation proceeding in which disclosure is relevant to the claims or defense of the advocate or sexual assault program; or</p> <p>(2) the survivor or other appropriate person consents in writing to the disclosure as provided by Section 420.073 or 420.0735, as applicable.</p> <p>(b) A communication, a record, or evidence that is confidential under this subchapter may be disclosed only to:</p> <p>(1) medical or law enforcement personnel if the advocate determines that there is a probability of imminent physical danger to any person for whom the communication, record, or evidence is relevant or if there is a probability of immediate mental or emotional injury to the survivor;</p> <p>(2) a governmental agency if the disclosure is required or authorized by law;</p> <p>(3) a qualified person to the extent necessary for a management audit, financial audit, program evaluation, or research, except that a report of the research, audit, or evaluation may not directly or indirectly identify a survivor;</p>	<p>Confidential information may be disclosed in court or a hearing if:</p> <ol style="list-style-type: none"> 1) The hearing is brought by the survivor and the information is relevant. 2) The survivor consents in writing. <p>Confidential information may be disclosed to:</p> <ol style="list-style-type: none"> 1) Medical or law enforcement personnel in cases of imminent danger to any person or if there is a probability of immediate mental or emotional injury to the survivor. 2) A government agency if the disclosure is required by law. 3) For program auditing, evaluation, or research, although the identity of the survivor may not be disclosed. 4) A person identified in the survivor’s written consent for release of information. 5) The supervisor of an advocate, but only for supervision purposes. <p>Confidential information should NOT be released to the parent or guardian of a survivor who is a minor if the parent or</p>

<p>(4) a person authorized to receive the disclosure as a result of written consent obtained under Section 420.073 or 420.0735; or</p> <p>(5) an advocate or a person under the supervision of a counseling supervisor who is participating in the evaluation or counseling of or advocacy for the survivor.</p> <p>(c) A communication, a record, or evidence that is confidential under this subchapter may not be disclosed to a parent or legal guardian of a survivor who is a minor if an advocate or a sexual assault program knows or has reason to believe that the parent or legal guardian of the survivor is a suspect in the sexual assault of the survivor.</p>	<p>guardian is suspected to be responsible for the sexual assault of the survivor.</p>
<p>Sec. 420.073. CONSENT FOR RELEASE OF CERTAIN CONFIDENTIAL INFORMATION.</p> <p>(a) Consent for the release of confidential information other than evidence contained in an evidence collection kit must be in writing and signed by the survivor, a parent or legal guardian if the survivor is a minor, a legal guardian if the survivor has been adjudicated incompetent to manage the survivor's personal affairs, an attorney ad litem appointed for the survivor, or a personal representative if the survivor is deceased. The written consent must specify:</p> <ol style="list-style-type: none"> (1) the information or records covered by the release; (2) the reason or purpose for the release; and (3) the person to whom the information is to be released. <p>(b) A survivor or other person authorized to consent may withdraw consent to the release of information by submitting a written notice of withdrawal to the person or sexual assault program to which consent was provided. Withdrawal of consent does not affect information disclosed before the date written notice of the withdrawal was received.</p> <p>(c) A person who receives information made confidential by this chapter may not disclose the information except to the extent that disclosure is consistent with the authorized purposes for which the person obtained the information.</p>	<p>Consent for release of confidential information must be in writing and signed by the survivor or person with the legal authority to sign on the survivor's behalf. The consent form must include:</p> <ol style="list-style-type: none"> 1) What information is being released 2) Why the information is being released 3) To whom the information is being released <p>The consent may be withdrawn by the survivor or authorized person at any time by submitting a written notice of withdrawal.</p> <p>A person who receives the confidential information may only utilize the information for the purpose for which it was provided.</p>

<p>Sec. 420.074. CRIMINAL SUBPOENA. Notwithstanding any other provision of this chapter, a person shall disclose a communication, a record, or evidence that is confidential under this chapter for use in a criminal investigation or proceeding in response to a subpoena issued in accordance with law.</p>	<p>If the confidential information is subject to a subpoena is must be released as instructed within the subpoena.</p>
<p>Sec. 420.075. OFFENSE. A person commits an offense if the person intentionally or knowingly discloses a communication, a record, or evidence that is confidential under this chapter, except as provided by this chapter. An offense under this section is a Class C misdemeanor.</p>	<p>Breaking confidentiality, unless it is for one of the permissible reasons identified in this statute, is a Class C misdemeanor.</p>
