Crisis Intervention

Lesson 1: Active Listening

Time: 8:30-10:15

Length: 1 hour, 45 minutes

Lesson(s): Introduction, Importance of Listening, Listening Skills, Essential Tools for Effective Listening, Tips of the Trade, Active Listening Skill Building

Learning Objective(s): To understand the importance of listening and to develop active listening skills.

Participant (s): Importance of Listening Figures 1 and 2, Active Listening Skills Sets 1 and 2

Lecture: Introduction
Time: 8:30-8:35 (5 Minutes)

- During Day 2, we identified the primary goal of advocacy as empowerment because empowerment is the foundation of healing.

Ask the participants if they have any questions about Day 2 content.

- Today we are going to talk about how empowerment translates into action; how your intervention as an advocate can be an empowering experience with survivors. We begin with the concept of active listening and continue with crisis intervention.

Activity: Importance of Listening
Time: 8:35 – 8:50 (15 Minutes)

1. Have the participants form pairs and sit back-to-back.

2. Provide one person from each pair with the Figure 1 drawing. This is the drawing they will be attempting to describe to their partner.

3. Provide the other person in the pair with a blank piece of paper. This will be used to draw on.

4. Instruct the person with Figure 1 to describe the drawing to their partner using either "yes" or "no" as an answer. Their partner can only ask yes or no questions. Time is limited to three minutes.

5. Have the pairs compare Figure 1 to the drawing.

6. Ask the participants what helped communication? What hindered communication?

7. Have the participants switch roles. Provide the other person with Figure 2 and have them describe the drawing to their partner. This time they can provide descriptive answers. Their partner can ask open ended questions. Time is limited to five minutes.

8. Have the pairs compare Figure 2 to the drawing.

9. Ask the participants what helped communication? What hindered communication?

Ask the participants what this activity demonstrated.

Discuss the following possible points:

<u>Hindered</u>
- Unable to see
- Assumptions
- Time limitation
- Noise

- Pressure

Helped

- Clear instructions
- Paying attention
- Clarification
- Feedback/Questions
- Rapport
- Familiarity
- Two-way communication

- Body language is a huge communication mechanism. Body language can convey additional communication cues. Many survivors are very adept at reading non-verbal cues. Therefore, be conscious of your body language when working with a survivor in person.

- We aren't able to read or use body language over the phone. What do we have? "Attending" verbal indicators: tone of voice, volume of voice, um, uh huh, mmm, etc.

- We've just demonstrated the importance of active listening. At this time we are going to discuss and practice some basic active listening skills.

- The key element in crisis intervention and advocacy in general is listening. Simply being heard may reduce the state of crisis that someone is in.

- A person is being heard when the listener provides total attention (their complete presence), asks questions for clarification, and accepts all that they hear seriously and fully.

- A person who is heard feels understood, cared about, connected, and hopeful.

- We are now going to do a quick activity to provide a simple introduction to crisis intervention and the importance of active listening skills.

Activity: Listening Skills
Time: 8:50 – 9:05 (15 minutes)

1. Have the group pair off. One will be taking on the role of listener and one will be the talker. Each person will get a turn at each role. Ask them to decide who will be the talker and listener first.

2. Instruct the talkers to talk about themselves for 2 minutes – who they are, where they live, what they do for a living, hobby; just light conversation (this is not the time to share personal history).

3. Instruct the listeners to listen with no expression. They are not to nod, smile or make encouraging or discouraging body movements. The object is to simply listen and take notice of your impulses.

4. Have the participants switch roles.

5. Ask participants to briefly jot down three things that impressed them the most about this experience.

6. Ask how it felt to be the listener, what were their impulses. How comfortable or uncomfortable was it to do this exercise?

7. Ask how it felt to be the talker. What was good or helpful about talking to a listener who exhibited no expression? What didn't feel good about it? How was the experience overall?

- The point of this exercise is to help you pay attention to your usual listening habits and to focus on what we want and need from a listener. For most of us, this happens on an unconscious level.

Ask participants to pay attention to their listening habits for the next week and to note when they feel heard and when they don't

feel heard. Have them ask themselves "What do I do when I listen? What do I need from a listener?"

- Let's quickly brainstorm what you consider to be essential tools for effective intervention during a crisis and what some of the barriers are to active listening.

Activity: Essential Tools for Effective Listening
Time: 9:05 – 9:30 (25 minutes)

1. Prepare a flipchart; divide it in half and label one side Effective Tools and the other side Barriers.

2. Ask the participants what are some effective tools for listening.

3. Ask the participants what are some barriers to effective listening.

Discuss the following possible points for effective tools for listening:

- Meet the client "where they're at"
- Believe them, their perspective
- Be mindful of body language
- Open-mindedness
- Use similar language/words
- Attentiveness to feelings
- Staying calm
- Be self-aware
- Belief in the survivor's ability
- Validation

- Know your role
- Take necessary amount of time
- Be open to differences

Discuss the following possible points for barriers to effective listening:

- Advice
    - What I would do… Why don't you… You should/could/must….
- Judgment
    - Why didn't you… I would have…
- Moralizing
    - That was good/bad of you… That was good/bad of your partner…
- Assumptions
- Negative body language
- Interrogation
    - "Who, What, Why" questions
- Personal disclosure
- Minimization
    - It's not so bad… Don't worry… Everything will be okay…
- Filling silences
- Talking over someone
- Joining their crisis

- Analyzing
    - What you need is… Your problem is…
- Giving false promises
- Directing/persuading
    - Yes, but… You really should consider…
- Sympathizing
    - You poor thing… I feel so sorry for you…

S: Other Barriers to Listening

- Personal problems – We all have personal problems. Your personal problems interfere with your ability to listen effectively when you neither really hear nor really care what someone else is saying. Know when to take a break.
- Similar experience as survivor – You assume the victim's experience is "just what happened to me," and you don't hear the survivor's individual concerns. Your assumptions get in the way of truly empathizing.
- Stereotyping – Believing you already know what the survivor is like or what their concerns are can lead you to start judging or thinking about what you are going to say next. If you think you know the solution before you've heard the problem, you are not listening.
- Planned responses – While in training you are given some ideas of what to expect and what some appropriate responses might sound like. Nevertheless, you should not have "canned" responses for your client. As you practice you will find your own style.
- Negative views of the survivor – Such feelings can arise from past experiences, prejudices, personal problems, and stereotyping. If negative feelings do arise, they get in the way of your ability to advocate. As an advocate you have to be willing to set your feelings and judgments aside.

Ask the participants what they can do if any of these barriers come up for them.
Discuss the following possible points:

- Talk to a supervisor
- Be aware of own biases
- Be aware of own triggers
- Practice with roleplays
- Have a plan if these feelings or situations come up
- Keeping these potential barriers to listening in mind, focus now on some general guidelines for effective listening:
    - Believe survivors.
    - Provide the speaker with the opportunity to do the talking by talking less yourself.
    - Listen for what is really being said – the feelings underlying the words. Hear what is not said as well.
    - Recognize and value the speaker as a unique person.
    - Empathize with the speaker, refusing to let your own ego or distractions get in the way. Put yourself in their shoes.
    - Accept the speaker unconditionally, recognizing any feelings as legitimate.
    - You are responsible to your clients, not responsible for them.

Lecture: Tips of the Trade
9:30 – 9:45 (15 minutes)

- As we mentioned, the key element in crisis intervention is listening. Listening is a powerful tool. Listening begins with paying attention. Active listening skills communicate this attention. There are several ways that we can do this.

S: Active Listening Skills

- Reflection:
  - Repeat/reflect back to victim what they have told you.
  - This technique shows that you are in tune with the client's emotional experience.
  - Do not tell them what they are thinking or feeling, but encourage them to set the direction of the conversation.
  - Helping someone identify their feelings can help with anxiety.
  - For example, "It sounds like you don't want to talk to your father about this because you think he will blame you."
- Clarification:
  - If the survivor says something you don't understand or that seems unclear, you may need to get more information to better understand their experience or perspective.
  - Open-ended questions are helpful.

- For example, "You said that you were feeling 'mixed up.' Can you tell me what you mean by that?"

- Paraphrase:
  - Restate, in slightly different words, what the survivor has told you.
  - Do use their important words. We are paraphrasing their world not ours!
  - Capture main thoughts of the conversation, leaving the survivor the opportunity to correct you by saying, "Is that right?" or "Have I got it?"
  - Paraphrasing is most effective when used during a long pause.
  - For example, "It sounds like you are saying…" or "What I hear you saying is…"
- Reframing:
  - This involves placing the information the survivor offers into a new context.
  - It can help them see things from a different perspective.
  - For example, if the survivor is blaming himself you can reframe the blame onto the perpetrator. Sometimes a question may be reframed like, "If your best friend told you what you have just shared with me, what advice or help do you think she would need?"
- Positive Support:
  - The victim will have some ambivalent feelings about themselves as a result of the assault.
  - Accent the positive side of this ambivalence.

- Be genuine and avoid sounding condescending.

- Try saying something like, "Look how well you were able to…"

- Focusing:

  - Provide leads for the victim to elaborate on points which seem to be significant, helping them move from the general to the specific.

  - A person in crisis may be so overwhelmed by the problems that she cannot take enough control to see the specifics of the problem.

  - Focusing helps the caller name the present problems concretely so they can be broken down into several solvable pieces.

  - A caller that brings up several issues at the very beginning of the call may benefit from hearing something like, "It sounds like you are dealing with a lot right now. I'm here to support you as you work though these things. What can I help you with right now?"

- It sounds so simple, but active listening does not come easy for most people. We so seldom do it.

- It takes practice to become skilled. That is why these exercises are so important. We know you can do it!

Note to Trainer: The co-trainers will model a few of these active listening skills before having the participants practice.

1. One trainer is the listener; one is the talker.

2. Talker: "Should I plant the daffodils in pots or in the garden?"

3. Listener: Listen for 15 seconds without saying anything then demonstrate a reflective, reframing, and summarizing response.

4. Reflective: "It sounds as though you don't know where to plant the daffodils?"

5. Reframing: "When you talk about your daffodils you look joyful. It seems that working in the garden makes you happy."

6. Summarize: "It sounds as though you don't really know how you want your finished garden to look, but it gives you a lot of pleasure in the process."

- At this time, we are going to practice these same skills using roleplaying statements.

Activity: Active Listening Skill Building
Time: 9:45 – 10:00 (15 minutes)

Note to Trainer: An alternative is to practice these in the larger group. The trainer can read the role plays aloud, having participants take turns practicing each skill. The larger group can debrief each scenario. This is especially helpful if the group has less than 10 people in it.

1. **Instruct one person to be the listener and one to be the talker.**

2. **Use the statements provided; each pair gets Set 1 and Set 2.**

3. **Tell the group that the goal is to practice each of the skills: reflection, clarification, paraphrasing, reframing, positive support, and focusing. Display the PowerPoint slide describing the active listening skills.**

4. **Have them switch roles; one person will use Set 1 statements and the other person will use Set 2 statements.**

5. **Debrief what went well and what was difficult between each skill set or at the end.**

Break 10:00 – 10:15

Lesson 2: Crisis Intervention

Time: 10:15 – 12:00

Length: 1 hour, 45 minutes

Lesson(s): Advocacy Tips, Crisis Intervention, Roleplays

Learning Objective(s): To learn about the stages of a crisis and practice listening and communication skills needed for crisis intervention.

Participant Handout(s): Advocacy Tips, Stages of a Crisis, Survivor's Role Cards

Framing:

- Now that we have spent some time learning some basics about active listening skills, let's explore how to use them as practical tools when receiving telephone calls.

- It is important to note that every caller will be different. Some will want specific things from you, some may not know what they need, and some will definitely be in a state of crisis.

- Therefore, we cannot provide you a road map as to how to handle every type of call, but we can give you some tools that might assist you.

- It is important to help callers determine how and to what extent their life has been disrupted by the sexual assault.

- With such an assessment you may be better able to help the survivor to see the progress they are making in coping and integrating their experience.

- The following questions may help the caller talk about their experience, but care should be taken to avoid "interrogating" the caller.

Silent Reflection Activity: Advocacy Tips –
Time: 10:15 – 10:30 (15 minutes)

Hand out Advocacy Tips. Ask participants to read through the handout silently and think about what tips they think are useful and how they could incorporate them into their advocacy work. Debrief after 10 minutes. What do they think they could add? Use some of the points below to encourage discussion.

Handout:

- ✓ Have they told anyone?
- ✓ What do significant others, social support system think of the sexual assault? How are they coping with it?
- ✓ What impact has the rape had on family balance? Work situation? Friends? Support network?
- ✓ What was their sense of self previous to the assault and how has it been affected?
- ✓ What has the caller done thus far to help themselves?
- ✓ What would caller like to do but hasn't yet?
- ✓ What is caller not willing to do?
- ✓ How has caller dealt with past problematic situations?
- ✓ What are their coping mechanisms?
- ✓ What are caller's perceptions about rape?
- ✓ What has happened recently to caller that has been the most/least helpful?

- ✓ What has caller been doing with their time? Have they resumed their usual routine?
- ✓ What changes has caller made in their life since rape/assault, and how do they feel about them?
- ✓ How does caller feel about their assailant?
- ✓ Has caller been pursuing counseling, and how do they feel about it?

During the group debrief of the silent reflection activity, consider making these additional points:

- More questions:
    - How do you feel…?
    - Was there something that happened today that prompted you to call?
    - Do you want to tell me about it?
    - What do you think your options are?
- Besides questions, you can say genuine things like:
    - What happened was not your fault.
    - You don't deserve…
    - Here's something I know about [sexual assault]…
    - You are not alone in your experience, feelings, etc.
- As we continue to practice roleplays you will be able to have these questions in front of you to assist you with your call.

Lecture: Crisis Intervention
Time: 10:30 – 11:15 (45 minutes)

- Let's talk about what exactly a crisis is, how it may look for someone, and ways to intervene.

- Crisis is a very personal and individual experience. Any kind of life change has the potential of causing crisis. Emotional crisis may occur when stressful events or experiences overwhelm our abilities and resources to cope.

Ask the participants to close their eyes if they feel comfortable doing so.

Tell them to take a moment and think about a crisis that they have experienced. This could be any kind of crisis, but not a triggering memory.

Ask them to remember back to right after the event that caused the crisis. Give them a minute to think about it.

Ask the participants: "What were some of the emotions that you remember experiencing?" People do not have to share their personal examples.

- Shock

- Extremely emotional

- Calm

- Protest

- Denial

- Numb

- Some people may not "feel" in the moment of crisis. We can reassure people that it's okay and they will have emotions when they are ready to.

Ask the participants: "How do people avoid feeling?"

- Eat

- Sleep

- Exercise
- Denial
- Busy work
- Drugs/alcohol

Tell them to think back to their own crisis. The initial shock has worn off and you're not in the position of having to deal with the crisis. As time passes, our emotions change.

Ask the participants: "Now that some time has gone by, what are you feeling now?"

- Anxiety
- Anger
- Fear
- Sadness
- Avoidance
- It's important to point out that this process is personal and different with every individual. Someone may not feel all the emotions listed or in the same order.
- The stages could take someone a week and another person a year. The stages of a crisis are not linear. If someone has felt fear at one point, it doesn't mean that fear won't be felt again.
- Because there is no one way that people respond to trauma this sometimes has created difficulties for helpers in other systems (police, judge, DSHS caseworker, etc.) in thinking that the person is not "acting like a victim." Give an example:

- Let's look at the stages of a crisis. Refer to the Stages of a Crisis handout.

- The Stages of a Crisis is a model that represents a person's perception and emotional reaction to a crisis.

- A person experiencing crisis may feel:

    - Devastated

    - Out of control

    - Like they are going "crazy"

    - Like they are hitting their heads against a brick wall

- A person starts reacting to this crisis by using their coping skills. The problem solving skills they have used in the past may be tried, but they may not be adequate in dealing with this new crisis.

Ask the participants: "When things aren't working for people can you imagine how they might feel?"

- Frustration

- Self-doubt

- Depression

- Loss of self-esteem

- Increased dependence

- Despair

- The crisis and emotions may lead someone down the Angle of Disorganization to Disequalibrium. This is a stage of maximum arousal, heightened suggestibility, and vulnerability to good and poor advice. This is why we don't give advice!

- They are using old coping mechanisms for a new crisis, and also looking for new solutions. This may be a long or

short process. Some survivors have been in the Disequilibriam stage for years.

- Crisis intervention involves helping survivors access their personal strengths and resources. This is based on the values of empowerment and self-determination.

- Hopefully, with our support, new coping strategies will be tried which will lead to some sort of resolution. Survivors may start to regain self-esteem, confidence, and hope.

- And eventually the survivor reaches a point of Recovery. There is a sense of relief and maybe a sense that things are back to normal. In Recovery, a person accepts the changes that came with the crisis and may have found opportunities for growth and new skills.
- We hear from survivors of sexual assault in every one of these stages. What we are likely to see is a "snapshot" of a person's experience and where they are at in the process. Rarely do we get the whole picture, and for that reason we need to support the person with where they are at and work with the information they are comfortable providing.

- The Stages of a Crisis model is a tool for us, but remember, each person is different. We can't expect their experiences to fit neatly into a box.

- It is important to note that a crisis differs from an emergency. A crisis is the inner state of a person who is reacting to stress when their normal coping mechanisms are not working. An emergency is a situation which requires immediate external action on the part of someone to prevent injury or death.

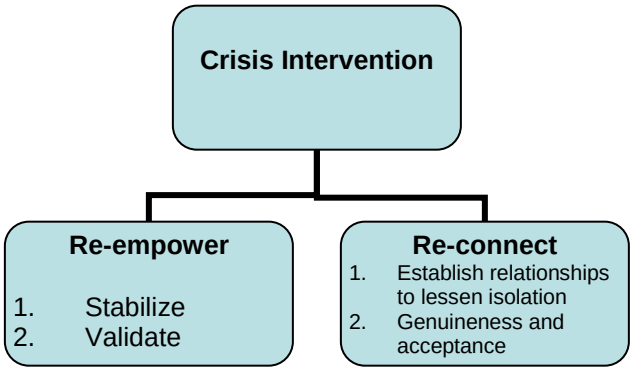
- It is possible for a person to be both in crisis and an emergency situation. An example is a person who is suicidal. We will be talking later about what to do if a caller is in an emergency situation.

- Crisis counseling is based on a set of guiding principles and goals. One is that the uniqueness of each person's crisis be respected. The other belief is that people in crisis are responding in a normal fashion to a toxic environment.

- The two most important goals at the crux of crisis intervention are re-empowerment and reconnection.

- Judith Lewis Herman states in her book, Trauma and Recovery (1992), that the core experience of trauma is disempowerment and disconnection. Thus, recovery is about reconnection and re-empowerment.

S: Crisis Intervention



- The goal of re-empowerment can be accomplished through two methods – stabilization and validation. We will first discuss stabilization.

S: Stabilization

- Some survivors may contact the center only hours following their assault and their emotions may be extremely intense.

- There are two ways to help stabilize someone:

    - Establish safety – Are they suicidal, in need of immediate medical care or immediate danger of further assault?

    - Help them manage their emotions – The goal is to help them calm down, to decrease overwhelming

emotional upset, to increase contact with the here and now and to increase survivor's sense of control.

- Stabilization strategies are typically more active or directive and involve strategies to assure immediate support and additional coping resources.

- Stabilization techniques establish concrete action steps for the survivors. This is done within the context of a collaborative relationship.

Read the following example: A survivor calls and is feeling hyperviligent, unable to sleep, unsafe, and is extremely angry at himself for "not fighting back."

Ask the participants if they can think of ways that might help stabilize someone who is feeling overwhelmed or out of control.

Discuss the following possible points:

- Let them know their reactions and feelings are normal.

- Help them find ways of making their surroundings safer (change locks, putting the phone by the bed, propping something up against the door).

- Grounding: "Look around the room and tell me what you see." "Take a deep breath."

- Get out of bed and do something else.

- Write down thoughts.

- If they had sleep disturbances in the past, what helped?

- Allow the survivor to talk until they are calmer.

S: Validation

- Validation is a core goal for our advocacy with all sexual assault survivors.

Ask the group about a time when they felt validated. What made them feel that way?

Ask them to think of a time when they didn't feel validated. What were the actions of the other person that caused them to feel invalidated?

- Validation occurs when the advocate shows concern for the survivor's well-being, communicates empathy for their experience and its effects, offers meaning emotional support, and provides helpful information.
- You can validate:
    - their value and rights as a person
    - feelings about the sexual assault
    - strengths and courage
    - ability to recover
    - sense of power and self-worth
    - empathy, not sympathy

S: Reconnection

- The second goal in crisis intervention is reconnection.
- We seek to establish a relationship that can lessen a survivor's feelings of alienation and isolation, both with us as advocates and their external support system.
- A trusting connection built on rapport is very important because it will, in part, determine whether the survivor follows up their initial contact with on-going support.
- Remember that aspects of sexual assault sometimes make the formation of this helpful working relationship a difficult task.

- The survivor is likely to experience strong emotions when talking about their experiences. This may translate into not keeping appointments, being late, etc. Do not take this personally. Talking to an advocate is liable to be unpleasant as well as helpful.

- Some survivors are extremely sensitive to the reactions of the advocate. This may include those who have experienced being blamed by others, being taken advantaged of, or abused by people in authority.

- Those who have a negative view of themselves in the aftermath of the assault (self-blame) may also expect to see such judgmental reactions in others.

- Reconnection also refers to establishing connections with other people in their lives. This type of reconnection can include self-disclosure to others, so it may be helpful to talk about ways the survivor can ask for help from others, gauge trustworthiness, assert healthy boundaries, etc.

Sources:
Herman, Judith Lewis (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror.* New York: BasicBooks.

Activity: Roleplay Introduction
Time: 11:15 – 12:00 (5 minutes)

- At this time we are going to build some skills related to the topics we have discussed over the past two days. We will be doing some roleplays in order to help you build those skills.

Note to Trainers: It is natural for participants to feel some degree of anxiety about role-playing. Preparing them thoroughly can help relieve some of the anxiety and make the experience more helpful and productive. Summarize the following:

Because it has a "performance" element to it, some participants feel hesitant and may suggest or prefer other teaching methods. Tell participants that it is normal to feel some hesitation about role-playing.

Participants need to know why you have chosen to use roleplaying. In addition to practicing skills and techniques, roleplaying also helps build empathy.

Point out the "emotional knowledge" that comes with doing roleplaying. For example, just as you may feel anxious, nervous, or hesitant doing roleplaying, survivors often feel the same about talking to us.

It is important to emphasize that role-playing is a great opportunity to practice skills, clarify information, receive support and feedback, and learn from other participants.

Help participants understand that this is a safe space to make mistakes and an opportunity to learn from them. We don't expect perfection!

Emphasize that learning may entail being challenged on their behaviors or attitudes. Ask them to try to remain open to feedback.

Encourage participation by expressing your confidence in their abilities.

Trainer Demonstration
11:20 – 11:30 (10 minutes)

Tell the participants that the trainers will first demonstrate, and then they will practice.

1. **Act out the scenario below.**

2. **Tell participants to observe.**

3. **Debrief the scenario by asking observers the following questions:**

   - What did the advocate do well?

   - What could be improved?

   - What would you have done differently?

   - What active listening skills did you observe?

Sample Survivor Role Card:

You were sexually assaulted three weeks ago and have told no one. You're afraid you're pregnant and can't imagine what you and your husband will do if you are. Since he has been out of town for the past month, he'll know that the child isn't his. You don't know where to begin.

Note to trainer: You can use any scenario.

Activity: Roleplays
11:30 – 12:00 (30 minutes)

1. Divide the group into triads – one will be the advocate, survivor, and observer.

2. Instruct survivors to develop their empathy skills by representing what a survivor may really be experiencing. Memorize the scenario and ad lib if necessary; don't overwhelm the new advocate!

3. Instruct the advocate to use their listening and communication skills to support the survivor.

4. Instruct observers to pay attention and provide feedback to both advocate and survivor.

5. Pass out roleplay scenarios to each group. Make sure each group gets at least three different scenarios so each person can practice each role.

6. Process the exercise as an entire group after the roleplays.

Points to cover:

- Encourage participants to talk about their successes and explore common issues or problems. Ask the group for suggestions to deal with particular challenges.

- Discuss how it felt to play different roles.

- Provide feedback from your own observations about how different techniques were used effectively.

- Provide participants with lots of positive reinforcement for being willing to show their vulnerabilities and learn from one another.

Lunch 12:00 – 1:00

Lesson 3: Suicide Intervention

Time: 1:00 – 1:30

Length: 30 minutes

Lesson(s): Suicide, Suicide Assessment

Learning Objective(s): To be aware of one's own thoughts and feelings related to suicide and to become familiar with lethality assessment.

Participant Handout(s): Suicide Intervention Flowchart

Lecture: Suicide
Time: 1:00 – 1:20 (20 minutes)

- The experience of sexual assault may bring up intense feelings of grief and loss for the survivor. Losses due to the sexual assault(s) may be many, including friends, family, partner(s), connections to communities, and physical health.

- As we discussed earlier, normal coping skills may be tried but unsuccessful. These feelings of grief and loss may precede a crisis and ultimately suicidal ideations.

- It is important that we know that sometimes/seldom the issue of suicide will come up. It is important to prepare for this before you are faced with the situation.

- It might be helpful to think about your own attitudes about death, dying, and suicide. Your personal beliefs about suicide must be put aside. Non-judgmental crisis intervention is required.

- If you are faced with a suicidal caller, crisis intervention takes a slightly different approach. As we mentioned, an emergency situation requires advocates to be more directive.

S: Suicidal Callers

- Use **active listening skills** and focus on establishing and maintaining empathetic contact with the client in order to reduce their feelings of isolation and helplessness.

- It is usually not useful to try to argue or debate about someone's decision to kill themselves. It is more useful to actively listen to their pain and isolation. This will help the person become aware of their ambivalence over killing themselves.

- If you are hearing hints of suicide, don't be afraid to ask the person, "Are you thinking of killing yourself?"

- Avoid euphemisms such as "are you thinking of doing something?" Your straightforward approach and willingness to talk will be refreshing for the client. If the client is not thinking of suicide, they will most likely tell you.

- **Assess lethality**. The lethality of the client will determine how you proceed with the call.

- An assessment tool is important for anyone counseling a suicidal person. It assists you in determining, as accurately as possible, how likely a given individual is to attempt suicide in the immediate future.

- Such an assessment:

    - Provides a basis for intervention

    - Aids in discriminating between a potentially lethal suicidal person, low lethal suicidal person, and acts of self-harm

    - Helps deal with your own anxiety by providing concrete action steps

- Suicide assessment steps:

    1. History –
        Any previous attempts?
        How many?
        When?
        Lethality of method used?
        Response of others?
        Note that lethality increases with the number and severity of previous attempts.

    2. Plan –
        Does survivor have a plan?
        How specific?
        How lethal is the method chosen?
        Are the means (pills, weapons, etc.) accessible?

    3. Resources -

        a. Internal - What are their strengths, flexibility? Ability and willingness to consider alternatives to suicide?

        b. External – What resources (family, friends, helpers, etc.) do they have? To what extent does client feel cared about by them? To what extent does the client feel able to communicate/ask for help?

- With suicidal survivors it will often be necessary to make a **referral**. To make a referral, you can say something like, "I'm really worried about you. I'd like to call someone who has more experience helping people who feel like you do."

- You may also need to get help from another advocate so that you can continue to help the caller. You can say something like, "I would like to talk to someone else who can help me help you. Can you promise you'll stay right where you are?"

- As you are ending the call, it is also important to try to get a **short-term agreement or "contract"** with the survivor. After you have established a relationship with the client, they are more likely to agree to a contract.

- For example, "Will you make a commitment to me that you will not do anything to hurt yourself today/tonight and that you will call a supportive person today/tomorrow? Will you agree to call me before then if you feel like hurting yourself again?" Be sure to add specific details.

- The time length of the contract should be no longer than 24 hours. There should be some stipulation that the person will contact a helping professional if the client is still considering suicide.

- There should be a very concrete, specific plan of what the client will do between now and the arranged call or visit to the helping professional.

- You should plan a **follow-up** call to see if the survivor followed through on the referral and contract.

Activity: Suicide Assessment
Time: 1:20-1:30 (10 minutes)

1. Read each of the scenarios aloud.

2. Ask the participants what active listening skills they would use.

3. Have the participants use their Suicide Intervention Flow Chart to determine the level of lethality.

4. Ask them if they would make a contract with the caller.

5. Have the participants list some possible referrals for the caller.

6. Debrief any of their questions and concerns.

Suicidal Survivor Role Card

It is 3 a.m. and the caller does not state their name. However, the survivor has called during this particular time on four other occasions. He doesn't want to talk about his situation tonight and won't talk about his feelings. Based on previous calls, the advocate thinks he might be suicidal, but he won't willingly talk about it tonight. He says he just doesn't want to be alone.

Suicidal Survivor Role Card

A 17-year-old girl calls and wants to talk about being raped by her neighbor. She is very confused about what to do. Her family blames her and says that if she didn't act like a slut he wouldn't have taken advantage of her. Now she feels like her reputation is ruined and she won't be able to find a good husband. She says she is feeling really depressed and has some pills that she is thinking about taking. She has had had two previous suicide attempts.

Wrap up the section.

Discuss the following possible points:

- Crisis work is very emotionally difficult and can be physically taxing too. You should get support for yourself as you do this work.

- It is important to realize that the suicidal survivor may choose to die. Don't put yourself into the role of all-powerful rescuer. If you fall into this trap it may be difficult for the client to move forward in the healing process. It may also be hard for you to come to terms with a survivor's possible or actual death. Be aware of this when handling a suicide call.

Medical Advocacy

Lesson 4: Medical Advocacy

Time: 1:30 – 2:45

Length: 1 hour, 15 minutes

Lesson(s): Why Is It Important?, The Medical Advocate's Role, Comfortable vs. Uncomfortable, Tips of the Trade, The Rape Exam: Helping the Victim

Learning Objective(s): To learn about the role of a medical advocate and practice the skills needed to provide effective advocacy.

Participant Handout(s): Tips of the Trade for Medical Advocates

- At this time we are going to discuss what is known as medical advocacy. This can include supporting a survivor through a forensic exam, accompanying them to terminate a pregnancy, ensuring follow up care, etc.

Activity: Why Is It Important?
Time: 1:30 – 1:40 (10 minutes)

1. Ask the participants what they think some the reasons that prompt medical care can be important for sexual assault victims.

2. List the responses on a flipchart. Be sure to discuss the following points:

- Detection and treatment of any physical injuries, both internal and external.

- Detection, treatment, and/or prevention of sexually transmitted infections.

- Detection and prevention of pregnancy.

- Collection of medical evidence that can be used during prosecution.

- Identification of any non-medical concerns of the victim and referral to other service providers.

- Providing reassurance that the victim can be cared for physically.

- Ascertaining the need for follow-up examinations and tests.

- It can be important for rape victims to seek medical care as soon as possible, both physically and emotionally.

- There are basically two types of medical conditions post-sexual assault: acute and non-acute.

- An acute medical situation is one in which a victim has recently been raped (particularly in the last 120 hours). This timeframe is crucial if the victim wishes to have forensic evidence collected for prosecution now or later.

- The forensic exam at the hospital emergency department will include collection of any forensic evidence.

- Your client may want to shower, bathe, or douche before going to the hospital but they need to be made aware of the fact that forensic evidence may still be on/in their body and that these "cleansing" actions may wash away that evidence.

- The victim may be thirsty, hungry, or want to smoke. Again, these actions may impact forensic evidence collection.

- If they need to use the restroom, ask the nurse if they want the victim to collect a urine sample.

- For non-acute medical situations, the victim may still seek medical care in order to determine if they incurred internal and/or external injuries, pregnancy if the victim is female, receive emergency contraception, and be given information regarding sexually transmitted infections.

- Regardless of the situation, the final decision of whether to have forensic evidence collected and/or receive medical care is a decision the victim must make for themselves. It is never appropriate to persuade a survivor to do something they don't want to do.

- Your role as a medical advocate is to provide them with all the information you have and support their choices.

Lecture: The Medical Advocate's Role
Time: 1:40 – 1:50 (10 minutes)

- The advocate who is present with a sexual assault victim in the hospital emergency department during the forensic and medical exam plays a crucial role in supporting the victim to become a survivor.

- It is during this crisis state that the victim needs an empathetic, open-minded, respectful, and understanding support person.

S: At the Hospital

- At the hospital, the advocate can serve as:
    - An information resource - Answering questions and explaining medical procedures, follow-up testing, possible future concerns, and crime reporting.
    - An active listener - Helping the victim sort through and identify feelings and concerns.
    - A resource identifier - Assisting the victim in thinking about those people in her/his life that could be a support.
    - A reality tester - Letting the victim know their reactions are normal, what may happen in the near future, and dispelling the myths and misconceptions they may have.
    - A representative of the rape crisis center – A person that will be there whenever and for whatever the need is.
- When a victim chooses to go to the hospital, this is a very difficult time. The victim will most likely be upset, scared, and anxious. Your role is to help the victim feel as comfortable as possible, and to prepare the victim for what will happen.
- It is important that you become very familiar with the steps that a victim goes through so that you can prepare survivors who are considering going to the hospital or to support a survivor who has already arrived at the hospital.
- You will need to know:
    - Check-in process
    - Where to take/meet the victim
    - Who to talk to
    - Evidence collection procedures

- Crime reporting options and outcomes

- Before we talk about what to do, I want to do a brief activity with you.

Activity: Comfortable vs. Uncomfortable
1:50-2:00 (10 minutes)

1. Most of us have experienced going to the doctor, emergency department, getting gynecological exams, having blood work drawn, surgery, etc.

2. Instruct the participants to take a moment to think about an uncomfortable medical experience and what made it uncomfortable or difficult, and what would have made it a more positive experience.

3. Ask the participants to list some uncomfortable medical experiences and why they were difficult or negative.

4. Ask the participants to list some positive medical experiences and why they were positive.

5. List the responses on a flipchart.

Wrap up the activity.

Discuss the following possible points:

<u>Uncomfortable:</u>
- Wearing exposing gowns
- Not being told what will happen
- Not being listened to
- Painful procedures
- Feeling out of control
- Waiting for results
- Lots of people around
- Not being asked permission before being touched
- Being cold
- Repeating information

Comfortable:

- Being told about procedures
- Knocking on the door
- Being listened to and respected
- Having someone give you a warm blanket
- Respecting the pain you are in
- Genuineness, warmth, compassion
- Asking permission to be touched

- Notice how the uncomfortable aspects of a medical experience can seem similar to the traumatic incident.

- Again, your role is to try and facilitate as much of the "comfortableness" as possible. Do the things that you would want someone to do for you.

- You should try to minimize distractions and discomfort as much as possible and increase the decision making and power of the victim.

Describe the following scenario:

- It is the middle of the night. You have just been at the hospital for four hours supporting a victim through a forensic exam. The victim is a young man with a small build. He decides to report the incident to the police. While waiting for an officer to arrive, you and he wait in a cold quiet room. You get a blanket to try and make him feel comfortable. When the officer arrives you see that he is 6'3" and weighs about 225 lbs. He is in uniform and has his baton and gun attached to his belt. This particular police officer has a very good understanding of sexual assault and attempts to decrease the uneasiness and power disparity by getting down on his knee to talk with the victim. What he did was incredibly sincere and made the victim feel more at ease.

Ask the participants what they would do if the officer did not have the same level of understanding and sincerity.

Discuss the following possible points:

- Politely offer the police officer a chair to sit in.
- Do not be confrontational; step out of the room to voice your concern.
- Report unacceptable behavior to your supervisor.

Break 2:00-2:15

Lecture: Tips of the Trade
Time: 2:15-2:30 (15 minutes)

- Follow your organization's protocols for responding to a hospital call.

- When on-call, go to the hospital when notified by victim, hospital staff, or police. Be timely, the victim may have been waiting a while or already have started the exam.

- Eat something before you leave the house; bring a snack! However, make sure to not eat in front of the survivor since they will not be able to eat. Also, bring a book or other activity, since you may be there for a while.

- Introduce yourself to the victim and identify yourself as an advocate. Explain what your role is. Obtain permission from the victim to stay and support them through the process.

- Celebrate a survivor's decision to decline your presence. It is not about you AND it shows that the survivor feels empowered to make decisions when a huge decision was just taken away from them. This is a positive step in the healing process.

- If an interpreter is needed, be sure to advocate for one. Children and/or relatives are not appropriate interpreters for many reasons. Some of the key reasons are that private information needs to be protected and medical terminology needs to be accurately translated.

- Act as an attentive and supportive listener if the victim wants to talk. Do not elicit information regarding the crime.

- Explain to the victim why medical care is important and what medical procedures to expect.

- Remain with the victim until the doctor or sexual assault nurse examiner/forensic examiner (SAFE/SANE) arrives for the medical examination.

- The victim has the right to have a support person present. Whether or not there is a support person present and who

that support person is, is up to the victim. Ask the victim if they wish for you to remain in the room during the medical examination for emotional support.

- Be prepared to be asked to leave. If you are asked to leave, offer other forms of assistance: check-in after medical examinations; give them a call in a few days, etc.

- If the survivor wants you to stay with them during the exam, keep in mind these tips of the trade:

    - The possibility of pregnancy may be something the victim is worried about. Be sure you are supportive and patient and clarify any information needed to make decisions.

        - Let the survivor know you have resources to refer them to if they do become pregnant. Be familiar with these resources in your community.

        - There are also hotline resources:
            - Amara – (206) 260-1700
            - Backline – (888) 493-0092

    - Be sensitive to cultural or religious concerns that the victim may have when discussing pregnancy. Put your own biases aside.

    - Have change for vending machines or bring snacks for victim to eat after the medical exam. The hospital may provide something for the survivor to eat because taking some medications on an empty stomach may cause nausea. Only offer food to the survivor yourself after getting an ok from medical staff.

    - If possible, provide the victim with a set of clean clothes and a few toiletries after the exam. The victim's clothes will be taken as evidence. Some hospitals allow rape crisis centers to store these kits in or near the exam room.

    - Try to get a good understanding about their value systems. Different cultures and communities will have

different values about expressing pain, what respect means, and dealing with medical personnel.

- One way to provide effective hospital advocacy is to assess from the victim what their concerns are and what they hope to get out of the procedure. Common concerns are pregnancy, injuries, and sexually transmitted infections. We will be covering those concerns in more detail.

- However, your job is not to interview the victim or get involved in the investigation. Whatever information you may need for your intake paperwork will likely be obtained just from listening to the victim talk to the sexual assault nurse examiner and/or police.

- Another important thing you will need to do is practice appropriate body language. Although you might not see a lot of blood and/or injuries, it is possible. You will certainly be hearing some really difficult information and stories. Your reaction is crucial. Should you flinch, vomit, pass out, etc. you may lose the respect and trust of the victim and hospital staff.

- Practice hearing difficult things with co-workers. This is something that should be roleplayed. You need to be able to react appropriately.

- Explain the importance of follow-up health care and supply victims with information about appropriate health care clinics.

- Advise the victim that additional services are available from the organization.

- Ask the victim for a phone number and indicate that you will call them in few days to check-in. If the victim gives you permission to call them, be sure and ask how to identify yourself over the phone and/or in messages.

Film: The Rape Exam: Helping the Victim
Time: 2:30-2:45 (15 minutes)

1. Show the film The Rape Exam: Helping the Victim

2. Ask the participants what they noticed about the advocate. How did she assist the victim? What information did she provide?

Note to trainer: Although this film is an excellent depiction of advocacy in action, it contains some outdated information about the forensic medical exam. Trainers should make themselves familiar with current practice by talking with a SANE in their community and/or viewing the Medical Advocacy lecture referenced below.

Lesson 5: Forensic Exams

Time: 2:45 – 3:45

Length: 1 hour

Lesson(s): Evidence Collection

Learning Objective(s): To understand the process of a sexual assault forensic exam and to view the medical instruments used by the nurse/forensic examiner.

Participant Handout(s): none

Lecture: Evidence Collection
Time: 2:45 – 3:45 (1 hour)

Note to trainer: Have this section presented by your local sexual assault nurse/forensic examiner. It is best to have the information presented by a practitioner if possible. A SANE/SAFE will be up-to-date on all the current practices, it will help build good relationships between your organization and the hospital, and participants enjoy interacting with a guest speaker. You may need to be prepared to provide clarification, additional information, and answer questions after the SANE/SAFE presentation.

If you are unable to have this section presented by a local SANE/SAFE, WCSAP has a videotaped lecture by Barb Haner, a SANE at Providence Intervention Center for Assault and Abuse, that covers this content. You can access this Medical Advocacy video at learn.wcsap.org in the Advocate Core Initial Training section. If you do not have an account, you can set one up for free by following the instructions in the lower left hand corner of the learn.wcsap.org homepage. After you have logged in, you will have access to the lesson, "Medical Advocacy" which covers this lesson. You can watch the video as a group, or assign it to participants as homework. Be sure to watch the video yourself ahead of time and be prepared to answer questions.

Lesson 6: Medical Concerns for Survivors

Time: 3:45 – 4:35

Length: 50 minutes

Lesson(s): Medical Concerns for Survivors, Roleplays, After the Exam

Learning Objective(s): To further understand the role of a medical advocate and practice the skills needed to provide effective advocacy.

Participant Handout(s): Survivor's Role Cards

Lecture: Medical Concerns for Survivors
Time: 3:45-4:00 (15 minutes)

- There are likely to be several medical concerns for survivors of sexual assault. They commonly include pregnancy and sexually transmitted infections. We will discuss these issues in detail as well as some other items that survivors may not have thought about.

S: Pregnancy

- The risk of pregnancy following a sexual assault is dependent upon the nature of the assault, time of the assault in relation to the survivor's menstrual cycle, their current use of contraception, and individual factors relative to their fertility and the assailant.
- The use of any post-rape forensic examination and/or treatment is a very personal matter, and as a health issue, should be seriously considered. Victims of rape should receive information, counseling, and/or referral with regard to all their options.

- Emergency contraception prevents an egg from being fertilized. EC will not affect a pre-existing pregnancy. It is equivalent to a larger dose of birth control pills. EC is most effective if taken within 72 hours of the sexual assault, but it can still effective up to five days (120 hours) following an assault.

- Emergency contraception, often referred to as the most common brand name, "Plan B", should be available as part of the forensic exam, and is a covered expense of the exam. Hospitals are required by law (RCW RCW 70.41.350 & WAC 246-320-370) to provide EC to victims of sexual assault.

- Recent court rulings have made EC legally available for purchase without a prescription. People 17 and older can obtain EC without a prescription, from a pharmacist (behind-the-counter). Victims under 17 may still need a prescription to obtain EC.

- For victims who choose not to have a forensic exam or seek other medical treatment, obtaining EC this way can be a good option.

- Though emergency contraception is not abortion, some medical facilities and some pharmacists have attempted to refuse to provide certain treatment due to a moral stance.

- Advocates should be aware that whether or not a victim discloses an assault in seeking EC, medical providers and pharmacists may make unhelpful or harmful judgments or statements when a victim seeks EC. If possible, advocates should know where a victim may obtain EC in their community without judgment.

- For more information about EC, view WCSAP's recent recorded webinar: http://www.wcsap.org/emergency-contraception-recorded-webinar.

S: Sexually Transmitted Infections

- While a victim's first medical concerns may be directed at physical injuries and possible pregnancy, there is also concern about the possibility of STIs.

- It may be a sensitive topic or the survivor may know little about it. You may have to bring the subject up, since exposure and prevention will be an issue during the medical exam.

- STIs are one of the most common kinds of infections in American today. Every year more than 10 million Americans get STIs passed primarily by sexual contact.

- As part of the medical examination, the examiner may prescribe STI prophylaxis. Follow-up tests should be conducted for gonorrhea culture in 3 to 8 days and a test for syphilis in 6 to 8 weeks.

- There is obviously nothing a victim can do to prevent primary exposure to STIs. However, what might be termed "secondary prevention" can be practiced.

- This includes self-examination for signs of possible infection, as well as taking the responsibility to go for screening tests at appropriate intervals and being faithful in following any prescribed treatment when diagnosed as having STD. Lastly, the victim must make sure they have been cured by returning for follow-up after treatment.

- Sexual assault victims should not be tested for HIV during the forensic exam. An HIV/AIDS test at this time would only provide information on whether or not a victim already has HIV/AIDS, not if she or he contracted HIV from the assault.

- Also, someone who has just been sexually assaulted is most likely not in the proper mental and emotional state to receive pre-test counseling for HIV.

- However, a healthcare provider can help victims assess immediate risks and whether HIV prophylaxis is warranted.

Post exposure prophylaxis must be determined on an individual basis. Be aware that prophylactic medications for HIV are highly toxic, and the regimen is difficult. PEP regimen is 2-3 medications for 28 days, and must be started within 72 hours of the sexual assault.

- High risk factors for contracting HIV include:
    - Anal rape
    - Vaginal rape when other STDs are present that would threaten the integrity of the vaginal muscosa
    - Vaginal rape with traumatic tearing injury
    - Known or suspected HIV positive offender
    - Known or suspected IV-drug use by the offender
- There are two common methods of HIV testing: anonymous and confidential.
- Anonymous testing sites have no way of connecting a person's name and address with the test information. Those who present for testing are given a code, which has to be remembered in order to find out the test results.
- Confidential testing sites record the names and addresses of those who are being tested. This information is then documented in the person's medical records. Even if the test is negative, the medical file will still state that an HIV test was performed. However, no one can give out patient results without permission, except as required by law.
- Anonymous testing is strongly recommended over confidential testing in order to protect the survivor’s privacy.
- All positive STI/HIV results are reported to the Health Department, regardless if anonymous or confidential.

S: Crime Victim's Compensation

- Payment for medical care services related to the assault may be a major concern for survivors.

- In Washington State and in all of the United States (VAWA) a victim is not required to report the incident to the police, in order to seek a forensic exam.

- A victim should never be billed for the forensic exam itself regardless of whether they choose to report the assault to law enforcement.

- The exam is performed, evidence is stored (duration depends on several local factors), and a police report can be made at a later time if the survivor chooses.

- Washington State's Crime Victim's Compensation is a secondary insurer that will cover expenses for the forensic exam, medications, and up to the full 28 doses of HIV prophylaxis even if there is no intention to follow through with prosecution.

- Crime Victim's Compensation (CVC) covers the cost of all Sexual Assault Forensic Exams in WA State. It is important for advocates to know that survivors DO NOT need to complete a CVC application to receive this benefit, it should be automatic and the survivor should not receive a bill or have to provide insurance information.

- The victim must file a CVC claim to have *associated care* covered. For example, if I was raped and broke my arm CVC would pay for the forensic exam but may or may not pay for the broken arm. A separate claim would need to be filed and a victim's insurance will be billed first.

- This can be done at a later time, when the survivor is not in crisis.

- Be prepared to assist the victim with CVC forms. If they are not available at the hospital, be sure and have one on hand.

- For more information about CVC, view WCSAP's recent recorded webinar: http://www.wcsap.org/crime-victims-compensation-what-sexual-assault-advocates-need-know-0

- You can also call the Crime Victims Compensation Program at (800) 762-3716 or visit their website: http://www.lni.wa.gov/ClaimsIns/CrimeVictims/About/.

Activity: Roleplays
Time: 4:00-4:25 (25 minutes)

1. Divide the group into triads – one will be the advocate, survivor, and observer.

2. Instruct survivors to develop their empathy skills by representing what a survivor may really be experiencing. Memorize the scenario and ad lib if necessary; don't overwhelm the new advocate!

3. Instruct the advocate to use their listening and communication skills to support the survivor.

4. Instruct observers should pay attention and provide feedback to both advocate and survivor.

5. Pass out roleplay scenarios to each group.

6. Process the exercise as an entire group after the roleplays.

Lecture: After the Exam
Time: 4:25 - 4:35 (10 minutes)

- After the exam, the victim may change clothes, receive instructions, and get prescriptions.

- Be sure written instructions are received since they are under extreme emotional stress and may forget verbal instructions.

- There may be difficulties in leaving the hospital. The victim may be afraid to leave, or may have no transportation.

- There may be feelings of grief and loss.

- At this time you, as the advocate, need to:

    - Help the victim sort through fears about leaving

    - Check to see what support base they can now turn to

    - Inform client of available and accessible support systems in the community which may be needed

    - Make sure they know about Crime Victims Compensation

    - Set up a follow-up call/appointment in 2-3 weeks if they want. Make sure you find out if it is okay to identify yourself when you call and to leave a message

    - Make sure they have and understand information about sexually transmitted infections

    - Make sure, if the client is able to conceive, that they have made an informed choice at emergency contraception

    - Make sure there is a safe place for the victim to go

    - Let the client know advocacy services are available as needed

- Try not to overwhelm the victim. Be sensitive to the process they just went through. Don't be surprised if they forget who you are when you call them to follow up.

Lesson 7: Medical Advocacy with Children

Time: 4:35 – 4:50

Length: 15 minutes

Lesson(s): Special Situations

Learning Objective(s): To provide a basic understanding of how child/teen forensic exams are different from adult forensic exams.

Participant Handout(s): Providing Health Care to Minors Under Washington Law

Lecture: Special Situations
4:35-4:50 (15 minutes)

- It is very important to become familiar with your county's child abuse protocols and develop collaborations with your local children's advocacy center.
- When working with children/teens, remember the assault was likely perpetrated by someone they know – they may be feeling guilty and sad.
- Help to alleviate fears and concerns. Keep things age-appropriate. Stay calm.
- Parents, who are generally as traumatized as the child, also need reassurance, guidance and warnings not to magnify the situation in front of the child.

S: Child Victims

- Children (age varies based on developmental appropriateness, usually under 12) are often taken to the Emergency Department or Children's Advocacy Center by

their caregivers upon learning that sexual abuse has occurred, regardless of when it happened.

- The dynamics of working with a child can be very different from working with adults.

- Reassure the parent/caregiver that the medical assessment children experience is similar to their child's regular medical exams. *Very seldom* is anything inserted into the child's body and if this is necessary, the child will be sedated.

- Besides documenting the history, health status, and injuries associated with the sexual assault/abuse and identifying any potential evidence, the exam is important to assure the child themselves that they are physically ok.

- It is normal to be normal. Meaning, only about 20% of children have medical findings that indicate sexual assault/abuse. This does not mean sexual assault/abuse did not happen! Advocates should be ready to normalize this and provide validation for children and caregivers.

S: Teen Victims

- Many of the same objectives exist for the teen victim of sexual assault as for the adult victim in the medical setting:

    - Support throughout the exam

    - Discuss options around STIs and pregnancy

    - Maintain appropriate records/paperwork as directed by your agency's protocols

    - Initiate follow-up health care and advocacy if appropriate

- There may be situations where it is advisable to have an advocate for the child and a separate advocate for the parent/caregiver. This is particularly important when the child/youth is consenting to services themselves, and the caregiver is receiving services separately. It can help

ensure that each survivor/secondary survivor receives adequate support unique to their needs.

S: Consent for Services and Mandated Reporting

- Washington law provides that youth may provide consent for some medical care services themselves (see handout). There is no law that specifically addresses youth consent for the forensic exam. Advocates should become familiar with the protocols of the hospital/CAC doing the exams, as practices across the state vary.

- If a teen is not allowed to provide consent to receive the exam themselves, they should still be able to say no to portions of the exam they are uncomfortable with. A medical provider should not force anyone to undergo a procedure unless it is a life-threatening emergency.

- However, even with teens who can consent to medical services, mandated reporting is still obligatory, so some of the dynamics will be different.

- There will be more systems to navigate – law enforcement, child protective services, hospital social workers, and parents.

- Medical providers and advocates are mandated reporters RCW 26.44.030. Even if the medical provider makes a report, the advocate should still make their own report. A mandated reporter should not abdicate their obligation to an employee from a different agency.

- Sometimes the medical provider may contact law enforcement or CPS prior to your arrival or without the child's or caregiver's knowledge.

S: Significant Others

- Many people may accompany the survivor to the hospital. It is important for the advocate to know whom the victim

wants with them at the forensic exam or medical assessment.

- The victim will have enough stress getting through the medical procedures, and they don't need additional interactions that may impact their coping ability.

- Additionally, the victim may censor what they say because of the friend/family member who is also in the room.

- The teen or adult victim needs to be in control of when and how family and friends are told.

- The significant other may be a parent, lover, partner, husband, sibling, roommate, friend, employer or teacher. This person will influence the recovery process in either a positive or negative way.

- Significant others, as well as victims, need to be counseled and supported. Another advocate may need to be called to the hospital to the support the significant other(s) while you are with the victim.

- You must maintain confidentiality for whomever you are an advocate for. Know who your client is.

- Be cautious that the significant other may be the perpetrator. For example, a man who has just beaten and raped his daughter may take her to the hospital.

Wrap Up

Lesson 8: Wrap Up

Time: 4:50 – 5:00

Length: 10 minutes

Lesson(s): Main Points, Wall of Wisdom

Learning Objective(s): To summarize the content that was covered and to prepare participants for the day of skill building.

Participant Handout(s): none

Lecture: Main Points
4:50 – 4:55 (5 minutes)

Today we discussed:

- Active listening, including reflection clarification, paraphrasing, reframing, positive support, and focusing.
- Crisis intervention, including the two main goals of re-connection and re-empowerment.
- Medical advocacy, including the role of a medical advocate, tips, and forensic exams.
- We hope that you have gained some skills that you can begin to practice in order to provide effective advocacy with survivors of sexual assault. At this time we would like to do a final exercise that will help you identify some of the key points that you have taken away from this part of the training.

Activity: Wall of Wisdom
4:55 – 5:00 (5 minutes)

1. Place a flipchart on the wall entitled "Wall of Wisdom."

2. Pass out colored post-it notes.

3. Tell participants to think of 1-2 new things they learned and became more "wise" about and/or what can be brought back home with them.

4. Have them write these on these on a post-it note and place it on the flipchart. This is now the "Wall of Wisdom."

5. Take a few minutes to have some participants review their responses. Tell them that they can also take some time to record the most relevant responses for review later.