MF1

INTERVENTION, TREATMENT AND PREVENTION OF SEXUAL ABUSE AND ASSAULT

A Training Program for Racial Minority Service Providers

FINAL REPORT

sota
it of
ions

MINNESOTA PROGRAM FOR VICTIMS OF SEXUAL ASSAULT

INTERVENTION, TREATMENT AND PREVENTION OF SEXUAL ABUSE AND ASSAULT

A TRAINING PROGRAM FOR

RACIAL MINORITY SERVICE PROVIDERS

coordinated by

Peggy Specktor, Director
Sharon Sayles Belton, Assistant Director
Dottie Bellinger, Assistant Director

of the

MINNESOTA PROGRAM FOR VICTIMS OF SEXUAL ASSAULT

written by

Peggy Specktor, Director
Minnesota Program for Victims of Sexual Assault

compiled and edited by

Rick Stafford, Minneapolis

Minnesota Program for Victims of Sexual Assault
a project of the Minnesota Department of Corrections
300 Bigelow Building
450 North Syndicate
St. Paul, Minnesota 55104
612-642-0256

ACKNOWLEDGMENTS

The Minnesota Program for Victims of Sexual Assault, Minnesota Department of Corrections, in its continuing effort to improve services and reach all sexual assault victims implemented an intensive nine-month training program for racial minority service providers. The Minnesota Program for Victims of Sexual Assault extends its thanks and appreciation to everyone who was involved in the project.

We wish to acknowledge the following members of the planning committee for conceptualizing the project:

Kenyari Bellfield
Noel Larson
Magdalia Riveria
Gloria Skeet
Sharon Sayles
Peggy Specktor

To Sharon Sayles, Dottie Bellinger and Peggy Specktor we acknowledge their untiring efforts in the development, coordination and implementation of the project.

A special thank you for preparing all the training materials each month is extended to:

Peg Exley, former Administrative Assistant,
Minnesota Program for Victims of Sexual Assault.

A special thank you to the following small group facilitators for the nine months of dedication, insight and time they devoted to the project:

Richard Kaufman
Rochelle Lopez
Jacequline Smith

Thank you to all the speakers, presenters, and trainers for giving of their time and expertise.

We also wish to acknowledge:

Perry Caranicas for statistically analyzing the data available from the monthly and final tests and evaluations, and

Rick Stafford for the cover design.

To the following people who were asked to review the draft of this report for its accuracy, thank you for your comments and suggestions:

Donna Anderson
Dottie Bellinger
Maritta Blue Eagle
Sharon Sayles Belton
Perry Caranicas
Esperanza Ceniceros
Raquel Cervantes
Richard Kaufmann
Noel Larson
Rochelle Lopez
Michael Loud
Charles Mays
Dan O'Brien
Linda Omizo
Beth Pokela
Lollie Smith
Jacqui Smith

A very special thank you for the many patient hours he devoted to the task of compiling, editing and preparing this report for publications is extended to Rick Stafford.

Thank you to the Northwest Area Foundation for providing the grant that made this project possible.

TABLE OF CONTENTS

I. INTRODUCTION

The Minnesota Program for Victims of Sexual Assault, a project of the state Department of Corrections, received a grant from the Northwest Area Foundation to conduct an intensive nine-month training program for racial minority human service professionals from September 1983 through May 1984. The project targeted three populations, Blacks, American Indians and Hispanics, and was designed to improve services to these groups. The objectives of the project were to improve the identification, intervention and treatment of sexual assault victims and their families who are of racial minority heritage.

This report has been prepared to document the project. It includes the project background and a statement of the problem. The implementation of the training program describes the trainee selection process and program format, and specifically reviews the topic content and mode of presentation of each segment. The impact of the project is analyzed utilizing participants' tests and evaluations. This report cites a number of issues that were identified during the training to improve services to minority communities. Also included are the actual tests, exercises, and group activities utilized during the project.

The statistical information on the incidence of sexual abuse included in this report is the data available at the time the proposal was being prepared in early 1983 and during the implementation of the project.

This report has been prepared to illustrate the amount of learning that can occur in an intensive setting, to share the training techniques and findings, and to assist other geographic areas in improving services to minority victims and their families.

II. BACKGROUND

A. THE MINNESOTA PROGRAM FOR VICTIMS OF SEXUAL ASSAULT

The Minnesota Program for Victims of Sexual Assault (MPVSA) is a project of the State of Minnesota Department of Corrections that was legislatively mandated in 1974 to provide services to all victims of sexual assault statewide. The program has as its primary aim the delivery of comprehensive services to sexual assault victims.

The Program:

* provides assistance to sexual assault victims and their families through a coordinated statewide network;
* administers grants to community based sexual assault programs which provide victim assistance, professional training and public education;
* provides training programs for law enforcement and criminal justice personnel, health care professionals, educators, human service personnel, and others in contact with victims of sexual assault;
* promotes understanding and sensitivity to the problems of sexual assault and its victims through media, literature, programs and forums;
* develops and disseminates materials relating to sexual assault and acts as a statewide clearinghouse on programs, services and resources for and about sexual assault victims; and
* works to affect public policy as it relates to the needs of sexual assault victims.

B. STATEMENT OF THE PROBLEM

Sexual assault is a violent crime which is primarily an aggressive rather than a sexual act. It is any sexual activity into which a person is forced without his/her consent. It includes rape, same-sex assault, child sexual abuse and incest. The victim of sexual assault may be young or old, male or female, single or married, urban or rural--no one is immune.

Child sexual abuse is the sexual exploitation of a child under 18 years of age who may be developmentally, physically and socially dependent upon the offender. The sexual contact may range from body exposure to penetration.

During Fiscal Year 1982, 2,998 victims utilized the services of the 26 sexual assault centers throughout Minnesota. Nine hundred and sixty-five (32%) of those victims were under the age of 18, and 408 (14%) were under the age of 13 (Minnesota Department of Corrections, 1982). A report prepared by the Minnesota Department of Public Welfare for calendar year 1981 states that their agency received 1,442 reports of child sexual

maltreatment. (The agency assumes that between 50% and 75% of the cases reported to local welfare departments are reported to the state. Therefore, the number reported to local authorities ranges from 1900 to 2900.) It is further known that for every case reported to local welfare departments in Minnesota, between 7-10 cases of child sexual abuse go unreported. Based on these statistics, it is estimated between 13,000 and 20,000 cases of child sexual maltreatment occurred in Minnesota during 1981.

In Minnesota there is a growing recognition that the needs of racial minority victims of sexual abuse and their families are not being met by existing service providers. The seriousness of the situation is exemplified by national victimization studies that indicate that minorities are victimized by the crime of sexual assault at a rate twice that of whites; and further, that minorities were unable to receive all the help they needed, their problems lasted longer and they suffered more psychologically and experienced more practical problems.

Minnesota Program for Victims of Sexual Assault surveys, both formal and informal, indicated that many minority persons were not familiar with existing services, and there lacked a coordination of services between minority human services agencies and the existing sexual assault service system. Additionally, the existing sexual assault service system was relatively ineffective in the identification, intervention, and treatment of racial heritage minority children, adults and families who have experienced sexual abuse, and there were very few trained personnel available to provide services to racial minority victims and their families. The realities and fear of institutional racism inhibited many minorities from reporting sexual assault and seeking supportive services. The fear of community rejection for betraying "one's own kind" inhibited the reporting of sexual abuse among minority populations. Further, myths and misconceptions about sexuality and violence, and lack of information regarding historical and cultural factors, family roles, sexual attitudes, and the impact of religion, resulted in inadequate treatment of minority victims and their families.

C. PREVIOUS STEPS TAKEN TO ADDRESS THE PROBLEM

The Minnesota Program for Victims of Sexual Assault had been cognizant of the unique problems that impact on the provision of effective services to racial minority victims for many years. It attempted to address the special needs of these populations in a variety of ways. Firstly, the MPVSA sponsored or cosponsored specialized training programs for criminal justice personnel, health care professionals, social services agencies and others in contact with victims of sexual assault. These training seminars included: The Black Community's Response to Sexual Assault: A Historical and Cultural

Perspective, which was held in March of 1981 and attended by nearly 100 human service providers; The American Indian Perspective on Sexual Assault brought together another 100 American Indian service providers at Grand Portage, Minnesota in November of 1981. The MPVSA also cosponsored with the Minnesota Migrant Council, a non-profit agency that provides statewide services to Hispanics, a training session in 1982 entitled, Sexual Assault and Domestic Violence: An Hispanic Perspective. Eighty service providers participated.

These training programs not only created a forum to begin discussing the unique issues surrounding the provisions of services to these populations, but also began the development of a network of concerned minority human service providers who became resources to the MPVSA as the program attempted to strengthen services to racial minority victims and their families.

Secondly, the MPVSA awarded grants to agencies within three ethnic minority communities. These agencies implemented community education programs on the nature and scope of sexual assault within each community. These special grant awards began in July of 1981 and these specialized programs continue to be funded.

Thirdly, the MPVSA worked closely with the community based programs that received funding from the Department of Corrections and encouraged them to develop program components such as outreach programs, outreach staff and adaptation of materials that would improve services to minority victims and their families.

Finally, the 1982 annual report for the MPVSA recommended "the development of techniques, services and training programs designed to educate professional personnel to meet the needs of racial minority victims of sexual assault and their families." To accomplish this it was necessary to target services to ethnic populations because of the unique problems regarding the provision of services to this group."

D. REASONS FOR THE PROJECT

It became clear that additional techniques must be utilized to enhance the identification, intervention and treatment of sexual assault victims and family members who are of racial minority heritage. One method to accomplish this goal was to expand the existing sexual assault service delivery system to include minority human service professionals. Providing training in the area of sexual assault for those professionals employed by agencies that provide a range of services to minority clients, was one way to expand the network and improve identification and intervention. These trained professional could then provide the leadership necessary to encourage each

minority community to actively respond to sexual abuse through the detection and treatment of victims and offenders.

Secondly, it became apparent that much of the materials and techniques currently utilized in the detection, intervention and treatment of sexual abuse were culturally biased and needed to be adapted in order to be effective with minority victims and their families. The availability of culturally appropriate techniques was critical and basic to effectively address the problem of sexual abuse within the Black, Hispanic and American Indian communities.

In the summer of 1982 a task force was comprised of representatives from the Black, American Indian and Hispanic communities, and human service professionals to develop ideas and formulate a plan of action to address the problems associated with providing sexual assault services, the lack of services, and unutilized services in order to target services to racial minority populations. The task force decided that MPVSA should apply to the Northwest Area Foundation for funds for this project.

Community agencies and service providers also recognized the need for this project. While the program's application for grant funding was being considered by the Foundation, letters of support for this project were received from local sexual assault centers that dealt almost exclusively with minority communities, and those which included minority populations; representatives of the criminal justice system; social and health service agencies; elected officials; and, leaders of racial minority community organizations.

Some of the comments from those letters included the following:

"...we are seeing increasing numbers of children who need sexual assault services. Unfortunately, most people of color have inhibitions toward using existing institutional or system-related programs." Rape and Sexual Assault Center, Minneapolis

"...often confronted with the fact that very few referral sources are available to work with Hispanic victims. A plan such as this one, to train Hispanic professionals, will meet an important need, and help us to more comprehensively serve our community." Minnesota Migrant Council

"The project will improve services to meet needs which are to a large extent still unmet--needs of minority children and their families, who are affected by sexual assault." State Senator Linda Berglin, Minneapolis

"...training program MPVSA wishes to mount is a well-designed intensive program, which will have specifically developed and previously unavailable content: culturally specific material on all aspects of sexual abuse of Black,

Hispanic and American Indian children....material is not available in professional journals or books." Meta Resources, P.A., Noel Larson, MSW, Ph.D.

"...believe that lack of knowledge of or inability to deal with important cultural factors such as sexual attitudes in different cultures, family roles and religious beliefs does not permit formulation of an adequate treatment plan. The need for training ...is long overdue." Legal Aid Society of Minneapolis

"Within the last six months there have been at least three times where there has been the issue of sexual abuse of minority children in my caseload. My choices for referral are limited, and I'm not always pleased with the attitude of the providers toward my clients." Family and Children Service, Minneapolis.

...we are confronted almost daily with the tragedy of sexual abuse of American Indian children.....but we badly need services such as the proposed project...aimed specifically at minority children." Indian Health Board of Minneapolis

"Members of racial minorities, however, are last to be reached by these programs. Sexual abuse of children is thought to be increasing in minority [communities.]. Many minority citizens are isolated from public service programs that already exist. Education of these minority populations by very special workers is needed." The Children's Hospital, St. Paul

"Finding assistance for victims and families involved in child sexual abuse has always been a problem, but especially so when the victim or family is suspicious of the "system" and/or hesitant to make use of available services. This is especially true when a minority person or family is involved." John D. Erskine, Superintendent, Minnesota Bureau of Criminal Apprehension

"....is the lack of trust within the minority community for the criminal justice system. As a result, cases go unreported. Second, cases involving minority children, there is a need to do a much better job in relating to the child victim and child's family." Thomas Johnson, Hennepin County Attorney

....project would enhance our local capacity to provide outreach and quality services to American Indian children who are victims of sexual abuse." Sexual Assault Program, Beltrami, Cass and Hubbard counties

"The alarming problem of sexual abuse in our society must be addressed in as many ways as possible. Gearing a project to minority groups would undoubtedly shed valuable light on the sexual abuse problem." State Representative Janet Clark, Chair, Criminal Justice Division Committee, Minnesota House of Representatives.

A grant award of $30,860.00 was received by MPVSA from the Foundation in June of 1983. An additional $19,282.00 of inkind services, such as staff time, were contributed to the project by the Minnesota Department of Corrections.

E. SUMMARY OF PROJECT

This project targeted three racial minority populations (American Indians, Blacks, and Hispanics), and was designed to improve the sexual assault service system and expand it to include professionals who are representative of the target population.

The goal of this project was to coordinate the development and implementation of an intensive nine-month training program for racial minority human service professionals. Objectives of the training program were:

1) To increase the participants' knowledge of the issues surrounding sexual abuse;
2) Familiarize participants with existing models and techniques of sexual assault service delivery;
3) To enhance participants' skills in the identification, intervention and treatment of racial minority heritage sexual assault victims and their families; and
4) To culturally adapt information, techniques and models to enable services to be more relevant for the targeted populations.

III. IMPLEMENTATION OF PROJECT

A. PARTICIPANT SELECTION PROCESS

Recruiting for participants in the training program began shortly after notification of the grant award was received by MPVSA. A list was compiled that included agencies that provide services to predominately Black, American Indian and/or Hispanic clients; community organizations and educational departments that reach the targeted populations; and individual racial minority human service professionals and community leaders.

An application form was developed that listed minimum academic or experience requirements and sought the time commitment from applicants and their agencies that this training project would demand. In addition to the usual biographical data, the form was designed to reflect the possible disparities regarding educational opportunities among minorities and the applicant's expectations of the project. All applications had to be accompanied by letters of support from the applicants' agency (see Appendix # 1).

The training project was widely publicized in a variety of ways. A statewide press release was issued by MPVSA. A cover letter, describing the project, and the application form was sent to the extensive mailing list already compiled. Key members of each targeted community that had either been involved in the development of the project or worked with the MPVSA on other projects were contacted. In addition, community members were asked to make personal contact with persons they thought would be likely participants and encourage them to apply.

Once applications were received, a committee composed of representatives from the target populations selected training participants. Individual interviews were held for some applicants.

Several barriers surfaced during the recruiting phase of the project that influenced participation in the project. There appeared to be a reluctance to participate in the project by some potential candidates. Some expressed a fear of the issue of sexual abuse--afraid to discuss it; afraid to identify it as a problem in their community; and afraid to be persons identified with the issue within their community. The time commitment, 3 days per month, expected of the participants was also problematic. Many prospective trainees were hesitant to apply because they felt that they could not be away from their agency, which in many cases was already understaffed. Some employers were reluctant to release staff for that amount of training time or to allow their employees to participate because they had the same fears outlined above for the potential participants. Additionally, some employers did not seem to recognize the value of the training program to their agency and

community. This resulted in some participants having to take vacation time in order tc participate in the training project.

Initally 35 persons were selected to participate in the training program--12 Blacks, 13 American Indians, nine Hispanics and one Asian. Twenty-four of the participants were female, 11 were male. Twenty-nine were from the metropolitan area and six traveled from other parts of the state.

The Asian member participated in the program to initiate awareness of the problem and provide some initial leadership in addressing the issues within the Asian community.

Thirty-two of the trainees (91.4%) completed the program. Certificates of completion were issued to those participants who completed the course and had submitted their final examination and evaluation.

For those who may wish to develop a similar project, the following are recommendations to improve the recruitment and selection process based upon this project's experiences:

1. Representatives from the project should meet individually with the heads of major human service agencies that provide services to minority clients to obtain their endorsement of the project and commitment to enroll members of their staff;

2. A list of potential participants should be identified and a more systematic method of individual contact should be developed and implemented.

List of Participants

Name	Agency**
Black Participants:	
Janet Anderson	Phyllis Wheatley Community Center, Minneapolis
Tony Anthony	Eden Youth/2020, Minneapolis
Bernadette Celine Benner	St. Paul Youth Services Bureau
Rochelle B. Graves	Hennepin County Attorney
Daisey P. Henderson	University of Minnesota, School of Public Health
Charles E. Mays	St. Paul Family Services
Thelma McGahee	Hennepin County Community Services
Gladys Randle	Phyllis Wheatley Community Center, Minneapolis
Carol J. Rucker	Hiawatha Branch, YMCA, Minneapolis
(Lois) Jean Webb	Hennepin County Child Protection
Charles Robert Williams	Hallie Q. Brown Center, St. Paul
Maryls Wilson	Legal Aid Society, Minneapolis
American Indian Participants:	
Donna J. Anderson	BHIA in Action, Duluth

*Madge Belgarde Spears	Indian Health Board, Minneapolis
Dale R. Childs	Minnesota Sioux Tribe, Inc.
*Orlando Contreras	American Indian Chemical Dependency Division Project
Kathy Denman	Indian Health Board, Minneapolis
Sam A. Gurnoe	Youth Diversion Program, Minneapolis
Bill Kays	Student, Indian Mental Health Program, U.M. School of Social Development, Duluth
Valerie King	Wrenhouse, Minnesota Indian Primary Residential Treatment Center, Inc.
Marrita Kitto-Blue Eagle	Women's Advocates, St. Paul
Michael Loud	Youth Diversion Program, Minneapolis
Gloria Mellado	Cass Lake Human Services
Renee Senogles	Eden Youth
Mary Ann Walt	Minnesota Council of Churches, Duluth
<u>Asian Participant:</u>	
Linda Sharon Omizo	Martin Luther King Program, Minneapolis
<u>Hispanic Participants:</u>	
Esperanza Ceniceros	Neighborhood House, St. Paul
Raquel Cervantes	C.L.U.E.S., St. Paul
John Hernandez	St. Paul School District #625
*Lawrence A. Lucio	Humboldt Junior High School St. Paul
Genevieve Morales	Minnesota Migrant Council
Dionicio Vega Puente	Hispanos en Minnesota, Inc., Chemical Abuse Service Agency St. Paul
Eulalia Reyes Smith	Centro Cultural Chicano, Minneapolis
Aida Tosca	Casa de Esperanza
Lillian A. Villarreal	Centro Cultural Chicano, Minneapolis

** agency at the begining of training
* did not complete training

B. FORMAT

A standardized format was developed and utilized each month, except for the months of September and April, for which there were special training activities (see Appendix #3).

Large group presentations. For each general topic area presentation were made to the entire group. The format of these presentation varied and included lectures, panel presentations, films, roleplays and demonstrations. In order to expose the participants to a variety of resources and

present varying points of view, more than 55 individuals made presentations to the large group during the nine-month project. These faculty members utilized were selected because of their general expertise on the topic. A major problem expressed by participants was that many of the presenters did not have knowledge of ethnic communities.

Small groups. An integral part of the training program was the small group work. Three group leaders were selected as permanent faculty for the nine months of the training program. The participants were divided into three groups at the beginning of the project by the staff of the Minnesota Program for Victims of Sexual assault and these group facilitators. An effort was made to balance each group in relationship to ethnic background, sex, previous experience in the field, type of agency and clientele. Participants met in the same small group throughout the project. These small groups met two to five times monthly. Twice during the training project the participants met with their respective ethnic group. The activities of the small groups varied from session to session and included discussion around specific questions, analyzing case histories, role playing and practicing specific skills such as interviewing and therapy techniques (see Appendix #4).

The project staff and the small group facilitators met between each session to evaluate the previous small group sessions and to plan the small group activities for the following month. At times the group facilitators and/or the project staff disregarded the planned activities so that that the small group time could be used to respond to immediate dynamics of the total group which appeared to be a reaction to a specific topic, discussion, or presenter. The small group facilitators did build in time for sharing and processing information. The project staff and the small group facilitators met during lunch to assess how the training day was going. This allowed for changes to be made in the format if necessary or for group leaders to discuss any concerns they were having with their groups. The disadvantage of this practice was that both the group facilitators and the project staff were not accessible to the participants during this time period.

Large group feedback. After each small group session the participants reconvened as an entire group. Each group reported on the discussion within the group with most information usually recorded on flip charts. This part of the program allowed for further dialogue and members of the small groups took turns reporting for their group, thereby gaining experience speaking in front of a group.

Skill Development. Skill development was incorporated into both large group presentations and the small group sessions. During several of the presentations speakers gave demonstrations of techniques such as support groups, play therapy and interviewing and participants actually had the opportunity to be a part of the activity.

Some of the small group sessions were specifically designated for skill development. For example, the trainees' groups participated in exercises or roleplays in order to practice interviewing child and adolescent victims, offenders, parents/ caretakers. Participants conducted individual and group counseling sessions and practiced play therapy, art therapy and structural/strategic therapy techniques, thereby gaining experience in utilizing a variety of therapy techniques (see Appendix # 5).

C. CONTENT OF THE TRAINING PROGRAM

The information necessary to understand and address sexual abuse were divided into the broad topic areas that were explored in depth in sessions ranging from one to eight days (see Appendix #2). Two special programs were integrated into the nine month program, the Sexual Attitude Reassessment Seminar conducted in September and a set of Mini-Sessions which were held in April. The following description of each broad topic area includes the specific content, various modes of presentation, small group discussion topics and skill development exercises used in the programs.

1. Sexual Attitude Reassessment Seminar (SAR)

The training program began with a three day Sexual Attitude Reassessment Seminar (SAR), conducted by persons of color. The SAR process assumes that persons in helping professions need to examine their own attitudes and behaviors about sexuality as a precursor to working with others. The purpose of the SAR was to examine the concepts of healthy sexuality and provide the participants with an opportunity to explore their own attitudes about human sexuality.

The SAR presented diverse learning experiences with experimental, didactic and audiovisual components involved. The seminar included large group presentations on topical issues in sexuality, definitions, early childhood messages, sexual myths, language, fantasy, sex roles, body images and professional issues.

Speakers also addressed the cultural aspects of sexuality from American Indian, Black and Hispanic perspectives. The seminar included a panel discussion on homosexuality where persons of color, who were openly living a lesbian/gay (homosexual) life-style, were willing to share their experiences and insights with the participants.

The small group discussions allowed the participants to reflect upon and emotionally and intellectually process the presentation and media experience. Media was an integral part of the SAR and contained both sexually explicit and non-

sexually explicit educational materials.

The SAR was incorporated into the training programs so that participants could establish an understanding of healthy sexuality before they began exploring abusive and exploitive behavior. Understanding how their own attitudes affect their work in the area of rape and sexual abuse was also a goal of the SAR.

2. Historical and Cultural Factors

The first two days of this section of the training program were devoted to an exploration of the historical, cultural and political factors that have an impact on sexual abuse in the American Indian, Black and Hispanic communities. Issues related to the American Indian culture were presented by representatives from the Lakota and Ojibwa tribes, which are native of Minnesota. They discussed tribal and family traditions, the importance of spirituality, attitudes toward sexuality, and the role of religion from their tribal bands' perspective.

The speaker on Hispanic culture addressed the impact of family roles, the church, language barriers, the patriarchal family system, and attitudes toward sexuality on victims and their families. The history of Blacks from slavery to current times was presented to the trainees. The family structure, myths surrounding Black sexuality, institutional racism and the role of the church were explored. These presentations provided an understanding of each targeted population's history, tradition and oppression.

During the small group sessions, cultural similarities and differences, participants' own stereotypes toward other cultures, and definitions of racism were explored. These sessions dealt with the mixed emotions, attitudes and feelings of the participants. The group began to appreciate differences among the ethnic populations during these initial small group sessions.

3. The System's Response to Sexual Abuse

A discussion of sexual abuse and the legal system and the system's involvement with victims of sexual assault was addressed in a one day segment. The legal segment included information regarding the criminal statutes on sexual abuse, the vulnerable adults act, and reporting maltreatment of minors. This session also involved a discussion of the courts dealing with sexual abuse such as district court, family court, juvenile court and probate court; and information on criminal prosecution including charging considerations, trial procedures, evidence, witnesses and sentencing.

During the presentation on the systems' involvement with sexual abuse the role of hospital, law enforcement, child protection and legal personnel were presented. Problems associated with each of these systems in regard to providing services to the targeted groups and sexual assault in general were discussed.

Small group discussions focused on the impact of the laws and legal system on ethnic populations and how the system responds to ethnic populations (see Appendix # 4A).

4. Victimization of Children Outside the Family

The topic of children victimized outside the family was incorporated into an entire monthly session consisting of three days. Large group presentations provided an overview that addressed definitions, statistics, information about victims, information on offenders, and treatment of offenders. Reactions of children and family members were addressed, as well as, intervention, which included a discussion of child development and its implications for intervention. Techniques for interviewing children were presented and demonstrated. Three different types of treatment models--play therapy, direct talk therapy and family therapy--were demonstrated.

Small group discussion focused on information about non-family child sexual abuse in the American Indian, Black and Hispanic communities; the community, family and child's response; and if help would be sought and from whom. Finally, application of the treatment models presented was discussed (see Appendix # 4B).

Two small group sessions were devoted to skill development, the final component of this segment. Participants practiced their interviewing skills through role playing. Each participant had the opportunity to conduct an interview, play a child, and observe and critique an interview session (see Appendix # 5A).

5. Incest--Family Sexual Abuse

Almost one-third (eight days) of the training program was devoted to the the topic area of incest--family sexual abuse.

The first month presentations included an overview of family sexual abuse that addressed incidence, demographic characteristics, and types of abuse. Identification of family sexual abuse discussed characteristics of the sexually abusive family, including the offender and non-offending spouse, family roles and rules, identifying child victims, and the behavioral signs and symptoms according to age. A discussion of incest family dynamics defined the dysfunctional family unit and explored boundary problems--between generations, between individuals and between reality and fantasy. Speakers with

experience in providing services to ethnic clients presented information on identification and characteristics of incest for the three targeted populations.

The final area addressed during the first month was interviewing. Additional techniques on interviewing children were introduced. The guidelines presented for interviewing adolescent victims included: socio-psychological pressures on the adolescent victim that influence obtaining information (such as prohibited language); victim and family roles; sexual taboos; their juvenile status; racial and cultural considerations; and the response of friends, school and community. The presenter also demonstrated the use of family sculptures as an interviewing technique. Methods for interviewing the parents and caretaker of an incest victim were demonstrated. Techniques to get an offender to admit the crime were illustrated.

Small group activities included discussior of different behavioral indicators for minority children and barriers to identifying the problem. Participants practiced their interviewing techniques through simulated situations designed to interview adolescent victims, fathers and mothers (see Appendixes # 4C & # 5B).

The second month's presentation on this topic focused on modals for treatment for family sexual abuse. A variety of treatment modalities were presented to the group, including behavioral modification, psychodynamic treatment, and structural/strategic treatment. Extensive information was provided on family treatment approaches including a demonstration using videotape and practice activities.

Techniques for using individual counseling, group therapy and art therapy with the child incest victim were introduced to the participants. The session on individual counseling addressed treatment techniques, utilization of the developmental therapy, and barriers to treating minorities. A case history was presented and discussed in small groups. A discussion on group therapy for children addressed the theory for group treatment, selection of children, activities for the group, and rules for the group. A demonstration with the participants playing the role of children was also a part of this activity. The information on art therapy included skills in building rapport between therapist and child; uses of a treatment modality for non-verbal children; and expressive therapies, enabling the blocked child to work through trauma or conflict without the necessity of verbally labeling painful emotions or events.

Discussion in the small groups focused on participants responding to the following questions: What are the cultural issues to consider when using the family treatment approach? What issues may arise when using treatment methods with Black, American Indian and Hispanic children? (see Appendix # 4D)

Several sessions were geared toward skill development and practice of treatment techniques. During one skill development period participants met in their small groups and the presenters rotated each hour so that each group was able to practice three different treatment models.

Two more days were devoted to the topic of family sexual abuse during the next month. The first day addressed treatment techniques for adolescent incest victims. A presentation on individual counseling discussed treatment issues and their implications, and the effect of minority status on sexually abused adolescents. The participants also had the opportunity to roleplay an initial interview with an adolescent victim (see Appendix # 5C).

Discussion of group treatment of adolescent incest victims covered selection of participants; group contracts; treatment techniques; and topics to address in the group. During the skill development segment participants worked in triads and practiced individual therapy using three case histories. They also had an opportunity to act as facilitators of an adolescent incest group.

The final session on family sexual abuse explored the topic of adults victimized as children. This included behavior characteristics of the victim and treatment assumptions and strategies. Representatives from a therapy group of adult women victimized as children spoke to the participants. This segment concluded with a demonstration of treatment techniques, using training participants who volunteered as the clients.

6. Treatment of Perpetrators

A full day was dedicated to a discussion of treatment of perpetrators. One-half day discussed treatment approaches for juvenile sex offenders. This included current treatment philosophies, assessment techniques, developmental and socialization needs, and treatment options such as education, individual, family and group therapy, and residential placement.

The final part of this segment focused on working with the adult sex offender. This presentation included definitions, typology, offending continuum, discussion of treatment versus punishment, guidelines for assessment and techniques for interviewing offenders. Three case histories were utilized to illustrate this information. The small groups examined reactions of the participants to working with perpetrators and the issues relating to their treatment (see Appendixes # 4E & 5D).

7. Sexual Assault of Adults

Five training days were devoted to the issues related to adult sexual assault. This segment began with an overview of the problem, including definitions, myths and facts, and the law.

Specific problems and responses to the following three types of sexual assault were discussed. A presentation on acquaintance rape included definitions, victim reaction, sex roles and stereotyping. The movie, "The Date", graphically illustrated this type of sexual assault. Information on male victimization focused on description of the problem, frequency and lack of reporting, victim responses, client intervention strategies, education and outreach plans. Finally, the topic of marital rape was addressed which covered evidence, legal issues and its impact on the recovery process for victims, and the impact of marital rape upon different populations.

A segment on the needs and responses of rape victims explored the victim's immediate responses, stages of reaction, rape trauma syndrome, effects of life-style, age, and ethnic background on the recovery process, and recovery of family members or friends. This information also covered immediate and long-term needs of the victims and intervention long after the assault has occurred. Crisis intervention goals and techniques were also addressed.

A half day was devoted to a discussion on the system's response to rape victims. This included information on the police and county attorney functions. Special issues relating to police response and the medical examination were addressed. The segment concluded with a discussion of the questions: Is the system doing what it should be doing? What are issues and problems for victims involved in the system? What issues effect minority populations?

In the small group the trainees participated in a values exercise entitled, "Pam's Story" (see Appendix # 5E). This generated a great deal of discussion. Trainees also explored their own reaction to victim's needs and responses and the system's response to rape victims (see Appendix # 4F). It became necessary to alter the final small group session of the month to give participants time to discuss some general issues and concerns.

Counseling issues were addressed during the final two sessions on the topic of rape victims. This included techniques for counseling of rape victims and working with secondary victims. Information regarding the development and conduct of a support group for primary and secondary victims explored what to look for in groups, the intake process, conducting a session, problematic group members, and resistance themes. This day concluded with a session on stress management

entitled, "Taking Care of Ourselves While Working with Victims".

Innovative counseling models for working with rape victims were presented to the group. The first technique, grief counseling with rape victims, addressed cultural responses to loss, difference in definitions, and grief as growth.

A presentation on Process Therapy emphasized that the therapeutic process was more important than content. A primary role of the therapist is to validate the woman's experience of her own reality and help her to know and understand it. One part of the client's recovery is to educate her about the impact of the white male system on her internal belief system and a recognition of it as a societal problem. This must occur in addition to helping the client examine her own internal process.

A model of Bioenergetic Analysis and Therapy included techniques for helping victims get in touch with and let go of the feelings that are locked up in the body. The idea is that feelings are bound up in the body "armor", i.e., parts of the body in which people hold tension from past emotions. Deep breathing and therapeutic body movements combined with verbal therapy were examples used.

8. Prevention

Two days were devoted to the critical topic of prevention. This segment began with an overview of prevention issues which included: information on issues which block or impair prevention efforts; definitions used in sexual abuse prevention education; clarification of primary, secondary and tertiary prevention; and a discussion on protection versus prevention. Participants were also asked to consider the cultural appropriateness of prevention messages, as well as necessary adaptations for specific ethnic groups.

The session on utilizing the TOUCH continuum began with reactions to the film, "Touch". Discussion included methods of teaching TOUCH concepts with preschool, elementary and adolescent age children, and identified various educational aids. Participants examined where further materials are necessary for specific ethnic groups.

A segment involving adaptations of the TOUCH continuum presented three models that illustrated how this concept has been used in local communities. The Rapeline Program in Rochester, Minnesota described how they present TOUCH using actors from a community theatre group. The Rape and Abuse Center of Fargo/Moorhead presented the "Red Flag, Green Flag" curriculum they developed in conjunction with the coloring book

by the same name. A representative from the Aid to Victims of Sexual Assault Program in Duluth, Minnesota illustrated the curriculum they developed utilizing the TOUCH cards as a basis.

The "Social Issues and Implementing Prevention Education" session centered on the concepts contained in "How to Take the First Steps", a guide for implementing a prevention program developed by the Illusion Theater. The discussion that followed examined larger social issues such as sexism, oppression and media images which perpetuate sexual abuse.

Representatives from the Minnesota Migrant Council, Upper Midwest American Indian Center and the Minnesota Institute on Black Chemical Abuse, agencies involved in providing education and training on sexual abuse in the targeted communities, participated in a panel. This dialogue focused on issues for sexual assault education and prevention in ethnic communities.

The highlight of the prevention segment was a theatrical production by the Illusion Theatre of the play, "No Easy Answers". This applied theater production, designed for adolescents, helped the audience think about general crime protection, concerns and questions about sexual development and the impact of media on our ideas and behavior. It also examined myths which surround sexual abuse, date rape and incest, and gave a summary of what adolescents can do to protect themselves. A moderator engaged the audience in discussion at various points of the play. Trainees were able to invite family members and co-workers to this segment.

9. Networking and Community Organizing

During the first session of this segment a model for developing a community treatment approach was introduced to the group. The discussion of this family treatment program illustrated how different agencies provide various components of the treatment program. One agency works with the perpetrator, another conducts a group for mothers, and another for victims of sexual abuse. The weekly schedule for such a model was outlined and its adaptability to a minority community explored.

The trainees actually implemented a project that combined networking and community organizing skills. During the last month of the training program a major metropolitan television station had conducted a special news project entitled, "Project Abuse". This week-long project included news specials, documentaries and a town meeting.

Participants in the training program felt that issues relevant to child sexual abuse and targeted minority populations were not included. The group decided to respond and created a name for themselves, developed a statement, planned and implemented a press conference and circulated a press release. This

spontaneous project gave the participants experience in community action (see Appendix # 6).

Finally, the participants met in small groups by ethnic community and began planning for education, prevention and treatment approaches for their community.

10. Mini-Sessions

Mini-sessions on topics relating to sexual abuse or in areas where participants wanted more information were held for one day during the training program.

A list of possible topics for mini-sessions was developed in collaboration with project staff, small group facilitators and training participants. The participants then selected the six mini-sessions they would most like to attend in preferential order. Three sets of one-and-one-half hour mini-sessions were scheduled.

Several workshops were offered during each session and participants were able to attend a total of three mini-sessions. The following mini-sessions were scheduled: "Stress Management", "Learning About Your Family of Origin", "Using Humor and Metaphor in Therapy", "Sex Counseling for Incest Parents", "Pornography and Sexual Violence", "Techniques to Get Kids to Talk and Protection Issues", "Juvenile Prostitution", and "Working with Shame Based Families."

This day of mini-sessions was concluded with a presentation by two training participants to the entire group. They shared an intervention and treatment model they had developed from working with primarily American Indian clients.

11. Final Banquet

A potluck dinner/final banquet was organized for one evening during the final month of the training program. Each participant brought a speciality dish representative of her/his culture and heritage. It was a fitting closure to an intensive and emotional, but meaningful, experience.

12. Resource Materials

The following materials were distributed to each of the training participants:

Incest: Confronting the Silent Crime, edited by Linda Muldoon. A manual for educations, law enforcement, medical human services and legal personnel.

Sexual Assault: A Statewide Problem, compiled and edited by Eileen Keller. A procedural manual for law enforcement, medical, human services and legal personnel.

Child Sexual Abuse Prevention Project: How to Take the First Steps, by Cordelia Anderson, Illusion Theater. A step-by-step guide to developing a child sex abuse prevention/education program in local communities based on the TOUCH and NO EASY ANSWERS curricula.

Red Flag, Green Flag, educational coloring book, and Annie, storybook by Joy Williams, Rape and Abuse Crisis Center. Also available in bilingual Spanish/English language edition.

A Note to Those Closest to Sexual Assault Victims, a pamphlet that explores the reactions and needs of secondary victims.

Are Children with Disabilities Vulnerable to Sexual Abuse? This 5-page brochure acquaints parents of disabled children with the problem of sexual abuse and outlines steps to take to protect children.

Child Sexual Abuse...It Is Happening, an informational pamphlet on various aspects of child sexual abuse.

Sexual Assault Against Men - It Does Happen, guidelines for same-sex assault crisis intervention and Same-Sex Assault: A Handbook for Intervention Training, compiled and edited by N. Douglas Elwood and Bruce Larson.

Sexual Assault: A Statewide Problem, a general informational brochure on various aspects of sexual assault.

Some Questions You May Ask About Going to Court and Some Answers That Will Help You, for children ages 8 and up, and Kids Go to Court, Too, for children under age 8. Both booklets are designed to help children understand the court system as it relates to sexual abuse of children.

Acquaintance Rape: Awareness and Prevention, a booklet that explores the phenomenon of acquaintance rape and suggests an approach to prevention, compiled by Py Bateman, Alternatives to Fear, Seattle, WA.

Participants had an opportunity to review the following materials:

Sexual Violence: A Resource Manual for Clergy and Church Groups, compiled and edited by Dottie Bellinger and Helen Monsees.

NO EASY ANSWERS: A Sexual Abuse Prevention Curriculum for Junior and Senior High Students, by Cordelia Anderson, Illusion

Theater. Aids adolescents in developing skills for communicating their feelings, attitudes and expectations relating to sexuality as well as to discuss the exploitive and abusive use of sex; emphasizes prevention skills.

Pre-School Sexual Abuse Study Cards, developed by Beltrami County Sexual Assault Program.

Preventing Sexual Abuse of Persons With Disabilities: A curriculum for Hearing Impaired, Physically Disabled, Blind and Mentally Retarded Students, by Bonnie O'Day, Minnesota Program for Victims of Sexual Assault.

Touch Continuum Study Cards, developed by Illusion Theater for grades K-8 for use in discussing sexual abuse prevention education.

Additionally, each month a wealth of materials were furnished by the speakers which included articles, informational handouts, statistical data, worksheets, guidelines and research papers. An extensive bibliography was developed utilizing references suggested by the trainers and previous bibliographies (see Appendix # 7).

13. Audio Visual Materials

A slide tape show and various films on the topic of sexual abuse shown to the participants throughout the nine months were used to enhance the participant's learning experience. Additionally, trainees became aware of and familiar with available audio visual materials.

Name	Date Used	Description
A Crime of Violence	October	This slide tape show presents a sharp look at the impact of sexual assault on the victim and society, role of the family and advocate, attitudes of medical and law enforcement personnel, problems of reporting and prosecuting, new laws, and measures to prevent assault.
Double Jeopardy	December	A film designed to sensitize helping professionals to the problems of the child victim during the judicial proceedings. The film's case histories demonstrate the benefits of the

		inter-disciplinary approach to dealing with child sexual abuse.
The Date	March	One of four films in the Acquaintance Rape series, deals with with sex role stereotypes, communication breakdowns, and teenage sexuality. Recommended for high school students.
Reality of Rape	March	A young hitchhiker is picked up on her way to work. We then see a devastating, powerful reaction of how a rapist "negotiates" for psychological control, as well as the violent act of rape itself. Subsequent scenes involved two officers of varying sensitivity as they respond to the emotional needs of the victim before proceeding to the preliminary interview.
TOUCH	May	Designed for children in K-6, parents and professionals who work with children. Shows examples of the range of touch from nurturing, to confusing to exploitive, and through dialogue with a moderator are asked questions about their own feelings and responses. Helps audience think of appropriate action to take if touch or other behaviors become abusive or exploitive.
Dream Speaker	May	Drama portrayal of a young disabled and violent boy institutionalized for setting fires. He escapes and meets an Indian and begins to communicate and react with his new friends. Stark and uncompromising as the boy is institutionalized again.

14. Problems/Concerns

Several concerns related to the content and its presentation emerged. They are listed as follows:

1. By attempting to expose participants to a variety of resources there was some repetition of the material.

2. Lack of availability of people of color who were knowledgeable and/or willing to speak on topic of sexual abuse.

3. Large and small group discussions dominated by a few of the participants.

4. Feeling by trainees that some of the speakers were not sensitive to people of color.

15. Recommendations

The following are suggestions to improve actual implementation of a similar training program in the future:

1. Identify minority therapists who may have experience working with sexual abuse victims.

2. Meet with minority therapists to interest them in being trainers.

3. Utilize team teaching with a majority and minority person presenting on the same topic.

4. Provide trainers with more information on the project and on participants.

5. Create a respectful atmosphere between trainers and trainees.

6. Be assertive with disruptive participants.

IV. IMPACT OF THE TRAINING PROGRAM

A. ISSUES IDENTIFIED TO IMPROVE RESPONSE TO MINORITY PERSONS IN THE AREA OF SEXUAL ASSAULT

Issues that may be helpful in improving the identification, intervention and treatment of racial minority sexual assault victims and their families emerged throughout the nine-month training program. These factors were raised by the presenters, during small and large group discussion, and by the individual trainees in their monthly and final tests and evaluations. Throughout the project it became apparent that almost no data, research or formal information is available relevant to sexual abuse and racial minority persons.

The considerations discussed below summarize the information gathered from all the above mentioned sources. The following subsections 1-5 are the opinions of the participants based on their interpretation of the information presented, formal and informal discussions and personal and professional experiences. They are presented here not as the answer to the problem, but as a basis for others to begin developing their own ideas, thoughts and techniques to improve services to racial minority victims.

1. The Legal System and Its Response to Ethnic Populations

The effects of current laws on ethnic populations that trainees identified are:

-- laws enforced in different ways in different areas;
-- laws are applied differently to different populations and minorities are treated differently;
-- state laws may conflict with tribal laws;
-- more minority women may report sexual abuse if they know that their past sexual history is not admissible in court;
-- many laws are made to help the system not the victim, especially if they are of minority heritage.

Problems/difficulties that face ethnic populations within the legal system as identified by participants:

-- pre-judgment based on client's appearance;
-- dominant society assuming knowledge of needs of ethnic groups;
-- lack of representation because of financial and economic needs;
-- absence of alternatives for sentencing;
-- courts not recognizing the need for social skill building before re-entry into society;
-- no minority staff;
-- tribal courts are not working;
-- most reservations do not have courts;

-- frustration over the way the system works and questioning the fairness of the system;
-- disregarding statements of and/or not believing the minority victim;
-- stereotypes and attitudes of criminal justice personnel toward ethnic minorities and institutional racism;
-- system is often biased against minorities and they are not afforded the same opportunities as whites.

Suggestions cited by participants to make the system more responsive to ethnic populations:
-- when working with minority victims one must do more advocacy to protect their rights;
-- be clear about expectations and make no promises to clients;
-- provide to criminal justice personnel an awareness and understanding of the cultural factors and needs of minority victims and their families;
-- provide an understanding of the legal system to clients to minimize mistrust;
-- actively recruit people of color for professional positions;

2. Sexual Abuse of Children by Non-Family Members

Participants identified various responses to victimization in three categories--by the community, family and child.

By the community: The participants generally felt that the reaction for all communities would be anger, fear, resistance, revenge and shame.

The reaction of the Black community would be an isolation of victim, shame for the victim, grief, shock, anger, minimization, don't get involved, protectiveness for other people in the community.

Response of the American Indian community depends on the locale of family, rural (reservation) or urban, since the community is family and are related to one another. In the city the community would rely on the grapevine or gossip and rally around friends and family. Overall reaction would be shock, sympathy, protectiveness of victims, fear, anger and shame. The community might ignore or deny the abuse or threats may arise. The Indian community would react with more denial if the perpetrator were Indian.

The overall response of the Hispanic community would be shock, shame, sympathy, outrage, confusion, anger and fear of the grapevine. Violence toward and/or ostracizing of the perpetrator are also possible responses.

By the family: Family response of Blacks could be pain, guilt, shame, fear, confusion, blame, helplessness, frustration, question their parental skills, become overprotective, threats and possible violence. The family's response to the child telling parents would vary. If the child reported the assault immediately, they would receive the support they need. The child would be suspected of lying if they told they were assaulted a week or more after the fact. Individual families would respond differently to the race of the perpetrator depending on their sensitivity to the race involved. But Black participants felt there would be more anger if perpetrator was Black.

The American Indian family's general response would be grief, denial, sympathy, shame, fear and anger. Family members would stay together because they do not trust outside community resources. Family's response to the child varies depending on the rate of occurrence and the individual problems due to the degree of assault.

The Hispanic family's general response could be to avoid the issues, suspicion of the victim, hurt, dishonor, helplessness, protectiveness, anger and sympathy. When the family/parents find out they would react with anger, frustration and shock to the child telling of the assault. They would react strongly to the race of the perpetrator, especially in the case of pregnancy.

By the child: Most Black children will tell if they have been assaulted. They would tell siblings, friends, teachers, extended family members and parents.

Most Indian children would not tell unless the assault were severe. If they told they would tell family members whom they trust.

Hispanic children would tell someone that would understand, who could make things better, who would not judge and who would provide cultural understanding. Older children would tell friends.

Factors regarding intervention of sexual abuse were addressed by participants from the following questions:

Is it likely that Black, American Indian and Hispanic families would seek outside assistance?

Overall, it is not likely that racial minority families would seek outside help if a child has been sexually abused. Generally, it would depend on socioeconomic levels; access to services; knowledge of services; acceptance that incident happened; comfort with sexuality; strength of the family internally.

Factors that would influence Black families seeking assistance include educational level, confidentiality, if the crime had to be reported, and availability of services.

For the American Indian family, whether or not to seek outside intervention would depend on the family's identity with culture, tribal affiliation, and whether the location of the family was urban or reservation. Reservation families would not seek assistance and would tend to take law into their own hands. Urban American Indians would be more likely to seek help because more resources are available.

The likelihood of Hispanic families seeking outside assistance depends on whether the family is traditional or non-traditional and includes factors such as family values, location, acculturation level, education, time factor, language and confidentiality.

<u>If families would seek assistance, from whom?</u>

The Black family would seek help from religious organizations or the church minister, perceived caretakers in the community, social groups, beauty or barber shop operators, bartender, godparents, play aunts and uncles, or a friend.

In general, seeking outside assistance would be very difficult for the Hispanic family. Families would be more likely to seek services from individuals and service agencies they have worked with in the past; that is, people they can trust with this difficult situation. Some will seek services from non-Hispanics outside the community; others will go to their church, to Hispanic social services, professionals of color, female professionals, the compadre system, or other trusted friends.

The American Indian family would seek assistance from Indian health services, Bureau of Indian Affairs or American Indian Movement.

<u>What factors would prevent minorities from seeking outside assistance?</u>

Common factors listed that would prevent minorities from seeking help from outside resources included no real choices in services; language barrier; low self-esteem; negative view of counseling; education and class of counselor may be perceived as a barrier; cost; racism; mistrust of system, institutions, forms and terms; loss of control; fear of research.

Others factors cited would be the threat to the internal mechanism for resolving family and community problems; previous relationship with social workers; fears about being perceived as sick if therapeutic help is sought; the community knowing; and fear of cultural values being discounted.

The Black family would not seek outside intervention because of mistrust, fear of children being removed from home, cultural barriers, dishonor, fear of system, shame and racism. The Black community would take the attitude of "we can handle it ourselves".

American Indian community also would not seek intervention because of mistrust of the system; language differences; process differences; posture differences; and fear of children being taken away.

Reasons cited that would prevent Hispanic families from seeking assistance were fear of embarrassment and shame; avoidance and denial of the assault; fear of making the occurrence worse; uncovering other family issues; feeling that it's a family matter; language barrier and acculturation level; lack of trust; and racism.

3. Incest - Family Sexual Abuse

Participants identified barriers and treatment considerations relating to Black, Hispanic and American Indian incest victims and their families.

Barriers in identifying incest among Blacks, Hispanics and American Indians cited by participants:

Common factors in minority communities that affect identifying incest include:

-- fear and shame of both victims and their families;
-- basic survival skills;
-- keeping it in the family keeps the family out of "systems" that are deeply distrusted";
-- lack of family awareness: may not know signs to look for in order to detect abuse of children; lack of knowledge about resources to aid the family; mistrust resources available;
-- dependency on perpetrators, including interpersonal relationships, economic dependency, and addiction to perpetrator;
-- denial in the family system;
-- protecting the family, including the perpetrators;
-- religion;
-- sexuality issues;
-- well trained children don't talk about family business outside of the house;
-- privacy of data obtained;
-- closeness of family;
-- protection of the community from outside influence;
-- we/they mind set.

Barriers to disclosure of abuse for Blacks noted were:

-- social-economic issues;
-- disclosures outside the family;
-- fear;

-- denial that it exists;
-- "traitor to your culture";
-- threatened by judicial system;
-- economic considerations;
-- guilt and shame;
-- family and community based stigma.

Identifying incest in American Indian families is influenced by:

-- social economic issues;
-- fear of having the children removed from their home;
-- the threat of removal of the offending family member;
-- loss of economic support;
-- threat of historical genocide; and
-- lack of trust and knowledge.

These factors impact identifying incest among Hispanics:

-- strong patriarchal family system;
-- Hispanic cultural system gives rise to fear, guilt, withdrawal and depression;
-- strong economic considerations function as a deterrent to reporting on father--"he is the breadwinner";
-- partner's role: fear of being stigmatized by community;
-- feelings of being trapped with knowledge of sexual abuse; might prefer to ignore or deny its existence;
-- victim might seek help from: priest, but only share surface information; or, seek help from another female;
-- main concern is keeping family together;
-- children and adolescents victims would withdraw as a defense;
-- fear of "all hell breaking loose", victim being outcast by family for violating secrecy rule, not knowing how to deal with problem and pain that comes with it.

<u>Issues to consider when providing treatment to Black, Indian and Hispanic incest victims:</u>

-- different home environments;
-- both parents versus single parent;
-- blocks to service, i.e., money, transportation, fear, anger, denial;
-- importance of confidentiality;
-- important to develop a protection plan for the victim while working with system;
-- credibility and trust may decrease when worker starts removing children from home.
-- how to break cycle in family when only the therapist is enforcing or teaching the child the rules;
-- what should the therapist do when there is no choice about who will be in a therapy/support group;
-- how to adjust a multi-problem structure to a non-traditional family;
-- families often have limited resources: helpers need to recognize this and be okay with it;

-- helpers need to learn to work around the system;
-- need to know your community and what is available;
-- staffing the case with other co-workers and developing a feeder system and go-between for community, child and family trust;
-- how does the therapist empower the individual to work the "system";
-- must be careful not to mislabel or misdiagnose the symptoms of the clients;
-- ethnic children take on more responsibility earlier in ethnic homes due to survival, large families and cultural history;
-- time is an important factor, as more time is spent with clients of color;
-- the language that one uses when dealing with a client is very important--you must be understood, talk within cultural perspective;
-- behavior indicators for blacks are more dramatic and intense; for example, if a child runs, as a rule, they've told the entire world.

Issues to consider when providing treatment to Black, American Indian and Hispanic incest families:

-- know the subtleties of the culture you're working with;
-- use caution in letting clients define family--could include grandparents and grandchildren;
-- determine who is the head of the household--who makes the decisions--sometimes an external family member has raised the child;
-- be aware of each family member's role;
-- know how touch is interpreted within the perpetrator's family, and how much touch is in victim's family;
-- direct eye-to-eye contact is not appropriate in certain cultures and often considered to be insolent and disrespectful by Blacks, Hispanics and Indians;
-- importance of using the correct terms specifically when addressing the older generations of family members--and bilingual families;
-- in terms of respect--first names are not to be used toward parents, uncles, aunts or grandparents;
-- therapist needs to explain his or her approach and ask for feedback from client about sensitive cultural issues;
-- minority families often involve quite an extended family--important to know who holds power in this extended family;
-- it is helpful for the practicing therapist to be of the same ethnic representation as family, in order to facilitate culturally appropriate role modeling and accurately diagnose ethnic family's heirarchy in addition to establishing respect and trust;
-- take into account value differences;
-- recognize that family systems can include single parent families, inter-generational households, and/or families with female heads of households.

4. Minority Adult Rape Victims

Issues to consider when treating minority rape victims cited by trainees were:

-- women of color have a tendency not to be believed when issues of rape are involved;
-- minority rape victims need strong advocate within system;
-- the Native American community is reluctant to accept rape as a problem;
-- ethnic background affects victims response to rape
-- victimization has been a way of life for generations of many ethnic people;
-- rape victims have need for confidentiality and protection from community grapevine;
-- ethnic minority victims reluctant to report to the police;
-- consideration for support groups include finding a location within the community using sensitive facilitators, and selecting a convenient time and a safe name for the group.

5. Community Needs

Members of each ethnic group met in small groups to define problems and attitudes that affect sexual assault services within their respective communities and to develop strategies to address these issues. The following are the opinions of the participants.

Within the Black Community

The Black participants stressed the need for educational programs on sexual abuse within the Black community for community leaders, such as the clergy, service providers and program boards, community organizations and parents. They also suggested the development of educational projects for children--preschool and K-12. The need for the development of media and public relation tools that are culturally relevant was also cited.

In the area of research this group suggested developing information on the Black historical perspective relating to sexual assault; gathering current information on the incidence of sexual abuse within the Black community, and on Black families, their roles, values and boundaries.

Training on the topic of sexual assault and specific skill development should be carried out for Black service providers by other Blacks and training to make the majority community aware of the needs of Black victims and their families should be conducted. Participants also suggested establishing a referral network directory that identifies individuals

experienced in working with Blacks and their areas of expertise. The establishment of an ongoing support group of Black professionals working in the area of abuse was also recommended; as well as groups for Black victims of sexual assault. The group recognized the need for appropriate funding to address these identified needs and requested assistance in grant writing.

Within the American Indian Community

The needs and suggestions discussed below from American Indian participants are their individual opinions.

To improve the community's response to sexual assault, the participants discussed the need for community awareness in a variety of areas, including sexual abuse, positive self-concepts, positive family concepts, inside and outside influences and services available. They cited the need for prevention educational programs.

The group also discussed the need for funds for research to gather statistics and data on sexual abuse in the American Indian community.

In the area of direct services the group mentioned need for strong legal and social service advocacy, crisis facilities such as foster care, safe homes and shelters, and the development of cultural and spiritual tools and services.

Tribal council training and networking were discussed. Finally, the need for funds to address community needs was stressed throughout the discussion.

Within the Hispanic Community

Hispanic participants identified a list of needs that would improve the community's response to sexual abuse. They recommended that all materials existing and new be linguistically and culturally appropriate; that community education facilitators and presenters be bilingual/bicultural; that a task force on sexual abuse with representatives of Hispanic service agencies be established; and that services be available in both Minneapolis and St. Paul.

Also suggested was development of a community education program that focuses on the metropolitan area with the target being Hispanic families, institutions, churches, community agencies and organizations, and schools. Other ideas for community outreach included home visits and meriendas. Participants saw a need to gather statistics regarding knowledge about and incidence of sexual abuse in the Hispanic community, and to develop a resource library.

In the area of treatment, participants suggested identifying existing Hispanic professionals working in the area of sexual

TABLE A - MONTHLY TESTS ANALYSIS

	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	Seven Month Total
I. Participants Taking:								
A. Pre-test	32	31	28	24	22	20	18	175
B. Post-test	32	20	27	20	25	13	20	157
C. Both tests	28	18	20	16	18	9	12	121
II. Results:								
MAX possible score	25	33	39	30	30	39	33	229
A. PRE-TEST								
Range of scores	15-23	17-30	23-32	17-25	14-25	23-32	18-27	N/A
Average score	19.1	23.8	27.8	20.6	19.4	28.7	22.9	162.3
% of MAX	76.4	72.1	71.3	68.7	64.7	73.6	69.4	70.9
B. POST-TEST								
Range of scores	16-24	21-31	27-36	18-27	14-28	23-38	22-31	N/A
Average score	21.8	27.1	31.2	21.5	21.9	31.9	26.3	181.7
% of MAX	87.2	82.1	80.0	71.7	73.0	81.8	79.7	79.3
III. Comparisons:								
Increase in average scores	2.7	3.3	3.4	.9	2.5	3.2	3.4	19.4
% Increase	14.1	13.9	12.2	4.4	12.9	11.1	14.9	12.0
% Increase for lowest score	31	24	22	24	43	0.0	44	N/A
Highest % increase	38	38	39	24	37	36	55	N/A

abuse; identifying individuals and agencies who are willing and available to provide sexual abuse treatment; soliciting and establishing community support and cooperation to develop treatment programs; and assuring that treatment needs be culturally and linguistically appropriate.

It was the hope of those involved in the ethnic minority training project that the issues identified will be helpful to others as they work to improve services to racial minorities. The overriding needs and issues identified throughout the training project was the need for more people of color as service providers and more funds to be directed to providing services for minorities.

B. EVALUATION INSTRUMENTS

1. Monthly Pre/Post Test

A pre/post test was developed for each monthly session. Each month the large group presenters were asked to submit questions relating to the material they were going to present. These questions were compiled by the project coordinators. An identical test was administered at the beginning and at the conclusion of each monthly session (see Appendixes 8A-G). These tests were taken by the persons attending at the time each test was given. Therefore, the group that took the pre-test differed slightly from the group that took the post-test.

Several problems relating to the pre/post test process were indentified. Sometimes the presenter did not provide adequate information to allow the participant to learn the correct answer to questions, and not all participants took both the pre and post test each month. To enable participants to gain the correct information from pre/post test questions, a clarification of certain unclear questions with correct responses, and why, were provided the following month (see Appendix #8).

The pre and post tests for each month were analyzed. Table A that appears on the previous page shows the number of participants taking each test and the number who took both tests each month. No attempt was made to determine how many tests each individual participant took all together.

The statistical analysis shown in Table A is based on those who took both the pre-test and post-test each month. A level of significance of 5% has been used throughout.

Over the seven month period a total of 175 persons took the pre-tests and 157 took the post-tests. Of those persons, 121 took both tests, an average of over 17 persons per month. The results shown are calculated separately for each month, since

both the MAX possible scores vary from month to month, as well as the number of participants who took both tests. For each test the range of scores is shown, along with the average score and percentage that this average represents. Generally all months show very similar results with the pre-tests averaging approximately 70% and the post-tests approximately 80%. This is a statistically significant and consistent improvement of 12% on the average.

January was the only month which the improvement was very different than the other months (4.4%). Possible explanations for this are the complexities of the topic, therapy techniques; the specific details addressed in the questions; the large number of different techniques presented; and the technical terminology used. Additionally, January was the month that the project's minority staff member left the project for another position. If the analysis is repeated excluding the January results, the increase in the scores would exceed 13%.

Looking further at the improvement of individual scores reveals that those persons who had the lowest scores in the pre-test, exhibited a score increase much higher than the average in all months except March. This increase is more than double the average of 12%, with three months showing an improvement of more than 30%. In other words, the participants who needed the new knowledge the most were the ones who showed above average improvements in the tests.

For the seven tests as a whole the pre-test average score was 162.3 and the post-test 181.7, representing 70.9% and 79.3% of the MAX respectively. This overall increase was statistically significant.

2. Analysis of Final Examination

The final examination was administered at the end of the program and covered material from all the monthly sessions. A total of 52 questions were included and they were selected from the seven monthly tests (see Appendix # 9). The over-all results of the final were:

Range of scores: 35 - 48
Average score: 41.5
% of MAX: 81.4%

When analyzing the correct responses for questions on their respective pre-tests the percentage of the maximum score was 69.3%. The 81.4% for the final examination represented an improvement of 17.5%.

Analyzing the results on a question-by-question basis allows identification of those questions that showed a high initial knowledge level in contrast with those that displayed lack of

knowledge, and the relative depth of learning achieved in each area of interest.

A total of 19 participants took the final. One question (No. 3) was invalidated due to a typing error that materially changed its meaning. The remaining 51 questions were analyzed by comparing the ratio of correct to incorrect answers, as they occurred in the respective pre-tests, to the same ratio as it occurred in the final.

The results were very revealing and the analysis that follows can serve as a guide for future planning of programs in this area. It may also be useful in identifying subject matter areas that may require special attention.

The percentages shown here are percentage of persons taking each test that answered the question correctly. Two questions (Numbers 23 and 33) showed a drop in the percentage of persons answering correctly. Two other questions (Numbers 12 and 21) had the same score for both the pre-test and final examination. All four were very specific questions that addressed very techincal aspects of various therapy techniques.

Another five questions were correctly answered by all participants both times. The questions were Numbers 7, 8, 32, 37 and 41.

An additional four questions showed no increase but they had very high pre-test scores:

	Pre-test	Final
Question No. 5	95	95
Question No. 19	95	95
Question No. 20	90	90
Question No. 22	85	85

Thirty-eight questions showed an increase in the percentage correctly answered between pre-tests and final. This increase varied considerably. A total of 13 questions reached 100% at the final: the five questions mentioned previously, six more that had pre-test scores above 85% and two questions (Numbers 13 and 48) which had 54% and 55% respectively at the pre-test level.

These two questions showed a remarkable increase in the knowledge level and dealt with whether parents of the victim should be questioned together in incest cases, and whether in bioenergetic theory, all traumatic events and conflicts end up in the body as tension patterns.

Eleven questions had a final score of 90% or 95%, indicating a very high level of knowledge. Generally these questions represented a significant increase in the knowledge level. On the average these 11 questions had a pre-test score of 76.8%

and a final score of 93.2%. This shows a significant 21% improvement, and is very representative of the overall picture. Approximately half of the questions were answered correctly by almost all participants.

The most dramatic demonstration of the success of the program is evident when one analyzes the 19 remaining questions that had the lowest scores at the pre-test level. Table B below shows the questions that scored between 55% and 70% at pre-test and showed an improvement of 19.5%, on the average. The pre-test average was 62.3% and the final average is 74.4%. This increase is of the same magnitude as that mentioned above.

TABLE B

Question No.	Pre-test	Final
51	55%	75%
52	55%	70%
30	61%	85%
35	61%	65%
15	64%	75%
38	65%	80%
24	67%	70%
40	70%	75%

By contrast, the questions with lower pre-test scores show a huge improvement.

Table C shows those questions that had a pre-test score of under 55% and as is apparent they all showed remarkable score increases. The average score was 31.5% at pretest and 64.6% at the final for an improvement of 105%. On the average the scores more than doubled.

TABLE C

Question No.	Pre-test	Final
36	13%	80%
46	15%	50%
34	17%	50%
16	25%	45%
17	25%	45%
18	33%	85%
27	38%	50%
43	39%	90%
29	44%	55%
50	45%	65%
39	52%	95%

In conclusion, the results of the true/false portion of the final examination demonstrated a remarkable achievement in learning, especially for those who had limited knowledge in certain areas. Only four questions were answered correctly by less than half the participants. More than 75% of the participants answered correctly at least 41 of the 51 asked questions.

Part B of the final examination included two sections. The first part listed 23 topic areas. The participants were asked to describe at least one important thing they had learned in each topic area and how it applies to working with clients who are ethnic minorities.

The following lists the variety of responses for each topic area. The number of times an item reoccurred is noted. These responses illustrate the variety, amount and depth of information learned by the trainees.

A. Attitudes Towards Sexuality (SAR):

--Communication is important. (3)
--Important to recognize my attitude about my own sexuality before working with clients who have sexual problems.
--Strongly believe that this is not relevant to minority people, BIHA as a whole.
--I feel this is good information for professional to work with majority clients.
--My attitudes have changed over time.
--To be in touch with your own sexuality.
--The same material that is exploitive can be used as constructive educational material.
--Help define perimeters of personal bias enhancing quality of service delivery.
--Healthy sexuality involves the consent of both parties;
--Freedom to talk about sex. The generation of people we are dealing with today do not have this.
--To be more accepting in my attitudes towards sexuality values and attitudes; mores of the particular culture group must be learned and understood.
--Most people are sexual human beings no matter what group, age, color, handicap or sex.
--Being a sexual person is okay!
--That it is healthy and important to examine one's own beliefs on sexuality and to assess them for appropriateness and reality.
--Allowed me to address my personal views of sexuality; be aware of clients cultural identification prior to or during process of discussing their sexuality.

B. System's Response to Sexual Abuse (medical, legal, social services deliveries)

--The system's response is better but still has a long way to go as far as minority needs are concerned. (4)
--Minority clients are not given the same opportunities as whites. So in working with minority clients you have to do more advocacy to protect their rights. (4)
--Victim must have support from medical, legal and social services. (2)
--System has responsibility to give victim professional help and support. (2)

--Inherent in the system are racist attitudes toward people of color.
--System response to sexual abuse is very one sided in its view; not a lot or any information for working with families of color.
--How a suspected case is investigated.
--That there is some attempt in the systems to work together, but there remains much to be done in establishing a smooth system for the benefit of the victims and prosecution of the perpetrator.
--All should work together to be supportive to the victim. Is often biased against minorities; one must be clear about expectations and make no promises.
--System has a responsibility to the victim to provide or make sure the safety, health and emotional needs of the victim are taken care after the abuse has occurred.
--Important to help victims understand the process and the court hearing.

C. Laws Relating to Sexual Assault

--Past sexual history no longer permitted as evidence except in very limited circumstances. (4)
--Sexual assault and abuse is a crime. (3)
--Laws are lenient and perpetrators go free. (2)
--Change in sexual evidence history helpful in getting more minority women to report sexual abuse.
--Are new and ambiguous.
--Can't trust laws.
--Implementation differs from state to state and county to county.
--Sexual assault should be reported.
--Learned the process of the legal side of prosecuting the offenders.
--Need to acknowledge and respect and sanction those systems operative and dormant in these communities.
--Legal dynamics are necessary to provide to clients when discussing this topic.
--Changing toward victims rights and make offenders responsible.
--Not all tribes operate under similar laws and governments; Minorities whether we like it or not are treated differently as far as the law goes.
--The law affords equal protection to victims regardless of relationship.
--The Chicano wife has historically/culturally been accepting of the husband's dominating role. The changing law should give support to these individuals.
--Laws relating to sexual assault are important in the social service delivery system.
--That the perpetrator must be punished.

D. Non-Family Child Sexual Abuse

--Child sexual abuse outside the family is less

traumatizing and easier to deal with than sexual abuse by a family members. (5)
--How extensive it is. (3)
--Non-family child sexual abuse happens less frequently than intra-familial sexual abuse. (2)
--Victim's family recovers much faster when there is abuse from a non-family person.
--The further the distance the quicker the recovery; no difference.
--Violation of trust is not as severe; more likely to be identified and reported.
--The resources available to families for treatment for their abused child and themselves are excellent!
--The possibility of the family handling this kind of situation is real.
--Various stages, typologies of sexual abuse with children.
--The effects on the child especially if a one time occurrence.
--That child sexual abuse can take place anywhere, at any time and that we need to be alert to accurately interpret behavior in children and make some type of intervention. Even at times of suspicion.
--Our children can't be protected/educated enough.
--It is usually someone the child knows or has seen before.

E. Treatment and Interviewing Techniques for Child Victims

--Techniques for play therapy and art therapy can be used with younger children and children of color. (5)
--Start with general questions then move to specifics (2)
--Important to let child know its not their fault, they are not responsible and that there are laws against what has happened. (2)
--Talk within their cultural perspective. Meeting the child in terms of her/his world is very crucial in the treatment and interviewing techniques for child victims.
--Very few minority therapists or dolls.
--Need to respect the victim's feelings, validating their feelings;
--Direct talk;
--Significant practical (common sense) application of non-verbal methodologies; transcultural communication via play therapy with children.
--Talking with children, types of questions to ask; use of puppets and dolls, group therapy with children and individual therapy.
--Flexibility in communicating to age appropriativeness and in mode which is appropriate developmentally of child.
--Language.
--Techniques such as art and play therapy.
--Not to ask questions but to be patient and listen carefully. Given an understanding or education that children have the right to be protected or not abused. That child will respond and ask for help.

--Rapport important.
--Not assuming child is incapable of describing and discussing abuse if it was geared toward a safe environment and child is allowed to express in his/her own language.

F. General Information on Incest

--It is a family secret. (3)
--Boundaries diffused or overly rigid. (3)
--Few statistics available on incest and ethnic populations. (3)
--Family dynamics. (2)
--There are strong cultural barriers and few places for minorities to go. The need for people of color in treatment positions.
--Learned what constitutes incest, legal and treatment issues regarding incest; learned the victim's and victim's family dysfunctional behavior and the long-term and short-term effects.
--Can include boyfriend or step-father.
--The different types of offenders, their psychological makeup; information on pedophiles.
--The anguish of the victim love/violation conflict; myths;
--Dynamics of offense seem sound yet need to be coupled with culturally specific role social norms.
--It is more abundant than thought; didn't know how widespread.
--How to stress belief in victim.
--Effective treatment may require at least two years of intensive therapy and support services for family members;
--Devastating and destructive to the growth and maturity of a person.
--Intrafamilial, different degrees of abuse, dysfunctional family settings.
--The psychological damage it does to a family.
--Incest is not Prejudical!

G. Incest Victims' Responses

--Learned victims feel shame, guilt, fear, confusion; feel it's their fault. (4)
--Developing intimacy/relationships are often confusing.
--They are protective of the actor and family and often are very concerned with what their reporting will do to the family.
--Minority families, often, involve quite an extended family. It is important to know who holds the power in these extended families.
--Victims not believed.
--Helpful with clinical assessments.
--The importance of power systems.
--Information on self abuse and how to stop that behavior over time.

--Learned that incest victims feel trapped, sometimes over achievers or underachievers, sometimes isolated, shy, quiet, sometimes the rebel and become delinquents, drug abusers, runaways, suicide, usually become victimized, over and over again.
--The victim is not to blame.
--There are few safe places for victims to turn to.
--That responses can be different depending on your ethnic orientation.
--Victims respond to incest in different ways depending on age, stage of development, relationship of the offender, whether there was force or coercion, the amount of trauma, family's ability to cope.

H. Dynamics of Incest Families

--Intergenerational (Incest passed down from generation to generation). (6)
--Everyone plays a part to keep the family functioning. (3)
--That due to cultural values and norms the dynamics of an ethnic incest family is often different from dynamics of the majority culture family.
--Roles, rules, loyalties, secrets; dynamics are culture bound.
--Usually family is headed and dominated by father figure, usually family member roles are very obscured. Lack of communication, sometimes isolated, usually sexual problems between adults in family.
--Information on patterns of interaction: boundaries, communication patterns and the different kinds of dynamics, like pan sexual.
--Strong, pathological bonds. Character disordered. Interactions are in actions rather than words. Offenders often were child victims. Similar dynamics apply across all minority.
--Family members are often protective and guilty about situation.
--Introverted, inter-family dependency, dysfunctional.
--Conservative religious groups are overrepresented in reported abusive families and Jews are underrepresented; myth in black community is that it doesn't happen.

I. Interviewing Incest Victims

--Need to recognize child may come with a sense of shame and guilt. (4)
--Move from less threatening to the specific. (2)
--Interview done alone, parents should not be present. (2)
--Importance of control--where it belongs, with the victim; hopelessness, powerlessness, confusion; note direction of interview and where control is; don't rape again; intercultural exploitation. (2)

--Get as much info from victim.
--Make child feel at ease, listen, be patient, let them tell their story of how it happened. Listening skills are crucial. The interviewer should avoid having the client explain over and over the incident.
--Emphasize that what happened was not their fault.
Helpful technique is not passing power conflicts with family hierarchy during family interviews.
--The many different approaches one can use; being respectful of boundaries; how to state questions so that they are not viewed as "leading".
--Learned that because of the child's limited knowledge of the world around them, need to come down to the child's level of understanding.
--Sensitive.
--Process is important; therapist needs to have cultural information.
--Non-threatening environment;
--Ask specific questions.

J. Approaches to Incest Treatment

--Structural and strategic therapy. (3)
--That there are a variety of treatment modalities and that they all have had very little involvement with minority communities.
--Many different approaches; need to know which fits for the client. Approach should be flexible given the nature of the incest experience.
--Deal with family system.
--Individual/family/and group therapy; short-term and long-term therapy.
--Play therapy.
--May differ with respect to the specific dynamic of the incestuous relationship e.g. removal of perpetrator, family treatment, offender remain in home; as institutional system entering to stop the violations may perpetuate the existing violations that exist between cultures.
--Age and developmental appropriate methodologies in interview and treatment modalities.
--Learned several new approaches and proper names for those I was already using.
--Team of professionals; court and counseling systems must work cooperatively.
--Shame is best reworked in a group; personality change is the goal.
--Indian chemical dependency as trigger to incest; black, unlikely to report.

K. Approaches to Treatment of Families

--Incest has a different function in different families.(3)
--System therapy. (2)

--30% of all incest families seek treatment for some other problem other than incest.
--Need individual, family and group therapy at various stages of their recovery.
--Approach should be flexible given the nature of the incest experience.
--I learned the intervention process necessary to facilitate family treatment.
--Methodologies must consider situation, cultural biases, language barriers, communicator pathways and epidemology of family to be most effective.
--Good to be well versed with ability to utilize several approaches depending on the "family".
--Awareness of specific cultural dynamics is important.
--Family system; structure and strategic.
--Learned that each family is different and providing the circumstances the family can be treated a family unit the first priority here being the safety of the victim, medically and emotionally.
--If whole family is not willing to participate, work with members willing to participate.

L. Approaches to Treatment of Sexually Abused Children

--Learned play therapy. (6)
--Learned direct therapy. (3)
--Having a safe environment for the victim and reassuring them that they are safe and will not be hurt. (2)
--Community education critical. (2)
--Variety of approaches; approaches should be flexible given the nature of the incest experience.
--Play therapy can work and is important for children, no matter how young.
--Watch for acting out behavior.
--Learned the process we should take in beginning treatment. From medical exam to play therapy.
--Importance of the issue of control and safety and where responsibility for the offender lies; offers good structure for the development of ethnic methodologies.
--Age and developmental considerations. Learning aptitudes, communication levels and child accommodation techniques.
--Group should be all the same minority.
--Varies with ages of children and duration of abuse and relationship to abuser.

M. Approaches to Treatment of Sexually Abused Adolescents

--Group therapy is an important approach because of peer support. (5)
--Approach should be supportive and flexible, given the nature of the incest experience. (3)
--The presentation on the make-up of a group, the steps, process was very good. (3)
--To approach the kids on their level. (2)

--Male/female co-therapists important for adolescent support groups. (2)
--There is little available that fits for minority youth. (2)
--Be direct, be patient, be specific; be supportive and flexible.
--Socialization skills, peer development, age and social setting accommodations.
--Dealing with incest thru peer groups can be supportive therapuetically to develop healthy sexuality; can work similarly with culturally knowledgeable facilitators.
--The curative factors experienced in a peer setting are very healthy.
--Assure them it is not their fault.
--Variety of approaches, again should focus on cultural aspects.

N. Adults Victimized as Children

--Incest needs to be remembered and not forgotten. Need to be brought to the present, and go thru every detail until they have pieced through it all. (4)
--Need to work with relieving the pain appropriately. The significance of continued/continual pain physically. (2)
--Group work; how much, how long. (2)
--Victims are caught in a paradox developmentally, the "little girl or little boy" and their adult self, pulling against each other. (2)
--Often need to work through their abuse; Should focus on cultural aspects.
--In many cases adult victimized as children may never had had the opportunity to release the shame, guilt, the feeling of blame and feeling of being dirty and all the other feelings associated to sexual abuse. When they have that opportunity it could hit them very severe at times, in terms of realizing the impact the act has had on them as well as the relief of finally dealing with it.
--Learned behavioral responses; developmental retardation.
--Taking a look at their behavior today and why it is happening.
--The need for these adults to develop a dependency-based relationship with the therapist in order to be successfully treated. Often needing help in not repeating victimization in the here and now; letting go.
--Need therapy to get over it; to lead a more productive life. Men who are victimized as children have work thru their sexual identity problems with homosexuality. Depressed, feeling helplessness, shame based--dependency based relationship.

O. General Information Regarding Perpetrators

--Perpetrators have a strong denial system and deny there is a problem. (5)

--Need to break through the denial system in order to treat effectively. They have learned patterns of behaviors that involve erotic arousal and is supported by a system of belief and attitudes that primarily serves non sexual needs. (3)
--Perpetrators were/are victims too. (2)
--Very little statistics available on the numbers of minority perpetrators. (2)
--There are different types of perpetrators. (2)
--Is emotionally and sexually immature.
--Often needing immediate consequences/pressure by external services in order to start the treatment process.
--Overly controlling and restrictive. Difficulty with impulse control. Project blame on victim.
--No stereotype.
--Family origin suggests perpetrators are themselves "stuck" developmentally and perhaps are "functional" in their behavior as perpetrator.
--The identification of sexual abuse continuum from non violent to violence psychological to physical.
--Could be anyone, in cases of young perpetrators are acting out their urges of sexual desires but in an abusive, inappropriate manner. In this cases usually learning inappropriate manners of learning about sexuality. In cases of adult perpetrators, that one not seeking sexual need but more of an emotional vacancy. Both, however, inappropriate, sick behavior. Intergenerational.

P. Approaches to Treatment of Perpetrators

--Cognitive restructuring and psychodynamic psychotherapy. (4)
--Important to have the court mandate his participation in treatment; The treatment has to deal with the crime he has committed as well as his emotional health. (3)
--Very little info regarding treatment of minority clients. Few therapists are skilled in working with minorities.
--Some therapists are able to work with both the victim and the perpetrator.
--Learned that in most cases, the first step is to change the perpetrators. Depending on the degree of the assault or abuse the perpetrators may be given the opportunity to undergo treatment inside the corrections facility or in the community. Treatment may consist of individual, family, couples therapy in marriage situation.
--That they stand a chance to recover.
--Will not work in my community.
--Approaches should be flexible given the nature of the crime.
--Also need therapy; incarceration will not cure problem.

Q. General Information Regarding Rape and Sexual Assault

--Victim does not deserve or asks to be raped and is not responsible for the assault. (4)
--Victims do not respond to rape in the same way. (4)
--Anyone can be raped. (2)
--Nearly 50-60% of rape victims know the man who has assaulted her. (2)
--Not every woman needs long-term treatment.
--Victim's involvement in group to process rape and sexual assault can be helpful.
--In some cases can be more traumatic if force and violence is connected with it.
--Prevailing myths and attitudes were reaffirmed.
--Alot of info was important and I learned alot; how to access their services, referral services, and agencies involved with issues.
--It's one example of manipulation, coercion, control by the use of power (physical) and abuse of position in society. Women have to look at issue of power.
--Act of violence and sexual assault is low or under-reported for minorities.
--That there are no people of color in the rape and sexual assault centers' staff.

R. Responses of Rape Victims

--Can't predict how victim will respond to rape. Victim response is different; based on experience. (2)
--Very few resources available for minority rape victims. (3)
--Self-blame; Not their fault. (2)
--Probably the most important loss of a rape victim is the loss of personal power.
--The responses one feels, loss of trust, insecurity, feeling and fear that it could happen again, usually. The fear follows the victims everywhere they go, home, work and social life.
--Can't predict the responses of the victims.
--Effects of such a trauma and how it is/is not handled.
--All too often the system continues to rape. Helpful to provide sensitive professional responses.
--That delayed shock can happen to the victims.
--Three stages of victim's reaction and what the counselor can do to assist them through those stages. The emotional reactions must be the same for all groups of women.
--Psychological violation of self.
--Women of color have a tendency to not be believe when issues of rape are involved.

S. Intervention With Adult Sexual Assault Victims

--Group therapy. (6)
--Help them to learn to stop abusing themselves and to stop being victims. (6)

--There are many resources in Minnesota.
--An intervention can occur in different ways. The hardest barrier to break is the denial. Once the denial is broken down, treatment can begin.
--Provide for the victim's safety; existing typical systems inadequately deal with these individuals.
--Interviewer must be alert to own biases.
--That even though they are adult, they need constant reassuring; With minorities this is of high priority.
--This is good if they report but very few report until much later.
--The therapy group model makes good sense to me because in numbers there is support--and support is what is needed here to gain the courage to share one's feelings.
--Should occur immediately; Needs lots of support an understanding at that time, don't press for information, re: perpetrator focus on her--her feelings.

T. Treatment Techniques for Adult Sexual Assault Victims:

--Group model provides support, intervention, which leads to change. (4)
--A variety of methods. Something that fits for many. (2)
--Decrease shame, increase awareness of self; increase flexibility.
--The therapy group model makes good sense to me because in numbers there is support and support is what is needed here to gain the courage to share one's feelings.
--That play therapy works even with adult victims.
--Individual, group or couples approach.
--Structural/strategic and bioenergetic therapy.
--Whites don't know how to work with minority clients.

U. Support Groups for: 1) Child Victims; 2) Adolescent Victims; 3) Adults Victimized as Children; and 4) Adult Rape Victims:

--Support groups for child victims utilize play therapy; child who is non-verbal is a good candidate. (2)
--Support groups for adolescent victims can utilize direct talk and meet once a week.
--Support groups for adults victimized as children utilize structural/strategic; structure a "new family" with health rules and roles.
--Support groups for adult rape victims there are single focus; time limited group; closed and open group.
--There are different needs in groups based on developmental stage, age and severity of event.
--I understand that the group needs to grow together and build trust and confidence to begin any type of treatment. The growth process is part of the treatment.
--Group, a helpful phase during treatment if appropriate to the developmental stage of client.
--I learned that there are support groups out there. I/It will help minorities with a referral network.

--If group all one minority it will work.
--Support groups for adolescent, adult and rape victims seem appropriate but not for child victims.
--Co-therapist, male/female, are most helpful in the treatment. Time, place, day, etc. should be consistent.

V. Strategies for Prevention:

--Minority communities need more awareness, education on healthy sexuality and information for children on sexual abuse and self-defense. (3)
--Education for parents, children, families, communities. (2)
--Education, through various methods, various vehicles, healthy sexuality education, for all different age groups, i.e., written materials, booklets, role play, theater, etc. reaching teachers, etc. that work with public parents is crucial in preventing/reducing the incidence of sexual assault. (2)
--To educate children at an early age without scaring them.
--Knowledge of culture dynamics important.
--Center message around the child and have children recognize their power.
--Teach children to be open with experiences and to talk to and educate what to do. Educate adults on what to do for their children and themselves.
--Education; treatment; center or attack message around child and his power.
--Teaching the message and centering around the children; Secondary preventions, self-defense/help the child recognize their power.

W. Stress Management:

--Breathing/relaxation techniques. (7)
--We should take care of ourselves if we are going to help others. (4)
--Positive self-talk. (2)
--How will we perceive ourselves has important factors of stress; Three stages of stress are alarm, resistance, exhaustion.
--Felt very traditional: Hispanic elderly would really relate to this treatment.
--Yoga and massage techniques.
--Very good area and it can be applied to people of color; Helpful for all individuals.
--Stress management is a important tool both for the professional working with clients in the field and a tool for the client.
--Something you can practice anywhere, anytime.
--Important to develop repitore of skills to deal, cope.

The second section of the written part of the final examination asked the participants to select two of eight therapy models and then discuss their advantages and limitations and identify what populations they are appropriate for.

The following notes the number of trainees that selected each model and summarizes their comments:

A. Behavior Therapy (4)
B. Psychoanalytic Therapy (1)
C. Structural/Strategic Therapy (6)
D. Direct Talk Therapy (2)
E. Play Therapy (12)
F. Bioenergetic Therapy (0)
G. Grief Counseling (3)
H. Process Therapy (4)

A. Behavior Therapy Model -- Advantages mentioned by trainees were changes in the behavior of the victim/individual. No limitations or appropriate populations were cited by the respondents.

B. Psychoanalytic Therapy Model -- The participants stated that it is fine with the didactic counseling modality. Limitations noted were: theoretical foundation does not provide for families; therapist sometimes drawn into advocacy of client against family members thereby limiting ability to be helpful. No appropriate populations were cited.

C. Structural/Strategic Therapy Model -- Various advantages cited were: Restructures boundaries; triangulates members through movement; reworks shame, focus of control, self-destructive behavior; structures new "family" with healthy roles; it does not challenge existing family values; can work on changing the family's processes and patterns of interaction in subtle ways while using their content issues as a means to keep them motivated and energized; can be used cross-culturally due to respecting the family's culture; real respectful to the family process; and can change the families process and pattern of interaction in a real subtle way.

Limitations mentioned by respondees included: Relearning new behaviors and assuming that's what is expected; long time to be in therapy, 3-4 years; limited if you can not get more than one person from the family to attend; and doesn't work if there is only one person or family refuses to cooperate. Appropriate populations to use this therapy cited were minorities and families.

D. Direct Talk Therapy Model -- The respondent cited the appropriate population for this therapy were adolescents and was not good with children.

E. Play Therapy Model -- Advantages given by participants included: Helps the child to work through feelings; works well with minority children as long as toys are culturally specific;

respectful, non-controlling, non-intrusive are some advantages; excellent method of communication utilizing other models other than voice, but need knowledge of symbols of culture and their use, impact, etc.; effective with non-verbal children that can play-out the sexual traumatization; helps children relate and understand the concepts related to sexual abuse and assault. This is also a vehicle with which children can use in releasing anger, confusion, fear and doubt and through the use of toys, dolls, puppets, children find these easy to do; can immediately begin specific behavioral changes; Effective with children, especially young children and adolescents.

Probably limited to upper class families where parent can transport and wait for child and lots of motivation needed were limitations cited by trainees. Other limitations included: income or medical coverage needed; if therapist is unaware of culture he/she is working with; making sure that your interpretations are correct; does not acknowledge feelings of client; discounts identity, culture; not good for adults, should be culturally relevant; and therapist inability to interpret clearly child's culture were given as limitations.

Play therapy could work across the board, was mentioned several times by respondees, as well as, excellent for very young children. It can be used cross culturally with just a small awareness of different symbolism usage in the culture; children and adults; and effective with non-verbal children.

F. Bioenergetic Therapy Model -- No participants responded to this therapy model.

G. Grief Counseling Model -- Respondents felt that this model can work with Black families, but no advantages or limitations were cited.

H. Process Therapy Model -- It does diagnosis and cure as the basis of their therapy; assumption the client knows more than what they need; holistic approach; anger, fear, rage issues are reworked; can get into here and now experience of the client; and helps people let go were mentioned as advantages to process therapy.

Limitations of process therapy were noted as some of the content, i.e., TA, Gestalt and Freudian, could be a problem in dealing and incorporating them for Third World communities; seems to be only a borrowed application from systemic-work; has no foundation in theory; client needs to be pretty verbal; relationship between client and therapist is important for it to work; and not focusing on other issues.

The third question of the final examination asked trainees the following: Drawing on your own experience and the content of the course, discuss at least two changes in the legal, medical, and/or social services delivery systems that you think need to be made to increase their response to ethnic minority victims.

How would you go about making these changes?

"Seven participants mentioned hiring more minority professionals in the delivery of the legal, medical and social service system; need more minority professionals in all areas; they need to be visible and have positions where they can impact on change and make a difference.

"Second, white professionals need to deal with their own racism and be more open (and therefore less threatened) by "differences", be it cultural, racial, sexual, etc.

"Levels of change, can start anywhere: personal, local/community, state, national, education, employment, training, get money!, networking, identifying resources, political.

"I believe that two of the most painful factors that keep minority victims and their concerned others are racism and discrimination. I know from experience that these two issues close a lot of doors and halt any progress that could be made in many, many areas. However, these two issues are real to the ethnic communities in the entire spectrum of the human health services delivery system of this country. I believe that one way of dealing with this reality is to increase staff members who are of color at all the levels of the continuum of care, i.e. nurses, doctors, police officers, counselors, therapists, attorneys, judges). One starting point would be the country's educational system. We need to break down the myths, stereotypes and fears we all have about one another. There is from my experience a lack of cooperation, at least in effort, from the different human health services delivery programs to work together as a team to help the victims of many social diseases. There needs to be more linkages between or among these agencies or programs to effectively treat the general population. For minority communities these factors are magnified because of the racism and discrimination. I believe that the ethnic communities need to take the issues of sexual assault and abuse into their own hands at all levels of the delivery system, i.e. research, education, prevention, primary therapy. I get very sick because in all the cases money seems to depend on everything else in terms of what programs get off the ground and which ones don't.

"Involve ethnic minorities early in the planning process of any sexual assault program to implement, validate and respect elements relevant to them even if only same people will benefit from it. The social, education, economic and political systems must be representative of our pluralistic society. Power, control, utilization across the board must be looked at--non people of color need not feel threatened when people of color are in a powerful position--respect

and validate their efforts or contribution by utilizing their service/program, etc.

"The church needs to be plugged into the above system. We heard the Hispanic presenters speak about the conflict a Hispanic victim of sexual assault may experience in seeking help. Anglo agencies do not seem relevant. Her upbringing has taught her to depend on her extended family at time of crisis. We also heard the presenter state that because of the strong taboos surrounding sexuality in Hispanic culture the victim may feel this source is not available to her. (How about the fear of deportation? For those women here illegally) The idea of rape as being God's punishment for some prior sin is not an unusual thought for a Chicano raised in a church on religion which emphasizes purity, guilt, etc. The church representative who can be part of the system can be a terribly important team member in helping the victim begin immediately to sense and recognize that the guilt and shame is not hers. Also, the influence that such a representative would have in sharing to this religious group his role in these helping systems.

"The minority communities have to have same status as other service providers.

"Cultural adaptation of materials. Incorporation of non-dominant societies models for treatment. Utilization of cultural community resources and people. Having ethnic communities do own research to see what models will work or if dynamics are different in Indian families. Treatment model needs to be developed by own ethnic groups incorporating the above.

"In the legal system I would advocate for mandatory therapy laws with jail sentences for more revise cases, and to heighten or make mandatory that all legal service providers, lawyers, judges, etc. have training in the area of sexual abuse. I would first present factual information and heighten public awareness, start lobbying on a low level and work up from there for the first one, re: laws. On the second, I would approach it the same way on a much broader scope. I would address the school systems that teach law and show the importance of having knowledge in this particular offense. I would also add more classes on minorities, how they live, values, etc.

"Legal developments should be more applicable to the situation and contextual "reality" of ethnically diverse individuals. Particular to American Indians. There is a myriad of governmental "conflicts" which are jurisdictionally confusing and ambiguous. Perhaps tribal government as a legally formed legislative body could determine these questions more appropriately to the "context" of their individual tribal needs, values, customs and beliefs. Service delivery may be most appropriately

provided to ethnic populations from within the framework and social context of the specific ethnic population.

"Professionals with expertise in the area working in our communities; funding, grants, program development and implementation and training and internships.

"Acknowledge ethnic systems, identify them; promote them; support them; sanction them; incorporate them into system delivery system. To make changes identify and utilize ethnic specific system.

"Address the unique differences in cultures and that laws are made for the majority population and are not adequate for BIHA people".

3. Monthly Evaluations

Each month the participants completed an evaluation of that segment of the training project. The participants rated each component of the the training program, and the presentations. They also had the opportunity to respond to the question what new information/attitudes/feelings did you experience and comment on the following: The large group presentations; the guest speakers; small group experience; large group feedback; small group facilitator; logistics (environment and food); and format (see Appendix # 10).

Information gathered from these evaluations gave a sense of the information learned by the participants, the effectiveness of the presenters, and reaction to the training format. The monthly evaluations provided feedback to presenters and information which will be helpful to plan future sessions. Summaries of these monthly evaluations can be found as Appendix # 11.

4. Final Course Evaluation

An overall evaluation for the course was made by the participants (see Appendix # 12). This evaluation had three components.

Part A of the final course evaluation consisted of seven questions. Participants were asked to answer each question in terms of their own goals and experience in the course. The following is a summary of the trainees' responses to each question.

1. Please list your original goals for attending the training? What did you hope to get out of the experience?

The participants listed a variety of original goals for attending the training. More than half of the trainees who

completed the final evaluation stated that they attended to gain general information about sexual abuse such as an understanding of family dynamics, the effects of sexual abuse, and increase, improve and/or enhance skills and techniques in order to better serve clients. Some specifics that were mentioned included recognizing and assessing sexual assault in clients, improving interviewing techniques, enhancing counseling skills and improving skills to work with people of color who were sexually abused. A substantial number of participants were attending to learn about treatment techniques and modalities for sexual assault victims, perpetrators and families, as well as models for working with people of color.

Other goals mentioned included learning about resources, networking, the development of programs and services in minority communities, learning similarities and differences of incest within various cultural communities and gaining credibility as a counselor.

2. To what extent were you able to meet each of these goals? Please explain.

The vast majority of the respondents felt that their goals were met to the fullest. In a few cases comments such as: "more depth than expected," "excellent variety," and "helpful in practice" were used. In general the participants found that the training reinforced their prior knowledge, provided new knowledge of therapy techniques and offered a variety of models that would be helpful to them in their work.

Some participants felt that the program was direct, specific, interesting and challenging and it offered them networking opportunities. A few stated that their goals were not met because they did not gain specific information on working with people of color. The following statement of one participant illustrated that frustration. "Information very good, but none has worked extensively with people of color to give a definite opinion that's valid."

3. List the information/learning experiences that were most helpful to you in the course.

"It is extremely difficult to list the most helpful because I see it in its entirety and how the overall process and experience has helped me broaden my awareness and to begin to deal with the problem in my community", was the response of one participant.

One half of the participants found information on treatment most helpful. Topics trainees mentioned specifically included workable treatment plans for adults, adolescent treatment programs and groups, therapy modalities for children, support groups for sexually abused clients and an understanding of how different treatment models work.

Several participants listed skill development opportunities, information on the dynamics of abuse, and resource identification as most helpful. The large group presenters, the small groups and presentations by people of color were also mentioned. Several specific presenters were listed as helpful as well as the way these people shared how they do therapy and give of themselves when doing therapy.

Trainees also found helpful cultural information, meeting and learning from people about other ethnic groups, sharing information and experiences, and the group interaction and discussion.

Stress management techniques, personal validation and personal empowerment were also cited as most helpful aspects of the program. Several trainees stated that all the information was helpful to them.

4. List the information/learning experiences that were least helpful to you.

More than half of the respondents stated that there was nothing that was least helpful. Several participants found least helpful factors relating to cultural issues, such as the speaker's lack of experience working with people of color, biases of non-ethnic speakers, the lack of ethnic perspectives in some presentations and the reprocessing of information to adapt to ethnic clients. A few mentioned the small groups as least helpful. One participant was not comfortable discussing in depth therapy for children. The repetitiveness of some information and S.A.R. movies were also listed as least helpful.

5. What do you see as the benefits to your having attended this training?

When listing the benefits of attending the training program most respondents listed knowledge-related benefits and personal use. Many of the participants mentioned the wealth and depth of new information they gained, as well as increased skills in the identifying and counseling of sexual abuse victims as benefits. Several trainees mentioned as advantages the recognition of the issues affecting services in each community; cultural and community issues, such as understanding the need for education on sexual assault in one's own community, gaining an awareness of sexual abuse as a problem for all ethnic groups, learning a vocabulary to convey information within one's own community; and, to better serve one's own community.

Over half of the trainees listed the opportunity to meet and work with other participants as a reward. Many wrote about gaining a group of people of color as co-workers and friends, establishing a network and identifying resources. Several felt

they could apply the knowledge learned to their work. One felt personal credibility was gained.

To one trainee the benefit was "to have the opportunity to receive the training with a special select group of people of color."

6. What are any negative consequences to you for having attended this training?

Over half of the participants listed as a negative consequence the time commitment away from work and the work backlog caused by attending the sessions. Several participants listed personal factors as a negative consequence, such as stress due to commitment to the group process; awareness of our limits and inabilities; stress, because of subject matter; stress, from being controlled; and the emotional drain of dealing with the personal anger of others.

Other negative consequences mentioned included too much information in too short a time; too advanced information; too long; limited number of presenters who were people of color and disenchantment with the staff. One quarter of the respondents listed no negative consequences.

7. What aspects of this training experience will you apply to your professional and/or personal life? Specify how.

The trainees stated that they would apply the training experience in a variety of ways, such as: assessing the needs of victims; identifying victims; and utilizing treatment techniques including play therapy, process therapy, structural/ strategic therapy and support groups.

Participants also listed teaching others, networking, developing programs in their community and educating their community. One respondent stated the information would be used to talk to their own children. One trainee said, "Now I feel confident to treat families and individuals involved with the problems of sexual assault, rape and incest.

Component B involved a set of 10 variables with each participant asked to rate each variable on a scale from one to five. Respondents were asked to rate them as follows: 5, Very Positive; 4, Positive; 3, Neutral; 2, Negative; 1, Very Negative.

The variables and their average value on the scale are shown below, starting with the one ranked the highest:

Mini-Workshops	4.38
Large Group	4.29
S.A.R.	4.29
Facilitators in small groups	4.29

Topics Addressed	4.24
Logistics	4.10
Overall Format	4.00
Small Group	3.90
Skill Development	3.67
Guest Speakers	3.62

The scaled variables shown above were all rated significantly above average. There was also a high degree of agreement among tne 21 participants who submitted these ratings. It is very hard to establish any pronounced differentiation among them. Ratings of 5 were extremely common for all of them as were ratings of 4. A rating of 2 occurred very rarely. This suggests that all components of the training program contributed to its effectiveness and were important parts of the project.

These results suggest that overall ratings by the participants were universally high. Statistically significant differences exist only with respect to Skills Development and Guest Speakers, both of which were rated lower than the rest.

Any differentiation among the other eight variables is purely by chance. No further significance should be attributed to the small arithmetic differences shown.

In addition to rating each part of the training program numerically, participants were also afforded the opportunity to comment on them. The question that asked the participants to comment on each part of the program was: If you were planning another training program, what would you do differently? Similarly? A few comments were made on the areas and the following is a summary:

Many respondents thought the choice of topics was excellent, informative, educational and appropriate. A few mentioned some topics being repetitive.

Several participants stated that more people of color should have been used as guest speakers.

The comments relating to skill development sessions stated that the sessions were very good; offered a good opportunity to apply information learned, especially play therapy and interviewing techniques; and needed more leaders with expertise in the skills being practiced.

Participant reactions to the small group experience stated that the interpersonal experience was good but the organization was not conducive to reach consensus; that the group was dominated by certain negative individuals; and they wanted more of an opportunity to meet in their own ethnic group.

One trainee thought too much time was spent on large group feedback. The response to the facility was excellent.

In the mini-sessions two trainees complained because they could not attend all sessions. Other comments stated that the choices were excellent and that the mini-sessions were helpful because there was better access to the presenters.

Written thoughts on the S.A.R. stated that the small group format was good; that the S.A.R. didn't deal with the cultural perspectives of sexuality; and should have included ethnic specific media. All thought the S.A.R. was very positive and something everyone should go through.

Part C of the final evaluation gave participants the opportunity to comment on any aspect of the program or their participation in the training program. About half of the respondents chose to include comments. The following are those comments:

-I feel the program gave me an opportunity to learn and reaffirm my own knowledge; a very good all around experience;

-So glad to have been a part of this; very educational both personally and professionally. Thank you so much;

-The training was good and quite beneficial. This has been a very valuable experience for me. The most negative part of the training was my small group experience. I take responsibility for my not being able to gain from that experience what I would have liked to have happened. I for whatever the reason at some point made either a a conscious or unconscious decision to let things go as they were going rather than try to change the format to get my needs met;

-It was validating professionally and personally;

-Very good program. Very happy to be a part of it. Learned a lot of new information that will be relevant to working with my people. Hopefully will lead to the a recognition that we of BIHA people know of how our children will receive information and treatment for people of color;

-Perhaps an advisory group of ethnic representatives could be a help in determining organizational processes which are less inimical to the social and political sensitivities of the participants;

-The training has afforded me information and skill to 1) Deal with the 5th and 6th grade youngsters helping them with questions of sexuality and giving me the opportunity to attempt to make them aware of the myths we have regarding women in our society. 2) Pass on information to teachers and help them to see the importance of a sex education curriculum. 3) Help to develop a community network of Chicano resources for those in need to perhaps participate in developing a program in our community, a resource program for Chicano/Hispanic groups to

draw on. 4) To encourage, through contacting organization, the tremendous need for young students of color to continue on in school so that perhaps they can enter the social service field where they are very much needed. 5) To attempt to impress agencies such as welfare and police again the need to recruit people of color;

-Training was stretched out too,too long;

-Did not like having small group sessions structured so much around another person's agenda. Felt more information could have been shared if an open, less structured space would have been allowed. Also need more time to meet with our own ethnic groups (assumed we had opportunities to do this). Slight format problems;

-Best training ever attended;

-Invaluable;

-Thank you for your acceptance and support through the program;

5. Participant Assessment by Group Leader

An assessment of each participant was conducted by the group leader. Each trainee's entry level knowledge or skill and increased knowledge or skill were ranked in six areas. The group facilitators also commented on the following questions: strengths and weaknesses relevant to providing services in the sexual assault field; benefits of training program to the participants; negative consequences for having attended the training; and contributions to the small group.

This evaluation also measured the trainee's learning from another perspective and identified strengths and weaknesses for referral purposes (see Appendix # 13).

C. THE EFFECTS ON THOSE INVOLVED

Throughout the training program, the participants, faculty, group facilitators and project staff grappled with many issues related to sexual assault services for ethnic communities including the impact of racism on those services.

Discussion of these issues occurred both in the small groups among the participants themselves, during large group presentations with the trainers and during large group feedback with project staff. Exploration of these issues was both stimulating and sometimes painful, as people struggled to communicate the depth of the problem, to reach new levels of awareness and to generate ideas for solutions. These issues impacted the training program and everyone connected with it.

Participants had to recognize their own stereotypes and prejudices toward the other ethnic groups and work toward understanding the differences in behavior and style of other populations, and build a trust level with the other participants. They also had to obtain information from trainers who were not people of color, which most could accept and adopt. Unfortunately, speakers from the majority population evoked deep anger in a few verbal participants which not only affected their learning but also resulted in negative consequences for other participants. For example, large group presentations were interrupted before all the material had been shared and thus others were deprived of information. These individuals also dominated many small group sessions, intimidated others so they would not speak, and prevented processing from occurring.

For the speakers, most of whom were experienced trainers but did not have experience speaking to a large group of minorities, participating in this project was extremely stressful. The same anger was exhibited by a few and these participants discounted the presenter's information, disrupted their presentations and were disrespectful to them as persons.

Participation in the training program was hard work for the small group leaders. They had to be flexible and be able to respond to the immediate dynamics of their group which could change instantly as a reaction to a specific topic, discussion or presenter. They also had to create an atmosphere that afforded each group member the opportunity to participate. At times the group leaders had to deal with an angry or non-communicative or disruptive group member. The group leaders also acted as confidants to some trainees and served as the linkage between the participants and project staff.

A change in the project staff in the middle of the training program impacted the project. The Black staff member with whom the participants were comfortable with left the MPVSA four months into the project. This left her successor and the director of MPVSA, neither of whom were of minority heritage, to administer the second half of the training project.

The program afforded the project staff the opportunity to examine their own racism, attitudes and feelings; to recognize their own ignorance regarding the needs and feelings of minorities and to better understand messages communicated by the participants regarding their issues, problems and frustrations.

Staff had to learn to acknowledge the inherent mistrust and adjust to the group dynamics while at the same time facilitate the implementation of the project. The staff had to sort through the concerns raised and react appropriately to those legitimate issues while tactfully dealing with the non-constructive pieces.

For the targeted communities the impact was immediate. A Community Development Survey completed by each participant was used as a referral and resource tool (see Appendix #13). It asked if the participant was willing to accept referrals and/or actively work to address the problems of sexual assault in the following areas: Direct services to victims, such as crisis intervention, interviewing, assessment, individual counseling and group counseling; training; public education, topics and groups they would address; building a system intervention and treatment model, and networking with other community agencies. Even before the training was completed, sexual training participants began to develop programs within their own agencies and some trainees developed internships for the participants to further develop their skills. Further, participants in the project began to act as a resource in their own community.

V. SUMMARY AND CONCLUSION

The Minnesota Program for Victims of Sexual Assault, a project of the state Department of Corrections, developed and implemented an intensive nine-month training program for racial minority human service professionals. The goals of the project, which was funded by the Northwest Area Foundation, was to enhance the identification, intervention and treatment of sexual assault victims and family members who are of racial minority heritage.

The training program, which took place from September 1983 through May 1984, targeted three racial minority populations, American Indians, Blacks and Hispanics. Thirty-five persons were selected to participate in the training, 12 Blacks, 13 American Indians, nine Hispanics and one Asian. Twenty-four of the participants were female, 11 were male. Twenty-nine were from the metropolitan area and six traveled from other parts of the state of Minnesota. Thirty-two (91.4%) of the trainees completed the program.

A standardized format was developed and utilized each month, except the months of September and April, for which there were special training activities. The major components of the training program included presentations by more than 55 individuals on general topic areas to the entire group, small group work in which participants met with some groups two to five times each month, large group feedback to facilitate reports from the small groups and skill development which enabled the participants to practice the interviewing, intervention and treatment techniques to which they had been exposed. On the final evaluation each of these components were rated significantly above average by the participants. The fact that there was no pronounced differentiation among them suggest that all components of the training program contributed to its effectiveness and were important parts of the project.

The content of the training program was divided into broad topic areas that were explored in depth in sessions ranging from one to eight days. Two special programs were integrated into the nine-month program, the Sexual Attitude Reassessment Seminar conducted in September and the Mini-Sessions which were held in April. The topic areas addressed were historical and cultural factors. The System's Response to Sexual Abuse; Victimization of Children Outside the Family; Incest--Family Sexual Abuse; Sexual Assault of Adults; Treatment of Perpetrators; Prevention; and Networking and Community Organizing.

The impact of the training program was evaluated utilizing several different methods, including monthly and final tests

and evaluations. A pre and post test were administered to the participants monthly and results calculated for each month. Generally, all months show very similar results with the pre-test averaging approximately 70% and the post-tests approximately 80%. The results were statistically significant and on the average showed a consistent improvement of 12%. Additionally, looking further at the improvement of individual scores revealed that those persons who had the lowest scores in the pre-tests exhibited a score increase much higher than average.

The results of the final examination administered at the conclusion of the training program also demonstrated significant learning had occurred. Fifty-two questions were included and the scores ranged from 35 to 48 with the average score of 41.5 or 81.4% of the MAX. Approximately half of the questions were answered correctly by almost all participants.

This report also provided information and data that illustrated progress toward reaching the original objectives of the project which are discussed below.

<u>To increase the participants' knowledge of the issues surrounding sexual abuse</u>.

The statistically significant improvement shown on the monthly pre/post tests, the results of the true/false portion of the final examination, the extensiveness of the responses listed in the narrative portion of the final examination and the number of participants that mentioned increased knowledge as a benefit of the training, all illustrate success in meeting this objective.

<u>Familiarize participants with existing models and techniques of sexual assault service delivery.</u>

To achieve this goal more than fifty-five presenters provided information to the group. Approximately 25 existing models and techniques for intervention and treatment of sexual abuse were presented.

<u>To enhance participants' skills in the identification, intervention and treatment of racial minority sexual assault victims and their families.</u>

The provision of information, demonstrations and skill development exercises were training techniques utilized to meet this objective. The evaluation of the participants by the small group leaders and the participant's self-evaluation both cited a significant improvement in skills.

To culturally adapt information, techniques and models to enable services for racial minorities to be more relevant.

During the small group sessions issues that need to be considered to culturally adapt techniques were discussed. However, the actual adaptation was not achieved.

The project was not without problems. These related to recruitment, the lack of availability of people of color to speak, and group dynamics. Throughout the training program, the participants, faculty, group facilitators and project staff grappled with many issues related to sexual assault services for ethnic communities including the impact of racism on those services.

Exploration of these issues was both stimulating and sometimes painful, as people struggled to communicate the depth of the problem, to reach new levels of awareness and to generate ideas for solutions. These issues impacted the training program and everyone connected with it.

It was also difficult to implement a project of this magnitude by just utilizing the staff of the MPVSA who were responsible for carrying out the regular program activities. In order to implement a project of this size in the future, it is recommended that a separate full-time project coordinator and a support staff person be hired.

The nine month training program was successfully completed. A wealth of information on sexual abuse was presented, and significant learning occurred. The participants identified barriers to the provision of comprehensive sexual assault services within each targeted community and developed strategies to address these problems. The participants developed among themselves a professional network for both referral and support. An intensive training program for selected minority human service providers appears to be an approach that is effective in improving sexual assault services to racial minority victims and their families.

DETAIL OF APPENDIXES

APPENDIX # 1

TREATMENT OF SEXUAL ABUSE AND ASSAULT WITH ETHNIC POPULATIONS

DEPARTMENT OF CORRECTIONS
Minnesota Program for Victims of Sexual Assault

MINIMUM REQUIREMENTS: 1) B.A. Degree in Social Science plus 2 years direct counseling with a minimum of 1 year working with children and/or families or 2) equivalent training plus 3-5 years direct counseling experience in therapeutic setting.

DATE: _____

NAME: _____ HOME PHONE: _____

ADDRESS: _____

_____
(city) (state) (ZIP code)

BIRTHDATE: _____ SEX: _____ MARITAL STATUS: _____

AMERICAN INDIAN: _____ BLACK: _____ HISPANIC: _____

AGES OF CHILDREN: _____

AGENCY AFFILIATION: _____ PHONE: _____

AGENCY ADDRESS: _____

_____

AGENCY POSITION: _____

DESCRIBE YOUR MAJOR WORK AREAS: _____

_____

_____

IMMEDIATE SUPERVISOR: _____

EDUCATION

	Name & Location	Dates Attended	Degree/Major
HIGH SCHOOL:			
COLLEGE (S):			
GRADUATE SCHOOL (S):			

EXPERIENCE

Please list employment or volunteer experience that is relevant to training project. List agency, dates of employment and major duties.

PAST POSITIONS: DATES:

_____

_____

_____

_____

_____

_____

RELATED COURSES TAKEN: (Attach additional sheets if necessary)

COLLEGE: _____

GRADUATE SCHOOL: _____

POST-GRADUATE WORK: _____

WORKSHOPS: _____

_____

_____

_____

_____ 1. Have your received approval from your supervisor about applying for training?

_____ 2. Will <u>your agency be willing</u> to provide you with time off for training?

_____ 3. Will you be willing to drive to a metro area location for 25-30 days of training during the next year? (Training will be offered in 3-day blocks)

_____ 4. If admitted to this program, will you be ready to start September 13, 1983?

_____ 5. Do you have demonstrated experience working with ethnic populations? What percentage of your time do you spend working with these ethnic groups?

_____ American Indian _____ Black _____Hispanic

6. What percentage of time do you spend working with:

_____ individual counseling _____family counseling _____peer group counseling

_____ 7. What percentage of time do you spend working with sexual assault/abuse?

_____ 8. Are you willing to continue to work with sexual assault/abuse?

_____ 9. Will you be willing to train other professionals in your community when your training is completed?

_____ 10. Will you be willing to act as a resource person for consultation with other professionals in your area?

_____ 11. Will you be willing to share your professional experiences by taping interviews or co-leading individuals, family or peer group counseling sessions?

_____ 12. Will you be willing to participate in the extensive training evaluation process? (Time is included in the classroom days).

REFERENCES: Please list two references from peers directly familiar with your practice and who are not in supervisory positions in relation to you. (We will contact them directly with a report form. Recommendations are requested on a confidential basis unless reference wishes to share them directly with applicant).

1. _____ 2. _____

_____ _____

_____ _____

_____ _____

Briefly indicate why you should be selected to participate in this project?

Signature of Applicant: _____ Date: _____

The above-named applicant has agency approval to apply, and if accepted, participate in this 9-month training program.

Signature of Immediate Supervisor: _____ Date: _____

PLEASE RETURN APPLICATION TO:

Sharon Sayles, Assistant Director
Minnesota Program for Victims of
Sexual Assault
430 Metro Square Building
St. Paul, MN 55101

APPLICATION DEADLINE: August 5, 1983
Trainees will be notified as soon as possible

_____ 7. What percentage of time do you spend working with sexual assault/abuse?

_____ 8. Are you willing to continue to work with sexual assault/abuse?

_____ 9. Will you be willing to train other professionals in your community when your training is completed?

_____ 10. Will you be willing to act as a resource person for consultation with other professionals in your area?

_____ 11. Will you be willing to share your professional experiences by taping interviews or co-leading individuals, family or peer group counseling sessions?

_____ 12. Will you be willing to participate in the extensive training evaluation process? (Time is included in the classroom days).

REFERENCES: Please list two references from peers directly familiar with your practice and who are not in supervisory positions in relation to you. (We will contact them directly with a report form. Recommendations are requested on a confidential basis unless reference wishes to share them directly with applicant).

1. _____ 2. _____

_____ _____

_____ _____

_____ _____

Briefly indicate why you should be selected to participate in this project?

Signature of Applicant: _____ Date: _____

The above-named applicant has agency approval to apply, and if accepted, participate in this 9-month training program.

Signature of Immediate Supervisor: _____ Date: _____

PLEASE RETURN APPLICATION TO:

Sharon Sayles, Assistant Director
Minnesota Program for Victims of
Sexual Assault
430 Metro Square Building
St. Paul, MN 55101

APPLICATION DEADLINE: August 5, 1983
Trainees will be notified as soon as possible

APPENDIX # 2

Treatment of Sexual Assault & Abuse
With Ethnic Populations

SYLLABUS

SESSION I — **SEXUAL ATTITUDE REASSESSMENT SEMINAR**

September 13, 14, 15

Trainees will assess their own attitudes about human sexuality and how these attitudes may impact their work with rape and incest victims and their family members. Similarities and differences among ethnic populations will be explored.

SESSION II — **PERSPECTIVES ON THE PROBLEM**

October 4, 5

An Introductory Analysis

This segment will include an analysis of historical, cultural and political factors that have an impact on sexual abuse in American Indian, Black and Hispanic communities.

Culturally specific information about how each of the above ethnic groups is affected by racism, religion and traditional cultural roles will be discussed.

October 6

The System's Response to Sexual Abuse

Sexual abuse laws; confidentiality issues and the roles of law enforcement, medical, legal and social service professionals will be presented and discussed.

SESSION III — **VICTIMIZATION OF CHILDREN OUTSIDE THE FAMILY**

November 1

Overview of the Problem

Information about non-family child sexual abuse will be presented including definitions, statistics, myths and facts, as well as a discussion of ethnic attitudes regarding the problem.

Response to Sexual Abuse

This segment will explore the feelings and responses of victims from developmental and ethnic perspectives including responses of family members.

November 2

Intervention Strategies and Interviewing Techniques

Information about appropriate intervention strategies will be presented. Trainees will participate in skill building activities designed to expand their interviewing skills.

November 3

Treatment Techniques for Non-Family Child Victims

Appropriate treatment models for non-family child sexual abuse will be presented. Culturally specific applications will be generated and discussed. Trainees will practice treatment strategies and techniques.

SESSION IV

INCEST - FAMILY SEXUAL ABUSE

December 6 & 7

Overview of Incest

An overview of incest including definition, statistics and assumptions about the problem will be presented. Information to assist in the identification of victims will precede a discussion of ethnic perspectives.

Dynamics of Incest Families

This segment will focus on the characteristics of the incestuous family. Similarities and differences as they relate to ethnic populations will be explored.

December 8

Interviewing Incest Victims

Developmentally appropriate interviewing techniques for data gathering from children, adolescents and adults will be demonstrated and practiced. Effective reporting strategies will be explored.

SESSION V

INCEST - FAMILY SEXUAL ABUSE: MODELS FOR TREATMENT

January 3

Approaches to Incest Treatment

Theoretical perspectives reflecting common treatment models will be explored. Conceptual frameworks for psychoanalytic, cognitive/behavioral, and structural/strategic (systems) orientations will be presented and critically contrasted. Culturally specific applications will be generated and discussed. Trainees will role play how the theoretical frameworks are applied in treatment settings.

January 4

Approaches to Treatment of Families

Critical issues in the treatment of incest families will be explored including boundaries, shame,

resistance and abandonment. Structual/strategic family therapy principles will be presented. Culturally specific applications will be generated and discussed. Trainees will role play practice interviews with simulated incest families.

January 5

Approaches to Treatment of Children

This segment will focus on treatment approaches when the child is the primary client, including impact of incest at developmental stages, treatment issues and several approaches such as art therapy, play therapy and individual and group therapy. Culturally specific applications will be generated and discussed. Trainees will practice the demonstrated techniques.

SESSION VI

INCEST - FAMILY SEXUAL ABUSE: MODELS FOR TREATMENT (continued)

February 6

Approaches to Treatment of Adolescents

This segment will explore several group models for adolescent treatment including the development of strategies for common issues such as self-destructive behavior patterns, dependency ambivalence, and acting out behavior. Similarities and differences among ethnic adolescent populations will be discussed. Culturally specific application of treatment models will be generated.

February 7

Adults Victimized As Children

This segment will present a conceptual framework for understanding the needs and underlying issues of adults victimized as children, such as suicide self-destructive behaviors, resistance, dependency-based behaviors, and distorted thinking patterns. A model for treatment will be presented, demonstrated and practiced by trainees.

February 8

Approaches to Treatment of Perpetrators

Information about perpetrators will be presented including a framework for assessing treatability. Critical factors which impact treatment such as denial and other forms of resistance will be reviewed. Various treatment models and strategies will be presented, demonstrated and practiced by trainees.

SESSION VII	**ADULT SEXUAL ASSAULT VICTIMS**
March 6	Overview of the Problem Information about female and male sexual assault will be presented including definitions, types, statistics, myths and facts as well as discussion of ethnic attitudes regarding the problem.
March 7	Response to Sexual Assault This segment will explore the feelings and response of adult sexual assault victims from both a general and ethnic perspective.
March 8	Intervention with Adult Sexual Assault Victims This segment will include crisis intervention strategies and techniques for interviewing adult victims from both a general and ethnic perspective. Trainees will participate in skill building activities designed to improve their intervention skills.
SESSION VIII	**ADULT SEXUAL ASSAULT VICTIMS**
April 3, 4	Treatment Techniques for Adult Sexual Assault Victims Appropriate treatment methods for adult victims of sexual assault will be presented including individual, family counseling, group counseling and peer support groups. Culturally specific applications will be generated and discussed. Trainees will practice treatment strategies and techniques.
April 5	Potpourri This day has been set aside for mini workshops on topics related to sexual abuse.
SESSION IX	**IMPLEMENTATION AND COORDINATION OF SERVICES**
May 1, 2	This segment will explore techniques to assess existing networks in each ethnic community, analyze power structures and their relationship to networking. Trainees will discuss strategies for developing a community network.
May 3	Strategies for Prevention This segment will include presentations regarding societal efforts toward the elimination of sexual violence and discuss adapting these efforts for ethnic populations.

APPENDIX # 3A

Treatment of Sexual Abuse & Assault
With Ethnic Populations
October 4-6, 1983 Session

OCTOBER SCHEDULE

OCT. 4 -	PERSPECTIVES ON THE PROBLEM
9:00-9:30	Pre-Test
9:30-11:30	A Cultural Overview -- A Lakota Perspective
11:30-12:30	LUNCH
12:45-2:45	An Ojibwa Perspective
3:00-4:00	Small Group
4:00-5:00	Large Group Feedback Discussion
OCT. 5	
9:00-11:00	A Hispanic Perspective
11:00-12:00	Small Group
12:00-1:00	LUNCH
1:00-3:00	A Black Perspective
3:00-4:00	Small Group
4:00-5:00	Large Group Feedback Discussion
OCT. 6 -	SYSTEM'S REPONSE TO SEXUAL ABUSE
8:45-9:30	Slide Show, "Sexual Assault: A Crime of Violence"
9:30-11:00	Sexual Assault and the Legal System
11:00-12:00	Small Group
12:00-1:00	LUNCH
1:00-3:00	The System's Response to Sexual Abuse
3:00-4:00	Small Group Discussion
4:00-4:30	Large Group Feedback Discussion
4:30-5:00	Post-Test Wrap-Up

APPENDIX # 3B

Treatment of Sexual Abuse & Assault
With Ethnic Populations
November 1-3, 1983 Session

NOVEMBER SCHEDULE

NOV. 1

8:45	Pretesting
	Overview of Child Sexual Assault Outside the Family
	Feeling & Response of the Victims and Their Family Members
12:30-1:30	LUNCH
1:30	Ethnic Attitudes and Perspectives Regarding Child Sexual Abuse Outside the Family (small group)
4:00	Large Group Feedback
5:00	ADJOURN

NOV. 2

8:45	Intervention Process - Child Sexual Abuse Outside the Family
10:30	Ethnic Perspectives Regarding Intervention Process (small group)
11:30	Large Group Feedback
12:30-1:30	LUNCH
1:30	Interviewing Techniques
2:30	Interview Skills Development

NOV. 3

8:45	Treatment Models for Non-Family Child Victims
11:00	Application of Treatment Models Among Ethnic Populations (small group)
12:00-1:00	LUNCH
1:00	Large Group Feedback
2:00	Treatment Skills Development
5:00	Weekly Wrap-Up (10 minutes)

APPENDIX # 3C

Treatment of Sexual Abuse & Assault
With Ethnic Populations
December 6-8, 1983 Session

DECEMBER SCHEDULE

DEC. 6

8:45	Pretesting
9:00	Overview of Family Sexual Abuse
10:15	Identification of Family Sexual Abuse
11:30	Ethnic Attitudes Regarding Family Sexual Abuse (small group)
12:30-1:30	LUNCH
1:30	Characteristics of the Incestuous Family
3:00	Ethnic Perspectives On Characteristics of Incestuous Families (small group)
4:00	Large Group Feedback
5:00	ADJOURN

DEC. 7

8:45	Identification and Characteristics of the Incestuous Family Among Ethnic Populations
12:30-1:30	LUNCH
1:30	Responses to Identification and Characteristics of Incestuous Families Among Ethnic Populations (small group)
3:00	Large Group Feedback
4:00	Film: Double Jeopardy

DEC. 8

8:45	Guidelines for Interviewing Child Victims of Incest Guidelines for Interviewing Adolescent Victims of Incest
12:00-1:00	LUNCH
1:00	Interviewing Parents/Caretakers
2:30	Interviewing Skill Development
4:30	Wrap-Up

APPENDIX # 3D

Treatment of Sexual Abuse & Assault
With Ethnic Populations
January 10-12 1984 Session

JANUARY SCHEDULE

JAN. 10 -	FAMILY SEXUAL ABUSE - MODELS FOR TREATMENT
8:30	Coffee and Pre-Test
9:00-10:40	Cognitive/Behavioral Treatment
10:40-12:20	Psychodynamic Treatment
12:30-1:30	LUNCH
1:30-3:20	Structural/Strategic Treatment
3:30-4:15	Small Group Activities
4:15-5:00	Large Group Feedback
JAN. 11 -	FAMILY TREATMENT APPROACH
9:00-11:00	Family Treatment Approach
11:00-12:00	Demonstration
12:00-1:00	LUNCH
1:00-2:00	Small Group Activities
2:00-3:00	Large Group Feedback
3:00-5:00	Issues and Practice
JAN. 12	
9:00-9:50	Art Play Therapy with Child Incest Victims
9:50-10:40	Individual Counseling with Child Incest Victims
10:40-11:30	Group Therapy with Child Incest Victims
11:30-12:30	Small Groups
12:30-1:30	LUNCH
1:30- 2:30	Large Group Feedback
2:30-4:30	Skill Development
4:30-5:00	Wrap-Up

APPENDIX # 3E

Treatment of Sexual Abuse & Assault
With Ethnic Populations
February 7-9, 1984 Session

FEBRUARY SCHEDULE

FEB. 7

8:30-9:00	Coffee and Pre-Test
9:00-10:30	Individual Counseling with the Adolescent Victim
10:45-12:15	Group Therapy for Adolescent Incest Victims
12:15-1:15	LUNCH
1:15-1:45	A Treatment Model
1:45-2:45	Small Group Activities
2:45-3:30	Large Group Feedback
3:30-5:00	Skill Development

FEB. 8

9:00-12:00	Adults Victimized as Children: Concepts and Therapy Techniques
12:00-1:00	LUNCH
1:00-3:00	Continuation of Morning
3:00- 4:00	Small Group Activities
2:00-3:00	Large Group Feedback

FEB. 9

9:00-12:00	The Juvenile Sex Offender: Overview, Assessment, Treatment Needs and Treatment Options
12:00-1:00	LUNCH
1:00-4:00	The Adult Sex Offender: Overview, Assessment, Treatment Needs and Treatment Options
4:00-5:00	Small Group

APPENDIX # 3F

Treatment of Sexual Abuse & Assault
With Ethnic Populations
March 6-8, 1984 Session

MARCH SCHEDULE

MAR. 6

9:00-10:00	Problems and Issues in Adult Sexual Assault
10:15-11:00	Small Group
11:00-11:30	Large Group Feedback
11:30-12:30	Acquaintance Rape: Problems and Responses
12:30-1:30	LUNCH
1:30-2:30	Male Victimization: Problems and Responses
2:30-3:30	Marital Rape: Problems and Responses
3:30-4:15	Small Group
4:15-5:00	Large Group Feedback

MAR. 7

9:00-11:00	Needs and Responses of Rape Victims
11:00-11:45	Small Group
11:45-12:15	Large Group Feedback
12:30-1:30	LUNCH
1:30-3:00	The System's Response to Rape Victims
3:00- 4:15	Small Group
4:15-5:00	Large Group

MAR. 8

9:00-11:30	Crisis Intervention: Strategies and Techniques
11:30-12:30	Small Group
12:30-1:30	LUNCH
1:30-2:15	Large Group
2:15-4:30	Skill Development
4:30-5:00	Wrap-Up

APPENDIX # 3G

Treatment of Sexual Abuse & Assault
With Ethnic Populations
April 3-5, 1984 Session

APRIL SCHEDULE

APR. 3

9:00-11:00	After the Crisis: Individual Counseling of Rape Victims
11:00-12:00	Small Group
12:00-1:00	LUNCH
1:00-3:00	The Support Group for Primary and Secondary Victims of Rape
3:00-4:30	Taking Care of Ourselves While Working with Victims
4:30-5:00	Large Group Feedback/Discussion

APR. 4 — Innovative Counseling Models and Techniques for Working with Rape Victims

9:00-10:30	Grief Counseling with Rape Victims
10:30-12:00	Bioenergetic Therapy with Rape Victims
12:00-1:00	LUNCH
1:00-2:30	Process Therapy with Rape Victims
2:30-3:30	Application of Therapy Techniques to Ethic Communities
3:30-4:15	Small Group
4:15-5:00	Large Group

APR. 5

9:00-10:30 Mini Session I

1. Stress Management
   Indian Health Board, Minneapolis
2. Learning About Your Family or Origin
   Family Therapy Institute, St. Paul
3. Using Humor & Metaphor in Therapy
   City/Southside, Minneapolis

APRIL 5 (Continued)

10:45-12:15 Mini Session II

1. Sex Counseling for Incest Parents
   CLUES, St. Paul

2. Pornography & Sexual Violence
   Pornography Resource Center, Minneapolis

12:15-1:15 LUNCH

1:30-300 Mini Session III

1. Techniques to Get Kids to Talk and Protection Issues
   Minneapolis Public Schools

2. Juvenile Prostitution
   Minneapolis Police Department

3. Working with Shame Based Families
   Family Therapy Institute, St. Paul

3:00-4:15 Presentation of Intervention & Treatment Model
Youth Diversion Program, Minneapolis

4:15-5:00 Wrap-Up

APPENDIX # 3H

Treatment of Sexual Abuse & Assault
With Ethnic Populations
May 1-3, 1984 Session

MAY SCHEDULE

MAY 1

9:00-10:00	Overview of Prevention Issues
10:00-10:30	Film - "Touch"
10:30-12:00	Utilizing the Touch Continuum
12:00-1:00	LUNCH
1:00-3:00	Adaptions of Touch Continuum - 3 Models
4:00-5:00	"No Easy Answers," Illusion Theatre

MAY 2

9:00-10:30	Social Issues & Implementing Prevention Education
10:30-12:30	Issues for Sexual Assault Education & Prevention in Ethnic Communities
12:30-1:30	LUNCH
1:30-3:30	Planning for Education & Prevention in Ethnic Communities Small Group
3:30-4:15	Large Group
4:15-5:00	Movie: "Dream Speaker"
Evening	FINAL BANQUET

MAY 3

9:00-10:00	Developing Community Treatment Models: One Approach
10:00-12:00	Planning Treatment in Ethnic Communities, Small Group
12:00-1:00	LUNCH
1:00-3:00	Final Small Group
3:00-3:30	Large Group Discussion
3:30-4:30	Closing Ceremony

APPENDIX # 4A

Treatment of Sexual Abuse & Assault
With Ethnic Populations
October 4-6 Session

SMALL GROUP ACTIVITIES

THURSDAY, OCTOBER 6, A.M.

Goal: Discuss the impact of the laws and legal system on ethnic populations.

Possible discussion questions:

1. How do current laws affect ethnic populations?
2. What problems or difficulties have you (your clients) observed?
3. What changes need to be made?
4. Who and how can we make changes?

THURSDAY, OCTOBER 6, P.M.

1. What problems or difficulties have you or your clients observed?
2. Suggestions or changes to make system more responsive to ethnic populations.

FOR EACH ETHNIC GROUP, ANSWER THE FOLLOWING QUESTIONS

What would be the typical family structure:

1. Who would have the most power in the family?
2. How would the power be exerted? (directly - indirectly)
3. Who has the most control and how would it be exerted?
4. What are the rules for males?
5. What are the rules for females?
6. What are the rules for kids?
7. What do males learn about sex (what messages do they get?)
8. What do females learn about sex (what messages do they get?)

APPENDIX # 4B

Treatment of Sexual Abuse & Assault
With Ethnic Populations
November 1-3 Session

SMALL GROUP ACTIVITIES

NOVEMBER 1

A.M. OVERVIEW - NON-FAMILY SEXUAL ASSAULT

1. What is the incidence of non-family child sexual assault in the American Indian, Black and Hispanic communities?

2. Where might these assaults occur?

3. Who are the perpetrators?

P.M. FEELINGS AND RESPONSE OF THE VICTIMS AND FAMILY MEMBERS

1. What is the overall community response/reaction?

2. What is the family's general response?

3. How might the response vary according to:
   a) the time between when the assault occurred and when the family/parent found out (e.g. child tells a week after, child tells a month after)?
   b) race of the perpetrator?

4. What are the children likely to do?
   a) Would they tell?
   b) Who would they tell?

NOVEMBER 2 INTERVENTION PROCESS

1. Is it likely that families in American Indian, Black and Hispanic communities would seek outside intervention?

   If so, from whom?
   If not, why not?

NOVEMBER 3 TREATMENT MODELS

1. Are the treatment techniques applicable to American Indian, Black and Hispanic populations?

2. Which techniques apply and why?

3. Which techniques don't apply and why?

APPENDIX # 4C

Treatment of Sexual Abuse & Assault
With Ethnic Populations
December 6-8 Session

SMALL GROUP ACTIVITIES

DECEMBER 6

A.M. OVERVIEW - FAMILY ABUSE

1. Attitude Test

2. How might the behavioral indicators be different for American Indian, Black and Hispanic children and adolescents?

3. Has your community been made aware of incest? How? By whom? Where?

P.M. CHARACTERISTICS OF THE INCESTUOUS FAMILY

1. What are the barriers in identifying incest among American Indians, Blacks and Hispanics?

DECEMBER 7

1. What are the similarities and differences among American Indian, Black and Hispanic incestuous families?

2. What methods do American Indian, Black and Hispanic victims and their families use to keep the "secret" of incest? Why?

DECEMBER 8

No small group questions

APPENDIX # 4D

Treatment of Sexual Abuse & Assault
With Ethnic Populations
January 10-12 Session

SMALL GROUP ACTIVITIES

Begin each group session by asking trainees to take a few minutes to share how they have used the training material from last month's session in the past four weeks. It is recommended that 3-4 persons share each day to ensure that all group members get the opportunity to participate in the exchange.

JANUARY 10 FAMILY SEXUAL ABUSE - MODELS FOR TREATMENT

1. Exchange information from previous month.
   Models for Treatment

2. Are you currently using any of these models?
   Psychoanalytic how many? _____
   Cognitive/behavioral how many? _____
   Structural/strategic how many? _____
   (Please be sure to get a count!)

3. Describe the individual/family that you think would be appropriate for:
   a. psychoanalytic approach
   b. cognitive/behavioral approach
   c. structural/strategic approach

JANUARY 11 A FAMILY TREATMENT APPROACH

1. Exchange information (See January 10)

2. What are the critical issues to consider when using the family treatment approach with American Indian, Black or Hispanic families?

JANUARY 12 TREATMENT FOR THE CHILD INCEST VICTIM

1. Exchange information (See January 10)

2. What issues may arise when utilizing these approaches to treatment with American Indian, Black and Hispanic children?
   NOTE: In order to work with most children, the counselor/therapist must gain the cooperation of the parent/guardian. (Likely issues include: transportation, level of acculturation, fear regarding confidentiality, religion).

3. What are the issues to consider when determining what treatment approach is most appropriate with American Indian, Black and Hispanic children?
   NOTE: Behavioral indicators should be easy to start with, i.e. depression, withdrawal, anger, hostility, etc.

APPENDIX # 4E

Treatment of Sexual Abuse & Assault
With Ethnic Populations
February 7-9 Session

SMALL GROUP ACTIVITIES

Begin each group session by asking trainees to take a few minutes to share how they have used the training material from last month's session in the past four weeks. It is recommended that 3-4 persons share each day to ensure that all group members get the opportunity to participate in the exchange.

FEBRUARY 7 TREATMENT TECHNIQUES FOR THE ADOLESCENT VICTIM OF INCEST

A. Small Group

1. Exchange information from previous month

2. Discussion of mini-sessions

3. Have the group consider the issues involved when working with American Indian, Black and Hispanic adolescent incest victims, both individually and in group therapy. (Likely issues include transportation, level of acculturation, confidentiality, religion, withdrawal or acting out, mistrust of authority, peer pressure, etc.)

B. Skill Development

1. Practice individual therapy using three case histories. Work in triads.

2. Conduct an adolescent group giving different people the opportunity to facilitate the group. Try to involve those who have not been involved before.

FEBRUARY 8 ADULTS VICTIMIZED AS CHILDREN

A. Exchange Information

B. Have the group consider the issues involved when working with American Indian, Black and Hispanic adults who were victimized as children (confidentiality, community reaction to therapist, etc.)

FEBRUARY 9 THE PERPETRATOR

Use this opportunity to discuss the issues and reactions to perpetrators and to process all the information on incest.

APPENDIX # 4F

Treatment of Sexual Abuse & Assault
With Ethnic Populations
March 6-8 Session

SMALL GROUP ACTIVITIES

MARCH 6

A.M. Distribute "Pam's Story" to group participants. Have participants rank individually - then attempt to reach a group consensus.

P.M. Have the group discuss the issues involved in working with acquaintance rape, male victimization, and marital rape within their community.

MARCH 7

A.M. Have the participants explore their own reactions to victim's needs and responses.

P.M.
a. Have the participants explore their responses to the system's response to rape victims.

b. Discuss how each community can support the victim as they confront (deal with) the system.

MARCH 8

Have the participants discuss what they will do when a victim comes to them in crisis.

APPENDIX #5A

Treatment of Sexual Abuse & Assault
With Ethnic Populations
November 1-3 Session

NOVEMBER SKILL DEVELOPMENT EXERCISE
INTERVIEW ROLEPLAYS

1a. You're a 12-year-old boy who was molested along with 3 other friends by your basketball coach. He masturbated you and had you masturbate him and another team member. One of your friends told about the abuse. You didn't tell for fear of people thinking you're a "fag". You have mixed feelings about telling about your abuse--you want the coach punished but you don't want to get into trouble with your parents or the kids on the team.

1b. You're interviewing a 12-year-old boy who was reported by a teammate to have been part of a group of boys molested by their basketball coach. You know the boy who reported the abuse had oral sex with the coach. The coach also took pictures of the boy in the nude by himself and with teammates. No one has directly asked the boy you're to interview if he was molested--not even his parents.

2a. You, a 5-year-old boy, told your mother, while she was bathing you, that your penis got "bigger, bigger, bigger." When your mom inquired about his, you said the babysitter had licked an ice cream cone. You did not tell your mom any thing else.

2b. A mother is bringing her 5-year-old son in. While giving him a bath, she heard him say that his penis got "bigger, bigger, bigger". When she tried to follow-up he made a comment about the babysitter licking an ice cream cone. She was unable to learn anything else. Her concern is whether or not he had been abused.

3a. You are a 10-year-old girl. While playing in the park, you wandered off from your friends, even though you had been told, many times, not to do that. A man offered you a ride home in his car but you refused and started to walk back towards your friends. He grabbed your arm and pulled you behind the building. You struggled but he pulled your pants down and started to rub your vulva. You bit his hand and he let go of you and you ran home and told. You feel responsible and don't want to tell anyone what happened.

3b. The 10-year-old girl you are interviewing wandered off from her friends at the park. A man offered her a ride home but she refused. He grabbed her arm and tried to pull her pants down. She got away. Parents are uncertain what happened.

4a. You are a 6-year-old boy who came home one day with a quarter. Your mom asked how you got it and you told her "from joining the club". You wanted to join Mike and Eric's "club". You're not sure exactly what goes on in the club. Your 4-year-old brother said he put his penis in Mike's mouth but you didn't believe him. You don't have many friends and you thought it was neat that the older boys (age 12) would play with you, and give you a quarter. You didn't think it was so bad when they had you take off all of your clothes.

APPENDIX # 5B

Treatment of Sexual Abuse & Assault
With Ethnic Populations
December 6-8 Session

DECEMBER SKILL DEVELOPMENT EXERCISES

ADOLESCENT VICTIM INTERVIEW SKILL EXERCISE

Scenario: Mary Johnson, age 13, is in counseling for a variety of behavioral problems, including withdrawal, drug and alcohol abuse and running away from home. She expresses indifference towards most things.

Counselor: Facilitate a disclosure of the sexual abuse from Mary.

Observer: List techniques used to solicit the disclosure.

FATHER INTERVIEW SKILL EXERCISE

Scenario: Mr. Johnson has been asked to visit Mary's counselors. Mr. Johnson does not know that Mary has told her counselor that he is sexually abusing her. He believes that he is coming to hear about her progress.

Counselor: Solicit an admission of sexual abuse from the father.

Observer: List all techniques used to break through the father denial of the sexual abuse.

MOTHER INTERVIEW SKILL EXERCISE

Scenario: The Johnson's have three children ages 7, 10 and 13. Mary, age 13, has been receiving counseling for a variety of behavioral problems. After several weeks of counseling, she admits that she is being sexually abused by her father. She states that she tried to tell her mother a long time ago that he was touching her, and her response was that she should try to avoid him. The father strongly denies any sexual contact with Mary. The mother believes the daughter, but does not want the husband to get in trouble. The mother is afraid of how the father might react and what he might do if the secret gets out.

Counselor: Convince the mother that she must report the sexual abuse to the authorities.

Observer: List factual information about incest that the counselor uses to convince the mother to report.

APPENDIX # 5C

Treatment of Sexual Abuse & Assault
With Ethnic Populations
January 10-12 Session

JANUARY ROLE PLAY EXERCISES

INSTRUCTIONS: --Have only the person role playing the victim read and select the role to play.
--Counselor should use their skills to elicit information and provide assistance.

1. The victim is a 25-year-old woman. She was living with her boyfriend at the time of the assault. He had left for the evening, and she was home alone when the attacker broke in. He took her money and then raped her as well. She reported the incident to the police and went to the hospital for the evidentiary examination. She returned to the hospital in a few weeks for her follow-up tests for venereal disease and pregnancy, which were negative. Her boyfriend and mother were supportive during the ordeal. The police were never able to apprehend the assailant. Two months after the assault, her boyfriend contracts gonorrhea. He insists he must have gotten it from her, and a checkup reveals that she also has gonorrhea. This causes real problems between her and her boyfriend, who wonders if she has been sleeping with someone else. She says she must have contracted it from the rapist. She is very bitter about the hospital's apparent foul-up of her tests and police department's ineffectiveness in finding the rapist. Her mother had suggested she come for help.

2. The victim is a 20-year-old man. He recently started his first full-time job at a community recreation center. One night the recreation director invites him over to his house for pizza and beer after a baseball game. He drank quite a bit, and the director suggested he spend the night rather than drive home. During the night the director raped him. He tried to fight back, but he was very drunk and not effective. The director also threatened him with loss of his job and a bad reference if he didn't give in. A few days later, the victim told a friend a little of what happened, and his friend suggested he call the agency. The call is referred to the person with special training in dealing with sexual assault.

3. The victim is a 35-year-old woman. She and her husband have been separated for six months. One night her husband has been out drinking with friends and decides to drive by the house. He sees her embracing a strange man. He waits until the man leaves and then comes into the house. His wife is taking a bath and the children are gone. He demands to know where the kids are. She tells him they're at her mother's house. He then demands to know who the man is. She says it's none of his business who she's with, and asks him to leave. He becomes enraged and beats and rapes her. She comes to the agency for financial help in getting the locks changed on her doors.

APPENDIX # 5D

Treatment of Sexual Abuse & Assault
With Ethnic Populations
February 7-9 Session

CASE HISTORIES

CASE #1

White male - 13 years of age.
Offense: Criminal Sexual Conduct - Fourth degree

Summary: Joe was referred to the agency by his probation officer. The police were called into this case by the father of Joe's half-sister. (Joe's step-father) Joe's sister, Melanie, is three-years-old. She told her father that "Joe touched me down there, and went to the bathroom on me." Police report indicates that Joe has admitted to touching his sister's vagina. Joe denies that he put his finger inside her vagina, although Melanie says he did. He is not going to be prosecuted. The Court has recommended the agency, but not ordered it. He had been placed on probation three months ago due to a vandalism charge, and is still on probation. Joe has not been sexually abused, nor has he been sexually active with anyone. Joe is only recently aware of secondary sexual characteristics, and has heard about masturbation but has not engaged in it. Joe admits to occasionally looking at "dirty magazines". Joe has done little dating, and nothing more than kissing. Both of Joe's parents are angry at Joe, and not very understanding. Joe is a good student, well liked by his teachers, but somewhat of a loner. He has not used any drugs, nor experimented with pot or alcohol. He is very nervous about this interview, cooperative, but only offering yes and no answers. Is unable to deal with open-ended questions.

CASE #2

Black male - 15 years of age.
Offense: Indecent exposure

Summary: David was arrested at home ten days ago, on a warrant alleging that he exposed himself to three female classmates, at the high school that he attends. He is in the 10th grade and an average student. David was held in the detention center overnight, and returned to the custody of his parents the next day. David is back in school, where everyone knows about what he did. David exposed himself to the girls, individually over about a two-week period. Each time he spotted a girl by herself, alone in the hallway. David admits that he would get an erection thinking about exposing himself. By the time that girl got close to him, he would have his pants unzipped and would call the girl's attention to his erect penis. The girls were too

embarrassed to do anything, or say anything about it, until they started talking among themselves. When they discovered that they were all victims, they went to the principal, who called the police. David's only insight into it is that he thought "if it's exciting for me, it's probably exciting for them also." David's family is supportive. David wants help. He says, "I tried to stop after the first time, and I couldn't." He is feeling a lot of shame and embarrassment. He is tearful during the interview. David is good at football and baseball, and plays on the varsity team. David is fairly knowledgeable about sexuality. He admits to masturbating, about once a week. He fantasizes about exposing himself, and being sexual with some of his female classmates. He has not been sexually abused. He has not engaged in sexual intercourse, though he has done some petting with a former girlfriend. He has not had any sexual activity with any males.

CASE #3

White male - 17 years of age.

Offense: Not charged.

Summary: Bill is at a residential treatment center, after numerous problems at home and in the community. Has been involved in delinquent behavior, but not adjudicated (vandalism, one burglary). Bill was referred to the program by his counselor at the RTC. Bill admitted to some sexual activity with his cousin, but would not be specific. In the interview Bill says that he wants some help for a sexual problem. Bill admits to having engaged in anal intercourse with his 14-year-old cousin, Tom. It has happened several times over the last two years. Tom has not objected, according to Bill. Bill has always been something of a big brother to Tom. Tom idolizes Bill and would do almost anything for him. Bill also admits to having Tom perform fellatio on him. Bill denies that he has allowed Tom to penetrate him in any manner. Bill is very out-going, is an average to poor student, with some possible learning difficulties. Bill is athletic and street-wise, and generally a leader among his peers. Bill has heard that some guys masturbate, but thinks it is probably "gay". He has done some dating, and has had intercourse with two different females of his age. Family life is chaotic with 9 younger siblings at home. Father is absent, mother supportive, but overwhelmed with parenting. Bill has been sodomized by a 30-year-old male neighbor many times over the last four years, as recently as nine months ago. Bill says that he used to get money for doing it. There was never any physical force involved. He has never talked about this before. Bill has experimented with several drugs, and uses alcohol and pot when he has the opportunity. Since being in the RTC, he has not used (nine months). Bill has a lot of questions about homosexuality.

APPENDIX # 5E

Treatment of Sexual Abuse & Assault
With Ethnic Populations
March 6-8 Session

MARCH EXERCISE

Have participants rank each individual mentioned in story according to how well they fulfill their responsibility to assist Pam. Then attempt to reach a group consensus.

"PAM'S STORY"

Pam is a 24-year-old waitress with 2 children. She has never been married. The father of the children drank and beat her, and moved out eventually.

She usually had to walk home after work because she could not afford a car. One night she took a ride from a customer she'd seen on several occasions. He stopped the car a block away by a vacant lot and raped her. Pam was too frightened to make any noise because he threatened to kill her if she screamed or if she brought in the police.

When it was over, Pam managed to get home and inside her house. She locked the door and called the police--2 officers came within a few minutes. They questioned her and looked around. They suggested she get medical attention and come to the LEC and press charges. Pam was still frightened over the death threat, however, and said she preferred not to. Sgt. Berg, one of the officers, became angry at that and told her they were all wasting valuable time if she wouldn't do her part.

After the police left, Pam sat up all night. In the morning she called her friend, Carol, and told her what had happened. Carol suggested medical treatment and volunteered to go along. She also told Pam to do whatever she thought best about pressing charges.

At the clinic, Pam was seen by Dr. King. He was heavily scheduled and rushed. He showed his irritation at Pam's obvious fear and nervousness about the examination. Because he was already behind schedule, he did not explain any of the procedures. Pam left the clinic feeling very upset.

Later that day, Pam felt the need to talk and confide in her parents. Her mother was sympathetic, but it frightened her. She said she didn't wish to talk about it any more and the best thing to do was forget it and go on. Her father became angry that she had not pressed charges and told her she had showed poor judgment by not doing so. He also felt that she should not have taken a job that required her to walk home so late.

Eventually, Pam told Don, her boyfriend. She had not planned to, but she was unable to respond to him sexually. Even a touch often left her upset and jumpy. Don was sympathetic and concerned. He vowed to wait it out with her until things got better. Things were never quite the same though, eventually a distance developed between them and they drifted apart. Three months later Don was seeing someone else and the relationship was over.

APPENDIX # 5

PRESS STATEMENT

COUNCIL OF ETHNIC PROFESSIONALS IN HUMAN SERVICES

Thursday, May 3, 1984 Contact:

FOR IMMEDIATE RELEASE

Due to the lack of ethnic involvement and perspective in the recent WCCO presentation "Project Abuse," we as professionals in service to our respective communities have called this press conference to express our opposition to the continued systematic exclusion of the issues relevant to Black, Hispanic, American Indian and Asian communities in the discussion of child sexual abuse. We recognize that sexual abuse exists in our communities and needs to be addressed in a manner which acknowledges the necessity for the development of ethno-specific and culturally appropriate methodologies relevant to funding, staffing, research, education, prevention, intervention and treatment in service delivery systems.

WCCO's omission, whether benign or intentional, is another example of the typical institutional response which devalues our communities, our families, and our most precious resource--our children.

It is this Council's opinion:

1) That little effort was made to present culturally appropriate information on child sexual abuse;

2) That no Black, Hispanic, American Indian or Asian professionals with expertise in the area of sexual abuse were utilized during the Project Abuse series;

3) That no Black, Hispanic, American Indian or Asian professionals were included on the hot line referral list;

4) That our children were systematically deprived of the full benefits of the Project Abuse series.

We are asking that sexual abuse be looked at as a problem that effects all American families. In a nation that prides itself upon cultural differences, the lack of culturally relevant input is an affront to every American ethnic heritage.

APPENDIX # 7

RESOURCE BIBLIOGRAPHY

Prepared by the Minnesota Program for Victims of Sexual Assault, Minnesota Department of Corrections, 1984.

Sexual Assault - General

Albi, F. J. Forcible Rape - A Manual for Patrol Officers - Police Volume. Superintendent of Documents, Government Printing Office, Washington, DC 20402 (No. 027-000-00619-1).

American Lutheran Church. Rape - Part Two. Correctional Service of Minnesota, 1427 Washington Avenue, South, Minneapolis, MN 55404, 1980.

Association of American Colleges. The Problem of Rape on Campus. Project on the Status and Education of Women, Association of American Colleges, 1818 R Street, N.W., Washington, DC 20009.

Barry, Kathleen. Female Sexual Slavery, Prentice Hall, Englewood Cliffs, NJ, 1979.

Becker, J. V.; Abel, G. G.; and Skinner, L. J. Impact of a Sexual Assault on the Victim's Sexual Life. Victimology 4(2):229-235, 1979.

Bellinger, Dottie and Monsees, Helen (eds.). Sexual Violence: A Resource Manual for Clergy and Church Groups. Sexual Assault Crisis Aid, 14 Exchange Building, Winona, MN 55987.

Beneke, Timothy. Men on Rape. New York: St. Martin's Press, 1982.

Brownmiller, Susan. Against Our Will: Men, Women and Rape. New York: Simon & Schuster, 1975.

Carrow, D. M. Rape - Guidelines for a Community Response - An Executive Summary. ABT Associates, Inc., Cambridge, MA 02138, 1980.

Clark, Lorenne and Lewis, Debra. Rape: The Price of Coercive Sexuality. Toronto, Canada: The Women's Press, 1977.

Faye, Jennifer and Flerchinger, B. J. Top Secret, King County Rape Relief, 306 South 43rd, Renton, WA 98055.

Forrest, L. Forcible Rape - Medical and Legal Information. Battelle Memorial Law and Justice Study Center, Superintendent of Documents, Government Printing Office, Washington, DC 20402, 1977.

Fortune, Rev. Marie. Sexual Violence: The Unmentionable Sin: An Ethical and Pastoral Perspective. Pilgrim Press, 1983.

Gager, N. and Schurr, C. Sexual Assault: Confronting Rape in America. New York: Gosset & Dunlop, 1976.

Greer, Germaine. "Seduction is a Four-letter Word". Playboy, 20 (1973) 1:80.

Griffin, Susan. "Rape: The All American Crime." Ramparts, 10 (Sept. 1971) 3: 26-35.

Griffin, Susan. Rape - The Power of Consciousness. New York: Harper & Row, Pub., 1979.

Haskell, Molly. From Reverence to Rape: The Treatment of Women in the Movies. Baltimore: Penguin Books, Inc., 1974.

Hennepin County Attorney's Office, Sexual Assault: Facts You Should Know. Sexual Assault Services, C-2100 Government Center, Minneapolis, MN 55487.

Horos, Carol V. Rape. New Canaan, Conn.: Tobey Publishing Co., 1974.

Hyde, M. O. Speak Out on Rape. McGraw-Hill, New York, NY 10020, 1976.

International Association of Chiefs of Police. Investigating the Crime of Rape. Gaithersburg, MD 20760.

Keller, Eileen (ed.). Sexual Assault: A Statewide Problem, Minnesota Program for Victims of Sexual Assault. Public Documents Division, 117 University Avenue, St. Paul, MN 55155.

LeGrand, C. "Rape and Other Crimes Against Women", Forgotten Victims - An Advocate's Anthology. Veterans Administration, Washington, DC 20420.

Levine, P. Rape is a 4-Letter Word. National Criminal Justice Reference Service MICROFICHE PROGRAM, Box 6000, Rockville, MD 20850.

McCahill, T. W.; Meyer, L. C.; and Fischman, A. M. Aftermath of Rape. Health Lexington Books, Lexington, MA 02173, 1979.

Medea, Andrea and Thompson, Kathleen. Against Rape. New York: Farrar, Staus and Giroux, 1974.

Minnesota Program for Victims of Sexual Assault, Sexual Assault: A Statewide Problem (brochure). MPVSA, 430 Metro Square Building, St. Paul, MN 55101.

Mohr, J. W. and Turner, R. E. "Sexual Deviations: Part IV - Pedophilia". Applied Therapeutics, 9, 362-5, 1967.

Norman, Eve. Rape. Los Angeles, Calif.: Wollstonecraft, Inc., 1973.

On Rape, Second Edition. Minneapolis: N.O.W. State Task Force on Rape, 1975.

Rinear, C. E. and Rinear, E. E. Sexual Assault Among Hospital Personnel. Victimology 4(1):140-150, 1979.

Russell, Diana. The Politics of Rape. New York: Stein and Day, 1974.

Sacco, Jr., Anthony M. Male Rape: A Casebook of Sexual Aggressions. New York: AMS Press, 1982.

Tyson, Gail. Violence In Our Lives: Focus on Rape. Harrisburg Area Rape Crisis Center, Harrisburg, PA, 1977.

Walker, Marcia J. and Brodsky, Stanley L. Sexual Assault. Lexington, Mass.: Lexington Bocks, 1976.

White, P. N. and Rollins, J. C. "Rape: A Family Crisis". Family Relations, 1980, 30, 103- 109.

Wickenkamp, C. K. and Rausch, D. K. Men Against Rape - What You Should Know. Direct Mail Advertising and Printing, 2461 Gardena Avenue, Long Beach, CA 90806, 1977.

Wilson, Carolyn F. Violence Against Women, an Annotated Bibliography. G.K. Hall & Co., Boston, MA, 1981.

Women and Sexual Violence. A study guide that can be used for five discussion sessions. In Response-Ability, No. 12, Fall, 1981. Available from: Division of Corporate & Social Mission, General Assembly Mission Board, Presbyterian Church in the United States, 341 Ponce de Leon Avenue, N.E., Atlanta, GA 30365.

Sexual Assault - Research & Reports

Amir, Menachem. Patterns in Forcible Rape. Chicago: University of Chicago Press, 1971.

Andersen, M. L. and Renzetti, C. Rape Crisis Counseling and the Culture of Individualism. Contemporary Crises 4(3):323-339, 1980.

Barnett, N. J. and Feild, H. S. Sex Differences in University Students' Attitudes Toward Rape. Journal of College Student Personnel 18 (2):93-96, March 1977.

Burgess, A. W. and Holmstrom, L. L. "Coping Behavior of the Rape Victim". American Journal of Psychiatry, 1976, 133, 413-418.

Charle, S. Sex Crimes Units Are Raising Conviction Rates, Consciousness, Costs. . . and Questions. Criminal Justice Publications, Inc., 801 Second Avenue, New York, NY 10017, 3(2):52-61, March 1980.

Copeland, L. Queen's Bench Foundation's Project Rape Response. Victimology 1(2):331-337, Summer 1976.

Cryer, L. G. Life Change Measurement: An Outcome Evaluation Study of a Public Health Nursing Program to Assist Rape Victims. Dissertation Abstracts International 40(11-B):5389, May 1980.

Downing, N. E. An Evaluation of the Effectiveness of a Training Program for Paraprofessional Rape Crisis Hotline Volunteers. Dissertation Abstracts International 41(5-B):1890, November 1980.

FBI Uniform Crime Reports: Crime in the U.S., 1978. Washington, D.C.: U.S. Dept. of Justice, 1979.

Forman, B.D. "Cognitive Modification of Obsessive Thinking in a Rape Victim: A Preliminary Study". Psychological Reports, 1980b, 47, 819-822.

Goldsberry, N. Rape in British Columbia - A Report to the Ministry of Attorney General. National Criminal Justice Reference Service MICROFICHE PROGRAM, Box 6000, Rockville, MD 20850, 1979.

Hilberman, Elaine. The Rape Victim: A Project of the Committee on Women of the American Psychiatric Association. New York: Basic Books, 1976.

Holmes, K. A. Services for Victims of Rape - A Dualistic Practice Model. Social Casework - Journal of Contemporary Social Work 62(1):30-39, 1981.

Holmes, Karen A. and Williams, Joyce E. The Second Assault: Rape and Public Attitudes. Westport, Conn.: Greenwood Press, 1981.

Holmstrom, L. L. and Burgess, A. W. Victim of Rape - Institutional Reactions. John Wiley and Sons, Inc. Ordering Processing Eastern Distribution Center, 1 Wiley Drive, Somerset, NJ 08873, 1978.

Kriesberg, L. A. "On Supporting Women's Successful Efforts Against Violence", Research Into Violent Behavior - Overview and Sexual Assaults.

LeGrand, Camille. "Rape and Rape Laws: Sexism in Society and Law." California Law Review, 61 (1973) 3: 919-941.

Marsh, Jeanne C.; Geist, Alison; Caplan, Nathan. Rape and the Limits of Law Reform. Auburn House Publishing, 1982.

Schultz, Leroy G., ed. Rape Victimology. Springfield, Ill.: Thomas, 1975.

Scutt, J. A. Rape Law Reform - A Collection of Conference Papers. Australian Institute of Criminology, Phillip Act, Australia 2606, 1980.

Sprung, S. Resolution of Rape Crisis: Six to Eighteen Month Follow-up. Smith College Studies in Social Work, 1977, 48, 22.

U.S. Department of Justice Law Enforcement Assistance Administration. Metropolitan Organization To Counter Sexual Assault Final Report - Kansas City, MO. Washington, DC 20531.

Veronen, L. J. and Kilpatrick, D. G. "Rape: A Precursor of Change". In E. J. Callahan and K. A. McCluskey (eds.) Proceedings of Seventh Lifespan Developmental Psychology Conference: Non-Normative Life Events. New York: Plenum, in Press.

Sexual Assault - Prevention and Self Defense

Bateman, Py. Acquaintance Rape: Awareness & Prevention. 1982, 24 pages. Available from: Alternatives to Fear, 101 Nickerson, Suite 250, Seattle, WA 98109, (phone: 206-282-0177).

Bateman, Py. Fear into Anger: A Manual of Self Defense for Women, 1982, 144 pages. Available from: Alternatives to Fear, 101 Nickerson, Suite 250, Seattle, WA 98109, (phone: 206-282-0177).

Community Education for Prevention of Sexual Assaults. Consultation and Rape Education and Didi Hirsch Community Mental Health Center, 1979.

Csida, June Bundy and Csida, Joseph. Rape: How To Avoid It and What To Do About It If You Can't. Chatsworth, Calif.: Books for Better Living, 1974.

Efros, S.; Williams, C.; Tadum, J.; Graham, N.; and Crowley, C. Acquaintance Rape Prevention. ODN Productions, Inc., 114 Spring Street, 7th Floor, New York, NY 10021, 1978.

Forman, B. D. and Sass, N. M. Developing a Data File for Rape Prevention Through Interagency Collaboration. Hospital and Community Psychiatry 32(2):129-132, 1981.

Freedom From Rape. Ann Arbor, Mich.: Women's Crisis Center, 1974.

Grossman, Rachel and Joan Sutherland, eds. Surviving Sexual Assault. New York: Congdon & Weed: Dist. by St. Martin's Press, 1983.

How To Protect Yourself Against Sexual Assault. (Booklet) GPO #027-000-01004-1. Complimentary copy available from Public Inquiries, Room 11A-21, National Clearinghouse for Mental Health Information, NIMH, 5600 Fishers Lane, Rockville, MA 20857. Additional copies available from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Kaufman, D. A.; Rudeen, R. D.; and Morgan, C. A. Safe Within Yourself - A Woman's Guide to Rape Prevention and Self-Defense. Visage Press, Inc., 108A South Columbus Street, Alexandria, VA 22314, 1980.

Kent, Cordelia Anderson. Illusion Theater Guide for Teaching Mentally Retarded Persons about Sexual Abuse Prevention Education, Illusion Theater, 528 Hennepin Avenue, #309, Minneapolis, MN 55409.

McKinley, S.; Graff, S.; McCrate, E. Fighting Back - A Self-Defense Handbook. Women Against Rape, P.O. Box 02084, Columbus, OH 43202, 1977.

Minnesota Program for Victims of Sexual Assault. Preventing Sexual Abuse of Persons with Disabilities: A Curriculum for Hearing Impaired, Physically Disabled, Blind, and Mentally Retarded Students. MPVSA, 430 Metro Square Building, St. Paul, MN 55101.

Newman, Felice. Fight Back! Cleis Press.

Queens' Bench Foundation. Rape - Prevention and Resistance. San Francisco, CA 94109, 1976.

Rape & Older Women: A Guide to Prevention & Protection. 1979, 171 pages, GPO #017-024-00849-4. Complimentary copy available from: Public Inquiries, Room 11A-21, National Clearinghouse for Mental Health Information, NIMH, 5600 Fishers Lane, Rockville, MD 20857. Additional copies available from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Rape Awareness & Educators (Resource book & curriculum guide). Available from: Rape Crisis Center of Syracuse, Inc., 304 Seymour Street, Syracuse, NY 13204.

Rape Prevention Workshops: A Group Leader's Guide. 1980, 155 pages. Available from: Women Against Rape, P.O. Box 02084, Columbus, Ohio 43202.

Signs. A Rape Prevention Program in an Urban Area. 5(3):238, 1980.

Stuart, Virginia. Sexuality and Sexual Assault: Disabled Perspective, A Manual for a Model Workshop, Health and Rehabilitation Service Program, Southwest State University, Marshall, MN July 1980.

Tschirhart, Linda and Fetter, Ann. In Defense of Ourselves - A Rape Prevention Handbook for Women. Garden City, New York: Dolphin Book, 1979.

U.S. Department of the Army Criminal Investigation Command Crime Prevention Division, Falls Church, VA 22041. U.S. Army Criminal Investigation Commands Suggestions for Rape Prevention in Your Command.

Women Against Rape. Freeing Our Lives - A Feminist Analysis of Rape Prevention. P.O. Box 02084, Columbus, OH 43202, 1978.

Sexual Assault - Victim Assistance & Treatment

Anoka County Attorney's Office, A Note to Those Closest to Sexual Assault Victims. Victim/Witness Assistance Program, Courthouse, Anoka, MN 55303.

Bard, Morton and Ellison, Katherine. "Crisis Intervention and Investigation of Forcible Rape." Police Chief, 41 (1974) 5: 68-74.

Bode, Janet. Fighting Back: How to Cope With the Medical Emotional and Legal Consequence of Rape. New York: MacMillian Publishing Company, 1978.

Brodyaga, Lisa and others. Rape and Its Victims: A Report for Citizens, Health Facilities, and Criminal Justice Agencies. Washington: National Institute of Law Enforcement and Criminal Justice, 1974.

Burgess, Ann Wolbert and Holmstrom, Lynda Lytle. "Crisis and Counseling Requests of Rape Victims." Nursing Research, 23 (1974) 6: 196-202.

Burgess, Ann and Holmstrom, Lynda. Rape: Crisis and Recovery, Robert J. Brady Co., A Prentice-Hall Co., 1979.

Burgess, A. W. and Holstrom, L. L. "Rape Trauma Syndrome". American Journal of Psychiatry, 1974, 131, 981-986.

Burgess, Ann Wolbert, and Holmstrom, Lynda Lytle. "The Rape Victim in the Emergency Ward." American Journal of Nursing, 73 (1973) 10; 1740-1745.

Burgess, Ann Wolbert, and Holmstrom, Lynda Lytle "Sexual Trauma of Children and Adolescents: Pressure, Sex and Secrecy." Nursing Clinics of North America, 10 (1975) 3: 551-563.

Citizens Committee for Victim Assistance, 11 South La Salle, Chicago, IL 60603. Service Guide for Professionals Who Assist Victims of Rape, Child Abuse and Domestic Violence.

Connell, Noreen and Wilson, Cassandra, Eds. Rape: The First Sourcebook for Women. New York: Plume Books, 1974.

Cryer, L. and Beutler, L. Group Therapy: An Alternative Treatment Approach for Rape Victims. Journal of Sex and Marital Therapy 6(1):40-46, Spring, 1980.

Davenport, J., Davenport, J. Rural Rape Crisis Center - A Model. Human Services in the Rural Environment 1(1):29-39, September-October, 1979.

Doweiko, H. Counseling the Victim of Sexual Assault. Journal of College Student Personnel 22(1):41-45, January 1981.

Drapkin, Israel and Viano, Emillio. Victimology. Lexington, Mass.: Lexington Books, 1974.

Elwood, N. Douglas and Larson, Brude, (eds.) Same-Sex Assault: A Handbook for Intervention Training and Sexual Assault Against Men - It Does Happen. Lesbian and Gay Community Services, 124 W. Lake Street, Suite E, Minneapolis, MN 55408.

Forman, B. D. "Psychotherapy with Rape Victims". Psychotherapy: Theory, Research and Practice. 1980a, 17, 304-311.

Garrett, C. A. and Ireland, M. S. A Therapeutic Art Session With Rape Victims. American Journal of Art Therapy 18(4):103-106, July, 1979.

Hankoff, L.D.; Micchorr, T.; Tomlinson, Karl E.; and Joyce, Sheila A. "A Program of Crisis Intervention in the Emergency Medical Setting." American Journal of Psychiatry, 131 (1974) 1: 47-50.

Haynor D. Sample Nursing Procedures Manual for Correctional Health Services. Michigan Department of Corrections Office of Health Care Correctional Health Care Program, Lansing, MI 48913.

How To Organize a Women's Crisis-Service Center. Ann Arbor, Mich.: Women's Crisis Center, 1974.

Law Enforcement Commission. Rape Protocol and Child Interview Techniques: A Basic Guide for Professionals Who Deal with Adult and Child Victims of Sexual Abuse. Chicago, IL: Citizens Committee for Victim Assistance, 1979.

Medical Procedures in Cases of Suspected Rape." American College of Obstetrics and Gynecologists Technical Bulletin #14, reprinted in Medical Aspects of Human Sexuality, 7 (1973) 9: 65-71. Amended 7-12: 166.

Meisel, A. Confidentiality and Rape Counseling. Hastings Center Report 11(4):5-7, 1981.

Ministries with Women in Crisis. Packet of materials. Cost: $1.95. Send to: Service Center, Board of Global Ministries, 7820 Reading Road, Cincinnati, OH 45237.

Palm Beach County Metropolitan Criminal Justice Planning Unit. Sexual Assault Assistance Program - Evaluation. West Palm Beach, FL 33401.

Rape Crisis Center. How to Start a Rape Crisis Center. ERIC Document Reproduction Service, P.O. Box 190, Arlington, VA 22210.

Reinshagen, L.; Meyer, M.; Mooney-Prokop, S.; Aarli, H.; Staat-Niederehe, R.; and Narod, S. Lay Advocate Training Manual - A Guide to Assist Rape Victims. Chicago Legal Action for Women.

Schultz, LeRoy (ed.). Rape Victimology. Springfield, IL: Chas. C. Thomas Publishers, 1975.

Silverman, D. C. "Sharing the Crisis of Rape: Counseling the Mates and Families of Victims". American Journal of Orthopsychiatry, 1978, 48, 166-173.

Sprei, J. and Goodwin, R. A. "Group Treatment of Sexual Assault Survivors". Journal for Specialists in Group Work, 1983, 8, 39-46.

Vera, M. I. Rape Crisis-Intervention in the Emergency Room - A New Challenge for Social-Work. Social Work in Health Care 6(3):1-11, 1981.

Viano, Emillio C. Victims & Society. Washington, D.C.: Visage Press, 1976.

Warner, Carmen. Rape and Sexual Assault: Management and Intervention. Germantown, MD: Aspen System, 1980.

Whiston, S. K. Counseling Sexual Assault Victims: A Loss Model. Personnel and Guidance Journal 59(6):363-366, February 1981.

Wood, Pamela Lakes. "The Victim in a Forcible Rape Case: A Feminist View." American Criminal Law Review, 11 (Winter 1973) 35: 345-347.

Yeaney, M. W. Catholic Virtue and Female Sexuality: Additional Trauma for Sexual Assault Victims. Counseling and Values 25(3):169-177, April 1981.

Sexual Assault - Marital Rape

Barry, Susan. "Spousal Rape, the Uncommon Law", American Bar Association Journal, September, 1980.

Finkelhor, D. and Yllo K. "Forced Sex in Marriage". Crime and Delinquency, 1982.

Groth, N. and Gary, Thomas. "Marital Rape". Medical Aspects of Human Sexuality, Vol, 15, No. 3, 1981.

Russell, Diana E. H. Rape in Marriage. New York: MacMillian, 1982.

Women's History Research Center. "National Clearinghouse on Marital Rape". 2325 Oak Street, Berkeley, CA 94708.

Sexual Assault - Offender Issues

Cohen, Murray L., et. al. "The Psychology of Rapists." Seminars in Psychiatry, 3 (August 1971): 307-327.

Eyman, J. S. How to Convict a Rapist. Stein and Day Publishers, New York, NY 10017, 1980.

Frisbie, L. V. Another Look at Sex Offenders in California, California Mental Health Research Monograph, No. 12. Sacramento: California Dept. of Mental Hygiene, 1969.

Frisbie, L. V. and Dondis, E. H. Recidivism Among Treated Sex Offenders, California Mental Health Research Monograph No. 5, Sacramento: California Dept. of Mental Hygiene, 1965.

Gebhard, P. H.; Gagnon, J. H.; Pomeroy, W. B. and Christenson, C. V. Sex Offenders. New York: Harper & Row, 1965.

Groth, Nicholas. Men Who Rape: Psychology of the Offender. Plenum Press, 1979.

MacDonald, John. Rape: Offenders and Their Victims. Springfield, Ill.: Charles C. Thomas Publishers, 1971.

Child Sexual Assault and Incest - General

Bagley, C. "Incest Behavior and the Incest Taboo". Social Problems, 16, 1969, pp. 505-519.

Burgess, Ann W., et. al. Sexual Assault of Children and Adolescents. Lexington Books, 1978.

Butler, Sandra. Conspiracy of Silence - The Trauma of Incest. New York: Bantam, 1979.

Cavenaugh, David N.; Lynch, Linda Jones; Porteous, Sandra McClure; and Gordon, Henry A. Migrant Child Welfare, 1977.

Child Abuse and Neglect; The Mexican American Community. Guadalupe Gibson, ed. - Angelina Moreno Torres, assoc. ed., 1982.

Finkelhor, David. Sexually Victimized Children. New York: The Free Press, 1979.

Forward, S. and Buck, C. Betrayal of Innocence. New York: Penguin, 1979.

Gagnon, J. H. "Female Child Victims of Sex Offenses". Social Problems, 1965, 13, 176-192.

Gil, D.G. Violence Against Children. Cambridge, Mass.: Harvard University Press, 1972.

Goodwin, Jean. Sexual Abuse: Incest Victims and Their Families. Boston: John Wright, PSG, 1982.

Helfer, R.E., M.D.; and Kemp, C.H., M.D.; Eds. Child Abuse and Neglect: The Family and the Community. Michigan State University, Ballenger Publications, 1976.

Herman, Judith. Father-Daughter Incest. Cambridge: Harvard University Press, 1981.

Hinojosa, David. The Self-Concept and Child Abuse, 1980.

Hopkins, Joan. "The Nurse and the Abused Child", Nursing Clinics of North America, Vol. 5, No. 4, December, 1970.

Johnston, M. S. K. Child Abuse and Neglect, Vol. 3, 1979, pp. 943-951.

Justice, B. and Justice, R. The Broken Taboo: Sex in the Family. New York: Human Sciences Press, 1979.

Kates, M. Incest: The Taboo Next Door. San Francisco: 1975, 36-38.

Kempe, R. S. and Kempe, C. H. Child Abuse. Cambridge, MA: Harvard University Press, 1978.

Kroth, Jerome. Child Sexual Abuse: Analysis of a Family Therapy Approach. Springfield, IL: Charles C. Thomas, Publisher, 1979.

Maisch, H. Incest. New York: Stein and Day, 1972.

Medlicott, R. W. "Parent-Child Incest". Australia/New Zealand Journal of Psychiatry, 1967, 1, 180-87.

Minnesota Program for Victims of Sexual Assault, Are Children With Disabilities Vulnerable to Sexual Abuse?, (brochure). MPVSA, 430 Metro Square Bldg., St. Paul, MN 55101.

Minnesota Program for Victims of Sexual Assault, Child Sexual Abuse. . .It Is Happening, (pamphlet). MPVSA, 430 Metro Square Building, St. Paul, MN 55101.

Minnesota Program for Victims of Sexual Assault, Say No, Get Away and Tell Someone, (brochure). MPVSA, 430 Metro Square Building, St. Paul, MN 55101.

Muldoon, Linda (ed.). Minnesota Program for Victims of Sexual Assault. Incest: Confronting the Silent Crime. Public Document Division, 117 University Avenue, St. Paul, MN 55155.

Mrazek, P. B. "Annotation: Sexual Abuse of Children". Journal of Child Psychology and Psychiatry, 1980, 21 (1), 91-95.

Nasjleti, Maria. Suffering in Silence: The Male Incest Victim. Child Welfare League of America, Vol. LIX, Number 5, May 1980.

National Resource Center on Child Abuse and Neglect for Mexican-American Migrants, Problemas De Familia, 1980.

National Resource Center on Child Abuse and Neglect for Mexican-American Migrants, Entendiendo El Abuso Y Descuido Del Nino, 1980.

Natural Resource Center on Child Abuse and Neglect or Mexican-American Migrants, Los Ninos Como Las Flores Necesitan Nutrirse. . .Para Crecer Fuertes Y Productivos.

Peters, J. J. "Children Who Are Victims of Sexual Assault and the Psychology of Offenders". American Journal of Psychotherapy, July 1976, 30 (3), 398-421.

Rosenfeld, A. A. "Sexual Misuse and the Family". Journal American Academy Child Psychiatry, 16 (2), 1977, pp. 327-339.

Sgroi, Suzanne M. "Sexual Molestation of Children." Children Today, (May-June 1975): 18-21.

Texas Migrant Council and Rosie Lee Camacho, Child Abuse and Neglect in the Mexican American Community, 1980.

Texas Migrant Council, Proceedings: of a work shop sponsored by the Texas Migrant Council on Child Abuse and Neglect in the Mexican American Community.

Time Magazine. "Attacking the Last Taboo". April 14, 1980.

Tooley, K. M. "A Young Child as Victim of Sibling Attack". Social Casework, 58, January, 1977, pp. 25-28.

Tormes, Yvonne. Child Victims of Incest. Denver: The American Humane Association, 1968.

U.S. Department of Health and Human Services, Selected Readings on Adolescent Maltreatment, 1981.

U.S. Department of Health and Human Services, Sexual Abuse of Children: Selected Reading, 1980.

Valiunas, Al. Issues in the Incidence of Child Abuse and Neglect Relative to Mexican Americans.

Walters, David R. Physical and Sexual Abuse of Children. Bloomington: Indiana University Press, 1975.

Weller, Warren. Indian Culture and It's Relationship to Child Abuse and Neglect, 1980.

Zaphiris, A. G. Child Abuse and Neglect; Mexican American Ethnic Perspective, 1980.

Zaphiris, A. G. Incest: The Family with Two Known Victims. Englewood, CO: American Humane Assoc., 1978.

Child Sexual Assault and Incest - Personal Accounts

Angelou, Maya. I Know Why the Caged Bird Sings. New York: Bantom, 1971.

Armstrong, Louise. Kiss Daddy Goodnight. New York: Hawthorn Books, Inc., 1978.

Brady, Katherine (Pseudonym) Father's Days: A True Story About Incest. Seaview Books, New York City, NY, 1979.

Marks, Judi. "Incest Victims Speak Out." Teen Magazine, February 1980.

McNaron, Toni A. H. and Yarrow, Morgan, (eds.) Voices in the Night. Cleis Press, Minneapolis, MN, 1982.

Meyers, Barbara. Incest: If You Think the Word is Ugly, Take a Look at Its Effects. Christopher Street, Inc., Minneapolis, MN, 1979.

Morrison, Toni. The Bluest Eyes. NY: Holt, Riernt and Winston.

Rush, Florence. The Best Kept Secret. New York: McGraw Hill, 1981.

Walker, A. The Color Purple. New York: Washington Square, 1982.

Child Sexual Assault and Incest - Research

Aberle, D. R., et. al. "A Biological Basis for the Incest Taboo". In: Godde, W. (ed.) Readings on the Family and Society. Englewood Cliffs, New Jersey: Prentice-Hall, 1964.

Award, G. A. "Single Case Study: Father-Son Incest, A Case Report". Journal of Nervous and Mental Disease, 162 (2), 135-139, 1976.

Barry, M. J. and Johnson, A. M. "The Incest Barrier". Psychoanalytic Quarterly, 27 (4), 485-499, 1958.

Benward, J. and Denson-Gerber, J. Incest as a Causative Factor in Anti-Social Behavior: An Explorative Study. New York: Odyssey Institute, 1975.

Brant, R. S. and Tisza, V. B. "The Sexually Misused Child". American Journal Orthopsychiatry, 47 (1), January, 1977.

Browning, D. H. and Boatman, B. "Incest: Children at Risk". American Journal Psychiatry, 134 (1), January, 1977.

Burgess, Ann W. and Holmstrom, Lynda L. "Sexual Assault of Children and Adolescents: Pressure, Sex and Secrecy". Nursing Clinics of North America, September, 1975.

Changles, S. and Brield, D. Sexual Abuse of Children: Implications for Casework. American Humane Association, Denver, 1967.

Cohen, Ronald, et. al. "The Susceptibility of Child Witnesses to Suggestion: An Empirical Study". Law and Human Behavior, Vol. 4, Winter 1980, pp. 201-210.

DeFrancis, V. "Protecting the Child Victim of Sex Crimes Committed by Adults." Federal Probation, 35 (1971) 3: 15-20.

DeMott, Benjamin. "The Pro-Incest Lobby", Psychology Today, March, 1980.

Gagnon, John. "Female Child Victims of Sex Offenses." Social Problems, 13 (1965): 176-192.

Garrett, Thomas B. and Wright, Richard. "Wives of Rapists in Incest Offenders", Journal of Sex Research, 1975 (May), Vol. 11(2).

Gutheil, T. G., et. al. "Multiple Overt Incest as Family Defense Against Loss". Family Process, 16 (1), March, 1977, pp. 105-116.

Hagen, W. G., Jr. "The Metaphysical Implications of Incest in Romantic Literature." Dissertation Abstracts, Vol. 35 (4A), October, 1974.

Henderson, J. "Incest: A Synthesis of Data". Canadian Psychiatric Association Journal, 1972, 17, 299-313.

James, J. and Meyerding, J. "Early Sexual Experiences as a Factor in Prostitution". Archives of Sexual Behavior, 1977, 7 (1), 31-42.

Kaufman, I.; Peck, A. L. and Tagiuri, C. K. "The Family Constellation and Overt Incestuous Relations Between Father and Daughter". American Journal of Orthopsychiatry, 1954, 24, 266-277.

Landis, Judson O. "Experiences of 500 Children with Adult Sexual Deviation." The Psychiatric Quarterly Review (Supplement), 30 (1956): 91-108.

Larson, N. R. An Analysis of the Effectiveness of a State-Sponsored Program Designed to Teach Intervention Skills in the Treatment of Family Sexual Abuse. Doctoral Dissertation, University of MN, Minneapolis, MN, 1981.

Lukanowicz, N. "Incest-I: Paternal Incest". British Journal Psychiatry, 120, 1972, pp. 310-313.

Machotka, P.; Pittman, F. S. and Flomenhaft, K. "Incest as a Family Affair". Family Process, 1967, 6 (1), 98-116.

Meiselman, K.C. Incest: A Psychological Study of Causes and Effects with Treatment Recommendations. San Francisco: Jossey-Bass, 1978.

Molnar, B. and Cameron, P. "Incest Syndromes: Observations in a General Hospital Psychiatric Unit". Canadian Psychiatric Association Journal, 1975, 20, 1-8.

Mrazek, D. A. "The Psychiatric Examination of the Sexually Abused Child". Child Abuse and Neglect, Vol. 4, (4), 1980, pp. 274-284.

Nakashima, I. I., et. al. "Incest: Review and Clinical Experience". Pediatrics, 60 (5), November, 1977, pp. 696-701.

Peters, P. The Psychological Effects of Childhood Rape. Philadelphia: Center for Studies in Sexual Deviance, 1973.

Porteous, Sandra McClure. Migrant Child Welfare, A Review of the Literature and Legislation, 1977.

Queen's Bench Foundation. Sexual Abuse of Children. Queen's Bench Foundation - Project on Child Victims of Sexual Assault in San Francisco, 244 California Street, Suite 210, San Franciso, CA 94111.

Rosenfeld, A. A. "Incidence of a History of Incest Among 18 Female Psychiatric Patients". American Journal of Psychiatry. 1979, 126, (3), 791-795.

Sholevar, G. P. "A Family Therapist Looks at the Problem of Incest". The Bulletin of the American Academy of Law and Psychiatry. 3 (1), 1975.

Stechler, Gerald, PH.D. "Facing the Problem of the Sexually Abused Child." New England Journal of Medicine, Vol. 302, No. 6 February 7, 1980.

Summit, R. and J. Kryso. "Sexual Abuse of Children; A Clinical Spectrum". American Journal Orthopsychiatry, 48 (2), April, 1978.

Texas Migrant Council and Lex Berrious, Child Abuse and Neglect Among Mexican American Migrants: A Study of Cases, 1981.

Tilelli, John A.; Turek, Dianne, and Arthur C. Jaffe. Special Article-Sexual Abuse of Children (Clinical Findings and Implication for Management). The New England Journal of Medicine. Vol. 302. No. 6.

Weinberg, S. K. Incest Behavior. New York: Citadel Press, 1976. (Originally Published, 1955).

Woodbury, John and Schwartz, Elroy. The Silent Sin: A Case History of Incest. New York: Signet, 1971.

Child Sexual Assault and Incest - Prevention and Education

Adams, Caren and Fay, Jennifer. No More Secrets: Protecting Your Child From Sexual Assault. 1981, 90 pages. Available from: Impact Publishers, P.O. Box 1094, San Luis Obispo, CA 93406.

Aid to Victims of Sexual Assault, Public Service Announcements made for television. Four PSA's regarding different aspects of sexual abuse with space available for advertising of local services. Aid to Victims of Sexual Assault, 2 E. 5th Street, Duluth, MN 55805.

Beltrami, Hubbard, and Cass Counties, Sexual Assault Program. Three in Every Classroom: The Child Victim of Incest, What You as a Teacher Can Do. Box 1472, Bemidji, MN 56601.

Beltrami, Hubbard, and Cass Counties Sexual Assault Program, Young Children's Touch Posters, 11 Large Posters for Educating Young Children About Sexual Assault. Box 688, Bemidji, MN 56601.

Carver County Program for Victims of Sexual Assault, Children Need Protection: A Guide for Talking to Children About Sexual Assault, 1980, 16 pages, 401 E. 4th St., Chaska, MN 55381.

Chetin, Helen. Frances Speaks Out: My Father Raped Me. Illustrated by Karen Olsen, New Seed Press, P.O. Box 3016 Stanford, California 94301.

Child Abuse Prevention Project, Dept. of Public Welfare, Directory of Services for Families Experiencing Incest. Public Documents Division, 117 University Avenue, St. Paul, MN 55155.

Cooperative Approaches to Child Protection: A Community Guide, Mary Urzi (ed.). Division of Social Services, Minnesota Dept. of Public Welfare, St. Paul, MN 55155.

DeFrancis, V. Protecting the Child Victim of Sex Crimes Committed by Adults. Denver: Children's Division American Humane Association, 1969.

Faye, Jennifer. Frog Talks About Touching, King County Rape Relief, Seattle, WA, 1981.

Fridley Police Department, My Personal Safety Coloring Book, 6431 University Avenue, N.E., Fridley, MN 55432.

Goodman, Gail S., et. al. "Would You Believe a Child Witness". Psychology Today, Vol, 15, No. 11, November, 1981, pp. 82-95.

Gibson, Guadalupe. Methods of Preventing Child Abuse and Neglect Among Mexican-American Families, 1980.

He Told Me Not to Tell (Parents guide for talking to children about sexual assault), 1979, 25 pages. Available from: King County Rape Relief Program, 305 S. 73rd St., Renton, WA 98055. (phone: 206-226-0201).

How to Talk to Your Children About Sexual Assault: A Guide for Parents, 1981, 18 pages. Available from: Sexual Assault Services, 7066 Stillwater Road, Oakdale, MN 55119 (phone: 612-777-5222).

Illusion Theater, Study Cards, for grades K-8 for use in discussing sexual abuse prevention education the Touch Continuum. Illusion Theater, 528 Hennepin Avenue, #309, Minneapolis, MN 55403.

Kent, Cordelia Anderson. Child Sexual Abuse Prevention Project: An Educational Program for Children, 1979, 120 pages. Available from: Sexual Assault Services, Hennepin County Attorney's Office, C-2100 Government Center, Minneapolis, MN 55487 (phone: 612-348-4053).

Kent, Cordelia Anderson. No Easy Answers: A Sexual Abuse Prevention Curriculum for Junior and Senior High Students, 1982, 208 pages. Available from: Illusion Theater, 528 Hennepin Avenue, Room 309, Minneapolis, MN 55403. (phone: 612-339-4944).

Kent, Cordelia Anderson. Child Sexual Abuse Prevention: Taking the First Step, Illusion Theater, 528 Hennepin Avenue, #309, Minneapolis, MN 55403.

Kleven, S. and Krebill, J. The Touching Problem and Sexual Abuse Prevention, Coalition for Child Advocacy, Whatcom County Opportunity Council, Bellingham, WA 98227.

National Committee for Prevention of Child Abuse, You Can Prevent Child Abuse, 1980.

Plummer, Carole A. Preventing Sexual Abuse - Activities and Strategies for Those Working with Children and Adolescents. Learning Publications, Inc.

Redlinger, Lawrence J. and Eller, Robin L. The Prevention and Treatment of Child Abuse and Neglect Among Migrant Farmworkers. Texas Migrant Council.

Ryerson, Ellen. The Kindergarten though Twelve Curriculum, Developmental Disabilities Project, Seattle Rape Relief, 1825 South Jackson, Suite 102, Seattle, WA 98144.

Sanford, Linda. Come Tell Me Right Away: A Positive Approach, (booklet) 1982, 23 pages. Available from: Lynn Sanford, Rush Meadow Road, Brownsville, VT 05037.

Sanford, Linda. The Silent Children: A Parents' Guide to the Prevention of Child Sexual Abuse. New York: McGraw-Hill Book Company, 1980.

Strategies for Free Children: A Guide to Child Assault Prevention, 1982 (manual for educating elementary school-age children). Available from: Child Assault Prevention Project, Women Against Rape, P.O. Box 02084, Columbus, OH 43202.

Sweet, Phyllis. Something Happened to Me (book for children), 1981. Available from: Mother Courage Press, 224 State Street, Racine, WI 53403. (phone: 414-632-3120).

Urzi, Mary. Cooperative Approaches to Child Protection. A community guide, 1980.

What Can I Do to Prevent Harm to Children? A Resource Guide for Mandated Reporters. Contact: Division of Social Services, Dept. of Public Welfare, 658 Cedar Street, St. Paul, MN 55155.

Williams, Joy. Red Flag, Green Flag, (educational coloring book), and Once I Was a Little Bit Frightened (storybook). Available from: Rape & Abuse Crisis Center, P.O. Box 1655, Fargo, N.D. 58107. (phone: 701-293-7273)

You Can Say Yes, You Can Say No (coloring book for children). Available from: Cathy Washabaugh or Carol Justin, Catholic Social Services, 207 E. Michigan, Milwaukee, WI 53202. (phone: 414-271-2881).

Child Sexual Assault and Incest - Intervention and Treatment - General

Anderson, Edward C. Prosecution of Child Abuse Cases, Technical Notes and Briefing Papers. Minnesota County Attorney's Council, 40 Milton Street, St. Paul, MN 55104.

Anderson, Lorna M. and Schafer, Gretchen. "The Character - Disordered Family: A Community Treatment Model for Family Sexual Abuse". American Journal of Orthopsychiatry, 49 (3) July, 1979, 436-45.

Besharov, Douglas J. "Building a Community Response to Child Abuse and Maltreatment." Children Today, (Sept. - Oct. 1975): 2-4.

Community Council of Greater New York, "Child Sexual Assault: Some Guidelines for Investigation and Assessment", Sexual Abuse of Children: Implications from the Sexual Trauma Treatment Program of Connecticut, 1979.

DeFrancis, V. (ed.). Sexual Abuse of Children: Implications for Casework. Denver: American Humane Association, 1969.

Ekeling, N. B. and Hill, D. A. Child Abuse: Intervention and Treatment. Acton, MA: Pub. Science Group Inc., 1975.

Gardner, Richard A. Psychotherapeutic Approaches to the Resistant Child. New York: Jason Aronson, 1975.

Giarretto, H. "Humanistic Treatment of Father-Daughter Incest". Journal of Humanistic Psychology, 1978, 18 (4), 59-76.

Giarretto, H. "The Treatment of Father-Daughter Incest: A Psycho-Social Approach". Children Today, July-August, 1976.

Holder, Wayne M. (Editor). Sexual Abuse of Children: Implications for Treatment. Child Protection Division, American Humane Association, 5351 South Roslyn Street, Englewood, Colorado 80111, 1980.

Krieger, M. J. Rosenfeld, A. A.; Gordon, A. and Bennett, M. "Problems in the Psychotherapy of Children with Histories of Incest". American Journal Psychotherapy, 1980, 34 (1), 81-88.

Larson, Noel R. "Family Treatment for Sexual Abuse", in Prohibited Relations, (ed.) Lone Backe, Nini Leick, Joav Merrick and Niels Michelsen. Copenhagen, Denmark: Hans Reitzel Publishers, LTD., 1982.

Larson, Noel and Maddock, James. "Incest and Other Adult-Child Sexual Contacts", in Treatment Interventions in Human Sexuality, (ed.) Carol Nadelson and David B. Marcotte. New York: Plenum Press, 1983.

Mayer, Adell. A Treatment Manual for Therapy with Victims Spouses, and Offenders. Learning Publications, Inc., Holmes Beach, FL, 1983.

Range Family Sexual Abuse Treatment Program, Treating Incest in Rural Families, P.O. Box 1188, 624 South 13th Street, Virginia, MN 55792.

Sepler-King, Fern. "The Problem of Incest and the Rationale for Treatment." Minnesota Department of Public Welfare, Centennial Office Building, St. Paul, MN 55155, 1982.

Sexual Assault Services, Some Questions You May Ask About Going to Court and Some Answers That Will Help You, and Kids Go to Court, Too (booklets), Office of the Hennepin County Attorney, C-2100 Government Center, Minneapolis, MN 55487.

Sexual Exploitation of Handicapped Students: A Description of the Elementary School Level Curriculum, 8 pages. Available from: Seattle Rape Relief, Developmental Disabilities Project, 4224 University Way N.E., Seattle, WA 98105. (phone: 206-632-7273).

Sgori, S. M. "Kids with Clap: Gonorrhea as an Indicator of Child Sexual Assault". Victimology: An International Journal, Summer, 1977, 2 (2), 251-267.

Sgori, Suzanne M., M.D. Handbook of Clinical Intervention in Child Sexual Abuse, Lexington Books, 1982.

Slager, Jorne P. "Counseling Sexually Abused Children". The Personnel and Guidance Journal, October 1978, 57 (2), 103-105.

Walters, David R. Physical and Sexual Abuse of Children: Causes and Treatment. Bloomington: Indiana University Press, 1975.

Yudkin, Marcia. "Breaking the Incest Taboo". The Progressive for the American Family, May 1981.

Child Sexual Assault and Incest - Intervention and Treatment - Interviewing Victims

Child Language Development, The Influence of the Form of Question on the Eyewitness Testimony of Preschool Children. No. 12 (ed. 161 - 297)

Dent, H. R., et. al. "Experimental Study of the Effectiveness of Different Techniques of Questioning Child Witnesses". British Journal of Social and Clinical Psychology, Vol. 18, February, 1979, pp. 41-51.

Flammang, C. J. "Interviewing Child Victims of Sex Offenses", Police, Vol. 16 (6), February, 1972, pp. 24-28.

International Association of Chiefs of Police. Interviewing the Child Sex Victim. Training Key No. 224, 1975.

Schutz, Leroy G. "Interviewing Child Victims of Sex Offenders", The Sexual Victimology of Youth. C. C. Thomas, 1980, pp. 175-186

Wolbert, Burgess. "Interviewing Young Victims". Sexual Assault of Children and Adolescents. Lexington Books, 1978, pp. 171-180.

Child Sexual Assault and Incest - Intervention and Treatment - Play & Art Therapy

Axline, Virginia. Play Therapy. New York: Ballantine Books, 1947.

DiLeo, Joseph. Children's Drawings as Diagnostic Aids. New York: Brunner/Mazee, 1973.

DiLeo, Joseph. Young Children and Their Drawings. New York: Brunner/Mazee, 1973.

Gardner, Richard A. Therapeutic Communication with Children: The Mutual Story Telling Technique. New York: Science House, 1971.

Harris, Dale B. Goodenough. Harris Drawing Test Manual. New York: Harcourt Brace Jovanovich, Inc., 1963.

Kramer, Edith. Art as Therapy with Children. New York: Schocken Books, 1971.

Schaefer, Charles E. (ed.). Therapeutic Use of Childs Play. New York: Jason Aronson, Inc., 1976, 1979. (An anthology of 54 articles on child therapy.)

Sexual Harassment - General

Albert, Jane. "Tyranny of Sex in the Office". Equal Times, Vol. 1 No. 19, August, 1977.

Alliance Against Sexual Coercion. Fighting Sexual Harassment: An Advocacy Handbook. AASC, P.O. Box 1, Cambridge, MA 02139, 1980.

American Federation of State, County and Municipal Employees (AFSCME). On The Job Sexual Harassment: What the Union Can Do. AFSCME, 1821 University Avenue, St. Paul, MN 55104, 1980.

Benson, D. J. and Thomson, G. E. "Sex, Gender and Power: Sexual Harassment on a University Campus." University of California at Berkeley. Working Women's Institute, 593 Park Avenue, NY, NY 10021, 1979.

Benson, Donna. "The Sexualization of Student - Teacher Relationships." 2829 Forest Avenue, Berkeley, CA 94705, 1977.

Bradford, David L; Sargent, Alice and Sprague, Melinda. "The Executive Man and Women: The Issue of Sexuality." Bringing Women into Management. Edited by Francine B. Gordon and Myra H. Strober. New York: McGraw Hill, 1975.

Council on the Economic Status of Women. "Sexual Harassment Survey - Twin Cities Personnel Officials". CESW, 400SW State Office Building, St. Paul, MN 55155, 1981.

District of Columbia Commission for Women. "Sexual Harassment in the Workplace, A Survey." DCCW, Room 204 District Building, Washington, DC 20004, 1980.

Farley, Lin. Sexual Shakedown. New York: McGraw Hill, 1978.

Faucher, Mary D. and McCullouch, Kenneth D. "Sexual Harassment in the Workplace - What Should the Employer Do?" EEO Today, Spring, 1978.

Freimuth, V. and Gronsky, B. "Sex Bias on the Campus of the University of Maryland." District of Columbia Commission for Women, Room 204, District Building, Washington, D.C. 20004, 1979.

General Mills, Inc. "Sexual Harassment." 9200 Wayzata Boulevard, Minneapolis, MN 55426.

Henley, Nancy. "The Politics of Touch." Radical Psychology. Edited by P. Brown, New York: Harper & Row, 1973.

Illinois Task Force on Sexual Harassment and Sangamon State University. Illinois House Judiciary Committee. Sangamon State University, Springfield, IL 62708. March 4, 1980.

Lindsey, Karen. "Sexual Harassment on the Job." Ms., November 1977.

MacKinnon, Catherine A. Sexual Harassment of Working Women. New Haven and London: Yale University Press, 1979.

Martin, Susan E. "Sexual Politics in the Workplace: The Interactional World of Policewomen." 1977.

Maryland Commission for Women. "A Survey of Sexual Harassment in Maryland State Government." MCW, 1100 North Eutaw Street, Baltimore, MD 21201, 1980.

Merit Systems Protection Board. "Summary of Preliminary Findings on Sexual Harassment in the Federal Workplace." Subcommittee on Investigations, Committee on Post Office and Civil Service, U.S. House of Representatives, September 25, 1980.

Munich, Adrienne. "Seduction in Academe." Psychology Today, February 1978.

National Advisory Council on Women's Educational Programs. A Report on the Sexual Harassment of Students. NACWEP, U.S. Department of Education, 1832 M Street NW, #821, Washington, D.C. 20036. August 1980.

Pogrebin, Letty Cottin. "The Working Woman: Sex Harassment." Ladies Home Journal. June 1977.

Project on the Status and Education of Women. "Sexual Harassment: A Hidden Issue." PSEW, 1818 R Street Northwest, Washington, DC 20009, June 1978.

Renick, James C. "Sexual Harassment at Work: Why It Happens, What To Do About It." Personnel Journal, Volume 59, No. 8, August 1980.

Rivers, Caryl. "Sexual Harassment; the Executive's Alternative to Rape". Mother Jones, Vol. III, No. 5, June, 1978.

Roy, Donald. "Sex in the Factory: Informal Heterosexual Relations Between Supervisors and Work Groups". Deviant Behavior. Edited by Clifton Bryant, Chicago: Rand McNally, 1974.

Safran, Claire. "Results of the Redbook Reader Survey: How Do You Handle Sex on the Job." Redbook, January 1976.

Safran, Claire. "What Men Do to Women on the Job: A Shocking Look at Sexual Harassment." Redbook, November 1976.

"Sex in the Price for High Grades." The Phoenix. San Franciso State University, November 8, 1973.

Shapiro Eileen. "Some Thoughts on Counseling Women Who Perceive Themselves to be Victims of Nonactionable Sex Discrimination: A Survival Guide." Leadership and Authority in the Health Professions. University of California Press, 1977.

Strock, William C. "Address on Workplace Sexual Harassment." 27th Annual Institute on Labor Law, Dallas, Texas.

Thurston, Kathryn A. "Sexual Harassment: An Organizational Perspective." Personnel Administrator, Volume 25, No. 12, December 1980.

Tillian, Darrel L. "Sexual Harassment, New Rules to the Game." Forum, July 1980.

Vick, Judy. "Sexual Harassment: Can It Be Stopped?" Corporate Report, October 1979.

Weisel, Kerri. "Title VII: Legal Protection Against Sexual Harassment." Washington Law Review, Vol. 53, No. 1, December, 1977.

Wolman, Carol and Hal, Frank. "The Solo Woman in a Professional Peer Group." American Journal of Orthopsychiatry, Vol. 45.

Pornography: General

Barry, Kathleen. Female Sexual Slavery. Englewood Cliffs, N.J., Prentice-Hall, 1979.

Cline, Victor B., comp. Where Do You Draw the Line? An Exploration into Media Violence, Pornography, and Cenorship. Provo, Utah: Brigham Young University Press, 1974.

Donnerstein, E. Pornography and violence against women. In D. Copp and S. Wendell (Eds). Pornography and Censorship: Scientific, Philosophical, and Legal Studies. New York: Prometheus, 1983.

Dworkin, Andrea. Pornography: Men Possessing Women. New York: Putnam, 1981.

Faust, Beatrice. Women, Sex, and Pornography: A Controversial and Unique Study. 1st American ed. New York: Macmillan, 1980.

Griffin, Susan. Pornography and Silence: Culture's Revenge Against Nature. New York: Harper & Row, 1981.

Herther, Nancy K., ed. Intellectual Freedom in Minnesota; the Continuing Problem of Obscenity. Minneapolis; Minnesota Library Association, 1979.

Lederer, Laura, ed. Take Back the Night: Women on Pornography. New York: Morrow, 1980.

Lovelace, Linda. Ordeal. New York: Citadel, 1980.

Malamuth, Neil M. "Rape Proclivity Among Males". Journal of Social Issues, 1981, 37, #4.

Morgan, Robin. The Anatomy of Freedom. New York: Anchor Press/Doubleday, 1982.

Morgan, Robin. "How to Run the Pornographers Out of Town (and Preserve the First Amendment)." Ms., November, 1978.

See, Carolyn. Blue Money; Pornography and the Pornographers - an Intimate Look at the Two-Billion-Dollar Fantasy Industry. New York: McKay, 1974.

U.S. Commission on Obscenity and Pornography. The Report. Washington GPO, 1970.

U.S. Federal Communication Commission. Report on the Broadcast of Violent, Indecent and Obscene Material. Washington: GPO, 1975.

U.S. Supreme Court. The Supreme Court Obscenity Decisions. San Diego: Greenleaf Classica, Inc., 1973.

Pornography: Child

Dudar, Helen. "America Discovers Child Pornography." Ms. August, 1977.

Linedecker, Clifford L. Children in Chains. New York: Everest House, 1981.

O'Brian, Shirley. Child Pornography. Dubuque, Iowa: Kendall/Hunt Pub. Co., 1983.

Preying on Playgrounds: The Sexploitation of Children in Pornography and Prostitution." Pepperdine Law Review, 1978, 809-46.

United States. Congress. House. Committee on Education and Labor. Subcommittee on Select Education. Sexual Exploitation of Children: Hearings Before the Subcommittee on Select Education and Labor, House of Representatives Ninety-fifth Congress, First Session. Washington: GPO, 1977.

United States. Congress. House. Committee on Education and Labor. Subcommittee on Select Education. Teenage Prostitution and Child Pornography: Hearings Before the Subcommittee, 97th Congress, 2nd Session, Hearings held in Pittsburgh, PA, April 23; and Washington, D.C., June 24, 1982. Washington, GPO, 1982.

United States. Congress. Senate. Committee on the Judiciary, Subcommittee on Juvenile Justice. Child Pornography: Hearing Before the Subcommittee, 97th Congress, 2nd Session, December 10, 1982. Washington, U.S.G. PO, 1983.

Domestic Violence: Battering - General

Fortune, Marie M. Rev. and Hormann, Denise. Family Violence, 1981.

Johnson, Carolyn; Ferry, John and Kravitz, Marjorie. Spouse Abuse. National Criminal Justice Reference Service, November, 1978.

King, Linda S. "Responding to Spouse Abuse: The Mental Health Profession." Response, May/June 1981.

Martin, Del. Battered Wives, 1976.

Massachusetts Coalition of Battered Women Service Groups, For Shelter and Beyond, 1981.

Mechau, D. Shelter for Abused and Battered Women and Their Children Operated by Abused Women's Aid in Crisis (AWAIC). Anchorage, AL. ERIC, July 31, 1978.

Schulman, Mark A. A Survey of Spousal Violence Against Women in Kentucky. U.S. Department of Justice, Law Enforcement Assistant Administration, July 1979.

Turner, Willie M. et. L. West. "Violence in Military Families". Response, May/June 1981.

Walker, Lenore E. The Battered Women, 1979.

Warrior, Betsy. Working on Wife Abuse, 1976.

Counseling Issues and Treatment - General

Assagioli, R. Psychosynthesis: A Manual of Principles and Techniques. New York: Hobbs-Dorman and Co., 1965.

Bernstein, B.E. et. al. Child Welfare, Vol. 61 (2), February, 1982, pp. 95-104.

Jacobs, Beth; Buschman, Randy; Schaeffer, Don, and Dendy, Robert. Training Manual for Counseling Skills. National Drug Abuse Center, Arlington, Virginia: 1974.

Lester, David. Unusual Sexual Behavior. Springfield, IL: Charles C. Thomas, Publisher, 1975.

Resnik, H. L. P. and Wolfgang, M. E. (eds). Sexual Behaviors: Social, Clinical and Legal Aspects. Boston: Little, Brown & Co., 1972.

Salasin, Susan (ed). Evaluating Victim Services. Beverly Hills: Sage Publishing, 1981.

Wyckoff, Hogie. Solving Women's Problems. New York: Gorve Press, Inc., 1977.

Counseling Issues and Treatment - Research

Garfield, Sol L. Clinical Psychology: The Study of Personality and Behavior. Aldine Publishing Co., Chicago, 1974.

Imber, S. D.; Nash, E. W., Jr., and Stone, A. R. "Social Class and Duration of Psychotherapy". Journal of Clinical Psychology, 11, 1955. pp. 281-284.

James, K. "Incest: The Teenager's Perspective". Psychotherapy: Theory, Research and Practice, 1977, 14 (2), 144-146.

MacKinnon, R. A. and Michels, R. The Psychiatric Interview with Clinical Practice. Philadelphia: W. B. Saunders Company, 1981

Maier, Henry W. Three Theories of Child Development. Harpers & Row, Publishers, New York, NY, 1969.

Turner, Francis, J. Social Work Treatment: Interlocking Theoretical Approaches. The Free Press, New York, NY, 1974.

Windlier, A. E. and Hersko, M. "The Effects of Social Class on the Length and Type of Psychotherapy in a Veterans Administration Mental Hygiene Clinic". Journal of Clinical Psychology, 11 (1955), pp. 77-79.

Yamamoto, J.; James, Q. C.; Bloombaum, M. and Hatlem, J. "Social Class as Factors in Patient Selection". American Journal of Psychiatry, 124, 1967, pp. 630-636.

Counseling Issues and Treatment - Group Counseling

Corey, G., M.S.; Callahan, P.J. and Russel, J. M. Group Techniques. Monterey: Brooks/Cole.

Corey, G. Theory and Practice of Group Counseling. Monterey: Brooks/Cole, 1981.

Dyer, Wayne W. and Vriend, John. Group Counseling for Personal Mastery. New York: Sovereign Books, 1980.

Konopka, Gisela. Social Group Work: A Helping Process. Engelwood Cliffs, N.J.: Prentice-Hall, 1972.

Sagu, Clifford J. and Kaplan, Helen Singer, (eds). Progress in Group and Family Therapy. New York: Brunner/Mazel, Inc., 1972.

Tsai, M. and Wagner, N. "Therapy Groups for Women Sexually Molested as Children". Archives of Sexual Behavior, 1978, 7 (5), 417-427.

Yalom, Irvin D. Theory and Practice of Group Psychotherapy. New York: Basic Books, Inc., 1970.

Counseling Issues and Techniques - Cultural Issues - General

Atkinson, Donald R.; Morten, George and Sue, Derald Wing. Counseling American Minorities: Across Cultural Perspective. 2nd edition. Dubuque, Iowa: Wm. C. Brown Company Publishers, 1983.

Brewton, Berry. Race and Ethnic Relations. Third edition, Houghton Mifflin Company, Boston.

Graves, T. D. "Psychological Acculturation in the Tri-Ethnic Community". Southwestern Journal of Anthropology, 23, 1967, pp. 327-350.

Morales, A. Social Work with Third World People, 26, January, 1981, pp. 45-50.

Padilla, A. M. "The Role of Cultural Awareness and Ethnic Loyalty in Acculturation". In A. M. Padilla (ed.), Acculturation: Theory, Models and Some New Findings. AAAS Symposium, 39, Westview Press, 1980, pp. 47-81.

Ruch, L. O. and Chandler, S. M. Ethnicity and Rape Impact - The Responses of Women from Different Ethnic Backgrounds to Rape and to Rape Crisis Treatment Services in Hawaii. Social Process in Hawaii 27:52-67, 1979.

Sue, Derald Wing. Counseling the Culturally Different: Theory and Practice. New York: John Wiley & Sons, 1981.

Stewart, Edward C. American Cultural Patterns: A Cross-Cultural Perspective, 1972.

Westmeyer, J. "The Apple Syndrome in MN: A Complication of Racial-Ethnic Discontinuity". Journal of Operational Psychiatry, 1979, 10 (2), 134-140.

Wolkin, G. H. and Moriwaki, S. "Race and Social Class as Factors in the Orientation Toward Psychotherapy". Journal of Consulting Psychology, 20 (1973), pp. 312-316.

Velasquez, J.; McClure, M. E. V. and Benavides, E. "A Framework for Establishing Social Work Relationships Across Racial Ethnic Lines". In Compton and Galaway, Social Work Processes, Revised edition, Homewood, IL: The Dorsey Press, 1979, pp. 197-202.

Counseling Issues and Techniques - Cultural Issues - Asian Americans

Chu, W. and Fong-torres, S. Rape: "It Can't Happen to Me." An Asian American Perspective 7(1):39-42, Spring 1979.

Counseling Issues and Techniques - Cultural Issues - Black

Bell, Peter and Evans, Jimmy. Counseling the Black Client - Alcohol Use and Abuse in Black America. Hazelden Foundation, 1981.

Scott, E. L. "Black Women, Crime and Crime Prevention." National Conference of Black Political Scientists (Jackson, Mississippi, April 1978).

Staples, Robert. The Black Family: Essays and Studies. Wadsworth Publishing Co., 1983.

Walker, Alice. In Search of Our Mothers Gardens. NY: Harber & Brace Co., 1983.

William, James D., ed. The State of Black America 1983. National Urban League, Inc., 1983.

Woodson, Robert L. Black Perspectives on Crime and the Criminal Justice System. Boston: G. K. Hall & Co., 1977.

Counseling Issues and Techniques - Cultural Issues - Hispanic

Aquilar, Ignacio, "Initial Contacts with Mexican-American Families". Social Work Journal of the NASW, Vol. 17, No, 3, May, 1972, (p. 66).

Castro, F. G. "Level of Acculturation and Related Consideration in Psychotherapy with Spanish Speaking/Surnamed Clients, Occasional Paper, No. 3 from the Spanish Speaking Mental Health Research Center, California, 1977, pp. 1-31.

Kantrowitz, Martin P.; Mondragon, Antonio and Coleman, William Lord. Que Paso?, An English - Spanish Guide for Medical Personnel, 1978.

Levine, Elaine S. and Padilla, Amado M. Crossing Cultures in Therapy: Pluralistic Counseling for the Hispanic. California: Brooks/Cole Publishing Co., 1980.

Lozada, Eddie. Counseling Dynamics - La Familia, Participant's Manual. Southwest Training Institute, Inc., 1980.

Martin, Patricia Preciado. La Frontera Perspective, 1979.

MN Migrant Council, Nadie tiene derecho de abusaria/No One Has The Right to Abuse You. Services for the abused booklet, 1982.

MN State Office of Migrant Affairs: A Report to the Advisory Committee. Migrant Affairs Office, 1976.

Miranda, M. R. and Castro, F. G. Cultural Distance and Success in Psychotherapy with Spanish-Speaking Clients. In J. L. Martinez, Jr. (ed.), Chicano Psychology. New York: Academic Press, 1976, pp. 249-262.

Mirande, Alfredo and Enriquez, Evangelina. La Chicana: The Mexican American Women, 1979.

Montoya, Jose R. Cultural and Ethnic Awareness Manual for Professionals Working with Mexican American Migrant Families. Resource Specialist and Trainer, by Texas Migrant Council, 1980.

Quinones-Sierra, S. "Rape Within the Hispanic Family Unit." ERIC.

Ramsey County Community Human Services Department, Hispanic Mental Health Needs Assessments, June 1980.

San Diego State University, Vision, Spring 1976.

Velasquez, J. S. and Velasquez, C. P. "Application of a Bicultural Assessment Framework to Social Work Practice with Hispanics". Family Relationships, 29, October, 1980, pp. 598-603.

Counseling Issues and Techniques - Cultural Issues - Native American

Attneave, C. L. "American Indians and Alaska Native Families: Emigrants in Their Own Homeland". In M. McGoldrick, J. K. Pearle, J. Giordano (eds.), Ethnicity and Family Therapy. New York: The Guilford Press, 1982.

Attneave, C. L. "Medicine Men and Psychiatrists in the Indian Health Service". Psychiatric Annals, 1974, 4 (11), 49-55.

Attneave, C. L. "Therapy in Tribal Settings and Urban Network Intervention". Family Process, 1969, 8, 192-210.

Attneave, C. L. "The Wasted Strengths of Indian Families". In S. Unger (ed.), The Destruction of Indian Families. New York: Association on Indian Affairs, 1977.

Barter, E. and Barter, J. "Urban Indians and Mental Health Problems". Psychiatric Annals, 1974, 4 (9), 37-43.

Beiser, M. and deGroat, E. "Body and Spirit Medicine: Conversations with a Navajo Singer". Psychiatric Annals, 1974, 4 (11), 9-12.

Beiser, M. and Attneave, C. L. "Mental Health Services for American Indians: Neither Feast nor Famine". White Cloud Journal, 1978, 1 (2), 3-10.

Bergman, R. L. "Navajo Medicine and Psychoanalysis. Human Behavior, 1973, 2, 9-15.

Bergman, R. L. "The Training of the Medicine Man as a Model for Psychiatry". In C. Tulipson and C. Attneave (eds.), Beyond Clinic Walls. University, AL: University of Alabama Press, 1974.

Hanson, W. "Counseling with Native Americans". White Cloud Journal, 1978, 1 (2), 19-21.

Kelso, D. and Attneave, C. Bibliography of North American Indian Mental Health. Westport, CT: Greenwood Press, 1981.

Lewis, T. "A Syndrome of Depression and Mutism in the Oglala Sioux. American Journal of Psychiatry, 1975, 32 (7), 753-755.

Meketon, M. J. "Indian Mental Health: An Orientation". American Journal of Orthopsychiatry, 1983, 53 (1), 110-115.

Red Horse, J.; Shattuck, A. and Hoffman, F. (eds.). The American Indian Family: Strengths and Stresses. Isletta, N.M.: American Indian Research and Development Association, 1981.

Red Horse, J. G.; Lewis, R.; Feit, M., and Decker, J. "Family Behavior of Urban American Indians". Social Casework, 1978, February, 67-72.

Stage, T. B. and Keast, T. "A Psychiatric Service for Plains Indians". Hospital and Community Psychiatry, 1966, 17, 131-133.

Townsley, H. and Goldstein, G. "One View of the Etiology of Depression in the American Indian". Public Health Report, 1977, 92 (5), 458-461.

Trimble, J. E. "Value Differences Among American Indians: Concerns for the Concerned Counselor". In P. Pedersen, W. Lonner and J. Draguns, Counseling Across Cultures. Honolulu: The University Press of Hawaii, 1976.

Unger, S. (ed.). The Destruction of American Indian Families. New York: Association on American Indian Affairs, 1977.

Westmeyer, J. "Erosion of Indian Mental Health in Cities". Minnesota Medicine, 1976, 59, 431-433.

Wolk, Elizabeth. Minnesota's American Indian Battered Women: The Cycle of Oppression, 1982.

Health Issues - Assertiveness

Bower, S. A. and Bower, G. H. Asserting Yourself: A Practical Guide for Positive Change. Readings, MA: Addison-Wesley Publishing Co., 1976.

Lange, Arthur J. and Jakubowksi, Patricia. Responsible Assertive Behavior. Champaign, IL: Research Press, 1976.

(See also section - Sexual Assault Prevention and Self Defense.)

Health Issues - Stress

Cherniss, C. Staff Burnout: Job Stress in the Human Services. Beverly Hills: Sage, 1980.

Cherry, N. "Stress, Anxiety and Work: A Longitudinal Study". Journal of Occupational Psychology, 1978, 51, 259-270.

Falger, P. R. Changes in Workload as a Potential Risk Consultation of Myocardial Infarction: A Concise Review. Gedrag Tijschrift voor Psychologic (Tilberg, Netherlands), 1979, 7, 96-114.

Feranson, D. A Study of Occupational Stress and Health. Erogonomics, 1973, 16, 649-664.

Gechman, A. S. and Wiener, Y. "Job Involvement and Satisfaction as Related to Mental Health and Personal Time Devoted to Work". Journal of Applied Psychology, 1975, 60, 521-523.

Health Issues - Sexuality - General

Boston Women's Health Book Collective. Our Bodies, Our Selves - A Book By and For Women. New York: Simon and Schuster, 1976.

Cooksey, P. and Brown, P. A Selected Bibliography on Sexuality, Sex Education and Family Planning, Planned Parenthood of Minnesota, 1965 Ford Parkway, St. Paul, MN 55116.

Diagram Group. Woman's Body: An Owner's Manual. New York: Bantam, 1978.

Lyon, Harold C. Tenderness is Strength: From Machismo to Manhood. New York: Harper and Row, 1977.

Health Issues - Sexuality - Persons with Disabilities

Bass, Medora S. Sexual Rights and Responsibilities of the Mentally Retarded, Proceedings of Conference. Source; Editor: Medora S. Bass, 216 Glenn Road, Ardmore, PA 19003.

Becker, E.F. Female Sexuality Following Spinal Cord Injury, Accent Special Publications, Cheever Publishing, P.O. Box 700, Bloomington, IL, 1978.

Blum, Gloria, M.A., and Blum, Barry, M.D. Feeling Good About Yourself, (Sexuality and Social Skills for Physically Disabled, Emotionally Disabled, Senior Citizens and Non-disabled Persons), Feeling Good Associates, 507 Palma Way, Mill Valley, CO 94941.

Canpling, Jo, ed. Images of Ourselves, Women With Disabilities Talking, Rotlidge, and Kagenpaul, Boston, MA, 1981.

Cole, T.M. and Cole, S.S. Sexuality and Physical Disability, University of Michigan, School of Medicine, Ann Arbor, MI 48104.

Comfort, Alex. Sexual Consequences of Disability, George F. Stickley Co., 210 W. Washington, Philadelphia, PA 19106 (1978).

Eisenberg, M.G. Sex and Disability: A Selected Bibliography. Rehabilitation Psychology, Volume 25, No. 2, 1978. Order: Rehabilitation Psychology, Business Office, P.O. Box 26034, Tempe, AZ 85282.

Fitzgerald, Max and Della Fitzgerald, et al. Sexuality and Deafness, May, 1979, Pre-College Program, Gallaudet College, Kendall Green, Washington, D.C. 20002.

Gordon, Sol. Living Fully: A Guide for Young People With a Handicap, Their Parents, Their Teachers and Professionals, The John Day Co., New York, NY.

Hague, Patricia and Engstrom, Cheryl. Responding to Disability: A Question of Attitude, Minnesota State Council for the Handicapped, 208 Metro Square Bldg., St. Paul, MN 55101, 1982.

Mooney, T.; Cole, T., and Chilgren, R.A. Sexual Options for Paraplegics and Quadraplegics, Boston, Little Brown and Co., 1975.

Planned Parenthood of Pierce County, Personal Development and Sexuality: A Curriculum Guide for the Developmentally Disabled, 312 Broadway Terrace Bldg., Tacoma, WA 94802.

Planned Parenthood of Seattle-King County, Human Sexuality: A Portfolio for the Mentally Retarded, 2211 East Madison, Seattle, WA 98112. Large illustrations on 11" X 17" plate cards specifically designed for teaching retarded person about human sexuality.

Sexuality and Disability: Journal; Human Sciences Press, 72 Fifth Avenue, New York, NY 10011.

Woodward, James. Signs of Sexual Behavior: An Introduction to Some Sex Related Vocabulary in American Sign Language, T.J. Publishers, Silver Spring, MD, 1979.

Directories and Resource Guides

Back, Susan M. and During, Linda. Spouse Abuse Yellow Pages, 1981.

Boston Women's Health Book Collective, Nuestros Cuerpos, Nuestras Vidas: Un Libro Por Y Para Las Mujeres, 1977.

Chappell, D.; Geis, G.; and Fogarty, F. Rape Bibliography With Special Emphasis on Rape Research in Canada. Canada Solicitor General Communications Division Programs Branch, Ottawa, Ontario, 1979.

Council on the Economic Status of Women, A Woman's Place, 1980 (also published in Spanish).

Council on Foundations, Inc., Hispanics and Grantmakers: A Special Report of Foundation News, Washington, D.C., 1981.

Greenstone, J. L. and Leviton, S. Hotline - Crisis Intervention Directory. Facts on File, Inc., New York, NY 10019, 1981.

Kemmer, E. J. Rape and Rape-Related Issues - An Annotated Bibliography. Garland Publishing, Inc., 10 East 44th Street, New York, NY 10017, 1977.

Minnesota Community Corrections Association, MCCA Corrections Directory, 1980.

Morris, Philip, A Guide to Hispanic Organizations, 1980.

Planned Parenthood Association of Wisconsin. Bibliography of Resources of Mental Retardation and Sexuality. 1135 W. State Street, Milwaukee, WI 53233. (1979)

Sepler-King, Fern. Directory of Services for Families Experiencing Incest. State Register and Public Documents. 117 University Avenue, St. Paul, MN 55155.

Serrano, Lupe and Miranda, Elvira. Directory of Resources, 1982.

SIECUS. A Bibliography of Resources in Sex Education for the Mentally Retarded. Informational Resources, Human Sciences Press, 72 Fifth Avenue, N.Y. 10011.

U.S. Commission on Civil Rights, Getting Uncle Sam to Enforce Your Civil Rights, 1980 (also published in Spanish).

U.S. Department of Health and Human Services, National Directory: Rape Prevention and Treatment Resources, 1981.

Walker, M. J. (eds.) Toward the Prevention of Rape - A Partially Annotated Bibliography. National Criminal Justice Reference Service MICROFICHE PROGRAM, Box 6000, Rockville, MD 20850, 1975.

Women's Bureau, Networking Together II: A Minority Women's Employment Conference Directory, U.S. Department of Labor, 1981.

APPENDIX # 8A

Treatment of Sexual Abuse & Assault
With Ethnic Populations

October 4-6, 1983

PRE/POST TEST

Social Security Number: _____ or I.D. Number: _____

PLEASE INDICATE IF THE STATEMENTS BELOW ARE TRUE OR FALSE:

1. __F__ A person can be charged with criminal sexual conduct only if penetration occurs.
2. __F__ Helping professionals must have proof that sexual abuse of a child has occurred before they report the case.
3. __T__ A medical examination can provide corroborative evidence for a sexual assault case.
4. __F__ In intrafamilial sexual abuse, the perpetrator must be a blood relative.
5. __F__ The victim decides whether or not a sexual assault case is charged by the county attorney.
6. __T__ Cases of child sexual abuse can be reported to ether the police or the child protection division of the county welfare department.
7. __T__ Unforced sexual conduct is considered criminal sexual conduct.
8. __T__ An adult victim can choose whether or not to report a sexual assault to the police.
9. __F__ A victim's prior sexual conduct is always admissible in court.
10. __F__ A child under the age of ten can never testify in court.
11. __T__ Forced sexual conduct between marriage partners is a crime.
12. __F__ A child protection worker investigates all types of child sexual abuse.
13. __F__ If sexual assault occurred more than five years ago, there is no reason to tell anyone.
14. __F__ Only criminal court handles intrafamilial sexual abuse cases.
15. __T__ There is a two-year statute of limitations for civil suits unless the victim is under the age of 18.

16. __X__ A non-abusing parent who knowingly permits sexual abuse to continue may (not) be charged with a crime. (Typo in question invalidated usage)

17. __F__ Sexual assault counselors will never have to testify in a rape trial.

18. __T__ A prison sentence may be stayed in any intrafamilial sexual abuse case.

19. __F__ What a rape victim tells another person about the crime is always hearsay and is inadmissible in court.

20. __T__ If a sexual assault occurred more than three years ago, it can never be prosecuted.

21. __F__ Sexual assault has a higher false reporting rate than any other violent crime.

22. __F__ The Minnesota Sentencing Guidelines grid presumes that all persons convicted of criminal sexual conduct will be given a prison sentence.

23. __T__ Professionals engaged in the care of vulnerable adults are mandated to report suspected cases of sexual abuse.

24. __T__ The cost of a medical examination for the purpose of gathering evidence in a sexual assault case must be paid for by the county in which the offense occurred.

25. __F__ Human service professionals must report cases of criminal sexual conduct against an adult to the police.

CLARIFICATION - OCTOBER PRE/POST TEST

5. The victim decides whether or not a sexual assault case is charged by the county attorney. FALSE. The victim may tell the police whether or not she/he is willing to prosecute a sexual assault case. Only the county attorney can decide whether there is legal specificity to charge a specific case. Therefore, the final decision on charging rests with the county attorney.

7. Unforced sexual contact is considered criminal sexual conduct. TRUE. With underaged victims, force or coercion is not required. Any sexual contact with a person under the age of 13 is criminal sexual conduct, and force need not be proved. Within a family, any sexual contact with a person under the age of 18 by an adult is intrafamilial sexual abuse. It may also be criminal sexual conduct without force if the victim is between 13 and 16.

10. A child under the age of ten can never testify in court. FALSE. As long as the child under the age of ten is able to describe or relate (in language appropriate for a child of that age) the sexual contact, she/he may testify.

12. A child protection worker investigates all types of child sexual abuse. FALSE. The child protection worker is responsible for the investigation of cases of sexual abuse within the family or within institutions, such as day care centers or foster homes. If the sexual abuse is outside the family unit or a facility, the child protection worker has the duty to provide services for the family but does not investigate the case.

14. Only criminal court handles intrafamilial sexual abuse cases. FALSE. In intrafamilial sexual abuse cases, the following courts may be involved: family court (custody, visitation, domestic abuse and restraining orders); juvenile court (dependency/neglect, termination of parental rights); probate court (mental commitment, psychopathic personality); district court (civil lawsuits for damages, criminal prosecution).

20. If a sexual assault occurred more than three years ago, it can never be prosecuted. TRUE. The current statute of limitations on prosecuting sexual assault cases is three years. A seven-year statute of limitations for intrafamilial sexual abuse went into effect August 1, 1982, but is not retroactive. We will begin to have the benefit of the longer statute of limitation after August 1, 1985.

21. Sexual assault has a higher false reporting rate than any other violent crime. FALSE. Studies show that only 2% of rape calls are false reports, which is no more than in the reporting of other felonies.

25. Human service professionals must report cases of criminal sexual conduct against an adult to the police. FALSE. Minnesota statutes require reporting of maltreatment of minors and vulnerable adults, but human service professionals are not mandated to report criminal sexual conduct against other adults.

APPENDIX # 8B

Treatment of Sexual Abuse & Assault
With Ethnic Populations

November 1-3, 1983

PRE/POST TEST

Social Security Number: _____ or I.D. Number: _____

PLEASE INDICATE IF THE STATEMENTS BELOW ARE TRUE OR FALSE:

1. __F__ Child sexual offenders generally are immature, aggressive people who have rather severe intellectual functioning.

2. __F__ Pedophiles are, for the most part, homosexual men who are attracted to young boys.

3. __T__ There are two main types of child sexual offenders: regressed offenders and fixated offenders.

4. __T__ Most child victims of sexual abuse are familiar to their offenders.

5. __T__ The most common treatment methods for sexual offenders in this country involve a combination of group, individual and family psychotherapy.

6. __F__ Any child who has had sexual conduct with an adult should immediately be evaluated by a child psychologist or psychiatrist.

7. __F__ Because they are secondary victims themselves, parents of a sexually molested child can seldom be relied on to support the child.

8. __T__ If handled well, talking to law enforcement, child protection and legal people can be reassuring rather than damaging to the child.

9. __F__ In most cases, there is no need to be concerned about sexual contact between a child and an adolescent, as this is just normal curiosity on the part of the adolescent.

10. __F__ It is usually less damaging for a child to experience sexual contact with an acquaintance or friend of the family than a stranger.

11. __F__ In moving from the general to the specific,the interviewer would focus on general touch issues before talking with the child about general family issues.

12. __F__ The best way to engage a resistant child is through a direct verbal approach.

13 __T__ The "3 B's" are: "Be direct, be patient, and be specific."

14. __T__ In detecting shame/guilt in the child, one would look for lack of eye contact, changing the subject, or refusal to answer questions about touch.

15. __T__ Reflecting back to the child what you observe in their behavior is one way of "paying attention to the affect" rather than the content.

16. __F__ Family therapy is a necessary part of recovery for a child victim.

17. __F__ It is important for family members to express anger about the assault directly to the child.

18. __T__ One indicator for the family intervention is silence on the part of the child.

19. __T__ Support by the family is a critical factor in a child's recovery.

20. __F__ It's OK to answer the telephone during a play therapy session, provided you explain to the child ahead of time that you will be doing so and that the call is really important.

21. __T__ Parents should usually not be allowed to observe a play therapy session with their child.

22. __T__ Keeping to the same place, day, and time each week are very important elements of providing the "safe structure" needed for effective play therapy.

23. __F__ The most important element for effective play therapy is a large room, well equipped with lots of toys.

24. __T__ When in doubt, it's best to keep your mouth shut rather than risk intruding upon the child's process.

25. __T__ Dissociation and acting out are the only two ways human beings respond to violence.

26. __F__ The "listing technique" means getting the child to list all people who have abused them.

27. __F__ It is too difficult to even try to use direct talking with the preschooler (age 2 to 4)

28. __T__ Children who have been sexually abused often act out what they need to talk about or be asked about.

29. __F__ Other people in the family should never bring up the sexual assault because it might damage the child.

30. __T__ For the very young child, the two most important things to teach are: "It's not your fault," and "You won't be hurt."

31. __T__ Sexual contact with a child before the age of 3 often involves the child being physically abuse.

32. __F__ Systematic genital masturbation is unusual before adolescence.

33. __T__ In interviewing young children, the best way to identify time and place of sexual conduct is to relate the incident to birthdays or holidays.

CLARIFICATION - NOVEMBER PRE/POST TEST

1. Child Sexual offenders generally are immature, aggressive people who have rather severe intellectual functioning. FALSE. Child sexual offenders are generally passive and submissive. Most have no intellectual deficiencies and have above-average intelligence. They seek out children to meet their dependency and intimacy needs.

11. In moving from the general to the specific, the interviewer would focus on general touch issues before talking with the child about general family issues. FALSE. When interviewing the child victim, it is important to ask general questions first then move to the specific. Interviewer establishes rapport best using this method. For example, the interviewer should first focus on general family and child related questions, then to general touch and abuse questions.

12. The best way to engage a resistant child is through a direct verbal approach. FALSE. The best way to engage a resistant child is by: 1) accept the resistance; and 2) attempt a non-threatening technique such as child's play to get the child to communicate with you. After rapport is reestablished, you can use the child's play activities to discuss the abuse.

16. Family therapy is a necessary part of recovery for a child victim. FALSE. Family therapy is generally most appropriate in working with the child victims of non-family child sexual abuse. Family therapy could be misinterpreted by the child that something is wrong with him or her, and this is most often not the case.

17. It is important for family members to express anger about the assault directly to the child. FALSE. Family members should not express their anger about the assault in front of the child. Anger could be misinterpreted by the child as: 1) being directed towards them; and 2) it may cause the child to withhold information. The family members should express their anger with other adults.

20. It's okay to answer the telephone during a play therapy session, provided you explain to the child ahead of time that you will be doing so and that the call is really important. FALSE. When conducting play therapy, it is important to maintain a space that is free and protected from all external interruptions. Every effort should be made to ensure no interruptions of the play therapy sessions.

21. Parents should usually not be allowed to observe a play therapy session with their child. TRUE. The child involved in play therapy has the right to privacy. Parents should not be allowed to observe their child while in a therapy session. Play therapy can, however, involve both parents and child, but only if they are active participants.

25. Disassociation and acting out are the only two ways human beings respond to violence. TRUE.

32. Systematic genital masturbation is unusual before adolescence. FALSE. Systematic genital masturbation commonly begins between the ages of 6 and 11 years.

APPENDIX # 8C

Treatment of Sexual Abuse & Assault
With Ethnic Populations

December 6-8, 1983

PRE/POST TEST

Social Security Number: _____ or I.D. Number: _____

PLEASE INDICATE IF THE STATEMENTS BELOW ARE TRUE OR FALSE:

1. __F__ In Black families, incestuous relationships occur only between male and female members.

2. __F__ Black incest victims are more likely to feel unloved in the family than their White counterparts..

3. __T__ Mother-son incestuous relationships in Black families frequently occurs because of absence of a father.

4. __T__ Black incestuous family members often feel emotionally isolated from one another and in the community.

5. __F__ Alcoholism is the most crucial contributing factor to incest in Black families.

6. __F__ The traditional Hispanic World View is similar to the Dominant Society's World View.

7. __T__ The Hispanic World View affects role expectations, values and customs.

8. __T__ The concept of "El No" means that the Hispanic individual feels worthless and powerless

9. __T__ It is important that the human service provider has a clear understanding of both the Hispanic World View and the concept of "El No" in working with Hispanic clients.

10. __F__ Stubbornness is a primary characteristic of the Hispanic client.

11. __T__ Incest in American Indian families is often triggered by alcohol dependency.

12. __F__ Boys are almost never incest victims in Indian families.

13. __F__ Indian incest abusers are usually physically abusive to the children they abuse as well as sexually abusive.

14. __F__ Research indicates that there is more incest in Indian families than in White families.

15. __F__ Incest victims are usually over ten years of age.

16. __F__ Four-year-olds and twelve-year-olds lie in the same manner.

17. __F__ Sexual abuse affects children of different ages in the same way.

18. F Sexual "abuse" can actually be a positive, "good" experience for some children.

19. T The parents of the victim should never be questioned together.

20. F It is not acceptable to use leading questions when interviewing the incest offender.

21. T Family members, including the incest offender, should be interviewed before the offender is aware that a report is made.

22. T If the father is reluctant to admit the sexual abuse, playing a tape recorded statement made by the victim may persuade the offender to admit to sexual involvement.

23. F If a family appears to be extremely religious, it is unlikely that there will be incest going on.

24. T Oldest daughters who take the "little mother" role in the family may be at risk for sexual abuse.

25. T The leading indicator of sexual abuse in children is inappropriate sexual behavior.

26. T Male offenders often have a hostile, paranoid view of outsiders to the family.

27. F Most wives of incest offenders are collusive in the incest.

28. F The most frequent type of incest is father-daughter.

29. F Incest usually happens with adolescent daughters.

30. F Typically, incest is a coercive act.

31. T You should inform all parties of the limits of confidentiality that applies before you begin the interview.

32. T Parents usually have the legal right to read what the juvenile is saying in private counseling.

33. F A client's not-talking about an incident you know happened is always the result of resistance or denial.

34. T A simple non-shaming way of accessing incest information is through the technique of sculptures.

35. T Incest impacts different family members differently.

36. F Inter-generational boundaries are boundaries between individuals of the same generation.

37. F Incest is primarily caused by a character-disordered individual who acts out his anger by having sex with his children.

CLARIFICATION - DECEMBER PRE/POST TEST

13. Indian incest abusers are usually physically abusive to the children they abuse as well as sexually abusive. FALSE. The incest may or may not be accompanied by physical abuse. Some abusers are kind enough to the children generally, but engage in inappropriate sexual behavior out of immaturity, not necessarily in connection with physical abuse.

18. Sexual "abuse" can actually be a positive, "good" exercise for some children. FALSE. Physical feelings may be positive, but the overall experience is always a negative experience.

27. Most wives of incest offenders are collusive in the incest. FALSE. Collusive disregards the process of denial. To be collusive means you know what's going on and choose to participate. But because of denial, most wives don't have a clue of what is going on.

28. The most frequent type of incest is father-daughter. FALSE. The most frequent incidence of incest is brother/sister incest. Father/daughter incest is most frequently reported.

29. Incest usually happens with adolescent daughters. FALSE. Incest typically begins around 9, 10 and 11, but doesn't get reported until the adolescent years.

30. Typically, incest is a coercive act. FALSE. Most people believe that in incest a threat is made or that there is physical coercion. In truth, incest is seductive.

33. A client's not talking about an incident you know happened is always the result of resistance or denial. FALSE. There are many factors other than denial that prevent a client from talking about incest such as dependency, symbiosis, a genuine distortion of the relationship, positive physical feelings, fear and protection of the other parent and other children.

36. Intergenerational boundaries are boundaries between individuals of the same generation. FALSE. Intergenerational boundaries are boundaries between individuals of different generations.

37. Incest is primarily caused by a character-disordered individual who acts out his anger by having sex with his children. FALSE. Incest is primarily pan sexual or affection-based and not anger-based.

APPENDIX # 8D

Treatment of Sexual Abuse & Assault
With Ethnic Populations

January 1984

PRE/POST TEST

Social Security Number: _____ or I.D. Number: _____

PLEASE INDICATE IF THE STATEMENTS BELOW ARE TRUE OR FALSE:

1. __F__ Insight is critical to the change process in behavior therapy.

2. __T__ With behavioral approaches to therapy, one assumes that feelings will change after the behavior pattern has shifted to a more productive pattern.

3. __F__ In behavior therapy, incest perpetration is seen as a problem which develops from fantasy distortions; therefore, changing the perpetrator's fantasies will fix the problem.

4. __F__ When attempting to change behavior, behavior therapists believe it is important to change only the specific unwanted behavior to avoid impacting other behaviors.

5. __T__ Behavior therapists generally believe that it is possible to successfully treat the perpetrator or victim without the whole family.

6. __T__ The basis of dynamic psychotherapy is trust.

7. Dynamic psychotherapy assumes:

   __T__ a) behavior patterns become habit which are most often unrecognized (unconscious) by the victim; and

   __T__ b) clients are helped by learning about their behavior patterns and consequences.

8. __F__ Children are so psychologically fragile that explicit sexual terms should be avoided in treatment.

9. __T__ Play with toys can assist the child in communicating as well as in dealing with their feelings and experiences.

10. __F__ The focus of therapeutic interventions with S/S therapy is the content of the sessions.

11. __T__ Diagnosis in S/S therapy consists of assessing patterns of interaction between people.

12. __F__ A basic assumption of S/S therapy is that insight is the critical factor in change.

13. __F__ Dealing with the extended family in incest cases is interesting, but of little value.

14. F Challenging defenses at the early stages of family treatment is important to let the family know who has the power.

15. F One should never believe the child in the family who looks the most disturbed.

16. F Most perpetrators have sex with their children as a way of expressing their anger at their spouses.

17. F S/S therapy with families is intensive, requiring several sessions per week.

18. F Family therapy is the best way to treat most perpetrators.

19. T The degree of psychopathology among perpetrators is highly variable.

20. F Mothers in father-daughter incest families always know.

21. T There are some critical differences between patterns of mother-son incest and father/daughter.

22. F The process of group development can be summarized by the terms "forming, norming, storming and reforming."

23. T Children who show signs of psychosis or autism are not appropriate for a group.

24. F Aggression toward other children in group is best dealt with by ignoring the aggressive child (non-reinforcement) and then reinforcing them later for more positive behaviors.

25. F A good group therapist for children should place an emphasis on control of the children in the group.

26. T Non-verbal children are appropriate clients for a sexual abuse treatment group.

27. T "Client determinism" is an essential ingredient to establishing a meaningful therapeutic relationship.

28. F Clinicians who are culturally biased and judgemental are as effective in the treatment of minority clients as clinicians who present a value free approach.

29. T Psychotherapy as a clinical approach primarily focuses on the unconscious with emphasis on neurotic and emotional problems.

30. T Facilitating catharsis is a therapeutic technique designed to get at deep-seated emotional feelings caused by one's victimization.

CLARIFICATION - JANUARY PRE/POST TEST

1. Insight is critical to the change process in behavior therapy. FALSE. Insight has very little to do with change. Structural modifications are critical.

10. The focus of therapeutic interventions with S/S therapy is the content of the sessions. FALSE. The focus is on process, not content.

12. A basic assumption of structural-strategic therapy is that insight is the critical factor in change. FALSE. Insight has very little to do with change in structural-strategic therapy. Structural modifications are critical.

14. Challenging defenses at the early stages of family treatment is important to let the family know who has the power. FALSE. The therapist will lose.

18. Family therapy is the best way to treat most perpetrators. FALSE. The type of therapy depends on the "type" of perpetrator and the level of violence.

22. The process of group development can be summarized by the terms "forming, norming, storming and reforming." FALSE. Performing, not reforming.

APPENDIX # 8E

Treatment of Sexual Abuse & Assault
With Ethnic Populations

February 7-10, 1984

PRE/POST TEST

Social Security Number: _____ or I.D. Number: _____

PLEASE INDICATE IF THE STATEMENTS BELOW ARE TRUE OR FALSE:

1. __T__ Sexual abuse is the sexual acting out of non-sexual needs.

2. __T__ Older adolescents who have been sexually abused may reveal the abuse because they wish to gain more freedom from the family for themselves.

3. __F__ There are six phases of sexual abuse.

4. __T__ The family in which there has been sexual abuse is isolated and fearful of outsiders.

5. __F__ It is more important for the counselor to be liked by the adolescent than to be honest and set limits.

6. __F__ "Emotional sexual abuse" (in which no physical sexual abuse occurs) produces the same or similar effects on victims and adolescents with both kinds of experience, can be mixed in one group.

7. __T__ Each member of a group should have a minimum of one hour of individual intake time, and should meet both group therapists (if more than one) before joining the group.

8. __F__ It's not usually possible to work effectively with an adolescent in an incest group unless all members of his/her family are also involved in treatment.

9. __T__ The main reason group is often the treatment of choice for adolescent incest victims is their need for peer support.

10. __F__ The most important reason for a male and a female to work as co-therapists in an adolescent incest group is to provide each other with peer support.

11. __F__ The self-abuse which most incest victims do to themselves is mainly punishment in order to make themselves feel worse.

12. __F__ Incest victims treatment can usually be accomplished in 8-10 weeks.

13 __T__ Adult women victimized as children need to develop a dependency-based relationship with their therapist in order to be successfully treated.

14. __T__ Some incest victims appear outwardly to have been only slightly affected by their sexual abuse.

15. F The primary focus of treatment for adults victimized as children is the CONTENT of what happened to them, i.e. the incest itself.

16. F The therapist must confront the denial of victims whenever possible, in order to facilitate their acceptance of reality.

17. F When Larson talks about constructing a "useful reality", she is talking about finding out what the truth is and making sure the victim believes it..

18. T Incest victims often experience a crisis with regard to their spiritual lives, believing that God, a "father figure" has abandoned them too, or he would have taken care of them.

19. F The degree of trauma for the victim depends on the extensiveness of the behavior.

20. F Since victims had very little parenting when they were children, it is important to take on the job of parenting them as best as you can, trying to fill the void in their lives with your nurturing.

21. T Currently, there are a number of very different treatment theories used for adolescent sex offenders.

22. T According to PHASE, the first goal in treatment is for the adolescent to acknowledge the fact that he has sexually exploited another human being.

23. F A therapist can predict the potential for reoffending in a particular client.

24. F Sex education and attitudes do not usually have to be taught to adolescent sex offenders.

25. T Increasing the offender's empathy for the victim is a critically important treatment goal.

26. F Since alcoholism is a main cause of sexual deviancy, alcoholism treatment is an effective treatment modality for many sexual offenders.

27. T The first stage of treatment for sex offenders are sociopathic personalities.

28. F The overwhelming majority of sexual offenders are sociopathic personalities.

29. T Sexual offenders as a group do not appear to possess stronger sexual drives than most other men.

30. T Most treatment provides favorable involvement of the criminal justice system in order to insure treatment follow-through.

CLARIFICATION - FEBRUARY PRE/POST TEST

3. There are six phases of sexual abuse. FALSE. There are four phases: engagement, sexual interaction, secrecy and disclosure.

6. "Emotional sexual abuse" (in which no physical sexual abuse occurs) produces the same or similar effects on victims, and adolescents with both kinds of experience can be mixed in one group. FALSE. Barbara Weller believes that it is important that all members of the adolescent group have actually experienced sexual abuse. Otherwise, may interfere with victim's identifying herself with other group members. She also believes actual abuse's impact is much more severe.

8. It's not usually possible to work effectively with an adolescent in an incest group unless all members of his/her family are also involved in treatment. FALSE. While working with other members of the family is certainly desirable, adolescents can gain a good deal from the group experience and the modeling of parental behavior on the part of the therapists.

11. The self-abuse which most incest victims do to themselves is mainly self-punishment in order to make themselves feel worse. FALSE. Self-abuse serves a relieving function for intense emotional pain.

13. Adult women victimized as children need to develop a dependency-based relationship with their therapist in order to be successfully treated. TRUE. A dependency-based relationship must be established with the therapist or group to temporarily replace the client's family, although the therapist must <u>not</u> attempt to recapitulate the parent role.

15. The primary focus of treatment for adults victimized as children is the context of what happened to them, i.e., the incest itself. FALSE. The primary focus of treatment is on exploring the <u>impact</u> of the abuse of the victim and <u>changing</u> the victim's behavior.

16. The therapist must confront the denial of victims whenever possible, in order to facilitate their acceptance of reality. FALSE. The therapist should not confront behavior that the client cannot yet change; instead the therapist should help the client construct a "useful reality" that is more healthy, yet may or may not correspond with true reality.

17. When Larson talks about constructing a "useful reality," she is talking about finding out what the truth is and making sure the victim believes it. FALSE. See No. 16, above.

19. The degree of trauma for the victim depends on the extensiveness of the behavior. FALSE. The degree of trauma depends on a number of things, including the length of abuse, the dysfunction in the family system, lack of parenting and nurturing, and the betrayal of trust in the relationship, in addition to the extensiveness of the actual sexual abuse.

23. A therapist can predict the potential for reoffending in a particular client.
FALSE. Therapists can determine the treatability of a general type of client, but not for an individual. Therapists can make statements about the probability of successful treatment based on their experience with a group of clients, but this does not guarantee that it applies to a particular individual.

28. The overwhelming majority of sexual offenders are sociopathic personalities.
FALSE. The number of sociopathic personalities make up a small minority of sex offenders.

APPENDIX # 8F

Treatment of Sexual Abuse & Assault
With Ethnic Populations

March 6-8, 1984

PRE/POST TEST

Social Security Number: _____ or I.D. Number: _____

PLEASE INDICATE IF THE STATEMENTS BELOW ARE TRUE OR FALSE:

1. __F__ According to Minnesota Law, adult men cannot be victims of sexual assault.
2. __T__ In over half of all sexual assaults, the victim and the perpetrator are acquainted.
3. __F__ Many victims provoke attacks by wearing sexy clothes.
4. __F__ The majority of rapes happen when women are out alone at night.
5. __F__ Most rapists are sexually deprived and they rape because they cannot get sex any other way.
6. __T__ In Minnesota last year, over 70% of all rapes occurred between people who had met before.
7. __T__ The majority of rape victims are between 15 and 19 years of age.
8. __T__ Rape is an expression of hostility, aggression, and dominance, and insensitivity.
9. __F__ When women are friendly, cheerfully, and helpful to men, this is a come on.
10. __F__ If a girl leads a guy on, she is asking to be raped.
11. __F__ If a girl has a "bad" reputation, she can be expected to be raped.
12. __F__ If a couple is going steady, the girl can't really be raped.
13. __T__ Sex role stereotyping may lead to acquaintance rape.
14. __F__ It's easier for the victim to report an acquaintance rape, since she's usually more angry.
15. __F__ All male victims of sexual assault are homosexual.
16. __F__ Counseling must focus primarily on helping the male victim understand how they contributed to their attack.
17. __T__ Assailants of male victims often attack in groups.
18. __F__ The majority of male sexual assaults are reported to authorities.

19. T Attackers of male victims are often confused and ambivalent about their own sexual orientation.

20. F Rape by husband and ex-husbands is the least prevalent form of sexual assault.

21. F Marital rape usually occurs in the context of wife battering.

22. F A majority of states in the U.S. have outlawed the marital rape exemption.

23. T The clinical, long-term effects of marital rape appear to be more severe than in rape by a stranger.

24. T Clinical intervention in a marital rape case will be influenced to a great extent by a person's cultural background.

25. F The cost of the medical evidentiary exam is done by the victim.

26. T Technically, corroboration is not needed to charge someone with criminal sexual conduct.

27. F Unfortunately, the judge can still instruct the jury as follows: The complainant's (victim's) testimony should be scrutinized more closely than that of any other witness in any other felony.

28. F One of the functions of the County Attorney is to represent the victim.

29. T In general, evidence of the victim's prior sexual conduct can no longer be admitted as evidence in a rape trial.

30. F Most people respond to crises in very similar ways.

31. T A determining factor in a person's response to sexual assault is past life experiences, including other crises, i.e. death, break up of relationships, loss, etc.

32. F The major goal of crisis intervention is to calm a person down.

33. T From the victim's perspective, sexual assault is often a life-threatening experience.

34. F All rape and sexual assault victims need professional help at some point, even if it happens years later.

35. F You can usually predict how a person will react to rape.

36. T Rape trauma syndrome includes physical, emotional and behavioral stress reactions as a result of rape.

37. F Rape trauma syndrome has two states: the immediate, or acute phase, and the temporary, or short-term phase.

38. F If an adult rape victim is afraid to report the crime, you should do it for her.

CLARIFICATION - MARCH PRE/POST TEST

7. The majority of rape victims are between 15 and 19 years of age. TRUE. The largest number of rape victims reporting to police are between 15 and 19 years of age. However, all age groups are vulnerable to rape.

21. Marital rape usually occurs in the context of wife battering. FALSE. Marital rape may or may not be accompanied by physical battering.

28. One of the functions of the County Attorney is to represent the victim. FALSE. The County Attorney represents the interest of the State.

32. The major goal of crisis intervention is to calm a person down. FALSE. The major goal is to help the person cope with the crisis. This includes such activities as acknowledging feelings, identifying resources and clarifying the problems.

37. Rape trauma syndrome has two states: the immediate, or acute phase, and the temporary, or short-term phase. FALSE. The two stages of the rape trauma syndrome are the acute or disorganization phase, and the long-term or reorganization phase.

APPENDIX # 8G

Treatment of Sexual Abuse & Assault
With Ethnic Populations

April 3-5, 1984

PRE/POST TEST

Social Security Number: _____ or I.D. Number: _____

PLEASE INDICATE IF THE STATEMENTS BELOW ARE TRUE OR FALSE:

1. __F__ Rape victims coming for therapy have the assault as their presenting issue.
2. __F__ Rape victims frequently need long-term therapy.
3. __T__ Most rape victims in therapy need to reassess the issue of power in their lives.
4. __F__ Recovery from sexual assault can be accomplished in a relatively short time.
5. __T__ Secondary victims respond to a sexual assault in ways similar to primary victims.
6. __T__ The primary focus of victim support groups is sexual assault.
7. __F__ Facilitators become group members.
8. __T__ Trust and safety must be established for group process to being.
9. __F__ It is not a good idea to allow group members to communicate with each other outside of group.
10. __F__ It is never appropriate for group members to have individual sessions with one facilitator.
11. __F__ G.A.S. is known as General Alarm System.
12. __F__ Stress is always harmful.
13 __T__ Deep breathing is a beginning technique for managing stress.
14. __T__ When under stress, the cardiovascular system speeds up.
15. __T__ When under stress, an appropriate managing tool is to surrender.
16. __F__ Periods of major decision-making produce unhealthy stresses.
17. __F__ When under stress, the Digestive System speeds up.
18. __F__ Intangible losses are easier to grieve, because less is lost.

19. __F__ Cultural values are less important in change in races other than Caucasian.

20. __T__ A sense of relief is frequently a part of grieving.

21. __F__ Our culture offers many supports for difference and individualism.

22. __F__ The normal grief period for non-death is about one to two weeks.

23. __F__ Traumatic shock is a psycho-physiological reaction that only certain personality types are susceptible to.

24. __T__ All traumatic events and conflicts end up in the body as tension patterns.

25. __T__ One of the ways people stop feeling things is by holding their breath.

26. __T__ Shock events and their reactions can spread to other family members even though they were not present.

27. __T__ Emotions are movements that occur in various parts of the body.

28. __F__ Process therapy does not use the beliefs from any other therapy.

29. __F__ Process therapy isolates and works only with a person's emotions.

30. __F__ Process therapy uses a medical model for therapy.

31. __F__ Since process therapy is a feminist approach to therapy, it cannot be helpful to men.

32. __T__ The approach of process to a victim's guilt and shame is one of supporting the guilt and shame.

33. __F__ Process therapy "pushes" a White cultural view of how people should act and think.

CLARIFICATION - APRIL PRE/POST TEST

2. Rape victims frequently need long-term therapy. FALSE. Most sexual assault victims utilize their own support systems and resources to facilitate their recovery. For some, short-term crisis intervention and advocacy in addition to their support system is very helpful. Few rape victims need long-term therapy as a direct result of the assault.

4. Recovery from sexual assault can be accomplished in a relatively short time. FALSE. For most victims, sexual assault is a major life crisis comparable in its impact to the death of a close relative or friend. Full recovery often takes years.

6. The primary focus of victim support groups is sexual assault. TRUE. Unlike therapy groups for adult incest victims, the sexual assault group stays focused on the assault and its impact on the victim. One of the reasons for this is that the group is very short term, usually 8-10 weeks in duration.

7. Facilitators become group members. FALSE. The support group facilitator should help keep the attention of the group focused on the members of the group rather than becoming a member her/himself.

15. When under stress, an appropriate managing tool is to surrender. TRUE. Acknowledging the situation and yielding up one's trying to control it can reduce the stress.

17. When under stress, the digestive system speeds up. FALSE. Although the cardiovascular system speeds up under stress, the digestive system slows down.

APPENDIX # 9

Treatment of Sexual Abuse & Assault
With Ethnic Populations

May, 1984 Session

FINAL POST-TEST

NAME: _____

SOCIAL SECURITY NUMBER: _____ or I.D. NUMBER: _____

PART A: PLEASE INDICATE IF THE STATEMENTS BELOW ARE TRUE OR FALSE.

__T__ 1. A medical examination can provide corroborative evidence for a sexual assault case. (October Pre/Post Test Question #3)

__T__ 2. Forced sexual contact between marriage partners is a crime in Minnesota. (October Question #1)

__X__ 3. A non-abusing parent who knowingly permits sexual abuse to continue cannot unfortunately, be charged with a crime. (October Question #16) (Typo in question invalidated usage)

__T__ 4. The cost of a medical examination for the purpose of gathering evidence in a sexual assault case must be paid for by the county in which the offense occurred. (October Question #24)

__F__ 5. Helping professionals must have proof that sexual abuse of a child has occurred before they report the case. (October Question #2)

__F__ 6. In intrafamilial sexual abuse, the perpetrator must be a blood relative. (October Question #4)

__T__ 7. Most child victims of sexual abuse are familiar to their offenders. (November Question #4)

__F__ 8. In most cases, there is no need to be concerned about sexual contact between a child and adolescent, as this is just normal curiosity on the part of the adolescent. (November Question #9)

__T__ 9. Children who have been sexually abused often act out what they need to talk about or be asked about. (November Question #28)

__T__ 10. Keeping to the same place, day and time each week, are very important elements of providing the "safe structure" needed for effective play therapy. (November Question #22)

__T__ 11. For the very young child, the two most important things to teach are: "It's not your fault," and "You won't be hurt." (November Question #30)

__F__ 12. It is too difficult to even try to use direct talking with the preschooler (age 2 to 4). (November Question #27)

__T__ 13. The parents of the victim should be questioned together. (December Question #19)

T 14. Oldest daughters who take the "little mother" role in the family may be at risk for sexual abuse. (December Question #24)

T 15. The leading indicator of sexual abuse in children is inappropriate sexual behavior. (December Question #25)

F 16. Most wives of incest offenders are collusive in the incest. (December Question #27)

F 17. Insight is critical to the change process in behavior therapy. (January Question #1)

T 18. Behavior therapists generally believe that it is possible to successfully treat the perpetrator or victim without the whole family. (January Question #5)

T 19. Dynamic psychotherapy assumes that clients are helped by learning about their behavior patterns and consequences. (January Question #7b)

T 20. Diagnosis in structured-strategic therapy consists of assessing patterns of interaction between people. (January Question #11)

F 21. Structural-strategic therapy with families is intensive, requiring several sessions per week. (January Question #17)

T 22. There are some critical differences between patterns of mother-son incest and father-daughter. (January Question #21)

T 23. The degree of psychopathology among perpetrators is very similar. (January Question #19)

T 24. Facilitating catharsis is a therapeutic technique designed to get at deep-seated emotional feelings caused by one's victimization. (January Question #30)

T 25. Sexual abuse is the sexual acting out of non-sexual needs. (February Question #1)

T 26. A simple, non-showing way of assessing information is through the technique of family sculptures. (December Question #34)

T 27. Non-verbal children are appropriate candidates for a sexual abuse treatment group. (January Question #26)

T 28. The main reason group is often the treatment choice for adolescent incest victims is their need for peer support. (February Question #9)

F 29. The self-abuse which most incest victims do to themselves is primarily self-punishment in order to make themselves feel worse. (February Question #11)

F 30. Intergenerational boundaries are boundaries between individuals of the same generation. (December Question #36)

T 31. Appropriate treatment approaches to an incest family depends on the function incest serves in the family. (December Question #39)

T 32. Play with toys can assist the child in communicating as well as in dealing with their feelings and experiences. (January Question #9)

F 33. Challenging defenses at the early stages of family treatment is important to let the family know who has the power. (January Question #14)

T 34. Adult women victimized as children need to develop a dependency-based relationship with their therapist in order to be successfully treated. (February Question #13)

T 35. Currently, there are a number of very different treatment theories used for adolescent sex offenders. (February Question #2)

F 36. A therapist can accurately predict the potential for reoffending in a particular client. (February Question #23)

T 37. The first stage of treatment for sexual offenders involves breaking through denial mechanisms. (February Question #27)

F 38. Alcoholism treatment is an effective treatment for many sexual offenders. (February Question #26)

T 39. Most treatment providers working with sexual offenders favor involvement of the criminal justice system in order to insure treatment follow-through. (February Question #30)

T 40. Sex role stereotyping may lead to acquaintance rape. (March Question #13)

F 41. Both offenders and victims of same-sex assault are usually homosexual. (March Question #15)

T 42. The clinical, long-term effects of marital rape appear to be more severe than in rape by a stranger. (March Question #23)

T 43. For the victim, sexual assault is often a life-threatening experience. (April Question #33)

F 44. Most rape victims completely recover in a relatively short time. (April Question #4)

T 45. Rape trauma syndrome includes physical, emotional and behavior stress reactions as a result of rape. (March Question #36)

F 46. One of the functions of the county attorney is to represent the victim. (March Question #28)

T 47. Deep breathing is one good technique for managing stress. (April Question #13)

__T__ 48. According to bioenergetic theory, all traumatic events and conflicts end up in the body as tension patterns. (April Question #24)

__F__ 49. The normal grief period for non-death losses is about one to two weeks. (April Question #22)

__T__ 50. One of the ways people stop feeling things is by limiting their breathing. (April Question #25)

__F__ 51. Process therapy uses a medical model for therapy. (April Question #30)

__F__ 52. Process therapy isolates and works only with a person's emotions. (April Question #29)

PART B: PLEASE ANSWER EACH QUESTION BRIEFLY.

1. For each of the following topic areas, describe: (a) at least one important thing you have learned; and (b) how it applies to working with clients who are ethnic minorities.

   A. Attitudes Towards Sexuality (S.A.R.)

   B. System's Response to Sexual Abuse (medical, legal, social services delivery systems)

   C. Laws Relating to Sexual Assault

   D. Non-Family Child Sexual Abuse

   E. Treatment and Interviewing Techniques for Child Victims

   F. General Information on Incest

   G. Incest Victims' Responses

   H. Dynamics of Incest Families

   I. Interviewing Incest Victims

   J. Approaches to Incest Treatment

   K. Approaches to Treatment of Families

   L. Approaches to Treatment of Sexually Abused Children

   M. Approaches to Treatment of Sexual Abused Adolescents

   N. Adults Victimized as Children

   O. General Information Regarding Perpetrators

P. Approaches to Treatment of Perpetrators

Q. General Information Regarding Rape and Sexual Assault

R. Responses of Rape Victims

S. Intervention with Adult Sexual Assault Victims

T. Treatment Techniques for Adult Sexual Assault Victims

U. Support Groups for: 1) Child Victims; 2) Adolescent Victims; 3) Adults Victimized as Children; and 4) Adult Rape Victims

V. Strategies for Prevention

W. Stress Management

2. Choose two (2) of the following therapy models. What are the models' advantages and limitations? What populations are they appropriate for?

A. Behavior Therapy
B. Psychoanalytic Therapy
C. Structural/Strategic Therapy
D. Direct Talk Therapy
E. Play Therapy
F. Bioenergetic Therapy
G. Grief Counseling
H. Process Therapy

3. Drawing on your own experiences and the content of the course, discuss at least two changes in the legal, medical, and/or social services delivery systems that you think need to be made to increase their response to ethnic minority victims. How would you go about making these changes?

APPENDIX # 10

Treatment of Sexual Abuse & Assault
With Ethnic Populations
October 4-6, 1983 Session

(SAMPLE) MONTHLY EVALUATION

MONTH: _____ SMALL GROUP NUMBER: _____

GENDER: 1) Male
2) Female

AGE: 1) 1 -17
2) 18-24
3) 25-34
4) 35-44
5) 45-54
6) 55-64
7) 65 and over

1. Please indicate the effect the following elements of this month's program had on you:

	Very Positive	Positive	Neutral	Negative	Very Negative
A. Large group presentations	5	4	3	2	1
B. Slide show	5	4	3	2	1
C. Small group discussion	5	4	3	2	1
D. Large group feedback	5	4	3	2	1

2. Please rate each program segment:

	Presentation was Relevant (Excellent ... Poor)					Speaker was Prepared, Effective and Organized (Excellent ... Poor)				
A. Overview of Child Sexual Abuse Outside the Family	5	4	3	2	1	5	4	3	2	1
B. Feelings and Responses of the Victim & their Family	5	4	3	2	1	5	4	3	2	1
C. Intervention	5	4	3	2	1	5	4	3	2	1
D. Interviewing Techniques	5	4	3	2	1	5	4	3	2	1
E. Treatment Models										
1. Direct Talk Therapy	5	4	3	2	1	5	4	3	2	1
2. Play Therapy	5	4	3	2	1	5	4	3	2	1
3. Family Therapy	5	4	3	2	1	5	4	3	2	1

3. What new information/attitudes/feelings did you experience?

4. Please comment on the following:

   The large group presentations:

   The guest speakers:

   Your small group experience:

   The large group feedback:

   Your small group facilitator:

   Logistics (environment, food):

   Format:

APPENDIX # 11A

Treatment of Sexual Abuse & Assault
With Ethnic Populations
October, 1983 Session

SUMMARY OCTOBER MONTHLY EVALUATION

I. A. Large group presentations, 4.06; B. Slide show, 3.93; C. Small group discussion, 4.25; D. Large group feedback, 4.22.

II. A. An Introductory Analysis: 1. A Lakota Perspective, presentation 4.61/ speaker 4.60; 2. An Ojibwa Perspective, 4.03/3.90; 3. A Hispanic Perspective, 3.87/3.93; 4. A Black Perspective, 4.58/4.73. B. Sexual Assault and the Legal System, 4.12/4.40; C. System's Reponse to Sexual Abuse, 4.48/4.46.

III. New Information (partial comments given): After listening to all this I can take some of this back to work with me; Getting to expand my resources and good feeling of being able to resolve differences, racism discussed; We, people of color are experiencing same frustrations towards systematic politics, also have different approaches; Working toward the same goals; Felt hurt, scared, attacked by my peers for pulling covers on our own attitudes towards each other; people do not understand tribal systems and roles; Wonderful experience to be in all people of color workshop to express yourself and to feel that is acceptable because of similarities of experience and respect.

IV. 1. Large group presentation (partial comments): Very informative, good, excellent and other positive adjectives used numerous times to describe reaction; Ethnic information didn't consistently help ro relate to understanding sexual assault; Good agenda changed to deal with topics of intense interest; Very upset about own personal feelings on ethnic group.
2. Guest speakers: All gave good, useful information; Group has better informed professionals that chould have addressed the issues more--more historians than hands on; Not people of color; Did not have opportunity to ask questions; Helps sort out my myths.
3. Small group exercises: Very good, helpful, excellent, excellent all used numerous times; Better able to hash out with more specific discussion; Shared soem own personal experiences, seemed to be a "group bonding" occurring; At times monopolized; Facilitator must pull data, facts together.
4. Large group feedback: Good, excellent, helpful, spontaneous, boring, tedious were all used to describe this area; Sometimes stuck on trivial issues; A slower process for me; Dynamics on target; Some people never get a change to grow in their leadership skills.
5. Small group facilitator: Ability to keep the issues on track; Not helpful enough; Attentive, excellent summary perspective; Difficult group to control; Good comfort level.
6. Logistics: Poor; Was the center ready for 35 people of color; Very uncomfortable, rude comments directed towards the participants.
7. Format: Excellent, good, etc.; Did well with amount of information presented; Mixed feelings; Format in written form might have been useful; Get to the point.

APPENDIX # 11B

Treatment of Sexual Abuse & Assault
With Ethnic Populations
November, 1983 Session

SUMMARY NOVEMBER MONTHLY EVALUATION

I. A. Large group presentation, 3.9; B. Small group discussion, 3.4; C. Large group feedback, 3.8; D. Skill Development, 3.9.

II. Program: A. Overview of Child Sexual Abuse Outside the Family, presentation 4.2 / speaker 4.2; B. Feelings & Responses of Victim & Family, 2.9/2.8; C. Intervention, 3.4/3.2; D. Interviewing Techniques, 4.5/4.4; E. Treatment Models: 1. Direct Talk Therapy, 4.1/4.1; 2. Play Therapy, 4.6/4.6; 3. Family Therapy, 2.7/2.9.

III. New Information (partial comments given): Redundant; Enjoyed role playing, felt part of process; Hard for me, but as I work mostly with Hispanic men I really don't know, but my feelings and personal experiences are mixed, been personally to a counselor; Don't think I could work with children; Frustration in attempting to utilize small group, poorly organized, controlling, directive facilitator.

IV. 1. Large group presentation (partial comments): Repetitious; Very good, well done; Concrete information; Need to be more focus on ethnic groups, information needs to be more pertinent to adapt into our own work setting and clients; Too many lectures, too long without breaks or changes of pace; People more honest, share information, feelings.
2. Guest speakers: Some friendly, some you just block out; Well informed generally on topic, but not specific to ethnic populations; Where are people of color speakers?; Hypothesis with group participants relate to personal dynamics, feel like this is a boundary violation.
3. Small group: Coming together, listening to each other, however, values and stereotypes emerging; Too structured; Poor facilitator; Need to clarify questions which are presented to group; Do not like being asked generalized questions, would rather spend time formalizing what questions, as specific ethnic people we need to ask not answer someone else's questions.
4. Large group feedback: Too long; Very helpful; Relevant; Learning experience.
5. Facilitator: Handles group well, sympathetic to needs of group; Encouraging role, but not responsible for content of agenda; Keeps us on tasks.
6. Logistics: Very friendly people; Better place, food and atmosphere than last month.
7. Format: Excellent; Need more breaks; Overload of information, time to digest is needed; Would like opportunity to review questions to deliberate rather than spontaneously; Would like to develop own questions.

APPENDIX # 11C

Treatment of Sexual Abuse & Assault
With Ethnic Populations
December, 1983 Session

SUMMARY DECEMBER MONTHLY EVALUATION

I. A. Large group presentation, 4.2; B. Small group discussion, 3.9; C. Large group feedback, 3.8; D. Skill Development, 4.1.

II. Program: A. Overview of Family Sexual Abuse, presentation 3.5 / speaker 3.4; B. Identification, 4.4/4.4; C. Characteristics, 3.5/3.9; D. Identification & Characteristics: 1. American Indian, 2.2/2.3; 2. Black, 2.5/2.7; 3. Hispanic, 4.6/4.6; E. Interviewing Child, 4.6/4.6; F. Interviewing Adolescent, 4.7/4.7; G. Interviewing Techniques, 4.5/4.6.

III. New Information (partial comments given): Techniques on therapy and interviewing; Different views on religious beliefs; Treatment models good; Excellent workable skills in dealing with families and clients; Police attitudes important; Increase honor over the experiences of the incest victims and their family members; I come here every month I wonder what I'm doing here, but this session was the best.

IV. 1. Large group presentations (partial comments): Very relevant information this session; Some were good, others weren't; When having several speakers, please schedule breaks as last speaker catches group's restlessness; Perhaps ask participants for speakers related to ethnic perspective; Not culturally relevant.
2. Guest speakers: Very good; Some good, some very poor; Disappointed with lack of information on Tuesday; Still too many white folks with little or no information on ethnic communities of color.
3. Small group: Need more time; Can't get comfortable in small group; Need to restructure; Extremely wasteful; Too controlling, repetitious; Difficult, started to withdraw and not want to be part because of process; Fine, good processing; Very good as usual; Bonding and growing well; Dislike role playing, let's do interviewing.
4. Large group feedback: Hate is ever present; Good, but gets carried away sometimes; Same people always monopolize questions; Boring.
5. Small group facilitator: Good, but needs to calm us down once in awhile; Not friendly enough; Keeps good group discussion; Poor, rigid, insensitive; Reserved, appears to be on different level; Respects us and our thoughts and feelings; Kept control as good as anyone could.
6. Film: Need to advocate more sensitivity of systems/workers; Excellent portrayal of all those incompetent service providers; Use as a tool, but wasn't very good; Great; Got angry at times.
7. Logistics: Good, rooms crowded; Convenient, excellent; Fair.
8. Format: Don't like role playing, too general and unrealistic; Discuss the scenarios from a cultural perspective and then discuss interview techniques for each; Not comfortable with format; Mixed feelings; Small group format, troublesome exercises and skill building should be in the morning.

APPENDIX # 11D

Treatment of Sexual Abuse & Assault
With Ethnic Populations
January, 1984 Session

SUMMARY JANUARY MONTHLY EVALUATION

I. A. Large group presentation, 4.2; B. Small group presentation, 4.5; C. Large group feedback, 4.0; D. Skill Development, 4.3.

II. Program: A. Cognitive/Behavioral Treatment, presentation 2.9 / speaker 3.9; B. Psychodynamic Treatment, 4.7/4.3; C. Structural/Strategic Treatment, 3.5/4.3; D. Family Treatment Approach, 4.3/4.1; E. Art Play Therapy, 4.3/4.1; F. Individual Counseling, 4.2/4.5; G. Group Therapy, 4.8/4.6.

III. New Information (partial comments given): Very stimulated with the process and wealth of information presented; Confidence; Gained new resources for working with incestuous families; Found I used a lot of techniques presented without knowing names; Really basic, however, genuine concern and common sense portrayed; Self awareness of attitudes.

IV. 1. Large group presentation (partial comments): Great, best Black presentation we have had so far; Lots of good information; Much of the material is becoming repetitive, but informative, helpful; Information is too compressed.

2. Guest Speakers: Excellent; Structural-strategic techniques were not clearly examplified; Felt they were knowledgeable and professional.

3. Small group: Real good; Like practical practice rather than answering questions; High energy; Pretty positive; Would get more out of the group if the leader would take charge more and not let certain people dominate; Really enjoyed the playroles and skill development.

4. Large group feedback: Excellent; Good; Very positive; Takes a long time; Average.

5. Small group facilitator: Getting better; Excellent; Good; Had control of group and was able to re-direct group back to topic of discussion; Needs to be more assertive and take charge of group more effectively; Questions are confusing and unclear, as well as the group process.

6. Case demonstrations: Very good; Group role plays were interesting; Wonderful.

7. Logistics: Good; Room very cold; Video hook-up distracting; Food dull.

8. Format: So much information in such a short time; More time for processing large group presentations needed; Need more people of color speakers; All very excellent.

APPENDIX # 11E

Treatment of Sexual Abuse & Assault
With Ethnic Populations
February, 1984 Session

SUMMARY FEBRUARY MONTHLY EVALUATION

I. Overall, 4.2.

II. A. Large group presentation, 4.2; B. Small group presentation, 3.8; C. Large group feedback, 4.2; D. Skill development, 4.6.

III. Program: A. Individual Counseling with Adolescent Victims, presentation 4.2/ speaker 4.3; B. Group Therapy for Adolescent Incest Victims, 4.4/4.3; C. Adults Victimized as Children, 4.3/4.4; D. Juvenile Sex Offender, 3.5/ 3.2; E. Adult Sex Offender, 4.7/4.7.

IV. New Information (partial comments given): Excellent; Getting tired, but worthwhile; Too long, repetitious, boredom; Group process for adult women victims educational; Need for ongoing experiences, communications, permanent; Develop issues in own communities.

V. 1. Large group presentation (partial comments): Confusing, not enough time for discussion; Lack of look at minorities; Most useful part of program; Phase presentation extremely dry.

2. Large group feedback: Get more from feedback; Enjoy roleplays; Need lectures to take time to show "how to do it".

3. Small group facilitator: Helpful, caring; Good listener; Flexible, makes appropriate adjustments; Don't like attitude; Good handouts.

4. Logistics: Prices high; Food boring, tasteless, expensive; Possibility of group coffee?; Small room too noisy; Not enough time for breaks.

5. Guest speakers: Too general.

6. Small group: Helpful, sharing; Feel free and secure in my small group; Educational; Closer; Don't like group experience; Needs to be a process tool after each lecture, instead of new material; Tired of questions, group should decide what's important.

7. Format: Handouts on types of experiences; Treatment could have begun earlier; Too much "overview" material; More demonstrations; Do exercises in large feedback group; More time for questions and discussion; Need to do something about smoker vs. non-smoker.

APPENDIX # 11F

Treatment of Sexual Abuse & Assault
With Ethnic Populations
March, 1984 Session

SUMMARY MARCH MONTHLY EVALUATION

I. Overall, 3.0.

II. A. Large group presentation, 3.7; B. Small group presentation, 4.0; C. Large group feedback, 4.2; D. Skill development, 3.6.

III. Program: A. Adult Sexual Assault, presentation 3.7 / speaker 3.4; B. Acquaintance Rape, 3.5/3.4; C. Male Victimization, 2.6/2.6; D. Marital Rape, 3.7/3.7; E. Needs and Responses, 3.6/3.3; F. Crisis Intervention, 2.6/2.7.

IV. New Information: Frustration; No new information, feeling disgusted; Continue more cultural presentations; Enjoyed visual part of acquaintance rape.

V. 1. Large group presentation: Very good; Poor; Very educational and beneficial; Ambivalent.

2. Guest speakers: Ambivalent; Poor; Redundant; Good to me.

3. Small group: Excellent; Growth experiences; Productive; Good once session broke into ethnic groups.

4. Large group feedback: Excellent; Needed time to find out what we were seeking from training session; Found unison; Productive.

5. Facilitator: Excellent; Good.

6. Format: Glad that air was cleared; Better, full of activities; Finally emerging.

APPENDIX # 11G

Treatment of Sexual Abuse & Assault
With Ethnic Populations
April, 1984 Session

SUMMARY APRIL MONTHLY EVALUATION

I. Overall, 3.9.

II. A. Large group presentation, 3.85; B. Small group discussion, 3.85; C. Large group feedback, 4.0; D. Mini-workshops, 4.64.

III. Program: A. Individual Counseling, presentation 2.5 / speaker 4.9; B. Counseling Secondary Victims, 3.0/3.28; C. Support Groups, 2.25/2.65; D. Taking Care of Ourselves, 4.4/4.5; E. Grief Counseling, 4.65/4.72; F. Bioenergetic Therapy, 4.0/4.15; G. Process Therapy, 4.15/4.29; H. Application of Therapy Panel, 4.23/4.16.

IV. Mini Workshops: A. Using Humor and Metaphor in Therapy, 4.77/4.88; B. Juvenile Prostitution, 4.75/4.75; C. Working with Shame Based Families, 2.8/3.4; D. Stress Management, 5.0/5.0; E. Sex Counseling for Incest Parents, 4.6/4.66; F. Pornography and Sexual Violence, 4.85/4.85; G. Learning about Family or Origin, 3.3/3.0; H. Techniques to Get Kids to Talk, 3.0/3.0.

V. New Information: One of the best sessions; Too tired to think, need time to assimulate; Speakers should be allowed to present, participants forget they came for training; Different perspective on metaphor and humor; Information on pornography excellent, need for education; Should have stressed pornography resource center; Stress session usefui.

VI. 1. Large group presenations: Some good, some terrible; All right; Like the dialogue, no criticism and put down; Always interruptions.

2. Speakers: Excellent and informative; Came with guards up, defensive; Taught be how to take care while in a session; Rich workable understanding on loss of control, shame based session okay, but no understanding of cultural issues in relationships.

3. Small group: Excellent; Not so good.

4. Logistics: Food boring; Good.

5. Format: Pacing poor; Repetitive; Mini series excellent.

6. Large group feedback: Relevant.

7. Small group facilitator: Encouraged interaction.

APPENDIX # 11H

Treatment of Sexual Abuse & Assault
With Ethnic Populations
May, 1984 Session

SUMMARY MAY MONTHLY EVALUATION

I. Overall, 4.15.

II. A. Large group presentation, 4.55; B. Small group work, 4.41; C. Large group feedback, 4.58; D. Movie: Touch, 4.30; E. Movie: Dreamspeaker, 4.72; F. Illusion Theater: No Easy Answers, 4.72.

III. Program: A. Prevention Issues, presentation 4.36/speaker 4.52; B. Adaptations of Touch, 3.68/3.76; C. Social Issues & Implementing Education, 4.33/4.43; D. Education in Ethnic Communities, 4.44/4.37; E. Community Treatment Models, 4.05/4.11.

IV. New Information (partial comments given): Reinforced self outlook; willingness of some people to support our efforts; Unity; Prevention; Development of Council; Determination to act on getting something done in community, treatment models; Hope for a change in the system.

V. 1. Large group presentation (partial comments): Very good; Cohesive; Exhilarating to see us united; Very positive; Press conference was excellent idea.
2. Guest speakers: First one to say she would help with funding; Good to great; appreciated dialogue speaker facilitated.
3. Small group: Productive; Positive; Great as always.
4. Large group feedback: Good; Very positive; Really got it together for press conference; Very productive.
5. Small group facilitators: Good; Great; Okay; Very positive.
6. Logistics: Good; Great; Adequate; As always.
7. Format: A lot more freedom which was nice as well as productive; Excellent 9 months, glad I was involved in training; It's over!

APPENDIX # 12

Treatment of Sexual Abuse & Assault
With Ethnic Populations

FINAL COURSE EVALUATION

NAME (optional): _____ SMALL GROUP NUMBER: _____

GENDER: 1) Male
2) Female

AGE: 1) 1-17
2) 18-24
3) 25-34
4) 35-44
5) 45-54
6) 55-64
7) 65 and over

PART A: PLEASE ANSWER EACH QUESTION IN TERMS OF EVALUATING YOUR OWN GOALS AND EXPERIENCE IN THE COURSE.

1. Please list your original goals for attending the training? What did you hope to get out of the experience?

2. To what extent were you able to meet each of these goals? Please explain.

3. List the information/learning experiences that were <u>most</u> helpful to you in the course.

4. List the information/learning experiences that were <u>least</u> helpful to you.

5. What do you see as the benefits to your having attended this training?

6. What are any negative consequences to you for having attended this training?

7. What aspects of this training experience will you apply to your professional and/or personal life? Specify how.

PART B: PLEASE RATE OVERALL, EACH PART OF THE TRAINING PROGRAM LISTED BELOW USING THIS SCALE:

5	4	3	2	1
Very Positive	Positive	Neutral	Negative	Very Negative

Then comment on each: If you were planning another training program, what would you do differently? Similarly?

1. The topics addressed:	5	4	3	2	1
2. The guest speakers:	5	4	3	2	1
3. The skill development sessions:	5	4	3	2	1
4. Your small group experience:	5	4	3	2	1
5. The large group feedback:	5	4	3	2	1
6. Your small group facilitator:	5	4	3	2	1
7. Logistics (environment, food):	5	4	3	2	1
8. Mini workshops:	5	4	3	2	1
9. S.A.R. (Sexual Attitude Reassessment):	5	4	3	2	1
10. Overall format:	5	4	3	2	1

PART C: PLEASE FEEL FREE TO COMMENT ON ANY ASPECT OF THE PROGRAM OR YOUR PARTICIPATION IN THE TRAINING.

APPENDIX # 13

Treatment of Sexual Abuse & Assault
With Ethnic Populations

PARTICIPANT ASSESSMENT BY GROUP LEADER

PARTICIPANT NAME: _____

GROUP LEADER NAME: _____

A. Please rank your assessment of the participant's overall knowledge or skill and/or increase in knowledge or sill in each area specified using this scale:

5 4 3 2 1
High Medium Low

Then comment: What behaviors did you observe that led to your conclusion? Special strengths or limitations that you observed?

	Initial Entry					Increase in Knowledge or Skill				
1. Knowledge of child sexual abuse issues:	5	4	3	2	1	5	4	3	2	1
2. Knowledge of adult sexual assault issues:	5	4	3	2	1	5	4	3	2	1
3. Sensitivity to victims (e.g., non-blaming, understanding their responses):	5	4	3	2	1	5	4	3	2	1
4. Skill in providing services to victims and their families.										
a) intervention and interviewing skills:	5	4	3	2	1	5	4	3	2	1
b) knowledge of treatment approaches:	5	4	3	2	1	5	4	3	2	1
5. Understanding one's own strengths & weaknesses in the sexual assault field:	5	4	3	2	1	5	4	3	2	1

	Initial Entry					Increase in Knowledge or Skill				
6. Application of material to participant's clientele & community:	5	4	3	2	1	5	4	3	2	1

B. PLEASE COMMENT ON THE FOLLOWING:

1. Strengths and weaknesses relevant to providing services in the sexual assault field:

2. Benefits to the participant for having attended the training:

3. Any negative consequences to the participant for having attended the training:

4. Contribution to the small group:

5. Other:

APPENDIX # 14

Treatment of Sexual Abuse & Assault
With Ethnic Populations

COMMUNITY RESOURCE DEVELOPMENT

Please use this form to indicate your areas of interest and concern, as well as what services you or your agency are willing to provide.

YOUR NAME: _____

ADDRESS: _____

_____

HOME TELEPHONE: (____) _____

AGENCY WHERE YOU WORK: _____

ADDRESS: _____

_____

WORK TELEPHONE: (____) _____

CLIENTELE OF AGENCY: _____

AGE RANGE OF CLIENTELE: _____

SERVICES PROVIDED BY
AGENCY: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

In which of the following areas would you be willing to accept referrals and/or actively work to address the problem of sexual assault?

_____ A. Direct services to victims (such as crisis intervention, interviewing, assessment, individual counseling, groups)

1. (Specify type of service): _____

_____

2. (Specify type of client--victim, family member, male, female, child, adolescent, adult):

_____

_____ B. Training (specify topics you would be willing to address):

_____

_____

_____

_____ C. Public education (specify topics and type of group you'd prefer to address):

_____

_____

_____

_____ D. Building a system intervention and treatment model, and networking with other community agencies (if possible, specify areas of interest such as funding, model development, changing the legal, medical, social service delivery system to better meet victim needs, technical assistance to other agencies):

_____

_____

_____

_____ E. Other (please specify):

_____

_____

_____