



Reactions and Responses to Sexual Violence



Self-Injury

By Jessica Bellock, Community Action Council, Sexual Assault Services

Key Learning Points:

- Because someone is self-injurious does not mean that they are suicidal. When someone is suicidal they are looking to “end” their pain and when someone is self-injurious they are trying to feel “better.”
- Self-injury is a coping mechanism. In order to stop hurting oneself, they must find something to replace that coping mechanism. Therefore you can not simply tell someone to quit hurting themselves without supporting them in finding a coping mechanism to replace it.
- People are self-injurious for many reasons. It is never safe to assume that someone who is self-injurious does it because they experienced sexual violence at some point in their life, or vice versa, that all sexual violence victims are self-injurious.
- It is important to focus on why the person is hurting themselves, not about the injury itself. They are injuring themselves because of something they’ve experienced and they need to find healthy ways of healing from that.

What is Self-Injury?

Self-mutilation. Self-harm. Self-abuse. Self-destructive behavior. Cutting. These are all terms used to describe self-injury. Self-injury is an action that one does against one’s own body that is conscious, deliberate, and causes physical harm. Self-injury does not mean a person is suicidal; it is a coping skill that the person has developed to ease emotional pain.

There are many different ways that someone may self-injure, such as cutting, scratching, burning, hair-pulling, bruising, and biting. If the intent is to relieve stress or tension, getting multiple tattoos or piercings can also be a way someone self-injures. Self-injury is a way people cope with pain, stress, and trauma. It is a way people find to survive what they have been through.

Many times people assume that someone who is self-injuring is trying to commit suicide. You can separate suicide attempts and self-injury by considering whether the person is trying to “end” all pain or trying to “feel better.” There are times where the self-injury goes further than intended and the injury becomes life-threatening. In addition, the feelings and situations that lead someone to cope or seek relief by self-injuring could later lead to them attempting suicide. So, although it is important to realize that self-injury and suicide are not the same, it is important to help the person who self-injures find more long-term solutions for coping with their situation.

Self-injury is commonly seen with victims/survivors of sexual violence, and advocates need to be prepared to respond to a victim/survivor who self-injures. As an advocate, it is important for you to understand why someone may self-injure and then learn ways to respond to someone who self-injures.

Why Would someone Self-Injure?

Many times people cannot understand why someone would choose to hurt themselves. Self-injury is a very complex issue, and there are many reasons why someone would do it. The following are some ideas about why someone would self-injure:

- Physical pain is easier to feel than emotional pain;
- Injuries are something concrete. The person can clean them and bandage them up. They take the person's attention away from other things. The person can care for his/herself when s/he feels like no one else will or can;
- The act itself releases chemicals in the body that calms the person down and numbs the body;
- The person may feel numb and detached, and use the act to bring him/her back to reality so that s/he can feel something;
- Self-injuries shift the focus and attention from the overwhelming emotional pain that the person is experiencing to the tangible physical pain that s/he has created. The person is in control of the pain and no one else is causing the pain;
- Self-injury is a way to release stress and tension. Everyone needs ways to do this, and the person who self-injures has adopted this strategy as the best way to feel a relief from what s/he is experiencing;
- Self-injury can become an obsession or an addiction. It can become a day to day activity. It can increase in both frequency and severity as the person needs more to cope with what is going on or s/he is feeling. It can be as hard to stop as trying to quit smoking or drinking. The person has triggers that make them want to self-injure;
- When the person doesn't have words to describe what s/he is feeling, the injuries become the words. The injuries show the pain, shame, and self-blaming;
- Sometimes people feel that they need to punish themselves for their thoughts or feelings. The person may think that s/he needs to punish him/herself for being in a situation where s/he was sexually abused or assaulted; and
- People are taught not to be aggressive or violent towards others. Self-injuring is a way that the person can take out his/her anger on something. It can be a way to express pent up feelings.

Sometimes people get caught up in the idea that a person is self-injuring to get attention. That can be true, but that does not mean that the person does not need help. Maybe the person doesn't know how to ask for help. Maybe the person doesn't think that there is help available. Maybe the person isn't getting the help and attention that s/he needs.

More often than not, the person does not talk about self-injuring or they tell only a select number of people they trust. Most people do it in secret and in areas of their bodies that they can keep hidden. Just as the victim/survivor may have shame and guilt regarding sexual violence, the victim/survivor may have shame and guilt surrounding his/her self-injuries.

What is the Connection Between Sexual Assault and Self-Injury?

The reasons listed above are some of the reasons why someone would self-injure, and you can see the relation to how someone may feel after they have been sexually

assaulted. Someone who has been sexually assaulted and is self-injuring may have been using self-injury as a coping skill prior to the sexual assault, or they may have developed it as a coping skill after the sexual assault.

Sometimes people assume because self-injury is common among survivors of sexual assault, it means that all people who self-injure have been sexually assaulted. It's important to know that just because someone self-injures, it does not mean they have been sexually assaulted. The same goes the other way around: just because someone has been sexually assaulted, it doesn't mean that the person will self-injure.

Victims/survivors have many different ways they learn to cope with the trauma they have been through. Just as they have survived a sexual assault, they are surviving all the feelings and thoughts that come afterwards. A victim/survivor may feel empty, lonely, shame, self-blame, a loss of power and control, and then may use self-injury as a way to cope with those feelings. Self-injury becomes a quick fix, but the relief is only temporary. Often this behavior magnifies the feelings that caused the person to use it as a coping skill, and the self-injury becomes a cycle. The person will need to find healthy ways to cope in order to facilitate the healing process.

How Should an Advocate Respond to Self-Injury?

- Do not focus on the physical injury; focus on the person. Self-injury is a sign and symptom of what is going on inside the victim/survivor. This is what needs attention.
- Listen to what the person is saying, and help them find words to describe what they are feeling.
- Do not tell or ask the person to stop self-injuring. The person needs help finding more coping skills.
- Talk with the person about a plan for what they can do next time they want to self-injure. Explore what has and hasn't helped them in the past. Help them identify the times they are more likely to self-injure.
- Think about how you may react if you find out that a victim/survivor is self-injuring. Be careful not to show disgust, disbelief, shock, or frustration.
- Assess suicidal risk while remembering that self-injury is not a suicide attempt.
- Affirm the victim/survivor's strength and courage for surviving the sexual violence they experienced and the courage it takes to be able to talk about it.
- Recognize that the person may pull back for awhile after telling you about the self-injuries. Give the person time, and let him/her know that you are there when they want to talk.
- Help the victim/survivor explore why they may be self-injuring and what they want to do about it. Just beginning to talk about how they are feeling can help lessen the need to self-injure.
- Discuss whether they want to talk to a professional. Recognize that you alone cannot help them and that overcoming self-injury can be a long process.

Often times, self-injuries are done in a location on the body that is easy to conceal. If you have suspicions that someone is self-injuring, respond as if they were self-injuring and follow the ideas above. If someone tells you that s/he self-injures or shows you his/her scars and injuries, remember that it takes courage and trust. You may be the first person they tell or the first person to respond in a way that doesn't make them feel embarrassed or ashamed.



If a victim/survivor self-discloses, you need to be aware how this could affect her/his healing process, as well as, options/resources within the community.



There might be times when you will be able to identify some of the warning signs with a victim/survivor you are working with. Are you prepared to have that conversation?



Are you prepared to have a conversation on sexual violence and self-injury? Do you carry anything that might make this conversation more difficult for you?

Bringing it Home:

- Are there specific resources in your community for victim/survivors that are struggling with self-injury?
- What are the counseling options in your community? Do they specialize in this area?
- Who within your community should become aware and understand the warning signs of a victim/survivor struggling with self-injury?
- What are measures your agency can do to bring awareness of this issue to your community?



Secondary Victims

By Tracy Sheeley

Revised by Kim Zimmerman

Key Learning Points:

- Secondary victims are also victimized by sexual violence when someone they know and care about (a friend, family member, or partner) experiences sexual violence.
- Many of the feelings victim/survivors generally experience are also experienced by the secondary victims on a different level.
- It is important that secondary victims not overprotect the victim/survivor. Although they have good intentions, they need to understand that it is crucial for the victim/survivor to feel empowered through the healing process, not be told what to do.
- Educate secondary victims on sexual violence, and clarify myths and facts. The more the secondary victim has an understanding of sexual violence and why it occurs, the less chance they will inappropriately support the victim/survivor. (i.e. "I'm sorry this happened, but why didn't you fight back?")
- Express to secondary victims that there is no definitive timeline for when they or the victim/survivor will "feel better." There is no "right way" of healing.

Secondary victims are family members, friends, and partners of sexual violence victim/survivors who are also victimized by this crime. Trying to be of support and assistance to a victim/survivor will be much more successful if they understand some general information about sexual violence. Unfortunately, some of the common feelings and reactions experienced by these secondary victims can delay the victim/survivor's process of regaining control in their life and healing. In addition, secondary victims may believe some of the myths that are prevalent in our society about the nature of sexual violence. It is crucial for secondary victims to examine their own attitudes and feelings in order to be a positive support person for the victim/survivor.

It is important to validate secondary victims' feelings. Sexual violence is a crisis for them, too. Crisis lines and advocates are available to assist them with their feelings and concerns. Encouraging them to take advantage of these options can be beneficial both for them and for the victim/survivor by removing some of the pressures on them. Victims/survivors are often placed in the position of caretaking for the significant other, when it is important for them to concentrate on themselves. Let secondary victims know that helping themselves in turn helps the victim/survivor, and they have no reason to feel selfish or guilty for examining and dealing with their emotions.

Feelings

- *Helplessness/Powerlessness*: Feeling there is nothing they can do to change what happened and there is nothing they can do makes things better.
- *Guilt*: Feeling responsible for the sexual violence; they should have been able to prevent it in some way.
- *Shame*: Shame comes from believing myths about sexual violence. They may be

By working with secondary victims you are ensuring a healthier healing process for the victims/survivors in their life.



The secondary victims you work with may be victims/survivors on a primary level as well. Keeping this in mind, you may need to support secondary victims through reminders of their own experience(s) with sexual violence.



concerned about reactions from family members or the community about the sexual violence. If they believe that sexual violence has more to do with sex than violence, they may doubt the victim/survivor's experience or hold them responsible for the situation.

- *Loss of intimacy:* Feeling that the victim/survivor is distancing themselves from the significant other, or "won't get over it." What appears to be distancing is actually completely related to the assault/abuse. Let the secondary victim know that re-establishing intimacy takes time, patience, and understanding.
- *Loss of routine:* The daily routine may change for the victim/survivor after a sexual assault. They may no longer like to go out at night, be in crowds, or be around others. They may find it difficult to go to school or work. Work with the secondary victims to be understanding and supportive of the victim/survivor's needs. Sometimes there is a fine line between allowing them the space they need and allowing them to retreat so far out of touch that it can be difficult to reach them again.
- *Frustration:* Through the process of regaining control, frustration can be felt towards the victim/survivor and/or the various systems encountered (law enforcement, judicial, etc.).
- *Anger:* Anger about the sexual violence is sometimes expressed towards the victim/survivor by saying that they "should've been more careful," etc.
- *Desire for retaliation:* It is very common for secondary victims to want to "take care of things." Talk about their feelings. Even if they don't bring it up, you need to have this conversation. Let them know it is ok and expected for them to have this feeling. But they must not act on these feelings for two very important reasons: they will get in trouble with the law, and they will not help the victim/survivor heal, instead they will create more pain and stress for the victim/survivor. The victim/survivor does not need to worry about their loved ones getting into trouble or getting hurt over what happened to them. Often this is one reason victims/survivors may not tell anyone what happened, as they don't want their loved ones to retaliate and get in trouble.
- *Overprotection:* This is another very common reaction for secondary victims. They were not there to prevent the first victimization, so they are going to "protect" the victim/survivor from now on by not letting them go anywhere or be alone. Even though this may make sense to the secondary victim, it may be damaging to the victim/survivor and slow the healing process for them. Any overprotection will feel like punishment rather than protection. Victims/survivors need to have the same freedoms they had before the sexual violence and be able to make their own choices and decisions.
- *Socialization:* (Especially pertinent for male partners.) Some men are socialized to not express their feelings and don't feel comfortable asking for help. Advocates understand that sexual violence is a crime of violence, and stems from issues of power and control. It is important to communicate this information both to victims/survivors and to their partners.

General education can be very helpful. Explain the inherently violent nature of sexual violence as a crime, and define the differences between common myths and facts. Treat all of their concerns respectfully and give factual answers. Any misconceptions that an advocate can clarify will take that burden off the victim/survivor.

Sexual violence removes a person's control over their body and personal physical

safety. One of the crucial elements in the healing process is empowering the victim/survivor through enabling or facilitating their decision-making—not by making decisions for them. Parents and partners often fall into the pattern of wanting to take control of the situation, hoping that they will alleviate the victim/survivor's pain by taking charge. Communicate the importance of being supportive versus demanding or overbearing, and of the victim/survivor's need to make decisions about the process on their own. The victim/survivor must decide their views on privacy; confidentiality; and when, with whom, and how much information they want to share.

Overprotection is a similar reaction, the desire to protect the victim/survivor from additional pain and danger is very common. Again, the most productive way to deal with a victim/survivor is to listen to their concerns and feelings, and respect their right to make decisions about safety, etc. Treating them as an adult instead of as a child will reinforce the trust the person has in the victim/survivor.

Prepare the significant other(s) for the possible psychological and physiological responses the victim/survivor may experience as a result of the sexual violence. Behavior changes such as insomnia, panic attacks, phobias, depression, and so forth are normal reactions.

Secondary victims often desire, as do primary victims, definite information: "When will I feel better?" or "How can I help them?" By expressing that there is no single "right" thing to do or that there is no specific timeline or pattern for recovery and healing, an advocate is relaying valuable information that can help all persons connected to the incident. Encouraging secondary victims to use hotlines, counseling, and other available alternatives to help with the healing process, whenever they need to, does a great service to everyone involved.



Secondary victims may inquire about support groups. It is something to consider doing within your agency if you have the staff/volunteers to facilitate.

Bringing it Home:

- Do you have literature specific for secondary victims (i.e. brochures, books)?
- Are there supportive services specific to secondary victims within your program?
- Does your agency present itself as one that secondary victims could utilize?
- How do you approach a secondary victim that you may encounter on a hospital call, when responding to a law enforcement agency, or at a court hearing? Are you providing support to them as well?



Impact Wheel

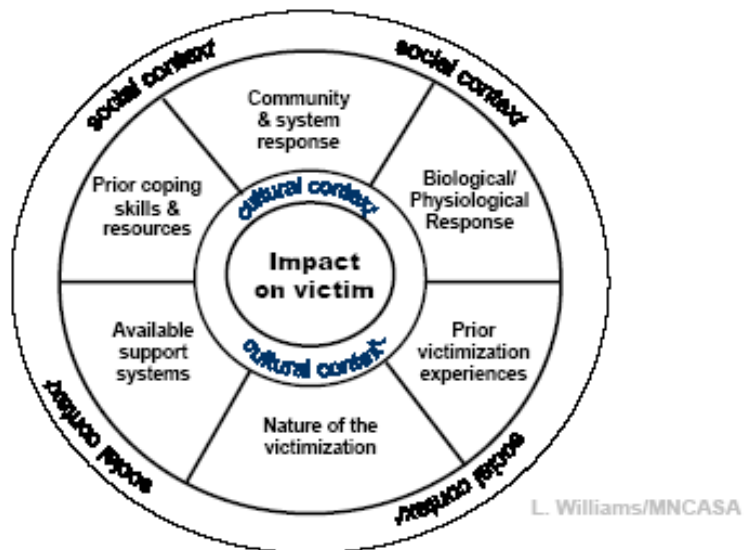
By Laura Williams, MNCASA

Key Learning Points:

- Legal definitions of sexual assault and associated penalties have limited value for understanding the impact of a sexual assault on a victim/survivor.
- While the impact of a sexual assault is unique to each individual, several factors can be considered: the victim/survivor's cultural context, available support systems, prior coping resources and abilities, biological/physiological response, the nature of the victimization, any prior victimization experiences, and the social context in which all of the above occur.
- The value of considering these factors is to broaden the thinking of advocates and allied professionals, furthering our ability to understand and assist victims/survivors.
- The Impact Wheel is not a diagnostic or predictive tool.
- A victim/survivor's experience is the ultimate authority.

Impact Wheel

Factors Influencing Impact of a Sexual Assault Incidence on a Victim/Survivor



Minnesota's sexual assault statutes rank the severity of sexual assault crimes based on the nature of the force used (e.g. a weapon, age difference) and the degree of penetration. Based in this understanding, the law considers the forcible penetration of a woman or man a greater violation than that of a 'touch' offense. While these distinctions are critical in the context of investigating, prosecuting, and adjudicating crimes, they are less significant when assisting victims/survivors in their healing journey. How a person experiences the impact of a sexual assault varies and is as unique as the individual themselves. This

Impact Wheel is offered as merely one way to consider and discuss the complex factors that seem to influence how the impact is felt and integrated.

Use of this training tool

Consider the impact of the messages the victim/survivor is receiving in each of the areas identified in the wheel. How is that affecting her/his decision-making and healing processes?



The Impact Wheel was designed to assist in training volunteers and allied professionals in considering the interconnected factors which affect how victim/survivors might experience the impact of a sexual assault. There is no intended sense of priority or weight implied by the order or size of the wheel segments. The degree to which these factors do or do not play a role in how a victim/survivor experiences the impact of a sexual assault will be unique to that survivor and her/his experience. The tool is grounded in the experience of advocates with extensive work with sexual assault victims/survivors. As with any tool which offers a way of describing and naming complex experiences, however, it should be used only to the degree that it is helpful. It is a descriptive tool, not a predictive one. Victim/survivors are the ultimate experts on their own experience.

Think about how those messages play out in terms of access to resources and services.



Description of the Wheel

The victim/survivor's experience is at the center of the wheel. It is surrounded with a ring labeled 'cultural context,' to reflect that each victim/survivor will experience and interpret all of the other factors and the social context through the lens of their cultural context. Culture here is broadly understood as the shared beliefs and values that a person experiences as part of a group with which they identify.

The six core factors and related discussion are found below:

Community/System Response

Help allied and criminal justice system professionals better understand the range of factors which affect how a victim/survivor experiences the impact of a sexual assault. While a main goal of criminal justice system advocacy efforts is to decrease barriers to reporting and improve the restorative potential of our response—we always need to remember there are many circumstances well beyond our control.



How does the victim/survivor's own community respond? For a given victim/survivor, community might mean the rural town they live in. For another it might mean the student body of the school or university they attend. For yet another, community might mean the ethnic community they most closely identify with (e.g. the Hmong-American community). Is sexual assault talked about in the victim/survivor's community? How is the perpetrator seen? What are the normative messages about the form of sexual violence that s/he experienced?

If the victim/survivor chooses to seek redress from a given system (e.g. criminal justice, civil justice, agency/discipline-specific review board) how is s/he treated? Is the report taken seriously? Is the response victim-centered?

Biological/Physiological Response

Recent research on brain development has shown that the brains of adolescents are not fully developed and process emotions and events differently than the brains of children or adults.¹ Other research has suggested that brains of children who repeatedly experience severe trauma may develop somewhat differently than those of children who do not. Brain research has also figured prominently in understanding risk factors for post-traumatic stress disorder and expanding intervention and

treatment possibilities to mitigate its effects.² Further, a victim/survivor with a pre-existing mental illness or cognitive processing disability may also experience the impact of a sexual assault differently than someone else. While responders do not have access to the way that a given victim/survivor's brain responds, and can respond effectively without it, it is simply important to note that not all brains are the same.

Another aspect of the biological or physiological response that can affect how a victim/survivor experiences the impact of an assault is the degree to which her/his body responded sexually to the assault. Some victims/survivors are deeply confused by their own physiological reactions such as having an erection or orgasm. Advocates can reassure victim/survivors that the human body is complex and designed to respond to sexual stimuli—a physiological reaction does not mean they consented to the sexual assault. Likewise, victims/survivors of same-sex assaults sometimes wonder if a sexual response from their body is evidence of a homosexual orientation. Again, victims/survivors can be informed that such as physical response to sexual contact during a sexual assault is not indicative of their sexual orientation.

Prior Victimization Experiences

Many victims/survivors experience sexual assault more than once in their life.³ While the contributing factors to this are many, it is worth noting that previous victimization experience will likely affect how a victim/survivor perceives and integrates the recent sexual assault experience. For our purposes, what are the implications for supporting victims/survivors who have prior victimization experience in their history? We might consider the following: Did the victim/survivor develop additional coping skills in response to a prior victimization that can be tapped into now? How old were they when the previous assault(s) occurred? How did people respond? Were they able to disclose? What was the result of the disclosure—were they believed, assisted, and protected?

Nature of the Victimization

As discussed above, the nature of the victimization will affect which laws (if any) will apply. This may affect how others characterize and respond to the crime in addition to how the victim/survivor herself or himself responds. All of this is important, but the key is to listen carefully to how the victim/survivor themselves is experiencing and describing the assault. What factors do they seem to highlight: that the perpetrator was someone they knew and trusted? That the sexual assault occurred in a place they had previously felt was safe and secure? That the perpetrator exploited a vulnerability like the victim/survivor's need for a place to sleep, for food, for drugs, for protection of someone they love? What physical injuries did the victim/survivor suffer? Will there be long-term consequences to these injuries (e.g. STI's, pregnancy, scarring, broken bones)? Did the sexual assault occur in a war zone or refugee camp—a place and circumstance that seems far from here but with little or no opportunity for redress or vindication? Or, did they immigrate to the United States with their perpetrator as a means of escaping where they were?

Available Support Systems

This is a look and assessment of the external resources available to a victim/survivor. Both professional support systems (counselors, social workers, faith/spiritual community representatives, etc.) and personal support systems (the web of supportive individuals people create for themselves) can be examined. Who is available to support the victim/survivor—in the crisis stage and throughout all of their phases of recovery, integration, and healing? Who does the victim/survivor see as their 'web of support' pre-assault? What has been the reaction by these supporters to their loved one's sexual assault experience? Is the assailant someone who had previously been someone they looked to for support (e.g. a helping professional, a partner, a parent)? Advocates can listen for and gently inquire about a survivor's support network, and explore appropriate and helpful ways to provide assistance to these secondary victims (e.g. assist with initial notification, explain some of what they might expect, offer their own opportunity for confidential support, explain criminal justice system processes).

Prior Coping Skills and Resources

What were the victim/survivor's internal coping abilities and resources prior to the assault? Are these available to be useful in the phases of recovery and integration of the experience? Did the assault come at a time when the survivor was experiencing other significant challenges to their coping abilities—such as financial trouble, health problems, divorce, loss of a loved one, job loss, challenges with addiction or depression? Does the victim/survivor have a cognitive disability? How has the victim/survivor responded to other crises in their lives? Are any of these same resources available to them now? What internal resiliency factors can victims/survivors draw upon (and others help to nurture) to assist themselves in their own healing?

A victim/survivor who was experiencing significant challenges to their coping abilities prior to the assault may face serious challenges in recovering from a sexual assault experience. This may be a time to find ways to appropriately add external support resources—advocacy, counseling, support groups, psychological assessment (if necessary).

Social Context—Outer Ring

Each of the factors described above, as well as the victim/survivor's understandings and interpretations of those factors, interact with a social context which carries specific messages about race, privilege, orientation, sexuality, gender, class and social status, age, ability, our sense of justice and injustice, and rules about moral and immoral behavior. These messages often intersect and fuse in a way that makes separating out their influence problematic. Three examples follow:

When a popular radio commentator made offensive comments about a collegiate women's basketball team in early 2007—a reporter asked team members if they were more offended as African-Americans or as women. This is a blatant example of how tempted we are to separate out complex, interconnected factors in understanding the experience of people different from ourselves.

Sometimes societal messages about 'right' behavior conflict. One example is the message women get from popular American culture that being desirable to men is a key aspect of female identity. These messages suggest to be desirable often means dressing provocatively and being sexually available. On the other hand, women who are sexually assaulted when dressed this way are typically blamed for bringing about their own victimization. Further, women who trade sex for food, a place to sleep, drugs, or protection from additional abuse are sexually victimized in a social context that suggests prostitution is not abuse.

The impact of sexual assault for a woman who is Deaf or Hard of Hearing may well be affected by the available support systems—both in terms of accessibility, cultural relevance (if the survivor identifies with Deaf culture), and messages society has about who rapes and who gets raped.

The impact of sexual assault cannot be considered in isolation. The main point in referencing the social context in which a victim/survivor works to integrate and heal from sexual assault is to better appreciate the complexity of the victim/survivor's experience, and give options for listening for the larger messages and beliefs that may hinder or help a victim/survivor's experience.

References

¹ A brief overview from the National Institutes of Mental Health can be found at <http://www.nimh.nih.gov/publicat/teenbrain>.

² See "Post Traumatic Stress Disorder Fact Sheet" from the National Institutes of Mental Health. Retrieved from <http://www.nimh.nih.gov/publicat/post-traumatic-stress-disorder-research-fact-sheet.cfm> on September 9, 2007.

³ The National Women's Study (1992) reported that 39% of survey respondents, or an estimated 4.7 million women (based on U.S. Census estimates) reported having been raped more than once, while an additional 5% were unsure as to the number of times they had been raped.

Bringing it Home:

Talk with other advocates and professionals about how some of these factors affect how we see and understand victims/survivors and the options we consider in our ways of assisting. Send feedback on how you see this tool is useful or limiting to info@mncasa.org.



Rape Trauma Syndrome: Possible Victim/Survivor Reactions and Responses

Adapted from Rape Trauma Syndrome by Ann Wolbert Burgess and Lynda Lytle Holmstrom
Revisions by Karla Nelson, MNCASA

Key Learning Points:

- Studies by the authors countered prevailing rape myths and attitudes (particularly in the 1970s) about how victims/survivors respond to rape and sexual assault. Often people deduce that if a victim/survivor isn't reacting how they "expect" or think they themselves might react (or how they saw someone on television react), it must not have really happened.
- Not all victims/survivors cry or are otherwise expressive in the immediate aftermath of an assault.
- Most sexual assault victims/survivors experience fear—they fear physical injury, mutilation, and/or death.
- RTS identifies four phases of victim/survivor response: impact, outward adjustment, resolution, and integration.
- The length and intensity of the phases will vary by individual.
- The healing process is not a linear timeline; phases may overlap.
- The healing process will look different for every victim/survivor. There is no "right way" to heal.

"Rape Trauma Syndrome (RTS) was identified by Ann Wolbert Burgess and Lynda Lytle Holmstrom in the mid-seventies after studying the typical patterns of rape survivors. RTS describes a process that rape survivors go through in response to the fear experienced during a sexual assault. Although each survivor has their own experience, there are common characteristics the individuals possess. These characteristics are the direct result of the profound fear inherent in sexual assault."

~ Amy Menna, LMHC, CAP, from her on-line article, Rape Trauma Syndrome: The Journey to Healing Belongs to Everyone, retrieved from: <http://www.gifffromwithin.org/html/journey.html> on June 21, 2007

Victims/survivors suffer a significant degree of physical and emotional trauma during the experience of sexual violence and the trauma that sets in after their experience. Victims/survivors consistently describe certain common reactions. Some of those reactions occur immediately after their experience, other may set in after time has passed. There is no "normal" or "right" way for victims/survivors of sexual violence to feel or react. Each individual has their own experience, and it is important to note that whether a victim/survivor experiences all of these common reactions or none of them, it is their own reaction and it is "normal."


Not every victim/survivor of sexual violence will react immediately following a sexual assault with a tearful, visibly upset reaction. A victim/survivor may feel so much shock and disbelief

that they do not express any physical emotion. Certainly some victims/survivors may react in a way that many people would expect - crying and visibly in crisis.

Physical Reaction

Acts of sexual violence may or may not be physically forced. Depending on the amount of physical force, if any is used, the victim/survivor may be experiencing a certain amount of physical pain from injuries.

Many victims/survivors talk about changes in their sleep pattern. It may be that they can not fall asleep or, if they do, they wake up in the middle of the night unable to get back to sleep. Having nightmares about the assault may trouble the victim/survivor and keep them from wanting to sleep. The details of the sexual violence can have an effect on a victim/survivor's sleep, for example, if the assault happened in the dark or in their bedroom.



Help victims/survivors and those in their web of support know what to expect. The value is in preparing (e.g. healing is a process) and normalizing (e.g. there is an actual name for the process) what the victim/survivor might experience. The key is to use the information to convey hope, not impose an awareness of future difficulties for the survivor (e.g. you have nightmares and panic attacks to look forward to).

A decrease in appetite following a sexual assault is often noticed by victims/survivors. They may complain of stomach pains or describe a loss of appetite or the food not tasting right. Frequently victims/survivors feel nauseated just thinking about the assault. It is important to determine whether these symptoms are related to the emotional reaction to the sexual violence or possibly a reaction to a medication prescribed to prevent pregnancy.

Victims/survivors also report physical symptoms specific to the area of the body that had been the focus of the attack. Those forced to have oral sex may describe irritation of the mouth and throat. Those forced to have vaginal sex may complain of vaginal discharge, itching, a burning sensation upon urination, and generalized pain. If forced to have anal sex, the victim/survivor may report rectal pain and bleeding.

Emotional Reactions

- Sense of betrayal;
- Rage;
- Shame and humiliation;
- Fear;
- Self-blaming;
- May feel loss of control over their life;
- May fear not being believed by friends, family, and professionals;
- Heightened fear or anxiety:
 - Post Traumatic Stress Disorder (PTSD);
 - Disassociation
- Difficulty concentrating;
- Fear of intimate relationships;
- Emotional numbing;
- Generalized fear of things reminiscent of the assault:
 - Season;
 - Location;

- Smell;
- Sounds; and/or
- Heightened responses at the anniversary time of the assault.

Victims/survivors may try to block the thoughts of the assault from her/his mind. A coping mechanism for some victims/survivors may be to simply not cope at all. Although it is not healthy to try to do this for the rest of her/his life, it may be something the victim/survivor needs to do right away. Victims/survivors deserve to have control of coping and healing in their own time.

Victims/survivors vary as to the amount of time they need for healing. The immediate feelings and reactions may last a few days to a few weeks. As time is put between the victim/survivor and the sexual violence, there will be other feelings and reactions s/he will experience, but there is no "right" amount of time for a victim/survivor to heal. The experience may be with them for the rest of their lives, but the time it takes to cope and heal is different for everyone.

Various factors seem to influence how the victim/survivor is impacted and copes with the sexual violence, such as her/his personality style, the people available to her/him who respond to her/his distress in a serious and concerned manner, and the way in which s/he is treated by the people with whom s/he comes into contact after the sexual assault.



Help others in the response network to better understand reactions they may see from victims/survivors when working/interacting with the victim/survivor.

Changes in lifestyle

Experiencing sexual violence is something that impacts a victim/survivor's life even down to her/his daily routine of living. In some cases, not only one but many aspects of the victim/survivor's life can change. Every victim/survivor will resume a different level of functioning day-to-day. Some victims/survivors will go to work or school, but are unable to be involved in much more than that. Other victims/survivors may respond by staying home, only venturing out of the house accompanied by a friend, or by being absent from or stopping work or school.

A victim/survivor may need to go so far as to relocate her/himself. S/he may not feel safe living in her/his current residence; her/his residence may remind her/him of the sexual violence s/he experienced; some may just want to start over in a new location. Along with a change of residence, the victim/survivor might feel the need to change her/his phone number to feel safe as well.

Fears and Phobias

Victims/survivors of sexual violence could develop fears and phobias specific to the circumstances of the sexual violence they experienced. Some common fears that victims/survivors may experience are:

- Being in crowds;
- Being alone;
- Specific fears related to characteristics of the perpetrator;
- Global fear of everyone; and/or
- Fear of being victimized again.



Know when and how to identify the compounded reaction to rape to know when more than crisis counseling will be needed.

Consider your response style, and identify resources for common challenges and reactions in advance. For example, discuss with seasoned advocates how to handle self-blaming statements from a victim/survivor.



Many victims/survivors report a fear of sex after experiencing sexual violence. The normal sexual style of the victim/survivor becomes disrupted after the sexual violence. If the victim/survivor has never had any sexual experience before the sexual violence, s/he has no other experience to compare it to and no way to know whether sex will always be so unpleasant. For a victim/survivor who had been sexually active, fear may increase when her/his partner confronts her/him with resuming their sexual pattern.

Consider the questions you might ask a victim/survivor to better understand what s/he is dealing with at this point in their healing process.



Phases of Victim/Survivor Response

The following phases have been developed to establish a very general frame of reference from which to consider the variety of responses. The length and intensity of each stage varies in different people, and the stages may often overlap.

Be warm, empathetic and consistent. Encourage expression of feelings.



Phase 1: Impact

During this stage, a large variety of emotions may be present. Disorganization and disorientation characterize the reaction of the victim/survivor; and feelings of shock and disbelief are strong. The person is operating at a high emotional level, and their normal coping skills may be unavailable at this point. Dealing both with their emotions and decision-making can seem overwhelming to victims/survivors in the impact stage. Enabling victims/survivors to make decisions and express feelings, and validating their feelings is important.

Provide information about options available to the victim/survivor.



The impact stage can last from a few moments to a few weeks.

Know that the attempt to normalize - and NOT deal with the effects - is normal and an important coping mechanism. You can validate this (no need to 'push' timing and tell the victim/survivor that s/he 'has to deal with it'), yet also say that if things change and coping gets more challenging, your services will be there.



Phase 2: Outward Adjustment

Outward adjustment is an attempt by the victim/survivor to shut off the reality of what they have experienced. This is a completely natural reaction in an attempt to restore some normalcy to their life. Victims/survivors may appear outwardly to have adjusted, but generally have not resolved the

sexual violence they have experienced. S/he may not want to discuss the assault or deal with it in any way. Victims/survivors may not approach sexual violence crisis centers in this phase. Concrete information about options can be valuable for victims/survivors, however, if they decide to seek supportive services at a later time. It is also important to reassure victims/survivors that they can seek supportive services and contact their local sexual violence crisis center *at any time* and when they feel they are ready to do so.

The outward adjustment phase can last from days to years.

Phase 3: Resolution

Resolution begins with a desire to work on the issues of the assault. Victims/survivors recognize their feelings. If a victim/survivor is feeling anger at this time, s/he may be

able to focus that anger on the perpetrator. S/he may be able to recognize some of her/his own strength and courage that has enabled her/him to reach this point.

Counseling is important in this phase. Victims/survivors need to have their feelings heard and hear options available to them at this point.

Resolution is a phase that may come and go for victims/survivors. It represents a large step in the healing process and can be very challenging.

Phase 4: Integration

Integration is as much an attitude as a phase. It represents the culmination of everything the victim/survivor has experienced. The victim/survivor has accepted the fact that the sexual violence has occurred. Moreover, s/he has integrated this fact into her/himself as another life event with a large impact. It does not have the ruling impact, however—s/he will control it, instead of it controlling her/him.

The victim/survivor has changed and grown. S/he has accepted the knowledge that parts of her/his former outlook are gone forever. S/he has acknowledged the new aspects of her/himself that have developed.

Summarizing the healing process may be beneficial. The victim/survivor has changed and grown. As a victim/survivor begins to integrate this experience, s/he may not feel the need to access her/his sexual violence crisis center anymore, but it is important for sexual violence advocates to let their clients know that they will be there if the client wants to check in sometime in the future. Because the victim/survivor has begun the process of integration does not mean that s/he is completely healed from the sexual violence and will not need support from time to time later in her/his life.

Summary

The crisis intervention done by sexual assault advocates is crucial to the reactions that victims/survivors have to the sexual violence they have experienced. If a victim/survivor receives a supportive response it can impact the way they continue to react to their experience. Again, keep in mind that every victim/survivor does not react the same way, and it is not appropriate to assume how a victim/survivor is feeling. It would not be fair to treat every victim/survivor the same way. Ask her/him what kinds of feelings s/he is having. You may need to even help her/him identify those feelings if s/he is having a difficult time identifying those feelings right away.

~Excerpted from Ann Wolbert Burgess and Lynda Lytle Holmstrom, *Rape: Victims of Crime*, (Bowie, Md.: Robert J. Braky Co., 1974), pp. 37-50.



Because a victim/survivor may be ready during this phase for counseling, be prepared to give referrals for appropriate counseling resources.



Let victims/survivors know that they are always welcome back to your crisis center for support and services.

Bringing it Home:

- What types of counseling resources are available in your community that you could refer a victim/survivor to?
- Identify the resources that exist in your community for helping survivors at the various phases of their healing process. How many of them are knowledgeable about sexual abuse and sexual violence?
- If your community has an interagency council or team (sometimes referred to as a Sexual Assault Multidisciplinary Action Response Team—SMART team) review their 'Inventory of Existing Services' for more on what is available in your area.



Flashbacks

By Carolyn G. Halliday, M.A.

Edited by Lisa Engebretson, Sexual Offense Services of Ramsey County

Revised by Karla Nelson, MNCASA

Key Learning Points:

- Flashbacks can be triggered by sounds, smells, feelings, locations, significant dates or times, or anything else that may remind the victim/survivor of the sexual assault.
- Not all victims/survivors may experience flashbacks.
- Although having flashbacks may be scary to a victim/survivor, they are safe and it is important to remind them of that. The assault is not happening again.
- Talking to victims/survivors about why flashbacks may be occurring can give them an understanding and can help in their healing process.

Many victims/survivors of sexual violence have flashbacks. These flashbacks are a reliving of the original sexual violence they experienced. This can happen visually in images one remembers of the sexual violence, or they can happen without any visual imagery. The sexual violence can be re-experienced with sounds, smells, feelings, or other such bodily memories. Flashbacks can either be very real or detached, like watching from afar. Either way, flash-backs are usually a frightening experience for the victim/survivor.

Some ideas for supporting a victim/survivor through a flashback:

- Name it. Not everyone realizes what they're suffering is a flashback.
- Tell the victim/survivor that it may feel real to her/him, but that it is not happening again. Keep reminding her/him that s/he is in a safe place.
- If someone is in the middle of a flashback, you may suggest that s/he do some sort of physical activity, for example wiggling her/his toes or opening her/his eyes may help the flashback end.
- Encourage her/him to take slow, gentle breaths. Tell her/him that s/he is remembering. Tell her/him that if s/he would, like s/he can remember what s/he needs to know without re-experiencing the physical pain. You may suggest to her/him to slowly, calmly look around the room to establish where s/he is (in her/his home, your office, etc.). You might want her/him to describe out loud where s/he is and the fact that the perpetrator is not present.
- If someone is worried about future flashbacks and worried that they may not be able to sort out reality, help them prepare ahead of time. When they have another flashback, this item can be their touchstone. It



You may experience callers on your crisis line or clients you are meeting face-to-face having flashbacks while you are present. It is important to have ideas about how to respond in a supportive, helpful way.

Remember that you are an advocate, not a mental health professional or "counselor". Be sure to refer clients to mental health professionals when it is more appropriate.



reminds them to breathe slowly and deeply, ground themselves in the present, and remember that the sexual violence is not happening now. With this in mind, the flashback is just a memory, and the victim/survivor may have an easier time experiencing the flashback.

- Victims/survivors may ask why they are experiencing flashbacks and why they occur. Although you are not able to give them reasons for certain, you may be able to give victims/survivors ideas as to why the flashbacks are happening. Flashbacks are sometimes seen as an indication that the person is ready to remember; that the body has important information to share. They can validate victims'/survivors' experiences.

Bringing it Home:

- Have you discussed within your agency how to respond to a client experiencing a flashback in your presence?



Dissociation

By Nancy Bronson, Central Minnesota Sexual Assault Center
Revised by Karla Nelson, MNCASA

Key Learning Points:

- Dissociation is a process that disconnects a person from their thoughts, feelings, surroundings, actions, and memories. It is a way for people to temporarily escape the fear and pain they are experiencing in that moment.
- The level of severity that people may experience dissociation can vary. On the less intense end of the spectrum a person may “daydream” while driving their car or “space out” while reading a book. For people that experience dissociation on the most intense end of the spectrum, they may not be able to function day to day.
- Dissociation often develops in children that have experienced repeated trauma. It provides the child a way to live life as if the trauma did not occur.
- As a person continues to live with dissociation, they become conditioned to it and may begin to use it as a way to cognitively escape whenever they feel threatened by something.
- If a victim/survivor receives proper treatment and therapy for dissociation, they can be successfully treated.

When we understand that dissociation is a remarkably effective survival skill, we can respect it as the powerful tool that it is. There are still far too many people, however,—including mental health professionals—who do not understand dissociation and who continue to foster myths and misunderstanding.

Dissociation is a common phenomenon which most persons experience in mild forms. When someone has suffered a severe trauma, such as sexual violence, dissociative reactions may be more intense and of longer duration. People who experience repeated severe trauma, such as severe childhood abuse, incest, and ritualistic abuse, may have developed a pattern of dissociative responses which may continue long after the abuse is no longer occurring. Dissociative experiences of all degrees are typically characterized by some disruption of one's memory and in most cases disruption of one's sense of self or identity.

Dissociation is a defense mechanism in which a person's mental processes are segregated in order to avoid emotional distress, or where an idea or object is separated from its emotional significance. There are many levels of dissociation. A useful way to understand it is to think of it as a continuum. On one end of the continuum are common dissociative states which most people have experienced. Examples of such experiences include day dreaming; “spacing out” while watching television, a movie, or a sunset; highway hypnosis; and getting lost in a good book. More intense dissociative states toward the middle of the continuum may be described by an individual as a feeling of “un-realness” or depersonalization, or sometimes a sensation that seems like one is out of their own body. It is not uncommon to hear a victim/survivor of incest say that while the abuse was going on they somehow “went” to another part of the room and watched, or that they “left” and went out of the window. On the far end of the continuum is more severe, chronic dissociation which includes multiple personalities or polyfragmented individuals. It is a condition of having two or more separate persons or personalities who inhabit the same body, and at

Because dissociation is seen most often in people that experience traumatic events, we must be aware that victims/survivors of sexual violence have a higher risk of using dissociation as a coping mechanism.



least two of these persons or personalities take control of the person's behavior. Multiplicity is often referred to as a highly creative survival technique, because it allows individuals enduring "hopeless" circumstances to reserve some areas of healthy functioning. As a child, an individual may completely block her/his memory of unpleasant experiences; in some instances, they may feel that there is another person inside of them who can control their body.

As advocates we can not diagnose someone with dissociation. If your client describes to you symptoms that may sound like dissociation, it would be most appropriate for you to talk to your client about seeking therapy if they are comfortable with that.



The following are some things to be aware of when working with someone who has multiple personalities. They are not crazy, even though at times they may feel crazy. Living with multiple personality disorder can be very complicated. Alternate personalities (alters) may come out at inappropriate times and disrupt a conversation or may not be able to converse on the level of the conversation. Time loss can be frequent, severe, and frightening. Up to months may seem forgotten. Things may appear to have happened in their lives that they cannot explain. Most multiples live in fear that someone will find out that they are multiple. They fear they will lose their jobs, other social positions, friends, and family members. People with multiple personality disorder are not possessed by demons. Traditional churches may want to attempt an exorcism on these individuals; this could be even more devastating and even trigger memories of past abuse. People with multiple personality disorder are constantly questioning their own perceptions and reality. Accepting one's diagnosis as multiple personality disorder is generally an on-going process during therapy. Multiple personality disorder is curable, but it takes time.

Bringing it Home:

- What mental health resources do you have available in your community?
- Can your program provide training to mental health providers to increase their understanding of sexual violence?



Repressed Memory

Repression is one coping mechanism used by victims/survivors of childhood abuse.¹ When a person experiences something that frightens them, or that they don't want to remember, they may subconsciously force the memory of it from their minds and may not be able to remember the experience.² Repression of memories is most common in cases of violent or incestuous sexual abuse³, and in abuse cases with younger victims.⁴

Studies suggest that it is common to repress memories of childhood sexual abuse. A large proportion of those sexually abused in childhood have had periods when they did not remember the abuse, and a large proportion of women who were sexually abused in childhood have no recall of the abuse, according to research studies.⁵ Many women, however, never repress the abuse and do have memories of it.

Many people enter therapy for reasons other than the abuse, such as depression or self-esteem problems. While addressing these problems, awareness of the repressed memories returns. Repressed memories can also surface spontaneously in response to "triggers." For example, certain physical sensations, emotional feelings, or watching a television program about abuse may remind the victim of the abuse and cause them to remember repressed memories. Significant life events such as giving birth, the death of the offender, or having a child reach the age at which ones' own abuse occurred may all trigger memories. Also, when repressed memories surface, they often surface in bits and pieces, or in "flashes," rather than having the complete memories surface in their entirety.

Some people believe that repression of memories does not exist, and that memories of alleged child sexual abuse that surface later in a person's life must be fabricated. They also believe that suggestions made by therapists can lead a person to believe s/he has been sexually abused in childhood and has forgotten the sexual abuse for several years, when in fact no sexual abuse has taken place. They allege that people are being falsely accused of child sexual abuse many years after the alleged sexual abuse has happened.

So-called "false" memories of child abuse is a phenomenon that has yet to be verified.⁶ There is no data to support claims that there is a national epidemic of false memories surfacing, except anecdotal, second- and third-hand stories.⁷

The few studies that suggest that false memories can be implanted in people examine only generic, non-traumatic memories with which most people could identify. It has not been proved that a traumatic memory, such as a memory of sexual abuse and the emotional effects of that trauma, can be created in a person's mind merely by suggestion.⁸

Throughout history, our society has denied the reality of sexual abuse and incest by labeling its victims/survivors as crazy or as liars. Some are still attempting to continue this trend in the face of growing awareness of sexual abuse, making it more difficult for victims /survivors to find justice.

References

- ¹ Williams, L.M (1994) Recall of Childhood Trauma: A Prospective Study of Women's Memories of Child Sexual Abuse *Journal of Consulting and Clinical Psychology*
- ² Emsdorff; G M & Loftus, E.F. (1993) Let Sleeping Memories Lie? Words of Caution About lolling the Statute of Limitations in Cases of Memory Repression *The Journal of Criminal Law & Criminology*, 84
- ³ Loftus, E.F., Polonsky, S., & Fullilove, MX (1994) Memories of Childhood Sexual Abuse: Remembering and Repressing *Psychology of Women Quarterly*, 18
- ⁴ Emsdorff; G M & Loftus, E.F. (1993) Let Sleeping Memories Lie? Words of Caution About lolling the Statute of Limitations in Cases of Memory Repression *The Journal of Criminal Law & Criminology*, 84
- ⁵ Williams, L.M (1994) Recall of Childhood Trauma: A Prospective Study of Women's Memories of Child Sexual Abuse *Journal of Consulting and Clinical Psychology*
- ⁶ Olio, K A & Cornell, W.F. (1994) Making Meaning Not Monsters: Reflections on the Delayed Memory Controversy *Journal of Child Sexual Abuse*, 3(3).
- ⁷ Calof, D L (1993) A Conversation with Pamela Freyd, PhD *Treating Abuse Today*, 3(3).
- ⁸ Emsdorff; G M & Loftus, E.F. (1993) Let Sleeping Memories Lie? Words of Caution About lolling the Statute of Limitations in Cases of Memory Repression *The Journal of Criminal Law & Criminology*, 84



Rape Trauma Syndrome and Post Traumatic Stress Disorder

By Donna Dunn, MNCASA

Key Learning Points:

- Rape Trauma Syndrome and Post Traumatic Stress Disorder are two tools that the mental health community has designed to help describe the aftermath of traumatic events such as sexual assault.
- Rape Trauma Syndrome grew out of the early days of the anti-rape movement and is specific to the lasting effects of sexual assault.
- Post Traumatic Stress Disorder describes many of the same symptoms and experiences but addresses trauma across assault, war, accidents, and other violent or traumatic events, not only sexual assault. PTSD is recognized in the Diagnostic and Statistical Manual used by mental health professionals to appropriately diagnose clients.
- PTSD, while called a disorder, describes a series of symptoms that reflect a **normal** response to an abnormal and traumatic event. It is in no way a mechanism to label someone as “crazy” or “unstable.”
- PTSD explains why some survivors of sexual assault experience intrusive thoughts, nightmares, are unable to sleep, perform, concentrate, etc.

There are two labels that are used to identify the effects of sexual assault on victims/survivors: Rape Trauma Syndrome and Post Traumatic Stress Disorder. Rape Trauma Syndrome was named in the early days of the sexual assault advocacy movement. More recent work done by the medical and mental health disciplines has identified that the diagnosis Post Traumatic Stress Disorder has application to victims/survivors of sexual assault as well as war veterans, battered women, child abuse victims/survivors, and victims/survivors of traumatic accidents or other traumatic events.

According to the DSM-IV, Post Traumatic Stress Disorder (PTSD) occurs when a person has been exposed to a traumatic event involving actual or threatened serious physical injury or death and the person’s response involves intense fear, helplessness, or horror.

The trauma is persistently re-experienced in one or more of the following ways:

- Recurrent and intrusive distressing recollections of the event;
- Recurrent distressing dreams of the event; and/or
- Acting or feeling as if the traumatic event were recurring (flashbacks, hallucinations, dissociative episodes, etc.).

The person persistently avoids stimuli associated with the trauma and experiences numbing of general responsiveness:

- Feelings of detachment or estrangement from others;
- Efforts to avoid thoughts, feelings, or conversations associated with the trauma; and/or
- Marked diminished interest or participation in significant activities, etc.

Persistent symptoms of increased arousal such as:

- Difficulty falling or staying asleep;
- Irritability or outbursts of anger;
- Difficulty concentrating;
- Hyper vigilance; or
- Exaggerated startle response.

It is important to understand that this response to the traumatic event is a normal response to an abnormally traumatizing experience. Clinicians and researchers have identified that PTSD is not only a psychological response to trauma but also a physiological response. Recent studies of the brain have located differences in brain activity that account for the body reactions that occur within those who have been diagnosed with PTSD. In simple terms, victims/survivors of trauma do not control or make choices to relive the traumatic experience – rather, because of PTSD, that part of the brain that controls the body’s response to danger, the amygdala, short circuits the rational part of the brain and releases stress hormones to help the body survive. It triggers the fight, flight, or freeze response. While that is a useful and life-saving technique we all need, victims/survivors of trauma often experience a return to that survival response that is triggered when something reminds the person of the traumatic event. Most often those memories are triggered by the senses – a smell, sound, vision, etc. can alert the body that it must move into protection mode. Many clinicians say that this survival mode “hijacks” the rational response and takes the victim/survivor back into the traumatic memories.

It is important to know about the range of responses a victim/survivor may experience so that you understand how to be a helpful person in this victim/survivor’s life.



Victims/survivors report feeling just as if they are back in the midst of the assault; they suffer physical responses to terror even when they know they are not in immediate danger. The brain response typically releases adrenalin which can result in:

- A racing pulse;
- Sweating palms;
- Rapid breathing;
- Tunnel vision; or
- Other symptoms sometimes associated with panic attacks.

Many victims who are experiencing PTSD, especially those who have always felt well in control of their lives, may now feel as if they are “going crazy.” It is important to help a victim understand that the trauma reactions to assault are normal – the body is doing its job of trying to protect the person.



Adrenalin surges are short lived and are hard on the body. Often, the result is exhaustion and the individual can feel very tired and drained. Clearly, this leads to a depletion of the physical energy that one needs for the healing process. PTSD can contribute to a victim/survivor feeling as if s/he “is losing it,” “is crazy,” “is out of control,” etc. People who are trying to support a victim/survivor can likewise experience confusion about this seemingly irrational response when the victim/survivor clearly seems safe. Again, it is important to remember that PTSD describes a cluster of symptoms that are normal for the victim/survivor of trauma. Most people who have experienced an automobile accident or near accident can identify with their hyper vigilance when hearing tires squeal or feeling a car swerve dramatically. This experience may help someone understand a small fraction of the reaction that sexual assault victims/survivors experience.

While advocates are not mental health professionals and are not in a role to diagnose or provide therapy to victims/survivors, it may be helpful to know and recognize the potential symptoms of PTSD so that one can reassure a victim/survivor that trauma can bring with it a lot of differing reactions and that those reactions are probably not abnormal for someone who has been terrified. It is a good opportunity to suggest that if these reactions keep a person from functioning normally or intrude in healthy behaviors, the person may want to find a mental health professional experienced in working with victims/survivors of sexual assault. There are strategies

Rape Trauma Syndrome was introduced in 1974 to describe the commonly shared experiences of rape victims/survivors and identified three phases:

- Acute Phase characterized by disorganization, physical and emotional issues;
- Reorganization or outward adjustment phase; and
- Resolution or integration phase.

While Rape Trauma Syndrome has largely been replaced in mental health treatment by PTSD, it does identify two very distinct differences in victim/survivor reaction to trauma in language not specifically addressed by PTSD. This distinction can be very useful to professionals who are trying to assess a circumstance of reported rape:

- Expressive style – the victim/survivor expresses stereotypical responses to trauma with crying, rage, sobbing, hysteria, tenseness, anxiousness, restlessness, etc.
- Controlled style – calm, numb, in shock, quiet, composed, reserved, difficulty expressing themselves, etc.

Roughly half of victims/survivors have an expressive style, half exhibit the controlled style. Because the former fits our stereotype of a trauma victim/survivor, it is inviting to consider that the controlled-style response must be a person who is not being truthful. It is important to help others understand that both responses to trauma are normal and expected. The controlled response is as much an expected response to trauma as the expressive.

The value of both RTS and PTSD is that they provide a way of understanding the experiences of a victim/survivor of sexual assault that is not placing judgment on the victim/survivor for her/his “inability to heal.” Many people simply do not understand the level of trauma that a rape victim/survivor experiences or how that trauma may work over time to keep a traumatic event still “fresh” for the victim/survivor. Sometimes, that experience can be inappropriately turned into victim/survivor-blaming statements:

- “That happened to her/him 3 years ago. S/he should be okay by now.”
- “S/he wasn’t really hurt – only touched. Why is s/he still in crisis?”
- “I think s/he likes to get attention and that is why s/he is acting this way.”

RTS and PTSD help us answer these concerns with information about the physical and psychological reality of trauma and its affect on victims/survivors.

Note: Rape Trauma Syndrome has had more application in most other states and carries greater weight and importance as an issue separate from or in addition to PTSD. In other states, RTS is often introduced as evidence in rape trials to explain why a victim/survivor might have delayed reporting, might have been perceived by others to not be in trauma, etc. (Similarly, Battered Women’s Syndrome is used to explain why a battered woman may be emotionally trapped with an abusive partner or why a battered woman might kill a battering partner in self defense when others might not perceive the immediate danger she feels.) In Minnesota, RTS is not used in the same way because expert witnesses or expert testimony on adult sexual assault cases have not been admissible due to some unfortunate case law that was set a long time ago! Expert testimony is only allowed to testify and generalize on the experiences of child victims/survivors of sexual assault.

Reference

Herman, Judith Lewis, M.D., [Trauma and Recovery](#), BasicBooks, HarperCollins Publishers, 1992.



Knowing that the trauma of sexual assault can deliver some long term effects, how might you think of making changes in advocacy to respond to this?

Bringing it Home:

- Do you know of mental health therapists in your community who are adept at working with Post Traumatic Stress Disorder and survivors of sexual assault?
- How does the information about both RTS and PTSD explain behavior or experiences you have seen or heard about with rape survivors?
- How do RTS and PTSD answer the question, “Why can’t she just get over it?”
- Does your program have a way of helping secondary victims understand the nature of trauma so that they can be helpful to their family member/ friend?
- Survivors of sexual assault who have gone a long way down the path of healing may be willing to talk with trainees about how the trauma of the assault affected them. Hearing the experiences of survivors is one of the best ways for advocates to learn!



Facts About Suicidal Calls

From the Minnesota Coalition Against Sexual Assault Train the Trainer Manual

Key Learning Points:

- If you have concerns of someone hurting themselves it is appropriate to ask if they are thinking of hurting themselves. It is not going to “put an idea in their head” or encourage them to do so. It can help the person through the fear and anxiety of talking about the thought of suicide.
- Assess the lethality of the method the person is talking of using and what kind of access they have to that method. (I.e. if talking about using a gun, do they have one in their home?)
- If you have reason to believe the caller is at great risk of hurting self or others, this is a time when confidentiality does not apply.
- Remember S.L.A.P. when evaluating suicide risk: **S**tatement of Intent, **L**ethal, **A**ccess, and **P**lan.
- Your goal in talking with someone you believe may hurt themselves is not to fix the problem or crisis that has brought them to suicidal ideations. It is most important to work on keeping them safe at that moment and intervening in ways that will keep them safe. (I.e. calling a suicide hotline with them or the police.)

Sexual Assault Victims/Survivors are:

- Four times more likely than non-crime victims to have thoughts about suicide.
- Thirteen times more likely than non-crime victims to have attempted/completed suicide.

Other Facts:

- Thirty-three percent of sexual violence victims have seriously considered suicide.
- Thirteen percent of sexual violence victims have attempted suicide.
- Adolescents from families with a history of suicide/drug/alcohol abuse are at greater risk.
- Media coverage of suicides may increase suicidal behavior in vulnerable teens.
- Individuals contemplating suicide want to end the pain. They are overwhelmed and full of despair.
- Individuals who call are seeking help because they still have some will to go on living.

Callers with suicidal thoughts/plans might say:

- I’m hopeless, worthless, or depressed.
- The world or my family would be better off without me.
- They have given away favorite possessions (especially teens).

Suicidal Callers Need:

- Caring from another person; contact with someone else.
- Hope that the pain will ease, but not false promises.
- Willingness on the part of the listener to talk about suicide or death.

Advocates Should:

- Ask questions such as: Why now? What has happened to cause these feelings today? Have you ever felt this way before, and what happened to stop you from committing suicide? What would help you

Answering the crisis line means that you will be talking to and supporting people that are on both ends of the spectrum of crisis. Some victims/survivors may simply need a listening ear and others may require more intervention. It is important that you are trained in being able to somewhat evaluate a person enough to know that you need to provide them additional resources or call for help.



- right now to reduce the suicidal feelings? Do you have a counselor or therapist?
- Validate and empathize with their feelings of wanting to die, but offer that there might be other options to reduce the pain and desire to commit suicide.
- Encourage them to discover others they can connect with and talk to.
- Help them identify ways they can put these feelings/actions on hold – read, exercise, go to the movies, get online, talk to someone, etc.
- Ask whether the individual wants to go to the hospital as a way to be safe.
- Make a time-limited contract with the individual to call back or call her/his therapist.
- Be prepared to call law enforcement or the local crisis team if the person is at risk of hurting self or others.

Advocates should NOT:

- Put the caller on hold.
- Make promises that can't be delivered.

After the call:

- Debrief with a supervisor.
- Pat yourself on the back for your efforts.

Suicide Calls

There is a great chance that you may encounter a client thinking of taking their own life. Sexual assault victims/survivors are 4 times more likely to have thoughts about suicide than non-crime victims and 13 times more likely to attempt or complete suicide.



Suicide calls can be scary or uncomfortable for the crisis intervention worker. The following guidelines may be helpful for you:

- Your first interest should be to establish a relationship, maintain contact, and obtain information. Be interested, assured, and accepting. (You might want to do some quiet relaxing.)
- It is often thought that people who are "serious" about suicide do not talk about it. This is false. Sometimes they don't and sometimes they do. Always take such discussion seriously. Suicide warning signs include:
 - Suicidogenic situations—precipitating crisis;
 - Depressive symptoms;
 - Verbal warnings;
 - Behavioral warnings;
 - Suicide plan—a method;
 - History of suicide attempts; and/or
 - Few resources and communication with significant others.
- Talk directly and specifically about a caller's suicidal feelings. If a caller sounds extremely depressed or gives indirect messages about suicide, it is appropriate to ask, "Are you thinking about harming yourself?" To talk directly about it without undue anxiety is helpful in reducing the caller's own fear of suicidal impulses.
- Talk about why s/he wants to commit suicide. Accept the caller's unhappiness. Try to find out what makes them feel the way they do, as well as what s/he has done to try to remedy the situation. What has triggered this crisis? If there is a specific precipitating event or trigger, it may be an indicator that this caller is quite serious.
- Assess other risk factors for suicide. These include the degree of lethality of the method proposed and access to that method.
 - Highly lethal methods: gun; jumping; hanging; drowning; carbon monoxide poisoning; barbiturates and prescribed sleeping pills; aspirin (high

dosage); car crash; or exposure to extreme cold.

- Methods of lower lethality: wrist cutting; house gas; nonprescription drugs (excluding aspirin and Tylenol); tranquilizers.
- If the caller has written a will, or gives you a sense of relief and release, they are probably at high risk.
- Your job is to try to avert the suicide, if possible, not necessarily to cure the problems that led to the desire for suicide. Trying to talk someone out of this suicidal desire too early in a visit is a common error. Arguing about the value of life or moral sanctions against suicide are not effective; nor is trying to convince someone that things are really not all that bad, or telling them that they will be letting others down.
- An effective means of suicide prevention may be to call a suicide prevention hotline in your area. If you have not gotten the caller's name, phone number or address, some areas have facilities to trace calls. A respectful approach may be to say, "It sounds like you're really serious about killing yourself. I'm going to get some help for you."
- Sometimes callers hang up before you get the information needed for an intervention. The uncertainty and guilt you may be feeling at this point may be high. Get some support for yourself in talking it through. The caller became a person to you, someone you feel you know; you are naturally concerned. You may have to accept the fact that you may never know what happened to them.

Bringing it Home:

- Do you have a local crisis connection or suicide hotline that you can connect people to directly when you are concerned they could harm themselves?
- Does your agency have any sort of official protocol when talking to someone that may be suicidal?
- Know your program's procedure for handling suicidal calls.

Evaluating Suicide Risk

If you suspect a victim/survivor might be suicidal, you **MUST** tell her/him why you are concerned and explain that you have a responsibility to evaluate her/him further, for their own protection as well as for your legal protection. The following is evaluation criteria:

S/he states suicidal intent;
S/he has chosen a lethal method;
S/he has access to the method; and
S/he has a plan of action.

S.L.A.P.

S = Statement of Intent

L = Lethal

A = Access

P = Plan

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

History of Attempts:

- Has the person ever tried to hurt themselves before?
- How did they try to hurt themselves?

Response to Previous Attempts:

- What happened afterward?
- How did their family respond?
- Did the person seek therapy or other assistance?



Eating Disorders

Information taken from Health Services department of Columbia University in the city of New York and National Eating Disorders Association
Additions by Karla Nelson, MNCASA

Key Learning Points:

- Eating disorders are not about food or a person's appearance, they are issues of control. For victims/survivors of sexual violence they can feel empowered and in control by making decisions about their eating habits, whether healthy or unhealthy.
- Eating disorders are dangerous and can be life threatening. Although they are an emotional coping mechanism, they can do severe damage to a person's body.
- A victim/survivor's healing process and treatment for an eating disorder go hand-in-hand. Both need to be worked on simultaneously in order to move through the healing process.

Eating disorders such as anorexia, bulimia, and binge eating are characterized by extreme emotions, attitudes, and behaviors surrounding weight and food issues. These emotions, attitudes, and behaviors are generally symptoms of a person's need for control. Sometimes these disorders can overlap. Eating disorders are psychological disorders which have physical manifestations. In fact, severe medical complications can sometimes lead to a life-threatening situation if an eating disorder is not treated.

The following are a list of the most common eating disorders and some of their symptoms:

Anorexia Nervosa is characterized by self-starvation and excessive weight loss.

Symptoms include:

- Refusal to maintain body weight at or above a minimally normal weight for height, body type, age, and activity level
- Intense fear of weight gain or being "fat"
- Feeling "fat" or overweight despite dramatic weight loss
- Loss of menstrual periods
- Extreme concern with body weight and shape

Bulimia Nervosa is characterized by a secretive cycle of binge eating followed by purging. Bulimia includes eating large amounts of food--more than most people would eat in one meal--in short periods of time, then getting rid of the food and calories through vomiting, laxative abuse, or over-exercising.

Symptoms include:

- Repeated episodes of bingeing and purging;
- Feeling out of control during a binge and eating beyond the point of

There might be times when you will be able to identify some of the warning signs with a victim/survivor you are working with. Are you prepared to have that conversation?



- comfortable fullness;
- Purging after a binge, (typically by self-induced vomiting, abuse of laxatives, diet pills and/or diuretics, excessive exercise, or fasting);
- Frequent dieting; and
- Extreme concern with body weight and shape.

Binge Eating Disorder (also known as Compulsive Overeating) is characterized primarily by periods of uncontrolled, impulsive, or continuous eating beyond the point of feeling comfortably full. While there is no purging, there may be sporadic fasts or repetitive diets and often feelings of shame or self-hatred after a binge. People who overeat compulsively may struggle with anxiety, depression, and loneliness, which can contribute to their unhealthy episodes of binge eating. Body weight may vary from normal to mild, moderate, or severe obesity.

Other Eating Disorders can include some combination of the signs and symptoms of anorexia, bulimia, and/or binge eating disorder. While these behaviors may not be clinically considered a full syndrome eating disorder, they can still be physically dangerous and emotionally draining. All eating disorders require professional help.

Eating Disorders and Sexual Violence

Eating disorders are common for victims/survivors of sexual violence.

- Some studies indicate that almost 30 percent of women suffering from bulimia were raped at some point in their lives.
- Girls who are sexually abused appear to be at a double risk for eating disorders.

Food can often become an area where a victim/survivor can exert control by:

- Deciding when and if they can eat;
- How much and what they eat;
- Denying themselves when they are hungry;
- 'Punishing' themselves for feelings or memories they have about the abuse, by not eating, or by eating and then purging;
- Working through the hunger; and
- Surviving on very little amounts of food.

Accomplishing these things can feel like victories in gaining control over their lives and bodies after sexual assault or abuse took that control and choice away. As with self-injury, it is the victim/survivor who controls the behavior, and not the perpetrator. Being able to decide when to eat, how much to eat, or whether or not they eat may leave a victim/survivor with feelings of empowerment.

Some victims/survivors may deny themselves food in order to become thin

and lose any resemblance of a female figure. Other victims/survivors may want to gain weight to cover or hide areas of their body, or to attempt to make themselves unattractive. We know that sexual violence does not occur because of sexual attraction, but some victims/survivors may feel that if they make themselves less physically or sexually appealing it may ward off attention from perpetrators. They may hope it will lessen the risk of experiencing sexual violence again.

Finding ways to cope with sexual violence, without harming oneself, is something we can assist victims/survivors with. Emotionally supporting victims/survivors is one of the most, if not the most important service advocates provide. When working with a victim/survivor that is using an eating disorder as a coping mechanism, it is important to talk about counseling if they are not already receiving services from a mental health professional. Eating disorders can become very dangerous if not treated appropriately. It is not the advocate's role to push counseling onto a victim/survivor. But, it should be the advocate's role to make a victim/survivor aware of the options s/he may have available in her/his community to help her/him find other ways of coping with her/his feelings.

Resources

Health Services department of Columbia University in the city of New York
National Eating Disorders Association
Additions by Karla Nelson, MNCASA



If a victim/survivor self-discloses, you need to be aware how this could affect her/his healing process, perception of self and others; as well as, options/resources within the community.



Are you prepared to have a conversation on sexual violence and eating disorders? Do you carry anything that might make this conversation more difficult for you?

Bringing it Home:

- Are there specific resources in your community for victim/survivors that are struggling with an eating disorder?
- What are the counseling options in your community? Do they specialize in this area?
- Who within your community should become aware and understand the warning signs of a victim/survivor struggling with an eating disorder?
- What are measures your agency can do to bring awareness of this issue to your community?

