BRIEF OVERVIEW

In 1994, Family Health International (FHI) began working with the Reproductive Health Response in Conflict (RHRC) Consortium and the Inter-Agency Working Group (IAWG) on Reproductive Health in Refugee Situations, convened by the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Population Fund (UNFPA). Subsequently, FHI collaborated with members of the RHRC Consortium in the elaboration of their *Refugee Reproductive Health Needs Assessment Field Tools*, published in 1997.

In early 2000, FHI began working with the International Rescue Committee (IRC--a member of the RHRC Consortium) in Kosovo to support a gender-based violence (GBV) project in Peja, Kosovo. In response to a need identified by the staff of FHI's and IRC's local partner, the Women's Wellness Center, FHI collaborated with IRC to develop a draft training curriculum on communication skills in working with survivors of GBV. In a workshop facilitated by Jane Schueller of FHI and Jeanne Ward of the RHRC Consortium, the training curriculum was field-tested in Peja in 2000.

Since 2000, the number of GBV programs operating in humanitarian settings has grown dramatically. However, resources to guide service providers on how to best engage with survivors are still limited. An important exception is the manuals created by Sophie Read-Hamilton of the IRC, which have been used to provide GBV-related counseling skills trainings in Tanzania and Sierra Leone. Sophie Read-Hamilton also contributed materials that constitute the introduction to the facilitation skills component of this curriculum.

This curriculum represents collaboration between FHI, the RHRC Consortium, and the IRC. The original curriculum used in Peja, Kosovo, has been supplemented and refined in subsequent trainings by FHI, as well as by the work of IRC's Sophie Read-Hamilton in Tanzania and Sierra Leone. The curriculum presented here has been finalized by Jeanne Ward of the RHRC Consortium, with feedback from FHI and IRC.

What follows is an outline of the overall goals of the training, a training outline, and a list of materials needed, as well as a list of transparencies, handouts, and activity sheets used in the training, an in-depth training curriculum, and all transparencies, handouts, and activity sheets necessary to conduct a training. The training is designed so that all the materials used in the training can be shared with participants at the end of the workshop (preferably in a binder), and they can conduct subsequent trainings on topics with which they feel comfortable. Participants are not expected to be able to train on the entire contents of the manual unless they have extensive training and psychosocial experience.

For questions or comments about the training materials, please contact Jeanne Ward at Jeanne@theIRC.org.

Communication Skills in Working with Survivors of Gender-based Violence

A Five-day Training of Trainers Workshop

OVERALL GOALS OF THE WORKSHOP

It is envisioned that the training course will provide participants with the following:

Day I **Overview of Gender-based Violence**

- An introduction to key concepts related to gender-based violence (GBV)
- An introduction to causes and contributing factors of GBV
- An overview of the multisectoral model for GBV response

Day II **Engagement Strategies in Working with Survivors**

- An understanding of and sensitivity to the needs and concerns of GBV survivors
- An introduction to basic engagement techniques in working with survivors
- An appreciation of the difference between assessment, assumption, and diagnosis

Day III **Engagement Strategies (con't)**

- An introduction to varying roles of service providers
- An understanding of how to apply the GATHER model to work with survivors
- An appreciation of multiple issues in working with survivors, including safety planning, cultural sensitivity, responding to special populations, and instituting safety precautions for the service provider

Day IV **Supporting the Service Provider**

- An understanding of vicarious trauma, its causes, and ways of managing and preventing vicarious trauma
- Knowledge of and practice in self-care techniques
- An introduction to supervision, including the roles and responsibilities of the supervisor and supervisee

Day V **Service Provider Responsibilities and Community Referrals**
Facilitation Skills Overview, Training Review and Evaluation

- Knowledge of the principles of record keeping and confidentiality
- An understanding of networking with other community services/sectors, making referrals and advocating on behalf of survivors
- An introduction to basic facilitation skills in using the Communication Skills Training Curriculum

Communication Skills in Working with Survivors of Gender-based Violence

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TRAINING OUTLINE

Day I **Participant Introductions and Overview of Gender-based Violence**

Session 1 Setting the Climate

- ❑ Welcome and Introductions
- ❑ Training Overview and Logistics
- ❑ Participant Expectations
- ❑ Establishing Ground Rules

Session 2 Understanding Key Concepts

- ❑ Sex vs. Gender
- ❑ Gender-based Violence (GBV)
- ❑ Examples of GBV

Session 3 Developing a Framework to Understand and Respond to GBV

- ❑ GBV in Your Community: Causes, Contributing Factors, Consequences
- ❑ Multisectoral Model

Day II **Engagement Strategies in Working with Survivors**

Session 1 Understanding the Survivor

- ❑ Basic Psychological Needs
- ❑ Brief Introduction to Trauma Theory
- ❑ Identifying Common Reactions to Trauma
- ❑ Coping Skills

Session 2 Introduction to Engagement Techniques

- ❑ What Makes an Effective Service Provider?
- ❑ Active Listening
- ❑ Barriers to Good Listening
- ❑ Assessment vs. Assumption
- ❑ Self-Assessment

Day III **Engagement Strategies (con't)**

Session 1 What is your role? What is your goal?

- ❑ Active Screening, Crisis Debriefing, Case Management, and Counseling
- ❑ GATHER Model

Session 2 Important Issues in Working with Survivors

- ❑ Special Populations
- ❑ Protocols for Action with Survivors with Challenging Concerns
- ❑ Safety Precautions for the Service Provider

Day IV **Supporting the Service Provider**

Session 1 Introduction to Vicarious Trauma

- ❑ Defining and Coping with Vicarious Trauma

Session 2 Introduction to Self-Care

- ❑ Self-Care for the Service Provider

Session 3 Supervision

- ❑ Role of the Supervisor
- ❑ Responsibilities of the Supervisee

Day V **Service Provider Responsibilities and Community Referrals**
Facilitation Skills Overview, Training Review and Evaluation

Session 1 Record Keeping and Confidentiality

- ❑ The Fundamentals of Record Keeping
- ❑ Ensuring Confidentiality
- ❑ Incident Report Form/Consent to Release Information

Session 2 Coordinated Community Response and Advocacy

- ❑ Coordinating a Community Response: Applying the Multisectoral Model
- ❑ The Service Provider as an Advocate

Session 3 Facilitation Skills Overview, Training Review and Evaluation

- ❑ Facilitation Skills Overview
- ❑ Week in Review
- ❑ Wrap-up and Evaluation

A Five-day Training of Trainers Workshop

MATERIALS NEEDED

- Overhead projector and screen
- Newsprint and markers
- Participant folders
- Name tags
- Tape
- String
- Thumb tacks
- Paper and pen for each participant
- Tape recorder and music
- Bag or hat for drawing
- Candy for award ceremony
- Question box
- Index cards

Communication Skills in Working with Survivors of Gender-based Violence

A Five-day Training of Trainers Workshop

TRANSPARENCIES, HANDOUTS AND ACTIVITY SHEETS

Transparencies

Day I

- Definition of Sex vs. Gender
- Which is it: Sex or Gender?
- Definition of Gender-based Violence (GBV)
- Types of GBV
- Extent of Problem
- Multisectoral Framework

Day II

- Psychological Needs
- Definition of Trauma
- Identifying Stress Reactions
- Trauma Response: The Physical Response
- Trauma Response: The Emotional Response
- Brief History of Trauma Theory
- Basic Principles of Providing Help to Survivors
- Barriers to Good Listening
- Assumption, Assessment, and Diagnosis

Day III

- What is Your Role? What is Your Goal?
- Interaction Techniques (1)
- Interaction Techniques (2)
- GATHER Model

Day IV

- Defining and Managing Vicarious Trauma
- Ten Beliefs that Prevent Helpers from Getting Help
- Empathy versus Sympathy
- How Can Our Organizations and Work Environments Help Us?

Day V

- Incident Report Form/Consent to Release Information
- Exceptions for Breaking Confidentiality

Handouts

Day I

- Pre-test
- Training Outline
- Daily Evaluation Form

Day II

- Normal Reactions to an Assault
- Recovery from Immediate Trauma
- Traumatic Event: Helpful Hints for the Survivor
- Introduction to Active Listening
- Attending: Using the SOLER Model
- Advising vs. Informing
- Daily Evaluation Form

Day III

- Interaction Techniques (1)
- Interaction Techniques (2)
- Stem Statements
- Helper Skills Evaluation Checklist
- Rape Trauma: Common Responses
- Safety Planning Assessment
- Power and Control Wheel
- Cycle of Violence
- Some Considerations in Assessing Child Sexual Abuse
- Changing Needs of Growing Children
- Crisis and the Continuum of Age: The Elderly's Reaction to Trauma
- Protocol for Action: Suicidal/Homicidal Clients
- Protocol for Action: Mentally Disturbed Clients
- Protocol for Action: Angry Clients
- Protocol for Action: Drug/Alcohol Abusing Clients
- Taking Precautions: Agency Visits
- Daily Evaluation Form

Day IV

- Responses as Guides for Action: Working with Victims of Domestic Violence
- Self-Care and Managing Stress
- Daily Evaluation Form

Day V

- Record Keeping Do's and Don'ts
- Scenarios for Resistant Participants
- Incident Report Form/Consent to Release Information
- Daily Evaluation Form
- Post-test
- Final Evaluation Form
- Training Certificate

Activity Sheets

Day I

- Gender Statements: Match the Proverb
- Match the Proverbs and the Sayings
- Violence in Your Community
- Violence Jeopardy Game
- Violence Jeopardy Game Answers
- Client Scenario

Day II

- Visualization of Traumatic Experience
- Visualization Exercise for Active Listening
- Which Is It: Assessment or Assumption?
- Self Assessment Exercise (1)
- Self Assessment Exercise (2)

Day III

- Guidelines for Giving Role Play Feedback
- Role Play for Protocols for Action

Day IV

- Case Vignettes: Ellen and Sara
- Self Care Plan
- My Great Worth

Day V

- Sample Record Keeping Exercises
- Scenarios for Resistant Participants

DAY I

OVERVIEW OF GENDER-BASED VIOLENCE

MATERIALS NEEDED:

- Overhead projector and screen
- Newsprint and markers
- Proverbs, each divided on separate sheets of paper
- Jeopardy Game posted on wall
- 4 pieces of newsprint posted on wall, each with one of the following titles: Health Response; Psychosocial Response; Police/Security Response; Legal/Judicial Response
- Tape
- String
- Paper and pen for each participant
- Question box and index cards
- Name Tags

TRANSPARENCIES:

- Definition of Sex vs. Gender
- Which Is It: Sex or Gender?
- Definition of Gender-based Violence
- Types of GBV
- Extent of Problem
- Multisectoral Framework

HANDOUTS:

- Pre-test
- Training Outline
- Daily Evaluation Form

ACTIVITY SHEETS:

- Gender Statements: Match the Proverbs
- Jeopardy Game and Answers
- Violence in Your Community
- Client Scenario

I.1 SETTING THE CLIMATE

Estimated time: 1 hour, 30 minutes

Objectives

At the end of the session participants should be able to:

- Identify organizers, facilitators, assistants, and participants of the workshop
- Give a summary of the workshop logistics, goals, objectives, and training methodology
- Outline participants' expectations
- Agree on a schedule and ground rules for the training

TIME	CONTENT	TRAINER'S NOTES
		Before starting the training, have room set up in a way that gives each participant adequate space to write and move around. If possible, room should be set up with tables arranged in a u-shape. Have a resource table set up with materials on GBV and working with survivors (many of which can be downloaded at **www.rhrc.org/resources/gbv**).
8:30 – 9:00	**Registration and Pre-test**	**Handout: Pre-test** Ask participants to complete pre-test as soon as they have registered and received their training materials.
9:00 – 9:15	**Welcome Speech by Organizers and Training Team Introductions**	Introduce training team and their role in the training to participants. Collect pre-tests.
9:15-9:30	**Team Building Exercise, Participant Introductions and Expectations**	Team Building Exercise, Participant Introductions and Expectations: Have the participants divide into 2 equal groups and move apart from each other. Give each group a long piece of string. Ask the participants to close their eyes and keep them closed for the duration of the activity until the facilitator says to open them. Then tell one group to form a square and the other to form a triangle, utilizing the string. Emphasize that they need to creatively work together to form the assigned shape. Continue to remind people to keep their eyes closed.

		After 2-3 minutes tell participants to remain in place and open their eyes to look at the shape they have formed. Then ask participants to be seated and facilitate a very brief discussion on what it was like to do the activity, e.g., how it felt, what kinds of reactions emerged, what effect the exercise had on individuals and the group. After the team building exercise, tell participants that part of becoming a team is getting to know the members. Request that participants now go around the room and give their names, organizations, a brief description of their work with survivors of GBV, and expectations for the workshop. Write expectations on newsprint and post around the room.
9:30 – 9:45	**Presentation of workshop goals, objectives, training methodology, and briefly highlight the "TOT" facilitation component of the training that will take place the final afternoon of the training.**	**Handout: Training Outline** Respond to participant expectations, helping them to be realistic about what will be accomplished during the week. Present brief overview of workshop. Note that the training is designed to provide participants with the materials and knowledge to conduct subsequent trainings, but it is not expected that all participants will feel comfortable facilitating trainings on all the topics covered during the week, as different topics require different levels of expertise and knowledge. Also inform participants that the training is not designed as a facilitator's workshop. However, we will spend time at the end of each day and at the end of the week reflecting on strategies for effective facilitation. Remind participants to observe throughout the week the different training methods that are used by the facilitators.
9:45 – 10:15	**Discuss workshop schedule and logistics and establish ground rules for training.**	Review proposed schedule and logistics, ask for suggestions and agree on ground rules (such as timeliness, active participation, active listening, allowance for different learning styles, language constraints, etc.).

		Timeliness will be key, thus it is important to get a commitment from participants on starting sessions on time each day. It is helpful to identify one person each day who will act as the timekeeper, announcing time for breaks, lunch, and ending the day. Note that Day III will be a half-day, in order to allow participants to relax and/or sightsee. It is especially important that participants agree to share their expertise, as some of them may have had previous GBV experience or training, and all are experts in living in their respective communities. Point out to participants what is contained in their folders. Explain that the index cards can be used to write down questions through the week. These cards can be placed in the **Question box,** which will be in a specified spot in the training room. Daily Evaluations will be completed by participants and reviewed by volunteers who will then report back each morning on the results of the previous day's evaluations.
10:15 – 10:30	**Rest of Day I Topics** Overview of Gender-based Violence Session 2: Understanding Key Concepts ▪ Sex vs. Gender ▪ Gender-based Violence ▪ Types of GBV ▪ Violence Jeopardy Game Session 3: Developing a Framework to Understand and Respond to GBV ▪ Violence in Your Community: Causes, Contributing Factors; Consequences ▪ Multisectoral Model	Outline for participants topics for the rest of Day I, as outlined to the left. Inform participants that Day I will involve a general overview of concepts related to GBV and GBV programming, in order to provide a foundation for more specific information on engagement skills.
10:30 – 10:45	**Break**	

I.2 UNDERSTANDING KEY CONCEPTS

Estimated time: 1 hour, 45 minutes

Objectives

At the end of the session participants should be able to:

- Differentiate between sex and gender
- Define gender-based violence
- Give examples of different forms of GBV

TIME	CONTENT	TRAINER'S NOTES
10:45-11:00	**Understanding Key Concepts**	**Activity Sheet: Gender Statements: Match the Proverbs** Using the "Match the Proverbs" Activity Sheet as a guide, write down half of each proverb on a separate piece of paper. Shuffle the papers and hand one piece of paper to each participant. If more participants exist than pieces of paper, give one piece of paper to a pair of participants. Ask participants to "find" the other half of their proverb. After participants have joined in pairs to complete their proverb, engage in a brief discussion of what countries these proverbs come from and how these proverbs illustrate cultural beliefs regarding men and women.
11:00-11:30	**Sex vs. Gender** **Sex:** Refers to physiological attributes that identify a person as male or female: ❑ Type of genital organs ❑ Type of predominant hormones circulating in body ❑ Ability to produce sperm or ova ❑ Ability to give birth and breastfeed children **Gender:** Refers to widely shared ideas and expectations (norms) concerning men and women. These include ideas about "typically" feminine/female and masculine/male characteristics abilities and commonly shared expectations about	**Transparency: Definition of Sex vs. Gender** After soliciting participants' understanding of the differences between sex and gender, ask them for examples of sex differences between men and women and gender differences between men and women. Then provide them the definitions of sex and gender as describe at left. Put up transparency with definitions for sex and gender. **Transparency: Which Is It: Sex or Gender?** After discussing definitions, put up transparency with gender/sex statements. Cover the transparency to reveal one statement at a time. Ask participants to identify whether

	how women and men should behave in various situations. These ideas and expectations are learned from: family, friends, opinion leaders, religious and cultural institutions, schools, the workplace, advertising and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.	the statement is an example of a statement about "sex" or "gender." Discuss and clarify.
11:30-11:45	**Gender-based Violence: Definition and Types** **Gender-based violence** is violence that is perpetrated against a person's will, and is based on his/her gender roles, responsibilities, expectations, privileges, and limitations. GBV may be physical, sexual, emotional, or social.	**Transparencies: Definition of GBV; Types of GBV** First ask participants to define GBV. Often they will provide examples of GBV rather than giving the definition. Use the transparency to clarify what gender-based violence means. Then ask participants to call out types of GBV in their communities, being careful to clarify the difference between violence that is gender-based and violence that is not gender-based. Use the second transparency to highlight types of GBV that might not have been mentioned by the group.
11:45-12:30	**Jeopardy Game** To address: ❑ Myths and facts ❑ Global Statistics and Information ❑ Characteristics of GBV ❑ Consequences of GBV ❑ Responding to GBV	**Activity Sheet: Jeopardy Game and Answers** Use instructions on activity to sheet to complete game. After game is completed, and if time permits before lunch, use **Transparency: Extent of Problem** to elaborate on some of the statistics introduced in the Jeopardy Game. Inform participants that the afternoon session will involve discussion of characteristics of some specific types of GBV, causes and contributing factors, and consequences of violence. We will also review the multisectoral model for responding to GBV.
12:30-1:30	**Lunch**	

I.3 DEVELOPING A FRAMEWORK TO UNDERSTAND AND RESPOND TO GBV

Estimated time: 3 hours, 30 minutes

Objectives

At the end of the session participants should be able to:

- Identify causes and contributing factors to GBV
- Identify consequences of GBV to the survivor
- Identify common community reactions to GBV
- Understand the multisectoral model and identify whether there is mulitsectoral response in participants' communities

TIME	CONTENT	TRAINER'S NOTES
1:30-1:50	**Violence in Your Community** Working group topics include: ▪ What causes GBV in your community? ▪ What are the contributing factors to GBV in your community? ▪ What are the consequences of GBV on individuals, families, and communities? ▪ What are community attitudes/responses towards GBV? ▪ Why do many survivors of GBV not seek help?	**Activity Sheet: Violence in Your Community (Write one question each on a sheet of paper and give each group one sheet of paper.)** Break participants up into 5 working groups, asking them to answer the questions to the left. Each group should assign a scribe to record the answers and to present (in 10 minutes or less) to the larger group. Be sure to emphasize that the participants are the experts in their own communities, and this is an opportunity to consider issues of violence within their respective communities and report back to the larger group.
1:50 – 2:50	**Report Back** ▪ What causes GBV? *Power and Control; cultural and social attitudes about men and women; learned behavior* ▪ What are the contributing factors to GBV? *War, poverty; alcohol* ▪ What are the consequences (psychological, social, and health) of GBV for survivors? *Psychological: anxiety; fear; guilt; grief;*	<u>Report Back:</u> Bring participants back together and ask each group to give a brief (10-minute) report on the results of their discussions. During this time, trainers should add to the discussion, as necessary, with the points at left. Trainers should also listen for any attitudes that many reflect a "blame the victim" stance, and assist participants to reflect on their own socialization. Participants should be asked to think about the reports just given and how this information relates to developing a framework to

	depression; sadness; isolation; worry; anger *Social: stigma; rejection; further exploitation; punishment* *Health: Pregnancy/Abortion; Vaginal Tears; Urinary Tract Infections; Broken Bones, Bruises; Gastrointestinal Problems* ▪ What are community attitudes/responses towards GBV? *Fear, blaming the victim, feeling that it is a "private" problem; happens to others; happens only to women; sexual violence is the result of uncontrolled sexual desire: "boys being boys"; a reasonable way to keep wives under control* ▪ Why do many survivors of GBV not seek help? *For all victims:* *1) shame; 2) inaccessibility of services; 3) poor response or inappropriateness of services; 3) fear of reprisals; 4) minimizing problem* *Special considerations for domestic violence victims:* *1) safer to stay in relationship; 2) potential loss of custody of children; 3) no economic support; 4) hopefulness about the violence stopping; 5) family/cultural expectations; 6) partner's threats; 7) NOT because they are masochistic*	understand and address violence against women.
2:50-3:00	**Multisectoral Model for Responding to Survivors**	**Transparency: Multisectoral Framework** Briefly introduce the Multisectoral Framework as a way of responding to the multiple needs of survivors. Emphasize that the survivor's needs are at the center of the multisectoral model. (Refer to the UNHCR *Guidelines on Prevention and Prevention and Response* (2003) for a thorough review of the multisectoral framework.)

3:00-3:15	**Sectoral Responsibilities**	Group Brainstorm: Post 4 pieces of newsprint around the room, each with one of the following titles: Health Response; Psychosocial Response; Police/Security Response; Legal/Judicial Response. Distribute colored markers to each of the participants. Ask participants to walk around the room and write what each sector should do to effectively respond to the needs of survivors.
3:15-3:30	**Break**	
3:30-4:00	**Review of Sectoral Responsibilities** **Health:** actively screen clients; ensure same-sex interviewers; respond to immediate health and psychological needs; provide services free of cost; collect forensic evidence; provide testimony; provide referrals; confidentially collect, document, and analyze health data and data on quality of services. **Psychosocial:** provide supportive and ongoing psychological assistance; confidentially collect, document, and analyze client data; offer safe haven (safe houses) for survivors who choose to leave unsafe environment; provide hotlines; offer income generation and training; conduct community education. **Police/Security:** zero tolerance policy for police, military, and peacekeeping forces who contribute to or commit acts of GBV; designate private interview rooms in police stations; same-sex police workers conducting interviews; specialized units to address sexual violence, domestic violence, trafficking; provide referrals; conduct community policing and education programs; institute ongoing training of personnel; standardize disaggregated data collection; collaborate with local organizations providing	Review the comments on the newsprint and fill in with information provided at left.

	assistance to survivors. **Legal/Judicial:** review and revise laws that reinforce GBV and gender discrimination; provide free or low-cost legal counseling and representation to survivors; conduct ongoing training to members of the judiciary to apply GBV laws and carry out judicial proceedings privately; institute provisions for monitoring court processes and collecting and analyzing data on cases; and conduct community education on existence and content of anti-GBV laws.	
4:00-4:20	**Multisectoral Coordination Game** Coordination is a key component of the multisectoral approach. Coordination includes: sharing information about GBV incident data; discussion and problem-solving among actors about prevention and response activities; collaborative monitoring, evaluation, and ongoing program planning and development; methods for information sharing, reporting, and referrals in and among sectors; facilitating communication in and among sectors.	Briefly discuss what coordination means within the multisectoral framework. Remind participants that without coordination, multisectoral response is not possible. After reviewing the basic components of coordination, play the coordination game, using the client scenario. **Activity Sheet: Client Scenario** Identify one person to act as a client and one person to act as the client's mother. Using the Client Scenario as a guide, give other volunteers in the room each a role within the scenario (e.g., MSF health worker, UNHCR protection officer, camp security official, host government police officer, NGO psychosocial worker, etc.). Ask all role play participants to stand in a circle in the middle of the room. Then give the client and her mother a piece of string, and as the scenario is read aloud, ask them to take the piece of string with them to trace their steps through the process of seeking assistance. After completing the scenario, ask the participants to reflect on the tangled string, and how it relates to a negative impact on the survivor.
4:20-4:30	**Is there a multisectoral response in your community?**	Now ask participants to go back to the newsprint charts and put a checkmark next to the services that are provided in their communities. (If there is more than one representative of a particular community, have

		them work together to make check marks.) After reviewing the response, which will likely indicate that most communities do not have a multisectoral response framework, ask participants to consider their work within the multisectoral framework. Highlight that there are many different roles and responsibilities for those working with survivors, and that this workshop will not focus on the more specific responsibilities of each sector. Point out, however, that a responsibility of all sectors is to engage constructively with survivors, which will be the focus of the next three days of the workshop.
4:30-4:45	**Brief Review of Facilitation Strategies** Different people process information in different ways. While it may be easier for some people to understand an idea through pictures, it might be easier for others to hear the idea spoken out loud. Different types of learning include: • Listening (auditory learning); • Watching (visual learning); and • Doing (participatory learning).	Tell participants that at the close of each day we will spend a few minutes reflecting on the strategies of facilitation that have been used that day. Ask participants to call out some of the training methods that were used in today's training. For each of the methods identified (large group discussion; small group work; role play; games; etc.), ask for a show of hands of favorite methods. Briefly review different types of learning identified at left. Ask participants to think about how their favorite method of learning during the day relates to their learning style, as well as why it is important to use a variety of facilitation methods when conducting trainings.
4:45-5:00	**Review of Day's Activities**	Review and Homework: After reviewing the day's activities, give the participants a brief assignment for the following day: ask them to write down on a piece of paper 5 qualities they believe make someone an effective helper to survivors of GBV. **Handout: Daily Evaluation Form** After participants have completed the daily evaluation form, ask two volunteers to review the evaluations and prepare feedback for the following morning.

DAY II

ENGAGEMENT STRATEGIES IN WORKING WITH SURVIVORS

MATERIALS NEEDED:

- Overhead projector and screen
- Newsprint and markers
- Tape
- 4 pieces of newsprint posted around the room, each with one of the following titles: 1) Emotional/Feeling; 2) Thought/Cognitive; 3) Physical; and 4) Behavioral
- One piece of newsprint with self-assessment questions listed
- Paper and pen for each participant
- Question box and index cards

TRANSPARENCIES:

- Psychological Needs
- Definition of Trauma
- Identifying Stress Reactions
- Trauma Response: The Physical Response
- Trauma Response: The Emotional Response
- Brief History of Trauma Theory
- Basic Principles of Providing Help to Survivors
- Barriers to Good Listening
- Assumption, Assessment, and Diagnosis

HANDOUTS:

- Normal Reactions to an Assault
- Recovery from Immediate Trauma
- Traumatic Event: Helpful Hints for the Survivor
- Introduction to Active Listening
- Attending: Using the SOLER Model
- Advising vs. Informing
- Daily Evaluation Form

ACTIVITY SHEETS:

- Visualization of Traumatic Experience
- Visualization Exercise for Active Listening
- Which is it: Assessment or Assumption?
- Self-Assessment Exercise (1)
- Self-Assessment Exercise (2)

II.1 INTRODUCTION TO TRAUMA AND SYMPTOM MANAGEMENT

Estimated time: 4 hours

Objectives

At the end of the session participants should be able to:

- List the basic psychological needs and related cognitive patterns of individuals
- Define trauma
- List two ways in which trauma may occur and give examples of traumatic experiences
- Identify common emotional, cognitive, physical, and behavioral responses to trauma
- Discuss the reactions of society to people's experiences of trauma within the context of history
- Identify general as well as culturally specific techniques that can be used to manage/cope with the effects/symptoms of trauma
- Make a creative presentation on techniques used to manage/cope with the effects/symptoms of trauma

TIME	CONTENT	TRAINER'S NOTES
8:30-8:45	**Welcome, Feedback on Evaluations, Questions, Housekeeping**	Welcome. Ask volunteers from previous day to provide feedback on daily evaluation. Ask for questions/concerns regarding Day I topics. Identify timekeeper. Ask participants to hold their homework until the afternoon. If they forgot to do their homework, remind them to do it over lunch. (Write down on a piece of paper 5 qualities they believe make someone an effective helper to survivors of GBV.)
8:45-9:00	**Review Day II topics** Session 1: Understanding the Survivor ❑ Examining the Basic Psychological Needs of Human Beings ❑ Brief Introduction to Trauma Theory ❑ Identifying Common Reactions to Trauma ❑ Building on Coping Skills Session 2: Introduction to Engagement Techniques ❑ What Makes an Effective Service Provider? ❑ Active Listening/Attending ❑ Barriers to Good Listening	

	▫ Assessment, Assumption, Diagnosis ▫ Self-Assessment	
9:00-9:45	**Basic Psychological Needs and Related Cognitive Patterns** 1) To feel safe and reasonably invulnerable to harm (safety); "I can protect myself"; "the world is safe." 2) To have support from others and to be able to trust one's own judgment (trust/dependency); "I can rely on others"; "my perceptions and judgements are trustworthy"; "people are trustworthy." 3) To control one's own behavior and destiny (independence); "I can control my thoughts, feelings, and behavior." 4) To control one's environment (power); "I can prevent bad things from happening to me." 5) To belong to a community and to have attachment to others (intimacy); "I can have meaningful relationships with others"; "I can enjoy being alone and being a friend to myself." 6) To understand and know oneself; to enjoy the inner experience of relating to oneself; to enjoy hope and faith in oneself (esteem); "I am worthy"; "I am valuable"; "I have hope for the future."	Post the newsprint with "Consequences of GBV for the Survivor" from the previous day's group work. Let participants know that in order to understand the impact of GBV on a survivor, it is helpful to have a framework for understanding humans' basic psychological needs. <u>Brainstorming Exercise:</u> Ask participants to call out the psychological needs that people have. After participants have identified some basic psychological needs, put up transparency and review. **Transparency: Psychological Needs**
	When a person experiences a disturbance in these psychological needs and related cognitive patterns, we say they have had a traumatic experience. A traumatic experiences occurs when: 1) an individual's ability to use normal coping mechanisms to adapt to a situation is overwhelmed; 2) an individual's frame of reference (e.g., beliefs about themselves and the world) is disrupted. Trauma is outside the range of usual human suffering and would be extremely	Introduce definition of trauma. **Transparency: Definition of Trauma** Ask participants if they know how trauma occurs.

	stressful for nearly anybody. Trauma often imposes a serious harm or threat to one's life or physical integrity, a serious threat to one's children, spouse, or other close relatives or friends. Trauma can occur in two ways: 1) through direct experience; and 2) through second-hand (vicarious) experiences, such as hearing accounts of violence. Examples include: 1) natural disasters; 2) a tragic accident; 3) physical assault; 4) death; 5) war; 6) GBV.	Ask participants to give examples of types of trauma.
	Visualizations	
9:45-10:00	Now that we have defined trauma, discussed the ways in which it can occur, and given examples of traumatic experiences, let's do a visualization exercise.	**Activity Sheet: Visualization of a Traumatic Experience** Ask participants to visualize a traumatic experience they have undergone and to remember some of the associated feelings, reactions and responses. Emphasize safety and the right of participant to select a visualization that is not overwhelming or to decline participation in the exercise. During and after the visualization, be sure to monitor participants' well-being and provide any individual support if needed.
	Identifying Trauma Responses	
10:00–10:30	1) *Emotional* – anxiety, social isolation, sudden mood shifts, depression, grief, guilt/shame, denial, fear 2) *Cognitive* – flashbacks, triggers, nightmares, dissociation, memory/concentration/attention problems, poor decision-making 3) *Physical* – difficulty breathing, dizziness, fatigue, sweating, high blood pressure, vomiting, sleep disturbance 4) *Behavioral* – withdrawal, increased/decreased appetite, acting	<u>Brainstorming Exercise:</u> After completing the visualization exercise, ask participants to take a minute to think about the visualization exercise we have just done and to think about what feelings, reactions, and responses they experienced both during and after the trauma. Participants should move around the room and write on the newsprint that is hanging on the walls the kinds of feelings and reactions they experienced under the respective headings (emotional, cognitive, physical, and behavioral). Then begin to discuss the responses to the left.

	out, substance abuse, homicidal/suicidal, etc.	**Transparency: Identifying Stress Reactions** Use transparency to highlight reactions that may not be identified on newsprint.
	These are normal responses to an abnormal event that results in a breakdown of usual coping mechanisms and adaptive abilities.	**Handout: Normal Reactions to an Assault** After reviewing common stress reactions: ** reinforce that these symptoms are "normal responses to an abnormal event." ** emphasize that it is important for the service provider to be familiar with potential trauma responses so as to be able to assess them in survivors.
	Break	
10:30-10:45 10:45-11:15	**Physical and Emotional Response to Trauma** Often these responses will occur in a typical order.	Discuss with participants the physical and emotional responses to trauma that often occur in a typical order. **Transparencies: 1) Trauma Response: The Physical Response; and 2) Trauma Response: The Emotional Response**
	The **immediate** *physical* response to trauma is based on our instincts. It includes: 1) physical shock, disorientation, and numbness and/or 2) "flight or fight" reaction (adrenalin pumps through body); body may relieve itself of excess materials – for example through vomiting; one or more physical senses may become very acute while others shut down; heart rate increases; hyperventilation or sweating may occur 3) exhaustion	Emphasize that the physical response that may happen during and immediately following a traumatic event may resurface weeks, months, or years after the trauma. Survivors may "re-experience" or "re-live" the traumatic experience as a result of a "trigger" event or "intrusive memories."
	The *emotional* response to trauma includes: 1) high anxiety or emotional shock 2) denial 3) anger 4) remorse	Emphasize that emotional responses may be informed by culture. Ask participants whether these types of responses occur in their culture. Remind participants that individual response

	5) grief 6) reconciliation **Brief History of Trauma Theory**	varies, and that the purpose of this presentation is to give participants a general sense of some common responses so that they are better prepared to deal with them when working with a survivor. Participants should never expect, however, that survivors will or should act according to certain standards of behavior.
11:15-11:30	▪ The victim has historically been held responsible (e.g., "hysterical women"; "shell shocked combatants") ▪ Societies have repeatedly engaged in "conspiracies of silence" ▪ To validate the victim often involves taking a political stance ▪ Psychological approaches that focus on internal responsibility of the individual often directly or indirectly reinforce "victim blaming" ▪ Trauma theory shifts the question from "Why did this happen to you and how can you change to prevent it from happening again?" to "What is your response and the society's response to what has happened and how can you manage that response so as to feel better?"	Highlight to participants that the responses to trauma that have just been discussed only focus on an individual's reaction to a traumatic experience. There are larger societal responses to people's experiences of trauma that are also very important to consider. **Transparency: Brief History of Trauma Theory** *If you have the technical background*, present a brief history of trauma theory, which looks at trauma in the context of the larger society, i.e., societal responses to trauma. (Refer of Chapter One of Herman, J., *Trauma and Recovery*, New York, Basic Books, 1992, for a useful overview of Western evolution of trauma theory.) Emphasize that just as individuals in society may minimize or ignore the impact of violence, societies also ignore and minimize violence. Ask participants for examples of how their societies have minimized or denied the existence of GBV.
11:30 – 12:10	**Symptom Management and Coping Skills** We are now going to begin to look at how you as service providers can best help survivors manage trauma symptoms and support their coping skills.	<u>Creativity Exercise:</u> Review handout on **Recovery from Immediate Trauma** with participants. Then divide participants into 4 groups of 5 or 6, and give each group an additional handout **Traumatic Event: Helpful Hints for the Survivor**. Thinking about their own cultures, ask each group to make a creative presentation (no more than 5 minutes) on how people cope with traumatic experiences. Participants could role play techniques, write a song/poem about the techniques, etc. The handouts should help

		prompt ideas, but urge them to consider the coping mechanisms that are commonly used in their own cultures. Have each group write those coping mechanisms directly on their handouts. **Handouts: 1) Recovery From Immediate Trauma; 2) Traumatic Event: Helpful Hints for the Survivor.**
	Report Back	Trainers should work closely with participants on this exercise.
12:10 – 12:30 12:30-1:30	Lunch	<u>Report Back:</u> Ask each group to make their presentation to the larger group.

II.2 INTRODUCTION TO ENGAGEMENT SKILLS TECHNIQUES

Estimated time: 3 hours, 15 minutes

Objectives

<u>At the end of the session participants should be able to:</u>

- List basic principles and qualities of an effective service provider
- Define and illustrate active listening skills
- Identify barriers to good listening
- Understand the difference between assessment, assumption, and diagnosis
- Understand the importance of understanding one's own values and beliefs when working with survivors

TIME	CONTENT	TRAINER'S NOTES
1:30-2:15	**What Makes an Effective Service Provider?** Memory Game	<u>Memory Game:</u> Ask participants to form a large circle. Ask everyone to recall the 5 qualities of an effective service provider they were to have written down the night before. Person # 1 starts by saying: "One quality of an effective service provider is….;

		Person # 2 then says: "Two qualities of an effective service provider are (quality given by #1) and (their own); Person # 3 then says: "Three qualities of an effective service provider are (quality given by # 1), (quality given by # 2) and (their own). This is repeated until someone forgets the order, and then the game begins again with the person who forgot, until everyone in the room has had the opportunity to mention one of the qualities they listed. No repeat qualities are allowed. Participants are permitted to look at their own list of 5 qualities when it is their turn to speak.
	Qualities of an Effective Service provider: 1) Service provider presentation: appropriate dress/appearance, professionalism, comfortable setting, etc. 2) Interpersonal style: emotional consistency, compassion, warmth, respect, empathy, sincerity, concreteness, listening abilities, sensitivity to cultural factors and social conditions and personal identities, etc. 3) Work ethic: dependability, punctuality, knowledge, confidentiality, etc.	After the Memory Game, facilitate a more in-depth discussion on what makes an effective service provider. Using the transparency, highlight the principles that are the foundation for providing assistance. Also add additional qualities listed to the left. **Transparency: Basic Principles of Providing Help to Survivors**
2:15-3:00	**Active Listening Skills** Visualization exercise: Think of a time when you really felt listened to. What was going on for you at the time that made you decide to talk to someone? It may have been a problem, difficulty, concern, or something you wanted to share with someone else. How did you feel about talking to this person? What were your fears, anxieties and thoughts about how it might be received? Think of the person you spoke to. What qualities did this person have that made you decide that it would be	**Activity Sheet: Visualization Exercise for Active Listening** Ask participants to visualize a time when they really felt listened to, utilizing the questions to the left.

	safe to talk to them? What were some of the things that they said to you? How did you know that the person really listened? What was it about them that made you feel comfortable? How would you describe the experience of having really been listened to?	Following the exercise, ask 2 or 3 participants to share their experiences. Remind participants that they should only share what they feel comfortable sharing, and that no one is required to reveal personal information they don't wish to reveal.
	These are examples of active listening, and these are the kinds of feelings that you want to elicit from the survivors when they come in for a group facilitation session. You want them to feel safe, comfortable, supported and open to sharing their thoughts and feelings.	Begin a discussion with participants about what active listening entails. **Handout: Introduction to Active Listening** Briefly highlight major points of the handout.
	Active listening involves listening with understanding and with total attention. It means paying attention to all the different ways in which a survivor expresses him/herself, including non-verbal behavior (posture, speed of speech, silences), the person's voice (tone and quality), the person's words, and the meaning behind the words and what is not said.	Discuss non-verbal communication and its importance in facilitating engagement. **Handout: Attending: Using the SOLER Model** Review the meaning of attending, as well as the three ways of attending. If helpful, use a flipchart to review the acronym SOLER (**S**quare, **O**pen, **L**ean, **E**ye, **R**elax). Ask a participant to give an example of attending using SOLER.
	In order to be able to listen with total attention, you need to be relaxed when talking with a survivor. This means that you lay aside your own concerns and pre-occupations while you are with your survivor, and create a space for the survivor to reveal what is troubling them. Try to relax physically; allow your manner to be natural; follow what the other person is saying and do not be afraid to ask clarifying questions; and let your verbal and non-verbal responses indicate to the other person that you are following what they are saying.	
	In working with survivors in crisis: be supportive; validate the survivor (believe him or her!); work with the survivor to help her become aware of her responses to her experience, especially in terms of her coping skills; take time to find out	Discuss the differences between advising and informing. Review with participants whether advising is a tradition in their cultures and ask

	what the survivor wants; and help survivor identify options rather than give advice. **Break** **Barriers to Good Listening**	them to consider why advising may not be helpful in promoting survivors' own coping skills. **Handout: Advising vs. Informing**
3:00-3:15 3:15-3:45	*Acoustics* ▪ Background noise ▪ Interruptions *Physical Environment* ▪ Inadequate seating ▪ Uncomfortable seating ▪ Lack of privacy in the engagement space *Body Language* ▪ Looking away from survivor ▪ Eyes darting around room ▪ Crossed arms ▪ Clenched hands ▪ Head bowed in hands ▪ Slouched posture ▪ Hands on hips *Delivery/Tone* ▪ Slow ▪ Monotone ▪ Emotional *Language* ▪ Unfamiliar or strange ▪ Too wordy ▪ Use of technical/medical terms ▪ Rambling speech *Appearance* ▪ Sloppy dress ▪ Unusual clothing *Other Barriers* ▪ Tired ▪ Preoccupied ▪ Uninterested ▪ Having a bias against the survivor ▪ Having bias against the topic being discussed	Facilitate a discussion with participants around barriers to good listening, utilizing the list on the left. **Transparency: Barriers to Good Listening.**

	▪ Making assumptions about the survivor ▪ Inappropriate touch **Introduction to Basic Assessment** Earlier we mentioned that making assumptions about a survivor can be a barrier to good listening. Making assumptions can also get in the way of your ability to make an accurate and unbiased assessment of the survivor. *Definition of Assumption* Assumption depends more on your individual perspectives and opinions; is based on limited information; does not encourage the process of inquiry; and leads to subsequent action based on opinion. *Definition of Assessment* The act of gathering information or data at a given moment of time and evaluating it for the purpose of making an appropriate decision about what course of action to take. Assessment uses the process of inquiry; is action based on evaluation of data; and depends less on your own opinion. Assessment prevents assumptions; creates grounds for developing an appropriate plan of action; and helps identify survivor strengths. *Definition of Diagnosis* Assessment is different from diagnosis. *Diagnosis* should be used only by a professional in the mental health field; focuses on psycho-pathology and psychological symptoms; is a conclusion about a person based on a series of observed symptoms or data; and should be made ONLY by trained professionals. **Self Assessment Exercise**	
3:45-4:15		Facilitate a brief discussion on assumption versus assessment, using information at left, then put up transparency. **Transparency: Assumption, Assessment, and Diagnosis.** **Activity Sheet: Which Is It: Assessment or Assumption?** After clarifying the difference between assumption and assessment, distribute activity sheet. Have participants write answers of questions on the handouts and then generate group discussion on correct answers.
4:15-4:35	**Ask participants to ask themselves:** • Why have I chosen to become a service provider?	**Activity Sheet: Self-Assessment (1)**

	• Why do I want to help others? • What do I get out of helping others? • How might my personal needs and interests interfere with my ability to help others? • What strengths do I have that will be useful in helping others?	Write the questions to the left on a piece of newsprint and post at the front of the room, and also hand out activity sheets with the questions. Ask participants to pair off, with each person in the pair taking 5 minutes to share with their partner their responses to the questions. Assure participants that whatever they choose to tell their partner will not be shared with the larger group. After ten minutes, ask for comments and reaction.
4:35-4:45	**Explore Your Values** From the list of attributes and values on the handout ask participants to number them in order from 1 to 11, with number 1 as the most important and number 11 as the least important. It is quite normal for people's values to differ. Each person is unique and each has a special way of experiencing the world.	**Activity Sheet: Self Assessment (2)** Ask participants to quickly complete the activity sheet, writing down their first reaction. There is no correct order; each person has his or her own priorities. Briefly compare lists. Invite participants to have friends, families, and colleagues complete the activity sheet as well, to highlight the fact that each individual has their own unique value system. Remind participants that knowing their own values and reasons for engaging in work with survivors is critical to being able to provide assistance to those whose values might be different. It is also important to understand our values and motivations so that we will not directly or indirectly attempt to influence the survivor, but will rather work from a position of supportive neutrality to assist them in identifying their own needs and making their own decisions.
4:45-5:00	**Review of Day's Activities and Facilitation Techniques; Daily Evaluation**	Remind participants about yesterday's discussion of different learning methods and facilitation strategies. Now ask participants to reflect on the techniques used by the facilitators to promote group discussion and participation and which techniques were most useful (e.g., encouragement, positive feedback, non-judgmental response). **Handout: Daily Evaluation Form.** Ask two volunteers to review the evaluations and prepare feedback for the following morning.

DAY III

EFFECTIVE ENGAGEMENT STRATEGIES, CONTINUED

MATERIALS NEEDED:

- Overhead projector and screen
- Paper and pen for each participant
- Newsprint and markers
- Hat or bag
- Tape recorder and music
- Question box and index cards

TRANSPARENCIES:

- What is Your Role? What is Your Goal?
- Interaction Techniques (1)
- Interaction Techniques (2)
- GATHER Model

HANDOUTS:

- Interaction Techniques (1)
- Interaction Techniques (2)
- Stem Statements
- Helper Skills Evaluation Checklist
- Rape Trauma: Common Responses
- Safety Planning Assessment
- Power and Control
- Cycle of Violence
- Some Considerations in Assessing Child Sexual Abuse
- Changing Needs of Growing Children
- Crisis and the Continuum of Age: The Elderly's Reaction to Trauma
- Protocol for Action: Suicidal Clients
- Protocol for Action: Mentally Ill Clients
- Protocol for Action: Angry Clients
- Protocol for Action: Drug Abusing Clients
- Taking Precautions: Agency Visits
- Daily Evaluation Form

ACTIVITY SHEETS:

- Guidelines for Giving Role Play Feedback
- Role Play for Protocols for Action

III.1 ROLES OF SERVICE PROVIDERS AND APPLYING THE GATHER MODEL

Estimated time: 4 hours

Objectives

At the end of the session participants should be able to:

- Identify varying roles of service providers according to the goals of active screening, crisis debriefing, case management, and counseling
- Identify specific techniques to facilitate interactions with survivors
- Understand and apply the GATHER model to work with survivors
- Identify and explain the special concerns and issues of vulnerable populations, such as sexual assault victims, domestic violence victims; children and adolescent victims; family members and friends of victims; elderly victims; and survivors from cultures that are different than the service provider's

TIME	CONTENT	TRAINER'S NOTES
8:30 – 8:45	**Welcome; Feedback on Evaluation; Questions; Housekeeping**	Welcome. Ask volunteers from previous day to provide feedback on daily evaluation. Ask for questions/concerns regarding Day II topics. Identify timekeeper. Remind participants that we will be ending the day at 3:30 for relaxation and sightseeing.
8:45-9:00	**Review Day III topics** Session 1: What is your role? What is your goal? ❑ Active Screening, Crisis Debriefing, Case Management, and Counseling ❑ GATHER Model Session 2: Important Issues in Working with Challenging Survivors ❑ Special Populations ❑ Protocols for Action with Survivors with Challenging Concerns ❑ Safety Precautions for the Service Provider	
9:00-9:30	**What is Your Role? What is Your Goal?**	**Transparency: What is Your Role? What is Your Goal?**

	Active Screening: Used by health care providers to assess and treat clients for histories of GBV. Crisis Debriefing: Used by trauma specialists to reduce the immediate impact of a traumatic experience on the survivor. Case Management: Used by social service providers to meet the practical needs of survivors through assessment, education, referral, and follow-up. Counseling: Used by psychologists and other social service providers to try and address the short- and long-term emotional and psychological needs of the survivor in order to assist the client to improve their quality of life.	Use the transparency to discuss different goals of engagement according to the intervention methods identified at left. Ask participants to identify the types of work they do with survivors. Write responses on newsprint in one column. In the next column, ask them to identify the skills they need for engaging with the survivor according to the goals of their work. Remind participants that it is not unusual to feel that a service provider must "be all things at all times" to a survivor. This perspective can lead to the service provider feeling overwhelmed and suffering "burn-out." It is therefore important for the service provider to understand their role and understand the objectives and boundaries of their work.
9:30-10:00	**GATHER Model** *Greet:* establish rapport; clarify goals of meeting; explain confidentiality *Ask:* ask client for a brief explanation of how you may assist her, i.e., why she is seeking assistance. Ask specific questions about exposure to violence. *Tell:* If survivor acknowledges experiences of violence, offer validation and support. Reassure her that you will try to assist her. *Help:* Once basic rapport has been established and you have identified the basic concerns of the survivor, it is important to conduct a more thorough assessment so that you better understand her experience of GBV and identify her related needs. *Educate:* Reflect back to survivor what you have understood are her needs and what you have heard as possible stress reactions. Provide information to survivor that will help normalize her	**Transparency: GATHER Model** Highlight that this model was adapted for this workshop from a reproductive health model for HIV counseling. The adapted model provides a conceptual framework for some of the important goals of working with survivors. The model can be adjusted according to the specific objectives of the service provider. Important aspects of this model to emphasize are: Structure: using a semi-structured interview is a useful strategy for assessment because it is an organized way to collect information, and also helps to decrease the possibility of the survivor becoming emotionally overwhelmed by keeping the focus of the interview goal-oriented. Validation and Education: At every opportunity, the service provider should offer validation to the survivor. The service provider should share knowledge and resources, rather than opinions, when providing the survivor with information. Referral: The service provider should always

	reactions. *Refer, Return, Review:* Be prepared with list of referrals that may assist survivor. Schedule follow-up if possible. Review plan with survivor.	seek to link the survivor to other services. Creating a good referral network prevents the service provider from feeling like he/she must meet all the survivor's needs, and helps the survivor to integrate or reintegrate into his/her community.
10:00-10:15	**Interaction Techniques** Interaction techniques are ways to communicate to a survivor that you are actively listening and to encourage survivors to share information about their experience so that you may make a more informed assessment.	**Transparencies and Handouts: Interaction Techniques (1&2)** Put up the first transparency and review techniques that promote positive communication. Ask for any additional suggestions. Then put up second transparency and review techniques that might inhibit communication with the survivor. Ask participants to identify why these techniques are less desirable and what types of reactions they might elicit in the survivor.
10:15-10:30	**Break**	
10:30-10:50	**Role Play**	**Handout: 1) Stem Statements; 2) Helper Skills Evaluation Checklist** Ask two participants to come to the front of the room. Drawing from their own experience, quickly design a scenario in which one participant is the survivor and one participant is the service provider. Ask them to role play for 15 minutes in front of the entire group, using techniques outlined in the GATHER model. Ask observers to refer to their Helper Skills Evaluation Checklist when reflecting on the quality of interaction between service provider and survivor.
10:50-11:30	**Role Play Feedback**	**Activity Sheet: Guidelines for Giving Role Play Feedback** Distribute activity sheet to group and clarify guidelines for giving feedback. Ask group for their reactions/comments on the role play. Discuss. If time permits, conduct an additional role play, using two more volunteers from the group. Be sure to emphasize that being a good

		service provider requires practice!
11:30-11:50	**Special Populations** Brainstorming Exercise *Special Populations* 1) Sexual assault victims 2) Domestic violence victims 3) Children and adolescent victims 4) Family members and friends of victims 5) Elderly victims 6) Survivors who are culturally different from service providers	<u>Brainstorming Exercise:</u> Ask participants to divide into 6 groups of 4 or 5 people, and assign each group a population listed to the left. Ask participants to discuss and record what they think the special needs and engagement issues in working with these populations may be and how a service provider might respond differently to those needs. Let the groups know that one person will be expected to give an overview of the group's discussion in a short (5 minute) report back, so a scribe should be assigned. **Handouts: 1) Safety Planning Assessment; 2) Rape Trauma: Common Response; 3) Power and Control; 4) Cycle of Violence; 5) Some Considerations in Assessing Child Sexual Abuse; 6) Changing Needs of Growing Children; 7) Crisis and the Continuum of Age: the Elderly's Reaction to Trauma**
11:50-12:30	**Report back** *Special Populations: Important Engagement Issues* 1) Sexual assault victims ▪ Confidentiality ▪ Physical safety ▪ Physical boundaries (extreme sensitivity on part of service provider to impact of touch) ▪ Police reporting ▪ Medical needs ▪ Relational and/or sexual issues ▪ Stigmatization ▪ Symptom management including dealing with flashbacks 2) Domestic violence victims ▪ Confidentiality ▪ Safety planning	<u>Report Back:</u> Ask participants to come back together. Each group will be given 5 minutes to present on their group's discussion. Supplement participant answers with the special concerns and facilitation issues found to the left after each group has finished presenting. Use the Power and Control Handout and the Cycle of Violence to supplement participants' responses. Emphasize that "violence" can be

	▪ Safety of children ▪ Legal issues ▪ Police reporting ▪ Power and Control and Cycle of Violence ▪ Future goals (remain in violent situation?) ▪ Isolation ▪ Symptom management 3) Children and adolescent victims ▪ Assessment of potential abuse or exposure to violence ▪ Dealing with parents ▪ Confidentiality and the law ▪ Typical child behaviors ▪ Behavior management according to stages of growth 4) Family members and friends of victims ▪ Dealing with and/or anticipating trauma responses ▪ Relational issues, including supportive listening 5) Elderly victims ▪ Stigmatization and ageism ▪ Isolation ▪ Physical vulnerability ▪ Live in past and different worlds ▪ Seasons of losses ▪ Regression ▪ Sense of the new and need for the old ▪ Change 6) Culturally different ▪ Communication (use of translator, etc.) ▪ Identification and acceptance of difference ▪ Trust ▪ Assessment of the accessibility of services	emotional, physical, psychological, and that it is based on abusive use of power and control. Also emphasize that Western theories of domestic violence suggest that it typically happens in a cycle, getting worse over time, and that this may be important for helpers to understand in order to predict danger and help-seeking behavior of survivors of domestic violence. It may be helpful to briefly discuss with participants whether the cycle of violence theory applies to their cultural context.
	In addition to the special populations we have just mentioned, it is likely that you will come into contact with difficult	Inform participants that after lunch we will focus on survivors/situations that pose special challenges to the service provider, such as

	survivors who will require additional attention and care. These include the suicidal/homicidal survivor, escalating survivor, drug or alcohol abusing survivor and mentally disturbed survivors. You may also come into contact with perpetrators who are angry or aggressive. Lunch	those identified at left.
12:30 – 1:30		

III.2 WORKING WITH SURVIVORS WITH CHALLENGING CONCERNS

Estimated time: 2 hours

Objectives

At the end of the session participants should be able to:

- Demonstrate various protocols of action for handling each of survivors with special challenges
- Suggest safety precautions and techniques for the service provider

TIME	CONTENT	TRAINER'S NOTES
1:30 – 1:50	**Protocols for Action: Dealing with Survivors with Challenging Concerns** 1) Suicidal/homicidal survivor 2) Angry/aggressive survivor 3) Drug or alcohol abusing survivor 4) Mentally disturbed survivors	Facilitate a brief discussion with participants on the 4 types of challenges that are outlined to the left, utilizing the handouts to be provided to participants. **Handouts: 1) Protocol for Action: Suicidal/Homicidal Clients; 2) Protocol for Action: Angry Clients; 3) Protocol for Action: Drug/Alcohol Abusing Clients; 4) Protocol for Action: Mentally Ill Clients**
1:50-2:00	**Safety Precautions** There are steps that service providers can take when dealing with difficult survivors situations, which focus more explicitly on safety precautions. These safety precautions are especially important when working with angry/aggressive survivors, or in a situation where a perpetrator may pose a threat to a service provider.	**Handout: Taking Precautions: Agency Visits** Facilitate a brief discussion on safety precautions that service providers can take when dealing with challenging scenarios.

	What are some the precautions you would suggest given your own experiences?	Add the following suggestions, if they are not mentioned by participants: ▪ Multiple people can handle difficulty better and more effectively than one person. ▪ A service provider should never feel like he/she must work *alone* with a survivor. ▪ A service provider should not work with both the perpetrator and the survivor (neither separately nor in the same interview). ▪ Leaving office door(s) open, leaving the office or home if feeling unsafe and establishing a code (e.g., code word) with co-workers to identify unsafe situations are also useful. ▪ Establish a relationship with local police or security. ▪ Use buddy system at work, and to and from work. ▪ Use case review and supervision to address security concerns: a group of people can address security more effectively than an individual!
2:00 – 2:20	**Role Play** 1) Suicidal/homicidal survivor 2) Angry/aggressive survivor 3) Drug or alcohol abusing survivor 4) Mentally disturbed survivors	Once it appears that participants are beginning to understand how to deal with potentially difficult survivors and related security precautions, have them move into a role play. <u>Role Play:</u> Divide participants into 4 groups. Ask the groups to randomly choose one of the 4 difficult issues from a hat (or some other container) listed to the left. **Activity Sheet: Role Play for Protocols for Action** Distribute an activity sheet to each group. Each group should create a 10-minute role play based on a service provider/survivor interview. Suggest that group members may wish to take on the roles of survivor, service provider, supervisor, receptionist, family member, etc. Each role play should incorporate the following protocols for action (systematic steps a

		survivor can take when dealing with a difficult survivor): 1) Review of indicators (clues) for suicidality/homicidality; agitation/escalation; drug/alcohol abuse; or mental disturbance 2) Assessment of survivor for suicidality/homicidality agitation/escalation; drug/alcohol abuse; or mental disturbance 3) Response of service provider (or others) if survivor acknowledges immediate plan to hurt him/herself or someone else; becomes agitated or upset; exhibits use of drugs or alcohol; or exhibits psychotic, delusional, or paranoid behavior 4) Consider worker safety
2:20-3:00	**Presentation of Role Plays**	Participants should present their role plays to the larger group. Discussion should follow the guidelines for role play feedback. Facilitators should clarify issues and suggest additional techniques during the discussion.
3:00 – 3:15	**Impact of Work on the Service Provider**	Ask participants to consider what feelings are evoked when dealing with a difficult survivor, as well as to think about what feelings are evoked when one hears a difficult trauma story from a survivor. Give participants a minute or two to think about this, and then ask them to write down on a slip of paper one feeling they might experience (or have experienced) when hearing a survivor's trauma story. Facilitators should then go around and collect these slips of paper.
3:15 – 3:30	**Review Facilitation of Role Plays and the Day's Activities**	<u>Review and Homework:</u> Review the day's activities and ask participants for any thoughts about facilitation methods, this time asking them to think about skills facilitators need during role playing and role play feedback. Tell participants that there will be no homework tonight, but that instead we will do a quick self-care exercise before they leave, as

		one way to take care of themselves. Relaxation/Stretching Exercise: Have all participants stand up and form a circle. Then ask them to mock or follow you as you go through some basic relaxation and stretching techniques. For example, if you move your shoulders, the participants must do the same; or if you bend over to stretch your lower back, they must do the same, etc. Give as many participants as possible a turn to be the leader and others must follow. Sounds may be used also, like sighing deeply or breathing in and then letting a noise out. **HANDOUT: Daily Evaluation Form.** Ask two volunteers to review the evaluation forms and prepare to report back the following morning.

DAY IV

SUPPORTING THE SERVICE PROVIDER

MATERIALS NEEDED:

- Overhead projector and screen
- Paper and pen for each participant
- Piece of newsprint with a list of feelings identified by participants in Day III
- Newsprint and markers
- Candy for awards ceremony
- Tape recorder and music
- Question box and index cards

TRANSPARENCIES:

- Defining and Managing Vicarious Trauma
- Ten Beliefs that Prevent Service Providers from Getting Help
- Empathy vs. Sympathy
- How Can Our Organizations and Work Environments Help Us?

HANDOUTS:

- Self-Care and Managing Stress
- Responses As Guides for Action: Working with Victims of Domestic Violence
- Daily Evaluation Form

ACTIVITY SHEETS:

- Case Vignettes: Ellen and Sara
- Self Care Plan
- My Great Worth

IV.1 INTRODUCTION TO VICARIOUS TRAUMA

Estimated time: 4 hours

Objectives

At the end of the session participants should be able to:

- Define and list causes of vicarious trauma
- Identify and explain strategies for preventing and managing vicarious trauma
- Describe a personal trauma they have experienced and apply this to the service provider/survivor situation
- Define and differentiate between sympathy and empathy

TIME	CONTENT	TRAINER'S NOTES
		Before the start of the day, facilitators should write the words that were handed in the day before onto a piece of newsprint and post on wall.
8:30-8:45	**Welcome; Feedback on Evaluations; Questions; Housekeeping**	Welcome. Ask volunteers from previous day to provide feedback on daily evaluations. Ask for questions/concerns regarding Day III topics. Identify timekeeper.
8:45 – 9:00	**Topics for Day IV** Session 1: Introduction to Vicarious Trauma ▪ Defining and Managing Vicarious Trauma Session 2: Self-Care for the Service Provider ▪ Introduction to Self-Care Session 3: Supervision ❑ Roles of the Supervisor ❑ Responsibilities of the Supervisee	Outline for participants the topics for Day IV.

9:00-9:10	**Defining and Managing Vicarious Trauma** Case Vignettes	**Activity Sheet: Case Vignettes: Ellen and Sara** Ask two participants to read aloud the case vignettes. Then ask other participants what the two narratives have in common. Participants will throw out ideas and will commonly identify the characters as being victims of violence rather than as service providers suffering from vicarious trauma. The vignettes introduce the concept of vicarious trauma which allows us to move into a review of the feelings written down the previous afternoon by participants.
9:10-9:20	**Review of Feelings** Many of the feelings that may be evoked when a service provider listens to a survivor's trauma story are normal. The impact of these feelings and reactions over time, if not dealt with, may lead to something known as vicarious or secondary trauma.	<u>Review of Feelings:</u> Examine words written on the newsprint posted on the wall, and review some of the feelings that may be evoked when hearing a survivor's difficult trauma story.
9:20-9:45	**Defining Vicarious Trauma** 1) A significant change in a service provider's inner experience as a result of emotional engagement with survivors of trauma and hearing their stories. 2) Significant changes that occur in the service provider's physical, emotional, and/or behavioral states as a result of constant exposure to traumatic stories or events. *Causes of Vicarious Trauma* 1) Constant exposure to stories of trauma; 2) Desire to help/change survivor's situation; 3) Feeling powerless when a service provider does not see positive	**Transparency: Defining and Managing Vicarious Trauma** Facilitate a discussion on vicarious trauma. Facilitate a discussion on the causes of vicarious trauma.

	changes in a survivor's situations; 4) Overly identifying with survivors; 5) Thinking that the service provider has the power to change a survivor's situation. *Managing the Risk of Vicarious Trauma* Some ways in which service providers have found it helpful to prevent and manage vicarious trauma include: 1) Awareness – being attuned to one's needs, limits, emotions, and resources; practice self-acceptance 2) Balance – maintaining balance among activities, especially work, play, and rest 3) Connection – maintaining supportive relationships; communication is part of connection and breaks the silence of unacknowledged pain; these connections help prevent isolation and increase validation and hope. Other ways to manage the risk of vicarious trauma are: 1) Being able to discuss the feelings with colleagues, either formally in individual and group supervision, or informally. 2) Being aware of one's own trauma histories and the feelings and emotions these evoke – sometimes service providers are reminded of traumatic experiences in their own life. 3) Trusting that you are smart, strong and able to do your job, and believing that you have the necessary resources and skills you need to be an effective service provider.	Facilitate a discussion on how to manage and/or avoid vicarious trauma. First, introduce the transparency and highlight the fact that service providers may be at even greater risk of vicarious trauma because of beliefs that prevent them from acknowledging the need for help and accessing help. Then brainstorm about ways to address vicarious trauma. **Transparency: Ten Beliefs that Prevent Service Providers from Getting Help**
9:45 – 10:15	**Drawing Exercise**	<u>Drawing Exercise:</u> Give participants 10 minutes to draw a picture that represents a trauma they have experienced. It can be an abstract or literal depiction, whatever participants prefer. Tell participants that they are free to pick whatever experience

		they want, and if they have memories they do not wish to think about or be reminded of right now, they should not pick any of those experiences. Then ask participants to turn to a neighbor and describe their experience and their picture. Remind participants that they should only provide as much information about their picture as they feel comfortable, and that whatever they choose to share will not be shared in the large group. Each person should take about 10 minutes to share their own story. Trainers should gauge the amount of dialogue going on, however, and extend the time, if necessary.
10:15 – 10:30	**Break**	
10:30 – 11:00	**Report Back** 1) What did it feel like when you were the *storyteller* (i.e., what it felt like to reveal the trauma)? 2) What did it feel like when you were the *listener* (i.e., what it felt like to hear the story). It is not uncommon for the listener to feel as overwhelmed, or more overwhelmed, than the storyteller. Being able to predict this response helps a service provider deal with feelings that come up when working with survivors.	<u>Report Back:</u> Bring the participants back together to facilitate a discussion using the questions on the left. Using the newsprint, draw a parallel between what the storyteller and listener feel. Write responses to the first question on one side of the newsprint. Write responses to the second question on the other side of the newsprint. **Handout: Responses as Guides for Action: Working with Victims of Domestic Violence** Briefly review handout as example of how there are often parallels, or similarities, between what a survivor feels and what a service provider feels.
11:00-11:15	**Empathy vs. Sympathy** It is also helpful for the service provider to be able to differentiate between *sympathy* and *empathy*. *Sympathy* is personal, emotional	Discuss differences between sympathy and empathy. Put up transparency to clarify and define. **Transparency: Empathy vs. Sympathy**

	identification with a survivor's experience and implies that the service provider feels sorry for the survivor. It is an emotional state that leaves the service provider vulnerable to over-involvement and can take power away from the survivor. *Empathy* implies intellectual/personal understanding and realistic/professional distance. It involves compassion and objectivity and leaves room for empowerment of the survivor.	
11:15-11:35	**Role Play**	<u>Role Play:</u> Divide the participants into four groups – two groups will represent the idea of sympathy and two groups will represent the idea of empathy. Ask each group then to create a short (10-minute) service provider/survivor role play that exhibits either sympathy or empathy in action, using the GATHER model as an outline for the interaction.
11:35-12:30	**Role Play Feedback**	Present role plays to the larger group. Participants should be encouraged to comment on the role plays and provide feedback, both on issues of empathy/sympathy as well as on the application of the GATHER model.
12:30 – 1:30	**Lunch**	

IV.2 SELF-CARE FOR THE SERVICE PROVIDER

Estimated time: 1 hour, 30 minutes

Objectives

<u>At the end of the session participants should be able to:</u>

- Identify and explain ways in which service providers can take care of themselves
- Identify their strengths and abilities as service providers

TIME	CONTENT	TRAINER'S NOTES
1:30 – 2:00	**Introduction to Self-Care**	<u>Brainstorming Exercise:</u> As a large group, ask participants to brainstorm

		the different ways in which they can take care of themselves as service providers. If they have a hard time starting the discussion, mention that they might consider things like setting boundaries, creating self-care plans, and seeking support in the workplace and from outside agencies.
	The following are ways in which a service provider can take care of him/herself: 1) *Creating Boundaries in the Workplace* This entails creating physical and emotional boundaries between survivor and service provider, such as: ▪ Limiting sessions to 50 minutes ▪ Not seeing survivors more than one time per week during stable phase ▪ Not working on weekends ▪ Not giving survivors money, etc. ▪ Balancing work and play	As participants are providing feedback, be sure to mention any points to the left that are missing from discussion. After completing discussion, distribute handout. **Handout: Self-care and Managing Stress**
	2) *Establishing Support within the Work Environment* There are several ways to establish support within your work environment. These may include: ▪ Discussing how your organization or agency can best support the self-care activities of staff ▪ Creating mentoring programs ▪ Creating self-care groups within your workplace ▪ Doing staff meeting "check-ins" • Conducting group and team-building exercises	Inform participants that there will be further discussion of how the work environment should support service providers after the afternoon break.
	3) *Seeking Assistance from Outside Agencies* It is important for service providers to be able to rely on other agencies within their communities, so as not to feel solely responsible for managing a survivor. Knowing agencies that exist to help victims and having a good referral	Remind participants of the multisectoral model: service providers should not work in isolation!

	network already in place are important parts of being a service provider. This also increases a survivor's choices for where to seek assistance and decreases their dependency on you. *4) Creating a Personal Self-care Plan* A personal self-care plan might include: ▪ Keeping a journal ▪ Practicing relaxation, meditation, or deep breathing ▪ Seeking assistance ▪ Exercising and eating healthily ▪ Taking a vacation	
2:00 – 2:10	**Homework: Self-Care Plan**	**Activity Sheet: Self-Care Plan** Distribute activity sheet and ask participants to use the activity sheet to create their own personal Self-Care Plan as a support tool for managing the stresses of their work. The 4 areas on which they should concentrate are: 1) physical well-being; 2) emotional well-being; 3) intellectual well-being; and 4) spiritual well-being. In creating a Self-Care Plan, participants should include personally meaningful activities that support them in their work. They should be sure to incorporate both on-the-job activities and activities outside of work. Participants do not need to share their plan with others, but should sign and date the plan, and store it either at their office or at home. Participants should be encouraged to occasionally review their self-care plan as a way of monitoring whether they are taking care of their own needs.
2:10 – 3:00	**Awards Ceremony** An important aspect of self-care is feeling confident and capable as a service provider, and recognizing and valuing one's unique skills.	<u>Awards Ceremony:</u> Ask participants to imagine that they are attending an award ceremony in their own honor. They are being presented with an *Award for Excellency in Engagement Strategies with Survivors.* **Activity Sheet: My Great Worth** Ask participants to take 5 minutes to complete the Activity Sheet. After everyone is finished writing, ask participants to come up to the front of the room one by one to deliver their speeches (in no more that 3 minutes each) in

		front of the larger audience. Remind participants to be confident! Speak loudly! Have fun! Celebrate themselves!
3:00-3:15	**Break**	
3:15-3:30	**Awards Ceremony (continued)**	If not completed before break, ask remaining participants to complete their acceptance speeches for their award. If completed, take a longer break.

IV.3 SUPERVISION

Estimated time: 1 hour, 15 minutes

Objectives

At the end of the session participants should be able to:

- Identify different forms of supervision
- Explain the role of a supervisor
- Explain the responsibilities of the supervisee

TIME	CONTENT	TRAINER'S NOTES
3:30-3:45	**What is Supervision?** Supervision is a key strategy for ensuring that service providers are working optimally, and are using self-reflection and communication to manage the personal and professional challenges of their work. Supervision of service providers can be generally distinguished in terms of two major categories: *Administrative Supervision* Administrative supervision is the process of evaluating whether a service provider is managing their job according to specific standards (e.g., coming in on time) and performing tasks as expected (e.g., completing paperwork).	Group Brainstorm Generate a discussion among participants about what supervision is. Ask participants to identify the two major categories of supervision and their goals, using the information at left.

	Professional Supervision Professional supervision of service providers working with GBV clients has the following aims: ❑ Provide service providers with the opportunity to discuss their interactions/interviews with survivors to ensure quality of service to clients; ❑ Provide service providers an opportunity to share their experiences, reflect on their work, and solicit support; ❑ Ensure that service providers are maintaining professional distance and are not becoming emotionally overwhelmed.	
3:45-4:00	**Methods for Professional Supervision** *Individual Supervision:* The process by which a supervising professional reviews cases with the service provider, through verbal discussion, review of written and recorded transcripts of interviews, and review of interview notes. The supervising professional is tasked with the responsibility of helping the service provider utilize techniques that meet the needs of the survivor while also helping the service provider to maintain professional distance. This type of supervision should be available to the service provider on a weekly basis, for a minimum of one hour. ***Case Conferences:*** Case conferences are an opportunity for a service provider to present to colleagues in a structured format any specific challenges that the service provider is dealing with in working with a particular survivor. The goal of a case conference is to seek the professional insight and opinions of colleagues, especially those	Write the four major methods for supervision up on four pieces of newsprint, referring to the list at left. Ask the group to identify components of each of these forms of supervision, including the goals of that type of supervision, as well as the structure (i.e., frequency and length) of that type of supervision.

	colleagues with extensive experience or special expertise. Case conferences can be scheduled as needed, and are usually one to two hours each. *Peer Supervision:* Peer Supervision is more informal than case conferences, and provides service providers the opportunity to talk with one another about their work, and share experiences and challenges. Peer supervision is an opportunity for peers to exchange strategies for overcoming challenges. Peer supervision also helps to promote cohesion among service providers, and helps service providers follow each others' cases. Peer supervision is generally scheduled once every two weeks, for a minimum of one hour (depending on number of participants). *Peer Support Group:* Peer Support Groups are the most informal of all types of supervision. They are designed to provide a way for service providers to talk amongst themselves about their feelings regarding the work, and to offer each other mutual support. Peer support groups do not included supervisors (who should have their own peer support group). Peer support groups focus more on the emotional needs of the service provider than on case management. Because service providers with demanding work schedules often neglect this important aspect of soliciting and receiving informal support, it is important that supervisors encourage peer support groups by allotting regular time (each week, each month, etc.) for coworkers to gather informally during work hours.	
4:00-4:15	**Role play of Individual Supervision**	Identify two volunteers to conduct a short role play (10 minutes) on an individual professional supervision meeting. Ask the participant playing the service provider to present a

		challenging issue to the supervisor based on his/her own work.
4:15-4:35	**Role Play Feedback** Role of Supervisor: 1) Model positive interaction through support and validation 2) Assist the service provider to reflect on how their engagement with the survivor positively or negatively impacted the outcome of the interview 3) Transmit knowledge of engagement techniques, as well as knowledge about survivor issues and referral sources 4) Assist in developing a plan of action in future work with the survivor Responsibilities of Service Provider: 1) To be prepared to discuss one or more cases, either with written notes or transcripts of interview; 2) To be prepared to review case write-up; 3) To be prepared to reflect on process and share personal impressions; 4) To be prepared with suggestions for referrals and future work with survivor.	When providing feedback, ask the participants to consider what the roles and responsibilities of the service provider and the supervisor are, using the information at left. Inform participants that the supervisor's responsibility to transmit knowledge extends to: relationship building skills; interviewing and assessment skills; communication skills; problem-solving skills; planning, coordination, and advocacy skills. Remind participants that a key responsibility of the service provider during supervision is to communicate! The service provider must not try to do his/her work in isolation.
4:35-4:45	**Review Methods Organizations can use to Support Service Providers** • Supervision • Case Review • Peer Support/Self-care Groups • Paired Debriefings • Group and Team Building Exercises	**Transparency: How can our organizations and work environments support us?** Using the transparency, review methods discussed throughout the day about how service delivery organizations can support their service providers. One method in the list at left not previously identified is *Paired Debriefings*. Paired debriefings provide the opportunity for one staff member to listen to another staff member tell of their experience in working with a particularly difficult client. The "debriefing" allows a staff member to share the details of a challenging incident. The purpose of the

		debriefing is for the staff member to be able to share a difficult experience so as not to carry the burden of the experience in silence. There is no supervisory component, and typically a staff member would not be paired with a supervisor for a debriefing.
4:45-5:00	**Review of Facilitation Techniques and the Day's Activities**	<u>Review and Daily Evaluation:</u> Ask participants for any questions or comments they have about facilitation techniques and strategies that have or *have not* been used effectively in the training. Write these questions and comments on a flipchart, to use for discussion in tomorrow's review of facilitation techniques. **Handout: Daily Evaluation Form** After completing the Daily Evaluation Forms and designating two volunteers to review the evaluation forms, end the day with a relaxation exercise.
	Relaxation Exercise Find a comfortable position in your chair. Resting your body against the back of your chair, keep your shoulders upright and the soles of your feet flat on the floor. Allow your hands to fall at your sides in a comfortable position. Close your eyes. Keep your eyes closed for the entire exercise. My voice will be your guide. Hear only my voice. Breathe in…hold. Breathe out. Now breathe in…hold…breathe out. Breathe in all the air you can…hold...and breathe out. Tighten your facial muscles. Close your eyes tightly. Feel the muscles of your forehead and chin contract. Imagine your chin touching your forehead. Hold it…and release. Use the muscles of your neck and upper body to pull your shoulders together.	<u>Relaxation Exercise:</u> Play music and go through the exercise to the left with participants.

	Tightening your arms at your sides, make a ball with your fingers and hands and squeeze them together firmly. Imagine your shoulders touching each other. Hold it...and release and breathe out slowly. Now, contract your stomach muscles and lower back. Tighten your middle body as much as you can. Hold it...and release. Contract the muscles of your upper thighs. Imagine your two legs becoming one. Hold it...and release. Tighten your knees and calf muscles. Hold it...and release. Tighten your toes and feet as hard as you can and imagine that you have no ankles. Hold it…and release. Very good. Now that you are relaxed, keep your eyes closed and think of your favorite place. A place that you love to go. A place that brings you happiness and peace. Go to that place where you love to be and find yourself relaxing. Remember the feelings of joy and peace that you experience at this special place. Think of all the things that you love most about this place. Touch those things. See those things. Smell them and hear them. Feel this special place that you love to go. Slowly admire your special place. Feel the joy and peace it brings you. Breathe in the joy…and let it out. Breathe in the peace…and let it out. Now, gently, hug yourself and continue to breathe deeply…in and out… Slowly open your eyes. Exchange a smile with the person closest to you. And enjoy the rest of the day.	

DAY V

SERVICE PROVIDER RESPONSIBILITIES, AND COMMUNITY REFERRALS
FACILITATION SKILLS OVERVIEW,
TRAINING REVIEW, AND EVALUATION

MATERIALS NEEDED:

- Overhead projector and screen
- Newsprint and markers
- Newsprint from Day I on responsibilities of each sector within the multisectoral framework
- Index cards from Question box, reviewed by facilitators and grouped into topical categories

TRANSPARENCY:

- Incident Report Form/Consent to Release Information
- Exceptions for Breaking Confidentiality

HANDOUTS:

- Record Keeping Do's and Don't's
- Incident Report Form/Consent to Release Information
- Daily Evaluation Form
- Post-test
- Final Evaluation Form
- Training Certificate

ACTIVITY SHEETS:

- Sample Record Keeping Exercises
- Scenarios for Resistant Participants

V.1 RECORD KEEPING AND CONFIDENTIALITY

Estimated time: 2 hours, 15 minutes

Objectives

At the end of the session participants should be able to:

- Explain the importance of record keeping
- List important survivor details that should be noted in case write-ups
- List survivor details that should *not* be noted in case write-ups
- Explain the importance of confidentiality
- Give examples of when it is appropriate to break confidentiality
- Explain ways to address issues of confidentiality with survivor
- Identify elements of a standard reporting form

TIME	CONTENT	TRAINER'S NOTES
8:30-8:45	**Welcome; Feedback on Daily Evaluations; Questions; Housekeeping**	Welcome. Ask volunteers from previous day to provide feedback on daily evaluations. Ask for questions/concerns regarding Day IV topics. Identify timekeeper.
8:45-9:00	**Topics for Day V** Session 1: Record Keeping and Confidentiality ▪ The Fundamentals of Record Keeping ▪ Ensuring Confidentiality ▪ Incident Report Form/Consent to Release Information Session 2: Coordinated Community Response and Advocacy ▪ Coordinating a Community Response ▪ The Service Provider as Advocate Session 3: Facilitation Skills, Training Review, and Evaluation ▪ Facilitation Skills ▪ The Week in Review ▪ Wrap-up and Evaluation **The Fundamentals of Record Keeping**	Review topics for Day V.

9:00 – 9:30	What do you think is the importance of record keeping? ▪ Funding ▪ Liability ▪ Survivor tracking How might records be used on behalf of survivors (keeping in mind advocacy)? ▪ Funding ▪ Legal advocacy ▪ Prosecution of perpetrators How might records be used against survivors? ▪ Divorce ▪ Custody battles ▪ Defense of perpetrator What do you think are important survivor details to note in case write-ups? ▪ Survivor name ▪ Dates ▪ Time of service ▪ Location of service ▪ Source of information ▪ Survivor response ▪ Treatment plan or next steps It is important that all of this information be complete enough so that another caseworker will understand and be able to work with survivor at a later time. What kinds of things might be helpful to <u>keep out</u> of a survivor's records? ▪ Psychological history ▪ Psychological diagnosis ▪ Past criminal behavior that does not impact the case ▪ Past history or abuse/victimization that is not relevant to case ▪ Batterer/perpetrator information that survivor wants kept confidential ▪ Address of relocation or shelter ▪ Highly subjective words of the survivor ▪ Personal notes of service provider	<u>Large Group Discussions:</u> Begin the day with an informal discussion around the importance of record keeping and confidentiality using the notes outlined on the left. Remember that this discussion will be more subjective then concrete, because laws and the judicial system may vary among participants, and/or laws may be unstable in the survivor's community. **Handout: Record Keeping Do's and Don't's;**

9:30 – 10:00	**Record Keeping Exercise**	**Activity Sheet: Sample Record Keeping Exercises** Ask participants to take 10 minutes to review the sample record keeping exercises, rewriting the first record in the space provided, and making notes on the rest of the records. After participants have finished reviewing the exercises, ask several volunteers to read what they have written. Discuss, emphasizing the importance of not including superfluous information in file that could potentially incriminate the survivor.
10:00 – 10:15	**Break**	
10:15-10:30	**Incident Report Form**	**Transparency and Handout: Incident Report From/Consent to Release Information** Using the overhead projector, go through the incident report form. Highlight the importance of using standardized forms to collect information. Refer participants to the UNHCR *GBV Guidelines* (2003) and the RHRC *GBV Tools Manual* (both available at www.rhrc.org /resource/gbv) for more copies of the incident report form, as well as for monthly reporting forms and standardized definitions.
10:30 – 10:45	**Ensuring Confidentiality** One critical aspect of record keeping is the issue of confidentiality. Why is confidentiality so important? ▪ Safety ▪ Respect of survivor How do you ensure confidentiality of records? ▪ Locked file cabinet ▪ Do not take records home ▪ Do not leave records lying on desk When might confidentiality be broken?	Put up the Consent to Release Information on the overhead and review with participants. Then review basic issues related to confidentiality described at left.

	▪ Emergency or life-threatening situations, such as client expressing suicidality or homicidality ▪ When client has indicated that a child or children may be in danger ▪ When there is evidence that the client intends to commit a future crime ▪ When there is evidence of violence being committed by a humanitarian worker against the client What is survivor consent and when do you seek survivor consent to release records and/or verbally break confidentiality? How do you address issues of confidentiality with a survivor? ▪ Always discuss confidentiality with a survivor at the beginning of session ▪ Inform survivor of exceptions to confidentiality (listed above)	**Transparency: Exceptions for Breaking Confidentiality** Ask participants for other examples of when confidentiality might be broken. Highlight the importance of informing the survivor of the limitations to confidentiality at the beginning of any interview.

V.2 COORDINATED COMMUNITY RESPONSE AND ADVOCACY

Estimated time: 1 hour

Objectives

At the end of the session participants should be able to:

- Explain the significance of coordinating a community response when working with victims of trauma
- Identify potential referral sources in the community for vulnerable populations such as sexual assault victims; domestic violence victims; children and adolescent victims; family members and friends of victims; and elderly victims
- Explain the role of the service provider as an advocate for the survivor and within the community

TIME	CONTENT	TRAINER'S NOTES
10:45 – 11:05	**Coordinating a Community Response Using the Multisectoral Model**	Brainstorming Exercise: Post the newsprint from Day I on the various responsibilities of different sectors in serving providers. Briefly review with participants. Also remind participants of the discussion on Day I about the importance of coordination among sectors and the impact on the survivor (as evidenced in the string game) if coordination mechanisms are not in place. Break the participants up into five groups of five according to the following categories: 1) domestic violence victims; 2) sexual assault victims; 3) children and adolescent victims; 4) family/friends of victims; and 5) elderly victims. Referring to the posted newsprint for prompting, ask each group to think of *people and places* to whom a service provider might refer a client.
11:05-11:30	**Report Back**	Using a scribe and a large piece of newsprint, ask each group to take 15 minutes to list as many potential referral sources as possible within each sector. Report Back: Upon completion, bring the groups back together to post their newsprint and report results. Remind participants that one of their responsibilities as service providers is to try and familiarize themselves with referral sources in their own communities.
11:30 – 11:45	**The Service Provider as Advocate** Some of the ways in which you can act as an advocate in your role as service provider include: ▪ working for a multisectoral response to violence in the community (this is actually a precursor to becoming an effective advocate); ▪ working with and/or on behalf of survivors to secure their needs/rights. ▪ acting as an advocate also can be an important part of managing feelings of helplessness that emerge in working	Large Group Discussion: Briefly introduce participants to the basic concept of advocacy and the role of service provider as advocate.

	with victims. Are there other ways in which you as a service provider can advocate on behalf of your survivors, your colleagues, or others?	

V.3 FACILITATION SKILLS OVERVIEW, TRAINING REVIEW, AND EVALUATION

Estimated time: 4 hours, 30 minutes

Objectives

At the end of the session participants should be able to:

- Understand basic facilitation skills in using the Communication Skills Manual
- Clarify or further explain questions or concerns that may have come up during the week of training
- Complete a final evaluation of the workshop
- Receive recognition for completing the workshop

TIME	CONTENT	TRAINER'S NOTES
11:45 – 12:00	**Review of different types of learning and the special value of participatory methods** **Different types of learning skills and associated training activities:** • Listening (auditory learning): discussions, lectures • Watching (visual learning): transparencies, flipcharts, handouts • Doing (participatory learning): Role plays, brainstorming, small group activities, games	Remind participants of the discussion on the first day of different types of learning skills. Ask participants if they remember what they are. Then ask participants to remember what activities throughout the training were used for different types of learners. After identifying different types of activities used in the training, ask participants to identify what their favorite activity in the workshop was, and what their least favorite activity was. As this is likely to generate a variety of responses, remind participants of the importance of using different techniques to meet the varying needs and learning skills of the participants. Now ask all participants what activities in the training helped them learn most effectively, and ask one participant to write what they list on the flipchart. Review the types of learning that

		are related to the activities on the flipchart.
	The value of participatory methods: While is it important to have multiple types of learning activities in any training, a preferred method is using participatory techniques, because most people learn more effectively when their abilities and knowledge are valued and when they are able to share and think about their experiences in a safe environment.	Generally, participants will give examples of participatory learning activities, because it is these activities that give participants the opportunity to practice skills and apply the knowledge they have learned, as well as their own experience. Emphasize that having a participant do the writing on a flipchart, rather than the facilitator, is an example of a participatory technique. Explain that in order to have a good participatory workshop, you must have good facilitation. Refer to the flipchart from the closing discussion of the previous day to follow up on any questions or comments about strategies that the facilitators have or *have not* used effectively in the training.
12:00-12:30	**Qualities of a Good Facilitator** **Good facilitators:** • Are excellent listeners • Are well-organized and well-prepared • Understand the topic areas on which they are training	<u>Role play: Good facilitator/bad facilitator</u> Ask for two volunteers to participate in a role play exercise. In private tell the first volunteer that he/she will be playing a bad facilitator and should think about bad traits a facilitator might have (very little patience, cuts participants off, ignores questions, gets angry, talks quickly or quietly, acts bored, etc.). Ask the second volunteer to play a good facilitator and tell him/her to think about the traits of a good facilitator (speaks slowly and clearly, encourages participation, is knowledgeable, uses different methods of facilitation based on the different learning styles, etc.). After giving the facilitators their roles, explain to the larger group that they will have two different facilitators who will each spend five minutes training everyone to SEW A SHIRT. Encourage the group to ask each facilitator lots of questions. After completion of the role plays, facilitate a discussion of what traits or skills are important for good facilitators.

	• Give participants confidence in the facilitator and in themselves • Communicate ideas clearly and briefly • Encourage mutual respect and understanding • Understand and value the different skills and ideas of participants • Maintain group order • Help the group accomplish the learning objectives of the training • Build on participants' ideas and comments, making connections with previous statements and ideas discussed • Encourage group discussion and equal participation from all members • Are open to feedback • Make all group members feel valued and accepted • Do not discriminate and treat all participants equally and fairly	
	Lunch	
12:30-1:30 1:30-1:45	**Planning a Communication Skills Training**	Emphasize that training is a planned process. In preparation for a training and throughout the training process, the content of the training should match people's needs and expectation, and be appropriate to their lives and work.
	Five key questions should be considered when preparing for a training: • Why? Has the community or another group asked for the training? Is their a need for the training? Does the training have specific goals and learning objectives? • For whom? What groups of people can be trained together and what groups should be trained separately? How many people will attend your training? • When? How many days should	Facilitate a brief discussion of the five key questions to consider when preparing for a training. Try to have participants be as specific as possible in their responses as they think about how they might apply the Communication Skills Training in their communities.

	you allow for preparation? Do you have scheduled tea breaks and lunch breaks? • Where? Is it convenient? Are there enough training resources? • How? Are all the materials ready in advance? Are different activities used for different learning types? Are all the handouts and transparencies clear and presented in an organized way? Is the facilitator well-informed? Are there enough games and energizers to promote fun and keep participants' attention?	
1:45-2:30	**Managing Difficult Situations** • What types of methods did the trainers use to respond to community resistance? • What methods worked? • How did the trainers feel?	<u>Role play: Dealing with Participant Resistance</u> Ask for three volunteers. These will be the trainers. Ask them to step outside the room. Once they leave, explain to the rest of the group that the trainers will be trying to train on the definition of gender, using material from the first day of the training curriculum. Explain that the group will be playing the role of a resistant community, and give them the activity sheet to explain the different scenarios for the three different volunteer trainers. **Activity Sheet: Scenarios for Resistant Participants** Give each trainer 5 minutes to train the participants on the definition of gender, with the participants using the first scenario for the first trainer, the second scenario for the second trainer, and third scenario for the third trainer. Make sure that the participants are not unruly. The key to this role play is to simulate actual resistance trainers may face, not to harass the trainers. Bring the group back together and discuss the questions at left. Tell participants that there will be times when both the participants and the facilitators may feel frustrated. Trainers should

	• How did the community members feel?	always remain patient; never argue; try to understand the different beliefs and attitudes of the community members; and work towards changing beliefs and attitudes that lead to GBV. While arguing is always counterproductive, facilitators should be prepared to respectfully challenge discriminatory remarks.
2:30-3:00	**The Week in Review** Here are the things we have learned this week: ▪ The nature of GBV, trauma responses, the importance of symptom management ▪ How to be an effective service provider and the importance of professionalism, active listening skills, and assessment skills ▪ How to implement various protocols for action when dealing with difficult survivors ▪ When and how to adjust one's approach to survivors according to survivors' varying needs (domestic violence victim, sexual assault victim, child/adolescent victim, family members/friends of victim) ▪ What skills are needed for working with challenging issues, especially suicidal/homicidal survivors, agitated survivors, drug/alcohol abusing survivors, or mentally ill survivors ▪ Service provider safety when working with challenging populations or in dangerous environments ▪ The impact of working with trauma victims on service providers; how to manage those effects through awareness of vicarious trauma, maintaining professional distance, focusing on self-care, and utilizing supervision ▪ The importance of record-keeping, with special consideration for	Tell participants that repetition is a great way to help those who are being trained to remember all that they have worked on. Ask participants how repetition was used in the training. Tell participants that we will now wrap up the training by reviewing the entire week, referring to the outline at left. <u>Week in Review:</u> Review with participants what they have learned during the past week utilizing the topics at the left. Ask participants to share what they have learned around these topics. ** Be sure to incorporate issues and potential challenging areas that have come up during the previous week.

	confidentiality of survivors ▪ How a service provider can advocate in the community on behalf of the survivor ▪ Understanding the multisectoral approach to preventing and responding to GBV ▪ Utilizing a multisectoral referral network to meet the needs of survivors	
	Break	
3:00 – 3: 15 3:15 – 3:45	**Questions and Answers**	<u>Question and Answer Session:</u> This is the time to respond to the questions/comments found in the Question Box. Facilitators should review questions in advance and group them under topic categories, in order to respond to as many issues as possible in the time allotted.
3:45-4:00	**Distribute Training Manuals**	Distribute the training manuals and ask participants to leaf through them to ensure that the materials in the manual are complete and in order. Ask participants for any further questions about using the manual.
4:00 – 4:30	**Wrap-up, Post-test, and Evaluation**	<u>Wrap-Up and Evaluation:</u> Ask participants to complete the post-test and then take approximately 10-15 minutes to fill out the daily evaluation and the final evaluation forms. **Handouts: 1) Post-test; 2) Daily Evaluation Form; and 3) Final Evaluation Form**
4:30 – 5:00	**Presentation of Training Certificates**	<u>Presentation of Training Certificates:</u> After participants have completed their final evaluations, end the day with a presentation of training certificates. **Handout: Training Certificate**

Communication Skills in Working with Survivors of Gender-based Violence

A Five-Day Training Curriculum

Reproductive Health Response in Conflict Consortium

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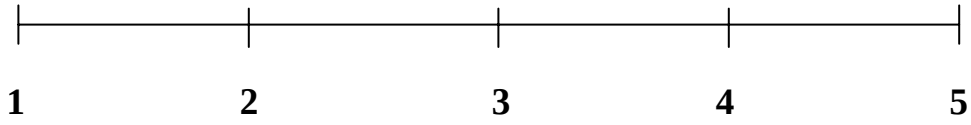
DAILY EVALUATION FORM

TODAY'S DATE _____

1) How valuable were today's sessions for you, based on a scale of 1 to 5? (1 = not valuable at all; 5 = extremely valuable)



1 2 3 4 5

2) Identify 3 things from today that will be useful to you in your job.

a. _____
b. _____
c. _____

3) Please provide any comments or recommendations regarding the content of today's training.

_____
_____
_____
_____

4) Please feel free to write any additional comments here.

_____
_____
_____
_____

Activity Sheet: Match the Proverbs and the Sayings*

Instructions

Write one half of each saying on separate pieces of paper and distribute one piece of paper to each participant.

Tell the participants the sayings have been divided and now the two halves of each saying are not matched correctly.

Ask the participants to match up the correct halves of the sayings. After they have "found" their other half, ask participants to stand in a line and discuss as a group what participants think the sayings mean.

Tell the participants what the sayings mean if they have not guessed this correctly.

***Excerpted from: Gender or Sex: Who Cares? IPAS (2001)**

Sample proverbs and sayings and their meanings

Men are gold, women are cloth

(saying from Cambodia: this means that women, like a white cloth, are easily soiled by sex while men can have repeated sexual encounters and be polished clean like gold each time)

Husbands of ugly women always wake scared

(saying from Brazil: this means that men think badly about women who are not beautiful)

Women are like a duiker's dung

(Bemba proverb from Zambia: this means that women are as plenty as duiker's dung; if your wife misbehaves, throw her away and find another one – a duiker is an antelope)

He who listens to women suffers from famine at harvest time

(Tonga proverb from Zambia: this means one must not put too much weight on women's words; it might lead to trouble later on)

Men are like cars and women are like parking spaces

(expression from an Asian country: this means that men can choose their partners (parking spaces) while women have no choice – anyone can park in them as they are fixed spaces)

Husbands who help their wives are called slaves of the wife

(saying from India: this means that men who help women are not "real men")

The kind of love between a husband and wife in the early days of the marriage is absent after the birth of children

(saying from India: this means that romantic love changes when parents have to take care of their children)

If the hours are long enough and the pay is short enough, someone will say it's women's work

(Swahili proverb: this means that women generally have to work harder and earn less then men)

It is believed that women are governed by weak "star" so they often become possessed by evil spirits

(a saying from India: this means that women tend to be more unstable then men)

A house without an owner is like a woman without a husband

(bilingual Summerian and Akkadian proverb: this means that a woman alone is not complete as a human being)

A woman's place is in the kitchen

(proverb from the USA: this means that women should stay at home and only do domestic work)

Strong winds and ugly women only break twigs

(saying from Brazil: they both cause problems)

In the hands of women rests the dignity of the house

(saying from India: this means that what people think about a family depends on a woman's behavior)

A boy who is a coward should wear bangles in his hands

(saying from India: this means that boys who are afraid or who do not like violence are like women or girls)

CLIENT SCENARIO*

Purpose: To demonstrate how lack of coordination among actors can negatively impact on clients.

Resources: A ball of string and pieces of paper or card, each with one of the following written on it: Women's Leader, Traditional Healer, Grievance Committee, Legal Advisor, Nurse, Police Officer, Doctor, Camp Security, UNHCR Protection Officer, Social Worker, Camp Management.

Method: Get the group to stand in a circle. Ask for a volunteer to be a client and a volunteer to be her mother and bring them into the centre of the circle. Give the mother the ball of string. Randomly give members of the circle each one of the pieces of paper with a different title and ask them to hold it up so everyone can see it.

Explain that the client is a seven year old girl living in a refugee camp and that her mother suspects that a neighbor has raped her daughter. Explain that the mother doesn't know what to do, so she takes her daughter to the 'Women's Leader' for advice. **Tell the mother to walk her daughter over to the person holding the 'Women's Leader' label and to give her the end of the string to hold onto while the mother keeps hold of the rest of the ball.** Explain that the mother tells the 'Women's Leader' the story and 'Women's Leader' sends the mother and daughter to the 'Traditional Healer'. **Tell the mother and daughter to walk over to the 'Traditional Healer' unrolling the ball of string. When they reach the 'Traditional Healer' the mother hands the string to that person to hold, but keeps the ball.** Explain the 'Traditional Healer' listens to the story, examines the daughter, says she thinks the girls has been abused, gives some medicine and advises the mother to go to the 'Grievance Committee'. **Tell the mother and daughter to carry the ball of string to the 'Grievance Committee' and give it to that person to hold onto, while keeping the ball.** Explain that the mother tells the 'Grievance Committee' the story and is told that rape is a crime under national law and that the mother must go and get legal advice. **Tell the mother and daughter to walk over to the 'Legal Advisor' and give this person some string to hold onto.** Explain that the mother tells the story to this person who advises her to take her daughter to the clinic for an examination. **Tell the mother and daughter to walk over to the 'Nurse' and give this person some string to hold onto.** Explain that the mother tells the story to the 'Nurse' who does a physical examination and tells the mother to go to the police. **Tell the mother and daughter to walk over to the 'Police Officer' and give this person some string to hold onto**. Explain that the mother tells the story to the 'Police Officer' who interviews the daughter and says he will investigate, but explains he needs a medical certificate from a doctor. **Tell the mother and daughter to walk over to the 'Doctor' and give this person some string to hold onto.** Explain that the mother tells the 'Doctor' the story and this person performs another physical evaluation and gives the mother a medical certificate to give to the police. **Tell the mother and daughter to walk over to the 'Police Officer' and give this person some string to hold onto.** Explain that a few days pass and the neighbor has come over and threatened the mother because he's

heard she's been talking about him in public. **Tell the mother and daughter to walk over to the 'Camp Security' and give this person some string to hold onto.** Explain that the mother tells this person the story and expresses that she is scared. This person advises the mother to go to the Police and to the UNHCR Protection Officer. **Tell the mother and daughter to walk firstly over to the 'Police Officer' who says he/she hasn't been able to investigate because there is no transport. Then tell the mother and daughter to walk over to the 'UNHCR Protection Officer' and give this person some string to hold onto.** Explain that the mother tells the story to the Protection Officer who says UNHCR will help with safety, but advises the mother to go to the NGO Social Worker who can also help. **Tell the mother and daughter to walk over to the 'Social Worker' and give this person some string to hold onto.** Explain that the mother tells the story to the 'Social Worker' who takes down the information, informs the mother of what services are available and the procedures to go through to get help and also tells the mother this has happened to many other girls and it would be good to tell camp management because then they might be able to take action to prevent further incidents.

Debrief: By this time the client and mother are in the middle of a tangle of string with all the different actors holding a piece of the tangle. Ask the group what they can see. After facilitating a discussion, review how many times the client and mother had to tell the story, how many examinations were undertaken, how much time and energy, and possibly, resources, the client and mother had to use. Ask for suggestions on how this can be avoided. Finally emphasize the importance of coordination and having a good system in place to help clients.

*Adapted from Vann, B, Training Manual Facilitator's Guide: Multisectoral and Interagency Response to Gender-based Violence in Populations Affected by Armed Conflict, JSI Research and Training Institute/RHRC Consortium, Washington, DC, 2004.

VIOLENCE JEOPARDY GAME *
Answers

* Adapted from Family Health International (FHI), Understanding Sexual and Gender-based Violence: an Introduction for Health Care Providers, June 2001.

MYTHS AND FACTS	GLOBAL STATISTICS AND INFORMATION	CHARACTERISTICS OF VIOLENCE	CONSEQUENCES OF VIOLENCE	Responding to Violence: Case Management
No. Alcohol and drug abuse do not cause violence. They can, however, intensify existing violent behavior.	No. Violence is a greater cause of death and disability among women than all the others combined.	Slapping; pushing; shaking; beating; pinching; biting; scratching; choking; burning; physically confining (locking in a room, tying up); using a knife, gun, or other weapon; and coercing others to commit such acts.	Unwanted pregnancy; gynecological problems; STIs, including HIV; miscarriage; pelvic inflammatory disease; chronic pelvic pain; unprotected sex; self-abortion; urinary tract infections; maternal mortality, and AIDS.	Lack of technical competence, training, and resources; cultural stereotypes and negative social attitudes around violence against women; time constraints; institutional restrictions; fear of offending the patient; frustration with the patient's non-compliance or resistant behavior; knowing the abuser; women's reluctance to disclose violence; and provider's own experience of abuse.
False. No one "asks for" or enjoys a violent physical or sexual attack. Rape is a violation of body, mind, and spirit. It takes away a person's control over their body and choices.	False. In most countries, it is legal for a man to rape his wife.	Actual or threatened use of physical harm to force a person to engage in a sexual act against their will; attempted or completed sex act with a person who is unable to avoid participation, communicate unwillingness, or understand the nature of the act; abusive sexual contact or touching a person's sexual body parts against their will; refusing to use contraceptives or condoms; and does not necessarily involve intercourse and can include unwanted touching or fondling or rape with an object.	Anxiety; fear; guilt; shame; embarrassment; grief; depression; suicidality; sadness; isolation; worry; low self-esteem; sexual dysfunction; eating problems; obsessive-compulsive disorder; anger/irritability; and post-traumatic stress disorder.	Assessment Support Education Referral Follow-up

False. While some studies have shown a correlation between poverty and levels of violence, others have indicated that women who are more educated than their husbands may be at greater risk of violence. Domestic violence affects all women, regardless of age, religion, ethnic or racial group, socio-economic status, educational background, and sexual orientation.	One.	Gender-based violence is violence that is perpetrated against a person's will, and is based on his/her gender roles, responsibilities, expectations, privileges, and limitations. GBV may be physical, sexual, emotional, or social.	Shame, inaccessibility of services, poor response or inappropriateness of services, fear of reprisals, minimizing problem, risk to children, family/cultural expectations.	Such plans might include keeping a bag packed with important documents, money, keys, and extra clothes for herself and her children; establishing a signal/code with family or friends; or identifying a safe place to go ahead of time.
False. Sexual violence is not an act of passion. It is a violent crime in which sex is used as a weapon.	Female genital mutilation.	Yes. Because of women's and girls' subordinate status in virtually all countries around the world, they are at greater risk of being harmed based on gender.	Miscarriage, premature labor, and delivery of premature or low birth weight infant.	May include shelters, legal services, social workers, police, hospitals, mental health services, local hotlines, child protective services, support groups, and trained clergy.

ACTIVITY SHEET

VIOLENCE IN YOUR COMMUNITY

- WHAT CAUSES GENDER-BASED VIOLENCE IN YOUR COMMUNITY?
- WHAT ARE THE CONTRIBUTING FACTORS TO GBV IN YOUR COMMUNITY?
- WHAT ARE THE CONSEQUENCES OF GBV ON INDIVIDUALS, FAMILIES, AND COMMUNITIES?
- WHAT ARE COMMUNITY ATTITUDES AND RESPONSES TO GBV?
- WHY DO MANY SURVIVORS OF GBV NOT SEEK HELP?

VIOLENCE JEOPARDY GAME*

Materials Needed:

- 5 sheets of paper with the following categories written on them: 1) Myths and Facts About Violence; 2) Global Statistics and Information; 3) Characteristics of Violence; 4) Consequences of Violence; and 5) Responding to Violence: Case Management
- 20 sheets of paper with the following amounts of money written on them: $200; $400; $700; and $1,000 (4 each) or amounts of money relevant to the setting where the training is conducted
- 20 sheets of paper with one question from the attached matrix written on each sheet (the answer should not be written on the paper)
- Prize for winning team

Instructions:

1. Prior to the start of the game, the categories should be posted on a wall. Below each category, four amounts of money ($200, $400, $700, and $1,000) and four questions should be posted. A question should be placed behind each amount of money, so that when the top sheet is removed, the question is revealed.

2. Divide the participants into three to four teams. Each team should line up one person behind the other.

3. The first person from Team 1 chooses a category and question by specifying a dollar amount. The facilitator then removes the dollar amount to reveal the question. That person has one chance to answer the question (with no help from his/her team members). If they answer correctly, then the next person in line gets to choose a category and question. This goes on until one of the team members is unable to answer a question correctly. Then the first person from Team 2 chooses a category and question. If they answer correctly, the next person on his/her team goes. If they answer incorrectly, then the first person from Team 3 takes a turn. When a person from Team 3 misses a question, it is Team 1's turn again. This goes on until all of the questions have been answered.

4. When a question is answered correctly, that amount of money goes to the appropriate team. At the end, the team with the most money wins and is given a prize.

* Adapted from Family Health International, Understanding Sexual and Gender-based Violence: an Introduction for Health Care Providers, June 2001.

VIOLENCE JEOPARDY GAME
Questions

MYTHS AND FACTS	GLOBAL STATISTICS AND INFORMATION	CHARACTERISTICS OF VIOLENCE	CONSEQUENCES OF VIOLENCE	Responding to Violence: Case Management
Do alcohol and drug abuse cause violence?	According to the World Health Organization, cancer, malaria, traffic accidents, and war are greater causes of death and disability among women than violence. True or False?	Name 3 forms of physical violence.	Name 3 reproductive health consequences of violence against women.	Name 3 barriers that providers may face when addressing violence against women.
Sexual assaults can be caused by the victims because of the way they dress or act – true or false?	In most countries, it is illegal for a man to rape his wife – true or false?	Name 3 forms of sexual violence.	Name 3 psychological health consequences of violence against women.	What are three important tasks for the provider when offering case management services to a survivor?
Domestic violence is more likely to affect poor, uneducated, rural women.	According to the World Health Organization's global statistics, how many women in 5 have been physically or sexually abused by a man at some point in their life?	Define gender-based violence.	Name 3 reasons a survivor might not seek help.	When helping a client to develop a personal safety plan, what are 2 courses of action a provider might recommend?
Sexual violence is an expression of the aggressor's sexual desire.	What form of violence have 100 to 180 million women and girls in the world suffered, mostly in Africa?	Around the world, women and girls are at greater risk of gender-based violence than men or boys. True or false?	Name 3 possible problems associated with battering during pregnancy.	Name 3 resources in your community where you could refer a woman who was being abused by her partner.

Communication Skills in Working with Survivors of Gender-based Violence Training Workshop

Pre-/Post-Test

1. Define gender-based violence.

_____
_____
_____
_____
_____

2. Name 5 types of gender-based violence.

_____
_____
_____
_____
_____

3. Name the sectors involved in a multisectoral GBV response framework:

a) _____
b) _____
c) _____
d) _____

4. What kinds of events can cause trauma?

_____
_____
_____
_____

5. Why is it not good for a service provider to advise a survivor what to do?

_____
_____
_____
_____
_____

6. What does the acronym GATHER stand for?

G: _____
A: _____
T: _____
H: _____
E: _____
R: _____

7. How can a service provider demonstrate active listening skills?

_____
_____
_____
_____

8. What is vicarious trauma?

_____
_____
_____
_____
_____

9. Identify two methods of supervision of staff who work with GBV survivors.

_____
_____
_____
_____

10. Why is staff supervision important when working with survivors of GBV?

_____
_____
_____
_____
_____

11. Name three things that are important to include in a case record of a GBV survivor.

_____
_____
_____
_____
_____

12. Name three things that you might NOT want to include in a case record of a GBV survivor.

_____
_____
_____
_____
_____

Communication Skills in Working with Survivors of Gender-based Violence

A Five-day Training of Trainers Workshop

TRAINING OUTLINE

Day I **Participant Introductions and Overview of Gender-based Violence**

Session 1 Setting the Climate

- ❑ Welcome and Introductions
- ❑ Training Overview and Logistics
- ❑ Participant Expectations
- ❑ Establishing Ground Rules

Session 2 Understanding Key Concepts

- ❑ Sex vs. Gender
- ❑ Gender-based Violence (GBV)
- ❑ Examples of GBV

Session 3 Developing a Framework to Understand and Respond to GBV

- ❑ GBV in Your Community: Causes, Contributing Factors, Consequences
- ❑ Multisectoral Model

Day II **Engagement Strategies in Working with Survivors**

Session 1 Understanding the Survivor

- ❑ Basic Psychological Needs
- ❑ Brief Introduction to Trauma Theory
- ❑ Identifying Common Reactions to Trauma
- ❑ Coping Skills

Session 2 Introduction to Engagement Techniques

- ❑ What Makes an Effective Service Provider?
- ❑ Active Listening
- ❑ Barriers to Good Listening
- ❑ Self-Assessment

Day III **Engagement Strategies (con't)**

Session 1 What is your role? What is your goal?

- ❑ Active Screening, Crisis Debriefing, Case Management, and Counseling
- ❑ Introduction to Assessment
- ❑ GATHER Model

Session 2 Important Issues in Working with Survivors

- ❑ Special Populations
- ❑ Protocols for Action with Special Populations
- ❑ Safety Precautions for the Service Provider

Day IV **Supporting the Service Provider**

Session 1 Introduction to Vicarious Trauma

- ❑ Defining and Coping with Vicarious Trauma

Session 2 Introduction to Self-Care

- ❑ Self-Care for the Service Provider

Session 3 Supervision

- ❑ Role of the Supervisor
- ❑ Responsibilities of the Supervisee

Day V **Service Provider Responsibilities and Community Referrals**
Facilitation Skills Overview, Training Review and Evaluation

Session 1 Record Keeping and Confidentiality

- ❑ The Fundamentals of Record Keeping
- ❑ Ensuring Confidentiality

Session 2 Coordinated Community Response and Advocacy

- ❑ Coordinating a Community Response: Applying the Multisectoral Model
- ❑ The Service Provider as an Advocate

Session 3 Facilitation Skills Overview, Training Review and Evaluation

- ❑ Facilitation Skills Overview
- ❑ Week in Review
- ❑ Wrap-up and Evaluation

SEX vs. GENDER*

*Adapted from Williams, S. *The Oxfam Gender Training Manual*, Oxfam UK, 1994.

Definitions of Sex and Gender

Sex refers to physiological attributes that identify a person as male or female:

- Type of genital organs (penis, testicles, vagina, womb, breasts)
- Type of predominant hormones circulating in the body (oestrogen, testosterone)
- Ability to produce sperm or ova (eggs)
- Ability to give birth and breastfeed children

Gender refers to widely shared ideas and expectation (norms) concerning women and men. These include ideas about 'typically' feminine or female and masculine or male characteristics and abilities and commonly shared expectations about how women and men should behave in various situations. These ideas and expectations are learned from: family, friends, opinion leaders, religious and cultural institutions, schools, the workplace, advertising, and the media. They reflect and influence the different roles, social status, economic and political power of women and men in society.

DEFINITION OF GENDER-BASED VIOLENCE

- ***Gender-based violence*** (GBV) is an umbrella term used for any harm that is perpetrated against a person's will and that has a negative impact on the physical or psychological health, development, and identity of the person.

    - The violence is the result of gender-based power differences between men and women, among males, and among females.

GBV may be physical, sexual, psychological, economic, or socio-cultural.

Categories of perpetrators may include family members, community members, and/or those acting on behalf of or according to the disregard of cultural, religious, or state institutions.

Almost always and across all cultures GBV principally impacts women and girls.

GLOBAL STATISTICS*

•A 1982 study of Guatemalan refugee women found that their most overwhelming fear was that of being raped

•20,000 to 50,000 women were raped during the war in Bosnia and Herzegovina

•The vast majority of Tutsi women in Rwanda's 1994 genocide were exposed to GBV; of those, it is estimated that a quarter to a half million *survived* rape

•An estimated 50,000-60,000 women in Sierra Leone have histories of war-related sexual assault

•An estimated 40,000 Burmese women are trafficked each year into Thailand's factories, brothels, and domestic work

•In a 1995 survey of post-conflict Nicaragua, 50 percent of female respondents had been beaten by a husband

•76 percent of prostitutes surveyed in Rwanda in 1998 who had undergone HIV testing were seropositive

•A 1999 national government survey found that 37 percent of Sierra Leone's prostitutes were less than 15 years of age, and more than 80 percent of these were unaccompanied children

•25 percent of Azeri women surveyed (2000) acknowledged being forced to have sex: those at greatest risk were among the internally displaced, 23 percent of whom acknowledged being beaten by a husband

***Statistics cited in Ward, J. If not now, when?: Addressing gender-based violence in refugee, internally displaced, and post-conflict settings, RHRC Consortium, 2002.**

For more statistics on the global prevalence of GBV, please visit www.rhrc.org

Types of GBV Around the World*

Sexual Assault and Abuse

Type of act	*Description/Examples*	*Can be perpetrated by*
Rape and marital rape	Forced/coerced intercourse	Any person, including husband, partner or care-giver
Sodomy	Forced /coerced anal intercourse, usually male-to-male or male-to-female	Any person in a position of power
Attempted rape or attempted sodomy	Attempted forced/coerced intercourse; no penetration	Any person in a position of power
Sexual abuse/ exploitation	Sexual interactions against her will (e.g., perform in sexual manner, forced undressing and/or nakedness, coerced marriage, forced childbearing, engaging in pornography or forced prostitution)	Anyone in a position of power, influence, control, including humanitarian aid workers

Child sexual abuse, defilement, incest	Sexual relations with a child (any person under 18 years of age)	Often perpetrated by someone the child trusts, including parent, sibling, extended family member, friend or stranger, teacher, elder, leader; anyone in a position of power over a child
Forced prostitution (also referred to as sexual exploitation)	Forced/coerced sex-trade in exchange of material resources, services, and assistance, usually targeting highly vulnerable women or girls unable to meet basic human needs for themselves and/or their children	Any person in a privileged position, in possession of money or control of material resources and services, perceived as in power. Includes Humanitarian aid workers
Sexual harassment	Any unwelcome sexual advance, request for sexual favors, or other verbal or physical conduct of a sexual nature	Soldiers/officials at checkpoints, teachers; employers, supervisors or colleagues; any person in a position

		of power, authority, or control.

Physical Violence

Type of act	*Description/Examples*	*Can be perpetrated by*
Physical assault	Beating, punching, kicking, biting, etc., with or without weapons; often used in combination with other forms of sexual and gender-based violence	Spouse, partner, family member, friend, acquaintance, stranger, anyone in position of power
Trafficking, slavery	Selling and/or trading in human beings for forced sexual activities	Any person in a position of power or control; often accompanied by promises of money and a “good job”

Emotional, Psychological and Socio-economic Abuse

Type of act	*Description/Examples*	*Can be perpetrated by*
Abuse / Humiliation	Non-sexual verbal abuse that is insulting, degrading, demeaning; compelling her to engage in humiliating acts, often in public; denying basic expenses for family survival	Anyone in a position of power and control; often perpetrated by spouses, partners or family members in a position of authority
Discrimination and/or denial of opportunities, services	Exclusion, denial of access to education, health assistance or remunerated employment; denial of property rights	Family members, society, institutions and organizations, government actors
Confinement	Isolating a person from friends/family, restricting movements	Anyone in a position of power and control; often perpetrated by spouses, partners or family members in a position of authority
Obstructive	Denial of access to	Family, community,

legislative practice	exercise and enjoy civil and political rights, mainly to women.	institutions and State

Harmful Traditional Practices

Type of act	*Description/Examples*	*Can be perpetrated by*
Female genital mutilation (FGM)	Cutting of genital organs for non-medical reasons, usually done at a young age; ranges from moderate to extreme cutting, removal of genitals, stitching	Traditional practitioners, supported, condoned, and assisted by families, religious groups, entire communities
Early marriage	Arranged marriage for girls under the age of legal consent (sexual intercourse in such relationships constitutes statutory rape, as the girls are not legally competent to agree to such unions)	Parents, community and State
Forced marriage	Arranged marriage for girls under the age of legal consent or women against their wishes; often a dowry is paid to the family; if she refuses, there are violent and/or	Parent, family members

	abusive consequences (Legally, such unions would not be considered marriage because of age and/or force)	
Honor killing and maiming	Maiming or murdering a woman or girl as punishment for acts considered inappropriate for her gender that are believed to bring shame on the family or community (e.g., pouring acid on a young woman's face as punishment for bringing shame to the family for attempting to marry someone not chosen by the family)	Parent, husband, other family members, or members of the community
Infanticide and/or neglect	Killing, withholding food, and/or neglecting female children because they are considered to be of lesser value in a society	Parent, other family members
Denial of education for girls or women	Removing girls from school so they can perform expected gender roles in families	Parent, other family members

**Source: Guidelines for the Prevention and Response of Sexual and Gender-based Violence Against Refugees, Returnees, and Internally Displaced Person,* UNHCR, Geneva, 2002.

WHICH IS IT: SEX or GENDER?*

1. **Women give birth to babies, men don't.**

2. **Little girls are gentle and boys are tough.**

3. **In one case, when a child brought up as a girl learned that he was actually a boy, his school marks improved dramatically.**

4. **Among Indian agricultural workers, women are paid 40-60 percent of the male wage.**

5. **Women can breast feed babies, men can bottle feed babies.**

6. **Most building site workers in Britain are men.**

7. **In Ancient Egypt, men stayed at home and did weaving. Women handled family business. Women inherited property and men did not.**

8. **Men's voices break at puberty, women's do not.**

9. **In one study of 224 different cultures, there were 5 in which men did all the cooking, and 36 in which women did all the house building.**

10. **According to U.N. statistics, women do 67 percent of the world's work, yet their earnings for it amount to only 10 percent of the world's income.**

***Adapted from Williams, S. *The Oxfam Gender Training Manual*, Oxfam UK, 1994.**

IDENTIFYING TRAUMA/STRESS REACTIONS

Emotional/Feeling Responses	
• Anxiety • Social isolation • Anger or emotional numbing • Sudden mood shifts • Irritability • Grief	• Depression • Identity problems • Guilt and shame • Denial • Feeling overwhelmed • Fear

Thought/Cognitive Responses	
• Reliving the experience • Nightmares • Blaming someone • Hyper-vigilance • Poor problem solving ability • Loss of orientation • Memory, concentration, or attention problems	• Flashbacks • Intrusive thoughts or images • Poor decision making • Dissociation • Blaming yourself

Physical Responses	
• Shock symptoms • Dizziness • Headaches • Chest pain • Difficulty breathing • Muscle tremors • Hyper-arousal, extra sensitivity to sights, sounds, smells, touches and tastes associated with the traumatic event	• Fatigue • Elevated blood pressure • Profuse sweating • Vomiting/nausea • Teeth grinding • Somatic disturbance

Behavioral Responses	
• Withdrawal • Heightened startle reactions • Increased or decreased appetite • Avoiding reminders of the traumatic event	• Acting out • Pacing the floor • Substance abuse • Homicidal or suicidal

Interpersonal Responses	
• Difficulty in forming intimate relationships • Sexual problems • Change in usual communication patterns	• Re-victimization • Suspiciousness

Which Is It?*

***Adapted from Safe Horizons, Volunteer Training Materials, NY, 2000.**

Directions: Evaluate the following statement. Are they assumptions or assessments? Why?

1. I see you are upset because you are crying.

2. I know you wanted to kill your husband after he gave you that black eye.

3. Your child is not talking like a four-year-old. He is probably developmentally slow.

4. I saw your teenage daughter talking to that known troublemaker. She is probably a troublemaker.

5. I am sure you are depressed about your situation and would like to seek counseling.

6. Your husband sounds crazy. I am sure he is pathological.

7. You need money again? Your sure can't manage your money.

Activity Sheet
Visualization for Traumatic Experience

Note to the person leading the visualization: It is VERY IMPORTANT, in this visualization, that you inform participants that they should only remember an event they feel comfortable remembering, and if they do not wish to participate in the visualization or want to stop the visualization at any time they are free to do so. The purpose of the visualization is NOT to make the participant feel bad, but to help them consider some of their feelings associated with a difficult experience they may have had, so that they have an understanding of what others' feelings may be, and also so that they are aware of the potential impact of their own experiences on their work with clients. If you are training a population that is highly traumatized (i.e. war-affected) you may choose not to do this exercise.

Relax, sit, or lie anywhere that you find comfortable. Close your eyes and listen to the music playing in the background. Relax. Breathe in and out slowly. In and out. In and out. (Repeat several times.)

With your eyes closed, I want you to think of an experience, one that frightened and scared you. It could be anything. Where were you at the time? What were you doing? What happened? Think about how you felt. Try to remember why it was so difficult. See the pain you felt. Visualize your facial expressions and the words you heard and/or said at the time.

How did you deal with the pain, the emptiness and the sadness? What did you think about doing to stop the pain? Why did you want to stop the pain? How did you stop the pain? Where is the pain now?

Now, listen to the music. Listen only to the music. Feel only the music. Visualize the sounds of the music. Breathe in and out slowly. In and out. Control your breathing. When you are ready, open your eyes slowly.

The person leading the visualization should assess how the participants are doing after completing the visualization. It is normal for people to feel sad; however, a workshop facilitator should be available to speak with anyone who may have become very uncomfortable or emotionally overwhelmed during the visualization.

Activity Sheet
Visualization Exercise for Active Listening

Note: The person leading the visualization should talk slowly and clearly, pausing between each question in the visualization. Remind all participants that they do not have to do the visualization if they don't feel comfortable and they should only visualize things which they wish to remember. For those who do the visualization, make sure they are seated comfortably and have their eyes closed before beginning to visualization.

Think of a time when you really felt listened to.

What was going on for you at the time that made you decide to talk to someone? It may have been a problem, difficulty, concern, or something you wanted to share with someone else.

How did you feel about talking to this person? What were your fears, anxieties, and thoughts about how it might be received?

Think of the person you spoke to. What qualities did this person have that made you decide that it would be safe to talk to them? What were some of the things that they said to you?

How did you know that the person really listened?

What was it about them that made you feel comfortable?

How would you describe the experience of having really been listened to?

Reflecting on Values *

Below are some values that people consider, consciously or unconsciously, when forming a philosophy of life: Survival, Love, Friendship, Family, Religion, Materialism, Aesthetics, Intellect, Social Consciousness, Career, Nature, Tradition, Community Actualization, Self Actualization.

Activity

Individual Exercise: If a situation occurred in which you had to give up the things in your life one a time, where would you start? Read through the list below and number them from 1 to 11, where 1 represents the thing you would give up first and 11 represents the last.

	My physical health
	My material wealth
	My home
	My country
	My religious beliefs
	My career
	My reputation
	My family
	My self-esteem
	My friends
	My community

*From Read-Hamilton, S, Counseling Training Workbook, IRC Tanzania, 2002.

RECOVERY FROM IMMEDIATE TRAUMA*

Many people survive a trauma and are able to reconstruct their lives without outside help. However, most people find some type of benign outside intervention useful in dealing with trauma.

Recovery from Immediate Trauma is Often Affected By:

- Severity of crisis reaction
- Ability to understand in retrospect what happened
- Stability of victim/survivor equilibrium after event
- Supportive environment
- Validation of experience

Recovery Issues for Survivors Include:

- Getting control of event in the victim's/survivor's mind
- Working out an understanding of the event and, as needed, a redefinition of values
- Re-establishing a new equilibrium/life
- Re-establishing trust
- Re-establishing a future
- Re-establishing meaning

*Adapted from Safe Horizons, Volunteer Training Materials, NY, 1999.

NORMAL REACTIONS TO AN ASSAULT*

1. FEAR AND ANXIETY:

The primary reactions people experience after an assault are fear and anxiety. Sometimes your feelings of anxiety may be the result of being reminded of the assault, at other times they may feel as if they come out of the blue. The feelings of anxiety and fear that you are experiencing can be understood as reactions to a dangerous and life-threatening situation. You may experience changes in your body, your feelings, and your thoughts because your view of the world and your perceptions about your safety have changed as a result of the assault.

Certain *triggers* and *cues* may remind you of the assault and activate your fears. These triggers may be certain times of the day, certain places, people approaching you, an argument with someone you care about, a certain smell, or a noise. Typically, after an assault, fear and anxiety are experienced in two primary ways:

1) Continuing to re-experience memories of the assault
2) Feeling aroused and jumpy

2. RE-EXPERIENCING THE TRAUMA:

People who have witnessed an assault often re-experience the trauma. You may find you are having flashbacks when visual pictures of the victim's body or some other aspect of the assault suddenly pops into your mind. Sometimes the *flashback* may be so vivid that you might feel as if the assault is actually occurring again. These experiences are intrusive and you feel that you don't have any control over what you are feeling, thinking, and experiencing during the day or night.

You may also find that you are re-experiencing the assault through *nightmares*. You may also re-experience the assault emotionally or cognitively without having a flashback or nightmare.

3. TROUBLE CONCENTRATING:

You may also find that you are having trouble concentrating. This is another common experience that results from a trauma. It is frustrating and upsetting to be unable to concentrate, remember, and pay attention to what is going on around you. This experience also leads to feeling that you are not in control of your mind or a feeling that you are going crazy. It is important to remember that these reactions are temporary. Difficulties concentrating are due to intrusive and distressing feelings and memories about the accidents. In an attempt to understand and digest what happened to you, your mind is constantly going over this material, bringing it back up, chewing on it, and trying to digest it.

4. NERVOUS ENERGY:

Other common reactions to an assault are arousal, feeling jittery, feeling overly alert, trembling, being easily startled, and having trouble sleeping.

Feeling tense and jumpy all the time may also lead to feelings of irritability, especially if you are not getting enough sleep.

As a result of the assault, you have realized that there is danger in the world and you want to be ready for it, your body is in a constant state of preparedness and arousal, so you can feel pumped and ready to respond immediately to a dangerous situation.

5. AVOIDANCE:

You may find that you are physically or emotionally *avoiding* people, places, or things that remind you of the assault. This avoidance is a strategy to protect yourself from situations that you may feel have become dangerous, and thoughts and feelings that are overwhelming and distressing.

Sometimes the desire to avoid memories and feelings about the assault may be so intense that you might find that you have forgotten important aspects of what happened. Another common strategy to avoid painful feelings and thoughts about the assault is *emotional numbness.*

6. SADNESS:

Another common reaction is sadness and a sense of feeling down or depressed. You may have feelings of hopelessness and despair; frequent crying spells; and sometimes even thoughts of hurting yourself and suicide. You may also experience a loss of interest in the people and activities that you once found pleasurable, as well as the feeling that life is not worth living and that plans you made for the future do not seem important any longer.

7. LESS OF CONTROL:

When people experience an accident, they often feel as if they have no control over their feelings. Sometimes the feelings of loss of control may be so intense that you may feel as if you are *going crazy* or *losing it*.

8. GUILT OR SHAME:

Feelings of guilt and shame may be present. Guilt and shame may be related to something you did or did not do to prevent the assault or help the victim. It is common to second guess your reaction and blame yourself for what you did or did not do.

Sometimes people feel that it could have been them in the assault, and then feel relieved that it wasn't them, and then guilty for feelings of helplessness, depression, and negative thoughts about yourself.

9. ANGER:

A feeling of *anger* is also a common reaction to an assault. The anger is mostly directed at the person who caused the assault or anyone who may have prevented it. Feelings of anger may be stirred up in the presence of people that remind you of the assault.

Sometimes you may find that you are so angry that you want to hit someone or swear; and if you are not used to feeling angry you may not recognize or know how to handle these angry feelings.

Many people also direct the anger towards themselves for something that they did or did not do during the assault. These feelings of anger directed at the self may lead to feelings of blame, guilt, helplessness, and depression.

Many people also find that they are experiencing anger and irritability towards those people that they love the most; family, their parents, and their children.

Sometimes you might lose your temper with the people who are most dear to you. This may be confusing since you may not understand why are most angry and irritable with those you care about most. While closeness with others may feel good, it also increases the opportunity for feelings of intimacy, vulnerability, and helplessness. Having those feelings may make you feel angry and irritable because they remind you of the assault.

*Taken from Mt. Sinai SAVI Advocate Training Manual, NY, 2000.

Introduction to Active Listening

Active Listening involves listening with understanding and involves total attention. The client will be communicating her message in many difference ways, and you must be tuned in to all the methods she is using.

1. **The client's non-verbal behavior: posture, expression, speed of speech, silences**
2. **The person's voice: tone, quality**
3. **The person's words and the meaning behind the words**
4. **What is not said**

From this you should be able to understand the person's story (the experiences that have caused them to seek counseling) and the person's feelings and emotions.

In order to be able to listen with total attention, you need to be relaxed while attending. This means that you lay aside your own concerns and preoccupations while you are with your client, and create a space for the client to reveal what is troubling her.

1. **Relax physically-- breathing, posture, etc.**
2. **Allow your manner to be natural-- no roles or poses**
3. **Follow what the other person is saying and do not be afraid to ask clarifying questions**
4. **Let your responses indicate to the other person that you are following what she is saying**

In working with clients in crisis

1. **Be supportive**
2. **Validate the client-believe her**
3. **Work with the client to help her become aware of her needs and coping skills**
4. **Deal with current crisis response first, before addressing previous crisis experiences**
5. **Take time to find out what the client wants**

Advising vs. Informing*

Giving Advice is:

- Telling someone what **you** think they should do and how **you** think they should do it
- Giving your personal opinion

Giving advice is not useful in providing professional services to survivors because:

- You can't know if you are giving the "right" advice.
- You might give the "wrong" advice and it can have a bad outcome for the survivor. This can lead to a survivor's problems getting worse and to you getting a reputation as a bad helper.
- Counselling is about the survivor's opinions and judgements, not the helper's.
- Providing assistance to a survivor is about empowering survivors to make thier own decisions about their own lives. Telling someone what to do does not help a person to understand her/his choices. It is up to the survivor to decide the best way to solve her/his problems.
- A survivor might feel that you are not listening if you tell her/him what to do.
- A survivor might feel you are not respecting her/him if you tell her/him what to do.
- Giving advice is based on your values and beliefs and doesn't help to change behavior.

Giving Information is:

- Telling someone facts so they can make an informed decision about what to do

Giving Information is useful in because:

- It empowers a survivor to have control over her/his choices.
- It shows you respect a survivor's opinions and judgements.
- The survivor has responsibility for making the right decisions about her/his life, not the service provider.
- The survivor is the one who will have to live with the consequences of her/his decision, not the service provider

* Adapted from Sophie Read-Hamilton, Counseling Training Workbook, IRC Tanzania, 2002.

TRAUMATIC EVENT
Helpful Hints for the Survivor*

Trying some of the following hints may help to alleviate the emotional pain associated with a traumatic event.

⇨ **For Yourself:**

- Try to rest a bit more
- Contact friends
- Have someone stay with you for at least a few hours or periods for a day or so
- Reoccurring thoughts, dreams, or flashbacks are normal: don't try to fight them – they will decrease over time and become less painful
- Maintain as normal a schedule as possible
- Eat well-balanced and regular meals (even when you don't feel like it)
- Try to keep reasonable level of activity
- Fight against boredom
- Physical activity is often helpful
- Re-establish a normal schedule as soon as possible
- Express your feelings as they arise
- Talk to people who love you
- Find a good counselor if the feelings become prolonged or too intense

⇨ **For Family Members and Friends**

- Listen carefully
- Spend time with the traumatized person
- Offer your assistance and a listening ear even if they have not asked for help
- Help them with everyday tasks like cleaning, cooking, caring for the family, minding children
- Give them some private time
- Don't take their anger or feelings personally
- Don't tell them that they are "lucky it wasn't worse"--traumatized people are not consoled by those statements. Instead, tell them that you are sorry such an event has occurred and you want to understand and assist them

If the symptoms described above are severe or if they last longer than six weeks, the traumatized person may need professional counseling.

Possible Solutions For These Problems Areas

⇨ **For difficulty in getting sleep:**

1. Avoid caffeine (coffee, colas, chocolate)
2. Make a list of what's on your mind
3. Do some gentle stretching exercises before retiring
4. Finish arguments before you try to go to sleep
5. Have a glass of milk before bed
6. Pray
7. Write in a daily journal or diary
8. Avoid catnaps in the evening (or afternoon)

9. Read a book or magazine
10. Listen to relaxing music
11. Try a relaxation/deep breathing exercise

⇨ **For waking up in the night:**

1. Go over some of the techniques in the preceding sections for "getting to sleep"
2. Get up and have some cereal with milk, or a cookie with a glass of milk
3. Keep a notebook to write in by your bed. Unload your feelings into it.
4. Allow yourself to stay up for an hour and enjoy the peace and quiet
5. Imagine your thoughts rolling off the top your head, down your side, and away from your body like a fountain
6. Picture yourself sitting under a warm shower or waterfall, letting your cares be washed away for the time being

⇨ **For disturbing dreams:**

1. When you wake with a disturbing or thought-provoking dream, write it down
2. Turn on the light, look around, and maybe get up in order to "shake" the intense feelings of the dream
3. Picture your own ending to the dream
4. If you need to "finish" a dream, concentrate on it before you go back to sleep, as a way of setting the stage
5. During the day, think about what your dreams might mean to you

⇨ **For waking too early:**

1. Get up and enjoy the day until you feel the need for a catnap
2. Go to bed later so you can sleep later
3. Put darker curtains over your windows
4. Use a fan to drown out noise

Relaxation Techniques

I. Meditation

- Assume a comfortable position, close your eyes, concentrate on a single word, sound, phrase, or image, and ignore all other thoughts
- Practice 10 to 20 minutes, once or twice daily

II. Tighten Muscles-Relax

- Sitting at a desk or meeting, tighten up some muscles, hold them what that way for a few moments, then let them relax
- Wring a handkerchief

III. Pushing

- Take a break. Push against a wall. Make some sounds as you resist the wall

IV. Yell

- Start or finish your day with some robust screaming!
- Before you scream in your auto, make sure the windows are pulled up

V. Find a listener

- Find someone who will listen to you. Talk about your feelings. Also discuss positive events that occurred in the situation. Remember laughter is a release.

In General:

- Exercise at least three times a week, 20-30 minutes per workout
- Reduce cigarettes and caffeine intake
- Drink alcohol in moderation
- Attend to your diet
- Take a lunch hour, as well as morning and afternoon breaks
- Listen to soothing music or a relaxation tape during breaks

YOU DESERVE TIME FOR YOURSELF!!!

***Taken from: Safe Horizons Westside Community Center, Volunteer Training Materials, NY, 1999.**

Attending: Using the SOLER Model*

To attend effectively to a survivor you must give yourself fully in order to really hear what it is that the survivor is saying or trying to say. This state of mind for 'active listening' involves skills and values. It also involves observation – the act of collecting information with our eyes, or to put it another way, "listening with our eyes. "

What is attending?

When survivors come to see you, it is important that they have a sense that you are attentive to them. Attending is the skill of creating a climate of attention and respect which aims to:

- Prepare the service provider to hear properly what the survivor is saying.
- Communicate the service provider's interest to the survivor.

It is both a *receptive* language skill and a skill in *expressive* language. From a receptive language point of view, attending helps the service provider to concentrate on what the survivor is saying or trying to say. The aim of attending is to focus completely on the survivor, to still distractions such as talking to yourself or thinking about other things while you are listening. When we attend well, we try to ignore external distractions such as other people or outside noises.

From an expressive language point of view, attending behaviors attempt to tell the survivor that you are there for them, that you really want to listen and to understand what is being said. When you attend well, the survivor is likely to feel confident to share her thoughts with you, and more confident to explore inner thoughts and feelings.

How to attend well

There are three ways to think about attending:

- Psychologically
- Contextually
- Behaviorally

* From Sophie Read-Hamilton, Counseling Training Workbook, IRC Tanzania, 2002.

Psychologically
Attending *psychologically* firstly means suspending your preconceived ideas about the speaker or the subject on which the survivor is talking. It means suspending your values and trying not to judge the survivor. As we have already discussed, we are sometimes put in the position of trying to help people who behave in ways of which we disapprove, or who hold values that are different from ours. This can make it hard for us to give them our full attention. However, with practice, we can learn to take a neutral position and focus our energies on the "here and now" moment of the survivor's attempts to express herself. This is especially difficult if we have preconceived ideas of what the topic of discussion is going to be.

The behavioral techniques shown below will help you stay *psychologically* focused.

Contextually
The *contextual* features of attending involve ensuring that the communication setting is comfortable, free of distractions or interruptions (or as free as possible), and one in which the survivor feels safe and secure. If either you or the survivor is concerned about being interrupted, then it will be hard for you to concentrate on the communication. If possible, arrange the furniture so that it is suitable for discussions to take place. You must make sure that there are no unnecessary distractions.

Behaviorally
Effective attending is often described in terms of five *behaviors* that are introduced by the acronym SOLER. Research has suggested that speakers feel more trusting of listeners who use these attending behaviors.

S stands for **Square**: This means facing the survivor square on, with your shoulders parallel to those of the speaker.

O stands for **Open**: This involves an open posture, particularly with your arms. It is suggested that speakers offer less trust to listeners who have their arms crossed.

L stands for **Lean**: When sitting, listeners who lean slightly forward engender a greater sense of intimacy than listeners who lean back in their chairs. You may have noticed this in your own experience. In some cultural groups the gender of the people who are communicating influences what is appropriate.

E stands for **Eye**: Eye contact is an important part of attending. Our survivors are less likely to communicate freely with us if we avoid eye contact with them. In fact, people will usually stop talking with another person if the listener withdraws eye contact. However, intense eye contact can also make communication difficult for the survivor. Here we need to engage in soft eye contact – regular, gentle eye contact that neither avoids direct gaze nor stares too intensely.

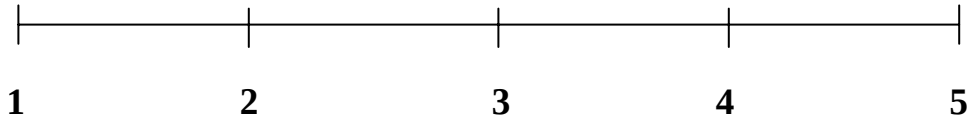
R stands for **Relax**: Finally, survivors are more likely to feel comfortable with service providers who are calm and relaxed. This means refraining from fidgeting, foot-tapping, wringing hands, cracking knuckles, breathing rapidly, and so on. Being relaxed is a state of mind that is shown in the body. However, concentrating on the body can aid relaxation. We all have our own ways of imposing a relaxed state on our bodies and for most of us this will involve gentle, deep, and regular breathing, relaxed muscles, and a still posture.

The behaviors outlined in SOLER have been found to promote increased trust and communication in some cultural contexts. They may not all be applicable in all cultures. For example, you may prefer not to face your survivor square on, or it may be more appropriate for you to avoid a direct gaze in particular circumstances.

DAILY EVALUATION FORM

TODAY'S DATE _____

1) How valuable were today's sessions for you, based on a scale of 1 to 5? (1 = not valuable at all; 5 = extremely valuable)



1 2 3 4 5

2) Identify 3 things from today that will be useful to you in your job.

a. _____
b. _____
c. _____

3) Please provide any comments or recommendations regarding the content of today's training.

_____
_____
_____
_____

4) Please feel free to write any additional comments here.

_____
_____
_____
_____

Barriers to Good Listening

Acoustics

- **Background noise**
- **Interruptions**

Physical Environment

- **Inadequate seating**
- **Uncomfortable seating**
- **Lack of privacy in the counseling room**

Body Language

- **Looking away from the individual**
- **Eyes darting around room**
- **Crossed arms**
- **Clenched hands**
- **Head bowed in hands**
- **Slouched posture**
- **Hands on hips**

Delivery/Tone

- **Slow**
- **Monotone**
- **Emotional**

Language

- **Unfamiliar or strange**

- **Too wordy**
- **Use of technical/medical terms**
- **Rambling speech**

Appearance

- **Sloppy dress**
- **Unusual clothing**

Other Barriers

- **Tired**
- **Preoccupied**
- **Uninterested**
- **Having a bias against the individual**
- **Having bias against the subject**
- **Making assumptions about the individual**
- **Inappropriate touch**

Assumption

- **Depends more on individual perspectives and opinions**
- **Based on limited information**
- **Does not encourage the process of inquiry**
- **Subsequent action based on opinion**

Assessment

- **Definition: the act of gathering information or data at a given moment of time and evaluating it for the purpose of making an appropriate decision about what course of action to pursue**
- **Based on gathering information**
- **Uses the process of inquiry**
- **Action-based on evaluation of data**
- **Depends on one's own opinion less**
- **Assessment is useful because it:**

  - **Prevents assumption and cause/effect thinking**
  - **Creates grounds for developing an appropriate plan of action**
  - **Helps identify client strengths**

Diagnosis

- **Used by professionals in the mental health field**
- **Focuses on psycho-pathology and psychological symptoms**
- **A conclusion about a person based on a series of observed symptoms or data**
- **Should be made ONLY by trained professionals**

TRAUMA RESPONSE*

The Emotional Response To Crisis

People who undergo crises may experience the following six (6) phases of emotional reaction. Sometimes these emotional reactions are mixed together and sometimes they are repeated.

PHASE I: High Anxiety or Emotional Shock

Victims in this phase usually display 2 types of reactions:

- Hysterical and very active
- Stunned, inactive, and depressed

A. Active Group- Sign and Symptoms

- agitation
- wringing of hands
- loud screaming or crying
- hyperactivity
- nausea
- vomiting
- rapid speech
- rapid breathing
- flushed face
- emotionally out of control

B. Inactive Group-Sign and Symptoms

- inactivity
- fainting
- nausea/vomiting
- staring into space
- dull eyes
- low blood pressure
- rapid, thready pulse
- sweating
- cold clammyskin
- pale appearance
- wandering around aimlessly

PHASE II: Denial
PHASE III: Anger
PHASE IV: Remorse
PHASE V: Grief
PHASE VI: Reconciliation

*From: Mitchell, J. and Resnik, H.P. Emergency Response To Crisis, 1981.

Basic Principles of Providing Help to Survivors*

Effective assistance to survivors should be based on some basic rules, or principles. In order to be a good service provider, you need to be familiar with them and you must be responsible for making sure you implement them.

The principles are:

- **Empathy**: Attempting to see things from the survivor's point of view and sharing that understanding with the survivor.
- **Respect**: Treating the survivor with dignity and accepting them without judgement.
- **Confidentiality**: Information provided by a survivor should be confidential unless the survivor requests otherwise or unless there are circumstances that mandate you to report. This means except for minor, and important exceptions, providing for survivors the promise that what they say will not be repeated to anyone else. From

* From Sophie Read-Hamilton, Counseling Training Workbook, IRC Tanzania, 2002.

the beginning you must be clear with a survivor what and with whom information might be shared.

- **Knowledge:** The service provider must know what she or he is talking about. All information given must be consistent and accurate.
- **Responsibility:** It is the service provider’s responsibility to facilitate the survivor’s work in ways that respect survivor’s values, personal resources and capacity for self-determination.

TRAUMA RESPONSE

Normal Reaction(s) to Abnormal Event(s)

The Physical Response

The normal, immediate, physical response to a traumatic event is based on our instincts. It includes:

1) Physical shock, disorientation and numbness

and/or

2) "Flight or fight" reaction

- **Adrenalin begins to pump through body**
- **Body may relieve itself of excess materials – for example through vomiting**
- **One or more physical senses may become very acute while others shut down**
- **Heart rate increases**
- **Hyperventilation or sweating may occur**

Exhaustion: Physical arousal associated with fight or flight cannot be prolonged indefinitely. Eventually, it will result in exhaustion.

DEFINITION OF TRAUMA

- **Overwhelms an individual's ability to use normal coping mechanisms to adapt to a situation.**
- **Disrupts an individual's frame of reference (beliefs about themselves and the world)**
- **The word trauma comes from Latin, meaning "wound." In this case trauma refers to a psychological rather than a physical wound.**

Trauma may occur in two ways:

- **Direct experience**
- **Second-hand (vicarious) experiences such as hearing accounts of violence**

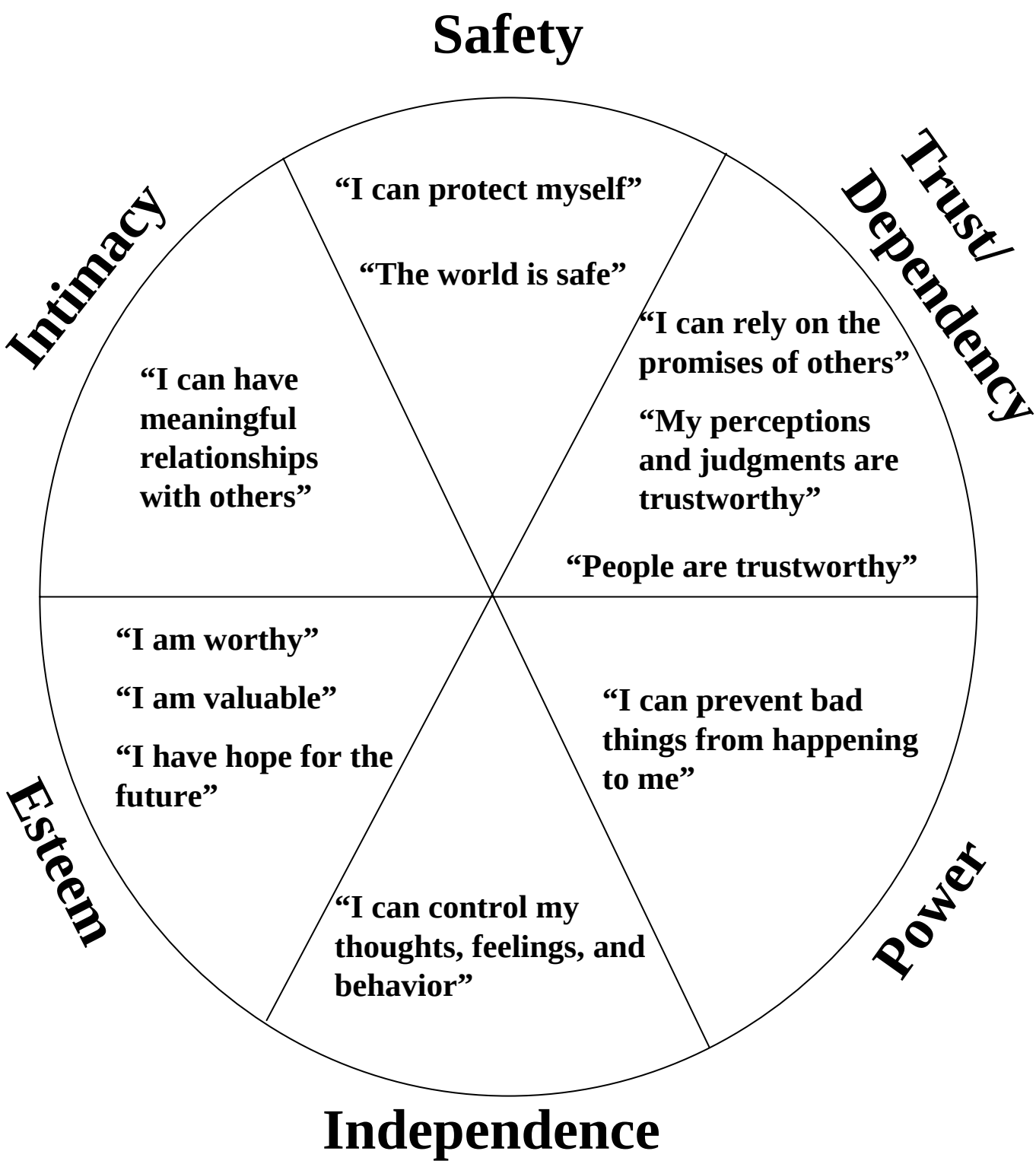
BRIEF HISTORY OF TRAUMA THEORY*

- **The survivor has historically been held responsible**
- **Societies have repeatedly engaged in "conspiracies of silence"**
- **To validate the survivor often involves taking a political stance**
- **Psychological approaches that focus on internal responsibility of individual often directly or indirectly reinforce "victim blaming"**
- **Trauma theory shifts the question from "Why did this happen to you and how can you change to prevent it from happening again?" to "What is your response to what has happened and how can you manage that response so as to feel better?"**

For more information, refer to Herman, J, *Trauma and Recovery*, New York, Basic Books, 1992.

PSYCHOLOGICAL NEEDS*

***Adapted from Safe Horizons, Volunteer Training Materials, NY, 1999.**



ACTIVITY SHEET

SELF ASSESSMENT (1)

- **Why have I chosen to become a service provider?**
- **Why do I want to help others?**
- **What do I get out of helping others?**
- **How might my personal needs and interests interfere with my ability to help others?**
- **What strengths do I have that will be useful in helping others?**

Some Considerations in Assessing Child Sexual Abuse*

I. Why Children Don't Disclose

Children don't disclose because they:

1) Fear punishment.
2) Are physically, psychologically, or emotionally dependent on the abuser.
3) Feel ashamed.
4) Made an agreement with the offender to keep the secret (due to bribery, threats, etc.).
5) Fear they won't be believed.
6) Fear the offender will hurt another loved one.
7) Feel guilty (the child assumes he/she is at fault).
8) Fear it will destroy the family.
9) They are ignorant of the consequences.
10) They are confused about what happened.
11) They have blocked the memory (as a form of self-protection).
12) They do not have the words, concepts, or ability's to articulate what happened.

II. Physical Indicators

1) Difficulty in walking or sitting.
2) Pain on urination or defecation.
3) Torn, stained, or bloody underclothing.
4) Pain or itching in the genital area.
5) Bruises, lacerations or scars in the anogenital area. Enlarged vaginal or anal opening.
6) Foreign bodies in the vagina, anus, or urethra.
7) Sexually Transmitted Disease(s).
8) Trauma to the breasts, buttocks, lower abdomen, or thighs.
9) Pregnancy.
10) Other physical indicators include infections and physical complaints that cannot be attributed to other causes. For example: urinary tract infection, cessation of menstruation, digestive and bowel disorders, body aches and pains, headaches, stomach aches and chronic sore throats.

III. Behavioral Indicators

1) A radical change in behavior (may act out or become a "model child").
2) The development of intense fears and phobias (in the case of female children they may become fearful of men).
3) Crying spells.
4) Eating disturbances (overeating, refusing to eat, vomiting).

*Adapted from Mt. Sinai Volunteer Training Materials, New York, 1999.

5) Sleep disturbances (nightmares, refusing to sleep alone, inability to fall asleep).
6) Deterioration of peer relationships, lack of trust in adults.
7) Become accident-prone.
8) Excessive bathing or refusing to bathe.
9) Regressive behavior (thumb sucking, clinging, separation problems, bed wetting).
10) Low self-esteem, feelings of worthlessness, deserving of punishment.
11) Truancy.
12) School failure.
13) Running away, delinquent and antisocial behavior.
14) Self-mutilation.
15) Obsessive preoccupation with discussions of sex, sexualized play, excessive masturbation.
16) Phobic reaction to sexual issues, wariness or fear of physical contact, cringes when touched.
17) Suicidal ideation.
18) Prostitution.
19) Drug and alcohol abuse.
20) Child discloses the abuse either directly or through interviewing techniques such as pictures or play.

CRISIS AND THE CONTINUM OF AGE: The Elderly's Reaction to Trauma*

Note: Elderly responses are, as with all age groups, culture bound as well as individualistic. The outline here, which is based on western models of aging and ageism, is meant to provide stimulus for discussion and thought, not to be definitive.

I. Growing Old

A. Age: 30-60

1. Language capability: peaks during this period.
2. Thought processes: develop knowledge; face choices and priorities; sustain and expand identity; sustained concentration; has short and long-term memory; concept of time is based on future orientation, and a "normal" length of passage.
3. Growth emphasis: sustenance.
4. Primary need: order and equilibrium.
5. Primary relationship: with peers; with family; status in relations is one of power.

B. Age 60-death

1. Language capability: may deteriorate; inability to recall words; expressions or thoughts may inhibit language use.
2. Thought processes: knowledge changes gradually to beliefs and wisdom; choice is limited and focus on choice is immediate; tend to lose sense of identity developed in earlier years; long-term memory is keen and short-term memory often lost; spasms of concentration; sense of time is oriented to the past; passage of time is rapid.
3. Growth: a time of physical, and emotional deterioration; also a "season of loss"—loss of income, job, privacy, health, friends, family, and control.
4. Relationships: primary relationships with peers but increased dependency on children and younger generation. Status in relationships tends to be characterized by decrease in power—marked by ageism.

II. Elder Reactions Trauma

A. **Overview**: Elder's reaction to a trauma will involve not only the impact of the catastrophe on their lives (what they saw, heard, felt, smelled, and so on), but a revisiting of crises in their past. This re-visitation is not simply a product of regression or trigger reactions. It is essentially a normal attempt to ground one's reactions in the familiar.

***Adapted from Victim Services' Volunteer Training Materials, New York, 1999.**

B. **Vulnerabilities**

1. Physical vulnerability
    A. Frailty
        a. The elderly are 4.5 times likely to suffer activity limitations.
        b. Some studies suggest that a person age sixty-five and over averages 6.5 physician visits per year.
        c. 85 percent of the elderly over sixty-five living outside of institutions report at least one chronic disease, and 50 percent have some limitations of normal activity related to chronic health conditions.
        d. Hospitalization rates for people over the age of 65 are 2.5 times more likely than for the population under 65.
            i. Single most critical age-related difference in physiology is a diminishing ability to respond to stress (physical and emotional) and to return to pre-stress level. This can be termed a decrease in homeostatic capacity. It is prominent in neuroendocrine interaction as well in the nervous and endocrine systems separately.
            ii. Chronic losses: loss of job, loss of status, loss of family members and friends through death, loss of mobility, loss of income, loss of health and sometimes loss of home.
            iii. Growth in dependence and a sense of powerlessness.
            iv. Loss of memory.
2. Social Vulnerability
    A. Ageism.
    B. Isolation.
    C. Issues in mental competence.

C. **Reactions to Trauma**

1. View of death
    A. Recognition of mortality.
    B. Understanding of permanence.
    C. Reconnection with friends, or past era.
2. Regression
    A. May be long-term regression.
    B. May move in and out of regressed state.
    C. May not know current friends or family.
3. Multiple losses
    A. Fear of competency.
    B. Loss of future.
    C. Loss of past values.
4. Need to integrate tragedy into context of life.
5. Disorientation as routine is interrupted. A parallel sense of isolation both in terms of place and time.

6. Immediate response after shock: primarily fear followed by anger and frustration.
7. Physiological responses: sleep disturbances, appetite disturbances, crisis spasms.
8. Sense of foreshortened future and retreat into past or fantasy for safety.

III. Some Coping Strategies for Elders

A. Rebuild and reaffirm attachments and relationships. Relationships are the connection to life. Let the elderly identify with whom they want to be attached. Do not assume family relationships are friendly. Nurturing and physical closeness is needed.
B. Ask for their concerns about safety. The elderly need to know they have options in making a choice about their safety. Evacuation is highly a controversial issue in disaster. The elderly may be more unsafe in evacuations than if they stay at the center of the disaster.
C. It is important to talk to elders about tragedy. However, remember that their ventilation may be about their life and not about the immediate event. Do not prevent ventilation; validating past concerns is an important part of establishing trust in preparation for dealing with current concerns. The elderly may wish to talk but they may also respond well to music and opportunities to paint or create art that communicates their reactions.
D. Caregivers should understand communication lapses in which the elderly go back and forth from the past to the present. Caregivers may be confused by an elder's discussion of past events or past relationships in terms of present realities. Remember the discussion may be entirely rational and logical from the perspective to the elder.
E. If an elderly person forgets a name, a place, or a portion of an event, the caregiver should take great precautions to avoid placing pressure on the elderly person to remember. In most cases, the elder will remember but pressure inhibits memory.
F. Caregivers should be prepared for the elderly to talk sporadically about the event--spending small segments of time concentrating on particular aspects of tragedy.
G. The elderly want to have factual information but may be able to absorb the facts in limited quantity and hence ask to have the information repeated a number of times. Eventually they will have integrated it and information will give them better control over the event itself.
H. The elderly should be given short-term predictions on what will happen to them immediately after the disaster. Specific times and places for events should be made clear. It will help to delineate events on a calendar or a clock so that they can more easily track the future. Caregivers should spend time addressing basic needs in a detailed way: who will feed the older person; where will s/he stay at night; where will the person be able to get clothes; what property may be rescued; and so forth.

Changing Needs of Growing Children*

*Adapted from Mt. Sinai Rape Crisis Center Volunteer Training Materials, New York, 1999.

Age	Child's Needs	Parent's Tasks	Abusive Parenting	Effect of Abuse	Healing Care
06 months **"Being" Stage**	Belong Trust Ned to know they can communicate needs	Provide physical care Delight in child Respond to cries Touch, hold, stimulate Protect and nurture	Being absent Ignoring cries, needs Hovering, "smothering" Spanking, pinching, screaming Withholding child support	Excessive crying Lack of self-worth Sleep disturbances Self-destructive behaviors Lack of facial expressions Eating disorders surfacing later	Maintain consistent care schedule Be more responsive Give unconditional nurturing Give lots of physical affection Identify and name needs
6-18 months **"Doing" Stage**	Do Explore sensations Try/check it out Explore environment Separate self from "other"	Offer unconditional love Baby-proof house Provide safe toys Care for self Give many "yeses" Interact & play with child	Confining child to crib Force feeding Beginning toilet training Expecting too much Failing to supervise Instilling fear, intimidation Yelling, screaming	Anxiety, inconsolable crying Withdrawal Fear of adults/authority Fear of new places Lack of mobility Limited language development School phobia surfacing later	Have realistic expectations Use sensory awareness play Distinguish feelings (mad/sad/scared) Insist on checking out fears Give consistent encouragement
18 months-3 years **"Thinking" Stage**	Separate from parent Say "no!" Think Learn to choose Speak out	Be the "grown up" Provide limited choices Honor the need to say "no" Be in charge of the rules	Being inconsistent Expecting too much Using physical punishment, spanking Failing to set limits	Demanding behavior Out-of-control behavior-hitting, biting, frequent tantrums	Distinguish angry feelings Teach non-violent expression of anger Use logical

		Demonstrate problem-solving Begin toilet training	Shaming child Using child to obtain information about other parent	Being over-adaptive to adults/people-pleasing Passivity Manipulative behavior Addictive disorders surfacing later	consequences Teach child to think of others Insist on verbal requests
4-6 years **"Identity & Power" Stage**	Separate real from pretend Learn differences between feelings, thoughts, & behavior Take action, initiate Develop sexual identity Solve problems	Allow child to make some choices Teach respect of own & opposite sex Teach how to get affection Separate child's reality from child's fantasy Read to and talk to child	Scaring/teasing to control Punishing for masturbation or sexual exploration Blaming child for parent's feelings "Sexualizing" child Using violence toward other parent	Sexual shame Excessive fears Extreme separation anxiety, bedwetting, nightmares Being over-adaptive/people-pleasing Adopting victim or perpetrator status Aggression	Permit child to ask for needs to be met Permit physical affection Control mythical "fairy-tale" thinking Discuss fears Offer comfort and assurance
7-12 years **"Problem-Solver" Stage**	Learn "I am able!" Form relationships outside the family Set limits on self Develop values Develop own rules about life	Permit arguing & negotiating Insist of responsibility & completion of tasks Support friendships Support activities outside of family Talk about values	Controlling access to friends, other parents, relatives Making rules too rigid or too lax	Inability to form relationships Anxiety about abilities Lying, cheating, stealing Extreme rebellion Headaches, stomachaches, ulcers Early interest in sexual activity Problem in school, truancy Aggression	Permit child to disagree Permit child to not tolerate abuse Require follow-through, responsibility Allow natural consequences Clarify values Encourage interests Use logical consequences

13-18 years **"Identity, Sexuality, Separation" Stage**	Become independent Act on own behalf Structure time Accept and love self Express mature love	Be available but not controlling Allow child to separate Give information & protection on sexual activities Allow child to experience consequences Teach living skills	Discounting nuturing needs Sexualizing child's feelings, choices Using teen for money, sex, or emotional support Teasing about body changes Giving repeated negative messages	Depresion/suicide attempts Seuxal assault offenses Running away to deal with problems Lack of internal controls Promiscuity Headaches, stomachaches, ulcers Chemical use Delinquency	Permit child to be both close and separate Accept need for autonomy and promote experiences Accept child unconditionally, heavier conditionality Provide counseling/treatment when needed
Every Stage	Feel unconditional love Receive health care for developing body Explore world & learn Receive predictable emotional support Increase self-reliance Be respected Experience success	Play with children Meet physical survival needs Give warmth and affection Read to/talk with children Provide consistent limits Assure safe environment Seek information & personal support from other parents	Failing to respond Failing to supervise Using violence/causing bodily harm Making sexual genital contact Spanking, pinching, name-calling Ridiculing Being violent to other parent, pets, property	Difficulty trusting others Difficulty maintaining relationships Lack of self-esteem, self-worth Addictive disorders Depression Delinquency	Be consistently involved Affirm feelings Show physical affection Listen to fears Encourage growth in developmental stages Teach responsibility

PROTOCOL FOR ACTION: DRUG OR ALCOHOL ABUSING CLIENT*

Recognizing the Substance Abuser

Abusing drugs or alcohol impairs the critical functions of the ego, which may render casework services ineffective and jeopardize a service provider's safety. The following functions will most likely be compromised in someone who is under the influence of drugs or alcohol:

- Reality testing
- Memory
- Judgment
- Impulse control
- Frustration tolerance
- Thought processes
- Defenses
- The stimulation barrier
- Integration
- Insight

Indicators of Substance Abuse

The impairment of any of these functions may indicate that the client is abusing drugs or alcohol. In addition, there are physical and behavioral indicators that a service provider may observe that could alert them to the presence of substance abuse. Some of these include:

- Slurred speech
- Poor motor control
- Shaking hands
- Red or watery eyes
- Constricted pupils
- Nasal irritation
- Dry mouth
- Slowed reflexes, drowsiness
- Hyperactivity, restlessness
- Needle marks
- An unhealthy appearance
- Rapidly changing emotions
- Confusion, agitation
- Poor concentration
- Dizziness, light-headedness
- Euphoria, inappropriate affect
- Nausea, headaches

If a service provider suspects a client of being under the influence of drugs or alcohol, it is best to set limits by letting the client know that you cannot help them in that condition. Offer to re-schedule the interview when the client can participate fully, without interference or influence of a substance.

*Guidelines adapted from: Arnold Goldstein, Philip J. Monti, Thomas J. Sardino, and Donald J. Green, Police Crisis Intervention, Pergamon Press, New York, 1979.

SAFETY PLANNING ASSESSMENT*

- Why did client decide to seek assistance now?
- What was the most recent event? What services or assistance did she seek afterwards, if any?
- Where is client living now?
- Is client living with the abuser?
- What contact does the client have with the abuser, if not living with him?
- What is the nature of the abuse – physical, verbal, emotional, or financial?
- Does client have children in common with abuser? Does she have children from other relationships?
- Where are the children living now?
- Is abuser physically abusive to children or threatening to harm client or client's children?
- Does client feel safe where she is staying?
- Is client in need of medical attention?
- What assistance was *client* hoping for?
- What are client's present feelings toward the abuser?
- What is client's source of financial support?
- What is client's source of social support (friends, family, church, etc.)?
- What physical, emotional, cognitive, and behavioral symptoms does the client notice in herself?
- What physical, emotional, or behavioral symptoms does the client notice in her children?
- Has client sought assistance in the past regarding her situation? If so, with whom (social services, courts, hospitals, police, mental health setting, etc.)?

OTHER QUESTIONS TO GUIDE YOUR ASSESMENT

HISTORY OF DOMESTIC VIOLENCE

- How long has the client been involved with the abuser?
- When did the abuse begin, and how?
- What was the most serious incident?
- Were there periods of escalation? Of calm?
- Can a cyclical pattern be detected?

*Adapted from Safe Horizons, Westside Community Center Volunteer Training Materials, NY, 1999.

Rape Trauma: Common Responses

Reactions and symptoms which are specific to people who have been victims of sexual assault or attempted sexual assault. (Note: these reactions may be culturally variable as well as different for each individual!)

I. Impact Phase

Duration: **Immediately post-assault until approximately 24 to 48 hours post-assault.**

Emotional Reaction: **During this period, survivors often display a wide range of emotions. Memory gaps are common. Responses are likely to reflect automatic coping styles. In general, responses can be divided in two broad categories:**

A. Expressed reactions: hysteria, anger, euphoria, etc.
B. Controlled reactions: calm, emotionally numb, minimizing, etc.

It is important to understand that any reaction is normal during this phase and that the intensity of the reaction does not in any way reflect the severity of the assault. A survivor who reacts calmly or who laughs and makes jokes has likely been just as traumatized as a survivor who is crying hysterically.

Healing Response: **When dealing with a survivor during the impact phase, the goal is to help the survivor return to a sense of safety and control. Speak calmly and reassure the survivor that nothing will be done without her consent. It is important to emphasize three things:**

A. She is now in a safe place.
B. She has been through a frightening experience.
C. She is not to blame for what happened.

II. Acute Phase

Duration: **Variable -- may last for 3 to 6 weeks or more. This is a period of disorganization in survivor's lifestyle as a result of the rape. Physical symptoms are often especially troubling for survivors and the predominant feeling noted is fear.**

Physical Reaction:
A. Skeletal muscle tension – such as headaches/backache, fatigue, sleep disturbances.
B. Gastrointestinal irritability -- such as stomach pains and nausea.
C. Genitourinary disturbances -- such as vaginal discharge, itching, burning, generalized pain.

Emotional Reaction: **Flashbacks, nightmares, sleep disturbances, appetite changes, poor concentration, emotional changes, memory loss, hyper-vigilance/terror, shame/self-blame, anger.**

Healing Response: **Because of the intensity of the emotional and physical responses to trauma, many survivors during this stage fear that they are "going crazy." It is very important to reassure the survivor that she is experiencing normal, expected reactions to a life-threatening event. At the same time, it is also important to reassure the survivor that with time she will get better. A supportive and non-judgmental attitude which squarely places the blame on the rapist and not the survivor is essential.**

III. Reorganization Phase

Duration: **Begins from 3 weeks to 6 weeks post-assault. This phase starts when the survivor begins to reorganize her lifestyle. The effectiveness of the reorganization is dependent upon many variables, such as ego strength, social supports, and prior history of victimization.**

This is frequently a time when survivors make many changes. They may move, change jobs, friends, lovers, etc. Because of the potential for either positive or negative change, it is a crucial time in the recovery process and a time when the support of other people is especially important.

With support and/or counseling: **The survivor gradually regains control, is able to trust self and then others. Learns to assert self and put blame where it belongs. Returns in most aspects to pre-trauma functioning though flashbacks, fearfulness, sense of vulnerability are likely to last for a long time.**

Without support and/or counseling: **Acute trauma symptoms lessen, but survivor is likely to suffer from one or more of the following difficulties:**

A. Isolation/withdrawal: avoids friends and/or family; difficult to trust others, especially men.

B. Lowered self-esteem: feels shameful, dirty, powerless, naive, stupid.

C. Restricted mobility: phobias arising from a traumatic event, such as fear of being alone, using elevators, going out at night, etc.; giving up previously enjoyable activities if connected to traumatic event; sense of life being limited due to fearfulness.

D. Depression/restricted effects: wary, clamping down on emotions, holding things inside, unable to enjoy previously pleasurable activities.

E. Sexual dysfunction: fear of sex, numbing, sometimes promiscuity resulting from fear of saying no.

Source: Ann Burgess and Lynda Holstrom, from Mt. Sinai SAVI Advocate Training Manual, NY, 2000.

STEM STATEMENTS

- Could it be that you're feeling …
- I wonder if…
- I'm not sure if I'm with you but…
- What I guess I'm hearing as…
- Correct me if I'm wrong, but I'm…
- You appear to be feeling…
- It appears you…
- Perhaps you're feeling…
- Maybe you…
- Maybe this is a long shot, but…
- I understand you're feeling…
- It seems that you…
- As I hear it you…
- Is that what you mean?
- Is that the way you feel?
- What I think I'm hearing is…
- Let me see if I'm with you, you…
- I get the impression that…
- The message I'm getting is that…
- As I get it, you felt that…
- Sometimes you think
- Tell me…
- Let's talk about…
- If I'm hearing you correctly…
- To me it's almost like you are saying…
- So, you are feeling…
- So, as you feel it, you feel…
- It sounds as though you are saying…
- I wonder if you are saying…
- I hear you saying…
- So, it seems you…
- So, from where you are…
- Right now you feel…
- I sense that you're feelings…
- You must have felt…
- Your messages seems to be
- Listening to you, it seems as if…
- I gather you feel…
- You convey a sense of…
- If I'm catching what you say…
- As I think about what you say…
- It occurs to me…
- I'm picking up that you…
- It might help if you could tell me…
- Say something about…
- I'm wondering if…

TAKING PRECAUTIONS: AGENCY VISITS

I. How is the interview room set up?

A. Does it have one or two exit doors?
B. Is it a private room?
C. Is it open and part of a larger room?
D. What are the physical dimensions?
E. Are the walls floor-to-ceiling, ¾ height, ½ height?

II. What furniture exists in the rooms?

A. Is there a desk, table, and enough chairs?
B. Is there a telephone in the room?

III. What pieces of furniture or other items could potentially be used as weapons?

A. Are there glass ashtrays?
B. Are there framed pictures or posters on the walls?
C. Are there pencils, pens, hard-covered books, etc., lying about?
D. If there is a telephone, is it a necessity?

IV. Are doors needed on the exits to the room?

A. Does staff need total privacy during this interview?
B. At a minimum, staff should be warned to leave doors open during any interview that is perceived to be potentially dangerous.

V. Are one or two rooms designated as the "risk rooms"?

A. Do these rooms have access or viewing windows?

VI. Is there a safe procedure for a service provider to request assistance?

A. Is there a code for communicating the need for back-up while in the survivor's presence?

Stage 1: - Discreetly call anyone for a "green file," while maintaining normal communication with survivor, and
- Co-worker joins you informally under the pretense of other business.

Stage 2: - Discreetly call for an "index catalog," and
- Security forces or additional workers will join you.

When confronted with potentially violent behavior, initiate **Stage 1** immediately, even if the need is doubtful, and take the following steps:

a. Casually interrupt the interview to call and request the "green file."
b. Continuously engage the survivor in conversation about their feelings or a specific problem.
c. Encourage the survivor to be seated, if at all possible. If a survivor suddenly becomes overtly abusive, it is easier to deal with him if he is sitting down, and the service provider should remain sitting as well.
d. Co-workers who join you must explain the reason in such a way as not to upset the survivor and then gently join in the helping process.
e. If the survivor becomes more threatening, explain the consequences of violent behavior without condemnation and remain calm.
f. Initiate **Stage 2**.

VII. Are all staff members aware of safety/security procedures?

A. Do receptionists, volunteers, and any other non-professional staff have equal knowledge of existing procedures?
B. Have these procedures been practiced, similarly to fire drills?

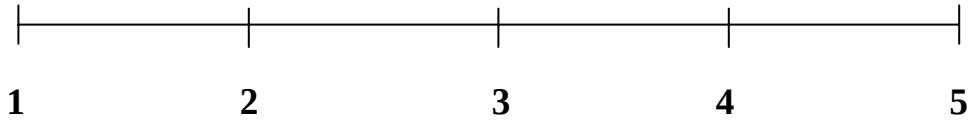
VIII. Are security personnel readily available?

A. Does internal security exist?
B. Are external security forces available?

DAILY EVALUATION FORM

TODAY'S DATE _____

1) How valuable were today's sessions for you, based on a scale of 1 to 5? (1 = not valuable at all; 5 = extremely valuable)



2) Identify 3 things from today that will be useful to you in your job.

a. _____
b. _____
c. _____

3) Please provide any comments or recommendations regarding the content of today's training.

_____
_____
_____
_____

4) Please feel free to write any additional comments here.

_____
_____
_____
_____

PROTOCOL FOR ACTION: MENTALLY DISTURBED CLIENTS*

Dealing with the Mentally Ill

Many service providers are understandably hesitant about dealing with clients who are mentally ill, but these fears are, to a great extent, unfounded. Regardless of diagnosis, number of hospitalizations, scores on standardized tests, or behaviors in a hospital, there is no systematic relationship between these factors and behavior in the community. This is not to say that the mentally ill never become violent, but their mental status is usually characterized by fear and confusion rather than by aggression. The following guidelines will enhance the service provider's ability to relate to mentally ill clients in the office or in the field:

- ❑ State clearly who you are and the purpose of your contact.
- ❑ Be empathetic, non-threatening and sincere in your intention to help.
- ❑ Give honest, factual answers whenever necessary. If you do not know, say so.
- ❑ Do not belittle concerns which the client raises.
- ❑ Particularly on initial contact, do not give advice as to the handling of their psychological problems. You may just be seeing the tip of the iceberg.
- ❑ Check out your own feelings in response to client statements. Respond from a professional, not personal, level.
- ❑ Attempt to be supportive in comments and gestures. Remember that non-verbal communication includes facial expressions and tone of voice.
- ❑ Do not assume mentally ill people should "know better" and are in need of a good lecture to straighten them out.
- ❑ Know how to activate emergency mental health back-up and use it if the client appears to be a danger to themselves or others.

*Guidelines adapted from: Arnold Goldstein, Philip J. Monti, Thomas J. Sardino, and Donald J. Green, Police Crisis Intervention, Pergamon Press, New York, 1979.

HELPER SKILLS EVALUATION CHECKLIST

Note: This checklist will help you to identify some of the important skills that workers should use when engaging with survivors. You may use it during roles plays, and you may also use it to reflect on your own work.

Interpersonal Skills

□ Greets clients

□ Introduces self

□ Introduces services and role

□ Discusses confidentiality

□ Engages clients in conversation

□ Attends to clients

□ Observes

□ Is supportive and non-judgmental

□ Shows empathy

□ Can deal with difficult emotions

Gathering Information

□ Encourages clients to speak

□ Uses good questions

□ Uses silence where appropriate

□ Seeks clarification

□ Summarizes main issues

Giving Information

□ Gives clear and simple information

□ Gives clients time to absorb information and to respond

□ Checks for understanding/misunderstanding

□ Summarizes main issues

Problem Solving

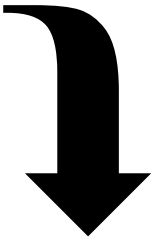
□ Is able to identify problems with clients

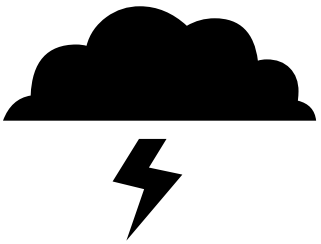
□ Encourages client to come up with own solutions

□ Does not tell client what to do/ give advice

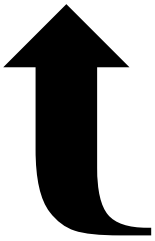
Cycle of Violence*

Phase I
Increased tension, anger, blaming and arguing.

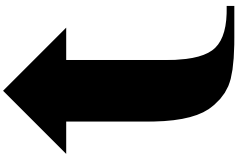




Phase 2
Battering – hitting, slapping, kicking, choking, use of objects or weapons. Sexual abuse. Verbal threats and abuse.



Phase 3
Calm Stage (this stage may increase over time). Man may deny violence, say he was drunk, say he's sorry, and promise it will never happen again.



*Helton, A. S. 1987. *Protocol of Care for the Battered Woman: Prevention of Battering during Pregnancy*. White Plains, NY: March of Dimes Birth Defects Foundation.

PROTOCOL FOR ACTION: SUICIDAL/HOMICIDAL CLIENTS*

Suicide: What You Can Do to Help

1. Recognize signs of depression and suicide risk:

- Change in personality: sad, withdrawn, irritable, anxious, tired, apathetic
- Change in behavior: cannot concentrate on school, work, routine, etc.
- Change in sleep pattern: oversleeping, insomnia, early wakening
- Change in eating habits: loss of appetite and weight, overeating
- Loss of interest in friends, sex, hobbies, activities previously enjoyed
- Worry about money, illness (either real or imaginary)
- Fears of losing control, going crazy, harming self or others
- Feelings of worthlessness, "nobody cares," "people will be better off without me"
- Feelings of overwhelming guilt, shame, self-hatred
- Hopelessness, "it will never get better, I will always feel this way"
- Drug or alcohol abuse
- Recent loss: through death, divorce, separation, broken relationship, or loss of health, job, money, status, self-confidence, self-esteem
- Loss of religious faith
- Suicidal impulses: gestures, statements, plans; self-inflicted cuts or burns; giving away favorite things or making out a will; previous suicide attempts; reckless behavior; inappropriately "saying goodbye"
- Depression that disappears and is replaced by a sense of calm – when there is not change of external circumstances
- Holidays, anniversaries, and the first weeks after discharge from a hospital can be difficult periods
- Agitation, hyperactivity, restlessness may indicate masked depression

2. Do not be afraid to ask: "Are you having thoughts of suicide?"

It can be a great relief if you bring the question of suicide into the open and discuss it freely without shock or disapproval. Asking about suicide shows the client that you take him seriously, that you care about him, and that you are willing to let him share some of his pain with you. Just about everyone has considered suicide, however fleetingly, at one time or another. There is no danger of giving someone the idea.

3. If the answer if "yes," you must take it seriously and follow it through:

Have you thought of how you would do it? Do you have the means? Have you thought about when you would do it? Have you ever attempted suicide before? What happened then? If the person has a plan, the means are available, the method has a high lethality risk, and the time is set, then the risk of suicide is very high. Your response will be geared to the urgency of the situation as you see it. Therefore, it is vital not to underestimate the danger by not asking for the details.

4. Do not leave the suicidal person alone if there is immediate danger:

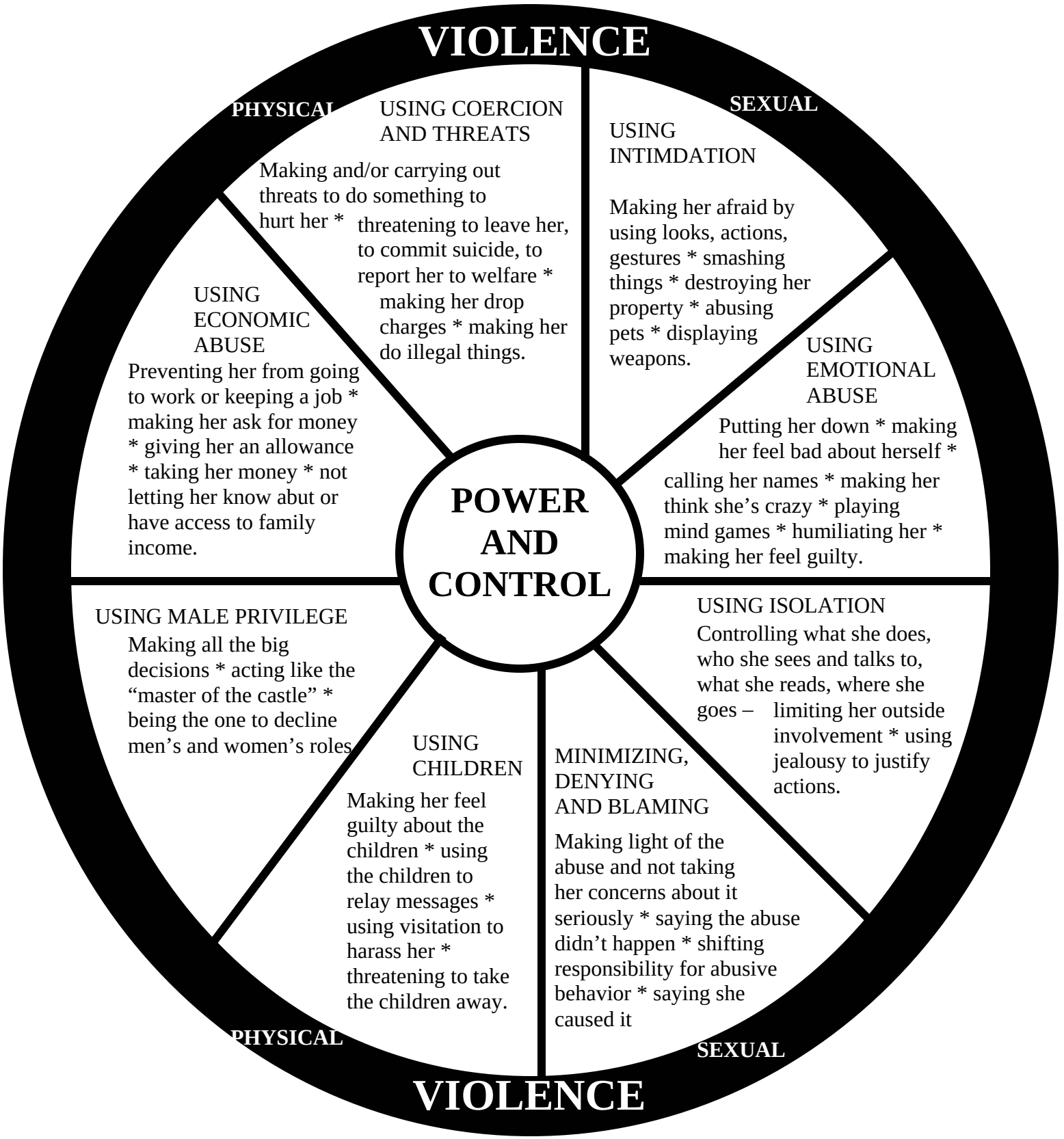
Stay with the person until help arrives or the crisis passes. Nearly everyone can be helped to overcome almost any kind of situation that might destroy their self-confidence if they have someone who will listen, take them seriously, and help them feel worthwhile and wanted again. Common to almost every suicidal crisis is strong ambivalence: "I want to kill myself, but I don't want to be dead – at least not forever." What most suicidal people want is not death, but some way out of the terrible pain of feeling "Life is not worth living, I am not fit to live, I am all alone with this, I don't belong, and nobody cares."

Your job is to listen. After being allowed to unburden – without interruption, without being judged or criticized, without being rejected, without being told what to do – then tension drops, the pain is relieved and the suicidal feelings pass; maybe not forever, but for now.

If you cannot get the person to talk, if he is hallucinating or influenced by drugs or alcohol, if the danger of suicide is imminent, get professional help. If the means are available, try to get rid of them. Do not try to go it alone. Whenever you deal with a suicidal person, get some outside help with the situation.

*Guidelines adapted from: Arnold Goldstein, Philip J. Monti, Thomas J. Sardino, and Donald J. Green, Police Crisis Intervention, Pergamon Press, New York, 1979

POWER AND CONTROL WHEEL



Day III Handout – Power and Control Wheel

Borrowed from: Domestic Violence Intervention Project
Duluth, Minnesota, USA

Interaction Techniques (2)*

*Adapted from Safe Horizons, Volunteer Training Materials, NY, 1999.

Less Desirable Techniques	**Examples**
1. Questioning	"Why did you run away?" "How come you left home?"
2. Reassuring	"I wouldn't worry about that." "You'll do fine." "I'm sure your parents love you."
3. Giving Approval	"That's good." "I'm glad that you…"
4. Rejecting	"I don't want to hear about…"
5. Disapproving	"That's bad." "I'd rather you didn't."
6. Disagreeing	"That's wrong." "I definitely disagree."
7. Advising	"I think you should…" "Why don't you?"
8. Challenging	"If you're dead, how can your heart be beating?"
9. Testing	"If you had a pregnancy test, what was the procedure?"
10. Interpreting	"What you really mean is…" "Unconsciously, you're saying…"
11. Lecturing	Giving speeches or telling stories.
12. Introducing Unrelated Topics	Changing the subject.

Interaction Techniques (1)*

*Adapted from Safe Horizons Volunteer Training Materials, NY, 1999.

Therapeutic Techniques	**Examples**
1. Open invitation to talk	"Maybe you could tell me a little bit about what happened," instead of "Have you been raped/beaten?"
2. Using Encouragers	"Yes," "Go on," "and then?"
3. Using Silence	Stay interested and alert, but don't always feel like you have to speak.
4. Reflecting Feelings	"Sounds like you feel angry..."
5. Seeking Clarification	"I'm not sure that I understand. Could you explain?"
6. Restating/Paraphrasing	Client: "I can't sleep. I stay awake all night." Counselor: "You have trouble sleeping."
7. Giving Broad Openings	"There seems to be something on your mind."
8. Exploring	"Could you tell me more about that?"
9. Attempting to place in sequence	"What seemed to lead up to this point?" "So this occurred."
10. Offering Self	"I'm concerned about what you are saying."
11. Giving Recognition	"It takes courage to tell me your story."
12. Suggesting Cooperation and/or Collaboration	"Together we can sort out the problems you're facing."
13. Summarizing	"Let's see if I've got this straight—you've said that…"

PROTOCOL FOR ACTION: ANGRY CLIENTS*

There are some pitfalls to be aware of when dealing with angry clients. Negative results occur when service providers:

- ❑ Pay more attention to the words said than to the feelings expressed by the client
- ❑ Take anger personally, take responsibility for it, or become defensive
- ❑ Discount the anger as irrelevant to the problem and its resolution
- ❑ Avoid the client's anger by making a hasty assessment and giving a referral inappropriately to get rid of them
- ❑ Refuse to acknowledge mistakes or inefficient casework
- ❑ Allow personal feelings about the client's anger to interfere with one's willingness to provide services
- ❑ Ignore the obvious signs of escalating violence and jeopardize the safety of the worker and client

Managing Anger – Verbal Techniques to Diffuse Anger

1. Ventilation: Allowing the client to express appropriately his/her anger and frustration. The client must be allowed to say what he/she wants to say without judgment or criticism by the service provider.

2. Distraction: Control the client's conversation by asking closed questions that require short responses. For example "Who did it?" "Where did it happen?" etc.

3. Reassurance: The service provider must demonstrate that he/she has the ability and willingness to help the client resolve the problem.

4. Understanding: Acknowledge the fact that the client is angry without judging the client and seek to understand why. Let them know you can identify with their feelings.

5. Modeling: Controlling the tone of one's voice, speaking in simple, quiet sentences, and demonstrating self-control.

6. Humor: Humor can help to alleviate some of the tension. However, one should never use humor if one is not good at it.

7. One-to-One: There should not be other people standing around. Having an audience can provoke a more exaggerated response.

8. Limit-Setting: Remind the client of the natural consequences if he/she cannot control their behavior.

*Guidelines adapted from: Arnold Goldstein, Philip J. Monti, Thomas J. Sardino, and Donald J. Green, Police Crisis Intervention, Pergamon Press, New York, 1979.

Gather MODEL*

Greet

- Identify yourself
- Identify the agency
- Explain the process: “I am going to ask you a series of questions that will help me to assist you.”
- Explain the principle of confidentiality (and when confidentiality might be broken)
- Check whether the client has any questions

gAther

Ask

- Explain to client that you would like to ask her some questions and tell her why you are about to ask those questions:
    - “In order for me to better understand how I can help you, I am going to ask you some questions about what brings you in today/what you’ve been through…”

- When asking about the client’s exposure to GBV, remember to ask specific questions: what, when, how. These will help to keep the client using her thinking skills, and reduce the likelihood of the client becoming emotionally overwhelmed during the interview. While you DO want to allow the client to express herself emotionally, you DO NOT want the client to leave the interview feeling overwhelmed.

gaTher

Tell

- As the client is telling you what she experienced, it is very important to give her support and validation (believe her!)
    - I'm sorry this happened to you
    - No one deserves to be abused
    - I'm glad that you were able to tell me. I think we can help you. Now I would like to ask you a few more questions that will give me more information so that together we can figure out the best options.

gatHer

Help

- At this stage, after you have gathered the basic information about the incident, it is important to gather as much additional information as you can about the GBV so that you can most effectively help the client. Do not move on to the next stage until you feel that you have comprehensive information!
    Who is the perpetrator?
    How long has the abuse been happening?
    Are you in danger now?
- If there is any indication that the client is in danger or may be in danger in the future, develop a safety plan
- Begin to identify what kinds of referrals client may need/want, identifying options rather than giving advice.

gathEr

Educate

- Begin the education phase by reviewing what you've heard: "you've said;" "we've discussed;" "you mentioned"
- Review stress reactions. "You mentioned that you are feeling more tired than usual…Have you experienced …?"
- Normalize the stress reactions: "It is not uncommon for people to experience…"; "Many people have similar feelings…"
- Strategize about how client can manage stress reaction. Ask what the client has done in the past that has been helpful in managing stress reaction. Identify and support strengths.

gatheR

Refer, Return, Review

- Be prepared with a list of organizations to which you may refer the client (social services, police, shelter). If necessary, call organizations while client is sitting with you to schedule appointments
- Schedule a time for the client to return for follow-up
- Review plans for self-care, referrals, and follow-up to make sure client understands

*Note: This model (and the term "GATHER") was adapted for use with GBV survivors from the Reproductive Health Interagency Field Manual, IAWG, 1999. The adaptation here relies on principles of trauma assessment and crisis debriefing.

Activity Sheet
Role Play for Protocols for Action

Incorporate the following into your role play and consider worker safety:

1) Review of indicators (clues) for:

- **suicidality/homicidality**
- **agitation/escalation**
- **drug/alcohol abuse**
- **mental disturbance**

2) Assessment of survivor for:

- **suicidality/homicidality**
- **agitation/escalation**
- **drug/alcohol abuse**
- **mental disturbance**

3) Response of service provider (or others) if survivor:

- **acknowledges immediate plan to hurt him/herself or someone else**
- **becomes agitated or upset**
- **exhibits use of drugs or alcohol**
- **exhibits psychotic, delusional, or paranoid behavior**

Guidelines for Giving Role Play Feedback

During the training you will be asked to give feedback to the other members of the training on their role play practice. In some instances, you will be role playing a survivor and will be asked to give feedback to the service provider who was helping you. You will be asked to talk about what was helpful to you and what you felt might have been done better. You will also be asked to talk about how it felt to play a survivor. Other times you'll be asked to give feedback to others' role plays.

Since it can be difficult and intimidating to hear and use feedback, below are some guidelines for giving role play feedback. These guidelines should also be applied to your work when giving feedback to colleagues about their interventions with clients.

1. Focus on the positive.

What did the service provider do to make you feel comfortable? How did the service provider feel at ease? How did the service provider show that you weren't being judged? When did you feel that the service provider really understood you feelings? What made you feel that way? How did the service provider help you to understand what the medical exam would be like? Was there anything in particular that you really liked that the service provider said?

2. Give critical feedback gently.

Everyone has a hard time being criticized and critical feedback is only useful if the recipient can learn something from it. Think about what others have done to make their critical feedback useful to you, and do this for the service provider to whom you are giving feedback.

3. Use "I" statement.

When you are playing the role of the survivor and giving feedback to your service provider make "I" statements. For example: "I got really confused when you started talking about the legal process and the grand jury and used all the technical language" instead of "You really blew it when you were describing the legal process."

4. Be specific about what you felt could have been handled better.

5. Give suggestions and options regarding what might have worked better.

For examples: "When *I* asked you about my risk for AIDS and you gave a long explanation about antibodies and the different tests, I got really lost. I guess what I wanted was a shorter answer about what my risk might be."

6. Balance the negative feedback with positive feedback.

Interaction Techniques (2)	
Less Desirable Techniques	**Examples**
1. Questioning	"Why did you run away?" "How come you left home?"
2. Reassuring	"I wouldn't worry about that." "You'll do fine." "I'm sure your parents love you."
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	you are saying”
11. Giving Recognition	“It takes courage to tell me your story”
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13. Summarizing	“Let’s see if I’ve got this straight – you’ve said that…”

What is your role? What is your goal?

- Active screening
- Crisis Debriefing
- Case Management
- Counseling

SELF-CARE AND MANAGING STRESS

SOURCES OF STRESS:	STRATEGIES:
Lack of Confidence	**Utilize supervision, peers** **Realize your own strengths** **Seek mentors and practice skills** **Seek training, observe others, read**
Personal Sore Spots	**Know your "buttons"** **Desensitize yourself (write the most troubling things a survivor could say/do and rehearse your response)** **Find a colleague for practice and support**
Built-up Stress	**Be aware of your own limits** **Know the signs of burn-out** **Attend to your needs for leisure, socialization, rest, and pleasure** **Know when to ask for help**
Physical Responses	**Practice relaxation** **Take slow, deep breaths** **Progressive muscle release** **Maintain a neutral expression** **Keep your voice calm and ready**
Organizational/Administrative Confusion	**Clarify agency policies** **Know and practice safety procedures** **Supervisors should advocate for staff safety** **Initiate a "buddy" system** **Establish liaisons with police**

Defining Vicarious Trauma

- A change in a service provider's inner experience as a result of empathic engagement with survivors of trauma and hearing their story.

- Changes that occur in the service provider's physical, emotional, and/or behavioral states as a result of exposure to traumatic stories or events.

Causes of Vicarious Trauma

- Exposure to stories of trauma
- Desire to help/change survivor's situation
- Feeling powerless when a service provider does not see positive changes in the survivor's situations
- Overly identifying with survivors
- Thinking we have the power to change the survivor's situations

Dealing with Vicarious Trauma

Some ways in which people have found it helpful to prevent and manage vicarious trauma include:

- Awareness – being attuned to one's needs, limits, emotions and resources; practice self-acceptance.
- Balance – maintaining balance among activities, especially work, play, and rest.
- Connection – maintaining supportive relationships; communication is part of connection and breaks the silence of unacknowledged pain; these connections help prevent isolation and increase validation and hope.

TEN BELIEFS THAT PREVENT HELPERS FROM GETTING HELP!

WE BELIEVE:

1. We should not experience personal problems…that we know better!

2. We view personal problems as a sign of inadequacy or failure.

3. We think that there is no safe place for us to get help.

4. We should be aware of all helping resources for all problems.

5. We have helping skills and can take care of ourselves.

6. We often intellectualize and/or disassociate from the emotional impact of our problems.

7. We often counsel family, friends, and significant others…a violation of boundaries.

8. We feel responsible for and often take the blame if a family member or significant other has a personal problem.

9. We feel embarrassed to seek help from fellow professionals.

10. As a result of the above, we often wait longer than others to let people help and often sabotage our own treatment.

Professional helpers often share the above characteristics. Early family experience may have contributed to becoming a caretaker at an early age and continuing that role into adulthood. It may also be a factor of being part of a small community (professional or social) where everyone knows everyone else.

How can our organizations and work environments support us?

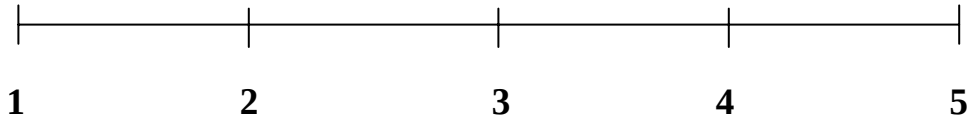
- supervision
- group case review
- self-care groups
- paired debriefings
- group and team building exercises

- other?

DAILY EVALUATION FORM

TODAY'S DATE _____

1) How valuable were today's sessions for you, based on a scale of 1 to 5? (1 = not valuable at all; 5 = extremely valuable)



2) Identify 3 things from today that will be useful to you in your job.

a. _____
b. _____
c. _____

3) Please provide any comments or recommendations regarding the content of today's training.

_____
_____
_____
_____

4) Please feel free to write any additional comments here.

_____
_____
_____
_____

Responses as Guide to Action: Working with Victims of Domestic Violence

Emotional Response

What You Can Do

	The Victim's Response	The Worker's Response	For the Victim	For Yourself
Fear	Of getting hurt again or being rejected by those close to her or by institutional personnel. Of being injured or killed. Specific phobias can develop.	Of getting involved. Of what might happen to you. Of getting hurt. That what happened to victim could happen to you. Specific phobias can develop.	Offer medical attention, safety options e.g., shelter, moving, living with friends. Listen to her fears. Help her anticipate dangers and plan for safety. Secure your work environment.	Do not discount any fears, they are based on reality. Establish safety procedures; 1) People who will look out for you. 2) Self-defense courses Talk out your fears.
Denial	Of the seriousness or even the *existence* of the problem. May put problem outside of her. She may say "this can't be happening" or "I have a problem; he doesn't."	Of the seriousness of the problem or that there *is* a problem or that it can happen to you.	Remember that denial is a *defense,* not a shortcoming. Continue to encourage communication while respecting the survival value of her defenses.	Find someone to talk to. Process cases or sessions. Attempt to learn more about you own victimization experience: your resilience, skills, and unresolved issues.
Overwhelmed	By lack or total inadequacy of options and resources. By feelings of terror, rage, helplessness. By urgency of need to drastically change her entire life, e.g., move, find new schools, new job. By other people's expectation.	By lack or total inadequacy of options and resources for victims. By hearing too many painful, scary stories. By anxiety because you cannot control client's fate. By anxiety because victim's safety is questionable.	Help her mobilize a support network. Help her prioritize and focus on safety as the primary concern. Help client articulate goals. Point out her personal strengths.	Establish realistic goals. Try to determine your own limits and personal needs. Talk out feelings. Check out your expectations for yourself and for clients. Use support networks for yourself and victim.
Discouragement	Being beaten down by having ventured forth before and finding that nothing worked. Constant confrontation with institutional indifference or hostility. Support systems will not come through and she may feel unable to mobilize herself anymore.	Cannot do *anything* for victim Victim's discouragement may produce overwhelming anxiety about your own helplessness. Violence makes you acutely aware of how helpless you can be.	Do not establish goals for client based upon *your* definition of "what's best." Help her see that there are alternatives. Try to understand the significance of even small steps. Help her believe she can regain control over her life.	Try to establish specific areas where you and victim can succeed. Share your concerns. Feel mastery in your job; know resources, helpful counseling ideas and what has worked for other programs.
Ambivalence	May question whether or not she should leave or terminate the relationship. Partner may be both loving *and* violent. She may have to make drastic life style changes and feels legitimately ambivalent about them.	May question whether or not victim should "break up family." May feel ambivalent about getting involved with victims.	Acknowledge ambivalence. Do not push her to change. She must make her *own* choices and resolve conflictual feelings. Allow her to express her ambivalence, and accept it.	Examine the sources of your ambivalence, value systems, societal pressure, stereotypes, etc. Acknowledge your own ambivalence. Do not avoid talking about client's ambivalence: accept it as part of the deal.

SELF-CARE PLAN

Physical Well-Being	Emotional Well-Being

Intellectual Well-Being	Spiritual Well-Being

Signed: _____ Date: _____

MY GREAT WORTH

Objective: To overcome barriers that keep advocates/service providers from receiving the full measure of self-esteem and self-worth available from their work.

Imagine yourself at an awards ceremony. What is it that you most wish someone from each of the following three categories would say about you and the work you have done?

An important supervisor:

A special survivor you once worked with:

A family member:

Case Vignettes

Sara is a 23-year-old woman who frequently wakes up in the middle of the night after having nightmares about a child being forced to have sex. Rarely does she have a full night's sleep and usually spends her days at work exhausted and irritable. Often she finds herself feeling anxious when she sees a young child with her father and wonders whether the parent has molested the child.

Ellen is a 25-year-old woman who has difficulty concentrating at work. She often keeps to herself and rarely speaks to her co-workers. Often she seems nervous and jumpy when someone approaches her to ask her a question. She seldom socializes outside of work and feels afraid of most men, thinking that they are probably abusive. She often finds herself crying at the slightest thing.

What do Ellen and Sara have in common?

EMPATHY vs. SYMPATHY

EMPATHY

Empathy is a psychological identification with or attempt to understand the feelings, thoughts, or attitudes of another person. It is the attempt to put oneself in the survivor's shoes.

SYMPATHY

Sympathy is the ability to share the feeling of another, especially in sorrow or trouble, as in compassion or commiseration. Sympathy describes a quality of relations between people or things whereby whatever affects one also affects the other. Sympathy also implies that the service provider feels sorry for the survivor.

EMPATHY

- **An intellectual/personal understanding**
- **A professional distance**
- **Maintenance of objectivity**
- **Compassion without companionship**
- **Leaves room for EMPOWERMENT of the survivor**

SYMPATHY

- **Emotional identification**
- **Loss of objectivity**
- **Personal attachment**
- **Compassion and companionship**
- **Open to co-dependency**
- **Can take power away from the survivor**

Sample Record Keeping Exercises*

How do you document the following information in the record?

1) A 35-year-old client who you are counseling for domestic violence reveals graphic details about incest with her father when she was a child. Do you include this in the record and if so, how?

All records should include: Client's name; date of appointment; location of appointment; client response; next steps or outcome.

Indicate whether you disagree with the write up. If you disagree, think of ways to rewrite the entry. The original records as follows:

Example 1:
24/3/96 Client is a victim of an assault by her ex-husband. She would like a counseling referral and assistance with finding a shelter. She also states that both she and her 16-year-old daughter are very afraid of the ex-husband

5/4/96 Client came in today to work on finding a shelter. She told me that her 16-year-old daughter is pregnant and client reports that she is going to encourage her to get an abortion.

Example 2:
Mrs. Jones thinks that her husband is drinking again. She is very upset about it. Her husband is very dirty; he never showers and smells of alcohol. He also says inappropriate things to her when they are in public.

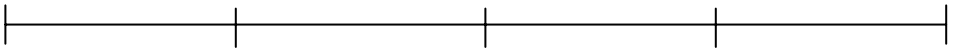
Example 3:
Client came in to discuss a date rape by her neighbor. She reported that she is afraid of her neighbor, yet she does not want to move and talks about him and his girlfriend in all of her sessions here. Although she reports having nightmares, in my opinion, I am beginning to doubt that the incident really occurred. I think the client might be mad at the neighbor for not leaving his girlfriend. I was also suspicious because she did not have injuries the first time she came in, even though it was right after the alleged incident.

*Adapted from Safe Horizons, Volunteer Training Materials, NY, 1999.

DAILY EVALUATION FORM

TODAY'S DATE _____

1) How valuable were today's sessions for you, based on a scale of 1 to 5? (1 = extremely valuable; 5 = not valuable at all)



1 2 3 4 5

2) List the 3 most important things you have learned today?

a. _____
b. _____
c. _____

3) How do you intend to apply these things to your job?

_____
_____
_____
_____

4) What forces will encourage or discourage you from applying the best ideas you have learned today when you return to you job?

_____
_____
_____
_____

GENDER-BASED VIOLENCE FIELD TOOLS*
SAMPLE INCIDENT REPORT FORM FOR REFUGEE SETTING

NOTE: In adjusting this form for non-refugee settings, efforts should be made to minimize changes, so as to ensure consistency in data collection in all humanitarian contexts.

INCIDENT REPORT FORM *CONFIDENTIAL*

Instructions	• Form to be completed by fully trained and designated staff • Original to be maintained in designated agency (outside camp) • Copy to be delivered to UNHCR Protection Officer, in sealed envelope, as soon as possible. (If survivor wishes to report incident to police, Protection Officer must have copy within 24 hours.) • Attach additional pages with continued narrative, if needed.
NOTE	***This form is NOT an interview guide. Staff must be properly trained in interviewing survivors. Separate forms are available for counseling and health exam/treatment.***

INCIDENT TYPE			Secondary incident type
Case Number	Camp		Date and Time of Interview
Previous Incident Numbers for this Client (if any)			

SURVIVOR INFORMATION			
Name	Age	Yr of Birth	Sex
Address	Tribe	Marital Status	Occupation
No. of children	Ages	Head of family (self OR name, relationship to survivor)	
UNHCR "Vulnerable" designation (if any)		Ration Card No. or ID Card No.	
If Survivor is a minor child, Name of Caregiver		Relation	

THE INCIDENT			
Location	Date	Day	Time
Description of Incident (summarize circumstances, what exactly occurred, what happened afterward)			

PERPETRATOR INFORMATION		
Name	No. of Perpetrators	Sex

Address	Nationality	Age	Tribe
Relationship to Survivor	Marital Status	Occup.	

If perpetrator unknown, describe him/her, including any identifying marks

Current location of perpetrator, if known: Is perpetrator a continuing threat?

If Perpetrator is a Minor, Name of Caregiver: Relation:

WITNESSES

Describe presence of any witnesses (including children)

Names and Addresses

ACTION TAKEN – Any action already taken, by anyone, as of the date this form is completed.

Reported to	**Date Reported**	**Action Taken**
POLICE Name		
SECURITY Name		
UNHCR Name		
LOCAL LEADERS Name		
HEALTH CARE see page 3 of this form for name/info.		
OTHERS Name		

MORE ACTION NEEDED AND PLANNED ACTION – As of the date this form is completed.

Danger Assessment & Immediate Safety Plan:

Is Survivor going to report the incident to the Police? □ Yes □ No

Is she/he seeking action by elders tribunal/traditional court? □Yes □No

What follow-up will be done by the Community Development/GV workers?

What further action is need by UNHCR and/or others?

Form completed by (Print Name): Signature:

Page 1 and 2 (filled) + Page 3 (1st two lines filled) to be hand carried by staff, with Survivor, to Health Center. Page 3 to be completed by health care staff. OR if Survivor did not have medical examination at the time of reporting the incident, explain reasons below.

SUMMARY OF MEDICAL EXAMINATION

Survivor Name	Yr of Birth	Sex
(If applicable) Reasons survivor did NOT have a medical examination at this time:		

TO BE COMPLETED BY HEALTH CENTER STAFF

Date of Exam	Time	Name of IPD/OPD

Before interviewing/examining the survivor, read pages 1-2 of this form.
Avoid asking survivor to repeat information s/he has already provided.
Medical Examination Findings are to be recorded on the appropriate health facility forms, in accordance with relevant protocols and guidelines.
Medical records, documentation, forms, etc. are confidential and are to be kept in the health facility in a secure location. Medical information is to be released only with specific survivor consent.
THIS PAGE DOES NOT REPLACE THE HEALTH FACILITY MEDICAL EXAM FORM (IT IS IN ADDITION).

Summary of Medical Treatment Given
NOTE
This information may be important for the counselor to know for follow-up assistance; however: *obtain survivor's consent to share this information*. Include information to EC, forensic examination, post-exposure prophylaxis for STIs/HIV/AIDS, referrals provided.

Medical Follow-Up Recommended

- ☐ Follow-up visit to health facility in two weeks
- ☐ Follow-up visit to health facility in six months
- ☐ Other, specify:

Additional Comments

Examination conducted by:

Print Name	Title
Signature	Name of organization & stamp

GENDER-BASED VIOLENCE FIELD TOOLS
CONSENT FOR RELEASE OF INFORMATION

Note: The purpose of this form is for you to obtain Survivor's permission to share her/his information about the incident with other applicable organizations/individuals.

To the staff member or volunteer completing this form:
Read the entire form to the client, explaining that s/he can choose any (or none) of the items listed. Obtain signature or thumb print with witness signature.

I, _____, give my permission for the
(print survivor name)
following organizations to share information about the incident I have reported in this form, and about my current needs. I understand this permission is needed so that I can receive the best possible care and assistance. I understand that the information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I need and request.

(Mark with an X all that apply)

☐ Community Services agency (name) _____

☐ Health Center (name of organization) _____

☐ UNHCR (Protection Officer, others)

☐ Police

☐Camp / block leader. Specify names:
_____

☐ Others, specify:
_____

_____

Signature or Thumb print _____

Witness (for thumb print) _____

Date _____

From: Gender-based Violence Tools Manual for Assessment and Program Design, Monitoring, and Evaluation, RHRC Consortium, 2004.

Record Keeping Do's and Don'ts*

1. **All records should include:**
   - **-- Survivor's name**
   - **-- Location of Interview**
   - **-- Survivor's response**
   - **-- Date of appointment**
   - **-- Reason for appointment**
   - **-- Next steps or outcome**

2. **Use ink for keeping records.**

3. **Record exact dates.**

4. **In dealing with survivors who are victims of abuse or other crimes, be careful about documenting details concerning the survivor's contact with someone who assaulted or battered the survivor. Think about how the information might impact the survivor if the information were released during a criminal/civil trial.**

5. **If the survivor is planning to relocate, do not include her intended destination in case file.**

6. **Do not include the details of an survivor's past criminal behavior, unless there is a strong reason to document the activity.**

7. **Always give the sources of information (e.g., was it provided by the survivor, a survivor's relative, other service providers) and attribute statements to the person who made them.**

8. **Avoid highly subjective words (e.g., house was "dirty") when describing persons or situations – try to use objective language.**

9. **Recording must be kept current and complete enough so that another staff member can pick it up without difficulty.**

10. **Do not make an informal diagnosis of a survivor's condition (e.g., "person seems schizophrenic," "person is psychotic").**

11. **Always follow up on next-step activities as indicated in the record – this is especially critical in documenting difficult cases, such as suicide, homicide, and child abuse.**

12. **Document any information that involves sharing, acquiring, or giving information to another person or colleague.**

13. **Document any areas where the survivor may not be complying with rules, regulations or an agreed upon program.**

14. **Document all critical incidents.**

15. **Never use negative information that the survivor says he/she is doing or not doing (e.g., if the person indicates they are not taking his/her medication).**

16. **Do not put your personal opinions in the records (e.g., "I don't like the person," "I think that..." "this person's injuries are not bad").**

17. **Never alter or falsify records, add or change a record at a later date, re-write an old record, or change another person's records or notes.**

*From Safe Horizons, Volunteer Training Materials, NY, 1999 and referencing Gorton, R, The Weakest Link in Your Risk Management Program: Documentation.

Communication Skills in Working with Survivors of Gender-based Violence Training Workshop

Pre-/Post-Test

1. Define gender-based violence.

_____
_____
_____
_____
_____

2. Name 5 types of gender-based violence.

_____
_____
_____
_____
_____

3. Name the sectors involved in a multisectoral GBV response framework:

a) _____
b) _____
c) _____
d) _____

4. What kinds of events can cause trauma?

_____
_____
_____
_____

5. Why is it not good for a service provider to advise a survivor what to do?

_____
_____
_____
_____
_____

6. What does the acronym GATHER stand for?

G: _____
A: _____
T: _____
H: _____
E: _____
R: _____

7. How can a service provider demonstrate active listening skills?

_____
_____
_____
_____

8. What is vicarious trauma?

_____
_____
_____
_____
_____

9. Identify two methods of supervision of staff who work with GBV survivors.

_____
_____
_____
_____

10. Why is staff supervision important when working with survivors of GBV?

_____
_____
_____
_____
_____

11. Name three things that are important to include in a case record of a GBV survivor.

_____
_____
_____
_____
_____

12. Name three things that you might NOT want to include in a case record of a GBV survivor.

_____
_____
_____
_____
_____

EXCEPTIONS FOR BREAKING CONFIDENTIALITY

- **Suspicion of child abuse or neglect**

- **Emergency of life-threatening situations**

  - **Suicidal individuals: Duty to warn/contact referral source or relative**

  - **Individual presents a threat to third parties: Duty to warn/contact police**

- **Intent to commit future crime: You may not be legally mandated to report future crimes; however, if you report them, you will not be breaching confidentiality**

IN SOME SETTINGS, WORKERS ARE MANDATED BY THEIR ORGANIZATIONS' CODE OF CONDUCT TO REPORT ANY INFORMATION RELATING TO ABUSE OF BENEFICIAIRIES BY HUMANITARIAN WORKERS

Scenarios for Resistant Participants

Scenario One

The community believes that GENDER is a foreign concept, that it is a Western idea, and that the trainer is trying to impose an idea on them.

Scenario Two

The community believes that in creating equity among men and women, their women will become difficult to manage, unruly, and might leave them.

Scenario Three

The community believes that the trainer is trying to reverse gender roles so that men do the women's work and women do the men's work.

(Training Organization)

grants this

CERTIFICATE OF COMPLETION

to

_____

for completion of training in

COMMUNICATION SKILLS IN WORKING WITH SURVIVORS OF GENDER-BASED VIOLENCE

held in City, Country, Month, Day, Year

_____ _____

Co-facilitator Co-facilitator

Please answer the following based on the entire week of training you have just attended.

Communication Skills in Working with Survivors of Gender-based Violence: A Training of Trainers Workshop

FINAL EVALUATION

---

1. Rate your overall impression of the workshop:

- ☐ **Excellent**
- ☐ **Good**
- ☐ **Fair**
- ☐ **Poor**

2. What was the most useful session of the workshop:

_____
_____
_____

3. What was the least effective session of the workshop:

_____
_____
_____

4. Which activity or exercise did you find the most helpful, and why?

_____
_____
_____

5. Which activity or exercise did you like the least, and why?

_____
_____
_____

6. Which, if any, of the activities or exercises will you apply in your own work as a counselor, and why?

_____
_____
_____

7. How could this Workshop be improved?

_____
_____
_____

8. Rate your overall impression of the Presenters on the following criteria:
(circle one number in each row)

PRESENTERS	Poor				Excellent
a. Knowledge of material	**1**	**2**	**3**	**4**	**5**
b. Preparedness	**1**	**2**	**3**	**4**	**5**
c. Communication skills	**1**	**2**	**3**	**4**	**5**
d. Attentiveness	**1**	**2**	**3**	**4**	**5**
e. Comfort level with training material	**1`**	**2**	**3**	**4**	**5**
f. Ability to engage participants	**1**	**2**	**3**	**4**	**5**

Comments:

_____
_____
_____

9. Did the workshop meet your expectations?

- ☐ **Yes**
- ☐ **No**

Please explain:

_____
_____
_____

10. Was the workshop <u>too long</u> or <u>too short</u>? (circle one)
Please explain:

_____
_____
_____

11. Would you recommend this workshop to others?

- ☐ **Yes**
- ☐ **No**

Please explain:

_____
_____
_____

12. What other suggestions or feedback do you have at this time?

_____
_____
_____

Thank you! Your comments, suggestions, and feedback are important to us!