Training Needs of Sexual Violence Crisis Workers

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ABSTRACT

To inform the design of in-house training, a literature review focussing on the training needs of sexual violence crisis workers was conducted and workshops were planned accordingly. Rates of post-traumatic stress disorder (PTSD) in survivors indicate the need for workers engaging with survivors to practise in a trauma-informed way while recognising the significant pitfalls of the PTSD paradigm. In addition, training should feature basic counselling and attending skills, power and control dynamics, and theories of empowerment, and the significant role that "psychological first aid" can play in mediating the psychological and physiological progression of traumatic stress responses. Survivors' intrinsic senses of shame, the reactions of family members and other involved professionals, and the specifics of work with young people are also necessary areas of training to ensure effective interventions for survivors. A pilot of two short participatory workshops with sexual violence trainees attempting to cover key areas identified by the review highlighted the impact that participants' different knowledge-bases, professional and personal backgrounds, and self-perceptions of training needs had on training delivery.

Keywords: *Sexual violence; Assault; Abuse; Professional development; Training; Best practice; Evidence-informed training; Rape*

INTRODUCTION

Sexual violence is recognised as a pervasive problem both nationally and internationally, with one in three women in New Zealand estimated to have experienced some form of sexual violence. The impacts of this can be far-reaching, and can include negative psychological, emotional, and social outcomes. High rates of re-victimisation, together with evidence of the extent to which survivors are re-traumatised throughout their journeys of disclosure, reporting, and help-seeking, highlight the need for extensive support from specialist organisations. In addition, the growing body of knowledge recognising the spectrum of traumatic effects from sexual violence reinforces the need for workers providing this support to be well trained in the dynamics of sexual assault and abuse, the nature of trauma and traumatic responses, and the range of interventions available to mediate these effects and protect against long-term harm. This literature review arose from the need to develop training seminars that would effectively position workers to attend to survivors of sexual violence in both an initial reporting and a court setting. Consequently, it focuses on immediate intervention in crisis periods rather than prolonged casework, and outlines the training needs for sexual violence workers.

DATA COLLECTION AND SEARCH STRATEGY

The majority of the literature included in this review was identified using EBSCOhost, with additional searches in ProQuest Social Science Journals and through the university library. The initial search was centred on sexual violence, trauma, psychological interventions, and training, but was then expanded to source further information on topics such as power and control, family interventions, and young people as these themes began to emerge. In addition, the literature indicated that sexual violence interventions were consistent with generalised trauma treatment, which prompted a new avenue to research for inclusion in this review. The initial Boolean search terms were "rape OR sexual AND assault OR abuse OR violence AND training OR professional development AND trauma". Once expanded, additional search terms included "trauma AND psychological first aid, trauma AND family, and sexual violence AND young people AND training". Relevant works cited within this literature were then entered into Google Scholar and sourced.

Selection criteria

Literature targeting non-social service professions (such as medical or legal) was excluded. Both qualitative and mixed-methods studies were selected, with most quantitative literature focussing specifically on measurable post-traumatic stress symptomatology for survivors following sustained clinical interventions and therefore deemed irrelevant for a crisis response training literature review. Research published prior to 2005 also was excluded on the basis that training needs were best identified based on recent studies into best practice, although exceptions were made if the material appeared highly relevant or gave historical context to a sub-topic.

Search outcomes

The multi-database EBSCOhost search presented 114 results, of which 23 appeared to have relevant titles and were then screened for content relevance. Eleven of these were then excluded due to the publishing date or irrelevant abstract content criteria. ProQuest yielded

423 results, 13 of which appeared relevant. After excluding articles due to time frame, abstract, or replication, 11 were selected for inclusion. Six were found through a university library search, and three by searching in reference lists of selected texts. An additional six were found through previous research, resulting in a total of 38. The data are organised thematically, with key findings grouped according to sub-topics and synthesised.

LITERATURE REVIEW

The literature included in this review primarily features qualitative studies with two core groups: survivors and their families and supporters, and professionals working with survivors. Some mixed-methods studies are included, particularly in literature aimed at gauging variations in post-traumatic reactions in a quantifiable way. Despite a wealth of resources available covering the causes, dynamics, and effects of sexual violence, there is a significant gap in the literature regarding meta-analyses of training content for professionals working with sexual violence survivors; moreover, the studies featuring professionals' experiences focus more on organisational challenges and perceived social and mental health needs of survivors than on their own interventions with them. Findings from the literature were classified into 11 main sub-topics, including the prevalence and nature of sexual violence, training approaches, basic counselling/attending skills, empowerment theory, power and control, trauma and post-traumatic stress disorder, psychological first aid, rape myths and secondary victimisation, the role of shame, family interventions, and work with young people.

Table 1. Prevalence of Sexual Violence Training Themes in the Selected Literature

Sub-topic	Number of Appearances
Overview of Sexual Violence	4
Training Approaches	5
Counselling and Attending Skills	11
Empowerment and Feminist Theory	5
Power and Control	5
Trauma and Post-traumatic Stress Disorder	11
Psychological First Aid	12
Rape Myths and Secondary Victimisation	10
The Role of Shame	4
Family Interventions	8
Working with Young People	6

SEXUAL VIOLENCE IN NEW ZEALAND

In New Zealand, one in three women is estimated to have been subjected to sexual assault or sexual abuse, and between 17 and 25% are thought to have been raped in their adult lifetimes (Campbell, 2008). Sexual crimes have the lowest rates of reporting and the highest rates of attrition of all crime types (Kelleher & McGilloway, 2009). The combination of the social stigma of sexual violence and its arguably traumatic nature culminates in severe psychological, cognitive, and emotional disruptions for many survivors (Amstaotter & Vernon, 2008). In New Zealand, rates of re-victimisation are high, with approximately 75% of adults who were victimised as children being subjected to second or subsequent sexual assaults in adulthood (Kaltman, Krupnick Stockton, Hooper & Green, 2005).

TRAINING

Staff training focusing specifically on attending to survivors in the immediate aftermath of sexual abuse, sexual assault, and rape has typically taken place in a Rape Crisis Centre setting (Hellman & House, 2006). This training generally utilises a reflexive learning style, where personal development plays a prominent role and discussions about wider social and political contexts of rape are encouraged (Rath, 2007). In keeping with this focus on open dialogue as a method of learning and discovering, a strong emphasis is kept on the learning environment as a "safe space" for opinions and experiences to be raised and explored (Rath, 2007). Frequency of training opportunities for staff members is correlated with both staff retention and staff satisfaction (Hellman & House, 2006). While the expectation is that workers operating within this organisational framework will be cognizant of the dynamics and effects of sexual violence, this is not consistently the case; consequently, training to combat workers' flawed beliefs must be a fundamental part of the training process (Campbell, 2008). The attitudes and interventions of workers significantly contribute to survivors' distress levels and may impact the likelihood of cases being progressed to trial stages (Jordan, 2001). These findings highlight the importance of training that positions workers to understand and react appropriately to experiences of sexual violence.

COUNSELLING AND ATTENDING SKILLS

One of the primary objectives of sexual violence workers is to enable survivors to achieve catharsis, which, depending on the individual needs of the survivor, often occurs spontaneously through workers' use of silence, encouragement, demonstrated empathy, and active listening skills (Murphy et al., 2011). While the use of empathy is assumed to be a certainty, research suggests that survivors can be harmed by the absence of empathy from initial interveners (Campbell,, 2001). This is confirmed by Jordan (2001), who suggests that the interpersonal relationship between survivor and worker has more influence on recovery than any individual intervention. Further, empathic listening is acknowledged to be a key determinant of the value of any "supportive" experience (Johnson, Pearce, Tuten, & Sinclair, 2003), suggesting that training for workers should contain a large component on developing effective listening and attending skills. These skills should include use of silence, physical positioning and non-verbal communication, minimal encouragers, mirroring, paraphrasing, reflecting, demonstrating empathy, validating, and acknowledging pain and distress (Hamilton & Coates, 1993; Murphy et al., 2011; Ullman & Townsend,

2008,). Cognitive reframing, another essential counselling tool, can play a vital role in assisting survivors to re-conceptualise their experiences so that their memories and the distress associated with them are more tolerable (Begehr, Marziali, & Jansen, 1999).

In addition to active listening, there may be a place for solution-focused interviewing to be applied in the aftermath of sexual violence, in order to stimulate mobilisation and pursue survivors' options (Rath, 2007). However, Ullman and Townsend (2008) warn against directive counselling strategies, advocating instead for approaches that protect survivors' sense of control. It is integral that survivors are considered in the context of their own positioning within their subjective worldviews, rather than feeling compelled to conform to workers' projected expectations (Burgess & Holmstrom, 1974). Survivors' post-trauma support needs vary considerably, with some rating the opportunity to offload verbally as their chief priority and others identifying the provision of information as their principal need (Jordan, 2001). Accordingly, survivors' own perceptions of needs should be explored early on in the engagement process (Jordan, 2001). Decker and Naugle (2009) list specific recommendations for interveners, namely: adopting an attitude of belief and not questioning survivors in ways that might signify doubt in their veracity; maintaining a non-intrusive stance; responding with consistent sincerity and respect; and moderating voice tone to project calmness.

FEMINIST/EMPOWERMENT THEORY

As sexual violence constitutes a loss of power over an individual's bodily autonomy, the restoration of survivors' self-determination and sense of control over their lives is paramount (Jordan, 2001). Empowerment includes fostering the development of survivors' positive coping strategies, self-reliance, decision-making capacity, and control over their post-trauma reactions (Regehr, Marziali, & Jansen, 1999). This can be considered the "earliest antidote" to sexual violence trauma (Decker & Naugle, 2009). Traditionally the model of choice employed by early Rape Crisis Centres, empowerment theory in sexual violence crisis work chiefly involves believing survivors' stories, promoting an understanding of sexual violence that is reflective of its true dynamics, adapting the type of support to each survivor's needs, presenting a range of options, and supporting individual choices (Jones & Cook, 2008; Woody & Beldin, 2012). These principles are still implicit in present training for sexual violence response workers (Jones & Cook, 2008).

POWER AND CONTROL

Societal subscription to beliefs about "masculine" and "feminine" attributes, otherwise known as gender roles, provides the foundation from which sexual violence is allowed to occur (Peace, 2009). Children's internalisation of messages about expected and acceptable behaviour from their parents and caregivers in part determines their propensity to exercise controlling, violent, and abusive behaviours over their partners or others, or to accept these behaviours from their partners or others (Dorais & Corriveau, 2009). This is demonstrated by parents' attitudes to child play, where children's use of aggression or nurturing is variously encouraged or discouraged by their caregivers depending on the child's gender (Ennew, 1986). This behaviour often evolves into positions of power or

powerlessness in adulthood according to gender, underpinning harmful power dynamics in relationships (Dorais & Corriveau, 2009). Training for workers providing support to survivors of sexual violence should explore the dynamics of power and control in situations where gender-based violence occurs, so that interventions can avoid further entrenching existing patriarchal structures of inequality and assist survivors to plan for alternative living situations (Rath, 2007).

SEXUAL VIOLENCE AS TRAUMA

Sexual crimes have long since been accepted as traumatic, however, there is significant divergence amongst professionals regarding the extent to which survivors must inevitably be traumatised following sexual abuse or assault, and, in addition, what threshold an event must reach in order to be considered traumatic (McNally, Bryant, & Ehters, 2003). While frameworks to explain the symptom sets that frequently occur in the aftermath of sexual violence have been formulated, it has been argued that the assumption that survivors will be traumatised precludes the possibility that they will be able to organise their experience of violence without any pathological effects (Gavey & Schmidt, 2011). This sets the expectation for survivors to fit their behaviour to a prescribed framework according to professionals' views about "normal" post-trauma reactions (Regehr et al., 1999). Moreover, symptoms considered as discrete units are unable to capture the complexity of the often distress-driven behaviour and psychosocial context of survivors (Ehrenreich, 2003). This in turn has implications for the recovery process, since treatment is designed to moderate specific pathological responses (Regehr et al., 1999). Consequently, there are concerns that these attempts to categorise subjective experiences of sexual violence ultimately disadvantage survivors whose symptoms do not conform to the dominant criteria, heralding the need for sexual violence services to be sensitive to a wide range of reactions (Gavey & Schmidt, 2011).

Sexual violence has been correlated with mental health outcomes such as emotional instability, depression, anxiety, self-harming behaviour and suicidality, substance abuse, personality disorders, and debilitating feelings of guilt and shame (McMillan, 2013; Woody & Beldin, 2012). Unlike other types of trauma, it also commonly results in transient dissociation and unstable schemas of the self (Ehrenreich, 2003). In the longer term, these effects may impact negatively on employment situations and relationships (McMillan, 2013). Growing awareness of the long-term effects of trauma has led to recognition among the helping professions of the need for practice with survivors to be trauma-informed, which is a notable shift away from the traditionally volunteer-led models of assistance initially utilised by Rape Crisis Centres (Woody & Beldin, 2012). This has implications on the required knowledge base of sexual violence workers and suggests that trauma-treatment theories should be integrated into training.

The clusters of post-rape symptoms exhibited by rape survivors show both parallels and differences from those shown by survivors of other types of trauma, initially leading to the classification of specific symptom sets as "rape trauma syndrome" (Gavey & Schmidt, 2011). This was then reframed as post-traumatic stress disorder, with the criteria for diagnosis requiring survivors to be experiencing recurring intrusion, avoidance, emotional

disruption and arousal symptoms (American Psychiatric Association, 1995). This may manifest through: playback memories, flashbacks, and nightmares; heightened distress, anxiety, and hyper-arousal when confronted with stimuli that trigger traumatic memories; avoidance and suppression of details; inability to feel a normal range of emotions and feelings of numbness; and disruptions of sleep, appetite, concentration, and mood stability (White, Trippany, & Wolan, 2003). In addition, survivors must have been subjected to a genuine or perceived threat to their lives, or have felt a comparable level of fear at the time of the trauma (American Psychiatric Association, 1995). Understanding the symptomatology of PTSD is useful for workers, as approximately one third of those subjected to sexual violence will develop the disorder, with between 30 and 50% experiencing symptoms throughout the remainder of their lives (New York City Alliance Against Sexual Assault, 1992). While the criteria serve as a useful explanatory framework, their practical utility is seriously undermined by their failure to account for the insidious and socially determined cognitive–emotional effects of survivors' experiences of sexual assault (Wasco, 2003). These experiences often include internalised shame and guilt derived from dominant cultural ideals of sexuality and blame (Wasco, 2003). In addition, it can be considered ethnocentric as it favours typical reactions of European cultures over others (White et al., 2003).

Risk factors for and protective factors against the development of post-traumatic stress symptoms have been identified. Susceptibility to PTSD is inversely correlated to both high cognitive abilities and strong networks of social support, but is heightened by family histories of emotional disruption, the presence of traumatic dissociation, and a self-critical analysis of one's own coping abilities (McNally et al., 2003). There is also a close association between a survivor's pre-trauma sense of self-efficacy and self-perception and her ability to recover from trauma (Regehr et al 1999). Correspondingly, negative conceptions of self, prior to trauma, may be reinforced by sexually violent experiences, ultimately resulting in the absence of adaptive coping skills (Regehr, et al., 1999). As a consequence, fostering positive self-schemas in the initial intervention phase may contribute to recovery.

PSYCHOLOGICAL FIRST AID

Research into the efficacy of immediate interventions for rape survivors has demonstrated that, in a majority of cases, a need for clinical mental health interventions is not indicated (McNally et al., 2003). In addition, the growing body of knowledge aligning sexual violence with other trauma types has led to the application of psychological first aid (PFA) with survivors (Pack, 2011). PFA is an empirically proven set of helping actions premised on the finding that immediate empathic responses may ameliorate the risk of traumatic symptoms escalating, thereby preventing the development of PTSD (Ruzek, Brymer, Jacobs, Layne, Vernberg, & Watson, 2007). This is thought to occur through two avenues; firstly, by interrupting the automatic physiological response to traumatic stress, and secondly, by safeguarding against cognitive distortions regarding risk and safety that frequently result from distress-driven thought patterns after trauma exposure (Ruzek et al., 2007). PFA has been endorsed by America's National Centre for PTSD, and can be delivered by any helping professional due to its non-clinical approach (Decker & Naugle, 2009).

PFA comprises a set of sequential stages, beginning with the building of rapport in order to facilitate a warm and therapeutic connection with the survivor (Parker, Everly, Barnett & Links, 2006). Next, immediate safety is discussed, and potential problems such as self-harming behaviour, aloneness, and risk of further violence are screened for and considered (Ruzek et al., 2007). This is followed by the orientation of clients to the present, in order to prevent episodes of dissociation (Ruzek et al., 2007). This can be done through guided breathing, body awareness, and validation and reassurance (Campbell, 2008). Attention should be paid to potential physical needs, such as water and clothing or medical assistance (Ruzek et al., 2007). Throughout the survivor–worker engagement, the worker should also provide assistance with integrating the survivor's experience into her cognitive framework, which helps to prevent the entrenchment of trauma-associated anxiety and distress (Parker, Everly, & Links, 2006). Providing psycho-education about the dynamics of assault, likely traumatic effects, and strategies for managing distress plays a prominent role in this process (Ruzek et al., 2007), along with work with families and support networks to ensure the continuation of post-trauma care (Campbell, 2008). Additionally, immediate therapeutic work may feature the normalisation of coping reactions and the integration of these into positive self-perceptions (Regehr et al., 1999). Finally, ensuring that clients have access to both specialist follow-up and the opportunity for engagement with a wide range of social services is integral (Pack, 2011).

RAPE MYTHS AND SECONDARY VICTIMISATION

The term "rape myths" denotes the widely adopted rape-supportive discourse that encompasses a set of socially sanctioned, prejudicial, and implicitly victim-blaming beliefs about rape dynamics (Baugher, Elhai, Monroe, & Gray, 2010). Typically, these involve attributions of blame based on survivors' actions, clothing style, or history (Gavey & Schmidt, 2011), and may also include beliefs that women "ask for" assault and report rape based on retrospective regret of sex (Kelleher & McGilloway, 2009). People subscribing to rape myths may also have limited views of abusive dynamics, with assaults that are non-violent or perpetrated by partners likely to be excluded from their narrow definitions of sexual violence (Gavey & Schmidt, 2011). The perceived legitimacy of sexual violence disclosures is negatively correlated with rape myth adherence, which affects the way that social services, police, and medical personnel treat survivors (Jordan, 2001). In addition, rape myths affect survivors' analyses about behaviour and blame (Jordan, 2001). Adherence to rape myths has been proven to be closely associated with other discriminatory attitudes relating to gender, race, and sexual orientation, and is intrinsically connected to highly gendered beliefs and negative attitudes towards women (Baugher et al., 2010). Assessing for, and challenging, these beliefs has been recognised as a key task for workers, as they affect professionals' treatment of survivors and partly determine the level of empathy received from survivors' families (Murphy et al., 2011). Crisis workers are not exempt from holding harmful beliefs, and consequently must question their own prejudices and reactions during and after work with survivors (Campbell, 2008).

Disbelief, insensitivity, and mistreatment throughout the post-assault legal and medical processes may result in secondary victimisation for survivors, otherwise known as re-traumatisation (Campbell, 2008) or as a "second rape" (Campbell et al., 2001). This occurs

when the loss of control felt during the assault or abuse is replicated, and is frequently experienced by survivors when they seek help from formal systems (Pack, 2011). Studies carried out overseas have demonstrated that having a trained support person willing to advocate on their behalf results in reduced levels of re-victimisation for survivors compared to those going through the reporting process unaccompanied (Hamilton & Coates, 1993), indicating a clear role for worker advocacy. Further, agencies working with sexual violence survivors should facilitate discussions with their workers regarding ways to respectfully challenge rape-supportive beliefs held by other professionals (Decker & Naugle, 2009; Hellman & House, 2006).

WORKING WITH SHAME

Amstaotter and Vernon (2008) define shame as a "self-conscious moral emotion resulting from a negative appraisal of one's self" (p. 395). Shame usually presents post-trauma and, for sexual violence survivors, unlike survivors of other types of trauma, often increases over time (Amstaotter & Vernon, 2008). This can be in part explained by society's adherence to rape-supportive discourse and concurrent stigmatisation of sexual crimes. As the assault or abuse becomes organised into frameworks of understanding by survivors, feelings of shame are threaded through their retrospective views of the events as a result of their own and others' beliefs about sexual integrity, responsibility, and blame (Amstaotter & Vernon, 2008). Assessing survivors' ability to challenge their own self-blaming tendencies and assisting them to externalise blame and attribute responsibility correctly is paramount to recovery from insidious self-blame, which can moderate their senses of shame and reduce it as a risk factor for on-going post-traumatic stress symptoms (Regehr et al., 1999). One strategy to achieve this is to facilitate knowledge acquisition regarding the criminal nature of sexual offending, in order for the survivor to reframe the experience in a way that locates the accountability with the offender (McMillan, 2013).

WORKING WITH FAMILIES

Family members' responses may precipitate survivors' return into a crisis state, particularly if they imply victim responsibility or withhold emotional warmth in times of distress (Decker & Naugle, 2009). Conversely, positive family responses may protect against both hyper- and hypo-alertness in survivors by enabling them to remain grounded in the present throughout the initial post-assault phase, and are consequently inversely correlated with prolonged distress (Decker & Naugle, 2009). This highlights the need for misconceptions about sexual violence to be addressed with family groups (Hellman & House, 2006). In addition, assisting clients who are preparing to navigate the often emotionally charged process of disclosing to family can lessen the anxiety associated with this (Campbell, 2008).

One of the long-lasting effects of sexual violence can be the alterations in relational styles, which can impact severely on the quality of peer, partner, and family relationships (Ehreinreich, 2003). However, strong familial support is a mediator of post-assault distress, creating a harmful dichotomy between survivors' relational responses to trauma and pro-social behaviour that would facilitate the protective responses (Decker & Naugle, 2009). To inoculate against the potential for the exacerbation of symptoms due to estrangement

from family, extensive psycho-education from workers about typical reactions to assault and ways to communicate with survivors is advised (Baugher et al., 2010). In later stages, working alongside family groups and encouraging the development of adaptive coping responses can elicit positive affective responses for survivors and lessen their environmental stressors (Whiste & Rollins, 1981). This is particularly indicated in cases where the family as a collective appears to be in a state of crisis due to the disruption the assault has caused to family functioning (Whiste & Rollins, 1981). Helping family units to externalise blame, challenge their own perceptions of fault and shame, and identify emotional needs are all areas for worker training (McMillan, 2013).

WORKING WITH YOUNG PEOPLE

The age at which survivors are subjected to sexual assault or sexual abuse affects the ways in which they are likely to be impacted (Kaltman et al, 2005). Young people are at elevated risk of sexual violence, with one study showing that 51% of university students had histories of sexual victimisation (Kaltman et al., 2005). The developmental stage at which this occurs influences the cognitive, emotional, behavioural and psychological consequences they are likely to experience (Whitman, 2007). Adolescent survivors are disproportionately likely to demonstrate intrusion and avoidance symptoms following their exposure to trauma, and experience higher levels of borderline personality disorder (BPD), dissociative disorders, and extreme distress (Kaltman et al., 2005). In part this is due to the developmental processes occurring in adolescence such as consolidation of identity, the move towards independence, sexual development, and cognitive changes (Whitman, 2007). Survivors of this age group often display increased levels of risky sexual behaviour and considerably lower levels of self-worth (Jordan, Patel, & Rapp, 2013). In addition, as a consequence of their cognitive abilities not being fully developed, they are more vulnerable to the internalisation of harmful societal messages about female sexual integrity and are less able to process and challenge flawed beliefs (Baugher et al., 2010). Finally, victimisation during adolescence is shown to be a key precipitant to girls' involvement in commercial sexual activity as a result of the distortion of their sexual identity, changes to their relational and social processes, and their post-trauma responses (Ahrens, Katon, McCarty, Richardson, & Courtney, 2012), again heralding the need to recognise and challenge thought processes related to risk and behaviour in young people.

In addition to the dissimilarities between adults' and young people's responses to trauma, adolescents have markedly different needs for service engagement. They typically demonstrate apprehension about confidentiality being broken, are attuned to non-verbal signals from adults and easily perceive judgment or rejection (Ahrens et al., 2012), and they require continuous patience, respect, and reassurance (Whitman, 2007). This suggests that the response of professionals to affected adolescents should differ from that to adults and include interventions relating to safe sexual behaviour, self-worth, and supported development of self (Jordan, Patel, & Rapp, 2013). Consistent safe boundaries should be modelled, and workers should be prepared for challenges to these boundaries (such as through intrusive questions) and ideally should have plans for responding (Whitman, 2007). However, services for sexual violence are primarily designed for adult survivors

and it is frequently difficult for workers to adjust their mindset and skillset for young people, particularly without adolescent-focused training (Whitman, 2007).

SEMINAR REFLECTION

Training needs were prioritised due to time constraints, and three components were identified as paramount: trauma-informed practice, power and control, and counselling and attending skills. This led to the establishment of three workshops containing participatory exercises designed to challenge existing perceptions, identify collective knowledge, and develop essential skills.

The trauma-informed practice for sexual violence and the basic skills workshops were combined and delivered in one long session due to organisational constraints. This began with an introduction to "trauma discourse", PTSD criteria, the pitfalls of diagnoses and a group discussion on factors that determine the extent of psychological impact. This was accompanied by an exercise presenting a range of scenarios that trainees were invited to rate from most to least likely to result in psychological harm, spurring robust discussion about which factors contribute most to trauma. Next was a brainstorm of effects that might be seen in survivors, followed by an explanation of the most common effects. Dissociation and its purpose, process, and physical and behavioural signs were then presented, together with smaller group discussions about the spectrum of dissociation, personal experiences, and signs of dissociation in clients. The basic tenets of flashbacks and panic attacks were then covered, with participatory exercises (trainees putting suggestions on titled paper on the walls using Post-It™ notes) drawing from the collective knowledge of the group. These were added to by the trainer as needed. Research findings about susceptibility to PTSD were then presented, and these were linked to the crisis role. Rape myths were explored and named, with trainees forming a continuum from agreeing to disagreeing. Brief narratives similar to those often voiced by clients, other professionals, or family members were then provided, and trainees in small groups planned responses to combat the rape-supportive discourse evident in each narrative and presented back to the group. This was followed by a discussion about shame and ways to work with the various manifestations of it, and exercises regarding re-traumatisation of survivors. Finally, the workshop featured a range of exercises designed to enhance attending, listening, and counselling skills, and concluded with a slide and discussion about secondary traumatic stress and self-care.

The second (shorter) workshop featured the power and control wheel, definitions of violence and abuse, discussion about the "gender symmetry" argument, the consequences of abuse, the reasons why women stay in abusive relationships, noticing and responding to warning signs, and identifying options and safety planning. Like the first workshop, the training was punctuated by scenarios, rating exercises, role-plays, and collective brainstorming to encourage participation.

Feedback indicated that participants found the explanations of physiological and psychological processes after trauma exposure and the exercises to entrench this knowledge beneficial. While exercises were designed to explore victim-blaming attitudes and the identification of rape-supportive discourse, this had limited success from the trainer's

perspective as the robust discussion included minimal challenging of implicit victim-blaming or highly gendered attitudes within the group. It was evident from the responses to facilitated discussions about constructions of gender and its impact on power dynamics that this component could have been further developed. On the other hand, exercises aimed at eliciting empathic responses to the specific social and emotional disruptions that may feature in survivors' narratives appeared more successful, with excerpts from survivors given to groups who fully participated in brainstorming and debating appropriate responses. On reflection, the training was premised on an assumption of shared basic knowledge that appeared not to be universal among trainees at the time of delivery. As a result, there was divergence in the degree to which each trainee was able to comprehend and build on the training material. This may be attributable to differences in qualifications, personal backgrounds, past training, and length/breadth of experience in the sexual violence sector. For future sessions it may be useful to evaluate the extent to which participants have the foundational knowledge that the training is designed to build on prior to delivering the seminars and, if necessary, delivering the training in stages in order to develop this foundational knowledge first.

CONCLUSION

Levels of initial and repeat sexual victimisation for New Zealand women underline the necessity of response agencies providing their workers with quality, evidence-based training. Sexual violence threatens survivors' senses of agency and physical integrity, and results in an often debilitating range of adverse effects, including psychological, emotional, cognitive, and behavioural disruptions. These frequently manifest in the form of post-traumatic stress disorder, signaling the need for interventions to specifically target the development of psychological and physiological traumatic responses. One suggested way of doing this effectively is through adherence to the stages of PFA. However, the unique dynamics of sexual violence require increased sensitivity to the social and cultural contexts in which victimisation occurs, and provision of multiple avenues for intervention. Training of sexual violence workers should consequently build foundations of effective attending and counselling skills, together with techniques for working with trauma, including PFA, empowerment theory, family interventions, and skills for working with young people. The training sessions developed from this review highlighted the need for workshops to assess levels of existing knowledge and include foundational skills accordingly, and to increase the amount of time spent on exploring and challenging gendered beliefs that are intrinsically connected to notions of blame and accountability for sexual violence.

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