CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

A PSYCHOEDUCATIONAL SUPPORT GROUP FOR SURVIVORS OF SEXUAL ASSAULT

A graduate project submitted in partial fulfillment of the requirement
For the degree of Master of Science in Counseling,
Marriage and Family Therapy

by

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The graduate project of Jessica Anne Ciarloni is approved:

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DEDICATION

I would like to dedicate this graduate project to the family and friends in my life, without whom none of this would have been possible.

To my parents, there are no words for how grateful I am to have two of the most supportive and loving people I know, as my Mom and Dad.

Dad, I owe all of my work ethic and value of school to you. You have gently guided me through my education, giving me more drive to succeed than you know. You would have done anything for me, at any time to help me reach my goals, and I can never re pay you for that.

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Lastly, I dedicate this culminating project to the hard working Marriage and Family Therapist Trainees and Interns at Valley Trauma Center who spend endless hours counseling and advocating for their clients. I hope this curriculum can be implemented and useful for the survivors and help in developing your therapeutic skills.

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ABSTRACT

A PSYCHOEDUCATIONAL SUPPORT GROUP FOR

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Psychoeducational support groups for survivors of sexual assault can be an effective therapeutic intervention. Survivors of sexual assault suffer from physical, emotional, and psychological trauma that can have lasting effects on individuals and their lives. This project presents a 12-session psychoeducational group curriculum for adult female survivors of sexual assault.

CHAPTER ONE

Introduction

It is estimated that every 2 minutes, someone in the United States is sexually assaulted with 262,800 victims each year. Statistics show that one out of every six American women has been the victim of an attempted or completed rape in her lifetime, with 80% of victims under age 30. These sexual assault survivors are three times more likely to suffer from depression, six times more likely to suffer from Posttraumatic Stress Disorder, thirteen times more likely to abuse alcohol, twenty six times more likely to abuse drugs, and four times more likely to contemplate suicide (RAINN, 2009).

It is common for sexual assault survivors to suffer from adverse emotional and psychological trauma, the most common being Posttraumatic Stress Disorder (PTSD). According to the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM-IV-TR), a person may develop PTSD, "following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or a threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person" (American Psychiatric Association, 2000, p.463). The symptoms may include, "re-experiencing the traumatic event through distressing images, thoughts, perceptions, dreams, illusions, hallucinations and dissociative flashbacks, avoidance of thoughts, feelings, activities, places or people associated with the trauma, diminished interest in previously enjoyed activities, feelings of detachment, estrangement, restricted range of affect, sense of foreshortened future, difficulty falling or staying asleep, irritability, outbursts of anger, difficulty concentrating, hyper vigilance, and exaggerated startle response" (American Psychiatric Association, 2000, p.464). According to Riggs,

Rothbaum, and Foa (1995) three weeks after an assault 79% of rape victims and 71% of female victims of nonsexual assault met the DSM-IV-TR criteria for PTSD.

The consequences of rape are extensive and can be traumatizing to the survivor if left untreated. Finding an effective treatment for sexual assault survivors would be the ultimate goal. Both individual and group settings for treatment can be helpful for the survivor. The group format might facilitate the modification of cognitions because of the greater exposure to alternative points of view and the confrontation of stuck points. The group format has advantages with regard to cost effectiveness and the potential for social support (Resick & Schnicke, 1992). Survivors in a group setting are able to recognize that their personal testimony is valued by and beneficial to others which may enhance the sense of empowerment and self esteem of participants (Hebert & Bergeron, 2007). Research has also shown a beneficial effect of group intervention for survivors of sexual assault in reducing feelings of powerlessness (Hebert & Bergeron, 2007).

Participating in a group which focuses specifically on psychoeducation can be an effective treatment for survivors of sexual assault. Explaining to individuals or groups what common reactions, including symptoms or feelings, have been found among those who have been exposed to a traumatic event is considered psychoeducation. The idea of pyschoeducation suggests that individuals may find comfort in knowing that their symptoms are normal reactions to extreme stress, that they are not crazy, and that there is help available if or when they need it. Psychoeducational groups can help reduce the stigma of stress reactions, encourage social support, and encourage survivors to seek help as needed (Krupnick & Green, 2008). Bisson, McFarlane, and Rose (2000) describe psychoeducation as a way of providing traumatized individuals with a "psychological

map to understand their reactions." There is reason to believe that an increase in factual knowledge about rape, which is the most significant outcome of group program participation, may be related to less severe distress following a sexual assault (Anderson & Whiston, 2005).

Statement of Need

Rape and sexual assault are a major problem in our society and can impact the survivor and the people in their lives tremendously. The effects of a sexual assault can last long after the trauma has occurred, and often these effects increase in severity as time goes on. Unfortunately, many survivors of sexual assault tend to neglect to consider the severity or long term nature of the psychological issues that can occur due to the trauma; therefore these symptoms often go untreated. Survivors have been found to experience disruption in their sense of identity, relationships, and spiritual well being. Survivors may also develop persistent symptoms characteristic of Posttraumatic Stress Disorder (PTSD) that can interfere with their daily functioning.

There are many reasons why a survivor may be reluctant to seek help after an assault. Survivors may not feel treatment is needed, may not want to experience the negative stigma sometimes associated with therapy, may be too fearful of the idea of talking about the assault, or think if they do not discuss the assault, the memories will just "go away." The lack of treatment leaves the survivor with little support, knowledge, and resources to help cope with the overwhelming symptoms that can develop in the aftermath of the trauma.

Becoming educated on the effects of the sexual violence that may be experienced after an assault has occurred may help survivors better understand and cope with their

trauma. Some of the effects can include depression, anxiety, flashbacks, substance abuse, self-harm, eating disorders, pregnancy, Dissociative Identity Disorder, and many more (RAINN, 2009). Educating survivors can be done in a way that will provide support, a feeling of universality, and empowerment. This can be done by developing a group therapy curriculum designed and implemented specifically for providing psychoeducation to survivors of sexual assault.

The types of coping strategies used by survivors have been found to be important mediators of the relationship between victimization and distress. Specifically, the uses of maladaptive coping strategies such as denial, avoidance, and withdrawal have been shown to predict poorer recovery in general as well as more severe psychological distress (Arata, 2000). The importance of teaching effective coping strategies in a safe and supportive environment can be the predictor of the success of the survivor's recovery. In the proposed program, effective coping strategies will be taught in a psychoeducational support group for survivors of sexual assault, giving group members' opportunity to implement these skills and discuss what is or is not effective for them. Having a place to discuss such issues and receive feedback and ideas from others is expected to be very beneficial in assisting survivor's treatment process.

Purpose of Graduate Project

The purpose of this project is to develop a structured group therapy curriculum for adult survivors of sexual assault. The curriculum will be used by Marriage and Family Therapist Trainees and Interns providing services to survivors of sexual assault at Valley Trauma Center (VTC), a community based sexual assault program located in Los

Angeles, California. This curriculum will enable a therapist/group leader to provide psychoeducation and therapeutic support in a group setting.

The program includes guidelines for twelve group sessions of 1.5 hours each and is designed for female survivors, age 18 and older. This psychoeducational group has the goal of increasing knowledge of the effects sexual assault can potentially have on an individual long after the assault has occurred. The goal is achieved by discussing topics such as: common symptoms experienced after a sexual assault, myths and realities of rape and sexual assault, effective coping strategies, common feelings and reactions, self care, safety planning, risk reduction strategies and victim's rights.

Terminology

- Coping Strategies: Skills developed to help face and deal with problems, difficulties, and symptoms successfully.
- Efficacy of Treatment: The identified treatment's capacity for producing a desired result or effect; treatments effectiveness.
- Group Intervention: A type of intervention which allows members of a group to share their experiences and to support others who are in a similar situation.
- Perpetrator: A person who commits an offense or a crime against another individual.
- Posttraumatic Stress Disorder (PTSD): A normal human reaction to an extreme or abnormal situation. Each person has a different threshold for what is perceived as a traumatic event. Many people experience PTSD as a result of a traumatic experience such as rape or sexual assault (RAINN, 2009).

- Psychoeducation: The term covers the provision of information about the nature of stress, posttraumatic and other symptoms, and what to do about them (Wessely, Bryant, Greenberg, Earnshaw, Sharpley, and Hughes, 2008).
- Rape: Nonconsensual oral, anal, or vaginal penetration of the victim by body parts or objects using force, threats of bodily harm, or by taking advantage of a victim who is incapacitated or otherwise incapable of giving consent. Incapacitation may include mental or cognitive disability, self-induced or forced intoxication, status as minor, or any other condition defined by law that voids an individual's ability to give consent (National Institute of Justice, 2010).
- Re-victimization: When an individual is victimized more than once.
- Sexual Assault: A wide range of unwanted behaviors that are attempted or completed against a victim's will or when a victim cannot consent because of age, disability, or the influence of alcohol or drugs. Sexual Assault may involve actual or threatened physical force, use of weapons, coercion, intimidation, or pressure (National Institute of Justice, 2010).
- Sexual Violence: Refers to a specific constellation of crimes including sexual harassment, sexual assault, and rape. The perpetrator may be a stranger, acquaintance, friend, family member, or intimate partner (National Institute of Justice, 2010).
- Survivor: An individual who experienced a traumatic event such as sexual assault and is in the process of healing. This term empowers the individual.
- Trauma: An experience that produces psychological injury or pain, can be produced by an emotional or physical wound.

Organization of Graduate Project

The following chapters of the graduate project will elaborate on survivors of sexual assault. Chapter two includes a review of the literature on sexual assault and posttraumatic stress disorder, re-victimization, effective therapeutic techniques for aiding in the treatment of survivors, efficacy of group interventions, and recovery patterns of survivors of sexual assault.

Chapter three describes the method in developing the 12-session model and explains whom the psychoeducational group is intended for. The qualifications required for implementing the curriculum and leading the 12-session group, as well as the ideal environment and equipment needed are also discussed.

Chapter four is the completed curriculum for the psychoeducational support group for survivors of sexual assault. This chapter contains a detailed outline of the group curriculum including the session goals, objectives, materials, procedures, handouts, and homework assignments. Each handout used in this group is also included in this chapter. These handouts are designed as supplemental tools to be used in addition to the curriculum.

Chapter five concludes the graduate project with a summary and discussion of future work and research needed. An evaluation of the project includes recommendations for future improvements in the group curriculum.

CHAPTER TWO

Literature Review

Introduction

Findings from a sexual assault education program study indicate that sexual assault psychoeducation programs are somewhat effective in changing attitudes toward rape and increasing knowledge about trauma (Anderson & Whiston, 2005). This chapter facilitates an understanding of the potential long-term negative effects resulting from sexual assault. The prevalence of PTSD in female survivors of sexual assault is reviewed and the possibility of re-victimization is explored. Effective treatment options are discussed including psychoeducation and group intervention. The recovery process for survivors of a sexual assault compared to survivors of a non sexual assault is also reviewed.

Review of Research

Posttraumatic Stress Disorder

Female survivors of assault often show a characteristic profile of symptoms that can include fear, avoidance, anxiety, and re-experiencing of the trauma. The psychological problems that often follow an assault can be conceptualized as posttraumatic stress disorder (PTSD), which has been described as an acute reaction and normative response to an assault. Valentiner, Foa, Riggs, and Gershuny (1996) studied coping behaviors and posttraumatic stress symptoms in female victims of sexual and non sexual assault in their study. Participants were between the ages of 17 and 65 and were recruited through advertisements, emergency room staff or police officers. Participants were included in the study if they were a victim of sexual or non sexual assault, if they

had no history of a mental disorder, and the assault was not committed by a family member or within an ongoing abusive relationship. Coping behaviors and posttraumatic stress symptoms of 215 female assault victims (103 rape victims and 112 non sexual assault victims) were assessed within two weeks following the assault, and 133 of them were followed up three months later using the *Posttraumatic Stress Disorder Symptom Scale (PSS;* Valentiner, Foa, Riggs & Gershuny, 1996).

Valentiner et al. (1996) found that there was a substantial decline in psychological disturbance in the 3 months following the assault. The results support the idea that PTSD symptomatology is a normative response to assault, especially sexual assault. The study also found that a substantial portion of assault victims develop enduring problems unless an effective intervention is provided. Three coping scales were constructed on the basis of exploratory factor analysis: Mobilizing Support, Positive Distancing, and Wishful Thinking. Three months post assault, rape victims in the study showed higher levels of wishful thinking and PTSD than non sexual assault victims. Results from this study suggest that coping through fantasy and self-blame impede recovery from traumatic assault, whereas cognitive distancing may facilitate recovery. The role of demographic variables was not examined in this study as age, socioeconomic status, and ethnicity may influence the recovery process (Valentiner, Foa, Riggs & Gershuny, 1996).

Women are approximately twice as likely as men to develop posttraumatic stress disorder (PTSD), but the cause of this disparity remains unclear. Cortina and Kubiak (2006) examined gender as a risk factor for posttraumatic stress disorder to explain this gender disparity. Their study evaluated two alternative explanations of gender differences in PTSD, one pointing to an intrinsic vulnerability in women and the other

emphasizing sexual violence across the life span. To test these theories, they analyzed National Violence Against Women (NVAW) Survey data from 591 victims of partner aggression. To obtain a national random sample for the study, interviewers used random-digit dialing to reach households with a telephone in all 50 states and the District of Columbia. The interviewers then identified all eligible household members which were adults age 18 and older and selected the adult with the most recent birthday to participate. A total of 8,000 men and 8,000 women completed the NVAW Survey which focused on current partner aggression. Of the 16,000 adults who completed the survey, 591 (194 men and 397 women) met partner victimization criteria and received the PTSD assessment (Cortina & Kubiak, 2006).

Results of this study suggested that gender, when considered alone, has a small but significant effect on PTSD symptom severity. However, once multiple regression models factor in sexual victimization history, the latter replaces gender as a key determinate of PTSD symptoms. These findings argue against theories of "feminine vulnerability," instead linking PTSD risk to a history of sexually violent situations. This study only focused on current PTSD symptoms and did not address lifetime PTSD, therefore we cannot determine whether the findings address apparent differences in PTSD onset or PTSD course. It did however, use a random sample and revealed an alternative explanation for apparent gender differences in PTSD symptoms pointing to life history of sexual violence as an important source of risk (Cortina & Kubiak, 2006).

Re-victimization

Women are often re-victimized throughout their lives in violent situations. Many studies have documented a link between childhood sexual abuse (CSA) and re-

victimization in the form of adult sexual assault (ASA; Arata, 2000). Researchers have found that CSA survivors are at least twice as likely to be re-victimized as women with no reported CSA (Messman-Moore & Long, 2003). A study done by Filipas and Ullman (2006) examined the psychological aftereffects of child sexual abuse and the factors that contributed to re-victimization in the form of adult sexual assault. Re-victimization was defined as CSA survivors who also experienced ASA, due to the strong link that has been found in the research from early to later sexual re-victimization (Arata, 2000). This was done by using a survey of 577 female college students recruited from introductory psychology classes and the criminal justice department. These 577 students which included those with no sexual victimization, CSA only, ASA only, and both CSA and ASA, completed a 20-page survey on stressful life experiences. Child sexual abuse characteristics, maladaptive coping in response to child sexual abuse, degree of self-blame at the time of the abuse and currently, and posttraumatic stress disorder symptoms were examined as predictors of re-victimization (Filipas & Ullman, 2006).

The findings from this study support a definite link between childhood sexual abuse and re-victimization in adulthood, with adult sexual assault being almost four times more likely for those individuals who experienced CSA. Results in this study indicated that individuals who reported both child sexual abuse and adult sexual assault had more PTSD symptoms, were more likely to use drugs or alcohol to cope, act out sexually, withdraw from people, and seek therapy services. In addition, the re-victimized group reported more self-blame at the time of the abuse and currently. The only factor that predicted re-victimization in this study was the number of maladaptive coping strategies used. It would be hard to distinguish whether re-victimization leads to these negative

coping patterns, or vice versa. They also report that educational programs in schools and through community outreach programs on child sexual abuse and its aftermath may help normalize survivors' feelings and help them find available resources in their community if they wish (Filipas & Ullman, 2006).

Research suggests that once a woman has been victimized in childhood or adolescence, she enters a "vicious cycle" where her risk for future victimization increases greatly. Because a woman's response in a potentially threatening situation depends on her judgments of that situation, it has been suggested that poor recognition of risk for potential danger may explain the relationship between subsequent victimization experiences. This may be especially relevant to victims of acquaintance sexual assault because the social context of the assault as well as the relationship with the perpetrator play key roles in the ability to respond to a potentially threatening situation (Norris, Nurius, & Dimeff, 1996).

A study done by Wilson, Calhoun, and Bernat (1999) investigated the differential impact of various levels of sexual victimization on women's perceptions of risk and evaluative judgments of sexual assault within a dating interaction. In this study, 330 undergraduate female single and multiple incident victims recruited from introductory psychology classes at a large Southeastern university, were compared with non-victims, with ages ranging from 15 to 27 years old. The stimulus material used consisted of an audio taped vignette involving a man and a woman engaged in sexual activity. The vignette involves a woman resisting sexual contact after a period of extended kissing with verbal appeals, followed by more blatant verbal demands, leading to a more forceful demand including shouting and crying. Decision latency in this study was defined as the

length of time needed by the participants to indicate when the man in the vignette had "gone too far" implying the woman was in a dangerous situation. Participants were asked to listen to the audiotape and press a button if and when they feel the man had gone too far (Wilson, Calhoun, & Bernat, 1999).

Results of this study supported the hypothesis that re-victimized women would exhibit longer latencies than either single incident victims or non-victims in signaling that an audiotape vignette of date rape should be halted. The researchers found that re-victimized women with greater posttraumatic stress disorder (PTSD) symptoms, arousal symptoms in particular, exhibited latencies similar to those of non-victims, whereas re-victimized women with lower levels of PTSD symptoms had significantly longer latencies. Dissociative symptoms were not found to be related to latency in this study. These findings suggest that PTSD related arousal symptoms may serve a buffering effect, increasing sensitivity to threat cues that indicate a sexually coercive interaction (Wilson, Calhoun, & Bernat, 1999).

Treatment for Sexual Assault Survivors

The aim of providing psychoeducation is to lighten or diminish the effects of exposure to extreme situations. The information given through psychoeducation can be given either prior to, or following the trauma. Explaining to individuals or groups what common symptoms or feelings have been found among those who have been exposed to a traumatic experience can prove to be very helpful in the recovery process. Some of the topics may include PTSD symptoms, common feelings such as anger, blame, shame, and guilt, and indications of when it may be time to seek professional help. Psychoeducation can range from brochures, self-help material, videos, and individual or group face-to-face

information sessions. A concern raised regarding psychoeducation is whether informing people about how symptoms of a disorder may somehow cause the individual to develop, or report these symptoms. Although this appears to be a reasonable concern, there is little empirical evidence that shows information leads to increased symptom development or reporting. The timing of the intervention, content and delivery mode and understanding the audience who will be receiving the information are all important factors to be considered when providing psychoeducation (Krupnick & Green, 2008).

Studies show that women, who participate in programs developed to educate participants and reduce women's risk of being sexually assaulted, display greater knowledge about rape, are less accepting of rape myths, and assign less blame to rape victims (Anderson & Whiston, 2005). Mouilso, Calhoun, and Gidycz (2010) evaluated a program in their study which included a psychoeducation component addressing common cognitions and emotions following rape and challenging common myths about rape and rape victims. They hypothesized that the psychoeducation component of the intervention would positively impact participants' attributions of self-blame and therefore act as a mechanism to decrease distress following re-victimization (Mouilso, Calhoun, & Gidycz, 2010).

The participants in this study were 450 undergraduate college women who participated in a prospective study designed to evaluate the efficacy of a sexual re-victimization risk reduction program. Participants were recruited from introductory psychology classes at a large Southeastern university and a midsized Midwestern university. In order for a participant to be eligible, she must be at least 18 years old and reporting sexual victimization in adolescence or adulthood. The mean age of the

participants was 19 with the majority of the group (89%) being predominantly Caucasian. Of the participants, 147 reported experiencing some form of unwanted sexual contact during a 4 month follow-up period, qualifying them for the study. The 147 participants had a history of attempted or completed rape prior to the study and at least one episode of sexual victimization during the 4 month follow-up period. Participants were prescreened using the *Sexual Experiences Survey (SES)* to assess history of sexual victimization. Participants were randomly assigned to either the wait-list control or to the intervention group. The intervention group completed a 4-hour, two session, sexual victimization risk reduction program in small groups of 5 to 12. The program consisted of psychoeducation addressing common cognitions and emotions following rape and challenging common myths about rape and rape victims. The program also included assertiveness training, social problem solving, and personal risk assessment components. After the intervention group participants completed the risk reduction program, the procedure for all participants was identical for the duration of the study with the use of the *Symptom Checklist-90-Revised, Posttraumatic Stress Diagnostic Scale (PDS), Rape Attributions Questionnaire,* and *The Ways of Coping Questionnaire*. At the 4 month follow-up, the *SES* assessed for any unwanted sexual contact in the period since the previous assessment (Mouilso, Calhoun, & Gidycz, 2010).

Results of this study indicate that participation in the sexual assault risk reduction program decreased the severity of women's psychological distress following re-victimization. Significantly fewer women in the intervention group met criteria for PTSD at Time 2 than at Time 1, despite the intervening re-victimization. These results suggest that such programs may be beneficial even to women who are later re-victimized.

The psychoeducational component could be expected to lessen the impact of self-blame attributions on participants' experience of psychological distress (Mouilso, Calhoun, & Gidycz, 2010).

Treatment Preference

Little is known about what factors influence a survivor's treatment preference after a sexual assault has occurred. Despite the high level of trauma exposure and PTSD, only a minority of women actively seek treatment. In order to address the gap in treatment, the factors that influence treatment preferences must be better understood. Cochran, Pruitt, Fukuda, Zoellner, and Feeny (2008) conducted a study to research just what those factors are. Their study involved 273 female undergraduate participants from the University of Washington and Case Western Reserve University. Participants were recruited from undergraduate psychology subject pools with a mean age of 19 years. The sample was primarily Caucasian and Asian. All participants reported some type of trauma exposure including serious accidents, life threatening illnesses, sexual and nonsexual assaults, and natural disasters (Cochran et al., 2008).

Participants first completed the self report measure provided, the *Posttraumatic Stress Diagnostic Scale (PDS)* used to assess trauma exposure and current PTSD. A hypothetical "if this happened to you, what would you do" sexual assault scenario was then presented. This scenario was presented with a description of the assault, symptoms currently being experienced, problems these symptoms are causing in daily functioning, desire to seek treatment, and two forms of possible treatment. The forms of treatment presented were Prolonged Exposure, a 9-12 session individual therapy, Zoloft (sertraline), an antidepressant medication, or no treatment at all. After reading the

hypothetical scenario the participants were then asked to read the descriptions of each treatment option and answer the questions that followed as if they were deciding on treatment for themselves (Cochran et al., 2008).

The results of this study show the most common responses of women when asked to describe their main reasons for treatment choices were the perceived effectiveness of the treatment, wariness of medication, and positive feelings about talking. Although the treatment rationales for prolonged exposure and Zoloft (sertraline) suggested that both treatments have undergone rigorous scientific evaluation and are helpful in reducing PTSD symptoms, many of the women still believed that the psychotherapy would be more effective in their treatment. The reasons being that many of the participants believed that the medication would only cover up, or mask, symptoms whereas, the psychotherapy would help resolve the issue and produce a long term effect. It was found that participants stated a wariness of medication due to risk of addiction, negative physiological effects, and potential return of symptoms with medication discontinuation.

Positive feelings about talking in psychotherapy were a strong predictor of treatment preference. Participants in this study consistently highlighted the need to talk through trauma problems, talk about the trauma itself, and share the experience with others. This study was limited to young women, and the findings may not extend to males or other age ranges, but the similarities were more apparent than the differences when comparing individuals with a sexual assault history or chronic PTSD to those without. The findings of this study help clinicians better understand the treatment preferences of women in a potentially high risk age range for sexual assault and may aid

in refining psychoeducational materials regarding the psychological consequences of sexual assault and treatment options (Cochran et al., 2008).

Treatment Effectiveness

Clinician-assisted emotional disclosure (CAED) is an adaptation of two of six emotion-focused therapy (EFT) treatment modules. CAED focuses on the elaboration of sexual trauma narratives and the emotional focusing and processing of these events. Anderson, Fende Guajardo, Luthra, and Edwards (2010) conducted a study designed to assess the effects of an EFT approach in alleviating distress experienced by survivors of adult sexual assault. They hypothesized that participation in CAED would lead to increased negative effects immediately after recounting the traumatic events, but would however at one and three months after treatment, show reductions in global, interpersonal, and traumatic stress symptoms relative to women in the control group (Anderson et al., 2010).

A total of 670 college women were screened for a history of sexual assault and current levels of general psychological symptoms. The women were recruited through introductory level psychology classes at a medium sized Midwestern university. Of the 670 women, 65 of them met both sexual assault and high psychological distress criteria for involvement into the study. Forty-three participants met the criteria and were asked to participate in the study. Of those, 17 completed the one month follow-up and 13 returned for the three month follow-up evaluation. The mean age for the sample was 19 years and the group was predominantly Caucasian (Anderson et al., 2010).

At the initial screening, participants filled out the *Sexual Experiences Survey (SES)*, a self-report measure designed to identify various levels of sexual victimization.

They also completed the *Outcome Questionnaire-45 (OQ)*, a 45 item general symptom measure. Participants who indicated having experienced a sexual assault (affirmative responses on any of the 6-10 items on the *SES*) and who had a score of 59 or higher on the *OQ* were asked to participate in further stages of the study. Participants who agreed were randomly assigned to either the experimental or the control group. The experimental group participated in four half-hour sessions with a therapist of CAED over a period of approximately ten days. Participants in the control group also reported for four sessions but only to complete questions about their mood and did not receive any form of treatment (Anderson et al., 2010).

The results of this study provide preliminary evidence that emotion-focused approaches may be useful for reducing interpersonal distress and avoidance of symptoms of PTSD for survivors of sexual trauma. CAED led to decreased avoidance symptoms given that avoidance is closely related to the severity and maintenance of PTSD. Participants in the treatment group reported relatively greater decreases in interpersonal problems, which is important because these interpersonal patterns may shape relationships with partners and significant others who are the most likely to re-victimize these women. There were no immediate gains at termination or the one month follow-up, but were significant findings at the three month follow-up which are consistent with recent findings of delayed effects from emotional disclosure treatment. It may be possible that the four sessions over the short period of ten days began the process of further emotional and cognitive processing. The effects were then apparent at the three month follow-up. The most significant limitation to this study may have been the small

sample size and that half of the sample did not return for the three month follow-up evaluation (Anderson et al., 2010).

Cognitive processing therapy (CPT) was developed to treat the symptoms of posttraumatic stress disorder (PTSD) in rape victims. Resick and Schnicke (1992) used CPT in their study, which is based on an information processing theory of PTSD and includes education, exposure, and cognitive components. In their study, twenty eight women were interviewed and assessed for participation in CPT. The participants had been raped at least three months previously, had never been incest victims, had no severe pathology, and were reporting significant PTSD symptomology. In total, nineteen women met these criteria as female sexual assault survivors with a mean age of 30 years and had all experienced one to three rapes (Resick & Schnicke, 1992).

The participants received CPT which consisted of 12 one and a half hour weekly sessions in a group format. The participants were assessed at pretreatment, post treatment, and three and six month follow-up. CPT subjects were compared with a 20 subject comparison sample which included 20 rape victims who met the same criteria and were on the waiting list for group therapy for at least 12 weeks. The participants completed the *Symptom Checklist-90-revised (SCL-90-R),* the *Impact of Event Scale (IES), PTSD Symptom Scale-Self Report (PSS-SR), Beck Depression Inventory (BDI), Social Adjustment Scale (SAS),* and the *Structured Clinical Interview* for DSM-III-R-*Non-patient version (SCID;* Resick & Schnicke, 1992).

They found that CPT subjects improved significantly from pre- to post treatment on both PTSD and depression measures and maintained their improvement for 6 months. The comparison sample did not change from the pre- to the post treatment assessment

sessions. Results of this study indicate that cognitive processing therapy, developed from an information-emotional processing theory of PTSD, is effective in improving symptoms in a large majority of participants. Many of the women reported substantial improvement in the quality of their lives as well as a greater sense of hope. Although the results in this study were favorable, there were some limitations such as the small sample size and the way in which the subjects were chosen which was not done randomly. Further research would be beneficial to determine if there are differences in outcome between group and individual CPT (Resick & Schnicke, 1992).

Group Intervention

Group therapy has been shown to be an effective intervention for survivors of sexual assault (Yalom, 1995). Yalom (1995) suggests that group work is often preferred over other forms of treatment because connecting with other survivors provides members with a sense of hope, information, reduced isolation, social skills, group cohesion, the opportunity to help others, and an environment that promotes catharsis. The act of disclosure of emotional experiences, acknowledging and openly discussing a problem with others, is commonly shown to be a powerful therapeutic agent (Cochran, Pruitt, Fukuda, Zoellner, & Feeny, 2008).

Group intervention as treatment for adult women who have been sexually abused as children or adults provides them the opportunity to share victimization experiences with other survivors in a safe environment. Sharing such experiences may be valuable when working through the issues of shame and secrecy due to sexual abuse. Group intervention offers a setting to observe and learn from others and can reduce isolation by creating a supportive social network for the survivor. Hebert and Bergeron (2007)

conducted a study to evaluate the effects of a group intervention based on a feminist approach offered to women who were survivors of a sexual assault. The feminist model used emphasizes action and awareness instead of introspection. The intervention offered was a closed format, semi-structured group led by two facilitators. The groups met once a week for three hours for 15 to 17 weeks. Each group consisted of six to eight adult women which included women who had been waiting for group intervention at a local sexual assault help center. The participants were aged 18 years or over, victims of childhood or adult sexual abuse, and were willing to participate voluntarily in the group (Hebert & Bergeron, 2007).

The measures used in this study included *The Beck Depression Inventory (BDI), The Psychological Distress Scale,* the *Self-Esteem Scale,* the *Modified PTSD Symptom Scale,* the sexual anxiety subscale of the *Multidimensional Sexual Self-Concept*, a brief version of the *Assertion Inventory*, and the revised *Conflict Tactics Scale*. Questionnaires were administered to participants after the first and last group sessions. A wait list comparison group was included and a follow up was performed three months after the end of the intervention to verify short-term maintenance of gains.

The results of this study revealed that the group intervention offered by the help center had positive effects in reducing consequences associated with sexual assault. After participating in the group intervention, participants obtained significantly lower scores on psychological distress and depression scales and higher scores on self-esteem, as compared with women in the wait-list group. Participation in the group also reduced the participants' level of self-blame and sense of stigmatization. The group intervention in this study was also found to have beneficial effects regarding survivors' feelings of

sexual anxiety, anxiety related to assertiveness, and effective coping strategies. This research adds to the body of empirical data lending support to the effectiveness of group modalities in the treatment of sexual assault survivors (Hebert & Bergeron, 2007).

Group work has often been identified as an effective intervention for survivors of sexual assault. VanDeusen and Carr (2004) developed a psychoeducational support group with an integrative theoretical orientation combining cognitive-behavioral, feminist, relational, and psychodynamic theories. This group is a supportive therapy group that focuses on helping members work through current issues where members are encouraged to share and explore issues related to their past. Members are also directed to focus on their future in terms of developing more healthy coping strategies and relationships. There is also an educational component focused on providing information about common sexual assault effects, rape myths, and coping strategies (VanDeusen & Carr, 2004).

Participants in the group were female university students who were recruited by campus flyers, newspaper articles, word of mouth and referrals from the University Counseling Center and Health Center. Members engage in a screening interview conducted by one of the group leaders which assessed the fit between survivors' needs and the group, survivors' support system, and prepares them for the content and process of group. Exclusion criteria include being actively suicidal, actively abusing substances, or having a mental condition that would place the survivor at risk, interfere with the safety or progress or others or completion of the group. The structure of the group is closed with five to eight members and met for duration of ten to twelve weeks. The goals of the group include empowerment, reduced isolation, safety needs, increased self-

esteem, healthy relationships, validation of feelings, development of healthy coping strategies, and regaining a sense of control over their lives (VanDeusen & Carr, 2004).

After completing nine weeks of group, members shared that they felt that connecting with others who shared similar experiences was the most helpful outcome of the group. A limitation noted most often by members was that the group was not long enough in duration. Through completion of an evaluation form regarding the group process, structure, and activities, it was found that members built relationships quickly and were very accepting of one another. Some members shared their experience of sexual assault for the first time stating it was beneficial to share in a safe and warm environment. A limitation described by one member was that she discontinued the group prematurely because she experienced increased symptomatology and instead chose to enter individual treatment. In this psychoeducational group, the effectiveness was shown through self report by the members in their post evaluation (VanDeusen & Carr, 2004).

Recovery

During the first weeks after a trauma, many female sexual assault survivors' exhibit symptoms that are consistent with the diagnosis for posttraumatic stress disorder (PTSD) according to the symptom criteria in the *Diagnostic and Statistical Manual of Mental Disorder* 4th edition revised (APA, 2009). Gilboa-Schechtman and Foa (2001) hypothesized that the after effects of rape would be more severe than the effects of a non sexual assault, as measured by the magnitude of the initial and peak reactions. They also suggest that the recovery from rape would be slower than the recovery from non sexual assault. Their study examined patterns of recovery from sexual and non sexual assault victims (Gilboa-Schechtman & Foa 2001).

Two studies containing data from female victims of these assaults were analyzed. In Study 1, 101 female victims of a sexual or a non sexual assault, with the mean age of 30 years, who had been assaulted within 30 days before the initial interview underwent 12 weekly assessments with measures of posttraumatic stress disorder (PTSD), *Beck Depression Inventory (BDI)*, and *The State Anxiety Inventory (STAI)* were used. In Study 2, 108 female victims of a recent sexual assault or non sexual assault occurring within the mean time of 11 days before the first interview and a mean age of 31 years underwent monthly assessments on the same measures. They examined the effects of type of trauma and time of peak reaction on long term recovery using intra-individual analysis of change (Gilboa-Schechtman & Foa 2001).

In both studies it was found that initial and peak reactions of rape victims were more severe than were those of non sexual assault victims on all measures of psychopathology. They also found that victims with delayed peak reaction exhibited more severe pathology at the final assessment than did victims with early peak reaction. Results of Study 2 indicated a slower recovery rate from sexual than non sexual assault and in Study 1, a similar pattern emerged. Although the results from this study confirmed the hypothesis that rape has a greater impact than non sexual assault and that recovery from rape is a slower process, the ability to generalize these findings may be restricted due to the limited sample which only included female victims who reported to the police and agreed to participate in the study. Overall, the study suggests that the type of victimization is found to be associated with post-trauma symptom severity (Gilboa-Schechtman & Foa 2001).

Summary

Through careful review of the literature on survivors of sexual assault, the importance of treatment and psychoeducation is evident. The literature states that PTSD symptomatology is a normative response to an assault, especially sexual assault. Studies reviewed found that a substantial portion of assault victims develop enduring problems unless an effective intervention is provided. If a survivor is experiencing PTSD symptomatology, and unsure of how to cope with the symptoms, a psychoeducation group may help educated and support the survivor in their recovery process.

As shown in the research, women are often re-victimized throughout their lives in violent situations. Many studies have documented a link between childhood sexual abuse and re-victimization in the form of adult sexual assault. Survivors who are re-victimized in their life report more PTSD symptoms, are more likely to use drugs or alcohol to cope and act out sexually, and withdraw from people in their life. In order to hopefully prevent future re-victimization, psychoeducation on safety tips, red flags, warning signs, and boundaries is needed.

Research conducted on sexual assault risk reduction programs indicates a decrease in severity of women's psychological distress following re-victimization. The psychoeducational component is expected to lessen the impact of self-blame attributions on participants' experience of psychological distress. This can be done through group intervention, which offers a setting to observe and learn from others and can reduce isolation by creating a supportive social network for the survivor. Group intervention is found to have beneficial effects regarding survivors' feelings of sexual anxiety, anxiety related to assertiveness, and effective coping strategies. There is a body of empirical data

lending support to the effectiveness of group modalities in the treatment of sexual assault survivors. Members of such groups report feeling that connecting with others who shared similar experiences was the most helpful outcome of the group.

CHAPTER THREE

Project Audience and Implementation Factors

Introduction

This graduate project presents a 12-session group therapy model focused on psychoeducational information in the treatment of trauma. Psychoeducation and group therapy are supported by the literature as being effective treatments for female survivors of sexual assault. This model will provide a framework for the Marriage and Family Therapist Trainees and Interns at Valley Trauma Center for women who are survivors of sexual assault. Survivors are often re-victimized and experience symptoms of posttraumatic stress that can intensify over time if left untreated. Intervention techniques implemented in the 12-session model include: psychoeducation on sexual assault and rape, common feelings and reactions following a rape or sexual assault, symptoms of PTSD, recognizing red flags and warning signs, developing healthy and effective coping skills, and information on date rape drugs. This psychoeducational support group can be used as an educational tool to provide survivors with the knowledge and understanding of the symptoms they may be experiencing, healthy coping techniques, common feelings, healthy boundaries, and future safety planning.

Development of the Project

After discussing the need of the center with the Executive Administrator, Dr. Charles Hanson, the idea of developing a psychoeducational group therapy curriculum arose. Working at Valley Trauma Center as a Marriage and Family Therapist Trainee for over two years allowed for the author to gain experience and knowledge required in working individually with survivors of sexual assault. Both counselors and clients at

VTC had expressed the need of and desire for group therapy for adult survivors. The idea was to provide the counselor's at VTC with a curriculum that could be used overtime, in a psychoeducational support group for survivors of sexual assault that could be altered if needed to fit the needs of the group. The idea was then discussed with the author's clinical supervisor, Wendy Massey, and Professor, Dr. Michael Laurent. With full support from the author's graduate project committee, development began from there.

The 12-session group therapy model for female survivors of sexual assault was developed by the author by combining effective treatment interventions from the literature, training from Valley Trauma Center, and group treatment planners. The first draft of the curriculum was based on the training provided at VTC and the model which counselors use when working individually with survivors of sexual assault. This draft was reviewed by the author's clinical supervisor and edits and suggestions were made in order to focus the curriculum on the psychoeducation component. The author made adjustments to the curriculum using her supervisor's suggestions, as well as goals and interventions from the Group Therapy Treatment Planner (2005) which focuses on rape survivors. Continued revisions and additions were made to the curriculum by all committee members and author.

The main purpose of a psychoeducational support group is to provide group members with knowledge about the normal reactions they may be having to an abnormal event. Providing clients with knowledge may help in their recovery process. Following a review of the literature, the author observed that after an assault has occurred many survivors exhibit and/or report similar symptoms, feelings, unhealthy or unsafe coping

mechanisms, and a need for support. Participation in the psychoeducation support group may ultimately decrease the severity of psychological distress experienced by the survivor.

A closed group format was suggested in order to provide group members the optimal opportunity to develop trust and cohesiveness in the therapeutic environment. Therefore, members could only join the group on the start date and new members are required to join a subsequent group.

All goals, objectives, procedures, handouts and homework assignments in the group curriculum are designed to, above all, educate the survivor. Each handout is provided at the end of the 12-session model and provides information on various topics relating to sexual assault. This information educates the client on topics she may be unaware of, as well as validate some of the common symptoms and reactions she may be experiencing and help in normalizing responses to the sexual assault. Handouts are intended to be reviewed and discussed during sessions and given to group members to keep for future reference.

Intended Audience

The intended audience for the 12-session model is female survivors of a sexual assault, age 18 and older. While the curriculum is female focused, the information is also helpful and can be transferable for male survivors. Survivors participating in the group may have experienced sexual abuse as a child, but must also have experienced sexual assault as an adult. Although most of the participants in the related literature studies are predominantly Caucasian and college aged, the group therapy curriculum should be able to encompass survivors of different ethnicities, cultures, sexual orientations, and

socioeconomic status. It is ideal that the survivor currently is or previously has been receiving individual counseling focusing on the sexual assault, but this not required. A group should be comprised of a minimum of 4 participants, and a maximum of 10.

Personal Qualifications

The group curriculum is designed to be implemented by Marriage and Family Therapist Trainees and Interns at Valley Trauma Center. Therapist Trainees are qualified to lead this psychoeducational group as they have attended a mandatory 60-hour training program provided by Valley Trauma Center. Following training, trainees provide emergency crisis intervention on a 24 hour hotline, accompany survivors of sexual assault for treatment services such as interview and examination immediately following the assault, advocate for survivors when needed, and provide individual counseling. Trainees are also enrolled in a Masters in Counseling, Marriage and Family Therapy program at a University, where they receive additional training and guidance in specific areas such as child abuse, domestic violence, ethics, and treatment techniques. Trainees and Interns are supervised on a weekly basis by Licensed Clinical Supervisors who guide them in their therapeutic work with clients.

Environment and Equipment

Group sessions are designed to be held in a room spacious enough to comfortably hold all participants. It is important that the group sessions are conducted in an environment which offers privacy from others in the building to ensure confidentially of participants. A scanner/copy machine, paper, and a printer are necessary for making copies of the client handouts including consent and 2-way release forms, homework assignments, handouts, and referrals.

CHAPTER FOUR

Project

A Psychoeducational Support Group for Survivors of Sexual Assault

Group Leaders:

Note: All session are designed for completion in one and a half hours. The curriculum includes an outline of sessions 1-12 including each session's goals, objectives, materials, handouts, procedures and homework assignments. All handouts can be found at the end of the curriculum. Group sign in roster should be used at the start of each session, and can be found in Appendix A.

Session #1: Introductions

Goals:

1. To introduce group members and leaders to each other.
2. To establish ground rules for group work.

Objectives:

By the end of the session, participants will be able to:

1. Identify the names of group leaders and group members.
2. Verbalize acceptance of the ground rules of the group.
3. Ask questions and/or share concerns group members may have.

Materials:

1. Chart paper or white board
2. Markers and pens
3. Easel or tacks
4. Clip boards
5. Group sign in roster

Handouts:

1. Consent form

Procedures:

1. Sign in: Each group member will sign in at the beginning of each session on the sign in roster.
2. Ask group members to introduce themselves, telling the rest of the group one thing (of their choosing) about themselves (e.g., where you are from, what you like to do for fun, what do you hope to get out of the group, etc.).
3. Handout, review, and sign consent form. Group leader will read through each statement on the consent form while group members follow along and initial each statement if they agree and understand, asking questions as needed. Group leader will sign the consent form once the member has completed it and will give each group member a copy to keep.
4. Define and establish the ground rules for the group and ask each member to commit to upholding them

a. Confidentiality: No talking outside the group among group members or talking with individuals outside of the group about what is said by whom in the group.
b. No substance use: No member can come to the group having just used alcohol or taken a drug aside from prescription medication. If substance use is a problem for the member, treatment must be sought before being a member of the group.
c. Policy on late or missed sessions: Members are encouraged to attend all sessions unless an emergency occurs. If a session is going to be missed, the member is asked to let the group leader know 24 hours in advance. Two no show sessions may result in removal from the group.

5. Ask group members what they would like to learn about each other and write the ideas on chart paper for all members to see. Ask group members to join into two person pairs and talk to each other about their responses to the questions/topics. After 10 minutes, ask each member of the pair to introduce her partner to the group.
6. Discussion Questions: Ask group members to share any questions and/or concerns they may about the group and contribute any rules they may feel the group should implement.
    a. What are your fears about talking in a group?
    b. How does the topic of sexual assault affect this fear?
    c. How would you like others to respond to your experience and concerns?
    d. What will help you talk openly and feel safe in the group?

Homework:

1. Encourage members to begin writing in a journal at home to reflect on today's session. Encourage them to note feelings they have, issues, and/or concerns that may have come up for them during or after session. This can be done immediately after the session has concluded, as well as throughout the week.

Session #2: Sexual Assault Psychoeducation

Goal:

1. To provide education/information on sexual assault.
2. To increase understanding about the experience of rape and sexual assault.

Objectives:

By the end of the session, participants will be able to:

1. Demonstrate increased understanding of the sexual assault continuum.
2. Differentiate between myth and reality of rape and sexual assault.

Materials:

1. Chart paper or white board
2. Markers and pens
3. Easel or tacks
4. Group sign in roster

Handouts:

1. Myths and Realities of Rape and Sexual Assault
2. Facts About Rape
3. Understanding Different Rape Situations

Procedures:

1. Instruct the group about the continuum of sexual assault, from suggestive comments or gestures, to unwanted touch, to rape. Review information from the handout "Facts About Rape."
2. Present different scenarios that will help members understand that the impact of the offending behavior defines it as "sexual assault" regardless of where the behavior lies on the continuum (e.g., obscene comments, flashing, and unwanted touch) as explained in the handout "Understanding Different Rape Situations."
3. Prior to distribution, review the handout "Myths and Realities of Rape and Sexual Assault." Ask the members to identify each statement as a myth or reality, and write the groups answer on chart paper before providing the correct response. Have participants share their reactions and how this changes or confirms what they thought about the topic.

4. Discussion Questions: Ask members to share any questions they may have about the information presented in today's session.
    a. Ask any questions about the statistics presented in "Facts About Rape" if clarification is needed.
    b. Share how this information has changed your perspectives on your own rape or sexual assault.
    c. What is a myth or reality of rape learned today that is a surprise to you?
    d. How does knowing this information alter how you think about rape or sexual assault?

Homework:

1. Continue journaling at home for 10-15 minutes 2-3 times a week, if possible. Reflect on the information provided in today's session and how it has changed the participant's view of rape and sexual assault. Encourage members to note any feelings they had during today's session while receiving the information provided.

Session #3: Expressing and Managing Feelings

Goals:

1. To assist participants in identifying various feelings.
2. To provide models for expressing feelings.
3. To provide techniques and strategies for modulating feelings

Objectives:

By the end of the session, participants will be able to:

1. Identify accurately and talk comfortably about a range of emotions.
2. Identify differing levels of intensity of emotion.
3. Identify strategies for expressing emotions appropriately.

Materials:

1. Chart paper or white board
2. Markers
3. Easel or tacks
4. Paper and pens
5. Clipboards
6. Group sign in roster

Handouts:

1. Feelings When Needs Are/Are Not Being Met

Procedures:

1. Ask members to identify as many feelings as possible by writing a list of their own on a piece of paper given to them. Once completed, ask members to share feelings with the group that are significant to their lives now.
2. Teach members how to rate emotions using the Subjective Units of Distress Scale (SUDS). Draw a line on the chart paper or white board with 10 hash marks along the scale to show the range of an emotion from 0-10. Ask members to draw their own scale on a piece of paper and identify an emotion they have experienced over the past week that they would like to rate. Then have group members rate that particular emotion's intensity from 0-10, 0 being completely un-distressing and 10 extremely distressing. Have them note what happened to trigger the emotion,

what their thoughts are associated with this emotion and how they experience the emotion in their bodies at each number on the scale.

3. Identify specific examples of ways to appropriately express strong emotions. Ask members to share as many ideas as they can about ways to express emotions. Note on chart paper the ideas that are appropriate or helpful, as well as the ones that are inappropriate or unhelpful.
4. Review the handout "Feelings When Needs Are/Are Not Being Met." Ask members to circle feelings that apply to them when their needs are being met and when their needs are not being met. Encourage members to share these feelings with the group. Group leader will draw a line down the middle of the chart paper or white board, one side for feelings being met and the other for feelings not being met. Have members write some of the feelings they circled for each category on the chart paper to allow the group to see similarities or difference in group members answers, and facilitate a discussion.
5. Discussion Questions: Ask members to share any questions they may have about the information presented in today's session.
    a. What did you learn from this session?
    b. How can you apply this information and learning to your present relationships?
    c. How do you notice the people in your life express their feelings?
    d. Were there rules in your family about feelings that can and cannot be expressed?
    e. How might you want to express emotions differently than they were in your family?

Homework:

1. Continue journaling at home for 10-15 minutes 2-3 times a week, if possible. Reflect on the information provided in today's session and suggest writing one or more strong emotions experienced during the week noting the situation that triggered the emotion, thoughts associated with the emotion and how the emotion was expressed. Encourage members to be aware of where they are at on the

subjective units of distress scale for feelings such as anger, anxiety, and sadness. Note the ratings for these feelings using the SUDS throughout the week.

2. If comfortable, begin expressing certain feelings in a different manner and/or with certain individuals.

Session #4: Common Feelings and Reactions to Sexual Assault

Goal:

1. To provide information on common reactions to sexual assault or rape.
2. To normalize symptoms, feelings, and thoughts.

Objectives:

By the end of the session, participants will be able to:

1. Identify the common personal, emotional, and physical symptoms associated with sexual assault.
2. Identify at least one symptom related to the rape or sexual assault she experienced.

Materials:

1. Pens and paper
2. Clipboards
3. Group sign in roster

Handouts:

1. Common Feelings after Rape or Sexual Assault
2. Fact Sheet on Post Traumatic Stress Disorder (PTSD)

Procedures:

1. Teach the group the emotional and physical symptoms associated with rape sexual assault. Review the handout provided on "Common Feelings After Rape or Sexual Assault."
2. Encourage members to add their own emotional and physical reactions to the list of common personal, emotional and physical symptoms associated with sexual assault.
3. Ask members to share the feelings and symptoms they experienced after the rape or sexual assault they survived. Give members permission not to respond so that they do not feel pressured to do so.
4. Self care; create a plan to manage feelings and symptoms during the week. Ask members to share healthy ways they will manage feelings that may come up before next session.

5. Discussion Questions: Ask members to share any questions they may have about the information presented in today's session.
    a. Does every survivor have PTSD?
    b. Is it normal for someone to have these symptoms?
    c. Do any other members in the group feel this way?
    d. Have the symptoms you experienced diminished or gone away? If so, what did you do to bring about the decrease?

Homework:

1. Continue journaling at home for 10 to 15 minutes 2-3 times a week, if possible. Reflect on the information provided in today's session. Encourage the members to note the feelings they experienced after the sexual assault, and the feelings they are currently experiencing. Note if talking about the assault brings up memories, forgotten elements of what happened or how you felt, nightmares or flashbacks, all of which are a normal process of working through the impact of the assault.

Session #5: Coping Skills

Goal:

1. To provide information on coping skills.
2. To provide the opportunity for participants to identify new coping skills.

Objectives:

By the end of the session, participants will be able to:

1. Identify healthy and effective coping strategies.
2. Implement relaxation techniques.
3. Describe at least one self care technique that the member could employ.

Materials:

1. Chart paper or white board
2. Easel or tacks
3. Markers
4. Paper and pens
5. Group sign in roster

Handouts:

1. Self Care Tips
2. Understanding the Recovery Process
3. Relaxation Techniques

Procedures:

1. Ask members to identify and discuss healthy coping skills that they have effectively used in the past for dealing with stressful situations or difficult events they have experienced. Write these on chart paper along with ineffective coping skills that they know people often use.
2. After reviewing the handout "Self Care Tips" discuss the coping skills members are currently implementing and if they are effective and healthy, or ineffective and unhealthy.
3. Provide members with the handout "Understanding the Recovery Process." Ask members to take turns reading information aloud as volunteered. Process with the group how they feel about the information being presented.

4. Teach members relaxation techniques including deep breathing, progressive muscle relaxation, guided imagery and grounding techniques. Group leaders will read from a transcript while the members participate in implementing the relaxation techniques. Handout "Relaxation Techniques" will be given to members.
5. Ask members to share their thoughts on the relaxation techniques taught in today's session and if they found them effective.
6. .Discussion Questions: Ask members to share any questions they may have about the information presented in today's session.
    a. Which, if any, relaxation techniques will you implement when needed?
    b. Are there any questions on the procedure for implementing the relaxation techniques shown today?
    c. What new coping skills would you like to practice? What would make it difficult to practice these?
    d. What could you do if a specific coping activity or strategy does not work?

Homework:

1. Continue journaling at home for 10 to 15 minutes 2-3 times a week, if possible. Reflect on the information provided in today's session, note thoughts and feelings regarding relaxation techniques taught during session. Implement relaxation techniques and self care daily. Practice relaxation techniques once a day for about 10 minutes. Read and review handouts provided. Note any questions or comments regarding the information provided, and bring it up at the next session.

Session #6: Healthy Boundaries

Goal:

1. To provide a definition on healthy boundaries in relationships.
2. To provide information on possible red flags or warning signs to be aware of when someone is crossing appropriate boundaries, and how to respond.

Objectives:

By the end of the session, participants will be able to:

1. Identify healthy and unhealthy boundaries.
2. List possible red flags or warning signs to be aware of.

Materials:

1. Paper and pens
2. Clipboards
3. Chart paper or white board
4. Easel or tacks
5. Markers
6. Group sign in roster

Handouts:

1. Boundaries
2. Red Flags

Procedures:

1. Explore healthy and unhealthy boundaries as shown in the handout "Boundaries." Ask members to share examples of healthy and unhealthy boundaries in their relationships. Write these on the chart paper.
2. Explain to the group the need to set healthy boundaries in all relationships. Explore the member's current boundaries and how they set them with the people in their life.
3. Ask group members to list and discuss possible red flags or warning signs of someone who is crossing the appropriate boundaries (e.g. possible perpetrator). Review the handout "Red Flags" and ask the members to identify possible red flags they were unaware of before today's session.

4. Ask for individual narratives as volunteered specific to red flags that may have been overlooked.
5. Discussion Questions: Ask members to share any questions they may have about the information presented in today's session.
    a. What is a red flag you are now aware of after discussing this information?
    b. Is there a red flag you learned about that you disagree with?
    c. What is a red flag you were aware of, but ignored in the past?
    d. How would you like to respond differently than you have to red flags you encounter?

Homework:

1. Continue journaling at home for 10-15 minutes 2-3 times a week, if possible. Reflect on the information provided in today's session and write about situations where you established an appropriate boundary. Encourage members to note the new information they learned, and how they feel reflecting on their ability to set healthy boundaries and identify red flags.

Session #7: Date Rape Drugs

Goal:

1. To provide information on date rape drugs.
2. To increase members understanding and awareness of date rape drugs to lower the risk of being drugged.

Objectives:

By the end of the session, participants will be able to:

1. Identify facts about date rape drugs.
2. Discuss common date rape drugs.
3. Verbalize increased understanding on risk reduction strategies for being drugged.

Materials:

1. Chart paper or white board
2. Easel or tacks
3. Markers
4. Group sign in roster

Handouts:

1. Date Rape Drugs: The Facts
2. Common Date Rape Drugs
3. Reducing the Risk of Being Drugged

Procedures:

1. Encourage members to share their knowledge of date rape drugs. Make a list of the known date rape drugs and write this list on chart paper. After the list is made, review the handout "Common Date Rape Drugs." Add to the list if needed after reviewing the handout.
2. Ask members to share their experiences with and/or feelings about date rape drugs. Review the handout "Date Rape Drugs: The Facts." Ask members to share which facts from the handout were new information to them.
3. Read and review handouts provided on "Reducing the Risk of Being Drugged." Explore member's knowledge of common date rape drugs and how they can be

hidden. Ask members to share if they know any other way to reduce their risk of being drugged.

4. Discussion Questions: Ask the members to share any questions they may have about the information presented in today's session.
    a. Can anyone be drugged?
    b. How long can a date rape drug stay in your system?
    c. How common is it for someone to be drugged?
    d. How will you know if you have been drugged?
    e. What do you do if you realize you have been drugged?
    f. Name one way to reduce your risk of being drugged.

Homework:

1. Continue journaling at home for 10-15 minutes 2-3 times a week, if possible. Reflect on the information provided in today's session. Encourage members to note feelings that may have come up in session and how their opinion and/or knowledge of date rape drugs may have changed.

Session #8: Impact of Sexual Assault and Safety Tips

Goals:

1. To work successfully through issues related to being sexually abused with consequent understanding and control of feelings.
2. To provide strategies for safety planning.
3. To provide opportunity for group members to describe plans to increase their own safety.

Objectives:

By the end of the session, participants will be able to:

1. Identify and express the feelings connected to their abuse.
2. Verbalize the ways the sexual abuse has had an impact on their lives.
3. Identify ways in which survivors can keep themselves safe in the future.

Materials:

1. Lined paper and pens
2. Clipboards
3. Group sign in roster

Handouts:

1. Safety Tips

Procedures:

1. Explore, encourage, and support group members in verbally expressing and clarifying feelings associated with the assault.
2. Ask members to make a list on their own of the ways sexual assault has impacted their lives (e.g. socially, intimately, physically, emotionally, etc.). Discuss the list content with the group if comfortable.
3. Encourage members to share safety tips with the group that they currently employ. Review the handout provided on "Safety Tips"; ask members to share safety tips they will implement in the future.
4. Self care: create a plan to manage feelings during the week. Ask members to share healthy ways they will manage feelings that may come up before next session.

5. Discussion Questions: Ask the members to share any questions they may have about the information presented in today's session.
    a. Which safety tip learned today will be most useful for you in the future?
    b. Can you add any additional safety tips to the list?
    c. Are there any safety tips covered in today's session you had not thought about before?

Homework:

1. Continue journaling at home for 10 to 15 minutes 2-3 times a week, if possible. Reflect on the information provided in today's session. Encourage members to note feelings that may arise throughout the week after having discussed the impact sexual assault has had on their life.

Session #9: Feeling Identification

Goal:

1. To provide information on common feelings following a sexual assault.
2. To provide opportunity for participants to express feelings about the sexual assault they experienced.

Objectives:

By the end of the session, participants will be able to:

1. Express feelings to and about the perpetrator, including the impact the abuse has had both at the time of occurrence and currently.
2. Write a letter to the perpetrator expressing feelings of shame, anger, and blame.

Materials:

1. Paper and pens
2. Chart paper or white board
3. Markers
4. Easel or tacks
5. Group sign in roster

Procedures:

1. Ask members to share feelings they have regarding their perpetrator, and if those feelings have remained constant, or changed since the sexual assault.
2. As volunteered, ask members to write feelings on chart paper they currently have toward the perpetrator.
3. Ask each member to think about writing a letter to the perpetrator expressing feelings about the sexual assault and feelings about the perpetrator; process what this will be like for the members. Discuss questions such as:
    a. How would it be beneficial to write such a letter?
    b. Do you need to send the letter in order for this exercise to be beneficial?
    c. How do you think the perpetrator would respond to your letter? How would you like the perpetrator to respond?
4. Self care discussion. Assist members in creating a plan if they experience overwhelming feelings related to group discussion during the week.

5. Discussion Questions: Ask the members to share any questions or comments they may have about the information discussed in today's session.
    a. What feelings came up for you when asked to think about writing a letter to your perpetrator?
    b. How do you think it will feel to write this letter?
    c. How will you cope with the possibly difficult emotions this may cause?

Homework:

1. Complete writing a letter to the perpetrator and bring the letter to next session. Encourage members to journal the feelings this activity may have brought up for them, and implement self care techniques as needed.

Session #10: Expressing Feelings

Goal:

1. To reduce feelings of guilt, shame, anger, and powerlessness.
2. To provide opportunity for participants to express feelings about the perpetrator and information on coping with these feelings.

Objectives:

By the end of the session, participants will be able to:

1. Share feelings regarding writing the letter and discuss what this experience was like for each member.
2. Implement behavioral and cognitive strategies to deal with the many painful emotions that result from talking about the sexual assault and the perpetrator.

Materials:

1. Chart paper or white board
2. Lined paper
3. Markers and pens
4. Easel or tacks
5. Group sign in roster

Procedures:

1. Ask each member to share her letter if she feels comfortable and discuss what it was like to write and/or read that letter.
2. Bring letters to a closure; explore options for members on how to let go of letter (e.g., rip, burn, burry). Ask members to share ideas for bringing their letter to a closure.
3. Elicit from the group constructive strategies for dealing with anger, sadness, guilt, shame, fear, mistrust, and worthlessness (e.g., doing something physically demanding, implementing relaxation techniques, expressing grief to friends or family, journaling feelings, challenging distorted thoughts that trigger guilt, engaging in empowering self-talk that generates confidence, building trust in small steps of "share and check", reminding self of those that appreciate you).

Write these strategies on chart paper giving the members a chance to copy them down on their own paper if desired.

4. Discussion Questions: Ask the members to share any questions or comments they may have about the information discussed in today's session.
    a. What was it like to complete the letter assignment?
    b. Were you surprised at how it made you feel?
    c. What did you do to deal with your feelings throughout the week? What will you continue to do in the future?

Homework:

1. Bring letter to a closure by client's preference.
2. Continue journaling at home. Reflect on the information provided in today's session. Encourage members to note the feelings they may experience after participating the letter writing, sharing, and closing. Also note their plans for coping with feelings related to group discussion.

Session #11: Victim to Survivor

Goal:

1. To guide group members in how to begin the process of moving away from being a victim of sexual assault and toward becoming a survivor.

Objectives:

By the end of the session, participants will be able to:

1. Decrease statements of shame, being responsible for the abuse, or being a victim, while increasing statements that reflect personal empowerment.
2. Make statements that identify self as a survivor, not a victim.

Materials:

1. Chart paper or white board
2. Markers
3. Easel or tacks
4. Note cards and pens
5. Group sign in roster

Handouts:

1. Survivor's Rights

Procedures:

1. Confront and discuss with each member any statements that reflect taking responsibility for the abuse or indicate she is a victim. Assist the client in feeling empowered by talking through the issues, noting changes in thinking that can be made and ways of thinking and behaving that represent letting go of the assault.
2. Describe to members the two elements of surviving rape: surviving the rape itself, and surviving the aftermath of traumatic feelings. Contrast the concept of survival with that of defeated victim.
3. Group discussion. Ask members to explore their ideas of a victim versus a survivor. Ask members to share with the group one statement that identifies them self as a survivor.
4. Group leaders will write the survivor statements on chart paper, and the members will write the statement of their choosing on a note card that will be kept with them as a reminder.

5. Review handout provided on “Survivor’s Rights.”
5. Discussion Questions: Ask the members to share any questions or comments they may have about the information discussed in today’s session.
    a. What are your thoughts and feelings about the idea of being a victim versus a survivor?
    b. How will you work to change the view you have of yourself as a victim, to that of a survivor?
    c. What is your reaction to learning about the rights a survivor has?

Homework:

1. Review handout provided. Continue journaling at home and read survivor statement once a day. Encourage members to reflect on feelings regarding termination of the group. Note the feelings experienced before beginning the group, and the feelings experienced now at the end of group.

Session #12: Closing of the Group

Goal:

1. To provide opportunity for group members to reflect and comment on members' experience in the group.
2. To provide experiences for enabling closure of the group.

Objectives:

By the end of the session, participants will be able to:

1. State safety planning that they will implement.
2. Describe at least one benefit of the group experience.
3. Note how they will actively seek support outside of the group.

Materials:

1. Paper and pens

Handouts:

1. Referral List

Procedure:

1. Facilitate members sharing of ways in which they can protect themselves from physical and/or sexual assault in the future.
2. Ask group members to describe how they have changed and/or benefited from the group experience.
3. Ask members to express appreciations they have for other group members, for the group experience itself and/or the group leaders.
4. Encourage group members to seek continued support through individual therapy. Discuss past experiences with individual counseling, and fears or concerns for those members who have not received individual counseling.
5. Ask each member to share any thoughts or feelings regarding the ending of the group. Discuss fears, hopes, and plans for the future.
6. Allow time for group members to share contact information if desired to continue contact after the closing of the group.

Homework:

1. Contact referrals as needed

Understanding What Happened: Myths and Realities of Rape and Sexual Assault

Myth: Women provoke rape by the way they dress and/or flirt.

Reality: No one asks to be raped, no one dresses in a way that indicates they are asking to be raped, nor does anyone's behavior or dress justify or excuse the crime. Many convicted sexual assailants are unable to remember what their victims looked like or were wearing. People have a right to be safe from sexual assault at any time, any place, and under any circumstances.

Myth: Most rapes are committed at night by strangers in dark alleys.

Reality: 84% of completed rapes are committed by someone who is known to the survivor (Justice Research & Statistics Association, 2011). The perpetrator is often a partner, husband, ex-partner, co-worker, neighbor, etc.

Myth: Men rape because they are sexually aroused or have been sexually deprived.

Reality: Rape is an expression of power and control and most often includes hostility towards women, the desire to feel and exert power and control, the desire to humiliate and degrade, and in some cases the desire to inflict pain. Sexual arousal is a strong urge, but it is a controllable urge. The difference lies in whether people feel they have the right to take what they want by force or whether they respect the feelings and wishes of others.

Myth: Women lie about being raped.

Reality: Rape is called the most underreported violent crime in America. Only 16% of rapes are ever reported to the police (Kilpatrick et al., 1992). Reporting a rape is especially difficult because of the need to discuss intimate details.

Myth: Men can never be raped.

Reality: According to the U.S. Department Justice (2011), an estimated 10 % of rape survivors are male.

Myth: It is impossible for a husband to sexually assault his wife.

Reality: Regardless of the marital or social relationship status, if a woman does not consent to having sexual intercourse, it is rape or spousal rape.

Myth: Women can avoid situations that can lead to rape.

Reality: Most survivors are assaulted in an environment they considered safe and were raped by someone they thought they could trust. According to the U.S. Department of Justice (2011) nearly 6 out of 10 rape/sexual assault incidents occur in the survivor's own home, at the home of a friend, relative, or neighbor.

Understanding What Happened: Facts About Rape

- Anyone can be raped. This includes women, men, girls, boys, children, infants, elderly, and teenagers.

- Rape is never the fault of the victim. It is painful, humiliating, and hurtful.

- Most rapes happen between people of the same race.

- You are more likely to be raped by someone you know than by a stranger.

- You can be raped by someone you have had sex with before. Each time you are asked to have sex you have the right to say no, even if previously you have said yes.

- Most rapists do not use weapons to force someone into having sex. Threats, emotional force, and physical force are more commonly used.

- If you say no, are under the influence of drugs or alcohol, or a minor, and someone forces you to have sex, it is rape.

- Most perpetrators plan their attacks and test their victims' tolerance of abuse over a period of time. This includes husbands, someone you are dating, family members, friends, as well as strangers.

- Not only is rape always wrong, it is also a crime. Rape and sexual assault are against the law.

Understanding What Happened: Understanding Different Rape Situations

I didn't resist physically
People respond to an assault in different ways. Many victims make the good judgment that physical resistance would cause the attacker to become more violent. Lack of consent can be expressed (e.g. saying no) or implied by the circumstances (e.g. if you are under the statutory age of consent, have a mental disability, or are afraid to object due to threats or physical harm).

I used to date the attacker
Rape can occur when the offender and the victim have a preexisting relationship. This is sometimes called "date rape" or "acquaintance rape." It can even happen when the offender is the victims spouse, "spousal rape." It does not matter whether the perpetrator is an ex-boyfriend or a complete stranger. It doesn't matter if you have had sex in the past. If it is nonconsensual this time, it is rape.

I don't remember the assault
Just because you don't remember being assaulted does not necessarily mean it did not happen and that it was not rape. Memory loss can result from the ingestion of date rape drugs or from excessive alcohol consumption. That said, without clear memories or physical evidence, it may not be possible to pursue prosecution.

I was asleep or unconscious when the assault occurred
Rape can happen when the victim is unconscious or asleep. If you were asleep or unconscious, you did not give your consent. Without your consent, it is rape.

I or the perpetrator was drunk
Alcohol and/or drugs are not an excuse or an alibi. The key question is still, "Did you consent or not?" Regardless of whether you were drunk or sober, if the sex was nonconsensual, it is rape. However, because each state has different definitions for "nonconsensual," contact your local rape crisis center or local police department with questions. Ultimately, both people must be conscious and willing participants.

I thought "no," but didn't say it
It depends on the circumstances. If you didn't say "no" because you were scared for your life or safety, it may be considered rape. Sometimes it isn't safe to resist physically or verbally. For example, when someone has a knife or gun to your head, or threatens you or your family if you say anything.

Feelings When Needs Are Being Met

How we are likely to feel when our needs are being met:

Absorbed	Concerned	Expectant	Involved	Relaxed
Adventurous	Confident	Exultant	Joyful	Relieved
Affectionate	Contented	Fascinated	Jubilant	Satisfied
Alert	Cool	Free	Keyed-up	Secure
Alive	Curious	Friendly	Loving	Sensitive
Amazed	Dazzled	Fulfilled	Mellow	Serene
Amused	Delighted	Glad	Merry	Spellbound
Animated	Eager	Gleeful	Mirthful	Splendid
Appreciative	Ebullient	Glorious	Moved	Stimulated
Ardent	Ecstatic	Glowing	Optimistic	Surprised
Aroused	Effervescent	Good-humored	Overjoyed	Tender
Astonished	Elated	Grateful	Overwhelmed	Thankful
Blissful	Enchanted	Happy	Peaceful	Thrilled
Breathless	Encouraged	Helpful	Perky	Touched
Buoyant	Energetic	Hopeful	Pleasant	Tranquil
Calm	Engrossed	Inquisitive	Pleased	Trusting
Carefree	Enlivened	Inspired	Proud	Upbeat
Cheerful	Enthusiastic	Intense	Quiet	Warm
Comfortable	Excited	Interested	Radiant	Wide-awake
Complacent	Exhilarated	Intrigued	Rapturous	Wonderful
Composed	Expansive	Invigorated	Refreshed	Zestful

Feelings When Needs Are Not Being Met

How we are likely to feel when our needs are <u>not</u> being met:

Afraid	Despairing	Frustrated	Lonely	Sleepy
Aggravated	Despondent	Furious	Mad	Sorrowful
Agitated	Detached	Gloomy	Mean	Sorry
Alarmed	Disaffected	Guilty	Miserable	Spiritless
Aloof	Disenchanted	Harried	Mope	Startled
Angry	Disappointment	Heavy	Morose	Surprised
Anguished	Discouraged	Helpless	Mournful	Suspicious
Annoyed	Disgusted	Hesitant	Nervous	Tepid
Anxious	Disheartened	Horrified	Nettled	Terrified
Apathetic	Dismayed	Horrible	Numb	Tired
Apprehensive	Displeased	Hostile	Overwhelmed	Troubled
Aroused	Disquieted	Hot	Panicky	Uncomfortable
Ashamed	Distressed	Humdrum	Passive	Unconcerned
Beat	Disturbed	Hurt	Perplexed	Uneasy
Bewildered	Downcast	Impatient	Pessimistic	Unglued
Bitter	Downhearted	Indifferent	Puzzled	Unhappy
Blah	Dull	Intense	Rancorous	Unnerved
Blue	Edgy	Irate	Reluctant	Unsteady
Bored	Embarrassed	Irked	Repelled	Upset
Broken	Embittered	Irritated	Resentful	Uptight
Chagrined	Exasperated	Jealous	Restless	Vexed
Cold	Exhausted	Jittery	Sad	Weary
Concerned	Fatigue	Keyed-up	Scared	Wistful
Confused	Fearful	Lazy	Sensitive	Withdrawn
Cross	Fidgety	Leery	Shaky	Woeful
Dejected	Forlorn	Lethargic	Shocked	Worried
Depressed	Frightened	Listless	Skeptical	Writhed

Common Feelings after a Rape or Sexual Assault: Common Responses

Anxiety
Nervousness, jitteriness, muscle tension, agitation, restlessness, trembling, feeling over-alert, excessive worry, fearful reactions, or panic attacks.

Fear
Related to death, violence, repetition of the assault, retaliation of the perpetrator, being in a crowd, or being alone.

Depression
Feelings of depressed mood, crying, hopelessness, feelings of guilt, worthlessness, loss of interest in things once enjoyed, suicidal thinking or attempts, sleep disturbances, chronic fatigue, weight gain or loss.

Difficulty Concentrating
Disorientation, difficulty focusing thoughts or making mental associations.

Intrusive Memories
Unwanted distressing memories of the assault and flashbacks that are difficult to control.

Hyper-arousal
Fight or flight, increased heart rate, rapid and shallow breathing, muscular tension, hyper-vigilance (on high alert, constant look out for danger).

Anger
Feels anger toward perpetrator, police, medical personal, family, counselor, self, experiences anger more rapidly and intensely than usual.

Guilt/Shame/Blame
A survivor blames them self in order to make sense of the assault. Guilty thoughts such as, "I shouldn't have been drinking" or "I should have fought back" are common among survivors.

Emotional Numbing
When overwhelmed by strong emotions, the body and mind sometimes react by shutting down and becoming numb. Survivors use it to protect themselves from emotional and physical pain.

Avoidance
Survivor avoids any people, places, things, conversations, thoughts, emotional feelings, or physical sensations that remind her of the assault.

Posttraumatic Stress Disorder (PTSD): Fact Sheet

Posttraumatic Stress Disorder can occur to a person following the experience or witnessing of life threatening events such as war, natural disasters, serious accidents, or violent personal assaults like rape.

It is your mind's way of coping with traumatic events. It is a normal response to an abnormal event. PTSD can manifest months or years following the traumatic experience.

Remember that there are treatments that may help you in your healing process.

People who have experienced PTSD often feel:

- Irritable, angry and sometimes have unexpected outbursts
- On guard, cautious, nervous, jumpy and fearful
- Vulnerable, afraid of many things and unable to be calm
- Unsafe, feel that the assault might happen again
- That disaster is around the corner and look for places to hide or are always looking over their shoulder
- Become over protective of people they love
- Easily frightened, especially when someone comes up behind them or they hear a sudden noise
- They don't want to talk about it
- They avoid people, places and activities
- They want to numb their emotions or what is happening to them sometimes by using drugs or alcohol
- Anxious and restless

It is also very common to notice:

- That people may keep thinking about the event(s) or seeing the event(s) flash through their minds. These are called flashbacks and it may seem that they take the person back in time and make them relive the event(s).
- People have difficulty falling or staying asleep. They may experience nightmares or restless sleep.
- People may have trouble concentrating and remembering.
- People may have panic attacks. This may cause trouble breathing, increase in heart palpitations and increased sweating.

Whenever you are experiencing the impact of your traumatic event, it is important to remember you are having a very normal reaction to an abnormal event.

Self Care and Recovery Process: Self Care Tips

There are times when the emotions and pain associated with a rape or sexual assault can be overwhelming. These can come immediately after the assault or many years later. The following are things that you can do to help take care of yourself as you recover from the assault that you experienced.

- If it is safe to do so, go for a walk.
- Make yourself a cup of tea or a soothing warm drink.
- Spend time talking with a trusted friend or family member.
- Take a warm bath.
- Spend time with a favorite pet.
- Workout. Exercise helps to increase your body's production or endorphins which help you to feel better.
- Read a favorite book.
- Write in your journal.
- Find a creative outlet: music, painting, writing, etc.
- Sign up for a self-defense course. It may help you to feel more in control and safe.
- Eat healthy food.
- Most importantly, remind yourself that it is alright for you to feel emotions like anxiety, anger, shame, and confusion, as they are normal reactions to an abnormal event.

There are also some things that survivors should try to avoid:

- Relying on alcohol or drug use.
- Disclosing personal information on the internet.
- Seeking out situations in which you feel unsafe.
- Taking actions that undermine your self-worth.
- Using food and unhealthy eating habits as a way to control your body and emotional state.
- Inflicting harm on your body.
- Blaming yourself for what happened.
- Using sex to try and overcome or take control of a sexual violation where you had no control.

Self Care and Recovery Process: Understanding the Recovery Process

- Recovery is an ongoing, daily, gradual process. It does not happen though sudden insight or "cure."

- Some level of continuing reactions is normal and reflects a normal body and mind. Healing does not mean forgetting your assault experiences or having no emotional pain when you think about them.

- Healing may mean fewer and less intense reactions to reminders of the sexual assault, greater confidence in your ability to cope with your memories, and/or greater ability to manage your emotions.

- When people are able to talk about their painful experiences and memories, something helpful often results.

- Most benefits of talking do not usually result from just one discussion; they may result from many discussions of the assault.

- Through talking about the sexual assault, many people can gradually reduce their physical and emotional responses to the memories and increase their ability to tolerate their painful emotions.

- One type of opportunity to talk through sexual assault experiences is in individual or group counseling.

Relaxation Techniques

Deep breathing for stress relief

With its focus on full, cleansing breaths, deep breathing is a simple, yet powerful, relaxation technique. It's easy to learn, can be practiced almost anywhere, and provides a quick way to get your stress levels in check. Deep breathing is the cornerstone of much other relaxation practices and can be combined with other relaxing elements such as aromatherapy and music. All you really need is a few minutes and a place to stretch out.

How to practice deep breathing

The key to deep breathing is to breathe deeply from the abdomen, getting as much fresh air as possible in your lungs. When you take deep breaths from the abdomen, rather than shallow breaths from your upper chest, you inhale more oxygen. The more oxygen you get, the less tense, short of breath, and anxious you feel. The next time you feel stressed, take a minute to slow down and breathe deeply.

- Sit comfortably with your back straight. Put one hand on your chest and the other on your stomach.
- Breathe in through your nose. The hand on your stomach should rise. The hand on your chest should move very little.
- Exhale through your mouth, pushing out as much air as you can while contracting your abdominal muscles. The hand on your stomach should move as you exhale, but your other hand should move very little.
- Continue to breathe in through your nose and out through your mouth. Try to inhale enough so that your lower abdomen rises and falls. Count slowly as you exhale.

If you have a hard time breathing from your abdomen while sitting up, try lying on the floor. Put a small object on your stomach, and try to breathe so that the object rises as you inhale and falls as you exhale.

Boundaries: How do we develop boundaries?

Boundaries begin to form in infancy. In a healthy family, a child is helped to individuate, to develop a self-concept separate and unique from the other family members. We learn about our boundaries by the way we are treated as children. Then, we teach others where our boundaries are by the way we let them treat us. Most people will respect our boundaries if we indicate where they are. With some people, we may need to actively define them. Boundaries require maintenance. Your skin is an obvious example of your physical boundary. Your emotional and relational boundaries may be less obvious, but they are just as important. If the barrier of your skin is breached by a scratch, you become vulnerable to infection. If your emotional or relational boundaries are breached, you also become vulnerable to harm. When these invisible boundaries are trespassed by the thoughtless or intrusive actions of others, it is called a boundary violation.

Healthy boundaries are flexible enough that we can choose what to let in and what to keep out. We can determine to exclude meanness and hostility and let in affection, kindness, and positive regard.

Healthy Boundaries:
Feeling like your own person
Feeling responsible for your own happiness
Togetherness and separateness are balanced
Friendships exist outside of the relationship
Focuses on the best qualities of both people
Achieving intimacy without chemicals
Open, honest and assertive communication
Commitment to the partner
Respecting the differences in the partner
Accepting changes in the relationship
Asking honestly for what is wanted
Accepting endings

Unhealthy Boundaries:
Feeling incomplete without your partner
Relying on your partner for your happiness
Too much or too little togetherness
Inability to establish and maintain friendships with others
Focuses on the worst qualities of the partners
Using alcohol/drugs to reduce inhibitions and achieve a false sense of intimacy
Game-playing, unwillingness to listen, manipulation
Jealousy, relationship addiction or lack of commitment
Blaming the partner for his or her own unique qualities
Feeling that the relationship should always be the same
Feeling unable to express what is wanted
Unable to let go

Red Flags

Warning Signs of Sexual Assault:

There can sometimes be warning signs before a sexual assault takes place. Some "red flags" can indicate that a person has the potential to commit sexual assault. However, the presence of these warning signs does not mean someone will definitely commit a sexual assault. The absence of warning signs does not mean a person is definitely safe from sexual assault.

Being aware of warning signs can be beneficial. If you notice these signs in (and feel uncomfortable with) your partner, date, or a person you are hanging out with, they should send up red flags in your mind. Take precaution as you deem necessary and trust your instincts. Do not worry that you will hurt your date's feelings or that he/she will not like you if you speak up or refuse sexual activity. If a person respects you and cares about you, he/she will not want to hurt you or make you uncomfortable.

Pressuring You to Drink

A perpetrator may try to "feed" a potential victim alcohol or pressure her or him to drink because it makes a victim vulnerable. A victim is less likely to notice warning signs and less able to react to an unsafe situation.

Crossing Your Boundaries

If someone is saying sexual things that make you uncomfortable, touching you in ways that make you uncomfortable, or standing or sitting too close, he/she is crossing your boundaries. A perpetrator may do this to see if a potential victim will react. Someone who does not react is seen as an easier target.

If someone is making you uncomfortable, SPEAK UP! Be assertive. Let the person know that what he/she is doing is not appropriate and that he/she needs to stop. Your actions and words should match. Step away from the person, do not smile, or say "I'm sorry." You should not be sorry for protecting yourself or keeping yourself safe.

Isolates You

A perpetrator will try to get a potential victim alone to reduce the risk of being caught committing sexual assault and to avoid sources of help for the victim.

Trust your instincts. If you feel uncomfortable having someone take you home, call a cab or a friend. Do not feel pressured to go off alone with someone you do not know well, even if it is in the same house, apartment or dorm with a lot of other people. If someone likes and respects you he/she will respect your boundaries and want you to feel safe with them.

Red Flags (continued)

Doesn't Listen To Your Opinions
If your date is making all the decisions, and not listening to your opinions or suggestions, it probably is a bad date, but it can also be a warning sign for potential sexual assault. If your date does not listen to you now, he or she may not listen later when you say "no".

Strong Gender Role Stereotypes
A potential perpetrator may have strong gender role beliefs about how men and women should interact and behave. Believing in stereotypes such as women should be submissive to men, that men are in charge of the relationship, and that men cannot control their sexual urges can make a perpetrator feel he is entitled to sex if he wants it, no matter what his partner wants.

Viewing Women as Objects
When someone views women as objects, they are not viewing them as people. It can be much easier to hurt an object rather than a person. The owner also does not need to take into account an object's feelings or objections to any action.

Intoxication
Someone who has been drinking or taking drugs can be more likely to commit sexual assault. The perpetrator may believe that being drunk gives them an excuse to commit the crime, (e.g., "I did not know what I was doing, I was drunk"). Alcohol and drugs also impair judgment. Someone may not react or recognize when the victim is unwilling to engage in sexual activity.

Just because someone has been drinking does not excuse their behavior if they commit sexual assault. They are still responsible for their actions.

Date Rape Drugs: The Facts

Both women and men should be aware of the risk of having a date rape drug slipped into a drink. The misuse of alcohol or other substances to facilitate rape is not a new phenomenon; nor is recreational drug use. But the increase in reports of drugs used to facilitate sexual assault warrants renewed attention to combating the problem.

- Date rape drugs are colorless, tasteless, and odorless substances that can be easily slipped into beverages undetected.
- They are strong relaxants, the effects of which can be felt as soon as 15 minutes after ingestion.
- The side effects of date rape drugs can include: blackouts, coma, impaired judgment, memory impairment, dizziness, headaches, confusion and loss of coordination.
- Alcohol can intensify these side effects.
- Date rape drugs may cause memory loss.
- Some date rape drugs only remain in the system for as little as 6-8 hours, making immediate testing imperative. If a survivor believes she has been given a date rape drug he/she should seek medical attention immediately and ask medical personnel to administer a test for date rape drugs

Common Date Rape Drugs:

- **Rohypnol:** also known as: roofies, circles, forget me drug, la rocha, mind erasers, poor man's quaalude, R-2, roachies, and ro.

  The effects of Rohypnol begin about 30 minutes after ingestion and can last, depending on the amount, up to 8 hours. It is commonly crushed and dissolved into alcoholic and non-alcoholic beverages because it is tasteless, odorless and colorless. The mixture of Rohypnol and alcohol (or other drugs) can have deadly consequences.

- **GHB:** also known by the following "street" names: cherry meth, easy lay, ever clear, gamma, liquid E, and liquid ecstasy.

  GHB is most commonly sold as a clear or syrupy liquid although sometimes it is sold as a white powder. Many rapists carry GHB in liquid form in an eye-drop bottle and administer a few squirts into an unwatched glass. Sometimes drinks laced with GHB have an unpleasant, plastic, salty taste and even a mild odor. Rapists often choose sweet liqueur or fruit juice drinks because the sweetness of these drinks often disguises the smell and taste of GHB.

- **Ketamine:** also known as Special K.

  Ketamine is a horse tranquilizer that is being sold on the street as a date rape drug. Ketamine is commonly crushed and dissolved in a drink. It can cause an "out of body" experience, impaired motor control, and lost time.

- **Alcohol:** remains the most commonly used date rape drug both on and off college campuses.

  For centuries alcohol has been used to facilitate sexual assault. Today it remains the substance most frequently associated with date rape, and the most easily accessible sedating substance. When large enough quantities are consumed alcohol can have a tremendous sedating effect leaving anyone vulnerable to assault.

  The physical effects of alcohol are very similar to those of sedating drugs and include impaired judgment and motor coordination, lower inhibitions, dizziness, confusion and extreme drowsiness. If enough alcohol is consumed an individual may fall unconscious or may not remember the details of what occurred.

Reducing the Risk of Being Drugged

- Do not leave beverages unattended.

- Remember, drugs do not have to be mixed with alcohol to work, but alcohol often increases their effects.

- Do not take any beverages, including alcohol, from someone you do not know and trust. If you feel uncomfortable refusing a drink, remember you do not have to drink it. Carry the beverage with you until you can toss it.

- At parties, do not accept open-container drinks from anyone. Do not drink from open container sources (like punch bowls) if you do not know what went into the beverage.

- At a bar or club, accept drinks only from the bartender or server. If possible, watch the bartender make your drink.

- If you have accepted a drink and it tastes funny, or "off", do not drink it. Tell the server or bartender and ask them to make you a new drink.

- Be alert to the behavior of friends and ask them to be alert of your behavior. Anyone who appears extremely intoxicated after consuming only a small amount of alcohol may have been slipped a date rape drug.

If you or a friend feels dizzy, confused or has other sudden, unexplained symptoms after drinking a beverage, call the police or 911 for help in getting to a hospital. Request a urine test as quickly as possible because date rape drugs metabolize and leave the body in a matter of hours.

Most importantly, remember that whether you follow these tips or not, if someone drugs and/or sexually assaults you, it is not your fault. You are never to blame for someone else's actions. No one deserves or wants to be raped.

Personal Safety Tips: Keeping Yourself Safe

In general:

- Be aware of your surroundings. Know where you are and who is around you may help you find a way out of a bad situation.
- Be assertive.
- Watch for nonverbal cues.
- Listen to your instincts.
- Take a course in self defense that is designed for women that enhance your ability to assert yourself and includes opportunities for you to practice against other people.
- Be direct, if someone is pressuring or threatening you, you have the right to respond firmly and to call attention to the threatening behavior.
- Use your common sense to avoid potentially dangerous situations, and to respond to an attack if one occurs.
- Keep emergency phone numbers handy, such as a rape crisis center 24-hour hotline, family, and friends that you can utilize in addition to 911.
- When you feel your personal space is being invaded, don't hesitate to say, "don't come near me; stop where you are" in a firm voice.

At A Social Event:

- Discuss safety techniques with your friends, family and neighbors.
- When you go to a party, go with a group of friends. Arrive together, check in with each other and leave together.
- Practice safe drinking. Try not to leave any beverages unattended or accept drinks from someone you do not know or trust.
- Have a buddy system. Don't be afraid to let a friend know if something is making you uncomfortable or if you are worried about your own friend's safety.
- If someone you don't know asks you to go somewhere alone, do not be afraid to say no.

Personal Safety Tips: Keeping Yourself Safe (continued)

On The Street:

- Walk with confidence and at a steady brisk pace. Be aware of others around you.
- Try not to load yourself with heavy packages or books. It is better to have a free hand.
- If you feel that someone is following you don't go home, instead go to the nearest police station.
- Be alert and aware. Look around you and assess your environment and the people in it.
- Travel with a friend whenever possible.

In Your Car:

- Try to park your car in a well-lit and easily visible spot.
- Keep your car in the best working condition possible, and keep an emergency kit in your car that contains first aid items, flash lights, small tools, road flares, etc.
- Avoid walking near hedges or bushes that might conceal an attacker, whenever possible.
- If possible, avoid walking to your car alone. Don't be afraid to ask a security guard to walk with you to your car.
- Return to your car with your key ready. Check under the car and in the back seat before getting inside your car.
- Be careful when people in cars ask for directions, and reply from a distance.

Most important, remember that even if these tips are followed, a sexual assault can occur, and if it does it is NOT your fault!

Survivor's Rights

- **You have the right to** determine whether or not you want to report the sexual assault to law enforcement.
- **You have the right to** request to be interviewed by a female officer if you decide to make a report.
- **You have the right to** report but not proceed with prosecution.
- **You have the right to** withdraw your testimony against the attacker at any time.
- **You have the right to** be treated in a considerate and sensitive manner by law enforcement and prosecution personnel.
- **You have the right to** sue a person or company for negligence if you were sexually assaulted in a place having unsafe conditions (e.g. apartment building or parking lots).
- **You have the right to** contact and be contacted by law enforcement and the district attorney's office.
- **You have the right to** obtain copies of police reports regarding the sexual assault.
- **You have the right to** report the attack to law enforcement and expect that all avenues within the law will be pursued to apprehend and convict the offender.
- **You have the right to** file a third-party report (e.g. a rape crisis center reports the crime but does not disclose your name).
- **You have the right not to** be exposed to prejudice because of your race, age, class, gender, sexual orientation, or occupation.
- **You have the right to** be considered a rape survivor regardless of the relationship of the assailant (e.g. spouse, acquaintance, relative, etc.)

Referral List

Emergency

- Advanced Psychological Services Emergency Line (888) 425-5227

Suicide Prevention

- Suicide Prevention Center (310) 391-1253
- Suicide Hotline (800) 725-8255

Sexual Assault

- RAINN (800) 656-HOPE/4673
- VTC Hotline (818) 886-0453 or (661) 253-0258

Victim Assistance Program

- VOC Central Office (213) 978-2097
- VOC Van Nuys Office (818) 374-3333
- VOC North Hollywood Office (818) 623-4056

Information

- Information Line 211
- Department of Mental Health (800) 854-7771

CHAPTER FIVE

Conclusion

Summary

Studies show that women, who participate in programs developed to educate and reduce women's risk of being sexually assaulted, display greater knowledge about rape, are less accepting of rape myths, and assign less blame to rape victims (Anderson & Whiston, 2005). The aim of providing psychoeducation in a group setting is to lighten or diminish the effects of exposure to an extreme situation, such as a sexual assault. The purpose of the project is to create a 12-session model for Marriage and Family Therapy Trainees and Interns at Valley Trauma Center to conduct group therapy experiences for adult survivors of sexual assault. The goal of the project is to provide the curriculum of this 12-session psychoeducational support group that can be used to implement the group at Valley Trauma Center.

The group curriculum consists of a 12-session model based on psychoeducation for adult female survivors of sexual assault. An outline of each session is provided which includes the session's goals, objectives, materials, handouts, procedures, and homework assignments. Handouts for each session are also provided which are to be used in session and/or reviewed as homework. The curriculum is designed for adult survivors, but can be modified to fit other populations such as male adult survivors, parents of survivors, or significant others of survivors.

The handouts are provided for group facilitators to utilize during sessions and to be given to group members to keep for their own learning purposes. Some handouts will be reviewed and discussed in length during session, and others will be given to the client

to take home and review on their own. Group members will have the opportunity at the start and end of each session to discuss any questions or comments they have regarding the information provided. Handouts review myths and realities of rape and sexual assault, facts about rape, different rape situations, common responses, PTSD facts, self care tips, relaxation techniques, the recovery process, red flags, boundaries, date rape drugs, safety tips, survivor's rights, and referrals.

Evaluation and Recommendations

A recommendation for this curriculum would be to translate it into Spanish to accommodate the Hispanic-Spanish speaking population serviced at Valley Trauma Center. The curriculum can also be modified for a group of male survivors or the parents and/or significant others of a survivor of sexual assault.

It may be beneficial for a survivor who has previously attended this support group to speak to the current group about her personal story and experience in the group. This may give new members a sense of hope and comfort speaking with someone who has experienced similar events.

Another recommendation would be to gain feedback from the group members in the later sessions and at the conclusion of the group. This feedback will allow for the group leaders to make additions, adjustments, and improvements to the curriculum for the next cycle.

Discussion

The development of this project came about as a result of working as a counselor in training at Valley Trauma Center with adult survivors of sexual assault. In working with adult survivors, common themes of feeling alone, feeling different, and confused

about the symptoms the individual was experiencing often came up in individual sessions. Survivors often express feeling that no one in their life understood what they were going through, and felt that they were the only one experiencing the difficult aftermath of an assault. A support group for these survivors focused on psychoeducation seemed to be what they needed to help in their recovery process.

Future Work/Research

This curriculum is the first step in providing counselors at Valley Trauma Center a tool to provide adult survivors of sexual assault a space to share experiences, receive support, and learn valuable tools to help aid in their recovery process. The curriculum can be improved to be more efficient over time with the help of feedback from group members and group leaders who have participated in the group. It is important to get verbal feedback, as well as feedback that can be measured. A way to do this may be to administer a pre- and post-test to participants at the first and last session of the group. This test can be developed by the group leader based on the objectives presented in each session. Standardized assessments such as Briere's *Trauma Symptom Inventory* (TSI: Briere, 1995) can be used to measure possible increases or decreases of PTSD symptoms.

An expansion to this project could include a workshop based on the information covered in the curriculum. This workshop will be presented to counselor trainees and interns at Valley Trauma Center before they implement the curriculum in a group. The workshop will include a review of each session and handouts provided. The procedures of each session will be explained in depth, and specific interventions or topics discussed will be the focus. This workshop will provide counselors with opportunities to ask questions, make suggestions, and hear from fellow counselors who have previously led

the group. This will leave the counselors better prepared to be a group leader of the psychoeducational support group for survivors of sexual assault. Involvement of the directors, supervisors, interns, and trainees in further development of the 12-session model will only improve the quality of the treatment provided to survivors of sexual assault at Valley Trauma Center.

APPENDIX A

Group Sign In Roster

At the start of each session, group members will sign in, and group leaders will sign at the bottom of the page.

Session #:
Date:

Members Sign In:

1. **_____**
2. **_____**
3. **_____**
4. **_____**
5. **_____**
6. **_____**
7. **_____**
8. **_____**
9. **_____**
10. **_____**

Group Leader Signatures:

1. **_____**
2. **_____**

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