Sexual Violence in Minnesota: A Resource Manual for Advocates
October 10, 2007

Dear Advocates and Trainers:

MNCASA is pleased to present this updated version of the Training Manual for Minnesota Sexual Assault Advocates. While the process of bringing these articles into the 21st century has been taxing, we have identified along the way that even bigger and better changes are called for! Rest assured that we are planning a (shorter) process for making that happen! To this point, we are asking that users of this manual find opportunities to give MNCASA feedback about the contents and usefulness of this product. You can help us shape the next generation.

In the meantime, please know that while the material in this manual is current and reflects the work of advocacy as we know it in 2007 in Minnesota, it is not the definitive or only word on the topic! You have all probably identified training resources that have been developed on the national level and that augment the articles collected here.

This manual is, then, our latest thinking on the variety of topics that we know arise when one considers community-based sexual assault advocacy. We have worked to make sure the critical areas of community, victim/survivor, and advocate response are covered. This manual does not instruct you how to present or discuss the material. That is part of what is yet to come as MNCASA staff work to create the ultimate training manual we have in mind!

For trainees who are seeing in this manual your introduction to sexual assault advocacy, do not let the volume of material in front of you dampen your enthusiasm. Consider this a resource that you may return to time and again as your advocacy experiences raise new questions. We hope that this manual in conjunction with your colleagues in your local program will provide the guidance, critical questions, and appropriate resources to help you navigate your way through sexual assault advocacy.

Thank you for your commitment to ending sexual violence. We believe this issue belongs to all of us in our communities, and your willingness to take on a crucial role is a gift to your community. You will find that this work not only changes the lives of others, but changes your life as well. For all of us at MNCASA, we honor your work.

Sincerely,

Donna Dunn
Executive Director
Acknowledgements

Believe it or not, revising the MNCASA Advocacy Manual was no small task! We could never have gotten through it alone. The MNCASA staff would like to acknowledge and thank the following people for their time and contributions to the revision of this manual.

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The Pennsylvania Coalition Against Rape

The Ohio Department of Health

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The Minnesota Department of Corrections
Disclaimer

We realize that when we choose our language we communicate a value. Many words have a multiplicity of meanings which require us to truly consider the meaning of our message. Due to the nature and history of sexual violence we must grant special attention to the language we use. As the violence against women movement has progressed, so has our language. We no longer consider sexual violence to be synonymous with rape. Acts of sexual violence now include/encompass unwanted touching, stalking, sexual harassment, rape, marital rape, and the list goes on.

As we revised and compiled this sexual assault advocate training manual we wanted to offer a disclaimer and thoughtful discussion into the language we chose. The committee’s discussion of current language and terminology resulted in (determined) the following:

- Throughout the manual the term Advocate will replace the word Counselor unless referring to mental health service providers.
- Throughout the manual the term Sexual Violence will be used instead of Rape or Sexual Assault unless referring to a specific form of perpetrated violence.
- Throughout the manual the terms Victim/Survivor will be used versus using one or the other.
- Throughout the manual the term Client will continue to be used.
- The terms Rape crisis center and sexual assault program will be replaced by the term “sexual violence advocacy center” (or program or agency).

The manual will include a list of definitions in the Introduction, referring to the terms and language used throughout the manual. In addition, statements will indicate language and terms used interchangeably. We expect that discordance may exist around this and we respect that each agency/organization may have a preference for certain language and terminology. Please use this manual as a basis for thoughtful discussion and learning.
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Program Information
Introduction
Key Learning Points:

• The Anti rape movement of the 1970s did not materialize out of thin air.
• Rape of women has historical roots in understanding women as the property of men, a legal, historical, and cultural context around the world.
• The anti-rape movement owes its genesis to other social justice movements of the last two centuries, including the women’s suffrage movement, the anti-war movement of the 60s, and the Civil Rights Movement of the 50s.
• The anti-rape movement has grown and changed between 1970 and now. What began as a radical change movement has become mainstream as evidenced by local, state, and federal funding that supports advocacy, systems change, and prevention.
• As a movement, we continue to assess our effectiveness in providing services and changing norms to make sexual violence a thing of the past.

The anti-rape movement of the 1970s did not materialize from thin air. Like all significant changes in the evolution of human history, the Anti-rape Movement is – on the one hand – a manifestation of the gradual progress of an evolving culture and – at the same time – a noticeable shift in the prevailing norms, mores, and beliefs of that culture.

The word “rape” is derived from the Latin “rapere”, meaning “to steal, seize, or carry away.” Forcible seizure and rape were accepted methods of claiming a wife in early history – and, in some cultures, this still occurs. Owning property and gaining wealth were considered marks of manhood. This ownership revolved around possessions and, without a wife, a man’s linage would end. According to Susan Brownmiller in Against Our Will, “Concepts of hierarchy, slavery and private property flowed from, and could only be predicated upon, the initial subjugation of women.”

Throughout most of history, rape was not viewed as a crime because women were considered property, and, therefore, without rights. Like taking land, men took women as an act of aggression; an affirmation of their strength and masculinity. In most cultures, marriages were arranged when the groom purchased the bride from her father. Rape was initially considered a crime only in terms of the property violation of another man. Punishment was delivered to a man who damaged the husband’s property – his wife – by rape. Very often the raped woman would also be punished as an adulteress, regardless of her lack of complicity in the assault. For instance, ancient Hebrew women who were raped were considered defiled, and stoned to death.

Throughout English history, punishment for rape included castration or death of the rapist. However, to receive legal justice, a victim had to be born into the privileged classes: “…if a member of the feudal class committed his crimes against anyone other than the king or a great lord, he was fairly safe from prosecution, or at least from punishment,” wrote Sidney Painter in History of the Middle Ages. Prior to the thirteenth century, a raped woman had to be a wealthy, propertied virgin to have legal recourse against her attacker.
In the late thirteenth century, English laws were rewritten to exact a penalty of death upon a man who raped an unmarried or married woman (except his own wife). Although this law was rarely enforced, it was one of the first laws making rape against all women a crime.

By the late 1700’s in the United States, women, seemingly one by one, recognized the powerlessness of women in the face of male domination in the educational, social, political, and economic institutions of this emerging nation.

Mary Wollstonecraft wrote the Vindication of the Rights of Women in 1790. Wollstonecraft recognized the failure of contemporary education for girls and the powerlessness of women in unhappy marriages. She ridiculed the notion of women as meek and modest; as attractive and shallow playthings for men. She maintained that women should be equal partners to their husbands. For the first time, a woman put words to the experience and perception of many women – these words served as a galvanizing force.

Women “galvanizing as a force” began with the anti-slavery movement. The Grimke sisters, Angelina and Sarah, were among early activists in the anti-slavery movement during the 1830s. They were born into a slaveholding family, but rejected their family and joined the Quakers who were notable abolitionists. They published a letter in the anti-slavery newspaper, and later went on speaking tours against slavery and championed the rights of women. Work in the anti-slavery movement thrust women into the political, activist arena. This work gave women a forum for discussing injustice and recognizing the similarities with all women’s lives.

The Women’s Rights Convention of 1848 solidified because men attempted to silence the women at the earlier Anti-Slavery Convention. The 1848 convention represented the first major national organizing around women’s rights. This convention grew out of abolitionism, which taught them how to organize, publicize, and articulate a political protest. Elizabeth Cady Stanton, Susan B. Anthony, Lucy Stone, and Lucretia Mott are considered among the mothers of the early feminist movement. They were also abolitionists who loosely held the belief that women were, in some sense, slaves, too.

Over 200 women attended the 1848 convention. The delegates passed the Declaration of Sentiments, written like the Declaration of Independence – calling on women to organize and petition for their rights. The right to vote passed by a narrow margin and was quite controversial – and a reflection of the racism so pervasive then (and now); tragically, women of color were not included in the right to vote. That decision and others resulted in a schism between white women and women of color that continues today.

Sojourner Truth connected the issues of women and race. She spoke of the role of black women in the fight for women’s rights in her famous speech “Ain’t I A Woman?”

In 1866, when the Memphis Riots occurred, Congress held hearings about the chaos and brutality during the riots. Black women testified before Congress about being gang raped by a white mob. These women were perhaps the first
women to break the silence of rape.

The issue of rape, race, women, and slavery was also addressed by a significant Supreme Court case, Missouri v. Celia, in 1885. The decision is, of course, a travesty – a black slave woman is declared to be the property of her owner with no right to defend herself against his rape of her. A decade later, the Equal Rights Association became the first organization in the U.S. to advocate national women’s suffrage.

During the post-Civil War years, women leaders gained more and more national attention as travel and communication systems improved. In 1872, Susan B. Anthony, along with fourteen other women, tried to register to vote; she was arrested and refused to pay the $100 fine. That same year, the Susan B. Anthony amendment, giving women the right to vote, was first introduced into Congress. Ida B. Wells-Barnett was also a notable black activist in the late 19th century. Her anti-lynching campaign stirred more and more African-Americans to speak out about the horrors of racism and segregation.

By the early 1900s, women were re-defining their roles as wives, mothers, and homemakers. Emma Goldman first wrote and spoke about women’s reproductive issues, and Margaret Sanger opened the first birth control clinic in Brooklyn, NY, in 1916.

In 1920, women gained the right to vote with the passage of the 19th Amendment. With new rights, greater emphasis on education, and massive mechanical and technological advances, women’s opportunities for employment blossomed. It was no surprise that women joined the workforce en masse during World War II, and over 400,000 women joined the military.

The second wave of women’s activism began with the Civil Rights Movement of the 1950s and the Student’s Free Speech Movement of the 1960s. The Civil Rights Movement, through the inspiration and work of women like Rosa Parks and Fannie Lou Hamer, gave hope that groups of committed citizens can fight against injustice and institutionalized violence, and obtain equal rights. Other social change movements at the time included: labor, peace, and anti-Vietnam War. Betty Friedan’s best-seller, The Feminine Mystique, sold millions of copies and laid the groundwork for the modern feminist movement. From the early consciousness raising groups to the establishment of women’s studies programs in universities, women’s voices, experiences, and realities joined the public debate about radical shifts in the power structure of institutions and relationships. The anti-rape movement did not materialize out of thin air.

The anti-rape movement of the 1970s set out to change the world. It is not like there was a choice; it was something that had to be done in order for women to survive.

Imagine, if you will, what women’s lives were before 1970:

- The North American Indian Women’s Association did not exist;
- The publication, Off Our Backs, had never been published;
- There were no speakouts on rape;
- There were no rape crisis centers;
• There were no shelters for battered women;
• Ms. Magazine had not been published;
• The National Women’s Studies Association did not exist;
• Women did not march in the University of Minnesota’s marching band;
• Abortion was not legal in the United States;
• Girls could not play Little League baseball;
• Olivia records was nowhere to be heard;
• There had never been a national lesbian feminist conference;
• Women made less than 59 cents to a man’s dollar;
• Women’s basketball was not an Olympic sport;
• The National Association of Black Professional Women did not exist nor did the National Alliance of Black Feminists;
• The National Coalition Against Sexual Assault was 9 years from introduction; and
• The National Women for Color Leadership Project for Sexual Assault Services and Policy didn’t yet exist.

In 1970, women’s lives were about to make an unprecedented break with the traditional image and role of the American woman. In the 1950s and 60s, the economic needs of families had prompted many women who had been employed during the war years to return to the labor force. Employment of women became more socially acceptable. At the same time, the emerging women’s movement raised the issue of women’s “second class status,” our relegation to working and non-working roles that were less valued, not as profitable, less diverse, and outside of the power and decision-making controlled by men, disproportionately white men. As more women began working outside of the home and pursuing educational opportunities beyond high school, women forever changed our society’s definition of gender roles and our thinking about the value of female lives.

All of these shifts laid the groundwork for change: new rules about decision-making, power, and authority. And women gave themselves and other women permission and support to risk the most intimate and one-sided relationship we knew: our relationship to men. Whether we were married to men, partnered to men, hoping to be one or both, someday or again, or not interested in men as partners, we knew that revealing our pain, joy, frustration, satisfaction, or ambivalence with and about men would be the hardest part of our work. Women knew from history that eventually men would concede some things: the right to work, better working conditions, the right to vote, a driver’s license, admission to professional associations, even divorce. But women had never before demanded – as a movement – that gender roles change, and that the expectations and the limits of behavior within those roles would be now and forever defined by women. As Gloria Steinem said:

“In our various ways we were mutually uncovering the secret of this land of opportunity. If you aren’t born white and male in America, you are statistically likely to end up as some sort of support system for those who are...[women] realized that they shared problems as women, and they needed to support each other to have any power at all. As for rights of sexual
expression and reproductive freedom, women finally discovered that all of us were endangered when one group was denied.”

The National Organization for Women had pushed to bring women “into full participation in the mainstream of American society.” NOW’s agenda focused on reproduction, equal pay for equal work, child care, housework, and sexuality, not to be confused with sexual orientation. We owe a debt of gratitude for the achievements of the early women reformers. And we must also acknowledge that by the late 1960s, the feminist movement had not yet recognized or analyzed the impact of interpersonal violence on women’s lives.

The work that needed to be done to stop the rape of women and lift us from the physical, psychological, and institutional brutality of second-class citizenship became crystal clear when women spoke publicly about the rape in their lives. In January 1971, the New York Radical Feminists held a speak out on rape at St. Clement’s Church in New York City. No one published the women’s voices from that evening, but I imagine the stories were the same painful, heart wrenching, and frightening stories we more than three decades later. From those moments forward, rape victim advocates knew that fundamental changes must occur.

Perhaps the most profound analysis by early feminists is that they declared the private is not separate from the social or the political. The anti-rape movement embodied this analysis as reflected in the Chicago Women Against Rape’s 1970’s statement of purpose:

“All rape violently reflects the sexism in a society where power is unequally distributed between women and men, black and white, poor and rich...In rape, the woman is not a sexual being but a vulnerable piece of public property; the man does not violate society’s norms so much as take them to a logical conclusion.”

The anti-rape movement listened to what survivors were saying. Survivors named those who blamed them for rape: law enforcement officers, prosecutors, boyfriend, friends, authors of literature, law scholars, reporters, sports figures, families, and just about everyone who learned their story.

The rape of Joan Little in August 1974, by a guard at the jail in Beaufort County, NC, galvanized public focus on the horror and terror of rape. Joan Little, a black prisoner in the Beaufort County Jail, was attacked by the white jailer, Clarence Alligood. Joan broke away from her rapist, killed him with an ice pick he had taken into her cell, and then broke free from the jail. She was caught and charged with murder, and Angela Davis led the national outcry to bring justice to Joan Little. Eventually, Joan, her lawyers, Angela Davis, and public support prevailed. A jury acquitted Joan Little of killing Clarence Alligood. As Angela Davis so eloquently stated before Joan’s trial:

“All people who see themselves as members of the existing community of struggle for justice, equality, and progress have a responsibility to fulfill toward Joan Little. Those of us – women and men – who are black or people of color must understand the connection between racism and sexism that is so strikingly manifested in her case. Those of

* Advocates may need to consider that a victim/survivor or secondary victim’s response may be connected to their age and the understanding of sexual violence that they were taught.
us who are white and women must grasp the issue of male supremacy in relationship to the racism and class bias which complicate and exacerbate it.

Let us be sure that the leitmotif running through every aspect of the campaign is unity. Our ability to achieve unity may mean the difference between life and death for sister Joan. Let us then forge among ourselves and our movements as indivisible strength and with it, let us halt and then crush the conspiracy against Joan Little’s life.”

The anti-rape movement sponsored speakouts, hosted forums, and distributed literature and fact sheets correcting the lies and the myths, desperately trying to shift blame to where it belonged: with the rapist. The anti-rape movement listened as survivors courageously disclosed the sexual violation in their lives by men, sometimes known to the survivor, sometimes not. Sometimes, it was an incident that occurred long ago, sometimes the night before. They said they did not have anyone to talk to about what happened. They said they wanted to go to the hospital, but were fearful that their humiliation would be multiplied and the origins of their injuries ignored. They never considered going to the police station.

These women said something needed to be created. Not for themselves, they said; it was too late. But they wanted to answer a telephone in the middle of the night to help chase away someone else’s nightmare, and they wanted to talk to nurses and doctors about how to treat a rape victim differently than anyone else who came to an emergency room. And, they wanted to talk to teenagers and college kids and all the women in the community about how to avoid rape. And a few of them said they wanted to teach police about how to respond to a rape victim, and how to interview her and to understand that women don’t make up this “stuff” to get someone else in trouble. Many of the survivors said they wanted to stand in the streets or in the classroom or on television or in Congress or anywhere else to let people know that rape is about women being controlled by men; that men rape because they believe they have a right to rape, and they believe they will get away with it, that men who rape believe they own the victim’s body. Survivors were becoming activists.

As Sandra Butler said in a speech in 1996 to the National Coalition Against Sexual Assault:

We saw what we needed and made it up. It was that simple. Nobody knew how to create a rape crisis center. Negotiate a modified collective. Develop crisis intervention for abused adolescents. Create on-going support groups for adult women. Engage the criminal justice system as allies in the effort to engage women in seeking justice in traditional institutions. No one had yet learned how to create protocol for examining a sexually abused child. No one. We were it. We just kept putting one foot in front of the other, making it up as we went along.

Survivors, and the women and men who supported them said if male authority, power, and privilege were re-distributed so that women had an equal share of that authority, power, and privilege, rape would be eliminated. The reasoning was – and is – a person who respects another person as his equal will not rape her.
The social and political analysis of how domination is based on social relationships of unequal power can no more be separated from the work of rape crisis centers than the analysis of poverty can be separated from the goals of education. Understanding why rape occurs is an integral part of how to stop rape and how to heal from rape.

For more than [thirty-five years], the anti-rape movement has worked to overcome misconceptions about the origin and nature of sexual assault, prejudice toward victims, and stereotypes about perpetrators. We have insisted that victims do not “ask for it” through provocative dress or behavior. We have maintained that an adult woman raped by a husband or someone else she knows deserves the exact same justice and support as the child raped by a stranger. We have been loud and clear about the fact that only rarely does a victim falsely report rape. We have insisted that someone who rapes is not necessarily crazy, mentally ill, or deranged. They are simply men who believe they have the right to control a woman or adults who believe they have the right to control a child.

The goals of the anti-rape movement have changed very little in the past [35 years]. As early as 1971-72, rape crisis workers established 24-hour crisis lines, conducted prevention education and training programs, created thousands of brochures, offered self-defense classes, organized and marched in “Take Back the Night” events, and devoted thousands of hours to helping victims heal from the devastation of rape.

Rape crisis workers advocated – and continue to advocate – for legislative reform; insisted – and continue to insist – that police increase their arrest rates; demanded – and continue to demand – privacy for rape victims in emergency rooms; and urged – and continue to urge – that prosecutors change their plea negotiation procedures.

No one had learned from formal education, professional conferences, or the media about how to do anti-rape work. But once survivors broke the silence about the terror of rape, women devoted their minds, hearts, time, and money to construct and sustain organizations that won groundbreaking victories. These organizations – rape crisis centers and state coalitions – changed practices in hospitals, police departments, courts, and the field of psychiatry. And, most importantly, women helped each other recover from the emotional and physical violation of rape.

As the anti-rape movement gained momentum, it became clear that this was a new field. Survivors and their advocates created rape crisis centers to fill a void – with a definition and purpose different than traditional mental health, public health, or social services. With its mission of social change, equality between men and women, and its fundamental principle of victim-centered services, the anti-rape movement offered a new model for institutional policies and individual healing. This model gained recognition and credibility with each new accomplishment.

The joint efforts of the women’s rights, women’s liberationist, and anti-rape movements yielded systemic changes; there were multiple occasions to celebrate legislative victories. Laws were created to standardize the collection
of medical evidence in emergency rooms. The Rape Shield Law made the victim’s sexual history irrelevant in trial and states overhauled sex crime statutes, making them gender neutral and creating a gradation of sex offenses in the effort to stop sanitizing the brutality of rape by calling it battery. New categories of victim service funds were authorized by states and Congress. The federal Victims of Crime Act of 1985 and the Violence Against Women Act of 1994 dramatically changed the number of full-time staff in rape crisis centers in the United States. In turn, the number of victims and the increased visibility and viability of rape crisis centers in local communities has increased remarkably.

In establishing the facts about rape, rape survivors and counselors taught the community and related professionals about the impact of rape on the victim’s life. Apart from the interpersonal, social, and political hierarchies that perpetuate a rape culture, the single incident of rape is the most degrading, demeaning, and humiliating violation perpetrated by one human being against another because it is about loss of control, loss of ownership, and loss of power over the one thing that is yours and no one else’s: your body.

The counseling developed in rape crisis centers focused – and continues to focus – on the victim’s ability and her right to reclaim control over her body and the decisions affecting her life. The victim determines the timing and pace for relating her experience. She alone defines whether to report the rape to law enforcement; she directs the course of her recovery. Rape crisis center personnel are there to support her decision and to facilitate her recovery.

Rape crisis services are the foundation to change public attitudes about rape and rape survivors. We have disclosed the use of violence to maintain power and control over women. We have educated the world that shame and guilt in rape belong to the perpetrator, not the victim; we have shown that women can help women; and we have proved that feminism can redefine personal relationships and institutional practices.

We have struggled to change not only the sexism inherent in our personal and institutional relationships, but the racism and classism that pervades beliefs and attitudes about people of color and people who are poor. From Susan Schechter in her book Women and Male Violence:

“Throughout the anti-rape literature there is a recognition that the system sometimes helps ‘legitimate’ victims – a white, married women who fought their [stranger] rapist and was visibly injured. Other victims – women of color, poor women, single women, women who dared to be out drinking or walking the streets late at night, prostitutes, women raped by judges or doctors – would never be consistently helped. Nor would the racist use of the rape charge, which helped whites brutalize the black community, ever cease without major social transformation. Exactly how rape was to be eliminated remained a difficult question. Profound social struggle would have to attack the sexism, racism and class domination in our society in order to end rape.”

The anti-rape movement, led by survivors and rape crisis centers, has never lost sight of its beginnings. The anti-rape movement gained strength and integrity as it uncovered the connection between the personal and the political. In order to combine the first-hand knowledge of anti-rape workers with the need to create a national forum for shared thinking and new thinking about the needs of rape
survivors, the National Coalition Against Sexual Assault (NCASA) was established in 1978. From its beginnings, NCASA staunchly advocated for public polices, resources, and collaborations that improved the lives of sexual assault victims.

NCASA sponsored a national conference each year for nearly two decades to provide exemplary training and staff development for workers in the anti-sexual assault movement. NCASA worked diligently and creatively to maintain a national network of services for victims of sexual assault.

Over the years, there have been changes in the service delivery of rape crisis centers and in their visibility as the community leaders for social change. The magnitude and pervasiveness of that change is difficult to measure precisely, but rape crisis centers have been compelled to create trauma-based counseling and therapy services to respond to the increasingly complex issues presented by rape survivors. In many instances, counselors trained in traditional schools of social work, psychology, or counseling have not been taught the political analysis of how rape is a natural consequence of women’s historically unequal relationship to men. To a social worker or counselor not steeped in the origins of rape and the impact on a woman’s life, the more obvious emotional and psychological indicators may distract that counselor from the devastation and insidious nature of rape. For instance, some women have coped with the pain of rape by using alcohol or drugs. If we do not understand, validate, and empathize with the trauma of rape, we will identify alcohol or cocaine as the most serious or as the only problems in a woman’s life, and that will distract us from how to do victim-centered counseling about the impact of rape.

The growing numbers of survivors that we see – and the growing complexity of their life struggles – feeds the other equally important reason for our existence: to eliminate inequality wherever we see it. Rape is about the threatening, intimidating, and forceful behavior of (at least) one person against another. Rape is about the misuse of power; rape is the enforcement of domination and control. It is why men primarily rape women and adults rape children and not vice versa. And until inequality is addressed and eliminated, we will have rape crisis centers; they will be overwhelmed with the individual, complex, excruciatingly painful needs of people who do not have anywhere else to turn; and they will not be adequately staffed by or utilized by people of color. We must recognize, speak out about, and hold fast about the devastating consequences of inequality wherever we see it. With racism, rape, and any form of oppression, when we speak and act with integrity, we create change.

Our struggle to create change through our work is continual. Having adequate funds to do this work and maintaining the presence of victim-centered services and social change for our community is often complicated by that necessary, elusive resource: money.

The first federal allocation of money for rape prevention and rape crisis services was distributed to sexual assault centers in 1982 through the Preventive Health and Health Services Block Grant. Those funds continue to be a strong base for rape crisis work. Subsequent funds through the Victims of Crime Act and the Violence Against Women Act have enabled centers to hire advocates, counselors, and prevention educators.
Passed by Congress, the Violence Against Women Act (VAWA), created new penalties for gender-related violence, and established the Rape Prevention and Education (RPE) Program administered by the Centers for Disease Control and Prevention (CDC) and S.T.O.P. grant funds administered by the Department of Justice. The Act was enhanced and re-authorized in 2000 and 2006.

RPE supports rape prevention and education programs in all 50 states, the District of Columbia, Puerto Rico, and U.S. territories. Nearly $44 million is distributed by the CDC, which is less than $1 million each when divided among all of the states, territories, and D.C. Obviously, $44 million is not enough to support rape prevention in America today.

Awareness and prevention programs, a cornerstone of RPE Programs, are implemented in a variety of settings. Sexual assault crisis centers conduct programs in schools and non-school settings with youths, faith-based institutions, and community-based organizations. Many RPE grantees focus on programs aimed at promoting healthy relationships and changing the social norms that permit rape.

The RPE Program also provides crucial support for state and local sexual assault hotlines. These hotlines provide 24-hour crisis intervention, referrals, and information about sexual violence. In 2004, RPE-supported hotlines received more than 400,098 calls. The hotlines provide a vital link to services for victims; the hotline call may be her first disclosure, a crisis call during a flashback to a long-ago assault, a request for an advocate at the hospital, or any other request for immediate support or information.

VAWA has made a difference. RPE has made a difference. RPE has pushed prevention to the forefront of our work in crisis centers. The focus has shifted away from teaching women and girls to stay safe. Now we have returned to our roots: focusing on social change, promoting male responsibility for stopping rape, and undoing the attitudes and associated behaviors that say it is okay for men to sexually exploit and violate women and children. This is real change - change that will make a difference. Now, the government allocates funds to support change: to help us eradicate sexism, racism, and the rape culture we live in. We have come so far, but we have so far to go.

There are several clear goals for the future of the anti-rape movement:

One goal is for rape crisis centers to hold on to the movement – to retain the unique voice, and philosophy and passion that lit the fire in the first place. Rape crisis centers and state coalitions need to challenge government and private funders to remember who started the movement: victims; and why they started the movement: they had truths to tell and needs to assert; and they were tired of being silent, pathologized, medicalized, and marginalized. As we professionalize and standardize our services – all good things, mind you – we need to retain the heart of the movement – which is first about listening to each victims’ story. Which is supporting her or him as the survivor sifts through options and moves steadily forward. Which is saying to the community: men must stop the rape of women and men, and adults must stop the rape of children. Which, first and foremost, is challenging men to speak up against rape, to stand up against sexism, to hold other men accountable, to demand justice and safety for all.
women and children, to support the crisis and prevention services of every crisis center – with their money, with their time, with their consciences.

Another goal for our future is to broaden our vision and our services. We need to increase our outreach to victims and communities that have been long underserved: people of color, people with disabilities, non-English speakers, the elderly, and the LGBT community. We need to create and enhance models to serve these populations. Models start with making our centers more closely reflect the entire community. Crisis centers’ staff, board, and volunteers need to reflect the populations they serve and need to develop competence to serve these populations.

One more goal takes us into the world of the flesh industry. We have long been aware that pornography culture supports rape culture, and that prostitution and sex trafficking are inextricably linked with the sexual subjugation of women. We need to use this knowledge to respond to those who are commodified, prostituted, kidnapped, or held captive – whether by economic threats, coercion, or force. We need to start building the service and prevention network to serve these victims of commercial sexual exploitation. And we need to prevent these abuses and the rape culture they magnify. This will take more resources, more research, more learning and teaching, and development of models we cannot yet envision. We created all the services that exist today – and we have this new work within us.

Throughout all of our work toward these goals, we must also focus on the elimination of racism in this society. The immorality, injustice, and deadliness of racism is inseparable from the immorality, injustice, and deadliness of the sexism that perpetuates rape. We have never gotten this quite right from the beginning. Let me describe the racism that oppresses African American people in this country as an example and how it served – and continues to serve – to undermine us in our efforts to bring equality and safety to everyone’s life. The unpunished rape of black females by white masters and other white men during slavery, and throughout the 19th and early 20th century, and the brutal lynching of black men predicated on false accusations of rape, have deeply affected the anti-rape movement. Since the beginning of the anti-rape movement, the women who spoke out about rape demanded more and better law enforcement to improve the apprehension and arrest of rapists; they demanded tough prosecution and serious penalties for the rapist. This pro-law and order stance by victims – and the feminists who supported victims in their fight for justice – flew in the face of many African American people who had raised the consciousness of America about the disproportionate number of black men in our jails and prisons, both at that time and throughout much of our history.

As you know, many female anti-rape activists came from the civil rights movement, the free speech movement, the peace movement, and/or the black power movement. Many of them were leaders in the new feminist movement; and they were committed to uncovering and challenging the racism and oppression that pervaded America, and was reflected in our laws and criminal justice system. White women activists did not consider their anti-rape work as contributing to historically racist practices, nor did they see it as less important than any other struggle for freedom and safety. And while that viewpoint may have reflected the true intentions of their hearts and may have been necessary.
to sustain the seriousness of the work, it exacted a price on the overall goal of freedom and safety for all oppressed Americans.

African American women activists could easily see the no-win, collision course that anti-sexism and anti-racism had unwittingly climbed aboard. Black women saw in the civil rights and black power movements opportunity for the brotherhood of African American men to climb out of the demeaned and usually impoverished status imposed by the white powers-that-be who feared their equality. At the same time, African American women understood sexism and its practices, but they could not refute the promising rise of black men from second-class citizenship. With the prospect of forward movement on the legal, political, and economic playing fields for black people, black women were going to be there for black men.

And for reasons that are sometimes clear, sometimes unclear, and always a source of great debate, these two great movements for human rights ended up with a wedge between them instead of a partnership. While women of color and white women in the anti-rape movement have forged working partnerships and friendships with one another as in few other places in the American labor force, there continues to be tension and unfinished work between women of color and white women that is a consequence of this history of slavery and the refusal of far too many white Americans to acknowledge those consequences, and denounce their immoral and divisive impact.

Oppression is pervasive and hurts us all, though not in the same ways. The experience of the oppressed group is very different. They can speak accurately about the daily experience of oppression — the slights, indignities, threats, fear, losses, and degradation that accumulate in the mind, spirit, heart, and body of the oppressed. Those with privilege cannot tell that story, nor should that person try. Rather, those of us with privilege must learn the reality of that privilege and how to use it to promote justice.

None of us invented these oppressions; we inherited a legacy of centuries. We also inherited the power to change it. There is no such thing as passive anti-oppression. We are either actively working against oppression or we are colluding with it, allowing it to continue in our name.

The Anti-Rape Movement is an impressive group of women — and, like the Marines, with a few good men, we are making a difference. We said we would change the world and we see enough daylight at the end of the tunnel that we pull one another onward.

The myths we hold are the most significant barrier to ending sexual violence. It is not enough that the medical profession provides appropriate and effective medical care and evidence collection. It is not enough that law enforcement intervenes and interviews victims appropriately and effectively. It is not enough that prosecutors vigorously pursue prosecution appropriately and effectively. It is not enough that judges conduct trials and give jury instructions appropriately and effectively. It is not enough that jurors, who may well be you and me, reach our decisions appropriately and effectively. It is not enough that advocates provide support and assistance appropriately and effectively. We must do more with our hearts and minds. We must hold and
share deep compassion for sexual assault survivors, and we must work to replace myths about rape, the victims of rape, and the perpetrators of the most heinous crime short of murder, with truths about the origin of rape, and its impact on the victim and our communities.

I love what Martha Burt, Janet Gornich, and Karen Pittman wrote in 1984. Listen to their words. They are still pertinent today:

“This work is never easy, either in terms of time or of the psychological stresses of repeatedly confronting the realities of rape in this culture. In addition, it seldom pays very well, if it pays at all. Thus the fact that so many people continue to do this work is encouraging. We take it as a sign of how well the feminist movement’s political activity raised issues surrounding rape and galvanized many women to devote their energies to trying to stop it and ameliorating the consequences. The movement’s insistence that society bears some responsibility for changing patterns of sexual assault continues to guide the activities of many rape crisis centers. For most women working in rape crisis centers, their activities reflect some level of commitment, often very great, to helping women help themselves recover and emerge strong after an assault experience. Recognizing and building on this base of commitment, rape crisis centers may want to be able to reexamine feminist analysis, take a new look at their understandings and expectations and reformulate their goals for their communities, their centers and themselves.”

We can make this a more caring and supportive nation for survivors of sexual assault. And, we can work together to stop rape so that we can tell our communities that rape crisis services are no longer needed. It is the only choice we have in face of the alternative.

References


7. While the words on pp. 49-52 are mine, I am grateful to Angela Davis for her original social/political analysis on this issue.

Introduction: The previous article by Polly Poskin details the history of the anti-rape movement. Critical to this is the understanding that this movement exists because individual women spoke up, demanded, and received recognition for the harm done to them in ways usually sanctioned by society. When women took on the brave and unpopular challenge to make their experience known and understood to a society that didn’t want to hear their stories, the world began changing. Hence, anti-rape work has its roots in the feminist analysis that at once created permission for victims to speak out, and started defining the best community intervention.

Feminism provides the basis for our work as sexual assault advocates. Sometimes misunderstood and cast aside, feminism is the philosophy we use when advocating, counseling, educating, and creating policies and laws to benefit sexual assault survivors. This is our analysis and our approach to working within our society where a rape culture still exists. Feminism is the foundation on which rape crisis centers and other advocacy organizations were created and have been sustained. Feminist analysis and the anti-sexual violence movement go hand-in-hand. Sexual violence is utilized as a tool of oppression to keep power in the hands of certain people, by creating an environment that limits freedoms to people who become vulnerable to this violence.

Feminism at its core is an analysis of our society and culture. This analysis then is applied practically in all areas of our work. This feminist analysis is based on the belief that our
entire American and worldwide society is built on basic inequalities between people who define who are accorded certain rights, privilege, and freedoms because who they are is valued. People are given power and a position in the hierarchy largely based on their status in society determined by innate features of themselves and the family to which they are born. These factors include gender, race, ability, sexual orientation, gender identity and expression, ethnicity, and religion. Central to this power inequity is men’s power due to status over women. Whether men utilize this power in their daily lives and personal relationships, the privileges still exist.

Patriarchy is a term used by feminists to describe the current structure of our society. This structure (or patriarchy) is a strict hierarchy of power that places certain people on top with the right and ability to make decisions about and use their power to oppress those lower in the hierarchy. Another aspect of this feminist analysis is the belief that patriarchy as defined here manifests in all of our public and private institutions including government, laws and policies, educational system, most religions, media, families, and workplaces. These institutions are key in defining the cultural norms and values of our society as a whole. These norms and values then provide the foundation for how our communities and institutions are created and sustained. This provides a strong cyclical effect that allows for a continuation of patriarchy despite attempts by groups of people and individuals to gain access to the power structure. Strict gender roles, the make up of the nuclear family, and assumed and expected heterosexuality also contribute to the proliferation of power inequity and, therefore, sexual violence.

Feminism is by its definition an active theology. Feminism requires action and a commitment to challenging the structure as it currently exists. Using a feminist analysis of sexual violence, the goal of sexual assault advocates is to deconstruct the patriarchy, and work toward equality and true freedom for all individuals. This involves not only having an understanding of the intersections of oppression, but the ability to apply that understanding to our work. We have the potential as a united group to work toward this common goal through utilizing this feminist analysis in organizational structure, education, counseling, advocacy, and policy change. Truly, feminism is a road map that everyone can use including men and women to build a new society. 

Feminism offers principles for guiding both the work of deconstruction (social change) and for providing support for those currently affected by sexual violence. These principles include:

- Re-defining power, non-violence, cooperation and mutual interdependence;
- True equality and access to decision making for all people; and
- Inclusion and consensus, and accountable leadership.

Through utilizing these principles in our work with individuals and within the community, we can work to build an alternative to patriarchy. This needs to be a group effort defined by a common vision. Carol Hanish coined the phrase “the personal is political” to describe what efforts are necessary to truly end oppression and violence. When a problem such as sexual violence is seen as a problem for only the person who was victimized and the solution being an individual solution of reporting the individual case and seeking individual counseling, the true epidemic level problem of sexual violence goes unsolved. It takes a movement of individuals working in solidarity with one another to create change.
White Privilege

Key Learning Points:

- White privilege is the term used to describe the web of institutional and cultural preferential treatment that is bestowed upon white people in general because of their heritage.
- While white people do experience other oppressions, they do so on the basis of already owning privilege as a member of the majority culture/race.
- Examples of white privilege can range from access to major services (e.g., children of white immigrants were allowed elementary school public education while children of Asian and African immigrants were not), to seemingly minor issues (e.g., birthday cards rarely show someone who looks like me!).
- The pressure to not recognize white privilege is great.
- Recognizing white privilege is an important step for white people to take in dismantling racism.

A History of White Privilege

U.S. institutions and culture give preferential treatment to people whose ancestors came from Europe over peoples whose ancestors are from the Americas, Africa, Asia, and the Arab world. Institutions and culture also exempt European Americans (white people) from the forms of racial and national oppression imposed upon peoples from these parts of the world. This web of institutional and cultural preferential treatment is called white privilege. While many people with white skin also experience forms of discrimination, such as sexism, classism, ageism, and homophobia, the doors associated with race remain open to them. In this respect, they are privileged in relation to people of color.

The history of white privilege goes back to the foundational roots of this country. Throughout U.S. history, non-ruling class whites have been granted specific civil, political, and economic rights that have been denied to people of color. Some examples from an article "What is White Privilege" and the film series Race: the Power of an Illusion include:

- The right of European (white) immigrants to become citizens, and hence landowners, was denied to most non-European (non-white) immigrants from 1790 to 1952.
- State laws prohibited non-citizen immigrants from owning land. This means that only European (white) immigrants could own land, and therefore had greater means to accumulate family wealth and opportunity for descendants.
- All European (white) immigrants were allowed the right to marry either before or after they came to the U.S., while most Chinese and Filipino immigrants were not...
allowed to bring families or to marry in the U.S.

- In the late 19th century, white children, children of European immigrants, were given the right to an elementary school public education. Children of color, namely children of African, Asian, and Chicano, or indigenous parents, were not.
- White women won the right to vote in 1920 after 100 years of struggle. In the South, however, black women and men were not legally able to vote until the 1965 Voting Rights Act was passed.
- After World War II, the federal government spent billions of dollars in loans to veterans for homes and college education. While the program was supposed to be for all veterans, because the federal government did not challenge the racist policies of university admissions programs or of suburban housing developments, the loans were effectively for white people only. In fact, less than two percent of the government money went to people of color.

Although just a few of a long list of examples, this overview exposes some of the history of white privilege and how the idea of race combined with these past laws and policies directly contribute to current societal inequities.

Having white people acknowledge the role race and privilege play in creating and maintaining our society's systems of advantage and disadvantage, is essential to effectively address these current inequities. Some white people argue that since the idea of race has served as a source of division among people, rather than working to adopt a sense of themselves as white, all people should work to move beyond the idea of race. While it's true that people created the concept of race, asking for a 'color blind' society effectively means erasing the fingerprints of history rather than dealing with their consequences. Only by taking seriously the social structures built through hundreds of years of exploitation, will we see how race and privilege are woven tightly into the fabric of society. When white people acknowledge that they are white, they are acknowledging that race affects them and is one of the forces defining their life situation/experience/position in our society.

White Privilege Today

Acknowledging white privilege can be challenging because, growing up in today's dominant culture, white is seen as 'normal.' Many of the advantages white people enjoy are also often seen as normal, and can largely go unnoticed. In an article, "White Privilege: Unpacking the Invisible Knapsack," Peggy McIntosh, associate director at Wellesley College Center for Research on Women, describes white privilege as an "invisible package of unearned assets that I can count on cashing in on each day, but about which I was meant to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools, and blank checks." As a white woman, McIntosh describes doing an exercise of looking at her life and identifying some of the daily effects of white privilege. Most, if not all, of these conditions are ones that her African American co-workers could not count on. A few of the items she mentions include:

- I can turn on the television or open the front page of the paper and see people of my race widely represented;
- When I am told about our national heritage or about civilization I am shown that people of my color made it what it is;
- I am never asked to speak for all of the people in my racial group;

White people believe things are as they are because that is just "normal." Think about "normal" and "the way it has always been done" as indications that privilege may be at work. What are some ways this looks within advocacy?
• I can criticize our government and talk about how much I fear its policies without being seen as cultural outsider;
• I can easily buy posters, post cards, picture books, greeting cards, dolls, toys, and children's magazines featuring people of my race;
• If I should need to move, I can be pretty sure of renting or purchasing housing in an area that I can afford and in which I would want to live; and
• I can be pretty sure that my neighbors in such a location will be neutral or pleasant to me.

McIntosh notes that the pressure to avoid recognizing this privilege is great. In seeing and acknowledging this privilege, one can no longer claim that life is an even playing field. If racism and white privilege are true, the U.S. is not such a free country; one's life is not just what one makes it; many doors open for certain people through no virtues of their own.

A big part of undoing racism in the U.S. depends on white people beginning to dialogue with each other and with their friends, neighbors, and co-workers of color about these privileges. They need to be able to recognize the privileges they have been taught to be blind to, and to see the ways in which intentional or unintentional personally-mediated racism and institutional racism keep racism and its negative effects alive. (Note: personally-mediated racism refers to prejudice or discrimination, such as differential assumptions about or actions towards others according to their race; institutional racism refers to the differential access to the goods, services, and opportunities of society by race.) In the article, "From White Racist to White Anti-Racist: the Life-long Journey", author Tema Okun encourages white people to take responsibility for racism even if they were not personally involved in its historical foundations. In doing so, white people may begin to understand that they are participants in racist institutions and a racist culture, that they do benefit from racism, and that they may participate in perpetuating racism, even when that is not their intention.

Resources

A few highlighted articles on white privilege:
Frances Kendall, 'Barriers to Clarity' or "What Keeps White People from Being Able to See Our Whiteness, and therefore, Our Privilege?"
Sharon Martinas, 'Shinin' the Lite on White' (also contains cartoon by Bennet on Affirmative Action)
Cynthia Kaufman, 'A User's Guide to White Privilege' - this article continues Peggy McIntosh's discussion on white privilege and further explores the ways racial privilege manifests itself in the lives of white Americans. It discusses some of the reasons why white privilege can be hard for white Americans to see, and how once seen, white Americans can responsibly take action in efforts to undo racism.

To be an effective advocate, one must be willing to understand how privilege of any sort – but especially white privilege – informs their world.

Bringing it Home:
• How has your program supported examining the role of privilege – white privilege, heterosexual privilege, male privilege?
• What has your program done to challenge itself about issues of privilege?
• How can this issue relate to other discussions about cultural competency, racism, and the accessibility of program services?
History of the Minnesota Coalition Against Sexual Assault

By Nancy Biele, Office of Drug Policy and Violence Prevention. Additions and revisions by Donna Dunn, Minnesota Coalition Against Sexual Assault, 2006

Key Learning Points:
- MNCASA is the statewide organization providing technical assistance, training, and networking opportunities for community-based advocacy programs.
- MNCASA grew out of the Department of Corrections Program for Victims of Sexual Assault.
- MNCASA started with a focus on advocacy program development. Over the years, sexual violence prevention and systems change have become major program areas of MNCASA.
- MNCASA has developed as a major policy voice in state government.

MISSION STATEMENT: The Minnesota Coalition Against Sexual Assault (MNCASA) is a voice for victims/survivors, sexual assault programs, and allies committed to ending sexual violence. To that end, the Coalition is committed to:

- Providing support through its network of programs and services to each person who has been victimized;
- Confronting the systems, issues and laws that perpetuate the crime of sexual assault;
- Initiating other systems, issues and laws to accomplish its mission; and
- Working to eliminate sexism, racism, homophobia, classism, oppression of people with handicaps, religious oppression, and ageism—the roots of sexual assault. (Adopted 9/10/87)

Rape crisis programs were born out of the most recent phase of the women’s movement when women began to speak out about their experiences with sexual assault. In 1971, a small group of women, determined that rape victims would not have to go through their trauma alone and isolated, started a program in a storefront in Uptown Minneapolis. The program was later absorbed by a larger agency in Minneapolis.

Programs followed both in St. Paul and Duluth. In 1974, the legislature mandated the Commissioner of Corrections to develop a statewide community-based program to aid victims of sexual attacks. In 1975, the Minnesota Program for Victims of Sexual Assault in the Department of Corrections was created to fund and provide assistance to sexual violence programs statewide. Additional programs began to spring up all over the state. Programs were often working in isolation, taking on a controversial issue without
community support. In 1978, at a National Organization for Victim Assistance Conference, a group of women working in sexual assault expressed the need for an organization offering sexual assault programs. They felt their specific needs were not being met by general victim groups. From that conversation, two organizations emerged. The National Coalition Against Sexual Assault was created as the national membership body of rape crisis centers, and the Minnesota Coalition of Sexual Assault Services (MCSAS) was created for statewide issues. It began as a grassroots, rather loosely organized group that met to share resources and support. Its purpose grew to include educational events and legislative education. The coalition grew in numbers and sophistication as its member organizations flourished. MCSAS was incorporated as a nonprofit corporation in 1982, a logo and letterhead were developed and membership dues were collected.

Introduction
The Coalition was still an entirely volunteer organization. Its leadership was provided by an Executive Committee comprised of an urban chair, rural chair, secretary, and treasurer. The Coalition provided input on an annual in-service provided to sexual assault programs statewide. The Coalition’s work was carried out by committees, including a media committee that responded to programming or advertising that promoted sexual assault, was sexist, or conveyed misinformation. Examples include the committee responding to the availability of pornographic materials in the Jet Stores (1985); CBS's coverage of the McMartin Daycare case (1987); Revlon and VanHusen companies for their sexist and victimizing ads (1987); Sports Illustrated, Time magazine, and Dayton's for their advertising; and the McPlaymate computer game for their programming (1989).

The Coalition's Public Awareness Committee worked with the state legislature to increase funding and to raise awareness on issues of importance to victims of sexual violence. The Standards Committee worked to develop minimum standards for volunteer programs including training and evaluation. It also developed the first training manual. The Public Policy Committee reviewed and worked to change public policy as it related to programs and the internal operations of the Coalition. The Women of Color Committee became a standing committee in 1988.

The Coalition has taken on issues in speak-outs, press conferences, and testimony to committees and task forces. Some of these include:
• Testifying against the Office of Management and Budget on revisions of lobbying laws and controls for non-profits (1983);
• A press release protesting the Victims of Child Abuse Laws (VOCAL) organization and its attempt to portray children as "lying" about sexual abuse (1985);
• An anti-homophobia statement supporting organizations that worked against homophobia in their agencies (1986);
• A press conference protesting the University of Minnesota's handling of a sexual assault case involving its basketball team (1986);
• A press conference and testimony against the provisions calling for decriminalization of child sexual abuse proposed by the Attorney General's Task Force on Child Sexual Abuse (1986);
• A speak-out at the State Capitol regarding incest;
• A press conference protesting the Minnesota Vikings' hiring of a convicted rapist and asking for more corporate responsibility by the team (1988);
• Testifying to the Minnesota Supreme Court on requiring mental and physical examinations of witnesses and the eradication of the rape shield law (the coalition

It can be easy to forget that the essential work you are doing in your program is connected with a larger vision for the state. There is strength in numbers, and MNCASA is one way for your program to connect with others doing similar work.
won on both issues) (1989);
• A rally and press conference to end violence against women in response to the many women killed by sexual and domestic violence (1991); and
• Participation on task forces such as the Sexual Exploitation by Counselors and Therapists Task Force (1984-87), the Attorney General’s Task Force on Violence Against Women (1988) and the Governor’s Task Force on Violent Crime (1990).

Other highlights include hosting the National Coalition Against Sexual Assault’s Annual Conference in Minneapolis in 1983, the preparation for which was a year-long task.

In 1984, the Coalition initiated its first long-range planning process. Members were involved in staffing 12 phone lines, 24 hours a day during Project Abuse, the two-week collaborative effort between WCCO and Illusion Theater on child sexual abuse.

In 1985, the Coalition was involved in educational events. It co-sponsored a three-day training on homophobia with the Minnesota Coalition for Battered Women. A training session on sexual assault in institutional settings and civil recourse in sexual assault cases presented by Dr. Judith Musick, the Director of the Institute for the Study of Sexual Assault in San Francisco, was also cosponsored by the Sexual Violence Center. Coalition members also staffed a booth at the state fair (also in 1985). The federal Victims of Crime Act was passed, and MNCASA members testified both locally and nationally on recommendations for its implementation.

• In 1986, the Coalition celebrated its 10-year anniversary with a “Decade of Light” featuring Oprah Winfrey.
• In 1987, the mission statement was adopted and a manual was first published to aid the individual programs in their training
• In 1988, the Coalition worked on the sexual assault evidence collection kit, Crime Victims Reparation language so that it did not re-victimize sexual assault victims, and sentencing guidelines.
• In 1989, sexual exploitation and AIDS policies were adopted. This year also marked the first time the state allocated direct funding for the Coalition, which enabled the group to hire staff and open an office. In December, the first director was hired.

In 1990, major transitions occurred within the office, and a Board of Directors structure was implemented. The next year was spent developing the policies and procedures needed for a funded nonprofit organization. Additional funding was solicited. A skills bank of member programs was developed. A Board of Directors retreat was held. Wanting to portray its mission more clearly, the Coalition changed its name from the Minnesota Coalition of Sexual Assault Services to the Minnesota Coalition Against Sexual Assault (MNCASA).

Throughout these years, MNCASA was a strong voice in the state planning arena. Funding for local advocacy programs was housed at the Department of Corrections. MNCASA held an ex-officio position on the statewide Sexual Assault Advisory Council hosted by DOC. This twelve-member council advised DOC on the funding needs and priorities of local advocacy programs. The resources available for granting came from both state dollars and Victims of Crime Act (VOCA) funds. MNCASA played an important role in articulating the statewide needs and assisting the council in finding the most helpful direction.

The mid-1990s saw the increasing federal interest in issues of violence against women. With the initiation of the Violence Against Women Act brought forward by Senator Joseph Biden, the federal focus of funds to combat domestic and sexual violence was honed. The passage of VAWA in 1995 brought the first block grant funds to Minnesota at the end of the decade. In addition to serving on the Sexual Assault Advisory Council, MNCASA became a partner in the state VAWA planning process housed at DOC. VAWA allowed Minnesota to dramatically
increase the funding for services for sexual assault victim/survivors as well as fund much needed systems change projects to ensure a stronger systems response to sexual assault.

After many years of debate about the state administration of state and federal grant dollars, Governor Jesse Ventura issued an executive order that moved all crime victim funding from DOC to the Department of Public Safety in late 1999. An office was created called Minnesota Center for Crime Victim Services and later renamed Office of Justice Programs. The crime specific advisory councils were ultimately abolished. During this time, the legislature authorized a program within MCCVS called Office for the Prevention of Sexual and Domestic Violence. Under this program, MCCVS took a focused look at the status of services to victims of sexual and domestic violence. Recommendations for the legislature were drafted and presented.

Victim Services of Dodge, Fillmore, and Olmsted Counties was awarded special project funding under the original VAWA allocation. With the funding, they proposed to establish statewide protocols on the investigation and prosecution of sexual assault cases. After much information gathering, involving partnerships with MNCASA, the protocol project recommended that rather than issuing a one-size-fits-all set of protocols, we would be better served by helping jurisdictions (counties, reservations, cities) get to their own best interagency protocols. After several years of testing the process and adapting it to meet the variety of needs in Minnesota, the MN Model Sexual Assault Response Protocol Process was established. At the conclusion of the demonstration project, the project needed a permanent home. In a year of transition featuring planning by both MNCASA and Victim Services, it was concluded that the project should continue and that MNCASA would be the best home for the project. Therefore, in July 2001, the Sexual Violence Justice Institute (SVJI) was established as a special program area of MNCASA. The central mission of the SVJI is to support multidisciplinary teams as they develop and implement their specific interagency protocols. Additionally, the SVJI is working to expand technical assistance to all disciplines in their roles regarding sexual assault cases. SVJI has continued to develop and implement special resources, focused training, consultation, and identifying emerging trends and issues to form its profile in Minnesota as well as nationally and internationally.

Another benefit from the growth of VAWA is that funding for Rape Prevention and Education has mushroomed. VAWA funds for primary prevention are given to the Centers for Disease Control and then are re-granted to state health departments. The Minnesota Department of Health, Injury and Violence Prevention Unit has worked in partnership with MNCASA to ensure that the messages of primary prevention of sexual violence are developed and spread throughout Minnesota. MDH has provided funding to MNCASA to support staff positions that focus on expanding the reach of primary prevention. In 2006, MNCASA hosted a training series for partner programs that brought them together under the lead of the Prevention Institute. The training was designed to help programs design primary prevention activities targeted at intervening in the policies, practices, and realities of existing in a rape culture.

Through the years, MNCASA has reconfigured itself to meet the emerging needs of this field. Membership changes, programs grow and shift, staff and leadership change. What remains constant is the commitment to work with Minnesota partners to eradicate sexual violence.

**Bringing it Home:**

- How has your program used the services of MNCASA to help in service provision?
- How have you made sure that MNCASA has heard of the needs of victims in your part of the state?
Overall, sexual violence remains a very silent crime. Thirty plus years of organizing in Minnesota find us still battling the myths about sexual violence, victims, and offenders.

The profile of sexual assault services in Minnesota continues to change as the political climate, victims/survivors’ experience(s), population demographics, and policy decisions, among other things, affect the environment. In 2007, many counties in MN have existing sexual assault advocacy programs: some of those provide only sexual assault services; some provide services to multiple victims, including domestic violence, child abuse, and general crime. These programs range in size from one or two staff people to multiple staff members. In some programs, advocates are cross-trained and therefore prepared to respond to any victim/survivor who needs assistance. A small handful of advocacy programs are housed within local government – either within community social services, public health, community corrections, or tribal government. The profile of advocacy services represents the diversity of our state and the variety of ways that advocacy programs came to be in Minnesota.

Through the years, there have been times when resources and focus were extended to ensure that cultural and ethnic communities which are traditionally underserved were better able to respond to sexual assault. Programs that served the Deaf and Hard of Hearing, African American populations, SE Asian populations, Hmong populations, and others were separately funded to provide advocacy and organizing assistance to those groups. Because of the many social taboos around sexual violence and decreasing resources on the state level, many of these programs have been defunded, and the services have returned to mainstream programs. While programs do remain in many Indian reservations in Minnesota, there are few culturally-specific resources in urban areas for victims of sexual assault.

A small number of cases involving the abduction and murder of young victims in Minnesota spurred some major policy changes as the public and policy makers rushed to respond to the perceived need for safety. All of these cases involved assailants who were strangers to the victims – all cases were horrific but did not fit the typical profile of an offender who is known to the victim/survivor. The resulting policy decisions have brought us longer prison terms, indeterminate sentencing, community notification, an expansion of offender registration, and attempts to reinstate the death penalty and/or castration of offenders. None of these policy debates have resulted in increased funding for advocacy – or immediate intervention services for victims or resources for prevention. We have watched our state budget grown exponentially in response to length of prison terms and civil commitment of individuals when their prison terms expire. While those costs have skyrocketed, victim service resources have diminished, forcing state funders to use most of the federal dollars formerly reserved for special projects and training to supporting basic advocacy services. Until the 2007 legislative session, advocacy programs had not experienced any increase in funding for over 10 years. In reality, programs suffered a loss of purchasing power and have reported that their community education and prevention programming was the first to go! A small increase of five percent was awarded in 2007 and will be repeated in 2008; the current funding is not guaranteed to extend after 2008.
As time has gone on, the anti-sexual violence movement has had new partners join the effort. The federal funding that supports the MN Department of Health’s primary prevention of sexual violence programming, including guaranteeing a prevention staff person at MNCASA, has offered a welcomed change of focus in Minnesota. This primary prevention work has identified a host of new collaborators who work with offenders, youth populations, strengthening families, education institutions, men engaging men in leadership development, and others. The richness of these new coalitions will ultimately bear fruit as communities learn new strategies for challenging the social supports for sexual violence.

Collaboration of a different sort has also arrived in Minnesota! SMART (Sexual Assault Multidisciplinary Action Response Teams) have been organized in 12 MN counties. Ten of those are still active, productive, and changing the systems that respond to victims of sexual assault. What started as a model protocol development project has developed into a broad scale systems change, policy development, and legal resources program that offers resources to law enforcement, medical providers, advocates, and prosecutors across the state.

While many changes have happened, some desirable and some not as desirable, the reality is that, in part, the public, juries, first responders, mental health professionals, and others do not understand sexual violence. At the same time, while this used to be an issue totally owned by the sexual assault advocacy movement, new partners have joined us. They have brought enhanced and sophisticated understanding of their roles and they contribute mightily to solving this problem of sexual violence. Their input is welcomed.
Key Learning Points:

- There are multiple myths about sexual violence that interfere with our ability to hear victims/survivors and their experiences.
- Most myths are constructed within our current social norms about sex, sexuality, and power.
- Most myths are connected with racism, heterosexism, sexism, and classism.
- Myths reinforce and are reinforced by stereotypes about victims/survivors, perpetrators, and the circumstances of sexual violence.

The myths about sexual violence are powerful in our society. Misguided beliefs in these myths keep people from understanding how sexual violence works, and who the victims/survivors and perpetrators are. Most myths focus blame for sexual violence on the victim/survivor. Some think that it is easier to believe the myths than to change society in ways that prevent sexual violence.

It is important to talk about myths and facts because belief in these myths often keeps victims/survivors silent, keeps communities from identifying perpetrators, and erects barriers to effective prevention. Knowing about these myths can help us become careful and critical thinkers about the reality of sexual violence in our communities. Here are some examples of the most commonly believed myths:

**MYTH:** Most sexual violence occurs between strangers.

**FACT:** While these are the stories that are most likely to make the news, stranger assaults are statistically the rarest kind of sexual violence. The U.S. Department of Justice cites that 70 percent of all sexual assaults are committed by someone the victim/survivor knows. In Minnesota, 93 percent of the victims/survivors who used advocacy services were assaulted by someone known to them such as a friend, family member, co-worker, date, or neighbor (Office of Justice Programs, 2001 data). Often, "prevention" efforts aimed at children and youths focus on stranger danger. While stranger assaults do happen, it is far more likely that an assailant is not a stranger to the victim/survivor.

**MYTH:** A person cannot be sexually assaulted by his or her partner or spouse.

**FACT:** Sexual violence is a crime regardless of the relationship between the victim/survivor and perpetrator. In Minnesota, as in most other states, an ongoing sexual relationship does not preclude a partner or spouse from committing or being charged with sexual assault. The issue is not the relationship, but whether and how force is used. Yet, victims/survivors
of intimate partner assault are less likely to report the assault for fear that they will not be believed or because of their emotional investment in the relationship. There is no reason to believe that assault by an intimate partner is somehow easier to experience or "get over." In fact, sexual assault by an intimate partner may result in increased emotional impact, and a heightened sense of violation and betrayal causing the victim/survivor to lose trust in others and in her or his own judgment.

**MYTH:** Some people ask to be sexually assaulted by their behavior or the way they dress.

**FACT:** This is one of the most prevalent and powerful myths. It asks us to find the cause of sexual violence in the victim/survivor’s behavior or choices. No one asks for or wants to be raped or assaulted, just as no one asks to have their car stolen, even if they forget and leave the keys in the ignition, be robbed, or hit by a drunk driver. Sexual assault is always the responsibility of the perpetrator and never the responsibility of the victim/survivor. While some behaviors we choose may put us at some risk, they are only risky when there are perpetrators who are ready to take advantage of someone who is vulnerable. How someone dresses, where they go, what they do, or who they are in a relationship with is never justification for sexual violence.

**MYTH:** People who are drunk or high have no one to blame but themselves when they are sexually assaulted.

**FACT:** The use of alcohol and other drugs is often a part of sexual assault scenarios. In some cases, victims/survivors are encouraged to use alcohol or drugs or are, unbeknownst to them, given intoxicating substances. Whether voluntarily or involuntarily intoxicated, neither the victim/survivor's nor the perpetrator's alcohol or other drug use is an acceptable defense in a sexual assault case. In some instances, a victim/survivor's intoxication can be understood to render her/him legally unable to give consent to sexual behavior.

**MYTH:** Victims/survivors often falsely report sexual assault.

**FACT:** The Federal Bureau of Investigation reports that less than two percent of all sexual assault reports are false. This is the same rate of false reporting for all other major crimes. Those rare instances of false reporting usually are connected with someone who is dealing with mental illness - not a vengeful "victim" intentionally trying to entrap another.

**MYTH:** Most sexual violence is spontaneous and happens when people become so sexually aroused they are unable to stop themselves.

**FACT:** While sexual acts are the tools of the assault, sexual violence is less about the sexual contact and more about hurting, overpowering, or otherwise humiliating another. Most sexual assaults are not spontaneous but are, in fact, planned ahead of time. Studies of convicted assailants indicate that the vast majority of assaults are premeditated - either involving the stalking of a particular victim/survivor or targeting
potential victims/survivors in a way to make them vulnerable to sexual violence. It is important to remember that sexual arousal is not the motivating factor for sexual violence. In addition, sexual arousal does not need to be followed by sexual intercourse; people can choose to stop before they go further.

**MYTH: Men who sexually assault boys are gay. Therefore, gay men should not be allowed to be teachers, coaches, Boy-Scout leaders.**

**FACT:** This myth fuels homophobia in our society. In fact, studies indicate that the majority of males who assault boys are heterosexual and have regular, consenting adult sexual partners. It is important to remember that sexual violence is less about sexual contact, and more about gaining control or overpowering another.

**MYTH: Only young, attractive women and girls are sexually assaulted.**

**FACT:** This myth again fuels the misconception that sexual gratification is the motivator for sexual violence. Statistics in MN show that victims/survivors can be attractive women and girls; they can also be infants, elderly women, or men. It is important to remember that anyone can be a victim/survivor of sexual violence; anyone can be an assailant.

**MYTH: White women are at risk for rape by men of color.**

**FACT:** Statistics identify that sexual violence happens between members of the same race much more frequently than across races. This myth comes from social messages of racism that are alive and thriving today. In fact, the historical experiences of interracial assault more often point to women of color being systematically assaulted by white men. Consider the history of slave women in the South and women in countries overrun by conquering armies.

**MYTH: Sexual violence is serious but a rare crime in the United States.**

**FACT:** Sexual violence is a very serious crime, true, but it is unfortunately quite common. According to the National Victim Center, approximately one in four girls and one in ten boys will be sexually assaulted before the age of 18; approximately one in three women and one in seven men will be sexually assaulted at some point in their lives. Unfortunately, victim/survivor of sexual violence remain quite hidden, fearing that their accounts will not be believed, that they will fall victim to these myths. Studies indicate that only 16 percent - 20 percent of victims ever come forward to report a sexual assault. In contrast, one in seven women in Minnesota report being sexually assaulted at some point.

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**Bringing it Home:**

- How has your program seen myths in action? Are there stories that illustrate the power of myths?
- Which of these myths are you most challenged by? Are some harder than others to understand as merely myths?
- Where do myths come from?
- What has your program done to help the community understand the false information that circulates in the form of myths?
- Myths are used to excuse the behavior of perpetrators.

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*Myths are powerful in their ability to shift public opinion, blame victims/survivors, and exonerate perpetrators.*

*Advocates who do educational programs should help community members understand the falsehoods behind these messages.*
### Definitions

**Sexual Assault**

Sexual Assault occurs when a person does not or cannot consent to any kind of sexual activity.

Forms of sexual assault include:

- Rape
- Sexual Contact (touching or grabbing)
- Obscene Phone Calls
- Exposing
- Sexual Abuse of Children
- Incest
- Sexual Harassment
- Sexual Exploitation of Clients by Professionals

Sexual assault is an act of violence. This can be obvious, as in a situation in which a weapon, physical force, or a threat is used against the victim/survivor or someone the victim/survivor cares about. In other situations, the violence is more subtle, as when a position of authority, age, size, or status is used to trick, scare or manipulate the victim/survivor.

Anyone can be a victim/survivor of sexual assault. People of all ages, races, socio-economic backgrounds, sexual orientations, and lifestyles have been victims/survivors. An individual of any gender can be a victim/survivor of sexual violence. All deserve help and support. No one deserves to be victimized.

**Sexual Violence**

Is the use of sexual actions and words that are unwanted by and/or harmful to another person. Many labels are given to the various ways that sexual violence happens including:

- Child Sexual Abuse
- Incest
- Sexual exploitation by a professional who violates boundaries of the professional/client relationship (e.g. clergy sexual misconduct, medical personnel, massage therapists, etc.)
- The trafficking and commercial sexual exploitation, such as the use of individuals for financial gain in the sex industry of prostitution, pornography production, stripping, etc.
- Non stranger rape
- Drug and alcohol facilitated sexual abuse (DFSA)
- Exposing
- Obscene Phone Calls
- Pornography
- Professional Exploitation
- Prostitution
- Rape
- Ritual Sexual Abuse
- Sexual Harassment
- Stalking
Racism

Racism is the belief that one race is superior over others. This is commonly expressed as white supremacy; it is institutionalized (e.g. social institutions believe in and act on practices that enforce the superiority of one race); it is also internalized by individuals who intrinsically believe in the construct of superiority of one race over another.

Racism = prejudice + power.

Racism is a combination of power and prejudice. When one uses their social power by the fact of their race, economic, or other status to impose or act on their prejudice, the resulting effect is racism.

Racism is also any attitude, action, or institutional structure which denies access to structures, inequitably distributes resources, and subordinates a person or group because of their race.

Racism can be either intentional actions or unintentional actions; the result is the same. The intent of the actor does not define whether or not an act, policy, statement is racist.

Sexism

Any attitude, action, or institutional structure which denies access to structures, inequitably distributes resources, and subordinates a person or group because of their gender.

Heterosexism

Any attitude, action or institutional structure which denies access to structures, inequitably distributes resources, and subordinates a person or group because of their sexual or gender orientation; specifically, the subordination of gay men and lesbians.

Ageism

Any attitude, action, or institutional structure which denies access to structures, inequitably distributes resources, and subordinates a person or group because of their age, or any assignment of roles in society on the basis of age.

Homophobia

The persistent, irrational fear of homosexuality and homosexuals; a prejudice based on myths and/or ignorance.

Prejudice

A judgment or opinion, favorable or unfavorable, formed before the facts are known, i.e. without knowledge, thought, or reason.

Bigotry

The negative side of prejudgment; intolerance.

Privilege

A special immunity, right, or benefit enjoyed by an individual or group; economic, social, and psychological validation and reward enjoyed by a person or group conforming to the values of a prejudiced society, e.g., whiteness, maleness, heterosexuality, etc.
Oppression
A systematic and broad-based method which limits freedom of choice, action, and ideas of self on an individual and group level. Systematic domination of a person based on race, class, and sexual orientation.

Institutional ‘Isms’
The practices and policies (intentional or unintentional) of major institutes (e.g., education, the military, corporations, the government, churches, etc.) which maintain and reinforce prejudicial beliefs and discrimination.

Stereotypes
The practices and policies (intentional or unintentional) of major institutes (e.g., education, the military, corporations, the government, churches, etc.) which maintain and reinforce prejudicial beliefs and discrimination.

Power
The ability or capacity to exercise control.

Internalized Oppression
The distress patterns that result from racism and oppression that are turned upon one’s own self, family, and people. The destructive, hurtful behaviors and feelings are not a part of real culture, they are simply chronic patterns resulting from systematic and institutionalized mistreatment.

Discrimination
The act, practice, or an instance of discrimination categorically rather than individually.

Sexual Orientation
The orientation within human beings, which leads them to be emotionally and physically attracted to persons of one gender or the other or both. One's sexual orientation may be heterosexual, homosexual, bisexual, or asexual. (from Outfront)

Intersex
Generally applied to individuals born with ambiguous genitalia (an outdated term would be “Hermaphrodite”). In the past, most intersexed individuals have had surgery shortly after birth in an attempt to give them an “identifiable” gender. There is now much discussion about this practice, but so far little has changed. Parents often feel forced to make a quick decision with little information. Most intersexed persons are raised as girls/women.

Transgender
A broad umbrella term for persons who have a self-image or gender identity not traditionally associated with their biological gender. Some transgender persons wish to change their anatomy to be more congruent with their self-perception, while others do not have such a desire. There is no absolute correlation between sexual orientation and transgender issues. A transgender person may identify as heterosexual, gay, lesbian, or bisexual.
The Spectrum of Sexual Violence
Sexual Violence by Multiple Perpetrators (Gang Rape)

By Dresden Jones, MNCASA

Key Learning Points:

- Although “gang rape” is commonly used to describe this type of sexual violence, it rarely has anything to do with organized street gangs.
- Sexual violence by multiple perpetrators can involve more physical harm and verbal insults to the victim than other types of sexual violence.
- Group dynamics dictate this type of sexual assault; there is always a leader and at least one reluctant participant.
- Victims/survivors of sexual violence by multiple perpetrators are usually isolated and seeking friendship, or vulnerable in other ways.
- Responses and reactions to this type of sexual violence are similar to those in other cases but may be compounded due to there being more than one offender.

Sexual violence by multiple offenders occurs when two or more people participate in the sexual assault of one person. This form of sexual violence has also been called “gang” or “group” rape. The perpetrators involved can be strangers or acquaintances of the victim/survivor. Although “gang” rape is commonly used to describe this type of sexual violence, not all sexual assault by multiple perpetrators occurs within the context of an organized street gang. “Gang” is simply used to imply that there is more than one perpetrator involved. In fact, in one study of urban street gangs, gang members overwhelmingly took strong stances against rape. Gang rape should not be confused with repeated victimization over time. The elements of gang rape victimization include a one-time episode by multiple perpetrators at the same time. Victimization can also occur by many offenders during different stages of a victim/survivor’s life.

Because there is more than one perpetrator involved, the victim/survivor is likely to be raped more than once. Sexual violence by multiple perpetrators can also occur without any penetration, however. One study showed that the following abusive behaviors are twice as likely to occur within the setting of rape with multiple perpetrators instead of rape with a single perpetrator: insult; forced fellatio; pulling, biting, or burning breasts; urinating on victim/survivor; putting semen on a victim/survivor’s body; and manual masturbation. Approximately one in ten acts of sexual violence in the United States
involves multiple perpetrators (Vetten & Haffejee, 2005). While this type of sexual assault is usually committed by groups of male perpetrators, females have been known to be a part of the group and even participate in a sexual assault. Victims/survivors are almost always female, but males can also be victims/survivors of sexual violence by multiple perpetrators.

Dynamics of Sexual Violence by Multiple Perpetrators

Group dynamics play a role in a sexual assault situation much as they do in other group situations; there is always a “leader”, someone who generally guides the group’s thinking and makes decisions for the rest of the group. The group leader is generally the person who has made the decision to commit the sexual assault. Also, there will always be at least one, if not more, reluctant participant. This is the member of the group who could stop the assault but, because s/he is not the group leader, they have little influence. Not all members of the group will necessarily participate in the sexual violence actively. The reluctant participant(s) may even leave the scene or call law enforcement. The notion of peer pressure is hard at work here as well: some group members who know what they are doing is wrong and harmful may go along with it anyway because they feel pressured to. Other members of the group are eager to participate and encourage each other to commit the sexual assault. While feeling pressured to commit rape is never an excuse, it’s important to understand these kinds of group dynamics so we can address them, especially with young people.

When a group seeks to commit sexual violence /survivor against a victim, they typically choose someone they see as vulnerable. Perhaps the person they choose is isolated, without many friends; s/he could be easily lured away with some attention and promises of friendship. One case of gang rape that received a lot of media attention was that of a young girl who was developmentally delayed. She was approached by a group of well-liked, popular young men and she went with them to one of their homes, where she was sexually assaulted by several of them. The aftermath was extremely difficult: the town largely rallied behind the young men who were good students and strong athletes. The victim/survivor was largely disbelieved because she was developmentally disabled. This incident took place in New Jersey in the 1990’s. To this day, the town is divided about what “really” happened. Some of the perpetrators served short jail terms. Community members couldn’t understand why intelligent, upper-middle class boys from good homes would commit such a violent act.

Effects on Victims/Survivors of Gang Rape

Victims/survivors of gang rape are likely to go through the same stages of trauma
that victims/survivors of other types of sexual violence experience. The potential exists for added trauma for the victim/survivor in the aftermath of sexual violence by multiple perpetrators. Since most victims/survivors of sexual violence know their perpetrator, there is always the possibility that they will have to see their perpetrator again (in school, at work, around the neighborhood, etc.). In the case where there are multiple assailants, the victim/survivor has a greater chance of coming in contact with those responsible for the attack.

Resources

*Our Guys: The Glen Ridge Rape and the Secret Life of the Perfect Suburb* by Bernard Lefkowitz

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**Bringing it Home:**

- Do schools in your area have policy for dealing with this type of offense?
- Has your community seen a case like this before? If so, what was the community response to the victim and the perpetrators?
Prostitution
By Evelina Giobbe, Women Hurt in Systems of Prostitution Engaged in Revolt

Key Learning Points:

- Prostitution is generally thought of as employment when, in actuality, it is ownership of and unconditional sexual access to a woman.
- A woman’s “choice” to engage in prostitution happens within a social context which condones sexual objectification of women.
- Culturally supported tactics of power and control facilitate the recruitment or coercion of women and children into prostitution and effectively impede their escape.
- By maintaining a society in which women are kept economically marginalized, the system of male supremacy ensures that a pool of women will be vulnerable to recruitment and entrapment in prostitution.
- Prostitution is sexual abuse because prostitutes are subjected to any number of sexual acts that in any other context, acted against any other woman, would be labeled assaultive or, at the very least, unwanted, and coerced.

Rape, or sexual assault, is commonly understood to mean the forced compliance or submission of an individual to unwanted or coerced sexual activity. Prostitution, conversely, is commonly believed to be an equal exchange of sex for money based on mutual consent. This paper presents a theory that the experience of being bought for sexual use is most like marital rape—even when women give mitigated consent.

Contrary to cultural mythology, the institution of prostitution most resembles the institution of marriage rather than a form of employment. Unlike a labor contract, traditional marriage and prostitution are both predicated on ownership and unconditional sexual access to a woman's body. Traditional marriage is premised on the long-term private ownership of a woman by an individual man, whereas the institution of prostitution is built upon the public ownership of women by many men.

A hypothesis that equates prostitution with rape must provide a working definition of free choice and examine a woman's "choice" to engage in prostitution within the social context in which it occurs. In order for a choice to be made freely, there must be an absence of coercion or violence. A freely made choice is an informed choice: one must know what she is choosing and realize the implications or consequences of the choice. Bribes, manipulation, or trickery are persuasive tactics that mitigate choice. Ideally, one would have personal or community support to actualize her choice. Minimally, one should have the right to change her mind should she realize that she has made a poor choice.

The function of the institution of prostitution is to allow males unconditional sexual access to females, limited solely by their ability to pay. Culturally supported tactics of power and control facilitate the recruitment or coercion of women and children into prostitution, and effectively
impede their escape. These tactics include: educational deprivation, job
discrimination, poverty, child sexual abuse, rape, battery, racism, classism, and
heterosexism.

Economic necessity is one factor that facilitates the recruitment of women and girls
into prostitution. By maintaining a society in which women are kept economically
marginalized, the system of male supremacy ensures that a pool of women will be
vulnerable to recruitment and entrapment in prostitution.

Although child sexual abuse, rape, and battery are crimes committed by individual men,
an argument can be made that they are institutionalized forms of social control. This
argument is based on the prevalence of these crimes, the fact that they differentially
target females, and the failure of male-controlled social institutions to prevent or
redress the victims' injuries.

Prostitution creates an environment whereby crimes against women and children
become a commercial enterprise. When a "John" uses a juvenile prostitute for his own sexual
gratification he is committing the crime of child sexual abuse. When he demands that a
prostitute allow him to use her in sadomasochistic sex scenes, he is battering her. When a John
compels a woman to submit to his sexual demands as a condition of "employment," he is guilty
of both sexual harassment and rape. The fact that a John gives money to a woman or a child
for submitting to these acts does not alter the fact that he is committing child sexual abuse,
rape, and battery—it merely redefines these crimes as prostitution.

By allowing men to traffic in women and children with impunity while simultaneously
prosecuting prostitutes, the legal system tacitly supports sexual exploitation and, through the
collection of fines, profits from it. Over all, sexism—the values and beliefs used to justify the
oppression of all women in a male supremacist system—overtly and covertly supports tactics of
control and, by so doing, maintains systems of prostitution in the culture.

In spite of the abusive conditions in their lives, prostitutes are afforded neither the status of
victim nor survivor, but are defined as fully consenting participants in an industry that, if viewed
objectively, would be understood to be the commerce of sexual abuse and inequality.
Prostitution is sexual abuse because prostitutes are subjected to any number of sexual acts
that in any other context, acted against any other woman, would be labeled assaultive or, at
the very least, unwanted and coerced. Yet because an exchange of money occurs, irrespec­
tive of whether the woman herself maintains control of or benefits from this exchange, the
client is given permission to use the woman in a manner that would not be tolerated in any
other business or social arrangement (including marriage in some states), and the woman's
acceptance of the money is construed as her willingness to engage in such commerce.

If this construction were applied to other victims/survivors of sexual assault, then one logically
would have to assume that women raped by their husbands or teenagers molested by their
fathers, for example, also choose abusive relationships because they accept monetary
considerations from their assailants in the form of food, lodging, and sometimes actual cash.
This analogy sounds strained only because we have learned to recognize the violence to which
these particular women and youths are subjected. We have learned to distinguish the victim/
survivor from the perpetrator. We do not assert that, because a victim/survivor is powerless at
a particular moment in time to change the objective circumstances of her/his life, s/he has
chosen those very circumstances, and in fact, is compensated handsomely for her
acquiescence. On the contrary, we create alternatives for those so victimized.

As other victims/survivors of sexual assault and battering, women and children used in
prostitution need and deserve tangible assistance to escape and overcome the trauma of commercial sexual exploitation.

Studies of marital rape have revealed that women who are raped by their partners suffer many of the same physical and emotional effects as other rape victims/survivors: physical trauma, humiliation, guilt, and self-blame. Like victims of marital rape, women typically report feeling humiliated by the acts in which they were repeatedly required to engage with multiple customers daily. Most reported feelings of degradation, defilement, and dirtiness, sometimes for years after leaving prostitution:

"I did have a broken nose, broken neck, stitches in my head. Those are health costs, those things healed, and they healed pretty fast. The mental, emotional part is still healing. Probably will for years and years, if ever. I don't know if that would ever be something that could be healed." (1989)

Common long-term effects of marital rape include lingering fears, emotional pain, flashbacks and nightmares, and an aversion to intimacy and sex. Information provided by women used in prostitution has revealed a pattern of responses that is shockingly similar to those expressed by women who have been sexually abused and raped by their husbands. Interestingly, marital rape victims who also suffered verbal abuse were called “no-good tramp” and “whore” by their husbands. Not unlike women who have been raped by their husbands, women escaping prostitution had subsequent difficulty establishing intimate relationships with men. Survivors of prostitution and marital rape typically express disdain for men and sometimes outright hatred.

The sexual abuse inherent in prostitution results in numerous health complications and lasting physical damage: trauma from beatings and rapes; complications from persistent bladder infections; and repeated exposure to sexually transmitted infections that often results in chronic pelvic inflammatory disease and infertility. It is the devastating emotional damage of prostitution, however, that women label as the most profound impact on their lives.

In recent history, marital rape was permitted by both church and state. The assumption of a male's ownership of his wife's body was so culturally entrenched that it was unthinkable for a woman to deny a husband sexual access. It was only by listening to women who had survived this ongoing sexual abuse in their homes that we, as a society, were willing to strike down the marital rape exemption in most states, thus sending a message to males that a $25 marriage license is not a license to rape their wives. We must send a similar message to males, through education and public policy, that that same $25 cannot buy them the right to rape any other woman.
Sex Trafficking in Minnesota
Edited by Vednita Carter, Breaking Free

Key Learning Points:

• An estimated 800,000 people are trafficked across international borders each year; 70 percent of them are trafficked for commercial sex purposes.
• The Twin Cities has been identified as one of the 13 most heavily trafficked areas in the country.
• Sex trafficking is a serious violation of federal law.
• Generally, traffickers use coercion, threats and bondage to keep their victims as slaves.
• Because many trafficking victims/survivors are from foreign countries, there can be a language barrier, as well as the threat of deportation or jail, that can keep victims /survivors from seeking help.

Trafficking in humans is a pervasive global problem. An estimated 800,000 people are trafficked across international borders each year. This is a particularly relevant issue for those in the movement against sexual violence because about 80 percent of trafficked victims are female, and 70 percent are trafficked specifically for the commercial sex industry. It is estimated that at least 20,000 of these victims are trafficked into the United States yearly. Furthermore, Minnesota is not isolated from this modern-day slavery. Our state has become one of the 13 most heavily sex- and slavery-trafficked states in the nation. A contributing factor is related to Minnesota’s physical geography which makes it a border state.

According to the federal government, sex trafficking is a modern-day form of slavery in which a commercial sex act is induced by force, fraud, or coercion. The presence of these elements are not required when the victim is under 18 years of age. Enactment of the Trafficking Victims Protection Act of 2000 (TVPA) made sex trafficking a serious violation of Federal law. As defined by the TVPA, the term ‘commercial sex act’ means any sex act on account of which anything of value is given to or received by any person.

The TVPA recognizes that traffickers use psychological as well as physical coercion and bondage. It defines coercion to include: threats of serious harm to or physical restraint against any person; any scheme, plan, or pattern intended to cause a person to believe that failure to perform an act would result in serious harm to or physical restraint against any person; or the abuse or threatened abuse of the legal process.
Sex trafficking leaves women and children physically, mentally, emotionally, and spiritually devastated. Recovery takes years, even decades—often, the damage can never be undone. These victims/survivors must be offered a range of services and support that will allow them to free themselves from the many co-factors that entrap them on the street, in poverty, and which make them at high risk of HIV: drug addiction, constant sexual abuse, lack of education, lack of employment, lack of social support, and lack of financial resources to care for themselves and their children.

The majority of victims/survivors of sex trafficking do not want to provide sex services. Few seek it out or choose it and, like prostitution, most are desperate to leave it.

The 2003 Innocence Lost National Initiative targeted the 13 highest intensity trafficking areas, including the Twin Cities. One reason for Minnesota’s high volume of trafficking is due to the fact that it is a border state. Trafficking is a serious issue which our legislators are paying attention to by providing millions of dollars nationally for purposes of research, education, and services to these victims/survivors.

International victims/survivors of sex trafficking face similar barriers to that of domestic victims/survivors of prostitution. One barrier that differentiates international from domestic victims/survivors of prostitution is language. It is critical to provide an interpreter when working with international victims/survivors of sex trafficking. It is also important to partner with an advocate, other than the interpreter, from their culture who can assist the victim/survivor to feel comfortable and to fully understand her rights as a victim of sex trafficking. Another barrier is that a sex-trafficked victim/survivor can be held in custody (jail) for however long it takes to close the case. If this victim/survivor does not want to assist Immigration Customs and Enforcement (ICE) or the Federal Bureau of Investigation (FBI) with evidence on the perpetrator, the victim/survivor stands the chance of being deported back to their country and ultimately ending up back in the hands of their perpetrator(s). As in domestic prostitution, giving up evidence on the perpetrator is difficult for the victim/survivor, as she has been brainwashed to believe that she may end up losing her life or the life of their loved ones. Another barrier presents itself within federal law that allows ICE to hold all trafficked individuals in custody, regardless of their status as victim/survivor or suspected victim/survivor. In order for an advocate to work with this individual while they are incarcerated, a form G28 must be completed. This form can be obtained through ICE; and it allows the advocate, attorney or representative of the victim access to enter the facility and speak with them while incarcerated. Some counties require that this form be completed prior to the victim’s incarceration. This poses a challenge for advocates who often only find out about the situation after the incarceration of the victim. Another barrier is that it is not uncommon for victims/survivors of sex trafficking to have all of their ID’s taken from them by the perpetrator(s) upon entering the country. Having no ID limits victims/survivors from being able to prove their identity and, in some cases, to seek assistance if they are able to prove their identity. It is important that advocates understand the basics of immigration law or have access to an immigration attorney in such situations.

In conclusion, anyone who has been involved in sex trafficking has been treated in an inhumane manner and deserves services necessary to restore their self-dignity. We must remember that this fight against sexual slavery, in the form of sex trafficking and prostitution, is the key to dismantling systems of dual oppression, of racism and sexism. Internalized oppression must be externalized. Only then can it be ended.
**Key Learning Points:**

- Pornography has become increasingly successful at marketing the violence and domination of women as sex, erotica, and intimacy in its content.
- Pornography teaches society three basic themes: all women want sex from all men all the time, women enjoy all the sexual acts that men perform or demand and that if a woman does not want sex at first, it can be remedied with a little force.
- Offenders access and use child pornography as a pattern of their sexual gratification, in preparation to offend, and as a method of grooming.
- Pornography influences gender socialization and encourages the normalization of sexual violence.
- Everyone in society is negatively affected by pornography.

**The Industry**

Women’s attempts to free themselves of the double standard were frustrated by the Left’s adoption and promotion of the Playboy philosophy as its sexual manifesto in the 1960s. This resulted in the replacement of the double standard with a single male standard in which sexual liberation became synonymous with the sexual objectification of women. The line between “Madonna” and “whore” has become increasingly blurred since.

With the explosion of “hard core” pornography onto the open market in the 1970s, the definition of a woman’s value as a sex object expanded to include her willingness to engage in the myriad of sexual acts in X-rated videos and magazines. With the invasion of pornographic cable programs and video cassettes into the home during the 80s, the “good woman” became equated with the “willing woman” as more and more women were pressured into emulating the scenarios of pornography.

As access to the internet and the advances of technology has increased, the availability of pornography has also increased. The use of the internet has dramatically changed the viewers of pornography. While the video brought pornography into the home, the use of the internet is increasingly providing the access of pornography to virtually any person regardless of age or maturity. This change in access has also created a shift in which, legally and culturally, public opinion of pornography has become more acceptable, ultimately allowing the porn industry to become more mainstream. The porn industry has successfully framed this propaganda as free speech, sexual freedom, sexual rights, and as part of “normal” sexual development.

**Feminist Perspective on Pornography**

The feminist perspective on pornography began gaining attention in the 1970s and 80s. As the Feminist Movement evolved to include multiple voices, views on pornography began...
to emerge. This resulted in a divide among feminists within the Second Wave of the Feminist Movement, and the Sexual Liberation Movement. The outcome resulted in three stances on pornography known as the radical, liberal, and pro-sex perspectives.

Radical feminists, also known as the anti-porn feminists, view pornography as exploitative and oppressive to women, treating them as objects of male control. In addition to pornography being oppressive to women, it also sexualized rape, battering, sexual harassment, prostitution, and child abuse. The sexualization of violence against women and children within pornography created messages that celebrate, promote, authorize, and legitimize such violence. Two radical feminist leaders, Catharine MacKinnon and Andrea Dworkin were the first to identify pornography as a form of oppression violating women’s civil rights. In 1983 and 1984, MacKinnon and Dworkin developed language for an anti-pornography ordinance in the cities of Minneapolis and Indianapolis, declaring pornography a civil offense and a violation of women’s civil rights. In Minneapolis, the city council passed the ordinance twice, only for it to be vetoed by the mayor. Meanwhile, in 1986, the Indianapolis ordinance was found unconstitutional by the U.S. Supreme Court, on the grounds that it violated our freedom of speech. Even though the anti-pornography ordinances were struck down, this was a crucial moment within the Feminist Movement. MacKinnon and Dworkin argued that a woman’s right to be safe from the harms of pornography should take precedence over First Amendment rights.

Liberal feminists tend to agree with radical feminists on the social implications of pornography. Even though liberal feminists incorporated the negative implications of pornography, they did not agree to the ordinance or any type of censorship. Among the liberal feminists, there was a concern with how censorship could be translated within society. The common belief was that efforts to control pornography could eventually translate into censorship threatening the political freedom of women and future forms of free speech. Additionally, the ability to censor such material could translate into the potential of censoring feminist theory and create additional struggle within the Feminist Movement.

Pro-Sex feminists, also known as individual feminists, believe that women have the right to choose what they will do with their bodies. Pornography allowed an avenue for women to become liberated through their own sexuality. “Society has historically sought to repress or control female sexuality, most often by demanding a virginal/non-sexual role for acceptable womanhood; therefore, pornography is liberating insofar as it acknowledges women are sexual beings with sexual desires-including the capacity to enjoy pornography”. The pro-sex feminists believe this liberation for women and individual sexuality discovery was positive and needed protection as stated by McElroy, “Pro-sex feminists retain a consistent interpretation of the principle of a woman’s body, a woman’s right and insist that every peaceful choice a woman makes with her own body must be accorded full legal protection, if not respect”.

As a result of these three stances on pornography, the topic is heavily debated. As advocates, we cannot judge or ridicule women for how they choose to freely express their sexual identity. Yet we cannot ignore the fact that pornography sexually objectifies women in many ways. Pornography exploits women, reinforces a rape culture, and is used against women. The dilemma is how we find a balance between celebrating women’s sexuality and individual rights, while educating on the sexual objectification of women in pornography, and showing how pornography is
translated in our society.

Pornographic Content

The content that current pornography viewers are seeing is not the same as previous generations. Contemporary pornography has become increasingly successful at marketing the violence and domination of women as erotica, and intimacy in its magazines and films. What is even more disturbing is how there is an increase in demand for the “hard core”, more violent content, within pornography.10

The content of pornography tends to exhibit three basic themes: all women want sex from all men at all times, women enjoy all the sexual acts that men perform or demand, and that if a woman does not want sex at first, it can be remedied with a little force.11 This teaches men and women their roles for sex. Pornography teaches men that sex is using and penetrating a woman’s body. A man has the right to do whatever he wants to a woman and assume that she enjoys it as much as he does.12 Pornography also teaches men that women are always available; even if she doesn’t want it, her mind can be changed to enjoy it. Women are taught to understand that sex means performance, doing whatever pleases a man, acting like she loves it, and looking good while doing it.13 Sex in pornography is not about what a woman wants, but is about being sexually available to a man and, regardless of the woman’s consent, the man will get what he wants.

In addition to sending false messages about the sexual availability of women, contemporary pornography incorporates any relationship of domination and subordination that can be sexualized and exploited.14 The primary domination eroticized in pornography is gender, but an additional theme found in pornography includes racial stereotypes.15 Black women are portrayed as dirtier, more whorish, and even more “worthy” of the violence than white women.16 Racism also emerges among Asian and Latina women. Asian women are depicted as slavishly obedient with exotic man-pleasing skills; meanwhile, Latina women are presented as naturally hot-blooded.17 The racist stereotypes found within pornography influence men regarding women and race. As discussed, men are taught that a woman’s purpose is to provide sexual pleasure. The inclusions of racial stereotypes teach men that black women are subhuman, Asian woman are exotic, and Latina women are difficult to control, virtually teaching men a racial hierarchy of value among women.

In addition to using and reinforcing racist stereotypes to sexually objectify women, pornography also exploits the LGBT community. For example, by depicting scenes of women having sex with each other for men, pornography teaches users that lesbian sexuality is really for men after all.18 Teaching men that lesbian sexuality is for male pleasure implies that lesbian sexuality does not exist. According to pornography, regardless of sexual orientation, deep down inside, all women want to sexually please men.

As pornography has become more acceptable, the level of brutality toward and degradation of women has intensified. “Anal sex is now a standard feature in pornography, and is often presented as being exciting for men because they see it as hurting or humiliating women”.19 The demand within the porn industry is for harder and more extreme pornography. As written in Pornography and Sexual Violence, “People just want it harder, harder, and harder…what are you gonna do next”.20 It is disturbing to know where pornography is going to go from here since profit is the

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primary motive for the porn industry.

Child Pornography

The idea of protecting children from sexual exploitation is relatively modern. As late as the 1880s in the United States, the age of consent for girls was just 10 years old. In 1977, only two states had legislation specifically outlawing the use of children in obscene material. The first federal law concerning child pornography was passed in 1978, and the first laws that specifically referred to computers and child pornography were passed in 1988. Since then, Congress and the Supreme Court have worked to maintain child pornography laws to keep up with the time.

Child pornography is defined as material that is either made using children, or through the use of modern technology, is made to appear that children are being used. In New York v. Ferber, 1982, the use of children in pornography became illegal. The advances on technology and ability to crop pornography have blurred the lines of child pornography. Making it appear as if as child is being used in pornography currently remains legal (Ashcroft v. Free Speech Coalition, 2002). Legislation and regulation are needed to protect children from exposure to pornography from traditional sources (television, magazines, etc.), while new criminal code provisions are required to meet the challenges posed by pornography on the Internet.

Child pornography does not have to involve obscene behavior, but may include sexually explicit conduct that is suggestive. In 1993, (United States v. Knox) a man was convicted for possessing videos that focused on the clothed genital region of young girls. Production, trading, and possession of child pornography is illegal; meanwhile, images from the Internet do not have to be saved for an offense to have occurred—they only need to have been accessed.

The following are actions made by Congress and the Supreme Court as an attempt to define, regulate, monitor, and prevent child pornography:

- In 1982, (New York v. Ferber) the Supreme Court upheld a state statute outlawing the promotion of a sexual performance of a child by selling non-obscene material depicting minors engaged in sexual conduct.
- The Child Protection Act of 1984 eliminated the need for the material to be obscene, raised the protection age to under 18, and included material traded, not just involved in commercial sales.
- The Child Protection and Obscenity Enforcement Act of 1988 prohibited the use of computers in the transportation, distribution, or receipt of child pornography.
- The Child Pornography Prevention Act of 1996 expanded the definition of child pornography to include “virtual” child pornography. In Ashcroft v. Free Speech Coalition, the Supreme Court struck down the statute and limited “virtual” child pornography to the use of actual children.
- The Communications Decency Act of 1996 prohibited sending indecent content to minors over the Internet.
- The Child On-Line Protection Act of 1998 restricts access to commercial pornographic website and, despite continuing legal challenges, the law remains in force (Stock).
The Child Protections and Sexual Predator Punishment Act of 1998 prohibits the transfer of obscene material to minors, and increases penalties for offenses against children and for repeat offenders. The Act also amends the Child Abuse Act of 1990 by requiring online service providers to report evidence of child pornography offenses to law enforcement.

The Internet poses increased problems when attempting to regulate child pornography. It is estimated there are more than one million pornographic images on the Internet, with 200 new images posted daily. It has been reported that one child pornographic site received a million hits a month. The challenge with tracking sites found on the Internet is that many exist for a short period of time, only to shut down and resurface with a different address. In addition to site moving, much of the trade on child pornography takes place at hidden levels of the Internet.

Adult and child pornography is easily accessible on the Internet. Research indicates that many perpetrators of Internet crimes against children possess child pornography. Offenders access and use child pornography for multiple reasons. Child pornography may be used as part of their pattern for sexual gratification. Pornography is also used to stimulate the offender in preparation to offend. Child pornography can also be created in the process of sexual abuse, or be used to groom potential victims and prepare them for abuse.

The actions taken by our government are attempts to not only regulate child pornography, but also to protect children from indecent material. The damage caused by child pornography goes well beyond the victimization of children depicted in the material. As written in Protecting Children from Child Pornography and the Internet: Where are We Now:

“The existence of traffic in child pornography images presents a clear and present danger to all children. . . . [T]he sexualization and eroticization of minors . . . [encourages] a societal perception of children as sexual objects leading to further sexual abuse and exploitation, . . . [and] creates an unwholesome environment which affects the psychological, mental and emotional development of children."

Why Does Pornography Matter?

Pornography plays a key role in creating a rape culture, by reinforcing the sexual exploitation of women and children. Each time a person is exposed to pornography s/he becomes desensitized to the sexual objectification of women and viewing of children as commodities. The content within pornography influences the gender socialization that encourages and normalizes sexual violence. For example, pornography can lead to increased callousness toward women or beliefs that types of sexual violence are not criminal offenses. Pornography use can lead to the desire to act out what was witnessed in the pornographic material. Some of these behaviors may include promiscuity, orgies, rape, child molestation, and bondage or painful sex. Ultimately, pornography contributes to a user’s difficulty in separating sexual fantasy and reality.

Pornography can also be viewed as a training manual, for abusers; teaching perpetrating behaviors, used to initiate victimization, and break down their resistance.
As discussed, child pornography is used prior to offending children, created in the process of sexual abuse, or used to groom potential victims and prepare them for abuse.

Consumers, or those who view pornography, are not the only individuals affected by pornography and the porn industry. Women and children are also negatively impacted by pornography. Indeed, pornography is ultimately the documentation of prostitution. Overall, women in pornography are typically young, recruited into the porn industry as teenagers. Easily manipulated and controlled, the porn industry can “recruit” these young women by luring them with false promises of fame and a fabricated financial incentive. Once the porn industry has these women trapped, they are required to submit to degrading and often violent sexual interactions. Additionally, they may be extremely vulnerable to sexually transmitted infections because they are unable to practice safe sex. There is no way to measure the emotional and physical trauma these women experience after routine degrading and violent acts.

In addition to the women objectified by the porn industry, women within society are affected. Pornography creates an image of women in unattainable measures. Many women have testified to their therapists that their significant others would rather masturbate to pornographic images than have sex with them. Furthermore, if their partners did want to have sex with them, they would be encouraged to emulate what was being done in pornography. Pornography erodes intimacy, leaving individuals within a “real” sexual relationship feeling alone.

Children forced into pornography often face devastating physical, social, and psychological effects. Victimization occurs each time they are perpetrated, recorded, and when the video is accessed. In one study, 100 victims of child pornography were interviewed about the effects of their exploitation. “Referring to when the abuse was taking place, victims described the physical pain (around the genitals), accompanying somatic symptoms (such as headaches, loss of appetite, and sleeplessness), and feeling the psychological distress (emotional isolation, anxiety, and fear)”.

The victims/survivors in this study testified that years later their feelings of shame and anxiety had intensified into a deep sense of despair, worthlessness, and hopelessness. In addition to physical and psychological effects, each victim/survivor was left with a distorted model of sexuality, and many had difficulty establishing and maintaining healthy emotional and sexual relationships.

“A child’s sexual development occurs gradually through childhood. Exposure to pornography shapes children’s sexual perspective by providing them information on sexual activity. However, the type of information provided by pornography does not provide children with a normal sexual perspective”. Without positive messaging, pornography will teach children that sexual activity is about power and control, real men are sexually aggressive, and women do not matter. The portrayal of rape and the dehumanization of females in sexual scenes are powerful forms of sex education that are counterproductive to the goal of healthy and appropriate sexual development.

What is Our Role as Advocates?

When an advocate meets with a victim/survivor who says s/he has been used in pornography, the advocate should work with that person as they would with any
victim/survivor of sexual violence. The healing process of victims/survivors is not determined by the type of sexual violence they experienced, but by their reaction to the victimization. Advocates must also consider the myths regarding pornography and must imagine the difficulty their client will encounter when talking about being victimized by pornography. There are multiple ways pornography can be used to victimize a person that should be taken into consideration when working with a victim/survivor. Some considerations to think about while working with a victim/survivor are: was s/he a child when introduced to pornography, was s/he forced into the porn industry, and/or was the victimization recorded? Each victim/survivor’s response will be different. One victim/survivor might experience victimization through the act, but another might experience a greater sense of victimization knowing that the video is available for any person to view.

References

1. Pornography: Driving the Demand in International Sex Trafficking,” published by Captive Daughters.
3. “Rape on the Public Agenda,” by Maria Bevacqua.
4. Ibid.
5. “Radical Feminist in Political Action: The Minneapolis Pornography Ordinance,” by the Center of Women and Public Policy Case Study Program. Distributed by the Humphrey Institute of Public Affairs, University of Minnesota.
7. Ibid.
10. “Pornography and Sexual Violence” by Robert Jensen with contributions from Debbie Okrina. Distributed by the National Online Resource Center on Violence Against Women.
11. “Who wants to be a porn star? Sex and violence in today’s pornography industry”. A slide show written and produced by Gail Dines, Rebecca Whisnant, and Robert Jensen
12. Ibid.
13. “Pornography and Sexual Violence” by Robert Jensen with contributions from Debbie Okrina. Distributed by the National Online Resource Center on Violence Against Women.
14. Ibid.
15. “Who wants to be a porn star? Sex and violence in today’s pornography industry”. A slide show written and produced by Gail Dines, Rebecca Whisnant, and Robert Jensen
16. Ibid.
17. Ibid.
18. Ibid.

Bringing it Home:

- Is your local law enforcement agency effectively trained and have the technology to investigate such cases? Prosecutors?
- What relationships should your agency have established to effectively advocate for a victim/survivor forced into pornography?
- What is the community climate around pornography?
- Look to your local media. Has your local news reported on such cases? What type of messages/myths do they reinforce?
- What type of myths/stereotypes do you currently have regarding victim/survivors forced into pornography?
21. Pornography and Sexual Violence* by Robert Jensen with contributions from Debbie Okrina. Distributed by the National Online Resource Center on Violence Against Women.

22. Ibid.

23. Ibid.


26. Ibid.

27. “Protecting Children from Child Pornography and the Internet: Where are We Now” by Mary Leary. Distributed by the National Districts Attorneys Association.


31. Ibid.

32. “Protecting Children from Child Pornography and the Internet: Where are We Now” by Mary Leary. Distributed by the National Districts Attorneys Association.


34. Ibid.

35. “Pornography and Sexual Violence” by Robert Jensen with contributions from Debbie Okrina. Distributed by the National Online Resource Center on Violence Against Women.

36. “Pornography’s Effects on Adult and Children” by Dr. Victor B. Cline.

37. “Pornography and Sexual Violence” by Robert Jensen with contributions from Debbie Okrina. Distributed by the National Online Resource Center on Violence Against Women.

38. Ibid.


40. “Pornography and Sexual Violence” by Robert Jensen with contributions from Debbie Okrina. Distributed by the National Online Resource Center on Violence Against Women.

41. Ibid.

42. “Child Pornography in the Internet” by Richard Wortley and Stephen Smallbone. Distributed by the U.S. Department of Justice.

43. Ibid.

44. Ibid.

45. “Pornography and Sexual Violence” by Robert Jensen with contributions from Debbie Okrina. Distributed by the National Online Resource Center on Violence Against Women.

46. Ibid.
Key Learning Points:

- It is important for children to understand how to use the internet safely and what to do if they experience something that makes them uncomfortable. It is also important for adults to know these safety tips and how to respond if they have an experience they are not comfortable with.
- In this article we focus on the idea of perpetrators luring their victims via the internet. Keep in mind that there are many other ways that sexual violence is perpetrated through the internet.
- Three of the most important internet safety tips for children are:
  - Never give out identifying information
  - Tell a parent, guardian or teacher right away
  - Never arrange a face to face meeting without telling a parent or guardian
- Remember that the person you are communicating with online may not be who they say they are.

The Internet is a useful tool that most of us use in our daily lives. It allows us to stay in touch with the people we care about through email. For students, the Internet can assist them in completing homework assignments or to research a topic. Other capabilities like instant messaging, chat rooms, blogs, newsgroups, game boards, or sites like MySpace or facebook make the Internet a fun, social place. Unfortunately, all of these different tools also open up doors of opportunity for perpetrators of sexual violence.

This article will focus on the way that perpetrators lure their victims via the Internet. It is important to keep in mind that the Internet can be used to perpetrate sexual violence in a multitude of ways. It may be used to groom a young victim with the intent to lure them to a place where a sexual assault may occur. Additionally, Internet users may be sent images, sexual in nature, to which they did not consent. People may also experience sexual harassment via the Internet. Child pornography is easily trafficked through cyberspace; children are exploited and sexually abused for purposes of creating this material. Pictures and video of people end up on the Internet without their consent. These are just a few examples of the ways that perpetrators can use the Internet to victimize children and adults.

*Online Victimization: A Report on the Nation’s Youth* was put out by the Crimes Against Children Research Center in June 2000 [http://www.copacommission.org/papers/ncmec.pdf](http://www.copacommission.org/papers/ncmec.pdf). 1,501 youths ages 10 to 17 who regularly use the Internet were interviewed. In 2006, the Crimes Against Children Research Center updated the report. The following statistics are included in these reports:

- Approximately one out of five youths received a sexual solicitation or approach over the Internet in 2000. A sexual solicitation or approach is defined as requests by an adult, whether wanted or not, to engage in sexual activities, sexual talk, or give personal sexual information. In 2006, that number dropped to one out of seven youths.
- Aggressive solicitations, meaning that the youth was either solicited to meet somewhere face to face; received phone calls from the solicitor; or was sent gifts, mail...
or money; have increased. One in 33 received an aggressive solicitation in 2000 compared to one out of 25 youths in 2006.

- Online harassment increased from six percent to nine percent.
- One in four was exposed to unwanted pictures of people having sex or naked people in 2000. In 2006, that number rose to one in three youths.

“Sexual predators may target children online while maintaining relative anonymity. The nature of online interaction facilitates deception about the predator's identity, age, and intentions. Millions of children online form a large pool from which predators can select victims.”

Youths as well as adults need to be aware that the people they encounter online may not be who they say they are. Perpetrators can be as deceptive as they choose. For example, they can send fake photos or create a false profile on a social networking site, such as MySpace. That false profile may be set up to make the perpetrator appear to be another youth when they are really an adult. They may even present themselves as female when they are truly male, to gain trust and access to potential victims.

No matter what decisions a victim/survivor makes, it is never their fault if sexual violence occurs online or through the use of the Internet; it is not the responsibility of the victim/survivor. It is important, however, to have some safety tips in mind while using the Internet. It is just as important for parents, caregivers, and guardians to supervise youths when they go online. The following tips are to be shared with children and teens:

- Never give out identifying information such as name, home address, the name of your school, or telephone number in a public message such as at a chat room or on bulletin boards. You should never send a person this information or a picture of yourself without first checking with your parent or guardian.
- Tell your parent, guardian, or teacher right away if you come across or are sent any information that makes you feel uncomfortable.
- Never arrange a face to face meeting without telling your parent or guardian. If a parent or guardian agrees to the meeting, it is a good idea to meet in a public place and have your parent or guardian go along.

Although these safety tips are targeted for children and teens, they can apply to adults as well. It is not safe to give out any identifying information to people you don’t know or to post your personal information in a chat room, on a blog, or on a bulletin board. If someone is harassing you and making you uncomfortable, talk to your local law enforcement and contact your local sexual violence crisis center. If you meet someone online, be cautious about meeting face to face. Consider creating a safety plan, inform others where you will be, meet in a public place, and consider bringing a friend. The Internet contains valuable information and is an extremely handy tool in the modern age. By educating ourselves and others about potential dangers in cyberspace, we can continue to use it without fear.

References

1. Ibid., page 21.
2. Ibid., page 23
Female Genital Mutilation
By Dresden Jones, SVJI, MNCASA

Key Learning Points:
- Female genital mutilation occurs in multiple countries.
- Experiencing FGM is painful and traumatic, both short and long term.
- FGM is sometimes practiced as a part of religion but not in all cases.
- FGM is a harmful, oppressive practice.
- When working to eliminate FGM, we must be sensitive to cultural issues.

“Badour, did you have to die for some light to shine in the dark minds? Did you have to pay with your dear life a price ... for doctors and clerics to learn that the right religion doesn't cut children’s organs.”

— Nawal El Saadawi, writer, Muslim feminist, victim of infibulation, the most severe type of female genital mutilation, in reference to the death of a 12-year old girl during a female circumcision.

For many of us, the subject of female genital mutilation (FGM), or female circumcision is disturbing and foreign. Yet, it’s a reality for women in various parts of the world, one that is truly violent and oppressive. FGM is the removal of the external female genitalia or other injury to the female genital organs, whether for religious, cultural, or other non-therapeutic reasons. There are several types, but the most common is the removal of the clitoris and the labia minora. There are immediate and long-term health concerns for women who undergo this procedure, including shock, severe pain, urine retention, injury to the adjacent tissue, and infection; longer term consequences include sexual dysfunction, painful intercourse, keloid scars, and difficulty bearing children. Recently, there has been some concern over the possibility of HIV transmission due to the instrument being used on more than one person before sterilization. Additionally, genital mutilation may leave a lasting mark on the life and mind of the woman who has undergone it. Women may suffer feelings of incompleteness, anxiety, and depression.

In cultures where FGM is an accepted practice, it is practiced by various religions. It is usually performed with crude instruments and without anesthesia. There are a multitude of reasons for the practice: to maintain chastity until marriage and faithfulness during marriage, and increase male sexual pleasure; as initiation into womanhood and to maintain social cohesion;

If the victim/survivor is saying she is experiencing pain or other physical symptoms that she believes are due to the FGM, encourage her to seek medical attention immediately.
to promote hygiene; and to enhance fertility and survival of children. Religious reasons are also given, although the practice pre-dates the Muslim religion, which is generally associated with FGM.

There are currently between 100 and 140 million women who have undergone FGM. It is practiced in 28 African countries, but many of the women who have experienced this live all over the world, increasingly in the United States. Many human rights groups, including Amnesty International, The World Health Organization, and The United States Agency for International Development, have cited the practice as oppressive and inhumane. Amnesty International states that FGM “affects the full enjoyment of human rights by millions of girls” and urges governments to enact policy that would ban the practice.

While the practice of FGM may not be seen in many countries as sexual violence, women who have experienced it may begin to feel lasting psychological effects, including shame, depression, and anxiety. As more women emigrate to the United States from countries where FGM is commonplace, sexual assault advocates may begin to see clients who underwent FGM and want support for when they are ready to express their feelings. These women may turn to support groups in their own communities, but if those are not available, they may seek support from sexual assault programs.

Many Western women have expressed conflict when it comes to the practice of female genital mutilation. As Western women, and certainly as American women, we are women of privilege; our experiences of oppression based on gender are extremely real and traumatic, but most of us have not been forced to have pieces of our genitals removed and/or sewed closed in the name of religion or culture. The question can be asked, “Can we as outsiders condemn a cultural practice that we know nothing about first-hand?” The answer is this: FGM, whether it is rooted in cultural tradition or religious belief, is a brutal, painful, and extreme form of oppression against women. No matter what is used to justify the practice of FGM, those interested in and fighting for women’s rights universally must recognize FGM for what it truly is. This quote from The United Nations Population Fund on the subject of FGM says it best: “The function of culture and tradition is to provide a framework for human well-being; cultural arguments can never be used to condone violence against persons, male or female.”

Eliminating this practice, however, must be approached in a way that is culturally and socially sensitive to the cultures that practice FGM. Helping a community understand that they can eliminate practices that harm people but still keep rich and valuable cultural traditions alive is paramount. Women seeking the support of sexual assault programs in Minnesota who identify that they have been victimized by FGM must be treated with respect and dignity, not pity; just as advocates should treat any other victim/survivor. It should also never be assumed that a victim/survivors seeking services who happens to be an immigrant woman from an African country or the Middle East has experienced FGM.

References

Amnesty International USA: http://www.amnestyusa.org/Violence/Womens_Human_Rights/
does not focus on the procedure; the victim/survivor is who needs your attention.

Never assume that a woman seeking services who has immigrated from an African or Middle Eastern country, has experienced FGM.

Bringing it Home:

- Does your community have a large immigrant population? If so, do you know where to refer women seeking culturally specific services?
- Has your agency worked with any FGM survivors?

Victims/survivors of FGM who have immigrated from other countries may not have been able to express their feelings regarding their experience until now.

FGM may be interesting or something you’d like to know more about, but do not focus on the procedure; the victim/survivor is who needs your attention.
Sexual Violence Within Prisons

Adapted from "Rape in Prison" fact sheet, Ithaca, New York Rape Crisis Center and by the Colorado Coalition Against Sexual Assault

Key Learning Points:

- Prisoner rape for male and female inmates can vary between each institution. A recent study in four Midwest states found that approximately one in 10 male inmates had reported being sexually assaulted. Approximately one in five male inmates reported a coerced or forced act of sexual violence. In one institution, 27 percent of female inmates reported a coerced or forced act of sexual violence. In another institution, seven percent of female inmates reported sexual violence. (www.spr.org/en/factsheets/basics.asp)
- Sexual violence runs an even higher risk of becoming deadly in prison due to rates of HIV being five to 10 times higher inside of prison versus outside. (www.spr.org/en/factsheets/basics.asp)
- We know that sexual violence is an act of power and this becomes clearer within prisons. Victim/survivors fear retaliation from those who hurt them. Many times if it is a staff person who attacked him/her, that victim/survivor may feel that no one would believe them.
- Society may feel that inmates “get what they deserve.” Working against sexual violence, we need to remind others that no one deserves to be sexually assaulted.

One of the most underreported crimes in the United States today is sexual violence in prison. There has been very little research into the subject, but what research has been done points to a problem far beyond the "official" statistics.

Both male and female inmates experience high rates of sexual violence while incarcerated. Some studies report that over 100,000 rapes/sexual assaults occur in U.S. prisons every year. The actual numbers of assaults in prison and jail is hard to determine in part because victims/survivors of sexual violence are often silent. When they do speak, they may not be believed or helped.

People of any sexual orientation commit sexual offenses and can also be victims/survivors of sexual violence. Most men who sexually assault other men identify as heterosexual, however. Both gay and straight men can experience similar feelings following a sexual assault, and both can be equally traumatized. Rape trauma syndrome happens to men as well as women.

Although "sexual" in nature, sexual violence is an act of power, aggression, domination, and control. In a prison setting, this becomes even clearer. This is also true for female perpetrators, regardless of their sexual orientation.

Acts of sexual violence are extremely traumatic. Its impact is long-lasting. There will also be inmates who have experienced sexual violence or other forms of abuse in the past. This can have an effect on the impact sexual violence will have on a victim/survivor experiencing it again. Victims/survivors in an institution of confinement have limited access to supportive legal or psychological resources. Even inmates who are not sexually assaulted themselves can be deeply affected by such violence. Hearing or witnessing sexual violence and living with the
constant threat or fear of a sexual assault is inherently traumatic.

Male Victims/Survivors


"It is in the institutions of confinement (prisons and jails, reformatories, mental institutions) and, to a markedly lesser extent, in other all-male residential settings (boarding schools, the military, etc.) that male rape is most common, even an accepted part of institutional life."

"Rape of males in confinement differs from male rape in society at large in that it is generally open, is accepted if not condoned by the prisoner subculture, usually involves repeated patterns of sexual assault following the initial rape, is far more likely to be interracial, and serves as a social function in converting heterosexual young prisoners into sexual slaves to be acquired by more powerful men. Thus, once raped, the victim is forced into a pattern of perpetual sexual abuse, which may in time appear consensual to a casual observer, but which is rooted in the need for protection of the rape survivor from further assaults."

From a review of the existing research on male-on-male sexual assault in jails, Donaldson summarized that victims are likely to be young, small, non-violent, first-time offenders, middle-class, not "streetwise", not gang-affiliated, not part of the dominant ethnic group in that jail, or without major fighting experience. The more factors that apply, the more likely the victimization. If most apply, sexual violence becomes a probability. Furthermore, many male victims/survivors are assaulted by multiple perpetrators.

Female Victims/Survivors

Abuse of women by fellow prisoners is not unknown, but so far little research has been conducted on the subject. Dynamics of female-to-female sexual violence may match some of those described for male-to-male sexual violence where the victim/survivor's survival in the prison is at stake, but sexual violence is always an issue of power and control.

A 1994 survey of the Nebraska prison system found that 7.7 percent of the women had been "pressed or forced to have sexual contact" against their will. This figure does not differentiate between rape by other prisoners versus by guards and other authorities. Extrapolation from that study's numbers suggests that there may be at least 3,600 female victims now in prison, however.
Staff-on-Inmate Abuse


Both male and female prisoners have been sexually assaulted by prison staff. Such abuse includes sexually offensive language, staff touching inmates' breasts and genitals when conducting searches, staff watching inmates while they're naked, and rape. In the overwhelming majority of complaints of sexual violence against female inmates by staff, men are reported to be the perpetrators. Contrary to international standards, prisons and jails in the U.S. employ men to guard women, and place relatively few restrictions on the duties of male staff.

When an officer's conduct is such that it violates international rules (prohibiting any staff/inmate sexual contact) and even criminal laws (concerning rape and sexual violence), the victim/survivor is often reluctant to complain because s/he may have good reason to anticipate that investigators will believe the officer. S/he may also fear retaliation.

Other forms of maltreatment may accompany sexual violence committed against prisoners. If the crime is reported, it may be investigated by personnel within the facility where the abuse occurred. Victims/survivors may easily not be believed. And, the problem is amplified by the attitude that victims/survivors in prison "get what they deserve" if they are raped in prison.

The problem of sexual violence in prisons is not limited to prisons. Once released, victims return to their communities without ever receiving counseling or any other kind of support. For example, male victims who have been emasculated in their forced role as sexual slave of a stronger prisoner(s) may seek to regain his masculine identity in the only way he has learned how: by raping another person in the community to which he returns. Or, if a person was a perpetrator in prison, they may have learned to regard coerced sex as a valid means of satisfying "sexual and power needs" and will likely continue to do so on the outside.

Working with Victims/Survivors

It will probably be rare for your agency to receive a call from a victim/survivor in prison. If you do, follow your agency protocol in working with the client. More likely, you may be working with a survivor who is now out of prison but experienced victimization previously.

Keep in mind that prisoner sexual assault is torture - the infliction of severe emotional and/or physical pain as punishment and/or coercion. As Stephen Donaldson put it, "long after the body has healed, the emotions remain traumatized, shamed, and stigmatized." The psychological effects of prisoner sexual assault can last a lifetime and often lead to substance abuse and domestic violence, among other things. Sexual abuse is the leading cause of suicide in confinement, and suicide is the leading cause of death behind bars.

Also, be sensitive to gender, sexuality, race, and other issues when working with current or former prisoners. Remember that having been sexually assaulted by a person of the same gender does not define that victim/survivor’s sexual orientation. Keep in mind, too, that a sexual assault in prison may have been a kind of "hate crime" targeting the victim/survivor's sexuality, race, ethnicity, or some other factor.
Key Learning Points:

- Professional sexual exploitation is the inappropriate use of sexual actions and words by professionals and volunteers within a helping context. Helping professions can include counseling, psychology, social work, therapy, health care, clergy, law, victim advocacy, education, and public health.

- A victim/survivor may not recognize right away that what they experienced was sexual exploitation and s/he may need time and help processing this. Something may not have felt comfortable to her/him but s/he may not be able to recognize the behavior of the perpetrator as abusive.

- Helping professionals are generally trusted by their clients. Therefore if they are behaving in ways that are sexually exploitive, their clients may trust that what the professional is doing is right because they are the professional, even if it makes the client uncomfortable.

Professional sexual exploitation is the inappropriate use of sexual actions and words by professionals and volunteers within a helping context. Any sexual interaction between helping professionals and clients is sexual violation (even if the victim/survivor sees it as consensual.) Helping professionals are bound ethically and/or legally to abstain from sexual interaction with clients, patients, and others they serve. Helping professions can include counseling, psychology, social work, therapy, health care, clergy, law, victim advocacy, education, and public health.

In 1984, the Minnesota legislature enacted a law that created the Task Force on Sexual Exploitation by Counselors and Therapists. For the next three years, hundreds of people from professional organizations, regulatory agencies, women's organizations, mental health advocacy organizations, victims' services groups, and consumer groups were involved in the task force or its work groups to provide leadership in creating laws, policies and education on sexual exploitation. The task force's accomplishments included:

- The first felony law prohibiting sexual contact between clients and therapists;
- A bill providing civil remedies for victims of sexual exploitation; and
- Increased activity by licensure boards providing practice-related consequences for offenders.

Three publications:

- It's Never Okay: A Handbook for Professionals on Sexual Exploitation by Counselors and Therapists
- It’s Never Okay: A Handbook for Victims and Victim Advocates on Sexual Exploitation by Counselors and Therapists
- It's Never Okay, a brochure.
The first national conference on sexual exploitation held in 1986, attended by over 200 people from 27 states, with suggestions for training, administrative policies, and intervention for victims and offenders.

Sexual contact by a person in a position of authority often constitutes a professional or ethical violation, but it is not just that. Such behavior is an abusive violation of power and can have long term effects on the victim/survivor, even if s/he may have considered the contact "consensual" at the time. Pamela Sutherland explains the problem of sexual abuse in the context of professional-client relationships:

“There are special characteristics of professional-client relationships which place the professional in a position of greater power and authority than the client and, in essence, render it "unfair" for the professional to gain any benefit at the client's expense. Legally, many professionals - therapists, physicians, attorneys, professors - are said to stand in a "fiduciary" relationship with respect to their patients, clients, or students. "Fiduciary" is a legal term describing the relationship that exists when one party reposes trust and confidence in the other, more powerful party. In a fiduciary relationship, the more powerful party has a duty to act only in the trusting party's best interest. Sexual contact may harm patients, clients, and students and is therefore a violation of the fiduciary's duty. Because of the fiduciary nature of professional-client relationships, professional-client sexual contact is prohibited.”

Warning Signs in the Context of Counseling Relationships

(Adapted from pamphlet "It's Never Ok: A Handbook for Victims and Victim Advocates on Sexual Exploitation by Counselors and Therapists," The Public Education Work Group of the Task Force on Sexual Exploitation by Counselors and Therapists, Minnesota CASA, revised June 1993.)

Sexual exploitation by a professional is not always black and white. When a victim/survivor has been exploited by a helping professional, s/he may need to process the emotional and psychological effects of her/his experience just like any other victim/survivor. S/he may need help identifying that the situation was, in fact, sexual exploitation of a professional or other relationship. The victim/survivor may have uncomfortable feelings about the relationship but may not be able to explain exactly why. They may feel that the behavior by the professional is "normal." They may feel that because the professional should know best, that they should trust that person and not question the behavior. The following feelings and behaviors may be useful for clients wondering whether they are being exploited by a person in a professional position:

• The professional avoids or refuses to give information about credentials, licensing or experience;
• The client has a feeling that something is wrong during meetings, appointments, conversations, etc. despite attempts to clarify or discuss this with the professional;
• The client has the feeling that what should be a professional relationship is giving in personally to the professional; and/or
• The professional suggests any mutual activity that is uncomfortable

In many cases, sexual contact is preceded by action which may be inappropriate or unprofessional, such as:

• Behavior which may feel sexual
− Telling dirty jokes;
− Looking at the client in a way that makes her/him uncomfortable; or
− Discussing the professional’s sex life.

• Giving client "special" status by:
− Scheduling after hours appointments or changing fees (when different from normal office procedure);
− Making out-of-the-office appointments (when not normal office procedure);
− Using the client as a confidant for personal support;
− Giving or accepting major gifts;
− Inviting client to social engagements;
− Borrowing money or getting involved in business deals with client;
− Making secrecy a part of the professional relationship; or
− Using or offering alcohol or drugs during meetings or appointments.

Clients who have been sexually exploited by professionals will go through a stage of gaining awareness of what has happened and being able to name it as abuse rather than an "affair" with the professional. This awareness can be triggered by a newspaper article, a television show, a chance remark by a significant other, or by finding out that there are other clients engaging in sexual activity with the same professional. When a victim/survivor of sexual exploitation seeks help, this person will need continuing support as options are explored and action is taken. Confusing and sometimes conflicting emotions will occur: shame, betrayal and memories of pleasure in reliving the experience, ambivalence about telling out of loyalty to the professional, fear of being discounted or disbelieved, fear of retaliation by the professional and of reaction of family, distrust of any other professional, grief over the loss of the relationship, relief in sharing the experience and finding an end to the isolation, anger at the professional and at the systems designed to intervene, self-blame, and confusion over what to do or who to tell.

There are a number of options that a victim/survivor can choose, no one action is better than another. A victim/survivor must ask what it is that is most important to achieve personally. S/he may be concerned about the professional being able to exploit another client, may need compensation for future therapy and damages, and may want to punish the professional for the exploitation. There are advantages and disadvantages to any choice. The options include:

• File a criminal complaint;
• File a civil suit for damages;
• Report to state or county authorities;
• Report to adult protection;
• Complain to ethics committee of a professional association;
• Make licensure or registration complaint;
• Confront the abuser in a processing session;
• Write or call the ex-counselor;
• Receive individual or group therapy around the issue; or
• Notify the relevant agency director, supervisor, or church hierarchy.

There are options for victims/survivors who experience sexual exploitation by professionals. As an advocate it is your job to make victims/survivors aware of those options.
If the victim/survivor chooses to pursue legal or other action (for example, a complaint to a licensing board) against their perpetrator, you may be able help them access the relevant resources. If the victim/survivor is a child, you may be obligated to make a mandated report.

The victim/survivor also has every right to do nothing. Some victims/survivors feel they cannot or do not want to take any specific action. The victim/survivor has a right to choose if or when to tell anyone or take action.

In aiding a victim/survivor of sexual exploitation, there are some basic guidelines. One is to avoid making assumptions about the sexual activity that occurred; explore specifically what occurred. Also, avoid making assumptions about how the sexual involvement affected the client. There may be conflicting or ambivalent feelings that may change over time. Focus initial intervention on crisis issues and practical decisions. Also, be aware of when to refer a client for therapy, medical help, or legal advice.

**Bringing it Home:**

- Has your agency worked with victims/survivors of sexual exploitation?
- If so, have you assisted victims/survivors in navigating some of the more specific options for sexual exploitation? (I.e. reporting to an ethics committee of a professional association.)
In the past, sexual violence was understood as an assault by a stranger upon an unsuspecting victim. As the knowledge base about sexual violence has advanced, it is clear that most sexual violence occurs between two people who know one another. Intimate Partner Sexual Violence (IPSV), refers to rape/sexual assault that occurs between two people who have or have had a consensual sexual relationship. This includes: dating relationships, marriages, or long-term gay and lesbian relationships. IPSV is also often a part of relationships in which other types of violence or domestic violence are occurring.

Sexism is often at the heart of intimate partner sexual violence, just as it is at the heart of most forms of sexual violence. The widespread idea that an intimate partner has a right to sex, and has a right to use their partner’s body for this purpose, makes it difficult for many in the mainstream U.S. culture to recognize sexual coercion in intimate relationships.

Intimate Partner Sexual Violence and the Legal System

At one time, there were no statutes that addressed sexual violence within intimate partner relationships. Most states, including Minnesota, have now identified in state statute that sexual violence within a marriage or any other long term intimate partner relationship is illegal and can be charged as a crime.

Statute Reference:
Minn. Stat. § 609.349 - Voluntary relationships

In Minnesota, even if the defendant and the victim/survivor were married or cohabitating at the time of the sexual assault, the defendant can still be found guilty of criminal sexual
conduct against the victim. If the partner used force, had sexual contact while the victim/survivor was asleep or physically helpless, or in most other ways violated the statutes regarding criminal sexual conduct, s/he can still be prosecuted! The law in Minnesota allows an exemption only for certain voluntary marital/cohabiting sexual relationships which would be unlawful otherwise because of the age or disability status of one partner. This statute (609.349) cannot be fully understood without reading the statutes listed which exempt married/cohabiting couples from certain types of criminal sexual conduct. If you look back at the statutes listed in that first sentence (i.e. parts of Minn. Stats. § 609.342, 609.343, 609.344, and 609.345), you will see that the situations referred to are age-based offenses, or offenses involving vulnerable adults where marriage or cohabitation of both persons makes the sexual activity lawful. In other words, sexual activity with certain minors and vulnerable adults would normally be unlawful, but is permitted by this statute so long as the two persons are married or cohabitating.

In addition to common feelings that any victim/survivor of sexual violence may experience, intimate partner sexual violence brings the following added impact:

- Victims/survivors of IPSV usually share homes and may have children with their perpetrator and therefore may be less likely to report the assault. As a result, it is possible that a victim/survivor of intimate partner sexual violence is likely to have been raped multiple times.
- Victims/survivors of intimate partner sexual violence may experience heightened forms of self-blame for being in or staying in the abusive relationship.
- Because the perpetrator is someone whom the victim/survivor had chosen to be with on other occasions, the victim/survivor’s sense that s/he can trust her/his own judgment is strongly affected.
- When a perpetrator is also a person with whom one has shared intimacy, the sense of betrayal of trust is keen.
- In certain circumstances, for example immigration, victims/survivors may fear deportation after reporting the assault to law enforcement.

What Can a Victim/Survivor Do?

It is often difficult for a victim/survivor of intimate partner sexual violence to perceive that there is a way out. Let victims/survivors know that the following options are available:
- Contact local advocacy/rape crisis center for support and assistance.
- Contact local law enforcement. Sexual assault is a crime in Minnesota, regardless of the relationship of the victim/victim and perpetrator.
- Seek medical attention at a local hospital. An evidentiary exam can be conducted and evidence of the crime can be documented. Even if the victim/survivor decides s/he does not want to report the assault to law enforcement it is still important to seek medical attention. A medical exam can screen and treat external and/or internal injuries, and tests for pregnancy and sexually transmitted disease.
- Find someone safe to talk with. No one deserves to be abused by anyone, no matter what the relationship is.

A victim/survivor of intimate partner sexual violence can apply for a Harassment Restraining Order (HRO) or an Order for Protection (OFP), restraining the perpetrator from committing additional acts of violence. This can be accomplished free of charge and can be made effective immediately. (For more information on HRO’s and OFP’s,
see the Legal section of this manual).

**How to Help a Victim/Survivor of Intimate Partner Sexual Violence**

- Believe the victim/survivor;
- Listen to the victim/survivor without making judgments;
- Provide options instead of making decisions for the victim/survivor;
- Help the victim/survivor access as much information as possible to help her/him determine the best option to take;
- Reassure the victim/survivor that s/he does not deserve to be hurt or abused;
- Reassure the victim/survivor that s/he is not to blame for the assault; and
- With IPSV, chances are that the victim/survivor is living with the perpetrator. Develop a safety plan with the victim/survivor.

As advocates, we need to let victims/survivors of IPSV know that being in a relationship with someone does not give her partner the right to be sexually violent.

**Bringing it Home:**

- Does your program offer services to assist victims/survivors of IPSV in filing an Order for Protection (OFP)? If not, do you have someone to whom you can refer your clients?
- Do you partner with your local domestic violence resources and do you know where the closest safe house is?
- Have you trained your local domestic violence resource on sexual violence?
Sexual Assault on College Campuses

By the Colorado Coalition Against Sexual Assault

Key Learning Points:
- Students on college campuses are at a high risk of experiencing sexual violence. Twenty to 25 percent of women will be sexually assaulted at some point during their college career.
- Victims/survivors of sexual violence on campus will often face a challenging, uncooperative campus system.
- When a student experiences sexual violence on campus, not only are they affected emotionally and physically, but their education is impacted. Generally speaking, victims/survivors can not perform as well academically as they were able to prior to the assault.

A person's chances of being sexually assaulted increase during college years, especially for women. Recent studies have shown that 15 to 30 percent of college women report having experienced acquaintance rape, and 7.7 percent of college men report having committed an act that met the legal definition of rape.¹

What accounts for this discouraging situation? Various factors have been identified - the highly social environment of college; communication difficulties between young men and women; sex role socialization; young people's struggles with sexuality and identity issues; the role of drugs and alcohol on campus; and the unsafe atmosphere of some campus settings (for example, fraternity, sorority and “house” parties). There is no single explanation for or solution to the epidemic of campus rape. Fortunately, more and more students have become educated about sexual assault and set up prevention programs, rape crisis centers, and other resources for students who are at risk for or victims of sexual assault.

College-age survivors of campus assault will face the same kinds of issues and after effects as their counterparts outside the university setting. Statistics show, however, that they may be even less likely than other survivors to report what happened to them or to seek support services.

Other issues survivors of sexual assault on campus often face is an uncooperative, inefficient, or victim-blaming campus justice system.² In some cases, offenders have been only mildly disciplined by university authorities wishing to avoid lawsuits or preserve their reputations as safe campuses. If a caller is having an experience like this, s/he may simply need to talk about it, or s/he may need your help identifying what other steps she can take to pursue her case outside the university.
Facts and Figures

Provided by the American Association of University Women

• 20-25 percent of women will be sexually assaulted during their college career.3
• 3 percent of college women nationally have experienced rape or an attempted rape during the academic year. This means, for example, that a campus with 6,000 coeds will have an average of one rape per day during the school year.4
• 13 percent of women are stalked during the academic year, and each stalking episode lasts an average of sixty days.5
• 90 percent of women know the person who sexually assaulted or raped them.6
• 75 percent of the time, the offender, the victim, or both have been drinking.7
• 42 percent of college women who are raped tell no one about the assault.8
• 5 percent of rape incidents are reported to the police.9
• 10 times more rapes are reported to crisis lines than are reported to the police.10
• 42 percent of raped women expect to be raped again.11

Debunking Myths

Provided by the American Association of University Women

Both college women and men harbor misconceptions about sexual assault. Getting the facts is essential to combating sexual assault on college campuses:

• 71 percent of rapes are planned in advance.12
• 80 percent of women who are raped try to physically resist.13
• 48.8 percent of the women did not consider what happened to them to be a rape even though researchers considered the incidents to be rape.14
• 43 percent of college-aged men conceded to using coercive behavior to have sex (including ignoring a woman’s protest, using physical aggression, and forcing intercourse), but did not admit that it was rape.15

Academic Achievement

Provided by the American Association of University Women

• In addition to physical and emotional damage, college students who have been victims of sexual assault suffer from a host of problems that impede their academic achievement.

• In nearly every case, victims cannot perform at the same academic levels that they
did prior to the attack.

- Sexual assault sometimes causes students to be unable to carry a normal class load, and they miss classes more frequently. This is often a result of social withdrawal or a way to avoid seeing the perpetrator.

- Student victims regularly withdraw from courses altogether.

- In more traumatic incidents, victims leave the school until they recover, sometimes transferring to another college.

References

4. Ibid.
5. Ibid.
6. Ibid.
12. DC Rape Crisis Center. Turning anger into change. Available at [www.dcrcc.org](http://www.dcrcc.org).
13. Ibid.

**Advocates need to know what kinds of other processes occur on campus when sexual violence occurs in order for us to advocate appropriately for victims/survivors.**

**Bringing it Home:**

- Are there college campuses or other types of secondary education institutions within your community? If so, what kind of relationship does your agency have with them?
- Do you know how your local college campus responds to students who come forward after experiencing sexual violence?
- Does the college offer any supportive services to students on campus? For example, many schools have a Women’s Center where supportive services may be housed.
Drug Facilitated Sexual Assault
By Staff at the Sexual Violence Justice Institute

Key Learning Points:

- Just as it is against the law to slip someone a drug to facilitate a sexual assault, it is also considered sexual assault if the victim/survivor knowingly and voluntarily ingests drugs or alcohol. Performing any sexual act(s) on a person who is unconscious or asleep, too drunk to withhold consent, or unable to communicate is against the law.

- The victim/survivor usually blacks out, and has no memory of the assault or the events surrounding the assault.

- The drugs that are commonly slipped to victims/survivors are eliminated quickly from the body, leaving no evidence that the drug was in the victim/survivor’s system, thus making it difficult to prove lack of consent. This factor, along with loss of memory, often works against the investigations of DFSA.

- It is important to work with your local law enforcement and prosecution to come to an agreement that victims/survivors of DFSA will not be prosecuted for minor consumption or recreational drug use. If victims/survivors know this will not be held against them, they may feel more at ease about reporting.

- The first urine void is vital because it may be the only evidence to show that the victim/survivor was drugged. Inform your clients that if they can not wait until they get to the ER, to urinate in a jar and bring it with them.

- Alcohol is still the most commonly used drug to facilitate sexual assault.

Drug facilitated sexual assault (DFSA) is taking advantage of the use of alcohol or other drugs which render a victim/survivor incapacitated or physically helpless in order to accomplish a sexual assault. DFSA can occur when an offender “slips a Mickey” to the victim/survivor - or secretly drugs a victim. It can also occur if the victim/survivor knowingly ingests alcohol or other drugs but does not consent to sexual intercourse.

Advocacy programs and medical personnel around Minnesota are reporting that the number of victims/survivors describing inexplicable intoxication and blacking out is increasing. In 2000, almost 5,000 emergency room visits were recorded nationwide as a result of the use of GHB, a common drug used to facilitate sexual assault. The evidence needed for the criminal justice system has been difficult to collect, however, and criminal charges of this type have likely not increased correspondingly to the increase in incidents.

Numerous factors can work against the investigation of a suspected DFSA case. Initially, the victim/survivor likely blacked out and has no memory of the events during or even before the sexual assault. S/he may be groggy for a long period of time after waking up, and may delay reporting the incident.
The drugs commonly used to secretly incapacitate a victim eliminate from the body very quickly – some as quickly as 8 hours from ingestion. Therefore they may not be present if the victim/survivor reports to the emergency room a day after the assault. Finally, without evidence of drugs or the quantity of alcohol in a victim/survivor’s system, juries may have a difficult time knowing just how helpless the victim/survivor may have been when she was assaulted – making a consent defense more likely to succeed.

The Bureau of Criminal Apprehension (the state crime lab) is now recommending that a urine and blood sample be collected from every person who is given a sexual assault forensic exam, regardless of a report of DFSA symptoms. The samples should be collected at the very beginning of the exam and refrigerated until a decision can be made to have them tested for the presence of drugs. It is imperative that victim advocates work with their local law enforcement and prosecution to gain an agreement that minors who use alcohol or people who use recreational drugs will not be prosecuted for those violations of the law. This will help ease the victim/survivor’s concern that their drinking or drug use detected in the urine sample will not be used against them.

For best practices protocols for systems agencies, contact SVJI

What Can Victim Advocates Do?

- The most important thing for advocates and volunteers to know is that the FIRST BLADDER VOID IS CRUCIAL. So, when speaking with victims/survivors who have been recently assaulted, encourage them to either wait to urinate at the ER, or collect the first bladder void in a jar to bring in with them; this urine sample may be the only thing which contains the evidence to show that they were drugged.
- Discuss concerns the victim/survivor may have regarding the urine sample. Remember the victim/survivor’s concerns are valid and you are there to assist them in making an informed decision. The victim/survivor may refuse the urine or blood sample.
- Support the victim/survivor and her/his decisions. You are there to assist the victim/survivor, not make decisions for him/her. It is crucial that you explain the importance of a urine sample in the investigative process. In doing this, make sure not to instill unnecessary fear in the victim/survivor. If the victim/survivor does not feel s/he was drugged, explain it as standard procedure for the forensic exam.

What can victim advocates and programs do to educate the community about the need for immediate collection of this evidence?

- Victim advocates can do a lot in their communities to educate on the issue of DFSA and the importance of the first bladder void. For example:
- Emphasize the importance of the first bladder void in cases of DFSA to volunteers in the initial advocate training process. Revisit the issue during follow-up trainings. Also, check with crisis line volunteers periodically about the issue, and reiterate the importance of discussing the issue of DFSA with victims/survivors on the crisis line.
• When doing local sexual violence presentations/trainings to schools, churches, or other organizations, stress frequency of DFSA.
• Make pamphlets, brochures, posters, or stickers with your program information and information on DFSA; and make them available at schools, medical facilities, law enforcement agencies, bars, etc. It maybe especially useful to put them in or near restrooms.
• When training local professionals, include discussions regarding the importance of collecting this evidence.

Bringing it Home:
• Do you have an arrangement with your local law enforcement and prosecution that victims/survivors will not be charged with a crime for consuming alcohol underage or using recreational drugs?
• Have you presented education in your community about DFSA?
• Do your local medical personnel take both a blood and urine sample from each victim/survivor with their permission no matter what symptoms s/he displays?
• Does your agency provide ongoing training to staff/volunteers about the issues of DFSA?
Sexual Harassment: A Matter of Power

Key Learning Points:
• Sexual harassment, like sexual assault, is a matter of power and control.
• Most sexual harassment is not criminal behavior, but is understood as sex discrimination and a violation of civil rights statutes.
• Many dismiss claims of sexual harassment as “just having fun” while victims/survivors of harassment can, in fact, experience deep trauma.
• Sexual harassment can be either quid pro quo (if you have sex with me, I will get you the promotion you want) or hostile environment sexual harassment (the environment is so discriminatory and/or sexualized that employees feel threatened.)
• What defines an act as harassing is whether or not the target of the behavior is consenting or willingly engaged in the behavior.

Sexual harassment is a form of sexual violence. Like rape and sexual assault, sexual harassment is not a sexually motivated act but rather an assertion of:
• Hostility;
• Power; and
• Dominance
expressed in a sexual manner and designed to intimidate, frighten, or otherwise unsettle another person.

Sexual harassment, unlike rape/sexual assault, is typically not a violation of the criminal code: it is usually not a crime. It is most often considered a violation of a person’s civil rights - an act of discrimination based on gender. Relief is available through the civil court process rather than criminal courts. Sexual harassment and other kinds of harassment, such as that based on race, sexual orientation, physical or mental capacity, come from the same roots and the same motivation. When a pattern of sexual harassment meets the definition of stalking, however, it then becomes a criminal issue.

Sexual harassment and sexual assault can often be linked. Some victims/survivors of sexual assault report that the person who ultimately sexually assaulted them started out with sexually harassing behaviors that escalated over time.

Sexual harassment can occur in a variety of circumstances, including but not limited to the following:
• The victim/survivor as well as the harasser may be a woman or a man. The victim/survivor does not have to be of the opposite sex;
• The harasser can be the victim/survivor’s supervisor, an agent of the employer, a supervisor in another area, a co-worker, or a non-employee. Typically, there is a power imbalance between the victim/survivor and harasser;
• The victim/survivor does not have to be the person harassed but could be anyone affected by the offensive conduct; and
• Unlawful sexual harassment may occur without economic injury to or discharge of the victim/survivor.

Sexual Harassment Defined

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:
• Submission to such conduct is made either explicitly or implicitly a term or condition of a person’s employment or access to services/education;
• Submission to or rejection of such conduct by an individual is used as the basis for decisions affecting the individual; and/or
• Such conduct has the purpose or effect of unreasonably interfering with an individual’s performance or creating an intimidating, hostile, or offensive work or learning environment.

In other words, sexual harassment can be either:

**Quid pro quo sexual harassment:** In the workplace, this occurs when a job benefit is directly tied to an employee submitting to unwelcome sexual advances. For example, a supervisor promises an employee a raise if she will go out on a date with him, or tells an employee she will be fired if she doesn't sleep with him. Quid pro quo harassment also occurs when an employee makes an evaluative decision, or provides or withholds professional opportunities based on another employee’s submission to verbal, nonverbal, or physical conduct of a sexual nature. Quid pro quo harassment also occurs in school settings when, for example, a teacher, administrator, advisor, or coach promises a good grade, a reference, or a spot on the starting line up to a student in exchange for sexual favors. Quid pro quo harassment is equally unlawful whether the victim/survivor resists and suffers the threatened harm, or submits and thus avoids the threatened harm.

**Hostile environment sexual harassment:** This occurs when an employee is subjected to comments of a sexual nature, unwelcome physical contact, or offensive sexual materials as a regular part of the work environment. For the most part, a single isolated incident will not be enough to prove hostile environment harassment unless it involves extremely outrageous and egregious conduct. The courts will try to decide whether the conduct is both "serious" and "frequent." Supervisors,
managers, co-workers, and even customers can be responsible for creating a hostile environment. Probably the most famous hostile environment sexual harassment case to date is Jenson v. Eveleth Taconite Co. which inspired the movie *North Country*. Hostile environment sexual harassment applies to school settings when behavior of a sexualized or violent nature is allowed to continue.

In both of these instances:
- The behavior that is being called harassing is **unwanted**; and
- It is repeated or patterned.

Who decides when behavior is harassing?

Sexual harassment is usually not understood solely by the type of action that the harasser or actor is doing – but by the fact that the action is **non-consensual, and is repeated or patterned**. Sexual harassment is in “the eye of the beholder” to determine! That means the individual who is the target of the action is the one who defines when behavior is harassing, non-consensual, intimidating, and creates a hostile environment. This is similar to sexual assault – the victim/survivor determines whether or not an event was agreed to, consensual, mutual, and desired. In summary:
- The one with the ability/power to define a situation as harassing is **not** the actor or the do-er.
- The effect of an act on the recipient is what defines the act as harassing.
- Intent of the do-er does not matter. (It is not an excuse for a harasser to say, “I was just having fun.” or “I didn’t mean anything bad by it!”)

Where does harassment happen?

Sexually harassing behavior can occur under many circumstances. The most obvious are work and school environments. Most employers and schools, whether public K-12 systems or institutions of higher learning, have put in place policies that are designed to guard against sexual harassment, training programs to ensure that all understand those policies, and systems of support for harassment victims/survivors. These resources are, for a variety of reasons, more or less well-followed or supported. In actuality, victims/survivors of harassment may find poor follow-up after reporting an incident of harassment at school or work.

Harassment at work may come from many sources, including co-workers, supervisors, customers, or clients. Sources of school-based harassment can include teachers, students, non-teaching staff, administration, parents, or members of the public. In all instances, the institution, whether school or worksite, has the obligation to protect employees and students from harassment. Employees and students should reasonably be able to have a safe worksite or...
Harassment can also occur in public. Being targeted with sexually-charged messages in public or by those providing public services can and does occur. Examples of this may include public workers such as law enforcement, fire fighters, utility company employees, or construction workers. While they are not co-workers, their behavior is still unacceptable if it is harassing and their employers or supervisors should be accountable to the victim/survivor of their harassment. Because harassment is usually understood as occurring multiple times or in a patterned manor, it may be difficult to identify that pattern among public harassers.

While most harassment is male-to-female directed, research and anecdotal evidence indicates that men are more often targeted with sexual harassment when they are employed in a predominantly female line of work such as nursing, clerical work, etc. Likewise, women working in traditionally male fields experience an increased level of harassment. The movie *North Country* documents such an experience for women in the taconite mining industry in Minnesota.

What forms can sexual harassment take?

Sexually harassing behavior can take many forms, such as:

- **Verbal:** name calling, using sexually offensive language, suggestive tone of voice and conversation, conversation that is of an unusually specific sexual nature (e.g., retelling sexual exploit stories), or telling jokes of a sexual nature;
- **Visual:** pictures, posters, t-shirt messages, or graffiti;
- **Actions:** sexually suggestive motions or messages, or skits or parade floats that are sexually suggestive in nature; and/or
- **Attitudes:** repeated attitudes that communicate that “girls/women just don’t know anything” or “girls/women are just dumb.”

Statistics

**Sexual Harassment in the Workplace**

- Approximately 15,000 sexual harassment cases are brought to the U.S. Equal Employment Opportunity Commission (EEOC) each year.
- Media and government surveys estimate the percentage of women being sexually harassed in the U.S. workplace at 40 percent to 60 percent.
- While the majority of sexual harassment complaints come from women, the number of complaints filed by men is rapidly increasing. In 2004, over 15 percent of EEOC complaints were filed by men with 11 percent of claims involving men filing against female supervisors.
Sexual Harassment in Education

- A 2002 study of students in the 8th through the 11th grade by the American Association of University Women (AAUW) revealed that 83 percent of girls have been sexually harassed, and 78 percent of boys have been sexually harassed.
- In their 2006 study on sexual harassment at colleges and universities, the AAUW reported that 62 percent of female college students and 61 percent of male college students reported having been sexually harassed at their university, with 80 percent of the reported harassment being peer-to-peer. 51 percent of male college students admit to sexually harassing someone in college, with 22 percent admitting to harassing someone often or occasionally.
- 31 percent of female college students admitted to harassing someone in college.
- In a 2000 national survey conducted for the AAUW, it was reported that roughly 290,000 students experienced some sort of physical sexual abuse or harassment by a public school employee, such as a teacher or coach, between 1991 and 2000.
- In a major 2004 study commissioned by the U.S. Department of Education, nearly 10 percent of U.S. public school students were shown to have been targeted with unwanted sexual attention by school employees.
- In their 2002 study, the AAUW reported that 38 percent of the students were sexually harassed by teachers or school employees.

History

The very public case of Anita Hill v. Clarence Thomas launched a lively public debate about sexual harassment in the early 1990s. While Thomas’ confirmation hearings for his seat on the U.S. Supreme Court were underway, a former law clerk, Anita Hill, came forward and disclosed some disturbing instances of sexual harassment that she said she experienced while working for Thomas. While her testimony was specific, genuine, supported, and above all disturbing, it did not stop the confirmation of Thomas to the Supreme Court! What it did do, however, was fuel a vigorous public debate about sexual harassment. What became clear is that many individuals believe that:

- Sexual harassment is a “made up” issue – it isn’t real but just a construct of the feminists;
- Sexual harassment is not really serious;
- It is really just joking around that someone without a sense of humor doesn’t get;
- It’s fun, it’s just flirting;
- People are just too touchy these days;
- It’s all been ruined by “political correctness”; and/or
- Those who would call themselves victims are just overreacting or looking for an easy buck (through a civil court settlement!)
In contrast, those who say they have experienced sexual harassment report a variety of serious personal affects on them. Sexual harassment is known as:

- A serious economic issue;
- An issue of morale and productivity at the worksite or in schools;
- A kind of bullying and intimidation;
- An act or acts which ignore the integrity of the individual;
- The single most widespread occupational and educational hazard females face; and
- Frequent and serious.

Effects of Sexual Harassment on Victims/Survivors

Initial Effects

We know that those on the receiving end of sexual harassment experience the following:

- Sexual harassment creates educational or economic barriers. Victims/survivors drop out of school or quit their jobs because of the intimidation of the worksite or school environment;
- They participate less in activities at the work site or school. Absenteeism increases; and/or
- Most victims/survivors initially deny that the cause is harassment; try to ignore the harassment, or even assume responsibility. “What am I doing to make this happen to me?”

Ongoing Effects

If the harassment continues, these early effects can become more serious and start to resemble the effects of sexual assault/violence. Common professional, academic, financial, and social effects of sexual harassment:

- Decreased work or school performance, increased absenteeism;
- Loss of job or career, loss of income;
- Having to drop courses, change academic plans, or leave school (loss of tuition);
- Having one's personal life offered up for public scrutiny - the victim/survivor becomes the “accused,” and his or her dress, lifestyle, and private life will often come under attack. (Note: this rarely occurs for the perpetrator.);
- Being objectified and humiliated by scrutiny and gossip;
- Becoming publicly sexualized (i.e. groups of people "evaluate" the victim/survivor to establish whether they are "worth" the sexual attention or the risk to the harasser's career);
- Defamation of character and reputation;
- Loss of trust in environments similar to where the harassment
occurred;
• Loss of trust in the types of people who occupy similar positions as the harasser or their colleagues;
• Extreme stress upon relationships with significant others, sometimes resulting in divorce, or extreme stress on peer relationships or relationships with colleagues;
• Weakening of support network, or being ostracized from professional or academic circles (friends, colleagues, or family may distance themselves from the victim/survivor, or shun them altogether);
• Having to relocate to another city, job, or school; and/or
• Loss of references/recommendations.

Court Decisions

Several court decisions in the 1980s and 1990s took a closer look at the seriousness of sexual harassment. Among other things, those decisions clarified that:
• There does not have to be economic loss to prove harassment. In other words, the emotional cost is significant enough. The victim/survivor does not have to prove economic loss;
• There does not have to be overtly sexual activity but just otherwise gender discriminatory behavior. So, women who are repeatedly being passed over for promotion, being given the smallest accounts, being ignored in company planning sessions or discussions all demonstrate gender discrimination. When men as a group routinely benefit from company practices to the detriment of female employees, the discrimination is clear. This is the basis of the “intimidating, hostile, or offensive environment”;
• Existence of a grievance policy and a policy against harassment does not protect an employer/school. So, simply having a policy, even a good policy, is not enough if it is not supported, followed, and used to protect those who identify that they are victims/survivors of harassment; and
• When an employer/school knew or should have known of the conduct and failed to take action, there is liability. In other words, having information that someone is displaying or using harassing behavior or has done so in the past (and one would presume that behavior would continue), and no action is taken to protect others in the school or work environment, creates liability for the employer or school.

Helping a Victim/Survivor of Harassment

• Because sexual harassment is primarily a violation of civil rights, the criminal justice partners do not play a role. Therefore, unless someone is threatened with physical harm, there is not a role for law enforcement in responding to sexual harassment cases.
Also, not all experiences of harassment result in court action. Anytime a student or employee feels harassed, however, they have the right to bring this to the attention of those in charge of the environment – supervisors, principals, deans, etc. All charges of sexual harassment should be promptly investigated, and the complainant should be guaranteed safety and anonymity.

A victim/survivor can always confront the harasser, and let him/her know that the behavior is unwelcome. It is not required of a victim/survivor to take this step, however; in some instances, a victim/survivor might feel it is unsafe to do so. Conversely, it is the responsibility of the harasser to not harass and of the employer/school to protect others from harassment.

If a victim/survivor feels as though s/he can confront the harasser, it is important to help anticipate the appropriate language and setting. Have the victim think of a safe place and/or time to have this conversation. You may also want to encourage the victim/survivor to have witnesses to the conversation who can attest to what was said. Appropriate responses to a harasser might be:
- I don’t like it when you do “xyz”;
- I don’t find your jokes funny or appropriate;
- I am offended by the kind of stories you tell; or
- Please stop.

A victim/survivor of harassment should also be encouraged to keep a log of incidents. Note time, content, witnesses, etc. in case future action is possible. This will make it much easier to recall the pattern of events for a supervisor, attorney, human resources staff, or other person who is in a position to help.

Victims/survivors should be encouraged to contact an attorney to determine the feasibility of a suit for damages if their attempts to stop the harassment are getting nowhere in the workplace or school environment.

Reinforce for the victim/survivor that s/he is not responsible for the harassment.

Encourage the victim/survivor to seek support counseling – from an advocate or therapist – to deal with the aftermath of harassment. Consider looking for a support group for victims/survivors of sexual harassment.

Refer victims/survivors to the Minnesota Department of Human Rights. They are charged with investigating sexual harassment cases. Their interactive website can help you determine a course of action: [www.humanrights.state.mn.us/interactive/index.html](http://www.humanrights.state.mn.us/interactive/index.html)

Check out the resources on MNCASA’s website on SVJI/Criminal Justice page. There is a fact sheet which outlines the MN law and legal resources.

**Bringing it Home:**

- Have there been stories about public sexual harassment cases in your community? How has the public responded?
- What are the policies and procedures of your public schools? Your colleges and universities? Do you know who the go-to-people are for those institutions?
- Knowing how prevalent sexual harassment is, can people in the group talk about experiences they may have had in school or at work? An incident does not have to have been reported for someone to call it an experience of sexual harassment.
- Do you know victims/survivors of harassment who would be willing to share their stories?
Stalking

The following material has been adapted and modified from the MN State Victim Assistance Academy Manual, with additions by Dani Lindner.

Key Learning Points:

• It is only recent that advocates and the criminal justice system have identified stalking as its own behavior and issue as well as reevaluating the ways in which they respond to victims of stalking.

• Stalking is about making contact with the victim/survivor, not just about keeping surveillance. This is why stalking is such a dangerous crime. A stalker would prefer to have negative contact with the victim/survivor rather than no contact at all.

• Some of the most common acts that victims/survivors experience are receiving unwanted phone calls; receiving unwanted letters or unwanted items; being followed, spied on, or having the perpetrator stand outside their home or place of employment; vandalized property; and killed or threats to kill a pet.

• Approximately 1,000,000 women and 400,000 men are currently being stalked in the U.S. This estimates that approximately 1 in 12 women and 1 in 45 men will be a victim of stalking in their lifetime. 77% of females and 64% of males know their stalker. (Tjaden and Theonnes 1998)

• “All states have enacted anti-stalking laws that make it a crime to willfully, maliciously, and repeatedly harass, follow or cause credible threat to another individual in an attempt to frighten or harm them.”

Stalking behavior has existed since the beginning of human history. Until recently, however, this behavior had never been labeled as a distinct pattern of deviant social behavior — let alone a crime. In fact, it was not until the passage of the first anti-stalking statute in 1990 that such behavior became illegal. Since this event, legislators, criminal justice professionals, and victim service providers have started to examine the nature of and psychological motivations behind stalking behavior. The study of stalking and the development of effective response strategies is a discipline that is continuing to grow. New information, issues, and challenges related to stalking come to light on a daily basis. The rapid evolution of this issue places ever-increasing demands on the field to stay current about how best to assist victims and respond effectively to stalkers.

Statistical Overview

• Data from the National Violence Against Women Survey (NVAWS), a nationally representative telephone survey of 8,000 men and 8,000 women ages eighteen and older, indicate that 2.2 percent of males and 8.1 percent of females report being stalked during their lifetime. The survey defines stalking as a course of conduct directed at a specific person that involves repeated (two or more occasions) visual or physical proximity; nonconsensual communication; verbal, written, or implied threats or a combination thereof that would cause a reasonable person fear. (NCVC, 2006)

• Four out of five stalking victims/survivors are women. By comparison, 94 percent of the stalkers identified by female victims and 60 percent of the stalkers identified by male victims/survivors were male. (Violence Against Women Grants Office, July 1998, 10)
• With respect to stranger and acquaintance stalking, 1.8 percent of all U.S. women, compared with 0.8 percent of all U.S. men, have been stalked by strangers; and 1.6 percent of all U.S. women, compared with 0.8 percent of all U.S. men, have been stalked by acquaintances. (Ibid., 12)

• Based on comparisons between estimated numbers of stalkers per total U.S. population, and numbers of cyber-stalkers per online population, it is estimated that there are 63,000 Internet stalkers cruising the information superhighway, stalking an estimated 474,000 targets. (Cyberangels, 2000)

Though the term "stalking" is somewhat new to the modern lexicon, the behavior itself is not new to human experience. The conduct generally associated with stalking — following, spying, unwanted calling/writing, accosting, harassing, and threatening — is as old as the history of human relationships. Yet, it has only been within the last decade that we have recognized such behavior as socially deviant — even criminal. Criminal justice and victim service professionals have always had to face such behavior, but they only began to think about and address it as a separate issue when the conduct was distinguished as a unique phenomenon, deserving its own name — stalking.

The process of distinguishing stalking from other deviant social or criminal behavior reached a defining moment in 1990 when the state of California passed the first statute that made stalking a crime. This was a watershed event that triggered similar statutes in other states and at the federal level. The enactment of the California statute resulted in a growing awareness of stalking among criminal justice officials, victim service professionals, and the general public — all of whom began to view the problem in a more serious light.

Following the enactment of the California law and other anti-stalking statutes, criminologists and forensic psychologists began to study the nature of stalking behavior and the motivation of stalkers. Law enforcement, previously lacking the power and authority to take any action in such cases, began to develop specialized response strategies for stalking cases. Some jurisdictions even created special units to take on a more pro-active role in stalking cases. Prosecutors embarked on an effort to educate themselves and one another about how stalkers could be charged under stalking statutes (as well as other criminal laws) and how to best prosecute such cases. Victim service providers began to reexamine the way in which they responded to stalking, expanding their services and enhancing case management strategies in an effort to better serve the needs of victims. Even victims of stalking have come to identify themselves as a distinct and unique constituency by forming support groups to help one another cope with the aftermath of the crimes committed against them.

The rapidly growing interest in stalking is spawning a new area of "specialization" among professionals whose roles regularly involve them in such cases. Yet, even the most experienced among such professionals would readily admit that they are just beginning to understand the complex problems that stalking poses for both victims and society-at-large. Most of these professionals agree that solutions to the problem of stalking are not likely to be found without a considerable amount of additional research.

Definition of Stalking

Traditionally, the general perceptions of stalking involve some dark and malicious character following and even spying on an unsuspecting person. This stereotypical view is far too narrow to encompass all the behaviors generally attributed to stalkers today, however. Stalkers may indeed follow their targets physically but they are just as likely to use a variety of other means to monitor the activities of their targets. Stalkers have been known to use binoculars, telescopes, cameras equipped with long lenses, video cameras, hidden microphones, the Internet, public records and accomplices (both witting and unwitting) to keep track of the whereabouts and activities of those they target.

Stalking is less about surveillance of victims than it is about contact with them. If stalkers only wished to view the objects of their obsession from afar, they would not pose a serious safety risk. Most stalkers, by their very nature, want more. They want contact. They want a
relationship with their victims. They want to be part of their victims’ lives. And, if they cannot be
a positive part of their victims’ lives, they will settle for a negative connection to their victims. It
is this mindset that not only makes them stalkers, but also makes them dangerous. Thus,
virtually all stalking cases involve behavior that seeks to make either direct or indirect contact
with the victim/survivor. A 1998 National Institute of Justice (NIJ) survey of stalking victims/
survivors provided the first glimpse into the kinds of tactics stalkers most often employ in the
commission of their crimes.

What follows is a breakdown by percentage of some of the tactics that victims report stalkers
using (Tjaden and Theonnes 1998):

- 82 percent followed, spied on, and/or stood outside home or place of work;
- 61 percent made unwanted phone calls;
- 30 percent sent unwanted letters or left unwanted items;
- 30 percent vandalized property; and
- 9 percent killed or threatened to kill a pet.

While most of these behaviors alone may not in and of themselves explicitly communicate a
threat, the number, nature, and context in which they occur may well communicate an implied
threat. It is this element of threat to the safety of another that makes the conduct a crime, and
most legal definitions of stalking specifically address the presence of an element of threat.

How prevalent is stalking? Until very recently, no empirical evidence was available to answer
this question. The most commonly quoted estimate had been that approximately 200,000
individuals are stalked each year in the U.S. The 1998 NIJ study first attempted to quantify the
number of stalking cases. Based on a survey of more than 16,000 adults, the study estimated
that 1.4 million Americans (approximately 1,000,000 women and 400,000 men) are currently
being stalked in the U.S. — a number seven times greater than the previous estimate of
200,000 (Tjaden and Theonnes 1998). This study estimates that approximately 1 in 12
women and 1 in 45 men will be a victim of stalking in their lifetime.

The violence against women movement has chosen to take on this issue by demonstrating the
connections between stalking, domestic violence, and sexual assault within the context of an
intimate relationship. Mullen et al. (2001) states that: “Opportunistically, and wisely, the word
stalking was harnessed by the domestic violence lobby in the USA to describe the persistent
pursuit of women by their ex-partners.” They go on to explain how the first laws were enacted
because of “star stalkers” but that more recent legislation has taken on a new form and looks
at stalking as an extension of domestic violence. Many suggest that this is a move in the right
direction because the majority of stalking cases are committed by someone known to the
victim. For women, many of their stalkers are current or former intimate partners. It is vitally
important to note, however, that this does not include all stalking victims.

The NIJ study reported that 57 percent of female victims/survivors will be stalked by a current or
former intimate partner. To make it even more compelling, they found that 81 percent of
women who were stalked by a current or former intimate partner reported that they had also
been physically assaulted by that partner, and 31 percent had also been sexually assaulted by
that partner. There is an obvious link here; one that deserve a great deal more attention.

To illustrate the seriousness of the crime of stalking, McFarlane et al. (1999) reported that 76
percent of intimate partner femicide victims had been stalked by the person who killed them.
They also found that 54 percent of intimate partner femicide victims had reported the stalking
to the police before they were killed by their stalkers. Stalking is a dangerous crime with
potential lethality which needs to be taken very seriously.

Stalking Statutes

While stalking statutes in each state vary considerably, most include language which defines
stalking as:

Any person who engages in a course of conduct directed at a specific person that places that person, or their family, in reasonable fear for their safety, is guilty of the crime of stalking (NIJ 1993).

In the state of Minnesota, the stalking and harassment statute is § 609.749, which was amended 2006, and can be found at www.leg.state.mn.us.

Service providers need to keep in mind that stalking victims/survivors may have the option of turning to the federal system for prosecution if their case falls within jurisdictional guidelines (i.e., if the offense occurs on a military base, involves crossing a state line, etc.). In addition to the anti-stalking provision of the Domestic Violence and Stalking Act (18 U.S.C. §§ 2261-2265), the statute also includes provisions related to the violation of protective orders. Crimes in violation of either provision may provide victims with the means to pursue prosecution in federal court — particularly when the stalker is a former spouse or domestic partner. The Federal Obscene or Harassing Telephone Calls statute (47 U.S.C. § 223) may also prove useful in stalking cases where the perpetrator uses the phone to stalk and harass his or her victim. Having the option of pursuing a case in federal court may prove critical to many victims. In cases where local authorities refuse to prosecute, or when the local authorities are the perpetrators, federal prosecution may be a victim's only option.

As of summer 2006, the majority of states had included electronic forms of communication within their harassment or stalking laws. In 2005, Minnesota revised the criminal code for harassment and stalking because of the enhanced use of technology in stalking cases.

Characteristics of Stalkers and Their Victims

Demographics of the Stalker

The demographics related to stalkers are both broad and diverse. As empirical evidence now shows, virtually anyone can be a stalker. Stalkers come from all walks of life and socioeconomic backgrounds. Despite their demographic diversity, data from the NIJ study shows that some characteristics are more common among stalkers than others.

- 87 percent are male;
- 80 percent are white;
- 50 percent are between the ages of 18 to 35;
- Most are of above average intelligence; and
- Most earn above-average income.

According to the RECON Typology of Stalking study released in 2006, 46 percent of stalkers had a mental health diagnosis at the time of their stalking, while 30 percent had none. Though almost half have a diagnosis, it’s important to avoid using this as a justification for their behavior. Stalkers are making the choice to engage in their behavior and stalk their victim regardless of their diagnosis.

Demographics of Stalking Victims

Just as anyone can be a stalker, virtually anyone can be a stalking victim. The characteristics of stalking victims typically cut across all demographic boundaries. But again, some characteristics are more common than others among stalking victims (Tjaden and Theonnes 1998):

- Seventy-eight percent are women;
- Eighty-three percent are white;

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• Seventy-four percent are between the ages of 18 to 39;
• Fifty-nine percent are married;
• Thirty-five percent have high school diplomas; and
• Forty-six percent graduated from college.

Relationship Between Stalkers and Their Victims

As mentioned earlier, stalking is most often about "relationships" — prior, desired, or imagined. Therefore, it is critical to know about any prior relationship between the victim/survivor and the offender. The NIJ study indicates that the clear majority of stalkers and their victims (60 percent) had a personal relationship before the stalking began. The majority of these cases (42 percent) involved spouses or partners, and another 14 percent had a dating relationship. In more than 4 percent of these cases, the stalker and the victim/survivor were actually related to one another. Nearly 18 percent of stalkers were acquaintances or co-workers of the victim/survivor, while only 22 percent were complete strangers (Tjaden and Theonnes 1998).

Nevertheless, the relationships between victims and offenders often follow broad, distinct patterns, allowing forensic psychologists to use the relationship between stalkers and victims as a means of categorizing stalking behavior and stalking cases. Still, it is important to keep in mind that some cases do not follow any pattern and may shift between categories as they evolve. Thus, these categories are only useful as broad guidelines to aid in the discussion and analysis of stalking as an emerging category of crime.

Categories of Stalking

As mentioned, forensic psychologists have begun to study stalking as a distinct pattern of criminal behavior by analyzing and categorizing identified patterns, and common characteristics of stalking cases. Chief among these characteristics is the relationship between the stalker and the victim. There have been many attempts to “classify” stalkers and their behavior. The most widely used classifications include: Simple Obsession, Love Obsession, and Erotomania. Recent developments, however, seem to indicate the need for a fourth category which could be termed “vengeance” or “terrorist” stalkers. In addition to these four categories, cyberstalking has evolved because of the array of cyber technologies that are used.

Simple Obsession Stalking

This category represents 60 percent of all stalking cases, including all cases arising from previous personal relationships (i.e., those between husbands/wives, girlfriends/boyfriends, domestic partners, etc.) Many simple obsession cases are actually extensions of a previous pattern of domestic violence and psychological abuse. The only difference is that the abuse occurs in different surroundings and through slightly altered tactics of intimidation. Thus, the dynamics of power and control that underlie most domestic violence cases are often mirrored in simple obsession stalking cases.

Stalking behaviors observed in many domestic violence cases are motivated by the stalker’s lack of self-esteem and feelings of powerlessness. Indeed, abuser/stalkers attempt to raise their own self-esteem by demeaning and demoralizing those around them. In most cases, they target their former intimate partners. The exercise of power and control over their victims gives stalkers a sense of power and self-esteem they otherwise lack. In this way, the victim not only becomes the stalker's source of self-esteem but also becomes the sole source of the stalker's identity. Thus, when victims attempt to remove themselves from such controlling situations, stalkers often feel their power and self-worth have been taken from them. In such cases, stalkers will often take drastic steps to restore personal self-esteem. It is when stalkers reach this
desperate level that they may feel they have "nothing to lose" and become most volatile. This
dynamic makes simple obsession stalkers dangerous, as individuals and as a group.

Simple obsession is the most likely category of stalking to result in murder. Thirty percent of all
female homicides were committed by intimate partners. Domestic violence victims run a 75
percent higher risk of being murdered by their partners. "If I can't have you, nobody will," has
become all too common a refrain in cases that escalate to violence. Many of these cases end
with the murder of the victim followed by the suicide of the stalker.

Love Obsession stalking

In this category, stalkers and victims are casual acquaintances (neighbors, co-workers) or even
complete strangers (fan/celebrity). Primarily, stalkers in this category seek to establish a
personal relationship with the object of their obsession — contrary to the wishes of their victims.
Love obsession stalkers tend to have low self-esteem, and often target victims who they
perceive to have exceptional qualities and high social standing. These stalkers seek to raise
their own self-esteem by associating with those whom they hold in high regard.

Love obsession stalkers become so focused on establishing a personal relationship with their
victims that they often invent detailed fantasies of a nonexistent relationship. They literally script
the relationship as if it were a stage play. When victims choose not to participate in the stalker's
imagined passion-play, however, the stalker may try to force victims into assigned roles. Often,
love obsession stalkers are so desperate to establish a relationship — any relationship — that
they settle for negative relationships, explaining why some stalkers are willing to engage in
destructive or violent behavior in an irrational attempt to "win the love" (more likely the
attention) of their victims. Such obsessive reasoning might explain why John Hinkley believed
he would win the heart of Jodi Foster by shooting President Ronald Reagan. It might also
explain why a man who proclaimed himself to be John Lennon's "biggest fan" shot him dead on
the sidewalk outside of his home.

While cases of "star stalking" often receive the most media attention, a greater number of love
obsession stalkers develop fixations on "average" people — non-celebrities. In one particularly
tragic case, a young computer engineer developed a fixation on a new female co-worker, Laura
Black. What began as seemingly friendly, even charming gestures on his part soon became
excessive and threatening. Shortly after he had been fired for the relentless harassment of Ms.
Black, he returned to the workplace and literally shot his way through the building. He killed
several employees and wounded many more, including Ms. Black. A search of the stalker's
home uncovered a scrapbook full of doctored pictures of himself and his victim on a ski trip
that never took place. This fantasy ski trip was part of a scripted relationship he wanted to
make a reality.

Erotomania Stalking

Unlike "simple" and "love" obsession stalkers who seek to establish or reestablish personal
relationships with their victim, erotomaniacs delude themselves into believing that such a
relationship already exists between themselves and the objects of their obsession.

Though relatively rare (comprising fewer than 10 percent of all cases), erotomania stalking
cases often draw public attention because the target is sometimes a public figure or celebrity.
Like love obsession stalkers, erotomaniacs attempt to garner self-esteem and status by
associating themselves with well-known individuals who hold high social status. Erotomaniacs
seek fame and self-worth by basking in the celebrity of others. While the behavior of many
erotomaniacs never escalates to violence, or even to threats of violence, the irrationality that
accompanies their mental illness presents particularly unpredictable threats to victims.

Perhaps the best-known case of erotomania stalking involved a series of incidents perpetrated
against the popular late night talk show host, David Letterman. This woman, first found hiding in Mr. Letterman’s closet, believed she was his wife. On numerous other occasions she was caught trespassing on his property. With her young son in tow, she once scaled the six foot wall surrounding Letterman’s property. On another occasion, she was arrested while driving Letterman’s stolen car. When questioned by police, she confidently stated that her husband was out of town and that she was going grocery shopping so she would have dinner ready for him upon his return. Despite the treatment she received during her many involuntary stays at a mental health center, she eventually took her own life.

Vengeance/Terrorism Stalking

The final stalking category is fundamentally different from the other three. Vengeance/terrorist stalkers do not seek a personal relationship with their targets. Rather, vengeance/terrorist stalkers attempt to elicit a particular response or a change of behavior from their victims. When vengeance is their prime motive, stalkers seek only to punish their victims for some wrong they perceive the victim has visited upon them. In other words, they use stalking as a means to ‘get even’ with their enemies.

One common scenario in this category involves employees who stalk employers after being fired from their job. Invariably, the employee believes that their dismissal was unjustified and that their employer or supervisor was responsible for unjust treatment. One bizarre variation on this pattern is the case of a scout master who was dismissed for inappropriate conduct and subsequently decided to stalk his entire former scout troop — scouts and scout leaders alike.

Law enforcement officers, judges, prosecutors, and defense attorneys are also possible targets of vengeance/terrorist stalkers. The stalker may be angry with them for a decision that was made, and may in turn stalk them as a way to get even.

Another type of vengeance or terrorist stalker, the political stalker, has motivations that parallel those of more traditional terrorists. That is, stalking is a weapon of terror used to accomplish a political agenda by utilizing the threat of violence to force the stalking target to engage in or refrain from engaging in particular activity. For example, most prosecutions in this stalking category have been against anti-abortionists who stalk doctors in an attempt to discourage the performance of abortions.

Cyberstalking

Stalking has now taken a turn into cyberspace on the information superhighway. Although there is no universally accepted definition of cyberstalking, the term is generally used to refer to the use of the Internet, e-mail, or other telecommunication technologies to harass or stalk another person. Essentially, cyberstalking is an extension of the physical form of stalking. Most state and federal stalking laws require that the stalker make a direct threat of violence against the victim, while some require only that the alleged stalker’s course of conduct constitute an implied threat. Although some cyberstalking conduct involving annoying or menacing behavior might fall short of illegal stalking under current laws, such behavior may be a prelude to real-life stalking and violence and should be treated seriously. Cyberstalking has the potential to move from a URL address to an IRL (in real life) address — from virtual to actual (Gregorie 2000).

In Cyberstalking: A New Challenge for Law Enforcement and Industry — A Report from the U.S. Attorney General to the Vice President (1999), cyberstalking is identified as a growing problem. According to the report, there are currently more than 80 million adults and 10 million children with access to the Internet in the United States. Assuming the proportion of cyberstalking victims is even a fraction of the proportion of persons who have been the victims of offline stalking within the preceding twelve months, the report estimates there may be
potentially tens or even hundreds of thousands of cyberstalking victims in the United States (Gregorie 2000).

Cyberstalking Techniques

Cyberstalkers use a variety of techniques. They may initially use the Internet to identify and track their victims. They may send unsolicited e-mail, including hate, obscene, or threatening mail. Live chat harassment abuses the victim directly or through electronic sabotage (for example, flooding the Internet chat channel to disrupt the victim's conversation). With newsgroups, the cyberstalker can create postings about the victim or start rumors which spread through the bulletin board system.

Cyberstalkers may also set up a Web page(s) on the victim with personal or fictitious information or solicitations to readers. Another technique is to assume the victim's persona online, such as in chat rooms, for the purpose of sullying the victim's reputation, posting details about the victim, or soliciting unwanted contacts from others. More complex forms of harassment include mailbombs (mass messages that virtually shutdown the victim's e-mail system by clogging it), sending the victim computer viruses, or sending electronic junk mail (spamming). There is a clear difference between the annoyance of unsolicited e-mail and online harassment. Cyberstalking, however, is a course of conduct that takes place over a period of time and involves repeated, deliberate attempts to cause distress to the victim.

Recommended Actions for Cyberstalking

In many cases, existing laws may cover the unlawful conduct at issue, but the use of the Internet is presenting numerous investigatory challenges with regard to jurisdiction, anonymity and constitutionally-protected free speech that should be addressed. To address the investigation, prosecution and prevention of cyberstalking, Attorney General Janet Reno (1999) made the following recommendations on cyberstalking:

• States should review their laws to determine whether they address cyberstalking and if not, promptly expand laws to include these behaviors.
• Federal law should be amended to prohibit the transmission of any communication in interstate or foreign commerce with intent to threaten or harass another person where such communication places that person in reasonable fear of death or bodily injury.
• Law enforcement agencies need training on the extent of cyberstalking and appropriate investigative techniques.
• The Internet industry should create an industry-supported Web site containing information about cyberstalking and what to do if confronted with the problem.

Impact of Stalking

There is little doubt that stalking has a tremendous impact on the lives of those who are targeted. Indeed, many victim service professionals contend that the threat of violence inherent in stalking cases can take a higher toll on its victims than those who have been victims of completed acts of violence. The following are signs of stalking-related stress:

• Loss of sleep;
• Weight loss;
• Depression;
• Anxiety; and/or
• Difficulty concentrating.

The 1998 NIJ study indicated that 30 percent of women and 20 percent of men in stalking
cases sought psychological counseling as a result of the victimization (Tjaden and Theonnes 1998). Moreover, many victims experience a loss of personal support systems at the very moment they need them most. Stalking victims often turn to family, friends, and co-workers for help, guidance, and emotional support. Given the intractability of many stalking cases, however, victims often find that their friends, co-workers, neighbors, and even their family members are unable to sustain levels of long-term support.

Additionally, the economic security of stalking victims may be shattered as a result of their victimization. The NIJ study provides an empirical perspective indicating that 25 percent of stalking victims lost time from work as a result of being targeted, and another 7 percent said that they were unable to return to work altogether. In some more egregious cases, victims have been fired by unsympathetic employers unwilling to accommodate special needs of victim employees.

Most stalking behavior has to do with power and control and is similar to intimate partner violence. As the Stalking and Domestic Violence Report to Congress (2001) states: “Stalkers employ various acts of terrorism over a period of weeks, months, years, or even decades, which has the cumulative effect of eroding victims’ self-confidence and sense of control over their lives.” In addition to this, the stress-related symptoms of stalking are very similar to that of domestic violence (Mullen et al., 2001).

Response Strategies

Each stalker is different just as every stalking case is different, and it is virtually impossible to construct a single strategy that is an appropriate response in all stalking cases. Response strategies must be tailored to fit the unique circumstances surrounding each case.

Given the complexities involved, most victims/survivors are unlikely to have the experience and knowledge to craft an effective response strategy without assistance. Victims/survivors’ strategic planning is better accomplished with the advice and active support of victim service professionals who have extensive experience in the management of stalking cases. For this reason, the best advice anyone could offer a stalking victim is to seek the assistance of victim/survivor service professionals at the earliest point possible.

A qualified service professional will first consult with the victim/survivor on risk-assessment. Based on the assessment, victims/survivors and service professionals will next jointly develop a safety plan or overall response strategy that will best serve victims’ interests. Often, victims/survivors are the best judges of the threat and the likely reaction that stalkers may have to any conceived strategy. No matter how carefully an initial plan is thought out, victims/survivors and advocates must be willing to alter the plan as circumstances warrant. The approach that may make the most sense upon first inspection may prove ineffective or even counterproductive when tested against real-life circumstances. Thus, both victims/survivors and their service providers — in conjunction with other allied professionals — must be willing to revisit and adjust their strategies and plans as events evolve. This dynamic partnership has proved to be most effective.

While each case is unique and must be addressed with a unique set of strategies, the vast array of options may appear daunting to the victim/survivor. Skilled service providers, however, can help victims/survivors find their way through the buffet of options so that victims/survivors can piece together response strategies.

What follows is a list of these strategies for stalking victims/survivors as developed by the National Center for Victims of Crime. Although this list is not intended to be comprehensive, the strategies are representative of alternatives that victims/survivors and service providers may want to consider when developing response plans.
Victims in Imminent Danger

The primary goal of victims in imminent danger should be to locate a safe place for themselves. Safety for stalking victims can often be found in the following places:

- Police stations;
- Residence of family/friend (if location is unknown to stalker);
- Domestic violence shelters/churches; and
- Public areas (stalkers may be less inclined toward violence or creating a disturbance in public places).

If departure from the current location is not possible and a telephone is accessible, a victim may contact local law enforcement via 911. Upon reaching safety, a victim may want to communicate with local law enforcement, victim services, mental health professionals, and/or social services in order to receive additional assistance and referrals.

Victims in Continual Danger, but No Imminent Threat

Some victims may not be in immediate danger, but they may assess the probability of impending danger. If stalking victims determine that they are at risk of being in a potentially harmful or violent situation, they may consider the following:

Restraining/Protective/Stay-Away Orders

Generally, these orders require the offender to stay away from and not interfere with the complainant. If violated, stalkers may be punishable by incarceration, a fine, or both. Unfortunately, restraining orders are not foolproof. They are not always complied with by stalkers or enforced by law enforcement officials or others in the criminal justice system. Therefore, victims should be cautioned against developing a false sense of security based on the issuance of a protective order. Orders are not assured — they are at the discretion of the sitting judge.

Anti-Stalking Laws

All states have enacted anti-stalking laws that make it a crime to willfully, maliciously and repeatedly harass, follow, or cause credible threat to another individual in an attempt to frighten or harm them.

Victims may call or visit their local prosecutor’s office to inquire about the state laws, municipal laws, and their applicability to specific cases. Stalking statutes are also available at www.leg.state.mn.us.

Other Illegal Acts

Victims may determine that the stalker has broken a law other than the applicable state stalking law if the stalker has entered the victim's household without permission, stolen, and/or destroyed the victim's property, physically and/or sexually assaulted the victim, etc.

Notifying the police of any of the above illegal acts may be important for the following reasons:

- If convicted, the stalker may be incarcerated and/or, if probable cause is shown at a hearing prior to conviction, ordered to stay away from the victim. The latter may be
ordered by a judge if:

- Charges may intimidate the offender, sending the message that his or her actions are illegal and will not be tolerated.
- Notification to the police produces documentation that may be useful in a future complaint for evidentiary or credibility purposes.

Documentation/Evidence Collection

- Documentation of stalking should be saved and given to law enforcement.
- Documentation of the stalkers’ actions may be useful in future complaints or proceedings for evidentiary or credibility purposes.
- Documentation may take the form of photos of destroyed property/vandalism or any injury inflicted on the victim by the stalker; answering machine messages saved on tape; letters or notes written by the stalker; affidavits from witnesses; and other materials.
- Document all behaviors in a log or notebook and carry it all of the time.
- All documentation and evidence collected should be kept in a safe place to prevent theft by the stalker.

Local Victim Advocate/Crisis Counselor

Assistance may be obtained from the following sources:

- Domestic violence shelters/counselors;
- Rape crisis counselors;
- Victim advocates in district attorney's/prosecutor's offices; and
- Local law enforcement.

Crisis counselors may either give a referral telephone number to a victim, or offer to make an initial call and have a service professional from the referral organization contact the victim.

When no appropriate referral is available in the victim’s vicinity, law enforcement agencies should be contacted.

Preventive Measures

- Install dead bolts. If a victim cannot account for all keys, change locks and secure spare keys;
- If possible, install adequate outside lighting;
- Maintain an unlisted telephone number. If harassing phone calls persist, notify law enforcement;
- Treat any threats as legitimate, and inform law enforcement;
- Vary routes taken, and limit time spent walking;
- Inform a trusted neighbor (and colleagues) regarding situation. Provide neighbors with a photo or description of the suspect and any possible vehicles he or she may drive. Allow them to serve as your “early warning,” which will buy you time to escape should the stalker appear;
- If residing in an apartment with an on-site manager, provide the manager with a picture of the suspect;
- Have co-workers screen calls and visitors; and

As an advocate you need to be knowledgeable about the options that are available for victims/survivors that have been or are being stalked. This will be important to keep in mind when creating safety plans with your clients.
• When out, stay in public areas, and try not to travel alone.

**Contingency Plans**

When victims are not in imminent danger, they still could be at risk at any time. For this reason, a contingency plan may be appropriate. Victims should consider:

Having quick access to critical telephone numbers and locations of:

- Law enforcement agencies;
- Safe places (friends, domestic violence shelters, etc.); and
- Individuals to be contacted after safety is secured (family, neighbors, friends, employers, attorneys, prosecutors, pet care, etc.).

Keeping a reserve of necessities that is easily accessible:

- A packed suitcase in the car, or at another ready location for quick departure. Include a toy, book and any special belongings for children;
- Money;
- Other necessary items such as bank and credit card information, creditors' numbers, medical insurance and birth certificates, as well as personal welfare items including medications; and
- A ready means of transportation (keep gas in the car, have money for a taxi, etc.) and back-up keys for neighbors.

Alerting the following critical people of the situation and potential crisis:

- Law enforcement;
- Victim Service Providers;
- Employers;
- Family/friends/neighbors; and/or
- Security personnel.

**Conclusion**

Stalking is one of the most difficult issues facing criminal justice officials and victim service professionals. Studies now show that stalking is far more common than previously estimated and its consequences to victims more profound than imagined. The demographics of stalkers and their victims are as diverse as the entire population. The complexity of stalking behavior and the motivations behind such crimes make it a problem as difficult to comprehend as it is to solve. Professionals in the fields of criminology, psychology, and victimology are just beginning to develop response strategies based on their initial study of experience with stalkers and stalking behavior. Only a comprehensive and coordinated response of committed individuals and institutions — both inside and outside the criminal justice system — will likely succeed in stemming the fear, violence, and death that stalking inflicts on millions of victims each year.

**Online Resources**

[www.aardvarc.org](http://www.aardvarc.org) – AARDVARC is An Abuse, Rape and Domestic Violence Aid and Resource Collection Web site designed to:

- Support stalking victims;
- Explain the parameters of the crime;
- Address issues that constitutes stalking;
- Define who is a victim;
- Explain what to do if one is stalked; and
- Explain how to exercise one's legal rights.

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The site also provides links to the stalking laws in all fifty states and research materials focusing on stalking.

www.cyberangels.org – Cyberangels has been in existence since 1995, and is considered the largest Internet safety and education program for parents and children. Cyberangels has Net Patrol teams that regularly monitor the Internet for child crimes, cyberstalkers, and fraudulent scams and report them to law enforcement authorities. The Web site provides support groups for victims of stalking and harassment over the Internet and gives tips on how to document and report cyberstalking. Cyberangels also provides additional site links and reviews and recommends blocking/filtering software.

www.ncvc.org – The National Center for Victims of Crime has a Stalking Resource Center with a multitude of resources, including research, myths and fact sheets, statistics, and safety planning resources.

References


Indecent Exposure
By Steve Sawyer, LICSW, CGP, Project Pathfinder Executive Director with Dresden Jones, MNCASA

Key Learning Points:

- Indecent exposure is a form of sexual violence.
- Victims/survivors of indecent exposure can experience the same short- and long-term effects as victims/survivors of other sexual violence.
- Indecent exposure can happen in several different ways.
- Exposers come from all different backgrounds and environments.
- An exposer may have a long history of exposing or it may be an isolated incident.

Indecent exposure or “flashing” is a sexual crime, may also be a formal sexual disorder, and is a form of sexual violence. Indecent exposure is defined as the exposing of sexual body parts to another person, usually a stranger, when it is unwanted and not asked for. The definition does not include unwanted touching or sexual contact, but indecent exposure is most often still frightening and confusing for victims/survivors who experience it.

Indecent exposure can occur in several circumstances: an exposer may expose her/himself to an unwilling and unsuspecting individual in a public location or may lure her/his victim/survivor to a private place. Exposers may know their victims/survivors but typically do not. In some instances exposing can be a part of a cycle of sexual abuse or part of stalking behavior. Exposers generally expose to multiple victims/survivors and may continue to do so until they are caught by law enforcement or seek treatment. An exposer may expose himself to his victim/survivor quickly, or he may expose himself and masturbate. Exposers are almost always male. There are a range of types or patterns: some exposers are under emotional or life stress, and commit the crime only once. Others have a psychiatric disorder or mental illness, and expose themselves many times and follow a similar pattern – typically exposing to strangers, typically to women, and typically in public places. Some have a sexual disorder and have exposed themselves to hundreds of people over many years. Some expose to adults and children. Some expose a part of a more complex criminal or anti-social pattern. Some can be successfully treated with therapy that may include prescribed medication. Those with long histories of exposing are among the most difficult to rehabilitate.

Victims/survivors of indecent exposure are often left stunned, scared and confused. Victims/survivors may feel that they are “overreacting” or should not come forward to seek support or report the crime because the perpetrator never physically touched them. Victims/survivors may feel that

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they have experienced a “lesser form” of sexual violence and that they should “get over it.” Victims/survivors of indecent exposure can experience the same reactions and feelings as any other victim/survivor of sexual violence, however: depression, self blame, flashbacks, nightmares, difficulty concentrating, etc. Long-term effects can include drug and alcohol abuse, self injury, eating disorders, etc. Victims/survivors of indecent exposure should be treated as any other victim/survivor of sexual violence; they need support, resources and referrals and assistance if they wish to report the crime to law enforcement.

References Used:
George Mason University Sexual Assault Services: www.gmu.edu
Child Sexual Abuse
Compiled by Tracy Sheeley, MNCASA
Additions and revisions by Alicia B. Nichols, LSW

Key Learning Points:
• Child sexual abuse is the exploitation or victimization of a child by an adult, adolescent, or older child. By definition, any sexual contact with a child is illegal. Incest is a form of sexual abuse that is committed by one family member against another and most often the victims/survivors of incest experience the sexual violence as a child.
• Approximately 85 percent of children who are sexually abused are abused by someone they know and trust.
• Many times, child sexual abuse is not violent but occurs through coerciveness or manipulation. This can leave children feeling afraid that, if they disclose the abuse, no one will believe them or that they will be blamed and even punished for the abuse. Children are not responsible for the abuse!
• Healthy sexuality is something that needs to be discussed with children in order for them to learn healthy boundaries and to know that it is okay to talk about sex.
• The myths about child sexual abuse will only deter society from learning how to prevent sexual violence against children and to intervene only when it has already happened.

Child sexual abuse is the sexual exploitation or victimization of a child by an adult, adolescent, or older child. These acts can include: fondling of the genitals or breasts; oral, vaginal, or anal intercourse (penetration by genitals or by an object); exposing sexual parts of the body; and/or sexual behaviors that do not include touching (e.g., peeping, flashing, or showing pornography to a child). When these acts occur within the immediate family, the sexual abuse is called incest.

Children are most commonly sexually abused by someone they know. This may be a single occurrence. More likely, however, the abuse will continue over a period of time. When repeated abuse occurs, the child is often promised special favors, told that it is education, given special attention, or has been threatened by the abuser. Eventually the continued abuse may lead to full sexual intercourse. The child continues to participate out of guilt, confusion, or fear that something terrible will happen if someone finds out.

The vast majority of child sexual abusers are teenage or adult males. Most are heterosexual men, many with children of their own. Abusers come from all socioeconomic levels, religions, and ethnic backgrounds.

Children who are sexually abused are:
• Usually not violently abused, but are coerced and manipulated;
• Usually molested by someone they know and may trust;
• Usually afraid to tell because of fear they will be blamed, punished, or not believed; and
• Not responsible for their abuse.

In 2000, the U.S. Department of Health and Human Services estimated that there are 60 million survivors of childhood sexual abuse in America.
Myths and Facts About Child Sexual Abuse

Myth: Child sexual abuse occurs only among strangers. If children stay away from strangers, they will not be sexually abused.

Fact: National statistics indicate that in approximately 85 percent of the cases, the offender is known to the victim. He/she is usually a relative, family friend, babysitter, or older friend of the child.

Myth: Children provoke sexual abuse by their seductive behavior.

Fact: Seductive behavior is not the cause. Responsibility for the act lies with the offender. Sexual abuse sexually exploits a child not developmentally-capable of understanding or resisting, and/or who may be psychologically or socially dependent on the offender.

Myth: The majority of child sexual abuse victims tell someone about the abuse.

Fact: According to a study by Dr. David Finkelhor, close to 2/3 of all child sexual abuse victims may not tell their parents or anyone else because they fear being blamed, punished, or not believed.

Myth: Men and women sexually abuse children equally.

Fact: Men are the offenders 94 percent of the time in cases of child sexual abuse. Men sexually abuse both male and female children. 75 percent of male offenders are married or have consenting sexual relationships. Only about 4 percent of same-sex abuse involves homosexual perpetrators; 96 percent of the perpetrators are heterosexual.

Myth: If the children did not want it, they could say, "Stop."

Fact: Children generally do not question the behavior of adults and have been taught to obey adults. They are often coerced by bribes, threats, and abuse of a position of authority.

Myth: All sexual abuse victims are girls.

Fact: Studies on child sexual abuse indicate that one in four females under the age of 18 and one in six to eight males under the age of 18 are child sexual abuse victims.

Myth: Family sexual abuse is an isolated, one time incident.

Fact: Studies indicate that most child sexual abuse continues for at least two years before it is reported. And, in most cases, it doesn't stop until it's reported.

You can help those in your community understand the dynamics of child sexual abuse while also educating on the facts and the myths.
**Myth:** In family sexual abuse, the "non-offending" parent always knows.

**Fact:** While some "non-offending" parents know and even support the offender's actions, many, because of their lack of awareness, may suspect something is wrong, but are unclear as to what it is or what to do. Also, the “non-offending” parent may be experiencing domestic and/or sexual abuse by the same offender.

**Myth:** Family sexual abuse happens only in low income families.

**Fact:** Family sexual abuse crosses all socioeconomic boundaries. There is no race, social, or economic class that is immune to family sexual abuse. Incest is estimated to occur in 14 percent of all families. 10 to 20 percent of American children are incest victims; 90 percent of the victims are female, and 90 percent of the abusers are fathers or stepfathers.

**Myth:** Non-violent sexual behavior between a child and an adult is not damaging to the child.

**Fact:** Nearly all victims will experience confusion, shame, guilt, anger, and a poor self-image.

**Guidelines for talking with child victims**
By Cordelia Anderson

- Support the child for talking.
- Ask the child what she/he wants.
- Identify the fears the child has.
- Assist the child in talking.
- Be honest about reporting requirements.
- Assure the child that what happened is not the child's fault.
- Affirm whatever confused love/hate feelings the child is having. Let the child know these feelings are okay.
- Do not blame the offender.
- Do not make promises; do not say this or that will happen.
- Avoid allowing yourself to be caught in keeping the child's secret.
- Use anatomically correct dolls to help a young child explain what happened, or have a child draw pictures to help explain what happened.
- Explain your reactions.
- Don't ask leading questions.
- Make your terms age-appropriate. Instead of asking, "Have you been raped?" ask "Have you been tricked into a touch that felt wrong or funny? What happened?"
- At the end of a session or contact, ask the child what they want you to do.
- Offer to stay with the child through the process or connect them with advocates who can.
- Identify and know your resources —community services, protective agencies, literature, media, counselors, etc.
- Have support for yourself.
Tips for Parents or Anyone Who Thinks a Child has Been Abused

• Believe the child. Children rarely lie about sexual abuse.
• Commend the child for telling you about the experience. Let the child know that she/he should tell you if it happens again.
• Convey your support for the child. A child's greatest fear is that she/he is at fault and responsible for the abuse. It is crucial to let them know it was not their fault.
• Don't assume you know what the child is feeling.
• Understand your own feelings regarding the matter. Temper your own reaction, recognizing that your perspective and acceptance are critical signals to the child. Your greatest challenge may be to not convey your own horror about the abuse.
• Do not pressure the child to talk about the incident, but provide opportunities to talk.

Signs of Sexual Abuse or Sexual Assault

The following are meant to be preliminary warning signals and do not automatically and/or necessarily mean that a child has experienced sexual abuse or assault. They could also be indications of other problems.

1. Emotional Changes
   • Anxiety;
   • Irritability;
   • Withdrawal;
   • Depression;
   • Sleep disturbances;
   • Change in appetite;
   • New fears;
   • Abrupt change in personality; and/or
   • Poor self-esteem.

2. Behavioral Changes
   Verbal:
   • Unusual interest in and/or knowledge of sexual acts or language inappropriate to the child's age;
   • Suicidal threats;
   • Denial of a problem with marked lack of expression;
   • Aggression, anger directed everywhere; and/or
   • Reluctance to go to a particular place or be with a particular person.
   
   Non-Verbal:
   • "Acting out" or attention-seeking behaviors such as frequent tardiness or absence from school, drug and/or alcohol abuse, delinquency or running away, rebelling, stealing, physical abuse of others and/or property;
   • Excessive masturbatory behavior;
   • Wearing many layers of clothing, regardless of the weather;
   • Drop in grades or change of attitude toward school; and/or

If you are working with a parent of a child who has experienced sexual violence, knowing this information will assist you in supporting the parent(s) as well as the child.

The Spectrum of Sexual Violence 40
• Accumulating gifts (money, candy, etc.).

Physical Changes
• Child may be diagnosed as having a sexually transmitted disease;
• Recurrent physical complaints such as infections, cramps or abdominal pains, dizziness, gagging, or severe headaches;
• Sudden weight loss, weight gain, or diagnosis of an eating disorder;
• Pregnancy when victim refuses to reveal information about the father of the baby; and/or
• Self-mutilation (i.e. cutting or burning oneself).

Signs in Young Children
• Nightmares and other sleep disturbances;
• Bed wetting;
• Clinging/whining;
• Regression to more infantile behavior;
• Agitation/hyperactivity;
• Irritability;
• Aggressiveness;
• Evidence of physical trauma to genital areas;
• Abuse of animals;
• Fire setting; and/or
• Sexual acting out on other children.

Signs in Older Children
• Depression;
• Withdrawal;
• Poor self-image;
• Passive or overly pleasing behaviors;
• Aggression or hostility;
• Chemical abuse;
• Running away, aversion to going home;
• Recurrent physical complaints;
• Self-mutilation;
• Suicide attempts;
• Truancy;
• School failure or marked change in school performance;
• Overtly seductive behavior;
• Limited social life; and/or
• Attention-getting or delinquent behavior.

Signs in Adolescents/Teenagers
• Talking about sexual abuse;
• No clear memory of childhood;
• Engaging in delinquent/criminal behavior;
• School failure or marked change in school performance;
• Finding an escape in school, hanging around after hours, or showing a reluctance to go home;
• Running away;
• Emotional withdrawal;
• Depression;
• Eating disorders;
• Drug/Alcohol abuse;
• Suicidal gestures or attempts;
• Sexual promiscuity;
• Overtly sexual behavior;
• Engaging in sexual activity with much older partners; and/or
• Pregnancy.

Children may ask for help by:

• Direct Report—Child reports incident(s) directly to a teacher, counselor, non-offending family member, or other person in authority.
• Indirect Report—Child may tell a classmate or friend, hoping they will tell an adult for them.
• Disguised Report—"I know a person who..." or "Mr. Smith wears funny underpants."
• Child tells teacher or counselor, but asks them to promise not to tell anyone.

What is Healthy Sexuality?
By Stop It Now!MN

Infants and children need to be touched in a comforting way. They will not properly develop without this touch. Children are also born as healthy sexual beings. Sexuality is as much a part of who we are as our ability to eat and sleep.

If healthy sexuality seems difficult to talk about, remember that children need guidance for their development. Consider the work done to teach children about eating—you are happy if the child had a good appetite, and proud when he/she can sit at the table and join in your conversations. Children are taught what is appropriate in society and in your family.

As we talk to our children about sexual values and rules, it is often helpful to understand a child’s healthy sexual development. The charts in the pages that follow can help you understand some of the healthy developments of preschoolers, school-age children, and adolescents.

What is Age-Appropriate Sexual Behavior?

Sexuality is a part of every human, regardless of age. In the chart below are some of the healthy developments for preschoolers to adolescents. These are only some of the developments and behaviors to be aware of, and it is always important to remember that each person develops at his or her own pace. If you have any
questions about your child(ren), call a doctor, nurse, or any of the many agencies and programs that work with adolescents. (For additional information, service providers, and resources, contact your local rape crisis center).

Preschool (0-5 years)

<table>
<thead>
<tr>
<th>Common</th>
<th>Uncommon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual language is used frequently, primarily related to differences in private body parts, bathroom talk, pregnancy, and birth; genital stimulation at home and in public is common; showing and looking at private body parts are common.</td>
<td>Discussion of sexual acts is uncommon; contact experiences with other children without clothing and adult-like sexual behaviors are rare.</td>
</tr>
</tbody>
</table>

School Age (6-12 years)

<table>
<thead>
<tr>
<th>Common</th>
<th>Uncommon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions center around menstruation, pregnancy, sexual behavior; experimenting with same age children is common, including kissing, hugging, holding hands, and role-playing. Genital stimulation is common in the home or other private places.</td>
<td>Masturbation is rare in public; use of explicit sexual words and discussing sexual acts is more frequent than during preschool years although still uncommon (10-20 percent); adult-like sexual behaviors are rare.</td>
</tr>
</tbody>
</table>

Adolescence (13-16 years)

<table>
<thead>
<tr>
<th>Common</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions focus on concerns about decision-making, social relationships, and sexual customs; masturbation is common and restricted to private place; experimenting between adolescents of the same age is common and includes open-mouth kissing, fondling, and body rubbing; also interest in other peers’ bodies; sexual intercourse occurs in approximately one-third of this age group.</td>
</tr>
</tbody>
</table>

References

Stop It Now!, http://stopitnow.org/warnings.html#appropriate.

Bringing It Home:

- What is your program doing to help prevent sexual violence against children?
- What supportive resources does your community make available to children and their families when sexual violence has already occurred?
- What is your agency’s policy when a child discloses sexual abuse to you?
- Who are your strongest partners (or who would you like as a partner) in your community that you can utilize as a resource, referral, or supporter against child sexual abuse?
- What have you done to raise awareness of child sexual abuse, and how have you used that to debunk the myths around this form of violence?
Incest
By Kim Zimmerman with contributions from Karla Nelson, MNCASA

Key Learning Points:
- We can not “rate” how traumatic one’s experience with sexual violence is, yet here are factors that may result in more of an impact on the victims/survivors life. Incest has several impacting factors due to the relationship of the victim/survivor to the perpetrator.
- In many cases of incest, the victim/survivor relies on the perpetrator. For this reason it can be especially challenging for a victim/survivor to disclose the sexual abuse to anyone. They care for the perpetrator and they may be in fear of what will happen to themselves or even the perpetrator if they tell someone.

Incest, also known as familial sexual abuse, is a form of sexual violence that is committed by one family member against another. It can be committed by a parent, sibling, other family member, or an unrelated person living with, or treated as part of the family. Minnesota statute 609.365 defines incest as “Whoever has sexual intercourse with another nearer of kin to the actor than first cousin, computed by rules of the civil law, whether of the half or the whole blood, with knowledge of the relationship, is guilty of incest and may be sentenced to imprisonment for not more than 10 years.”

Because this form of sexual abuse is perpetrated by family members, and often the victim/survivor is a child, victims/survivors are victimized by the people they most trust and depend on. The perpetrator is trusted by the child because it is their father, mother, or another relative and they have no reason to fear that person. This creates a very confusing situation for a child experiencing incest; they may know that what is happening is not right, but they believe this person loves them and would never harm them intentionally.

When a child is being sexually abused they often become trapped between affection or loyalty for the perpetrator and the sense that the sexual activities are terribly wrong. If the child tries to break away from the sexual relationship, the perpetrator may threaten the child with violence or loss of love. The child may fear the anger, jealousy or shame of other family members, or be afraid the family will break up or be dishonored if the secret is told.

Each victim/survivor experiences sexual violence in their own way; it is not “better” or “worse” than someone else’s experience. But there are different variables that may affect to what degree a victim/survivor is impacted by sexual violence. This is true for any victim/survivor of sexual violence, including a victim/survivor of incest. These include the following:
- Relationship between the victim/survivor and the perpetrator: The more a victim/survivor trusts and loves the perpetrator, the more traumatic the event may become.
• Duration of the sexual abuse: Children who have had to live with regular sexual abuse may be more impacted, as their survival becomes connected with the abuse.

• Victim/Survivor’s age and developmental level: Younger children may not understand that what the perpetrator did to them was harmful.

• The reaction of the parents or other important people around the victim/survivor: Victims/survivors need to know that their loved ones believe them and will support them.

Other thoughts to keep in mind when working with victims/survivors of incest:

• Families and family issues are difficult for most people who are victims/survivors of incest. Their sense of family may have been shattered at an early age. We need to support them in however victims/survivors choose to deal with their families.

• Talking about the abuse means "breaking the secret." Many victims/survivors are faced with the terror of "breaking the secret" each time they talk about the abuse. The concept of "keeping the secret" is so entrenched in them that it is a major step each time that a secret is broken.

• Many victims/survivors of incest never come forward or wait many years to tell anyone what has happened. A family event, such as a wedding or even the death of the perpetrator may spark their need for support. You, the advocate, may be the first person they have ever told.

• Remember that many victims/survivors of incest deeply love the person who has sexually abused them. We must understand and accept that and not pass judgment on it.

References


Other information from articles written by Cedar Morrigan previously submitted to MNCASA training manual.
Reactions and Responses to Sexual Violence
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.
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
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.

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

Reactions and Responses to Sexual Violence 1
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

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.

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

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. 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. 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 a 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. 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. STIs, 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.


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.”


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.

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;
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 personal¬ity 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.

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 accompa¬nied 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.

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

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

**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.

**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.

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

**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.


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, flashbacks 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 she is in a safe place.
- If someone is in the middle of a flashback, you may suggest that she/he do some sort of physical activity, for example wigging 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 she/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.
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.

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.

**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 daydreaming; “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-reality” 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
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.

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.

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.

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.

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


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


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.

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.

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 my 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 that can be used to help overcome the symptoms of PTSD.
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


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.
• 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...
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

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
  - Medium-lethal methods: prescription 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.

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?

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.
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
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?
Advocacy
Victims/survivors of sexual violence have multitudes of feelings and stresses with which to deal. For some victims/survivors, working the assault through the legal system is a process that can be helpful and healing (though hard). For other victims/survivors, dealing with these systems is not a viable option. Sexual assault advocates can help the victim/survivor by assisting in finding other options for dealing with the feelings and pressures of the assault and healing. Healing choices are very individual—what is necessary to one victim/survivor may be impossible for another. The advocate’s role is not to make the victim/survivor do one or another, but to suggest options and help the victim/survivor think of others. Here’s a list compiled by one group of advocates and victims/survivors. It’s made to be expanded.

- Find a therapist you can trust
- Find a good place to cry
- Talk to a sexual assault advocate
- Learn relaxation exercises
- Call a trusted friend
- Find a support group
- Take a bubble bath
- Make a list of places you can go and go there
- Get a pet
- Take action: volunteer for something you believe in
- Talk to someone about your options in reporting to law enforcement
- Build or create something
- Write a letter to the perpetrator (send it or not)
- Write a letter to yourself
- Talk to a religious leader
- Make a list of safety concerns you might have
- Talk with someone you trust about your safety concerns and try to find solutions
- Consider your options for a civil suit
- Push against somebody while they push back
- Dance or take dancing lessons
- Play sports
- Go to sporting events to scream
- Go out to dinner with someone who makes you laugh
- Have a pillow fight
- Get a haircut
- Write in your journal
- Listen to music that makes you want to dance or that makes you relax
- Make music
- Scream in a cornfield
- Throw ice cubes at trees
- Join a women’s group
- Exercise
- Determine negative situations in your environment you can change and change them
• Find support from family/friends
• Identify your strengths
• Validate your feelings
• Have an imaginary talk with your perpetrator
• Curl up in a blanket
• Take a self defense class
• Political involvement: find something you are passionate about and become involved
• Eat chocolate
• Run, bike, ski, skate, swim
• Cuddle a stuffed animal
• Install new locks
• Pamper yourself
• Consider seeing a doctor for medication to address diagnosis such as depression or anxiety
• Meditate
• Go for a drive
• Sculpt, draw, paint, weave, knit
• Find a new job
• Establish a positive routine
Introduction to Advocacy
From the Minnesota Coalition Against Sexual Assault *Train the Trainer Manual*

**What is Advocacy?**

Advocacy is commonly defined as active support. Essentially, sexual violence victim advocacy encompasses assisting individuals in exploring and understanding their options and empowering them to make their own decisions. Advocacy is not about “fixing” the problem or having all of the answers. It is about fostering a safe environment where victims/survivors can tell their story and be heard without judgment. Advocates assist individuals in finding answers to their questions, understanding their options, and building support systems. (WCASA Manual, p. 41).

**Goals of Advocacy**

- To provide victims/survivors with information regarding their options so that they are able to make informed decisions
- To motivate victims/survivors to advocate for themselves
- To always listen and believe the victim/survivor
- To provide unconditional support while ensuring that the victim/survivor is treated with respect
- Not to “investigate” the circumstance or judge the victim/survivor
- Be an ally, a person the victim/survivor can trust

(Adapted from the OVC Manual)
Is Sexual Violence Victim Advocacy the Right Choice for You?

The decision to become a sexual violence victim advocate is a substantial decision, and one that can result in significant rewards. As a sexual violence victim advocate you make a difference by becoming a part of the solution by working against the problem of sexual violence.

Victim advocacy work is invaluable to victims/survivors of sexual violence. With that thought in mind, it is crucial for advocates to become aware of their own issues regarding sexual violence. An advocate that has not dealt with his or her own issues could potentially cause more harm than good in an advocacy situation. If a person feels that they may be uncomfortable working with victims/survivors, agencies often have other opportunities available.

Why do you want to be a Sexual Violence Victim Advocate?

*Determine your real motivation(s)*

It is of utmost importance that you become aware of and acknowledge your real motivations for working with victims/survivors of sexual violence. Your motivations will impact your own well-being while doing the advocacy work and also may have an impact on the agency you are working for, and it will ultimately affect the victims/survivors that you assist.

The activities in this section will assist you in assessing your motivations and help you decide whether victim advocacy is right for you. It is important to remember that there are no right or wrong answers and your responses should reflect your true feelings, not how you think you “should” feel.

Please list the factors that have motivated you to become involved in sexual violence victim advocacy:

1. _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

2. _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

3. _________________________________________________________________
   _________________________________________________________________
   _________________________________________________________________

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Advocate Role
From the Office of Victims of Crime Manual

Crisis Line

Crisis line advocacy is very important as the phone lines need to be covered by staff or volunteers 24 hours a day, 7 days a week. To cover the crisis line, an advocate must have extreme confidence in his/her ability to handle difficult situations. To prepare for crisis line work, it is imperative that you complete the required sexual violence advocacy training and you feel comfortable with your knowledge of sexual violence.

Sexual violence advocacy crisis lines are frequently staffed by trained volunteers, and the purpose is to deliver information and immediate support to victims/survivors of sexual violence. Calls received by the crisis line address a wide array of needs from a much diversified population. Some calls are from recent victims/survivors who need assistance in understanding that forced sex is indeed rape, even if it was with a trusted person. Other calls are from victims/survivors that may be experiencing flashbacks or recurrent memories of an assault that may have occurred decades ago.

Secondary victims, otherwise known as concerned family or friends may call with fear that their safety may be at risk or concerns about a friend, acquaintance, or loved one. They may need support or resources for themselves. Other callers may be calling with concerns because they are being stalked, and they need information and options that are available to them in order to find safety.

Furthermore, some callers may be calling to get information on obtaining a harassment order (HRO) or an Order for Protection (OFP). (For more information on HRO’s or OFP’s please see the Legal section of the manual). Yet, other community members may call to get information on registered sex offenders in their community.

Moreover, evaluation of suicide and homicide risk is a crucial aspect of crisis line advocacy. It is important that advocates are properly trained in this area and also know when it is time to involve local law enforcement. A complete understanding of the legal consequences of action and inaction in these particular cases is imperative, as is the capability of making decisions and acting under significant pressure.

Fortunately, with modern technology is it rare that volunteer advocates have to work onsite during their volunteer shift. Most often, calls are transferred to your home or cellular phone.

Medical-Evidentiary Exam Response

Many sexual violence advocacy agencies have agreements with their local hospitals to have their advocates called to the emergency room when a victim/survivor of sexual violence arrives without contacting the agency. The advocate’s central task is to provide the victim/survivor with information about his/her options, answer questions, extend support and crisis intervention, and to advocate on his or her behalf with the medical personnel providing care.

Victims/survivors of sexual violence often require much needed support during the
medical evidentiary exam process because of emotional response to the assault and the invasive procedures required during the exam. Moreover, the advocate is there for the victim/survivor. At no time should the advocate become involved with the actual medical procedure or forensic investigation.

Law Enforcement Accompaniment

If the victim/survivor chooses to report the assault to law enforcement, the initial report is often taken at the hospital with the advocate present. The victim/survivor usually gives their official statement to law enforcement at a later time or day, and the advocate may accompany him/her to the appointment.

While the victim/survivor gives their official statement to law enforcement the advocate is present solely for emotional support. An advocate should allow the officer or investigator to answer questions that the victim/survivor may have and, most importantly, the advocate should never interrupt while the victim is giving her/his statement.

Court Accompaniment

The advocate often offers to accompany the victim/survivor to any attorney appointments as well as to the courtroom. The purpose is to familiarize the victim/survivor with the process and the courtroom, including where they will sit and what they will be asked to do or communicate.

Furthermore, there are often court hearings where it is not required that the victim/survivor be present. An advocate may offer to attend these hearings on the victim/survivor’s behalf and report pertinent information back to the victim/survivor afterwards.

Family/Partner Supportive Counseling

The advocate typically works with one primary victim/survivor along with many secondary victims: the partner, family, or close friends who have been negatively affected by the assault of their loved one. The more the advocate can assist these secondary victims initially, the more supportive they are likely to be of the victim/survivor. If family and loved ones are present during the evidentiary exam, it may be helpful if the advocate spends time with them while a SANE or other support person is with the victim/survivor. It is imperative that the advocate communicate with the victim/survivor when working with his or her loved ones. If the victim/survivor does not want his or her loved ones to know certain details, the advocate must respect that decision.

Walk-In Crisis Intervention

Sexual violence advocacy programs often have victims/survivors of sexual violence who come into the office without an appointment and no prior contact with the agency. As with crisis line advocacy, walk-in clients present with varying
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degrees of issues and responses to trauma. Advocates who respond to these victims/survivors often deal with similar circumstances to which crisis line advocates do.

Individual, Ongoing Supportive Counseling

Sexual violence advocacy programs usually have staff available to provide ongoing, supportive counseling to victims/survivors of sexual violence. This role of a staff person often requires advanced training in counseling, but advocates can still be helpful by utilizing basic supportive listening skills. If a victim/survivor has many psychological issues, referring them to a therapist is often the best strategy.

Support/Educational Group Facilitation

Support groups are becoming very popular and are often a sufficient way to help sexual violence victims/survivors obtain the support they may need to heal. Sexual violence advocacy programs often provide support or educational groups for victims/survivors in their community.

Advocacy Program Support Roles

From the Minnesota Coalition Against Sexual Assault  
*Train the Trainer Manual*

Advocacy at the Legislature

Sexual violence advocacy programs need support from individuals at the local, state, and national levels who are willing to communicate their views and concerns regarding future legislation. Often, you only need to have an understanding of the issues and a willingness to communicate your views. Individuals with advanced knowledge on the issues may enjoy testifying in front of committees advocating for or against pending legislation.

Educating the Schools and the Community

Sexual violence advocacy programs are often asked to speak in schools and at community organizations about the prevalence of sexual violence, prevention, safety, and other related topics. Presentations and trainings on sexual violence vary greatly depending on the audience and the purpose of the event. Videos, role plays, and discussion of scenarios can be very educational with most groups.

Educating the public about sexual violence is imperative to the prevention and the eradication of sexual violence in our community. (For more information on prevention, please see the Prevention chapter). Volunteers at sexual violence advocacy programs can be helpful in this area as staff are not always available to provide the presentations due to their case loads. High schools and college
campuses are usually in dire need of information on sexual violence, and information provided by peers may be better received. If you are a trained sexual violence advocate and feel comfortable providing public presentations, please contact the volunteer coordinator or available staff to express your interest in educating the public about sexual violence.

Court Watch

Some sexual violence advocacy programs now utilize staff and volunteers to watch court cases involving sexual violence. Court watch can be done to record information for a victim who may not want to attend the hearings but would like the information provided and the decisions of the hearings. Court watch can also be effective for monitoring and recording any biases that may occur on behalf of judges or other court officials. Programs can use this information in working with the criminal justice system to implement change and fairness for victims of sexual violence.

Program Evaluation

Evaluation of sexual violence advocacy programs is crucial, especially for funding sources. Most funders require sufficient data to show that the money provided is being utilized to serve victims and prevention efforts. Sexual violence advocacy programs use intake information on victims, and this information needs to be tallied for quarterly reports and year end reports for funders. This may be an easy, yet essential task for volunteers to do.

Fundraising

Sexual violence advocacy programs can always utilize more funds. Often, companies will match funds to a local agency when requested by an employee. See if your employer has such a program or will match funds you contribute or raise for your local sexual violence advocacy program.

Traditional fundraising efforts can also be useful for sexual violence advocacy programs, however, staff of the agency may have limited time to plan and organize such an event. Offer to hold a bake sale, candy sale, gift sale, fun run, car wash, golf tournament, or garage sale to raise money. You can get your friends, family, faith community, and/or local community involved and have fun while you raise money.

Administrative Support

Staff at sexual violence advocacy programs are often overworked with their direct service case load and, as a result, have little time to take care of administrative tasks. Volunteer to come in and assist with copying, filing, stuffing envelopes, word processing, data entry, or answering phones. It doesn’t take much effort, and
it is usually very helpful to overwhelmed staff.

**Traits of the Effective Advocate**

*From the Minnesota Coalition Against Sexual Assault*  *Train the Trainer Manual*

**Empathy**

Sexual violence advocates need to be able to perceive correctly what the victim/survivor is experiencing and communicate that perception. This does not mean that an advocate has to have been sexually violated to feel empathy towards a victim/survivor. The advocate must identify with the trauma of the experience, however. It can be very difficult to identify completely with individuals whose life circumstances, socioeconomic status, race/ethnicity, and sexual orientation differ from one’s own; therefore it is imperative not to overemphasize similarities. Rather, the focus should be on displaying interest and concern for the victim/survivor’s particular circumstance.

**Respect**

Sexual violence is a traumatic experience and, for this reason, respect is an important and influential element in the helping relationship. Respect insists the advocate display genuine appreciation for the worth of the victim/survivor, which embraces their experiences and their behaviors. This entails protecting the victim/survivor’s rights to make their own decisions, their assessment and account of the situation, and their ability to overcome the crisis they are facing. Respect for the victim/survivor will assist the advocate from becoming overprotective or from viewing the victim/survivor in a negative regard.

**Warmth**

Being treated in a warm manner by an advocate can be very comforting to a victim/survivor of sexual violence. Warmth generates a sense of care, concern, and reassurance that results in trust. It is possible to display warmth in many ways, especially non-verbally. Advocates should be mindful that their nonverbal cues such as body language, eye contact, and facial expressions communicate appropriate messages.

**Genuine**

Advocates should be themselves when working with victims/survivors of sexual violence, being mindful to not assume behaviors or express opinions that are not authentic. Being “real” allows the advocate to relax and focus on the victim/survivor, rather on his or her own behavior or appearance. Genuineness implies to the victim/survivor the advocate’s credibility and willingness to assist.
Concrete

One common reaction to sexual violence is a feeling of disorientation, which can lead to a sense of powerlessness and confusion. Therefore, an advocate must be as specific and clear as possible in his or her interactions with a victim/survivor. This does not mean, however, being directive (giving unsolicited advice or instruction), but rather providing detailed information in concise and understandable terms. This concept is related to the need for immediacy – discussing issues in the here and now.

Sensitivity to Cultural Factors, Social Conditions, and Personal Identities

Advocates need to comprehend how cultural factors, social conditions, and identities impact a victim/survivor’s experience of sexual violence. The relationship will be considerably strengthened by an advocate that can demonstrate knowledge and respond sensitively to people from various cultural and social groups. This involves being aware of who the victim/survivor is, learning something about her/his background and how social issues affect her/his life. It is imperative not to make assumptions based on generalizations and stereotypes. If necessary, check with the victim/survivor about their background to understand better ways in which their culture and identity influence their life and the way s/he perceives their assault.

Potent

An advocate should be convincing, dynamic, and have charisma – characteristics which help the victim/survivor feel credible and safe. It is important to demonstrate that an advocate will indeed be able to contribute some of their experience and skills to the successful resolution of the crisis.

Adapted from PCAR’s Trainer’s Toolbox #9 p. 522 – Adapted from Legal Advocates Manual: A Survivor Centered Approach to Legal Advocacy and Systems Change: New York State Coalition Against Sexual Assault

Essential Advocacy Premises

from the Minnesota Coalition Against Sexual Assault Train the Trainer Manual

Advocacy is most powerful when the advocate has a basic comprehension of the sociological and psychological implications of sexual violence, and implements this knowledge to each individual advocacy relationship. Advocates need to be cognizant of, and to share with victims/survivors, some pivotal assumptions.

• The perpetrator, not the victim/survivor, is responsible for the assault – always.
• Victims/survivors have made the best choices and decisions possible – given
the pressures, fears, feelings, and circumstances at the time. The person survived.

- No one “deserves” to be sexually assaulted. Sexual violence is not about something that was “wrong” with the victim/survivor – or anything that s/he did, said, wore, or thought.

- Circumstances regarding culture, race, and socioeconomic background may be involved in the healing process. Advocates should be culturally competent and recognize their differences, but at the same time not make broad assumptions about the victim/survivor based solely on those differences.

- Victim/survivors have amazing strength and healing capacity. The healing journey may take time and endurance, but every victim/survivor can move through the process and recover from sexual violence.

(Jane Doe Manual – Massachusetts)

**Bringing it Home:**

- Are your motivations for doing this work clear to you? If so, are they appropriate motivations for you to provide support to victims/survivors of sexual violence?

- Do you possess effective traits of an advocate? Do you feel working in advocacy for sexual violence victims/survivors is a good fit for you?

- Do you understand the role an advocate plays in each scenario?

- How do you see yourself fitting into these roles of advocacy?

- What are the services your program offers (i.e. support groups or counseling)?
Crisis Intervention
From the Minnesota Coalition Against Sexual Assault *Train the Trainer Manual*

Key Learning Points:

- A crisis has many phases to it, but with early crisis intervention, healthy and effective coping mechanisms are more easily established.
- Common feelings that many victims/survivors of sexual violence may experience during crisis are anxiety, helplessness, guilt and shame, anger, and ambivalence. It is important to remember that everyone experiences crisis differently and there is no “right” way to react, especially regarding sexual violence.
- Some of the basic crisis intervention techniques are to define the problem, ensure safety, provide support, examine alternatives, and make plans.

Crisis intervention is quite possibly one of the most important roles of a sexual assault advocate. It should begin as soon as possible, usually when the victim/survivor presents to the hospital for a forensic exam. Crisis intervention has been found to be very effective and usually entails providing support and information to assist the victim/survivor in communicating his/her feelings, dealing with the assault, and creating effective and healthy coping mechanisms (Ledray, 1982).

When working with sexual assault victims/survivors, crisis intervention should include recounting the sexual assault in detail; building a supportive connection to show sensitivity, empathy, support, and to initiate the recovery process; restructuring thoughts underlying negative symptoms; collecting information; teaching positive coping mechanisms; determining social support; assisting with medical and legal needs; safety planning; and helping with follow-up treatment.

Basic Crisis Intervention Techniques:
- Define the problem
- Ensure safety
- Provide support
- Examine alternatives
- Make plans

Questioning Techniques to Avoid:
- Avoid asking multiple questions at once
- Avoid asking questions that are off the topic
- Avoid questions that abruptly change the flow
- Avoid *why* questions, which can make people feel defensive
- Avoid imposing values
- Avoid making the victim/survivor defensive
- Avoid questions that assume there is only one answer
- Avoid questions that cut off discussion of feelings
- Avoid making assumptions
Crisis Definition

A crisis is a stressful situation that disrupts a person’s ability to cope and cause a stage of lack of equilibrium (i.e. knocks you off your usual balance).

A crisis may have several phases where the tension level increases. The tension may reach the breaking point (with resulting personality disorganization) unless:

- Significant forces are supported in the early phases.
- The person’s own emergency problem solving mechanisms are able to resolve the crisis in a healthy way.

How a Crisis is Experienced

Although not everyone will experience all of the following feelings, they are the most common in any crisis.

- Anxiety - This is a response which can mobilize a person for action; great anxiety, however, produces confusion, poor judgment, questionable decisions, and self-defeating behavior. This is the time when the best service is given through concrete suggestions, information, and a helpful ability to listen.
- Helplessness - This is a common feeling. Encouraging a person through some action can be a way to counteract the helpless feelings.
- Guilt and Shame - This feeling is due mainly to feelings of incompetence and the need to depend on others.
- Anger – This is often hidden behind the expression of other feelings and may be directed at another person such as the volunteer or turned inward, producing depression.
- Ambivalence - This reaction may be caused by the need to regain control while there is a loss of control. Reaching out for help while trying to manage by oneself produces a decrease in self-esteem and leaves an individual extremely vulnerable.

Since normal coping ability is challenged in a crisis, the individual finds their world shaky and uncertain. In rare cases, fears, which may have been hidden, are now on the surface (e.g., nightmares, fear of going out, etc.). All of these fears bring on uncertainty, discomfort, and the feelings listed above.

Some people may act angry, demanding, or manipulative. These behaviors are often the defense against feelings of anxiety and helplessness. People in this state are trying to gain or regain a sense of control.

Resolution of a Crisis

Any crisis state is resolved by a decision towards action of some type. No crisis can be resolved without some decision, which could even be the decision not to decide. Time is a complicating factor in a crisis state, because usually time to decide is severely limited. A crisis can be of short duration if the intervention is effective. After the immediate crisis is resolved, change and feelings will continue, but making that first decision starts to bring about the resolution of the crisis.
Crisis Intervention Strategies
Adapted/reprinted with permission from the Pennsylvania Coalition Against Rape (PCAR, 2000).

• Provide Information: Talk about the likely course of reaction, emphasizing that each person is unique, but that these are some common responses sexual violence victims have reported.
• Provide information about relating cues with terror/panic reactions. Helping victims/survivors relate cues with reactions may help her/him feel less “crazy” and possibly lead to working on desensitizing that specific cue.
• Normalize Reactions: Let the victim/survivor know that many reactions are common. This can also facilitate effective information gathering, such as “Many sexual assault victims experience flashbacks, have you had any?”
• Facilitate verbal desensitization: Let the victim/survivor talk as much as possible about the assault or how s/he is feeling. This can help with any denial s/he may feel. Find out whether the victim/survivor has anyone else to talk to about the assault or any support networks. Inform her/him that the agency is also available for significant others. Be alert to see whether s/he needs to protect others and take care of their needs.

If the victim/survivor does not want to talk, let her/him know that there may be a time when s/he will want to talk. Is there someone else who will listen? Let her/him know that someone can be there to listen.

Try to identify sources of support (i.e. family or friends). Also talk about the first response of a significant other to the disclosure.

• Discuss victim/survivor concerns: Let the victim/survivor express concerns about self-image; reaction of others; prosecution; and feelings of blame, guilt, betrayal of trust, etc.
• Gather resources: Help the victim/survivor initiate the sources of support identified.
• Assess the need for referral: Examine indicators that suggest a victim/survivor may need a referral:
  – A history of repeated victimization;
  – Other significant life problems besides the assault, such as divorce, problems with children, loss of job; and/or
  – Self-blame.

Referrals are generally not made unless the victim/survivor asks you to do so, or you have met with the victim/survivor many times to have sufficient information to assess that a referral is appropriate or necessary. A victim/survivor may follow up with another agency and still continue with the sexual assault agency for support.

References

Confidentiality

Key Learning Points:

- Confidentiality is the beginning of empowerment, for it assures the victim/survivor that s/he alone has the right to choose to disclose information about the sexual violence.
- Keep conflict of interest issues in mind and refer when necessary. For example, it may be helpful to have two different advocates – one for the victim/survivor, one for the parents.
- Get written permission for release of information from the victim/survivor before discussing a victim's/survivor’s situation with a representative of any agency or organization. (This includes referrals.)
- Staff and/or volunteer personnel information must also be confidentially maintained. Make sure you receive direction from your agency attorney about your staff and volunteer rights to privacy.
- A sexual assault advocate must meet all of the following:
  - Have undergone at least forty hours of sexual violence advocacy training
  - Work under the direction of a supervisor in a crisis center,
  - The crisis center’s primary purpose must be to render advice, counseling or assistance to victims of sexual assault.
- The victim/survivor retains the right to know any and all exceptions to the confidentiality privilege, including the fact that the advocate is a mandated reporter of child abuse.

Confidentiality is the basic policy of crisis centers. It requires that all information provided to volunteers, advocates, and staff by victims/survivors or by friends and families of victims/survivors, be kept confidential. The following guidelines should be adhered to in contact with callers and clients.

When talking directly with a victim/survivor:

- Notify the victim/survivor that all information will be kept confidential. Confidentiality is the beginning of empowerment, for it assures the victim/survivor that s/he alone has the right to choose to disclose information about the sexual violence. Discuss limitations, if any, on confidentiality, such as mandatory reporting, Tenneson Warning, and group contacts.
- Always request the victim/survivor’s permission before contacting others. Example: "I want to help you, but I need more information. I’d like to discuss this with my supervisor if that is okay with you."
- When filling out any log sheets, keep details concise and factual.
- If you need to get another advocate for outreach or any other reason, get the victim/survivor’s permission.
- Let the victim/survivor do the talking to staff at the hospital, police station or county attorney's office. Try not to put words into the victim/survivor’s mouth. Allow the victim/survivor to decide whether you should be present at any of these interviews.
- Do not question the answer a victim/survivor gives to others even though it may differ from what you think you heard. You may want to ask for clarification later in
When talking to relatives or friends of victims/survivors:
- If a victim/survivor has not given permission for your contact with any significant others, give general information about sexual assault victims/survivors and sexual assault issues.
- If a victim/survivor has given you permission to talk with family or friends, do so. Remember that it is always best to suggest that the callers convey their concerns directly to the victim/survivor. At times you may be able to facilitate this.
- Family and friends of victims/survivors also have rights to confidentiality. If family members do not want their call relayed to the victim/survivor, that is their prerogative.
- Keep conflict of interest issues in mind and refer when necessary.

When talking with anyone else:
- When referring to a victim/survivor, use a general phrase such as "young woman" or "a man I am working with," NEVER a victim/survivor's name.
- Do not tell anyone that an individual has contacted you.
- Get written permission for release of information from the victim/survivor before discussing a victim/survivor's situation with a representative of any agency or organization. (This includes referrals.)

Information about volunteers is also confidential:
- Only use your first name when talking with a victim/survivor or significant others.
- When referring to another advocate, use only first names.
- Do not give out your phone number or home address. Anyone who needs to reach you can always call the crisis number and leave a message. The advocate on call can relay that to you.
- Outreach volunteers should not go to a victim/survivor's home. Arrange to meet at a public place—a restaurant, hospital, police department, etc.

Communication Between an Advocate and a Victim/Survivor is Not Always Confidential

In Minnesota, Sexual Assault Advocates may generally not be compelled to testify about any opinion or information received from or about the victim/survivor with whom they are working. See, Minnesota Statute §595.02 subd. (k). There are, however, some exceptions to this general rule.
Do you meet the definition of a sexual assault advocate?

A sexual assault advocate must meet all of the following:

- Have undergone at least forty hours of crisis counseling training;
- Work under the direction of a supervisor in a crisis center; and
- The crisis center’s primary purpose must be to render advice, counseling, or assistance to victims/survivors of sexual assault.

**HOW PRIVILEGE IS WAIVED:**

If you meet the definition, then communication is deemed privileged unless that privilege is waived. Waiver of the privilege may occur in more than one way:

**Victim/Survivor Consent**

- If the victim/survivor consents to having the advocate testify, the communication that has occurred will no longer be deemed privileged.
- The privilege belongs to the victim/survivors, and it is their right to waive that privilege if they choose.
- If the victim/survivor does in fact wish to have the advocate testify, the waiver will need to be stated on the court record so the advocate is clear that s/he is granted permission to testify.
- It would be wise for the advocate to communicate with the prosecutor on the case to verify that the waiver has in fact been made before they testify.

**Court Deems Good Cause is Shown**

- This waiver applies when the advocate’s information relates to neglect or termination of parental rights. (Note: These fact patterns may lead to a situation requiring mandatory reporting.)
- Victim/survivor does not consent to having the advocate testify.
- Court is ordering this testimony or disclosure of information.
- The court must perform a balancing test in order to determine if good cause exists for disclosure.
- The balancing test requires the court to weigh the public interest and need for the disclosure against the effect on the victim/survivor, the relationship between the advocate and the victim/survivor, and the services provided if disclosure occurs.
- In this instance, the advocate if called to testify would assert on the witness stand that the information they possess is confidential. The court will then rule on the issue, and the advocate will be informed as to whether they will be required to testify and what the boundaries of their testimony, if any, will be.
- It is also important to note that Minnesota Statutes §626.556 and 626.557 address issues of maltreatment of minors, and these statutes should be consulted if your situation involves these issues.

**Third Party Conversations**

- Victim/survivor does not knowingly consent to the advocate’s testimony.
- Conversations between victim/survivor and advocate occur in the presence of a third party. For example, a meeting between the advocate, victim/survivor and law enforcement.
- Conversations between victim/survivor and advocate are subsequently purposefully disseminated to a third party. For example, after victim/survivor meets with an advocate, the victim/survivor then tells someone else about the content of the meeting.
- The communication is no longer confidential because it has been shared with someone outside the confidential relationship.
- Once the information is disclosed to someone else, even though it was by choice, the victim/survivor may not later assert privilege when disclosure is sought by someone else.
- This concept is not unique to the relationship between sexual assault advocates and clients. It also applies to other disciplines including lawyers and their clients.

**What Can I Do?**

- The above information is not meant to discourage advocates from providing support to the victims/survivors in their meetings with third parties. Instead, the information is intended to help you understand the limits of confidentiality as you assist victims/survivors.
- If you meet with a victim/survivor and they are being interviewed by law enforcement, remember the role of the advocate is to provide support for the survivor. Do not take notes; the officer will likely be recording the conversation. This reinforces the notion that the advocate is a support person and not an investigator. It also prevents the advocate from having to disclose those notes.
- Discuss with the victim/survivor the ways in which the cloak of confidentiality may be waived so that they have knowledge of this issue from the beginning of the working relationship.
- Talk to the local prosecutors in the jurisdiction in which you work. Discuss the potential ramifications within your community if victim/survivors do not have a confidential resource to talk to concerning sexual assault.
- Let your local prosecutor know that you would be willing to testify as an expert witness on the issue of sexual assault. This may alleviate some of the issue of having advocates testify concerning case specific information.
- If you are going to meet with the victim/survivor and someone else, ask that an additional person be present as well. That additional person may then be called as a witness. This will not be an absolute bar to you being called to testify, but it is an argument that your testimony would be duplicative and thus unnecessary.
Active Listening and Communication Skills

Compiled by Tracy Sheeley
Revisions by Karla Nelson, MNCASA

Key Learning Points:

- When a victim/survivor calls the crisis line s/he often has several thoughts racing through her/his mind. It is part of the advocate’s role to listen actively and help the victim/survivor articulate those thoughts.
- While advocates listen to victims/survivors of sexual violence and support them in articulating what they feel they need, it is not the advocate’s role to tell a victim/survivor what s/he needs. Victims/survivors need to make decisions for themselves which will leave them feeling empowered.
- Listening to the feelings a victim/survivor may have about themselves or of the sexual violence they have experienced may at times be frustrating. It is important that even if the advocate does not understand or agree with what the victim/survivor is feeling, the advocate must accept those feelings and support the victim/survivor.
- Open-ended questions are a non-judgmental way of encourage a conversation and talking more in-depth. They are a very useful tool when exploring with a victim/survivor her/his thoughts and feelings.
- Listening is not just about hearing. When talking with victims/survivors advocates must be aware of both their own and the victim/survivor’s body language and tone of voice. Paraphrasing and clarifying what the victim/survivor is also very important because it shows her/him that you are listening and understanding her/him.

Advocates help sexual violence victims/survivors in numerous ways. Two of the major areas of assistance they provide are giving information and listening to the victims/survivors.

Sometimes victims/survivors have a clear picture of the services or information they desire:
- “Where do I file a complaint about sexual harassment?”
- “Can I have information on support groups?”

More often, s/he is concerned about more than one issue. Active listening is crucial when working with victims/survivors in crisis because a victim/survivor's needs will vary, and s/he may have difficulties articulating those needs. It is important to let a caller know that you are available to listen, but not to push if s/he is not ready. Try to leave the door open to crisis callers —“Please feel free to call back if we can help with anything else or if you need to talk.”

It is also important to remember that victims/survivors have been exposed to the myths about sexual violence in our society. S/he has the right to non-judgmental communication.
While communicating with victims/survivors, keep the following in mind:

**Trust**: Each of us has the ability and power to make our own decisions and resolve our own problems. This ability is empowering and crucial in a sexual violence victim/survivor's recovery. An advocate's role is to help the victim/survivor explore feelings and courses of action—the decisions are always theirs to make.

**Acceptance**: We must listen to and accept the victim/survivor's feelings even if we wish they weren't their feelings or believe that we'd feel differently in the situation. Accepting her/his feelings enables them to move beyond them and/or understand where they are coming from. For example, guilt is a common feeling for victims/survivors. It is very beneficial for them to examine why they feel guilty and move on from that understanding to realize they don't have to feel that way. Acceptance also provides an atmosphere of safety for the victim/survivor to work on these issues. Active acceptance can be frustrating for advocates. Advocates know the victim/survivor is not at fault, and we do not want them to blame themselves for the sexual violence. People do not control their feelings, however, and whatever their emotions are represent the issue(s) to be dealt with at that time.

**Empathy**: Empathy is the ability to share in another person's emotions or feelings. Empathizing with the victim/survivor brings about trusting and honest communication. It is important not to get so caught up in the caller's emotions that you lose your ability to respond to their crisis; this will not help either of you in dealing with the situation. If you share their panic, fear, rage, etc. entirely, you will not be able to offer them options and suggestions for coping with those emotions.

**Respect**: We respect the victim/survivor's right to confidentiality, to make their own decisions, and to get help in their own way and time.

**Open/closed questions**: Closed questions can usually be answered with a yes or no, or with a short declarative statement. Closed questions can be useful to elicit information or clarification. "Did the perpetrator have a weapon?" "Have you received medical attention?" Open-ended questions encourage longer, in-depth responses. They are especially helpful for eliciting feelings and perceptions. Much of our talk focuses on facts and opinions, rather than feelings. Open-ended questions are useful for exploring in a non-judgmental way. "How do you feel about it?" "What do you feel we have accomplished today?" "What do you think you'd like to do about it?"

**Listening for Feelings**

Part of an advocate's role is to help guide victims/survivors to look inside to discover what they are honestly feeling. Unless these feelings are identified and realized on a conscious level, a lot of important information will be overlooked in the determination of an appropriate course of action. It is likely that, if feelings are unidentified, a person will only react to them instead of rationally determining what they want to do with their feelings.

Remember, feelings are not right, wrong, good or bad - they just are. Ignoring the
realistic of a feeling or placing judgment on it will only complicate the process of changing it or seeing it as a resource.

Responding to feelings you identify and/or suspect can be beneficial in many ways:

- It helps the person recognize what is really happening inside emotionally.
- It establishes a safe, trusting bond which allows the person to share and explore a variety of feelings that may be confusing.
- It provides a place for the victim/survivor to safely express emotions without judgment.
- It helps you check out your assumptions and get a holistic picture of the extent of a crisis or situation.

**Telephone Skills**

Active listening on the telephone can be a challenge. There are many facets of face-to-face communication that we take for granted. (Nods, facial expression, shrugs, gestures, posture, and eye contact all help determine our interpretations of conversations and help us communicate with others.) Phone conversations do, however, offer advantages to the caller. They have the control to end the conversation at any time and may feel safer on the phone if they are concerned about confidentiality. Immediately remind the caller that partners can track calls, and take appropriate steps to maximize privacy and safety. Some guidelines to follow:

- Be prepared to answer the telephone. Be attentive both physically and mentally. Separate yourself from all distractions. When you return a call, give a brief explanation of who you are and why you are calling. Prior to the call, dial *67 if necessary to prohibit the call from being traced. Be sure you have the right person on the line; do not violate the client’s confidentiality by telling another person where you are from or what you are calling about. Don’t leave a message. Beware of additional stalking technologies. Check to see whether it is an okay time to talk.
- Be aware of your tone and your voice. Speak clearly. Try to keep your voice calm and reassuring.
- The person has called with some need. Listen and focus on the caller’s want, rather than on what you think s/he needs.
- Help the caller identify specific issues. If s/he seems overwhelmed, help them isolate the most important issue.
- Explore options with the caller. Help the caller determine which choices are best for them. In talking to a victim/survivor, remember and convey that s/he is in control and making the decisions.
- There may be pauses or silence during the conversation. Silence can be all right. Learn to recognize when it is a comfortable thing, and do not rush to fill in the gaps.
- Use active listening skills, making comments in a supportive manner. Remember to reflect the feelings you hear and to check your perceptions periodically, especially if there is any confusion: “Do I understand that what you want is...?”
- If you do not have the necessary information, say so. Do not try to fake it. It is okay to say, “I don’t know, but I’ll find out.” Never make promises you can’t keep. Be firm and clear about your own limits.
• Be aware of your own feelings and reactions. It is all right to share some of your feelings occasionally, especially as an expression of understanding and empathy. Do not let your feelings and reactions take away the focus from the caller and their needs.
• Phone contacts can be short or long. Your job is to respond to the crisis. Focus on the here and now.
• Always believe the victim/survivor. No matter how bizarre the incident or story, believe them.
• Assure the caller of confidentiality.
• Know your resources. Make referrals based on the victim/survivor’s needs. If you need more time to explore resources, let the caller know you will get back to them.
• Summarize at the end of a contact. Provide a sense of closure. Review any follow-up or other plans the caller has made.
• Let the caller know you’re glad they called before hanging up. It can be a difficult step to take.
• When you have had to handle a difficult situation, pay attention to your own feelings about it. Get the support you need from other advocates or staff.

Open-Ended Questions

Open-ended questions are designed to encourage victims/survivors to explore issues, as well as share and process thoughts and feelings. Open-ended questions can assist advocates in facilitating crucial conversations with victims/survivors. Listed below are examples of open-ended questions.

• How does it look to you?
• Tell me more about it.
• What do you think you’d like to do about it?
• What seems to be your greatest obstacle?
• How do you suppose you could find out more about it?
• What was your reaction?
• How does this affect you?
• How would you go about it?
• How do you suppose it will work out?
• What are some other possibilities?
• What information do you have about that?
• How do you plan to do it?
• What do you plan to do about it?
• What was it like?
• What have you tried so far?
• What are the likely solutions?
• What would you like to talk about today?
• What’s new?
• What if that doesn’t work?
• How have things been going?
• What experience have you had with this sort of thing?
• How does this fit in with your future plans?
• What do you feel we have accomplished today?
• How would you summarize your discussion?
• What have you been thinking about since we last talked?
• What do you want to do after you leave school?
• For instance?
• What do you think is best?
• What would you do in a case like this?
• What seems to be the difficulty?
• What have you figured out so far?
• Tell me about yourself.
• Where will this lead?
• What is your ultimate objective?
• How do you fit into this picture?
• Anything else?
• In what way?
• Will you fill me in on the background?
• If you had your choice, what would you do?
• What do you make of it all?
• Can you give me an example?
• What does it all add up to, as you see it?
• What will you have to do to accomplish it?
• In what way do you think you could improve the situation?
• Are there any other angles you can think of?
• Where do you go from here?
• What are you next steps?
• How do you explain those feelings to yourself?
• What would be the greatest thing that you could accomplish in your lifetime?
• How do you feel about it?

Communication in the Helping Relationship
Adapted/reprinted with permission from the Pennsylvania Coalition Against Rape (PCAR, 2000).

The first stage of the helping relationship is building the relationship and it involves skills for understanding, support, and crisis intervention.

Skills for Understanding: Listening

This is not a passive activity. It is a very active process, involving not merely hearing the victim/survivor's words, or watching the victim/survivor's body language, but a total involvement with the victim/survivor - insightful, intuitive, instinctive listening. It doesn't mean "What is this person saying?" It means "What is going on right here, right now, with this person?" Active listening skills are basic to helping. There are separate skills involved in this process.

Attending

The primary element of attending is eye contact - not staring at the victim/survivor, but looking naturally at their eyes, in a manner that displays a warm, genuine interest in the person. It says "I hear you, I understand." Eye contact allows the
advocate to pick up nonverbal clues from the victim/survivor. It is important to be mindful of the distance between you and the client. Pay attention to signs of discomfort from the victim/survivor relative to physical space and eye contact. The degree of both is culturally learned, and thus, not identical for all people.

The second element of attending is posture. A good helper needs to appear relaxed and should lean towards the client while listening. Related to posture are gestures. In other words, the nonverbal messages the advocate gives through the use of arms, hands, sitting position, or facial expressions.

The final element of attending is the verbal message that accompanies the nonverbal behaviors. These verbal messages need to be reflecting and confirming words that help and encourage the victim/survivor to continue and to focus on feelings and experiences.

Paraphrasing

Paraphrasing is repeating the victim/survivor's message using similar but fewer words. It is a test of the advocate’s understanding of the victim/survivor. Additionally, if the message repeated is correct, it encourages the victim/survivor to continue knowing that s/he was really heard and understood. It assists the victim/survivor in clarifying their own thoughts and feelings, and gives a sense of direction to continue communication. Paraphrasing is adding no new words or ideas to the message. The helper should be thinking "What is this person's thought and feeling message to me?" It is important that an advocate not become stilted in paraphrasing, though initially the process may feel awkward.

Clarifying

This is more than paraphrasing, for it is used when the message from the victim/survivor is unclear, vague, rambling, or roundabout. The advocate makes a guess, interprets, or explains what s/he thinks the message is. The advocate needs to admit that s/he is confused or doesn't understand, for it may not be the victim/survivor's message but the advocate’s listening that is the problem. The advocate is admitting confusion, and then restating what s/he thinks was said or is asking for clarification.

Perception Checking

This process is a way of asking for feedback — checking to see whether the advocate’s paraphrase is correct. It is a way to correct misperceptions before they become a misunderstanding later on in the communication process.
Skills for Understanding: Leading
Adapted/reprinted with permission from the Pennsylvania Coalition Against Rape (PCAR, 2000).

This is an important part of the communication process, and these skills are most important in building the relationship in its earliest stages.

Indirect Leading

This helps the victim/survivor start talking and continuing to take responsibility for the direction of the conversation. It includes such phrases as "Why are you here?" "Please tell me more about that?" "How did that make you feel?" "What do you think that means?" Indirect leading is the message to the victim/survivor that the advocate-victim/survivor relationship is her/his responsibility, that s/he sets the course.

Direct Leading

This is more focused encouragement to the victim/survivor to elaborate, clarify, or illustrate. The goal is to encourage the victim/survivor to a greater awareness and understanding of feelings and concerns/issues. An example is "How do you mean that you felt frustrated?"

Focusing

This is most helpful if the victim/survivor is rambling or wandering over several topics at once. This may happen after an indirect lead by the advocate. It is a statement that emphasizes a single feeling or idea from those presented. It can be done by selecting one word or phrase and repeating it back as a question.

Questioning

Indirect leading, direct leading, and focusing are often expressed in the form of a question. The most effective type of question, in terms of continuing the communication process is open-ended. It is one that cannot be answered by a simple yes or no statement. Questions should be used sparingly and should elicit feelings or clarifications rather than information. It is best to avoid "why" questions.

Skills for Understanding: Reflecting
Adapted/reprinted with permission from the Pennsylvania Coalition Against Rape (PCAR, 2000).

Reflecting is another element of the communication process, and is a message to
victims/survivors that the advocate is in their frame of reference. Reflecting occurs in three areas: feelings, content, and experience.

Feelings

The purpose of reflecting feelings is to bring vaguely expressed feelings into awareness, and to assist the victim/survivor in owning the feelings. The role of the advocate is to help the victim/survivor determine the feeling, describe it accurately, observe the reaction of the victim/survivor, and judge if the reflection facilitated continued communication or obstructed it. Even if the advocate is not accurate, it can still help the process, because the victim/survivor may correct the advocate and state/own the correct feeling. The helper must be mindful not only of words, but nonverbal cues in determining feelings.

Content

This is simply repeating in fewer and fresher words the essential ideas of the victim/survivor, and is similar to paraphrasing. It is a clarification of ideas the victim/survivor may be having difficulty expressing.

Experience

This type of reflecting is a descriptive feedback of observations of nonverbal cues. The advocate describes the observed behavior and then the feeling that is attached to it. An example is, 'You say you are not angry, but the way your hands are clenched, it seems you may be angry.'

The reflection of feelings, experience, and content are not mutually exclusive, but blend together. The advocate must read the total message, select the best mix of feeling/content/experience, make the reflected statement, wait for a response, and based on the response continue the process. The advocate should be aware of timing; that is, the advocate should not reflect after every statement, nor allow lengthy monologues that cannot be captured in simple statements. The advocate should beware of reflecting too much. And most importantly, language should be appropriate to the victim/survivor's age, education, culture, and present condition. If the advocate is sincere, warm, empathetic, genuine, and open, these qualities will outshine any "mistakes."
Skills for Understanding: Summarizing
Adapted/reprinted with permission from the Pennsylvania Coalition Against Rape (PCAR, 2000).

Summarizing is simply pulling together the concerns/issues, feelings, and plans at the conclusion of the contact between the advocate and the victim/survivor. It enables the victim/survivor to feel a sense of accomplishment and closure, and to be aware that s/he has been heard and understood. It is also a final check of the victim/survivor's messages to the helper. It is an excellent idea to have the victim/survivor summarize, if appropriate in the context of the contact. "How do things look to you now?" or "Let's see what we've talked about?" are good ways to bring that about.

Barriers to Effective Listening
Adapted/reprinted with permission from the Pennsylvania Coalition Against Rape (PCAR, 2000).

Over time, most of us have developed a series of bad listening habits, and we need to discover and unlearn them. If we are free of the following barriers, we are on our way to becoming effective advocates in crisis situations.

- Judging or Evaluating Everything Heard: The victim/survivor speaks and before s/he has had the opportunity to get the message across, we jump in, having already decided what is correct or incorrect. We have begun to formulate our response, and from that point on do not hear what is being said.
- Jumping to Conclusions to Supply Details and Ramifications: We jump to conclusions, fill in the blank spaces, put words in another's mouth, embellish what is being said — the non-critical inference syndrome.
- Assuming Everyone Thinks the Way We Do: We have beliefs, convictions, and assumptions that are so fixed that we assume everyone else holds those same ones near and dear; therefore, there is no need to really listen.
- Closed Mind: We know the answer without any doubt, so listening isn't necessary. When this bad listening habit is accompanied by the next one, it is known as verbal diarrhea and constipation of thought.
- Infatuation with Own Words: The incessant talker is NOT a listener at all, and won't be quiet long enough to listen to anyone.
- Wishful Thinking: This is hearing only what we want to hear.
- Short Attention Span: Our minds tend to wander after a very short period of time. Most of us are mediocre listeners and need to concentrate all of ourselves on the speaker.
- Semantics: The meanings of words, phrases, and terms vary from profession to profession, culture to culture, or one educational level to another level. We
cannot assume words mean the same thing to everyone.

- **Superiority**: We must learn to overcome the belief that we are superior to whoever is talking, to get rid of the idea that we know everything and have nothing to learn. We each can learn something from every person we meet.

- **Fear**: We all fear change. If we really listen, we may hear something that will upset our thinking, ideas, or convictions. Then we may have to change our thinking. We may have to admit that someone else was right. We don't listen because we are too afraid to listen.

Along with not listening well, many of us do not respond in constructive ways that facilitate positive interactions. Unfortunately, poor listening and responding often go hand-in-hand.

### References

Developing and Demonstrating Healthy Boundaries

Adapted/reprinted with permission from the Pennsylvania Coalition Against Rape (PCAR, 2000) and from the Minnesota Coalition Against Sexual Assault Train the Trainer Manual

The news is full of accounts of boundary and other violations -- priests sexually abusing altar boys, teachers having affairs with students, doctors sexually violating patients. While most participants will be aware of these kinds of news reports, they will probably not be aware of the extent to which they occur. Of equal or greater importance is the need for participants to identify ways in which they -- with the best of intentions -- might transgress appropriate boundaries while "helping" victims of sexual assault. While these transgressions may never make the evening news, they are still inappropriate and may cause harm. --Pennsylvania Coalition Against Rape, The Trainer's Toolbox

A Boundary in an interpersonal relationship is the line between appropriate sharing for two individuals, and what is invasive or inappropriate. Moreover, boundaries can also be physical, such as the physical distance a person is comfortable with keeping between themselves and another person. Boundaries can also be behavioral or emotional, meaning the types of behavior and level of emotional sharing that is appropriate within the context of a relationship. In one relationship a certain behavior may be acceptable, but the same behavior in a different relationship may be deemed inappropriate. Hugging a friend or parent is quite different than hugging someone you just met or a victim/survivor.

Furthermore, victims/survivors of sexual violence or any other type of physical abuse may be especially sensitive to physical boundaries. Oftentimes as a result of the physical nature of the abuse they have endured they have little tolerance for others to touch them.

Key Learning Points:

- Developing and demonstrating healthy boundaries are essential to effective advocacy.
- Advocacy work is very challenging and the boundary lines tend to blur in many situations, but the first step to maintaining appropriate boundaries with victims/survivors of sexual violence is to always be aware of them in your interactions.
- Set clear boundaries from the start. It is always easier to establish boundaries at the beginning rather than initiate them once the relationship has become unhealthy.
- Self examination is a constant process one needs to engage in as an advocate.
- Remember, a good advocate is one who knows her/his limitations. Understand you may not be effective with every victim/survivor.
Developing and demonstrating healthy boundaries is essential to effective advocacy. In helping relationships, such as advocacy, “helpers” tend to have a significant impact on the individuals they help. In an advocate/survivor relationship, the victim/survivor may view the advocate as having certain credibility and authority. Additionally, victim/survivors may also be at a time in their lives where they are feeling especially vulnerable. Because of these factors, a victim/survivor may agree to “go along” with the advocate based on assumptions that the advocate must know best or because s/he feels powerless to challenge the advocate. It is the advocate’s responsibility not to abuse this power with the victim/survivor by trying to influence the victim/survivor’s decisions, initiating emotional intimacy such as a friendship, or initiating a sexual relationship.

Advocacy work is very challenging and the boundary lines tend to blur in many situations, but the first step to maintaining appropriate boundaries with victims/survivors of sexual violence is to always be aware of them in your interactions. It is important to be consistently checking in with yourself and your supervisor or other advocates when you start to wonder if you are overstepping your bounds. It is also important to be open to feedback from others who may raise concerns to you about your boundaries.

Definitions of Boundaries

- Boundaries are used to designate and preserve times, places, spaces, relationships, ideas, and people for a specific purpose – safely and effectively.
- Boundaries provide a dedicated space, place, relationship, or agreement devoted to protecting what is vulnerable, and safeguarding what is valuable.
- Boundaries in relationships work to keep us faithful to the purpose of that relationship.
- Boundaries make it possible for us to safely venture into relationships of trust and vulnerability.

Boundaries: Setting Limits

- Set clear boundaries from the start. It is always easier to establish boundaries at the beginning rather than initiate them once the relationship has become unhealthy.
- Express boundaries factually, without apologies, rationalizations, or anger.
- Expect that clients will test these boundaries and be consistent about enforcing them.
- Setting and enforcing boundaries should be done without anger or personal attacks. Focus on the behavior not the individual’s character.

As sexual Assault Advocates, we are expected to follow a professional code of responsibility. Whether paid or volunteer staff, we are expected to put the needs of sexual assault victims/survivors before our own interests.
Sexual Misconduct by Professionals Quiz

Circle the correct answer.

1. Records of sexual misconduct by religious leaders go back to the:
   A. Old Testament
   B. Puritans
   C. Victorians
   D. 1970s

2. What percent of female college students have been sexually harassed by academic faculty?
   A. 2%
   B. 7%
   C. 17%
   D. 30%

3. An article in the American Journal of Psychiatry in 1986 reported that ________ of psychiatrists admitted having sexual contact with a patient.
   A. 4%
   B. 7%
   C. 12%
   D. 20%

4. Physicians who had sexual contact with patients admitted to having sexual contact with an average of ___ patients.
   A. 1
   B. 2
   C. 4
   D. 6

5. The Presbyterian Church USA estimates that as many as _________ of clergy have engaged in inappropriate sexual behavior or contact with parishioners, clients, or employees.
   A. 3%
   B. 10%
   C. 15%
   D. 23%

6. Sexual misconduct by professionals results from:
   A. women coming on to them.
   B. women needing to have their sexual hang-ups addressed.
   C. the professionals putting their own interests and desires above the needs of the client.
   D. it's not misconduct; it's an affair.

7. Individuals at greatest risk for exploitation by a professional are:
   A. going through a crisis.
B. have a mental illness.
C. are victims of child sexual assault.
D. lonely.

Sexual Misconduct by Professionals Quiz Answer Key

1. The correct answer is A. In the book of I Samuel, it is recorded that the sons of Eli had sexual relations with women who came to the temple. Letter B gives you an opportunity to talk about The Scarlet Letter by Nathaniel Hawthorne. In discussing letter C, mention that even during Victorian times religious leaders were accused of sexual misconduct. The Rev. Henry Ward Beecher, whom some considered the greatest preacher since St. Paul, had sexual relations with a member of the congregation who was the wife of his best friend. There was a lawsuit, private admissions of guilt, and the recognition that there had been other women similarly abused, but Beecher did not lose his job. For people who selected letter D, it might surprise them to know that it wasn’t until 1976 that the term sexual harassment came into use as we know it today.

2. The correct answer is D. In multiple studies, between 20-30% of female college students have been sexually harassed by college faculty. Letter C represents the percentage of female graduate psychology students who have been sexually intimate with a professor. An additional 30% had been approached and declined.

3. The correct answer is B. Of 1,057 male psychiatrists who responded to a survey conducted by Judith Herman, 7.1% admitted to having sexual contact with a patient even though the Hippocratic Oath and Code of Ethics for the American Psychiatric Association both prohibit sexual contact between doctor and patient.

4. The correct answer is D. Thirteen percent of doctors admitted sexual involvement with patients. Most had sexual involvement with more than one patient. The average number was 6.

5. The correct answer is D. In addition to the estimates of the Presbyterian Church, a study at the University of Wisconsin found that over 20% of the clergy participating in the survey were identified as being vulnerable or at-risk for sexual misconduct. Other research indicates that 10% of clergy have been or are sexually involved with a member of their parish and another 15% are on the verge, waiting for the opportunity.
6. The correct answer is C. In any one-way relationship where one person seeks out the experience, knowledge, or help of another and surrenders or exposes her physical or inner self, financial assets, dreams, or vulnerabilities, it is with the expectation that the professional will act in the best interests of the person seeking assistance. Letter D provides an opportunity to discuss the difference between “affairs” where both individuals are of equal power, resources, and control, and misconduct by professionals where there is power imbalance. Where one person has more to lose -- job, class grade, needed expertise, or connections to resources.

7. All of these answers can be correct. When we are in the midst of a crisis, we are more vulnerable and less able to connect with our own power. We turn our power over to another, someone we believe to have more knowledge, skills, and resources to deal with the issue. We may not know what to expect and, therefore, may be unable to recognize when an approach, treatment, etc. is not appropriate, ethical, or in our best interest. As many as one third of women who report being the victim of incest seek therapy and become sexually involved with their therapist. This rate is two to three times higher than the overall incidence of therapist-patient sexual involvement. Some believe that women with histories of incest are at the highest risk for sexual exploitation by therapists. These women may see sexual abuse as a normal part of their lives and expect that relationships with individuals of greater power and authority will result in sexual activity.

Information/statistics for this exercise were gathered from:

Sex in the Forbidden Zone by Peter Rutter.

When Helping Becomes Harmful - Warning Signs

It is much easier to avoid boundary problems with a victim/survivor by recognizing warning signs in advance rather than finding yourself in trouble after it has occurred. The following is a list of feelings/behaviors within an advocate/survivor relationship that should be considered indicators to the possibility of boundary problems. Some warning signs are clearly problems while others are more subtle. These feelings/behaviors may not always be inappropriate, but the advocate needs to be aware of the potential for serious boundary violations. The advocate must be aware of his/her own feelings and why s/he is feeling or behaving in a certain way. Self examination is a constant process one needs to engage in as an advocate. The following are subtle warning signs that you may be at risk of violating boundaries with your client:

* There might be times when you will be able to identify some of the gray/red flags with a victim/survivor you are working with. Are you prepared to honestly evaluate the situation with yourself and supervisor?
• Frequently allowing sessions to run long with a victim/survivor.
• Accepting calls at all hours from a victim/survivor, without setting limits.
• Over-identification with a victim/survivor - assuming a client's pain/happiness/anger.
• Feeling angry at, manipulated by, and/or resentful toward a victim/survivor.
• Wearing an outfit a client said s/he likes, in anticipation of seeing the victim/survivor.
• Frequently thinking of the victim/survivor throughout the day/night; often feeling compelled to discuss the client with co-workers and others.
• Feeling emotional in response to a victim/survivor’s anger or disapproval.
• “Showing up” at places, meetings, etc., knowing in advance the victim/survivor will be there.
• Sharing personal details of your life that don't directly benefit the victim/survivor.
• Feeling afraid of a victim/survivor.
• Allowing a victim/survivor to violate pre-established guidelines of the helping relationship, while other clients are not permitted to do so.
• Wanting to punish a victim/survivor.

These are major violations of boundaries. The relationship has moved towards serving the interests of the advocate rather than those of the victim/survivor. When these feelings are acted out by the advocate, s/he has committed a boundary violation.

• Thinking you are the only one who understands the victim/survivor and nobody else can help him/her as much as you can.
• Attending social functions at the victim/survivor’s request.
• Inviting the victim/survivor to attend social functions with you.
• Reluctance to terminate with a victim/survivor when termination is appropriate.
• Volunteer advocates placing themselves in the role of therapist.
• Seeking advice or comfort from a victim/survivor.
• Performing tasks for a victim/survivor that are more appropriate for the victim/survivor to do, thus fostering greater client dependence.
• Thinking the victim/survivor is the only one who understands you.
• Specifically scheduling a victim/survivor at times you know there will be nobody else in the office.
• Using the advocate-victim/survivor relationship in any way as a means of fulfilling your own emotional needs or wishes.
• Considering another role with the victim/survivor -- friend, co-worker, employee of the victim/survivor.
• Complaining to a victim/survivor about your co-workers, supervisor, or working environment.
• Failing to honor or respect a victim/survivor’s personal space.
• Touching/hugging a victim/survivor without her/his expressed consent, or when non-verbal communication indicates s/he does not wish to be hugged or touched.
• Feeling sexually attracted to a victim/survivor.
• Feeling sexually aroused in response to a victim/survivor’s description of a
sexually (or other) abusive incident.
• Drinking or taking drugs with the victim/survivor.
• Having any form of sexualized contact with the victim/survivor.

Guidelines for Those Who Feel They Are at Risk for Violation

If you have not had adequate supervision, please seek supervision immediately.
• Have you explored why you are having problems with this victim/survivor?
• Following supervision and self-examination, is it in the victim/survivor’s best interest for you to continue as the advocate?
• Remember, a good advocate is one who knows her/his limitations. Understand you may not be effective with every victim/survivor.

Self-Awareness Inventory

Please consider the following questions about yourself when becoming an advocate:
• Why did you decide to become an advocate?
• Can you identify what you are feeling? Do you feel comfortable expressing anger, sorrow, etc.?
• What are your feelings about men? About women?
• Have you ever been in treatment? If yes, for what issues?
• Are you a survivor of sexual violence? If yes, where are you in your process of treatment as a survivor?
• How do you feel about working with the GLBTQ community?
• How do you feel about working with underserved communities?

* Have you honestly answered the questions in the self awareness inventory? Are there additional circumstances you should address?

Bringing it Home:

• Have you talked with your supervisor on the agencies policies for professional conduct?
• Have you evaluated why you want to be an advocate? What are your motivations?
• What does the agency you volunteer/work for actively do to ensure healthy boundaries while working with a victim/survivor?

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Resources

Advocates are there to respond to the needs of others. It is crucial to remember, however, that advocates have needs of their own as well. Particularly in working with victims/survivors of sexual violence, advocates may experience emotional stress and the depletion of resources. To feel that you are giving all of yourself and your time can leave you with a sense of emptiness - with nothing left to offer. You may feel that you have no more energy, strength, or resources left.

Advocates also have legitimate needs. We have needs for recognition and support, for validating the difficult jobs we do. We also have expectations of ourselves — sometimes expecting that if we serve the needs of the victim/survivor, it means that we don't have needs of our own. Setting aside our own needs in order to focus on the needs of a victim/survivor may become a habit that spills over into our other interactions, or may have been a habit we previously learned.

Hearing several painful stories in a row can be emotionally draining. Sometimes the stories victims/survivors tell and the feelings they express can hook into our own personal issues. When the needs of victims/survivors are urgent, it may become harder for us to say "no" and to set limits. The rhythms of crisis counseling can also work to undermine the well-being of the advocate; you may see someone in crisis, but not when they're healing and thriving. We may make excessive demands on ourselves and our colleagues. We may forget to develop our own support systems or to take advantage of the ones that are available to us.

Burnout can also creep up on people working in any human services field before they are aware of it. If you begin to experience one or more of the following, consider the possibility that you are burning out:

Key Learning Points:

• As an advocate, to be able to support victims/survivors of sexual violence, you must take care of yourself physically, mentally, and emotionally. If you are not taking care of yourself you will lose the ability to support your clients in a healthy way.
• Listening to your clients talk about their experiences of sexual violence can be emotionally draining. Be sure to talk with other staff and/or volunteers within your agency for support when you need to.
• Remember that we are human and we will feel emotion in doing this work. It is important to be aware of how you are feeling and not to ignore your own needs.
• Know that you can provide victims/survivors with support and empower them with knowledge, but you can not "fix" the situation for them.
• For as draining as advocacy can be at times, do not lose sight of all of the great work that you do! Advocating against sexual violence can be difficult but it is also something rewarding and enjoying.
• Feeling physically depleted or chronic exhaustion;
• Numbness or feeling emotionally drained;
• Detachment;
• Inability to empathize with victims/survivors;
• Experience the pain the victim/survivor describes;
• Problems with sleeping and/or eating;
• Ongoing irritability, disproportionate anger;
• Self-harm;
• Suicidal thoughts or behaviors;
• Cynicism;
• Impatience;
• Omnipotence;
• Suspicion of being unappreciated;
• Disorientation;
• Depression or hopelessness;
• Inability to have fun;
• Denial of your feelings;
• Lessened satisfaction;
• Psychosomatic illnesses;
• Loneliness;
• Rigidity; and/or
• A need to please everyone at once.

There are no simple prescriptions or recipes to avoid or to heal burnout. It is important for advocates to have ways to care for themselves. Just as passengers on airplanes are encouraged to put on their own air mask in order to assist others, advocates should care for themselves in order to better support victims/survivors. In addition, just as every victim/survivor has their own pattern of recovery and healing, every advocate has unique possibilities for regaining energy and interest. Some options shared by advocates:

• Use your center's resources. Other advocates and staff are there for you.
• Speak up about your own needs. If you've had a call that was especially hard, ask to process it with staff or peers. If you need a leave of absence from providing advocacy, talk to the program coordinator. They will understand; they are concerned about your well-being, too.
• Learn to ask for help from others.
• Acknowledge the challenges and personal impact of advocacy.
• Take a moment to decompress. Color a picture, take deep breaths, count to ten, visualize serenity, decorate your office, or make a quick phone call to a friend.
• Know your limits, and stick to them.
• Remember that the process belongs to the victim/survivor. You can't control it for them, "fix it", or guarantee that they get what you want them to get. Have faith that the victim/survivor received from you what they needed or were able to receive. Maybe on another occasion, they'll go further or take the next step.
• Keep some balance in your life. Play. Have fun. Nurture yourself. If you've had a difficult situation or call, do something especially nice for YOU, that rebuilds your energy and reminds you that life is good and that you are worthwhile.
• Prioritize your life goals. Learn and move toward where you want to be.
• Develop positive addictions: hugs from people you love; music; dancing;
walking or jogging; good, healthy foods; reading good books; the amount of sleep
you need to feel good; hobbies you enjoy.

• Laugh. Laugh as much as you can—at silly jokes, at yourself, at the strange and
wonderful potpourri of life.

Working with victims/survivors of sexual violence can be joyous and satisfying. That
may sound odd, but it is the experience of many. We are doing something active and
important. We can see the differences our responses make to people in need. We get
as much energy back from this work as we put in. To be in that state, we need to pay
as much careful attention to our own processes as we do to those of victims/survivors.
Just as with those we advocate for, we do know what we need, we do have resources
to draw upon, and we can learn new coping skills. We are whole persons.

From Cordelia Anderson, Sensibilities, Inc.

If you had a jar of your own personal “restorative balm” – nourishes, nurtures, renews
your body, mind, soul:
• How full is it by the end of a work day?
• What takes away from you having a full “R balm?”
• What fills up your balm (spiritually, work, family, friends, life partner, play/fun/
pleasure, exercise, hobbies)?
• At the end of the day, what do you have left to renew with and/or share with those
you love?
• How do you refill your “R balm”?

Ways to Practice Self Care
From the Office of Victims of Crime

• Watch a feel-good movie, read a book featuring resilient characters, find
activities that bring you joy and invite family or friends to join you, or spend
time with children.
• Rebuild your shattered beliefs about the world by exposing yourself to
goodness.
• Travel, visit new places, fly a kite, go hiking, go camping, or be with nature.
• Identify activities that give you a complete new sensory experience and that
will literally expand your worldview.
• You need a variety of experiences to balance your exposure to trauma. Meditate, do
yoga, exercise, dance, write in a journal, or create art.
• Enhance your ability to connect to yourself and others.
• Get a massage, pedicure, or facial.
• See a therapist of your own.
• Take a long bath.
• Light a candle, lie down, and listen to your favorite music.
• Take a personal day off to participate in activities you enjoy.
• Take care of yourself at work, too! Take a lunch break away from your desk.
• Ask your agency for supervision and debrief calls with a supervisor or colleague.
• Embellish your workspace with bright colors or fun decorations.
• Attend a conference to recharge your battery.
• Walk around the block for a quick refresher.
• Eat well.
• Discover a favorite hobby and pursue it.

**Bringing it Home:**

- What do you keep in your jar of “restorative balm?”
- Does your agency provide an encouraging environment for staff/volunteers to talk to one another about the stresses of advocacy and the toll it can take on you personally?
- Have you had feelings of burnout? If so, what have you done about it?
Guidelines for Making an Appropriate Referral

Key Learning Points:
• Before making the referral, talk with the victim/survivor to establish what her/his needs are (i.e. counseling, financial assistance, etc.)
• After establishing what type of service the victim/survivor is asking for, search for agencies offering this service. If there is more than one, give the victim/survivor that information. This will allow her/him to have options to choose from which can feel empowering.
• It is helpful to call an agency and inquire if you are unsure of something, for example, what services they provide or if there is a cost to their services. This will save the victim/survivor the hassle and stress of calling an agency only to find out they can not help.
• Remember that it is always up to the victim/survivor as to what resources or services they choose to look into and receive.

Your role as an advocate will often mean that you will need to refer sexual assault victims/survivors to other community agencies. Situations often arise that you do not have the resources or expertise to deal with. It is important that you be aware of local agencies that provide services for the victim/survivor.

Your local center will maintain a list of community resources that will assist you in providing a victim/survivor with an appropriate referral.

Steps in making an appropriate referral:
• What are the victim/survivor’s immediate needs?
  – Medical: injuries, evidentiary exam, STI, pregnancy, and other medical problems;
  – Law Enforcement: reporting, protection, or safety;
  – Legal: prosecution, Order for Protection, divorce/separation, or sexual harassment;
  – Financial: information or assistance;
  – Food/Shelter; and/or
  – Counseling/Therapy: sexual assault, chemical dependency, marital, family, support groups, long-term therapy, etc.
• What community agencies offer those services?
• Know the resources available in your area and utilize the internet for additional services.
• If several agencies offer a service, check with your program coordinator about which may be most appropriate related to the victim/survivor’s needs.

• If several agencies offer a service, it is empowering to offer more than one option.

• The ultimate decision to seek other services belongs to the victim/survivor. The advocate’s role is not to insist or to pressure the victim/survivor to seek such services.

• In some areas and in some cases, you might offer to accompany the victim/survivor to the appropriate agency (e.g., hospital emergency room, police).

• In some referrals, it is helpful to check some issues out with the referral agency ahead of time. For instance, it may be helpful to inquire whether certain therapists/counselors have experience with issues of sexual assault and have openings in their schedules before referring victims to them. Victim/survivor’s rights need to be protected in such cases. Maintain confidentiality. In particular cases you may wish to have a client sign an authorization for the release of confidential information.

• Similarly, in certain agencies it may be most helpful to refer victims/survivors to specific staff. Check with your program coordinator.

• Be respectful when referring. Listen, probe, and clarify to be sure that you have a grasp on all the victim/survivor’s needs. Do not refer like a "hot potato". The victim/survivor may also need you to listen and validate feelings or to provide other services through your agency.

Part of your role as an advocate is providing victims/survivors information about their options. An important piece of that is making them aware of other services that are available to them.

It is a good idea to have knowledge about services in your community in order for you to give the best referrals to your clients.

Bringing it Home:

• Are you familiar with all of the different types of service providers in your area?
• Does your agency have a resource book or some kind of easy access to this information for you to refer to?

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There are many other professionals with whom you may come into contact with as an advocate. They may include law enforcement officers or representatives of the courts; nurses and doctors and other medical personnel; social workers; psychologists, counselors and therapists; other volunteers and members of other crisis centers. While interacting with these other service providers, it might be helpful for you to consider these guidelines:

- Clarify and identify your role. You're not doing their job or threatening it.
- Be respectful of their own problems in their job.
- Take a "How can we work on this program together?" approach rather than "You're doing something wrong." Give affirmation and recognition wherever possible.
- Don't demand confidential information they can't share.
- If possible, go to them. Meet them at their own place, try to adapt to their schedule. Speak the language with which they are familiar.
- Don't assume they know the basics of sexual assault. Check it out. Make them aware of the training opportunities that may be relevant to them. Recognize that service providers may have anxieties or fears about sexual violence. Help them feel more comfortable. Keep them up to date on the latest developments in the sexual violence field, as well as the resources your program offers. Encourage them to develop skills for working with sexual violence issues from their own agency standpoint.
- Ask for their input. You can always learn something new from someone specialized in another area. In some cases your center may want to invite them to provide a special training session for your workers.
- Encourage interagency meetings or teams to build professional relationships before responding to a sexual assault. Try to eliminate turf issues. There are many areas where a coordinated approach between agencies is the best way to get the best service for clients. Sexual assault victims/survivors are best served by a coordinated and consistent response system.
- Work out differences as soon as they surface. Don't wait to let feelings fester. Be careful about dumping or being dumped on. Don't criticize other service providers behind their backs. Be assertive and share your concerns in a professional manner with whom you have problems.
- Admit your own mistakes with others. We all make them and need to own up to them.
- Recognize your limitations. You can't please everyone all the time. Don't compromise your beliefs and philosophy to meet their needs. Decide what your integrity requires.
Health and Medical Issues
Health and Medical Issues in Sexual Violence: An Overview

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Key Learning Points:

• Victims/survivors of sexual assault have rights when receiving medical attention.
• It is important to explain the purpose of the evidentiary exam to the victim/survivor; some victims/survivors feel very uncomfortable having a pelvic exam after a sexual assault.
• Identify ahead of time a quiet and private place you can wait with the victim/survivor at the hospital to ensure confidentiality.
• Establishing rapport with hospital staff can help make your job and the victim/survivor’s experience easier.
• The victim/survivor may have fears about pregnancy or STI infection; make sure they get their questions answered, and make sure the victim/survivor gets testing and prophylaxis if s/he requests it.

Due to the nature of sexual violence, victims of sexual assault and/or abuse may need or desire medical care. An exam at a medical facility can accomplish multiple goals: to collect evidence to help in prosecuting the assailant (if the victim chooses) and to check for injuries and other health-related concerns. An advocate can be extremely helpful in a medical setting for the victim. This chapter includes:

• Introduction
• Responding to the Initial Call
• Victims Rights Receiving Medical Attention
• When the Victim Arrives at the Emergency Room
• Role of the Advocate in a Medical Setting
• Role of Medical Personnel
• Role of Law Enforcement, if called
• The Physical Examination
• Exam Payment
• Follow-up Medical Care
• Health Issues of Sexual Assault Survivors
• Sexually Transmitted Infections
  – Pregnancy
  – HIV/AIDS and Sexual Assault
  – HIV Testing Sites in Minnesota
    ◦ Glossary of Medical terms
    ◦ Additional Resources
    ◦ List of References
• Drug Facilitated Sexual Assault (DFSA)
Introduction

One option available to victims/survivors of sexual violence is to seek attention at the emergency room (ER) or emergency department (ED). Visiting the ER/ED, however, can be an overwhelming experience as it can be a very busy setting. It would be nice to say that the victim/survivor will be treated and cared for immediately but, the reality is that it may be some time before they are seen. It is valuable to take into account the following resources that can be provided by the ER/ED:

- To document any injuries the victim has and to begin treatment for those injuries. Frequently following an assault, a person's normal state of shock may mean they are unaware of injuries;
- To prevent sexually transmitted infections (STIs);
- To evaluate and prevent the risk of pregnancy resulting from the assault;
- To collect evidence for possible prosecution if and when the victim/survivor chooses to report the assault to law enforcement. It is vital that this evidence be collected as soon as possible for it will be lost as time passes; and
- To take the first steps toward regaining control of one's life.

Responding to the Initial Call

When a victim/survivor contacts a rape crisis center after an act of sexual violence, the points below should be given priority. This list is not an exhaustive discussion of responding to a crisis call. Only those points relative to the evidentiary exam are discussed here. This list presumes that you have established rapport, reassured the caller that this is a safe line and safe place to pose questions and learn options, helped the caller assess her immediate safety, established yourself as a supportive and helpful resource and attended to all of the initial needs talked about elsewhere in this manual.

- If the assault occurred recently – roughly within the past 72 hours – discuss the option of being seen at the local ER/ED as soon as possible. If the assault happened longer ago, medical attention may still be offered as an option. While it is less likely that evidence can be collected, it is up to the nurse or physician to determine whether or not medical attention is warranted. Referral to the ER/ED is a good and appropriate step.
- The payment for the evidentiary exam is covered by the county in which the assault occurred. This is true whether or not the victim chooses to make a report to law enforcement.
- There may be some costs associated with the non-evidentiary part of the exam such as medical treatments, etc. that the victim/survivor may be responsible for paying. Check with your local hospital to see what is covered by the county. You can let the victim know there are other means of meeting some of those costs (e.g. crime victim reparations, emergency fund, etc.)

Being seen at the ER/ED will not result in a report to law enforcement unless the assault is involves a mandated report (a child who is assaulted by a person in position of authority or in significant relationship OR a vulnerable adult. See chapter on mandated reports). or unless the victim wishes to report the crime to the police. In Minnesota, there is no mandatory report requirement for sexual assaults for competent adults.

Health and Medical Issues 2
Health care providers are required to report to law enforcement any gunshot wounds, burns, and other injuries that the medical provider has reasonable cause to believe have been inflicted by a perpetrator of a crime using a dangerous weapon other than a firearm.

Advise the victim/survivor that they have a right to have an advocate available at the hospital to offer support and information. Let them know you or another advocate will meet them there. Make sure the victim/survivor knows which hospital to go to and where to meet. Because not all medical settings in a community perform the evidentiary exam, you should verify which location performs the exams in your community. Usually, a family physician will not perform the exam because of the particular legal nature of the process.

Often victims/survivors have not considered the potential of sexually transmitted infections or pregnancy as a result of an assault. As you discuss the reasons to go to the ER/ED, be aware that these suggestions may be startling to a victim. Ensure the individual that they may address these concerns and seek appropriate medical care for them at the ER/ED.

If the victim/survivor is undecided about reporting the assault to law enforcement, the exam should still be offered as a strong option (most victims start with the assumption that they will NOT be making a report!). Collecting evidence now will be important if the victim decides later to make a report. Evidence available now will not be available in subsequent days. If the victim ultimately decides not to report, the Sexual Assault Evidence Collection Kit can simply be destroyed. In either case, the county will pay for the collection of evidence. If the victim/survivor ultimately decides to report the assault, it may greatly enhance the case if physical evidence was collected and is available. (There is information in the legal section of this manual about the reporting process.)

Advise the victim/survivor NOT to shower, bathe, douche, wash hands, brush teeth, comb hair, or urinate/defecate before going to an ER/ED; those actions may destroy evidence. Also, advise them NOT to change or destroy clothing, or straighten themselves up. As hard as it may feel not to clean up, doing so may destroy important evidence. If the victim/survivor is at home, suggest that s/he should arrange to take a change of clothing along to the hospital because the clothing they wore during the assault may be collected as evidence.

If the victim is unsure about being seen at the ER/ED or feels s/he must urinate, advise the victim to collect the urine in a clean container so that it can be brought to the ER/ED to be tested for date rape drugs, including alcohol, and to keep the specimen in her/his possession until s/he gives it to the appropriate medical personnel. The purpose for doing this is to gather evidence of chemicals including alcohol that may have been used to facilitate the assault. The first urine void is the most promising way to catch some drugs that leave the system very quickly.

If the victim/survivor decides to go to the ER/ED, the advocate should follow the protocols established locally. If there are no protocols established, the advocate should call the ER/ED, and with the victim/survivor’s permission, alert them to the pending arrival of a victim/survivor of sexual assault. Their name should not be shared with the hospital at this point. The advocate should also let them know that s/he or another advocate will be dispatched to meet the victim at the ER/ED. With this notification the hospital may have time to make a private room available, secure the supplies necessary to do the exam, and call the appropriate staff — SANE (Sexual Assault Nurse Examiner), nurse, or physician. Also advise the victim/survivor not to clean up the scene if the assault happened in a place they have control of such as her/his place of residence, vehicle, etc. Evidence can be collected later when/if law enforcement arrives.
enforcement becomes involved.

Rights of Sexual Assault Victims/Survivors Receiving Medical Attention

A sexual assault victim/survivor has the right to:
• Gentleness and sensitivity during the medical examination;
• Privacy during the collection of medical evidence;
• Request a friend, family member, or advocate to accompany them in the examination room;
• Have each procedure explained to them in detail before it is done;
• Have an explanation of the reason for each test, form, or procedure;
• Refuse any portion of the collection of evidence.
• A change of mind once the exam procedure has begun. A victim can ask that the exam stop and expect that the request will be honored.
• Request prophylactics for sexually transmitted infections and/or pregnancy; however, it may not be paid for by the county. The victim/survivor and/or their insurance may be responsible for the charges, please check your local situation;
• Request that law enforcement officers, advocates, others leave the examining room;
• Request copies of medical reports;
• Expect strict medical confidentiality; and
• Have his/her reactions to the act of sexual violence understood rather than considered abnormal behavior. Everyone has different shock reactions such as delayed reporting, crying, hysterics (or lack of either), quiet, loud, angry, sleeplessness, nightmares, anxiety and fear, to name a few.

When the Victim/Survivor Arrives at the Emergency Room

A victim/survivor may present to the ER/ED with or without a referral. They may arrive on their own terms, with a friend or family member, law enforcement, or an advocate.

If the victim/survivor has made contact with an advocate, it is recommended that they agree on a place and time to meet. The advocate should have an official identification name badge or identification card (these should be supplied by the advocacy agency or the hospital). It is important that you introduce yourself to the victim/survivor, hospital staff, the SANE, and law enforcement (if present) in a manner that does not breach the confidentiality of the victim/survivor. This may be done by handing or showing your identification rather than speaking. It is important that you explain who you are, why you are there, and what services you can provide. Let the victim/survivor know that you can assist them in contacting friends and/or family members if they choose. Try to do all of this in a private place where you cannot be overheard. It is very important to protect the victim’s privacy, so be sure to ask the victim/survivor exactly what they want you to say to the person(s) you are calling.
If a victim/survivor arrives without referral from an advocate, a SANE (if the hospital has one) or a doctor or nurse, and a sexual assault advocate should be contacted immediately. With changes in federal privacy regulations (HIPAA) some hospitals have changed their procedures for calling advocates. Work with your hospital to address any concerns they may have about calling for an advocate. Try to secure a private waiting area for the victim/survivor.

The victim/survivor may wait for a period of time before they can be seen. Use this time to provide information and support about what to expect before and during the examination from medical and law enforcement. Providing them with such details helps them to feel more prepared. Also discuss with them the importance of being totally honest regarding any information, including alcohol/drug use. Check with your county on policies regarding any charges to the victim (such as underage drinking) while reporting sexual assault. Most counties will not pursue these charges against the victim/survivor.

Use this time to see to the victim/survivor’s physical and emotional needs, and to make arrangements for any concrete needs, such as contacting a significant other/family/friend or securing a safe place to stay.

Roles of Those Attending to the Victim/Survivor in the ER/ED

**Advocate**: Here is a short list – see the “Role of the Advocate in a Medical Setting” article after this section.

The primary role of an advocate in the medical setting is to:

- Provide a victim/survivor with information regarding their options and rights;
- Answer questions or find the answers to questions s/he may have;
- Provide emotional support and crisis intervention assistance;
- Help the attending professionals understand what the victim wants. Advocate for those requests to be honored.
- Work with the hospital staff. You are both united in wanting quality care for the victim/survivor. Ask about things you don't understand so that you can explain the procedure(s) to the victim/survivor. With an advocate available to attend to these needs, the medical provider can be freed to perform their tasks without interruption; and
- Work with law enforcement. If the victim/survivor chooses to report, let them tell their story. Do NOT tell law enforcement details the victim “forgot.” DO NOT talk or ask questions during the statement. If the victim/survivor chooses not to report law enforcement and they have been erroneously called, explain to them without violating the victims privacy, that they are not needed at this time.

**Medical Provider**: The medical provider may be a SANE, RN, or physician/physician's assistant (PA). A SANE is a registered nurse who has received advanced training and education in the medical-forensic examination of sexual violence victims/survivors. A SANE also has been trained to respond to the psychological and emotional trauma that a victim/survivor may experience as a result of the assault. Some hospitals have SANES available; most provide nurses, physicians, or PAs to conduct the exams. In the absence of a SANE, a nurse will usually conduct the
exam with the internal genital examination done by a doctor.

The principle responsibilities are to:
• Provide medical care for the physical health concerns of the victim/survivor; and
• Conduct an evidentiary exam to collect any forensic evidence that may be present on the victim/survivor’s body.

Other responsibilities of medical personnel include:
• Providing information regarding STI testing and treatment options, and follow-up (see later section on testing);
• Making sure the victim/survivor is aware of their rights;
• Obtaining informed, written consent for certain procedures;
• Providing written instructions for follow-up and information about available resources;
• Acting as a liaison to advocates, law enforcement, and/or other resources requested by the victim/survivor; and
• Being able to provide testimony if the case goes to court.

Law enforcement (if requested by the victim or in cases where reporting is required):
The primary role of law enforcement is to interview the victim/survivor. *

Other responsibilities include:
The officer may or may not pick up the evidence from the evidentiary exam. Every hospital/county has different protocol, so please check the situation in your area;
• Making the decision to arrest the offender if they feel they have enough information to do so;
• Assessing the risk to the community; and
• Assessing the offender’s risk of flight.

*It is not unusual for medical personnel who have not been well trained to assume that all sexual assaults require a call to law enforcement. That is not true. If a law enforcement officer has been called to the ER/ED erroneously by the medical provider and the victim/survivor remains unsure about reporting the assault, they have the right to not speak to the officer.

Role of the Advocate in a Medical Setting

Your primary responsibility is to the victim/survivor. Be courteous and tactful to the hospital, but remain aware of the needs and rights of the victim/survivor.

It may be that your first meeting with a victim/survivor of sexual violence is at the hospital. In many respects, this can be an ideal setting because help can be provided in several areas at once. The advocate can assist in explaining procedures and policies, offer concrete aid as needed, assist in clarifying options about such issues as reporting or possible pregnancy and, most importantly, be with the victim/survivor at a painful and lonely time. You may need to repeat or to check with her/him for understanding. A calm soothing manner can be helpful to the victim/survivor. Try to avoid technical language, medical jargon, or words that they may not
understand. When the person has adequate and accurate information about what to expect, choices to make, and his/her rights in the situation, anxiety and helplessness can be significantly reduced. Empowerment and healing can begin.

Your primary responsibility is to the victim/survivor. Be courteous and tactful to the hospital, but do remain aware of the needs and rights of the victim/survivor. Try to stay out of the way of hospital personnel performing their tasks and examinations. If you do not know the answer to a question or the reason for a procedure, ask the attending nurse or physician to explain. Many hospitals have had training to sensitize personnel to issues of sexual assault victims/survivors. The ethic of healing and caring is shared by you and health care professionals. Hospitals can be extremely busy places (especially emergency rooms), however, and sometimes procedures can become bureaucratic. If you feel that a staff member is not sensitive to the person’s needs, ask to speak to them in the hall. Explaining how the victim/survivor is feeling and the effect their behavior has on them can be effective.

You may have arranged to meet the victim/survivor in the emergency room, been called by hospital personnel, or be accompanying the individual to the hospital. When presenting to the hospital, bring a business card or other identification that states you are from a sexual violence advocacy program so that you do not need to say out loud why you are there. If you enter with the victim/survivor, let her/him give their name and answer any questions. Your job is to make sure this is done in a private area away from the general public. If you are meeting the victim/survivor there, ask the person in charge of the emergency room for the name and/or location of the victim/survivor.

When you meet the victim/survivor, assess their emotional state and what their needs are. Their needs may include the following:

- Support and understanding;
- Desire to talk about the act of sexual violence;
- Information: medical, legal, etc.; and
- Concrete assistance: notifying a significant other/family member/friend or partner; a change of clothing; transportation home; a safe place to go after leaving the hospital.

Use the time you have together to begin meeting these needs. A wait before examination can be used to process feelings, give explanations, or make arrangements. Explain the medical exam. Stress the importance of this exam to be sure s/he is physically okay and to begin treatment for any injuries. By emphasizing the person’s safety, well-being, and health, you can help the victim/survivor to deal with feelings of being scared and hurt by the assailant.

If the victim/survivor identifies as a female and has never had a pelvic exam before, she may be very anxious about the procedure. Waiting time can be used to explain what will happen if she seems anxious about it. Women who have had pelvic exams before should be assured that the procedure is basically the same as those they have had before. A victim/survivor may be worried that the exam will be painful because of her possible injuries, and it may be. She should be assured that the physician will be as gentle as possible.

In the victim/survivor’s mind, the exam may be the second time in a short period that someone has had access to her/his genitals against their will. It’s...
understandable that the process may bother them. It may help if the advocate, a family member, or friend is in the room with them during the exam. Be aware that law enforcement and hospital staff prefers not to have family or friends in the room while the victim/survivor is stating what happened. The victim/survivor may not reveal all the details necessary if someone close to them is in the room. Explain this to the victim/survivor, and let them know that you, the advocate, could remain if s/he would feel more comfortable. If s/he is adamant about having a family member or friend present, s/he has that right. During the actual exam s/he can have whomever s/he wants in the room for their comfort. Explain that some victims/survivors prefer to be accompanied and some do not. It is their choice.

If s/he does choose to have an advocate present in the examining room, there are a number of ways you can be helpful. S/he may tense up from fear, making the exam more uncomfortable. Stand at the head of the bed and look at his/her face or the wall to provide them with some privacy. Try to help them relax, use deep breathing techniques, offer that s/he can hold your hand, and talk in a soothing manner. They may or may not want you to explain the procedures. Take your cues from them. DO NOT ask if you can hold their hand, and do not grab their hand without permission.

Before or after the exam itself, the advocate can clarify questions about reporting the act of sexual violence to law enforcement. Whether to report the act of sexual violence may be an issue to help clarify for the victim/survivor. By reporting the crime, a victim/survivor is providing evidence the police may use to apprehend or prosecute the assailant(s). Check your county's policy. If s/he seems uncertain or does not want to report the crime at this time, you might suggest that having the evidentiary exam would keep options open for the future. Without the evidentiary exam, the victim/survivor will foreclose options for retrieving evidence that could have been collected in the exam. Just because s/he forgoes the exam, however, does not close her/his options for reporting or prosecuting (for further information, see the chapter on Legal Issues). The choice is theirs. You might offer to contact law enforcement if the victim/survivor so desires.

If the person is alone, ask whether there is anyone s/he would like to have called. The victim/survivor may wish to ask them to come to the hospital or just let them know where they are. An advocate should check with the victim/survivor about what kind of information to convey: is it okay to say that the individual has been sexually assaulted? Is it okay to talk with whomever answers the phone, or should the advocate talk only to the specific person named? If family or friends are present, the advocate can inform and reassure them about the victim/survivor’s condition. Providing information about how victims/survivors, as well as friends and family members, often cope can help to ease issues they may face later.

If the victim/survivor is a female, you may want to help her assess whether there is a possibility that she is pregnant. Be sure to listen in a non-judgmental way and provide her with information about her options.

Some victims/survivors may wish to talk about the incident(s) now, either to you or to medical and police personnel. Let the person do so freely. Due to shock, victims/survivors may repeat the story as if in a daze or because the events seem so unreal.
Others may not wish to talk about these traumatic events. They may find medical or legal questioning distasteful and frightening. They may be withdrawn or expressive. Whatever their feelings or style of expressing feelings, validate the individual. Someone who can't stop crying may feel that they do not understand what is happening or that they are going crazy. Your reassurance can be important.

Let all victims/survivors know that you or other advocates at your sexual assault advocacy program will be available to talk when they want to do so. Be sure that, before you leave, the person has the phone number of your program center.

The advocate should check the person's safety when s/he leaves the hospital. If going home is not a possibility for some reason (for instance, the attack occurred there), the advocate can help arrange for a safe place for the victim/survivor to go (to the home of friends, other family members, women's shelters). They may decide to go home but want someone to accompany them or stay with them, especially immediately after an assault. The advocate can help to identify such persons and contact them.

Why the Medical/Evidentiary Examination is Important

As an advocate, it is essential to understand why the medical/evidentiary examination is important. The following points may help to inform your work and support of the victim/survivor:

• To document any injuries the victim/survivor has no matter how minor, and to begin treatment for injuries. Frequently following an assault, a person's normal state of shock may mean they are totally unaware of injuries.
• To prevent sexually transmitted infections, and to evaluate and prevent the risk of pregnancy resulting from the assault —this assists in easing fears the victim/survivor may have about these consequences of sexual violence.
• To collect evidence for possible prosecution if and when the victim/survivor chooses to report, and a suspect is caught. It is vital that this evidence be collected as soon as possible, for it will be destroyed as time passes. Know your local policies about who keeps the kits and how long before the kits are destroyed if the victim/survivor chooses not to report.
• To take the first steps toward regaining control of one's life.

Physical Examination

Physical evidence of a sexual assault can be quickly lost. Optimally, victims of sexual violence should be referred for a medical-evidentiary exam within the first 72 hours after the assault. The sooner the victim presents to the emergency room for the medical-evidentiary exam the better. Evidence, however, still may be found after the 72 hour window has expired. It is recommended that victims still be referred to medical personnel within a reasonable period of time if it is thought that physical evidence may still be present. The medical personnel, based on their professional opinion, will decide if an exam should still be completed.

If the victim was held captive, if significant physical force was used during the assault, or if the victim was not able to clean her/his body after ejaculation had...
occurred, evidence may still be available. Specifically, in captivity, a victim may have had limited access to clean up or may have experienced repeated assaults causing significant injury, which may result in physical evidence lasting longer than 72 hours. Moreover, bruises or cuts can sometimes be apparent for days or weeks. And in some cases, it may take days for bruises to develop.

Elements of the Exam

The medical-evidentiary exam, which is conducted by the SANE (Sexual Assault Nurse Examiner) or other medical professional (usually an ER nurse and doctor), will consist of two main procedures:

- **Interview or Medical-Legal Assault History**: is an interview of the victim to establish what events occurred during the assault and a physical examination. The purpose of the interview is to assist in guiding the SANE in the collection of evidence and examination of injuries. The victim will be asked questions similar to these:
  
  - General information — name, address, age, why the victim is at the emergency room.
  - Specific aspects of the incident that are required to do the exam such as — date, time, place; body orifices involved; whether the assailant ejaculated and where on the body; whether or not the assailant used a condom; whether or not there was an object used in the assault and where; contraceptive devices ordinarily used by the victim.
  - Menstrual history — date of last menstrual period, menstrual abnormalities, length of usual menstruation, current medications and contraceptives, etc. This information is to evaluate pregnancy risk and information required for evidence evaluation.
  - Time of last intercourse — questions about previous consensual sexual intercourse are posed to assist the lab in separating physical evidence of the consensual partner from evidence from the assailant. While this question might seem intrusive, assist the victim in understanding the importance of identifying the source of physical specimens.
  - The individual will be asked to sign one or more release or consent forms.
  - The individual will need a change of clothes in order to leave the hospital. If s/he was not in a position to obtain a change of clothing before arriving at the emergency room, you can help make arrangements to obtain them. Some hospitals keep a supply of donated sweatshirts and toiletries to assist victims at this time.

- **Physical Exam or the Medical-Legal Exam**: After completing the interview, the medical provider conducts a physical examination to collect any forensic evidence. The directions in the Sexual Assault Evidence Collection Kit supplied by the Bureau of Criminal Apprehension lead the provider step by step through the required process. Each medical facility that performs evidentiary exams will be supplied Sexual Assault Evidence Collection Kits free of cost by the Bureau of Criminal Apprehension, a branch of the MN Department of Public Safety.
  
  - The medical provider will collect any clothing that may have possible
evidence. If the victim is still wearing the clothing worn during the assault, s/he may be asked to remove the clothing while standing on a sheet. This sheet is used to collect any evidence, such as hairs and fibers, which may fall when removing the clothing. The sheet and the clothing will be placed in separate paper bags, sealed, and marked as evidence. Plastic bags are not used as they may support the growth of mold and mildew. Paper bags allow the items to dry naturally without destroying evidence.

- Elements of a general examination include the following:
  ◊ Collect urine at the start of the exam to save for drug testing to document drug facilitated sexual assault (see later section on DFSA). If it will be a long wait for the exam, advocates can ask that the urine be collected as soon as possible and then wait for the exam.
  ◊ Blood pressure, pulse, temperature and respiration rate will be taken.
  ◊ The medical provider will check for and document bruises, cuts/tears, marks, blood, traces of semen on the outside and the inside of the vaginal area. Pictures of injuries will be taken for documentation and to corroborate force. Reminder: Often bruises do not appear until several hours after the assault. A victim who sees bruises becoming more defined should be prompted to return to the ER/ED for additional photos.
  ◊ Pelvic and rectal examinations will be conducted if details of the assault warrant them. A speculum will be inserted into the vagina to check for injuries or abnormalities.
  ◊ Vaginal and perineal swabs will be taken to collect sperm and DNA.
  ◊ A blood test for STIs and urine samples for a pregnancy test will be taken.
  ◊ Pubic hair combings may be taken. This is usually done by the victim. S/he will be asked to sit on a piece of paper and using a small plastic comb will comb through the pubic hair. Whatever is released onto the paper will be enfolded in the paper and placed into an envelope for laboratory testing. Elements from the crime scene may be recovered. (Old practices called for pulling pubic and head hair for comparison with potential assailants. That step is no longer taken.)
  ◊ Saliva tests may be taken. This is usually done with a buccal swab.
  ◊ Material under the victim's fingernails may contain evidence useful to prosecution. This is only done when the victim reports scratching the assailant.
  ◊ A Wood's light may be used to check the body. This ultraviolet light can detect semen, saliva and other fluids on the victim's body. Scrapings or swabblings of areas that fluoresce under the Wood's light will be sent for laboratory testing. These swabbings may provide important DNA evidence.
  ◊ The victim's emotional status and feelings about the assault will be documented to also corroborate force and to assess her/him for emotional safety following the
The victim should be assessed and treated for any physical wounds that resulted from the assault when treated in the ER. The medical-evidentiary exam should also include the assessment of risk and prophylactic treatment of sexually transmitted infections; assessment of risk and emergency pregnancy interception; and crisis intervention, (see later sections on STD/STI testing and Emergency Contraception in the ER).

Chain of Custody

When evidence is collected at an ER/ED visit, the attending medical provider must be able to testify to the security of the evidence. This is called the "chain of custody." While the medical provider is in "custody" of the evidence, s/he must be able to account for it either being in her/his possession or locked and unavailable to anyone else. Chain of custody is documented on the outside of the kit or on a separate evidence form.

If a medical provider steps out of the room and does not lock up the evidence, the advocate may be put in an uncomfortable position of being called to testify about the security of the evidence. Medical personnel need to retain oversight of the evidence and should never ask an advocate to "keep an eye" on it while s/he leaves the exam room. Some facilities have the means to lock up the evidence when the person conducting the exam must leave the room. You should check with your local hospital.

At the conclusion of the exam, the kit can be turned over to law enforcement. Sometimes this will happen immediately but it is likely that it will be picked up at a later time or date. Just because the kit is turned over to law enforcement does not mean that the victim has to report the assault. Law enforcement will hold or send the kit to the BCA, depending on the victim’s decision to report.

Often, hospitals will hold and store a kit until the victim decides whether or not to report. Hospitals retain kits for various amounts of time and the advocate should talk to the hospital staff about their protocol. Advocates should talk to the victim about the implications of delaying a report. Any delay between the assault and report can be used by the defense to raise questions about the validity of the report.

Evidence Collection at the “Crime Scene”

Remember, the process being conducted at the ER/ED is part of the investigation of a crime and hence has legal ramifications. As an advocate in the medical setting it is imperative to remember that you are there to support the victim, not to become directly involved in the investigation. It is therefore critical, that you maintain this role and refrain from any acts or behaviors that might impact the investigation. For example, do not ask the victim questions related to the crime, do not take notes, and do not advise the nurse or physician about how to conduct the exam. Often, the advocate will have more experience with supporting the victim through an evidentiary exam than the attending nurse or doctor. It is not unusual for a medical
provider to ask the advocate what they should do next. Resist the temptation to answer that question! Refer the doctor/nurse to the step by step directions in the Sexual Assault Evidence Collection Kit.

Exam Payment

In Minnesota, the victim does not pay for the medical costs associated with gathering forensic evidence of a sexual assault. The county where the sexual assault occurred pays these costs. The county must cover these expenses, even if the victim decides never to report the assault to law enforcement and even if the assault is never prosecuted or investigated. While the victim can request that insurance be billed for the evidentiary exam the county cannot require that of a victim. The hospital can only ask the victim about the insurance option after the exam is completed. The hospital must also reassure the victim that not using insurance will not affect her/his ability to receive services. Each county interprets the “costs” a little differently so we encourage you to check with your local hospital(s), county attorney, police department(s), and/or MNCASA.

Payment for Sexual Assault Exams When the Assault Occurs in One State BUT the Exam Occurs in a Different State

If a sexual assault occurred in another state and the exam is done in Minnesota, please contact your counterpart in the state where the assault occurred to find out more about their current laws regarding payment for exams.

Health Issues of Sexual Assault Survivors

Sexually Transmitted Infections (STIs): Routine protocol as a part of the medical/evidentiary exam is to test for STIs, including HIV/AIDS. The reason for this testing is NOT to determine whether the victim contracted an infection at the time of the assault, but to establish a baseline against which to test the victim in the future. Infections and pregnancy do not show up immediately, so injury of this nature can only be determined by the follow up testing several days or weeks following the assault and initial exam. For that reason, there are some important considerations:

- If a victim knows or believes s/he already has an STI and is worried that this information could become a part of the legal process, s/he can refuse testing at the time of the evidentiary exam and go to another facility (Planned Parenthood, or a public health clinic such as the Red Door, etc.) to have the baseline tests conducted. That way if the hospital records are used for legal reasons, the court will not have records of her/his previous STI status.
- Some medical facilities do not test for STIs but routinely administer prophylactics - a heavy dosage of antibiotics to counteract any possible infection. Due to the prevalence of STIs today, it is safe to assume that
the individual was exposed to an STI. This is an acceptable and common way to respond to the threat of infection.

- It is very important for advocates to encourage a victim to go to any follow-up medical exams that are scheduled. These exams, usually scheduled between 2 and 6 weeks after an act of sexual violence, can determine whether or not infection or pregnancy occurred as a result of the crime. Please see the section regarding Medical Follow-Up Care.
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| Chancroid          | Chancroid is a highly contagious sexually transmitted infection caused by the bacteria *Haemophilus ducreyi.* | - Begin 4-10 days after exposure.  
- Chancroid causes ulcers, usually of the genitals.  
- Painful and draining open sores in the genital area.  
- Painful, swollen lymph nodes in the groin. | - Vaginal Sex.  
- Oral Sex.  
- Anal Sex.  
- Skin to skin contact with infected lesions or sores. | If left untreated, Chancroid can:  
- Cause destruction of foreskin tissue on penis; and/or  
- Open sores can become infected with other germs. | - Always use latex condoms during vaginal and anal sex.  
- Use a latex condom for oral sex on a penis.  
- Use a latex barrier for oral sex on a vagina or anus.  
- Limit the number of sex partners.  
- Get tested if you suspect you have it.  
- Notify your sex partner(s) immediately if you are infected.  
- Infected sex partner(s) should be tested and treated. | - Chancroid can be cured by antibiotics.  
- Requires medication prescribed by doctor.  
- Treat partners at the same time. |
| Chlamydia          | A bacterial infection caused by the bacterium *Chlamydia trachomatis.* It is the most commonly reported bacterial STI. | - Known as a “silent” disease, Chlamydia is symptomless at first.  
- After the disease progresses, some of the symptoms include: odorless discharge and burning during urination, and later on may lead to Pelvic Inflammatory Disease (PID). | - Vaginal sex.  
- Oral sex.  
- Anal sex.  
- From an infected mother to her baby during a vaginal birth. | - Urethritis in men.  
- PID in women.  
- PID can lead to infertility and tubal pregnancy. | - Latex condoms can reduce the risk of Chlamydia.  
- Chlamydia screening is recommended annually for all sexually active women 25 years of age and younger, for older women with risk factors for chlamydia (a new sex partner or multiple sex partners), and all pregnant women. | - Can be treated and cured by antibiotics. |
| Gonorrhea          | Gonorrhea is a bacterial infection caused by the bacterium *Neisseria gonorrhoeae.* | Symptoms appear within 2 days to 4 weeks:  
- Painful urination;  
- Pus-like discharge;  
- Bumps on the cervix - anal irritation;  
- Painful bowel movement; and/or  
- As it worsens, pain in the lower abdomen on both sides, vomiting, fever, and irregular menstrual periods occur. | - Vaginal sex.  
- Oral sex.  
- Anal sex. | Can lead to Pelvic Inflammatory Disease (PID), which can cause infertility and tubal pregnancy. | Latex condoms can reduce the risk of Gonorrhea. | - Can be treated with antibiotics.  
- Many strains of gonorrhea are resistant to antibiotics, so if symptoms persist the individual should go back to their doctor. |
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<td>Hepatitis B</td>
<td>Hepatitis B is a serious liver disease caused by a virus which is called hepatitis B virus (HBV).</td>
<td>Symptoms include: - Yellow skin or yellowing of the whites of your eyes (jaundice); - Tiredness; - Loss of appetite; - Nausea; - Abdominal discomfort; - Dark urine; - Grey-colored bowel movements; and/or - Joint pain. Many people also do not display symptoms.</td>
<td>- Sex (vaginal, anal, or oral) with an infected person and from a mother to child during childbirth. - Exposure to infected blood from skin puncture or contact with mucous membranes. - HBV is not spread through food or water, sharing eating utensils, breastfeeding, hugging, kissing, coughing, sneezing, or casual contact.</td>
<td>May develop chronic (lifelong) infection, which increases the risk for cirrhosis (scarring of the liver), liver cancer, and liver failure.</td>
<td>- The Hepatitis B vaccine is the best prevention against Hepatitis B. - Latex condoms may also help to reduce the transmission of HBV.</td>
<td>There are no medications to cure HBV infection. There are antiviral drugs available for the treatment of chronic HBV infection.</td>
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<td>Herpes, Herpes Simplex Virus (HSV)</td>
<td>Herpes is a viral infection caused by the herpes simplex viruses type 1 (HSV-1) and type 2 (HSV-2).</td>
<td>Most individuals have no or only minimal signs or symptoms from HSV-1 or HSV-2 infection. When signs do occur, they typically appear as one or more blisters on or around the genitals or rectum. The blisters break, leaving tender ulcers (sores) that may take two to four weeks to heal the first time they occur. Typically, another outbreak can appear weeks or months after the first, but it almost always is less severe and shorter than the first episode.</td>
<td>HSV-1 and 2 can be found and released from the sores, but they are also released between episodes from skin that does not appear to be broken or to have a sore. HSV-2 infection is most likely during sexual contact with someone who has a genital HSV-2 infection. HSV-1 causes infections of the mouth and lips, (“fever blisters.”) A person can get HSV-1 through the saliva of an infected person. HSV-1 infection of the genitals may occur by oral-genital contact with a person who has the oral HSV-1 infection.</td>
<td>Herpes can cause recurrent painful genital sores, and herpes infection can be severe in people with suppressed immune systems. Regardless of severity of symptoms, genital herpes frequently causes psychological distress in people who know they are infected. It can also be potentially fatal for a baby who contracts HPV from its mother.</td>
<td>The consistent and correct use of latex condoms can help protect against infection with herpes. Condoms do not provide complete protection because the condom may not cover the herpes sore(s), and viral shedding may nevertheless occur. If either you or your partner have genital herpes, it is best to abstain from sex when symptoms or signs are present, and to use latex condoms between outbreaks.</td>
<td>Since there is no treatment that can cure herpes, the infection can stay in the body indefinitely. The number of outbreaks tends to go down over a period of years, but antiviral medications can help to shorten and prevent outbreaks during the period of time the person takes the medication.</td>
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<td>Human Immuno-Deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)</td>
<td>HIV is a virus that creates a deficiency with the body’s immune system. As the virus takes control of the body and the CD4 T cell count declines, AIDS develops.</td>
<td>Typically, a person will show no outward signs of illness. It may be years before symptoms appear. Severe flu-like symptoms may eventually appear after the initial infection as a sign that the immune system is kicking-in to fight off HIV.</td>
<td>HIV is spread by sexual contact with an infected person, by sharing needles and/or syringes (primarily for drug injection) with someone who is infected, or, less commonly, through transfusions of infected blood or blood clotting factors. HIV-infected women can infect their babies before or during birth, or through breast-feeding. HIV is transmitted by the following fluids: blood, semen (including pre-semenal fluid), vaginal secretions, and breast milk.</td>
<td>A person who has developed AIDS will eventually struggle to fight other illness-causing infections, some of which can be life-threatening.</td>
<td>Condoms may help to reduce the risk when engaging in vaginal, anal, or oral sex. Consider getting tested for HIV regularly.</td>
<td>There is no cure for HIV/AIDS. A variety of drugs are used to slow down the damage that HIV does to the immune system. When they are effective, these drugs reduce the amount of HIV in a person's body. The drugs do not totally rid the body of the virus.</td>
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<td>Human Papilloma Virus (HPV)/&quot;Genital Warts&quot;</td>
<td>Genital HPV infection is caused by Human Papilloma Virus (HPV). HPV is the name of the group of viruses that includes over 100 different types, over 30 of which are sexually transmitted. Certain types of these viruses are &quot;high-risk&quot;. Other types of these viruses cause genital warts.</td>
<td>Most people don't know they are infected. Others get visible genital warts. Genital warts can be found on the vulva, cervix, in or around the vagina or anus, and on the penis, scrotum, groin, or thigh. They look like a small hard bump or cluster of bumps. They start off as small, painless spots. Some cannot be seen by the naked eye. The types of HPV that cause external genital warts are not linked with cancer. Two strains of HPV have been linked to cervical cancer. Generally, as many as 70 percent of all sexually experienced people may have one of many genital warts viruses; less than one percent of these infected people will develop visible warts.</td>
<td>The types of HPV that infect the genital area are spread primarily through sexual contact with someone who is infected. &quot;High-risk&quot; HPV may cause abnormal Pap smears and cancer of the cervix, anus, and penis.</td>
<td>HPV can occur in genital areas that are covered or protected by a latex condom. They can also occur in areas that are NOT covered or protected. Latex condoms can reduce the risk of HPV only when the infected areas are covered or protected by the condom. In addition, the use of latex condoms has been associated with a reduction in risk of HPV-associated diseases, including genital warts and cervical cancer. The recent development of a vaccine—Gardasil—may also help to prevent the contraction of certain strains of HPV.</td>
<td>There is no &quot;cure&quot; for HPV. Diagnosis of genital warts is usually made by a direct visual exam, however, there is a magnification procedure for locating warts on the cervix. Genital warts can be treated easily with cryotherapy (dry ice treatment). Drugs like podophyllin solution and trichloroacetic acid (TCA) can also be used directly on the warts. Most women are diagnosed with HPV on the basis of abnormal Pap smears.</td>
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<td>Nongonoccal Urethritis (NGU)</td>
<td>NGU is most often caused by Chlamydia.</td>
<td>Most people have no symptoms. Symptoms may develop within 1-3 weeks of exposure. There may be: clear, yellow, or white pus from the penis; discharge or burning of the vagina; burning or pain during urination.</td>
<td>Vaginal sex. -Oral sex. -Anal sex. -An infected mother can also spread the germs to her baby.</td>
<td>Can lead to more serious infections. -Reproductive organs can be damaged. -May lead to infertility in men and women. -Can be spread to other sex partners.</td>
<td>Use of latex condoms may reduce the spread of NGU.</td>
<td>-The bacterial causes of NGU can be cured with antibiotics. -Sexual partner(s) should be treated at the same time.</td>
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<td>Pelvic Inflammatory Disease (PID)</td>
<td>PID is a general term that refers to infection of the uterus, fallopian tubes, and other reproductive organs. It is a common and serious complication of STIs, especially Chlamydia and gonorrhea.</td>
<td>Symptoms may include: -Lower abdominal pain -Fever -Unusual vaginal discharge that may have a foul odor -Painful intercourse -Harmful urine -Irregular menstrual -Bleeding -Pain in the right upper abdomen (rare). Symptoms may vary from none to severe</td>
<td>PID occurs when bacteria move upward from a woman's vagina or cervix into her reproductive organs. Many different organisms can cause PID, but many cases are associated with gonorrhea and Chlamydia</td>
<td>PID can damage the fallopian tubes and tissues in and near the uterus and ovaries. -Untreated PID can lead to serious consequences including infertility, ectopic pregnancy, abscess formation, and chronic pelvic pain.</td>
<td>Women can protect themselves from PID by taking action to prevent STIs or by getting early treatment if they do get an STI. -Also, regular use of latex condoms can reduce the risk.</td>
<td>-PID can be cured with antibiotics. -It is important not to delay treatment of PID as the consequences may worsen.</td>
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<td>Pubic Lice</td>
<td>Also called “crabs,” pubic lice are parasitic insects found in the genital area of humans.</td>
<td>Symptoms include: -Itching in the genital area -Visible nits (lice eggs) or crawling lice.</td>
<td>Usually spread through sexual contact. -Rarely, it can be spread through contact with an infected person’s bed linens, towels, or clothes. -Highly unlikely to get it from toilet seats.</td>
<td>N/A</td>
<td>Avoid sexual contact with a person who is infected with pubic lice. -Also avoid contact with an infected person’s clothes, sheets, and towels.</td>
<td>There are a variety of treatments available for pubic lice. Some may be obtained without a prescription at your pharmacy.</td>
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<tr>
<td>Syphilis</td>
<td>Syphilis is a bacterial infection caused by the bacterium Treponema pallidum.</td>
<td>-May not develop for years. -Primary symptoms: sores, or “chancres” (usually firm, round, small, and painless) on the external genitals, vagina, anus, or in the rectum. Sores also on the lips and in the mouth. -Rash, fever, swollen lymph glands, sore throat, patchy hair loss, headaches, weight loss, muscle aches, fatigue and mucous membrane lesions characterize the secondary stage of symptoms.</td>
<td>Syphilis is passed from person to person through direct contact (vaginal, anal, or oral sex) with a syphilis sore. Pregnant women can pass it to the babies they are carrying.</td>
<td>If symptoms go unrecognized or untreated the following complications may arise: -Difficulty coordinating muscle movements Paralysis; -Numbness; -Gradual blindness; -Dementia; and/or -Damage may be serious enough to cause death.</td>
<td>It is important that persons be screened for syphilis on an ongoing basis. -Latex condoms can help to reduce transmission.</td>
<td>Syphilis can be cured with antibiotics in its early stages.</td>
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<td>Trichomonas - “Trich”</td>
<td>Trichomoniasis or “trich” is caused by the parasite <em>Trichomonas vaginalis</em>.</td>
<td>Women may have no signs at all, or may have: - A frothy, creamy, yellowish or greenish discharge with itching; - Vaginal odor; - Abdominal pains; and/or - Frequent urination. Some men may have no signs at all while others have itching and/or lesions.</td>
<td>N/A</td>
<td>Latex condoms can reduce the risk of transmission of trichomoniasis.</td>
<td>-Trichomoniasis can be cured with a prescription drug called metronidazole. -Treatment must be given to both partners at the same time so that they won’t reinfect each other.</td>
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This section was created with the help of information from the Centers for Disease Control and Prevention, the Minnesota Department of Health, and the Minnesota AIDS Project.
**Pregnancy:** Pregnancy is a serious concern for victims/survivors of sexual assault, and approximately five percent of such cases result in pregnancy. This estimate may be different if the sexual violence included more than one act of sexual intercourse or if some form of birth control/protection was used (http://www.rainn.org/statistics/pregnancies.html). When the nature of the crime is such that the victim could become pregnant, then the victim may be interested in taking steps to respond to that possibility. Examples of sexual violence with risk of pregnancy include:

- Penile/vaginal penetration, however slight;
- Ejaculation in or near the vagina; and/or
- No protection or birth control method was used.

This is a response that requires immediate attention should the victim choose. Emergency Contraception (EC) is a method that can prevent the possibility of pregnancy.

- Hospitals will only prescribe EC once they have determined that the victim is not currently pregnant (a pregnancy that predates the assault.) Therefore, a pregnancy test is usually required before dispensing EC.
- EC, often called the "morning after pill," is marketed as Plan B. Plan B is similar to a high dosage of birth control pills. EC can prevent pregnancy when a woman takes it within 72 hours (3 days) of sexual contact. When taken within 72 hours, EC can reduce a woman's chance of becoming pregnant by 75-89 percent. It is important to note that EC is most effective when taken within the first 24 hours.
- EC, like ordinary birth control pills, can prevent ovulation, fertilization, or implantation before pregnancy occurs when taken within the 72 hour timeline.
- EC cannot cause an abortion or harm an already established pregnancy.
- When administered by medical professionals, EC is not typically dangerous for a woman and does not usually result in serious side-effects. The most common side-effects include nausea, vomiting, and cramping. It is important to follow the medical professional’s directions.
- EC should not be confused with the drug RU-486, a non-surgical abortion option for early pregnancies. Unlike EC, RU-486 obstructs a hormone that is required for pregnancy to continue (FDA, 7/20/05).

Emergency contraception may be available through a medical facility, by prescription, or at a local pharmacy. If the victim is 18 years of age or older, she may obtain it without a prescription from some pharmacies for approximately $40. In the case that she would like to use insurance to help her cover this cost, she will need a prescription. Some clinics are willing to keep a prescription on-hand (NARAL*). If the victim is 17 years or under, she will need a prescription to obtain EC. She may check her local family planning clinic (such as Planned Parenthood) or with her doctor. It is important to remember that it must be taken soon in order to be effective.

During the 2007 Minnesota legislative session, MNCASA worked with NARAL Pro-Choice Minnesota to on a bill that would require emergency rooms in hospitals state-wide to provide emergency contraception (Plan B) for sexual assault victims upon request. It also requires emergency rooms to provide prophylaxis for Chlamydia and Gonorrhea. The bill passed in the House and the Senate and was not vetoed by Governor Pawlenty. All Minnesota hospitals...
will be expected to comply with this new legislation. MNCASA and NARAL Pro-
Choice Minnesota will begin working on a project to disseminate further
information to sexual assault programs in Fall 2007. For more information
about emergency contraception, please visit http://www.prochoiceminnesota.org/
s06factsheets/2003110510.shtml

Because some medical providers consider this to be abortion-producing, there is
some controversy around the provision of this service. It is important that the
advocacy agency know whether the physicians are directed to prescribe this
medication and if the hospital pharmacy will dispense it. In some instances,
hospitals will make special arrangements to ensure that emergency contraception is
available. In some instances, the victim may be required to fill the prescription at
another pharmacy. Work with your local medical providers and pharmacists to
know where a person can and cannot obtain EC. Remember that timing is critical.
*http://www.prochoiceminnesota.org/
s06factsheets/2003110510.shtml

HIV/AIDS and Sexual Assault
By Laura Williams, Rapeline, with research assistance from Jean
Marconett
Updated Nov. 2006, by Cheryl Yamott, RAAN (Rural AIDS Action
Network)

It is understandable that victims of sexual assault greatly fear the risk of contracting
HIV. HIV, the Human Immunodeficiency Virus, is the virus that causes AIDS,
Acquired Immune Deficiency Syndrome. The prevalence of HIV/AIDS has exploded
and developed into an epidemic in the United States. At the end of 2003, an
estimated 1,039,000 to 1,185,000 persons in the United States were living with
HIV/AIDS. Perhaps even more frightening is that approximately 24-27 percent are
unaware that they are infected with HIV/AIDS. Minnesota statistics indicate that a
cumulative total of 7,824 cases of HIV infection have been reported in Minnesota.
Of this number, 4,812 have AIDS. There have been 2,772 deaths related to
AIDS.1

Because the virus is spread through blood or sexual contact with someone who has
the virus, it raises special concerns for victim/survivors of sexual violence.
Statistically, the possibility of becoming infected with HIV from one episode of
sexual assault is low, but it is possible.

A person is at greater risk of contracting HIV if they:
• Have been repeatedly sexually assaulted (as in domestic violence, hostage
  situations, or rape with multiple offenders);
• Have been sexually assaulted by more than one assailant;
• Have cuts, tears, burns or inflammation of the vagina, anus, mouth, or lips;
• Are currently menstruating; and/or
• Have a sexually transmitted infection or if the attacker has a sexually
  transmitted infection.

The possibility of having been exposed to HIV during on-going, sexually exploitative
or sexually-abusive situations means that sexual assault victim advocates need to
be knowledgeable about the medical, social, psychological, and legal aspects of

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HIV/AIDS if they are to assist sexual assault victim/survivors to heal. Information about HIV/AIDS and its transmission are essential for advocates to have at their disposal. It is essential for advocates to know about community resources for repeat testing and support. Sharing this information with victims can go a long way towards easing anxiety.

The following section is intended to give basic information to sexual assault victim advocates on transmission and testing for HIV/AIDS, and to introduce some of the issues it raises for victims/survivors. Sexual assault programs and advocates are encouraged to contact other community resources, especially those working directly with HIV/AIDS issues, to keep informed about new and changing information in this area, and to begin to think about the broader implications of this disease.

General information on HIV/AIDS

AIDS or Acquired Immune Deficiency Syndrome is the result of an infection caused by the Human Immunodeficiency Virus. HIV can infect and disable cells all over the body, but primarily attacks white blood cells and T-lymphocytes, which are important to the body's immune system. When this happens, the body can no longer fight infections, and eventually the body's vital systems are damaged through other diseases that the body can no longer fight off. These diseases or infections, often referred to as "opportunistic," signal the onset of AIDS. HIV infection has become a treatable — NOT curable - disease. Persons infected with HIV may look and feel healthy, as it usually takes between five and 10 years before they develop physical symptoms of HIV infection. The time period between becoming infected and developing symptoms is called the asymptomatic period. It is very important to understand that once a person is infected with HIV, they CAN infect others. HIV is primarily found in the blood, semen, and vaginal fluids of infected people.

A test is the only way to know whether someone has HIV, and only a doctor can diagnose AIDS. Early diagnosis and treatment for HIV infection can help improve the health and quality of life for the infected person, and give them important information about preventing the spread of HIV. It could take 2 – 3 months from the day you think you may have been infected to get an accurate test result.

How HIV is spread

HIV is spread through blood-to-blood, or sexual contact with someone infected by the virus. The main ways that people become infected are:

- Through sharing needles or syringes with someone who has the virus;
- Through having vaginal, oral, or anal sex with someone who has the virus;
- Through exposure of a baby to an infected mother's blood during pregnancy or delivery, or — rarely—through breast-feeding; and/or
- Through receiving blood transfusions, blood components or blood clotting factors, or transplants infected with the virus (this is very rare in the United States since testing of the blood supply began in
HIV is NOT spread through casual contact with an infected person; it is not spread through the air or water.  

How likely is it that I got HIV/AIDS from the sexual assault?

Assuming that the assailant is infected with HIV and no barrier protection was used (such as a latex condom), the risk of a survivor becoming infected with HIV from the sexual assault depends on the following factors:

- Number of assailants;
- The virulence of the viral strain;
- The number of exposures;
- The kind of sexual assault (vaginal, anal, or oral);
- The violence of the attack and physical injuries it causes;
- The victim/survivor's susceptibility to infection; and
- The victim/survivor's general health status.

If the potential exposure to HIV is the result of a single act of sexual intercourse (not combined with injected drug use, or multiple sexual acts and/or assailants), the victim/survivor's likelihood of becoming infected with HIV is low. In fact, a victim is more likely to become pregnant or contract a sexually transmitted infection or hepatitis than to become infected with HIV as a result of a one-time exposure. Yet, since many forms of sexual assault are not one-time exposures, and other factors affect the likelihood of infection, the rate of transmission due to sexual assault is not currently known. The only way a victim/survivor can truly determine her/his HIV status is to be tested for the evidence of HIV infection.

How is HIV testing done?

Testing for HIV is actually done by testing for antibodies. HIV antibodies are substances the body produces to fight an infection such as HIV. On average it takes most people between six to 12 weeks to develop HIV antibodies. This period of time between when a person is exposed to HIV and when antibodies form and are detectable by current testing methods is called the window period.

The two tests currently used in the United States to test for HIV antibodies are named ELISA (Enzyme-linked immunosorbent assay, which is a screening test), and Western Blot (which is confirmatory). These tests are so sensitive that they are considered more than 99.8 percent accurate in detecting HIV-infected blood. They are also considered 99.8 percent accurate in determining who is not HIV-infected (with persons outside the window period). In the United States, specimens that show the presence of HIV antibodies with the ELISA test must be retested with the ELISA and confirmed with the Western Blot test.
before testers consider the results positive. When the two tests are combined, experts predict that only one out of 100,000 uninfected people will have a false positive test result.\textsuperscript{8}

How important is it that I be tested?

Making a decision to be tested may be a difficult decision for some victims/survivors. They may fear the reaction of others within and outside their support network if the test result is positive, as the history of HIV and AIDS in the United States has included stigmatization of HIV-infected people. While HIV/AIDS education is attempting to reduce the stigmatization, victim/survivors may fear discrimination in employment, housing, or insurance,\textsuperscript{9} as well as other areas. They may also be concerned about the privacy of testing and test results.

In listening to victims/survivors’ concerns, sexual assault victim advocates who are knowledgeable about HIV testing can assist the victim/survivor in evaluating her or his options. Several of the reasons for victim/survivors to consider being tested are:

• To gain information in order to be in control of her or his own health. While there is currently no cure for HIV, there are some important things that can be done to help delay the destructive effects of the virus; Doctors can monitor the health of the HIV-infected person and with a range of treatments they can prevent, delay, or treat opportunistic infections and help control the virus itself. This treatment can significantly improve the quality and length of an HIV-infected person’s life;

• To gain information in order to prevent the spread of HIV, during the window period, when a victim/survivor will not know their HIV status, or upon learning of a positive test result, effective pre- and post-test counseling can inform victims/survivors about measures they can take that will reduce their likelihood of infecting someone else;

• To help make informed reproductive choices; and

• Victims/survivors who are pregnant at the time of the assault, are considering pregnancy, or who become pregnant as a result of the assault deserve access to accurate information about the potential transmission of HIV to their child to enable them to take precautionary measures and/or make informed reproductive choices. This information should be given again in the pre-/post-test counseling session. Treatment for HIV during pregnancy can reduce the incidence of transmission to baby from 27 percent to 4 percent.

When and where should I be tested?

Some of the issues to consider around testing are: accessibility to testing (location, cost), privacy of testing (location, confidential vs. anonymous testing), availability of pre- and post-test counseling, and when to be tested.

There are several reasons why being tested for HIV at an emergency room immediately following a sexual assault may not be ideal. First,
making an informed decision about testing at the point of crisis may be difficult. Furthermore, standard pre- and post-test counseling will probably be least beneficial at this point. Second, because it takes time for a person to develop antibodies to the virus, testing immediately following a sexual assault will not determine whether the victim/survivor has become infected with HIV from the sexual assault, as it takes time for the body to develop HIV antibodies (it will, however, provide a baseline). Third, a test done at the time of an emergency room visit following the sexual assault may not be confidential. For these reasons, it may be advisable for a victim/survivor to be given the option of being tested at a later time and at a location which offers confidential or anonymous testing (see Hospital Notification and Role of the Advocate).

While being tested during the emergency room visit or at the same time as the evidentiary exam has drawbacks, there are important reasons why a victim/survivor may want to consider being tested within the first week after a sexual assault, or even during the early part of the window period. As with other sexually transmitted infections, testing at this time is often referred to as baseline testing, as it documents the victim/survivor's status at the time of the sexual assault. Baseline testing for HIV provides documentation of a victim/survivor's HIV status prior to and at the time of the sexual assault. If the victim/survivor should later test positive for HIV (after the window period), this documentation helps to substantiate the source of the HIV transmission as the sexual assault. Outside of possible claims for damages in civil court, an area which has yet to be explored, this documentation could also affect criminal charges. Currently in Minnesota, sexually transmitted infections given to the victim/survivor during a sexual assault are proof not only of penetration, but also of injury, and may increase the severity level of criminal charges. Therefore, evidence of the transmission of HIV/AIDS through a sexual assault should increase the severity level of charges. While no case law currently exists in this area relative to sexual assault, a sexual assault in which the perpetrator knowingly and intentionally infected the victim/survivor with HIV may result in charges with a higher severity level than first degree criminal sexual conduct.

As with other medical issues related to the sexual assault, the sexual assault victim advocate may assist the victim/survivor by providing accurate information and options. At the time of an emergency room visit, they can indicate to the victim/survivor that since there is a possibility that s/he was exposed to HIV at the time of the assault, s/he may want to consider being tested. Victim/survivors in the emergency room should be informed that they have the option of being tested at a later time and at a location which can offer confidential or anonymous testing and pre-/post-test counseling. Persons who want documentation of their HIV status prior to the assault should consider being tested within a week of the assault, with follow-up tests at three and six months.

Hospital notification

In Minnesota, hospitals are required by law to give written notices to sexual assault victim/survivors, or their parents or guardians when
appropriate, concerning information about sexually transmitted infections, including HIV. The notice must include information on the risk, symptoms, recommendations for testing, locations for confidential testing, and information necessary to make an informed decision about whether to request a test of the offender.

Can the assailant be tested?

Minnesota law does allow for the sentencing court to order a convicted sex offender to submit to HIV antibody testing if the victim requests it and the prosecutor moves for the test in camera. The nature of the sexual assault also needs to be such that the victim was put at risk for exposure to HIV. Victims/survivors should be informed, however, of the limitations of relying on an offender's test results to gain information about their own possible HIV status.

A court order requiring the offender to submit to HIV testing becomes an option only upon conviction in Minnesota. If the victim/survivor uses this to help determine whether to be tested, it may delay important treatment and/or information necessary for the victim/survivor's health and the health of her/his partner(s). Even if this option is available and pursued, learning an assailant's HIV status cannot be an accurate indication of the victim/survivor's HIV status. The most reliable way for a victim/survivor to learn their own HIV status is to be tested themselves.

Should the court order the offender to be tested for HIV, Minnesota law specifies that "any results given to the victim or a victim's parent or guardian shall be provided by a health professional that is trained to provide HIV test-related counseling." Results are available, upon request, to the victim, or if the victim is a minor, to their parent or guardian, and positive test results will be reported to the Commissioner of Health.

Role of the sexual assault counselor/advocate

While individual programs providing services to sexual assault victims/survivors will need to develop policies and procedures for responding to HIV/AIDS in their agencies and work with victim/survivors, the following are some suggestions to consider:

- Incorporate information or discussion about HIV/AIDS with victims/survivors where and when appropriate. This may mean raising the topic prior to being tested at the emergency room, it may be when the victim/survivor raises the issue, or it may be in the context of talking about other health concerns, such as pregnancy, and other sexually transmitted infections. While each situation may be somewhat unique, guidelines and discussions with sexual assault programs about appropriate ways to handle this information can increase an advocate's comfort with addressing this topic.
- Remember that there are many forms of sexual violence. Consider how HIV/AIDS may relate to the different forms. Current HIV/AIDS prevention education makes assumptions that people receiving the education feel some amount of ownership over their own sexuality.
and their own bodies. It also assumes that all people are able to assert themselves safely, and that their wishes will be respected. This may not be true for every victim/survivor. The sexual assault counselor/advocate aware of these issues will be able to help address barriers for some victims/survivors in reducing their risk of exposure to HIV or preventing HIV transmission.

- Check out the victim/survivor’s existing knowledge and awareness of HIV/AIDS. Also ask about her/his beliefs and values associated with HIV and AIDS. Since discussing these topics means dealing with issues which are very culturally linked—sexuality, health, illness, and dying—this discussion will help you be sensitive to and work within the victim/survivor’s own cultural context. As with issues of STIs or pregnancy, determining her/his level of comprehension and existing knowledge will also help you guide the discussion appropriately.

- Be knowledgeable about HIV/AIDS, and provide accurate and well-timed information. While wondering about possible HIV infection may be an overwhelming component of the victimization, good information can assist the victim/survivor in regaining control.

- Also consider how different forms of oppression (i.e. ableism, classism, heterosexism, racism, sexism, etc.) affect our understanding and knowledge of HIV/AIDS as well as our work with individual victims/survivors.

- Learn the facts and keep informed. Information about HIV/AIDS changes rapidly as more is being discovered about the virus and the disease. And as more and more people become infected with HIV and develop AIDS, the social, legal, ethical, and psychological dimensions of the epidemic develop as well. (See the resource section at the end of this section for further information.) Many of these organizations have excellent brochures and other resources that may be useful in presenting basic HIV/AIDS information to victims/survivors.

- Be prepared to discuss HIV/AIDS-related anxiety during and throughout the victim/survivor’s healing process. And, if the victim/survivor does become infected with HIV, be prepared to assist in making appropriate referrals and provide support.

- Dialogue with people working on HIV/AIDS issues. Since most of the HIV/AIDS prevention education currently being done assumes equal power in sexual situations, sexual assault victim advocates must get involved in developing prevention strategies and language which demonstrate sensitivity to and awareness of the prevalence of sexual violence. This may involve talking with people in your community doing HIV/AIDS prevention education, providing support to HIV infected people and persons—with AIDS and those doing testing for HIV—including physicians and others doing pre-and post-test counseling. Ultimately, this will increase the effectiveness of HIV/AIDS prevention efforts and assist sexual assault victims/survivors.

- Sexual assault victim advocates are accustomed to providing information and support for victims/survivors in relation to difficult issues. With training on HIV/AIDS, we can further assist victims/survivors in their healing from sexual violence, and advocate for responsive HIV/AIDS policies and procedures.
As an advocate, how do I discuss HIV/AIDS with victims/survivors?

The following are some suggestions:

- Review the victim/survivor's risk and desire to take the test;
- At the appropriate time, explain testing and transmission, including the pros and cons of being tested. Discuss limitations and specifics of testing, especially of the offender. Inform of options regarding where and when testing can be done, and stress the importance of good pre-/post-test counseling.
- Support the grief and loss with this dimension of the sexual assault. Allow the victim/survivor to discuss how the concern of HIV/AIDS has affected them;
- Answer questions and provide referrals for more information and/or support, including risk-reduction strategies for transmission during the waiting period; and
- Consider the medical, psychological, and financial needs of the victim/survivor before, during, and after the testing period. Make referrals when appropriate.

End Notes

1. For current statistics contact the CDC National AIDS Hotline at 1-800-342-AIDS or the Minnesota AIDS Project at 1-800-248-AIDS.
2. "As of 1988, scientists say that 25 percent to 50 percent (or more) of all HIV-infected people will develop AIDS within five to ten years of infection." (The American National Red Cross, American Red Cross HIV/AIDS Instructor’s Manual, p. 97.) Estimates vary, however; as more is being learned about HIV and AIDS. In "Part I: What we know after 10 years of AIDS," Rosemary Cashman writes that the asymptomatic interval (here called the incubation period) averages between nine and 10 years. (Mayo today, p. 9.)
3. The American National Red Cross, Ibid., p. 129,
6. In 1990, medical reporter Victoria Brownsworth extrapolated that the risk for contracting HIV infection as a result of rape by an assailant whose HIV status is unknown at six percent. This is higher that the estimate of two percent which has been given as the chances for infection from a one-time exposure. While based on scientific data, Brownsworth’s estimate is more speculative than scientific. More research clearly needs to be done on this area. (Center for Women’s Policy Studies, Ibid., p. 7).
7. The American National Red Cross, Ibid., p. 176, Dr. Rodney Thompson, chair of the Mayo Clinic Rochester Infection Committee, believes that the window period may vary with the type of exposure and among individuals. He estimates that the "average" window period may be two to three months. (Cashman, p. 9)
9. Minnesota Statutes, § 72A.20, subdivision 29 attempts to protect
crime victims and offenders who are tested for HIV from
discrimination by insurers. It also requires that an authorization for
the release of medical records for insurance purposes must exclude
any test for the purpose included in this statute, regardless of
whether the exclusion is expressly stated. See Minnesota statutes,
section 72A.20 subdivision 29, for precise wording.

10. If the victim/survivor chooses to report the sexual assault to law
enforcement, they may be asked to sign an authorization to release
records related to an evidentiary exam, as this information is often
an important part of the investigation. Once these records become
part of the criminal investigation it may be difficult to ensure the
victim/survivor's privacy relative to the test.

11. From conversations with Lieutenant Roger Peterson, Rochester
Police Department, Rochester, Minnesota, 17 August 1993.

12. See Minnesota Statute 611A.19, subdivision 1.

13. "Because of the potential for false test results and the delays in
antibody formation, the American Public Health Association believes
that relying on an offender's HIV test results is not an appropriate
standard of care for rape survivors." Quoted in Center for Women
Policy Studies, p. 13, where there is an excellent discussion of this
issue.

14. See Minnesota Statute 611A 19 subdivision 2. The statute further
explains the privacy of the information.

15. Barbara Nissley's paper explores this in much more detail. Sexual
assault programs are encouraged to get a copy of the paper and
discuss implications for program guidelines and policies.

16. Also see Barbara Nissley, Policy Issue Paper #3: Acquired Immune
Deficiency Syndrome and Victim*) of Sexual Violence, and Diane

17. Liz Galst, "Assumptions of HIV/AIDS Prevention Education:
Interviews with Gay Male Incest Survivors," SEICUSReport, April/May
1993, p. 19. For more information on how sexual abuse relates to
HIV/AIDS, see the other articles in the April/May 1993 issue of this
same report.

Additional Resources

American Red Cross —
St. Paul Chapter
176 South Robert Street
St. Paul, MN 55107
(612)291-6711 or your local Red Cross

Minnesota AIDS Project
2025 Nicollet Avenue S.,
Suite 200
Minneapolis, MN 55404
612-341-2060

Minnesota Coalition Against Sexual Assault (MNCASA)
161 St Anthony Ave Suite 1001
St Paul MN 55103
The HIV/AIDS Treatment Information Service (ATIS) is a central resource for Federally approved treatment guidelines for HIV and AIDS. ATIS is staffed by multilingual health information specialists who answer questions on HIV treatment options, using a broad network of Federal, national, and community-based information resources. Callers can reach this confidential, personalized service at 1-800-HIV-0440 (1-800-448-0440). More information is available online at www.hivatis.org.

References


Timothy C. Baker et al, "Rape Victims' Concerns About Possible Exposure to HIV Infection," Journal of Interpersonal Violence, March 1990, pp. 49-60,


James Cassese, "The Invisible Bridge: Child Sexual Abuse and the Risk of HIV Infection in Adulthood," SEICUSReport, April/May 1993, pp. 1-7,

Drug Facilitated Sexual Assault (DFSA)

Increasing concern that drug facilitated sexual assaults are being missed led a multidisciplinary group of advocates, law enforcement, and medical personnel, prosecutors, and scientists from the Bureau of Criminal Apprehension to create protocols that encourage practitioners to aggressively pursue evidence collection and investigation to document the use of alcohol and other drugs to facilitate sexual assault.

Drug Facilitated Sexual Assault – A Definition

Drug facilitated sexual assault involves sexual assault which is accomplished by means of any substance, ingested intentionally or unintentionally by the victim, which incapacitates or renders the victim physically helpless.

This protocol recognizes that, at the time a sexual assault medical exam is performed, the medical personnel have some but not all of the information ultimately obtained regarding the circumstances of the alleged sexual assault. Later investigation by law enforcement may develop information which raises the question whether the victim had ingested, knowingly or unknowingly, a substance which may have contributed to the occurrence of the alleged sexual assault. Preservation of those samples will further the ability of law enforcement to determine the presence of a drug facilitated sexual assault.
enforcement to investigate the sexual assault complaint.

This protocol also recognizes that many of the common substances used to facilitate sexual assault are eliminated very quickly by the body, and may be detectable only briefly after the arrival of the victim at the medical facility. Obtaining and preserving those samples immediately enhances the likelihood that such substances will be detected when testing is performed.

Application

In speaking with a sexual assault victim, the advocate may become aware that the victim is describing symptoms consistent with incapacitation due to intentional or unintentional alcohol or drug ingestion. As with all information, advocates should use care in reacting and suggesting options to ensure that they not unreasonably alarm a victim/survivor who already may be in crisis.

If it appears appropriate and the advocate believes the victim is capable of handling the information, however, the advocate should encourage the victim to wait to void his/her bladder until arriving at the medical facility for a sexual assault exam.

At the time the medical exam is performed, the newest recommendation by the BCA is that a urine and/or blood sample will be collected at the outset of each exam, regardless of whether it appears to be a DFSA or not. Advocates should be very clear with clients that, as with any other portion of the medical/forensic exam, they have the right to refuse to provide a urine and/or blood sample, and yet continue with the remainder of the exam if they so desire.

In the following situations, however, the advocate should encourage the client to collect the first bladder void herself/himself immediately:

If the victim is either unsure about reporting to an emergency room; or if there is any possibility that the victim absolutely must void before reporting to the emergency room.

Urine samples may be collected in any container with a lid. Sterility is not required, but the victim should avoid using any container that might have once held other drugs, such as a pill bottle. The lid should be kept in place and the container should be refrigerated until the victim either speaks to law enforcement or goes to a medical facility. If possible, tape should be placed over the top of the lid with the date, time, and the victim’s initials (to show that the lid was not tampered with).

Work with law enforcement and prosecution in your jurisdiction to gain their cooperation in agreeing not to charge victims reporting sexual assault with any offenses relating to the consumption of alcohol or substances. Advise victims that they will not be prosecuted if law enforcement discovers such offenses. Advocacy programs are encouraged to implement public education and information to raise awareness of the urgent necessity of collecting the first bladder void in cases where victims suspect drug facilitated sexual assault.
Drug Facilitated Sexual Assault: How Advocates Can Assist Victims/Survivors

What is drug facilitated sexual assault?

Drug facilitated sexual assault (DFSA) is taking advantage of the use of alcohol or other drugs which render a victim incapacitated or physically helpless in order to accomplish a sexual assault. DFSA can occur when an offender “slips a Mickey” to the victim – or secretly drugs a victim. It can also occur if the victim knowingly ingests alcohol or other drugs but does not consent to sexual assault.

Does DFSA really happen?

Advocacy programs and medical personnel around Minnesota are reporting that the number of victims describing inexplicable intoxication and blacking out is increasing. In 2000, almost 5,000 emergency room visits were recorded nationwide as a result of the use of GHB, a common drug used to facilitate sexual assault. The evidence needed for the criminal justice system has been difficult to collect, however, and criminal charges of this type have likely not increased correspondingly to the increase in incidents.

Why are DFSA cases so difficult for prosecutors and law enforcement to address?

Numerous factors can work against the investigation of a suspected DFSA case. Initially, the victim was likely blacked out and has no memory of the events during, or even before the sexual assault. S/he may be groggy for a long period of time after waking up, and may delay reporting the incident.

The drugs commonly used to secretly incapacitate a victim eliminate very quickly from the body – some as quickly as eight hours from ingestion. They may not be present if the victim reports to the emergency room a day after the assault.

Finally, without evidence of drugs or the quantity of alcohol in a victim’s system, juries may have a difficult time knowing just how helpless the victim may have been when she was assaulted – making a consent defense by the offender more likely to succeed.

What can be done to improve the collection of the vital evidence of drugs or alcohol in the victim’s system?

The Bureau of Criminal Apprehension (the state crime lab) is now recommending that a urine and blood sample be collected from every person who is given a sexual assault forensic exam, regardless of a report of DFSA symptoms. The samples should be collected at the very beginning of the exam, and refrigerated until a decision can be made to have them tested for the presence of drugs.

What if a victim has voluntarily ingested?
It is imperative that victim advocates work with their local law enforcement and
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Prosecution to gain an agreement that minors who use alcohol or drugs, or people who use recreational drugs will not be prosecuted for those violations of the law. This will help ease the concern of victims that their drinking or drug use detected in the urine sample will not be used against them. For best practices protocols for systems agencies, contact SVJI.

What can victim advocates do to assist victims in these circumstances?

The most important thing for advocates and volunteers to know is that the FIRST BLADDER VOID IS CRUCIAL. Thus, in speaking with victims who have been recently assaulted, encourage them to either wait to urinate at the ER, or collect the first bladder void in a jar to bring in with them. This urine sample may be the only thing which contains the evidence to show that they were drugged. Discuss concerns the victim may have regarding the urine sample. Remember the victims concerns are valid, and you are there to assist them in making an informed decision. The victim may refuse the urine or blood sample altogether. Support the victim and her/his decisions. You are there to assist the victim, not make decisions for him/her. It is crucial that you explain the importance of a urine sample in the investigative process. In doing this, make sure not to instill unnecessary fear in the victim. If the victim does not feel s/he was drugged, explain it as standard procedure for the forensic exam.

What can victim advocates and programs do to educate the community about the need for immediate collection of this evidence?

Victim advocates can do much in their communities to educate on the issue of DFSA and the importance of the first bladder void. For example:

- Emphasize the importance of the first bladder void in cases of DFSA to volunteers in the initial advocate training process. Revisit the issue during follow-up trainings. Also, check with crisis line volunteers periodically about the issue and reiterate the importance of discussing the issue of DFSA with victims on the crisis line;
- When doing local sexual violence presentations/trainings to schools, churches, or other organizations, stress the frequency of DFSA;
- Make pamphlets, brochures, posters, or stickers with your program information and information on DFSA and make them available at schools, medical facilities, law enforcement agencies, bars, etc. It maybe especially useful to put them in or near restrooms; and
- When training local professionals include discussions regarding the importance of collecting this evidence.


What to do if you suspect that you or someone else has been drugged:

- Call 911 or go to the hospital emergency room;
- Request a urine test for Rohypnol and/or GHB;
- Rohypnol can be detected in the urine for up to 60-72 hours after ingestion; and

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• GHB can be detected in the urine for up to 48-72 after ingestion.
• If the urine test is being requested in conjunction with a sexual assault, a
  free test can be requested.
• The free, national testing service has been created by Hoffman La Roche,
  the manufacturers of Rohypnol, and is performed by El Soy Laboratories.;
• The free testing service can be accessed by law enforcement, emergency
  room personnel, and by rape crisis centers investigating cases of sexual
  assault;
• The free testing service provides screening for a variety of prescription and
  non-prescription medication (e.g. benzodiazepines, marijuana,
  amphetamines);
• The urine sample must be taken by a medical professional following chain-
  of-custody procedures;
• The lab follows chain-of-custody procedures to preserve the results as legal
  evidence; and
• The lab will share the results with the medical professional in approximately
  one week.

http://www.washington.edu/students/saris/office/Substances.html

Follow-Up Medical Care

After the initial visit to the Emergency Room, a victim of sexual assault most likely
will be asked to go to their doctor or a community clinic such as Planned
Parenthood for follow-up medical care. A victim/survivor can expect to visit a doctor
approximately:

2-3 weeks after the assault
• Testing for possible STIs acquired from the assault; and
• Testing for pregnancy as a result of the assault.

3 and 6 months after the assault
• The victim should seek testing for HIV/AIDS if s/he is concerned s/
  he may have been exposed. There are many places where s/he can
do this for free or for a small donation.
Bringing it Home:

- Are you familiar with the hospital you’ll be responding to?
- Does your local hospital have a SANE on-call, or will the exam be performed by an ER doctor or nurse?
- Are you clear on your county’s policy regarding payment for evidentiary exams?
- Is there any history of your program’s relationship with the hospital, good or bad?
**HIV/AIDS Glossary**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>AIDS</strong></td>
<td>Acronym for <em>Acquired Immuno-Deficiency Syndrome</em>. A person with HIV can develop AIDS when their HIV disease is advanced. AIDS occurs when the immune system of someone with HIV has deteriorated to the point where they are developing <em>opportunistic infections</em> (see definition). People with an AIDS diagnosis can still live for years, depending on their medical care, self care and the severity of their opportunistic infections.</td>
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<tr>
<td><strong>Anonymous Testing</strong></td>
<td>A way to test for HIV that does not use any identifying information (such as a name) that could link the test results to the person being tested. Only the person being tested can find out their test results by use of a testing code that will be assigned to them. In the state of Minnesota, anonymous testing is prohibited (Minnesota AIDS Project).</td>
</tr>
<tr>
<td><strong>Antibodies</strong></td>
<td>Also known as immunoglobin. They are proteins produced in the body’s immune system that identify and fight infectious organisms and other foreign materials that enter the body, such as viruses, bacteria, fungi, and parasites. Usually antibodies defend the body against these disease agents; however, the HIV antibody does not give such protection (Red CroM, p.263, &amp; AIDSinfo).</td>
</tr>
<tr>
<td><strong>Asymptomatic Period</strong></td>
<td>The period from the point of infection to the onset of symptoms. It may take up to 15 years for people with HIV to develop AIDS.</td>
</tr>
<tr>
<td><strong>Baseline Testing</strong></td>
<td>Refers to HIV testing done around the time of the sexual assault to determine and/or document the victim/survivor’s HIV status at the time of the assault.</td>
</tr>
<tr>
<td><strong>Confidential Testing</strong></td>
<td>A way to test for HIV that will ask for a first name or full name. The individual being tested may also provide an identifying code as a condition for testing. Many confidential testing sites will not ask to see any ID, so the individual can choose whether to use their actual name or not. If a real name is used the test results may be recorded in her/his medical file by the physician who does the test. The test results will not be revealed without written permission from the person being tested, except as is required by state law. Minnesota does require that positive test results be reported to the State Department of Health. The testing site will ask for your name, address and telephone number to make the report. You are not required to provide this information, and if you choose not to, the testing site will simply report the positive result to the Department of Health. This information is used for statistical and public health purposes. Specific information about you is not available for public use for any reason. These records are kept confidential (Minnesota AIDS Project).</td>
</tr>
</tbody>
</table>
ELISA  Acronym for enzyme-linked immunosorbent assay, a blood test used to detect the presence of antibodies to HIV. Results of an ELISA test showing the presence of HIV antibodies must be confirmed by the Western Blot before a person is considered HIV-infected. Sometimes abbreviated as E1 A (Red CroM, p.266).

HIV  Acronym for Human Immunodeficiency Virus. HIV is a retrovirus (see definition) transmitted through via blood, semen, vaginal fluid and breast milk.

In camera  In chambers, in private. The issue will be heard by the judge either in her private chambers or when all spectators are excluded from the courtroom (Blacks Law Dictionary, 5th ed., p. 684).

Incubation  The period between infection and the onset of symptoms (Red CroM, p.98).

Opportunistic  Referring to a variety of diseases or infections that occur in people who do not have fully functioning immune systems. These same diseases or infections either do not occur or are more easily controlled if a person’s immune system is not weakened by HIV.

Opportunistic Infections  The Centers for Disease Control and Prevention has identified opportunistic infections that regularly occur in people with advanced HIV disease and are an implication that the immune system is extremely compromised. They include:

- Pneumocystis carinii pneumonia: pneumonia caused by a fungal organism that is widespread in our environment but does not cause illness in individuals with a healthy immune system.
- Toxoplasmosis: Disease caused by a parasite; this parasite is found in more than 60 million people in the U.S. but most do not get sick from it.
- Tuberculosis: A bacterial lung infection spread through the air. Anyone exposed to tuberculosis should see a doctor for treatment.
- Extreme weight loss and wasting (atrophy and shrinkage of muscle); exacerbated by diarrhea which can be experienced in up to 90% of HIV patients worldwide.
- Meningitis and other brain infections: Inflammation of the tissue surrounding the brain and spinal chord. Can be bacterial or viral.
- Fungal infections: Including thrush and other oral infections, yeast infections, and skin fungal infections. These occur chronically in someone with a compromised immune system.
- Syphilis: an STI caused by bacteria that has 4 stages. Syphilis can be treated if caught in an early stage.
- Malignancies such as lymphoma, cervical cancer and other types of cancer, including Kaposi’s Sarcoma, a cancer of the connective tissue in the body.

Pre-test Counseling  Given by trained counselors at specific testing sites prior to an HIV test. The counselor will provide basic information about the HIV test, and its benefits and consequences. They will also explain HIV/AIDS and the ways it is spread, prevention, and confidentiality of test results. The counselor will also ask what impact the test results will have on her/him, what kind of support system the individual has, and what to do if the results indicate HIV infection (CDC, Voluntary HIV Counseling & Testing: Facts, Issues and Answers, Sept. 1991 & 1999).
Post-test Counseling

Given by trained counselors at specific testing sites after the HIV test. Counselor gives test results and, regardless of the results, provides information on protecting their health and the health of others. If the results are negative they will discuss re-testing at an appropriate time, especially if the individual engaged in behaviors that put them at risk in the three months prior to the test. If the test is negative, they will also discuss ways to remain HIV-negative. In the case of a positive test result, the counselor will assess the individual’s understanding of the results and their emotional response. They will also provide information about how to avoid transmitting the virus to others, treatment options, follow-up care and support services, and self-care (CDC, 1999).

A blood test used to detect antibodies to HIV. It is used to confirm ELISA results.

Retrovirus

A virus that contains an enzyme called Reverse Transcriptase, which allows the virus to convert its RNA to DNA and then integrate, and take over, a cell's own genetic material. Once taken over, the new cell - now HIV infected - begins to produce new HIV retroviruses. HIV replicates in and kills the helper T cells, which are the body’s main defense against illness.

Western Blot

A blood test used to detect antibodies to HIV. It is used to confirm ELISA results.

Window Period

Time between an exposure to HIV and when antibodies form and are detectable by the ELISA and Western Blot tests for HIV antibodies. This time can vary among people, and may be different depending on the exposure. Most experts estimate the window period to be between six to 12 weeks.
HIV Testing Sites in Minnesota

The following is a list of confidential testing sites in the state of Minnesota. The list is by NO means exhaustive. You may also contact your physician for an HIV/AIDS test if you choose.

African American AIDS Task Force
310 E. 38th St.
Minneapolis, MN 55409
612.825.2052
Hours: Mon-Fri. 8:30 a.m. - 4:30 p.m.; call ahead; no fee.

African Health Action*
1931 1st Ave. S., Suite 100
Minneapolis, MN 55403
612.229.2679
Testing free.
Services available in French, Pidgin, Bamileke, Mina and other Cameroonian dialects.
*Formerly Zyombi International Project

AIDS Resource Center of Wisconsin - Superior Board of Trade Building
1507 Tower Ave., #230
Superior, WI 54880
715.394.4009 or 877.242.0282
www.arcw.org
Free; does not need to be a WI resident.

Community University Health Care Center (CUHCC)
2001 S. Bloomington Ave.
Minneapolis, MN 55404
612.638.0700

Delaware Street Clinic
Fairview-University Medical Center
420 Delaware St.
Minneapolis, MN 55455
612.625.4680

The Doctors Uptown
1300 Lagoon Ave., Ste 200
Minneapolis, MN 55408
612.284.1772

Face to Face Health & Counseling Services
1165 Arcade St.
St Paul, MN 55106
651.772.5555

Family Tree Clinic
1619 Dayton Ave, Suite 205
St Paul, MN 55104
651.645.0478

Healthcare for the Homeless
525 Portland Ave., Level 3
Minneapolis, MN 55415
612.348.5553

Annex Teen Clinic
4915 N. 42nd St.
Robbinsdale, MN 55422
763.533.1316
Call to make an appointment; fees are based on a sliding fee scale.

Cedar Riverside People’s Center
425 S. 20th Ave.
Minneapolis, MN 55454
612.332.4973
Healthcare for the Homeless
438 Main Street
St Paul, MN 55102
651.290.6814

Indian Health Board of MPLS
1315 E. 24th St.
Minneapolis, MN 55404
612.721.9800

Indigenous Peoples Task Force
1433 East Franklin Ave., Suite 18A
Minneapolis, MN 55404
612.870.1723
or
Brainerd, MN
877.317.8246

Lake Superior Community Health Center
2 East 5th St.
Duluth, MN 55805
218.722.1497

Leech Lake Band of Ojibwe
Health Division
116 2nd St NW, Suite E
Cass Lake, MN 56633
218.335.4500 or 800.282.3389
* Members of the Native American community.

Minnesota AIDS Project
1400 S. Park Ave
Minneapolis, MN 55404
612.373.2437

Olmsted County Public Health Service
2100 Campus Drive SE
Rochester, MN 55904
507.285.8370
www.olmstedcounty.com/publichealth/
Testing by appt only, limited weekdays; insurance not accepted - cash, check, or medical assistance okay.

Outlook Clinic
651.674.4570
www.outlookclinic.com
* Locations in Mora, Cambridge, Chisago City, and North Branch.
Appointments encouraged; $10-15 fee.

Planned Parenthood
800.230.7526 (to locate nearest clinic)
www.ppmns.org
Testing available at all Planned Parenthood sites; accepts public assistance and Medicaid; they do work on a sliding fee scale, but testing costs may still be considerable.

Red Door Clinic
525 Portland Avenue
Minneapolis, MN 55415
612.348.6363
Testing: Mon. 11:00 a.m. – 7:00 p.m., Tues-Fri. 8:00 a.m. – 4:00 p.m.; cost: donations are requested, but if you are unable to pay, the test will be free of charge.

Rural AIDS Action Network (RAAN)
208 NE 2nd St.
Little Falls, MN 55456
800.966.9735
*Also in Willow River, Bemidji, Hibbing, and Alexandria

Room 111 Clinic
555 Cedar Street, Floor 1
St. Paul, MN 55101
651.266.1357

Southside Community Health Services
2431 S. Hennepin Ave,
Minneapolis, MN 55407
612.822.3186

Uptown Community Clinic
4730 Chicago Ave.
Minneapolis, MN 55405
612.374.4089

* Members of the Native American community.
West Side Community Health Services
153 Cesar Chavez Street
St. Paul, MN 55107
651.222.1816
Testing available Monday-Friday 8:00 a.m. – 5:00 p.m.; $16 blood draw fee.

SEMCAC Family Planning & STI Clinic
76 3rd St. W.
Winona MN 55987
507.452.4307 or 800.657.5121
www.semcac.org
Sliding fee scale.

Women's Health Center
32 E 1st St., Suite 300
Duluth, MN 55802
800.735.7654
Introduction to Law Enforcement and Legal Issues

The following chapter contains information regarding the process of reporting sexual assault to law enforcement and the process that takes place when prosecution becomes involved. Each case is different, and there will be some unique factors. This chapter is intended to provide very basic information on the reporting process and prosecution; it is not expected that advocates become fluent in the legal process. Victims/survivors will choose whether or not to involve law enforcement. Your role as an advocate is to support their decision either way. When assisting a victim/survivor and dealing with law enforcement and prosecution issues, here is a brief list of “Do’s and “Don’ts” that may be helpful.

**DO:**
- Support the victim/survivor in their choice to report or not report.
- Be honest with a victim/survivor if you do not have or know the answer to a legal question.
- Remember that you are there to support the victim/survivor always, not law enforcement or prosecution.
- Form working relationships with law enforcement and prosecution if they are involved in the case. Check in with them about how the case is progressing so that you can keep the victim/survivor informed.
- Seek answers to legal questions you do not know the answer to by utilizing a legal advocate or a local legal agency, such as Legal Aid.
- Familiarize yourself with legal statutes pertaining to sexual assault, and keep up-to-date as legislation changes.

**DON’T:**
- Never pressure a victim/survivor to report to law enforcement.
- You cannot provide legal advice to a victim/survivor. Even if you are a lawyer by profession, in this case, you are a sexual assault advocate.
- Never make assumptions about whether or not a case will be charged.
- Refrain from speculation about how a case will progress during the prosecution phase.
Sexual Violence: The Legal Aspects
From MNCASA Legal Advocacy Manual

Key Learning Points:

- Criminal sexual conduct statutes are quite complicated; advocates should never attempt to advise a victim about which statute(s) pertain to her/his case.
- If a victim is afraid to report, the best thing an advocate can do is help her/him understand what the fear might be and then attempt to find answers or resources that might help minimize the fear.
- A victim should be fully aware that reporting to law enforcement does not guarantee that the case will be charged and/or prosecuted.
- Sexual assault within the black community was often overlooked because the issue of racism was considered to be more important.
- A victim choosing to report to law enforcement who does not want the case charged and/or prosecuted must be informed of how law enforcement handles these cases in her/his jurisdiction.
- If a victim is really frightened of consequences of reporting and suspects that local law enforcement already has this person on their radar, an anonymous report may be helpful or at least informative.
- If a victim reports to law enforcement, it is important that she/he understand the kinds of questions they will be asked.
- The advocate’s role during the law enforcement interview is to support the victim, not aid in the investigation.
- It is not unusual for a sexual assault investigation to take weeks or even months.
- There are pros and cons to reporting sexual assault to law enforcement; a victim should make an informed decision and should never be pressured one way or the other.
- A victim may choose to file a civil suit against a perpetrator, seeking money to cover damages.
- Only a small number of sexual assaults are prosecuted; this is generally because of the reluctance of the victim or a lack of evidence.
- Almost any sexual assault case that goes to trial will require the victim to testify. This can be very stressful for the victim.
- There are 7 steps that any case the goes to trial must go through. It is important that the victim understands the process.
- If there is a conviction, sentencing of the perpetrator is determined by The Minnesota Sentencing Guidelines Commission. The sentence will be based on past criminal history, as well as the severity of the crime they were convicted of.
- During prosecution, the advocate can be extremely helpful by continuing to be supportive and explaining the process the case is going through, as well as terminology that they may not understand or may find offensive.
- If the defendant is acquitted, an advocate can help the victim deal with the verdict; helping her/him understand that the verdict is not a reflection on her/his character is important.
- “Advocate privilege” means that any sexual assault advocate (as defined by the statute) cannot be called to testify about their communication with the victim. An exception may be a child abuse/neglect case, if there is good cause determined by the court.

The information in this advocacy manual is abridged and only covers briefly the criminal justice process related to sexual assault. For a more complete discussion of the criminal
justice system and the advocate's role, please refer to the Legal Advocacy Manual produced by the Sexual Violence Justice Institute.

Criminal Sexual Conduct Statutes

In Minnesota, the criminal sexual conduct statutes (609.342 - 609.3451) are quite complicated. In general, what defines a sexual assault under the statutes involves:

- Relative ages of the parties when one is a minor;
- Relationship of the assailant to the victim/survivor when one is a minor or the assailant is in a professional or familial relationship to the victim/survivor;
- Amount of force/coercion used by the assailant;
- Whether sexual conduct was touch/contact or penetration.

Each of these elements is described in detail in the statutes. Advocates should never attempt to advise a victim/survivor about the statutes that may apply to her/his experience. Given nuances of the assault, prosecutors may also be able to determine multiple charges stemming from what would otherwise appear to be one incident. It is risky and unethical for non-lawyers to speculate about charges with a victim/survivor.

There are five levels of Criminal Sexual Conduct (CSC) in Minnesota Statute. First through Fourth Degree CSC are felony crimes or the most serious level of crime. Fifth Degree CSC is a gross misdemeanor, a less serious offense. In general, the following chart identifies how the statutes differ:

<table>
<thead>
<tr>
<th>SIMILAR IN TYPE OF ASSAULT: PENETRATION</th>
<th>MORE FORCE</th>
<th>LESS FORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSC 1</td>
<td>Penetration – higher degree of force*</td>
<td>CSC 3</td>
</tr>
<tr>
<td>CSC 3</td>
<td>Penetration – lower degree of force*</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIMILAR IN TYPE OF ASSAULT: CONTACT</th>
<th>MORE FORCE</th>
<th>LESS FORCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSC 2</td>
<td>Contact – higher degree of force*</td>
<td>CSC 4</td>
</tr>
<tr>
<td>CSC 4</td>
<td>Contact – lower degree of force*</td>
<td></td>
</tr>
</tbody>
</table>

*(The degree of force referred to on this chart can relate to age of the victim/survivor, relationship of the perpetrator to the victim/survivor, use of multiple perpetrators, use of a weapon, use or threat of physical harm, use of alcohol/drugs, vulnerability of the victim/survivor, etc.)
Reporting the Assault

Considerations for Victims/Survivors

The FBI states that sexual assault is probably the most under-reported crime in the United States. Some studies show that only 16% of assaults are ever reported. Other estimates indicate that only 1 in 3 or 1 in 10 assaults come to the attention of law enforcement agencies. Whatever the real statistic, for a variety of reasons, sexual assault victims/survivors often do not report.

An adult may have several options regarding reporting the assault:

- Not reporting
- Report for the purpose of prosecution
- Report with no intention of having the case prosecuted
- Third party report

The importance of a medical/evidentiary exam to the investigation and prosecution process cannot be underestimated. See the medical section of this manual for discussion about that exam.

Not Reporting

Often the decision to not report an assault is based on a combination of fears. Sometimes those fears are real and sometimes they are based on bad or no information about the process ahead. The best thing an advocate can do is help a victim/survivor understand what her/his fear might be and then attempt to find resources or answers that can minimize those fears. Of course, some fears are very real and cannot be minimized. Whatever decision the victim/survivor makes about reporting is her/his decision and should be respected and supported.

Some common fears that victims/survivors cite:

- The assailant will kill me if I tell
- When I get into court, the defense attorney will cross examine me like I see on “Law and Order”
- The newspapers will splash my name all over
- My sexual history will be open to everyone
- No one will believe me
- Everyone will tell me it is my fault

An advocate cannot promise that none of these will happen, but the advocate's role is to assist the victim/survivor in finding concrete answers about the likelihood of these. See "Barriers to Reporting" later in this section.

Check your jurisdiction to see if a victim/survivor can talk with law enforcement casually before reporting an assault, as that may allay their fears. If they are met with a caring officer who demonstrates that s/he believes the victim/survivor, it can go a long way to encouraging the victim/survivor to move forward with the report. In some jurisdictions that is not possible; law enforcement is directed to move forward on any crime about which they have knowledge.

If the victim/survivor remains undecided about reporting, discuss with her/him the
implications of a delayed or no report. Ultimately support her/his decision and assist with resources that are available such as:

- Order for Protection or Harassment Restraining Order,
- Emergency funding if necessary,
- Reading materials that are designed to assist victims/survivors after an assault
- Referrals to additional support and assistance: support groups, counseling, and other supportive resources.

Reporting for the Purpose of Prosecution

Make arrangements as soon as possible to have the victim/survivor meet with law enforcement if s/he decides to report the assault with the expectation of the assailant being prosecuted.

A victim/survivor should be fully aware that reporting the assault does not necessarily mean it will be charged and/or prosecuted. The victim/survivor's role is to provide law enforcement all the information possible to explain how this was an assault and not consensual sexual contact. It is then the role of law enforcement and prosecution to determine if they have the evidence necessary to successfully charge and prosecute the assailant. Victims/survivors do not prosecute; the State of Minnesota (or whoever has jurisdiction) prosecutes on behalf of the victim/survivor, in what our system of criminal justice perceives is a crime against the community. Victims/survivors become critical witnesses in the State's case. An effective and sensitive prosecutor will typically seek input and communication from an advocate and/or the victim/survivor, but it is important to note that the prosecutor is not a victim/survivor’s attorney in the way a civil attorney might be. The investigation and prosecution process will be discussed in detail later.

Report with No Intention of Having the Case Prosecuted

One option in some jurisdictions may be to make a report to law enforcement but state clearly that the victim/survivor does not want further action/prosecution to happen. If this is the case it is important that the victim/survivor make this clear to the investigating officer from the beginning. Jurisdictions vary in their handling of such requests. Therefore, before reporting to law enforcement, a victim/survivor should be advised of a few things by her/his advocate:

- Once a report is made to law enforcement, the victim/survivor may not be able to change her/his mind and decide that s/he no longer wants the investigation to go forward.
- Some jurisdictions act on the concept that once the investigator is aware of a possible crime, s/he has an obligation to discover whether a crime was committed and to report that to the prosecutor.
- While the victim/survivor's wishes should be considered, the criminal justice system may not comply at all times with her/his wishes. Work with your local law enforcement and prosecution regarding their policies on this topic.

Realistically, law enforcement and prosecutors know that without a willing victim/survivor who is prepared to testify, these cases are difficult or impossible to
carry forward. However, different jurisdictions have varying approaches. It is not unknown to have a victim/survivor subpoenaed or charged with falsely reporting a crime for refusal to "cooperate" in a prosecution. Therefore, it is important for the victim/survivor to know ahead of time the context of her/his decision.

One result of reporting when a prosecution does not happen is that the case can be used as supporting evidence in other cases involving the same assailant. If the details of the assault are similar, the case, whether or not charged and/or prosecuted might be used as this "Spriegl" evidence. If the victim/survivor might be concerned about safety, inquire as to how her/his information or report will be kept and who will have access to it.

Third Party or Anonymous Report

Some jurisdictions will facilitate this type of reporting. Third party/anonymous reports are the equivalent of "John Doe is a perpetrator but I am not going to tell you who I am." The anonymous report may give details of the assault but does not identify the victim/survivor. If a victim/survivor is really frightened of consequences of reporting and suspects that local law enforcement already has this person on their radar, this type of report may be helpful or at least informative. Check with your local jurisdiction regarding this type of reporting. Some jurisdictions may be concerned about retaining information naming a potential assailant without the named person ever being able to know or respond to the allegations (a potential constitutional issue).

The Process of Reporting to Law Enforcement: What Victims/Survivors and Advocates Need to Know

An advocate provides support to the victim/survivor; law enforcement investigates criminal cases. Clarification of roles and boundaries should be clear before an advocate arrives at law enforcement with a victim/survivor.

The victim/survivor needs to report the assault in the city or county in which it occurred not where s/he lives. Occasionally, a law enforcement agency can do a 'courtesy interview.' For example, if the victim/survivor is currently residing quite a distance from where the assault occurred, the law enforcement agency where it occurred could request the law enforcement agency where s/he lives to conduct the interview on their behalf. There are potential benefits and drawbacks to this approach including: single vs. multiple investigators talking with the victim/survivor; single vs. multiple advocates working on the case, and time and travel for the victim/survivor. Advocates can be helpful in sorting this out and helping the victim/survivor and system professionals consider options to make reporting go as smoothly as possible. Make certain you inform the victim/survivor that s/he can have you (if applicable) or another advocate with her/him as s/he makes the report.

The Law Enforcement Interviews

There are both initial and in-depth interviews with the victim/survivor about the
assault.

- Often the initial interview is conducted by a patrol officer, not an investigator. This is especially true if the victim/survivor is reporting soon after the assault occurred, or contacts law enforcement on their own. The initial interview gives the officer a brief sketch of the situation, enough to determine initially that a crime has been committed. There is a great deal of discretion about how much information is taken at the initial interview. There are both advantages and disadvantages to a lengthy report at this time. One advantage is that it may be easier for the victim/survivor to recall details at this time rather than a few days later. Moreover, it may be cathartic for the person to relate the events at this point, reducing feelings of guilt, anger and fear. On the other hand, the victim/survivor may be disturbed, not willing to speak, uncertain if they want to make a report or even speak with law enforcement, or a combination of emotions. This can be especially true if the victim/survivor had ingested any drugs or alcohol. At this point, it is best if the victim/survivor can determine what they feel they can handle.

- The in-depth interview covers the assault in minute detail in order to begin building a legal case against the defendant. The in-depth interview may be conducted at the time of the initial report or at some other time, ranging from a few hours to several days later. Some law enforcement centers have officers who have received special training in sexual assault cases who conduct the in-depth interview. The same information may be covered more than once, even in the same interview.

At the Emergency Room

- If the victim/survivor has been seen at the ER/ED and law enforcement arrives there, often the initial interview will be conducted in order to determine if there is evidence to secure at the scene of the assault. If the assailant is perceived to be extremely dangerous to the general public, law enforcement may want to gather enough information from the victim/survivor to have "probable cause" to take the suspect into custody.

- If the in-depth interview will not be conducted immediately following the evidentiary exam the investigating officer will want to schedule an interview for a later time.

- Remind the victim/survivor that you can accompany them to the law enforcement center if the victim/survivor would like. Let the investigating officer know that you or another advocate will be coming along as a support person.

Prior to the interview it is important to help the victim/survivor understand the kinds of questions the officer will be asking:

- The investigator will ask very detailed and specific questions about the sexual assault. The law makes very small distinctions as to which body part was used, whether or not penetration occurred, etc, so the investigator must be very specific about those things. This should not dissuade a victim/survivor from reporting, but a good advocate will prepare the victim/survivor for this type of questioning and explain that the investigator must ask those questions to be thorough. Furthermore, the prosecutor will need these details in order to ascertain how the assault fits into the elements of the
As expected, the investigator will be talking about the sexual parts of the body, sexual acts, men's and women's bodies, whether or not the assailant ejaculated, etc. The victim/survivor also may be asked in the interview when s/he last had consensual intercourse. This question is asked because if the rape kit indicates multiple semen sources, the officers need to be able to explain the presence of semen from someone other than the assailant.

Help the victim/survivor understand that while these questions may be very embarrassing, the officer will try to help put the victim/survivor at ease. The advocate may find it helpful to speak with the officer beforehand regarding the victim/survivor's apprehension. The advocate may suggest to the officer that s/he explain to victim/survivor the reasons for the questions being asked. Simply put, you can ask the victim/survivor if it would be helpful to them in answering if they knew why the question was being asked. Be certain to have this conversation before the interview begins. An advocate needs to remain silent throughout the interview.

Let the victim/survivor know that the interview will most likely be audio-taped. This is to create an indisputable record of what the victim/survivor said. The tape recorder may or may not be visible in the interview room. To the extent possible, the victim/survivor should try to forget about the recorder and just focus on the officer's questions.

The investigator will likely ask what the victim/survivor was wearing, where s/he had gone, what s/he had been doing, who else might have been there, whether or not the victim/survivor struggled, whether drugs or alcohol were being used. While a victim/survivor may hear these and wonder if the investigator is blaming her, the reason for these and similar questions is to document evidence (clothes s/he wore), witnesses, and dynamics of the assault.

Perhaps the most important thing for an advocate to explain to a victim/survivor before s/he gives a report to law enforcement is that the most damaging thing the victim/survivor can do is lie—about anything! A victim/survivor may feel guilty about drinking, using drugs, flirting or doing something embarrassing or illegal and may not want to be honest. Thinking that s/he is making the case stronger or her/his innocence as a victim/survivor clearer the victim/survivor may omit information or lie about details. But lying to cover up something s/he is ashamed of or to add something that never happened can ruin a criminal case. Much of the time, the success of a case hinges strongly on the credibility of the victim/survivor. If the investigator or the prosecutor later discovers that the victim/survivor was lying—even about seemingly small facts—they may decide not to pursue the case further. Otherwise, these false statements may be raised at trial giving a jury reason to question the entire assault report. Law enforcement and prosecutors understand that questionable behavior does not excuse a rapist. Extreme alcohol or drug use may in fact help the prosecution make a case for the victim/survivor's vulnerability.

Most jurisdictions invite advocates to sit with victims/survivors during the interview. Usually as the officer starts the tape s/he will identify by name who is in the room—victim/survivor, officer and advocate. If the advocate does not want their last name used, indicate this to the officer prior to the beginning of the interview. Sometimes victims/survivors will ask if a friend or family member can sit with them in the interview. Law enforcement generally does not welcome this because they fear the presence of someone close to the victim/survivor may affect the victim/survivor's ability to be...
candid.

• The advocate’s role during the law enforcement interview is to support the victim/survivor only - not to aid in the investigation.
  - While sitting in an interview with law enforcement, the advocate should remain silent. The advocate should not take notes or ask questions either of the officer or the victim/survivor while the tape recorder is on.
  - The advocate should never do anything that appears to be coaching or suggesting what the victim/survivor should say or do - those actions could be raised at trial.
  - If the advocate realizes that the victim/survivor has forgotten important information in the interview that the advocate is aware of, the advocate may approach the investigator after the tape is off and indicate that s/he may want to ask the victim/survivor about a certain subject. This allows the investigator to get the information directly from the victim/survivor in her/his words without prompting by the advocate. The officer can then restart the tape and continue the interview.

• Most victim/survivor interviews cover these topics:
  - Description of the suspect
  - Victim/survivor’s prior activities leading up to the assault
  - Recent intercourse with ANY partner
  - Victim/survivor’s relationships to the suspect
  - Visible injuries (These should be in the medical report but bruising may have appeared that was not present in the medical exam)
  - Resistance to the assault, if any (the victim/survivor does not have to show physical resistance)
  - Clothing worn by the victim/survivor
  - Exact words of the suspect (If the victim/survivor cannot remember exact words, the statement should be labeled “approximate” wording)
  - Time span of the assault. S/he does not need to be exact

• If this is a delayed report and a span of time has passed since the assault occurred, an investigator or detective may be the person who takes the initial report. Even if a number of years have passed since the sexual assault, victims/survivors should still consider reporting to law enforcement. Statutes of limitations only apply to the ability of the prosecutor to file charges, not to the time when an investigator can take a report on crime. Even if they cannot proceed on this particular victim/survivor’s case, law enforcement might be able to use the report to prove an allegation made by another victim/survivor. Obviously, the other considerations regarding a victim/survivor’s readiness to report will apply even after time has passed.

• No matter when the assault happened, the role of the investigator is to search for the truth, and if the evidence indicates a crime has probably occurred, to report the information to the prosecuting authority for charging. The role of the investigator is not to prove that a crime occurred but merely to investigate the report of a criminal offense.

• Generally, when law enforcement has a suspect in a case, they will investigate and bring the evidence to the prosecutor’s office (typically the County Attorney’s office) office for review. To do this:
  - The investigator will interview the victim/survivor,
The investigator will interview other people who may have information about what happened before, during or after the assault. They may be able to talk about the victim/survivor's demeanor that supports her/his allegations that an assault occurred.

− The investigator will interview or attempt to interview the suspect.
− If there was a sexual assault medical/forensic exam, the investigator will get the reports from the medical personnel.
− If there is still a crime scene where evidence of the event might be present, the investigator will go there, take photos and collect evidence.
− If the victim/survivor has bruises or other physical indications of an assault, the investigator will take photos of her/him.
− If the victim/survivor's clothing shows signs of a struggle, or could contain evidence of the assault, the investigator will collect the clothing.

The investigator may consult with the prosecutor during this time to determine if there are other directions of investigation to pursue. Once the investigator feels s/he has completed the investigation, the case will be referred to the prosecutor's office for charging. Usually the investigator shares her/his opinion about the potential charges based on the information uncovered in the investigation.

The County Attorney or Assistant County Attorney will then decide whether or not there is enough evidence to charge the suspect with a felony (namely, Criminal Sexual Conduct in the first through fourth degree) or a gross misdemeanor (Criminal Sexual Conduct in the fifth degree). If there is enough evidence the suspect will be charged; if not, the suspect will not be charged. The case may also be returned to the investigator for further investigation.

• Only in certain instances will law enforcement arrest the suspect in sexual assault cases.
  − Arrest is used to confine a suspect that law enforcement and the courts believe to be a flight risk or ongoing risk to the general public.
  − Additionally, when a suspect is held in jail a time limit begins. Law enforcement and the prosecutor have only a window of a few days to complete the whole investigation and charge the suspect with a crime.
  − Due to the complicated nature of sexual assault investigations, it may be difficult to interview all the relevant parties and gather and assess evidence before the timeline runs. It could mean that the state misses an opportunity to charge the suspect fully. Furthermore, interviews with suspects in custody often yield different results than those with suspects who are not in custody.
  − Instead of arrest, if/when the county attorney decides to charge the assailant a summons to appear will be delivered to the assailant advising her/him of a time to report to court to hear the charges.
  − For the above reasons, it can be helpful to explain to a victim/survivor that a decision not to immediately arrest a suspect does not mean law enforcement does not believe her/him.

• It is not unusual for a sexual assault investigation to take several weeks or
even months.

- The investigator needs to interview numerous people and follow up on their statements.
- The investigator may also be waiting for the test results from the Bureau of Criminal Apprehension or another laboratory, which can take a long time.
- During that time, law enforcement, with the assistance of the advocate should stay in touch with the victim/survivor to keep her/him informed of the progress of the case.
- The police reports will not be disclosed to the victim/survivor while the case is pending and depending upon the prosecutor, may not be disclosed until the case is completely resolved. This is based on data practices statutes which make the investigation private, even from the victim/survivor, until an individual has been charged or convicted.

Pros and Cons of Reporting

There are advantages to reporting a sexual assault to law enforcement agencies as soon as possible. Ordinarily, evidence of sexual assault disappears rapidly. Prompt police investigation will preserve evidence necessary to obtain effective prosecution. Remember that the decision to report rests solely with the victim/survivor. The victim/survivor may be helped by the advocate’s clarification of the options.

Frequently, sexual assault victims/survivors do not think they want to report the crime. Experience shows, however, that many do change their minds later on. If the crime has not been reported, chances of a successful prosecution later on are remote. Make certain you fully explain to the victim/survivor their options and consequences of making a report or not thereby ensuring the victim/survivor made an informed decision.

Although prosecution cannot occur without reporting, be aware that making the report does not guarantee prosecution. In each case, the prosecutor must make a legal judgment on whether there is sufficient evidence to prove the case beyond a reasonable doubt.

Many victims/survivors find that reporting the crime and following through with the prosecution helps them work through the emotional trauma of the experience. Some victims/survivors are motivated to report in order to prevent others from harm and find satisfaction in being active to this end. Others may be strongly motivated to report the assault as part of their healthy anger and desire to see retributive justice done.

From society’s point of view, if every victim/survivor were to report sexual assault, law enforcement would be better able to assist the community. The more reports there are, the greater the possible number of arrests, prosecutions and convictions. It is important for an advocate to express to a victim/survivor, that even if the case is never prosecuted, it still may help to prove a different sexual assault by the same perpetrator. This use of prior offenses at trial is called "Spreigl” evidence.
Barriers to Reporting

Given all these advantages of reporting, why don't victims/survivors report more often?

- One common reason is fear of retaliation from the offender if the victim/survivor reports. Even though our experiences over time show that these threats are rarely carried out, the victim/survivor still must deal with their very real fears about this.

- Victims/survivors also fear that their name and the assault will become public knowledge, although in many jurisdictions the victim/survivor's name is not in the criminal complaint. Moreover, the media practice throughout Minnesota is to not publish or broadcast names of sexual assault victims/survivors. Regardless, a sexual assault is a humiliating and degrading experience. Victims/survivors fear stigma being attached to them if others find out about the assault. Again, given the myths our society perpetuates about sexual assault, this is not an unreasonable fear.

- Another reason for not reporting is the denial of the fact, or impact of the assault. This is an inherent part of some responses to assault. Reporting the crime to authorities is an explicit statement that the assault did happen and that it caused harm to the victim/survivor. This may be very difficult for someone who wants most of all to "just forget about it."

- Victims/survivors may also fear law enforcement's reaction to the assault. Victims/survivors may be afraid that they will not be believed, or that law enforcement will say that they "deserved it." Doubt of law enforcement sensitivity and effectiveness in sexual assault cases is still widespread. However, this attitude on the part of professional law enforcers is changing, as many of them receive new knowledge and training on such issues. It is important to keep in mind that law enforcement officers have varying levels of knowledge about the dynamics of violent crimes, especially those crimes generally perpetrated against women, and also vary in how responsive they are to the needs of victims/survivors.

- Victims/survivors may also fear they will not be believed or they will be blamed by friends and family. Some people will indeed not believe and/or blame a victim/survivor. There are many ignorant people in the world. Often victims/survivors learn that their fears about being blamed are overstated - loving family and friends often surprise victims/survivors with their unconditional support. The advocate's role in helping secondary victims/survivors understand the impact of the assault is important.

- Finally, victims/survivors may be apprehensive to report the assault if they have been partaking in an illegal activity such as minor consumption/underage drinking, drug possession/consumption or they have had past negative contact with law enforcement. Many jurisdictions will ignore these infractions as they see the sexual assault as a much more critical crime to address. (The Sexual Violence Justice Institute recommends that law enforcement and prosecutors agree not to punish minor violations of the law by victims/survivors reporting sexual assaults. The advocacy program should work with these agencies to gain an agreement that minor consumption; curfew, drug possession/consumption, or other relatively minor offenses by the victim/survivor will not be charged. Warrants for the victim/survivor's arrest should also be discussed. This will allow the victim/survivor to be truthful even when s/he is admitting to a criminal offense. This agreement should be reached as a policy matter before a specific case arises.)
Role of the Advocate in Reporting Procedures

An advocate should never pressure a victim/survivor to report the assault. As with all other decisions, victims/survivors have the right to decide whether or not it will be best for her/him to report. The advocate’s most useful role is to knowledgeably explain to the victim/survivor the advantages and disadvantages of reporting and to assist the victim/survivor to come to an informed decision that fits her/his unique circumstances.

Giving accurate information about legal procedures is a crucial part of clarifying options. For instance, people confuse reporting and prosecuting. They may think that once they report the crime, prosecution automatically follows. If they are misinformed or apprehensive about the legal procedures involved, they may hesitate to report. Therefore, it is imperative that the advocate provide accurate and informed information. If an advocate does not know the answer, seeking out the information and assistance is far preferable to giving incorrect information to a victim/survivor.

Victims/survivors may also need to know if their names will become available to the public. Victims/survivors’ names will not become public by reporting the assault. However, if the assailant is charged with a crime and the case goes to trial the court records are publicly accessible. In other words, any individual who wants can go to the courthouse to look at the records or to observe the trial. Many court administrators create separate confidential files containing victim/survivor records. Some records such as the victim/survivor impact statement or restitution affidavit might, however, be available to the public. Be sure to check with your local court administrator to define your jurisdiction’s practice. Also refer to Minnesota statute 611A.035 for information about additional measures victims/survivors can take to have their data kept private. If victims/survivors have additional privacy and/or safety concerns about a particular person (e.g. relative, friend, colleague) in a responding agency having access to their report or records, an advocate can assist by advocating for additional privacy measures to be taken.

Civil Suit

Victims/survivors have the option of pursuing a civil lawsuit against a suspect. Some victims/survivors pursue a civil suit as an alternative means of seeking justice as the burden of proof in civil cases is lower than in criminal cases. The remedy for harm in a civil lawsuit is money to cover expenses claimed by the victim/survivor. The victim/survivor must retain a private attorney for such an action. To make such an action worthwhile, the suspect must usually have money. Occasionally, there may be a negligent third party who can be sued for actions or omissions that facilitated the suspect’s crime. In these instances, there may also be a case for punitive damages that is designed to For persons considering this option, the advocate might suggest they set up an appointment with an attorney to have an initial discussion of the time, energy, expense, stress and the possibility of success in the case before making a decision as to whether they want to pursue such a suit. Often, attorneys who take civil suit cases will agree to meet with a potential client at no charge in order to assess the
worthiness of a case. The National Crime Victim Bar Association (www.victimbar.org) provides information for advocates, attorneys, and victims/survivors. They can also provide referrals to attorneys who have experience in civil litigation for crime victims/survivors.

Court Procedures

The court process can be confusing even to those who are somewhat familiar with it. For a victim/survivor who has never had a reason to know about the court procedure, it can be frightening. Accurate information ahead of time about court and trial procedures is an important tool for empowering victims/survivors to make their own choices about the disposition of their cases. Providing information about the steps in the court process allows the victim/survivor to make an informed decision and may also reduce stress during this process.

The following describes the court process for adult defendants. When the defendant is a minor the court procedure will change. See the Legal Advocacy manual for more details. Also refer to the court flow charts later in this section.

Pros and Cons of Prosecuting Sexual Assault

Only a small minority of reported sexual assaults is prosecuted. In many cases this is because the victim/survivor is reluctant to face the possible ordeal of a trial. In other cases it is because police or prosecutors may decide there is not enough evidence for a successful prosecution. Even when cases are prosecuted, it is often more difficult to obtain convictions in sexual assault cases than in other violent crimes. The private nature of the crime or evidentiary problems may make conviction difficult. Juries may believe the myths about sexual assault (e.g., that someone was flirtatious, dressed provocatively or intoxicated is “asking for it”) or be reluctant to label someone a sex offender, especially if he is a respected member of the community. However, as communities become more educated about sexual assault, prosecutors have become increasingly successful at overcoming these obstacles.

Most cases result in a guilty plea, but if it goes to trial, the victim/survivor must almost always testify. The victim/survivor may find it very stressful to recount to a group of total strangers the most intimate details of a terrifying and degrading experience. The person may feel as though s/he is on trial instead of the defendant, especially if the defendant claims the act was consensual. There are positive sides to prosecution, however. The State of Minnesota has some of the most progressive sexual assault laws in the country. In the past few years, many attorneys and judges have received awareness training in sexual assault. Many professionals are frequently more willing to prosecute such cases and to defend victims/survivors’ rights than they previously were.

Some real benefits from prosecuting the case may be experienced. Victims/survivors may have the satisfaction that s/he took some action. Prosecuting such cases also helps to bring the whole area of sexual assault into the open, reducing the shame and secrecy that have shrouded these crimes for centuries. Furthermore, even if the offender is not convicted, s/he may recall the ordeal of going to court and the publicity surrounding her/his name. This may have a
deterrent effect on her/his future behavior. Also, if the case is plea bargained instead of going to trial, the court has more control over her/his future action than it had before s/he was charged with a crime.

Steps in the Court’s Procedures

1. Filing the Complaint (Charges)
   Charges may be filed against a suspect by means of a complaint. A complaint is issued under the authority of the county attorney. The complaint sets forth the offenses with which the defendant is charged. Complaints are signed by the investigating officer after having been prepared by the county attorney according to the facts presented. The complaint names the person who is accused, gives a short description of the relevant events and states the crime or crimes that the person is accused of committing. The complaint will list the statutory maximum for any offense charged. However, this does not represent the likely sentence the defendant will receive.

   The prosecutor represents the State of Minnesota, not the victim/survivor of the crime. In deciding whether to file a complaint, the prosecutor knows that to obtain a conviction, he or she will eventually have to prove “beyond a reasonable doubt” that the crime occurred. While crime victim/survivor rights statutes (MN Statutes 611A) indicate that victims/survivors have rights to notification and providing input at various stages throughout the process, the decision whether to file a complaint and pursue a case lies with the prosecutor.

2. Initial Appearance
   Once the assailant has been arrested and charged, s/he will appear before a district court judge. The complaint is then filed with the court. The defendant is given a copy of the complaint and any documents attached to the complaint. The court at this time will inform the defendant that s/he has a number of rights, including the right to remain silent, the right to an attorney, and the right to a trial. The court also assesses the defendant’s financial circumstances and decides whether to appoint a public defender. Public defenders are criminal defense attorneys who work for the government and represent low-income criminal defendants in criminal cases. The prosecutor can request at this time that the court order the defendant booked, photographed and fingerprinted. If the defendant has been charged with a felony or gross misdemeanor, the defendant does not have to plead guilty or not guilty at this appearance. The defendant is ordered by the court to appear at the arraignment with her/ his attorney. This usually takes place within 14 days of the initial hearing. In sexual assault cases, the court will usually issue a no-contact order at the first appearance.

   If the defendant is in custody (jail) at the time of the initial appearance, the prosecutor will usually request bail be set with certain conditions of release. Bail or bond is an amount of money the defendant must post with the court to be released, and that money can be kept (forfeited) if the defendant fails to show up for future court appearances. In Minnesota, every criminal defendant has a right to bail before her/his guilt is decided. In other words,
before the guilty plea or trial, the court must set bail that the defendant could post and get out of jail.

The conditions of release may be set even if the defendant is not in custody at the time of the Initial Appearance and may include things like no contact with the victim/survivor, no leaving the state, no use of drugs or alcohol, use of an electronic home monitoring bracelet or other conditions s/he may be brought back to court to consider whether bail should be set or increased as a result of the defendant’s actions. Defendants cannot be held without bail before trial even for violations of the conditions of release.

3. Arraignment – Rule 5 Hearing
The next appearance is usually made within 14 days of the initial appearance. At this appearance the defendant is arraigned, that is, the charges are read and the defendant enters a plea of guilty or not guilty. If the plea is guilty, a sentencing date is set. If the plea is not guilty, a date is set for the Omnibus Hearing. Bail may be discussed again at this time. In some counties, the judge will make a finding of probable cause based on the sworn complaint, but other pretrial issues are reserved for the Omnibus Hearings. Once probable cause is found and defendant has entered a not-guilty plea, s/he has a right to demand trial within 60 days.

4. Omnibus Hearing
The purpose of the Omnibus Hearing is to:

- Show probable cause the offenses charged were, in fact, committed;
- Show probable cause that the suspect charged was, in fact, the assailant. (Probable cause is almost always determined on the basis of a sworn complaint rather than actual testimony.)
- Determine whether any of the defendant's constitutional rights were violated by reason of a search and seizure, by reason of any statements he may have made to the police, or by reason of the identification procedures used in the case, such as a lineup or showing photographs.

**Legal Issues:**
The defendant has the right to waive the Omnibus Hearing and consideration of the constitutional or probable cause questions. Waiver of the probable cause aspects of the Omnibus Hearing simply means that the defendant acknowledges probable cause exists to hold the defendant for trial. A defendant does not admit guilt by waiving the Omnibus Hearing. Guilt must be determined by the higher standard of proof “beyond a reasonable doubt”. The purpose is simply to determine whether there is reason to hold the defendant for trial and whether evidence obtained is constitutionally admissible. If the defendant either waives the right to an Omnibus Hearing or the judge finds that probable cause exists, the defendant will be ordered to stand trial. Some counties conduct this portion of the Omnibus Hearing immediately prior to trial.

5. Pretrial Hearing – Plea Negotiations Settlement Conference
Some counties set a separate hearing between the Omnibus Hearing and trial in an attempt to settle the case. This is referred to as plea bargaining.
Plea bargaining is an agreement between the prosecution and the defense that recommends a disposition of the case to the court. Usually the defendant agrees to plead guilty to a lesser charge in order to receive a lesser sentence than what he risks by going to trial. The judge is not bound by any agreement between the prosecution and the defense but generally will accept the settlement they have agreed upon. If the judge does not accept the plea agreement, the defendant has the right to withdraw his guilty plea and stand trial. Plea bargaining may occur at any time from the time the crime is reported until the verdict is read to the defendant. The prosecutor must make reasonable efforts to notify a sexual assault victim/survivor of the proposed settlement before it takes place (see MN Statutes 611A.03, 611A.0301, and 611A.031).

6. Trial
If the defendant pleads not guilty and there are no successful plea negotiations, the case will go to trial. At trial, the State proceeds first and attempts to sustain its burden of proving the defendant committed the act charged beyond any reasonable doubt. In most cases, the prosecution will call as witnesses: the victim/survivor, the police officers and anyone who may have seen or heard the incident. Most prosecutors will meet with a victim/survivor ahead of time to prepare her/him for what to expect in court. The victim/survivor will be asked to identify the defendant in the courtroom. The victim/survivor may be asked by both prosecution and defense to reconstruct the offense in detail. After the State has rested its case, the defense will present its witnesses, which may include the defendant. If the defendant does not testify, this fact may not be commented upon because he has a constitutional right to silence. When all the evidence has been presented, the court will instruct the jury as to what the applicable law is that should use in its deliberations. The jury then retires to the jury room to deliberate and must reach a unanimous decision for a finding of guilty.

7. Sentencing
If the defendant pleads guilty or is found guilty, the sentencing process begins. It will typically be three to eight weeks from plea or verdict to sentencing. Usually, the court will order a pre-sentence investigation (PSI) prior to sentencing for criminal sexual conduct convictions. A PSI is a detailed report to the judge about the defendant’s individual characteristics, circumstances, needs, potentialities, criminal record and social history, the circumstances of the offense and the harm caused by it to others and to the community. This report is completed by a probation officer, who must make reasonable efforts to contact the victim/survivor to notify him/her of the conviction, the sentencing date, the right to restitution and other relevant information. The PSI will contain confidential information about the defendant—perhaps medical, psychological or other private data. For that reason, it is private and is disclosed only to the defendant, the prosecutor, the court and other agencies that ultimately will work with the defendant after sentencing. It is not disclosed to the victim/survivor of the crime.

Recommendations by corrections as to the sentencing suggestions however may be shared with the victim/survivor. If the defendant is found guilty of more than one count relating to the same incident and the same victim/survivor, he will be sentenced only on the most serious (kidnapping and

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burglary are exceptions to this rule). When the case involves multiple victims/survivors, the offender may be sentenced for each, and the sentences can run consecutively. Once a defendant has been adjudged guilty—either after trial or after a plea—the judge decides the appropriate sentence. Especially in cases of felony criminal sexual conduct, a pre-sentence investigation and sex offender assessment must be completed before sentencing. This assessment includes mental health testing as well as previous records from medical, corrections, juvenile court and welfare agencies. The assessor compiles the information and makes a recommendation to the court as to what if any treatment options are best suited to this offender’s problem. These are reports which assist the judge in deciding what the best sentence would be and whether and what type of treatment would best benefit the offender in the hopes of reducing the chances he will re-offend.

If the defendant is being sentenced to a prison sentence, the court may waive this assessment or may not order treatment, as treatment in prison is voluntary only. This tool is mainly geared towards a probationary sentence where the defendant is required to meet certain conditions like treatment or towards a civil commitment decision.

A victim/survivor of the offense has the option of presenting a Victim Impact Statement (VIS) as part of the PSI. This is an important chance for the victim/survivor to inform the court what the offense has meant in his/her life, how it has affected her/him, whether s/he has required medical or mental health treatment as a result and what s/he wishes to see done at sentencing (see MN Statute 611A.037 and 611A.038).

The VIS can be an important tool for a busy judge to fully understand the personal implications of this offense to this victim/survivor, and if a victim/survivor is capable, s/he should be encouraged to give this input. However, the comments should be directed to the judge, not the defendant and should not be personal attacks against the defendant. The point is to tell the judge what ought to be done, not berate the defendant. It can be read aloud at sentencing or given to the judge whichever way the victim/survivor chooses. The advocate may assist the victim/survivor with this process but be careful that it is the wishes and thoughts of the victim/survivor not the advocate that are being expressed.

Sentencing Guidelines

After receiving the PSI and sex offender assessment, the court will look to various other sources to direct the sentencing decision. It is very important to realize that the maximum penalties set out in statute, and in the complaint, do not reflect the most likely sentence the offender will receive. Rather, the recommended sentence for felony offenses in Minnesota is generally set according to a commission organized under the Minnesota Supreme Court. This commission, called the Minnesota Sentencing Guidelines Commission, has created a system whereby a combination of the criminal history of the defendant and the severity of the offense of conviction are used to reach a “presumptive” sentence which the judge normally must follow. The commission has created a grid which indicates the presumptive sentence based upon a “score” which is given to each defendant according
to his or her criminal history, and a “level” which is given each offense according to how serious it is (see the Sentencing Grid in the Legal Advocacy Manual).

The court is able to vary from the presumptive sentence, but only under very unique circumstances. If the court finds “substantial and compelling” mitigating or aggravating circumstances, the court may deviate or “depart” from the guidelines. Upon a finding of mitigating factors, such as the offender playing a minor role in the offense or because of the offender’s mental impairment, the court may determine that the guidelines sentence is too severe and depart downward to reduce prison time or allow an offender to go on probation rather than go to prison.

Similarly, if the court finds aggravating factors that were not present in the elements of the offense itself, such as the victim/survivor being particularly vulnerable, or being treated with particular cruelty, the court may depart upward and sentence the offender to longer prison time or give prison rather than probation. Advocates should work to familiarize themselves with the Sentencing Guidelines.

Certain cases decided by the Minnesota Courts and the U.S. Supreme Court also affect how the criminal history score is determined and when upward or downward departures are available. A case called Blakely decided recently by the U.S. Supreme Court has affected upward departures for sentencing. It says that any factors used by a court to go higher than the presumptive sentence must be admitted by the defendant in a plea, or must be found by the jury “beyond a reasonable doubt” at trial. The precise parameters of the decision are unclear, but it does make it more complicated for the court to increase a sentence over the presumptive guidelines sentence (see the Legal Advocacy Manual).

As with any legal issue, advocates are wise to avoid giving advice or guessing what a sentence might be. Sentencing in Minnesota is based upon a quite complicated mixture of factors that are difficult to interpret at best. Second guessing the prosecutor or advising the victim/survivor what the sentence “should be” will many times serve to confuse and perhaps dismay the victim/survivor inappropriately. It is mainly important to understand the basics so that you can assist the prosecutor in interpreting the sentencing options for the victim/survivor. Advocates can also help the victim/survivor articulate his/her wishes in an informed way to the prosecutor.

Role of the Advocate in Prosecution

As in other systems, the advocate’s role is to assist the victim/survivor in dealing with an unfamiliar situation and set of procedures. The fear of a trial and testifying may become overwhelming for a victim/survivor. It is therefore the advocate’s role to assist the victim/survivor by explaining the steps that will take place.

- It may be helpful to explain that after a suspect has been arrested, he may be released on bail or on his own personal recognizance (promise that s/he will appear in court). It is the victim/survivor’s right to be notified of the
suspect's release from jail. Suspects are instructed that they are not to see or talk to the victim/survivor at any time or in any way. This includes third party contact, meaning, the suspect cannot relay messages to a victim/survivor through another person. If s/he does, the victim/survivor should report the circumstances to law enforcement immediately. Any violations of the conditions of the suspect’s release can be grounds for the judge to increase his bail or return him to jail. Contact from the victim/survivor to the suspect is also prohibited.

• In our legal system, every accused person is treated as innocent until proven guilty. Someone is arrested because there is probable cause that s/he is believed to be the person who committed the crime. Thus, law enforcement and the prosecutor will often call the person under arrest “the suspect,” “the accused,” “the alleged rapist,” or “the defendant.” Victims/survivors who hear this language may feel their credibility is being undermined. Explain that such terms reflect the philosophy of our legal system rather than a judgment on them. The person suspected of committing a crime has a right to know who has accused her/him of the crime. Her/his lawyer will receive copies of all the statements and reports taken by police and medical records. The defendant is treated as innocent until proven guilty in a trial. If the person accused of the crime is a juvenile, some rules are different from those for adult suspects, but most are parallel. Ask the prosecutor to explain any special juvenile proceedings.

• It is the responsibility of the prosecutor to keep the victim/survivor up to date about the facts of the case, to inform her/him of all hearings, trial dates and the results of any testing done on evidence. Some counties have victim/survivor/witness assistance programs in the county attorney's office. The assistant/advocate for the victim/survivor/witness program can help explain the human and business side of the court process. It is important to keep in mind that such advocates are arms of the prosecution and have, therefore, a somewhat different role from that of community advocates. For example, the victim/survivor witness advocate is not required to keep conversations between the victim/survivor and the advocate confidential. These conversations will be shared with members of the county attorney’s office.

• An advocate may accompany the victim/survivor to any interviews or hearings pertaining to prosecution that require the person to be present as a witness. The advocate may also attend other hearings that do not require the witness to appear, and keep the latter updated on these proceedings. The advocate confers with the victim/survivor on all steps of the criminal case—such as interviews, pretrial hearings, and plea bargaining. If the case goes to trial, the advocate can attend with the victim/survivor to offer support during and between court times. The advocate may serve as a referral source, helping to secure follow-up medical treatment, counseling or mental health services, baby-sitting and transportation assistance.

• The advocate can also help victims/survivors talk about fears they may have about the prosecution of their case. Presenting the facts may be helpful. For instance, victims/survivors may fear long delays of waiting for court proceedings. There can be delays, but aggressive prosecution can often minimize these. The victim/survivor can also request (though not demand) trial within 60 days. A felony case normally takes two to four months from
arrest to trial or plea although the actual trial may last only a few days. Victims/survivors may be fearful of testifying in open court. This fear may be based on an emotional response (that everyone knows or can tell that they are a victim/survivor). While the courtroom is open to the public, usually the only people in court are those the victim/survivor invites. Victims/survivors may fear defense attorney tactics, such as being verbally abused, having their credibility attacked, or having personal or sexual information brought out by the assailant’s attorney. The Criminal Sexual Conduct Law specifically forbids attorneys from bringing out personal or sexual information about victims/survivors except when the judge has ruled ahead of time that it pertains to the case; the judge hears arguments about this in closed chambers. In the event a judge rules certain evidence admissible, the prosecutor can discuss these decisions with the victim/survivor and bring the information out on direct examination, thus minimizing the trauma or embarrassment.

Victims/survivors have no obligation to talk to or have any contact with the defendant’s attorney or any of his agents (such as a private investigator) before the trial. A victim/survivor may hear “investigator” and assume the person is from law enforcement. Victims/survivors need to know they do not need to talk to anyone other than the prosecutor or law enforcement.

• Victims/survivors have no obligation to talk to or have any contact with the defendant’s attorney or any of his agents (such as a private investigator) before the trial. Once the case has been charged by the prosecutor and the defendant has hired an attorney, it is possible that the defense investigator or attorney may contact the victim/survivor or other witnesses. The purpose of the contact is to re-interview witnesses and look for support for the defendant’s side of the case.

• Victims/survivors and witnesses should be warned of this possibility, and notified that they do not have to speak to anyone about the case if they do not choose to do so. Most prosecutors would prefer that witnesses not speak to the defense personnel, but anyone contacted by an investigator should verify for whom the investigator works. If the investigator works for the defense, the witness should immediately notify the prosecutor that such contact has been made.

• Defense investigators are not police, and do not work under the same rules and procedures as police, they frequently do not tape interviews, but rather characterize the witness’ answers in their own words to suit their purposes. Witnesses should be cautious when speaking to anyone other than the police about the investigation.

• The advocate can be helpful at specific times during prosecution. For example, after receiving the case from the police, the prosecuting attorney may interview the victim/survivor to make the determination as to whether the case will be prosecuted. Even though the law requires only “probable cause” of criminal conduct for the prosecutor to charge an offender, the reality is that the prosecutor must be satisfied that s/he can prove the case “beyond a reasonable doubt” at trial before proceeding. Thus, even though the prosecutor may personally believe that the report of sexual assault is valid and that the suspect is guilty of a crime, s/he must take into consideration how other people may view the situation, namely a jury. Victims/survivors may have trouble understanding that lack of sufficient evidence to convince a jury is not the same as not believing their story or condoning the assailant’s act. An advocate can assist the victim/survivor by setting a meeting with the prosecutor to explain the denial or “turn down”. 
• Often, the victim/survivor would like to see the offender convicted, but wants to avoid trial. This is one of the many factors the prosecutor will assess in making a judgment on whether to accept a plea of guilty to a lesser charge than that which the defendant would have faced in a trial. Other types of plea bargains involve a plea to the original charge with an agreement that the offender will serve less than the “Guidelines” sentence. Sometimes the prosecutor may simply agree to a Guidelines sentence instead of seeking an aggravated or increased sentence. The settlement of any individual case depends on an assessment of the whole picture including all strengths and weaknesses. About 80 or 90 percent of all sexual assault cases are settled without trial. The prosecutor must make a reasonable effort to notify the victim/survivor of the plea and of her right to object to the plea at sentencing. The advocate can assist victims/survivors by preparing them for the possibility of pleas and by making sure the prosecutor has their input and provides them any information wanted.

• If the prosecutor refuses to meet with the victim/survivor or give information about the decision, their supervisor might be willing to intervene at the request of the advocate. A written letter to the prosecutor with the victim/survivor’s wishes is also a good idea if the advocate and victim/survivor feel they are not being heard. Finally, if all efforts at communication seem to have failed, The Minnesota Office of Justice Programs takes complaints about prosecutors who may not have followed the victim/survivor’s rights statutes. This should be a last resort, however, as open and effective communication between the advocate and prosecutor is best for the current victim/survivor, as well as future victims/survivors.

• During a trial, the advocate can be helpful in several ways. The advocate may offer information about the courtroom, the trial process, how the victim/survivor/witness should dress and act in court, where the victim/survivor may wait before testifying, etc. Usually the prosecutor will also help to prepare the victim/survivor in these ways. The prosecutor may also prepare the victim/survivor by going over their testimony and what the victim/survivor may expect from the defense counsel during cross examination. Victims/survivors can often spend long hours waiting to testify. Court proceedings can be lengthy and schedules may often be changed at the last minute. This can be nerve wracking for an individual waiting to testify. An advocate can help keep victims/survivors calm during these difficult times. Seemingly irrelevant conversation may be helpful in diverting pressure. Follow their lead. If they want to talk about the trial and their testimony while waiting, fine. If not, don't push them into doing so. Unless the advocate is herself a witness, she may sit in during the victim/survivor's testimony for moral support.

• If the defendant is acquitted, the advocate can help the victim/survivor deal with the verdict. Remind the victim/survivor that a verdict of “not guilty” does not mean that the jury found him/her “innocent.” It only means that the suspect's guilt was not proven beyond a reasonable doubt to all 12 jurors. It is not a reflection on the victim/survivor's character or integrity. The support of the prosecutor and law enforcement may be vital here. If a victim/survivor feels supported and believed by them, it will be easier to deal with a not guilty verdict. They know that many professional people did all they could to assist the case. You can also help victim/survivor discuss options for future
Suggestions for Testifying

The following suggestions may be useful to offer to the victim/survivor/witness:

- Rather than trying to memorize what you are going to say, try instead to picture the scene, the objects there, the distances involved, and just what happened. This way you may recall accurately when you are asked. Review police reports or your earlier statements and all prior written statements to refresh your recollection and to note any errors. Since these reports are provided to the defense, any inconsistencies will be pointed out by the defense. However, don't bring anything to read from when you testify. Rather, note events such as time, places, and events to be stated in a positive manner. Never guess if you can't recall some things, just say “I don't remember”. Before testifying, familiarize yourself with the courtroom. (Many prosecutors will, especially if requested, take you to a courtroom before a trial to make you more comfortable.) Observing another trial may help “de-mystify” the proceedings.

- A neat appearance and “proper” dress in court are important. While clothing ideally should have nothing to do with the credibility of your testimony, jurors do use appearance as one of several ways to judge credibility. Hence, in sexual assault cases avoid any dress that could be considered sexually suggestive.

- Reply to questions in a convincing manner. Listen carefully to the questions asked of you. Have questions repeated if necessary.

- When the prosecutor has completed direct examination, the defense will cross-examine. No matter how nice the defense attorney may seem on cross-examination, he may be attempting to hurt you as a witness. Talk to members of the jury. Look at them while speaking. Show self-confidence and sincerity. Try to give a positive, definite answer rather than saying, “I think” or “I believe.” On the other hand, don't let yourself be tricked into saying something definite when you're really not sure. If a defense attorney tries to box you in (such as demanding a yes or no when the answer is more complex), explain your problem (e.g., I can't answer in one word, my answer to part of the question is yes, but it's not to the second part). The judge will instruct the attorney to rephrase the question or permit you to explain. Remember, when the defense attorney is done questioning you, the prosecution can follow up to clarify anything brought up in the defense examination by asking questions which permit you to explain.

- Do not lose your temper or permit the defendant's counsel to upset, intimidate or harass you. Stop instantly when the judge interrupts or an attorney objects to what you say.

- Continue only when they give you permission. Take a deep breath, compose yourself and answer in a dignified way. Do not argue with counsel or be evasive. Try to give the prosecutor time to object to the defense attorney's questions before you answer. If you do not understand any questions, say
so. Likewise, if you do not know the answer, say so. Do not volunteer
information. Don't say, "Nothing else happened," instead say "That's all I
recall." You may remember more later on. Clarify beforehand with the
prosecutor what your answer will be if you are asked whether you have
talked with anybody about the case; be honest about whom you've
spoken. Always tell the truth. Even minor fabrications can discredit a witness
and weaken an entire case. Never explain your reply nor elaborate. This only
gives the opposing attorney more ammunition to use against you.

- Speak loudly and distinctly enough to be heard and understood by the judge
  and jury. Avoid distracting mannerisms such as chewing gum or fidgeting;
  do not use profanity at any time unless you are requested to relate
  something someone said to you that included profanity.

- If you are in court but not witnessing, it's important to maintain a calm and
  respectful exterior. If you are unable to remain quiet, leave the courtroom
  until you are able to control yourself. Many prosecutors will ask you to leave
  the courtroom or even the courthouse when your testimony is complete. This
  is to avoid the appearance of being too interested in the case (out to get the
defendant) and to prevent the jury from considering anything about the
  victim/survivor (or any other witness) other than what occurs in open court.
  Other prosecutors may want the victim/survivor to stay in the courtroom to
demonstrate that s/he takes the process seriously. In addition, many
  attorneys request, and judges order victim/survivor’s sequestration prior to
  their testimony to prevent even the appearance that one witness’ testimony
  may have been affected by hearing another's testimony.

Tips for Testifying

- Review written or taped statements
- Don't rehearse or memorize what you are going to say
- Walk confidently to the witness stand.
- Do not chew gum.
- State your answers truthfully. Say “I don’t know” if you don’t!
- Think before you speak. If you don’t understand a question ask to have it
  repeated or rephrased.
- Listen to the question asked and answer only that question. Do not
  elaborate.
- Dress conservatively for court.
- Correct wrong or unclear answers immediately.
- Talk to the jury. Look at them, speak to them. They are the ones who need
  to understand what happened.
- Be polite, serious and even-tempered. Stay calm even if the attorney is
  trying to make you get angry.
- Stop immediately if the judge interrupts you or an attorney objects. Resume
  only when the judge tells you.

The Advocate as Witness

For the purposes of this statute, a sexual assault counselor is a person with at
least 40 hours of crisis counselor training and under ongoing supervision whose primary goal is to render advice, counseling or assistance to victims/survivors of sexual assault. The general rule is that communication between the victim/survivor and sexual assault counselor are “privileged”, meaning that the counselor may not be called to testify about “opinions or information…from or about the victim/survivor” unless the [survivor] consents. However, the law allows the counselor to be called to testify about a child abuse or neglect investigation if good cause exists, i.e. the counselor possesses information so unique it cannot be gathered from another source. In making its determination, the court will weigh the public interest in needing the information versus the potential further harm to the victim/survivor. If an advocate is subpoenaed to testify h/she should immediately contact the prosecutor.

Additionally, when an advocate and victim/survivor meet with a third party (law enforcement officer, nurse, prosecutor) the communication is no longer private and protected and an advocate could be called to testify as to the content of those conversations. Typically, however, the advocate has nothing to offer that is not already known so her/his testimony would not significantly alter the evidence. The only exception to this is if the defense alleged that the officer, nurse or prosecutor inappropriately prompted the victim/survivor to answer questions in a certain way or created records that do not reflect what happened in the meeting. Privilege applies only to those private conversations between only the advocate and the victim/survivor.

A person qualified as a sexual assault counselor is not obligated to testify about what a victim/survivor has discussed with her counselor. Minn. Stat, § 595.02 Subd. 1(k) states that an advocate cannot disclose information—either in verbal or written form—without consent of the victim.
Felony Process

1. While court procedures are covered under Minnesota Rules of Court, each jurisdiction may interpret the Rules differently or call hearings by other titles. This section is a general outline of typical court process for an adult defendant.

References
Facts About Minnesota's Community Notification Act

• Minnesota's Community Notification Act was effective January 1, 1997.

• Assignment of risk levels is the statutory responsibility of the Minnesota Department of Corrections.

• Community notification is the statutory responsibility of law enforcement.

• Level 3 offenders — those determined at high risk to reoffend — are identified on a public website.

• Offenders are subject to Act provisions for as long as they are required to register as predatory offenders.

• Of all offenders who have been assigned risk levels, approximately 62 percent are level 1; 2.5 percent are level 2; and 13 percent are level 3.

• Approximately 100 level 3 offenders are living in the community in Minnesota.

What is Minnesota's Community Notification Act?

The Act requires assignment of a risk level to offenders subject to registra-tion as a predatory offender before they are released from confinement in a state prison or treatment facility. The Act also requires that community notification of the offender's release occur. Effective January 1, 1997, the Act applies to offenders released on or after that date (M.S. 244.052).

What is registration?

Since July 1, 1991, predatory offend-ers in Minnesota have been required to register their addresses with local law enforcement agencies (M.S. 243.166). Law enforcement agen-cies forward the information to the Minnesota Bureau of Criminal Apprehension, which maintains a database that can be used by law enforcement agencies as an investi-gative tool.

Who is assigned a risk level?

Risk levels are assigned to predatory offenders:

1. Released from a state prison in Minnesota;
2. Released from a state prison in another state who come to Minnesota under supervision;
3. Released from a federal prison and intending to reside in Minne-sota;
4. Released from confinement who were committed as sexually dangerous persons or psycho-pathic personalities; or
5. Upon request from local law enforcement if released from a federal prison or another state's prison (and not under supervision).
As of January 1, 2006, about 4,000 of Minnesota’s 17,000 registered predatory offenders fall under the above categories and are assigned a risk level.

What are the risk levels?

Level 1 - low public risk
Level 2 - moderate public risk
Level 3 - high public risk

Who assigns risk levels?

An End-of-Confinement Review Committee (ECRC) is established at each Minnesota state prison or treatment facility to determine risk levels. For offenders released from federal or out-of-state prisons, an ECRC in the Minnesota Department of Corrections (DOC) Central Office performs this function.

Who serves on the ECRC?

1. The prison warden or treatment facility head where the offender is confined, or that person’s designee;
2. A law enforcement officer;
3. A treatment professional trained in assessing sex offenders;
4. A caseworker experienced in supervising sex offenders; and
5. A victim services professional.

Who provides notification to the community?

The DOC provides information from the ECRC to law enforcement, which is responsible for notification in the community where the offender is to reside.

Are risk levels public?

Levels 1 and 2 are not public, except as released by law enforcement as specified in the Act. Information about level 3 offenders is posted on the DOC’s website once a community notification meeting has been held (www.doc.state.mn.us/level3level3.asp).

What does the ECRC consider when assigning risk level?

A variety of information, including:

1. Seriousness of the offense;
2. Offender’s prior offense history;
3. Offender’s characteristics, such as response to prior treatment efforts and history of substance abuse;
4. Availability of community support to the offender, such as therapeutic treatment, a
stable and supervised living arrangement, familial and social relationships, and consideration of the offender's lack of education or employment stability;

5. Whether the offender has indicated, or credible evidence in the record indicates, that the offender will reoffend if released into the community; and

6. Whether the offender demonstrates a physical condition that minimizes risk of reoffense, including but not limited to advanced age or a debilitating illness or physical condition.

Can a risk level be changed?

Yes. Within 14 days of assignment at level 2 or 3, an offender can request reduction from an administrative law judge. Also, after three years from initial risk level assignment, an offender can request that the ECRC consider a level reduction.

Who may law enforcement notify about release or relocation of an offender?

- **Level 1** - Victims of and witnesses to the crime, other law enforcement agencies, and anyone identified by the prosecuting attorney to receive the information,
- **Level 2** - Anyone included in the Level 1 information release. In addition, notification may be given to schools, daycare centers, and other organizations where individuals who may become victims of the offender are regularly found. Law enforcement may also choose to notify certain individuals that they determine to be at possible risk. The information is not to be redistributed by organizations.
- **Level 3** - Requires broad public notification, usually done through a public meeting. Law enforcement may also notify individuals and agencies included in Level 1 and Level 2 notifications, and may use the media and other distribution methods to get information to the public.

What is included in the notification?

General area of residence, description of the offender and photo, and description of the pattern of behavior that the offender has been known to display.

How long are offenders subject to community notification provisions?

For as long as they are required to register as predatory offenders. Registration is generally required for ten years after release or until correctional supervision ends, whichever is longer.
Sexual Violence and Underserved Populations
Sexual Violence in the Transgendered Community
By Dresden Jones, MNCASA

Key Learning Points:
• Transgender individuals are experiencing an extremely confusing disconnect between their physical sex and their gender identity.
• Many transgendered individuals have left home or have been asked to leave because of their gender identity.
• Because making a living in traditional jobs can be difficult for transgendered individuals, some may turn to survival sex or prostitution simply to support themselves.
• Sexual violence against transgendered individuals is often more physically violent and brutal because there is generally the element of extreme hatred on the part of the perpetrator.
• A transgender victim/survivor should be treated with the same respect and compassion as you would show any victim/survivor.

I have committed no crime. My only “sin” was to be born in the wrong body.
~Caroline Cossey, transgendered model

Anyone who has browsed the Target shelves for a baby shower gift has had the experience of pausing to consider the unborn child’s gender before making a purchasing decision. It’s very simple: pink for girls, blue for boys. If the gender of the child is unknown, people stick to what are considered neutral colors: brown, green, white. So then the child is born and the doctor announces “It’s a girl!” that’s all we need to know, right? We’ll run out and spend a fortune on pink onesies and little patent leather shoes. Mom and Dad will sign her up for dance classes and gymnastics. She will go through life doing what girls do. But what if that isn’t it? What if this little girl feels out of place, confused, and sad? What if every time she is made to wear a dress, she feels like she is wearing a costume, a mask, or pretending to be someone she is not? What if every time she looks at herself naked in a mirror, she knows that something is wrong?

It’s hard to understand what it’s like for a person who struggles with their gender identity; most of us are born male or female, and we can’t imagine it any other way. Some people suffer from gender dysphoria, however, which means they are in a state of conflict between their gender and their biological sex. I use the word “suffering” because many people experiencing gender dysphoria are confused, and feel isolated and alone. At a very young age, they do not have a name for what they are feeling. But the feeling is so incredibly strong that even though they may try to suppress it, they eventually find they cannot.

“Gender” is a component of one’s identity, while “sex” is the physical form. Most people who have the awareness that their gender identity is opposite of their physical sex know
that as early as 4 years old. As they mature and begin to go through puberty, that confusion intensifies. Many transgendered people “come out”, or tell someone how they are feeling, in their teens. With information widely available on the internet, teens experiencing this can find out that there are others going through the same thing. Coming out can be a tremendous experience, if there is support, love and resources available. Many transgendered teens do not have that kind of support and acceptance, however. Many transgendered teens run away from home to escape abusive parents or siblings. Amazingly, some families will even “disown” a transgendered family member. 73.7 percent of transgender youths reported hearing homophobic remarks “sometimes” or “frequently”, which means they are facing discrimination at school, at their place of worship, etc.

While it is true that sexual violence is never the victim’s fault, it is also true that many perpetrators will seek out victims they see as vulnerable or isolated. Certainly a transgendered teen who has been kicked out of their home or forced to leave because of abuse is in need of resources. Some of these teens get involved in what has been termed “survival sex”: sexual activity in exchange for a place to sleep, food to eat, or clean clothes to wear. Survival sex can certainly lead to prostitution as a transgendered individual searches for a way to survive financially. For example, Allie (not her real name) was a male-to-female “pre-op” transgender. (Pre-op is the term commonly used to describe a transgendered individual who has not undergone sex reassignment surgery.) Allie left her home in rural northern Minnesota at the age of 16 and moved to the Twin Cities, leaving behind a deeply religious and very unsupportive family. She attempted to get a job so that she could support herself; Allie had dreams of becoming a famous artist, and she was quite talented. But when she filled out applications, she was unsure if she should write “Allie”, which was her chosen name, or “Jason”, which was the name on her birth certificate. Allie’s drivers licence said “Jason”; any employer would need to make a copy of her licence and her Social Security card...which also said “Jason.” Figuring out which public restroom to use was difficult enough. While there are some establishments that might welcome a transgendered person as an employee, there are more that won’t. Eventually, Allie turned to survival sex, feeling used, degraded and depressed. When she found she could no longer support herself that way, she began selling drugs, which took her into dangerous, unfamiliar places. Allie states that she was sexually assaulted multiple times in her teen and adult life. Sometimes it was in the context of her drug deals, when someone would discover her physical sex; sometimes it was a man she’d met who didn’t know that she was physically male until they were intimate and became enraged at the discovery; sometimes it was someone who claimed to be her friend, offering to pay her rent in exchange for sex.

Allie’s story is a reality for many transgendered people. We live in a society that forces people to be male or female. There is no in between, and the way you dress, the way you act, and the name you call yourself must match your physical sex. Ignorance about transgendered people leads to fear, which, in some cases, can lead to violence. Hate crimes occur much more often than most people are aware. Homophobia and heterosexism fuel hate crimes against the GLBTQ community. Many GLBTQ people are sexually assaulted as part of a hate crime. A transgendered person who is a victim of a violent hate crime, including a sexual assault, is least likely to come forward due to fear of the way they will be treated by law enforcement, medical, and other systems. Statistical data on sexual assault in the transgendered community states that 50% of those interviewed say they have experienced sexual assault by a romantic partner. Attacks on transgendered people

When working with a transgendered victim/survivor, it might be helpful to ask them how they like to be addressed, whether it’s “he” or “she” or by a name that is different than their legal name.
are usually very brutal. Transgendered people are often targeted for sexual violence not only because they identify with one gender and are biologically another, but also because of the same misogynistic society values that fuel sexual violence against biological women. Raping a male-to-female transgendered person vaginally is done so to further humiliate and dominate that person; it is intended to “punish” them for not accepting their physical sex.

When a transgendered person does come forward to report sexual assault, they must be treated as an individual who needs support and resources. An advocate is always charged with supporting the victim/survivor, no matter who they are. When working with a transgendered victim/survivor, an advocate may also need to pay close attention to the way the individual is treated by medical staff and law enforcement. Questions asked out of sheer curiosity or judgement (i.e., “So how long have you been living as a female?” or “Why do you want to pretend to be male when you’re really a girl?”) are not appropriate and not relevant to the matter at hand. Medical staff must treat the individual as they would treat any sexual assault victim/survivor; it is not an opportunity for them to “experiment” or lecture the person on using non-prescribed hormones. If and when prosecution is involved, they should proceed based on evidence and not on whether they can win a case with a transgendered victim/survivor. If an advocate perceives that a victim/survivor is being treated differently because of their transgendered status, it is important to address this so that it can be stopped.

A victim/survivor from the transgendered community may be interested in support groups specifically for transgendered people. An advocate should contact their local GLBTQ organization to find out what is available. If there is not a local organization, contact state-wide organizations such as OutFront Minnesota or Crisis Connection. If your location is rural and the victim/survivor has no means to get to the closest organization or support group, help them do some internet research for online support.

As different groups oppressed for various reasons begin to speak out and stand up for themselves, they are quickly replaced with another group of people that the majority can dominate and deny basic rights. This is the era of oppression based on sexual orientation and gender identity. Other groups still experience oppression, racism, and sexism, but as GLBTQ communities worldwide demand equal rights and equal protection, the inequities and hate they are facing becomes more evident.

Resources

P-FLAG: Parents, Families and Friends of Gays and Lesbians
Michigan State University Alliance of Les-Bi-Gay-Transgender and Ally Students
www.mermaids.freeuk.com: An Internet Forum for Transgendered Youth

Bringing it Home:

- Are you familiar with organizations in your area that specifically work with the transgendered community?
- Are you able to be supportive and listen despite the fact that you may not fully understand the person’s life experiences?
- Has there been a history of transgendered individuals being mistreated by law enforcement or medical staff in your community?
- Has your organization made any connections with organizations serving the GLBTQ community?
Sexual Violence in Later Life
By Linda Davis, edited by Tracy Sheeley, MNCASA, Updated by Kim Zimmerman, Sexual Assault Program of Beltrami, Cass and Hubbard Counties

Key Learning Points:
• People in later life possess characteristics that perpetrators find vulnerable and opportunistic. Some of those characteristics are their physical vulnerabilities, medical vulnerabilities, more isolation from society, and reliance on other people to care for her/him.
• Coming from a generation that has not openly discussed sexual violence, the reactions they know and even may have had in their lifetime could be one of victim-blaming. People later in life may have an even greater understanding of the myths of sexual violence rather than the facts.
• Similar to overall statistics about sexual violence, most people who experience sexual violence later in life are victimized by someone they know, many times a family member.
• The theory of Caregiver Stress is not an excuse for elder abuse. If it were, we would be saying that if the elderly person did not have to rely on the abuser for care, the abuse would not be happening.

Possible Obstacles in Reporting
Just like any victim/survivor who experiences sexual abuse, a person experiencing sexual abuse later in life will have their own unique experience. There are common differences
in experiencing sexual abuse that older victims/survivors may share, however. The myths that we struggle to get rid of in our society today about sexual violence stem from long ago. Older people grew up in generations when it was widely believed that sexual violence was the victim/survivor’s fault. Victims/survivors may still hold on to those myths. Some of those myths are:

• Men have sexual urges and cannot control them;
• It is the woman’s responsibility to turn down those urges or, if they are married, to fulfill them;
• It is not appropriate to talk about sex;
• If you are sexually assaulted, you must have done something to ask for it; and
• Only young, promiscuous women are sexually assaulted.

A victim/survivor’s support system could have an impact on deciding whether s/he should report. Later in life support systems can change and become fewer, leaving an older person more isolated. Family members, friends, and peers pass away. Additional possibilities for isolation and not having a potential large support system can include: having less opportunity to be in the community or at community functions in order to build and maintain relationships, difficulty with transportation, and no longer being employed. Therefore, when experiencing something as traumatic as sexual abuse, there may be few support systems established where or to whom an older person would feel comfortable disclosing. If there is a trusted support system, this support system might believe in and reinforce the internalized myths about sexual violence. If this does happen, it could reinforce the sense of isolation for the victim/survivor. The fear of experiencing a negative and unsupportive response from her/his support system, like any victim/survivor, could prevent an older person from coming forward.

An older person might also be more likely to not report the sexual abuse if they feel that the abuse is their fault or something they deserved. In addition to believing myths about sexual abuse, they may feel alone and believe they are unable to cope with what they have experienced. Internalizing the abuse or denying that the abuse occurred are two examples of negative coping mechanisms that might be used to try and live with what happened to them.

An additional factor to consider for a victim/survivor later in life is whether the perpetrator is her/his caregiver. The victim/survivor’s caregiver, either professionally or a family member, could be the perpetrator and use force, threats, or trickery to create additional concerns or fears. For example, the caregiver could reinforce myths about sexual abuse, use isolation to the perpetrator’s advantage, and create unwarranted threats to keep the victim/survivor silent. The fear for their safety, of retaliation, or of not having someone to take care of them could be strong enough to prevent an older victim/survivor from coming forward.

Medical Care

A general physical examination is recommended for an older person following any sexual violence. While pelvic injury and sexually transmitted infections are possible, the older victim/survivor may easily sustain damage to the soft tissue, bones, or internal organs that have resulted from aging. As a possible result, an older person may be at greater risk of infection if s/he does not seek medical care. Infection could occur from tearing or by contracting an STI. The sexual
abuse could also physically or emotionally exacerbate an existing chronic illness such as a heart problem or arthritis.

Medical services must be made easily accessible to older victims/survivors, or they may not be willing or able to seek medical assistance. In some cases, a centralized hospital emergency room may not be a preferred treatment site. Depending on the circumstances or life experiences of the older person, discussing sexual abuse to someone they do not know, who is a different gender, and/or younger may cause additional anxiety. For example, if an older victim/survivor is talking to a doctor who reminds them of their grandchild, s/he might be reluctant to come forward about the sexual abuse. An alternative may be a private physician or clinic, or a specialized outpatient crisis center; an older victim/survivor should be accompanied by a friend, relative, or advocate to her/his initial medical visit. This initial visit may be combined with a home visit follow-up by a geriatric nurse practitioner and a social worker who can link the victim/survivor to needed support services.

Psychological Considerations

A victim/survivor who has experienced sexual abuse later in life may feel humiliation, fear, anger, and depression associated with the abuse. Advocates report that the first reactions of older victims/survivors to sexual violence often include embarrassment, shock, disbelief, or denial. Some have even felt grateful that it didn't happen to a younger relative. It is extremely important to note that the real psychological impact may come later; after contact with a physician, the police or legal aid, and advocacy groups, or when the victim/survivor is alone. At that time, general anxiety, fear of retribution, and depression are likely to set in, and could be especially severe in the case of an older person who is isolated and has no confidante.

It is essential, therefore, to follow through on long term support when working with an older victim/survivor. Continuing outreach may be necessary. Activities such as mutual support groups, therapeutic groups, and home visits are considered appropriate for older victim/survivors. Group activities should be conducted in a setting both accessible and comfortable to the older victim — possibly a church, senior center, or other location.

Families may also provide an especially good resource for continuing psychological support. Since older victim/survivors are generally considered blameless, relatives and friends initially rally around to help. If family members are willing, it is a good idea to discuss the dynamics of sexual violence with them, and educate them on what this experience may be like for someone later in life and the importance of continued support over time.

Additionally, as an advocate, keep in mind there is a loss of privacy as professional caregivers become increasingly involved with the victims/survivors' lives. Furthermore, this reliance on others may increase the feeling of vulnerability for an older person. If a caregiver assaults an older person, the victim/survivor has either been told by the caregiver or feared that she/he may have to choose between seeing that person again or not receiving the care or service again. In such circumstances, the older victim/survivor’s sense of independence might be temporarily distorted. Providing options and additional support is crucial.
support during decision-making can help with empowering the older victim/survivor. Possible concerns/needs that might need to be taken into consideration can include:

• Changing account numbers/pin numbers if the caregiver had access to financial records.
• Deciding who will assist with financial obligations if the caregiver had this responsibility.
• Legal assistance
• Health insurance or Social Security information
• Determining a new schedule for daily needs such as housekeeping, running errands, or taking care of pets.

It may be helpful for the advocate to have a conversation with the older victim/survivor to identify a trusted family member or friend to assist them with their own practical needs. This person can assist in needed activities or contact appropriate resources until such time that the victim/survivor can resume a routine level of self-sufficiency. It is crucial, however, to respect the victim/survivor's right to make choices and have control over her/his own life. The assumption is too easily made that the older person needs to be “taken care of,” or is childlike.

A very special approach may be needed to bring services to older sexual violence victim/survivors. Many older women and men are simply not familiar with the positive assistance, aspects of the women's movement, the human rights movement, and the related network of sexual violence crisis centers. It is important to treat an older victim/survivor with the respect and dignity they deserve. Each step in the healing process is for her/him to own. As an advocate, it is important to provide them with information/resources and education on sexual violence in order for the older victim/survivor to make informed decisions.

End Notes

Sexual Violence and the Immigrant and Refugee Communities in Minnesota
By Donna Dunn, MNCASA

Key Learning Points:
- The terms “refugee” and “immigrant have distinct legal definitions.
- Immigrants and refugees are vulnerable to being trafficked sexually as an exchange for travel to the U.S. or “safe” housing here.
- Many immigrant communities are small tight-knit, so victims/survivors may fear that an interpreter from her/his community may not keep her/his experience in confidence.
- Immigrants and refugees may be less able to reach out for help for political, family, or religious reasons.

This issue is one that deserves attention given the changing demographics of Minnesota. For the purposes of this manual, we believe it is important to address some broad issues related to the many immigrant and refugee communities in Minnesota. This is, by no means, an exhaustive examination of the issue. Clearly, continued connection with these communities must be made at the state and local level to ensure that services are accessible and appropriate.

The History of Rape and War

Rape/sexual assault and war are inexorably linked in history. In the introduction to this manual there is brief mention of the pairing of war and rape. Recent history and current events reinforce that war and rape often co-occur. Experiences from Viet Nam, the former Yugoslavia, Somalia, and now Iraq make that clear: those who are vanquished become targets for sexual assault and some who participate in invading armies (women, gay men, e.g.) are also targets for sexual violence from their compatriots.

During times of political unrest in countries, whether or not war has erupted, members of opposition groups are targeted with violence including sexual violence. Sometimes the individuals themselves may be assaulted; often their family members, particularly daughters, mothers, sisters, are the targets of sexual violence as a way of disempowering the opposition forces. However it occurs, the combination of wartime or political violence and sexual violence cannot be denied.

Refugee vs. Immigrant

These terms are sometimes used interchangeably, but they do carry very distinct legal definitions.
- A refugee is someone who has been forced from their home country by war, civil conflict, political strife, natural disaster, or gross human rights abuses. Most of the time, refugees must flee their home and villages without warning, taking with them only the clothes on their backs. The majority of refugees (80 percent) are women and children. Men in wartime are frequently forced to fight or are killed during the unrest. A significant proportion of refugees have experienced severe trauma. Many have been tortured, separated from their families, and subjected to personal and/or sexual violence. (American Refugee Committee)
- An immigrant is a person who chooses to relocate from one nation to another not necessarily to
escape persecution or danger. Commonly, immigrants come to the U.S. because they are pursuing higher education, moving to be with family members, for better employment opportunities, etc.

Recent History in Minnesota

Minnesota has had a long and strong history of welcoming refugee/immigrant populations. The American Refugee Committee has had a strong presence in Minnesota and provided leadership in the 1970s, 80s, and 90s which brought refugees from war torn Viet Nam, Cambodia, Laos, and Thailand to the state. More recently, refugees and immigrants from Bosnia/Herzegovina, Somalia, Eritrea, Eastern Europe, Central and South America have come to Minnesota as a result of war or other armed conflict which has threatened their safety or their general ability to create a productive life. They often bring with them personal and family experiences of sexual violence that, for a variety of reasons, they have suppressed in the past.

Following are some of the considerations that immigrants and refugees in Minnesota communities face regarding past or current sexual violence:

• Anniversaries or other reminders of sexual violence can renew trauma for a victim/survivor. While the assault may be years old, the anniversary date, or sensory reminders (sights, smells, etc.) of the perpetrator or violence can make the trauma more present for the victim/survivor.
• Many refugees tell stories of sexual violence happening not only in the war zones but also during their stays in resettlement or refugee camps while they waited for permission to enter the U.S.
• Cultural and religious practices may make it very unsafe for a victim/survivor to reveal her/his experience(s) with sexual violence. Living in a community that talks about sexual violence, helps victims/survivors find resources, and presents prevention messages on the media may help a survivor within a refugee or immigrant community feel as though s/he can finally talk.
• For some, seeking medical attention for injuries or illness (HIV/AIDS, STDs) related to sexual violence can be an opportunity for service providers to offer the opportunity to talk. Very often, however, this does not happen, and many victims/survivors have said that if only someone had asked, they would have talked about their experience(s).
• Victims/survivors may keep silent about past experiences of sexual violence in their belief that their silence will protect family in the home country. Their fear about family safety may interfere with their ability to seek help. For instance:

An immigrant woman from a sub-Saharan African country sought services at an organization for individuals with chronic health problems. During her intake screening, she spoke of the civil war that was tearing apart her country. As a social worker in her native country, she was a target for harassment and even physical harm. She revealed to her intake worker that she had been raped by a group of soldiers, on two separate occasions. She spoke of it easily, as if it was something long ago that she had since healed from. After a lengthy pause, however, she quietly said that she had never told anyone before. It was the first time she had said the words out loud. Most of her family had been murdered, but her remaining sister didn’t know about the rapes because the woman needed a place to stay and if her sister found out, she would be told to leave and shunned by the entire community, not because she had been raped, but because she had been raped twice.

• Some individuals may come to the U.S. under false identities for a number of reasons (e.g., they could masquerade as a member of another family who has an extra entry visa) and are reluctant to seek help until absolutely necessary because they fear deportation.
• Immigrants and refugees are vulnerable to being trafficked sexually as an exchange for travel to the U.S. or “safe” housing here. Because they are indebted to someone, they may end up trapped in a prostitution ring and unable to seek or find help.
• Many immigrants and refugees have come from countries awash in political unrest and...
feel as though they cannot trust anyone – particularly someone representing a branch of
government such as law enforcement or prosecution.

• Helping a non-native English speaker navigate our systems can be difficult. Finding
interpreters who do not jeopardize a victim’s sense of safety may be difficult. Many
immigrant communities are small and close; victims may fear that an interpreter from
her/his community may not keep her/his experience in confidence.

• Because immigrant and refugee communities are smaller and a necessary support for
someone who has come to the U.S. from other cultural and religious experiences, victims/
survivors can choose to not expose sexual violence within that community or that may be
perceived to cast a negative light on the community. Victims/survivors may make a
calculated decision to choose safety in their community in the U.S. over exposing a
perpetrator and risk being ostracized from the community.

• Immigrants and refugees who are not native English speakers can be very vulnerable to
sexual predators. These victims/survivors may be less able to reach out for help for
political, family, and/or religious reasons; their lack of familiarity with U.S. customs may
make them vulnerable to cons such as “doctors” who make house calls for the purpose of
exams; they may not understand Minnesota statutes or be able to recognize/name sexual
violence when it happens, etc.

While these experiences create huge barriers for immigrants and refugees, we understand that
they can come into contact with advocacy services if and when their coping strategies are not
working any longer, or the need for safety and help escalates. 24-hour crisis lines, walk-in
services, accompaniment services, and community outreach resources should all be
scrutinized to ensure advocates are accessible and appropriate to the growing diversity of
Minnesota communities.

Community Resources

Alexandra House
(763) 780-2330
Shelter Program.

Asian Women United of Minnesota
Business Line (651) 646-2118
24-hour Crisis Line (612) 724-8823
Phones answered 8 a.m.– 4 p.m.
Advocacy for Asian women and their children. Not a shelter program, community advocacy
only. Offers legal and immigration advice related to domestic violence cases. Assistance
available in Cambodian, Chinese, Hmong, Japanese, Korean, Lao, Tagalog, Thai,
Vietnamese & more.
The crisis line is transferred to Eagle’s Next Shelter from 5 pm to 9am.

Casa de Esperanza
Shelter Crisis Line (651) 772-1611
Community Outreach (651) 646-5553
Domestic Abuse Service Ctr. (612) 348-6385
http://www.casadeesperanza.org
Shelter and community program for Latina women. First come, first serve shelter.

Community Action Council
B. Robert Lewis Houses
Eagan 651-452-7288
Hastings 651-437-1291
Shelter and support for women and children experiencing domestic violence. Outreach
services for women who choose not to stay at the shelter but still need help. Advocates answer
questions and assist with the legal process. Trained family support workers are available 24
hours a day, every day, to talk things over in-person or over the phone.
Community University Health Care Center
(612) 638-0700 (x.209)
Community advocacy for battered women and female victims of sexual assault. Bilingual, bicultural staff on site.

Hennepin County Domestic Abuse Center
(612) 348-5073
Employs Somali, Hmong, and Spanish-speaking advocates. Other languages available upon request. Help with orders for protection, legal advice from city and county attorneys, assists in finding temporary housing.

House of Peace
(612) 724-8823
Shelter that advocates for women who are victims of domestic violence. Eligibility requirements for shelter stay is based on an on-call intake system.

Ramsey County Sexual Offense Services
Business line (651) 643-3022
24-hour crisis line (651) 643-3006
24-hour crisis counseling, advocacy, information and referral. Multilingual interpreting services provided. Advocacy and support during medical, police and legal procedures. Individual counseling/support groups. Referral for therapy, shelter, and financial needs. Community education programs on sexual violence.

St. Paul Domestic Abuse Intervention
(651) 645-2824
Legal advocacy, hospital advocacy and general community advocacy for women in St. Paul. Has culturally specific programs to help battered Latina and Southeast Asian women utilizing the criminal court system.

Mental Health and Social Service Programs (Twin Cities)

AIDS Ministry Office
(612) 672-4345
Groups held in English every day and evening. All services are free. Provides emotional and spiritual support to HIV+ individuals and their friends/family. Clients in need of therapy will be referred elsewhere. Sponsors a volunteer “buddy” program.

Centro Cultural Chicano
(612) 874-1412
Provides social services and referrals for Spanish-speaking people, food shelf, counseling, and the NOSOTRAS women’s program.

Chicanos Latinos Unidos en Servicio-CLUES
St. Paul (651) 379-4200
Mpls (612) 746-3500
http://www.clues.org
Provides social services for Latinos, which include employment search, HIV/AIDS case management, sexual assault program, chemical dependency program, individual counseling and couple’s counseling.

Children’s Home Society Crisis Nursery
(651) 641-1300
24-hour, free service for families in Dakota, Ramsey and Washington counties who are in crisis and have children ages newborn through 12 years of age. Free diapers. No interpreters available. A second office is located in South St. Paul
Confederation of Somali Community in MN
(612) 338-5282
Advocacy and assistance for Somalis, on issues such as health care, employment, housing and immigration. The project has offices at two South Minneapolis locations: the Brian Coyle Community Center and Waite House.

Community University Health Care Center
(612) 638-0700
Cultural and language-specific programs, mental health services. Call for more details. Sliding fee services.

English Learning Center for Immigrants and Refugee Families
(612) 874-9963
ESL classes, math skills tutoring, computer and citizenship courses and advocacy for immigrants and refugees. Children’s Program (ages 4+) for children related to the adult students. Eligibility Requirements: Immigrant or refugee adults and families. *Staff speak English, Spanish and Somali

Face to Face Health and Counseling Services
(651) 772-5555
Ages 11-23. Hmong, Spanish; other languages with advance notice. Adolescent/young adult medical care, mental health case management. Mon. 1:00 p.m.- 5:15 p.m.; Tues. & Thurs. 1:00 p.m.- 8:30 p.m.; Wed. 1:00 p.m.-5:15 p.m.

Guadalupe Alternative Programs
(651) 222-0757
Alternative Education Center in St. Paul with an alternative high school for teens, adult literacy, ESL, and early childhood education.

Hmong American Partnership
(651) 495-9160
Three program areas which focus on building the strengths of the Hmong community; self-sufficiency, family, and youths.

Int’l Institute of MN Refugee Self Sufficiency Project
(651) 647-0191
ESL and self-sufficiency classes (parenting, nutrition) for African refugee women. Day Care and transportation provided.

LaFamilia Guidance Center
(651) 221-0913
http://www.lafamiliaguidance.org
Culturally competent mental health services and social services for Latino youth and families. Bilingual staff, counseling, psychiatrist’s assessment and medication management, and psychological evaluations. 8:30 a.m. – 5:00 p.m., Mon.–Fri.

Lao Assistance Center of MN
(612) 374-4967
http://www.laocenter.org
Assist Laotian refugee and immigrant population with employment issues, advocacy, ESL, GED and other community services.

Minnesota AIDS Project (MAP)
(612) 341-2060
AIDSLine
Mon.-Thurs. 9:00 a.m. - 9:00 p.m.
Fri. 9:00 a.m. - 6:00 p.m.
(612) 373-2437 or (800) 248-2437
http://www.mnaidsproject.org/
All services are free. Testing by appointment. Clinic 8:30 a.m.-5:30 p.m. Spanish (limited). HIV Testing and case management. AIDS hotline (AIDSLine) provides info, resources and support. Provides health benefits counseling, legal and house hunting assistance to HIV+ clients.

Parent WarmLine
(612) 813-6336
Parent WarmLine offers support and advice on child behavior. Leave your name, number, and a brief message about your problem. Questions range from how to stop a child from biting to how to handle the death of a child’s friend or family member.

Regions Hospital International Mental Health Services
(952) 967-7201
Mon. - Fri. 8:00 a.m.- 5:00 p.m. Mental health, individual, group and family counseling and medication management. Psychiatrist and psychologist on staff each day. Culturally specific services: Vietnamese Men’s group; Prison Camp survivors; Hmong diabetes group; Hmong women’s support group.

Uzuri African Women’s Resource Center
(612) 521-2986
Community advocacy/resources for African-American and African immigrant women.

Wilder Social Adjustment Programs for Southeast Asians
(651) 647-9676
http://www.wilder.org
Mon. thru Fri. 8:30 a.m.- 5:00 p.m.
Open to all Ramsey, Anoka, Dakota and Washington County Southeast Asian refugees and immigrants. Hmong, Cambodian, Vietnamese (do not offer interpreting services as a stand alone service). Mental health, individual, group and family counseling. Adults and children. (Counseling on site, at school and at home.) School-based Hmong family program, parent education, and Hmong resettlement program.
Sexual Violence in Southeast Asian Communities
by Valli Kanuha (taken from the previous MNCASA manual)
Additional comments reflected in the adjunct materials provided by Der Her

Key Learning Points:

- The concepts of “shame” and “damaged goods” are very powerful considerations for sexual assault victims who are from the identified communities. These create huge barriers for women reporting the crime.
- If the perpetrator is a loved one or family member or head of the family, the barriers to reporting are similarly powerful.
- Non-native English speakers experience not only language barriers, but other cultural barriers.
- Lack of understanding about the system, how long an investigation may take, Members of SE Asian communities may not trust the western systems. They may have had bad experiences with medical providers, child protection, and law enforcement in the past that lead them to believe the system does not understand and will discriminate against them and their traditional practices.
- While these barriers are being connected with this article on Sexual Assault in Southeast Asian Communities, they have resonance with other immigrant, refugee, or marginalized communities.
- While we are referring to SE Asian Communities as if they are one, it is important to remember that cultural experiences and experiences vis-a-vis the US Government differ greatly between and among the Vietnamese, Cambodian, Laotian, Hmong, and Thai populations. It is important to acknowledge that these differences exist.

Many of the countries in Southeast Asia have been engaged in civil or international warfare for a number of decades. This condition of daily violence on the geography, psychology, and history of rich and diverse peoples has had a devastating effect on the coping mechanisms that have been developed by refugees prior to their relocation in the United States.

Over the last 25 years, the number of refugees from other countries who have sought new lives in the United States has grown steadily. From Southeast Asia alone, an estimated 820,000 people have escaped conditions of torture and suffered great losses to relocate to America.

For refugees, acculturation to American society has been accompanied by the usual conflicts that learning to live in a new culture entails. One adjustment that many refugees have had to make involves the level of awareness and subsequent approaches to mental health and social problems that characterizes American society. The U.S.’s relative openness in dealing with topics such as sexuality, sex roles, family interactions, and other "more personal" matters clashes with the private nature of many non-Western cultures. These conflicts manifest themselves in many ways—between refugee parents and their newly Westernized children, and among refugees themselves who are at various levels of
assimilation into American culture. For social service and mental health providers in the United States, the adjustment issues involved in refugee resettlement have presented challenges to the usual ways of delivering service. While some of the preferred modes and methods of helping are certainly universal, more creative strategies have needed to be developed in order to make our systems more responsive to refugee people.

The following article is the result of observations and discussions with community members and mental health/social service staff representing the Hmong, Lao, Cambodian, and Vietnamese cultures in Minnesota. As a result of a grant from the Minnesota Department of Corrections, direct services to Southeast Asian sexual assault victims and training for bilingual workers have been offered for several years. This article will describe some of the characteristics of those refugee communities and how they impact the problem of sexual assault. In addition, intervention strategies that have been helpful in dealing with refugee sexual assault victims and their families will be discussed.

General Cultural/Historical Issues Relevant to Sexual Violence

While it is not within the purview of this paper to detail the specific cultures and histories of the various countries of Southeast Asia, a number of salient points need to be made in order to understand the ways sexual assault is dealt with in these communities.

Many of the countries in Southeast Asia have been engaged in civil or international warfare for a number of decades. This condition of daily violence on the geography, psychology and history of rich and diverse peoples has had a devastating effect on the coping mechanisms that have been developed by refugees prior to their relocation in the United States. These experiences of personal violence combined with deeply rooted religious traditions help explain why refugee people approach mental health issues indirectly, if at all.

For many Southeast Asians who are influenced by Buddhism, their belief in determinism ("karma") results in the philosophical acceptance of difficult life situations as having a purpose beyond the control or understanding of mere mortals. Therefore, be it in conditions of societal destruction, such as war, or in more personal tragedy, such as sexual assault, one is often expected to move through life with honor, pride, and the belief that there is a larger lesson to be learned from the experience. Influenced by these philosophical/religious traditions, many refugees have learned to deal with painful situations by using tolerance, denial, or stoicism.

In terms of sexual assault issues, there are a number of additional aspects of Southeast Asian cultures that affect intervention on behalf of victims and their families. A primary factor in the reluctance of many Southeast Asian communities to deal with sexual assault is the status of women and women's roles in most Asian cultures. In many cultures of Asia, women are still considered the property of men as evidenced by dowries and arranged marriages. There is the belief that females who are raped are either "damaged goods" or should marry their assailants. The still restrictive rights and opportunities that have been accorded girls and women in Asian societies certainly compromise the ability of males and females to deal more sensitively with an issue such as sexual assault.
The use of shame as a societal control mechanism in Asian societies has a significant impact on dealing with sexual assault. The stigma attached to any form of public humiliation, especially as it reflects on one’s moral/religious character, functions as a powerful tool to prevent families and communities from discussing any “personal problems” that would bring shame upon oneself or others. The relative privacy and secrecy that surrounds sexual behavior in Asian cultures, combined with the ownership of women (and women’s bodies) and the avoidance of shameful disclosures, such as being raped, creates an atmosphere that prevents Southeast Asian victims, their families, and their communities from getting the support and assistance that would be available to them.

For Southeast Asian refugees who have survived sexual assault then, there are many complex issues that are related to cultural, religious, and relocation/adjustment factors that affect the ways refugee communities and American social service providers are able to intervene.

Intervention Strategies with Southeast Asian Victims

As is true in almost every country and culture in history, the victimization of women and others who have a vulnerable status in society is also a reality in Southeast Asian communities. Formal laws prohibiting sexual assault and abuse are reportedly not consistently enforced in any of the Southeast Asian countries. In local towns that have sanctions against sexual abuse, the closed nature of those communities often mitigates punishment for perpetrators. As discussed earlier, the degree of shame and protective nature of family honor require that the existence of a problem such as sexual assault can either be ignored, denied, or dealt with in private.

Initial intervention

In the first stages of contact with Southeast Asian sexual assault victims/survivors, there are unique issues for the service provider to be aware of. One of the most painful results of war is the systematic rape and torture of conquered peoples. Many refugees who have immigrated to this country have shared their stories of being raped not only in their home communities and towns, but also during their internment in refugee camps and on their voyages overseas to the United States. While females are the most common victims/survivors of these violent assaults, males are beginning to speak of similar harrowing experiences. Like rape victims/survivors in the United States who often do not seek help until a period of time has passed, many refugees have histories of past sexual abuse that go back many years to wartime and camp experiences.

Another important factor in the initial contact with a Southeast Asian sexual assault victim/survivor is to use indirect methods to gain more information about the abuse situation. While the use of indirect methods varies considerably with the degree of acculturation and assimilation, it is not uncommon to use metaphor, third-party references, discussion of other conditions, or even asking other trusted friends or family members to answer questions. In a number of cases, bilingual workers reported talking to refugee victims/survivors about fictitious friends who had been sexually assaulted and the ways those friends were given help. The use of indirect helping styles has been widely supported in interventions with many people of color.

Other initial intervention strategies include:
• Assess and/or treat, wherever possible, presenting symptoms which may be similar to those that trauma victims/survivors report. These include: sleeping/eating disturbance; mood swings; phobias; school/work avoidance; social withdrawal; sexual impotence/acting out; body pains; depression; and anxiety.
• Work on establishing a trusting relationship with the victim/survivor. Do not insist on either discussion or admission of sexual assault.
• For both male and female sexual assault victims/survivors, use a female interviewer for the initial stages of intervention. The degree of shame inherent in a sexual assault situation usually results in the rape victim/survivors feeling more comfortable with a female helper, who is thought to judge the victim less harshly.
• If the survivor is a child or female, contact should be made with the victim/survivor alone, or with the victim/survivor and mother. Again, this is related to the role of females and mothers in caretaking.
• Encourage the use of health resources, such as sexually transmitted infection and evidentiary exams, but do not insist, due to the shame implied in the process of sharing the assault experience with American or other bilingual providers.

All of the above intervention strategies depend on the sexual assault survivor developing a trusting relationship with the provider. In addition, every strategy should be balanced with factors related to the general health and safety of the victim/survivor and/or her family.

Other Intervention Strategies

One of the critical factors for any refugee seeking help from predominantly Anglo systems is the language barrier. The use of interpreters who are not only fluent, but trained in the issue of sexual assault is helpful. It is also important, in the use of interpreters, to assure clients of confidentiality regarding personal concerns. Due to the fact that many refugee communities are located in towns or cities where bilingual workers are extended family members, there have been situations where relatives were asked to translate for victims/survivors in hospital emergency rooms or police departments. For reasons of safety, as well as minimizing the degree of shame that Southeast Asian survivors must face, bilingual workers from the various ethnic communities should receive training regarding sexuality, sexual assault issues, and the importance of confidentiality within communities.

The use of American medical providers with refugee sexual assault victims/survivors has not been addressed extensively. Many workers—both American and Southeast Asian—report that the preference of the rape victim/survivor should be the primary factor in determining who should work with her. It is not within the cultural norm for many Asians, especially women, however, to directly state a preference for someone who will help them. Therefore, we recommend once again that the degree of acculturation and assimilation of the refugee victim/survivor, along with the availability of sensitive and trained workers, be seriously considered in the provision of service.

If a woman from one of the targeted communities in this article were to call your crisis line, do you feel prepared to respond appropriately?
For every case we have known about where a refugee sexual abuse victim/survivor was comfortable working with someone from her own cultural group, there have been others who have felt safer working with an American with no ties to her/his community.

A key issue in providing services to Southeast Asian sexual assault victims/survivors is choosing the most effective mode of intervention. While many sexual abuse centers use groups as the primary mode of support for rape victims/survivors, our Southeast Asian workers do not recommend groups for most refugee victims/survivors. Due to the shame associated with public admission of sexual abuse, one-to-one interventions usually result in a greater degree of comfort and protection for the survivor. Related to this is the use of family or community members in advocacy or counseling with rape victims/survivors.

Again, many rape victims/survivors feel very protective of their families and fear admitting to behavior that would bring shame upon them. Involving family members in interventions should be done with the victim/survivor’s consent—usually from discussion in private. Involvement of parents, particularly mothers of the victims/survivors, could be an important adjunctive service. Many Southeast Asian mothers feel responsible if their children have been hurt in any way. Giving mothers support for their feelings, while assuring them that they are not responsible for the assault, can be healing for the entire family. Support to fathers/husbands, which encourages them to understand and not ostracize their children/wives, is a difficult but important task for any provider working with Southeast Asian families.

Finally, it is recommended by our Southeast Asian bilingual workers that important messages for younger sexual assault victims/survivors to receive are: hope for a better future; potential for marriage for women victims/survivors; going forward with a happy life; and removing fault or blame. For older victims/survivors, a provider should focus on: acceptance; going on with one's life; removing blame; and a philosophical approach that emphasizes that life has suffering and hard times in it, but that one will survive.

In summary, the issues are not substantially dissimilar for Southeast Asian refugees or Americans who have been sexually assaulted. The adjustment processes for victims/survivors involve the need for support and healing, of which many principles and techniques are universal. Additional education and training for communities of Americans and Southeast Asians would enhance the possibility that survivors and families will make effective use of the existing services that have been developed in this country.

**Bringing it Home:**

- Is your program accessible to the victims/survivors from SE Asian populations in your area? How might you assess that and make changes?
- Do you know about the Asian immigrant communities in your area?
- Have you been able to recruit staff, board members, or other volunteers from the Asian populations in your area?
- Who else in your community exists to serve primarily this population group? Do you have relationships with those agencies?
Cultural Sensitivity and Cultural Competency in Assisting Victims/ Survivors of Sexual Violence

Key Learning Points:

• It is important to understand the role that culture plays when assisting victims/survivors of sexual violence.
• Previous experiences with law enforcement, medical and other systems may be cause for a victim/survivor’s mistrust of responders to sexual violence.
• Differences in ways of communicating may cause misunderstanding when a victim/survivor is seeking assistance.
• Cultural sensitivity is an awareness, understanding, responsiveness and respect for the beliefs, values, customs and institutions (family, religious, etc.) of a group of people, particularly those of a race culture or ethnic group different from one’s own.
• Cultural competency is a life-long effort which requires a commitment to fairness, self-discovery, and learning about others.

Culture can be defined as the beliefs, values, customs, art, institutions (family, religious, etc.), and all other products of human work and thought created by a people or group. In order to provide effective and humane services to victims/survivors of sexual violence, it is important to recognize the role that culture may play in how the victims/survivor reacts to the assault and to individuals providing assistance and services (e.g., law enforcement personnel, hospital emergency department staff, and advocates). A person’s cultural background may also affect the degree and way in which s/he is able to heal and recover.

Previous experiences of the victim/survivor or members of her/his cultural group may be a cause for mistrust in working with the medical, law enforcement, legal, or social system. For example, an African American woman who has been raped by an African American man may be reluctant to press charges because of feeling that if she does she will be betraying her community as a whole because of the political, economic, and social issues raised by the disproportionate number of African American men already incarcerated. Culture may also influence to whom a survivor goes for support and assistance after the assault. For many cultures, being involved with the mental health system carries a stigma, and the victim/survivor will instead go to someone within her/his community and cultural group for assistance.
Differences in ways of communicating among cultures may also be a cause for misunderstanding in the examination and treatment process. Different cultures often use different words to describe sexual acts or body parts. In addition, depending on a person’s culture, it may be considered rude or improper to talk about sex or other things that are considered private. These differences could cause misinterpretations during interactions throughout the medical exam or police interview.

In addition, cultural values may influence other factors such as whether or not the victim/survivor blames her/himself for the attack, who s/he tells about the rape, who s/he goes to for support, etc. Some communities are quite small and many of the people associated with them know each other, or each other’s family members. A victim/survivor may seek services in a different area to specifically avoid someone from their community finding out.

Cultural sensitivity is an awareness, understanding, responsiveness, and respect for the beliefs, values, customs, and institutions (family, religious, etc.) of a group of people, particularly those of a race culture or ethnic group different from one’s own. Providing culturally-relevant and competent services means incorporating this awareness, understanding, responsiveness and respect for the beliefs, values, ethnic heritage, etc. of individuals into training, treatment, and services designed to impact upon, or meet the needs of, individuals or groups. A strong sense of the basic worth and dignity of each human being should also be apparent. It is a life-long effort which requires a commitment to fairness, self-discovery, and learning about others.

Bringing it Home:

- Are you familiar with the different cultures in your community?
- Are there culturally-specific organizations in your community that you can refer survivors to?
Sexual Violence in the Black Community

By Dresden Jones, MNCASA

Key Learning Points:
- Sexual assault was used by white slave owners as a means to control their female slaves and increase the workforce.
- Black women fled the South after slavery to escape sexual violence.
- Black men were often accused of sexual assaulting white women and, as a result, were beaten and sometimes killed.
- Sexual assault within the black community was often overlooked because the issue of racism was considered to be more important.
- Black women who are sexually assaulted by Black men may hesitate to come forward because of distrust of law enforcement and the criminal justice system.

That man over there says that women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman?

~ Sojourner Truth, addressing the audience at the Women’s Convention, 1851, Akron, Ohio

Any child who has been through the public school system in the United States knows that there was this system called “slavery” and that eventually, President Abraham Lincoln abolished slavery, but not before Harriet Tubman freed some slaves in something called “The Underground Railroad.” Children may also know that George Washington Carver invented peanut butter and that Martin Luther King, Jr. was a great man, Malcolm X a slightly less great man but also admirable. This is generally where the average history class moves on to cover the Vietnam War. The understanding of Black history and Black culture in the United States is incomplete and incorrect. This incomplete and incorrect understanding of the history of a oppressed people is what has lead us to what Black Americans face in such large numbers today: a modern form of enslavement in the form of systematic oppression that has our adult men filling prisons nation-wide, institutionalized racism that keeps our children from achieving what they are capable of in the classroom and the continued sexual assault of Black women, children and men.

Sarah Knowles Bolton says to “forget the past and live the present hour.” But this does not mean that we can negate the history of an entire race of people and how that history effects the way that race of people is perceived, and perceives themselves, today. The earliest record of slaves in the United States was in 1619 (according to some scholars; the exact date is debated). Africans were taken from their home countries, largely in West Africa, to work as slaves in the United States and the Caribbean. Most
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of us know, or have some idea, that slaves were forced to work in treacherous conditions, often beaten, sold from one plantation to another without warning and forced to give up their culture, language and anything else that made them who they were. But there are parts that we don’t read or learn about. Black women slaves were seen as doubly valuable because they could bear children and increase the slave population. Black women slaves were literally fully owned by their White masters: their reproductive organs were fair game. White masters routinely raped their female slaves, sometimes for their own sexual pleasure, but sometimes to simply increase their workforce. We can imagine that there were many Black slave women that fought back but what was their recourse? In addition to being brutally raped, they would also be beaten severely if they continued to resist. In recent years the “relationship” between Thomas Jefferson and one of his slaves, Sally Hemings, has been portrayed to us as a secret affair between two sneaky, lustful lovers. It is rarely seen for what it surely was: the repeated rape of Sally Hemings at the hands of her White master.

The migration of Black people from the South to the North is often talked about in terms of violence: Black people fled North to escape the lynching that was rampant in the Southern half of the United States, roughly from 1880 to 1940. Lynching was seen as a method used by White racists to continue to exert their power over Black people, despite the abolition of slavery. But it is unusual that any man, even a hateful racist, would simply lynch another man without cause…or the illusion of cause. Black men were most often the targets of lynching and they were so because somewhere, at some point, a rumor surfaced amongst White men—and White women—that the uncontrolled sexual prowess of Black men threatened the delicate purity of White women. Rarely in the anti-sexual violence movement do we give credence to the hysteria surrounding false reporting of sexual assault…but I’m afraid that false reporting was indeed the cause of more than a few lynchings of Black males in the United States. This fabrication of sexually deviant Black males is often referred to “social fear of the Negro.” If White women socialized with Black men, they would surely become their victims. The basis of this “false reporting” of sexual assault of White women by Black men was much more complex than “she lied.”

Often, these false reports were made by White men, not women. A Black male standing too close to a White woman was just cause to rally the troops for a lynching. It is also conceivable that a friendship between a Black male and a White female, or even a romantic relationship, once discovered by the community, resulted in the lynching of the Black male involved. Indeed, the brutal slaying of 14-year old Emmitt Till occurred in 1955 because he whistled at a White woman, unaware of the hostility towards Black men in the South. Emmitt was from Chicago…a very different place of Black males at that time. Emmitt was unrecognizable when he was found. The men who killed him never went to prison. None of this is to say that Black men weren’t capable of committing sexual assault; indeed Black men did commit rape…but they raped Black women. They had watched, for many years, White men exert power and control by raping. Black men were brutally oppressed; usurping power where and when they could—even against their Black sisters—was commonplace.

While Black men were most often the targets of lynching, Black women were still routinely sexually assaulted by White men, even though they were no longer their slaves. Black woman had no recourse with the law or with society. A Black man, enraged by the rape of his sister, mother, wife or friend might take
the law into his own hands but doing so meant death for him. And no Black man in that time could expect a quick death; Black men, in addition to being lynched, were burned alive, drowned, mutilated and dragged to death. The migration of the Black community to the North was indeed to escape violence, both lynching and sexual assault.

As society progressed and the Black community began to realize the power and strength of their numbers, so was the Civil Rights Movement born. Between 1955 and 1968, Black people rose up in protest of Jim Crow laws and other tools of oppression. White allies marched along-side Black men and women, demanding change. However, with the Civil Rights Movement came a shroud of silence placed firmly over the issue of intra-racial sexual assault. During the Civil Rights Movement, Black people perceived their greatest threat to be racism: this is what was holding them back, keeping them out of the job market, out of safe housing, without a proper education. All issues within the Black community itself were unimportant, including the rampant misogyny within the Black Nationalist Movement and the Black Panther Party, two groups that fought against a racist society. Elaine Brown, a pioneer member of the Black Panther Movement, talks of women in the movement being routinely referred to as “bitches.” The Civil Rights Movement was seen as a “manly” movement, one of strength and power, qualities that women did not possess in the eyes of men. As Black women began to get involved with the anti-racism movement, they were met with a harsh reality: as their Black brothers fought to eradicate the laws and social norms that kept Black people down, Black women were still women, and therefore, second class citizens. In the film No! The Rape Documentary filmmaker and Black activist Aishah Shahidah Simmons interviews many Black women who played a major role in the Black Nationalist Movement, including Elaine Brown, Dr. Gwendolyn Zohara Simmons, Barbara Smith and many others. Dr. Simmons tells her story of being sexually assaulted by a well respected leader in the movement when she was a young college student, eager to be a part of such an extraordinary movement. When she reported the attack to another leader, she was told that this wasn’t the first time he had committed such an act. She was also told that the movement didn’t have time for this...that sexual assault wasn’t the issue. In response to this lack of response by Black male leaders, Dr. Simmons, Elaine Brown and many other Black women made it their goal to become leaders within the movement so they could change the way Black women were being treated. Dr. Simmons says that as a result of that, she, and other Black women attempting to hold Black men accountable, were seen as “amazon” and branded as lesbians, whether they were or not. They were also seen as something far worse: traitors to the race.

Black women were expected to be “black first, women second.” What this meant was that Black women who experienced sexual assault by a Black man were expected to let it go. Calling law enforcement, especially during the Civil Rights Movement and even today, to report a Black male means sentencing that man to a system that continues to be racist and unfair. Any Black woman in the United States who has a Black male in her life that she has love for will always worry that someday, that loved one will happen to be in the wrong place at the wrong time and, as a result of a racist system, face prison time or even death. Does this mean that Black men do not commit crimes? Absolutely not. Criminals, including rapists, come in all races. But the silence surrounding sexual assault in the Black community is due in large part to fear: fear that White society will use such things as fuel for the racist fire; fear that a man we love, even though he hurt us, will go to prison for the rest of his life because he is Black, not because he raped me.
The Civil Rights Movement, despite its major flaws, accomplished extraordinary feats: the abolition of Jim Crow laws and a movement towards further change for Black people in the United States. It also created a movement amongst Black women to stand up for their equality and the right to be treated as human beings. Black women throughout history have taken a stand for Black women: Sojourner Truth, Ida B. Wells Barnett, Mary McLeod Bethune and many others paved the way for Black women in the 1960’s, 1970’s and beyond who saw the need for change. The time period following the Civil Rights Movement saw an onslaught of Black female writers, poets, artists and activists speaking out. Writers such as Alice Walker, Maya Angelou and Toni Morrison wrote openly of the sexual assault of Black women and girls, sometimes at the hands of their own fathers. Black women in the United States began to see the struggles they have faced since slavery published, lectured on and validated. As the anti-sexual violence movement began to take hold in the early 1970’s, Black women found themselves underrepresented in what they had known as a typically White feminist movement. In 1972, The DC Rape Crisis Center was incorporated as one of the first rape crisis centers in the United States. From 1972 to 1975, the DCRCC operated as a collective think-tank, rather than with an organizational hierarchy structure. Most of the first women to be a part of the DCRCC were Black women. In fact, the DCRCC was seen as the unofficial “headquarters” for Black women seeking to address sexual assault in the Black community. From there, the anti-sexual violence movement has blossomed, not without difficulty, to be inclusive of all women.

So where do we stand today? What is the state of Black women in the United States? If you watch television, see movies, read magazines and/or listen to popular music, Black women are still “bitches” and “ho’s.” Certainly, Black women continue to face oppression and sexual assault. The one thing that has shifted slightly is that more and more Black women and girls seem to be buying into these myths about ourselves. Music videos featuring Black women being sprayed with champagne, scantily clad and gyrating sexually, mouths open, ready to have sex with anyone who asks aren’t just made by White men…they are also made by Black men and Black women. What’s that all about? As I stated before, we cannot negate the history of an entire race of people. The history of Black people in the United States begins and ends with oppression and a people oppressed by the majority begin to turn that oppression inward. Is that an excuse? Of course not. But American society beats Black people, enslaves us, denies us our culture, denies us adequate education and housing, hangs us from trees, breaks up our families, puts us in prison in record numbers, conducts medical experiments on us, sexualizes us to the point where we are objects, both women and men, and then everyone wants to know why Black people are the way we are. When radio personality Don Imus referred to a women’s college basketball team as “nappy-headed ho’s”, attention almost immediately shifted to the rap music industry and its flagrant use of the words “ho”, “bitch”, “slut”, etc in reference to women. Contemporary Black feminists continue to take issue with the sexualization of Black women by the rap music industry and Russell Simmons, along with some well-meaning scholars, announced that record executives and other industry leaders “voluntarily ‘remove/bleep/delete the misogynistic words ‘bitch’ and ‘ho’ and the racially offensive word ‘nigger’ from their airwaves.” But the why is what’s missing. Why should men, White and

Black female victims/survivors do not need to be treated in a different or special way than other victims/survivors; their concerns may be unique, however, and some advocates may not know how to respond.
Black, and women, White and Black, have a problem with the use of these words? Because it demeans our girls and our women. It makes us objects rather than human beings with ideas, dreams and intelligence and it continues to foster a culture where sexual harm will prevail.

What does this mean for Black women, children and men who are victims of sexual assault? It means that less Black people come forward to report sexual assault, because of fear of law enforcement, fear of the medical community, fear of how White society will perceive us. Black women who are victims of sexual assault may fear that the system will not treat them fairly and may not believe them. There are more Black women and men working in the anti-sexual violence movement now than ever before. There is work being done on behalf of Black women to foster a system that treats Black women and men fairly and hold systems accountable when they do not. The work is being done…but there is a lot of work to be done. We all need to pitch in.

Black women who are victims/survivors of sexual assault may have extreme distrust of law enforcement due to past experience.

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**Bringing it Home:**

- Does your organization have any ties with organizations in your community that are specifically designed to address the needs of the Black community?
- Does your organization have employees, volunteers, or Board members who reflect the needs of your community?
Native Women: Creating a Response to Sexual Violence

By Eileen Hudon, Minnesota Indian Women’s Sexual Assault Coalition, March 2007

Key Learning Points:
• Efforts to support Native victims/survivors of sexual violence can be complicated by confusion over who has jurisdiction, which often leads to no response from the criminal justice system.
• Many organizations working with Native victims/survivors do not have Native people on staff, and lack knowledge and skills to effectively advocate for Native victims/survivors of sexual violence.
• There is a history of institutionalized displacement and disenfranchisement of Native people that has lead to a legacy of bias and discrimination by health care providers, law enforcement, and advocates.
• The development of sexual assault protocols between medical providers, law enforcement, and advocates is complicated by the necessity of multiple jurisdictions to work together.
• Tribes have the authority to enact and enforce laws to prevent sexual violence on their reservations, but they do not have jurisdiction over non-Indians who travel to the reservations and commit sexual violence.

“We know from our traditional teachings that the waters of the earth and the waters of our bodies are the same water. The follicular fluid which bathes the ripening ovum on the ovary; the dew of the morning grass; the waters of the streams and rivers and the currents of the oceans - all these waters respond to the pull of our Grandmother Moon. She calls them to rise and fall in her rhythm. Mother's milk forms from the bloodstream of the woman. The waters of our blood stream and the waters of the earth are all the same water.”

~Katsi Cook, traditional Mohawk midwife, Director of the Iewerokwas Program of Running Strong for American Indian Youth

Women are the First Environment – Indian Country Today – December 23, 2003

Introduction

Our Native ‘systems’ are spirit-based as reflected in our understanding of our relation to all creation and our Creator. There is a belief that each of us knows how to speak from the heart and to treat one another with the deepest human respect. We know how to behave in this way in thought, word, gesture, and action. This belief extends to the honor of having been entrusted with the stories of those victimized by sexual violence and the grief, pain, terror, and shame of that experience.

“In studies of sexual victimization among American Indian women, rates have ranged from

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12 percent to 49 percent. These high rates are part of the legacy of racism and oppression perpetrated against American Indians, and the loss of traditional family and cultural practices through forced institutional childrearing in boarding schools and other attacks on native culture (e.g., Duran et al., 1998; Hamby, 2000).”

The historic sexualization of racism, and the consequent marginalization of Native women is rooted in colonization. Society ignores Native women victimized by sexual violence; their systems are disabled by its own failure to act. These and a community bound by silence is the world in which Native women seek help and healing. We believe today’s complexities in responding to sexual violence originate in the United States’ public policy. Established in historical times, these policies and practices are perpetuated through institutional relationships. Our jurisdictional legacy pose particular dilemmas for us as Native people because we are forced to gain objectivity about our own subjugation as a people, to face the trauma we carry in our hearts for those we love, often to encounter the ghosts of our own victimization. Our communities appear silent. The ‘silence’ has been forged by trauma, crippling limitations on sovereignty, degradation of Native ‘law’, past prohibition of Native religions, and the continued potency of the boarding school era. The current situation is the responsibility of all who have authority to respond. Ultimately, the lack of coordination between systems and education about federal Indian law and tribal law leaves victims in a quandary of how to get help and advocates with the dilemma about how best to help them.

As advocates for Native women, we carry a message of sovereignty, self-determination, autonomy, and safety from sexual and domestic violence. Our understanding of sexual violence against Native women has come from the stories we have heard in our families and from our communities. Knowing the conditions encountered by Native women, we place the context of safety for our women within the political sphere of our people.

Understanding sexual violence in American Indian Communities requires an examination of the full context of Native women’s experience. The political will to embrace this understanding will be necessary to systemically alter the situation. The sexual violence in Native communities impacts everyone. One out of three American Indian and Alaska Native women will be raped in her lifetime (USDOJ, 2000). This staggering situation is minimized when one examines the few resources allocated to the problem. The multi – jurisdictional barriers too often result in the idea that ‘no one will do anything’. Law enforcement, as initial responders, have the responsibility of informing victims of their inability to take action. Knowing this, victims come to believe ‘the community’ is incapable of responding. However untrue, it is a complex political undertaking of the leadership of multi-jurisdictions to assume their role and responsibility in addressing the legal barriers. One example of removing legal barriers is the ‘cross deputization’ which is now an accepted practice between law enforcement agencies in Oklahoma. Other examples include the creation of a ‘Memorandum of Understanding’ (MOU) or ‘Memorandum of Agreement’ (MOA) between jurisdictions. Tribes entering into these legal agreements are exercising their sovereign authority.

While non-Native SART teams rely on cooperation within a county jurisdiction, Native SART teams will require cooperation between multiple jurisdictions unaccustomed to recognizing tribal sovereignty and tribal law enforcement. These efforts are just now beginning and none have yet been effectively implemented in Minnesota. Those tribal communities engaged in these efforts need to be acknowledged for their commitment to the safety of women and for the support of
tribal leadership.

The economic disadvantages become extreme barriers when seeking services in isolated rural areas. The same conditions exist in urban Indian communities, however. Nearly 29 percent of American Indian households lack a vehicle, and 22.2 percent have no telephone. The comparable rates for white households are 7.8 percent and 2.1 percent.

Native women who experience rape are like every other woman who is raped, yet, the conditions of implementation required to meet her needs may differ dramatically. Therefore, non-Native models of responding to sexual violence should be examined for their usefulness. When tribes attempt to implement non-Native models they reach a point where they discover they may not have the necessary resources to replicate these models.

The existing models of response to sexual violence have been developed within the context of non-Native infrastructures. Available funding requires Native communities to create similar responses. Ideally, a response to Native women experiencing sexual violence would be one developed by examining the needs identified by Native communities, which may differ between reservation, rural, and urban Native communities. Currently in Minnesota, there are six reservation sexual assault programs, with most having one funded advocate position. There is one advocate for urban Indian communities in Minnesota. These resources, while essential, barely meet the minimum need in those funded communities.

A list of Federally Recognized Minnesota Tribes:

Ojibwe (Chippewa Reservations):
- Bois Forte (aka Nett Lake);
- Fond Du Lac;
- Grand Portage;
- Leech Lake;
- Mille Lacs;
- Red Lake; and
- White Earth.

Sioux (Dakota Reservations):
- Lower Sioux;
- Prairie Island;
- Shakopee Mdewakanton; and
- Upper Sioux.

Community Silence

Native women encounter community silence and sometimes community retaliation for speaking out about sexual violence. It is not uncommon for a Native woman to have experienced multiple rapes in her lifetime. This is true for young women as well as older women. Native women seek a number of ways for healing, including traditional ways and tribal-specific advocacy, counseling, and therapy. The community silence encountered by Native survivors of sexual violence is the most heartbreaking. Changing community perceptions and beliefs is the greatest challenge. Simultaneously helping women heal from sexual violence and seriously addressing the multi-jurisdictional problems are needed in Native communities, reservation, urban, and rural.
Cultural Competency

State-funded sexual assault programs are under-funded. In rural areas in particular it is difficult to access funding from private foundations. The limited resources to address sexual violence is additionally complicated by a volunteer model with minimal staff. Staffing problems restrict hiring and leads to the dilemma of how best to meet the needs of ‘special populations’. Native communities end up being put in this category. As sexual assault programs attempt to rectify this situation they frequently opt into a practice of ‘cultural competency’. Those programs actively promoting cultural competency are respected for their efforts. This practice sustains status quo hiring practices, however, and impedes the development of an honest strategy to acquire the expertise of Native people. Cultural competency is a term indicative of a service and/or systems provider being unable or unwilling to develop a strategy of hiring or training Native people to work within non-Native systems or programs. Organizations and agencies often rely on minimal ‘cultural awareness’ training. In some instances, those who have a primary professional responsibility to assist women resort to victim blaming when they lack knowledge and skills to effectively advocate for Native women experiencing sexual violence. Some service providers substitute referrals in place of substantive assistance. A term that has been introduced to replace ‘cultural competency’ is ‘cultural humility’. It is unrealistic to expect that an individual can take a course or training in ‘cultural competency’ and to have an adequate understanding of another culture. Cultural competency training is acknowledged as an action taken to become an ally, to show respect, and to offer support.

Indian Boarding Schools

Indian boarding schools were instituted by the War Department as another Indian termination policy of the United States and lasted for nearly a century. Native children were institutionalized as young as age three. They were stripped from their families and communities and forbidden to speak their Native language or to practice their cultural ways. The “Boarding School Era” is considered to be the predominant source of violence within Native communities.

May 12, 2004 - (United Nations) The policy was to “kill the Indian and keep the man.” The aim of a boarding school system established by U.S. officials in the 19th century was to assimilate American Indian children into the dominant white society, speakers told a panel discussion at the U.N. Permanent Forum on Indigenous Issues on Wednesday. That meant forbidding their languages, clothing, hair styles -- their culture, in fact -- using as much violence as was needed, they said. The residential school system began with president Ulysses Grant’s 1869 “Peace Policy” and continued well into the 20th century, taking 100,000 American Indian children from their homes to live and study in Christian boarding schools. Students, as young as two years of age, were placed in the schools until the age of 18, many returning home speaking a different language (English) than when they left. Many were also physically and sexually abused.

These institutions were structured to train children for a life of servitude (slavery); they were not the institutions we imagine, boarding schools for the privileged. As the
‘boarding schools’ were being phased out, some of the sites became educational institutions for the state. One of the former Indian ‘boarding school’ sites is now the University of Minnesota at Morris. Another former boarding school site was the recently demolished St. Benedicts at White Earth.

In the 1950s and 1960s, the Indian Adoption Project placed hundreds of Native American children with white parents, the first national effort to place an entire child population transracially and transculturally. The Indian Child Welfare Act of 1978 reversed this policy. By defining children as collective resources, essential to tribal survival, it stands as a significant exception to the rule of individualism in American law, where children’s best interests are invariably assessed case by case.

In 1978, Congress took a giant legal step toward consolidating group rights to children by passing the Indian Child Welfare Act. In this case the federal government overcame its reluctance to legislate because of a long history of displacement of Native American children, significant and systematic enough to be considered a genocidal policy by many tribes.

Today, Native communities are left with the profound impact of the Boarding School Era. The history of sexual violence in Native communities emerged from that era and is a legacy complicating the response to sexual violence now experienced in our communities.

Legal

In coming to the courts, Indian women confront a system that was unaccustomed and often resistant to acknowledging the political, domestic, and economic power that they often held. The result was decisions that stripped women of this power, sometimes in the name of civilization and sometimes in the name of the law.

In the United States there are three sovereigns, the federal government, state government, and tribal governments. The legal authority of each sovereign includes the ability to enact laws. The primary federal laws impacting Native peoples response to sexual violence victims are the Major Crimes Act and Public Law 280 (Read Article – Sexual Assault on Minnesota Indian Reservations - By Sarah Deer, Staff Attorney, Tribal Law and Policy Institute). Native victims of sexual assault must deal with multiple jurisdictional issues so profound that typically one needs legal training to comprehend the basics. Often the victim has experienced sexual abuse as a child, sexual harassment in school, acquaintance rape as a youth or adult, gang rape, stranger rape as a woman of any age, and rape by an intimate partner before she ever approaches an advocate or legal system for help.

If a Native woman pursues a criminal justice response, in the absence of a sexual assault protocol, she will have the sole responsibility of engaging multiple jurisdictions for assistance including tribal courts and law enforcement, county courts and state law enforcement, and sometimes, federal courts and BIA and/or FBI law enforcement. Occasionally, this may include the jurisdictions of a neighboring state, and in fewer instances border tribes may require advocacy with Canadian jurisdictions. The intersection of a Native woman’s poverty status, gender bias in the courts, institutional racism and the complexity of jurisdictional resolution requires the most knowledgeable and skilled advocates and other professionals to respond to her needs. In doing so they must have a comprehensive understanding of tribal, state, and federal systems,
and have the ability to navigate the complex jurisdictional barriers.

Public Law 280

The Supreme Court has explicitly stated that the United States is directly responsible for ensuring the well being and security of people who live on Indian Reservations. PL 280 causes a dangerous situation on Indian reservations because law enforcement agents are confused over jurisdiction, and the Federal and State courts argue constantly about jurisdiction over police actions, often not responding to police calls.

Under general principles of federal Indian law, states do not have direct jurisdiction over reservation Indians. Congress has the power to vest federal authority with the states, which it has done with the 1953 passage of Public Law 83-280. PL 280 established state jurisdiction without abolishing tribal jurisdiction. Thus the powers are concurrent. Tribes are sovereign and self-governing. Tribes have the power to pass and enforce laws to prevent violence against Indian women on their reservations. In most situations tribes retain a broad degree of civil jurisdictional authority over members and non-members on the reservation, particularly where the conduct threatens or has some direct effect on the political integrity, economic security, or the health or welfare of the tribe. Due to the Supreme Court ruling in Oliphant v. Suquamish Indian Tribe, however, tribes are not allowed to exercise criminal jurisdiction over non-Indians. A myth has developed over the past 40 years that the legislation deprived tribes of jurisdiction. This caused the tribes to generally fail to develop internal systems to deal with legal issues, but instead to rely upon, and see themselves dependent upon, state legal systems.

Tribal governments may not have protocols with off-reservation law enforcement, therefore, it is unlikely that a criminal investigation will occur. This is beginning to change in some reservation communities. Tribal governments are examining their tribal codes to include new codes to address sexual violence within their tribal jurisdiction, exercising tribal sovereignty to protect our people. Minnesota is a Public Law 280 state with concurrent jurisdiction with nine of the eleven tribes. Red Lake was not included in PL 280 and Boise Forte retroceded from PL 280. The impact of PL 280 extends to all Native people in Minnesota.

Federal Trust Relationship with Native Americans

The federal government has a special relationship with Native Americans, commonly referred to as a “trust” relationship, requiring the government to protect tribal lands, assets, resources, treaty rights, and health care, among other obligations. This unique government – to – government relationship is based on Article I, Section 8 of the United States Constitution and has been given substance through numerous Supreme Court decisions, treaties, legislation, and Executive Orders. The principal legislation authorizing federal funds for health services to recognized Indian tribes is the Snyder Act of 1921. Congress passed the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) to provide tribes the option of assuming from the HIS the administration and operation of health services and programs in their communities, or to remain within the IHS direct health system. This federal obligation is the result of Native Americans ceding over 400 million acres
of tribal land to the United States pursuant to promises and agreements that included providing health care services, among other benefits. The disparities in health status and outcomes experienced by Native Americans are an indictment of the federal government’s commitment to fulfilling its moral and legal obligation to provide for the health of Native Americans.

IHS protocols and policies in responding to sexual assault and abuse vary between HIS Area Directors. An area director may or may not permit medical personnel to be released from work to participate as a witness to a rape prosecution. Advocates have reported this problem and others. A tribe may contract for medical/health services with an off reservation non-Native medical clinic/hospital provider. Medical providers need to be knowledgeable about their responsibilities to respond to Native victims of sexual assault and sexual abuse.

The development of sexual assault protocols between medical providers, law enforcement, and advocates is complicated by the need for multiple jurisdictions to work together to create the protocols. The tribe, IHS medical providers, and county law enforcement must have strong relationships and administrative support to create and implement an effective sexual assault protocol.

Typically, the reservation or tribal community is divided between two or more county jurisdictions. Developing effective sexual assault protocols will require all jurisdictions within tribal boundaries to respond to the sexual assaults of Native women. In a PL 280 tribe this means tribal law enforcement (where they exist) and county law enforcement of two or more counties. For instance, White Earth Reservation encompasses three counties, Becker, Mahnomen, and Clearwater counties. Any jurisdiction refusing to participate is ignoring their legal responsibility to respond. The initial question for tribes attempting to create a sexual assault protocol is, “How can the sexual assault protocol development team overcome or bypass the barriers created by politics between the tribe and the county or counties, the resistance by individuals and systems to work together, and the general ignorance about legal responsibility with concurrent jurisdiction as determined by PL 280?” A tribe might adopt codes to address sexual violence, they may develop a sexual assault protocol within the tribal jurisdiction, however, and with concurrent jurisdiction the state must play an active role.

A long history of disenfranchisement; extermination of tradition, language, and land rights; broken treaties; sterilization of Native American women; placement of Indian children in Indian boarding schools; and other experiences of oppression have established a deep-rooted intergenerational anger, intergenerational grief, and mistrust of government that persists to this day. Conscious discrimination is not as common as the unconscious bias frequently displayed by health care providers serving Native American communities. Studies have discovered that while unintentional, health care providers make treatment decisions based on their cultural and racial biases and stereotypes. One study concluded that “[t]oo often, a physician’s perception of a patient’s race and ethnicity, which is not based on any communication with the patient, is being recorded and used by the health-care team to make clinical decisions and medical and social judgments about the patient. This practice perpetuates physician paternalism and racism.”
Medical Response

Medical resources including Indian Health Services are unprepared to respond to Native victims of sexual violence. Medical providers near reservation communities may be unresponsive for a number of reasons. Indian Health Services staff may be limited to a rape exam and not be able to be released from work to provide testimony in a sexual assault prosecution. Contracted medical services have not proven to be an accessible resource for Native victims of sexual violence. This lack of response can be examined from many viewpoints.

The conditions shaping the current response to Native women experiencing sexual violence appear to be without empathy or pity. The following statement from the Snyder Act of 1921 could be describing the current situation encountered by Native women seeking help from sexual violence.

“The Indian is never alone. The life he leads is not his to control. This is not permitted. Every aspect of his being is affected and defined by his relationship to the Federal Government – and primarily to one agency of the Federal Government: the Bureau of Indian Affairs. ………Even when exercised illegally, the total power of the bureau is virtually unchallengeable and unreviewable. Where the normal citizen has three avenues of redress political, judicial, administrative – the Indian has none.


Indian Health Services is engaged in a process to change the current response. Survivors of sexual violence encounter the realities of existing conditions and complexities of receiving a consistent and viable response. In a few tribal communities in Minnesota, the surrounding communities respond well to Native victims, but drastic improvement is needed to adequately assist survivors.

Health and Wellness after Sexual Assault

Our Native communities have seen the devastation of lives and families from someone ‘coping’ with sexual trauma by self-medicating with alcohol and/or drugs. In these instances, women are ashamed to ask for help. Those who were drinking at the time of the assault will blame themselves for what happened. Living with self-blame, self-criticism, shame, guilt, or fear, the victim will have a great struggle to regain control over her life and live a drug-/alcohol-free life.

While there is a need for traditional healers and healing ways, they should be:

• Screened for safety;
• Screened for confidentiality; and
• Trained to work with victims/survivors of sexual assault.

Are there traditional medicines available for use by the victim/survivor at their request? Has hospital/clinic staff been trained on the use of traditional medicines within a medical setting?

Native advocates are reclaiming traditional teachings, life ways, stories, and language to counteract the violent oppression experienced by our grandmothers, mothers, aunts, sisters, daughters, and all those in our community who have suffered sexual violence including our men.
If culturally- and linguistically-appropriate health services are desirable to Native Americans based on their unique cultures and the unique relationship with the federal government, distinctive approaches to health care should also be included in the delivery of health services to this population. Many Native Americans continue to employ traditional medicines and practices either as their sole form of health care or as a component of their overall health care. Accordingly, in March 2002, the Association of American Indian Physicians unanimously approved a resolution acknowledging and supporting Native American traditional healing and medicines as part of the spectrum of health care appropriate for Native Americans. As part of this resolution, the association intends to work collaboratively with traditional healers for the benefit of Native patients and community health.

It’s very important to make each woman victimized by sexual violence feel comfortable and safe, feel trust, and to let them leave with hope. Native women will differ in their need to have access to traditional healing ceremonies and medicines. Since there have been so few sexual assault resources in Native communities, there is a strong likelihood that you may be the first advocate she has encountered. If she requests therapy or counseling, ensure the therapist or counselor is experienced in working with Native women.

Native Women Remain Silent About Sexual Violence

Native women have told advocates some of the reasons why it took so long to disclose the sexual violence: She is not believed because she is a Native woman; her silence is linked to the community’s silence and apparent resistance to address sexual assault.

Native women talk about community secrecy and unresponsive institutions as well as distrust of systems - police, courts, hospitals, service providers, etc. They don’t know who to trust with information about the assault and are unfamiliar with available resources.

Native survivors of sexual violence don’t understand the legal system or may be too afraid of facing the rapist in court to report the rape to anyone in the legal system. Many have seen the negative response to other Native women who have reported rape. They may be afraid of retaliation either from partners, family, friends, community, and/or others. It is not yet common to see it as rape if assaulted by a husband or boyfriend, or if she is a battered woman and the rape occurred as part of the battering. Known perpetrators may be in positions of influence or authority, and appear to be protected by the community. Multiple sexual victimization complicates asking for help or reporting the rape. Native women mistrusting those around her don’t want to ‘make things worse’ by reporting.

Those experiencing sexual trauma may believe that if the sexual assault and its impact is not discussed ‘it’ will go away, or if she remains silent that ‘it’ will stop. Additionally, she may avoid talking or thinking about the rape, fearful that it may trigger an emotional crisis, and she doesn’t want to do that to herself. Others just want to go on with their life, to move past the rape experience and to heal. Women have expressed the idea of not wanting to get stuck in the trauma of rape by dredging it up. Others believe they can’t do anything about it.
Community Silence: Generational Trauma and the Impact on Native Communities

The long-range generational effects of trauma have been widely reported in literature, especially regarding the Holocaust. It is clear, however, that intergenerational trauma is not confined to war experiences, but is quite widespread. A central clinical feature is the silence that occurs in families surrounding traumatic experiences. The process of psychotherapy sometimes replicates that means of coping by not encouraging open discussion. Interventions that facilitate opening a dialogue about secret trauma are often crucial to the treatment of current symptoms, as well as to the prevention of future problems. Reaching back to older generations and building open communication with younger generations can provide much understanding and relief to families. Consideration of repressed or denied trauma in individual or family therapy can assist both in halting the transmission of trauma from one generation to another and improving overall individual and family functioning.

The chemical health field in Minnesota has long addressed generational trauma in training treatment center staff. Yet there is no therapeutic model in Minnesota Native communities specifically designed to address generational trauma. We have traditional ways of healing which may be inaccessible in urban areas and even in some reservation communities – crime victims reparations doesn’t cover this kind of ‘therapy’ for victims of sexual violence.

American Indians experienced massive losses of lives, land, and culture from European contact and colonization resulting in a long legacy of chronic trauma and unresolved grief across generations. This phenomenon, labeled “historical unresolved grief”, contributes to the current social pathology of high rates of suicide, homicide, domestic violence, child abuse, alcoholism, and other social problems among American Indians.

As a tool of assimilation, the residential school system failed, but it was successful in causing irrevocable damage to First Nations culture. Its damaging impact has had serious consequences. Children were held taken from their families and communities, and held as captives within these schools. Parental care and guidance were lost and replaced by institutionalized child care characterized by authoritarianism, often to the point of physical, psychological, and sexual abuse “bordering on (and often passing into) the realm of torture, such treatment often being rationalized as discipline by those inflicting it”. The legacy of residential schools on the children who attended, their parents, and the subsequent generations, can be described as internalized collective trauma. This type of trauma is the result of separation from family, cultural denigration, physical abuse, sexual abuse, and spiritual abuse.

Within our tribal communities, we are confronted with the internalized oppression of generational trauma. Predominantly, this is being addressed on an individual basis, and in some instances through training and education. The conditions created by this dynamic can result in victim-blaming of sexual assault survivors.

Ultimately, the generational trauma of the boarding school era persists. Native people have organized to address the problem through public policy like the enactment of the federal Indian Child Welfare Act, and the Minnesota Indian Family Preservation Act, but as a people, we have the conditions of past termination policies permeating our communities and complicating our ability to develop strong legal and medical models to address sexual violence.
Historical Grief and Trauma is “a cumulative and psychic wounding across generations related to massive root trauma.”
~Maria YellowHorse BraveHeart

Historical trauma is very complex. Historical trauma exists across generations and beyond the life span. Historical grief is the result of past trauma that has not been addressed or dealt with. It is an ever-growing issue among Native Americans. Historical Grief and trauma is loss of land, language, identity, culture, spiritual beliefs, and family values which are the affects of broken treaties, boarding schools, missionaries, greed, and disease. The consequences includes racism, anger, prejudice, hate, resentment, cultural self-hate, frustration and confusion. To educate the community and Indian country on how historical trauma affects its members through physical and emotional illness.

Goals and Topics

- Address social problems affecting the physical, emotional, spiritual, and mental-health of Native Americans with a focus on intergenerational effects of trauma across various victim/survivor populations.
- Address the cultural, political, economic, and health problems within Native American communities because of the effects of historical trauma and grief.
- Educate community people, non-native social workers, clergy, substance abuse counselors, and other professionals working in the Native American communities.
- Begin the healing process from the effects of historical grief and trauma.

Prostitution

The sexual victimization of women was long accepted as a ‘right of conquest’. The underpinnings of that ‘right’ intersected with the colonization of Native people and the oppression of women in this country. It has been further complicated by generational trauma, poverty, and the institutionalization of Native children. Creating a strong and effective response to the sexual violence of women will require an examination of societal norms about prostitution in general and for Native women will involve the perspective of the colonization of Native people. As Native people, we believe that we must look at the past to change the future. This perspective focuses on altering the conditions that permit a problem to continue. It is not about placing blame; it is about taking responsibility.

Fur was the main attraction to Canada, and First Nations women were especially essential to the fur traders. The Europeans used the presence and influence of First Nations women to penetrate new territories and secure new markets. Thus, First Nations women were integral to the creation of commodity production. Their position in that new society was one of slave, however. For example, in 1714, a Hudson's Bay Company officer, as part of an expansionist strategy, "obtained" a Chipewyan woman whom he referred to as "slave woman". He "obtained" or kept her with him for two years so that she might learn they system of commodity exchange and the value of British goods and private property. She was then sent into the interior to recruit
Chipewyan people to come to York Factory and begin trade. Her confinement to the fort was a form of hostage taking where she was forced to accept the Western values of capital and private property.

One historical perspective of ownership and entitlement is reflected in the following statement. As the Minnesota Supreme Court clarified in La Framboise v. Day, a man might be the son of a white man, might speak English, might work as a clerk in a general store, yet still divorce his Indian wife by leaving her if he observed Indian customs, “particularly in the matter of buying and abandoning their women.

Statistics

- Indian women, as a group, experience more violence than any other group in the United States. The average annual rate of rape and sexual assault experienced by American Indian Women is 3.5 times higher than for all other races. (BJS, 1992-1996)

- Sexual violence starts very early in life. More than half of all rapes of women (54 percent) occur before age 18; 22 percent of these rapes occur before age 12. For men, 75 percent of all rapes occur before age 18, and 48 percent occur before age 12 (Tjaden and Thoennes, 2000).

- 75 percent of Indian female homicide victims during the period of 1979-1992 knew their assailant, with almost one-third being killed by a family member (Centers for Disease Control, 1993).

- 61.4 percent of all American Indian and Alaska Native women will be physically assaulted in their lifetime (USDOJ / CDC, Tjaden and Thoennes, 1998).

- In the NVAWS, almost half of the rapes reported by American Indian women were committed by intimate partners (Tjaden and Thoennes, 1998; 2000). Although this is contrary to common stereotypes, which suggest that the typical rape is a stranger assault; it is consistent with data showing most sexual victimization is committed by men who are known to the victim (Rennison and Rand, 2003).

- Indian women suffer 7 sexual assaults per 1,000, compared to 3 per 1,000 among Black Americans, 2 per 1,000 among Caucasians, and 1 per 1,000 among Asian Americans (Greenfeld and Smith, 1999).

- Existing data suggest that large numbers of American Indian women have been sexually victimized. American Indian women experience more rape, by both strangers and intimate partners, than other U.S. racial and ethnic groups, according to the National Violence Against Women Survey (Tjaden and Thoennes, 1998; 2000).

- Studies in the majority U.S. culture indicate that many victims of sexual victimization (26 percent to 52 percent) will be victims of physical partner violence as well (Koss, Ingram, and Pepper, 1997). Rates of physical partner victimization and intimate partner homicide among American Indians are also high, often higher than for other U.S. ethnic groups (Arbuckle et al., 1996; Hamby and Skupien, 1999; Tjaden and Thoennes, 2000).
• When researchers have examined the prevalence of different types of rape, they have found that marital rape accounts for approximately 25 percent of all rapes. (Randall and Haskell, 1995; Resnick, Kilpatrick, Walsh and Vemon, 1991)

• Some people believe that a “real” sexual assault involves violence and physical injury to the victim. As a result, many adult women who choose not to resist in order to avoid injury in a sexual assault feel self-blame and guilt, and are blamed by others (Renner, et al., 1988).

• Rates of physical partner violence and intimate partner homicide among American Indians are also high, often higher than for other U.S. ethnic groups (Arbuckle et al., 1996; Hamby and Skupien, 1998; Tjaden and Thoennes, 2000).

• One woman out of every five worldwide is likely to be a victim of rape or attempted rape in her lifetime (World Health Organization).

• One United Nations estimate says from 113 million to 200 million women around the world are demographically “missing.” Every year, from 1.5 million to 3 million women and girls lose their lives as a result of gender-based violence or neglect.

What can be done by non-Native advocates and advocacy programs?

All advocates need to be committed to working to overcome their own biases and stereotypes in order to be an effective advocate for Native women. We come from communities with differing cultural backgrounds and situations. The advocate must be aware of how her language conveys her philosophy, attitudes, and stereotypes. Her language should acknowledge Native women and act as a counter to negative images.

• Recognize that Native and non-Native advocates share the same goals.
• Acknowledge that both Native and non-Native advocates are working to end the sexual violence of all women.
• Accept the differences between us and explore how we can share our expertise.
• Respect the differences in our histories and approaches to sexual violence.
• Determine what cross training is needed to improve our response to Native women victimized by sexual violence.
• Prepare to change practice and policy (barriers to Native women seeking help)
• Professional training is needed to alleviate racism.
• Extend your action and involvement to creating a culture of respect for Native women.
• Present non-Native leadership with options for change.
• Change the mindset of the people with regarding Native women as rape-able.

The Minnesota Indian Women’s Sexual Assault Coalition – Founded 2001

MIWSAC VISION STATEMENT: Creating Safety and Justice for Native Women
The Minnesota Indian Women’s Sexual Assault Coalition (MIWSAC) has been in existence to address the high rates of victimization against American Indian and Alaska Native women and girls since 2001. As the only sexual assault coalition in the country specific to Native women and children, MIWSAC strives to incorporate culture and spirituality into every aspect of program operations: meetings, conferences, internal policies, as well as community involvement. The membership is comprised of representatives from 11 federally recognized tribes of the Ojibwe and Dakota Nations as well as a large Native urban population in Minnesota. The members bring with them extensive cultural knowledge and long histories of working in domestic violence and/or sexual assault programs. MIWSAC’s leadership is reflective of their tribal values by referring to the board as Circle Keepers, and by utilizing the consensus decision-making model versus voting-based decision-making models. MIWSAC recognizes that reintroducing and modeling traditional values that honor the sovereignty of Native women and children, including the work place, are fundamental to restoring safety from sexual violence in Native communities.

MIWSAC has a committed group of members who attend as many meetings as possible, and they work hard to ensure that the goals they set are being carried out. The coalition meets quarterly and information packets are sent out to members as well. They meet at various locations around the state in order to include involvement from each of Minnesota’s eleven federally recognized tribes. To ensure participation, the coalition pays for their member’s meals, mileage, lodging, and childcare stipends. They also provide technical assistance, training, and support to American Indian and Alaska Native women advocates in Minnesota by providing training at bi-monthly meetings, and hold one meeting per year to honor advocates and their work in conjunction with visioning and planning for the future. MIWSAC also holds an annual Native Girls Retreat, an annual Statewide Conference, a Strengthening Sovereignty and Safety Policy Summit for Tribal Leadership, in addition to creating public awareness materials and training curriculum.

Note: In this article differing terms refer to Native people and their homelands. The terms used are those used in the source of information. The legal term defined by the federal government is American Indian and Alaskan Native. There are over 560 federally recognized Indian tribes within the United States boundaries. Numerous tribes are state recognized but not federally recognized. In Minnesota the Ojibwe tribes live on Reservations while the Dakota tribes are called communities and there are Minnesota tribes who are not yet federally recognized. These terms came about through federal Indian law and termination policies.
The following members provide advocacy to Native victims:

**Tribal Coalitions**

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<thead>
<tr>
<th>Organization Name</th>
<th>Address</th>
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<tbody>
<tr>
<td>Minnesota Indian Women's Sexual Assault Coalition (Statewide)</td>
<td>1619 Dayton Ave., Suite 303</td>
<td>1-651-646-4800</td>
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**Community Resource Alliance (White Earth)**

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<tr>
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<tbody>
<tr>
<td>St. Paul, MN 55104</td>
<td>607 Main Street</td>
<td>1-218-375-2762</td>
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**Min-Ne-Ayo-Win Human Services Center**

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<tbody>
<tr>
<td>Duluth, MN 55802</td>
<td>218-878-3782</td>
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**Technical Assistance Providers to Tribal Grantees – VAWO**

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<td>202 East Superior Street</td>
<td>1-218-722-2781</td>
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<tr>
<th>Organization Name</th>
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<tbody>
<tr>
<td>Tribal Law and Policy Institute</td>
<td>1619 Dayton Ave., Suite 305</td>
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<tr>
<td>American Indian Community Housing Organization</td>
<td>419 North 1st Avenue West, #C</td>
<td>218-722-7225</td>
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<tr>
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<tr>
<td>Sexual Assault Services, Inc.</td>
<td>217 South 7th Street, Office 112</td>
<td>218-828-0494</td>
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<tr>
<td>Minnesota Indian Women’s Resource Center</td>
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<tr>
<td>Women of Nations</td>
<td>73 Leech Street</td>
<td>651-222-5836</td>
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<tr>
<td>DOVE</td>
<td>White Earth Reservation Tribal Council</td>
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<td>Mille Lacs Band Women’s Project</td>
<td>17222 Atage Dr.</td>
<td>1-877-290-2677</td>
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<tr>
<td>Sexual Violence and Underserved Populations</td>
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Attachment 1

*Suggestion: This questionnaire may be used by a trainer during the section addressing the sexual violence of Native women.*

Relationship Building with Native Communities

1. Does the sexual/domestic violence agency/program have a plan to discover what people in Native communities are willing to do and what they think, and using that as the basis to develop a partnership with the community to end violence against Native women?

2. Does the sexual/domestic violence agency/program enlist the help of community-based organizations to survey community women about their safety needs?

3. Does the sexual/domestic violence agency/program attend and participate in Native social gatherings, community meetings, etc., and talk to people about what they can do to keep Native women safe?

4. If so, have they taken the time to learn how to do this in a respectful way?

5. Does the sexual/domestic violence agency/program create forums for community dialogues to discuss violence against Native women?

6. If so are they held on a periodic basis and is the focus on violence against Native women and/or developing Native women based strategies to address the violence?

7. Does the sexual/domestic violence agency/program hold mainstream culture accountable for the images of violence perpetrated upon Native people? In what ways?

8. Do the policies of the agency address racial harassment of employees and/or Native women and children using their services?

9. Do the hiring policies of the agency address hiring staff who reflect the population served, i.e. Native women, older women, youth, etc.?

Direct Services

10. Does the sexual/domestic violence agency/program offer a Native women’s support group?

11. Does the sexual/domestic violence agency/program offer other Native specific resources or access to culturally specific activities (i.e. transport to ‘Sweat Lodge’, etc.)?

12. Does the sexual/domestic violence agency/program conduct outreach meetings to Native women and communities?

13. Does the sexual/domestic violence agency/program provide an environment that is welcoming to Native women? What would this look like?
14. Does the sexual/domestic violence agency/program have established relationships with Native Resources?

15. Does the sexual/domestic violence agency/program know how to access Native resources; tribal, state, federal, national?

16. Does the sexual/domestic violence agency/program assist Native Women with safety plans which address Native specific safety issues; i.e. jurisdiction, full faith and credit of Tribal protective orders, ICWA, accessing traditional healing ways, etc.?

17. Does the sexual/domestic violence agency/program share their resources with the local Native communities; legal, shelter, funding sources, etc.?

18. Utilizing the criminal justice system is one option for safety, what other options are provided to access cultural practices by Native women?

19. Does the sexual/domestic violence agency/program actively involve Native allies who offer guidance/technical assistance to program staff assisting Native women and children?

20. Does the sexual/domestic violence agency/program provide services to children of all ages?

21. Do shelter policies ensure that Native boys over the age of 13 are able to stay at the shelter?

22. Does the local shelter accept families with three or more children?

23. Does the sexual/domestic violence agency/program conduct focus groups where Native women talk about their experiences of violence and how the system responds to them, as well as ask what responses/strategies they think might work and provide safety for them?

24. Does the sexual/domestic violence agency/program provide workshops about internalized oppression FOR Native women experiencing violence?

25. If so, are the workshops conducted by Native trainers?

26. Does the sexual/domestic violence agency/program have a strategy for building stronger relationships with Native women and support Native women to organize in their communities?

27. Do they support Native staff to do so on work time – and without limitations?

28. Does the sexual/domestic violence agency/program educate family members of Native women experiencing violence to enhance support?

29. Does the sexual/domestic violence agency/program ensure that Native women are in all decision-making positions, and are equally represented in all levels of programming and administration?
Training and Education

30. Does the sexual/domestic violence agency/program invite Native providers to their advocacy trainings/workshops?

31. Does the sexual/domestic violence agency/program receive and/or offer training on jurisdictional issues encountered by Native Women seeking safety and protection?

32. Does the sexual/domestic violence agency/program receive and/or provide training on the Indian Child Welfare Act?

33. Does the sexual/domestic violence agency/program enlist Native trainers for their advocacy training programs for paid and unpaid advocates?

34. Does the sexual/domestic violence agency/program provide political education to paid and unpaid staff and community that stresses how gender violence has served as an instrument of colonization?

35. Is there an active understanding about the conditions that dramatically limit Native communities ability to provide full protection and safety for Native women and how these conditions primarily originate in existing public policy?
Attachment 2

110th CONGRESS
1st Session
S. J. RES. 4
To acknowledge a long history of official depredations and ill-conceived policies by the United States Government regarding Indian tribes and offer an apology to all Native Peoples on behalf of the United States.

IN THE SENATE OF THE UNITED STATES
March 1, 2007
Mr. BROWNBACK, (for himself, Mr. INOUYE, Ms. CANTWELL, Mr. DODD, Ms. LANDRIEU, and Mr. CRAPO) introduced the following joint resolution; which was read twice and referred to the Committee on Indian Affairs

JOINT RESOLUTION
To acknowledge a long history of official depredations and ill-conceived policies by the United States Government regarding Indian tribes and offer an apology to all Native Peoples on behalf of the United States.

Whereas the ancestors of today's Native Peoples inhabited the land of the present-day United States since time immemorial and for thousands of years before the arrival of peoples of European descent;

Whereas the Native Peoples have for millennia honored, protected, and stewarded this land we cherish;

Whereas the Native Peoples are spiritual peoples with a deep and abiding belief in the Creator, and for millennia their peoples have maintained a powerful spiritual connection to this land, as is evidenced by their customs and legends;

Whereas the arrival of Europeans in North America opened a new chapter in the histories of the Native Peoples;

Whereas, while establishment of permanent European settlements in North America did stir conflict with nearby Indian tribes, peaceful and mutually beneficial interactions also took place;

Whereas the foundational English settlements in Jamestown, Virginia, and Plymouth, Massachusetts, owed their survival in large measure to the compassion and aid of the Native Peoples in their vicinities;

Whereas in the infancy of the United States, the founders of the Republic expressed their desire for a just relationship with the Indian tribes, as evidenced by the Northwest Ordinance enacted by Congress in 1787, which begins with the phrase, `The utmost good faith shall always be observed toward the Indians';

Whereas Indian tribes provided great assistance to the fledgling Republic as it strengthened and grew, including invaluable help to Meriwether Lewis and William Clark on their epic journey from St. Louis, Missouri, to the Pacific Coast;
Whereas Native Peoples and non-Native settlers engaged in numerous armed conflicts;

Whereas the United States Government violated many of the treaties ratified by Congress and other diplomatic agreements with Indian tribes;

Whereas this Nation should address the broken treaties and many of the more ill-conceived Federal policies that followed, such as extermination, termination, forced removal and relocation, the outlawing of traditional religions, and the destruction of sacred places;

Whereas the United States forced Indian tribes and their citizens to move away from their traditional homelands and onto federally established and controlled reservations, in accordance with such Acts as the Indian Removal Act of 1830;

Whereas many Native Peoples suffered and perished--

(1) during the execution of the official United States Government policy of forced removal, including the infamous Trail of Tears and Long Walk;

(2) during bloody armed confrontations and massacres, such as the Sand Creek Massacre in 1864 and the Wounded Knee Massacre in 1890; and

(3) on numerous Indian reservations;

Whereas the United States Government condemned the traditions, beliefs, and customs of the Native Peoples and endeavored to assimilate them by such policies as the redistribution of land under the General Allotment Act of 1887 and the forcible removal of Native children from their families to faraway boarding schools where their Native practices and languages were degraded and forbidden;

Whereas officials of the United States Government and private United States citizens harmed Native Peoples by the unlawful acquisition of recognized tribal land and the theft of tribal resources and assets from recognized tribal land;

Whereas the policies of the United States Government toward Indian tribes and the breaking of covenants with Indian tribes have contributed to the severe social ills and economic troubles in many Native communities today;

Whereas, despite the wrongs committed against Native Peoples by the United States, the Native Peoples have remained committed to the protection of this great land, as evidenced by the fact that, on a per capita basis, more Native people have served in the United States Armed Forces and placed themselves in harm's way in defense of the United States in every major military conflict than any other ethnic group;

Whereas Indian tribes have actively influenced the public life of the United States by continued cooperation with Congress and the Department of the Interior, through the involvement of Native individuals in official United States Government positions, and by leadership of their own sovereign Indian tribes;

Whereas Indian tribes are resilient and determined to preserve, develop, and transmit
to future generations their unique cultural identities;

Whereas the National Museum of the American Indian was established within the Smithsonian Institution as a living memorial to the Native Peoples and their traditions; and

Whereas Native Peoples are endowed by their Creator with certain unalienable rights, and that among those are life, liberty, and the pursuit of happiness: Now, therefore, be it Resolved by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. ACKNOWLEDGMENT AND APOLOGY.

The United States, acting through Congress—

(1) recognizes the special legal and political relationship the Indian tribes have with the United States and the solemn covenant with the land we share;
(2) commends and honors the Native Peoples for the thousands of years that they have stewarded and protected this land;
(3) recognizes that there have been years of official depredations, ill-conceived policies, and the breaking of covenants by the United States Government regarding Indian tribes;
(4) apologizes on behalf of the people of the United States to all Native Peoples for the many instances of violence, maltreatment, and neglect inflicted on Native Peoples by citizens of the United States;
(5) expresses its regret for the ramifications of former wrongs and its commitment to build on the positive relationships of the past and present to move toward a brighter future where all the people of this land live reconciled as brothers and sisters, and harmoniously steward and protect this land together;
(6) urges the President to acknowledge the wrongs of the United States against Indian tribes in the history of the United States in order to bring healing to this land by providing a proper foundation for reconciliation between the United States and Indian tribes; and
(7) commends the State governments that have begun reconciliation efforts with recognized Indian tribes located in their boundaries and encourages all State governments similarly to work toward reconciling relationships with Indian tribes within their boundaries.

Resource

Latina Victims/Survivors of Sexual Violence

By Mary Harders, Crime Victim Services, Inc., and Lindsay Gullingsrud, MNCASA

Key Learning Points:
• It is important to know about the individual’s culture and background, which may present additional barriers within the system, but also remember the influence of society and the changes occurring within the Latino community.
• Latinas in the United States come from many different countries, they have different backgrounds and family customs, and naturally there are cultural differences.
• Machismo can be defined in both negative and positive terms. Defining and applying it appropriately is necessary for effective communication.
• Latino families base their relationships on interdependence and mutual respect.
• Something to consider when working with Latinas can include: their legal status, family ties, possible language barriers, economic needs, and transportation.

Please note: The word “Latina”, in the Spanish language, refers only to females. The word “Latino” means both male and female when speaking in plural forms or generally. Throughout this document you will see both forms. “Latina” is used when specifically talking about a female, while, “Latino” is used when speaking in plural/general terms. Sexual victimization occurs among both genders, but this chapter is primarily dedicated to “Latinas”.

When working with Latinas in the community, an advocate may come across different, complex issues that are not present when working with other populations. It is important for the advocate to know about the individual’s culture and background, which may present additional barriers within the system, but also to remember the influence of society and the changes occurring within the Latino community. While remnants of past customs continue to exist, many Latinos in the United States have adapted their ways to better fit into the American culture.

Background

A misperception of Latinos, by many Americans, is that they are all Mexicans. While the majority of Minnesota’s Latinos do have ancestry tracing back to Mexico, Puerto Ricans, Cubans, Colombians, Ecuadorians, El Salvadorians, and Guatemalans have immigrated to Minnesota from their countries of origin.1 Latinos come to the United States for different reasons, many of them in search of opportunities for education and work, which provide them with a better life for themselves and their families. Development activities, both economic and entrepreneurial, created by Latinas provide tax dollars and new services throughout the state of Minnesota.2

A great majority of Latinas, especially those who have immigrated from Mexico, continue
financially supporting their families who remain in their country of origin. Due to the fact that Latinas in the United States come from many different countries, naturally there are cultural differences. While it is important to keep this in mind, it is possible to gain education through research, which suggests that Latino families have some similar cultural themes, including the importance of family, religion, and gender roles.

Machismo is a Latino term that has been misconstrued. While some individuals claim that this word refers to a male who brutally dominates his spouse, it is neither the proper meaning nor legally acceptable. Negative stereotypes and the American media, which is influenced by machismo, have insensitively represented the traditional roles of males and females in the Mexican culture. Historically, machismo defines a male who provides protection, food, and shelter for his family, while often times, a male who is over-aggressive, temperamental, controlling, and boastful will be referred to as a “macho”. In reality, Mexican families base their relationships on interdependence and mutual respect.

The importance of family in the culture of many Latinas is somewhat apparent in the ties that many individuals hold with extended family. While marriage, children, and family life may be important to a Latino/a, grandparents, parents, aunts, uncles, and cousins also play an important role to many people who continue to uphold traditional Latino customs. These ties with relatives who are not in the immediate family could create extra burden, barriers, or support for the individual. Assuming that a Latina only has her husband and children to care for in the home, would underestimate her responsibilities and may confuse her role as an individual in the household.

Religion is another cultural theme that Latinos historically held at a high level within their communities. Catholicism, in particular, is the predominant religious practice for most Latinos. Many times, Latinas who devote themselves to Catholicism practice not only in their churches, but in public places, as well as in their homes. Again, outside influences have a great impact on the stability of these customs, and this religious belief, like culture among Latinas, is different from family to family. While help and support can be found within the church for many Latinas, stereotypes, myths, and society viewpoints still play a large part in the support a victim/survivor of sexual violence will receive, even within their religious institution.

Documentation

Documentation can be a barrier for Latinas in the community, but it can also create an issue for advocates working with Latinas. Resources must be available for both the advocate and the victim/survivor to understand rights and regulations that the U.S. government grants to those undocumented individuals. Explaining these rights may be necessary, as often times no one explains them to an undocumented person, nor is it well understood by many, including advocates, as it pertains to the individual’s status.

At times, international politics and personal prejudices create complex issues when working with undocumented residents, as many individuals do not become conscious of the reality of the person’s situation. The undocumented individuals
fleeing war and poverty become easy prey for consumer fraud, employment exploitation, housing discrimination, and victimization within the criminal justice system due to the lack of assistance from governmental authorities and fear of deportation. It is important to remember that Spanish-speaking individuals from Puerto Rico are natural citizens of the United States and do not have the same concerns with deportation as undocumented people from other Spanish speaking countries. While many individuals assume that Latinas in the United States are mainly undocumented persons, 60 percent of Latinas in Minnesota are native-born U.S. citizens. Latinas in Minnesota, whether documented or undocumented, have difficulty accessing health care, higher education, and transportation.

Additional Barriers for Latinas

Advocates must also be aware of the other barriers that minorities face, especially when working in a rural area. Latinas in Minnesota are found in all parts of the state, almost equally in urban, suburban, and rural areas. Transportation for some of these individuals, as well as access to other resources, may be the most significant barrier for a minority if living in a more isolated area.

The civil and human rights of Latinas that are working in low-wage occupations, whether permanent or migrant residents, legal or undocumented immigrants, are threatened and abused regularly. These individuals often do not make efforts to ensure fair and safe employment conditions because they fear retaliation by the employer. A study from the National Survey of America’s Families found far reaching racial and ethnic disparities in the U.S., and showed that 61 percent of Hispanic people are more likely to fall into the low-income bracket, which is significant in comparison to the 49 percent of blacks and 26 percent of whites. Hispanics were also found to report not having good health at a higher rate than blacks and whites, which coincides with the higher percentage of uninsured children in Hispanic homes. In comparison to whites, Hispanics also experience housing hardship at rates twice as high.

When studying family violence, research shows that violence was not reported most often to the police because the incident was a “private/personal matter” or it was “reported to some other official.” Other victims/survivors felt that the incident was “not important enough”, the victim/survivor had “fear of reprisal”, they said they wanted to “protect the offender”, or that they thought the crime was “not important to police.” In 2000, Hispanic victims/survivors of violent crimes sustained a rape or sexual assault at two percent. In the Bureau of Justice Statistics Special Report, Hispanic Victims of Violent Crime, 1993-2000, statistics showed that Hispanics were as likely to report a violent crime committed upon them, as whites, blacks, or persons of other races. The same report also indicated that in 2000, Hispanics were victims/survivors of rape and sexual assault at lower rates than those for whites, blacks, and American Indians.” (Bureau of Justice, pg 2) Significantly, a third source states, “Hispanics were victims of overall violence at a rate higher than non-Hispanics.”

The Role of Advocates

Victim/survivor-specific resources, as well as traditional resources, should be available when organizing an agency so that minorities can see that victim service providers are responsive to their needs and informed of their preferred beliefs and
practices. In order to be responsive to these minority populations, it is necessary to look at the ethnic and racial composition of the community, and spend time researching on it. For example, more than one out of every three Latinas living in Minnesota is younger than 18, which makes for a relatively young population. This may influence the manner in which a victim service provider promotes services for the organization. Also, interacting with and learning from this population are an effective way to educate oneself on the culture and customs of the Latinas in the community.

Those who speak Spanish are often referred to as “Hispanic”, but not everyone speaks Spanish within Spanish-speaking countries. For example, the natives from the central mountains in Mexico do not speak Spanish. It is important to have resources available that the victim advocate may provide in addition to materials that are translated into their primary language. The criminal justice system becomes more accessible to a non-English speaking victim/survivor when multilingual handbooks and brochures are made available.

Overgeneralizations are frequent when noting commonalities among Latinos, which subsequently causes individuals to fail to notice the distinctions within the population. While distinguishing among cultural groups, it is important to remember the variety within the particular cultural group and the distinctions of socioeconomic status, degree of acculturation, generation, age, and gender intertwined throughout our ethnic and racial identities. An important aspect to remember, when gaining knowledge and working with Latinas, particularly those who have resided in the United States for some time, is to take into consideration the influences that have changed or altered their perception along the way. The strong influence in much of American culture has and is changing the beliefs and attitudes of many immigrants, which subsequently changes the way their culture is viewed.

End Notes

2. Ibid.
3. Ibid.
6. Ibid.
8. Ibid.
9. Ibid.
12. “Immigration in Minnesota, Discovering Common Ground” the Minneapolis Foundation.
13. Ibid.
15. “Immigration in Minnesota, Discovering Common Ground” the Minneapolis Foundation.
17. Ibid.
18. Bureau of Justice Statistics: Victim Characteristics, By the U.S. Department of Justice, Distributed by Office of Justice Programs.

20. Bureau of Justice Statistics: *Victim Characteristics*, By the U.S. Department of Justice, Distributed by Office of Justice Programs.


22. “Immigration in Minnesota, Discovering Common Ground” the Minneapolis Foundation.

Working with Male Victims/Survivors

Compiled by Craig Martin, Male Services Coordinator, Central Minnesota Sexual Assault Center
(This information is an expansion of previous articles compiled by Peter Dimock and Tracy Sheeley)

Key Learning Points:

• There are many myths about male sexual violence that act as a barrier to male victims/survivors seeking support services.
• Male victims/survivors are often reluctant to disclose sexual violence, and they may often have current concerns that appear more important than the sexual abuse.
• It is important to understand how and why male victims/survivors of sexual violence can be affected by stereotypes about sexual abuse and male victims/survivors.
• Male victims/survivors are often less likely to validate their experience(s) of sexual violence as harmful to themselves.
• Male and female victims/survivors will often experience similar emotions after experiencing sexual violence, such as shame, guilt, fear, and anger.

“Acknowledging the impact of sexual abuse in the lives of men is a recent phenomenon. This phenomenon of male childhood sexual abuse has been hidden from the public eye by a constellation of societal myths regarding the meaning of being a male. With their experiences invalidated, male victims/survivors have suffered in silence” ~ (Mendel, 1999, p.101).

The secrecy of sexual abuse must be broken to better understand what has prevented men from coming forward with stories of their personal victimization. “Although society has slowly acknowledged that men are indeed sexually abused, the estimates of the number of men who have been affected by sexual abuse have continued to increase. The underreporting of sexual abuse has occurred because men have felt uncomfortable or unable to discuss their personal abuse. Men are often not even able to refer to themselves as victims/survivors” (Dimock, 1991). Therefore, in order to create an environment for men to share their stories, both personal barriers and societal stigmas need to be identified.

In 1988, the first conference for male sexual abuse victims/survivors was held in Minneapolis, MN. This conference was an opportunity for mental health professionals to come together with men who had experienced sexual violence in order to create additional ways for the men to share their experiences. Since that time, the therapeutic and advocacy communities have continued to create additional avenues for men to share their stories of abuse. The strength and courage of these male victims/survivors who have shared their stories continues to help other males to ask for and receive additional services involved with recovery. Rue (2002) presented, “Approximately one in six males will experience sexual violence in his lifetime.” This evidence, compared to statistics from the early 80’s, suggests that the number of male victims/survivors who have shared their stories of sexual abuse has more than doubled in the last 20 years.
Men may or may not identify sexual abuse as the cause of their problems, but because of pressures or influences from external forces, these men seek services for a variety of other reasons. “Whether the message was heard voluntarily or involuntarily and/or came from sources such as the media, legal concerns, or therapeutic communities, the men need to be informed that they, too, can be victims/survivors of sexual abuse. Many victims/survivors feel both the urgency and terrible dread of the prospect of the abuse coming to light. They want terribly for someone to know but at the same time dread being found out. Mostly, they wish the bad feelings would just go away” (Bass & Davis, 2003).

The motivation for men to seek services may vary from individual to individual, but they often share common underlying factors such as internalized feelings of shame, fear, low self-esteem, sexual orientation, legal/relational difficulties, and/or addictive behaviors. An essential part of each person’s journey is the self-awareness of being sexually abused. It is during this stage of personal awareness that men will seek help or resources to unburden themselves or to acknowledge an assortment of destructive/painful behaviors, thoughts, or feelings. During this stage, the male journey will often intersect with several different stages of recovery and appear to be circular in nature. The male victim/survivor may experience several differing emotions and will benefit from a support system as he begins his journey of self-awareness.

In Child Sexual Abuse in the Catholic Church, Martin (2003) offers the following statement:

“I wanted someone to listen to me. I wanted someone to help me. I wanted to break the silence and despair that was killing me. Many times people like John Doe must reach a low point in their lives before they can ask for help.”

“The decision to heal from childhood sexual abuse is a powerful, positive choice. It is a commitment every victim/survivor deserves to make. Healing can bring to your life a richness and depth you never dreamed possible” (Bass & Davis, 2003). These authors quotes one victim/survivor who said, “Taking the risk was the most promising choice I had.”

The belief exists that men and women have different needs after being assaulted. Although it is true that programs specifically tailored for men are needed to reach out to the male victim/survivor, there are several human responses common to sexual violence. Male and female victims/survivors will often experience similar emotions such as shame, guilt, self-hatred, fear, and anger. All victims/survivors need to know that they are not alone with their pain, that healing is possible, and that whatever the circumstances, being sexually assaulted was not their choice.

The following statements identify and discuss some of the possible differences as to how male and female victims/survivors may react or be affected by sexual violence:

• Males are less likely to report being sexually assaulted due to repercussions. While all victims/survivors often have feelings of powerlessness/weakness, men will often feel they should have done something to prevent being assaulted. This is especially true in cultures where male dominance is the
norm. As a result, males feel that their masculinity is questioned and would rather deny what happened than risk being labeled helpless or weak. From an early age boys are taught that men are not victims/survivors; they need to be strong to protect themselves and others. These beliefs will often cause men to struggle with issues of control and trust. Men will experience further challenges in forming personal support systems or therapeutic relationships.

- Men may question their sexual orientation and/or sexual identity more often than women. If the male had some basic emotional needs met by the perpetrator or was physically aroused by the sexual assault, it is likely that he will be very confused about relationships. This can be true for any man, whether or not their orientation is gay, straight, bisexual, and/or undeclared. For males who identify as straight, they may think that the sexual assault means they are gay. Also, feelings of homophobia are often intensified for male victims/survivors of sexual assault, thus resulting in extreme sexual, emotional, or physical behaviors. The male victim/survivor may react in a hypersexual way to re-enforce his heterosexuality or to re-enact the sexual abuse experience with others. If the perpetrator was a female, the male may see the abuse as an expected or normal sexual experience rather than sexual violence. Males may consider this a form of flirtation or initiation. Trauma and shame are triggered when men are conflicted between personal choice and societal male stigmas or peer pressure. In order to benefit the victim/survivor, it is critical to identify how sexual violence is associated with power and control.

- Men are far less likely to validate their experience of sexual violence as harmful.

Men are less likely to ask for help. Instead, they are more likely to seek psychological help for other problems such as relationship issues, anger, or legal difficulties. Victims/survivors often ease their pain by developing coping skills or behaviors that are identified as self-medicating. These coping behaviors or defense mechanisms may encompass several of the following internal/external concerns: self-destructive behavior; post-traumatic stress reactions; poor body imagery; sleep disturbance; nightmares; anorexia/bulimia; relational/sexual dysfunction; and/or compulsive behaviors like alcoholism, drug addiction, gambling, overeating, overspending, and sexual obsession/compulsion. These compulsive behaviors may temporarily reduce the tension or the anxiety that has built up within men as they deal with the effects of sexual abuse. The early stages of these coping behaviors or defense mechanisms can create “feel good” sensations within both the physical and mental make-up of the victim/survivor, but often lead to more addictive or compulsive behavior. Men will also utilize these behaviors to disassociate or avoid the pain and trauma of sexual violence. Oftentimes, the end product of such coping behaviors can produce negative consequences that conflict with societal norms plus complicate or increase physical and mental health problems. The victim/survivor is then faced with an additional layer of shame that adds to or possibly masks the sexual abuse trauma. The societal stigmas associated with addictions will only intensify the guilt or shame that is already present within victims/survivors’ lives.

- Research suggests that men are more likely to be abused by people outside the immediate family. 80-90 percent of sexual assaults are committed by someone the victim/survivor knows. The perpetrator is likely to be an authoritative figure...
or in a position of power. The perpetrator will develop a relationship with the victim/survivor that may take on several different forms including that of a parent role, authority figure, friend, coach, clergy, or mentor. But, most importantly, the relationships are characterized by a personal closeness. Ainscough and Toon (2000) described the grooming process as a way for perpetrators to begin an association with the victim/survivor. This description will help men to better understand the process of being abused and how they were not responsible for the abuse. The power differential in the relationship between the victim/survivor and perpetrator is an important component in understanding the dynamics of sexual abuse. Perpetrators will often premeditate the sexual activity/abuse. As perpetrators initiate the sexual activity, it is their goal to overcome any inhibitions or defenses the intended victim/survivor may have. Perpetrators will often need to justify their actions to overcome a victim/survivor’s resistance or reaction to the sexual act or abuse. To do this, perpetrators will make themselves look very attractive or important to their victim/survivor. They will supply the intended victim/survivor with treats and shower him/her with flattery or use threats to control the victim/survivor’s behavior. Next, the perpetrators create an environment where they can be alone with their victim/survivor and use tactics to separate the victims/survivors from sources of safety/protection. In addition, perpetrators will introduce such things as alcohol, drugs, or pornography to overcome any possible resistance to being abused. A combination of these tactics will almost always create a “power differential” and thus the perpetrator is able to overcome the victim/survivor’s resistance.

- Males are more likely to react to sexual violence in an aggressive manner. Men report more frequently than females a desire to hurt others as a result of the sexual abuse. This reaction is based on the permission men have to express their pain through anger and revenge. While both women and men have legitimate anger at their perpetrator, men can get stuck in this mode and may attempt to work out all of their feelings through anger. This behavior will complicate relationships (personal/therapeutic) and create additional complications for the victim/survivor. It is vital for male victims/survivors to identify and comprehend the underlying emotions/feelings that trigger their anger. By utilizing the stories of other males, the victim/survivor is able to validate his own emotions/feelings and reduce the stigmas or secrecy attached to sexual abuse. Denial or unsupported response to such stories are types of invalidation used by perpetrators and/or society to keep men silent and prohibit them from sharing the internalized feelings associated with being sexually assaulted. The secrecy of sexual abuse is often a major factor for victim/survivors who do not seek resources or support from the people in their lives that can provide the compassion and dignity they deserve.

**Common Misconceptions Regarding Male Sexual Violence**

There are several misconceptions about the sexual abuse of males that continue to persist. Belief in or reinforcement of these misconceptions by either the victim/survivor or advocate will create barriers that hinder the individual from accessing resources and support. As advocates, it is important to know and provide accurate information to the victim/survivor so that misconceptions do not hinder his journey of self-awareness.
MYTH: Most same-sex sexual abuse of boys is perpetrated by homosexual men.

FACT: While it is true that some gay men molest young boys, it is more often true that boys are abused by men who identify themselves as heterosexual in their consensual sexual activities. These are often men who have abused several individuals over a long period of time. They may not discriminate the gender of the victim/survivor, but will choose whoever is most vulnerable or available. Sexual violence is about power and control. The rape of males does not provide precise proof regarding the sexual orientations of either the victim/survivor or the perpetrator. Likewise, if a male were to have emotional feelings toward the perpetrator (incestual/familial) or experience a physiological reaction (ejaculation) to being abused, there is no supporting evidence that sexual abuse contributes to sexual identity (heterosexual, bisexual, homosexual). It is common for victims/survivors to experience conflicting or confusing behaviors in regard to their sexual functioning.

MYTH: Most child molesters were victims/survivors themselves of sexual violence, or the converse, most victims/survivors turn out to be abusers.

FACT: About 35 percent of perpetrators report being victimized as children. This percentage is approximately 20 percent higher than what non-offending victims/survivors have recently reported. At this time there is no known research as to how many male victims/survivors become perpetrators, but we are learning that many more men have been sexually abused than previously surmised and these men are not identified as sexual predators.

MYTH: In cases of sexual abuse, boys are often willing participants.

FACT: When a male responds physically or emotionally to sexual abuse, he may find himself debilitated by the idea that he was a willing participant. If abused by a male, men often experience sexual identity concerns or if abused by a female, the abuse may not be seen as harmful by many in our society; in fact, it might easily be considered part of his normal sexual experience. Yet, if the roles are reversed, i.e., the seduction of a teenage girl by an older man, it would more clearly be defined as sexual abuse. “Rogers & Terry (1984) report that boys who are bribed or who prostitute themselves are rarely identified as victims/survivors, but are often perceived as hustlers even though they may have experienced earlier sexual violence. Lanning & Burgess (1984) report that the primary victims/survivors of adult sex rings and pornography are boys” (Sheeley, 2003).

MYTH: Boys are less traumatized by the abuse experience than girls and/or as men they should have been able to protect themselves from sexual abuse.

FACT: Victims/survivors of sexual abuse often are familiar with the perpetrator. Utilizing a process defined as “grooming,” the offender will break down the victim/survivor’s defenses in a variety of ways. Drugs and alcohol are used to incapacitate victims/survivors. Physical strength is not always sufficient.
protection. Issues of trust and coercion arise in an acquaintance situation more commonly than physical force. Societal stigmas or myths have also hindered men from understanding how they may have been affected by sexual violence or how sexual abuse can create adverse coping behaviors/barriers. Men will often cite various dysfunctional behaviors as the reason for problems rather than identify themselves as a victim/survivor of sexual violence.

MYTH: Male rape only happens in prison and is due to the lack of sexually available women.

FACT: The rape of men in prison, attacked by gangs, assaulted with weapons, and/or taken by surprise, are classic examples of using rape as a means of power and control. Male rape happens much more in society at large than in prison. Yet, these victims/survivors rarely tell anyone. Many rape crisis centers report that as many as 10 percent of their callers are male victims/survivors. Understanding how homophobia is connected to the stigmas and misconceptions of sexual violence will help the male victim/survivor to share his story/experience of being abused.

MYTH: Women don’t rape men.

FACT: Women can and do commit rape of men, although it is much less common than rape by men. Most research supports that males often commit a large majority of violent crimes (approximately 90 percent), but sexual violence is also associated with exploitation, harassment, and coercion of victims/survivors by perpetrators (grooming). Sexual assault of a man by one or more women is just as serious as any other type of violation.

Guidelines for Crisis Counselors

• When first encountering a male who acknowledges having been a crime victim/survivor or one who calls for information, it is important to respond openly and honestly. He may be hesitant to identify himself as a sexual assault victim/survivor. Be attentive and ask how you can assist him. As a victim/survivor it will be extremely important that he feels believed. Remember that males are often reluctant to disclose and may have several current concerns that will appear more important than the sexual abuse. Providing empathy and resources will help to establish a safe environment for each individual to share their story.

Because male victims/survivors are often reluctant to come forward, it is important that they are believed. Provide empathy.
• Offer empowerment to the victim/survivor. Remind him that empowerment is a vital part of the process. It is often therapeutic for him as he begins to gain a sense of control when making decisions as to what he can or wants to do next. Use the victim/survivor’s words and concepts initially. Using words like "rape," "sodomy," "sexual assault," etc., prematurely may make him uncomfortable and hamper your communication, but at some point will help the victim/survivor and advocate to gain credibility and/or trust.

• Help to create a safe space and/or establish a safety plan if necessary. Ask if there is a support network and/or offer additional resources such as web sites, reading material, professional counseling (individual/group or different treatment modalities), and/or medical or law enforcement resources if this person is not feeling safe. The utilization of listening skills and empowerment will help provide the victim/survivor with the necessary support to feel that his story is being heard. This is essential in creating a pathway of healing and recovery.

• It is important to understand how or why sexually abused males are affected by cultural norms or societal stereotypes. Providing “the stories of other men” or other educational material will allow the victim/survivor to feel safer when experiencing or being placed in a vulnerable setting. Helping men to understand that they are not the cause for the abuse and that they still have control of their life will increase your effectiveness. Providing information that challenges or corrects misconceptions of sexual abuse will help in breaking the secrecy that is a key component of sexual violence.

• Do not try to convince a male victim/survivor that the incident is more or less serious than he presents it. Following his lead is one way to assist him in regaining a sense of control. Men are often in crisis when reporting their abuse. It is beneficial for the advocate to work together with the victim/survivor to help stabilize the current situation. Men will also need to know that there are several ways to heal from sexual abuse but they may not be able “fix it” immediately. Allow the victim/survivor to share their feelings when they feel safe and/or ready.

• It is important to understand why rape exists in our culture. The mythology about sexual assault is extensive and no less so when it involves the rape of men. Presenting the facts can alleviate some of a male victim/survivor’s anxiety.

• Be aware that recovery systems for male sexual assault victims/survivors are often difficult to locate and/or utilize. Male sexual abuse victims/survivors have reported that the emotional intimacy of a therapeutic relationship has
similarities to what they had experienced while being “groomed” during the abuse experience. Providers need to develop certain sensitivities to the therapeutic relationship when providing services for the male victims/survivors, especially in the areas of trust and vulnerability. It is important to remember that male victims/survivors may present concerns that appear separate from their own sexual abuse. Developing awareness of these concerns and/or sensitivity to the relationship between abuse and those concerns will be vital in providing services to the male victim/survivor.

- Remember to take care of yourself during and after working with sexual abuse victims/survivors. Victim/survivor stories can often trigger and/or traumatize those working with this population. Prepare yourself with educational material, training programs, support contacts and awareness of your own history (personal story). Remember, honesty and respect to the victim/survivor is vital to forming a safe environment for these men to “share their stories.” Assuring confidentiality, identifying that anger is a reaction that hides underlying feelings, and explaining that tears can be helpful in releasing emotions are all ways for men to share their thoughts. Releasing these emotions may feel terrifying to both the advocate and the victim/survivor. The client will often feel calmer and more in control of himself if these expressions of emotion are met with support and understanding. Help men to celebrate when they can share these thoughts and feelings.

One of the most successful ways this writer has found for allowing men to share their stories of abuse was to empower them to break the secrecy involved with their own childhood male sexual abuse. It will be vital for anyone involved therapeutically or advocating for male victims/survivors to develop certain competencies that would encompass the knowledge and/or skill necessary to work with both common and special concerns of males affected by childhood sexual abuse. Examples include areas such as how victims/survivors view male masculinity; how victims/survivors are able to identify with personal concerns and not be influenced by societal misconceptions; how compulsive behaviors and/or addictions can misplace the focus from being abused to create negative coping behaviors; how important it is for victims/survivors to feel heard by both therapists and society (having their stories believed); how to utilize methods to increase understanding/coping with the feelings associated with shame, betrayal, grief/loss; and how to create a space for other victims/survivors to share their stories of being sexually abused. The next step would be to empower each man to identify his own needs, including several different methods of therapy or recovery. Finally, the most important task is to create a pathway for each victim/survivor to meet and/or communicate with other victims/survivors. While this material may not
establish a specific model for working with the male victim/survivor, it should help to open additional venues for male victims/survivors to share their stories and receive the compassion and dignity they deserve while breaking the secrecy of sexual abuse and ending its vicious cycle.

References


Additional Resources


Bringing it Home:

• Does your agency have a program to offer support services to male victims/survivors?
• What myths about sexual violence committed against men does your agency perpetuate? How can you work to change these misconceptions?
April). The Relationship Between Sexual and Physical Abuse and Substance Abuse Consequences. Journal of Substance Abuse Treatment, 22 (3),

Web Sites


Special thanks to Mic Hunter and Peter Dimock for their dedication to the Male Survivor Organization and the first Male Survivor Conference in 1988
Sexual Violence and Persons Who Are Deaf or Hard of Hearing

Compiled by Kathy Schumacher
Edited by May Hung Lee
Edited by Paula Detjen and Melanie Matson

Key Learning Points:

- People who are Deaf or Hard of Hearing who have been victimized by sexual violence will have the same basic needs and fears that a hearing person has.
- There are resources available that will allow you to connect with the Deaf and Hard of Hearing community throughout Minnesota, including the Minnesota Relay Service and interpreting services.
- Some Deaf or Hard of Hearing people may be reluctant to seek help after experiencing sexual violence because they do not want to struggle with communication barriers and be re-victimized by the system.
- Many service providers overlook the needs of the Deaf and Hard of Hearing community because they are considered a small incidence population.

There are about 275,000 people who are Deaf or Hard of Hearing in Minnesota. The majority of these people live in the seven county metro area. This population is underserved due to the communication barriers and the relative invisibility of this disability. Deaf-ness itself is not the handicap, rather, people who are Deaf or Hard of Hearing are handicapped by lack of access to services which do not or cannot provide sign language interpreters. Not all agencies have a TTY/TDD (teletypewriter/telecommunications device). We do have the Minnesota Relay Service, which enables people who hear and people who are Deaf or Hard of Hearing to communicate through a third party. Unfortunately, many people who are Deaf or Hard of Hearing assume services without a TTY will not be accessible in any other way either. The few people who are Deaf or Hard of Hearing who have experienced sexual and domestic violence may be reluctant to approach victim services because they know they might have to struggle with communication barriers. It is hard enough to be a victim/survivor; no one wants to be re-victimized by the system.

Most hearing sexual violence victims/survivors have a number of services to choose from; they can go to some place near their homes or, if desired, as far away as possible. These services are not always available to people who are Deaf or Hard of Hearing because staff are not always knowledgeable about deafness or are not fluent in American Sign Language (ASL). Many agencies and service providers overlook the needs of people who are Deaf or Hard of Hearing because they are considered a small incidence population.

The definition of Deaf is a hearing loss of such severity that the individual must depend primarily upon visual communication such as writing, lip reading, manual communication,
and gestures. The definition of Hard of Hearing includes individuals who are both Deaf and Hard of Hearing. It is an all-inclusive term involving any degree of hearing loss, from mild to profound resulting in a functional loss, but not to the extent that the individual must depend primarily upon visual communication. From this point on, the term Hard of Hearing will be used.

Immediate Response to the Person Who is Hard of Hearing

- Do not panic.
- If a person who is Hard of Hearing seeks services, the person will have the same basic needs and fears that a hearing person has. The person needs to feel welcome. Motion the person to follow you to a quiet office. Tell the person your name. Write it down on paper if the person does not seem to understand. Ask whether the person wants an interpreter – there are sign language interpreters as well as oral interpreters. Also let the person know (on paper if necessary) that you will be calling for an interpreter if they would like one.
- It is important to have the person's attention before speaking. Since the person cannot hear the usual call for attention, use a wave of the hand or other visual signals to gain attention. Be aware that some people are sensitive to touch or may not want to be touched, so try to gain the person’s attention without touch. Do not speak before the person is ready to listen.
- If the person is wearing a hearing aid, do not assume that person will or should have good hearing, as the person may still have some difficulty hearing and will benefit from your consideration.
- Whether the person can read lips or not, body language and gestures will help communication. Write down any words that you or the Hard of Hearing person seems to be having trouble communicating. Be sensitive to the fact that the person will be closely observing your body language and will pick up on visual signs of frustration. Try to relax and to help the person relax.
- Look directly at the person while speaking. Even a slight turn of the head can obscure the person's vision. Do not talk if your back is turned or when you are in the dark or in another room. Do not turn away in the middle of a sentence. Other distracting factors affecting communication include mustaches which obscure the lips, smoking, pencil-chewing, and putting your hands in front of your face.
- Do not speak to a person who is Hard of Hearing with your back to a light, window or mirror. Have the light in YOUR face, not theirs.
- Every person who is Hard of Hearing will communicate in a different way. Some will use speech only; some will use American Sign Language only; some will use a combination of sign language, finger spelling, and speech; some will use body language and facial expressions to supplement their interactions. People who are Hard of Hearing use many ways to convey an idea to another person. Sign language is an inclusive term that refers to any method of communication: American Sign Language, signing exact English, finger spelling, and any combination of these.
- Just as hearing people have their own style of speaking, grammar usage, vocabulary, and favorite idioms and clichés, people who are Hard of Hearing also have their own individualized manner of speaking in sign language. People who use exact English are probably more able to converse through written means. Often, hiring a sign language interpreter will be your only effective communication method with someone whose primary language is ASL. Understand that ASL is not the same as English. The interpreter is trained to
recognize and utilize similar signs as the person who is Hard of Hearing.

- Examples of American Sign Language, as written, may be:
  - “Movie last night. Wow good. Should see you. Laugh roll.” ("The movie I saw last night was very good. You should see it. I laughed so hard I was almost falling on the floor.")
  - “Home many problem. Not good my house. Want out finish trouble.” ("There are a lot of problems at home. My house is not a pleasant place now. If my husband/boyfriend/partner leaves, the trouble may stop.")

- To someone familiar with sign language, this manner of expression is quite clear. Interpreting word for word is not always understandable.

- Try to maintain eye contact with the deaf person. Eye contact helps convey the feeling of direct communication. If an interpreter is present, continue to talk directly to the Hard of Hearing person. Do not use phrases such as "Tell the person that..." Instead, speak to the person directly.

- Be flexible in the use of language. English may not be the person's primary language and, therefore, you may need to simplify your sentences. Deafness or being Hard of Hearing may not be the only factor affecting communication, some people may have an additional disability, making language more difficult.
  - Pantomime, body language, and facial expressions are important factors in communication. Experiment with different techniques. Be sure you use all of them.
  - Do not shout or use exaggerated lip or facial movements. Use an almost normal rate of speaking - not too fast, but not so slowly that the natural rhythm is lost. The thought should come as a whole. Take care to "round off" words. Enunciate clearly and distinctly, keeping the voice as vibrant as possible.
  - Do not assume the person can read lips.
  - Use words with the most lip movement, such as "25 cents" instead of "a quarter".
  - If the person does not understand, change the wording. Use other expressions which get the same point across. Do not repeat the same phrase over and over.
  - People with some hearing loss find it hard to hear in the presence of background noise, so be sure to move away from such noise, or turn down the radio or TV when trying to converse.
  - Ask the person to let you know what to do to better communicate - as hearing ability will vary with rooms, background noise, fatigue, and many other factors.

**Working with an Interpreter**

- An interpreter bridges verbal communication, as opposed to a translator who converts written communication.

- The interpreter should be seen as a tool that the professional is using to be victim-centered and meet the victim/survivor where they are.

- One of the best ways to find an ASL interpreter is to go to the Minnesota Department of Human Services website (www.interpreterreferral.org) for a listing of interpreters.

- The interpreter should sit next to and slightly behind you. This improves your ability to establish and maintain rapport with the person you are working with.
• Be sure to talk directly to the person who is Hard of Hearing, not the interpreter, as if speaking to a hearing person, and maintain eye contact at all times.

• Remember that the interpreter will interpret every noise or communication in the room. If you do not want the person who is Hard of Hearing to “hear” something, such as side comments or phone conversations, do not say it in the presence of the person or the interpreter.

• Be sure not to discuss the person’s case with the interpreter, the interpreter is there only to bridge the communication and should be spoken to only in order to clarify communication issues.

• Ask the interpreter to leave just before the person who is Hard of Hearing. Since the community, and the number of professionals serving the community, is small, there is the likelihood that they know each other. It may reduce any anxiety the person who is Hard of Hearing may feel that you and the interpreter are discussing the situation without the person present. Also, it will relieve the interpreter from a situation in which the person may ask the interpreter for some form of feedback or other inappropriate advice.

Support Groups

• Seat Deaf and Hard of Hearing people to their advantage. Usually this will be across from the speaker, so that the person can see the speaker's lips. Recognize that lighting is an important factor; make sure the speaker is illuminated clearly.

• Circular seating arrangement should be considered whenever possible. This arrangement gives the person who is Hard of Hearing the best advantage for seeing all participants. When sitting in rows it is impossible to sit close to the speaker, and still hear and see the questions coming from the rows behind. Small tables are better than large.

• Provide a new vocabulary in advance. It is difficult, if not impossible, to lip-read unfamiliar vocabulary. If it is not possible to present new vocabulary in advance, write the terms on a piece of paper, chalkboard, or on an overhead projector. A brief outline or script of a film or lecture will help the person who is Hard of Hearing follow the presentation.

• Avoid unnecessary walking or talking with your back turned. It is difficult, if not impossible, to lip-read a person in motion and impossible to lip-read a person whose back is turned. Write or draw on the board, then face the group and explain the information. Turn, touch, and talk is a good rule to follow. If you use an overhead projector, do not look down at it while speaking.

• Use visual aids whenever possible. Vision is the primary means for receiving information for people who are Hard of Hearing. Films, overhead projectors, diagrams, chalkboards, etc. are all useful tools for visual demonstration of concepts. Whenever available, order films and slides which are subtitled or captioned.

• Make sure the person who is Hard of Hearing does not miss vital information. If there are last minute changes in meeting times, assignments, additional instructions, please write them down and give this to the person immediately. Do not assume the person will guess. If you are showing written materials, allow time to look it over and ask you any questions before you speak. The person will then be able to follow the gist of the conversation.
• Slow the pace of communication slightly. This will facilitate communication because speakers often talk fast. For the lip-reader, this means words look as if they are running together. It makes the message that much more difficult to decipher. Allow extra time for the person who is Hard of Hearing to ask or answer questions.

• Repeat questions or statements made from the back of the room. Remember people who are Hard of Hearing are cut off from whatever happens outside their visual area. When there is a speaker or discussion, either have all questions repeated from the front of the room, or have people raise their hands when ready to speak. In a circular seating arrangement, make sure the person who is Hard of Hearing knows when the speaker changes in order to focus on the person who is talking for the purpose of lip-reading.

• Allow full participation in the discussion by the person who is Hard of Hearing. People who are Hard of Hearing cannot participate in group discussions when they are not sure when speakers have finished. The group leader can facilitate this participation by recognizing the person who is Hard of Hearing from time to time.

• Use hands-on experience whenever possible in training situations. Like other people, the person who is Hard of Hearing learns quickly by "doing." What may be difficult to communicate verbally may be explained easily by demonstration.

• Use a note-taker. When taking notes, it is not possible to write and watch the lips of the speaker or the interpreter at the same time. While writing, valuable information may be missed. Frequently, another person in the group who is known to take complete notes is willing to make copies and share the notes with the person who is Hard of Hearing.

• Use an interpreter in a large group setting. If the person who is Hard of Hearing uses sign language as the primary method of communication, a sign language interpreter makes communication much easier.

• Do not ignore Deaf and Hard of Hearing people in conversation. Talk directly to the person. The others, who can hear, do not need to be talked to directly. Assist the person who is Hard of Hearing, as needed, in following a conversation by explaining the general topic. Give short explanations of your phrase or topic if necessary, such as "Male Victims of Sexual Violence." If the person does not use sign language, ask whether the person would like an oral interpreter.

Tips for Better Communication

• The person who is Hard of Hearing knows what form of communication is most comfortable for them. If it is more comfortable for the person to speak and lip-read what you say, respect those wishes, unless you cannot become accustomed to the person's speech; you have the right to communication you understand, too.

• If you use note-taking to communicate, you can start writing as you normally would. If this does not work well, however, follow the tips below:
  − Keep it simple and short. Short sentences or phrases are fine. For example, do not write "How long did you work there?" Instead, write "Work there - how long?"
  − It can be helpful to separate the question words from the rest of the message. Question words include: who, what, when, where, why, how, how much, and how many. (ex. "When did you last take a shower?" Do write "Shower- when?")
  − Avoid putting two questions or ideas in one sentence. Only ask the second question (or say the second idea) after the first one has been answered or acknowledged.
Questions can sometimes be difficult for some people who are Hard of Hearing to answer. If you ask a "where" question, you might get a "when" answer. Also, questions that require a simple yes or no answer might elicit a long, detailed answer. To handle this if it occurs, you can give the person some answers to choose from. For example, do not write "Are you feeling ill?" Instead write "Sick? Yes-no."

- Facial expressions can be used even with notes. If you are handing the person a note with a question on it, have a questioning expression on your face (raise your eyebrows). This will give the added clue that you expect an answer.

- Do not be afraid to repeat what the person has said (maybe in other words or with something visual) to make sure you understood their meaning. Repetition is a part of everyday life to people who are Hard of Hearing, and it's necessary to make sure you have understood one another.

- Be careful not to be condescending to people who are Hard of Hearing if you have to adjust your writing for them. This attitude is sensed very easily. If you want to see whether your message is clear, avoid saying "Understand?" which has a condescending connotation to it. Instead, realize that you are responsible for delivering a clear message and a misunderstanding could be your fault for not being clear. Instead of saying "Understand?" you could ask something like "Am I clear?" which will indicate to the person that you are also taking responsibility in making the communication understandable.

TTY/TDD (Telephone Communication for People Who are Deaf or Hard of Hearing)

- New technology such as Videophones, Video Relay Services (VRS), cell pagers, and email allow for improved communication. Of course, be aware of the potential lack of confidentiality offered by different forms of technology.

- A TTY is a device used by people who are Hard of Hearing to communicate through a telephone. With such a device, the Hard of Hearing person can contact any person with a similar device. TTY is an acronym for "Teletypewriter." The term TTY genetically refers to large teletype machines formerly used by telecommunication companies. These machines were available at a reasonable cost when purchased used from these companies. A special coupler is necessary when they are used by Deaf and Hard of Hearing people. Costs for these machines range from approximately $150 to $400, including the coupler. Besides being quite large and heavy, these machines are also quite noisy. The message comes through on a printed copy.

- TDD is an acronym for "Telecommunications Device for the Deaf." These are small portable units which may have LED readouts, printed copy, or both. These machines cost from $150 to $1,000 and up. The chief advantages are that these machines are extremely portable and not as noisy as the TTY machines.

- Both TTY and TDD machines can be used with most existing phone systems. The machines are quite easy to operate, requiring the same type of skills as using a typewriter. It is recommended that you get one with a printer so you can save the paper for reference, or to get an address and phone number. It is usually recommended that you lease one from Qwest to save on repairs, which can be costly. For agencies, the monthly lease is about $12.00 a month in addition to a separate phone line. If the TTY breaks, you can call U.S. West and they will send UPS to pick it up, and bring a new replacement at no additional cost to you. If you choose to buy a TTY, remember to maintain it as any other piece of office equipment. Repairs or checkups may be needed every 2 or 3 years and can run...
as high as $200 each time.

- It is important that you become familiar with using a TTY/TDD and that your typing is reasonably steady. It takes a lot for most people who are Hard of Hearing to call for assistance. Then, they have little patience with those people who seem to take too much time trying to figure out how to use the TTY and how to type.

- Because many places do not have a TTY, the Minnesota Relay Service was established around 1989. This service is a real boon to bridging communication between people who are Hard of Hearing and those who are not. The Relay Service is located in downtown St. Paul and hires many operators who work in shifts. This Service is operated 24 hours a day, seven days a week. If you look on your phone bill, you will notice a charge of 10 cents a month that goes into the fund that runs this service. The Relay Service works this way: a hearing person without a TTY can call the Relay, give their name and phone number as well as the name and number of the person who is Hard of Hearing that you want to call. The operator has a headset and a TTY. The operator will then call the number on the TTY. When the person answers, the operator will begin relaying the TTY messages to spoken communication and then type what was said onto the TTY. People who are Hard of Hearing as well as hearing people are grateful for this service. Before this service was established, people who are Deaf or Hard of Hearing had to ask neighbors, family members, children, or friends to help them with calls. There was no privacy this way. Likewise, people who are hearing can call people who are Hard of Hearing directly. The number for the Relay in the Metro area is 651.297.5353, for Greater Minnesota the number is 1.800.627.3529.

Accessibility

In our society, the telephone provides easy access to information about services and benefits available to us. For people who are Hard of Hearing, a TTY/TDD provides equal access to the same types of information. Many programs are required under Federal and State laws to be accessible to persons with disabilities; the installation of a TTY/TDD is a key component in creating program access for people who are Hard of Hearing people. For more information about acquiring TTY/TDD equipment, please contact the Regional Service Center for Hearing Impaired People: 612.341.7100 V/TDD.

Receiving a TTY Call

- Always identify yourself immediately. Since the caller does not hear your voice, it is important to type your name and place of work, if any. Abbreviate, if possible, just so the caller knows she dialed the correct number. For example: HELLO BARB HERE AT LMS GA.

- It is desirable to avoid typing "May I help you?" Though a common idiom heard on voice phone, it feels different when seen in writing. The person who is Hard of Hearing takes pride in making the call without asking for help, and may feel put down if offered help when you have no idea who is calling or what it is about.
Placing a TTY Call

- Turn on the TTY, and check the monitor light to be sure that you have a dial tone - a short steady light on the monitor. When placing the receiver in the coupler (in most models), the cord should be toward you or to the left. The monitor light tells you whether the phone number you dialed is ringing: a long, slow flash or two slow flashes with a pause in between. A busy signal will make a short, continuous flash.
- Let the phone ring (which makes the light flash) longer than you would for a non-TTY call.
- When the phone is answered, you will see an irregular light signal as it is being picked up and placed in the coupler. There are many wrong numbers, as unaware callers without a TTY try to call on non-TTY voice phones.
- Always be ready to respond when the person answers; they may think no one is there and hang up.

Punctuation

- Omit all punctuation, even the periods, because some keys and functions on TTY models do not match other models. For example: when you type a period, the old reconditioned TTYs are thrown into upper case where they sometimes stay stuck.
- If the machine is not shifted back down, the other person will be reading a lot of numbers. When this happens, sometimes you can press on the FIGS key at the right of the TTY. This will sometimes help to unlock the shift and put it back down again. You have to ask the person to repeat. Then you can say “SORRY BUT I GOT YOUR MESSAGE IN NUMBERS PLEASE REPEAT AFTER YOU SAID SEE YOU AT THEN WHAT QQ GA.”
- If you misspell and it is still readable, do not correct it unless it is an address or it is important that the name is right. For example, this is suitable: “HI BONNIE THIS IS KTHY AT MNCASA,” or you might make an error and instead of going back to correct it you might type: “THE ADDRESS YOU WANTED IS 23FYXXXXXX 23456 LAKEVIEW DRIVE.”
- It is fine to type out numbers if you are not comfortable with shifting: “THE ADDRESS IS TWO THREE FOUR FIVE SIX LAKEVIEW DRIVE.”
- If you are a slow typist, be aware that there may be some feeling of impatience on the part of the person who is Hard of Hearing. This should by no means stop you from using the TTY/TDD to talk to the person, however. Practice will help increase your typing speed. If you do not type or are uneasy with typing on a TTY, try to practice when you are alone; you can turn on the machine without using the phone, if you wish. In an emergency situation or a time of crisis, however, it may be a better alternative to have someone else who is faster do the typing for you as you dictate. (If you are not alone, mention this to the caller.)

Ending the TTY Call

- Sign off with brief warm words. If the other person types with warm words
first, do take a moment to type “SAME TO YOU” before “SKSK.” When you see “THANK YOU” on your paper or screen, please take a moment to type “YOU ARE WELCOME.” An abrupt “SKSK” feels cold and rude. Compare the difference in the following sample endings:

- “OK I’LL SEE YOU FRIDAY NIGHT FOR GROUP TAKE CARE GA OR SK”
- “SKSK” OR
- “OK I’LL SEE YOU FRIDAY NIGHT TAKE CARE GA OR SK”
- “OK THANKS FOR CALLING BYE NOW SK”
- “OK SKSK”

- After you “SKSK,” be sure to hang up the receiver.

Code Words

The following code words are used to abbreviate frequently repeated words and phrases.

<table>
<thead>
<tr>
<th>Code</th>
<th>Word/Phrase</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>Go Ahead (Signal to start typing: do not interrupt until GA appears)</td>
</tr>
<tr>
<td>Q</td>
<td>Question</td>
</tr>
<tr>
<td>HD</td>
<td>Hold</td>
</tr>
<tr>
<td>PLS</td>
<td>Please</td>
</tr>
<tr>
<td>U</td>
<td>You</td>
</tr>
<tr>
<td>SMILE</td>
<td>Conveys humor</td>
</tr>
<tr>
<td>HAHA</td>
<td>Laughter</td>
</tr>
<tr>
<td>GA TO SK</td>
<td>Go ahead if you have more to say, I’ve finished</td>
</tr>
<tr>
<td>TTY</td>
<td>Teletypewriter</td>
</tr>
<tr>
<td>TDD</td>
<td>Telephone Device for the Deaf (includes all models, a TTY is a TDD)</td>
</tr>
<tr>
<td>SKSK</td>
<td>Stop</td>
</tr>
</tbody>
</table>

Resources

*Communication Services for the Deaf (CSD)*

Voice phone: 651-297-6700
TTY: 651-297-6700
Fax: 651-297-6766
Email: www.c-s-d.org
Minnesota Relay Service 1-800-627-3529

*Deaf and Hard of Hearing Services (8 regional offices)*
A state organization that provides information and referral, interpreter education and advocacy, message relay, and equipment and book lending library. There are currently eight centers in the state:

**DHHS Northern Region**

**DHHS Northeast**

Government Services Center  
320 W. 2nd St, Suite 710, Duluth, MN 55802  
Voice: 218-723-4962 / 1-888-234-1322  
TTY: 1-866-488-3833  
Fax: 218-723-4969  
Email: dhhs.duluth@state.mn.us

**DHHS Northeast**

Olcott Plaza, 820 N. 9th St, Suite 250, Virginia, MN 55792  
Voice: 218-748-2253  
TTY: 1-866-488-3997  
Fax: 218-748-2288  
Email: dhhs.virginia@state.mn.us

**DHHS Upper Northwest**

616 America Ave. NW, Suite 320, Bemidji, MN 56601  
Voice: 218-333-8283 / 888-663-8329  
TTY: 1-866-488-3940  
Fax: 218-333-8279  
Email: dhhs.bemidji@state.mn.us

**DHHS Northwest**

Family Service Center of Clay County  
715 11th St N, Suite 204, Moorhead, MN 56560  
Voice: 218-291-5880 / 800-456-7589  
TTY: 1-866-488-3829  
Fax: 218-739-7309  
Email: dhhs.moorhead@state.mn.us

**DHHS Central Region**

**DHHS E/W Central**

3333 W Division St, Suite 209, St. Cloud, MN 56301-4322  
Voice: 320-255-3502 / 800-456-3690  
TTY: 866-488-3909  
Fax: 320-654-5157  
Email: dhhs.stcloud@state.mn.us

**DHHS Metro Region**

**DHHS Metro**

Site: 130 E. Seventh St, Downtown St. Paul  
Mail: Department of Human Services, 444 Lafayette Road  
St. Paul, MN 55155-3814  
Voice: 651-297-1316  
TTY: 888-206-6513  
Fax: 651-215-6388  
Email: dhhs.metro@state.mn.us

**DHHS Southern Region**

**DHHS Southwest**
Sexual Violence and Underserved Populations

12 Civic Center Plaza, Suite 1670, Mankato, MN 56001
Voice: 507-389-1626
TTY: 866-266-2461
Fax: 507-389-1703
Email: dhhs.mankato@state.mn.us

DHHS Southeast
Cedarwood Plaza, 4104 NW 18th Ave, Rochester, MN 55901
Voice: 507-285-7295 / 800-311-1148
TTY: 866-266-3779
Fax: 507-280-5531
Email: dhhs.rochester@state.mn.us

Regions Hospital Health and Wellness
Health and Wellness Program Serving Deaf and Hard of Hearing
Hours: 8am – 5pm, Monday - Friday
Voice: 651-254-4786 / 888-322-2354
TTY: 651-254-4786 / 651-254-1888 (TTY answering machine)
www.healthpartners.com
Statewide Medical and Legal Emergency Advocacy and Training Project
Sexual assault of children, adolescents, and adults with disabilities is a pervasive problem and does not involve only occasional, isolated cases.

- An estimated 90 percent of women and men with developmental disabilities are sexually victimized in their lifetime, and only 3 percent of the assaults are reported. (National Center for Victims of Crime, 2006)
- Women with disabilities are assaulted, raped, and abused at a rate two times greater than women without disabilities. They also report greater numbers of perpetrators and longer time periods of individual episodes than women without disabilities. (Young, et.al., 1997)

Perhaps a basis for understanding the impact of sexual assault on people with disabilities and for understanding the issues which contribute to their vulnerability can first be addressed by exploring the misconceptions in regards to the sexuality of people with disabilities. Common misconceptions include:

- They are not interested in sex;
- They lack the ability to understand sex;
- They are like children, regardless of age;
• They lack the responsibility to control their desires; and
• They will have a hard enough time in "our world" without sex adding more challenges.

Some of the misconceptions that perpetuate the notion that people with disabilities are never sexually assaulted include:
• People feel too sorry for them;
• They are not sexually attractive;
• Even if they are assaulted, they won't understand and thus won't be hurt by a sexual assault; and
• People who work with people with disabilities do so for purely altruistic motives.

These are dangerously simplistic beliefs that only undermine our ability to teach healthy sexuality and to understand the scope of the problem of sexual assault.

These myths allow sexual assault to continue against people with disabilities. Sexual assault is an act of power, control, and domination which uses a sexual act as a way to hurt someone. Historically, individuals with disabilities have been labeled with many derogatory names. These oppressive—yet at one point, accepted—labels perpetuated the stereotypes of a person with a disability as being easily manipulated and as incapable of understanding "our world." Therefore, along with the misconceptions discussed above, offenders may sexually assault a person with a disability because they believe:

• They can get away with it;
• People with disabilities won't be able to understand what is happening; and/or
• No one would believe the offender would do such a thing.

Another historical implication, The Eugenics Movement which began during the early 1900's, may also have provided a social construct of oppression with current implications. The Eugenics Movement focused on the adoption of genetic "policies"; it arose while industrialization was changing the nature of society. As jobs grew more specialized and hierarchical, individuals with disabilities began to stand out. Their apparent differences provided an obvious group of individuals to use as a scapegoat for the new social ills. Criminality and sexual deviancy were attributed to people with disabilities. There was wide-spread fear and panic that these individuals were going to "infect" our society and "breed" other "degenerates." The hysteria continued until two "solutions" were determined: non-consensual institutionalization (segregation) and sterilization. Beyond the obvious ethical wrong-doings of this, a pattern was established based upon false assumptions that enabled certain basic rights to be absolved. We destroyed opportunities for individuals with disabilities to have positive interactions with others in "normal" environments and did not allow personal choice regarding their sexual selves.

It is also crucial to examine some of the more concrete and current issues that contribute to the silence surrounding sexual assault and people with disabilities. Many of these issues are intertwined, yet are not necessarily the same for each individual. Many of these issues are not exclusive to persons with disabilities and contain similar challenges for other victims/survivors. Acknowledging these facets of abuse provides a framework for further understanding of this curriculum.

Ninety-nine percent of perpetrators are known to a victim/survivor with a disability. This
can be highly confusing to a person with a disability. The perpetrator may play an integral part in the person's daily life. The person with a disability may also be highly dependent upon the perpetrator for personal care. Thus, a fine line of appropriate and inappropriate behavior exists when toileting, bathing, and dressing a person with a disability or when teaching these skills. During these situations a care provider is usually left alone with the person for the sake of privacy. Yet, this may provide a perfect opportunity for abuse to take place. At the same time, special education curricula addressing self-protection skills have traditionally been based on teaching students personal safety when approached by a stranger. This is ironic, however, in light of the fact that we now know the overwhelming majority of offenders are not strangers to persons with disabilities.

In addition, this fine line of appropriate versus inappropriate behavior may be difficult for a person with a disability to distinguish as traditionally they have not been taught about sexuality in general. Perhaps at bedtime a family member kisses a child with a disability, yet the child does not know that it is exploitative for the bus driver to kiss her/him upon saying good-bye. Or, perhaps at bedtime, a family member kisses a child with a disability, but the child does not realize that another family member who kisses her/him during the same scenario and also touches her/his genitals is being sexually abusive.

Fear, punishment, compliance, and worries over credibility are also prevalent feelings and behaviors that exist in people with disabilities in response to sexual assault. Due to coercion, threats, or past treatment, a person with a disability may fear specific forms of punishment which may be perceived as being worse than the abuse itself. For example, an individual who was once institutionalized and has since moved to a group home may fear re-institutionalization if s/he discloses that a group home staff member is committing sexual abuse. Perpetrators may limit assistance, accessibility, or contact with others for individuals with physical disabilities in order to gain compliance, such as removing physical aides (walker, cane, wheelchair, eyeglasses, etc). In addition, a perpetrator may threaten that no one will believe the person or help them if they report the perpetrator.

A person with a disability may also construe sexual abuse as a form of punishment for certain behavior. Educating individuals with disabilities has primarily and consistently focused upon positively reinforcing someone for an appropriate behavior and punishing them for an inappropriate behavior. Therefore, it is not unrealistic for a person with a disability to perceive sexual assault as another form of punishment that must be endured.

Along with this construct of reinforcement and punishment, individuals with disabilities are taught to comply with authority figures. For example, often their daily schedules are created by service providers, and they are taught not to question these decisions. Or, a particular job is selected for them, perhaps due to availability and resources, yet they may not be given a choice in the selection process. Therefore, if a care provider decides that every night before a resident goes to sleep, s/he must perform oral sex, the person with a disability may not even realize that s/he can protest. The issue of credibility may also be apparent in that even if a survivor with a disability wants to disclose this information, s/he may have an overwhelming feeling that s/he will not be believed when compared to the credibility of a service provider.

Verbal communication skills are another point to consider. There may be many language, speech, or vocabulary barriers that inhibit or do not allow a survivor with a disability to protest to or disclose a sexual assault. Victims/survivors with a disability may tell seemingly confusing stories due to a variety of limited communication skills. If the
individual uses an augmentative communication system, such as a picture board or a light-talker, the system may not even include the appropriate pictures or phrases to disclose a sexual assault. Individuals with disabilities may not have been taught the specific vocabulary, regarding body parts or sexual acts that would enable them to disclose the abuse. Along with this, people with disabilities may not have knowledge of the resources available to them to disclose a sexual assault. People with disabilities may not realize that one option may be to call the police after a sexual assault. Many community resources are designed for people without disabilities, and have limited training and accessibility for serving people with additional physical or communicative needs.

Another concern that must be addressed is looking for "signs and symptoms" of sexual abuse in persons with disabilities. Any erratic behavior which may traditionally constitute a sign or symptom is all too often attributed to the disability rather than potential abuse. While this may indeed prove to be true, it is also crucial to examine alternative explanations, including sexual abuse. For example, if a student’s attention span has shortened, it usually is attributed to Attention Deficit Disorder-like behavior. Or if a student is engaging in increased self-stimulatory behavior, this may be attributed to autistic-like behaviors. Or if a student has a loss of appetite, this may be attributed to medication. Again, while all of these could be legitimate conclusions, it is nevertheless appropriate to look for other explanations such as sexual abuse or assault.

Therefore, it is important to be aware of options and resources when working with people with disabilities. Discussions should include:
• Identify individuals the person can safely trust;
• Repercussions of which the person is afraid;
• The person’s understanding of what happened to them;
• The person’s safe support network and additional community resources; and
• Additional safety planning.

References

Sexual Violence in the LGBT Community

Key Learning Points:

• Victims/survivors of sexual violence who are lesbian, gay, bisexual or transgender may face specific and overwhelming barriers to reporting a sexual assault, particularly in the medical setting.
• Fear of being “outed” keep many LGBT victims from seeking medical help.
• Victims/Survivors in the ER/ED who are not “out” in the community may be very keen to the language being used around them as a barometer of the hospital/clinic’s openness to LGBT clients.
• LGBT people are often targeted for sexual violence – making the sensitive and appropriate provision of services critical.

When Homophobia and Heterosexism appear in the medical setting:

• When female victims/survivors who happen to be lesbian or bisexual present at the ER or ED, they often are faced with the reality of heterosexism. Because most medical professionals are accustomed to seeing female victims/survivors who have been assaulted by males, and because heterosexism or homophobia is alive and well, medical personnel can get caught into making assumptions about the victim and her support systems as well as who assaulted her. You may hear medical personnel, while trying to be helpful assume the woman has a male partner/husband/boyfriend to whom to turn for support. They may assume any perpetrator is male.

• Lesbian and bisexual women may present with assaults that are perpetrated by either males or females. Of course, if the assailant has been a female, it is imperative to the medical exam that the nurse or doctor knows that. The evidence collection will be quite different. If the assailant was male, the medical provider may miss the fact that the victim is lesbian. Additionally, the medical person may miss entirely that sexual assault was part of a hate crime scenario.

• The role of the advocate is NOT to “out” the victim/survivor to the medical providers, but to help the victim/survivor think about whether or not she wants to speak up about mistaken assumptions. It can become very awkward for the victim to “play along” with the assumption that she is heterosexual if she chooses to not clarify things. Additionally, this type of scenario can be very alienating for the victim/survivor who may choose to steer clear of the system for fear that she may have to come out or come out to those she may not know or trust.

* It is important to keep in mind that any victim/survivor you work with may be lesbian, gay, bisexual, transgender even if that is not immediately apparent to you.

* Your role is not to “out” the victim/survivor but to help that person determine how to proceed if feeling uncomfortable.
Likewise, gay men who access medical care following sexual assault are also likely to meet heterosexism in the medical response. Because our paradigms of relationships and sexuality are overwhelmingly heterosexual in this country, it is tempting for first responders to assume that gay men who are sexually assaulted are either just engaging in rough or “kinky” sex. Same sex sexual assault can be the result of intimate partner violence, an issue in any community, or an assault by a heterosexual assailant that is part of a hate crime. Not all same sex sexual assault is related to the sexual orientation of the victim/survivor. “Homosexual” assault is a term that should not be used with regard to same sex sexual assault.

Transgendered people – those who were born male and present as female and vice versa, regardless of having had sex reassignment surgery, are targeted at very high rates for sexual assault. Their fear of being discriminated against, not an irrational fear, often keeps them from seeking health care and services. Medical personnel may respond inappropriately due to their lack of familiarity and/or training regarding transgendered people.

In all of these cases, it is critical that the advocate ensure that the victim/survivor get the best service from the medical provider(s). The best way to ensure this is to provide training to the medical providers in the community well in advance of a case so that all victims/survivors receive supportive and appropriate care. Otherwise, it is the advocate’s role to help empower the victim/survivor in these circumstances to say and do what is needed to feel safe and served.

Bringing it Home:

- Have there been incidents of sexual assaults that target LGBT people in your community? What do you know about the public’s reaction?
- Putting yourself in the position of an LGBT person, what might you see in your agency office or in the medical setting that would either help or hinder you sense of comfort in seeking services?
- Do you know LGBT community leaders who will talk with your group about the issues in this community?
- Have LGBT victims/survivors spoken out about their concerns?

Advocates can work with medical providers and the LGBT leaders in your area to provide training that will assure better services to this community in the time of crisis.

With the victim’s/survivor’s permission, it may be important for you to speak up in the medical setting and help providers understand how their intervention may be more helpful.
Sexual Offenders
Sex Offenders: An Introduction
By Dresden Jones, MNCASA

Key Learning Points:

- Sex offenders come from varied economic backgrounds; they are gainfully employed and unemployed, they are religious and non-religious, and they are all different races and ethnicities.
- “Sex offender” is a generic term for all persons convicted of crimes involving sex.
- It is important to distinguish between an adult who sexually molests or abuses a child and someone whose primary attraction is to children.
- Sex offenders know their victims 90 percent of the time.
- There are many reasons why someone might commit a sex offense and they differ depending on the individual.
- While sex offenders should absolutely be held responsible and accountable for their actions, they can also benefit from treatment to lessen their chances of reoffending.

There are many preconceived notions the general public have regarding sex offenders. We see images in films and on television of suspicious looking strangers in trench coats, living in run-down trailers, surrounded by child pornography. He is the man lurking in the bushes in a ski mask, waiting for children at the bus stop, and laboriously planning his next attack on an innocent victim. These images are meant to scare us into caution, but they are false. The truth is, sex offenders come from varied economic backgrounds; they are gainfully employed and unemployed, they are religious and non-religious, and they are all different races and ethnicities. And, in most cases, they know their victims.

So what do we really mean when we say “sex offender”? “Sex offender” is a generic term for all persons convicted of crimes involving sex, including statutory sexual assault, rape, molestation, sexual harassment, and certain forms of pornography production or distribution. Sex crimes are forms of human sexual behavior that are crimes. Someone who commits these crimes is said to be a sex offender. The term sex offender can apply to someone who molests children, a father who is engaged in sexual activity with his child, a college student who forces sexual intercourse on a classmate, or anyone else committing acts of sexual violence.

Sex Offenses Against Children

A “child molester” is described as an older person, male or female, who experiences any type of sexual act with another person who is a child. The majority of child molesters, more than 95 percent, are male.
A “pedophile” is someone whose primary attraction is to prepubescent children. Pedophilia is an actual psychological diagnosis, most often given to males, although females can also be diagnosed with the disorder. In order for someone to be diagnosed with pedophilia, they must have the following characteristics:

- Over a period of at least six months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age 13 or younger).
- The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The person is at least 16 years old and at least five years older than the child or children they are having fantasies, urges, or behaviors towards (excludes an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old).

Individuals diagnosed with pedophilia must receive on-going treatment designed to control their urges. Treatment is usually conducted in prison, unless the pedophile seeks treatment before acting upon his/her urges.

It is important to distinguish between an adult who sexually molests or abuses a child and someone whose primary attraction is to children. Many people use the word “pedophile” to describe anyone who sexually abuses children; that is inaccurate. While almost all pedophiles are child molesters, all child molesters do not meet the criteria for diagnosing pedophilia.

Other Facts about Sex Offenders

Sex offenders know their victims 90 percent of the time. They may be a family member, neighbor, student, co-worker, classmate, friend, intimate partner (such as a boyfriend, girlfriend, or spouse) or known to the perpetrator in some other way.

Someone who is a “sexual predator” is considered a dangerous sex offender, such as someone who uses a weapon when committing sexual violence, or injures their victim. Although the definition differs from state to state, most sexual predators commit sexually violent acts with the primary goal of victimizing individuals.

Most states require convicted sex offenders to go through treatment while in prison or while on probation. Recent studies show that cognitive behavioral therapy can help reduce the rates of sexual reoffending by as much as 40 percent.

Most sex offenders are male and identify as heterosexual. They range in age from adolescent to middle age on average. Some sex offenders are married, some are single or in long-term relationships. Adult male sex offenders who offend against male children are not necessarily gay.

Most sex offenders are not violent, and many do not have any prior history of criminal behavior.

There are many reasons why someone might commit a sex offense and they differ depending on the individual. In some cases, someone with no prior sexual behavior issues may “act out” due to extreme distress, or a feeling of hopelessness or powerlessness may lead them to a one-time isolated incident that is sexually abusive.
Many sex offenders offend multiple times in their lifespan, however. Sexual violence is rooted in the need to have power and control - to dominate someone weaker. This is why most sex offenders are male and most victims are female or children.

The most important things to remember are that not all sex offenders can be lumped into the same category, and sex offenders come from all kinds of backgrounds and experiences. While sex offenders should absolutely be held responsible and accountable for their actions, they can also benefit from treatment to lessen their chances of reoffending. We tend to think of sex offenders as sick monsters. Seeing them as human beings is important because it reminds us that sex offenders are not living in some alternate society that occasionally intersects with “normal” society. They are our friends and family members, and they need to face the consequences of their actions.

Resources

The Pennsylvania Board of Probation and Parole
www.crimelibrary.com
www.medem.com

Bringing it Home:

- Is your organization informed about community notification meetings, and do you or someone else attend them when you can?
- Are you comfortable answering questions regarding sex offenders?
- Has your organization connected with an agency providing sex offender treatment so that you can better understand the subject?
Myths and Facts About Sex Offenders
By Center for Offender Management, August 2000

Established in June 1997, CSOM’s goal is to enhance public safety by preventing further victimization through improving the management of adult and juvenile sex offenders who are in the community. A collaborative effort of the Office of Justice Programs, the National Institute of Corrections, and the State Justice Institute, CSOM is administered by the Center for Effective Public Policy and the American Probation and Parole Association.

There are many misconceptions about sexual offenses, sexual offense victims/survivors, and sex offenders in our society. Much has been learned about these behaviors and populations in the past decade, and this information is being used to develop more effective criminal justice interventions throughout the country. This document serves to inform citizens, policy makers, and practitioners about sex offenders and their victims/survivors, addressing the facts that underlie common assumptions both true and false in this rapidly-evolving field.

Myth: “Most sexual assaults are committed by strangers.”

Fact: Most sexual assaults are committed by someone known to the victim/survivor or the victim/survivor’s family, regardless of whether the victim/survivor is a child or an adult.

Adult Victims/Survivors

Statistics indicate that the majority of women who have been raped know their assailant. A 1998 National Violence Against Women Survey revealed that among those women who reported being raped, 76 percent were victimized by a current or former husband, live-in partner, or date (Tjaden and Thoennes, 1998). Also, a Bureau of Justice Statistics study found that nearly 9 out of 10 rape or sexual assault victimizations involved a single offender with whom the victim/survivor had a prior relationship as a family member, intimate, or acquaintance (Greenfeld, 1997).

Child Victims/Survivors

Approximately 60 percent of boys and 80 percent of girls who are sexually victimized are abused by someone known to the child or the child’s family (Lieb, Quinsey, and Berliner, 1998). Relatives, friends, baby-sitters, persons in positions of authority over the child, or persons who supervise children are more likely than strangers to commit a sexual assault.
**MYTH:** "The majority of sexual offenders are caught, convicted, and in prison."

**FACT:** Only a fraction of those who commit sexual assault are apprehended and convicted for their crimes. Most convicted sex offenders eventually are released to the community under probation or parole supervision.

Many women who are sexually assaulted by intimates, friends, or acquaintances do not report these crimes to police. Instead, victims/survivors are most likely to report being sexually assaulted when the assailant is a stranger, the victim/survivor is physically injured during the assault, or a weapon is involved in the commission of the crime.

A 1992 study estimated that only 12 percent of rapes were reported (Kilpatrick, Edmunds, and Seymour, 1992). The National Crime Victimization Surveys conducted in 1994, 1995, and 1998 indicate that only 32 percent of sexual assaults against persons 12 or older were reported to law enforcement. (No current studies indicate the rate of reporting for child sexual assault, although it generally is assumed that these assaults are equally under-reported.) The low rate of reporting leads to the conclusion that the approximate 265,000 convicted sex offenders under the authority of corrections agencies in the United States (Greenfeld, 1997) represent less than 10 percent of all sex offenders living in communities nationwide.

While sex offenders constitute a large and increasing population of prison inmates, most are eventually released to the community. Some 60 percent of those 265,000 convicted sex offenders noted above were supervised in the community, whether directly following sentencing or after a term of incarceration in jail or prison. Short of incarceration, supervision allows the criminal justice system the best means to maintain control over offenders, monitor their residence, and require them to work and participate in treatment. As a result, there is a growing interest in providing community supervision for this population as an effective means of reducing the threat of future victimization.

**MYTH:** "Most sex offenders reoffend."

**FACT:** Reconviction data suggest that this is not the case. Further, reoffense rates vary among different types of sex offenders and are related to specific characteristics of the offender and the offense.

Persons who commit sex offenses are not a homogeneous group, but instead fall into several different categories. As a result, research has identified significant differences in reoffense patterns from one category to another. Looking at reconviction rates alone, one large-scale analysis (Hanson and Bussiere, 1998) reported the following differences:

- Child molesters had a 13 percent reconviction rate for sexual offenses and a 37 percent reconviction rate for new, non-sex offenses over a five year period; and

- Rapists had a 19 percent reconviction rate for sexual offenses and a 46 percent reconviction rate for new, non-sexual offenses over a five year period.
Another study found reconviction rates for child molesters to be 20 percent and for rapists to be approximately 23 percent (Quinsey, Rice, and Harris, 1995).

Individual characteristics of the crimes further distinguish recidivism rates. For instance, victim/survivor gender and relation to the offender have been found to impact recidivism rates. In a 1995 study, researchers found that offenders who had extrafamilial female victims/survivors had a recidivism rate of 18 percent and those who had extrafamilial male victims/survivors recidivated at a rate of 35 percent. This same study found a recidivism rate for incest offenders to be approximately 9 percent (Quinsey, Rice, and Harris, 1995).

It is noteworthy that recidivism rates for sex offenders are lower than for the general criminal population. For example, one study of 108,580 non-sex criminals released from prisons in 11 states in 1983 found that nearly 63 percent were rearrested for a non-sexual felony or serious misdemeanor within three years of their release from incarceration; 47 percent were reconvicted; and 41 percent were ultimately returned to prison or jail (Bureau of Justice Statistics).

It is important to note that not all sex crimes are solved or result in arrest and only a fraction of sex offenses are reported to police. The reliance on measures of recidivism as reflected through official criminal justice system data (i.e., rearrest or reconviction rates) obviously omits offenses that are not cleared through an arrest (and thereby cannot be attributed to any individual offender) or those that are never reported to the police. For a variety of reasons, many victims/survivors of sexual assault are reluctant to invoke the criminal justice process and do not report their victimization to the police. For these reasons, relying on rearrest and reconviction data underestimates actual reoffense numbers.

**MYTH: “Sexual offense rates are higher than ever and continue to climb.”**

**FACT:** Despite the increase in publicity about sexual crimes, the actual rate of reported sexual assault has decreased slightly in recent years.

The rate of reported rape among women decreased by 10 percent from 1990 to 1995 (80 per 100,000 compared to 72 per 100,000) (Greenfeld, 1997). In 1995, 97,460 forcible rapes were reported to the police nationwide, representing the lowest number of reported rapes since 1989.

More recently, when examining slightly different measures, it appears that rates have continued to drop. The arrest rate for all sexual offenses (including forcible rape and excluding prostitution) dropped 16 percent between 1993 and 1998. In 1998, 82,653 arrests were logged for all sexual offenses, compared to 97,955 arrests in 1993 (Federal Bureau of Investigations, 1997 and 1998).

**MYTH: “All sex offenders are male.”**

**FACT:** The vast majority of sex offenders are male, but females also commit sexual
In 1994, less than 1 percent of all incarcerated rape and sexual assault offenders were female (fewer than 800 women) (Greenfeld, 1997). By 1997, however, 6,292 females had been arrested for forcible rape or other sex offenses, constituting approximately 8 percent of all rape and sexual assault arrests for that year (FBI, 1997). Additionally, studies indicate that females commit approximately 20 percent of sex offenses against children (ATSA, 1996). Males commit the majority of sex offenses, but females commit some, particularly against children.

MYTH: "Sex offenders commit sexual crimes because they are under the influence of alcohol."

FACT: It is unlikely that an individual who otherwise would not commit a sexual assault would do so as a direct result of excessive drinking.

Annual crime victim/survivor reports indicate that approximately 30 percent of all reported rapes and sexual assaults involve alcohol use by the offender (Greenfeld, 1998). Alcohol use, therefore, may increase the likelihood that someone already predisposed to commit a sexual assault will act upon those impulses. Excessive alcohol use is not a primary precipitant to sexual violence, however.

MYTH: Children who are sexually assaulted will sexually assault others when they grow up.

FACT: Most sex offenders were not sexually assaulted as children and most children who are sexually assaulted do not sexually assault others.

Early childhood sexual victimization does not automatically lead to sexually aggressive behavior. While sex offenders have higher rates of sexual abuse in their histories than expected in the general population, the majority were not abused. Among adult sex offenders, approximately 30 percent have been sexually abused. Some types of offenders, such as those who sexually offend against young boys, have still higher rates of child sexual abuse in their histories (Becker and Murphy, 1998). While past sexual victimization can increase the likelihood of sexually aggressive behavior, most children who were sexually victimized never perpetrate against others.

MYTH: "Youths do not commit sex offenses."

FACT: Adolescents are responsible for a significant number of rape and child molestation cases each year.

Sexual assaults committed by youth are a growing concern in this country. Currently, it is estimated that adolescents (ages 13 to 17) account for up to one-fifth of all rapes and one-half of all cases of child molestation committed each year.
year (Barbaree, Hudson, and Seto, 1993). In 1995, youth were involved in 15 percent of all forcible rapes cleared by arrest—approximately 18 adolescents per 100,000 were arrested for forcible rape. In the same year, approximately 16,100 adolescents were arrested for sexual offenses, excluding rape and prostitution (Sickmund, Snyder, Poe-Yamagata, 1997). The majority of these incidents of sexual abuse involve adolescent male perpetrators. Prepubescent youths also engage in sexually abusive behaviors, however.

**MYTH: "Juvenile sex offenders typically are victims/survivors of child sexual abuse and grow up to be adult sex offenders."**

**FACT:** Multiple factors, not just sexual victimization as a child, are associated with the development of sexually offending behavior in youths.

Recent studies show that rates of physical and sexual abuse vary widely for adolescent sex offenders; 20 to 50 percent of these youths experienced physical abuse and approximately 40 to 80 percent experienced sexual abuse (Hunter and Becker, 1998). While many adolescents who commit sexual offenses have histories of being abused, the majority of these youth do not become adult sex offenders (Becker and Murphy, 1998). Research suggests that the age of onset and number of incidents of abuse, the period of time elapsing between the abuse and its first report, perceptions of how the family responded to the disclosure of abuse, and exposure to domestic violence all are relevant to why some sexually abused youths go on to sexually perpetrate while others do not (Hunter and Figueredo, in press).

**MYTH: "Treatment for sex offenders is ineffective."**

**FACT:** Treatment programs can contribute to community safety because those who attend and cooperate with program conditions are less likely to re-offend than those who reject intervention.

The majority of sex offender treatment programs in the United States and Canada now use a combination of cognitive-behavioral treatment and relapse prevention (designed to help sex offenders maintain behavioral changes by anticipating and coping with the problem of relapse). Offense-specific treatment modalities generally involve group and/or individual therapy focused on victimization awareness and empathy training, cognitive restructuring, learning about the sexual abuse cycle, relapse prevention planning, anger management and assertiveness training, social and interpersonal skills development, and changing deviant sexual arousal patterns. Different types of offenders typically respond to different treatment methods with varying rates of success. Treatment effectiveness is often related to multiple factors, including:

- The type of sexual offender (e.g., incest offender or rapist);
- The treatment model being used (e.g., cognitive-behavioral, relapse prevention, psycho-educational, psycho-dynamic, or pharmacological);
- The treatment modalities being used; and
- Related interventions involved in probation and parole community supervision.
Several studies present optimistic conclusions about the effectiveness of treatment programs that are empirically based, offense-specific, and comprehensive (Lieb, Quinsey, and Berliner, 1998). The only meta-analysis of treatment outcome studies to date has found a small, yet significant treatment effect—an 8 percent reduction in the recidivism rate for offenders who participated in treatment (Hall, 1995). Research also demonstrates that sex offenders who fail to complete treatment programs are at increased risk for both sexual and general recidivism (Hanson and Bussiere, 1998).

**MYTH:** "The cost of treating and managing sex offenders in the community is too high—they belong behind bars."

**FACT:** One year of intensive supervision and treatment in the community can range in cost between $5,000 and $15,000 per offender, depending on treatment modality. The average cost for incarcerating an offender is significantly higher, approximately $22,000 per year, excluding treatment costs.

As noted previously, effective sex offender specific treatment interventions can reduce sexual offense recidivism by 8 percent. Given the tremendous impact of these offenses on their victims/survivors, any reduction in the re-offense rates of sex offenders is significant. Without the option of community supervision and treatment, the vast majority of incarcerated sex offenders would otherwise serve their maximum sentences and return to the community without the internal (treatment) and external (supervision) controls to effectively manage their sexually abusive behavior. Managing those offenders who are amenable to treatment and can be supervised intensively in the community following an appropriate term of incarceration can serve to prevent future victimization while saving taxpayers substantial imprisonment costs (Lotke, 1996).

**Statistics and Characteristics of Adult and Juvenile Sex Offenders**

**Sexual assault statistics:**

- 1995 estimates indicate that 260,300 rapes and attempted rapes and nearly 95,000 sexual assaults and threats of sexual assault were committed against persons 12 years of age or older (Greenfeld, 1997).
- In 1998, 20,608 arrests were made for forcible rape and 62,045 arrests were made for other sexual offenses (FBI, 1998).
- 43 percent of all rapes/sexual assaults occur between 6 p.m. and midnight.
- Six out of every 10 rapes/sexual assaults occur in the homes of victims/survivors, family members, or friends (Greenfeld, 1997).
- Sexual assault victimizations are highest among young adults between the ages of 16 and 19, low income individuals, and urban residents (Greenfeld, 1997).

**Criminal history characteristics of adult sex offenders:**

- In 1994, it was estimated that 12 percent of imprisoned violent sex offenders had a prior conviction for rape or sexual assault, while 61 percent had a prior felony conviction for other crimes (Greenfeld, 1997).
- In 1997, approximately 234,000 convicted sex offenders were under the care, custody or control of corrections agencies on an average day. Nearly 60 percent were under conditional supervision in the community (Greenfeld, 1997). By
1998, this number grew to 265,000.

Characteristics of juvenile sex offenders:
• Juvenile sex offenders are typically between the ages of 13 and 17.
• They are generally male.
• 30-60 percent exhibit learning disabilities and academic dysfunction.
• Up to 80 percent have a diagnosable psychiatric disorder.
• Many have difficulties with impulse control and judgment.
• 20-50 percent have histories of physical abuse.
• 40-80 percent have histories of sexual abuse.

Acknowledgements

The Center for Sex Offender Management (CSOM) would like to thank Rob Freeman-Longo for principal authorship of this brief. We would also like to thank Donna Reback for her contributions to this document. Kristin Littel and Scott Matson edited the document.

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References

Association for the Treatment of Sexual Abusers, "Reducing Sexual Abuse through Treatment and Intervention with Abusers," Policy and Position Statement (Beaverton, OR, 1996).
Becker, J. and Murphy, W., "What We Know and Don't Know about Assessing and Treating Sex Offenders," Psychology, Public Policy and Law 4 (1998): 116-137.
Greenfeld, L., "Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault," U.S. Department of Justice, Bureau of Justice Statistics (Washington, DC, 1997).
Hall, G.C.N., "Sex Offender Recidivism Revisited: A Meta-Analysis of Recent


*This project was supported by Grant No. 97-WT-VX-K007, awarded by the Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.*
Sexual Offenders

Grooming of Victims

By Dreseden Jones, MNCASA

Key Learning Points:

- Grooming is how sex offenders gain trust and confidence with their potential victims.
- Sex offenders groom their victims with gifts, friendship, and threats.
- Since most victims/survivors know their perpetrator, they may feel trapped once the abuse begins.
- Grooming potential victims over the internet is happening more frequently.
- Perpetrators can find out personal information on the internet about their potential victims.

We tell children to never keep secrets. If someone asks you to keep something a secret, you should tell a trusted adult right away. Of course, as children get older, they distinguish between harmless secrets their friends tell them in giggling confidence, and secrets that they are asked to keep that involve someone getting hurt or someone hurting someone else. These days, because of media attention surrounding sexual abuse and better informed parents, children are more aware of “good touch, bad touch.” It is not enough for a sex offender to tell a child “don’t tell anyone, it’s our secret.” Very few sex offenders will offend against a child they do not know; most victims/survivors know their perpetrator. But beyond just knowing the victim/survivor, sex offenders take their time to gain the child’s trust, confidence, and gain a position of power. This is called grooming.

Sex offenders not only groom potential victims but also their parents and caregivers, in order to get into the child’s inner circle. Once the child views the perpetrator as someone to be trusted, the perpetrator will begin introducing the child to different types of sexual touch. This is done slowly to desensitize the child as the inappropriate behavior escalates. Some perpetrators also use pornography, sometimes involving children in sexual situations with adults, as a way to normalize what they are doing. During the grooming process, the perpetrator might buy the child gifts that will allow them to have contact with the child that parents/caregivers will not find out about, such as a cell phone or a webcam.

Once the abuse has begun, the child may feel trapped because the abuser is a family member or friend whom everyone loves. The abuser may constantly remind the child of this, claiming no one will believe them if they come forward or using guilt (“If you tell anyone, I’ll get in trouble and go to jail.”). The abuser may also bribe them with gifts (“I’ll buy you that new iPod if you let me do this.”), or threaten them or their family (“If you say no, I’ll do this to your little sister.”). This further traps the victim.

Young victims/survivors who have been groomed by their offender may express guilt for coming forward because of the close relationship they have with their offender.

Victims/survivors who have received gifts as a part of being groomed by their offender may blame themselves for taking the gifts.

If the perpetrator has made threats as a part of grooming, the victim/survivor may be fearful that they or a family member or friend could be harmed as a result of their coming forward.
into cooperating and accepting the abuse.

With new technology, perpetrators are now able to groom victims over the internet. By chatting with an underage child in a chat room, the perpetrator can ask the right questions to create a feeling of familiarity and trust. The internet allows the perpetrator to see whenever the child is online, so they can make contact at any time. Many children are not aware how easy it is for sex offenders to find out information such as addresses and which school they attend. Some adult perpetrators even pretend to be adolescents themselves online so that the child they are grooming trusts them even more easily.

Resources

King County Sexual Assault Resource Center:  [www.kcsarc.org](http://www.kcsarc.org)
Key Learning Points:

- Understanding men who commit sex crimes is helpful for advocates so they can advocate for treatment and legal consequences in an effort to prevent further victimization.
- In the majority of cases, these men know that they are committing a sex offense and they know that it is wrong.
- Many offenders feel victimized by the consequences of their actions. Part of the treatment process is to help them see how they have hurt other people.
- Many, but not all, men who commit sexual offenses were victims of some kind of abuse or neglect in their childhood.
- There is no single profile of a man who commits a sex crime. While there are some similarities, each person must be assessed and treated as an individual.

It is important for those who assist victims/survivors of sexual assault to have an adequate understanding of adults who commit sex crimes and their treatment needs. That knowledge will allow them to advocate for those forms of treatment and/or legal consequences which will best assure that more crimes are not committed. We hope that it will provide a basis of understanding that will assist in providing an atmosphere that protects and heals victims/survivors as well as the community, produces as much change as possible in the offenders and, when change is not possible, provide adequate safeguards for the community.

Understanding Men Who Commit Sex Crimes

First of all, the label “sex offender” tells us nothing about the person, their history, the nature of their offense, other medical conditions or relevant circumstances, nor does the label give us guidance about effective intervention or management. This label is only a legal term with a legal or social definition. To truly understand these individuals we must look at the person, his (we will use the male pronoun as most people who commit sex crimes are men) history, his personality, his social environment, and many other factors. Hence, we refer to them as men who commit sex offenses and do not rely on the label.

Second, to treat these men, we first need to understand how they perceive themselves and their offense. Without that understanding, it is like trying to unlock a door without a key - it simply will not work. Third, there are many myths and misunderstandings about this group of men, and the effective methods of assessing and treating them. We will address some of those misunderstandings in this section. At the end of the section is an excerpt from a publication from the Center for Sex Offender Management that explains some myths and facts about sex offenders.
A sexual offense is comprised of behaviors and psychological dynamics, much of which most men deny, avoid, or suppress. Only in the rare case of mental illness or an alcohol- or chemically-induced blackout is the offense truly outside conscious awareness; in the majority of cases men know they are committing the offense, and they know it is wrong. Many men do not identify with their own psychological forces, however; they feel alienated, or disown their own traits and desires as though these belonged to someone else, or in rare cases, they do not feel remorse for their actions. This type of psychological defensiveness is not unusual; defenses are common in many people and must be overcome in order to increase self-understanding. Consequently, the impact and consequences of the offense are often a devastating (though deservedly so) reality check, and many men initially focus more on the “unfairness” (of getting caught and prosecuted) than on the actual offense and its impact on others. In the eyes of the offender, he has suffered many losses. He loses his freedom, experiences public humiliation, and may lose his job or family. He has to pay out money for treatment, fines, lawyers, and court costs. He may have to move out of the family home. He may not be allowed contact with his children, grandchildren, or others. In the midst of feeling victimized by the consequences of the offense, he also must learn to genuinely recognize how he has harmed others.

Many but not all men who commit sex crimes were victims of some form of abuse or neglect earlier in life. It is not true that they all were sexually abused, however, nor is it true that childhood sexual abuse causes men to become sexual abusers. Taking responsibility for his offense in adulthood means that he must finally come to terms with the effects of his abuse - a task some men avoid. Because he has avoided it, he may carry the long-term effects of victimization: the damage to self-worth or feelings of anger, rage, and vengeance. Some men choose to maintain a victim stance – never consciously coming to terms with their anger and hatred toward their own perpetrators. Those who carry these dangerous residues chose early in life whether to resolve the impact of their own abuse experience, or direct their pain and anger outwards against others or inwards against themselves.

As adults in treatment they learn to take full responsibility for all the psychological issues they have studiously avoided. This is one of the major areas of attention in treatment. They cannot, however, do that alone. It is the responsibility of treatment providers to assess, at each step of the process, the degree to which each man can hold up his end of the bargain. All of these men need the support and involvement of family and friends in treatment process and accountability to the corrections system and society.

What Makes These Men Difficult to Assess and Treat

No two men who commit a sex crime are the same. Their motives, personality dynamics, choice of victims, degree of assault, level of developmental integrity, and support system vary immensely. They can be lawyers, doctors, entrepreneurs, clergy, teachers, childcare providers, family members, friends of the family, strangers, etc. Another complicating factor is that there are many different kinds and degrees of offenses: rape, child molestation, exposing, window-peeping, internet-related offenses, or obscene phone calls. Some men are compulsively focused on one offense behavior, while others behave on a continuum, increasing their level of aggressiveness and harm over time, thus becoming increasingly dangerous.

For these reasons assessment is critical. Those who assess and treat offenders use a

Having a better understanding of men who commit sex crimes helps advocates to refrain from demonizing the offender; this is important, considering most victims know their perpetrator.
variety of instruments and procedures that assess personality traits, strengths and weaknesses, thought processes, intellectual ability, sexual history, and arousal patterns. Assessment seeks information on the presence of other sexual disorders, relationship problems, history of being a victim of abuse, degree of ownership of behavior, degree of victim empathy, status of sexuality, history of compulsive or obsessive behaviors, and degree of criminal thinking. Recent research has also provided additional tools to assess patterns of sexual interest and risk for recidivism. Therapists also review police reports, criminal history, Pre-Sentence Investigation reports, victim impact statements, and information from family or friends. All this is used to determine whether an individual is treatable and what strategies will need to be employed to create fundamental change. Several factors are crucial to understanding these men:

- A sex offense hurts others and for most men is shameful to admit. Normal psychological defense mechanisms often protect men from the uncomfortable feelings underneath. A goal of treatment is to reveal these emotions, and learn to express and manage them in productive effectively.

- There is no single profile of a man who commits a sex crime. There are similarities among some groups of offenders such as: some pedophiles are sexually attracted to young boys and not adults while others are attracted to both boys and adult women. Or, a man can molest a young girl or boy and not meet the diagnostic criteria to be called a pedophile; in that case we use the term child sex abuser. Therefore, each must be assessed and treated in a manor that addresses those unique characteristics.

- A thorough understanding of history, psychological dynamics, medical conditions, other psychiatric disorders, capacity for self-control, and support system is essential to manage and treat them effectively. For some men medication is essential for recovery. For others, close monitoring and supervision is necessary.

- Many men can be rehabilitated if they have the motivation to change. A sexual offense is most often the result of a build up of behaviors, thoughts and emotions that can be identified and understood. This understanding serves as the foundation for understanding and changing abusive behavior.

- Many men who commit sex crimes are shame-based. Treatment is not shame-based, but educates men and holds them accountable while providing support for the changes that are necessary.

- Except for a very few who are mentally ill or in some form of chemically-induced blackout, these men know they are committing a behavior that is wrong, harmful, or that is offensive. Because this behavior is a choice, they must be able to take responsibility for their actions.

What Does Treatment Include?

Effective treatment has many dimensions, and most programs include the following elements:

*Ongoing monitoring and supervision.* The majority (about 70 percent) of men convicted of sex crimes in the last 20 years in Minnesota were placed on probation in the community for a period typically ranging from 1-30 years. While on probation
they must report regularly to their probation officers. Some are on intensive supervision, a newer option that requires frequent face-to-face visits, as well as visits to home and work sites. Failure to comply with treatment expectations is usually considered to be a violation of the conditions of probation. Probation officers stay in close contact with treatment staff and clients to verify progress and discuss issues of concern.

Supportive friends and family. Many programs include family and supportive adults in the treatment process. Men in treatment are often required to obtain a sponsor who will attend individual sessions on a regular basis. Family members are often informed of the offense and may become involved in the treatment process as well. A support network is developed to provide guidance, support, and a safe person to lean on in tough times. Educational and support groups are offered for partners and family.

Structured program expectations and goals. Treatment programs are structured, usually around group therapy and individual therapy. Most programs have specific goals that each client must complete. In addition, programs often use written materials such as workbooks and videos that are useful adjuncts to treatment. The workbooks are filled with exercises and readings that allow treatment participants to take more initiative in their treatment process.

Objective measures. The use of Polygraph and Phallometric Assessment. Programs are increasingly utilizing these technologies to gather additional information about self reports and sexuality. These procedures provide objective information that helps increase accountability and understanding.

Self report. Weekly reporting of all sexual behavior and fantasy, ongoing journaling and practice of relaxation exercises, weekly monitoring of degree and quality of participation in the treatment group. This reporting activity includes periodic progress reports to the courts.

A sex positive approach. Teaching clients that they are sexual beings with needs for touch, sensuality, and intimacy, and that these needs must be met responsibly.

Individual and group therapy. Usually clients attend weekly therapy groups and individual, marital, or family therapy sessions on a regular basis.

Goals and Issues in The Treatment Process

Most treatment programs utilize a series of goals and expectations which must be met in order to complete treatment. Working within a goal-oriented program allows the client to see whether he is making steady progress, and holds him accountable for a roster of vital and specific issues related to abusive behaviors. Below we describe a common course of treatment.

In the very beginning of treatment, it is clearly established that illegal or abusive sexual behaviors are not tolerated. Clients need to report ongoing urges or sexual fantasies. It is expected that he be able to admit to others that he committed the offense. Treatment does not work with those men who are in complete denial of the offense. Usually, clients in denial are given a limited time.
to take responsibility for their actions. If they fail to take responsibility for their offense within the time limit they are remanded back to the judicial system for disposition by the court.

Treatment begins with an orientation to treatment procedures and expectations, including commitments and obligations, expectations about involvement of family and sponsors, basic sexuality information, relaxation exercises, journaling, use of fantasy, and treatment materials.

Before looking into underlying issues, he is asked go back into his offense in a very specific way and be able to present to others the story and details of that offense, both in the therapy group and to people brought in from his life. This includes providing a history of all illegal behaviors, sexual and otherwise, going back to childhood. This exercise puts his current offense and life circumstances in perspective and provides a deeper understanding of what led up to the offense. This will help him see possible patterns that led up to the offense and must be done with such authenticity that those listening to it are convinced it happened as it is being recounted. If he does this autopsy-like work his sponsor and/or family will get a different picture of him and his problems. Most men hate this part of the process. They often want to “take care of it” themselves, without exposing the reality of their actions. Up to this point, their wives or family members have usually gotten a whitewashed version of the offense - a version which makes the offense seem more accidental, less serious, and less intentional.

Until he gets through this part, he often does not take treatment seriously or thinks he has much to gain from it. He does not recognize yet what was underlying the offense, and thinks he can just decide to not do it again, ignoring the deep and resistant roots of the problem. He also has to acknowledge and recognize that he actually chose to offend, that the offense involved a decision-making process that he could have stopped at any number of points along its progression. A sex offense is not an accident. It is usually a long time in the making and if he committed previous crimes, then he has given himself permission to keep moving in a certain direction and reinforce a sense of entitlement.

At this point he starts working on underlying issues - those long-standing problems which, if worked upon seriously enough, will change the kind of person the offender is and make him capable of choosing not to offend again. These include shame and guilt and the sense of worthlessness and inferiority. It can also mean tackling family of origin issues or having to inventory the experiences of his own victimization and determine whether be resolved the effects of those victimizations or not. He also has to figure out how he misused sexuality in his offense - using sex to get other psychological needs met.

These men often lack communication and relationship skills, and are unable to interpret the signals of other people accurately. Many have to become more direct with others and learn how to handle conflict. Most importantly, they need to develop empathy - to put themselves in the victim’s shoes and experience the offense from the other end. This is incredibly difficult for most men. Tapping into inner feelings and seeing what impact their offense had on the victim usually requires digging inside themselves and acknowledging for the first time how deeply and negatively they have been affected by circumstances in their own lives. It is important that he do this without slipping into a victim stance of his own.
He needs to recognize the parts of him that can overpower or over-ride his own sense of morality, allowing him to choose to violate his own standards. That part must be changed, and the needs associated with it must be resolved. The entire treatment process is often threatening, and some men need an external consequence to help hold them accountable, such as court-ordered treatment carried out under the threat of additional imprisonment or other serious consequence. Therapists expect the attitude of these men to be negative when treatment begins; no one likes to be forced to do anything. At some point, however, his attitude has to shift. He has to begin taking initiative for his treatment and move out of the passive-aggressive stance in which he is just doing what he is told.

Not all men have the personal strength and/or outside support system to make all the necessary changes. Some will simply try to rearrange their surface and believe that is enough. Others will learn the right things to say and try to bluff their way through treatment. Some will always require monitoring and reminders are simply not enough to make fundamental, internalized change that alters their life course in a positive direction. Some will not be able to sustain change without strong family back up or a healthy spiritual community that is aware of their offense and vulnerabilities. Some offenders will need the constant threat of consequences to stay on the “right road.”

Treatment Format

Most treatment groups are open-ended, men are in the group and treatment program until they change! In this format there are always new members and old members in the same group. The advantage is that those getting closer to completion can provide leadership and confront new clients with more authenticity. Also, new clients can see goals and issues worked on first-hand and experience the standards required by the group. Peer group culture is essential to change. Treatment cannot be successfully completed alone, or in one-to-one therapy. The offense represents a hidden world and must be brought into contact with other people and made accountable to the community, both inside and outside of treatment.

The final stages of treatment involve testing his resolve and commitment. Some programs require the client to arrange and carry out community service to pay back the victim or community for the damage he has done. He should be able to demonstrate that he now has a strong support community who know his weaknesses and temptations and will hold him accountable over time. He should also be able to design a relapse prevention plan that demonstrates awareness of precursors, stress points, and vulnerabilities and have fail-safe back-up programs in place, should the pressures of life challenge his ability to maintain what he has gained in treatment.

The final months of treatment also include agreement by his probation officer that he is ready to complete, and, that there is commitment to aftercare and follow-up sessions so that ongoing law-abiding behavior is monitored and maintained. Finally, there is some kind of completion ritual that acknowledges the whole process of change and his role and contributions to the group. These final hurdles can be frustrating but are critical because they represent the ability to handle frustration, recognize, and intervene on “red flag” areas, and have a support system that can take over for what treatment formerly provided. That support, along with his understanding of his risks and relapse prevention plan, is what makes him safe to re-enter the community.

While completing treatment goals and working on issues, he must continue to satisfy probation requirements, participate in psychological testing and assessment as required,
involve family and friends in treatment, pay regularly on his bill, attend treatment regularly, and satisfy the criteria for each goal. Once treatment is completed, there is often an aftercare component as well. Juggling treatment expectations along with work, maintaining sobriety, and paying additional court and treatment costs is not easy and is a significant accomplishment when all is completed.

Summary

Treating men who commit sex crimes is a clinical specialty, and a difficult undertaking made more so by the wide variety and degree of offenses, motivational differences, personal history of abuse, and other individual traits. Other factors such as alcohol and drug abuse, family and community support, criminal history, and the ability to maintain healthy and functioning adult relationships also add to the difficult task of change. Successful treatment and true change takes time. This is why treatment programs are open ended – men are in treatment until they make all the necessary changes. The first step is admitting the need to change, and then the process follows with learning how to change and integrating those changes into self-concept and relationships. Most importantly, these men must take complete responsibility for their offense and their future behavior. While this process of change goes on, treatment and the corrections system seek to minimize the risk to the community.

We have focused this chapter on men who have been convicted and are under supervision by the court. There are also men who receive treatment for sexual behaviors who are not under court supervision. The treatment approach and expectations are the same for these men even though they are not accountable to the public.

We have addressed only the surface of the complex undertaking of treating this unique and very heterogeneous group of men. Other sections of this chapter include Myths and Facts and sex offender registration laws.

References

Association for the Treatment of Sexual Abusers, "Reducing Sexual Abuse through Treatment and Intervention with Abusers," Policy and Position Statement (Beaverton, OR, 1996).


Becker, J. and Murphy, W., "What We Know and Don't Know about Assessing and Treating Sex Offenders," Psychology, Public Policy and Law 4 (1998): 116-137.


Greenfeld, L., "Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault," U.S. Department of Justice, Bureau of Justice Statistics (Washington, DC, 1997).


Prevention
The Prevention of Sexual Violence

By Dresden Jones, MNCASA

Key Learning Points:

- It is possible to prevent sexual violence.
- The root causes of sexual violence need to be considered when working on prevention.
- Primary prevention is the most effect level of prevention, but secondary, tertiary and risk reduction efforts are also valuable.
- Sexual violence is never the victim’s fault; for this reason, prevention efforts must be focused on changing societal norms rather than individual behaviors.
- The Spectrum of Prevention is a useful tool in planning prevention strategies in your community.

What would a world without sexual violence look like? What would it feel like to live in that world? Some of the responses to this question have included:

“I will rest.”
“My daughter and I would be safe.”
“We could let our children play outside.”
“We would be comfortable with our bodies.”
“There would be gender equality.”
“Our society would feel more relaxed.”

All of these reasons, as well as many others, are why we must work to end sexual violence. Being an advocate means that you are committed to the issue of ending sexual violence and helping survivors. Advocates also play a vital role in sexual violence prevention because each one of us has a responsibility to work for a safer, healthier world.

The prevention of sexual violence and sexual assault is a widely debated topic. For many years, prevention efforts in this movement focused almost solely on victims/survivors and potential victims. Women and men have been resisting sexual violence for centuries. Everyone working in this field is committed to ending sexual violence, but in the midst of an ongoing crisis and budget cuts, primary prevention is often an afterthought.

For the purposes of this manual, we will be focusing on all stages of prevention: primary, secondary, tertiary, and risk reduction. Make no mistake, all efforts to end sexual violence are important, difficult, and crucial. This chapter is not meant to give more weight, or importance, to one or another.

The Root Causes of Sexual Violence

What causes sexual violence? What would motivate a person to commit an act against
another that causes so much trauma, humiliation and shame? Why does our society seem to foster and even condone sexually violent acts against women, children, and men? There are a wide range of theories attempting to find answers to such questions. In order to prevent sexual violence, we must gain an understanding of the root causes.

Sexual violence is about power and control, not sexual gratification. In fact, research has confirmed that motives of power and anger are more prominent in the rationalization of sexual violence versus sexual desires. Our society accepts and encourages sexual violence by creating norms that reinforce a rape culture. Norms are our attitudes, beliefs and standards that are often based in culture and tradition. According to the National Sexual Violence Resource Center, there are at least five kinds of damaging norms that contribute to an environment in which sexual violence can occur. The five damaging norms include:

- Gender: limited roles, objectification, and oppression of women;
- Power: value placed on claiming and maintaining power (exerting over another);
- Violence: tolerance of aggression and attribution the blame on victims;
- Masculinity: traditional constructs of manhood, including domination, control, and risk-taking; and
- Privacy: notions of individual and family privacy that foster secrecy and silence.

Sexual violence is a form of sexism and functions to reinforce other systems of oppression such as racism, classism, and heterosexism. Sexual violence occurs as a result of societal attitudes and distribution of power in our culture. It is accepted, reinforced, and maintained by the society in which we live. Attitudes, beliefs, and standards regarding gender, power, violence, masculinity, and privacy are maintained through norms reinforced through media, our families and/or communities, and institutions. The media provides constant and consistent messaging based on notions of femininity, masculinity, power, and violence. Images, pornography, the internet, and television teach women that the ideal definition of femininity is to be small, white, beautiful, and heterosexual. Meanwhile, men are taught to be dominant, in control, and powerful. Men, particularly white men, are born into the power of entitlement. Power and violence are reserved for men to use at their discretion; it is considered their natural born right. Women are expected to give up what little power they have and to expect violence to be part of their life experience, in some cases to enjoy violence. Such messages within the media define what is considered a “legitimate” sexual assault and reinforce rape myths. Acceptance of rape myths is strongly related to adversarial sexual beliefs, tolerance of interpersonal violence, and gender role stereotyping.

Formal institutions have a history rooted in sexism, heterosexism, racism, and oppression. Our political and social history is rife with intentional and deliberate acts to create and maintain a hierarchical society where the distribution of power is maintained by the dominate culture. The history of our country is based on oppression; each time the dominant culture encounters a group of people they can exploit, oppress, and abuse, they do. For example, most of us know the history of oppression faced by Native Americans and African Americans in the United States, but few understand that the educational system, the criminal justice system, our government, and other systems that we all must participate in continue to deny certain groups of people access to equality. This oppression reinforces a rape culture by creating power dynamics within institutions based on sexism, racism, heterosexism, and oppression.
Informal institutions such as our families, communities, and peer groups contribute to the socialization of supportive violent behavior when they reinforce sex role stereotypes and attitudes that condone the use of violence. Families and communities play a role in raising children and influencing the attitudes, beliefs, and standards they hold. Peers, however, are considered to be more influential in shaping individual behavior than biology, personality, family, religion, or culture. Peer groups include influences from multiple families and communities. Our peers may hold very different beliefs and values than our biological or adoptive family does, therefore negative norms can be reinforced, or unhealthy attitudes can be reshaped in a positive way, depending on our peer group.

There have also been studies that suggest various neurological facts that contribute to an individual’s sexually violent behavior. In some cases, repeat sexual offenders have shown increased levels of testosterone that are outside the “normal” limits. Indeed, some convicted of sexually violent acts have been diagnosed with mental illness or are considered developmentally delayed. Most sex offenders are not mentally ill, however, nor do they have a personality disorder, an out-of-control drug habit, or traumatic brain injury. (An exception to this is pedophilia, which is a diagnosed psychological disorder.) While some of the above factors may contribute to an individual’s behaviors, the more pressing, urgent issue is our society’s overall, consuming need for violence and oppression. That, surely, is a stronger influence than almost anything.

The Prevention Spectrum

The Prevention Institute of Oakland, CA, has created “The Prevention Spectrum”, which describes six levels of prevention. This Spectrum can be used for different social change movements.

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<td>Promoting Community Education</td>
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<td>Strengthening Individual Knowledge and Skills</td>
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Each level of the Spectrum is vitally important, and each level works in tandem with the others. Influencing Policy and Legislation means enacting laws and policies that support healthy community norms and a violence-free society. An example of this would be working with the state to mandate that all coaches working with men’s college teams have contracts that include a code of conduct that fosters healthy relationships, healthy aggression, and masculinity. Changing Organizational Practice involves adopting regulations, and shaping norms to prevent violence and improve safety; an example might be working with a local high school on incorporating training for teachers and administrators on modeling respectful, equitable behavior and helping their students to do the same. Fostering Coalitions and Networks is bringing together groups and individuals for broader goals and greater impact. An example of fostering coalitions and networks is creating a sexual violence prevention task force at the local high school with law enforcement, community members, faculty, students, etc. Educating Providers is the level at which we inform providers who will transmit skills and knowledge to others and model positive norms; for example, working with web developers on creating positive and healthy pop-up ads on the internet. Promoting Community Education is about reaching groups of people with information and resources to prevent violence and promote safety. An example of community education would include creating and distributing packets of information about preventing childhood sexual abuse to new parents at a birthing center. Finally, Strengthening Individual Knowledge and Skills means enhancing an individual’s capability of preventing violence and promoting safety; this could include focusing parts of new student orientation at colleges on sexual violence prevention.

Each level of the Spectrum works in tandem with the other levels. Activities in the top level feed into and inform activities on the bottom level, as well as all the levels in between. This is commonly referred to as the “synergy” of the Spectrum. You cannot operate on any one level and not on the others.

Many sexual assault programs are currently doing prevention activities that fit into one or more of these categories. The Spectrum is simply a way to organize these efforts and better understand how they can work together. The Spectrum can also help to plant the seed for new ideas. In each stage of prevention—primary, secondary, tertiary, and risk reduction—the Spectrum can be used to organize efforts.

Primary Prevention

“No epidemic has ever been cured by focusing on the affected individual.”

~ Dr. George Albee

The above quote demonstrates the thinking behind primary prevention. Prevention is defined as “a systematic process that promotes healthy behaviors and environments and reduces the likelihood or frequency of an incident, condition or illness occurring.” Primary prevention is defined as “taking action before the onset of symptoms.” For our purposes, this would mean addressing the root factors and societal causes of sexual violence before people commit sexually violent acts. The PREVENT Institute, based at The University of North Carolina Chapel Hill, describes primary prevention as “moving upstream” to build fences to keep people from falling into the water.
The point of primary prevention is to find ways to stop sexual violence before it ever occurs. It’s a difficult task, to be sure. How can we prevent something that hasn’t even happened yet? Many professionals focusing on the primary prevention of sexual violence believe that sexual violence is a public health issue. Because of what we know about how the physical and mental health of sexual violence victims/survivors is affected—depression, unintended pregnancy, eating disorders, drug and alcohol abuse, suicide, etc.—many argue that the health of our communities is at stake; therefore, sexual violence is a public health issue. By preventing sexual violence before it happens, our society will be significantly healthier.

Primary prevention of sexual violence means addressing the factors in our society that foster sexual violence and normalize sexual harm. These factors are all around us, and they shape our lives every single day, whether we realize it or not. They determine our values and beliefs, and how we express them.

- **Family**: Our family is our first understanding of behaviors and relationships. We learn how to interact with others and form relationships, healthy and/or unhealthy.
- **Peer groups**: Our classmates, co-workers, and friends influence the way we live our lives and help to shape our opinions about things.
- **Community**: This can mean where we live physically or a community we feel personally connected to, such as the Lesbian, Gay, Bisexual, Transgender community or the African American community.
- **Media**: This includes the nightly news, television shows, video games, music, music videos, the Internet, magazines, etc. The images we see and hear each day, even just in passing, help influence our lives.

These are just some examples of the factors that influence our lives and how we live. Many of these factors are currently fostering unhealthy sexuality and a sexually violent society. They “normalize” sexual harm, meaning they make sexual harm seem like a normal, every day part of life. Men and women in our society see sexual violence as an inevitable part of life. Many feel this expression of values and beliefs can change, however. By changing these values and beliefs that foster sexual violence, we can prevent sexual violence from ever occurring.

But how do we put primary prevention into action? To best answer that question, here are some examples of primary prevention activities using the Spectrum of Prevention. In this example, we will focus on primary prevention of sexual violence with youths in a college setting.
All of the above activities take time, effort, and commitment. The collaboration process with a college, or any other organization or business, takes time. Developing the relationships with the appropriate people is key. Often organizations can be resistant; for example, a college administration may think that agreeing to collaborate to develop new policy regarding sexual violence prevention could shed light on past issues they have had. Often, we have to “sell” primary prevention to organizations, and this takes time.

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<th>Primary Prevention of Sexual Violence with Youths in a College Setting&lt;sup&gt;10&lt;/sup&gt;</th>
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| **Influencing Policy and Legislation** | • Create separate sexual assault policy focusing on sexual harassment.  
• Create legislation mandating sexual violence prevention funding for all Minnesota college campuses.  
• Create policies for Greek system code of conduct regarding sexual violence.  
• Mandate sexual violence screening in health centers on campus. |
| **Changing Organizational Practice** | • Training on new policies for administration and faculty.  
• Infusing sexual violence prevention into specific curriculum.  
• Administration position created to enforce policy and update practices. |
| **Fostering Coalitions and Networks** | • Create a campus Task Force comprised of students, administrators, faculty, and community members to address sexual violence prevention.  
• Link issue with any groups addressing alcohol abuse, drug abuse, homophobia, and/or racism on campus. |
| **Educating Providers** | • Mandate sexual violence prevention training, and training on new policies for incoming: faculty, campus security, coaches, resident advisors, and/or administrators. |
| **Promoting Community Education** | • Hire and train peer educators to work with incoming freshman and community members.  
• Create training for parents of students on sexual violence prevention and new policies. |
| **Strengthening Individual Knowledge and Skills** | • Mandatory sexual violence prevention training in Freshman orientation.  
• Offer on-going education courses in sexual violence prevention and related topics.  
• Develop poster campaign about healthy sexual relationships and consent. |
Secondary Prevention

Secondary prevention is defined as “immediate responses after sexual violence has occurred to deal with the short-term consequences.” The most recognizable example of secondary prevention of sexual violence is victim advocacy. Victim/survivor advocates deal with the immediate problem of sexual violence by preventing further harm to the victim/survivor; they make sure the victim/survivor is in a safe place, they ask the victim/survivor what s/he needs at the moment, and sometimes advocates accompany a victim/survivor to make a police report or to seek medical attention. This form of secondary prevention is often referred to as “crisis intervention.” In almost all cases, it is focused entirely on the individual who has been victimized.

Another example of secondary prevention is a community-based awareness campaign. These are often implemented in communities that have experienced sexual violence incidents. Also, school-based education programs are often sought out by schools that are aware of the problem of sexual violence and want to decrease incidents in their school and/or community. Another form of secondary prevention is rape deterrence with the threat of criminal sanctions. These are all efforts that occur after sexual violence has occurred or in response to the growing problem of sexual violence.

Secondary prevention is extremely important. Media campaigns to promote awareness of the problem may not be preventing violence before it occurs, but there is much value in educating communities. Victim advocates provide an invaluable immediate response to sexual violence, as do law enforcement officials.

Tertiary Prevention

Tertiary prevention is defined as decreasing the disability associated with, and preventing the reoccurrence of the problem. Tertiary prevention can include treatment options for victims/survivors, such as therapy or counseling, as well as community-wide interventions, such as rape crisis hotlines, health care interventions, and criminal justice services. Tertiary prevention also includes interventions with sex offenders after the fact, such as sex offender treatment programs. The reform of rape statutes, the enforcement of existing laws, and the prosecution of accused rapists are more examples of this prevention strategy.

The point of tertiary prevention efforts is to deal with the long term consequences of sexual violence. As we all know, the long term effects of sexual violence on a victim/survivor can include depression, drug and/or alcohol abuse, sleep disorders, eating disorders, Post Traumatic Stress Disorder, and other lasting conditions. This is why counseling and health care interventions are sometimes important for victims/survivors. Also, treatment and/or prosecution of sex offenders is seen as tertiary prevention: by getting the offender off the streets, we assure that they cannot commit further acts of sexual violence for a designated amount of time. Long-term sex offender treatment programs can help offenders identify their problematic behaviors and actions, and, hopefully, stop them from offending again.

Rape crisis hotlines, mentioned above, can also fall into secondary prevention; often, victims/survivors call a rape crisis hotline shortly after an assault. Victims/survivors experiencing emotions or situations that trigger an assault that occurred in childhood
or at a different time in their lives also call rape crisis hotlines for assistance.

The value of tertiary prevention cannot be underrated. In a time when much emphasis is being placed on primary prevention of sexual violence, tertiary prevention efforts may seem like “too little, too late,” but it’s important that we as a society continue to place value on helping victims/survivors through the long-term challenges they face after a sexual assault, as well as holding sex offenders responsible for their actions and providing treatment when available.

Risk Reduction

As stated in the beginning of this chapter, there has been much debate about prevention of sexual violence. In the past few years, many in this movement have moved away from promoting risk reduction as prevention. There is value, however, in teaching individuals and communities about reducing their risk. But please note that the only person who can stop a sexual assault from occurring is the person who is committing the sexually-violent act. An individual could take all the steps in the world to protect themselves from situations that might lead to sexual violence and still experience sexual violence at some point in their lives. Remember: sexual violence includes many things - sexual harassment, incest, drug facilitated sexual assault, to name a few. Risk reduction often only deals with reducing one’s risk for stranger or acquaintance rape. Risk reduction models are quite effective when dealing with issues such as HIV; by helping someone who is addicted to heroin get clean needles, we are reducing their risk of HIV infection. By providing a sexually active person with condoms and teaching them how to use condoms correctly, we are hopefully reducing their risk of contracting HIV. The ultimate goal may be to get an addicted person into drug treatment, or help an individual limit their number of sexual partners. But, we know that HIV is a growing epidemic and if we run an HIV prevention program, our focus is decreasing the number of people contracting HIV. Risk reduction in terms of sexual violence does not work the same way; however, here are some examples of risk reduction that many people feel are effective to teach individuals.

Self Defense

Self defense classes, largely attended by women, teach students how to defend themselves should they be attacked. Students learn how to hit, kick, or get out of a hold an offender has put them in. They also learn how to be vocally assertive during an attack. Self defense also teaches students to be aware of their surroundings and to “follow their gut” if a situation feels uncomfortable or scary. Many victims/survivors of sexual violence take self defense classes to regain confidence and empower themselves. Self defense students often report that since taking the classes, they feel safer. Many people benefit from the lessons they learn in self defense classes.

The Buddy System

Many people, mostly young women, are taught from an early age not to be alone in certain places at night, or not to travel to certain areas alone. Teaching young people the value of teaming up with others or enlisting a “buddy” to travel with them
at night or to areas they are unfamiliar with can be very valuable. An offender is more likely to target someone who is alone.

Trust Your Instincts

It’s very simple: if a situation doesn’t feel right or is uncomfortable for you, get to a safe place. Maybe that means having a friend or two be in the room with you so that you aren’t alone with someone, or leaving a party that you feel has gotten out of hand. For many young people, this can be difficult; they are often worried what their peers will think of them. But those of us who work with young people should do our best to teach them that listening to their instincts is valuable and sometimes can get them out of potentially dangerous situations before they are harmed.

Limit Alcohol and Drug Use

A person who drinks too much alcohol at a party or smokes marijuana to the point where they are impaired and confused does not deserve to be sexually assaulted. But people believe that if a person limits their drug and/or alcohol intake in settings such as a high school party or at happy hour after work are reducing the probability of being sexually assaulted because they are fully aware of what is going on and can respond with a clear head if something dangerous arises.

Risk reduction and empowering activities can definitely aid people in being more aware of their surroundings and potentially dangerous situations. They can also help survivors regain confidence and heal after sexual assault. But, it is important to understand, always, that the only person responsible for sexual violence is the person committing it. The victim/survivor is never to blame, whether s/he has been drinking, using drugs, or walking alone at night or alone with the offender.

Prevention in Minnesota

Minnesota is often seen as a leader in sexual violence prevention by other states. We are the first state coalition to train Partner programs in the prevention theories of The Prevention Institute. Our state Sexual Violence Prevention Action Council (convened by the Minnesota Department (MDH) of Health Sexual Violence Prevention Program) has been collaborating with The Prevention Institute for a number of years on working toward broader Organizational Policy and Practice Change, as well as Influencing Policy and Legislation. Our partnership and collaboration with MDH has created many exciting prevention-focused projects, including designing trainings for youth workers and sexual assault advocates in healthy youth development as primary prevention of sexual violence.

Every three months, MNCASA, MDH, and The Office of Justice Programs bring together sexual violence professionals, law enforcement, educators, prosecutors, youth workers, and others to spend an afternoon learning about a topic relevant to the prevention of sexual violence. These meetings are open to anyone who wishes to attend. Past topics have included media advocacy, working with male victims/survivors, preventing childhood sexual abuse, the recruitment of youths into prostitution, the role of housing in sexual violence prevention, and online safety. The meetings have been going strong since 1998 and are always well-attended.

MNCASA has also convened a Sexual Violence Prevention Policy Team. The Team includes representatives from MDH, Stop It Now! Minnesota, Minnesota
Association for the Treatment of Sexual Abusers, the Minnesota Women’s Consortium, and Prevent Child Abuse Minnesota. We are always looking to add new organizations that do policy work. Our Team’s goals are to bring a concise definition of sexual violence prevention at a policy level to the Legislature to push for funding for programs so that they can do prevention work in their communities. We also plan to weigh in on bills that can potentially affect the state of sexual violence prevention in our state, including proposed sex offender laws. We also plan to voice our support for continued increases in funding for advocacy programs.

MNCASA is also committed to serving on the Stop It Now! Minnesota Advisory Board. Stop It Now! Minnesota is a program of Project Pathfinder that seeks to prevent childhood sexual abuse by providing potential offenders and concerned adults an anonymous helpline they can call to find treatment professionals. Stop It Now! Minnesota’s Advisory Board provides input, guidance, and feedback on these prevention efforts. MNCASA has been an integral part of Stop It Now! Minnesota since its inception.

MNCASA is also part of the Minnesota PREVENT Team, which received training from The PREVENT Institute in January and August of 2006 at the University of North Carolina Chapel-Hill. Out of this training came a Team committed to illustrating the connections between sexual violence, teen pregnancy, and STD/HIV infection to foundations that fund programs. The Team also includes representatives from MDH; the University of Minnesota Prevention Research Center; the Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting; the Minnesota Department of Education; the Minnesota AIDS Project; and St. Paul-Ramsey County Public Health.

MNCASA is committed to the prevention of sexual violence and is constantly taking on new projects to push our state farther. Advocates can play a key role in prevention on many levels.

References

1. Colorado Coalition Against Sexual Assault
3. Ibid.
4. Colorado Coalition Against Sexual Assault
5. Ibid.
6. Ibid.
8. All examples taken from Group Spectrum Activity conducted at The Prevention Institute Training for MNCASA Programs, conducted May 23, 2006, St. Paul, MN.
9. The Prevention Institute, Oakland, CA
10. All examples taken from Group Spectrum Activity conducted at The Prevention Institute Training for MNCASA Programs, conducted May 23, 2006, St. Paul, MN.
11. Centers for Disease Control and Prevention’s Sexual Violence Prevention: Beginning the Dialogue
12. Colorado Coalition Against Sexual Assault
13. Ibid.