Working with Victims with Mental Illnesses

This module provides service providers with general information to assist them in serving sexual violence victims who have a mental illness.[1]

Key Points

- A mental illness is a medical condition that causes a mild to severe disruption in a person's thinking, emotions, mood, ability to relate to others and daily functioning. There are many types of mental illnesses; they can be temporary or chronic in nature and usually are treated with medications and other forms of therapy.[2] Persons with mental illnesses are at higher risk of sexual victimization than the general population.
- Service providers should simply clarify with victims their needs and desired assistance and offer accommodations as necessary, rather than making assumptions about the root causes of behaviors (e.g., that they are reactions to sexual violence or indicative of a mental health issue). Service providers' responses must stay within the scope of their professional role and level of expertise.
- Victims who have a mental illness may face barriers in accessing services. Service providers should consider that —
  - Responders' misconceptions about mental illnesses can prevent victims from being taken seriously. Service providers must address their own fears and discomforts about working with persons with this type of disability before engaging with them.
  - Caregivers may be offenders. Service providers can help victims who are abused by their caregiver plan for safety and differentiate between healthy and unhealthy relationships with caregivers, as well as support victims in addressing their needs.
  - The perceived lack of credibility of these victims' accounts of what occurred is a key reason why sex offenders target this population and why these victims are reluctant to come forward. When they do come forward, service providers must treat them with the same respect and empathy as they do with any other victim.
  - Being able to trust service providers may be difficult for some victims (e.g., those with feelings of paranoia or anxiety). Maintaining the confidentiality of victim information—unless there is a need for a mandatory report—is one way that service providers can build trust and help victims move toward recovery.
  - Sexual violence may exacerbate some types of mental illnesses.
- Victims with mental illnesses should be aware of the potential consequences of disclosing sexual violence (e.g., changes in mental health treatment, loss of a caregiver or even institutionalization). Service providers can aid victims in considering their options.

C5. Working with Victims with Mental Illnesses

Purpose

A 24-year-old female Army officer discloses to you that she was sexually assaulted several months ago while she was at a military rehabilitation center—she was injured in combat, losing a foot. She was also dealing with post-traumatic stress and depression. She hasn't reported the assault—the perpetrator was another patient who told her that nobody would believe her since she was a "nut case." She doesn't want him to "drag her reputation through the mud" or jeopardize her career. She is calling mainly because she is scared that since the assault, her overall feeling of despair is intensifying.[3]

Service providers outside of the mental health field assist sexual violence victims who also have a mental illness. This module offers basic information and guidance on the initial response to these victims, while urging service providers to stay within the scope of their professional role and skill level when they respond.

As illustrated in the scenario above, sex offenders often target individuals who have a mental illness. These individuals may be less willing or able to report sexual violence. If they do disclose victimization, their account of what happened may be questioned. Unfortunately, the stigma associated with mental illnesses may lead these victims to do without the vital help they need. This module can be a tool for service providers to explore how to counter this stigma in their work. Ultimately, a service provider's goal when responding to sexual assault victims is not to determine whether or not victims have a mental illness, but how to best offer them support and accommodate their needs so they can deal with their reactions to the violence and begin to heal.

Objectives

Those completing this module will be able to:

- Discuss what mental illness is and its prevalence in the United States;
- Describe the risk of sexual victimization for persons who have a mental illness;
- Identify behaviors that may be indicative of a mental illness and possible accommodations to enable victims coping with such behaviors to discuss and address their needs; and
- Discuss barriers to accessing services that victims who have a mental illness may face and related considerations for service providers.

Preparation

- Review *Disabilities 101. Tips for Communicating with Persons with Disabilities*.

Part 1: CORE KNOWLEDGE

What is a mental illness?

A mental illness is a medical condition (which can be temporary or chronic) that causes a mild to severe disruption in a person's thinking, emotions, mood, ability to relate to others and daily functioning. It often results in a diminished capacity for coping with the ordinary demands of life

and can cause reactions to distress that society considers extreme. It can be treated, in many instances very successfully, with medications and other forms of therapy. It is *not* the result of personal weakness, lack of character, poor upbringing or a lack of intelligence.[4]

There are many different conditions recognized by health professionals as mental illnesses. A few examples include clinical anxiety, depression, mania, post-traumatic stress and schizophrenia.[5] Mental health professionals typically refer to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) to diagnose these conditions.[6,7]

FYI—Service providers outside of the mental health field do not need to be experts on mental illnesses. It is not their role to attempt to make clinical diagnoses or rule out the possibility that a victim may have a psychological condition. However, when providers increase their knowledge and comfort level in working with victims who have a mental illness and overcome associated misconceptions, they are better positioned to help these victims achieve their goals.

FYI—Keep in mind that a victim who has a mental illness is not defined by that disability. When working with a victim with a mental illness, always ask yourself and the victim if the disability is even relevant to your conversation. (See *Disabilities 101. Person First Language.*)

What is the prevalence of mental illnesses in the United States?

An estimated 26 percent of Americans ages 18 and older—about one in four adults—are diagnosed with a mental disability in a given year.[8] A much smaller proportion of the U.S. population—about 6 percent or 1 in 17—experience serious mental illnesses that cause a severe disruption in functioning.[9]

FYI—Individuals can experience multiple co-occurring medical conditions. For example, a person may have anxiety and depression. A person with cerebral palsy may experience post-traumatic stress. Someone with schizophrenia may be deaf.

How prevalent is the sexual victimization of persons with mental illnesses?

In the U.S., one in six women and one in 33 men has been the victim of an attempted or completed rape in their lifetime.[10] (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors.*) Studies reveal much higher rates of victimization for persons with mental illnesses:

- One study showed that 87 percent of a sample of individuals with severe mental illnesses had been sexually or physically assaulted within their lifetime. The women in this study were 16 times more likely to report having been the victim of a violent crime in the past year than women from a general population sample.[11]
- Sexual abuse in childhood is associated with higher rates of mental illnesses, poorer outcomes for mental health treatment and re-victimization as adults.[12] Higher rates of childhood sexual abuse are reported by adolescents and adults with diagnosed mental illnesses and range from 6 to 50 percent, whereas general population studies of reported rates of childhood sexual abuse range from 13 to 17 percent for women and 2.5 to 5 percent for men.[13]

What behaviors are indicative of a mental illness? How do service providers accommodate victims displaying these behaviors?

There are some common indicators that an individual may have a mental illness. Each indicator in the chart below is defined by a group of behaviors. Service providers may observe these behaviors as they interact with victims or victims may disclose them. However, some of these behaviors may actually be reactions a victim has to sexual violence. (See *Sexual Violence 101. Crisis Intervention, Sexual Violence 101. Indicators of Sexual Violence* and *Sexual Violence 101. Understanding and Addressing Emotional Trauma*.) With this in mind, **service providers must avoid making assumptions about root causes of behaviors and simply clarify with victims their circumstances, needs and desired assistance.** They can also offer accommodations to aid these victims in discussing and addressing their needs (see the following chart for examples).

Remember that the response in each case depends on the situation. (See *Sexual Violence 101. Crisis Intervention* and *Sexual Violence 101. Safety Planning.*)

FYI --The suggestions for accommodations listed below build upon tips cited in *Disabilities 101. Tips for Communicating with Persons with Disabilities*. They are intended to guide service providers as they do initial intake or crisis intervention with clients who have been sexually victimized. A referral for mental health treatment may be warranted in some instances. *Reviewing these suggestions is not a substitute for the specialized training a mental health professional receives to be able to diagnose and treat persons with specific mental illnesses.* Also see the end of *Part 1: Core Knowledge* and *Part 2: Discussion* for case scenarios and dialogue about accommodations and considerations.[14]

Anxiety: characterized by being constantly on edge, restless and agitated, and/or having seemingly excessive intrusive thoughts, obsessive fears and/or ruminations about a traumatic event.

Possible accommodations during the initial response: Talk with the person in an environment as free from distractions as possible. Help her calm down; be accepting of her feeling of anxiety and believe she can overcome it. Ask her simple questions to help break any patterns of compulsive talking (e.g., about obsessive fears). Note that, initially, it may be difficult for her to separate her fears from reality. Work with her to build a trusting relationship before challenging her reality. Discuss what she wants to do to get through her fears and help her identify her needs for assistance. Be aware that if she is very agitated, the conversation may need to continue at another time.

Depression: characterized by pervasive feelings of hopelessness and despair, unshakable feelings of worthlessness and inadequacy, withdrawal from others and/or the inability to engage in productive activity. May manifest as physical symptoms (fatigue, stomach pain or sleep disturbances) and emotional symptoms (inability to concentrate, irritability or low mood).

Possible accommodations during the initial response: Convey acceptance, caring and hope to the person. Initiate conversation if needed. Help her identify ways to regain control of the situation, identify her needs and develop a plan to address these needs.

Disorientation: characterized by a dazed expression, memory loss and/or inability to give the date or time, identify current location, recall recent events and/or understand what is

happening.

Related to disorientation is **dissociation**, a mental process that causes a lack of connection in a person's thoughts, memory and sense of identity. With severe dissociation, a person may appear distant or catatonic and have little memory of the dissociation.[15]

Possible accommodations during the initial response: Talk with the person in an environment as free from distractions as possible. Get her attention. Initiate conversation if needed. Be brief, simple and repeat as necessary. Attempt to identify her needs for assistance. Be patient but aware that discussion may not be possible at this time.

Hallucinations or delusions: characterized by hearing voices, seeing visions, delusional thinking and/or excessive preoccupation with an idea or thought. Often associated with severe mental illnesses. Also common with persons under the influence of drugs or alcohol.

Possible accommodations during the initial response: Be accepting, calm, straightforward, caring, nonthreatening and reassuring. Keep the conversation simple and brief. Be aware that rational discussion may not be possible on some or all topics. Don't argue or try to differentiate her hallucination or delusion from reality; instead, respond to her feelings and needs and help her identify what assistance she would like to address her needs. If she is agitated but poses no immediate threat to anyone's safety, allow her time to calm down before engaging her in conversation, or transition her to a safer/calmer conversation. Take breaks as needed.

Mania: characterized by expansive or irritable mood, inflated self-esteem, decreased need for sleep; increased energy; racing thoughts; feelings of invulnerability; poor judgment; heightened sex drive and impulsive sexual acts; and/or denial that anything is wrong. Associated with the use of some substances. A person with bi-polar illness may cycle between feelings of depression and mania.

Possible accommodations during the initial response (also see above under "Depression"): Be straightforward. Get the person's attention if needed. Ask simple questions to break the pattern of racing thoughts. If she is over-stimulated, don't pressure her to concentrate. Don't expect a rational discussion. If she is agitated but poses no immediate threat to anyone's safety, allow her time to calm down before engaging her in conversation, or transition her to a safer/calmer conversation. Take breaks as needed. Help her in identifying her feelings and needs and in developing a realistic plan to address those needs.

Substance abuse: When presented with a life stressor such as sexual victimization, many individuals self-medicate with drugs or alcohol to help them temporarily lessen the pain and other negative feelings.[16] Persons with specific mental illnesses have an increased risk for substance abuse.[17] Substance abuse may aggravate a pre-existing mental illness and reactions to sexual violence.

Possible accommodations during the initial response: Approach the person in a calm, nonthreatening and reassuring manner. Keep the conversation simple, brief and focused. Help her identify her needs and create a plan to address those needs. If she is under the influence of alcohol or drugs, recognize that she may not be able to have a rational conversation and may need to continue talking at another time. If she is agitated but poses no immediate threat to anyone's safety, allow her time to calm down before engaging her in conversation. Do not attempt to force her into treatment.

Suicidal thoughts: characterized by talking about suicide, including remarks such as "I wish I were dead or hadn't been born;" obtaining items that could be used to commit suicide, such as a gun or pills; withdrawing from social contact and wanting to be left alone; dramatic mood swings, such as being emotionally high one day and deeply discouraged the next; being preoccupied with death, dying or violence; feeling trapped or hopeless about a situation; abusing alcohol or drugs; changing normal routines, including eating or sleeping patterns; risky or self-destructive behaviors, such as driving recklessly; giving away belongings or getting affairs in order; saying goodbye to people as if they won't be seen again; and/or acting out of character, such as becoming very outgoing after having been shy. Although most persons with suicidal thoughts do not attempt or commit suicide, the extent of suicidal thoughts should be evaluated and re-evaluated as circumstances require (e.g., if a client who has talked to you about suicide in the past now tells you she has a written suicide plan and has acquired the means to commit suicide).[18] Studies indicate that more than 90 percent of persons who commit suicide have a diagnosable mental disability,[19] most commonly depression or substance abuse.[20] It is not the disability itself that increases the risk of suicide, but the combination of a mental illness and life stressors.[21]

Possible accommodations during the initial response: Ask the person about her suicidal thoughts. Asking won't push her into doing something self-destructive; rather, it offers her a chance to talk about her thoughts and may reduce the risk of acting on these thoughts.[22] If she is at imminent risk of suicide or just made an attempt, seek immediate emergency assistance according to your agency's policies and stay with her until help arrives.[23] If risk is not imminent, offer to assist her in developing a plan for her safety. (See S*exual Violence 101. Crisis Intervention* and *Sexual Violence 101. Safety Planning.*)

What barriers to accessing services may victims who have a mental illness face? What are related considerations for service providers?

See the chart below. Keep in mind that the focus of a service provider's initial response to a disclosure of sexual violence should be to offer support, validation, information, crisis intervention and hope as needed for the victim to heal. Mental illnesses may influence the type of accommodations needed, as discussed above, but they should not be the focus of the response unless it is the victim's choice.

People with mental illnesses face significant stigma and discrimination. While progress has been made in the treatment and public awareness of mental illnesses, the stigma related to this form of disability still results in prejudice and stereotyping. For example, the media often portrays individuals with mental illnesses as "scary" or "dangerous," yet fails to recognize they are much more likely to be the victims of a crime. Another example is that a prosecutor may not pursue charges because he views the victim's account as unreliable solely because she has schizophrenia.

How to help: Service providers must address their own fears and discomforts about working with these victims before engaging with them. Their ongoing support for victims with mental illnesses is critical to facilitate healing, regardless of community reactions and criminal justice outcomes. (See *Disabilities 101. Person First Language* and *Disabilities 101. Tips for Communicating with Persons with Disabilities*.)

Persons with mental illnesses may be sexually assaulted by a caregiver. They may be

reliant on others to carry out the tasks of daily living that they cannot accomplish on their own. Sex offenders who are caregivers may take advantage of this imbalance of power and victimize their charges. They may be able to “get away” with their crime by convincing their victims that sexually abusive behavior is a legitimate component of their caregiving responsibilities (e.g., by saying they were just bathing the person’s genital areas). They may persuade their victims that what they think happened was in fact a nightmare or hallucination or that the victims were too intoxicated or medicated to remember events correctly. (See *Sexual Violence 101. Sexual Victimization of Persons with Disabilities: Prevalence and Risk Factors.*)

How to help: Service providers can help victims of sexual violence perpetrated by caregivers consider their safety risks and options. They can help victims understand the differences between healthy and unhealthy relationships with caregivers, as well as support victims in addressing their needs to the extent possible. (See *Sexual Violence 101. Safety Planning.*) Depending upon the circumstances, service providers may be required to report the victimization to local authorities. (See *Sexual Violence 101. Mandatory Reporting*.)

The credibility of the victim’s account of sexual violence is often questioned. Offenders may be able to keep victims with mental illnesses from seeking help or reporting by telling them that no one will believe them. If victims do disclose sexual violence to others, offenders very likely will attack the credibility of their account of what occurred. Sex offenders often target people with mental illnesses because they recognize that their claims of sexual violence may be ignored or discounted by investigating authorities and the courts.

How to help: Service providers must remember that it is not their responsibility to determine the credibility of victims’ accounts of sexual victimization. If the case is one requiring a mandated report, it is sufficient that there is a suspicion that sexual violence occurred. (See *Sexual Violence 101. Mandatory Reporting*.) When a victim with a mental illness does come forward, she deserves to be treated with the same respect and empathy as any other victim. When service providers ignore, immediately discount or question a disclosure of sexual assault, they are re-victimizing the victim. Even individuals who are experiencing delusions or hallucinations may be able to provide accurate information related to their sexual victimization.

FYI—Although it is not common, it is possible that a person could hallucinate that they were sexually assaulted and be unable to separate the hallucination from reality. Regardless of the evidence in such a case, service providers should recognize that the person believes the assault occurred and may be traumatized. They can offer support to the person to deal with the impact of the trauma she is experiencing and assist her with her related needs (crisis intervention, safety planning, linking her with mental health treatment if permitted and warranted, etc.). (See S*exual Violence 101. Understanding and Responding to Emotional Trauma.*)

Being able to trust service providers may be difficult for some victims. Helping a victim in need infers a sharing of problems, concerns and anxieties. This sharing cannot be done without trust between the victim and the service provider. That trust is built upon mutual respect and the understanding that discussions are confidential. However, gaining trust is sometimes difficult when working with a person who has feelings of paranoia, anxiety and/or a history of being abused or discounted by others.

How to help: Service providers must demonstrate they are trustworthy by maintaining the confidentiality of information that victims share with them, unless the case requires a mandatory report or the victim consents to releasing the information to specific individuals or agencies. (See *Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Confidentiality.*) Service providers should:

- Not assume that a victim lacks competency to make her own decisions or needs a guardian. In West Virginia, only the courts have the power to make these determinations for residents. (See *Disabilities 101. Guardianship and Conservatorship.*)
- Not assume that the victim's information should automatically be shared with her guardian—in reality, service providers and victims must assess this need on an individual case basis.
- Not assume that it is necessary to involve a mental health treatment provider.

Being able to trust service providers may be the first step for a victim towards gaining the confidence and resources needed to make a report or to recover.

A mental illness may exacerbate a victim's reactions to sexual violence (e.g., triggering depression, anxiety, hallucinations, dissociation or suicide attempts).

How to help: Service providers can help victims realize that a mental illness may intensify their reactions to the sexual assault and discuss the options available that may help relieve their symptoms, including utilizing local mental health resources. Note that victims may or may not already be working with a local mental health provider and may or may not welcome their interventions. (See *Sexual Violence 101. Understanding and Addressing Emotional Trauma.*)

If victims appear to be a danger to themselves or others, they may require immediate emergency assistance. Service providers should follow their agency's policies regarding specific actions to take in these situations. (See *Sexual Violence 101. Mandatory Reporting* and *Sexual Violence 101. Crisis Intervention*. Also see the previous section in this module on suicidal thoughts and possible accommodations.)

The fact that a victim has a mental illness may influence the consequences that she faces when she discloses sexual violence, such as having her abusive caregiver taken away and her independence reduced, changing mental health treatment and/or even being institutionalized (e.g., because she is perceived as being a threat to herself/others and/or unable to live on her own).

How to help: Service providers can encourage victims with mental illnesses to discuss their concerns and options regarding the potential consequences of disclosing/reporting. For example, a victim may disclose a sexual assault along with increased anxiety and substance abuse, but be reluctant to talk with a mental health provider because she doesn't want to increase her medication or participate in inpatient treatment. The service provider can help the victim consider her needs and options related to self-care.

To close *Part 1: Core Knowledge*, let's return to the scenario that opened this module and discuss how service providers might respond. Here's the scenario:

A 24-year-old female Army officer discloses to you that she was sexually assaulted several months ago while she was at a military rehabilitation center—she was injured in combat, losing

a foot. She was also dealing with post-traumatic stress and depression. She hasn't reported the assault—the perpetrator was another patient who told her that nobody would believe her since she was a "nut case." She doesn't want him to "drag her reputation through the mud" or jeopardize her career. She is calling mainly because she is scared that since the assault, her overall feeling of despair is intensifying.

A service provider's initial response to this victim might include:

- Validating her for seeking help, regardless of whether she reports the assault to law enforcement;
- Asking her what assistance she would like, explaining the agency's services and any limitations;
- Asking her if she feels safe (from the offender or if there is a danger of self-harm);
- If she reports that she doesn't feel safe from self-harm, follow agency policy for activating immediate emergency assistance;
- Asking her to talk more about her reactions to the victimization and her related feelings, fears and concerns;
- Asking her what she would like to do to deal with these feelings, fears and concerns and what would help her to regain control of the situation;
- Discussing available options to address her needs (including her contacting a counselor or mental health provider to further explore how to deal with the despair);
- Discussing if she requires accommodations to address her needs and to access resources; and
- If she permits, helping her plan for her future safety and the next steps in addressing her concerns.

(For more specific discussion on initial responses, see *Sexual Violence 101. Understanding and Addressing Emotional Trauma, Sexual Violence 101. Crisis Intervention* and *Sexual Violence 101. Safety Planning*.)

Even if you do not complete *Part 2: Discussion* of this module as part of a group dialogue, it may be helpful to review the activities in that section, especially those with the case scenarios. They provide the opportunity to practice responding in different situations to persons who may have a mental illness and to think about how to accommodate their needs.

FYI—It may be helpful for those agencies that do not have in-house mental health expertise to partner with a local mental health provider, particularly one with experience in working with sexual violence victims. When agencies partner in this way, they help staff recognize their agency's scope of service and limitations in assisting victims with mental illnesses, as well as to know if and when to reach out to an outside mental health provider for specialized assistance (e.g., for consultation to guide their own response to a victim or to connect an interested victim to appropriate treatment services).

Test Your Knowledge

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

1. What types of disruptions can a mental illness cause? What are examples of different types of mental illnesses? *See pages C5.2-C5.3.*
2. One in how many people suffers from a serious mental illness? *See page C5.3.*
3. Is the prevalence of sexual victimization among persons with mental illnesses less than, equal to or greater than it is among the general population? *See page C5.3.*
4. What are examples of common indicators of various mental illnesses and possible accommodations victims might need? *See pages C5.4–C5.6.*
5. What should service providers do if a victim is suicidal? *See page C5.6.*
6. What are examples of societal misconceptions about mental illnesses that might impact sexual assault victims? *See page C5.6.*
7. What can a service provider do to assist persons with mental illnesses who were victimized by their caregivers? *See page C5.7.*
8. What are examples of how the issue of credibility can influence a community's response to a person with a mental illness who discloses sexual assault? How can a service provider help a victim deal with credibility issues? *See page C5.7.*
9. How might a mental illness influence a victim's reactions to sexual violence? How can a service provider help? *See page C5.8.*
10. What are examples of potential negative consequences for a person with a mental illness who discloses or reports sexual victimization? How can a service provider help? *See page C5.8.*

West Virginia Resources/Services for Persons with Mental Illnesses

STATE MENTAL HEALTH AGENCY

Division for Adult Mental Health
Bureau for Behavioral Health and Health Facilities
Department of Health and Human Resources
Phone: 304-558-0627
Fax: 304-558-1008
E-mail: obhs@wvdhhr.org
Internet: www.wvdhhr.org/bhhf/adultmh.asp

The Division for Adult Mental Health provides information about admission, care, treatment, release and patient follow-up in public or private psychiatric residential facilities in West Virginia.

STATE SUBSTANCE ABUSE AGENCY

Division of Alcoholism and Drug Abuse
Bureau for Behavioral Services and Health Facilities
Department of Health and Human Resources

Phone: 304-558-0627
Fax: 304-558-1008
E-mail: obhs@wvdhhr.org
Internet: http://www.wvdhhr.org/bhhf/ada.asp

The Division of Alcoholism and Drug Abuse provides information about the treatment and care of substance abuse disorders in West Virginia.

ADVOCACY

NAMI West Virginia
Phone: 304-342-0497
Toll-free: 800-598-5653
Fax: 304-342-0499
E-mail: namiwv@aol.com
Internet: www.namiwv.org

The National Alliance on Mental Illness (NAMI) maintains a helpline for information on mental illnesses and referrals to local groups. Local self-help groups have support and advocacy components and offer education and information about community services for families and individuals.

ADVOCACY

West Virginia Mental Health Consumers' Association
Phone: 304-345-7312
Toll-free: 800-598-8847
Fax: 304-414-2416
Internet: www.wvmhca.org

Statewide consumer organizations are run by and for consumers of mental health services and promote consumer empowerment. They provide information about mental health and other support services at the state level and are active in addressing and advocating for mental health system issues.

FAMILY SUPPORT

Mountain State Parents, Children and Adolescent Network
Phone: 304-233-5399
Toll-free: 800-244-5385
Fax: 304-233-3847
E-mail: ttoothman@mspcan.org
Internet: www.mspcan.org

This statewide, family-run organization provides support and information to families of children and adolescents with serious emotional disorders.

STATE PROTECTION AND ADVOCACY AGENCY

West Virginia Advocates, Inc.
Litton Building, Fourth Floor
Phone: 304-346-0847 (TDD)
Toll-free: 800-950-5250 (Nationwide/TDD)
Fax: 304-346-0867

Internet: www.wvadvocates.org

Spanish language assistance available.

West Virginia Advocates, Inc. is the federally mandated protection and advocacy agency for the rights of people with disabilities in West Virginia. It provides advocacy services and investigates reports of abuse and neglect that arise during the transportation or admission to facilities that care for or treat individuals with disabilities, during residency in them or within 90 days after discharge from them.

INVESTIGATION OF FRAUD AND MISTREATMENT

WV Medicaid Fraud Control Unit (MFCU)
Office of Inspector General, Department of Health and Human Resources
Phone: 304-558-1858
Fax: 304-558-3498
Tipline: 888-372-8398
Internet: http://www.wvdhhr.org/oig/mfcu/

The MFCU investigates complaints of alleged fraud and mistreatment of patients in facilities receiving payment from medical programs of the state.

LOCAL SOURCES OF INFORMATION

Also consider local resources. Your area mental health center and other branches of city or county government may be able to help. For example, your local board of education office might have information about help for children and the agency for the aging might know about services for senior citizens. Also, family physicians or area hospitals may be able to make referrals. For legal advice, contact the local bar association or go to www.findlegalhelp.org. The library and telephone yellow pages may offer applicable resource lists.

National/Regional Resources for Persons with Mental Illnesses

Centers for Medicare and Medicaid Services (CMS)
Phone: 410-786-3000
Toll-free: 877-267-2323
TDD: 866-226-1819
E-mail: question@CMS.gov
Internet: www.CMS.gov

CMS, a component of the U.S. Department of Health and Human Services, addresses patient complaints about treatment facilities that receive Medicare and Medicaid funding (e.g., see its Beneficiary Complaint Response Program). Concerns may also be shared with staff at West Virginia's regional office for CMS:

Philadelphia Regional Office (Region 3)
Centers for Medicare and Medicaid Services
Phone: 215-861-4140
Fax: 215-861-4140
Internet: www.CMS.gov/RegionalOffices/04_RO3.asp

National Mental Health Consumers' Self-Help Clearinghouse
Phone: 215-751-1810
Toll-free: 800-553-4KEY (539)
Fax: 215-636-6312
E-mail: info@mhselfhelp.org
Internet: www.mhselfhelp.org

This clearinghouse promotes and helps to develop consumer-run self-help groups across the country. Technical assistance and materials are available on such topics as organizing groups, fundraising, leadership development, incorporating, public relations, advocacy and networking.

Consumer Organization and Networking Technical Assistance Center (CONTAC)
Phone: 304-345-7312
Toll-free: 888-825-TECH (8324)
Fax: 304-345-7303
E-mail: usacontac@contac.org
Internet: www.contac.org

CONTAC is a resource center for consumers/survivors and consumer-run organizations. Services and products include informational materials, on-site training and skill-building curricula, electronic and other communication capabilities, networking, and customized activities promoting self-help, recovery, leadership, business management and empowerment.

Mental Health America Resource Center
Phone: 703-684-7722
Toll-free: 800-969-6642
TDD: 800-433-5959
Fax: 703-684-5968
E-mail: infoctr@nmha.org
Internet: www.nmha.org

Mental Health America (formerly the National Mental Health Association) maintains a referral and information center and can help you locate local chapters. These local groups have information about community services and engage in national and state level advocacy.

National Empowerment Center
Phone: 978-685-1494
Toll-free: 800-769-3728
Fax: 978-681-6426
E-mail: info4@power2u.org
Internet: www.power2u.org

This center, run by mental health consumers, carries a message of recovery, empowerment, hope and healing to people who have been diagnosed with a mental illness. It provides information and referrals to consumer resources and offers technical assistance to individuals and groups involved in consumer empowerment activities.

ADDITIONAL NATIONAL ONLINE RESOURCES

National Alliance on Mental Illness (NAMI)
www.nami.org

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

National Suicide Prevention Lifeline (24 hour)
www.suicidepreventionlifeline.org

1-800-273-TALK (8255)
Calls are routed to the nearest crisis center in a national network of more than 140 crisis centers.

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov

Part 2: DISCUSSION

Projected Time for Discussion

2 hours

Purpose and Outcomes

This discussion is designed to help participants apply the information presented in *Part 1: Core Knowledge* of this module to their work with sexual violence victims. It could be incorporated into forums such as agency staff meetings as well as volunteer meetings or trainings. Anticipated discussion outcomes include skill building and increased understanding of service providers' roles in working with sexual violence victims who have mental illnesses.

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

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 have expertise in responding to persons with mental illnesses who are also victims of sexual violence.
- Participants and the facilitator should review *Part 1: Core Knowledge* of this module before the discussion, as well as *Disabilities 101. Tips for Communicating with Persons with Disabilities*.
- Bring the following supplies and materials to the meeting: flipcharts and colored markers, sufficient copies of participant materials, office supplies (tape, pens, paper, etc.) and a clock/watch to monitor time. Optional items include name badges and table tents.

Suggested Activities and Questions

1. **Invite participants to identify discussion ground rules to promote open communication.** Utilize the following principles: *(10 minutes)*

- An environment of mutual respect and trust is optimal. Everyone should feel comfortable expressing their opinions and feelings about the scenarios. 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 participants and ultimately may shut down dialogue. The purpose of the role play scenarios is to provide an opportunity to practice new skills and obtain constructive feedback.
- Be clear about what information discussed during this meeting is confidential and what the expectations are for confidentiality in the context of this partnership.

2. **Invite participants to share their general experiences in working persons with mental illnesses, as well as with sexual violence victims with mental illnesses**. *(15 minutes)*

a. What are common issues and challenges?

b. What unique issues and challenges arise when interacting with victims with specific mental illnesses?

c. Does your agency have in-house expertise on mental health issues and/or partnerships in the community? Describe.

d. What additional actions or resources would be helpful to improve your agency's capacity to effectively serve these victims?

3. Have participants break into small groups and assign each group one or more of the scenarios below. **Ask each group to consider the issues and challenges specific to that scenario and then outline how they would respond to that victim** (what they would say, discuss, share and ask). Remember the focus is on the initial response during intake or crisis intervention. Be careful not to step beyond your professional role within your agency. Each small group should select a recorder to take notes and a reporter to report back to the large group. (10 to 15 minutes per scenario; time will vary depend on how may scenarios each group reviews)

Scenario 1

A 23-year old woman was sexually assaulted by her pastor, whom she was seeing regularly to talk about her severe anxiety. Her fears are "smothering her"—she can't stop thinking that she will have an anxiety attack and die if she sees the pastor again, that she will get AIDS and die, that she will have to face the humiliation of a sexually transmitted infection, that she will become pregnant, that the congregation will rally behind the pastor and ostracize her, that the pastor's wife will think she was trying to seduce him, that her parents will literally die of embarrassment, etc. What do you do to help?

Scenario 2

A 15-year-old male calls you and discloses that he woke up in the middle of the night last evening to find his step-father fondling his penis. He is humiliated by what happened and says that he wants to kill his step-father and will do so if tries to touch him again. Although he wants to leave home, he feels he must stay there to protect his sister from his step-father. He admits that since the attack, he has tried to calm himself by taking more anti-depression medication than he is prescribed. He also has been cutting himself and obsessively washing to rid himself of the" feeling of his step-father's touch," to the point where his skin is raw and bleeding. He refuses to tell you his name, the step-father's name or where he lives. What do you do to help?

Scenario 3

A 30-year old woman with chronic depression discloses a history of child and adult sexual victimization. She has sporadically sought mental health treatment and frequently stops taking her anti-depression medications due to negative side effects. She self-medicates with alcohol. She has a great sense of humor, which helps her cope, especially when she sees her 45-year-old brother who sexually abused her throughout her childhood. She has never confronted him or disclosed his abuse to any family member; he maintains power over her by constantly putting her down. She worries about whether he has abused other children. She is a frequent caller to your agency (so you are aware of her circumstances), reaching out when she has flashbacks, bouts of self-loathing, interactions with her brother, or is intoxicated. She often feels suicidal. What do you do to help?

Scenario 4

A 50-year-old man tells you he has been fired from his job after he disclosed to his supervisor that "ever since he had that 'problem with the IRS' a few years ago, tax auditors have blackmailed him to perform oral sex on them, threatening to start an IRS investigation on him unless he meets their demands." Ultimately, he lost his job because he refused mental health treatment (and still does not want it). He reported the incidences to law enforcement, but they "didn't believe him." His family and friends have "abandoned" him because they "think he is crazy" and he is now close to losing his home. He is desperate for someone to believe him and do something about "the blackmail by the IRS." What can you do to help?

4. As a large group, **facilitate a review and discussion of issues, challenges and appropriate responses for each scenario**. Ask a reporter from each assigned group to report back and then use the below "scenario considerations" to help guide discussions. *(10 minutes per scenario, for a total of 40 minutes)*

Scenario 1: Considerations

Validate the victim for seeking help. Help her calm down as needed so she can engage in a conversation with you. Ask what assistance she would like from you/your agency, briefly explaining your agency's services and limitations. If it was a recent assault, let her know that she can go to the local hospital for a sexual assault forensic medical examination to address her concerns about her health (e.g., get emergency contraception to prevent pregnancy and preventative treatment for sexually transmitted infections) and have evidence gathered. Discuss her options to report to law enforcement. Aid her in understanding that she is experiencing common reactions to being sexually assaulted, but her reactions may be more

intense and intrusive due to her anxiety. Ask her what she has done in the past to get through these feelings and help her plan how she will use these and other tactics to deal with her current concerns. If she is at a point that she can discern her anxiety from reality, talk with her about replacing her fears with facts (e.g., it is unlikely she would die from an anxiety attack, that she will contract AIDS or a sexually transmitted infection or die from these conditions, or become pregnant). Discuss with her that sexual assault is always the fault of the perpetrator; nothing she did provoked his assault. Help her prepare for the reality that some people may make assumptions about what happened, not wanting to consider that they misplaced their trust in the pastor. She can't control what other people think, just how she deals with their opinions. Help her plan how she wants to deal with these situations, including identifying who she can turn to for support.

Scenario 2: Considerations

Validate the victim for seeking help and ask what assistance he would like from you/your agency, briefly explaining your agency's services and limitations. Share with him the common feelings that victims of sexual violence experience, such as humiliation, pain and fear, and let him know the abuse was not his fault and that he can heal from it. Let him know that, like him, some victims self-medicate and self-mutilate to divert emotional pain. Some obsessively try to wash the touch of the perpetrator off of their bodies. Discuss with him healthier options available for dealing with these feelings. Talk with him about his safety and that of his sister and his options for protection, as well as potential consequences of retaliation against the offender—and help him develop a plan for safety if he permits. Help him identify persons whom he can turn to for support (e.g., a counselor, teacher, relative, friend, etc.). Explain what will happen if he reports the abuse to Child Protective Services (CPS) or law enforcement and provide him with the contact information. Let him know he and his sister deserve to be safe from his step-father and that you would like to make a report if he would provide you with the pertinent contact information (even though he may refuse to provide it). Explain that he can also go to the local hospital to address any health concerns (e.g., if he gets an infection from the obsessive washing).

Scenario 3: Considerations

This scenario deviates from the others in that the victim has previously disclosed sexual violence to your agency, but she frequently calls in crisis. Trauma caused by sexual victimization is rarely a one-time event, but rather can be repeatedly triggered throughout one's lifetime. Depression intensifies traumatic reactions for this victim. Each crisis call from a frequent caller needs to be treated as a new crisis requiring the development of a new action plan (even if the plan ends up being similar for each crisis).

Validate her for seeking help (she already is aware of your agency's services) and focus on providing crisis intervention to help her deal with her suicidal thoughts, self-loathing and fears produced by the flashbacks. Ask her if she is actively planning to kill herself and has the means (if so, seek immediate emergency assistance). Ask her about her drug/alcohol use. Help her determine how she will get through the current crisis, reminding her that she has gotten through crises before and can again. Aid her in developing a plan to become more stable (this plan may include her contacting her mental health provider to discuss medications and crisis needs). Encourage her to call again if she is in crisis, as well as to interact with and seek help from her support system (her counselor, doctor, a support group, friends, etc.).

Scenario 4: Considerations

Regardless of whether the events the man describes actually happened or are a hallucination/distortion of reality, you can validate him for seeking help and let him know you understand he believes the sexual violence occurred. Ask what assistance he would like from you/your agency, briefly explaining your agency's services and limitations. Assure him that by contacting law enforcement he has warned the community about this problem. It may be useful if a law enforcement detective explains to him why his case was closed/what evidence was lacking (offer to connect him with the law enforcement agency). Ask him what he would like to do to deal with this trauma in his life. Offer to help him explore his options and make a plan for rebuilding a support system, his emotional health, financial stability, housing, etc. You can offer information about available counseling and mental health services (e.g., he might be more receptive to ongoing therapy or a support group than psychiatric care). Recognize, however, that he may not be able to have a rational discussion about what he is experiencing, whether or not he has a mental illness.

5. **Closing.** Ask participants what they learned from this module and how they will apply the lessons learned to their practice settings. *(10 minutes)*

Project partners welcome the non-commercial use of this module to increase knowledge about serving sexual violence victims with disabilities in any community, and adaptation for use in other states and communities as needed, without the need for permission. We do request that any material used from this module be credited to the West Virginia Sexual Assault Free Environment (WV S.A.F.E.) project, a partnership of the West Virginia Foundation for Rape Information and Services, the Northern West Virginia Center for Independent Living and the West Virginia Department of Health and Human Resources (2010). Questions about the project should be directed to the West Virginia Foundation for Rape Information and Services at www.fris.org.

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[1]Partnering agencies refer to the persons they serve as "clients," "consumers" and "victims." For convenience, "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]Paragraph drawn from National Alliance on Mental Illness (NAMI), *Mental illness facts* (Arlington, VA, accessed May 12, 2010), through http://www.nami.org/. Note that all 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. Note, however, that this reference to female victims does not imply that most persons who have mental illnesses are women—statistics on gender vary depending on the type of mental illness. Discussion of these statistics is beyond the scope of this module.

[4]Paragraph drawn from NAMI.

[5]Drawn in part from WebMD, *Types of mental illness* (2009), http://www.webmd.com/mental-health/mental-health-types-illness.

[6]Another publication that is sometimes referred to classify mental illnesses is the International classification of diseases by the World Health Organization.

[7]In addition to mental illness, the *DSM* classification system speaks to other mental disabilities. For instance, it identifies autism and intellectual disabilities (also referred to as mental retardation) as forms of developmental disabilities, not mental illnesses. Autism affects brain functioning; it may impact communication and social skills, and can cause extreme sensitivity to physical contact (as cited in Autism Defined Net, Autism defined (2010), http://autismdefined.net/). An intellectual disability is characterized by a significantly below-average score on a test of mental ability or intelligence and limited daily living skills (as cited in NAMI; and Centers for Disease Control and Prevention, *Intellectual disabilities* (Atlanta, GE, 2005), http://www.cdc.gov/ncbddd/dd/ddmr.htm).

[8]R. Kessler, W. Chiu, O. Demler & E. Walters, Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Co-morbidity Survey replication, *Arch Gen Psychiatry* 62(6) (2005), 617-27. Note that the term "mental disabilities" in this article is inclusive of more conditions than just mental illnesses.

[9]Kessler, Chiu, Demler & Walters.

[10]P. Tjaden & N. Thoennes, *Prevalence, incidence and consequences of the violence against women: Findings from the National Violence Against Women Survey* (Washington, DC: National Institute of Justice and Altanta, GE: Centers for Disease Control and Prevention, 1998), http://www.ncjrs.gov/pdffiles/172837.pdf.

[11]L. Goodman, M. Salyers, K. Mueser, S. Rosenberg, M. Swartz, S. Essock, et al., Recent victimization in women and men with severe mental illness: Prevalence and correlates, *Journal of Traumatic Stress,* 14(4) (2001), 615-632. As cited in Kentucky Association of Sexual Assault Programs, Recognizing Sexual Victimization of Persons with Disabilities (2007),
http://kyasap.brinkster.net/Portals/0/pdfs/pro%20guide%20pages/RecognizDisabilPg14.pdf.

[12]A. Clayton, Sexual abuse and mental health sequelae, *Primary Psychiatry* (2010), http://www.primarypsychiatry.com/aspx/articledetail.aspx?articleid=682. This article provides information about multiple studies that support this statement, as well as additional comments of the author.

[13]J. Coverdale & S. Turbott, Sexual and physical abuse of chronically ill psychiatric outpatients compared with a matched sample of medical outpatients, *Journal of Nervous and Mental Disease,* 188(7) (2000), 440-445; S. Friedman, L. Smith, D. Fogel, et al., The incidence and influence of early traumatic life events in patients with panic disorder: A comparison with other psychiatric outpatients, *Journal of Anxiety Disorders,* 16(3) (2002), 259-272; and S. Dinwiddie, A. Health, M. Dunne, et al., Early sexual abuse and lifetime psychopathology: A co-twin–control study, *Psychological Medicine,* 30(1) (2000), 41-52. As cited in Clayton.

[14]For more information on the following symptoms and behaviors, see the *Diagnostic and statistical manual of mental disorders* (DSM) by the American Psychiatric Association.

[15]With the exception of the last sentence, drawn from Mental Health America, Factsheet: *Dissociation and dissociative disorders* (Alexandria, VA, 2010), http://www.nmha.org/go/dissociation.

[16]For more on sexual violence and substance abuse, see Wisconsin Coalition Against Sexual Assault, *Sexual violence and substance abuse, information sheet series* (Madison, WI: 2000), http://www.prandicenter.org/Resources/sexual%20assault%20and%20substance.pdf.

[17]For example, the risk for persons who have experienced a major depressive episode is about 4 percent more than for the general population; almost 15 percent more for those who have had a manic episode; and about 10 percent more for those who have schizophrenia. From the National Institute of Mental Health, as cited in National Drug Intelligence Center, *Drug abuse and mental illness fast facts* (Johnstown, PA: U.S. Department of Justice, 2004), http://www.justice.gov/ndic/pubs7/7343/index.htm.

[18]M. Gliatto & A. Rai, Evaluation and treatment of patients with suicidal ideation, *American Family Physician* (1999), http://www.aafp.org/afp/990315ap/1500.html.

[19]E. Moscicki, Identification of suicide risk factors using epidemiologic studies, Psychiatric Clinics of North America, 20 (1997), 499-517. As cited in Gliatto & Rai.

[20]Gliatto & Rai.

[21]C. Rich, D. Young & R. Fowler, San Diego suicide study. I. Young vs. old subjects, *Archives of General Psychiatry,* 43 (1986), 577-82; and Moscicki. As cited in Gliatto & Rai.

[22]Gliatto & Rai.

[23]Mayo Foundation for Medical Education and Research, *Suicide: What to do when someone is suicidal* (2010), http://www.mayoclinic.com/health/suicide/MH00058.