Crisis Intervention

This module is designed to assist service providers in developing a basic understanding of crisis intervention; identifying common reactions and coping mechanisms of sexual violence victims; and learning responses to effectively assist victims in crisis.[1]

Key Points

- Through crisis intervention, service providers can provide a safe environment where individuals can express their feelings and develop healthy coping strategies to deal with their traumatic reactions to sexual violence. When providing crisis intervention, service providers can: support victims and help them meet their needs; stabilize their reactions to the trauma; help them prioritize and plan to resolve their concerns; and provide informational and referral services.
- Basic crisis intervention responses are the same regardless of whether or not a victim has a disability. Each victim's specific needs should be taken into account as they may influence communication methods, accommodations, mandatory reporting, confidentiality, informational and referral resources, and options identified to help them cope with the crisis.
- There is no wrong or right way for a victim to react to the trauma of sexual violence. Examples of common victim responses include anxiety or fear; depression; shock; disorientation; intrusive memories and flashbacks; hyperarousal;[2] anger; self-blame and shame; avoidance of memories; suicidal thoughts; withdrawal; emotional numbness; negative beliefs about self, family, friends and the future; problems with relationships; sleep disturbances and nightmares; physical health symptoms and problematic coping behaviors.
- Specific recommendations for service providers when responding to a victim in crisis include the following: Remain calm and help calm the victim. Make sure the victim is safe. Determine if the victim needs any accommodations. Address the victim's medical concerns, urging her to seek any needed care following the sexual assault. Discuss reporting options. Address specific concerns of the victim, helping to prioritize the concerns in terms of urgency. Tell the victim what your agency can and cannot do for her. Disclose any mandatory reporting requirements. Provide the victim with contact information for the local rape crisis center, explain services offered and, with her permission, connect her with a victim advocate.[3] Strive to display acceptance, empathy and support for the victim.

B9. Crisis Intervention

Purpose

What do service providers do if a client they are working with, who has disclosed sexual victimization, is in crisis? The initial support and reaction that victims receive after a disclosure of sexual assault can profoundly impact their own reactions to their victimization and their recovery. While rape crisis center advocates are specifically trained to provide crisis intervention to victims of sexual violence, other service providers are not. For example, service providers in agencies serving persons with disabilities may interact with clients who, for the first time, disclose sexual victimization. They must then provide basic crisis intervention if it is

needed. Therefore, it is critical that service providers are informed and competent in their initial responses, as well as able to quickly connect victims to rape crisis centers for additional crisis intervention and ongoing support.

This module is designed to assist service providers in developing a basic understanding of crisis intervention; identifying common reactions and coping mechanisms of sexual violence victims; and learning specific supportive responses to effectively assist victims in crisis. (For a more in-depth examination of indicators of sexual violence and trauma that victims may experience, see *Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Objectives

Those completing this module will be able to:

- Define crisis intervention;
- Identify possible responses to the trauma of sexual violence; and
- Understand appropriate intervention responses to victims in crisis to facilitate post-trauma healing.

Part 1: CORE KNOWLEDGE

What is a "crisis" for sexual assault victims?

Merriam-Webster's dictionary defines crisis as… *an unstable or crucial time or state of affairs in which a decisive change is impending; especially one with the distinct possibility of a highly undesirable outcome.*[4] In the case of a sexual assault, crisis sometimes is narrowly defined as 72 hours after the traumatic event.[5] However, since the impact of sexual assault often lasts for years, and since most victims never report the violence or seek help, many factors can re-introduce the trauma of the assault for a victim. For example, hearing a song in an elevator can trigger memories of an assault if that same song was on the radio at the time of the rape. Knowing that an offender is going to be released from prison after 25 years can cause a resurgence of fear and other emotions. Unresolved trauma in unreported cases can result in similar emotional responses. For example, having to attend class on a daily basis with the offender or having weekly Sunday meals with an offending relative can prevent the victim from overcoming the feelings of stress, fear and helplessness often associated with a crisis. Therefore, this module recognizes that many incidences over time can trigger crisis responses, rather than viewing a crisis as occurring only within a predetermined time frame after a sexual assault. It also acknowledges that crisis responses can impact the physical, mental, emotional/psychological and spiritual health of the victim.

What is crisis intervention?

Intervention simply means to *mediate, get involved or intercede.*[6] Crisis intervention attempts to stabilize the reactions to an immediate problem. Sometimes referred to as "emotional first aid" designed to "stop the emotional bleeding;" management, not resolution, is the goal.

What is the role of service providers in providing crisis intervention?

Through crisis intervention, service providers can provide a safe environment where a victim

can express her feelings and develop healthy coping strategies to deal with her traumatic reactions to sexual violence. In general, when providing crisis intervention to a sexual assault victim, service providers can support the victim and help her meet her identified needs; stabilize her reactions to the trauma; help her prioritize and plan to resolve her concerns; and provide informational and referral services (including connecting her with the local rape crisis center).

To offer crisis intervention, service providers must be knowledgeable about sexual victimization, the laws and potential resources. (See the *Sexual Violence 101 modules.*)

How do victims of sexual violence react in a crisis?

Just as each person reacts differently to stress, each person also reacts differently to trauma. (See *Sexual Violence 101. Understanding and Addressing Trauma.*) It is critical that a service provider not judge a victim based on her response to the sexual violence (e.g., assume she is unaffected by the rape if she is calm and seems in control of her emotions). A victim's response can begin with avoidance or denial (e.g., "If I don't think about it I won't have to deal with it" or "It wasn't rape"). A common reaction is shock. Some victims become hysterical. Others may be unable to cry. These are all natural responses after a crisis. Feelings slowly surface as a victim finds the strength to deal with the reality of the assault.

Many victims are angry if their offender is someone they know. They may feel betrayed. They may feel anger at their family or friends for not protecting them. They may be angry with themselves for being vulnerable. Victims may blame themselves. They may think: "If I hadn't worn that dress…" or "If I hadn't hired that caregiver…" or "If I hadn't been drinking…" or "If I hadn't gone to that particular party…" These feelings of self-blame are often the reasons that victims do not report, so it is important for service providers to challenge these beliefs. (*See page B9-7.*) The offender is always responsible for the sexual violence, not the victim.

Other victims may be afraid. Fear is a common reaction if the offender is a stranger or if the offender is someone known to the victim and has threatened further harm if she reports the assault.

For many reasons, a victim may have difficulty labeling an attack as sexual assault. For example, she may have had previous consensual contact with the offender (e.g., kissing or dancing). She may have voluntarily consumed alcohol or drugs prior to the assault. She may not remember the attack or only have vague memories of it (e.g., because she was drugged by the offender). She may not have physically fought back or tried to get away. She may not have been physically injured. If she is in a relationship with the offender, she may justify sexual violence as "just rough sex." She may not be able to understand or want to believe that an authority figure (e.g., a teacher or clergy) sexually abused her (e.g., possibly because they "are in love" and she "enjoyed it"). Again, it is important for service providers to challenge these reasons, educate victims about what constitutes sexual violence and stress that the victim's behavior did not cause the violence.

There are many possible victim responses to sexual violence. They include:

- Depression
- Shock, disorientation and difficulty concentrating

- Unwanted and/or intrusive memories and flashbacks
- Hyperarousal (constantly alert, on the lookout, etc.)
- Anger
- Self-blame/guilt and shame
- Avoidance of memories/reminders
- Suicidal thoughts
- Withdrawal, shutting down/emotional numbness
- Negative beliefs about self, family, friends and the future
- Problems with other relationships
- Sleep disturbances/nightmares
- Physical health symptoms (stomach aches, migraines, etc.)
- Problematic coping behaviors (avoidance, denial, etc.)

(Also see *Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Is crisis intervention for sexual violence victims who have disabilities different from crisis intervention for those without disabilities?

No, basic crisis intervention strategies should be used regardless of whether or not a victim has a disability. Additionally, each victim's needs should be taken into account as they may influence communication methods, accommodations, mandatory reporting, confidentiality, informational and referral resources, and options identified to help cope with the crisis. Consider:

- A crisis may exacerbate pre-existing conditions related to a person's disability. For example, if the person has a disability that affects her speech, a crisis may cause this disability to be more evident and make communication difficult.
- Disabilities that affect thought processes may be directly influenced by a crisis. For example, a person with a cognitive disability who has difficulty finding words to communicate effectively may find that a crisis renders her at a complete loss for words.
- A disability may be a factor in escaping the crisis. For example, a victim may feel unsafe in her home, but be unable to flee due to a physical disability.

To learn about a victim's circumstances, service providers need to:

1. **Listen** to what she says about herself (e.g., I had a stroke a few years ago that left me with memory loss).
2. **Ask questions** (e.g., What, if any, accommodations do you need to access services?).
3. **Observe verbal/nonverbal cues** (comments such as "It's not worth living like this" [said in a

flat tone of voice] or "He's not here but I feel him burning me" [said in a trembling voice followed by hysterical crying]); slurred or stuttering speech; dazed appearance; and visible accommodations (e.g., presence of a service animal or use of a wheelchair).

Respect a victim's decisions about disclosing details of her situation—she may feel that some information is not pertinent for service providers to know (her disabilities, age, if there is a guardian, marital status, sexual preference, employment history, substance use, criminal record, etc.). She may not be cognizant of what information is relevant—gentle probing by service providers may help obtain a better picture of her circumstances. For example, a client tells a service provider that last week five boys from her church decided to "fall in love with her." She is now very upset that they are saying mean things about her and don't "love her" anymore. The service provider may ask open ended questions to learn/confirm she has Down syndrome and that the boys gang raped her.

FYI—In working with any victim, it is good practice to ask "Is there anything I should know that will enable me to better assist you?" This one question can help identify the services that a victim needs and wants.

(Also see the *Disabilities 101* modules, particularly *Tips for Communicating with Persons with Disabilities* and *Accommodating Persons with Disabilities.*)

How should service providers respond to a victim who is in crisis?

To immediately respond to a victim who is in crisis, service providers should:

- **Remain calm and help calm the victim.** Although it is difficult to do so if the victim is hysterical, try to calm her so she can make rational, informed decisions. (*See Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)
- **Make sure the victim is safe.** If she is not, encourage her to take the necessary steps to enhance her safety. If there is imminent danger, seek emergency assistance according to the policies of your agency. (See *Sexual Violence 101. Safety Planning.*)
- **Determine if the victim needs any accommodations**, such as an American Sign Language (ASL) or language interpreter, materials in an alternate format and/or assistive technology such as a communication device. If requested by the victim, help secure/coordinate needed accommodations. (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- **Address the victim's medical concerns.** If the assault just occurred and the victim has been physically injured, urge her to seek medical assistance. Sometimes injuries are not visible, so encourage her to seek treatment if she is unsure. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
- **Discuss options for reporting.** Explain that, in West Virginia, she can decide whether or not to report a sexual assault to law enforcement, unless the situation meets the criteria for mandatory reporting requirements.[7] A West Virginia resident over the age of 18 is presumed to be competent unless a court determines otherwise. If someone is declared legally incompetent, they are considered a protected person and a court will appoint a guardian and/or conservator. (See *Sexual Violence 101. Mandatory Reporting* and *Disabilities 101. Guardianship and Conservatorship.*)

- **Address the specific concerns of the victim.** To provide effective crisis intervention, a service provider may be asked to answer specific questions and address specific concerns of the victim. Below are examples of possible issues, along with the titles of other modules where further information can be found.
  - Is what happened to me illegal? (See *Sexual Violence 101. Sexual Assault and Abuse Laws* and *Sexual Violence 101. Sexual Harassment.*)
  - I can't afford to go to the hospital or pay for medical treatment. Can someone pay for it? (See *Sexual Violence 101. West Virginia Crime Victims Compensation Fund.*)
  - I'm afraid I'll get pregnant or HIV because of the rape. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - What do I do to preserve evidence of the assault? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - What's going to happen if I go to the hospital? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - Why did the law enforcement officer I spoke with tell me not to eat, drink, go to the bathroom or change my clothes until after I am examined at the hospital? (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)
  - I'm afraid he'll come back. (See *Sexual Violence 101. Safety Planning.*)
  - I don't feel safe in my home anymore. I'm also afraid for my children's safety. (See *Sexual Violence 101. Safety Planning.*)
  - I'm worried about telling my parents or partner about the assault (See *Sexual Violence 101. Safety Planning* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

Service providers can help calm a victim by reassuring her that they will assist her in addressing all of her needs (in collaboration with others, particularly the local rape crisis center) and ***then help her prioritize her concerns in terms of urgency.***

- **Provide the victim with the contact information for the local rape crisis center** for additional crisis intervention services, hospital accompaniment and follow-up support. If the victim agrees and agency policies permit, the service provider can immediately connect her with a local advocate (e.g., by calling the local rape crisis center directly or through the national 24-hour sexual assault hotline at 1-800-656-HOPE).

FYI—Service providers should be knowledgeable about the services of the local rape crisis center to be able to effectively assist victims. (The *West Virginia Protocol for Responding to Victims of Sexual Assault*, available through www.fris.org, provides an overview and checklist on the role of the advocate and the services provided by a rape crisis center.) For example:

- What are the scope and limitations of services offered? (e.g., Does the agency provide transportation for victims? Do advocates provide victim accompaniment during the forensic medical examination? Are counseling services and support groups available through the center? Are legal services offered?)

- Are there age limits for the victims served? Are services provided to family members and significant others of victims?
- How are services accessed? Are they free?
- What specific resources exist within the rape crisis center for serving victims with disabilities? (E.g., Is there a list of interpreters? What other accommodations are offered? Does the center collaborate with other agencies to secure needed accommodations?) (See *Disabilities 101. Accommodating Persons with Disabilities.*)
- What informational materials are available for victims? Is the information available in alternate formats (e.g., large print, Braille, etc.)?

- **As soon as possible in their interactions with the victim, service providers should tell her what they can and cannot do for her.** They should inform her about reporting requirements—for example, if they are a mandated reporter to Child Protective Services (CPS) and/or Adult Protective Services (APS). They should let the victim know they are there to help and to support her decisions. They should also know their own limitations. If service providers are uncomfortable or overwhelmed, they should ask their supervisors for assistance and/or consult with the local rape crisis center.

Throughout their interactions, service providers should display acceptance, empathy and support for the victim.

- ***Acceptance*** can be conveyed verbally (e.g., comments such as "I believe you" or "It's not your fault") or demonstrated non-verbally (e.g., listening, maintaining eye contact, etc.).
- ***Empathy*** can also be demonstrated verbally (e.g., "I'm so sorry this happened to you" or "You must have been terrified") or non-verbally (e.g., helping find clothing for her to wear home from the hospital if her clothes are kept for evidence or by providing tissues if she is crying).
- ***Support*** can be shown in many ways. For example, service providers can:
  - *Reassure the victim she took the right action by asking for help* and that you are glad she told you.
  - *Remind the victim that any response to the trauma of sexual victimization is normal and valid.* Service providers can reassure her that many victims experience similar reactions—and these feelings will not last forever. Providing this information soon after the assault may reduce or prevent depression, post-traumatic stress disorder (PTSD) and anxiety by preventing the development of potentially damaging negative thoughts.[8] (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)
  - *Challenge self-blaming comments.* For example, if a victim is blaming herself because she went to a fraternity party, service providers can try to refocus her attention on her survival and coping skills. Service providers can reassure her by saying "Had you known you would be raped, you wouldn't have gone to the party." Self-blame tends to increase if drugs or alcohol were involved. Service providers can reassure her that her willingness to go to the party or to drink did not mean she consented to sex.

- *Let the victim know about the recovery process.* Service providers can help her understand that emotional healing is as important as physical healing. They can assess her social support systems, discuss any need for additional assistance—medical, legal, emotional and spiritual—and then make referrals as appropriate to her situation and choices. It is helpful to be knowledgeable of available community services. (See *Collaboration 101. Creating a Community Resource List.* Also see the resources available through the state sexual assault coalition website at www.fris.org.)
- Anticipate that the *victim will have additional questions and concerns after a period of time.* Knowledge is power and information may help her regain control. Service providers can encourage the victim to seek further assistance from the local rape crisis center and other community resources.

Whatever the situation, the overriding way to be supportive of victims is to listen and believe them. The healing power of just those two components—listening and believing—is extraordinary.

FYI—Service providers who work with sexual violence victims, regardless of their field of work or agency affiliation, can experience vicarious trauma after providing crisis intervention. They should make sure that they practice self-care, as they can best help others when they take good care of themselves.

Test Your Knowledge

Refer to the pages in this module as indicated to find the answer to each question.

1. What are examples of situations that might trigger a crisis for a sexual assault victim? *See page B9.2.*
2. What is the purpose of crisis intervention in general? As specifically related to sexual assault victims? *See pages B9.2–B9.3.*
3. What reactions to sexual violence are “normal” for victims? *See pages B9.3–B9.4.*
4. Does the crisis response vary if the victim has a disability? *See page B9.4.*
5. What specific actions can service providers take when responding to a victim who is in crisis? *See pages B9.4– B9.7.*
6. What are ways that service providers can convey acceptance, empathy and support for a victim? *See pages B9.7–B9.8.*

Part 2: DISCUSSION

Projected Time for Discussion

2 hours

Purpose and Outcomes

This section is designed to help participants apply the information presented in *Part 1: Core*

Knowledge of this module to their actual work with sexual violence victims. These role-play activities could be incorporated into forums such as agency staff meetings as well as volunteer meetings or trainings. Anticipated discussion outcomes include an increased understanding of service providers' roles in crisis intervention when serving sexual assault victims and the opportunity to practice crisis intervention skills using case scenarios.

Refer to the learning objectives at the beginning of this module for specific outcomes for this module on crisis intervention.

Key Points for the Group to Consider

All skills take practice to perfect and it is preferable not to practice crisis intervention skills with a victim in crisis! One of the best ways to practice intervention skills is to role play different scenarios that a service provider might experience. Although role playing can seem awkward for some, consider that it is an opportunity to "do no harm" during the learning process. It enables service providers to identify areas in which they need additional information and practice without impacting a victim's healing process. If all group members agree to approach the activities as a learning process with the goal to help each other, then the commitment to investing some thought and creativity into the roles will add more reality to the experience.

Planning

- Ensure that the meeting is held at an accessible location. Ask participants prior to the meeting if they need any accommodations—if so, work with them to secure accommodations.
- Select a facilitator. The facilitator should be familiar with crisis intervention, victims' responses, and role-playing.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, blank attendance sheet, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges or table tents.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(5 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the scenarios. In general, there are no right or wrong responses, only different approaches.
- Avoid personalized comments that are negative as they can lead to defensiveness and confrontation among the participants and ultimately may shut down dialogue. The purpose of the role play scenarios is to provide the opportunity to practice new skills and obtain constructive feedback.

2. **Explain/demonstrate role-play activities.** Spend a few minutes discussing the concept of

role-plays and their purpose in developing intervention skills. Some group members may have never had the experience of role-playing. Talk about the value in using individual creativity in building upon the roles outlined in the scenarios. If requested, have the facilitator demonstrate by role-playing the first scenario with a more experienced member of the group serving in the role of the victim (as directed in Activity 3). Following the demonstration, discuss the pertinent questions listed in Activity 4.

3. **Facilitate role-playing.** (*See Role-Play Scenarios* below. Keep in mind that in scenarios 1–5, the victims could have a disability even if one is not noted.)

Separate participants into pairs or small groups (the facilitator needs to determine how the group will be divided). Ideally, participants should be divided into groups of two, with each member of the pair rotating between playing the role of the service provider and the role of the victim. (Adapt the gender of the victim in each role-play to match the gender of the persons participating.) After two to three role-plays, new pairs should be formed. Continue the process with the next set of role-plays. Follow each role-play with a discussion as directed in Activity 4. *(Allow 5 minutes for each role-play, for a total of 30 minutes.)*

For individuals who are reading these scenarios without the benefit of a role-playing partner, write down an outline of how you would respond as the service provider in each scenario. After writing down your responses, look at the end of this module for some suggested responses to consider for each scenario.

Scenario 1

A woman calls who was sexually assaulted earlier in the evening. She wants help and wants to report the crime. What do you do? Would your response change if she discloses she is blind?

Scenario 2

You receive an email from a 14-year-old girl who was raped two days ago at a party. She is extremely scared that she is pregnant and wants emergency contraception. She hasn't told anyone and, although she is close to her mother, she is afraid that her mother will not believe her and will be angry because she was drinking. She does not want to make a report to law enforcement. How do you explain mandatory reporting laws (if applicable)? How do you help make it safe for her to get services? Would your response change if she discloses she is deaf?

Scenario 3

A caller who was sexually assaulted the night before is concerned about AIDS. She would like to have a medical exam but is unsure about reporting the assault to law enforcement. She's heard that there's a drug to prevent AIDS. Is there? If so, she has no money. Can you help her? If you do not have all the information she is requesting, what do you do? Would your response change if she discloses she has a mental illness and "tends to obsess about things?"

Scenario 4

A 19-year-old college freshman had too much to drink 10 days ago at a campus party, was gang raped and never reported the incident because she was afraid of being charged with underage drinking. She kept her clothes and did not wash them. The guys are now bragging on campus. She is angry and wants the offenders to be held accountable. What are her

options? Would your response change if she discloses she has a cognitive disability which makes communication difficult? (She does not have a guardian.)

Scenario 5

A caller was raped a number of weeks ago by his male date. He has an extensive history of being abused and wants to talk about the painful details of the assault. What do you do? Would your response change if he discloses that he has had depression periodically for 10 years?

Scenario 6

A 24-year-old woman who appears to have Down syndrome stops by your table at the mall health fair. In the course of her general conversation, she tells you about the bus driver at her group home. Females in the home call him "Uncle Bob," and he brings them candy. He often touches her "private area." She is afraid he will stop giving her candy if she says she doesn't want him to touch her there anymore. She says it's really good candy. What do you do?

4. **As a large group, facilitate a review and discussion on each scenario.** Use the questions below, as well as the suggested action steps, to help guide the discussions. *(10 minutes per scenario, for a total of 60 minutes)*

a. After each role-play, have one or two pairs present their intervention responses and actions to the large group. Discuss whether their actions were appropriate. The facilitator should summarize the ideas on how to respond to the situation and re-instruct on specific best practices as necessary.

b. What key facts in the scenario impacted your response? Did your response change when you knew the victim had a disability? (Note that basic crisis intervention strategies and goals are consistent across victim populations, but that responses may be influenced by factors such as age, cultural beliefs and values, type of sexual violence, disabilities, etc.)

c. What laws or specific resources did you need knowledge of to be able to help the victim?

d. What aspects of this scenario made it uncomfortable for you to assist the victim?

Suggested action steps for each scenario:

Scenario 1—suggested actions and issues to consider

This scenario requires basic crisis intervention. Determine her age and if she has the capacity to make her own decisions. Assess her injuries and safety. Find out her needs. Briefly explain any available services and her options regarding the forensic medical exam and reporting. If she chooses to have a forensic medical exam, discuss transportation to an appropriate facility. Advise her to not wash, change clothes, urinate, defecate, smoke, drink, eat, brush her hair or teeth or rinse her mouth and to bring the clothes she was wearing when assaulted (or a change of clothes if she is still wearing the clothes she wore during the assault). Identify if there is someone she trusts who can support her. Provide unconditional support. Activate advocacy, medical, law enforcement and other relevant first responders as she directs. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

If the victim discloses that she is blind, discuss accommodations she may need to access

services (material in an alternate format, help in filling out forms, use of a service animal, etc.). (See *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 2—suggested actions and issues to consider

Service providers are often unclear about mandatory reporting laws. (See *Sexual Violence 101. Mandatory Reporting.*) Review them thoroughly and discuss with your supervisor. Most service providers have mandatory reporting requirements. How can you serve this victim once you know her age? How would that change if you know her age, but do not know her name or phone number? *Can* you provide services without obtaining identifying information from the victim? How would the age of the offender impact your response? What is the time period for taking emergency contraception? Where can it be purchased, and what are the related age limitations? In such calls it is critical to create safety for the caller, identify her concerns and explore what options are available to her. Always recognize your limitations and refer for services when necessary.

Any victim communicating through an unsecured technological device (including email, cell phone or texting) should be advised that confidentiality issues are present and should utilize more secure methods of communicating.

If the victim discloses that she is deaf, she may have access to a text telephone (TTY) or Telecommunications Relay Services (TRS). The service provider would need to be familiar with communicating via these devices. Discuss accommodations she may need to access services (e.g., ASL interpreter). (Also see *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 3—suggested actions and issues to consider

Under West Virginia law, victims can have a forensic medical exam conducted within 96 hours of a sexual assault. Exams can be conducted without reporting the assault to law enforcement (with the exception of cases requiring mandatory reports). The collected sex crimes kit will be sent and stored at Marshall University Forensic Science Center for up to 18 months. During that time, the victim can choose to report. Unless service providers are medical professionals, they are unqualified to give medical advice. In general, prophylactic/preventive treatment is available in most communities if started within 72 hours of exposure. The treatment's side effects can be difficult to tolerate. The known risk of contracting HIV from one unprotected sexual encounter is slight. Encourage the victim to go to or contact the hospital to receive detailed information on HIV prophylactic treatment from medical professionals as well as other services (if she chooses), such as a forensic medical exam, advocacy and an opportunity to report the crime. HIV treatment could possibly be paid out of the West Virginia Crime Victims Compensation Fund; however to access those funds, the rape would have to be reported to law enforcement. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination* and *Sexual Violence 101. West Virginia Crime Victims Compensation Fund.*)

If the victim discloses that she has a mental illness and "tends to obsess," it may be useful to again stress that it is unlikely she has been exposed to HIV, but that it is important to quickly address her concerns with a health professional and decide whether she is a candidate for prophylactic treatment. Discuss accommodations she may need to access services (e.g., transportation if she doesn't drive, accompaniment, etc.). (See *Disabilities 101. Working with Victims with Mental Illnesses* and *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 4—suggested actions and issues to consider

This is a good example of a case that has several additional variables. First, the victim could conceivably be charged with underage drinking; it is helpful to know your local prosecutor's position on that issue. In most cases, forensic medical exams are conducted up to 96 hours following a rape. However, each case needs to be considered separately. If she was gang raped, there may have been significant tearing and bruising, which still could be visible and documented. The fact that she did not wash her clothes could provide the necessary DNA evidence. DNA, if not destroyed, can remain indefinitely. You would want to review the options with the victim. Those options would also include any appropriate reporting and disciplinary actions available through the local college. Utilize the services of the local rape crisis center for additional support and information. (See *Sexual Violence 101. Sexual Assault Forensic Medical Examination.*)

If the victim discloses having a cognitive disability that makes it difficult to communicate, discuss accommodations she may need (e.g., the method in which you communicate with her, assistance in filling out forms, etc.). (See *Disabilities 101. Tips for Communicating with Persons with Disabilities* and *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 5—suggested actions and issues to consider

Crisis intervention is a normalizing process that strives to return victims to pre-crisis levels of functioning. Having callers remain in an extreme emotional state or repeatedly revisit a traumatic event can be counterproductive. For some victims, the process of telling and re-telling the story can be therapeutic. Focus on what the caller needs right now. If he has never talked about the assault, then support him in disclosing and listen. If he has focused only on the assault since the rape and seems fixated on the attack, continue to listen but recognize that he may need additional interventions. Review his safety plan. Help him return to the present moment, find out how he helped himself feel better in the past, identify his support systems and make a self-care plan for the next few days. Possibly refer him for ongoing counseling. (See *Sexual Violence 101. Safety Planning*.)

If the victim discloses that he has a history of depression, talk with him about accommodations he may need (assistance in reaching out to other service providers, financial aid for counseling, etc.). Also, discuss how the most recent victimization may exacerbate his depression, as well as trigger unwanted thoughts about any past victimization. If he is open to it, talk with him about what he usually does to cope with depression, if there is anyone supporting him in dealing with it, and if so, encourage him to connect with them for additional support. (See *Disabilities 101. Working with Victims with Mental Illnesses* and *Disabilities 101. Accommodating Persons with Disabilities.*)

Scenario 6—suggested actions and issues to consider

This scenario presents several complicating factors: Is this a case of sexual abuse by an authority figure? Is the victim's capacity to consent to these sexual acts an issue? Are you a mandated reporter? While the victim may not be in crisis, since she views the sexual act as a means to an end (candy) rather than abusive, you need to take the suspected abuse seriously. Find a private place to talk with her. Validate her decision to tell you about the situation and explain that help is available. You should disclose that you are a mandated reporter (if you are). Explain in language she can understand that if she tells you that someone is harming her,

you must tell someone on her behalf. Remember that your role is not to investigate the abuse, but to provide support and report any suspected abuse of those who cannot speak for themselves. (See *Sexual Violence 101. West Virginia Laws on Sexual Assault and Abuse* and *Sexual Violence 101. Mandatory Reporting.*)

Ask her for the information you need to make a report to APS, such as her contact information and any specifics about what occurred (when, where, etc.). Ask if there is someone that helps her make decisions (the term "guardian" may have no relevance to her). If so, ask for contact information for that person and for the group home. (See *Sexual Violence 101. Confidentiality* and *Disabilities 101. Guardianship and Conservatorship.*)

FYI—To close this activity, stress to participants that **when providing crisis intervention services, it is important to remain in the role of providing support for the victim.** Once people disclose victimization, in addition to dealing with the trauma of the assault, they usually begin wrestling with whether they took the right action by telling you about it. **Your reaction is critical to their healing process. Focus on their immediate needs by providing the support and information they need.**

5. **Closing.** Ask participants to write down any questions they have or additional information they need based on the role-play activities. Discuss their plans for getting the information they need to better provide crisis intervention services. *(10 minutes)*

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, the terms "victims" and "clients" are primarily used in this module. Also note that the terms "sexual violence" and "sexual assault" are generally used in this module to encompass sexual assault, sexual abuse and other forms of sexual violence.

[2]Symptoms that stem from high levels of anxiety, such as: "Having a difficult time falling or staying asleep; feeling more irritable or having outbursts of anger; having difficulty concentrating; feeling constantly on guard or like

danger is lurking around every corner; and being jumpy or easily startled." (M. Tull, *About.com* Health's disease and conditions: PTSD (*hyperarousal*) (2009), http://ptsd.about.com/od/glossary/g/hyperarousaldef.htm.) Note this and other online documents referenced in this module were available at the links provided at the time the module was written. It is suggested you check the sites for any updates or changes. If you experience difficulty accessing the documents via the links, another option for locating documents is doing a web search using titles.

[3]Although males and females are both victimized by sexual violence, most reported and unreported cases are females (see the endnotes in the *Toolkit User's Guide* for a full citation). Therefore, in this module, victims are often referred to as female.

[4]Merriam-Webster Dictionary (accessed October 23, 2009), www.merriam-webster.com.

[5]L. Ledray & S. Moscinski, *Advocate/counselor training, Training manual* (Washington, DC: Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice), 104.

[6]www.merriam-webster.com (accessed October 23, 2009).

[7]*Legislative Bill HB08-1217* (Division of Criminal Justice, 2008)(accessed October 23, 2009), http://dcj.state.co.us/OVP/Documents/Forensic%20Exams/Information_for_Medical_Facilitiesweb.pdf.

[8]Ledray & Moscinski.