



B. What You Need to Know

TABLE OF CONTENTS

Introduction	3
B1. Sexual Violence and Related Crimes.....	4
Sexual Violence Laws	4
Criminal Justice Response.....	6
Civil Legal Remedies	7
Child Sexual Abuse	8
Drug Facilitated Sexual Assault	9
Sexual Harassment	10
Related Issues	11
Dating Violence.....	11
Stalking and Harrassment.....	12
Bullying.....	12
Cybercrimes	14
B2. Background.....	16
Gender Bias	16
Victim Blaming	16
Sex Offenders	18
Power and Control	18
No Typical Profile.....	19
Likelihood of Reoffending.....	19
Sentencing.....	19
B3. Responding to Disclosures of Sexual Violence	21
Coordinated Response	21
Health Consequences	21
Traumatic Reactions.....	22
State Requirements Related to Disclosures of Victimization.....	23
Mandatory Reporting	23
Informed Consent and Guardianship/Conservatorship.....	24
Confidentiality.....	25
Initial Response to a Victim in a Group Setting.....	25
Customizing Your Response	26
Crisis Intervention.....	26
Preservation of Evidence.....	27
Planning for Safety	27
If a Victim Has a Disability	28

B4. Preparing to Present Sexual Violence Training and Prevention Programs.....	30
Approach to Prevention	30
Collaborating to Enhance Prevention Efforts	30
Characteristics of Effective Prevention Programs.....	31
Tips for Facilitating Training and Prevention Activities.....	31
Cultural Competence.....	32
Promoting Healthy Sexuality and Healthy Relationships.....	33
Addressing Bystander Intervention	34
If You Have a History of Sexual Victimization.....	38
Including Details of Survivor’s Experiences in Presentations.....	38
B5. Program Evaluation.....	40
What is Evaluation.....	40
Different Types of Evaluation.....	40
Process Evaluation	41
Outcome Evaluation	41
Evaluation Design	43
Planning for Evaluation.....	43
Employing a Logic Model in Your Evaluation Planning.....	44
Sample Logic Model: Middle School Sexual Violence Prevention Program.....	46
Sample Participant Questionnaire.....	47
References.....	49

INTRODUCTION

Presenting prevention programs and trainings on sexual violence involves more than making a presentation. For example, with most other prevention topics, just sharing the message and the consequences of not heeding the warning are enough for effective programs. Simple, powerful messages alone such as “don’t drink and drive;” “wear seatbelts;” and “smoking can cause cancer” have changed behaviors and saved lives.

Sexual violence training and prevention work is different. Sexual violence involves the most intimate of personal violations and is the most underreported violent crime. In doing sexual violence presentations, the presenter must have sufficient knowledge to address not only the prevention or training content, but also be able to provide crisis intervention and support to those in the audience who disclose sexual victimization. Rape crisis center staff report that disclosures of victimization occur at many of the awareness/prevention programs they present.

The following is a brief overview of the key issues that the creators of this toolkit believe are critical for anyone presenting sexual violence trainings and prevention programs. It is divided into the following main sections:

- Sexual violence and related crimes (B1);
- Background information (B2);
- Responding to victim disclosures (B3);
- Preparing to present sexual violence training and prevention programs (B4); and
- Program evaluation (B5).

You are encouraged to learn more about these issues through the West Virginia Foundation for Rape Information and Services (WVFRIS) at www.fris.org and by partnering with your local rape crisis centers

when coordinating prevention programs, trainings and activities.



Note that many of the topics covered in this section of the toolkit were adapted from the following sources:

- *WV S.A.F.E. Training and Collaboration Toolkit—Serving Sexual Violence Victims with Disabilities*, available through www.fris.org;
- Training modules of WVFRIS and West Virginia’s rape crisis centers; and
- Information provided through WVFRIS web pages at www.fris.org.



Remember that acquiring new knowledge and putting it into practice is a process. *You are not expected to “know” the information in the toolkit all at once.* Instead, you can work through toolkit sections at your own pace, building your knowledge base as you go and considering how new information fits into your programming efforts.

After a sexual assault, victims should be encouraged to go to a local hospital emergency department for medical care and evidence collection. Forensic evidence can be collected in West Virginia within 96 hours of an assault, whether or not a report is made to law enforcement. However, if abuse or neglect of a child or an incapacitated adult is suspected, it must be reported to the state Department of Health and Human Resources at 800-352-6513. (Also see B3. *Responding to Disclosures of Sexual Violence* in this toolkit.)

B1. SEXUAL VIOLENCE AND RELATED CRIMES

Sexual violence is broadly defined by the World Health Organization (Krug et al., 2002) as any sexual act or attempt to obtain a sexual act (as well as unwanted sexual comments or advances or acts to traffic) directed against a person's sexuality using coercion. For the toolkit's purpose, this overview of sexual violence is focused on those acts which are considered crimes in West Virginia. Examples of crimes of sexual assault and abuse include:

- Rape—sexual intercourse against a person's will;
- Forcible sodomy—anal or oral sex against a person's will;
- Forcible object penetration—penetrating someone's vagina or anus, or causing that person to penetrate her/himself, against that person's will;
- Unwanted sexual touching;
- Sexual contact with a person who lacks the capacity to give consent;
- Incest (sexual contact between family members); and
- Any other nonconsensual sexual contact.

The related issues of sexual harassment, stalking, sexual violence in dating relationships, and harassment/sexual solicitation involving use of the computer/Internet are also discussed in this overview.

Sexual Violence Laws

You should be aware that sexual assault and sexual abuse are the two major classifications of sex offenses in West Virginia (WVC§61-8B).

Sexual abuse occurs when a person subjects another to sexual contact without her/his consent, and that lack of consent is due to physical force, threat or intimidation. *The three levels of sexual abuse in West Virginia are:*

- **1st Degree:** Sexual contact without the victim's consent due to forcible compulsion, the victim is physically helpless, or the victim is younger than age 12 and the perpetrator is age 14 or older.
- **2nd Degree:** Sexual contact with someone who is mentally defective or mentally incapacitated.
- **3rd Degree:** Sexual contact with a victim under age 16 without her/his consent.

Sexual assault is sexual intercourse or sexual intrusion without consent. *West Virginia's three levels of sexual assault include:*

- **1st Degree:** The perpetrator inflicts serious bodily injury, uses a deadly weapon, or the perpetrator is over age 14 and the victim is younger than 12 years old and is not married to that person.
- **2nd Degree:** Sexual intercourse or intrusion without consent and lack of consent is due to forcible compulsion or physical helplessness.
- **3rd Degree:** Sexual intercourse or intrusion with someone who is mentally defective or mentally incapacitated, or when someone age 16 or older assaults someone less than 16 who is at least 4 years younger than the perpetrator and not married to him/her.

Explanation of Terms: WV Sexual Abuse and Sexual Assault Laws

(see www.legis.state.wv.us)

Forcible compulsion: (a) physical force that overcomes such earnest resistance as might reasonably be expected, under the circumstances; (b) threat or intimidation, expressed or implied, placing a person in fear of immediate death or bodily injury to him/herself or another person or in fear that he/she or another person will be kidnapped; or (c) fear by a person under 16 years of age caused by intimidation, expressed or implied, by another person who is at least four (4) years older than the victim. For the purpose of this definition, "**resistance**" includes physical resistance or any clear communication of the victim's lack of consent.

Married: for the purpose of this article, in addition to its legal meaning, includes persons living together as husband and wife regardless of the legal status of their relationship.

Mentally defective: a person suffers from a mental disease or defect which renders that person incapable of appraising the nature of his/her conduct.

Mentally incapacitated: a person is rendered temporarily incapable of appraising or controlling his/her conduct, as a result of the influence of a controlled or intoxicating substance administered to that person without his/her consent or a result of any other act committed upon that person without his/her consent.

Physically helpless: a person is unconscious or for any reason is physically unable to communicate unwillingness to an act.

Sexual contact: intentional touching, either directly or through clothing, of the anus/any part of the sex organs of another person, or the breast of a female or intentional touching of any part of another person's body by the actor's sex organs, where the victim is not married to the actor and the touching is done to gratify the sexual desire of either party.

Sexual intercourse: any act between persons involving penetration, however slight, of the female sex organ by the male sex organ or involving contact between the sex organs of one person and the mouth or anus of another person.

Sexual intrusion: any act between persons involving penetration, however slight, of the female sex organ or of the anus of any person by an object for the purpose of degrading or humiliating the person so penetrated or for gratifying the sexual desire of either party.

Bodily injury: substantial physical pain, illness or any impairment of physical condition.

Serious bodily injury: bodily injury which creates a substantial risk of death, which causes serious or prolonged disfigurement, prolonged impairment of health, or prolonged loss or impairment of the function of any bodily organ.

Deadly weapon: any instrument, device or thing capable of inflicting death or serious bodily injury and designed or adapted for use as a weapon or possessed, carried or used as a weapon.

Note that while some of these terms are not the most sensitive choice of language, they currently define the law and influence charging decisions. Prevention educators and trainers are urged to avoid use of legal terms such as "mentally defective" in their presentations as their use could increase a victim's reluctance to seek assistance with safety, healing and justice.

The West Virginia Code also describes additional sex offenses:

- Use of minors in filming sexually explicit conduct (*WVC§61-8C-2*);
- Distribution and exhibiting of material depicting minors engaging in sexually explicit conduct (*WVC§61-8C-3*);
- Sexual abuse by a parent, guardian, custodian or person in a position of trust to a child; a parent, guardian, custodian or person in a position of trust to a child allowing sexual abuse to be inflicted on that child; and displaying of a child's sex organs by a parent, guardian or custodian (*WVC§61-8D-5*);
- Sending, distributing, exhibiting, possessing, displaying or transporting of material by a parent, guardian or custodian depicting a child engaged in sexually explicit conduct (*WVC§61-8D-6*); and
- Incest—engaging in sexual intercourse or sexual intrusion with one's father, mother,

brother, sister, daughter, son, grandfather, grandmother, grandson, granddaughter, nephew, niece, uncle or aunt (*WVC*§61-8-12).

See *Child Sexual Abuse* below for more discussion of sex crimes involving minors.



Here are some basic sexual assault statistics that may be useful as talking points for your presentations.

- About one in six women and one in 21 men in West Virginia indicated they were victims of an attempted or completed rape, according to the 2008 *West Virginia Behavioral Risk Factor Surveillance System Survey* (West Virginia Bureau for Public Health).
- According to the 2004 U.S. Department of Justice's *National Crime Victimization Survey*, 15 percent of sexual assault and rape victims were under age 12, 29 percent were age 12 to 17, 44 percent were under age 18, and 80 percent were under age 30. Ages 12 to 34 were the highest risk years; in particular, girls ages 16 to 19 were four times more likely than the general population to be victims of rape, attempted rape or sexual assault (RAINN, 2009).
- According to the West Virginia State Police 2010 Incident-Based Reporting System, 86.1 percent of sexual assault victims knew their offenders: 48.1 percent of sexual assaults were committed by an acquaintance, 7.4 percent by an intimate partner, 30.6 percent by other family members, and 4.5 percent by a stranger. In 9.4 percent of these cases, the relationship between victim and offender was unknown.
- National studies indicate that only 14 percent to 39 percent of all sexual assaults are ever reported (Kilpatrick, 2000).

Note that studies from which the data is extrapolated may define sexual violence differently and examine only certain forms, such as rape or sexual assault.

Also note that the statistics about prevalence and incidence only tell part of the story. The impact of sexual victimization on individuals' lives can be profound, potentially leading to serious short- and long-term physical, mental/emotional, sexual and reproductive health problems. Victimization can also affect those close to victims—family, friends, coworkers, classmates, etc. (See *B3. Responding to Victim Disclosures.*)

CRIMINAL JUSTICE RESPONSE

With criminal offenses such as sexual abuse and sexual assault, the county prosecuting attorney makes the decision whether or not to prosecute the case and what level of offense is charged. An offense is considered either a misdemeanor or a felony. With a misdemeanor, the lesser charge is punishable by fines and/or up to one year in a county jail. A felony is a more serious charge, punishable by at least one year in a state prison. A 1st degree sexual abuse offense is a felony, whereas 2nd and 3rd degree sexual abuse are misdemeanors. All degrees of sexual assault are felonies.

There is no statute of limitations for felony sex offenses in West Virginia. There is a one-year statute of limitation for misdemeanors, so 2nd and 3rd degree sexual abuse must be charged within one year after the offense was committed (*WVC*§61-11-9).

Once a crime of sexual abuse or sexual assault is reported to law enforcement, a criminal investigation may begin. Law enforcement makes the initial determination of what charges to file against a suspect. However, at the time an indictment is sought, the prosecuting attorney makes the decision as to what charge(s) should be brought in connection with a case.

To charge a suspect with sexual abuse or sexual assault, sufficient evidence that the

crime occurred is needed. Law enforcement seeks to help reconstruct details about the crime during an investigation. Physical evidence on victims' bodies can be collected for approximately 96 hours after the crime occurred—and potentially longer if evidence has not been destroyed by washing or showering, if the actual time of the assault is unknown, and/or if there are visible physical injuries. (See *B3. Responding to Disclosures of Sexual Violence* for information on forensic medical examinations for victims.) Evidence may also be found at the crime scene, on the suspect's body/clothes and at other locations. To support evidentiary findings, investigators seek statements from victims, suspects and witnesses.

Be aware that victims may be reluctant to report sex offenses to law enforcement.

Some of the most common reasons are self-blame, fear of retaliation, fear of rejection by family/friends, and unwillingness to deal with the humiliation, loss of privacy and negativity they perceive might accompany criminal justice system involvement (Office on Violence Against Women, 2004). In order for victims to make informed decisions about reporting, it is helpful for them to:

- Receive information about what they can expect when reporting and during any subsequent investigation, the benefits of reporting, and appropriate contact information;
- Discuss their concerns; and
- Become aware of other resources and civil legal options for assistance.

Rape crisis center advocates are available to provide this information to victims, support them throughout their involvement in the legal system and help them in obtaining other assistance. Victims can contact their local rape crisis center directly or by calling 1-800-656-HOPE. (See *D8. Resources for Victims.*)

CIVIL LEGAL REMEDIES

Whether or not there are criminal charges filed, civil legal remedies may also be available to sexual assault victims. The Victims Rights Laws Center at www.victimrights.org/ is a resource to learn about various civil legal issues that can arise in these cases (e.g., related to privacy, safety, employment, education, housing, immigration and public benefits). Victims can also seek monetary compensation for damages related to a sexual assault through a civil lawsuit.



It is helpful to have a general sense of what happens in a criminal or a civil case, so you can

explain the processes if needed (International Association of Forensic Nurses, 2010; Brandl et al., 2007). The following may be useful:

Under criminal law, when a person is a victim of another person's criminal act, the crime is considered to be committed against the community and not against an individual victim. Thus, prosecution represents the state rather than victims in criminal cases.

Certain restrictions are placed on prosecutors, in order to protect the rights of the accused. For example, the accused has the right to have an attorney, to not be subjected to unlawful search or seizure, to confront witnesses, and to not be forced to testify against oneself. Prosecutors are required to share any information with the defense that might prove that the accused is not guilty or less culpable of a criminal act.

Civil cases occur when private individuals or states file lawsuits against an individual, corporation or the government for harm/loss that has occurred. A civil lawsuit may list one or more torts (civil wrongs or injuries), including assault, negligence, infliction of emotional distress, false imprisonment or wrongful death. Sanctions usually include the injured party

receiving monetary compensation. Sometimes other awards can be made, but imprisonment cannot be imposed. Note that the burden of proof in a civil case is a “preponderance of the evidence,” a lower standard than required in a criminal case (in which guilt beyond a reasonable doubt is the standard).

Child Sexual Abuse

There is no one universal definition of child sexual abuse (American Psychological Association, 2011). However, "a central characteristic of any [child] abuse is the dominant position of an adult that allows him or her to force or coerce a child into sexual activity" (American Psychological Association, 2011). Each state has its own legal definition of sex offenses against children.

Generally speaking in West Virginia, **child abuse** involves a *parent, guardian or custodian of a child who knowingly or intentionally inflicts an injury upon that child*; and **sexual abuse of children** includes, but is not limited to, *sexual intercourse, sexual intrusion and sexual contact* (West Virginia Department of Health and Human Resources, Child Protective Services, 2008) (See *WVC§61-8B, 8C and 8D*). Note that not all sexual violence committed against children is child sexual abuse as described above. Teenagers, for example, can experience sexual assault perpetrated by their peers.

Examples of child sexual abuse include:

- Sexual touching and fondling of a child’s sexual body parts;
- Forcing a child to touch another person’s sexual body parts;
- Exposing a child to adult sexual activity or pornographic material;
- Having a child undress, pose or perform in a sexual manner;
- Taking pornographic pictures of a child;
- Voyeurism (“peeping” into private areas to watch a child);
- Exposing oneself to a child;
- Attempted or actual oral, anal or vaginal penetration;
- Sexualized talk;
- Making fun of a child’s sexual development, preferences or organs;
- Masturbating in front of a child;
- Forcing overly rigid rules on dress or forcing a child to wear revealing clothes;
- Stripping to hit or spank, or getting sexual excitement out of hitting; and
- Having the child engage in sexual activity with animals.

While child sexual abuse can be isolated to a single event, many children are sexually abused in some way over a period of years.

A child who is being sexually abused may display symptoms such as:

- Sleep disturbances/nightmares;
- Excessive clinging or crying;
- Bedwetting;
- Depression and/or anxiety;
- School problems;
- Running away;
- Hostility or aggression;
- Sexually transmitted diseases;
- Change in eating habits;
- Fear/dislike of particular adults/places;
- Drug/alcohol problems;
- Withdrawal from family, friends or usual activities;
- Frequent touching of private parts;
- Sexual behavior inappropriate to the age of the child;
- Physical symptoms involving the genital, anal or mouth area; and
- Any dramatic change in behavior/development of new behaviors.

Note, however, that the presence of such symptoms is not necessarily reflective of child sexual abuse.

Common emotional responses of children to sexual abuse include:

- *Fear* of the abuser, of getting into trouble or getting a loved one into trouble and/or of not being believed;
- *Guilt* for not being able to stop the abuse, for believing they consented to the abuse, and/or for telling/keeping the secret;
- *Shame* about the abuse and/or their body's reactions;
- *Confusion* due to their emotions (e.g., because they love the abuser);
- *Anger* at themselves and/or the abuser and others who failed to protect them;
- *Sadness* at being betrayed by someone they trusted; and
- *Isolation* because they feel alone and have trouble talking about the abuse.

To support a child when abuse has occurred (also see *B3. Responding to Disclosures of Sexual Violence*):

- Stay calm. Don't panic or overreact. Believe the child.
- Assure the child that she/he is not to blame for what happened.
- Let the child know it was brave to tell you and you are glad she/he told.
- Protect the child immediately from the suspected offender.
- Report the abuse at once to the West Virginia Department of Health and Human Resources, Child Protective Services (1-800-352-6513) or a law enforcement agency.
- Get a medical exam for the child, even if the child appears to be unhurt.
- Connect the child with a counselor.

Drug Facilitated Sexual Assault

In West Virginia, someone who is drunk or drugged cannot give consent to sex.

Perpetrators may intentionally drug their victims or prey on persons who have been voluntarily drinking in order to have sexual intercourse with them. If a person has sex with someone who is in such an incapacitated condition, it is sexual assault.

Sexual assaults are often linked to the abuse of drugs, primarily alcohol, that decrease inhibitions and make the user incapacitated. In addition to alcohol, the **drugs most often used to facilitate sexual assaults** are GHB, Ecstasy, Rohypnol (a benzodiazepine), Ketamine and Soma, although other benzodiazepines and sedative hypnotics are used as well. These drugs cause unconsciousness—an effect that is quickened and intensified when the drugs are taken with alcohol. They can also cause intense sleepiness, memory loss, nausea, lack of coordination, slurred speech, loss of inhibition, confusion, seizures and death. **Victims may be unconscious during all or parts of the sexual assault and, upon regaining consciousness, may experience anterograde amnesia**—the inability to recall events that occurred while under the influence of the drug.

Victims often are reluctant to report drug facilitated sexual assault because of a sense of guilt, embarrassment or perceived responsibility because they lack specific recall of the assault. Many of the drugs used in committing sexual assaults are rapidly absorbed and metabolized by the body, thereby making them undetectable in routine urine and blood drug screenings.

Signs that a person may have been drugged include:

- Feeling more intoxicated than usual for the amount of alcohol that was consumed;
- Waking up feeling very hung over, experiencing memory lapse and not being able to account for periods of time;
- Remembering taking a drink but not being able to recall what happened for a period of time after consuming the drink; and
- Thinking sex occurred, but not being able to remember any of the incident.

If individuals think they have been drugged and sexually assaulted, it is important to encourage them to get help immediately, go to a safe place, preserve evidence, and go to a hospital emergency department as soon as possible for a forensic medical examination.

To preserve evidence prior to the exam, they should not urinate, shower, bathe, douche or throw away clothes that they wore during the incident. They should also save other materials that might provide evidence (e.g., a glass that held the drink).

The first urine after the assault needs to be collected in a clean container for drug toxicology testing. Preferably the urine should be collected at the hospital. The likelihood of detecting the drugs used to commit the sexual assault lessens each time the person urinates. (Also see *B3. Responding to Disclosures of Sexual Violence.*)

Sexual Harassment

Sexual harassment includes unwelcome sexual advances, conduct of a sexual nature and requests for sexual favors.

According to the Equal Opportunity Employment Commission, it must explicitly or implicitly affect a person's employment, unreasonably interfere with school or work

performance or create an intimidating, hostile or offensive school or work environment. During the 2010-11 school year, 48 percent of students in grades seven through 12 experienced some form of sexual harassment (Hill & Kearn, 2011). Nearly two-thirds of college students experience sexual harassment at some point during their college years (Hill & Silva, 2006).

Sexual harassment can be:

- **Verbal** (e.g., making sexually degrading jokes or sending unwanted sexually harassing e-mails and text messages);
- **Physical** (e.g., standing in someone's way to sexually intimidate them); or
- **Non-verbal** (e.g., displaying sexually explicit pictures or making sexual gestures).

It can include offering benefits (e.g., better grades or a work promotion) in exchange for sexual favors or making threats after sexual advances are rejected.

Sexual harassment is a violation of federal and state discrimination laws in qualifying settings. Federal laws apply to certain work sites (Title VII of the Civil Rights Act of 1964) and school settings (Title IX of the Education Amendment of 1972). West Virginia law (*WVC§5-11, Legislative Rule Title 77*) addresses certain work settings. In addition to unwanted sexual conduct, hostile or physically aggressive behavior may also constitute sexual harassment under state law if the harassment is based on gender.

To report sexual harassment, victims should follow their school/workplace complaint policy, reporting the behavior to the proper authority using the written procedures of their school/workplace.

If the harassment continues after a reasonable amount of time following a report, victims may

have the right to file a formal complaint with the West Virginia Human Rights Commission at www.wvf.state.wv.us/wvhrc/ (for qualifying schools/workplaces), the West Virginia Equal Employment Opportunity Office at www.eeo.wv.gov (for state employees), the U.S. Equal Employment Opportunity Commission at www.eeoc.gov/ (for qualifying workplaces), or the Office of Civil Rights, U.S. Department of Education at www2.ed.gov/about/offices/list/ocr/index.html (for schools receiving federal financial assistance).

Related Issues

DATING VIOLENCE

Sexual violence can occur in dating situations. **Dating violence is the act/threat of violence by one partner in a dating relationship toward the other partner.**

Teens and young adults can experience the same types of abuse in relationships as adults:

- **Physical abuse**—intentional use of physical force with the intent to cause fear or injury, such as hitting, shoving, biting, strangling, kicking or using a weapon;
- **Emotional abuse**—non-physical behaviors such as threats, insults, constant monitoring, humiliation, intimidation, isolation or harassment; and
- **Sexual abuse**—action that impacts a person’s ability to control her/his sexual activity or the circumstances in which it occurs, including rape, coercion or unwanted sexual contact.

Violence in dating relationships can escalate in frequency and intensity from early incidents of emotional abuse to increasingly severe physical and sexual violence. Teens often report electronic aggression—receiving threats by text messages or being stalked on social

networking sites such as Facebook (see *Cybercrimes* below).

In addition to physical and emotional harm, dating violence for adolescent girls can be associated with an increased risk of substance use, unhealthy weight-control, sexually risky behaviors, pregnancy and suicidal thinking (Molidor, Tolman & Kober, 2000). Students experiencing dating violence may skip class to avoid an abuser, have difficulty concentrating, fail academically and/or drop out of school. The most serious acts are often committed during or after the breakup of the relationship, when the offender experiences a loss of control over his partner. Abuse almost always reoccurs in a relationship. It seldom just goes away.

A national survey found that approximately 12 percent of high school students reported experiencing physical violence in a dating relationship (Centers for Disease Control—CDC, 2000). Approximately one in five female high school students report being physically and/or sexually abused by a dating partner (Silverman et al., 2001). Adults who use violence with their dating partners often begin doing so during adolescence (Foshee et al., 1996). Studies suggest that the rates of dating violence among gay, lesbian, bisexual and transgender youth are comparable or even higher than those for heterosexual couples (Elze, 2002; Freedner et al., 2002).

You can educate individuals about potential warning signs of an abusive dating partner. For example, an abuser might frequently check his partner’s cell phone or email without permission, constantly tell his partner what to do and put her down, be extremely possessive, jealous and insecure, be moody, have an explosive temper, be financially controlling, and try to isolate his partner from family or friends.

STALKING AND HARASSMENT

Stalking or harassing behaviors might occur before or after a sexual assault. The Stalking Resource Center defines **stalking as a course of conduct directed at a specific person that would cause a reasonable person fear**. Under this definition, stalking can include a variety of behaviors, including harassment. However, **West Virginia law (WVC §61-2-9a) differentiates stalking from harassment:**

- To be charged with stalking in West Virginia, someone must repeatedly (two or more times) follow another person, knowing or having reason to know that the conduct causes the person followed to reasonably fear for his or her safety or suffer significant emotional distress.
- To be charged with harassment, someone must repeatedly (two or more times) harass or make credible threats against another person.



Note that the term stalking is used henceforth in this toolkit to refer to stalking and harassment.

There is a strong link between stalking and other forms of interpersonal violence.

The Bureau of Justice Statistics' 2006 *Supplemental Victimization Survey* found that nearly three in four stalking victims knew their offenders (Baum et al., 2009). Another national survey found that 81 percent of women who were stalked by a current or former partner were also physically assaulted by that partner and 31 percent were also sexually assaulted by that partner (Tjaden & Thoennes, 1998). Yet, it is important to recognize that stalking can and does occur in the absence of a relationship.

Many behaviors may constitute stalking.

For example, stalkers might repeatedly follow victims on their way to school or repeatedly

wait for them outside of their schools, homes or offices. They may slash tires, vandalize property and threaten victims and their loved ones, and use weapons. Some send gifts and cards to intimidate their targets. Stalkers may approach, confront and even harm victims, perhaps in violation of a protective order. They may use technology to stalk (see *Cybercrimes* below). They may call and make threats or hang up each time their victims answer. Some monitor victims' phone calls or computer use. Some use the Internet and cell phone texting to defame the reputations of their victims. Some enlist others to assist them.

Depression, anxiety and insomnia rates are higher among stalking victims than the general population (Blauuw et al., 2002). Victims' employment could suffer because of lost time from work, frequent interruptions or disturbances by stalkers, or lost productivity due to anxiety, fear or other causes related to the stalking behavior. If victims are in school, their academic performance could be affected. Some victims feel that they have to move to end the stalking.

While stalking victims may or may not be in imminent danger, the potential always exists. Therefore, it can be useful for victims to develop a safety plan (see *B3. Responding to Disclosures of Sexual Violence*). Stalking that occurs in response to the recent ending of an intimate relationship tends to escalate and can be extremely dangerous for victims (Tjaden & Thoennes, 1998).

BULLYING

Sexual violence prevention educators are sometimes asked by schools to address bullying in their education sessions as part of the spectrum of youth violence. **Bullying typically includes the following elements** (Farrington & Ttofi, 2010; CDC, 2011):

- Attacks or intimidation with the intention to cause fear, distress or harm that is physical (e.g., hitting or punching), verbal (e.g., name calling or teasing), and/or psychological or relational (e.g., social exclusion);
- A real or perceived imbalance of power between the bully and the victim; and
- Repeated attacks or intimidation between the same children over time.

Bullying can occur both in person and through technology (CDC, 2011). Bullying using technology is commonly termed cyberbullying or electronic aggression (see *Cybercrimes* below).

Bullying is a pervasive problem:

- About 20 percent of high school students completing a 2009 nationwide survey reported being bullied on school property in the year preceding the survey (Eaton, 2010; CDC, 2011).
- During the 2007-2008 school year, 25 percent of public schools reported that bullying among students occurred on a daily or weekly basis. More middle schools reported daily or weekly occurrences of bullying than primary and high schools (Robers, Zhang & Truman, 2010; CDC, 2011).
- In a national survey of students ages 12 through 18 (DeVoe & Murphy, 2011), about 28 percent of students reported being bullied at school during the 2008-09 school year.



Children with disabilities may be at a higher risk of being bullied than other children (Rigby, 2002).

A person can be a bully, a victim or both (CDC, 2011). The U.S. Department of Health and Human Services, U.S. Department of Education and U.S. Department of Justice

(n.d.) offer **warning signs for children who are being bullied and for children who bully others** (although they may also be indicative of other issues and problems).

Warning signs of a child being bullied:

- Comes home with damaged or missing clothing or other belongings;
- Reports losing items such as books, electronics, clothing, or jewelry;
- Has unexplained injuries;
- Complains frequently of feeling sick;
- Has trouble sleeping/bad dreams;
- Has changes in eating habits;
- Hurts him/herself;
- Is very hungry after school from not eating lunch;
- Runs away from home;
- Loses interest in being with friends;
- Is afraid of going to school or other activities with peers;
- Loses interest in school work or begins to do poorly in school;
- Appears sad, moody, angry, anxious or depressed upon coming home;
- Talks about suicide;
- Feels helpless;
- Often feels not good enough;
- Blames self for problems;
- Suddenly has fewer friends;
- Avoids certain places; and
- Acts differently than usual.

Warning signs of a child bullying others:

- Becomes violent with others;
- Gets into fights with others;
- Frequently is sent to the principal's office or detention;
- Has extra money or new belongings that cannot be explained;
- Is quick to blame others;
- Won't accept responsibility for actions;
- Has friends who bully others; and
- Needs to win or be best at everything.

Children and youth who are bullied are more likely than other children to be depressed, anxious, feel lonely, have low self-esteem, feel unwell and think about suicide (Limber, 2002; Olweus, 1993). They may fear going to school, using the bathroom and riding on the school bus (National Education Association, 2003). They also may be physically injured while being bullied. For bullies, bullying behavior can escalate into violence later in adolescence and adulthood, as well as result in substance abuse and academic problems (Smokowski & Kopasz, 2005). For students who witnesses bullying, bullying creates a climate of fear and disrespect in schools and negatively impacts student learning (National Education Association, 2003).

Smokowski and Kopasz (2005) noted several factors that can increase the risk of a youth engaging in or experiencing bullying. Those more likely to engage in bullying may be impulsive, have been the recipients of harsh parenting, and have attitudes accepting of violence. Those more likely to be bullied may have friendship difficulties, poor self-esteem, and have a passive and nonassertive manner (CDC, 2011). However, the presence of these factors does not mean that a person will definitely become a bully or a victim (CDC, 2011).

There are number of **promising elements of school-based programs that prevent bullying** (Farrington & Ttofi, 2010; CDC, 2011):

- Improving student supervision;
- Using school rules and behavior management techniques to detect and address bullying;
- Providing consequences for bullying;
- Having and consistently enforcing a whole school anti-bullying policy; and
- Promoting cooperation among different professionals and between school staff and parents.

CYBERCRIMES

Cybercrimes are criminal activities facilitated through the use of technology.

Technology used is not limited to computers and the Internet, but can extend to a broad range of electronic devices and media (e.g., telephones, fax machines, TTY/TTD equipment, cameras, webcams and spycams, and computer software and hardware such as global positioning systems, caller ID systems, computer monitoring software, and keystroke logging systems and software). Three forms of cybercrimes are discussed in this section because they are sometimes a component of or connected with sexual violence (preceding it or occurring in the aftermath):

- The use of the Internet to lure potential victims;
- The use of technology to bully; and
- The use of technology to stalk.

Online sexual solicitations. Sexual predators can victimize youth online using several strategies. Examples of strategies include (Wolak, Mitchell & Finkelhor, 2006):

- Requests to engage in sexual activities/talk or give personal sexual information that were unwanted or made by an adult;
- Solicitations involving offline contact with the predator or attempts/requests for offline contact;
- Unwanted exposure to sexual material; and
- Harassment.

Teenagers are particularly at risk for solicitations, as they often are unsupervised on the computer and are more likely than younger children to be involved in online discussions regarding companionship, relationships or sexual activity (National Center for Missing and Exploited Children,

2011). Sexual predators also use the Internet to lure adult victims.

Cyberbullying is “willful and repeated harm inflicted [by bullies] through the use of computers, cell phones and other electronic devices” (Hinduja & Patchin, 2010). The term is used almost exclusively to describe behaviors of and toward children and teens.

Electronic aggression is another term used to describe any kind of aggression perpetrated through technology, such as Internet and cell phone harassment or bullying (Hertz and David-Ferdon, 2008). The Internet creates opportunities for bullying to occur through e-mails, instant messaging, chat room exchanges, website posts, creating web pages, videos or profiles on social networking sites, taking pictures and distributing them, and uploading videos and posting them on-line for the world to see. The cell phone—via phone calling, texting, taking/distributing photos/videos, and connecting to the Internet—is another popular tool for bullies.

The Pew Internet Survey (Lenhart, 2007) found that almost one-third of teens had experienced cyberbullying. In a national survey of students ages 12 through 18 (DeVoe and Murphy, 2011), about 6 percent of students reported they were cyberbullied (either in school or outside of school) during the 2008-09 school year. Hinduja and Patchin (2010) noted that youth who experience cyberbullying may feel depressed, sad, angry and frustrated as well as be afraid or embarrassed to go to school. They also indicated that cyberbullying might be connected to low self-esteem, family problems, academic problems, school violence and delinquent behavior. In extreme cases, cyberbullying may also evoke suicidal thoughts in victims.

Cyberstalking, for this document’s purposes, is the willful and repeated use of any form of electronic or technological media and/or devices by stalkers to threaten, harass or intimidate. It has been called the adult form of cyberbullying (Roe, 2011). Cyberstalkers may target adults and/or minors, both those they know as well as strangers. With their technology arsenals, stalkers can easily gather information and spy on victims, impersonate them, intercept and monitor their communications with others, and embarrass, insult, harass and exploit them. They may use technology alone or in combination with other tactics (e.g., following) to stalk their victims. As a consequence of victimization, individuals may experience sleep and eating disturbances, nightmares, hyper-vigilance, anxiety, shock and disbelief, and a feeling of helplessness and loss of personal safety (National Center for Victims of Crime, 2010; WVFRIS, n.d.).

Victims of cybercrimes may need assistance in:

- Identifying the full extent of the problem;
- Developing a plan to address their concerns;
- Dealing with the psychological trauma resulting from their victimization;
- Planning for safety; and
- Obtaining additional information and referrals for service.

Education may be needed for all parties involved to recognize the seriousness of the situation and look at ways to reduce the risk of future incidences. In the case of minor victims, parents/guardians and school systems may need to be involved.

B2. BACKGROUND

Why does society tolerate sexual violence? Why would victims be blamed by others for being sexually violated? Why do individuals commit sex crimes and what is being done to prevent convicted sex offenders from reoffending? While these questions demand rather complex answers, this section briefly explores the role of gender biases in supporting sexual violence and the phenomena of victim-blaming. It also offers very basic information on sex offenders.

Gender Bias

Gender bias is prejudice in treatment or action toward other persons on the basis of their sex (www.legal-explanations.com).

In the United States, the women's rights movement of the last century ushered in dramatic advances in the political, legal, social and economic status of females. However, bias against females can still be found in almost any arena.

For example, in mainstream media, women much more so than men are bombarded with unrealistic images of what they should look like (ultra thin, sculpted faces, smooth skin regardless of age, big breasts, etc.) and messages regarding the extreme lengths they should go to obtain and maintain that look (dieting, cosmetic surgery, etc.). In government, the vast majority of elected officials are males despite the fact that females represent more than half of the population. In politics and the press, female politicians and news correspondents are often judged on their beauty, clothing and demeanor rather than their intelligence and skills, and criticized for placing careers over family in a way that most male politicians and reporters never have to endure. In schools, girls are underrepresented in math and science related classes, leading to female

underrepresentation in these career fields. In places of worship, women are often viewed as unequal to men and denied access to participate as clergy. In employment, women may not be paid equal to men for comparable work. In criminal and civil justice systems, stereotypes and misconceptions about girls and women can undermine investigative and judicial processes.

Girls and women are more at risk for violence throughout their lives due to gender bias. This bias underlies common beliefs in our society related to sexuality and gender roles, such as:

- What it means to be male and female in mainstream culture (e.g., it is acceptable for males to be sexually aggressive, while females are expected to set and enforce limits on male sexual behavior);
- Dating relationships (e.g., if a guy spends a lot of money on his date, he may be expecting sex in return);
- Sexual harassment (e.g., it's acceptable to tell jokes that degrade women).

Specific acts of gender discrimination may be a violation of federal and state discrimination laws in qualifying settings.

You are encouraged to examine and reject stereotypes and misconceptions you may hold related to gender. This examination can help you be more comfortable and capable in your work in dispelling the many myths that exist around sexual violence.

Victim Blaming

A key reason for a victim's reluctance to report or seek help following an act of sexual violence is society's tendency to blame the victim. **Victim blaming in essence removes the responsibility for the violence from the offender and places it upon the victim.**

Sadly, it is common for a victim to experience some degree of victim blaming from her family, friends, classmates, school faculty/staff, fellow employees, criminal justice officials, health care providers, etc. Some examples of myths that people believe that support victim blaming include:

- If a woman wears revealing clothing, flirts with or walks home with the perpetrator, she is enticing him, so it can't be sexual assault.
- If a woman is out alone at night, she deserves what she gets.
- If a woman did not physically resist the perpetrator's advances or there was no "real" threat of physical harm, then it cannot be sexual assault.
- If an individual has dated/had sex previously with the perpetrator, it can't now be sexual assault.
- A woman might fabricate a sexual assault to seek attention or revenge.

Victim blaming is intricately linked to gender bias against girls and women. However, gender bias and victim blaming impact male victims as well as females. Male victims may be even less likely than female victims to seek help following a sexual assault because of the general perception that this crime only happens to females. If a male was sexually assaulted by another male, a common assumption is that it occurred because they are homosexuals or he appears feminine or weak. If a male was assaulted by a female, the public may question why he just didn't enjoy the sex instead of complaining about it.

The blame that victims receive from others often erodes their confidence and develops into self-blame, which can manifest into feelings of guilt, shame, anxiety, depression, lack of trust and isolation. Just as damaging, victim blaming can lead to backlash and retaliation against victims—

for example, a victim might be labeled a "slut" by peers after being sexual assaulted by a classmate or sexually harassed by a teacher or employer. If the incident is reported, a victim may be subjected to retaliation not only by the offender (e.g., stalking), but also potentially by school/work administrators (e.g., to do "damage control" to their institution's reputation) and others (e.g., she may be harassed if the offender is a popular public figure such as an athlete or elected official). In addition, the media often adds to the damage by portraying victims in a negative light (e.g., by quoting a witness as saying that the victim was wearing a revealing blouse and flirting with men).

Why do people blame the victim? Some thoughts and theories include:

- ***Men and women are socialized to believe stereotypes that support gender discrimination, including gender-based violence.*** To question these assumptions is to challenge dominant culture and risk backlash.
- ***The "just world" hypothesis focuses on the belief that the world is a fair and just place and that good things happen to good people while bad things happen to bad people.*** People want to believe that as long as they behave appropriately, nothing bad will happen to them. This belief leads to the view that victims must have done something to encourage or deserve their attacks and, therefore, are to blame. This way of thinking allows those who blame victims to feel a false sense of security because they view themselves as good. Along the same lines is the "invulnerability theory." Basically, in an effort to not have to think about their own vulnerability, people believe that victims did something to deserve their assaults. If people can avoid doing that particular action, they

think that they will not be vulnerable. (Bullet adapted from Rape Crisis Information Pathfinder, n.d.)

- **People often believe that sexual violence is caused by uncontrollable sexual desire**, which leads them to conclude that the way a person looks or behaves can elicit irrepressible sexual arousal on the part of others.
- **People often find it difficult to comprehend that a person, especially someone they know, is capable of sexual violence.** They would rather believe that only a person who fits the traditional stereotype of a sex offender (e.g., a knife-wielding stranger who jumps out of the bushes at night) could commit such a crime than accept the unsettling fact that most incidents of sexual violence involve a victim and perpetrator who are often in the same social circle.
- **People are not educated about the nature of sexual victimization.** For example, they don't necessarily understand that a delay in reporting sexual assault to law enforcement or a victim's controlled reaction does not mean that the victim is fabricating the assault. Some people maintain victim blaming attitudes simply because they have not been taught about the realities of sexual victimization and have not had the opportunity to counter their assumptions and biases with facts.

Counter victim blaming myths and stereotypes with facts and straight talk. In addition to directly challenging individuals who are justifying violence, there are other venues to address victim-blaming, such as letters to the editors of local news publications, online posts, media campaigns, professional trainings, educational presentations, planned community dialogues, etc. Ultimately, you want to:

- Increase understanding of the realities of sexual victimization; and

- Engage community members in dialogue about their roles in sexual violence prevention and effective responses if and when sexual assault occurs.

Encourage community members to become part of the solution (elimination of sexual violence) rather than the problem (victim blaming and perpetuation of the violence).

Sex Offenders

(Partly drawn from the Center for Sex Offender Management publications, through www.csom.org)

POWER AND CONTROL

The primary motivation for sex offenders to commit sexual violence is generally not sexual gratification, although that may be part of it. More commonly, **offenders use sexual violence as a tactic to overpower, control and/or humiliate another person.** They often have a need to compensate for their own feelings of inadequacy, anger and powerlessness. By humiliating victims, their anger is discharged and their feelings of strength and capability are validated. Offenders' dehumanizing acts may help them gain a temporary sense of control, while leaving their victims feeling devastated, traumatized and powerless.

A critical component of sexual violence education is to include information about the dehumanizing nature of the crime and the fact that sexual violence is not typically about the offender's need for sex, but instead his need for power and control. With this understanding, a victim will more likely receive the respect and support she deserves and the offender will be held accountable for his criminal behavior.

NO TYPICAL PROFILE

(Drawn from CSOM, 2010; Gilligan, 2008)

There is no profile of a typical sex offender (Becker & Murphy, 1998; Hunter, 2006; Marshall, 1996; Talbot, Gilligan, Carter & Mason, 2002). Instead, sex offenders vary from one another in terms of demographics, range of offending behaviors and patterns, motivations, intervention needs, and levels of risk they pose to the community (Carter, 2008). Sex offenders can be adults or juveniles, young or old. The vast majority of sex offenses are committed by males, but females do commit these crimes (FBI, 2005; Schwartz & Cellini, 1995). Sex offenders vary in their marital status, socio-economic levels, levels of education and family ties. Some have been victims of sexual abuse, but many have not—being sexually abused does not cause people to become sex offenders. They may offend against adults or children, males or females, or both. Their sex crimes can range from non-contact offenses such as flashing or voyeurism to contact offenses such as fondling or rape. Most commit multiple sex crimes against multiple types of victims with whom they have varying types of relationships (Denver Police Department, Victim Assistance Unit, 2011). They may have a long criminal history or none at all.

LIKELIHOOD OF REOFFENDING

(Drawn from CSOM, 2010)

Between 12 and 24 percent of convicted sex offenders are known to have repeated sex crimes, as indicated by a new charge or conviction for a sex offense (Hanson & Harris, 2004; Hanson & Morton-Bourgon, 2005). However, these rates likely are underestimated since most sex crimes are not reported. There is usually no single factor that makes someone more likely to reoffend, but rather a combination of factors that might include problems in relationships, difficulty in

dealing with emotions such as anger, having antisocial values, hostile attitudes toward women, or being sexually attracted to children. Treatment may help sex offenders develop skills to manage their behavior, which can reduce their chances of reoffending. But whether they will be successful depends on whether they are motivated to change their behaviors (Aos, Miller & Drake, 2006).

SENTENCING

(Drawn from CSOM, 2010)

The courts can impose a variety of sentences for sex offending behavior, depending upon the offender, the facts of the case and state laws. While some offenders are sentenced to prison or jail, others are sentenced directly to community supervision (e.g., probation). Depending on their age and conviction, some are on the sex offender registry for their lifetimes, others for 10 years, and some not at all. For those sentenced to prison or jail, some are released with parole or probation supervision, while others are released with no supervision. When they are under community supervision, sex offenders are required to abide by certain restrictions and rules, such as the following:

- No contact with their victims;
- No or limited contact with minors;
- Participation in sex offender-specific treatment;
- Limited or no Internet access;
- No use of alcohol or drugs;
- Restrictions on where they can live and work;
- Restricted movement within the community and within and across state lines; and
- Reporting to a probation/parole officer as required.



In every state, law enforcement agencies must maintain registries of certain convicted sex offenders

(e.g., including data such as offenders' names, addresses, photographs and crime or conviction). For public access to the West Virginia sex offender registry, go to www.wvstatepolice.com/. The State Police administers the registry, as per the stipulations of the *Sex Offender Registration Act (WVC§15-12)*. In addition to updating the registry on a daily basis, the State Police is required to distribute registrant data to the FBI and local entities in the county that the registrant resides, owns or leases property that he/she regularly visits, or is employed or attends a school/training facility.

B3. RESPONDING TO DISCLOSURES OF SEXUAL VIOLENCE

Given the prevalence of sexual assault, it is likely you will interact with victims of sexual violence in the course of presenting prevention programs and trainings, whether in small group settings such as a classroom presentation or at larger group events. Many victims have never told anyone about their experiences. It is critical to be prepared for disclosures of victimization when conducting presentations.



The response of the first person to whom someone discloses is often a significant factor in how the victim will cope from that point forward.

The first responder's words and actions can have a tremendous impact on the victim. Reacting to a disclosure with judgment and blame may lead the victim to think that the violence was her fault and lead her to suffer through her traumatic reactions alone. Conversely, responding with support, compassion and accurate information about sexual violence, traumatic reactions and available resources may empower the victim to seek further assistance and begin the process of healing.

This section offers basic information on:

- Coordination with other first responders;
- Health consequences related to sexual violence;
- Traumatic reactions to sexual violence;
- State requirements related to suspicions/disclosures of victimization;
- Initial response to a victim in a group setting;
- Crisis intervention; and
- Planning for safety.

Coordinated Response

The coordination of interventions among those involved in the immediate response to disclosures of sexual assault is critical to helping victims. As a prevention educator or trainer, you should identify community agencies with whom you might be working. Completing this task will help ensure that you can connect individuals who disclose sexual assault to the services they might require (to address their need for safety, crisis intervention, medical care, mental health care, preservation and collection of evidence, legal remedies, support, advocacy, etc.). Once identified, it is helpful to initiate working relationships with these responders and formalize procedures for coordination.

There may be several professionals/agencies in a community involved in the immediate response to a sexual assault, but at a minimum they usually include:

- Advocates from your local rape crisis center;
- Emergency medical staff (often sexual assault nurse examiners or SANEs); and
- Law enforcement representatives.

In addition, prosecutors are sometimes involved in an advisory capacity during immediate response.

A sexual assault response team (SART) may exist in your community to promote a coordinated response in sexual assault cases. Check with your local rape crisis center to see if there is a SART and how to get involved as a team member. (See www.fris.org for more information on SARTs.)

Health Consequences

Sexual victimization has many potential health consequences for victims. Some victims sustain physical injuries during the

violence. Many fear their victimization will lead to pregnancy and sexually transmitted infections, including HIV. Some develop gynecological and sexual problems as a result of their victimization. As discussed below, emotional trauma from their victimization can lead to physical, emotional and cognitive problems. The health consequences of sexual victimization can profoundly impact individuals' capacity to lead productive and healthy lives.

Traumatic Reactions

Understandably, experiencing sexual violence causes emotional trauma for many victims. **Examples of factors that may influence whether a person's emotional reactions to sexual violence are traumatic** include: severity and frequency of the event; personal history (e.g., if there was a prior victimization); individual coping skills, values and beliefs; and the level of support from family, friends and/or professionals (Santa Barbara Graduate Institute et al., n.d.). Traumatic reactions may include one or more of the following **symptoms** (Santa Barbara Graduate Institute et al., n.d.):

- **Physical:** e.g., eating/sleep disturbances, sexual dysfunction, low energy and chronic, unexplained pain.
- **Emotional:** e.g., depression; spontaneous crying; feelings of despair and hopelessness; anxiety and panic attacks; fearfulness; compulsive and obsessive behaviors; feelings of being out of control, irritable, angry and resentful; emotional numbness; and withdrawal from normal routines and relationships.
- **Cognitive:** e.g., memory lapses (especially about the sexual violence), difficulty in making decisions, decreased ability to concentrate, hyperactivity and impulsivity.

Additional symptoms—intrusive re-experiencing of the trauma, emotional numbing and avoidance, and hyper-vigilance and overreactions—are key indicators of **post-traumatic stress disorder (PTSD)**. Nearly one-third of rape victims develop PTSD during their lifetimes (Kilpatrick, Edmunds, & Seymour, 1992). **PTSD symptoms specific to survivors of sexual violence are also known as rape trauma syndrome (RTS)**. Phases of RTS include (Burgess & Holmstrom, 1974):

- **Acute phase:** Occurs immediately after the assault and usually lasts a few days to several weeks. Common reactions include being openly emotional, being controlled/without emotion and experiencing shock, disbelief and/or disorientation.
- **Outward adjustment phase:** Individual resumes what appears to be her "normal" life, but inside is suffering from considerable turmoil. Primary coping techniques include: minimization (pretends that "everything is fine" or that "it could have been worse"); dramatization (cannot stop talking about the assault—it dominates her life and identity); suppression (refuses to discuss or acts as if it did not happen); explanation (analyzes what happened); and flight (tries to escape the pain by moving, changing jobs, changing appearance, changing relationships, etc.).
- **Resolution phase:** The assault is no longer the central focus of the individual's life. She may recognize that while she will never forget the assault, the pain and negative impact usually lessen over time.

If not addressed, emotional trauma can result in lasting negative effects for victims, such as substance abuse, compulsive behavioral patterns, self-destructive and impulsive behaviors, inability

to make healthy professional or lifestyle choices, dissociative symptoms, feeling permanently damaged, a loss of previously sustained beliefs, and feelings of ineffectiveness, shame, despair and hopelessness (Santa Barbara Graduate Institute et al.). It can also contribute to sexual problems, the inability to maintain close relationships or choose appropriate friends and partners, social withdrawal, and feelings of being constantly threatened and hostile towards others (Santa Barbara Graduate Institute et al.).



It is important to be prepared to help victims understand their reactions to sexual violence (including how it can cause traumatic reactions and the potential impact of the trauma) while affirming that it is possible to heal.

You can also assist victims in identifying available resources for support in dealing with emotional trauma. Rape crisis centers have specially trained staff to assist victims in dealing with this trauma and to help them restore a sense of control, dignity and self-respect in their lives. *To contact a rape crisis center near you, call 1-800-656-HOPE.*

State Requirements Related to Disclosures of Victimization

In West Virginia, a victim can decide whether or not to report sexual violence to law enforcement, unless the situation meets the criteria for mandatory reporting. If a mandatory report is required, encourage the victim to initiate the report and offer assistance in reporting. Fulfill all mandatory reporting responsibilities.

MANDATORY REPORTING

In West Virginia, state law (WVC§9-6-9) has identified individuals who must report suspected abuse or neglect of adults who

are incapacitated or of emergency situations where adults who are incapacitated are at imminent risk of serious harm. These mandated reporters include:

- Medical, dental and mental health professionals;
- Christian Science practitioners;
- Religious healers;
- Social service workers;
- Law enforcement officers;
- Humane officers (Each county sheriff designates these officers to investigate complaints of inhumane treatment of animals. In their work, humane officers may witness or suspect the abuse of incapacitated adults or children.);
- State or regional ombudsmen (an advocate for residents of nursing homes, board and care homes, and assisted living facilities); and
- Employees of nursing homes or other residential facilities.

An adult who is considered “incapacitated,” according to state law, is someone who cannot independently conduct daily life sustaining activities due to a physical, mental or other infirmity (note the incapacity can be temporary as in the case of someone under the influence of alcohol or someone with an injury that will heal, such as a broken leg).

Abuse, neglect or an emergency situation involving an adult who is incapacitated should be reported immediately to the local Department of Health and Human Resources (DHHR), Adult Protective Services (APS), or the 24-hour hotline provided for this purpose (800-352-6513). If it is suspected that a crime has occurred (e.g. a sex offense), report to the local law enforcement agency.

The oral report to DHHR should be followed with a written report within 48 hours, using

DHHR's forms or forms your organization has developed for this purpose.

Mandatory reporters of suspected or observed mistreatment of a minor in West Virginia include:

- Medical, dental or mental health professionals;
- Religious healers and members of the clergy;
- Christian Science practitioners;
- Social service workers;
- School teachers and other school personnel;
- Child care or foster care workers;
- Humane officers (see above);
- Emergency medical services personnel;
- Peace officers or law enforcement officials;
- Circuit court and family court judges;
- Employees of the Division of Juvenile Services and magistrates;
- Youth camp administrators or counselors, employees, coaches or volunteers of an entity that provides organized activities for children; and
- Commercial film or photographic print processors.

Reports should be made immediately to DHHR, Child Protective Services (CPS) or 800-352-6513 (same as above number). In any case it is believed that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall *also* immediately report, or cause a report to be made, to the State Police and any law enforcement agency having jurisdiction to investigate the complaint. If the mandatory reporter is a staff member or a volunteer of a public or private institution, school, entity that provides organized activities for children, facility or agency, the reporter should immediately notify the person in charge of that institution school, entity, facility or

agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made.

The oral report to DHHR should be followed with a written report within 48 hours if so requested.



In addition to the above mandatory reporters, ***any person over the age of 18 who receives a disclosure from a credible witness or observes child sexual abuse or sexual assault*** is required to immediately report or cause a report to be made to DHHR, the State Police, or the law enforcement agency having jurisdiction to investigate the report.

INFORMED CONSENT AND GUARDIANSHIP/CONSERVATORSHIP

It is critical to respect the right of victims of sexual violence to make their own decisions, to the extent possible (unless a situation meets the criteria for mandatory reporting). Help ensure that victims' decisions are well-informed by offering them information about their options (about reporting, having a sexual assault forensic medical examination, seeking support and counseling, Crime Victims Compensation Fund, etc.) and the potential impact of their decisions.

A West Virginia resident over the age of 18 is presumed to be competent to make her own decisions unless a court determines otherwise. If a person is declared to be legally incompetent, the circuit court may determine she is a "protected person" and appoint a guardian/conservator to make decision on her behalf. A **guardian** is responsible for the personal affairs of a protected person. A **conservator** is responsible for managing the estate and financial affairs of a protected person. The terms and conditions of a court appointment

indicate the scope of the guardianship or conservatorship.

Who should be contacted for help? If abuse or neglect of a protected person by a guardian/conservator is suspected, report suspicions to DHHR at 800-352-6513. If it is suspected that a crime has been committed against a protected person, call local law enforcement. If it is suspected a protected person is in imminent danger, call 911. If it is suspected that a guardian/conservator is not acting in the protected person's best interest, contact the circuit court that appointed the guardian/conservator or a private attorney for information on options. In cases in which DHHR is the appointed guardian, contact DHHR.

CONFIDENTIALITY

Maintaining confidentiality is a key to developing trust with victims. **Information should not be released about victims without their informed, written consent** (except in cases requiring mandatory reporting).

Special conditions regarding release of information and informed consent exist for minors and some "incapacitated" adults (WVC§9-6-9) with cognitive disabilities. Minors are typically unable to legally provide informed consent. Therefore, when the victim is a minor, the written release of information should be signed by the minor where possible and her/his non-abusive parent or guardian. Emancipated minors and minors who are married, however, can make most of their own decisions and do not need a signature of their parent or guardian (WVC§49-7-27). With adults who are incapacitated, the issue is whether they are competent to give consent. If an adult victim is not capable of providing consent to release information, the written release should be signed by the adult where possible and the non-abusive guardian, if one exists.

Release of information forms should be time-limited and specific.

Initial Response to a Victim in a Group Setting

In a group setting in which interpersonal violence is being discussed, it is helpful to acknowledge that there may be people in the room who have experienced violence and request that everyone in the group be mindful of this fact. Let group members know how to contact you (or another appropriate professional such as a victim advocate from the rape crisis center) if anything related to the discussion disturbs them or motivates them to disclose an experience of victimization.

If a person discloses sexual victimization during a training or educational presentation, attempt to acknowledge the disclosure without stopping the presentation. A sincere comment (e.g., "I am so sorry that you had to go through that experience and I would be happy to talk with you after this presentation") validates the disclosure and offers support without shifting the presentation's focus to their victimization.

Most disclosures will occur after a presentation. One individual may want to talk about the assault; another may just want referral information. Find a safe place where the person can talk without fear of disclosing personal information to others. You do not need to ask questions about the details of the incident; only ask about the person's immediate needs. Answer questions and provide referral information. Do not judge or tell her what she should do. Offer assurance that she can heal and that there are people who can help her in the recovery process.

Customizing Your Response

Your response to a victim must be adapted to that person’s needs and circumstances. Keep in mind that a victim’s experiences and reactions to sexual violence may be affected by multiple factors, such as (Office on Violence Against Women, 2004):

- Age/developmental level;
- Gender and/or gender identity;
- Existence of a disability;
- Language and communication needs;
- Ethnic and cultural beliefs and practices;
- Economic status, including homelessness;
- Immigration and refugee status;
- Sexual orientation;
- Military status;
- History of prior victimization;
- Past experiences with responding systems (medical, criminal justice, victim advocacy, etc.);
- Whether the violence involved alcohol and/or drugs;
- Prior relationship with the offender, if any;
- Whether the assault was part of a broader continuum of violence and/or oppression (family violence, gang violence, hate crimes, trafficking, etc.);
- Whether physical injuries were sustained and the severity of the injuries;
- Whether the victim was engaged in illegal activities at the time of the violence or has outstanding criminal charges;
- Whether the victim was involved in activities prior to the violence that traditionally generate victim blaming (drinking alcohol); and
- Capacity to cope with trauma and the level of support available.



Because there are so many variables that can affect a victim’s experience of and reaction to sexual violence, it is critical to **ask each victim: “Is there anything I should know that will enable me to better assist you?”** Listen carefully to what she has to say, observe her verbal and non-verbal cues, and let her guide you in how to best support her in healing.

Crisis Intervention

Many incidences can trigger crisis responses for a sexual violence victim—traumatic reactions to the assault itself, disclosing the assault, memories of the assault (e.g., hearing a song that was on the radio at the time of the assault), events connected to the assault (e.g., the release of an offender from prison after 25 years) and unresolved trauma related to an assault (e.g., having weekly Sunday meals with an offending relative). **Crisis intervention attempts to stabilize a person’s reactions to an immediate problem.** Crisis intervention is sometimes referred to as “emotional first aid” designed to “stop the emotional bleeding.” Crisis management rather than resolution is the goal.

The response to a victim in crisis may include:

- Helping to calm the victim so she can make rational, informed decisions;
- Ensuring the victim’s immediate safety/planning for short-term safety;
- Determining if the victim needs any accommodations;
- Addressing medical concerns and encouraging her to seek needed care;
- Discussing reporting options and encouraging evidence collection, if appropriate;
- Addressing specific concerns and helping to prioritize their urgency;

- Telling the victim what you can/cannot do for her (including your mandatory reporting requirements);
- Providing contact information for the local rape crisis center, explaining services and connecting her, with her permission, with an advocate; and
- Providing additional information and referrals as needed.

Those who are providing crisis intervention can offer a safe environment for victims to express their feelings, identify, prioritize and plan to resolve their concerns, obtain needed information and referrals, and ultimately develop healthy coping strategies to deal with traumatic reactions. Rape crisis centers in West Virginia have 24/7 hotlines that offer crisis intervention for victims of sexual assault. To contact a rape crisis center near you, call 1-800-656-HOPE.

Preservation of Evidence

If victims disclose having been sexually assaulted, steps should be taken to preserve evidence if they are considering reporting the crime to law enforcement and/or having a forensic medical exam. Once victims are safe, it is important to preserve any potential evidence that may help in the investigation and prosecution.

To preserve potential forensic evidence, victims are generally advised:

- Do not shower, bathe or clean any body parts. Do not douche, brush teeth or comb/brush hair.
- Do not go to the bathroom.
- Do not eat or drink anything.
- Do not change clothes. Extra clothing should be taken to the hospital to replace any items law enforcement may take to test for evidence. If clothing must be changed prior to going to the hospital, remove

carefully, place each item in a separate paper bag and take to the hospital with you.

- Do not touch, straighten or clean anything at the crime scene area.

Even if the victim is uncertain about reporting the crime, she can still be encouraged to preserve evidence and get medical care.

In West Virginia, licensed medical facilities can provide care and collect evidence without reporting the assault to law enforcement, if the victim wishes (except in mandatory reporting cases). The evidence will be collected and stored for at least 18 months. With no statute of limitations on felony sexual assaults, the victim can later decide to report the crime to law enforcement and the evidence can then be retrieved. If the victim does not want a forensic medical exam to collect the evidence, medical care is still important to treat physical injuries and address possible exposure to sexually transmitted diseases and pregnancy.

It is equally important to address the emotional trauma that results from sexual violence (see *Traumatic Reactions to Sexual Violence* above).

Planning for Safety

Safety planning for a sexual violence victim is a thoughtful, deliberate process in which a helper and a victim together create a plan to enhance safety for the victim. Each victim's safety concerns are unique. Short-term safety planning may be a component of responding to a victim in crisis; longer-term planning is usually done when a victim has more time and is not in crisis.



Safety planning with victims in crisis:

- Ask if they have immediate/pending safety concerns for themselves, their family, pets or service animals.
- Ask them if you can help in developing a plan of action to address their immediate safety needs. The plan should identify:
 - Specific steps victims can take to address immediate safety concerns;
 - Supportive persons who can help with safety and their roles;
 - Specific safety strategies that may prove difficult to achieve and accommodations needed to reduce or eliminate barriers;
 - Any essential items that victims need if they flee their current locations; and
 - Referrals to community resources to meet their urgent needs.
- Encourage the victim to seek the assistance of the local rape crisis center to develop a longer-term plan for safety and other assistance as appropriate.

To contact a rape crisis center near you, call 1-800-656-HOPE.

Whether assisting victims with short- or longer-term safety planning, it is important to be aware of a resource that may be available to them. **A victim of sexual violence or stalking in West Virginia can request a protective order through magistrate court—a *Personal Safety Order (PSO)* for victims in non-domestic relationships or a *Domestic Violence Protective Order (DVPO)*.** Filing fees may be waived. These are civil remedies; *there is no obligation to file a criminal report in order to obtain a PSO.*

The petition may be filed by any person for themselves, or by a parent, guardian or custodian on behalf of a minor child or incapacitated adult (as described on page 23). Upon filing the petition, if a magistrate

finds reasonable cause to believe the offender committed the sex crime or stalking offense, then a temporary order can be issued. Under a PSO, the magistrate can order the offender to “stay away” —from the victim’s home, work, and school; refrain from contact, whether direct or indirect; not interfere with the victim and, if the victim is a minor, any siblings or minors in the home. Under a DVPO, additional remedies can include temporary custody, possession of the residence and/or financial support.

If a Victim Has a Disability

Given that almost 19 percent of West Virginia’s population has a disability (U.S. Census, American Community Survey, 2010), **it is likely you will interact with people with disabilities during your prevention presentations or trainings, including those who have been sexually victimized.**

Sexual violence victims may have a cognitive, sensory or mobility disability or mental illness, or any combination of disabilities. Like other victims of sexual violence, victims with disabilities may feel powerless, vulnerable and afraid. However, many factors can complicate their ability to disclose the assault to others, reach out for help and/or access services. Knowing that persons with disabilities are at an increased risk for victimization and how to effectively interact with persons with disabilities will make your trainings and prevention programs more relevant to all audience members.

Commonly cited risk factors for sexual victimization for persons with a disability include (Ticoll, 1994; Day One et al., 2004):

- Negative public attitudes towards persons with disabilities may lead sex offenders to view them as easy targets;
- Gender—like victims in the general population, females with disabilities have

a higher risk of victimization than males with disabilities;

- Type of disability—risk may be higher for persons with certain physical and cognitive disabilities, developmental disabilities and severe mental illnesses;
- Reliance on others for care, assistance and management of personal affairs;
- Communication barriers;
- Social isolation;
- Lack of resources/knowledge of resources;
- Lack of accessible transportation;
- Poverty; and
- Lack of knowledge about sexuality and healthy intimate relationships.

Potential barriers to seeking help for persons with disabilities include: lack of accessibility to services (e.g., due to reliance on an abusive caregiver to access resources); situational factors (e.g., lack of a needed service in the community); fear of perceived consequences (e.g., retaliation by an offender, loss of independence or negative reactions by family); and socialization and education (e.g., to be compliant or manipulated to feel blame). Added barriers can be created by physical/programmatic inaccessibility of services themselves.

When interacting with a person with a disability (Adaptive Environments, Inc., 1992; Ward and Associates, 1994):

- Keep in mind that a disability may influence the person’s ability to communicate.
- Remember that a person with a disability is entitled to the dignity, consideration, respect and rights you expect for yourself.
- Use terminology that places the person before the disability (e.g., “a person with epilepsy” rather than “an epileptic”).
- Take the time to listen and understand

the situation.

- Be honest if you do not understand the message a person is trying to communicate. Ask for suggestions to improve the interaction.
- If someone with a disability is accompanied by another individual, address the person with the disability directly. Don’t speak through the other person.
- When interacting with a person who uses a wheelchair, sit at her level. Do not touch the wheelchair. If you inadvertently bump into the wheelchair, excuse yourself.
- If you offer assistance and the person declines, do not insist.
- Empower victims with disabilities to make their own choices about what they need to heal, to the extent possible. Avoid “fixing” the situation for them.

If a victim discloses having a disability, it is helpful to identify her concerns related to if and how the disability may affect her reactions to the assault, her safety or her ability to access services, and what accommodations would be useful. An accommodation is a modification to goods, services and structures that allows for inclusion and participation by a person with a disability.

B4. PREPARING TO PRESENT SEXUAL VIOLENCE TRAINING AND PREVENTION PROGRAMS

This section discusses several broad issues to consider when preparing to present programs on sexual violence:

- A general approach to prevention;
- Healthy sexuality, healthy relationships, and encouraging bystander intervention;
- Tips for facilitating training and prevention activities;
- Cultural competency;
- If you have a history of sexual victimization;
- Including details of survivors' experiences in a presentation; and
- Program evaluation.

Discussion of issues specific to the population you are serving can be found in other sections of this toolkit.

Presentation Skill Building Resource

Massachusetts Coalition Against Sexual Assault and Domestic Violence, Jane Doe, Inc. (2006). *The Power of Education: Presentation Skills Training*. This curriculum provides a framework for enhancing presentation skills and techniques. (See *E. Resources* for more on this manual.)

Approach to Prevention

(CDC, 2004. Also see *C. Primary Prevention of Sexual Violence* in this toolkit.)

In the public health field, sexual violence prevention efforts exist on a continuum (primary, secondary and tertiary prevention).

- **Primary prevention** takes place before sexual violence occurs in order to prevent initial perpetration or victimization. Primary prevention is the focus of several resources in this toolkit. (Also see *E.*

Resources).

- **Secondary prevention** encompasses immediate responses after sexual violence to deal with the short-term impact of violence.
- **Tertiary prevention** includes the long-term responses after sexual violence to deal with the lasting consequences of the violence and sex offender treatment interventions.

Together these efforts seek to bring about change in individuals, relationships, communities and society through strategies that promote the factors associated with healthy relationships and healthy sexuality, and counteract the factors associated with the initial perpetration of sexual violence.

COLLABORATING TO ENHANCE PREVENTION EFFORTS

The primary prevention of sexual violence cannot be accomplished in isolation. Rather, it “takes a village” for a community to embrace intolerance for sexual violence. Part of the role of a sexual violence prevention educator is to collaborate with others to disseminate and promote prevention messages, reach a target audience and engage them in prevention work, and create an infrastructure that rejects sexual violence and supports healthy sexuality and respectful relationships. If effective prevention efforts for your target audience are already underway in your community, tap into those rather than starting from scratch.

Collaborative efforts can help you and others accomplish much more than can be done alone.

When planning prevention program strategies, don't forget to identify potential collaborators, then plan the details of making the collaborations a reality. There may already be structures in place in your

community to help support collaboration, such as a violence prevention taskforce. If so, use it to extend and enhance your efforts. At a minimum, reach out to the local rape crisis center to discuss partnering opportunities. The center will have access to many of the resources listed in *Section E* of this toolkit.

Characteristics of Effective Prevention Programs

Nation et al. (2003) found the **following nine characteristics to be associated with effective prevention programs**:

- Comprehensiveness;
- Use of varied teaching methods;
- Exposure to a sufficient dose of activities to have an effect;
- Activities that are theory driven;
- Activities that foster positive relationships between children and adults;
- Programming that is appropriately timed for participants' developmental level;
- Activities that are socio-culturally relevant;
- Use of outcome evaluation; and
- Programming implemented by staff who are sensitive to the issue, competent and have sufficient training, support and supervision.

Tips for Facilitating Training and Prevention Activities

Often times as a trainer or prevention educator, your programming will call for you to facilitate dialogue among participants and guide their conversations to ensure they stay focused on the topic at hand.

General tips for facilitators include (PREVENT, n.d.):

- **Clarify purpose of session and roles:** At the start of the session, explain the purpose of the session to participants, your role as facilitator and their role as participants.
- **Create a non-threatening and friendly environment.** Consider how the environment encourages participation, interaction and dialogue.
- **Manage participation with serious play:** Consider fun activities and approaches to engage participants without pushing them beyond their comfort zones.
- **Encourage all participants to participate:** Communicate clearly about the process for the session to engage and maximize participation.
- **Ask open-ended questions:** Be prepared to ask questions that will likely elicit various perspectives and stimulate thinking.
- **Use probes:** Follow up your facilitation questions with probes to clarify and add depth to responses such as: "Why?" "Can you talk more about that?"
- **Stay on track:** The facilitator should be easy-going but firm, stay on track and maintain leadership without threatening or detracting from interactions.
- **Seek opportunities for learning:** If a participant asks a question that you are unable to answer, let them know that you will follow up with them either at the next session or another time.
- **Competently close your session/workshop:** Consider asking participants to recap what they learned (What), how they reacted to the session/workshop (Gut), how they interpreted what they learned (So What), and how they will take what they learned and apply it to their work (Now What).

You will need to keep in mind the age and developmental level of your audience, as

these factors can impact how you will present issues and the depth of conversations you should anticipate.

Cultural Competence

You will likely interact with people of many different cultures when presenting sexual violence prevention programs and trainings. Culture refers to “integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups” (such as sororities and fraternities, communities of Deaf persons, populations with different sexual orientations, military personnel and their dependents, etc.) (Anderson et al., 2003). Most individuals belong to several cultures, although they may identify more with one culture than another. Being culturally competent implies that you/your program have the capacity to function effectively within the context of the cultural beliefs, behaviors and needs presented by specific individuals and their communities (U.S. Department of Health and Human Services, 2001).

To be culturally competent in your programs, it is important that you:

- Be aware of your cultural values;
- Acknowledge and accept different cultural beliefs and values, especially those which influence a person’s understanding of sexual violence and prevention;
- Create an environment that maximizes learning for people of all cultures and promotes open/honest communication; and
- Adapt program strategies to fit the cultural context of your target audience.

It is essential that all activities in your presentation strategy—from collecting and analyzing data about the target population

and issues you will be addressing, designing and implementing programs, and evaluating your efforts—take cultural issues into account (CDC, 2004).

A few key points regarding culture issues to keep in mind:

- **Learn about the demographics of your audience prior to program implementation.** Just because you are not aware of a specific cultural group in your community does not mean they do not exist! You can reach out to those populations, as well as others as applicable, to gather information about cultural issues relevant to sexual violence and prevention.
- **If you are not part of the culture of an audience you are educating, seek input from people who are part of that culture to help ensure that the program is relevant and appropriate.** Consider enlisting the help of someone representing that population to assist in presenting the program.
- **Target your programs to your audience as much as possible.** Targeted education is more complicated than simply creating a brochure in another language. It involves really considering the different ways cultures talk and think about sexual violence and prevention (CDC, 2004).
- **Recognize that you and your audience can learn from each other.** For example, a participant may be able to emphasize a key point through a personal example. Engage the audience in a way that encourages the sharing of knowledge about different cultures and experiences.
- **When seeking feedback from your audience on the usefulness of the program, ask questions related to cultural competency.** Methods might include satisfaction surveys, follow-up focus group discussions and individual interviews. You can also informally solicit feedback at the end of a program (What did you like best? What would you do to improve the program?).



Some cultural practices reinforce sex discrimination against females, particularly in places where girls and women have few rights. For example, in some developing countries, it is acceptable for a female who has been raped or whose husband was unfaithful (and as a result, is thought to have brought shame to the family) to be killed to restore the family's honor. Some cultures consider genital mutilation a rite of passage from childhood to womanhood. It is important that you are prepared to discuss the historical and cultural context of such practices and how they influence perceptions of and reactions to violence for those within that culture. At the same time, if an individual discloses that she was the victim of such gender-based violence tolerated by her culture, the appropriate response is to support her in identifying her options (what she wants to do in response, if anything) and available resources, and then support her in her choices. (Also see *B2. Background.*)

Being culturally competent and developing a culturally competent program is a complex task, albeit one that will allow your program to be vastly more effective in reaching out to your target populations. One resource for more information on this topic is the *Cultural Handbook* (Warrier, 2005). It is available through www.futureswithoutviolence.org and was written for those who work with victims of domestic and sexual violence.

Promoting Healthy Sexuality and Healthy Relationships

One tactic a sex offender may use in a dating violence situation, or in a situation involving sexual abuse by a person in authority, is to take advantage of the victim's lack of knowledge or distorted perspective about what is a healthy intimate relationship.

Effective prevention programs help individuals identify healthy sexuality in a relationship and provide basic information to them on this topic. Armed with this knowledge, individuals can better understand how an offender might try to manipulate or trick someone to do something sexual they do not want to do or to remain in an abusive relationship. Prevention programs can reduce perpetration by teaching about boundaries in healthy relationships and taking responsibility for one's own actions. It is critical to reaffirm that the offender, not the victim, is always responsible for sexual violence.

According to the World Health Organization, **sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality.** It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. A sexually healthy person (McLaughlin, Topper & Lindett, 2009):

- Knows her/his body parts and that sexual feelings are healthy and normal.
- Knows the choices she/he has about what to do with her/his sexual feelings.
- Knows about sexual pleasure.
- Knows the different sexual acts and how she/he feels about them.
- Knows how to be sexually responsible.
- Knows which behaviors could cause a pregnancy and sexually transmitted diseases and how to reduce the risk of both.
- Knows what consent is; how to get it; how to ask for it; and how to give it.
- Knows how to make decisions about sex and sexuality.
- Knows how to communicate about sexuality and relationships.

- Knows that she/he is sexual and deserves information about sexuality.
- Knows that she/he has the right to ask questions about sexuality.
- Knows her/his sexual rights.

Programs designed to respond to and prevent sexual violence can stress that the positive attributes of healthy sexuality naturally create a buffer against violence and abuse (Perry, 2006).

For example, individuals in a healthy relationship would likely (Perry, 2006):

- View each other as deserving of respect;
- Recognize and value each other's contributions to the relationship;
- Respect differences of opinion;
- Be honest about their feelings and actions; and
- Enjoy each other's company.

Perry noted that safety can be thought of as a by-product of such healthy relationship components—by promoting these components, education programs can prevent violence and foster more satisfying relationships between people.

Addressing Bystander Intervention

(Tabachnick, 2009)

A bystander intervention approach explores how the behaviors of others— such as friends, families, teachers, classmates and witnesses that surround any act or pattern of abuse—**offer opportunities to prevent violence before it occurs.** This approach has been employed to combat a variety of social problems including drinking and driving, racism and intimate partner violence. It can be an essential component of sexual violence primary prevention efforts.

When considering how to stop sexual violence, we usually think of intervening in the actual assault. Yet rarely is the assault the only opportunity to intervene. Instead, there are often many comments, harassing behaviors and other forms of abuse that lead up to the sexually violent act. Thus, there really is a continuum of behaviors that could evoke different interventions. At one end of the continuum are healthy, age-appropriate, respectful and safe behaviors. At the other end are violent behaviors. Between the ends are other behaviors (e.g., those that begin to feel inappropriate, coercive or harassing).

Each situation is an opportunity for bystanders to intervene by reinforcing positive behaviors before a behavior moves further towards sexual violence.

Just one voice speaking up can change the social norm in a situation. One child on the playground speaking up for another who is being bullied can give courage to others to rally on the victim's behalf. A fraternity brother can express his strong opposition to the plans of a few to add drugs to drinks at a party. Peer pressure to conform guides the behavior of many. **Bystanders, by intervening, can help redirect the peer pressure toward respectful social norms.**

Background

Researchers Darley and Latane (1968) theorized that, in group settings, **the responsibility for intervening is diffused among the bystanders**, such that individuals were less likely to feel responsible for taking action and more likely to think that somebody else may intervene or would call for help. They introduced **five steps that bystanders move through before they are able to take action:**

1. Notice the event as something that falls along the continuum of behaviors that lead to violence;
2. Interpret the event as requiring intervention;
3. Decide to assume responsibility to act;
4. Choose how to help; and
5. Are confident in their capacity to intervene (and can do it safely).

Given the complexity of most interpersonal violence situations, bystanders often find these steps overwhelming and choose to do nothing. Several decades of research has detailed situational factors that may affect a person’s willingness to act. These include: the presence and number of other witnesses, the uncertainty of the situation, the perceived level of urgency or danger for the victim, and the setting of the event. Bystanders’ behaviors may also be influenced by their relationship to the victim and/or perpetrator, their attitudes and beliefs, their perception of social norms, their perception of the potential personal costs of their action, and their intention to act.

Types of Bystanders

In bystander theory, there are **passive bystanders** who do nothing in the face of a potentially dangerous situation and **active bystanders** who do something to decrease the likelihood that something bad will occur or get worse. Bystander intervention addresses the behaviors of others that surround an act or pattern of violence, offering an opportunity to address behaviors BEFORE violence has

been perpetrated.

If bystanders are to be active and intervene, they need to feel good about identifying potentially risky behaviors. They need to **understand the five steps to intervention** listed above. It’s important that they **take an honest look at themselves and what keeps them from acting**. We all have walked away from situations or failed to “check things out” when our gut has alerted us to something concerning. What keeps bystanders silent? They need to **identify their obstacles and learn to work around them**.

Obstacles to Response

Bystander dynamics can create obstacles to action:

- ✓ **Diffusion of responsibility:** As previously mentioned, bystanders are more likely to help in a potentially abusive situation if they are by themselves and less likely to help when more people are around because responsibility literally diffuses.
- ✓ **Evaluation apprehension:** Bystanders risk embarrassment if they act and the situation turns out not to be an emergency or if a bystander does something wrong. Fear of getting embarrassed can dramatically decrease the chance bystanders will do anything.
- ✓ **Pluralistic ignorance:** If the bystander is not sure if the situation is an emergency, they may look around to others and see how they are

responding. If they aren't, bystanders don't.

- ✓ **Cause of misfortune:** Bystanders are less likely to help if they perceive the person to be responsible for his/her own misfortune.
- ✓ **Other:** Bystanders may face other obstacles, such as peer influence or personal issues (shyness, fear of confrontation, safety concerns, feeling like it is not their business, etc.).

But, here is the key: **if bystanders see someone else modeling a helping behavior, they are more likely to step up and provide assistance themselves.**

Options for Responding

The [Green Dot Bystander Intervention Program](#) uses the “3 Ds” for responding, giving bystanders **options for how they can intervene**:

1. **Direct:** directly interacting with the people involved and addressing your concerns. It may be a confrontation “Hey—what are you doing?” or it may just be checking in with a friend, “Are you OK?”
2. **Distract:** diverting the attention of the people in the situation. If you see a situation and can think of a way to divert the attention of the people in the situation, distraction is the perfect option. Sometimes all a situation needs to diffuse is a small diversion.
3. **Delegate:** recognizing a potentially high-risk situation where you may be uncomfortable saying something yourself or feeling like someone else is better suited to handle it (e.g., a

friend, police or bartender). The action can be just as effective if you get someone else to do it. It also has the additional benefit of making someone else aware of what is going on and that something needs to be done.



Example of the 3 Ds: You are in the cafeteria and you see a female student getting harassed by a group of older boys. Given your obstacles, what are you most likely to do?

Distract: Go up to them and say that Mrs. Jones, the gym teacher, needs to see the girl immediately in the office.

Direct: Go up to the older boys and ask them what they are doing? Or go up to the female and tell her you want to talk to her right now.

Delegate: Seek out an adult and tell them what is happening.

Safety First

Safety is increasingly an issue for bystanders the closer they are to a situation, the fewer people that are around and the more imminent the violence. Bystanders need to consider:

- ✓ How can I keep myself safe?
- ✓ Are there others I may call upon for help?
- ✓ What are my available options?
- ✓ What are the benefits/costs for taking action?

Those facilitating bystander intervention programs should take the time to brainstorm with participants how to keep in mind and address their own safety

when intervening. Creating a plan for their own safety may increase the likelihood they will feel more confident about intervening in these situations.

Features of Effective Bystander Intervention Programs

This list of features of effective bystander intervention programs (Powell, 2011, as cited by Prevent Connect) builds upon the nine characteristics of effective prevention programs (Nation et al., 2003):

- ✓ Bystander strategies will be most effective when they exist as **one component of a broader approach or of a multi-level program in one setting.**
- ✓ There is growing evidence to show the importance of **grounding prevention programs in sound and testable theory** that make clear the link between program activities and intended outcomes.
- ✓ **Involving the entire school community** (faculty, staff, students and parents) along with other **organizations** in the community as **partners** in identifying targets for change and designing strategies is critical to creating sustainable programs.
- ✓ The **application of gendered analysis** to program design and development will ensure the program strategies and outcomes are appropriate for all genders.
- ✓ There is concern within the broader literature regarding the importance of **tailoring programs to specific contexts and communities**, rather than simply replicating programs in new settings. Prevention strategies must **take into account the localized norms and structures that may be relevant to violence prevention.**
- ✓ **Longer interventions (across multiple sessions)** are more effective than short (one-time) interventions, and **in-depth coverage of a smaller range of topics** is found to be more effective than shallow coverage of a large range of topics.
- ✓ **Professional educators and/or program facilitators are found to be most effective.** It is essential to train and support them in their roles.
- ✓ There is evidence to support a **mixture of single-sex sessions and mixed-sex sessions across education-based programming.** While mixed groups appear to result in greater attitudinal change for females than single-sex groups, single-sex groups appear more effective for changing behavioral intentions. For boys, mixed-sex groups appear more effective for changes to their behavior intentions.
- ✓ The literature indicates a concern that the effects of violence prevention programs may fade over time, highlighting the **importance of evaluation at various intervals** before and after participation in prevention programs.



There is a wealth of literature, tools, programs and campaigns on bystander intervention in sexual violence. Many focus on encouraging schools to teach students, staff and parents to be proactive bystanders to prevent sexual violence, but the basic concepts are applicable to any situation. Go to www.nsvrc.org for a listing of related resources.

If You Have a History of Sexual Victimization

Many individuals who are survivors of sexual violence go on to become advocates and/or activists for ending sexual violence. **If you are a survivor and are doing training or prevention education, be sure to address your own needs related to healing.** Even if you have fully “recovered,” it is still possible that unpleasant thoughts and feelings related to the violence could be triggered from time to time, especially if you are frequently talking to others about sexual violence. Self-care and knowing when to reach out for help are critical to your personal wellbeing and effectiveness as a presenter.

Some suggestions as you prepare for presentations or other program activities include:

- Practice presenting the prevention program to staff at the local rape crisis center. Allow them to provide you with emotional support if needed. Seek constructive feedback.
- Assess if you are ready to respond to individuals who disclose victimization or perpetration. Consider co-presenting with a victim advocate from the local rape crisis center—which is also a good idea since disclosures often occur during/following presentations.
- Have a personal support person at your presentations. Also, ask this person or someone else to be available to debrief with you after presentations when necessary.

It is not necessary (nor usually appropriate) for you to disclose your own victimization in the course of providing training and education programs. While there may be situations where a personal disclosure may be appropriate (see below), do not put yourself in a situation that may trigger a flashback or bring up unresolved issues. Sharing your personal experiences could also be overwhelming for audience members. If you do decide to share your experiences, be prepared to provide emotional support to audience members as some may have a personal reaction to what you have shared (Bristen & Peatow Nickels, 2008). Also, recognize that there are probably both survivors and offenders in the audience—be prepared for a variety of responses.

Including Details of Survivor’s Experiences in Presentations

(Bristen & Peatow Nickels, 2008; FRIS, 2010)

As a presenter, you must consider whether or not it is appropriate and safe to disclose information about a survivor during educational and training programs.

Some related suggestions:

- You might decide to share details of survivors’ experiences during a presentation in order to: cultivate empathy for survivors and what they have experienced, demonstrate the prevalence of sexual violence, breakdown myths about both victims and perpetrators, make an impact on the audience, and give the audience ideas on what they can do (e.g., to practice bystander interventions).
- Avoid sharing details of survivors’ experiences merely to provide shock value, demonstrate your experience/knowledge on the issue (either as a survivor yourself or in working

with survivors), or when statistics and/or other forms of information would be just as effective to make your point.

Recognize the potential danger of these details re-traumatizing survivors or inciting offenders in the room.

- Don't ask a survivor to share her experience if she has not worked through the trauma, has not had the time to emotionally heal or has no experience in sharing her story with a large audience. Also consider that people who know the survivor may be in the audience.

When preparing for a presentation, plan your objectives and consider (perhaps in consultation with a co-worker or advocate from the rape crisis center):

- The intent and purpose of utilizing survivors' experiences: What are the benefits? Are there alternative solutions in creating a presentation that is interesting, factual and that will make an impact on the audience without compromising the confidentiality of survivors?
- Who is in the audience and what do you expect to gain by utilizing a personal experience? What do you know about the audience beforehand to help determine appropriateness?

If you do decide to share details about survivors' experiences, there are several steps you will want to take to prepare.

Obtain a signed release form from the survivor to discuss the details of her experience (it is recommended that you do not ask a survivor who is currently receiving services from your organization as she may not feel comfortable declining your request). Arrange to have a support person available with whom participants can debrief if needed. Plan early in your presentation to state your

intention to use survivors' experiences, the purpose of sharing this information and its connection to your intended program outcomes, as well as identify the support person who is available to debrief with participants. Describe the basic materials to be covered in the presentation to allow participants to make informed decisions about staying in the room.

If you plan to share survivor information anonymously, examine how the details may lead an audience to deduce information about the survivor (especially in rural communities or "contained" population such as a school or group home). You may consider intentionally changing details to conceal the survivor's identity, but be sure to let the audience know you have done so. It is also a good idea to mention that many experiences have similarities due in part to the prevalence of sexual violence. Finally, inform the audience that you gained the survivor's permission to share her experience.

B5. PROGRAM EVALUATION

Evaluation can be an essential tool in developing and maintaining the best possible trainings and prevention programs.

Evaluation enables you to determine if your programs are changing attitudes and behaviors. For prevention programs, evaluations can help determine if the changes are actually preventing sexual violence. Both the positive feedback and constructive criticism about your program obtained through evaluation can enhance your efforts and identify ways to change your program to make it more effective. Extensive experience or expertise in evaluation is not necessary to successfully evaluate your program or utilize the data gathered about your program—instead, you simply need knowledge about different kinds of approaches and strategies used to do evaluation and practice using that knowledge. Evaluation doesn't have to be complicated or resource intensive.

This section provides you with basic information on evaluation to help facilitate evaluation planning and implementation.

The three primary sources of information for this section included the *Sexual and Intimate Partner Violence Prevention Programs Evaluation Guidebook* (Valle et al., 2007), *Understanding Evaluation: The Way to Better Prevention Programs* (Meraskin, 1993) and *Evaluation 101* (Shanholtzer, 2010). For more in-depth information on this topic, see these resources.

What is Evaluation?

Evaluation is a systematic process of obtaining information to be used to assess and improve a program. In general, organizations use program evaluations to distinguish successful program efforts from ineffective ones and to revise existing

programs to achieve successful results. More specifically, **evaluation can be used to** (McKenzie, Neiger & Smeltzer, 2005):

- Prove that a program has delivered the intended services and met objectives;
- Show that the program has made an impact on a certain population;
- Improve the program implementation;
- Provide accountability to funding agencies, the community and other stakeholders;
- Increase community support for the initiative;
- Contribute to the scientific knowledge on the issue; and
- Inform policy decisions.

Program evaluation is often conducted when performance measures (e.g., x number of people attending a presentation) are not sufficient to demonstrate a program's results or when outcomes are not readily observable (e.g., prevention of violence).

Different Types of Evaluation

Various types of program evaluations exist; the type of evaluation you conduct depends on the questions you want to answer.

The main types of evaluation are:

- **Process evaluation** monitors the process of your program's implementation to find out *if your program is being delivered as intended* (Valle et al., 2007).
- **Outcome evaluation** studies *if your program is meeting or progressing towards your program goals. Is it having the intended effect?* Outcome evaluation can look at the immediate or direct effects of the program on participants, as well as longer-term and unintended program effects. This type of evaluation may also be called **impact evaluation**.

PROCESS EVALUATION

A process evaluation assesses the extent to which the program is functioning as planned. It examines the quality of program delivery and identifies gaps between what was intended and what actually happened. If a program does not produce the intended results, it may be due to flaws in the implementation or audience selection rather than simply because the program itself is ineffective. Results of a process evaluation can help you correct these issues before the program is delivered again. Conversely, if desired outcomes are being achieved, a process evaluation can identify what was done well so successes can be replicated.

In short, process evaluation can help you document your work, monitor and improve delivery, identify barriers and challenges, ensure adherence to your implementation plan, maintain accountability and quality control, provide a context for understanding outcome evaluation results; and provide timely feedback during and after the program (e.g., for a three-part presentation, a short satisfaction survey could be completed by the audience after each part).

What do you want to know about your program's process? For each of your programs, be prepared to collect process evaluation data by asking questions such as (Fisher et al., 2006):

- What specific topics were addressed in the presentation? What amount of content (e.g., dosage) did the participants receive? What activities were utilized to deliver this material?
- What were the characteristics of participants attending this presentation? (E.g., number of people participating, age/grade level, socio-economic status, racial/ethnic composition, language

preference, etc.) Did you reach your target audience?

- Did the program follow the basic plan for delivery?
- What was the overall satisfaction level with the program? (E.g., what did the participants like/dislike about the presentation, were the facilities and tools such as handouts or presentation materials conducive to learning, and did the presenter do an adequate job?)
- What was the staff's perception of the program?

OUTCOME EVALUATION

An outcome evaluation examines program objectives and provides information about program results, ultimately to determine if your program made the difference that was intended. Outcome evaluations can look at both short- and longer-term changes in participants' knowledge, skills, attitudes, behaviors and behavioral intentions. If your ability to conduct outcome evaluation depends on available resources, consider prioritizing resources initially for those programs that involve more intense skill-building rather than one-time presentations.

For **outcome evaluation during or immediately after a program, a retrospective post-test is the least time and resource intensive of the various outcome evaluation models you could use. However, you may elect to conduct a pretest/posttest design for determining if you met your goals and outcomes.** This approach typically involves administering the same questionnaire to participants before and after a presentation or series of presentations so you can assess how individuals' knowledge, skills, attitudes and behavioral intentions changed. This comparison requires matching the pre-and post-tests through a unique identifier—for instance, a unique code might be made up of the first

four letters of the city/ town in which participants were born and the first four letters of the first elementary school they attended. Note that one drawback to the pre-test/post-test design is that you cannot say conclusively that differences after the intervention are due to your program's efforts.

As part of your post-program follow-up, you can also have participants complete a questionnaire (e.g., three or six months after the program) to assess how they have used what they learned and what successes and barriers they have experienced. In addition to a questionnaire, **follow-up evaluation tools can include post-tests** (to assess how long change lasts/knowledge is retained), **interviews with individual participants** either in-person or by phone, **focus group discussions and site visits** to observe changed behaviors.

Some tips for outcome evaluation questions include:

- Questions on a pre-test/post-test questionnaire should pertain directly to the material presented. For example, do not ask questions about sexual assault statistics if such data is not presented.
- Questions to assess knowledge change can be true/false or multiple-choice. A sample question might read, "Is the following statement true or false? Low academic achievement is a risk factor for sexual violence perpetration."
- Questions to assess attitude change can also be true/false or multiple-choice questions. They can also be done with a Likert scale (a 5-, 7- or 10-level scale that participants use to rate their level of agreement with a statement). Scales typically range from strongly disagree to strongly agree or from not at all to very much. A sample question might read, "Using a scale of 1 to 5, with 1 being strongly disagree and 5 being strongly

agree, respond to the following statement: I believe sexual violence can be prevented."

Questions to assess knowledge/skills change can target:

- **Willingness or intent to use the knowledge/skills gained.** A sample question for an audience of middle school teachers who received training might read, "Using a scale of 1 to 5, with 1 being strongly disagree and 5 being strongly agree, respond to this statement: "I will discuss with parents ways to talk with their children about healthy dating relationships." Or you can ask participants to list three things they will take action on when they get back to their work site. To increase the chances of success, include a suggested time period within which these actions will take place.
- **Level of confidence in using the knowledge/skills.** A sample question might read, "Using a scale of 1 to 5, with one being strongly disagree and 5 being strongly agree, respond to this statement: I feel comfortable talking with youth about healthy dating behaviors."
- **Improved ability or skill.** This type of question is aimed at determining the extent to which the training boosted ability or practice. A sample question might read, "Using a scale of 1 to 10, with 1 being not at all and 10 being very much, respond to the following statement: This training has improved my ability to address sexually harassing behavior I see happening in the hallways at school."
- **Utilization.** For professionals who are already engaged in sexual violence prevention, you might ask about the extent to which the presentation contributed to the use of the particular knowledge/skills on which you provided training.

Evaluation Design

(Fisher, Lang & Wheaton, 2010)

An evaluation design simply describes the type of evaluation you are going to conduct. Process evaluations can help answer the question, “What is my program doing?” Outcome/impact evaluations can help answer the questions, “Is my program achieving its goals and objectives?” and “Is my program effecting change?”

Examples of different types of evaluation designs (some of these have already been discussed):

- Logs and checklists—to collect process data (the who, what, when, where, why, how);
- Knowledge tests—to collect outcome/impact data;
- Surveys/questionnaires—to collect process and outcome/impact data;
- Interviews—to collect outcome/impact data; and
- Focus groups—to collect outcome/impact data.

Evaluation tools often include process and outcome/impact evaluation questions.

See the attached *Sample Participant Questionnaire* (drawn in part from the Office for Victims of Crime) which can be customized for your use.

The data you collect may be quantitative (e.g., number of program participants) or qualitative (e.g., feedback from participants on improving a program or how the program changed their attitudes and behaviors).

Evaluations often blend quantitative and qualitative data collection. The choice of the type of data to collect should be made with an understanding that there usually is more than one way to answer any given question (Muraskin, 1993).

Whether you are creating your own evaluation tool or using an existing measure (e.g., see Valle et al., 2007, pp.119-145 for a variety of instruments that may be useful), you will need to ensure that the tool is appropriate for your audience’s developmental and literacy levels, language capacity, etc. For example, an evaluation tool for a middle school audience will likely be different from a college audience or a teacher/faculty audience. Note that participants with disabilities that impact communication may require accommodations to complete an evaluation (e.g., in alternative formats).

Planning for Evaluation

An evaluation plan ideally is developed prior to program implementation, as it can help you decide what will be evaluated (e.g., your overall program or an aspect of your program), what you want to know (e.g., how effective the program is in achieving the intended goals), how you will know the answer to your question when you see it (e.g., evidence), and when to collect the data. The plan also can help you identify the best methods for collecting, analyzing and interpreting the data you collect, as well as reporting the results of your evaluation.

Taylor-Powell, Steele & Doughlah (1996) suggest **exploring the following questions to facilitate your evaluation planning** (see Valle et al., 2007 for a related worksheet):

- What is the purpose of the evaluation?
- Who are the key stakeholders in the evaluation? What are their roles in the evaluation? How will they use the evaluation results?
- What are the specific evaluation questions to be answered?
- What information is needed to answer the questions? Where will we get this information? What specific methods will be used?

- When will the data be collected (before, during or immediately after the program or later)?
- Who will collect the information?
- How will the data be analyzed? Who will do the analysis?
- How will the information be interpreted? Who will do the interpretation?
- Who will summarize the evaluation results?
- How will evaluation results be shared (with whom, when, where and how)?

EMPLOYING A LOGIC MODEL IN YOUR EVALUATION PLANNING

To answer some of above questions, you will need to consider the links among your program's overall goals, objectives and activities. **Creating a logic model of your program can assist you in demonstrating these links and guide you in developing evaluation questions and activities**—see the *Sample Logic Model* included in this section (drawn in part from Valle et al., 2007; Shanholtzer, 2010). Note the sample could be further developed with more details (by applying the ABCDE method described below). For further information on using logic models in evaluation, see Valle et al.

As part of a logic model, you will want to define your program's goals and objectives. A **goal** is a measurable statement of the desired long-term, global impact of the program. Goals generally address change. For example, a goal may be prevention of sexual violence among middle school-aged children. An **objective** is a specific, measurable statement of the desired immediate or direct outcomes of the program that support the accomplishment of a goal. For example, "Our program will provide primary prevention education on sexual violence to six middle schools in our service area during the school year."

The **ABCDEs of writing measurable goals and objectives** are offered to guide the development of goals and objectives and clarify the evaluation plan:

- **Audience**—Who is the population for whom the desired outcome is intended? (E.g., persons with developmental disabilities, campus athletes).
- **Behavior**—What is to happen? What results are expected? (E.g., increase in participants' knowledge of traits of healthy sexuality and relationships).
- **Condition**—By when? What are the conditions under which measurements will be made? This may refer to the timeframe and/or implementation of a specific intervention. (E.g., the overall timeframe for program implementation is the 2014/2015 school year, but change might be measured immediately after a program and again three months later).
- **Degree**—By how much? What quantification or level of results is expected? (E.g., knowledge of 10 characteristics of healthy sexuality and intention to increase healthy sexuality in 3 of 14 areas as identified by McLaughlin, Topper & Lindett, 2009).
- **Evidence**—As measured by what criterion or instrument? (E.g., a pre-test/post-test, follow-up surveys or individual interviews; could also use an established instrument such as the *Attitudes About Aggression in Dating Situations Scale*, developed by Slep et. al., 2001).

You can use the above method to identify elements of each desired outcome and then formulate goal/objective statements using the applicable elements.

Additional Written Evaluation Resources

Puddy, R. & Wilkins, N. (2011). *Understanding Evidence Part 1: Best Available Research Evidence. A Guide to the Continuum of Evidence of Effectiveness*. Atlanta, GA: Centers for Disease Control and Prevention. (Available at no cost through www.cdc.gov.) This document explains the continuum of evaluating the effectiveness of prevention programs, policies and practices. Advocates, researchers and policy makers can use the information in this guide to determine if they are achieving outcomes and making the intended changes.

Riger, S., Wasco, S., Schewe, P. & Campbell, R. (2002). *Evaluating Services for Survivors of Domestic Violence and Sexual Assault*. Sage Publications, Inc. (Can be purchased at www.sagepub.com/books/Book225465, paperback \$59, Hardcover \$104.) The website includes the following book description: "Evaluation programs that effectively measure the success of domestic violence and sexual assault services are essential not only to assure high levels of client service and continued funding, but also in evaluating how far society has come in the effort to end violence against women. *Evaluating Services for Survivors of Domestic Violence and Sexual Assault* provides comprehensive guidelines and field-tested tools for direct service evaluation programs. It also chronicles and celebrates over thirty years of progress made by the anti-violence movement. The authors offer a wealth of practical information at the same time identifying key issues and placing them in the broader context of social and political change..."

Additional Internet Resources (adapted from Shanholtzer, 2010)

- CDC's Evaluation Framework: www.cdc.gov/eval/framework/index.htm
- Community Tool Box: ctb.ku.edu/en/
- American Evaluation Association: www.eval.org/
- Coalitions Work: coalitionswork.com/
- Writing Goals and Objectives: apps.nccd.cdc.gov/dashoet/writing_good_goals/menu.html
- Basic Guide to Program Evaluation: www.cdc.gov/healthyyouth/tutorials/writinggoal/index.htm
- Kellogg Foundation Evaluation Handbook: www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx

SAMPLE LOGIC MODEL: MIDDLE SCHOOL SEXUAL VIOLENCE PREVENTION PROGRAM

(Drawn in part from Valle et al., 2007; Shanholtzer, 2010)

Program's Theory Base: Societal norms condone sexual violence. In such an environment, individuals learn violent behavior, acceptance of violence and victim blaming from sources such as family, peers and the media. This program seeks to positively change these social norms and influence individual attitudes and behaviors.

Outcomes: The ultimate goal of the program is to prevent sexual violence among middle school students in our service area. To accomplish that, the program's immediate/intermediate goals are to promote zero tolerance for sexual violence; develop students' knowledge, skills, behavioral intentions and behaviors that support nonviolent behaviors, specifically healthy sexuality/relationships; and decrease the likelihood of sexual violence.

Resources Available to Operate the Program: e.g., staff, volunteers, time, materials, equipment, technology, finances and partnerships.

Program Activities: 6 Middle Schools	Objectives: 2014-2015 School Year	Process Questions & Evaluation Methods	Outcome Questions & Evaluation Methods
Classroom education	Increase students' knowledge, skills, attitudes, behavioral intentions and behaviors that promote zero tolerance for sexual violence and that help develop healthy sexuality and relationships.	Are classroom activities being implemented as planned? <i>Observe classroom using checklists and rating scales.</i>	Is the program positively influencing students' attitudes, knowledge, behavioral intentions and behaviors? <i>Pre/post test surveys and post-program focus groups.</i> Is the program making a positive difference? <i>Observation during student role plays and follow-up surveys, interviews and focus groups.</i>
School staff education School policy/practice review and development	Increase school staff knowledge, skills, attitudes, behavioral intentions and behaviors that promote zero tolerance for sexual violence at school and that support students' healthy sexuality/relationships. Promote practices/policies that promote the above.	What are staff issues and concerns as trainings are implemented? <i>Interview staff.</i> Are staff satisfied with trainings? <i>Survey staff.</i> Is staff reviewing policies/practices and adjusting or developing as needed? <i>Review meeting minutes.</i>	Are trainings improving the school climate? <i>Follow-up surveys, interviews, pre/post test surveys and post-program focus groups.</i> Are there school policies/practices supporting zero tolerance for sexual violence? <i>Records review.</i> Are school events free of gender stereotyping and images of violence? <i>Post-training observation of events.</i>
Parent education (pre-K-12)	Increase parental modeling and monitoring that promote zero tolerance for sexual violence and that support students' healthy sexuality/relationships.	Which parents are reached? <i>Review attendance sheet.</i> Are parents satisfied with the information and guidance offered? <i>Survey parents.</i>	Is the program increasing parental supervision and monitoring? <i>Follow-up surveys, interviews, pre/post test surveys and post-program focus groups.</i>
Community networking	Activities promote partnerships to support students' healthy sexuality/relationships and that have zero tolerance for sexual violence.	Which agencies are included in collaborative efforts? Are collaborators satisfied with the level of partnerships? <i>Survey and/or interview staff and community agencies.</i>	Do community agencies support schools in promoting healthy relationship behaviors and having zero-tolerance for sexual violence? <i>Follow-up surveys, interviews and focus groups.</i>

SAMPLE PARTICIPANT QUESTIONNAIRE

[This sample questionnaire, which includes both process and outcome evaluation components, can be customized for your audience and then administered at the close of a presentation. It can be one of several evaluation tools you use.]

Name of Presentation: _____ Date _____

Part 1: Participant Information

School: _____ Grade _____ Age _____

Check one: Male Female

[Insert additional questions for participant characteristics you want data on here]

Part II: Please indicate the extent to which you agree or disagree with the following statements about the presentation.

1 – I strongly disagree with this statement.

4 – I agree with this statement.

2 – I disagree with this statement.

5 – I strongly agree with this statement.

3 – I neither agree nor disagree with this statement. NA – Not applicable

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Not Applicable
1. As a result of this presentation, I can [insert training/presentation objective 1 (e.g., describe traits of healthy sexuality/healthy relationships)].	1	2	3	4	5	NA
2. As a result of this presentation, I can [insert training/presentation objective 2].	1	2	3	4	5	NA
3. As a result of this presentation, I can [insert training/presentation objective 3].	1	2	3	4	5	NA

[Edit, delete and/or add questions in the above chart to fit the evaluation needs of your program. This section measures participant confidence in knowledge/skills gained; a pre-test/post-test could help verify knowledge/skills acquisition.]

Part III: Please indicate your level of satisfaction or dissatisfaction with each statement.

1 – Very dissatisfied

4 – Satisfied

2 – Dissatisfied

5 – Very satisfied

3 – Neither satisfied nor dissatisfied

Instructor 1: _____	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
1. Instructor's level of preparation	1	2	3	4	5
2. Instructor's knowledge of the subject	1	2	3	4	5
3. How the instructor encouraged discussion	1	2	3	4	5
4. How the instructor responded to questions and comments	1	2	3	4	5
5. Instructor's level of respect towards participants	1	2	3	4	5

Instructor 2: _____	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
6. Instructor's level of preparation	1	2	3	4	5
7. Instructor's knowledge of the subject	1	2	3	4	5
8. How the instructor encouraged discussion	1	2	3	4	5
9. How the instructor responded to questions and comments	1	2	3	4	5
10. Instructor's level of respect towards participants	1	2	3	4	5
Overall	Very Dissatisfied	Dissatisfied	Neither Satisfied nor Dissatisfied	Satisfied	Very Satisfied
11. Overall quality of presentation materials (handouts, audiovisuals)	1	2	3	4	5
12. Comfort of the meeting space	1	2	3	4	5
13. Time allotted for the material presented	1	2	3	4	5

[Edit, delete and/or add statements in the above chart to fit the evaluation needs of your program.]

14. What aspects of this presentation were most helpful and why?

15. Identify three things you plan to do or change as a result of the education you received through this presentation.

16. Do you have any specific suggestions for changing the presentation to make it better for future participants?

[Edit, delete and/or add questions to fit the evaluation needs of your program.]

Thank you for completing the Participant Questionnaire.

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