DOCUMENT RESUME

ED 352 525 CE 062 685

TITLE	Client Mental Health Issues. Final Report.
INSTITUTION	TIU Adult Education and Job Training Center, Lewistown, PA.
SPONS AGENCY	Office of Educational Research and Improvement (ED), Washington, DC.
PUB DATE	30 Jun 92
NOTE	109p.; Some pages contain thick filled-in print.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	*Adult Basic Education; Counseling; *Crisis Intervention; Family Violence; *Mental Disorders; Mental Health; Policy Formation; *Program Implementation; *Staff Development; Substance Abuse; *Workshops
IDENTIFIERS	353 Project

ABSTRACT

A project was conducted to provide adult basic education (ABE) personnel with a better understanding of the special needs of clients suffering from mental health problems and to provide information that will help them to develop agency policies and procedures for this type of client. During the project, four workshops were organized and delivered, and a detailed final report and training outlines of the workshop content were developed. Workshop topics were crisis situations and suicide threats and attempts, issues in mental health, substance abuse, and violence. Approximately 125 ABE instructors and employment and training staff members involved with ABE clients were served through the workshops. (This report contains the training outlines of the four workshops, including agendas and information sheets on the four topics, recruitment information, workshop evaluation, and agency crisis policy.) (Author/KC)

Final Report

Client Mental Health Issues

Adele Craig, Project Director

1991-1992

June 30, 1992

Tuscarora Intermediate Unit
Adult Education and Job Training Center
1020 Belle Vernon Avenue
Lewistown, PA 17044
717-248-4942

99-2008 - $8,498

The activity which is the subject of this report, was supported in part by the U.S. Department of Education. However, the opinions expressed herein do not necessarily reflect the position or policy of the U.S. Department of Education or the Pennsylvania Department of Education, and no official endorsement should be inferred.

Acknowledgement

We wish to thank the Pennsylvania Department of Education for funding this project and especially Dr. John Christopher, Ed.D., Director, Bureau of Adult Basic and Literacy Education for his support of our programs.

We also extend gratitude to PDE Special Projects Advisor, Dan Partin, for his technical assistance and guidance. Funding for "Client Mental Health Issues" has allowed us to enhance and develop our programming and delivery of much needed services to our area's adults.

As always we value the support of the Tuscarora Intermediate Unit Board and our Executive Director, Dr. Dale Heller. The Intermediate Unit continues to recognize our unique contribution to the total organization.

-Adele Craig, Project Director

Contents

Abstract

Title: Client Mental Health Issues

Director: Adele Craig
Address: TIU Adult Education and Job Training Center
1020 BelleVernon Avenue
Lewistown, PA 17044 **Phone Number:** (717) 248-4942

Duration of Project:
From: 7/1/91 To: 6/30/92

Federal Funding: $8,498
Number of Months: 12

Objectives:

- To develop four staff training workshops on Client Mental Health Issues.
- To implement the workshops with at least 20 ABE personnel.
- To develop an agency policy which will define the role and limitations of the instructor in crisis and classroom situations.
- To produce four training outlines and a final report for statewide dissemination.

Description:

"Client Mental Health Issues" is designed to provide ABE personnel with a better understanding of the special needs of clients suffering from mental health problems. Staff will also receive information that will aid them in developing agency policies and procedures for this special client.

Target Audience:

The audience benefiting from this program were 22 ABE practioners as well as 20 employment/training staff involved with ABE clients.

Products:

Training outlines reflecting the content of our four workshops. The final report documents the entire project.

Method of Evaluation

A successful evaluation was based on

1) organizing four workshops.
2) delivery of four workshops.
3) outlines and dissemination of a detailed final report of the project.

Client Mental Health Issues

Introduction

"Client Mental Health Issues" addressed the need for staff development in-service workshops for instructors, tutors, counselors, and administrators.

"Client Mental Health Issues" was a program designed to provide adult educators with a better understanding of clients and their mental health problems. There is a need for Adult Basic Education (ABE) staff members to become more knowledgeable and acquire more skill in identifying and understanding the increased number of mental health issues affecting their students.

Four workshops were planned which were open to all adult educators in our region. This project in no way proposed to have adult education staff take on the role of mental health counselor. The project allowed for increased understanding and identification of mental health issues and clients and supported the development of a referral system.

Throughout the 1991 - 92 year, workshops were conducted for over 125 staff of our agency and other adult training centers. The time frame for the project activities follows:

<u>Stage 1</u> July, August, September and October 1991 - research, development, and scheduling of seminars.

<u>Stage 2</u> November 18, 1991; January 7, 1992; February 4, 1992; and March 3, 1992 - 3 hour workshops were held at the County Courthouse.

Stage 3 April, May 1992 - follow-up was conducted and training outlines were produced.

Stage 4 June 1992 - final report was produced documenting success of the project.

Statement of Problem

The growing number of students with significant mental health problems ranging from chemical dependency to suicidal tendencies is having a major impact on our ABE programs. The instructor's ability to effectively assist the student in reaching his/her educational goals is greatly hindered by lack of understanding of the problems and lack of knowledge about adapting teaching styles and/or instructional methods to meet the needs of this special student.

Because ABE personnel are generally not trained as counselors, they need information and techniques that can be used when instructing clients with mental health problems. Why has this problem currently come to light? We theorize that because our services have become so well known and stable in our community more area agencies that serve mental health clients are making referrals to us. Also, because we have worked successfully with some mental health clients, the word has been spread, and clients themselves are requesting services. In the past our staff has felt insecure in dealing with the crisis situations which may arise with these students: suicide threats, drug and alcohol abuse, violence, etc. Our goal with this project was to develop training outlines for the lay person so that they can meet the challenge of working with these clients. In turn, they will be able to identify the problem and make the appropriate referral to other community agencies.

Goals and Objectives

To meet the need to provide staff training on client mental health issues, the following goals and objections were developed:

- To develop four staff training workshops on Client Mental Health Issues.
- To implement the workshops with at least 20 ABE personnel.
- To develop an agency policy which will define the role and limitations of the instructor in crisis and classroom situations.
- To produce four training outlines and a final report for statewide dissemination.

Procedures

The general design of "Client Mental Health Issues" was in three parts.

Part 1 - Staff researched mental health issues, planned workshops, scheduled speakers, and recruited participants. During this first stage of the project, we worked with a variety of mental health professionals to establish what should be included in the training sessions. We scheduled guest speakers for each of the four workshops. Some speakers required an honorarium. Our audience consisted of staff members from our Center (staff of 24); the Mifflin County Library Literacy Program; Juniata County Library Literacy Program; Juniata County SETCO staff; Fulton, Huntingdon, and Centre Counties literacy and ABE programs, and other training staff from Clinton, Centre and Snyder counties.

Part 2 - Workshop Presentations

Topics for the four workshops were:

Workshop 1 - Crisis Situations, Suicide Threats and Attempts

Workshop 2 - Issues in Mental Health

Workshop 3 - Substance Abuse

Workshop 4 - Violence

Part I - Victims of Violence

Part II - Crisis Prevention/Intervention

Part 3 - Staff developed an agency policy identifying roles and limitations of instructors in crisis situations.

The information provided in each of our in-service sessions is included in a training outline which may be easily reproduced and disseminated for ABE centers across the state to adapt to their own in-service needs.

Results

Objective # 1

To develop four staff training workshops on Client Mental Health Issues.

This objective was successfully met by September 1991. Several meetings were conducted with local mental health professionals to determine specific topics to be covered in the training seminars and select the most appropriate individuals to present the information.

Objective # 2

To implement the workshops with at least 20 ABE personnel.

We were very successful in meeting this second objective. Each of the workshops average attendance was 38 participants. ABE personnel from Mifflin, Centre, Huntingdon, Juniata, Perry, Snyder and Clinton counties were in attendance. The response provided through the evaluation indicated that workshop participants overwhelmingly felt that the sessions were "very relevant to our client population, extremely informative, and well presented."

Objective # 3

To develop an agency policy which will define the role and limitations of the instructor in crisis and classroom situations.

This objective was met when a referral procedure for emergency situations was developed following the four workshops. This referral procedure provides specific information for all staff to follow when dealing with a client who is suicidal, is experiencing serious emotional problems, is under the influence of drugs/alcohol, or is involved in an abusive situation. The procedure outlines our agency's role and limitations in a step by step manner, includes all necessary telephone numbers to local referral agencies, and indicates required follow-up responsibilities.

A full staff meeting was held to discuss the referral procedure in detail and directions were provided to insure its immediate implementation.

Objective # 4

To produce four training outlines and a final report for statewide dissemination.

The workshop outlines and final report were completed for dissemination.

Evaluation

Evaluation of the project was an on-going process. Measurement of success was based on:

a) Organizing four workshops within the planned time frame of October through February.

b) The development and implementation of four workshops provided to more than 20 ABE personnel. The average workshop attendance was 38. Workshop participants completed specific evaluations on each session which provided valuable information and also indicated the success of each workshop.

c) The successful production of four training outlines and the dissemination of a detailed final report.

Dissemination

This project will be available for dissemination through:

Bureau of Adult Basic & Literacy Education
Pennsylvania Department of Education
333 Market Street
Harrisburg, PA 17126-0333

and

AdvancE
Pennsylvania Department of Education
333 Market Street
Harrisburg, PA 17126-0333

Specific questions should be directed to:

Adele Craig, Employment and Training Director
Tuscarora Intermediate Unit
Adult Education and Job Training Center
1020 BelleVernon Avenue
Lewistown, PA 17044
(717) 248-4942

Conclusions/Recommendations

Our "Client Mental Health Issues" provided much needed staff development to our ABE staff. The four workshops were particularly helpful in 1) providing an overview of mental health issues common to our clients, 2) disspelling many myths about individuals suffering from mental health problems and 3) making our staff more sensitive to our clients with these specific problems. The workshops helped staff to feel more comfortable and empathetic when dealing with a student experiencing mental health problems. The training helped many staff inexperienced with mental illness to understand how these problems affect the client's learning and what possibly to expect in the future. One participant commented, "This was one of the rare in-service workshops that I have attended that was filled with useful information the whole two hours. Thank you. It was worth the time and the drive."

While all the workshops were informative and appropriate, some selected topics were simply too broad and extensive to cover in one session. Topic # 2, "Issues in Mental Health" was very broad. When presented, the topic centered around definitions of certain terms common to the mental health profession. The information was useful but needed a more direct link to our client population and the issue of instruction.

Recommendations for the future include providing longer sessions, making some topics more specific, and locating better accommodations. These workshops were very valuable. All ABE personnel benefit from such training and many topics still exist for further training.

TRAINING MATERIALS

TRAINING OUTLINE

Topic # 1: Crisis Situation

1. General Information and National and Local Statistics
2. Suicide Knowledge Test
3. Danger Signs of Suicide
4. Major Factors in Assessing Depression and Suicide Potential
5. Ten Crucial Questions in Suicide Assessment
6. Counseling Guidelines with Suicidal Clients
7. How You Can Help in a Suicidal Crisis
8. Where to Get Help

SUICIDES IN MIFFLIN COUNTY

YEAR	AGE	GENDER	METHOD
1987	22	M	CO
	22	M	CO
	25	M	GUNSHOT (HEAD)
	29	M	CO
	36	F	STRANGULATION
	38	M	GUNSHOT (HEAD)
	45	F	CO
	45	F	CO
	48	M	GUNSHOT (CHEST)
	48	M	GUNSHOT (INTOX)
	75	M	CO
	90	M	GUNSHOT (CHEST)
1988	19	M	HANGING
	29	M	HANGING
	30	M	GUNSHOT (HEAD)
	46	M	GUNSHOT (HEAD)
	64	M	GUNSHOT (HEAD)
	66	M	GUNSHOT (CHEST)
	74	M	GUNSHOT (HEAD)
	74	M	SUFFOCATION (PLASTIC BAG)
	80	M	SHOT GUN
	80	M	GUNSHOT (CHEST)
	87	F	SUFFOCATION (GARBAGE BAG)
1989	21	M	GUNSHOT (HEAD)
	22	M	OVERDOSE (CHRONIC D&A)
	41	M	CO
	41	M	STRANGULATION (HANGING)
	68	M	CO
	74	M	GUNSHOT(HEAD)
	75	M	GUNSHOT
	76	M	GUNSHOT(HEAD)
	78	M	GUNSHOT (HEAD)
	83	M	GUNSHOT (HEAD)

YEARS:
10-19 = 1
20-29 = 7
30-39 = 3
40-49 = 7
50-59 = 0
60-69 = 3
70-79 = 7
80-89 - 4
90-99 - 1

**CO - CARBON MONOXIDE

U. S. SUICIDE 1989 OFFICIAL DATA

	NUMBER	PER DAY	RATE	% OF DEATHS
Nation	30,796	84.4	12.7	1.5
Males	24,272	66.5	20.5	2.2
Females	6,524	17.9	5.2	0.6
Whites	28,217	77.3	13.7	1.5
Nonwhites	2,579	7.1	6.9	0.9
Blacks	1,963	5.4	6.6	0.8
Elderly(65 +years)	6,464	17.7	21.7	0.4
Young (15-24 yrs)	4,924	13.5	12.9	13.0

COMPLETIONS:

Average of 1 person every 17.1 minutes killed themselves.
Average of 1 old person every 1 hour 21 minutes killed themselves.
Average of 1 young person every 1 hour 47 minutes killed themselves(If the 251 suicides below age 15 are included, 1 young person every 1 hour 42 minutes).
8th ranking cause of death in U.S. (13th for old; 3rd for young(behind accidents, homicide).
3.7 male completions for each female completion.

ATTEMPTS (these figures are estimates; no official national attempt data are compiled in the U. S.):

240-600,000 annual attempts in U.S.
8-20 attempts for every completion for nation. 100-200; 1 for young, and 4:1 for the elderly
5 million living Americans (estimate) have attempted to kill themselves.
3 female attempts for each male attempt.

SURVIVORS (i.e.,family members and friends of a loved one who died by suicide):

EACH SUICIDE INTIMATELY AFFECTS AT LEAST 6 OTHER PEOPLE. (estimate)
Based on the number of suicides since 1970 (through 1988), it is estimated that the number of survivors of suicides in the U.S. is 3.1 million and that grows 180,000 each year. If there is a suicide every 17 minutes, then there are 6 new survivors every 17 minutes as well.

U.S.Suicide Rates by Age
(Rates per 100.000 population)
1986 vs 1987

Age Groups	1986 Rate	1987 Rate
5-14	0.8	0.7
15-24	13.1	12.9
25-34	15.7	15.4
35-44	15.2	15.0
45-54	16.4	15.9
55-64	17.0	16.6
65-74	19.7	19.4
75-84	25.2	25.8
85+	20.8	22.1
65+	21.5	21.7
Total	12.8	12.7

10 Leading Causes of Death in the U.S.,1987
(total of 2,123,323 deaths)

Rank & Cause of Death	Rate	No.of Deaths
1.Diseases of the heart	312.4	760,353
2.Malignant neoplasms	195.9	476,927
3.Cerebrovascular disease	61.6	149,835
4.Accidents	39.0	95,020
5.Chronic obstructive pulmonary diseases	32.2	78,380
6.Pnuemonia & influenza	28.4	69,225
7.Diabetes mellitus	15.8	38,532
8.Suicide	12.7	30,796
9.Chronic liver disease & cirrhosis	10.8	26,201
10.Atherosclerosis	9.2	22,474

Old made up 12.3% of 1987 population but committed 21.0 of the suicides.
Young were 15.7% of 1987 population and committed 16.0% of the suicides

Official data sources: Mortality: National Center for Health Statistics (1989) Advanc .report of final mortality statistics, 1987.NCHS Monthly Vital Satistics Report, Population U.S. Bureau of the Census.(1988)

SUICIDE KNOWLEDGE TEST

Your understanding of suicide is your first line of defense against it. Check yourself out by answering True or False to these twenty questions.

TRUE/FALSE

_____ 1. Suicide accounts for very few deaths annually among the young.

_____ 2. Suicide in adolescence has doubled over the past ten years.

_____ 3. A leading cause of death among the young is hopelessness about the future

_____ 4. About half of suicidal youngsters are involved in some form of drug or alcohol abuse shortly before their suicidal death.

_____ 5. Children never commit suicide.

_____ 6. Children, like adults, have well thought out plans, if they are seriously suicidal.

_____ 7. Approximately 10 percent of the suicidal youth feel that their families do not understand them.

_____ 8. Death by firearms is the most common method used by both sexes.

_____ 9. Repeated statements such as "I would be better off dead" from a young person should never be taken seriously.

_____ 10. Minority young Americans are more suicide-prone than whites.

_____ 11. Suicidal adolescents rarely seek medical attention, so it is difficult to identify them.

_____ 12. Suicide is inherited and "runs in families".

_____ 13. The chances of suicide can be reduced by avoiding the subject.

_____ 14. Once a child or adolescent is suicidal, he or she is always suicidal.

_____ 15. The presence of a psychosis increases the likelihood of suicide.

_____ 16. The incidence of suicide among teenage unwed mothers is high.

_____ 17. A person with a history of suicide committed by a close family member is a higher suicide risk.

_____ 18. Improvement of a suicidal person means the danger is over.

_____ 19. There are over 500,000 depressed children in this country, and half of these children have suicidal ideas.

_____ 20. Suicide is more common among lower economic status groups than among the higher economic status groups.

U.S. SUICIDE

DANGER SIGNS OF SUICIDE

1. SUICIDE THREATS OR SIMILAR STATEMENTS

2. A SUICIDE ATTEMPT

3. PROLONGED DEPRESSION (THE "THREE H'S" - HELPLESSNESS, HOPELESSNESS AND HAPLESSNESS)

4. MARKED CHANGES OF BEHAVIOR OR PERSONALITY

5. THE MAKING OF FINAL ARRANGEMENTS

DANGER SIGNS OF SUICIDE

1. SUICIDE THREATS OR SIMILAR STATEMENTS

2. A SUICIDE ATTEMPT

3. PROLONGED DEPRESSION (THE "THREE H'S - HELPLESSNESS, HOPELESSNESS AND HAPLESSNESS)

4. MARKED CHANGES OF BEHAVIOR OR PERSONALITY

5. THE MAKING OF FINAL ARRANGMENTS

MAJOR FACTORS IN ASSESSING DEPRESSION AND SUICIDE POTENTIAL

ONE OR MORE IN ANY CATEGORY SHOULD INDICATE NEED TO PURSUE CHANGE

BEHAVIOR

_______ Break up of a romantic relationship

_______ Reluctance to communicate

_______ Defensive attitude

_______ Withdrawn/seclusive

_______ Frequent crying

_______ Impulsiveness

_______ Depression

_______ Sudden outbursts

_______ Inconsistant, inappropriate behavior

_______ Memory loss/disorientation

_______ Absent-mindedness

_______ Mood Swings

_______ Fatigue

_______ Hyperactivity/nervousness

_______ Indecisiveness

_______ Alcohol abuse

_______ Drug abuse

FAMILY

_______ Recent loss (moved, divorce, death)

_______ Troubles in family (financial, emotional, health, separation, unemployment, etc.)

_______ Family restructuring
Changing rules

ACADEMIC/EMPLOYMENT

_______ Grades falling markedly

_______ Handwriting worsening

_______ No effort

_______ Irresponsible behavior

_______ Short/no attention span

_______ Lack of motivation

_______ Excessive absences

_______ D & A Patterns

PEERS

_______ Dropping friends

_______ Excluding/avoiding friends/peers

_______ Frequent conflict

APPEARANCE/HEALTH

_______ Undiagnosed health problems/complaints

_______ Neglect of personal appearance

_______ Drastic weight loss or gain

_______ Lingering disease or serious illness/handicap

TEN CRITICAL QUESTIONS IN SUICIDE ASSESSMENT

1. How will you do it?

2. How much do you want to die?

3. How much do you want to live?

4. How often do you have these thoughts?

5. When you are thinking of suicide, how long do the thoughts stay with you?

6. Is there anyone or anything to stop you?

7. Have you ever attempted suicide?

8. Do you have a plan?

9. On a scale of 1 - 10, what is the probability that you will kill yourself?

10. What has happened that makes life not worth living?

COUNSELING GUIDELINES WITH SUICIDAL CLIENTS

IF A SUICIDAL PERSON WANTS TO TALK:

1. Accept what is said, and treat it seriously.

2. Do not give advice. (Let the person discover his/her own solution).

3. Do not say everything will be all right.

4. Do not back off or try to delay dealing with the person.

5. Help the person explore feelings. Do not add to the person's guilt. ("Think how your parents, friends, etc. would feel!")

6. Ask if the person is considering suicide if such information is not evident in the conversation.

7. Try to focus the problem.

8. Help determine what needs to be done or changed.

9. Help identify the resources needed to improve things.

10. Help the person recall how he/she used to cope.

11. Get the person to agree to do something <u>constructive</u> to change things.

12. Arrange with the person to be back in contact within a few hours.

13. Trust your suspicions that the person may be suicidal.

14. Communicate your concern for the well-being of the person. Be an active listener and show your support.

15. Talk openly and freely and ask direct questions about the person's intentions. Try to determine whether the person has a plan for suicide - the more specific the plan, the greater the risk.

16. Encourage the person to seek help from a school professional, minister, or someone who is trained to help solve emotional problems. If the person resists, you may have to get the necessary help for them.

17. Get help if the situation is immediately life-threatening.

18. Do not leave the person alone if you believe the risk of suicide is high.

19. Do not swear in "secrecy" to the suicidal person. You may lose a friendship, but you may save a life.

20. Do not debate whether suicide is right or wrong. This may make the person feel more guilty and worthless.

HOW YOU CAN HELP IN A SUICIDAL CRISIS

1. RECOGNIZE THE CLUES TO SUICIDE. Look for symptoms of deep depression and signs of hopelessness and helplessness. Listen for suicide threats and words of warning, such as "I wish I were dead", or "I have nothing to live for". Notice whether the person becomes withdrawn and isolated from others. Be alert to suicidal thoughts as a depression lifts.

2. TRUST YOUR OWN JUDGMENT. If you believe someone is in danger of suicide, act on your beliefs. Don't let others mislead you into ignoring suicide signals.

3. TELL OTHERS. As quickly as possible, share your knowledge with parents, friends, teachers, or other people who might help in a suicidal crisis. Don't worry about breaking a confidence if someone reveals suicidal plans to you. You may have to betray a secret to save a life.

4. STAY WITH A SUICIDAL PERSON. Don't leave a suicidal person alone if you thing there is immediate danger. Stay with the person until help arrives or a crisis passes.

5. LISTEN. Encourage a suicidal person to talk to you. Don't give false reassurances that "everything will be O.K.". Listen and sympathize with what the person says.

6. BE SUPPORTIVE. Show the person that you care. Help the person feel worthwhile and wanted again.

7. URGE PROFESSIONAL HELP. Put pressure on a suicidal person to seek help from professionals during a suicidal crisis or after a suicide attempt.

IF THERE IS A

SUICIDE CRISIS

CALL

MH / MR OFFICE
242-0351

LEWISTOWN HOSPITAL
EMERGENCY ROOM
248 -5411

IF THERE IS A NEED FOR
SUICIDE INFORMATION OR REFERRAL

YOU CAN
REQUEST INFORMATION OR SERVICES
BY CALLING

MH / MR OFFICE
242-0351

NP HEALTH SERVICES
242 7264

GENERAL INFORMATION - RE: 7A Patients

CONTACT PERSONS ON 7A:	SUE SHAWVER - Social Worker 242-7358 or 242-7145 Monday thru Friday - 8:00 AM - 4:00 PM
	BOB STRAWSER - Crisis Education Specialist 242-7145 Monday through Friday - 12:30 PM - 9:00 PM
TELEPHONE NUMBERS FOR PATIENTS:	242 7145 or 242 7146
BEST HOURS TO CALL PATIENTS:	8:00 AM - 9:30 AM 12:00 NOON - 1:00 PM 3:00 PM - 9:00 PM
VISITENG HOURS	MONDAY THROUGH FRIDAY -6:00 PM - 8:00 PM SATURDAY, SUNDAY & HOLIDAYS 2:00 PM - 4:00 PM & 6:00 PM - 8:00 PM

I am hurt
   I will hide
   said the self.

And it did.

As surely
   as intricately
   as green leaves
   enfold the petals
   of the most delicate
   of flowers
   the self hid.

The body
   governed by laws
   which determine
   its natural processes
   grew.

But the self
   willed by the self
   to hide itself
   hid.

One day gentle hands
   probed and touched
   that tiny tense tight self.

Slowly, tremulously
   color began to peek out
   mingling shyly like petals
   with their green leaf covering.

And shape emerged
   tiptoeing cautiously
   with covering and color.

Eventually
   self said

I want to live

And it did.

June Heidenreich

ANSWER SHEET

SUICIDE KNOWLEDGE TEST

Your understanding of suicide is your first line of defense against it. Check yourself out by answering True or False to these twenty questions.

TRUE/FALSE

F 1. Suicide accounts for very few deaths annually among the young.

T 2. Suicide in adolescence has doubled over the past ten years.

T 3. A leading cause of death among the young is hopelessness about the future

T 4. About half of suicidal youngsters are involved in some form of drug or alcohol abuse shortly before their suicidal death.

F 5. Children never commit suicide.

F 6. Children, like adults, have well thought out plans, if they are seriously suicidal.

T 7. Approximately 10 percent of the suicidal youth feel that their families do not understand them.

T 8. Death by firearms is the most common method used by both sexes.

F 9. Repeated statements such as "I would be better off dead" from a young person should never be taken seriously.

F 10. Minority young Americans are more suicide-prone than whites.

F 11. Suicidal adolescents rarely seek medical attention, so it is difficult to identify them.

T 12. Suicide is inherited and "runs in families".

F 13. The chances of suicide can be reduced by avoiding the subject.

F 14. Once a child or adolescent is suicidal, he or she is always suicidal.

T 15. The presence of a psychosis increases the likelihood of suicide.

F 16. The incidence of suicide among teenage unwed mothers is high.

T 17. A person with a history of suicide committed by a close family member is a higher suicide risk.

F 18. Improvement of a suicidal person means the danger is over.

T 19. There are over 500,000 depressed children in this country, and half of these children have suicidal ideas.

F 20. Suicide is more common among lower economic status groups than among the higher economic status groups.

TRAINING OUTLINE

Topic # 2: Issues in Mental Health

Part I

1. What to Expect from People with Mental Health Disorders
2. How to Identify People with Mental Health Disorders
3. Instructing Students with Mental Health Problems
4. Mental Health Commitment Procedures

Part II

1. Communication
   A. Empathic/Active Listening
   B. Non-defensive Communication

Psychoactive Substance Use Disorder

Schizophrenia

Mood Disorders
- Manic
- Bi Polar
- Major Depression - Single or Recurrent
- Dysthymia

Anxiety Disorders
- Panic Disorder - with agoraphobia or without agoraphobia
- Social Phobia
- School Phobia
- Obsessive Compulsive Disorder
- PTSD
- Generalized Anxiety Disorder

Adjustment Disorders

Personality Disorders

Behaviors characteristic of recent and long term functioning and lead to impairment of social or vocational functioning.

I. Paranoid Personality Disorder

A) Frequent interpretations of actions of others as deliberately demeaning or threatening.
(must have 4)
a) expects to be exploited.
b) questions the loyalty of friends.
c) reads hidden or demeaning meanings into benign remarks.
d) bears grudges.
e) reluctant to confide.
f) easily slighted and quick to anger.
g) questions fidelity of spouse or partner.

II. Schizoid Personality Disorder

A) Pervasive pattern of indifference to social relationships and a restriction of emotional experience and expression.
(must have 4)
a) neither desires or enjoys close relationships.
b) almost always chooses solitary activities.
c) rarely claims to experience strong emotion.
d) little desire to have sexual experience.
e) indifferent to praise.
f) no close friends.
g) constricted affect.

III. Schizotypal Personality Disorder

A) Interpersonal problems with peculiar ideations and appearance.
(must have 5)
a) ideas of reference.
b) excessive social anxiety.
c) odd beliefs.
d) unusual perceptual experiences.
e) odd or eccentric appearance.
f) no close friends and confidants.
g) odd speech
h) inappropriate affect.
i) suspiciousness or paranoid ideations.

IV. Antisocial Personality Disorder

A) Must be 18.
B) Evidence of a Conduct Disorder in childhood.
C) Pattern of irresponsible or antisocial behavior.
(must have 4)
a) unable to sustain consistent work.
b) fails to conform to social norms.
c) aggressive.
d) fails to honor financial obligations.
e) fails to plan ahead.
f) no regard for truth.
g) reckless.
h) cannot responsibly care for children.
i) cannot sustain monogamous relationships for one year.
j) lacks remorse.

V. Borderline Personality Disorder

(must have 5)
a) unstable or intense interpersonal relationship (extremes).
b) impulsiveness in 2 areas, spending, sex, substance.
c) affective instability.
d) inappropriate display of anger.
e) recurrent suicidal thoughts.
f) persistent identity disturbances i.e., sexuality, long term goals.
g) chronic feelings of emptiness.

VI. Histrionic Personality Disorder

A) Excessive Emotionality.
(must have 4)
a) constantly seeks or demands reassurance.
b) inappropriately sexually seductive in appearance.
c) is only concerned with physical attractiveness.
d) expresses emotion in inappropriate exaggeration.
e) needs to be center of attention.
f) shallow emotions.
g) self centered.
h) impressionistic speech without detail.

VII. Narcissistic Personality Disorder

A) Pervasive pattern of grandiosity, lack of empathy. (must have 5)

a) reacts to criticism.
b) interpersonally exploitive.
c) grandiose sense of self importance.
d) believes his problems are unique.
e) preoccupied with fantasies of unlimited success.
f) has sense of entitlement.
g) needs constant attention and admiration.
h) lacks empathy.
i) preoccupied with feelings of envy.

VIII. Avoidant Personality Disorder

A) Pervasive pattern of social discomfort. (must have 4)

a) easily hurt by criticism.
b) has no close friends.
c) unwilling to get involved with people unless there is certainty of being liked.
d) avoids social and occupational activities that involve people.
e) shy in social situations for fear of being foolish.
f) fear of embarrassment.
g) exaggerates potential difficulties.

IX. Dependent Personality Disorder

A) Pervasive pattern of dependence and submissiveness. (must have 5)

a) unable to make decisions.
b) allows others to make decisions.
c) agrees even when he knows they're wrong.
d) cannot initiate work or work alone.
e) will do unpleasant tasks to get people to like them.
f) uncomfortable and helpless alone.
g) devastated when close relationships end.
h) preoccupied with fears of being abandoned.
i) easily hurt by criticisms.

X. Obsessive Compulsive Personality Disorder

A) Pervasive patterns of inflexibility.
(must have 5)
a) perfectionism.
b) preoccupation with details.
c) unreasonably insistent.
d) excessive devotion to work.
e) indecisiveness.
f) overconscientiousness.
g) restricted expression of affection.
h) lack of generosity.
i) inability to discard worthless objects.

XI. Passive Aggressive Personality Disorder

A) Pervasive pattern of resistance.
(must have 5)
a) procrastinates.
b) sulky when asked to do something he doesn't want to do.
c) seems to work deliberately slow.
d) protests without justification that others make unreasonable demands.
e) forgets alot.
f) resents useful suggestions about efficiency and productivity.
g) obstructs others.
h) unreasonably criticizes people in authority.

COMMUNICATION:

Each of us search for security. Our seach is hampered by fallacy of our facades.

1. Your eyes see what they are trained to see.

2.Beliefs shape your experiences and not the other way around.

To succeed we need to make "new tapes" of new inner rules, dialogues and beliefs. Add feelings, subtract evaluations and you give yourself the power to choose. We grow as a person when we honor ourselves, stop criticizing and learn.

When security is located within yourself, it lies less in others. You then accept others as they are, even when you don't agree with them.

As teachers/service providers - you are asked to play many roles in order to increase the possiblity of success for your pupils/clients and you come upon resistance.

You can negotiate anything-

1. information - needs

2. time - organizational pressure and time.

3. power - 2 forms:

PRECEDENT - those who are convienced that they can't - won't try =results, inability to negotiate. Proving they were right to begin with.

LEGITMACY - power derived from higher-up/authority.

EMPATHIC LISTENING | ACTIVE LISTENING

SYSTEM I : Authoritative -Explortative - "Chew 'em up & Spit'em out"

climate high fear, low trust - little concern is shown for people's growth or needs.

SYSTEM II : Authoritative - Benevolent - "Salute the flag & Big Daddy too"

knows what is best for people- controlled for their own good. Competition for favorable attention at the top - produces defensive behavior in climate where fear is almost as high as in system I and trust is almost as low.

SYSTEM III : Consultative - "Ask'em & Listen"

encouraged to be more involved with organizational goals - taken more seriously as responsible adults. Goal setting/decisions still done near the top, people further down consulted, expertise is valued and used where feasible. Lower fear, higher trust produces a less defensive climate.

SYSTEM IV : Participative - "Let'em do it"

more people can influence decisions by using their competence and initiative. More decisions are made further down in the system, more coordinated than controlled at the top. Of the 4- this one is least defensive because of trust shown in people and low-fear learning environment.

REACT/ACT defensively	ACT NON-DEFENSIVELY
. others make your choices for you.	. you make your own choices.
. others have power over you.	. you have power over yourself.
. you defend your position against others.	. you extend your resources with other
. you increase your odds of losing.	. you increase your odds of gaining.

SUPPORTING CAST = ACHIEVING SUCCESS !

1. ESTEEM BUILDER - helps develop and maintain a strong self-image, capable, worthy of success. 1st.step - being accepted -feelings as good as those around you.

2. CHEERLEADER - encourages us to succeed, emotionally supports and nurtures us during our setbacks - a strong sense of perspective -allowing us to step away from a situation long enough for panic to subside and our wits to return.

3. CELEBRATOR - helps us commemorate the good times- provides immediate rewards for our accomplishments- rewards that make long-term success seem more worth the effort- emotional compensation.

4. ADVISOR - may help you understand the world and your place in it.
-interpret for you the actions of other people.
-give you advise on how to proceed in your career.
- give you insights and knowledge about the political realities of a given organization.
- generally gives you "progress reports" on your life and career.
-guide you in choosing other supporters.

5. CONSTRUCTIVE CRITIC - actually pokes holes in our arguments and plans to encourage us to come up with better strategies. (often one's personality/attitude will stifle criticism, to stifle constructive criticism is to stop energy and ideas).

6. SPONSOR - someone who personally intercedes in your behalf.

7. CONTACT - someone directly backs you.

8. PUBLIC RELATIONS SPECIALIST - helps us gain the needed visibility. Someone who oftens acts on our behalf as an interface between us and the rest of the world.

9. TECHNICAL SUPPORTER - ensures that time constraints won't undermine our efforts to succeed.

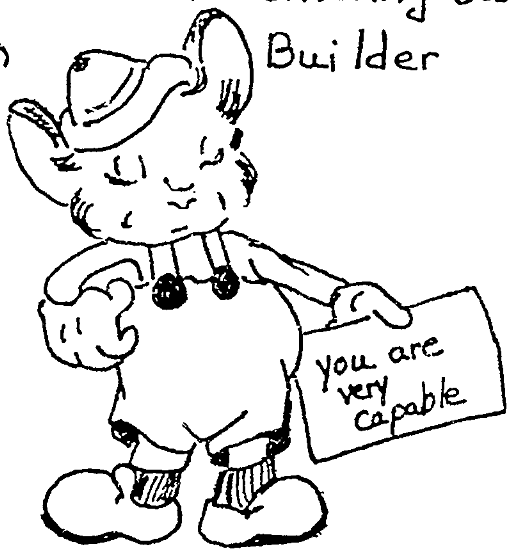
10. FINANCIER - lends you the money, invests in your career, advises you to invest or spend.

11. ROLE MODEL - the one we most want to imitate, copy. That person supports us to the extent that he/she contributes to our ultimate self-image and acts as a source of hope even though we may never actively interface.

Supporting Cast = Achieve success

In general the more roles people around you fill the greater your chances of achieving success.

Esteem Builder

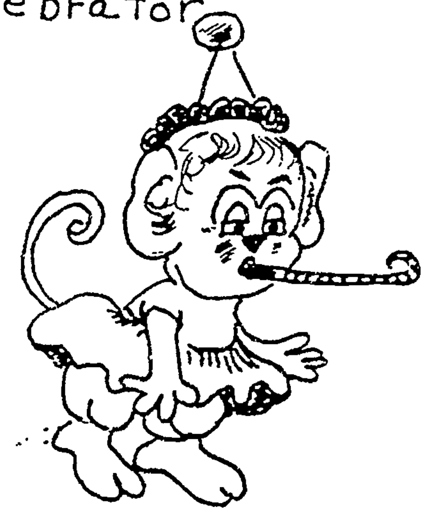


1.

Cheerleader

2.

Celebrator



3.

Advisor

4.

Constructive Critic

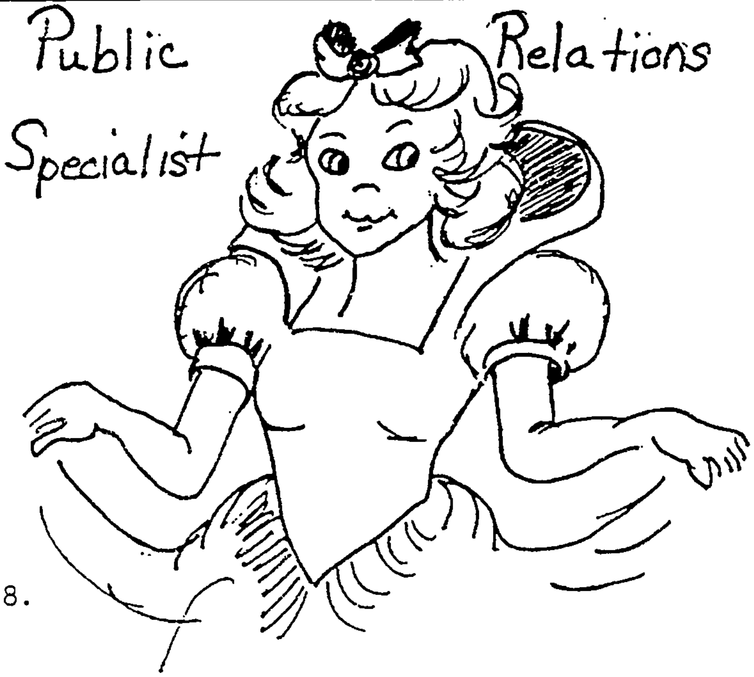
Sponsor

6.

The Contact

7.

Public Relations Specialist



8.

Technical S[illegible]orter

9.

The Financier

10.

The Role Model

NINE REASONS PEOPLE SUPPORT OTHERS.

1. You seem like a winner.

2. You have something others want.

3. You are charismatic.

4. People identify with you.

5. You are liked.

6. You can be trusted.

7. People are altruistic.

8. People feel sympathetic towards you.

9. People fear you.

WHEN OTHERS OWN THE PROBLEM	YOU OWN THE PROBLEM
. [illegible]'re a listener	.you're a sender
. you're a counselor	. you're an influencer
.you want to help the other	. you want to help yourself
.you're a sounding board	. you want to sound off
. you facilitate the other's finding his/her own solution	. you need to find a solution yourself
. you accept the other's solution; you don't need to be satisfied.	. you must be satisfied with the solution
.you are primarily interested in the other's needs.	. you are primarily interested in your own needs.
.you are more passive.	. you're more assertive.

NON_DEFENSIVE COMMUNICATION IS: absence of threat, centering, taking responsibility for oneself, planning, taking risks and keeping control over self.

BEING YOUR OWN PERSON defined by; control of self, considering others, sense of personal worth, self-confidence, self-esteem, and personal integrity.

DURING CHANGE WE UNFREEZE, ADD THE CHANGE, AND REFREEZE.

NDC is useful whenever you feel threat. How you deal with threat is how you know yourself.

WHEN OPTIONS ARE FEW, DEFENSES ARE MANY. The vicious circle is hard to break out of.

MUTUAL RECIPROCAL

.you know you are on the way to communicating ND when;

1. you are responsible TO yourself.
2. take ownership OF your feelings, attitudes and behavior.
3. responsible WITH others.
4. share your knowledge, experiences, listen, add and build on ideas.
5. you can listen and hear other people's concern and enthusiasm WITHOUT feeling you have to do something about them. You support by giving and receiving feedback, obtaining clear information.

GROWTH CAN BE PAINFUL. THERE IS MUCH PAIN WITHOUT GROWTH. THEREFORE IF YOU ARE GOING TO HAVE PAIN YOU MAY AS WELL GROW THROUGH IT. IN THE LONG RUN IT MAY BE MORE PAINFUL NOT TO GROW!

People learn defensiveness.

"Why can't you behave like your sister Hazel?"

"...and stay in your room, young man!"

TRAINING OUTLINE

Topic # 3: Substance Abuse

1. Introduction
2. Video: Chalk Talk
3. Signs and Symptoms of Substance Abuse and Dependency
4. Treatment Aspects

AGENDA

TOPIC:

Substance Abuse and Treatment Issues.

I. **INTRODUCTION:**

Presenters: Mary Beth Wolfe, Clinical Mental Health Therapist/Educator
Sandra Vannote, Drug and Alcohol Therapist

II. **VIDEO:** Chalk Talk

5 minute break

III. **SIGNS AND SYMPTOMS OF SUBSTANCE ABUSE AND DEPENDENCY:**

- Identification
- Progression - Use, abuse, dependency
- Denial
- Codependency
- COA

IV. **TREATMENT ASPECTS:**

- Referral - Why? Where? Cost?

N/P Health Center, Lewistown Hospital, Counseling Center, Individual and Family Counseling (Clark and Associates), Student Assistance Program (SAP)

- Treatment modalities - individual, group, family, detoxification Rehabilitation, Alcoholic Anonymous, Narcotics Anonymous, Alanon

- Funding - insurance, medical card, O.V.R. - Office of Vocation and Rehabilitation, MH/MR.

V. **QUESTIONS/ANSWER:**

Address audience questions and or concerns.

IDENTIFYING CHILDREN OF ALCOHOLIC PARENTS

The following list of behaviors may be indicative of children of alcoholics in the school setting. The important aspect in identifying these children is the development of patterns, which may either be obvious or require astute observations. Individual behavioral acts do not constitute behavior patterns: Be careful not to jump to conclusions or to label.

GENERAL INDICATIONS

- morning tardiness (especially on Mondays)
- consistent concern with getting home promptly at the end of a day or activity period
- strong body odor, or unkempt appearance
- inappropriate clothing for the weather
- regression, e.g., thumbsucking, enuresis, infantile behavior
- scrupulous avoidance of arguments and conflict
- friendlessness and isolation
- poor attendance
- frequent illness and need to visit nurse, especially for stomach complaints
- fatigue and listlessness
- hyperactivity and inability to concentrate
- sudden temper and other emotional outbursts
- exaggerated concern with achievement and with satisfying authority by children who are already at the head of the class
- extreme fear about situations involving contact with parents

INDICATIONS DURING ALCOHOL EDUCATION

- extreme negativism about alcohol and all drinking
- equation of drinking with getting drunk
- greater familiarity with different kinds of drinks than peers
- inordinate attention to alcohol in situations in which its evidence is marginal, e.g., in a play or movie not about drinking
- normally passive or distracted child becoming active or focused during alcohol discussions
- changes in attendance patterns during alcohol education activities
- frequent requests to leave the room
- lingering after activity to ask innocent questions or simply to gather belongings
- mention of parent's occasionally excessive drinking
- mention of drinking problem of friend's parent or other relative
- strong negative feelings about alcoholics
- evident concern with whether alcoholism can be inherited

Taken from *Broken Bottles, Broken Dreams*, Deutsch, 1982.

Do

- try to remain calm, unemotional and factually honest in speaking with the problem drinker about his behavior and its day-to-day consequences.
- Let the problem drinker know that you are reading and learning about alcoholism, attending Al-Anon or Alateen, and the like.
- Discuss the situation with someone you trust—a clergyman, social worker, a friend, or some individual who has experienced alcoholism either personally or as a family member.
- Establish and maintain a healthy atmosphere in the home, and try to include the alcoholic member in family life.
- Explain the nature of alcoholism as an illness to the children in the family.
- Encourage new interests and participate in leisure-time activities that the problem drinker enjoys. Encourage him or her to see old friends.
- Be patient and live one day at a time. Alcoholism generally takes a long time to develop, and recovery does not occur overnight. Try to accept setbacks and relapses with calm and understanding.
- Refuse to ride with the alcoholic person if he insists on drinking and driving.

WHILE WAITING FOR THE "RIGHT TIME"

Do Not

- attempt to punish, threaten, bribe, preach, or try to be a martyr. Avoid emotional appeals which may only increase feelings of guilt and the compulsion to drink.
- Allow yourself to cover-up or make excuses for the alcoholic person or shield him from the realistic consequences of his behavior.
- Take over his responsibilities, leaving him with no sense of importance or dignity.
- Hide or dump bottles, or shelter the problem drinker from situations where alcohol is present.
- Argue with the alcoholic person when he is drunk.
- Try to drink along with the problem drinker.
- Above all, do not accept guilt for another's behavior.

HERE'S LOOKING AT YOU: 2000

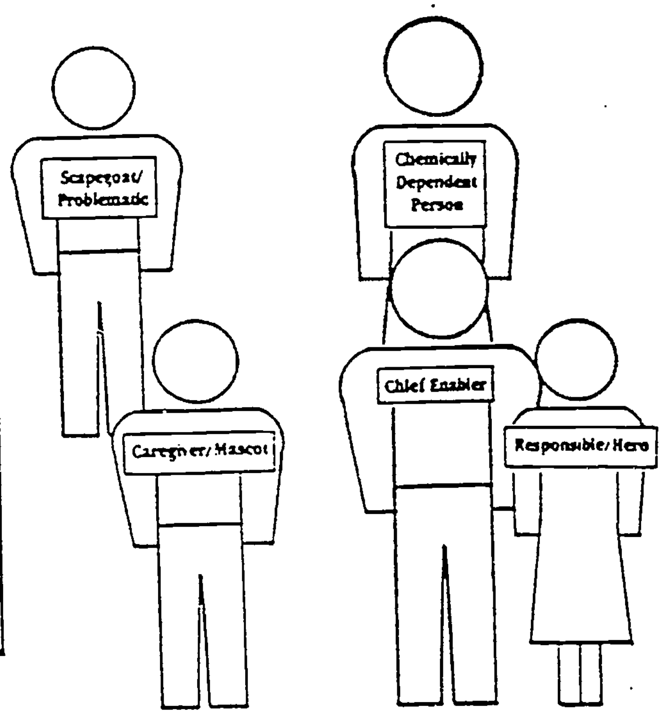
CHARACTERISTICS OFTEN FOUND IN MEMBERS OF CHEMICALLY DEPENDENT FAMILIES

Chemically Dependent Person	Chief Enabler (provides family with respectability)	Responsible/ Hero (provides family with self-worth)	Scapegoat/ Problematic (provides family with target for blame)
Behaviors: blaming, charm, self-righteousness, perfectionism, rigidity, grandiosity, self-pity, hostility	**Behaviors:** super-responsibility, seriousness, manipulation, self-blame, self-pity, martyrdom, control-seeking	**Behaviors:** leadership, seriousness, control-seeking, approval-seeking, workaholism, focus on tangible tasks	**Behaviors:** defiance, identification with peers, confrontation, early chemical use, rebelliousness (linked to self-esteem)
Feelings: anger, fear, guilt, remorse, self-hate, shame	**Feelings:** anger, fear, guilt, helplessness, inadequacy, self-doubt	**Feelings:** anger, confusion, fear, guilt, inadequacy, loneliness	**Feelings:** anger, fear, inadequacy, loneliness, rejection, resentment

Caregiver/ Mascot
(provides family with emotional relief)

Behaviors:
warmth, sensitivity, ability to listen, clowning, avoidance of conflict, hyperactivity, approval-seeking

Feelings:
anger, fear, guilt, inadequacy, insecurity, loneliness



Lost/Adjuster
(provides family with flexibility)

Behaviors:
compliance, spontaneity, aloofness, imagination, materialism, excessive weight

Feelings:
anger, fear, inadequacy, isolation, loneliness, powerlessness, unworthiness

SYMPTOMS OF ALCOHOLISM

1) Are you preoccupied with planning when you can have your next drink? Do you look forward to when you can have your next drink?

2) Do you drink when you are alone?

3) Do you drink the first couple of drinks quickly to get an immediate effect? (rapid intake?

4) Do you use alcohol as medicine, depending on the intoxicating effect to feel better.

5) Do you keep a supply around just in case you may have company or you might not have enough for the weekend? (Always feel you need extra around)

6) Do you ever drink more than you intended? (You plan on only having a couple and it gets out of control)

7) Do you have an increased tolerance and greater capacity? Are you proud that you are able to drink your friends under the table? (Amounts you used to dri don't affect you anymore)

8) Do you ever have blackouts or memory loss?

* If you have at least four of these symptoms, it is probable that you do have a drinking problem.

Slang Names for Drugs

* Designer Drugs

A-Bomb--Marijuana w/ Heroin
Acapulco-- Marijuana
Acid-- LSD
Ace-- Marijuana
*Adam-- MDMA
Angel Dust-- PCP
Animal Trank-- PCP
Bam-- Amphetamines
Barbies-- Barbituates
Barrels-- Heroin
Beans-- Amphetamine or Mescaline
Bennies-- Amphetamines
Bernice-- Cocaine
Bicycle-- LSD
Bhang-- Marijuana
Big C-- Cocaine
Big D-- LSD
Black Beauties-- Amphetamines
Black Russian-- Heroin
Black Stuff-- Opium
Black Tar-- Heroin
Block Busters-- Barbituates
Blotters-- LSD
Blue Birds-- Barbituates
Blue Cheer-- LSD
Blue Heavens-- Barbituates or LSD
Blue Mist-- LSD
Blues-- Barbituates
Bomb-- Marijuana
Broccoli-- Marijuana
Brown Sugar-- Heroin
Bumblebees-- Amphetamines
Bush-- Marijuana
Caballo-- Heroin
California Sunshine-- LSD
Candy-- Barbituates
Cartwheels-- Amphetamines
Chalk-- Amphetamines
Charles-- Cocaine
Chick-- Heroin
Chicken Powder-- Amphetamines
China White-- Heroin
Chiva-- Heroin
Chocolate Chips-- LSD
Christmas Trees-- Barbituates
Cola-- Cocaine
Coke-- Cocaine
Colombian Gold-- Marijuana
Contact Lens-- LSD
Copilots-- Amphetamines
Crap-- Heroin
Crank-- Amphetamines
Cross-- Amphetamines
Crossroads-- Amphetamines
Crystal-- PCP

Cubes-- LSD or Morphine
Cupcakes-- Heroin
Deeda-- Heroin
Dexies-- Amphetamines
Diet Pills-- Amphetamines
*DMT-- Short-Acting Tryptamines
D.O.A.-- PCP
*DOB-- Amphetamine-Based Hallucinogens
Dogie-- Heroin
Dolls-- Barbituates
*DOM-- Amphetamine-Based Hallucinogens
Domes-- LSD
Doobie-- Marijuana
Dope-- Marijuana
Double Cross-- Amphetamines
Downers-- Barbituates
Dream-- Cocaine
Dry High-- Marijuana
Dust-- Heroin
Dynamite-- Cocaine w/ Heroin
Ecstacy-- MDMA
Elephant-- PCP
First Line-- Morphine
Flake-- Cocaine
Flats-- LSD
Flowers-- Marijuana
Fly-- Cocaine
Flying Saucers-- LSD or Morning Glory Seeds
Food of the Gods-- Psilocybin
Forwards-- Amphetamines
Fours-- Codeine
Freebase-- Cocaine or Crack
Frogs-- LSD
Fry-- Crack
Fry Daddies-- Crack
Ganja-- Marijuana
Gauge-- Marijuana
GB-- Barbituates
Ghost, The-- Heroin
Giggle Weed-- Marijuana
Girl-- Cocaine
God's Flesh-- Psilocybin
Goofballs-- Barbituates
Goofbutts-- Marijuana
Grass-- Marijuana
Green Dragons-- Barbituates
Harry-- Heroin
Hash-- Marijuana
Hawk, The-- LSD
Hay-- Marijuana
Haze-- LSD
H-Caps-- Heroin
Hearts-- Amphetamines
Heaven Dust-- Cocaine
Hemp-- Marijuana
Herb-- Marijuana
Hocus-- Morphine

Hoffman's Bicycle-- LSD
Hog-- PCP
Horse-- Heroin
Horse Tranquilizer-- PCP
Idiot Pills-- Barbituates
Indian-- Marijuana
Indian Hay-- Marijuana
J-- Marijuana
Jam-- Cocaine
Jamaican-- Marijuana
Jive-- Marijuana
Juanita-- Marijuana
Junk-- Heroin
Lady-- Cocaine
Lady Snow-- Cocaine
Leaf-- Cocaine
Leapers-- Amphetamines
Lids-- LSD
Lightning-- Amphetamines
Ludes-- Methaqualone
M-- Morphine
Magic Mushrooms-- Psilocybin
Mandrakes-- Methaqualone
Marshmallow Reds-- Barbituates
Maui Wowie-- Marijuana
Mary Jane-- Marijuana
*MDA-- Amphetamine-Based Hallucinogen
*MDM-- Amphetamine-Based Hallucinogen
Mellow-- LSD
Mexican-- Marijuana
Mexican Mud-- Morphine
Microdots-- LSD
Miss Emma-- Morphine
MJ-- Marijuana
Moon-- Mescaline
Morph-- Morphine
Mud-- Morphine
Mushrooms-- Psilocybin
Mutah-- Marijuana
Nebbies-- Barbituates
Nimbies-- Barbituates
Nose Candy-- Cocaine
Nuggets-- Amphetamines
Oranges-- Amphetamines
Panama Gold-- Marijuana
Panama Reds-- Marijuana
Paradise-- Cocaine
Pasta-- Cocaine
*PCC-- Phencylidine Analogs
*PCE-- Phencylidine Analogs
Peace Pill-- PCP
Peanuts-- Baribituates
Pearl-- Cocaine
Pep Pills-- Amphetamines
Phennies-- Barbituates
*PHP-- Phencylidine Analogs
Pink Ladies-- Barbituates

Pinks-- Barbituates
*PMA-- Amphetamine-Based Hallucinogen
Pod-- Marijuana
Pot-- Marijuana
Powder-- Heroin
Qualudes-- Methaqualone
Ragweed-- Marijuana
Rainbows-- Barbituates
Red Birds-- Barbituates
Red Devils-- Barbituates
Reds-- Barbituates
Roach-- Marijuana
Rock-- Cocaine or Crack
Royal Blue-- LSD
Sabzi-- Marijuana
Sacred Cactus-- Peyote
Sativa-- Marijuana
Scag-- Heroin
Scat-- Heroin
Schoolboy-- Cocaine or Codeine
Seccies-- Barbituates
714's-- Methaqualone
Shit-- Heroin
Shrooms-- Psilocybin
Siddhi-- Marijuana
Sinse-- Marijuana
Smack-- Heroin
Smoke-- Marijuana
Snow-- Cocaine
Soles-- Marijuana
Soper-- Methaqualone
Speed-- Amphetamines
Speedball-- Cocaine w/ Heroin
Stardust-- Cocaine
Strawberry Fields-- LSD
Stuff-- Heroin
Stumblers-- Barbituates
Subdshi-- Marijuana
Sugar-- LSD
Supergrass-- Marijuana w/ PCP
Sweet Lucy-- Marijuana
*TCP-- Phencyclidine Analogs
Thaisticks-- Marijuana
Thing-- Heroin
Tic-- PCP
*TMA-- Amphetamine-Based Hallucinogens
Tooies-- Barbituates
Toot-- Cocaine
Trips-- LSD
Truck Drivers-- Amphetamines
Turnabouts-- Amphetamines
Uppers-- Amphetamines
Wedges-- LSD
Weed-- Marijuana
White-- Cocaine

Whites-- Amphetamines
White Crosses-- Amphetamines
White Lady-- Cocaine or Heroin
White Lightning-- LSD
White Stuff-- Heroin
Whizbang-- Cocaine w/ Heroin or Morphine
Windowpane-- LSD
*XTC-- MDMA
Yellow-- LSD
Yellow Jackets-- Barbituates

TRAINING OUTLINE

Topic IV: Violence

Part I: Victims of Violence

1. Victimization Exercise
2. Fac'- about Domestic Violence
3. Myths about Domestic Violence
4. What You Can Do

Part II: Crisis Prevention/Intervention

1. Points to Remember
2. Kinetics/Body Language
3. Verbal Escalation Continuum
4. Empathic Listening
5. Rational Detachment
6. Integrative Experience

PENNSYLVANIA'S COMMITMENT TO VICTIMS OF SEXUAL VIOLENCE

PENNSYLVANIA'S HISTORY

In 1972, the first rape crisis centers were organized in Pennsylvania. Begun, almost entirely, by women active in the Women's Liberation Movement, these centers grew out of an anger and outrage at the treatment of rape victims by the criminal justice and legal system.

In 1976, the Pennsylvania Coalition Against Rape was founded to advocate for rape crisis centers and sexual assault victims throughout the Commonwealth. The primary objectives of PCAR and its members were and still are: **1) prevention of sexual violence; 2) provide services to victim/survivors of sexual violence; 3) educate the public to the causes and effects of sexual violence; and 4) expand programs so that every victim of sexual violence may obtain immediate and comprehensive service.**

- **In 1980, the PA Department of Public Welfare, through PCAR, helped fund 19 rape crisis centers serving 22 counties. In 1989, 45 centers serving 58 counties received funding.**
- **During 1980, 3,200 persons were served. Between July, 1988 and June, 1989, over 24,000 persons were served by centers.**
- **The number of education programs provided by PCAR centers increased during the past decade. In 1980, there were 2,400 education programs presented to Pennsylvania communities. Over 8,500 programs were conducted between July, 1988 and June, 1989.**
- **From fiscal year 1984/85 to fiscal year 1987/88, a period of only four years, the number of persons served by rape crisis centers increased by almost 100%. The number of adult victims increased by 127%; and the number of child victims by 107%.**

A TYPICAL WEEK FOR PENNSYLVANIA'S CENTERS

During May 2 - 3, 1988, PCAR conducted a survey of direct service activity of its funded centers. The purpose of the survey was to develop a picture of the persons currently being served by our centers. The portrait of those served by rape crisis centers in Pennsylvania is revealing. It confirms findings of national studies conducted by notable professionals in the sexual assault field. Specifically, that centers serve a wide variety of persons and have expanded service to include far more clients than the adult rape victim for whom services were first initiated.

Findings of the May 2 - 3, 1988 survey reveal:

- **68% of the total clients served were victims and 36% were family members or friends of the victim.**
- **Nearly 40% of the victims seen were children under 18 years of age.**
- **97% of all assailants were men whose victims were almost exclusively women and children.**
- **A stranger was the assailant in less than one in ten cases where the victim was under 18.**
- **In 90% of cases, the assailant was either related to or an acquaintance of the victim. In 40% of non-stranger assaults, the assailant was a friend, date or boyfriend.**

* The most frequently occurring age of victims under 18 was between 12 and 17 years and between 22 and 34 years for victims over 18.

* The most frequently occurring age for all assailants was between 22 and 34 years of age.

* Nearly 50% of those adults victimized as children waited at least 5 years or more to seek help.

This one week gives an accurate picture of the clients served by rape crisis centers in Pennsylvania. As public awareness grows and society's attitudes change, the number of victims seeking service increases accordingly.

Sexual violence is isolated only by secrecy, stigma, embarrassment and fear; not isolated by age, race, economic status, geography, family structure or gender. PCAR and its agencies will continue to work so that the objectives established in 1976 will someday become a reality.

For Assistance or Information Contact

THE PENNSYLVANIA COALITION AGAINST RAPE

1-800-692-7445 (In Pennsylvania)
(717) 232-6745 (Outside Pennsylvania)

OR

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by the PA Department of Public Welfare

June, 1989

SEXUAL VIOLENCE: THE TIE THAT BINDS

The lives of victims of sexual violence are forever changed. They are emotionally, psychologically and physically harmed. Whether adult or child, male or female, the impact of sexual violence destroys trust and threatens safety. The challenge, once victimized, is to become a survivor - to regain power over one's own life.

Sexual violence exacts a price that is paid by each individual who is abused, assaulted or molested as a child or attacked as an adult. However, the price of sexual violence is also paid in ways that are only now becoming clear. As public awareness increases, the public price of continued sexual violence is more obvious. Recent studies of the clients of other human service systems repeatedly indicate the presence of sexual violence.

*Between 70% - 80% of adult sex offenders were sexually abused as children. (Groth, Freeman, Longo 1979; Longo, 1979; Longo, 1980; Kline, 1987)

*In one study, 50% of the adults admitted to a mental health center had a history of sexual abuse. (Saunders, Kilpatrick, Resnek, Towell; 1989)

*74% of alcoholic women had experienced sexual abuse, most often rape and/or incest. "...Alcoholic women are exposed to a wider variety of perpetrators, experience more instances of abuse, and have more multiple instances and longer duration of sexual abuse. They also report more incest and rape." (Covington, 1982)

*50% of women in treatment for substance abuse (crack, heroin, co-addiction) had been sexually abused as children, most often incest and rape. (Woodhouse, 1989)

*54% of psychiatric female inpatients had been sexually abused as children. (J.B. Bryer, 1987)

*65% - 75% of prostitutes were sexually abused as children. (Bryer and James, 1982)

*One study shows that 54% of pregnant adolescents had been victims of sexual abuse. (Butler and Burta, 1988)

*In another study, 61% of pregnant adolescents reported that their first sexual experience was unwanted. The average age when their first coerced sexual experience occurred was 11.5 years. 50% had been abused between two to ten times. (Gersheron, et al; 1989)

*A study of persons institutionalized with disabilities revealed that 60% of women and 76% of men had been sexually abused. 34% of the incidents occurred within the institution. (Nibert, Cooper, Crossmaker; 1989)

*73% of female runaways and 38% of male runaways were either sexually abused before leaving home or once they were on the streets. (Burgess, 1987)

*85% of children sexually exploited by pornographic rings were classified as missing at the time. (Burgess, 1984)

*Abuse is repeated at the rate of 30% from one generation to the next. (Kaufman, Ziegler; 1989)

These and other studies consistently report that clients with vastly different problems share the experience of sexual violence in their lives. It is not yet clear whether the sexual abuse is a direct or primary cause of later behavioral or psychological problems. However, it is reasonable to assume and borne out by the anecdotal experience of sexual assault centers, that in many instances, a causal relationship does in fact exist.

The consequences of sexual violence fall to the individual who is victimized and who must survive. But, as we are increasingly aware, the consequences extend beyond the individual and exact a high price from other service systems that must also provide service to persons with multiple and complex problems that affect themselves, their families and their communities.

For Assistance or Information Contact

PA COALITION AGAINST RAPE
1-800-692-7445 (In Pennsylvania) or
(717) 232-6745 (Outside Pennsylvania)

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by the PA Department of Public Welfare

February, 1990

Every victim of sexual assault should have the right:

- to be treated with dignity and respect by institutional and legal personnel.
- to have as much credibility as a victim of any other crime.
- to be considered a victim of rape when any unwanted act of sex is forced on her/him through any type of coercion, violent or otherwise.
- to be asked only those questions that are relevant to a court case or to medical treatment.
- to receive medical and mental health treatment, or participate in legal procedures only after giving her informed consent. (Information should include all possible options.) *
- to be treated in a manner which does not usurp control from the victim, but which enables her/him to determine her/his own needs and how to meet them.
- to not be exposed to prejudice against race, age, class, lifestyle or occupation.
- to have access to support persons, such as advocates, outside of the institutions.
- to have access to peer counseling.
- to be provided with information about her/his rights.
- to have the best possible collection of evidence for court.
- to not be asked questions about prior sexual experience.
- to have common reactions to the rape, such as sleeplessness, nightmares, hostility towards men, anxiety, fear, etc., not be considered pathological behavior.
- to have access to a secure living situation, or other measures which might help to allay fears of future assault.
- to have her/his name kept out the media.
- to be considered a victim of rape regardless of the assailant's relationship to the victim, such as the victim's spouse.
- to have deterred her/his assailant by any means necessary. No victim should be criminally prosecuted for harming the assailant during or immediately after the rape or for harming the assailant in the process of preventing an attempted rape.
- to receive medical treatment without parental consent if she/he is a minor.

-to have access to supportive legal advice.

-to have a preliminary hearing in each case when an arrest has been made.

-to be advised of the possibility of a civil suit.

*Some states have laws which require counties to pay for medical and/or mental health treatment resulting from a sexual assault. Currently, Pennsylvania has no legal provision for such expenses.

RAPE PREVENTION TACTICS

As the problem of rape grows more serious, more women feel the need to protect themselves. We would like every woman to be trained in self-defense, but this isn't easy to do, and even so, this in itself won't stop rape. We must, as women, feel stronger about ourselves, and this cannot happen unless we are aware of our situations and of how we might control some of them. The following rape prevention tactics are only one step in gaining control of our lives, but they are an important step.

WHERE YOU LIVE

Many rapes and attacks happen in the houses and apartments where women live. The landlords do not often provide adequate security, and they should be pressured to do so.

1. There should be lights in all entrances where you live.
2. All windows should be in place and have locks. In basement and first floor apartments and houses, windows should be protected with bars provided by the landlord. Curtains and/or blinds should be on every window.
3. There should be strong deadbolt locks (maybe double locks) for every door.
4. Be aware of places where men might hide; under stairs or between buildings.
5. If you live by yourself or with other women, don't put your full name on your mailbox or in the phonebook; use first initials instead (e.g., S. Smith, instead of Sue Smith).
6. Know your neighbors, and which ones you can trust in an emergency.
7. Always find out who is at your door before you open it. If it is a service person, ask for identification. If you're alone and not expecting anyone, respond to a ring or a knock with "I'll get it Bill".
8. When returning home at night, have your keys ready before you get to the door. If someone is watching you, don't let them know where you live.
9. If there is a suspicious person on the elevator with you, push the emergency button and all the floor buttons. Get off as soon as the elevator stops at a floor.

ON THE STREET

How you look is important. An attacker expects a passive victim, so if you walk slowly or in a daze, you will seem untogether to many men. Walking at a steady pace, looking confident, and knowing where you are going make a difference.

1. Try not to overload yourself with packages, large purses, or books. Pockets are more practical, keeping your hands free. (Most men on the streets have their hands free.)
2. Dress for use: many styles are nice, but can make it harder to move quickly. Clogs and platform shoes shouldn't be used if you're walking alone (or, learn how to run in them, since they are good for kicking). Capes, scarves, long necklaces and the like are easy to grab. Tight skirts and pants make it hard to run.
3. At night, don't walk through dark parking lots (they should be reported to city council), parks, or other places where men might hang out or hide.
4. Don't walk through a group of men. Walk around them, or if possible cross the street.
5. If you are alone, be extra aware of what's around you. Listen for footsteps and voices nearby. Look around to see if someone is following you. If you think so, change your walk – either quicker or slower – to see what happens. Try crossing the street; try walking down the middle of the street; stay near the lights. If you fear danger yell loudly. Yell "FIRE", not "HELP", or "RAPE". Go to the nearest lighted place and get in quickly. Break a window instead of ringing the bell. If you break into a run, make it quick and yell the whole way.
6. Carry a whistle wrapped around your wrist and use it when you think you should.
7. Don't walk alone if you're upset, drunk or high or on drugs. Ask a friend to go with you.
8. Don't walk too close to the inside of the sidewalk, near bushes, alley entrances, driveways, or entrances to private places.
9. If you are waiting for a friend outside, a bus, or light to change, notice how you stand. You should be balanced, feet apart and hands outside your pockets. (Your elbows are easy to grab, but hard to free quickly.) Don't lean against streetlights or signs. Be aware of cars that might pull up next to you, or cars that pass you more than once.
10. If you carry a purse, newspaper, or umbrella, keep it tucked under your arm.
11. It is always best to arrange transportation with people you work with, go to school with, or are friends with.
12. Don't walk home the same way every day. (Rapists often follow their victims and plan the attack beforehand.)

WHILE USING TRANSPORTATION

1. If you use a car, check the back seat before getting in (many attackers hide in cars and wait for the driver to return). While driving, keep doors locked and windows rolled down a little bit.
2. If you are using public transportation, keep valuables you're carrying under your arm while standing. Try not to stand near a group of men.
3. While sitting (on buses or subways) look aware and don't fall asleep.
4. If you're not sure where you're going, ask a driver and sit near the front.
5. If you have to hitchhike, see separate section.

"LEGAL WEAPONS" AS PROTECTION

Weapons should not be relied upon because they can be taken away from you and used against you. If you are confronted with an attacker's weapon, yours might not do any good; they are hard to handle correctly, and many times they aren't in your hand when you need them. (A hat pin, for example, is useless at the bottom of your purse if someone grabs you.) The following weapons should be used ONLY TO STOP AN ATTACK WITH ENOUGH TIME TO GET AWAY. Don't worry about winning when your life is being threatened; worry about saving your life and getting away. Remember the attacker will usually expect a weak, unaware victim and any effort to fight back will surprise him.

1. LIGHTED CIGARETTE: Smash it out on area of face.
2. PLASTIC LEMON: They will squirt as far as five feet. Fill it with "caution" liquids such as ammonia. Always aim

for the eyes; momentary blindness gives you time to get away. Same idea holds for spray cans (hairspray, perfume).

3. CHAIN – HEAVY RING: If you can afford one, wear it with the heavy part inside and go for a good, strong slap in the face of the attacker.
4. UMBRELLA: Place one hand in the center of it and the other hand behind it. Use quick jabbing motion to neck or stomach. You can also place one hand on each end and force it down against attacker's face or neck.
5. HATPIN: Carry it in your hand, tightly, or pin it to your clothing. With your hand wrapped around it, scrape it across face or jab at the neck.

SOME BASICS ON YOUR BODY

1. If you just throw your hands out for striking, they can be grabbed by an attacker and used to get you down.
2. If an attacker is close to your body, use your elbows for striking the neck or his sides, or even his stomach to take him by surprise.
3. Any strikes with your hands in fists should go right to the face; eyes, ears, nose, and mouth are weak areas, and if force is used, he might be gotten off guard.
4. If he's real close to you never forget your voice in the ears, and your teeth.
5. If you want to kick, don't just throw your leg around; aim at his knees, this will knock him off balance. (If you aim to high, you might lose balance).
6. Don't always think you can knee an attacker in the groin; he will usually protect this first. If you must go to the groin, use your hands to grab, then pull.
7. Pulling hair or clapping your hands over his ears are fairly effective.
8. Your most reliable strong points to think about are forehand, hands, elbows, knees, and feet. Know what you can and can't do with them.

For more good material on self-defense (with pictures) here is a good book:

Self-Defense for Women by Jerrold Offstein
850 Hansen Way, Palo Alto, CA 94304
(should try ordering through local book store or public library)

IF YOU MUST HITCHHIKE

Hitchhiking isn't a cool, or safe thing to do, but many women find it a necessity. If there is any other way of getting around (cab or bus), that is suggested. Also, don't be embarassed to ask friends with cars to take you places; they should also have an interest in your safety.

1. Try not to hitch by yourself.
2. Please, try not to hitch at night.
3. Hitch rides where there is lots of traffic; stay away from deserted places.
4. Never accept a ride with more than one man. Don't be afraid to refuse a group.
5. Encourage as many women as possible to pick up female hitchhikers.
6. When entering the car, look to see if someone is hiding in the back seat.
7. Make sure there is an inside door handle that works on your side.
8. Make sure that the man is fully clothed and his pants are zipped up.
9. Make sure he keeps his hands on the steering wheel or leaning on the window.
10. Don't get into a car with beer or liquor bottles on the floor; he may be drunk.
11. Don't accept a ride with a speedster who slammed on his brakes to pick you up.
12. Don't take a ride from a guy who changes directions to pick you up, like making a turn, or changing blinkers to turn a different way.
13. Always keep your window partly rolled down in case you have to scream.
14. Wear a whistle (good metal ones cost 50¢) to blow in driver's ears or to use as a help signal out the window.
15. If you smoke, keep a cigarette lit. (See "lighted cigarette" under weapons).
16. Ask him what direction he's headed in before you tell him where you're going. You should never get dropped off next to where you're really going.
17. If you carry a bag, hold it in your lap with your left hand, and keep the right hand on the door handle. The bag can be used against an attack, and you need to get out quickly. Your left elbow can be jabbed into his ribs.
18. If the man wants to make a "stop" first; get out as soon as possible.
19. Also make sure you know where you are going in case he makes a "wrong turn".
20. Never hitch into country places or outer-city parts where he could drive quickly and without stopping.

There may come a time when you might have to jump out of a moving car. (This also holds true if you are forced into a car.) Make sure that you can roll to a clear spot away from other moving cars. Throw your shoulders first with your right hand near your body. Tuck your head in to your neck and keep your body curved. Let your feet follow. It'll hurt, but if you feel danger, and you aren't near any stop signs or lights, then this may be your only choice. Also, whether you are in or near a car with a threatening man, remember the license plate number of the car. He should be reported and also described to other women. REMEMBER, you are seen in a weaker position if you accept a ride from a man, and if anything happens to you and you report it to the police, they may put a lot of blame on you. Don't forget that as long as he doesn't have a weapon, you might try to attack him; he still has the car to control. Don't forget about screaming in a ear either.

CONCLUSION:

We know that it's impossible to follow all of these suggestions. We also know that in some cases, these tactics haven't worked. They can help you, but they are not foolproof. Think about the situations which make you feel most open to danger and least powerful. Choose and practice the tactics which fit these dangerous situations and make you feel more safe. The most important thing is to try to remain calm at all times, although it may be difficult. Make sure you know what is going on around you at all times, and act confident and strong, whether you really are or not. You can stop possible attackers, and you may eventually convince yourself of your own strength. We will continue to think of other ways to protect ourselves, and of ways to get out of dangerous situations. Spread the word about prevention tactics, and share this with your friends, relatives, and co-workers.

Reprinted by permission of
Rape Crisis Center
P.O. Box 21005, Washington, D.C. 20001

Courtesy of
Pennsylvania Coalition Against Rape
2200 North Third Street, Harrisburg, PA 17110

SEXUAL VIOLENCE: IT EFFECTS US ALL

THE CRIME

Sexual violence occurs whenever a person is forced to submit to another person against her or his will. It is a crime that involves power as the motive, sex as the weapon and aggression as the method. However, the method used does not matter - fists, verbal threats, weapons, use of drugs or alcohol, physical isolation or the weight of one's body.

Sexual violence takes many forms. Sexual assault involves physical force - **stranger, acquaintance, marital or gang rape.** Sexual abuse involves the use of psychological pressure - **incest.** Sexual exploitation is forced or pressured sexual activity that usually includes economic motive - **child prostitution, pornography.**

Anyone can become a victim of sexual violence regardless of age, sex, race, appearance or economic status.

* **Every six minutes during 1987, one American was forcibly raped. (Federal Bureau of Investigation, Uniform Crime Reports, 1988)**

* **Rape is the most under-reported violent crime with only 5% to 20% reporting. (Helen Benedict, "Recovery: How to Survive Sexual Assault", 1985)**

THE EFFECTS

The trauma resulting from sexual violence can be devastating. Victims suffer physically and psychologically. A myriad of problems may result - sleep and eating disorders, nightmares, anxiety, fear, feelings of shame, anger and revenge. Individuals may contract sexually transmitted diseases, become pregnant or suffer life-long disability.

Individuals may also suffer physical injury ranging from bruises, lacerations, broken bones, internal bleeding or even death.

Unresolved trauma can lead to damaging behavior such as drug and/or alcohol abuse, inability to remain employed, broken relationships with family or friends, failure in school, abuse of others or suicide.

* **30% of injured violent crime victims incurred medical expenses: 12% of the expenses were below $50; 25% were between $50 and $249; and 29% were more than $250. (Bureau of Justice Statistics, 1986)**

* **For years following a rape, 60% of rape victims experience Post Traumatic Stress Disorder and 16% still suffer with emotional problems 15 years following the rape. (HRS Rape Awareness Program, Tallahassee, FL, 1987)**

* **12% to 24% of adolescent incest victims become pregnant as a result of the abuse. 2% to 5% of adult rape victims become pregnant. (PA Coalition Against Rape, "Sexual Assault: The Facts", 1988)**

HELP IS AVAILABLE

Rape crisis centers are located throughout the country to provide support and assistance to victims whenever they seek help. Centers provide 24-hour hotlines; crisis and on-going counseling; accompaniment to medical, police and court facilities; and support services to family and friends. You **do not** have to file charges against the assailant(s) to seek help from a rape crisis center. Help is also available to individuals victimized in the past.

Remember you are not to blame nor are you alone. There are people who care and are willing to help. With support, you can become a SURVIVOR of sexual violence.

For Assistance or Information Contact

THE PENNSYLVANIA COALITION AGAINST RAPE

1-800-692-7445 (In Pennsylvania)
(717) 232-6745 (Outside Pennsylvania)

OR

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by the PA Department of Public Welfare

June, 1989

ACQUAINTANCE RAPE

Acquaintance rape is using physical force, emotional bargaining, blackmail, or mind games to force sexual intercourse. Over 80% of rape victims know their attackers - friend, date, neighbor, co-worker, lover or ex-lover.

The most common of acquaintance rapes are those that occur in dating or romantic situations. These rapes occur as the result of sex role behaviors and misunderstood communications. Males are taught to "score" with women and that "no" means "yes" or "maybe" and a "little" persuasion is acceptable. Women are taught that flirting is a harmless game. Yet, if "things get out of hand", they are responsible for the male's behavior. Communication is nonexistent and misunderstood. Rape does happen - EVEN AMONG FRIENDS! (PA Coalition Against Rape, "EVEN AMONG FRIENDS", 1985)

All the following statistics are from Robin Warshaw's book, "I Never Called It Rape", 1988.

* 1 out of every 4 college women has been the victim of rape or attempted rape.
* A woman's risk of being raped by someone she knows is four times greater than being being raped by a stranger. 84% of the victims knew their assailant.
* Only 5% reported the rape to the police. 42% told no one.
* 1 in every 12 college men admitted to committing acts that meet the legal definition of rape.
* 75% of the men and at least 55% of the women involved in acquaintance rape had been drinking or taking drugs prior to the attack.
* 41% of the victims expect to the raped again. 30% contemplated suicide. 31% received psychotherapy. 22% took self-defense courses. 82% reported permanent changes in their lives as a result of the rape.
* In a 1986 study conducted at UCLA, 30% of the men said they would commit rape if they knew they would not be caught. 50% of the men said they would force a woman to have sex if they were sure they would not be caught.

For Assistance or Information Contact

PENNSYLVANIA COALITION AGAINST RAPE
1-800-692-7445 (In Pennsylvania)
(717) 232-6745 (Outside Pennsylvania)

or

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by the PA Department of Public Welfare

June, 1989

THE SEX OFFENDER

There are five primary reasons that men rape: 1) to assert power and strength; 2) to control and exploit; 3) to degrade, hurt and humiliate; 4) to deny sexual anxieties and doubts; and 5) to reaffirm identity and competency. Rapes committed by men can be put into three categories. The power rape where the purpose is not to inflict harm but to assert control over their victim. 55% of all rapes are **power rapes**. 40% of all rapes are **anger rapes** which involves physical brutality. 5% of all rapes are classified as **sadistic** where the offender derives pleasure from inflicting pain and seeing the victim suffer. **(A. Nicholas Groth, "Why Men Rape", 1979)**

* 95% of all sex-related crimes are committed by men. (A. Nicholas Groth, "Why Men Rape", 1979)

* Over 50% of adult sex offenders have committed their first sexual crime prior to age 18. (Michael O'Brien, Walter Berg, "Adolescent Sex Offenders: A Descriptive Typology", 1986)

* 83% of child molesters are heterosexual. The remaining 17% are bi-sexual. (A. Nicholas Groth, "Why Men Rape", 1979)

* 90% of all sex offenders act alone. (PA Coalition Against Rape, "Maltreatment of Children", 1986)

* A study of 411 outpatient sex offenders revealed that over a ten year period they had attempted 238,711 sex crimes. The group had successfully committed 218,900 crimes during the same period - an average of 533 crimes per offender. (Fay Honey Knopp, "Retraining Adult Sex Offenders: Methods and Models", 1984)

For Assistance or Information Contact

PENNSYLVANIA COALITION AGAINST RAPE
1-800-692-7445 (In Pennsylvania)
(717) 232-6745 (Outside Pennsylvania)

or

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by the PA Department of Public Welfare

June, 1989

SEXUAL VIOLENCE AND CHILDREN

Incest is legally defined as sexual intercourse between family members; this includes step-parents and step-siblings. Victims are trapped within the family unit and in their confusion and fear, remain silent. The assailants depend on this secrecy to continue the victimization. **(PA Coalition Against Rape, "Child Sexual Abuse: The Family Secret", 1984)**

Several conditions have been associated consistently with higher risks of abuse: 1) a child lives without one of the biological parents; 2) a mother is unavailable to the child due to illness, disability or employment; 3) the parent's marriage is conflictual or unhappy; 4) the child has a poor relationship with the parents; 5) the child is subjected to extremely punitive discipline or physical abuse; and 6) the child has a stepfather. Surveys have not found any correlation between the incidence of child sexual abuse and socioeconomic status or race. **(David Finkelhor, L. Baron, "Risk Factors of Child Sexual Abuse", 1986)**

Child sexual assault includes indecent exposure, molestation, corrupting morals, exploitation and rape. The majority of assaults on children do not involve brutality or extreme physical violence. **(PA Coalition Against Rape, "Child Sexual Assault: What You Don't Know Can Hurt", 1984)**

* **It is estimated that as many as 40 million Americans, one in six people, experienced sexual victimization as children. (Psychology Today, February, 1987)**

* **1 in 4 girls and 1 in 7 boys will be sexually victimized before age 18. ("Preventing Sexual Abuse", Spring, 1986)**

* **The most common ages of children when sexual abuse occurs are between 8 and 12. (David Finkelhor, "Child Sexual Abuse: New Theory and Research", 1984)**

* **Child sexual abuse is seldom a one time occurrence. Abusive relationships last an average of 1 to 4 years, many last much longer. (National Committee for the Prevention of Child Abuse, 1979)**

* **75% to 80% of all children assaulted or abused were victimized by someone they knew. (Ann Burgess, Lynda Holmstrom, "Sexual Trauma of Children and Adolescents", 1979)**

* **One of five rape victims are under age 12. 10% of all rape victims are under age 5. (Robert Geiser, "The Hidden Victim: The Sexual Abuse of Children", 1979)**

For Assistance or Information Contact

PENNSYLVANIA COALITION AGAINST RAPE
1-800-692-7445 (In Pennsylvania)
(717) 232-6745 (Outside Pennsylvania)

or

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by PA Department of Public Welfare
June, 1989

MARITAL RAPE

Marital rape is a crime of violence and aggression inflicted on one's spouse. There are three types of marital rape: **battering, non-battering** and **obsessive.** Battering rapes are the most brutal and involve a great deal of physical abuse. Non-battering rapes are substantially different. The desire is to establish control, assert power or teach a lesson. Obsessive rapes are characterized by unusual sexual preoccupations of the husbands. Most are obsessed with pornography and find humiliation stimulating. **(PA Coalition Against Rape, "Marital Rape: Facts and Fiction"**, 1984)

All of the following facts are from Diana Russell's book, **"Rape in Marriage"**, 1983.

* **Of all marital rapes, 45% are battering, 45% are non-battering and 10% are obsessive.**
* **10% to 14% of all married women have been raped by their husbands.**
* **In cases sampled, husbands raped their wives at least twice and in one-third of the cases, more than 20 times.**

For Assistance or Information Contact

PENNSYLVANIA COALITION AGAINST RAPE
1-800-692-7445 (In Pennsylvania)
(717) 232-6745 (Outside Pennsylvania)

or

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by the PA Department of Public Welfare

June, 1989

MALE RAPE

Male rape is vastly ignored and unrecognized. Male rape is not just confined to prisons; it can happen anywhere - in an isolated location, your place of employment or your home. Any man can be raped regardless of size, strength, appearance or sexual orientation. Rape is a crime of control - violence perpetrated in the form of sexuality. (Helen Benedict, "Recovery: How To Survive a Sexual Assault", 1985)

While many aspects of the male's reaction to sexual violence are the same as a women's, there are unique responses. Males that have been victimized as children or adolescents are more prone to become offenders. There is greater abuse of drugs and alcohol as a result of the assault. There is greater anger and need for retaliation. Severe problems with their sexual identity are more prevalent. There is also a greater sense of vulnerability and lower self-esteem. (Dean Kilpatrick, "NOVA Newsletter", December, 1986)

* 7% to 10% of all adult rape victims are male. (Helen Benedict, "Recovery: How to Survive Sexual Assault", 1985)

* Only 5% to 20% of all rape victims report the crime. Even fewer male victims report. (Helen Benedict, "Recovery: How to Survive Sexual Assault", 1985)

* 56% of all male rapes are committed by strangers. 33% are committed by acquaintances. (A. Nicholas Groth, "Why Men Rape", 1979)

* Multiple sex acts are demanded more often by perpetrators of male rape. A study revealed that 45% of all male rapes involved multiple sex acts. (A. Nicholas Groth, "Why Men Rape", 1979)

* There is evidence that males are victimized or assaulted more often by multiple assailants than are females. (American Journal of Psychiatry, 1980)

* In cases of male rape, a weapon is used more often and the associated violence results in more serious physical injuries than when females are the victims. (American Journal of Psychiatry, 1980)

For Assistance or Information Contact

PENNSYLVANIA COALITION AGAINST RAPE

1-800-692-7445 (In Pennsylvania)
(717) 232-6745 (Outside Pennsylvania)

or

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by the PA Department of Public Welfare

June, 1989

GANG RAPE

Gang rape involves three or more assailants and usually one victim. The primary motive is camaraderie with the other members of the group. Participants are also trying to satisfy their need for affiliation, recognition, status, group membership and confirm their masculinity. The act of committing gang rape is given sanction, support and validation.

In most cases of gang rape, the leader instigates the plan and is the first to rape the victim. Co-offenders play different roles during the rape. They may actively assist in restraining the victim, take turns raping the victim or verbally encourage the active participants. The amount of brutality and aggression increase in relation to the number of active participants.
(A. Nicholas Groth, "Why Men Rape", 1979)

All the statistics below are from A. Nicholas Groth's book, "Why Men Rape".

* 9% of sex offenders commit gang rape. 90% of the rapes are against a single victim. 7% of gang rapes involve two victims.
* 77% of gang rapists are between the ages of 17 and 27. 77% of the victims are between the ages of 16 and 28.
* 87% of the victims are female while 10% of the victims are male.
* Of the sex offenders committing rape, 63% are strangers to the victim and 37% were acquaintances of the victim.

For Assistance or Information Contact

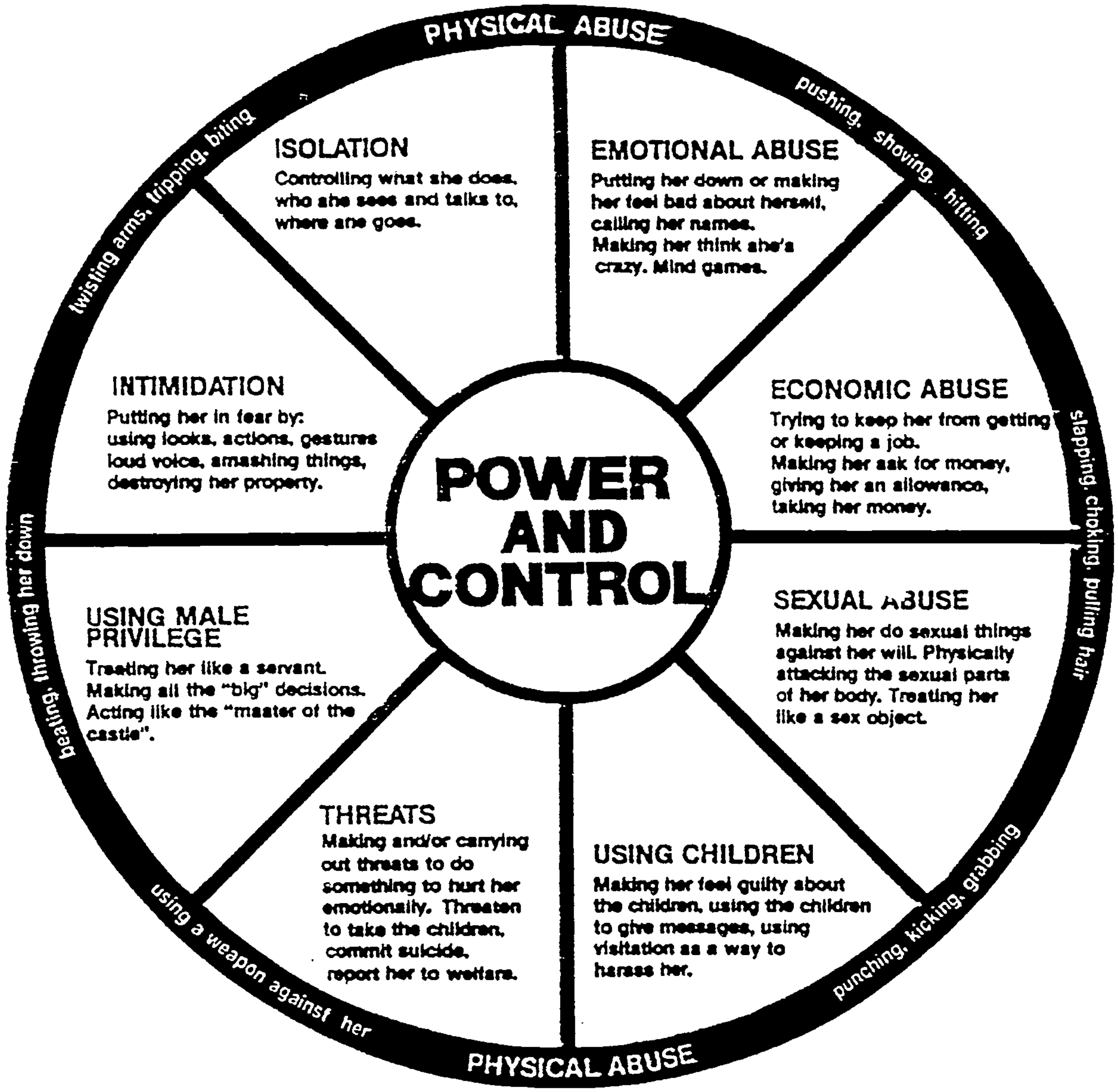
PENNSYLVANIA COALITION AGAINST RAPE
1-800-692-7445 (In Pennsylvania)
(717) 232-6745 (Outside Pennsylvania)

or

YOUR LOCAL RAPE CRISIS CENTER

Developed in part with funds provided by the PA Department of Public Welfare

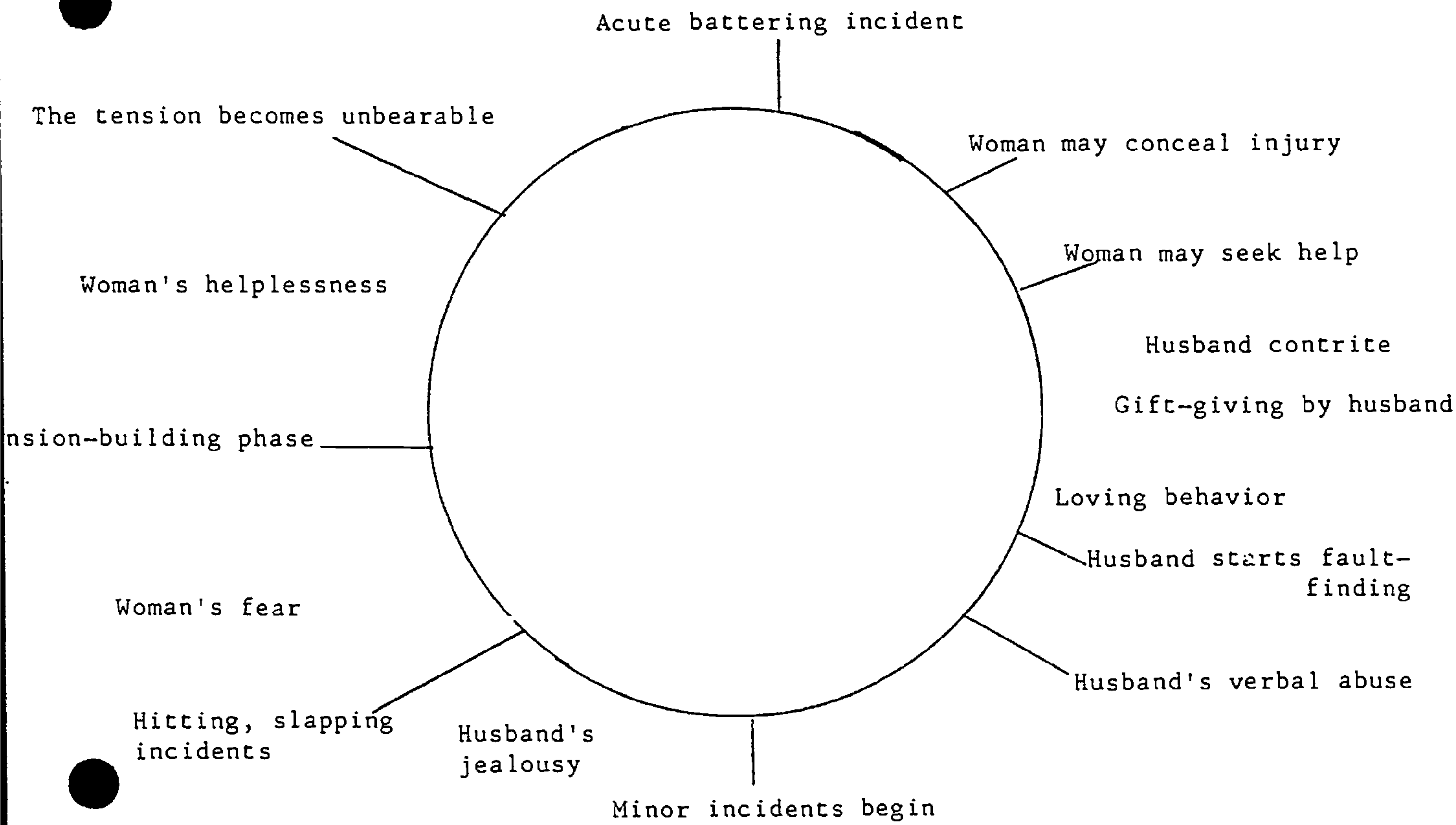
June, 1989



COMMON CHARACTERISTICS OF ABUSE VICTIMS

- Low self esteem
- Believes in traditional sex role stereotypes
- Accepts responsibility for battering
- Feels guilt - denies terror and anger that she feels
- Presents passive face to outsiders - yet has strength to manipulate her environment to a degree
- Uses sex to try to develop intimacy with partner
- Severe stress reactions - frequent psychosomatic complaints
- Believes no one can really help her out
- Overwhelmed by decisions
- Feels helpless - passive at home, no help from systems, fear of losing security
- Feels she must stay to help him
- Overwhelming fear and anger, often covert - seen as guilt and hurt
- Isolated - may not be working or has never worked, self image defined by his criticisms, family and friends may be alienated by previous incidents of violence
- Financially and emotionally dependent
- May have learned pattern of violence as a child

CYCLE OF VIOLENCE



I. Tension-Building Stage
   A. Minor battering incidents
      1. Physical
      2. Verbal
   B. Duration
   C. Escalation - moves rapidly into Acute Battering Stage

II. Acute Battering Stage
   A. Surprise and unpredictability
   B. Concealment
   C. Abuse -- physical and verbal
   D. Powerlessness
   E. Intervention/potential for getting help here

III. Loving Respite
   A. Loving, kind, contrite behavior
   B. Duration
   C. Cycle begins again

DATING VIOLENCE QUESTIONNAIRE

Women In Transition — Family Service of Philadelphia

Mark an "X" for agree or disagree for each statement, according to your opinion.

Age________ Male________ Female________

Agree	Disagree	
____	____	1. It's all right to tell your friends about what happens in your relationship with your boyfriend or girlfriend.
____	____	2. People my age hardly ever hit each other when dating.
____	____	3. The guy should have the final say in making decisions in a dating relationship or marriage.
____	____	4. Men rarely hit women.
____	____	5. When a girl is going with a guy, she should not talk to other guys if he doesn't like it.
____	____	6. Drugs and alcohol are causes of fights.
____	____	7. It's never okay to hit anybody.
____	____	8. If a boy slaps a girl because he is jealous, he is proving his love.
____	____	9. Young women make their boyfriends hit them.
____	____	10. A young man who beats up his girlfriend will probably get into fights with other people as well.
____	____	11. Couples who hit each other don't really love each other.
____	____	12. If a girl's boyfriend is unable to take her out because he is working or something, she should not go out on her own with her own friends.

(See Over)

Agree	Disagree	
______	______	13. Guys who hit their girlfriends usually treat them special when they are around other people.
______	______	14. If a girl does something she knows her boyfriend doesn't like, it's all right if he slaps her or pushes her around a little.
______	______	15. If there has been jealousy and threats, or even slapping during dating, getting married will usually improve things.
______	______	16. Children need a father even though he beats or abuses their mother.
______	______	17. In a marriage, a woman's career is just as important as a man's career.

Questions developed by:

Women's Coalition, Inc., Duluth Minnesota

Women In Transition

Family Service of Philadelphia

MYTHS ABOUT BATTERING

1. Battering effects a small percentage of the population.
2. Battered women are masochistic.
3. Battered women are crazy.
4. Middle class women do not get battered as frequently or violently as poor women.
5. Minority women are battered more frequently than Anglos.
6. Religious beliefs will prevent battering.
7. Battered women are uneducated and have few job skills.
8. Batterers are violent in all of their relationships.
9. Batterers are unsuccessful and lack resources to cope with the world.
10. Drinking causes battering behavior.
11. Batterers are psychopathic personalities.
12. Police can protect the battered women.
13. The batterer is not a loving partner.
14. A wife batterer also beats his children.
15. Once a battered woman, always a battered woman.
16. Once a batterer, always a batterer.
17. Long-standing battering relationships can change for the better.
18. Battered woman deserve to get beaten.
19. Battered woman can always leave home.
20. Batterers will cease their violence "when we get married...."
21. Children need their father even if he is violent.

DO WOMEN PROVOKE OR ENJOY IT?

The women who have been battered do not want or get satisfaction from being beaten. They live with the violence because of fear; because of other things they want or appreciate in the relationship;and/or because they feel unable to do anything else.

IT IS THE ABUSER'S BEHAVIOR THAT PROVOKES AND CONTINUES THE VIOLENCE.

Why Does She Stay?	Why Does He Batter?
fear	a need to control others
economic dependency	low self-esteem
depression & learned helplessness	extreme jealousy
hesitancy to break up the family	insecurity and fear or being alone
isolation	denial of responsibility
mixed emotions of love and hate her spouse	society tolerates and condones domestic violence
a desire to protect her children	battering is a very effective tool to gain control
hopes that he will change	learned behavior
no resources	
low self-esteem	

THE PURPOSE OF ABUSE IS TO DOMINATE AND CONTROL OTHERS AROUND THE ABUSER.

PATTERNS IN ABUSIVE RELATIONSHIPS

I. Tension Building

- Tension mounts in the relationship.
- The batterer is irritable, frustrated, and unable to cope with everyday stresses.
- The battered woman will attempt to appease the batterer by becoming compliant, nurturing, or staying out of his way.
- She often assumes responsibility for controlling his anger.
- She denies the inevitability of the beating, as well as her terror.
- The batterer fears that she will leave him--his fears are reinforced by her coping strategy of withdrawing and avoiding him.

II. The Battering Incident

- The batterer's intent is to teach her a lesson, not to inflict injury--in the process he loses control of his rage.
- Only the batterer can end this phase.
- The victim needs a safe place during this phase.
- Once over, the victim will deny the incident, her injuries or her terror.

III. Calm Respite of "The Honeymoon"

- The batterer is:
  - kind and loving.
  - charming.
  - very afraid she will leave.

- The victim is:
  - wanting to believe that her suffering is over.
  - believing that this "good" side of his personality is the man she loves.
  - developing learned helplessness.

STATISTICS ON BATTERING

* Battering is the single major cause of injury to women in the United States today, more significant than auto accidents, rapes or muggings.
  - Sociological Monograghs, London 1984

* In the United States, a woman is beaten every 18 seconds. The total number of battered women in the United States is estimated to be over 40 million.
  - F.B.I.

* In Pennsylvania, it is estimated that one out of six women, or more than 800,000 women, are battered each year.

* Annually, nationwide, some 2,000 to 4,000 women are beaten to death.
  - F.B.I.

* Studies indicate that up to 60% of all married women are subject to physical violence by their husband at some time during their marriage.
  - Jennifer Fleming, Stopping Wife Abuse

* There are 3 - 6 million reported cases of domestic violence per year in this country. The majority of these are wife abuse cases.
  - H.E.W. - Office of Domestic Violence

* Only one in ten cases of spousal abuse is ever reported to the authorities.
  - H.E.W. - Office of Domestic Violence

* From 1982 to 1986, 143 Pennsylvania women were killed by their spouses.
  - PA State Police

* Seven percent of the total homicides in this country were committed by husbands or boyfriends.
  - F.B.I

* Between 1982 and 1984, less than half of all violent crimes were committed by strangers with 8% being committed by relatives. Most crimes (77%) were committed against women, with spouses committing two-thirds of all crimes by relatives against women.
  - National Crime Survey

* Physical violence occurs between family members more often than it occurs between any other individuals or in any other setting except for wars and riots.
  - National Institute of Mental Health

* Twenty-five percent of all murders involve close family members; in over half of these cases, one spouse killed another, with wives being the victims in 52% of the cases, and the "criminal" in 48%.
  - International Association of Chiefs of Police

* Although husbands and wives kill each other with equal frequency, wives are seven times more likely than husbands to have killed in self-defense.

- National Commission on the Causes and Prevention of Violence

* A Kansas City study of "domestic assaults and homicides" reveals that prior to the last serious or fatal attack, police had responded to previous calls for help in 85.4% of the cases. In over half of these, they had already been summoned five or more times!

- Jennifer Fleming, Stopping Wife Abuse

* About one-third of the incidents of domestic violence against women in the National Crime Survey would be classified by police as "rape," "robbery," or "aggravated assault," felonies in most states. The remaining two-thirds would likely be classified by police as "simple assault," a misdemeanor in most jurisdictions. Yet, based upon evidence collected in the Survey, as many as half of the domestic assaults actually involved injury as serious as, or more serious than, 90% of all rapes, robberies and aggravated assaults.

* Domestic violence is a crime, and when treated as such by arresting the abuser, further violence is deterred. Victims of domestic assault are about twice as likely to be assaulted again by the abuser if the abuser is not arrested by the police.

* Calling the police after an incident of domestic violence appears to reduce the risk of subsequent violence (within the next six months) by as much as 62%.

* Only two percent of the men who beat their wives are ever prosecuted.

- Rep. B. Mikulski

* Police receive more calls for help from victims of wife abuse than any other serious crime.

- Jennifer Fleming, Stopping Wife Abuse

* Forty percent of all police injuries and 22% of all police deaths occur while answering domestic violence calls.

- F.B.I.

VIOLENCE IN THE FAMILY

PART FIVE: WHY DOES SHE STAY?

The following information is taken from the classroom presentation of Ms. Ellen Moyle Harris, Executive Director of the Domestic Violence Service Center.

In order for many of us even to imagine that any woman would knowingly subject herself to abuse or submit to it, we need to believe that she is somehow different from other women, that something is wrong with her. Some of us use the question to set ourselves apart from "her," to validate our differentness, our superiority, and/or our own safety. If we know what makes her different, then we can be assured that it will never happen to us. Others of us use the question to explore the ways in which she might have provoked the violence. if she deserves, or even likes, the abuse then it is her own fault that she is battered.

Admittedly, sometimes the question can be used to help the battered women explore the options that might be available to help her end the violence in her life. For instance, if she stays because of economic dependence, perhaps those options might include job training or cash assistance. These options, however, are rarely readily available to the battered woman and are very much dependent on many other factors such as her own safety while pursuing them, child care, transportation, availability of housing, etc. Often the obstacles to utilizing the available options are, themselves, overwhelming.

As used by most individuals and institutions the question, "Why does she stay?" is a prime example of victim-blaming. The fact is that the only thing that significantly sets her apart from me, that makes her somehow different, is that she is beaten -- and I am not.

Each time such victim-blaming questions are asked, domestic violence workers respond with a litany of appropriate psycho-social reasons. Poor self-image. No job skills. Hope that her abuser will change. Children. No other support system. Fear of retribution. These reasons are self-evident -- battered women do not STAY nearly as often as they simply CANNOT LEAVE. Each time, however, that the question is asked, domestic violence workers expend their energy to react rationally to the irrational, victim-blaming, and sometimes patriarchal mindset from which the question often comes. As a result, through our energetic, reasonable, rational, and constant explanations, we actually might be reinforcing the patriarchal system's ability and power to control the lives of women. (For example: You ask why she stays, what makes her different. Even though you might not be aware of it, the question most often blames the victim in that it puts the burden of responsibility for the violence on her -- if she didn't stay, then she could not be battered. I answer your question by reinforcing her differentness, at least socially and economically. I, therefore, allow you to continue thinking of hears different and to continue to blame her in some way for her own victimization. What's worse is that I, myself, am encouraging you to do so by responding to the question that you present.)

The more appropriate question that requires and deserves an answer is one that battered women and domestic violence wonders are rarely given an opportunity to address. That question is: WHY DOESN'T SOMEONE MAKE HIM STOP ABUSING HER?

Some of the answers to that question are addressed by Murray Strauss in "Sexual Inequality, Cultural Norms, and Wife Beating." Strauss asserts that battering is not a personal abnormality but that it has its roots in the structure of society and the family and in Western cultural norms. American cultural norms reflect a hierarchical and male-dominant society. The right to use force exists to provide the ultimate support for the existing power structure of the family particularly when one who has the least power refuses to accept her "place" or role as defined by the one who has the most power.

Strauss discusses the cultural contradictions of the desire for peace and harmony while, at the same time, we glorify violence and aggression through the media. Wife-beating is often legitimized by the legal system. (The Protection from Abuse Act has been a law in Pennsylvania only since 1976.) The police often fail to act in ways which provide for the safety of battered women once the police leave the scene. Victim compensation is rarely available to battered women because the funds might in some way benefit their abusers if they continue to reside together. Cultural approval of violence is further demonstrated by the failure of prosecutors and courts to invoke criminal penalties for perpetrators of domestic violence. Strauss further asserts that the male orientation of the American criminal justice system guarantees the inability of battered women to seek legal relief.

Every day, battered women and domestic violence workers are witness to the results of woman-battering which is allowed to occur and is even encouraged by the society in which we live. There are so few realistic options open to battered women, all of whom would prefer to have a violence-free lifestyle. The options that do exist often have overwhelming strings attached. Like the apartment owners who won't rent to them for fear of having the abuser show up and cause trouble in the neighborhoods. Like the duty magistrate who sees no reason to issue an emergency Protective Order on Saturday night when the battered woman can just take herself and her children to the local Shelter for the weekend instead of forcing her abuser to leave "his home." Like the well-meaning family members who encourage her to stay and "work things out" for the "sake of the children." Like the friends who reinforce the notion that her abuser is a "wonderful guy" when he's not drinking. Like the clergyperson who tells her to "pray for guidance" to become a better wife. The list goes on...and still no one but battered women ask, "Why doesn't someone make him stop?"

DATING VIOLENCE QUESTIONNAIRE

Women in Transition — Family Service of Philadelphia

Mark an "X" for agree or disagree for each statement, according to your opinion.

Age__________ Male__________ Female__________

Agree	Disagree		Statement
____	____	1.	It's all right to tell your friends about what happens in your relationship with your boyfriend or girlfriend.
____	____	2.	People my age hardly ever hit each other when dating.
____	____	3.	The guy should have the final say in making decisions in a dating relationship or marriage.
____	____	4.	Men rarely hit women.
____	____	5.	When a girl is going with a guy, she should not talk to other guys if he doesn't like it.
____	____	6.	Drugs and alcohol are causes of fights.
____	____	7.	It's never okay to hit anybody.
____	____	8.	If a boy slaps a girl because he is jealous, he is proving his love.
____	____	9.	Young women make their boyfriends hit them.
____	____	10.	A young man who beats up his girlfriend will probably get into fights with other people as well.
____	____	11.	Couples who hit each other don't really love each other.
____	____	12.	If a girl's boyfriend is unable to take her out because he is working or something, she should not go out on her own with her own friends.
____	____	13.	Guys who hit their girlfriends usually treat them special when they are around other people.
____	____	14.	If a girl does something she knows her boyfriend doesn't like, it's all right if he slaps her or pushes her around a little.

Agree	Disagree	
_____	_____	15. If there has been jealousy and threats, or even slapping during dating, getting married will usually improve things.
_____	_____	16. Children need a father even though he beats or abuses their mother.
_____	_____	17. In a marriage, a woman's career is just as important as a man's career.

Questions developed by:
Women's Coalition, Inc., Duluth, Minnesota
Women In Transition
Family Service of Philadelphia

DOMESTIC VIOLENCE AND ITS EFFECTS ON CHILDREN

Domestic violence is a family problem. Children who live in a violent home environment are affected by the violence, even if they are not the appointed targets of abuse. These children are affected by witnessing the violence itself. They are affected by the attitudes of their parents. They are affected by the feelings they have about the violence. They are affected by the messages they receive about the violence, the attitudes and the feelings. The following is a list of characteristics of children who witness domestic violence prepared by Donna Miller, M.S.W.

1. For some children, the problems of domestic assault begin before they are born.
2. Domestic violent families are often socially isolated, therefore parents may be the child's only role models available.
3. The child learns that violence is an acceptable way to solve problems, and assumes that violence is the norm.
4. The child blames himself/herself for causing the violence.
5. Mom's helplessness communicates to the child that the violence is inevitable. The child sees few options.
6. There tends to be violence toward their siblings and sometimes toward their parents in later life.
7. The family moves frequently, often separating family members for periods of time.
8. Children often experience school adjustment problems.
9. Children tend to have difficulty making relationships with peers.
10. Children are taught stereotypical roles.
11. There are often role reversals in the family which confuse children as to who they are.
12. The children frequently fantasize "saving" their parents relationships. When this fails, they may fantasize escaping from the home (running away, early marriage, pregnancy, etc.)
13. Children sometimes fantasize killing themselves and/or their parents (either father or mother) and sometimes attempt or complete suicide or homicide.
14. The children are likely to continue the pattern of violence in their own adult relationships.

A majority of the children do not have the ability or are afraid to put words to their feelings and concerns. Therefore, it is more likely to find the children acting them out and giving non-verbal clues. Attention seeking or withdrawn behaviors are often used by children to express their feelings and concerns. Children, growing up in an environment where women frequently are passive and exhibit helplessness and where men use violence as a problem-solving strategy, learn to pattern those behaviors.

By helping the children have a better understanding of their home situations and alternatives to dealing with their feelings, we are helping to stop the cyclical pattern of domestic violence in their lives.

(Taken from the PCADV training manual)

PROFILE OF MEN WHO BATTER

Listening to victims of domestic violence, I became aware that there was a great deal of similarity in the experiences that they related. Yet each woman believed she was the only person to experience such atrocities. As certain elements were repeated over and over, the following profile emerged:

Men who batter exhibit most of these eleven traits--sometimes to an extreme degree:

1. Jealousy of Partner. Men who batter almost routinely accuse their partners of having other sexual relationships. Slight evidence is sufficient to fire their imaginations. A van parked across the street was proof enough for one client's partner. Another accused his wife of fellatio with another whenever she suffered influenza symptoms. Such intensely irrational jealousy may arise from the man's own insecurities and projections: He may be having sexual liaisons outside their primary bond himself. Objectification of women is a third contributing factor.

2. Control and Isolation of Partner. Perpetrators of domestic violence will go to extreme lengths to isolate and control their partners. One woman was not permitted to go into her backyard because her husband called every hour or two. If she did not answer on the first ring, she might have been beaten. Nor could she talk with anyone else by phone, because her husband could hear a busy signal. This woman, like many others, was not permitted to go anywhere alone. Counselors repeatedly hear about this kind of severe isolation. While the male who batters tends to be a loner, he enjoys the company of his own family and friends: Neither is permitted to her.

3. Jekyll and Hyde Personalities. Men who have a problem with violence exhibit drastic personality changes. Much of the time they are gentle and loving husbands and fathers. This is the personality with which the woman fell in love originally and continues to love. Periodically, sometimes in rather predictable cycles, he seems to metamorphize into an ogre. Some men display their Dr. Jekyll side to the public consistently. Mr. Hyde emerges only at home. This is doubly treacherous to the partner because others do not believe her when she speaks of his monstrous acts.

4. Explosive Temper. A most trivial happening such as failure to balance a checkbook or burning the toast can trigger a beating. In other cases there is no apparent precipitating event. Many women have been pulled from bed while sleeping soundly and beaten. A frequent response of the victim is to attempt to be the perfect wife and mother. An often repeated lament is, "I feel like I'm walking on eggs."

5. Legal Problems. The Illinois Coalition Against Domestic Violence explored the circumstances of abusers whose victims took refuge in shelters in July and August of 1981. Fifty-six percent have been involved with the law because of their violent behaviors. Arrest records from other areas of their lives are not uncommon (Safman, 1982). This high percentage may represent a shelter bias.

6. Projection. A man who batters is a master at blaming other people and external events for his own behavior. A life-long pattern of avoiding the consequences for his behavior effectively limits his sense of personal responsibility for his destructiveness as well as suppresses any motivation to change. The partner becomes a surrogate punching bag. Therefore, when a battered woman says, "He needs me," she is right in one sense; if he can project his faults onto her, thereby not having to deal with them himself, he is able to perpetuate his own blameless state.

7. Verbal as well as Physical Abuse. An enormous amount of verbal abuse accompanies physical abuse. A barrage of derogatory labels such as "stupid bitch"..."ugly slut"..."cheap whore" are heaped upon the victim. Mind games are rampant. Some verbal abuse is less obvious to the abused party. It can be so subtle in fact that the woman is unable to identify the intent of the words. She accepts this judgment that her housekeeping is sloppy, her children lax, and she is a hopelessly unappealing drudge; her self-esteem slips ever lower.

8. A History of Family Violence. Forty-two percent of the abusers of those victims interviewed by the Illinois Coalition Against Domestic Violence were abused as children. Fifty-three percent had seen violence in their homes. Of those who had witnessed violence, seventy-five percent had seen their fathers beat their mothers. To the researchers these findings indicate that battering is a problem both for families and for society generally (Safman, 1982).

9. More Violent When Partner Is Pregnant or Soon after She Gives Birth. More shocking to observers than the other characteristics is the observation that the batterer is more violent when the partner is pregnant or soon after the birth of their child. This leads to speculation about "womb envy." Men who batter seem to want to impregnate, yet not necessarily to father or nurture their offspring. It is not unusual for them to tamper with their partner's birth-control measures or to assert that they had vasectomies when they have not. A recurring theme is: "If you would have my baby, or one more baby, then our problems would abate." Yet wifebeating has been called "the poor woman's abortion." Women have had miscarriages or stillbirths after savage attacks by their mates. Does envy of woman's procreative power become a force for male violence?

There is anthropological support for rituals in less-sophisticated cultures that deal with this phenomenon. The nuclear family in our civilization does not offer a way for both males and females to share equally in the rites of passage into parenthood.

10. Denial. "I didn't hit her" or "I just pushed her a little bit" are almost universally uttered denials. Sometimes awareness of his own behavior is so totally repressed that he will notice his partner's injury that he inflicted the previous evening and ask, "What happened to you?" Indeed, one ofthe most crucial aspects of treatment for men who batter is to help them get in touch with their violence. When they acknowledge the truth of their past behavior, they may encounter within themselves a backlog of guilt and revulsion of themselves, so overwhelming that they either fall into a depression or regress into

deeper denial (Everett, 1980).

11. Cycle of Violence and Contrition. Often it seems that the male who batters purposely is trying to drive away his partner. When he succeeds, he will go to great lengths to retrieve her. He may abduct the children; cry real tears; plead; bring flowers; promise to go to counseling every day ("if that is what it takes"); vow to stop drinking; and tell her that he needs her and cannot survive without her. These actions are very convincing. Each time she leaves, then returns, the cycle escalates. The violence becomes more severe; the contrition state become craftier. She, sadly, reinforces his behavior by believing him and attempting to resume her life with him.

The statements on this sheet reflect certain beliefs which you may or may not share. Mark each statement "True" or "False" depending upon what your belief is.

_____ 1. Wife-beating is a private family matter.

_____ 2. Battering occurs most often in low-income families.

_____ 3. Battering is most often caused by alcohol and/or drugs.

_____ 4. Battering most often occurs in age bracket 20 - 30 years.

_____ 5. Violence is a natural way for a man to let off steam.

_____ 6. A woman must like being abused or she wouldn't stay.

_____ 7. The police don't like to get involved in domestic problems.

_____ 8. It is better for children if an abused woman stays in the relationship (provided the children aren't being abused) because the children need their father.

_____ 9. Religious beliefs will prevent battering.

_____ 10. Batterers are violent in all relationships.

_____ 11. A battered woman may always leave home.

_____ 12. Domestic violence is a relatively recent problem.

_____ 13. Statistics show that domestic violence is an enormous problem in our society.

_____ 14. If a man beats his wife once, he's likely to do it again.

_____ 15. Long-standing battering relationships can change for the better.

SEXUAL VIOLENCE & THE SURVIVORS

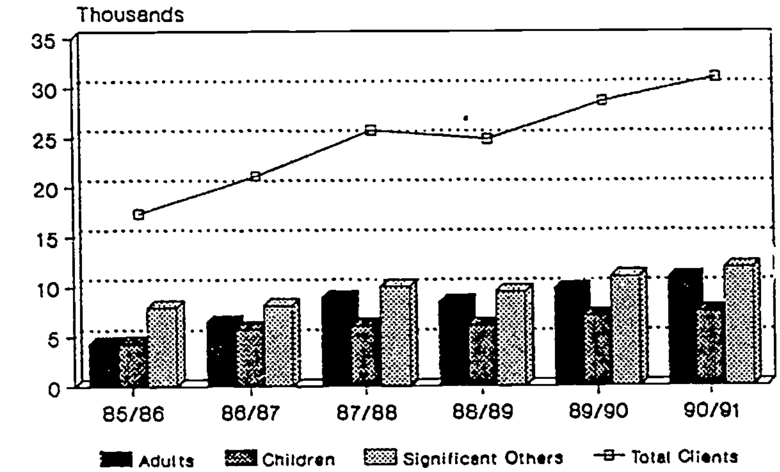
Understanding the Issue

Sexual violence is any unwanted sexual contact forced upon a person by a stranger or an acquaintance. Sexual violence is a crime committed out of power and anger by controlling, dominating or humiliating the victim. Anyone can become a victim regardless of age, sex, race, appearance or economic status. Unfortunately, sexual violence has touched the lives of many. Pennsylvania Sexual Assault Centers continue to serve adult and children victims/survivors in growing numbers.

Among the services provided by Sexual Assault Centers are: crisis intervention; individual and group counseling; and hospital, police and court accompaniment. Services are also provided for 'significant others,' such as, relatives or friends. While these persons are not the primary victims of abuse, they are affected and are often important to the victim/survivor's healing.

SEXUAL ASSAULT IN PENNSYLVANIA

Persons Served by Sexual Assault Centers



Source: PA Coalition Against Rape

Facts & Figures

PA Sexual Assault Centers served 30,360 persons in FY 1990/91. This is a 82% increase since FY 1985/86. The most dramatic increase in persons served by PA Sexual Assault Centers has been in the number of adult victims -- an increase of 151% over the past six years (PCAR Statistics, 1992). Centers report that adult survivors of incest and child sexual abuse request service in ever increasing numbers.

In Pennsylvania, 10,917 adult victims/survivors were served; 7,524 child victims/survivors were served; and the number of significant others served was 11,919. Sexual Assault Centers provided over 230,000 hours of direct service in FY 1990/91 (PCAR Statistics, 1992).

Of the victims/survivors served by PA Sexual Assault Centers, 95% were female and 5% were male (PCAR, 1992). The FBI estimates that 10% of all sexual assault victims are male (Parrot, 1991).

The FBI continues to list rape as the most under-reported crime. It has been estimated that only 5% to 20% of rapes are reported (Benedict, 1985). The FBI has stated that false claims of rape [illegible] no higher than that for other major crimes; 2% of reports to law enforcement agencies.

In Pennsylvania, there were 3,130 forcible rape offenses reported to police departments in 1990, an average of 9 each day or one reported every 2 hours and 48 minutes. This is a 6.5% increase from reports in 1989 (PA Uniform Crime Report, 1990).

More than 100,000 women reported being raped in 1990; more than in any other year in U.S. history. There was a 6% increase in the number of rapes from 1989 to 1990. There were up to twelve rapes per hour in 1990; nearly 300 every day (FBI, 1991). In other words, a person in the U.S. is raped every 5 minutes.

The vast majority of rapes occur in a private dwelling or other private property (Bancroft, 1982). 25% of rapes occur in the victim's home, 20.2% occur on the street, 14.9% occur at a friend or relative's home (U.S. Dept. of Justice, 1988).

A woman is 20 times more likely to be raped in the U.S. than in Japan; 13 times more than in England; 4 times more than in Germany (U.S. Dept. of Justice, 1988).

White victims are raped by white perpetrators 81.5% of the time. Black victims are raped by black perpetrators 85.3% of the time (U.S. Dept. of Justice, 1988).

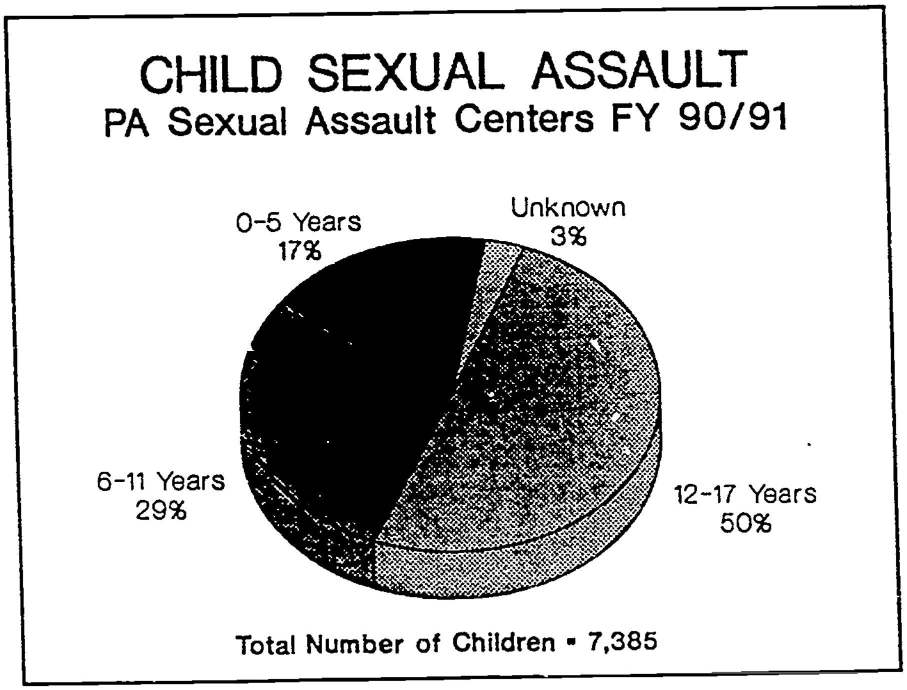
PENNSYLVANIA COALITION AGAINST RAPE
910 NORTH SECOND STREET, HARRISBURG, PA 17102-3119
A state network of centers serving victims of sexual assault.

CHILD SEXUAL ASSAULT

Understanding the Issue

Child sexual assault is sexual contact between a child and an adult or another child to exert power or control. Child sexual assault occurs in both rural and urban areas. Both the victims and offenders come from all ethnic and socio-economic backgrounds.

Unfortunately, reported incidents of child sexual assault are on the rise. Children desperately want approval from adults and, therefore, are vulnerable to do whatever an adult demands. Generally, children are sexually abused by adults who are related to them or known by them or their families. Threats and bribes are often used to keep children from telling anyone.



Facts & Figures

In FY 1990/91, PA Sexual Assault Centers served 7,524 child victims/survivors of sexual assault. 82% of the children served were female and 18% were male children. (PCAR Statistics, 1992)

Of the children served by PA Sexual Assault Centers in FY 1990/91, 50% were 12-17 years in age, 29% were 6-11 years and 17% were 5 years or younger (PCAR Statistics, 1992). National studies have found the median age for sexual abuse to be 9.9 for boys and 9.6 for girls, with over 20% occurring before age 8 (Finkelhor, Hotaling, Lewis and Smith 1990).

In Pennsylvania, 7,951 reports of child abuse were substantiated in 1990. Nearly one half (48.8%) of these reports involved sexual abuse. 2,976 or 76.8% sexually abused children in 1990 were girls; 901 or 23.2% sexually abused children were boys (1990 Child Abuse Report, PA DPW).

Some 375,000 children were reported as victims of sexual abuse to child protective service agencies in 1990 (Daro and McCurdy, 1991). One in four girls and one in seven boys will have been sexually assaulted by age 18 (Finkelhor, 1978; Russell, 1983).

Of the children served by PA Sexual Assault Centers in FY 1990/91, 40% were abused by relatives, 38% were abused by acquaintances and only 7% were abused by strangers (PCAR Statistics, 1992). Nationally, an estimated 77% of reported abusers are parents (57% of the total being natural parents), 16% are other relatives and 6% are non-related. In addition, males are reported to be the abusers in 80-95% of cases (Thoringer, Krivacska, Laye-McDonough, Jarrison, Vincent and Hedlund, 1988).

Child sexual abuse is seldom a one time occurrence. Abusive relationships last an average of 1 to 4 years, many last much longer (National Committee for the Prevention of Child Abuse, 1979).

In a study conducted at the Tufts New England Medical Center, in 68% of the cases the offender coerced the child to comply either through threats or actual physical aggression. Parents were as likely as any other group of offenders to use violence (Gomes-Schwartz, Horowitz, Cardarelli 1990).

Children are more likely to report sexual abuse when they feel less loyalty toward the offender. When a child was abused by a natural parent, more than 53% did not tell of the abuse (Gomes-Schwartz, Horowitz, Cardarelli 1990).

PENNSYLVANIA COALITION AGAINST RAPE
910 North Second Street, Harrisburg, PA 17102-3119
A state network of centers serving victims of sexual assault.

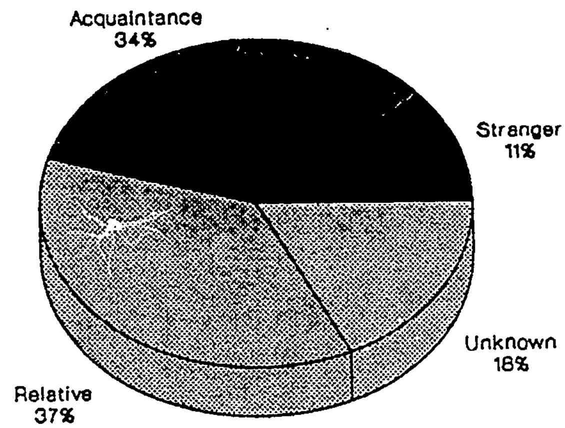
SEXUAL ABUSE RELATIONSHIPS

Understanding the Issue

Sexual violence is any unwanted sexual contact forced upon a person by a stranger or an acquaintance. Realistically, those closest to us can most easily take advantage of us. Most often sexual abuse occurs by someone the victim knows and trusts -- a friend, date, neighbor, co-worker and, many times, a relative.

Acquaintance rape is using physical force, emotional bargaining, blackmail or mind games to force sexual intercourse. There are many different types of acquaintance rapes. One of the most common and confusing kinds of sexual abuse occurs in a dating or romantic situation. Often, date rapes occur as a result of sex role behaviors and misunderstood communications. The fact is, any sexual intercourse without the consent of both persons is rape.

SEXUAL ASSAULT VICTIMS/SURVIVORS
Relationship to Offender
FY 1990/91



Source: PA Coalition Against Rape

Facts & Figures

In Pennsylvania, of the victims/survivors served by Sexual Assault Centers in FY 1990/91, 37% were abused by relatives, 34% were abused by acquaintances and only 11% were abused by strangers (PCAR Statistics, 1992).

A woman's risk of being raped by someone she knows is four times greater than being raped by a stranger. 84% of the victims knew their assailant (Warshaw, 1988).

4% of adult survivors served by PA Sexual Assault Centers in FY 1990/91 were sexually abused by a spouse or an ex-spouse (PCAR Statistics, 1992). National studies have shown that 10% to 14% of all married women have been raped by their husbands. In cases sampled, husbands raped their wives at least twice and in 1/3 of the cases, more than 20 times (Russell, 1983).

In a study conducted at the Tufts New England Medical Center, the majority of children treated were sexually abused by a family member, including natural parents (19%), surrogate parents such as stepfathers or live-in boyfriends (21%), and other relatives (22%), while only 3% were victimized by strangers (Gomes-Schwartz, Horowitz, Cardarelli 1990).

[illegible]% of rapes where the perpetrator is a stranger are reported to police, while 19% of acquaintance rapes are reported. Of acquaintance rapes, only 2% of rapes were reported when the perpetrator was a friend of the family or a date (Russell, 1986).

When acquaintance rape occurs, the two most common forms of coercion used by men are the threats of ending the relationship and arguing that sex should be performed (Parrot, 1983). Force, however, seems the most successful strategy to get the victim to comply with the assailant's wishes (Parrot, 1991).

According to Professor Mary Koss who conducted the largest national survey on acquaintance rape in 1987, more than 80% of the rapes were committed by an acquaintance (Parrot, 1991).

1 out of every 4 college women has been the victim of rape or attempted rape (Warshaw, 1988). 1 in every 12 college men admitted to committing acts that meet the legal definition of rape (Warshaw, 1988). About 1/4 of male college students admitted to having made forcible attempts at intercourse (Koss and Oros, 1982).

In a study by Professor Mary Koss at Kent State University, one out of every eight women students had been raped; of those, 10.6% reported being raped by strangers, 24.9% reported being raped by acquaintances, 30% by steady dates; 21% by casual dates; 8.9% by family members (Michigan Council on Crime and Delinquency, 1991).

PENNSYLVANIA COALITION AGAINST RAPE
910 North Second Street, Harrisburg, PA 17102-3119
A state network of centers serving victims of sexual assault.

FOCUS: CURRENT EFFECTS

The following list was put together by the men who participated in a weekend recovery workshop for male and female incest survivors. The items on the list are in response to the question, "In what ways does the childhood sexual abuse continue to affect your adult life?" Not all of these responses apply to every survivor. I have presented them all, without editing, as they were listed by the participants.

--Nightmares (intense; violent)
--Fear that everyone is a potential attacker
--Shame
--Anger
--Guilt
--Fear of expressing anger/difficulties in starting to get angry
--Need to be in control
--Need to pretend that I am not in control (Helplessness)
--Fear of being seen/fear of exposure/agoraphobia
--Running from people
--Fear of intimacy/running away from intimacy
--"Avoidism"
--Pain and memories of physical pain
--Flashbacks
--Not being able to "think straight"
--Difficulties in communicating
--Intruding thoughts
--Compulsive eating/not eating/ dieting/ bingeing/purging/etc.
--Self-abuse
--Wanting to die
--Sexual acting out
--Feeling asexual
--Sexual dysfunction

ASSESSING WHETHER BATTERERS WILL KILL

Some batterers are life-endangering. Officers should evaluate whether an assailant is likely to kill his partner, other family members, and/or police personnel.

1. Threats of homicide or suicide. The batterer who has threatened to kill himself, his partner, the children or her relatives must be considered extremely dangerous.

2. Fantasies of homicide or suicide. The more the batterer has developed a fantasy about who, how, when and/or where to kill, the more dangerous he may be. The batterer who has previously acted out part of a homicide or suicide fantasy may be invested in killing as a viable "solution" to his problems.

3. Depression. Where a batterer has been acutely depressed and sees little hope for moving beyond the depression, he may be a candidate for homicide and suicide.

4. Weapons. Where a batterer possesses weapons and has used them in the past in his assaults on the battered woman, the children or himself, his access to those weapons increases his potential for lethal assault.

5. Obsessiveness about partner or family. A man who is obsessive about his female partner, who either idolizes her and feels that he cannot live without her or believes he is entitled to her no matter what because she is his wife, is more likely to be life-endangering.

6. Centrality of battered woman. If the loss of the battered woman represents or precipitates a total loss of hope for a positive future, a batterer may choose to kill.

7. Rage. The most life-endangering rage often erupts when a batterer believes the battered woman is leaving him.

8. Drug or alcohol consumption. Consumption of drugs or alcohol when in a state of despair or fury can elevate risk of lethality.

9. Pet abuse. Those batterers who assault and mutilate pets are more likely to kill or maim family members.

10. Access to the battered woman and/or to family members. If the batterer cannot find her, he cannot kill her.

If an officer concludes that a batterer is likely to kill or commit life-endangering violence, he should take extraordinary measures to protect the victim and her children. This may include providing transportation and conducting meticulous follow-up. The victim should be advised that the presence of these indicators may mean that the batterer is contemplating homicide and that she should immediately take action to protect herself and should contact the local battered women's program to further assess lethality and make safety plans.

THE RIGHTS OF VICTIMS OF SEXUAL ASSAULT

Every victim of sexual assault should have the right:

-to be treated with dignity and respect by institutional and legal personnel.

-to have as much credibility as a victim of any other crime.

-to be considered a victim of rape when any unwanted act of sex is forced on her/him through an type of coercion, violent or otherwise.

-to be asked only those questions that are relevant to a court case or to medical treatment.

-to receive medical and mental health treatment, or participate in legal procedures only after giving her/his informed consent. (Information should include all possible options.) *

-to be treated in a manner which does not usurp control from the victim, but which enables her/him to determine her/his own needs and how to meet them.

-to not be exposed to prejudice against race, age, class, lifestyle or occupation.

-to have access to support persons, such as advocates, outside of the institutions.

-to have access to peer counseling.

-to be provided with information about her/his rights.

-to have the best possible collection of evidence for court.

-to not be asked questions about prior sexual experience.

-to have common reactions to the rape, such as sleeplessness, nightmares, hostility towards men/women, anxiety, fear, etc., not be considered pathological behavior.

-to have access to a secure living situation, or other measures which might help to allay fears of future assault.

-to have her/his name kept out of the media.

-to be considered a victim of rape regardless of the assailant's relationship to the victim, such as the victim's spouse.

-to have deterred her/his assailant by any means necessary. No victim should be criminally prosecuted for harming the assailant during or immediately after the rape or for harming the assailant in the process of preventing an attempted rape.

-to receive medical treatment without parental consent if she/he is a minor.

-to have access to supportive legal advice.

-to have a preliminary hearing in each case when an arrest has been made.

-to be advised of the possibility of a civil suit.

*Some states have laws which require counties to pay for medical and/or mental health treatment resulting from a sexual assault. Currently, Pennsylvania has no legal provision for such expenses.

ATTACHMENTS

1. Recruitment Information
2. Workshop Evaluation
3. Agency Crisis Policy

Tuscarora Intermediate Unit

Adult Education and Job Training Center

CAROL MOLEK
Adult Education Co-ordinator

ADELE T. CRAIG
JTPA Director

November 14, 1991

The TIU Adult Education and Job Training Center is sponsoring a series of workshops on client mental health issues through special Adult Education 353 project funding from the Pennsylvania Department of Education. Attached is a flyer with information about each workshop. We would like to invite you and your staff to attend any or all of these workshops. Please complete the attached registration form(s) and return by the dates indicated.

We look forward to your participation and feel that these workshops should be very beneficial to all adult educators.

Sincerely,

Adele T. Craig
Project Director

ATC:smk
Attachment

Juniata-Mifflin Vo-Tech School (717) 248-4942
1020 BelleVernon Avenue (717) 242-1423
Lewistown, PA 17044 (717) 248-8610 FAX
TIU 11 is an equal rights and opportunities educational service agency.

Ms. Barbara Inch
Juniata County Literacy
498 Jefferson St.
Mifflintown, PA 17059

Ms. Cathy Forsythe
Mifflin County Literacy
123 N. Wayne St.
Lewistown, PA 17044

Mr. Curtis Kauffman
SETCO Office
RD4, Box 140
Mifflintown, PA 17044

Ms. Dawn Lowe
SETCO Office
Perry County Courthouse
New Bloomfield, PA 17068

Mr. Dayton Tweedey
McConnellsburg Elementary School
Cherry St.
McConnellsburg, PA 17233

Mr. Harold Kimmel
Huntingdon Co. Child & Adult Dev.
PO Box 325
Orbisonia, PA 17243

Ms. Monica Kindig
Mid-State Literacy Council
117 E. Beaver Ave.
State College, PA 16801

Ms. Margaret Welliver
State College School District
411 S. Fraser St.
State College, PA 16801

Ms. Edie Gordon
Centre Co. Area Vo-Tech School
CIU 10 Dev. Center for Adults
Pleasant Gap, PA 16823

Ms. Barbara Druckenmiller
Mifflin Co. Assistance Office
1125 Riverside Drive
Lewistown, PA 17044

Ms. Barbara Bowers
Job Center
21 S. Brown St.
Lewistown, PA 17044

Mr. Gary Gill
Job Center
21 S. Brown St.
Lewistown, PA 17044

Ms. Carol Sheaffer
Snyder Co. JTPA
209 W. Pine St.
Selinsgrove, PA 17870

Ms. Carroll Rhodes
Clinton Co. Training Office
151 Susquehanna Ave.
Lock Haven, PA 17745

Ms. Penny Deets
Columbia Co. JTPA
1119-A Old Berwick Rd.
Bloomsburg, PA 17815

Mr. Barry McLaughlin
Union Co. JTPA
103 S. Second St.
Lewisburg, PA 17837

Mr. Dick Hritzko
STEP, Inc.
1221 W. 3rd St., PO Box 1328
Williamsport, PA 17703

Mr. Frank Zook
Juniata-Mifflin Co. Vo-Tech School
1010 Belle Vernon Ave.
Lewistown, PA 17044

Mr. Gary Hoover
Mid-State Employment & Training Con.
318 N. Allegheny St.
Bellefonte, PA 16823

Ms. Carolyn Foust
Juniata-Mifflin Co. Vo-Tech School
1010 Belle Vernon Ave.
Lewistown, PA 17044

'Client Mental Health Issues'

In-service workshops for instructors, tutors, counselors, and administrators. Designed specifically to provide adult educators with a better understanding of clients and their mental health issues. Sponsored by the TIU Adult Education and Job Training Center through special Adult Education 353 project funding from the Pennsylvania Department of Education.

Topic	Date	Time	Location
I. Issues in Mental Health	January 7, 1992	9:00-12:00	Mifflin County Courthouse Room B, 2nd Floor
II. Substance Abuse	February 4, 1992	9:00-12:00	Mifflin County Courthouse Room A, 2nd Floor
III. Violence Part I - Victims of Violence Part II - Crisis Prevention/Intervention	March 3, 1992	9:00-12:00	Mifflin County Courthouse Room B, 2nd Floor

"Client Mental Health Issues"

Workshop Registration

Topic I: Issues in Mental Health

Name: ______________________ Number of Staff Attending __________

Agency: ______________________________

Address: ______________________________

____

Phone: ______________

Please return registration form by 12/6/91 to:

TIU Adult Education and Job Training Center
1020 Belle Vernon Avenue
Lewistown, PA 17044

Attention: Adele Craig

"Client Mental Health Issues"

Workshop Registration

Topic II: Substance Abuse

Name: ______________________ Number of Staff Attending ____________

Agency: ______________________________

Address: ______________________________

____

Phone: ________________

Please return registration form by 1/2/92 to:

TIU Adult Education and Job Training Center
1020 Belle Vernon Avenue
Lewistown, PA 17044

Attention: Adele Craig

"Client Mental Health Issues"

Workshop Registration

Topic III: Violence
Part I Victims of Violence
Part II Crisis Prevention/Intervention

Name: ____________________ Number of Staff Attending __________

Agency: ____________________

Address: ____________________

____

Phone: ____________________

Please return registration form by 2/7/92 to:

TIU Adult Education and Job Training Center
1020 Belle Vernon Avenue
Lewistown, PA 17044

Attention: Adele Craig

Tuscarora Intermediate Unit

Adult Education and Job Training Center

CAROL MOLEK
Adult Education Co-ordinator

ADELE T. CRAIG
JTPA Director

Client Mental Health Issues
Workshop Evaluation

Workshop #2 - January 7, 1992
Mental Health Issues

Name____________________ Agency____________________ Position____________________

Content:

Was the content useful to you? Why or Why not?

What was the most important thing you learned?

Did any of the content seem inappropriate to you? If so, what?

Did the program fulfill your expectations?

Presenters:

How would you rate the presenters?

Presenter - Joe Manducci	Excellent	Average	Poor
Presenter - Linda Davis	Excellent	Average	Poor

Facility:

How would you rate the facilities? Excellent Adequate Poor

Did you plan to attend any future Adult Education and Job Training Center workshops based on this experience?

Yes No

Any additional comments or recommendations are greatly appreciated.

Thank you

Juniata-Mifflin Vo-Tech School (717) 248-4942
1020 BelleVernon Avenue (717) 242-1423
Lewistown, PA 17044 (717) 248-8610 FAX

Tuscarora Intermediate Unit
Adult Education and Job Training Center

CAROL MOLEK
Adult Ed' :ation Co-ordinator

ADELE T. CRAIG
JTPA Director

Client Mental Health Issues Workshop Evaluation

Workshop #3 - February 4, 1992 Substance Abuse

Name__________________ Agency__________________ Position__________________

Content:

Was the content useful to you? Why or Why not?

What was the most important thing you learned?

Did any of the content seem inappropriate to you? If so, what?

Did the program fulfill your expectations?

Presenters:

How would you rate the presenters?

Presenter - Mary Beth Wolfe	Excellent	Average	Poor
Presenter - Sandy Vanote	Excellent	Average	Poor

Facility:

How would you rate the facilities? Excellent Adequate Poor

Did you plan to attend any future Adult Education and Job Training Center workshcps based on this experience?

Yes No

Any additional comments or recommendations are greatly appreciated.

Thank you

Juniata-Mifflin Vo-Tech School (717) 248-4942
1020 BelleVernon Avenue (717) 242-1423
Lewistown, PA 17044 (717) 248-8610 FAX

Tuscarora Intermediate Unit
Adult Education and Job Training Center

CAROL MOLEK
Adult Education Co-ordinator

ADELE T. CRAIG
JTPA Director

Client Mental Health Issues
Workshop Evaluation

Workshop #4 - March 3, 1992
Violence
Part I - Victims of Violence
Part II - Crisis Prevention/Intervention

Name____________________Agency____________________Position____________________

Content:

Was the content useful to you? Why or Why not?

What was the most important thing you learned?

Did any of the content seem inappropriate to you? If so, what?

Did the program fulfill your expectations?

Presenters:

How would you rate the presenters?

Presenter #1 - Abuse Network	Excellent	Average	Poor
Presenter #2 - Lewistown Hospital	Excellent	Average	Poor

Facility:

How would you rate the facilities? Excellent Adequate Poor

Did you plan to attend any future Adult Education and Job Training Center workshops based on this experience?

Yes No

Any additional comments or recommendations are greatly appreciated.

Thank you

Juniata-Mifflin Vo-Tech School (717) 248-4942
1020 BelleVernon Avenue (717) 242-1423
Lewistown, PA 17044 (717) 248-8610 FAX

REFERRAL PROCEDURES FOR EMERGENCY SITUATIONS

There are certain situations which arise with our clients that are considered emergency situations and require action on our part. These situations include:

- a client who is threatening to harm himself/herself or others.
- suspected child abuse or neglect.
- a client who comes to the Center under the influence of drugs and/or alcohol.
- other situations which are disruptive to the functioning of our programs.

1. In any of the above situations, staff should immediately inform the top person on this list if they are at work:

   Emergency referral staff:

   Carol Molek
   Adele Craig
   Helen Guisler
   Suzanne Fisher
   Penny Willard

2. The person will then:

   1) see the client and assess the level of emergency.
   2) make appropriate referrals. In the case of a client threatening suicide or homicide we must make a referral.

3. If client is seeing a counselor or physician, make contact with that person or office. Possibly:

   Probation - 248-3953
   Individual & Family Counseling - 242-3070
   N/P Health Services - 242-7264
   Counseling Center - 248-6611 or (814) 463-2014
   Skills - 242-0313
   Mental Health/Mental Retardation - 242-0351 or #29

If client is not working with a mental health professional, call one of the following based on client's behavior/condition:

A. Suicidal or experiencing other serious emotional problems

   - NP Health Services 242-7264.
   - Mental Health/Mental Retardation 242-0351 or #29.
   - Abuse Network 242-0715 or #36 (Lewistown Office) Hotline 242-2444 or #34. 436-2402 (Mifflintown Office)
   - Police 911 (Mifflin County

B. Under the influence of drugs and/or alcohol or other dangerous behavior

   - Police (911 Mifflin County)

4. In a situation where child abuse or neglect is suspected, contact:

Children and Youth 248-3994
Childline 800-932-0313

We will transport these clients only on a minimal basis. Our preference is to have the agency arrange the transportation or to have the police transport them. When our agency does transport, two staff must accompany the client.

Please note: Our obligation is to make the appropriate referrals but <u>not</u> to provide this type of counseling at our site.

5. Follow up must be conducted before a client returns. The staff who made the emergency referral (or another on the list) must talk with the client before he/she is permitted to return.

This person needs to ascertain that the emergency situation has passed and that the client has made appropriate support contacts. Also at this meeting it must be emphasized to the client that personal problems should be dealt with as much as possible outside of our Center. (Exceptions are when dealing with these problems are part of the program. Ex: Single Parent/Displaced Homemaker,SPOC)

Remember: these emergency situations are difficult for everyone. It is important that we

1. REMAIN CALM.
2. Gather as much information as possible.
3. React quickly.

The Tuscarora Intermediate Unit 11 is an equal opportunity educational service agency and will not discriminate on the basis of race, color, national origin, ancestry, sex, handicap, age or religion in its activities, educational and vocational programs or employment practices as required by Title VI of the Civil Rights Act of 1964, Title IX of the 1972 Educational Amendments, Section 504 of the Rehabilitation Act of 1973 and the Pennsylvania Human Relations Act of 1955 as amended. For information regarding civil rights or grievance procedures, contact Jacqueline Vocke, Equal Rights and Opportunity Coordinator, at Tuscarora Intermediate Unit 11, RR 1, Box 70A, McVeytown, PA 17051, Phones: 814-542-2501 or 717-899-7143.