ALLIANCE for HOPE INTERNATIONAL

Draft

Polyvictimization Assessment Tool

Resource Guidebook

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Introduction

Creating Pathways to Justice, Hope and Healing Polyvictimization Demonstration Initiative

The Creating Pathways to Justice, Hope and Healing Polyvictimization Demonstration Initiative seeks to address the complex and interconnected needs presenting in survivors coming through Family Justice/Multi-Agency Centers (Centers). The current service provision system is often based on a linear model of problem solving which focuses on one victimization at a time such as domestic violence, sexual assault, substance use, child abuse, or homelessness (Edmund & Bland, 2011). However, single-focus service models do not address the complex needs of those who have suffered multiple types of trauma known as polyvictims. Cross-sector collaboratives such as the Family Justice Center model help bridge the gap and build partnerships among various agencies, providing relief and bringing together a fragmented system to simplify the healing journey for survivors, both adults and children.

Professionals in Centers often encounter clients who have long-standing trauma, many times from their childhood, and/or who have been victimized in their intimate partner relationships. However, in many instances clients have also been victimized in their communities and by systems meant to serve them. Often Centers are not equipped to provide services for survivors who have been victimized outside of intimate partner relationships. This means survivors must search for services elsewhere to address other types of victimizations otherwise they are left to mitigate the impact of this trauma on their own.

The Office for Victims of Crime (OVC) has created a strategic vision, Vision 21, to challenge service providers to transform the way services are provided and to screen for polyvictimization and address the holistic needs of child and adult survivors of trauma. The Polyvictimization Assessment Tool (Tool) and Resource Guidebook were developed under the Creating Pathways to Justice, Hope and Healing Polyvictimization Demonstration Initiative (Initiative) led by Alliance for HOPE International (Alliance) and six national demonstration sites, which include the Family Justice Center Sonoma County, Stanislaus Family Justice Center, New Orleans Family Justice Center, Sojourner Family Peace Center, Tulsa Family Safety Center, and the Queens (NYC) Family Justice Center. The purpose of the Initiative is to 1) Identify and document the prevalence and impact of polyvictimization in adults served in Centers; 2) Help professionals tailor and better provide long-term holistic services that address the multiple forms of trauma survivors face; 3) Provide a feedback loop for Centers by identifying additional partners/services that Centers need to bring on-site; 4) Mitigate the impact of trauma by educating, normalizing, and contextualizing the lived experience of survivors through advocacy and services; and finally 5) Integrate survivors into a long-term community of support to increase hope and empowerment.

This Initiative would not have been possible without the tireless work, dedication, and leadership at each of the Centers and without the commitment of the frontline staff who are constantly finding ways to better support survivors. We are thankful for their input and commitment to bringing HOPE to the lives of survivors in their communities.

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Understanding Polyvictimization

Sojourner Family Peace Center, Milwaukee Wisconsin

Several terms have been developed to describe the complex and interconnected traumas a survivor may experience. Fields ranging from mental health, to victim advocacy, to substance use have used terms such as co-occurring issues, complex trauma, multi-abuse trauma, and polyvictimization to describe these interconnected traumas. While many of these terms are similar, they are not identical and often have different connotations. Polyvictimization is defined as having experienced multiple types of victimizations, such as sexual abuse, physical abuse, bullying, and exposure to family violence during a specific time frame and usually at the hands of different perpetrators (Finkelhor et al., 2011). The term polyvictimization best describes the intended use and framework for this Tool because it allows staff and service providers to look past the focus of intimate partner violence and expand services, education, and advocacy for survivors of multiple types of trauma.

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Research on polyvictimization shows that the more types of victimization a child experiences the more they are likely to have negative long-term health outcomes physically, emotionally, socially, and mentally. Research also demonstrates that survivors who have been victims of intimate partner violence may have also been victims of neglect as children, experienced bullying, witnessed shootings or stabbings in their community, and/or have experienced death of a loved one through illness or violence (Finkelhor et al., 2011). In fact, the connection and correlation between different types of victimizations is high, 81% of individuals who experienced emotional abuse also experienced physical abuse (compared to 20% of those who had not experienced emotional abuse), and 65% of individuals who witnessed domestic violence as children also grew up with substance-using parents (compared with 23% of those who did not witness domestic violence) (Dong et al., 2004). While polyvictimization research has not come to a consensus on the exact number of victimizations that constitutes a polyvictim, Finkelhor, Ormrod, and Turner define a polyvictim as an individual who has experienced four victimizations or more in the span of a year, although they note that the range of victimizations can vary between three to 15 or more victimizations (Finkelhor et al., 2007). Furthermore, research shows that children who have experienced seven or more types of victimizations in one year are particularly distressed and more vulnerable to other types of victimization in other areas of their life (Finkelhor et al., 2011). These polyvictims often experience symptoms higher levels of anxiety, avoidance, and numbing among many other symptoms. Through their research, Finkelhor, Ormrod, and Turner demonstrated that polyvictims are more likely to experience greater stress symptoms than those who are exposed to only one type of violence, even if that violence occurs more frequently (Finkelhor et al., 2011).

While much of the polyvictimization research has been documented in children, implications of adverse childhood experiences (ACEs) and the connection to negative adult experiences and lack of well-being have also been established. Children with an ACE score of four and over (polyvictims) are four to 12 times more likely to suffer from alcohol, drug abuse, depression, suicide attempts, more likely to smoke, be obese, and contract sexually transmitted diseases as adults (Felitti, et al., 1998). This Tool attempts to screen adults for polyvictimization in Centers and build their capacity to treat, prevent, and better understand clients lived experience. Ultimately, this Tool should help provide and guide tailored services in Centers.

Trauma Examples

(Center for Substance Abuse Treatment, 2014)

Caused Naturally	Caused by People	
Tornado	**Accidents, Technological Catastrophes**	**Intentional Acts**
Lighting Strike	Train derailment	Arson
Wildfire	Roofing fall	Terrorism
Avalanche	Structural collapse	Sexual assault and abuse
Physical ailment or disease	Mountaineering accident	Homicides or suicides
Fallen tree	Aircraft crash	Mob violence or rioting
Earthquake	Car accident due to malfunction	Physical abuse and neglect
Dust Storm	Mine collapse or fire	Stabbing or shooting
Volcanic eruption	Radiation leak	Warfare
Blizzard	Crane collapse	Domestic Violence
Hurricane	Gas explosion	Poisoned water supply
Cyclone	Electrocution	Human trafficking
Typhoon	Machinery-related accident	School violence
Meteorite	Oil spill	Torture
Flood	Maritime accident	Home invasion
Tsunami	Accidental gun shooting	Bank robbery
Epidemic	Sports-related death	Genocide
Famine		Medical or food tampering
Landslide or fallen boulder		

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Language: Terms and Definitions

This Resource Guidebook and Tool were created for multi-disciplinary professionals at Centers. The language used should make the information accessible and easy to understand across disciplines and levels of expertise in the field. We have attempted to use simplified language for terms used in a mental health setting, have spelled out acronyms the first time they are used, and included an appendix with definitions of commonly used terms.

While the initial user of this Tool may be an Advocate, Navigator, or Screener at a Center, we recognize a broad spectrum of professionals may use this during service delivery. Therefore, we will be referring to the users as “frontline staff” or “staff” rather than individual titles such as Advocates, Case Managers, Therapists, Civil Legal Providers, etc. We recognize that different disciplines refer to the people they are working with in different ways (client, victim, patient, or survivor) and that these terms carry specific nuances and significance. The goal of this Initiative is to be survivor-centered and humanize the experience of people we serve rather than to categorize and label them. For the purpose of this Resource Guidebook, we will use the words survivor and client interchangeably. The trauma-informed approach in addressing survivors is to ask them what they would like to be called. In almost every circumstance, they want to be called by their name (Gwinn, 2015). We therefore recommend Centers use client names when working with survivors, as this not only builds community but also diminishes the power differential survivors often feel when receiving services.

When completing this Tool, staff should answer questions based on the survivor’s perspective, and focus on the survivors’ experience and the impact they believe situations had on their life. However, users may refer to definitions provided in the Glossary, refer to state law, and ultimately make a judgement call on what they think is appropriate and note this in the Notes section of the Tool. It is important to remember that the definition of a term is less important than the impact the experience has on a survivor and how it affects the staff’s perceptions of need or services provided (Pilnik & Kendall, 2012). The definitions of symptoms are adapted and borrowed from Identifying Polyvictimization and Trauma Among Court-Involved Children and Youth: A Checklist and Resource Guide for Attorneys and other Court-Appointed Advocates, the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5), the Adverse Childhood Experiences Questionnaire (ACE), and the National Stressful Events Survey PTSD Short Scale (NSESSS). Events and symptoms in the Tool should help inform thinking about a survivor’s experience and help staff consider the impact of past traumatic experiences rather than to label or diagnose survivors. Users of the Tool are encouraged to work with mental health professionals in their Center, when confidentiality and information sharing agreements have been signed by the survivor. In addition, mental health professionals should provide ongoing training to users of the Tool on psycho-education and strength-based strategies for working with survivors. This will help non-clinical staff integrate psycho-education and strength-based strategies in all interactions.

It is important to note that some of the symptoms included in the Tool (ex: easily distracted, jumpy) are associated with many other conditions besides trauma. However, many times the effects of traumatic experiences are misdiagnosed as attention deficit disorder or attention deficit/hyperactivity disorder particularly in children and teens (Pilnik & Kendall, 2012). Research has shown that traumatic experiences can lead to higher levels of post-traumatic stress disorder, depression, eating disorders, suicidality, or the creation of other unhealthy coping mechanisms (Pilnik & Kendall, 2012). Staff should keep in mind that some of the behaviors in the Tool may be typical for people recently exposed to traumatic experiences and/or have been developed as a coping mechanism for survival. Only extreme, unusual and new/sudden behaviors should be cause for concern. Based on current symptoms identified, it is important to recommend additional assessments be conducted by qualified mental health professionals. Frontline staff and partners should focus on helping survivors connect their traumatic experiences to their physical symptoms and find ways to mitigate and ameliorate these symptoms through holistic services offered in Centers.

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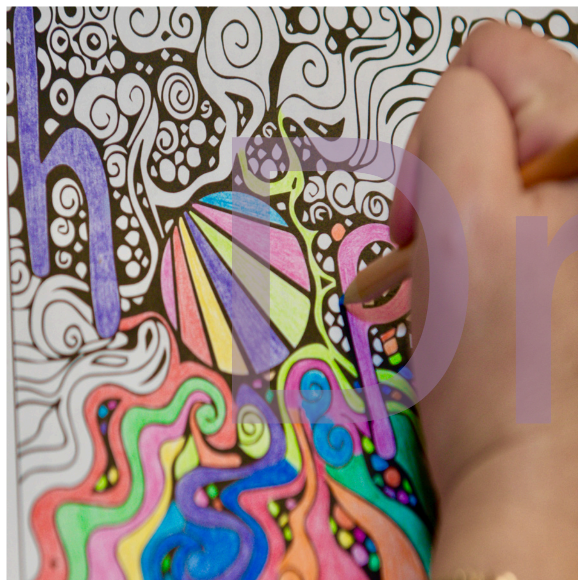
The trauma-informed approach in addressing survivors is to ask them what they would like to be called



The definition of a term is less important than the impact the experience has on a survivor and how it affects the staff's perceptions of need or services provided (Pilnik & Kendall, 2012)

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Frontline staff and partners should focus on helping survivors connect their traumatic experiences to their physical symptoms and find ways to mitigate and ameliorate these symptoms through holistic services

Background and Context: The Polyvictimization Assessment Tool

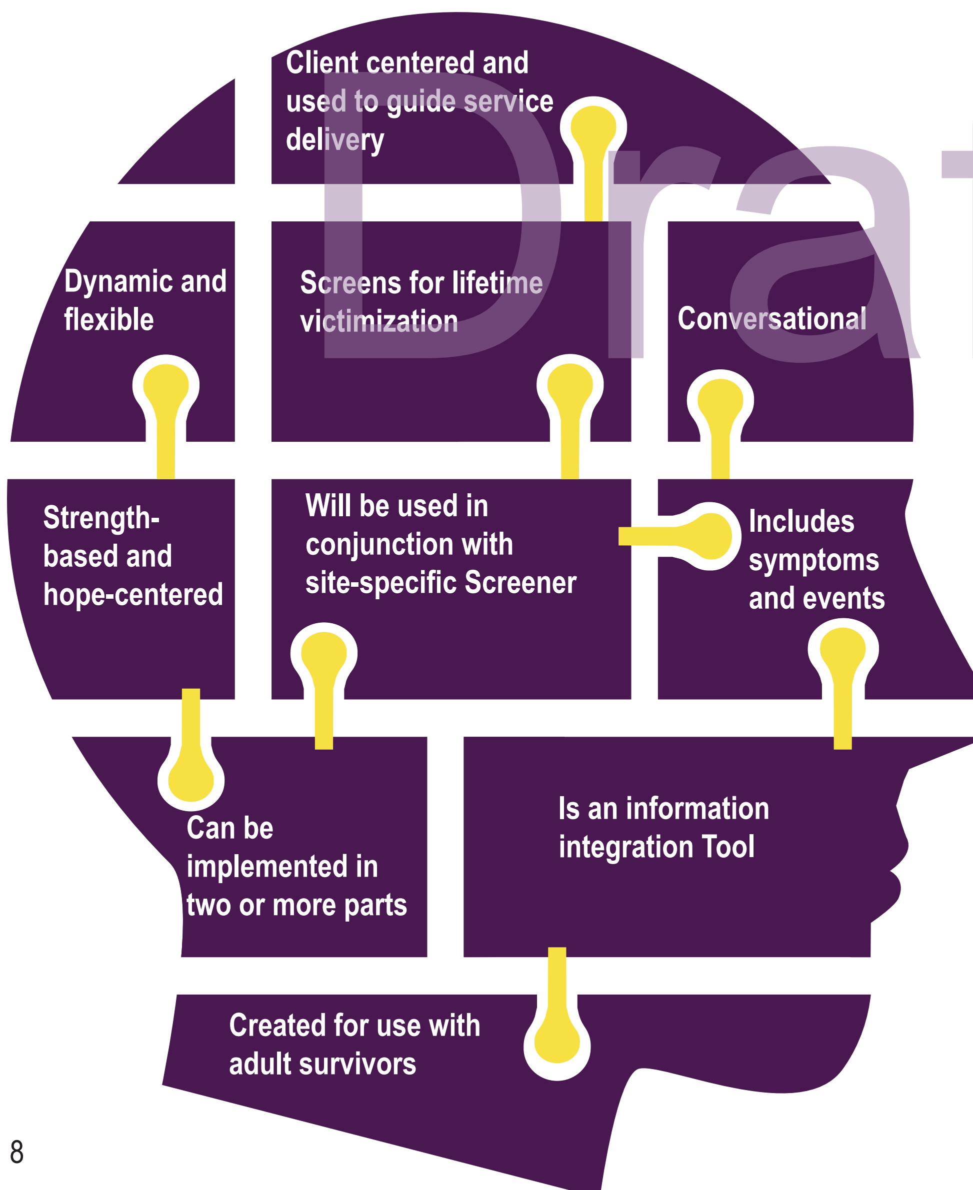
This Resource Guidebook was created in order to provide guidance for staff and service providers about ways and resources to improve services for polyvictims and educate the community about polyvictimization. This Initiative acknowledges that polyvictimization affects every part of a survivor's life, as such the Tool covers both victimizations and adverse life experiences in order to capture a holistic picture of the survivor's life. Due to the complex nature of polyvictimization, OVC and the Alliance believe a multi-disciplinary team is better equipped to develop an integrated, responsive plan to address all the needs of the survivor as opposed to a single professional. To learn more about Family Justice Centers and Polyvictimization read Addressing Polyvictimization in a Family Justice Center Setting.

This Tool is intended to be used with adult survivors, and was developed to allow for flexibility, so Center professionals and intake staff may complete this Tool over a period of time (for example, 1-3 intake sessions) with a survivor in order to build rapport and to first address immediate needs.

This Tool is not meant to be diagnostic. It is a Tool for Center staff and partners to better understand survivors' exposure to trauma and its influence on behaviors and needs. The term polyvictim or polyvictimization should never be used to label, diagnose, pathologize, or judge a person receiving services but rather to acknowledge and validate survivors' experiences (Edmund & Bland, 2011). Instead, the Tool should inform strategies to mitigate trauma through holistic and long-term services. While collaboration and information sharing often help survivors accomplish their goals and pushes them further in their journey to healing, the Polyvictimization Assessment Tool should always be used with appropriate informed consent, information sharing, and confidentiality permission from survivors.

Before implementing this Tool, leadership should ensure trauma-informed practices are in place, the presence of holistic and long-term services at the Center are available, support and debrief mechanisms are in place for frontline staff, extensive and appropriate training is held for users of the Tool, and that all users review, discuss, and understand this entire Resource Guidebook.

Polyvictimization Assessment Tool Guiding Principles



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Case Scenario:

(Adapted from A Treatment Improvement Protocol -Trauma-Informed Care in Behavioral Health Services, 2014)

Maria is a 31-year-old woman who came to the Center for services because a past boyfriend is stalking her on social media and via text messages. Their relationship ended over two years ago, but in the last few months her ex-boyfriend has realized she has a new boyfriend and has now begun reaching out to her constantly. At first Maria responded and asked him to leave her alone, but now he is constantly checking in on her and refuses to stop. This has made her nervous and distracted her daily life so she came to the Center looking for solutions.

After high school Maria moved from her home town to a new state. Maria tried to find a job in order to support herself, but could not find one and sought help from a women's shelter. Maria stayed at the women's shelter for 30 days before she decided to move back to her home town in the search of a job.

From ages 8 to 12, Maria was sexually abused by an uncle. She never told anyone about the abuse for fear that she would not be believed. Her uncle remains close to the family, and Maria still sees him on certain holidays. When she came in for services, she described her emotions and thoughts as out of control. Maria often experiences intrusive memories of the abuse, which at times can be vivid and unrelenting. She cannot predict when the thoughts will come and efforts to distract herself from them do not always work. She often drinks in response to these thoughts or his presence, as she has found that alcohol can dull her level of distress. Maria also has difficulty falling asleep and is often awakened by nightmares. She does not usually remember the dreams, but she wakes up feeling frightened and alert and cannot go back to sleep.

Maria tries to avoid family gatherings but often feels pressured to go. Whenever she sees her uncle, she feels intense panic and anger but says she can usually "hold it together" if she avoids him. Afterward, however, she describes being overtaken by these feelings and unable to calm down. She also describes feeling physically ill and shaky. During these times, she often isolates herself, stays in her apartment, and drinks steadily for several days. Maria also reports distress pertaining to her relationship with her current boyfriend. In the beginning of their relationship she found him comforting and enjoyed his affection, but more recently she has begun to feel anxious and unsettled around him. Maria tries to avoid sex with him, but she sometimes gives in for fear of losing the relationship. She finds it easier to have sex with him when she is drunk, but she often experiences strong feelings of dread and disgust reminiscent of her abuse. Maria feels guilty and confused about these feelings.

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The case scenario above helps illustrate the importance of having an in-depth conversation with survivors about their life and experiences. Many survivors coming to Centers have co-occurring trauma and only an in-depth conversation can help identify underlying trauma and provide an opportunity to address them during service delivery. This scenario also demonstrates the importance of asking about event-based trauma as well as symptomology and the physical and emotional changes a client may be experiencing.

This Tool was only implemented in Centers after two years of intensive work which included Center assessments, in-depth training on trauma-informed approaches, a review of client processes and mapping, and training of frontline staff on mental health, hope theory, strength-based interviewing, and other critical subjects. A multi-disciplinary team was developed at each Center, consisting of frontline staff, FJC Directors, and mental health professionals. Each team tasked with implementation of this Tool also met with other demonstration sites in order to discuss successes, challenges, and implementation. Therefore, to be system changing and meaningful for survivors, the Alliance recommends outside facilitation and assistance prior to implementation of the Tool, as well as ongoing support after implementation. If a Center is interested in utilizing and implementing the Polyvictimization Screening Tool, please contact Alliance for HOPE International at info@alliancefohope.com.

Using the Polyvictimization Assessment Tool

It is critical that survivors in crisis first receive support and services that address safety, wellbeing, immediate housing needs, access to food and water, and/or medical care prior to frontline staff completing this Tool.

This Tool is an "information integration tool" and is meant to be a summary of information gathered during an intake(s) at a Center. It allows intake staff, advocates, and partners, with survivor/client consent, to use and organize information gathered about past/current victimizations and any symptoms. This Tool is designed to be completed by Center staff based on client information provided at various intakes rather than administered as a self-report form.

The Tool examines a survivor's entire life experience from their childhood to adulthood and provides the ability to note experiences across the lifetime of a survivor. The events portion of the Tool covers 26 events and is broken down into three categories, "Child and Teen," "Adult," and "In the last year". The symptoms section of the Tool covers 18 symptoms and is broken down into three categories, "Child and Teen," "Adult," and "In the last year" as in the events section, but also includes a "Current Symptom" category. The current symptom category allows staff to triage current symptoms and allows for a deep historical understanding of when these symptoms developed and how long they have been in present in the survivor's life.

In order to allow a conversational approach to the Tool, each victimization in the events and symptoms sections is accompanied by examples that aim to make it easier to explain the event and symptom. Please note that the examples are not exhaustive and do not cover all possible scenarios. While this does not create standardization across users, it does allow for flexibility and survivor led conversations. As such, please follow the survivors lead on how they would like to define and identify an event or symptom. For each question in the events section please circle "Y" for yes and "N" for no as applicable for the different stages of the client's life (Child and Teen, Adult, and In the last year). When marking an event or symptom "In the last year" or "Current Symptom" (symptom section only) please also mark the respective time period it would fall under. For example if a survivor discloses "bullying" in the last year and they are 22 years old, the user would mark "Y" in the last year and "Y" in the adult category as well.

The Tool also includes a coding system to facilitate the rotation of the Tool between various staff members. If the survivor does not acknowledge and/or indirectly avoids the question when asked the user should circle "A" for "client did not respond." If the user of the Tool ran out of time when using the Tool, or if they started the Tool and the client never returned for follow up, the user should circle "B" for "user did not ask." If the survivor explicitly expresses that they do not want to address the topic or shares that they are uncomfortable talking about a specific type of victimization or age, the user should circle "C" for "not appropriate to ask." Answer option "C" was created with the intention of ensuring that a client is not asked by a future clinician/user of the Tool about a topic that they have explicitly said that they do not want to discuss. For questions that are not applicable to all clients an additional "does not apply" response has been included.

When professionals at a Center ask survivors about events or symptoms in the Tool, it is important they keep in mind confidentiality, ethical rules, mandated reporting issues (Pilnik & Kendall, 2012). This is particularly true in any additional notes or information recorded on the Tool. The Tool provides space for notes which staff can utilize to include additional information, symptoms, services needed, or potential follow-up questions. Notes should be kept in a private secure place to ensure confidentiality. It is important staff not include information that could be used against the client in the Tool. It is particularly important that privileged professionals not include their case notes on the Tool if it is being shared among partners. In addition, if a survivor wishes to have a copy of the Tool it should be provided.

The Tool should help inform users of a holistic and trauma-informed way of working with survivors. After completing the Tool, users should review the flowchart for general guidance on immediate and long-term steps based on the information gathered. Please note that the flowchart does not provide all the possible next steps your Center should take and is only intended to be used as guide.

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Staff are encouraged to continue updating and adding information to the Tool at regular intervals. Staff should note progress in the healing journey and add new events, symptoms and victimizations. This will help staff update the service plan as additional support and services are requested. Negative developments, lack of progress, or change in situations can be traumatic, and interactions with systems can be triggering, therefore it is important frontline staff continue tracking changes with survivors and provide ongoing support (Pilnik & Kendall, 2012).

New symptoms may begin to appear after a prolonged amount of time even with positive changes and improvements in a survivor's situation. It is important users of the Tool reassure survivors that changes in symptoms are part of the healing process and that Center staff are there to support them along the way. It is also important to keep in mind that a survivor who has experienced one or more types of victimizations but does not exhibit stress symptoms, or has no trouble in day-to-day functioning, may not need additional services other than the specific incident or need(s) that brought them to the Center. However, staff should watch for new symptoms and continue utilizing the Tool throughout their contact with the survivor to identify changes.

Family Justice Center Sonoma County

Audience and Use

Establishing rapport and trust with a survivor is an important part of the healing journey because it is only through relationship building that most people share their life experiences openly.

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Building Rapport

Establishing rapport and trust with a survivor is an important part of the healing journey because it is only through relationship building that most people share their life experiences openly. Earning trust is a long-term process that takes time especially with those who have experienced multiple forms of trauma and have been let down by systems, service providers, and loved ones. Staff can build rapport with clients through mutual attentiveness by getting to know the survivors they are working with and understanding their interests. This is demonstrated by attentively listening to the client and validating their experiences. The second step staff can take is to ensure their interaction with the client is positive by being friendly and caring. Positivity can be conveyed through verbal and non-verbal communication. Warmly greeting the client when they come in, offering them water, coffee, tea and/or food, and inviting them to sit in a warm and friendly atmosphere can make the survivor feel cared for and valued. The third step staff can take is to create a feeling of being "in sync" with the client and their needs. Staff can foster this by customizing the service plan for each client and meeting their unique needs. Staff should walk the client through the entire service plan to ensure the client understands what will be taking place and when (Tickle-Degnen and Rosenthal,1990, p. 286). It is critical frontline staff include survivors in developing their service delivery plan; have open conversation with survivors of what they can and cannot provide to ensure no surprises; follow confidentiality; be clear about consent and mandated reporting; believe survivors stories; and acknowledge that many times service providers do not have all of the answers (Edmund & Bland, 2011).

Psychoeducation and Validation

The Tool should help users provide nuanced psycho-education for survivors to assist in their healing process (Pilnik & Kendall, 2012). This psycho-education should help survivors understand the interconnected nature of their trauma and help normalize the physical, emotional, and behavioral changes they may be experiencing. It can also help users build connections between a survivor's core belief about themselves, their lives, and their past experiences. When accompanied with in-depth advocacy

Ways to Build Rapport with Survivors:

1. Active listening
2. Verbal engagement
3. Asking open-ended questions
4. Allow room for silence during the session
5. Use the client's name

this Tool will help survivors contextualize the trauma they have experienced, connect it with current symptoms, provide them with an inventory of the strengths and resources they have, and finally help them articulate goals and pathways for the future. It is important to remember that there is no standard definition for success when working with survivors. As such a survivor's definition of success will often be unique (Edmund & Bland, 2011). Listening to survivors' goals and dreams and using that information to help tailor resources will honor a survivors' definition of success and increase hope. This Tool has been reviewed by mental health experts, Alliance staff, staff from Centers, and national experts and partners in this Initiative.

Staff also play a pivotal role in helping survivors process their trauma by making it clear that no one deserves the violence they have experienced and that it is not their fault (Edmund & Bland, 2011). The Alliance recommends using five key statements to convey this message: 1) I am concerned for your safety and wellbeing; 2) I am concerned for the safety and wellbeing of your children; 3) You do not deserve to be treated like this; 4) We have resources here to help you move forward; and 5) We are here for you whenever you need us (Gwinn & Strack, 2006). Validating the frustrations, feelings, physical ailments, and emotions of survivors during service delivery helps survivors overcome mistrust and build a transparent relationship with partners and staff at the Center. Helping survivors connect physical symptoms or behaviors to their trauma may help them build empathy for themselves and connect their trauma to their lived experience. Frontline staff should find ways to discuss this connection and seek training and support from other professionals if necessary.

Grounding Techniques:

(Adopted from Center for Substance Abuse Treatment, 2014)

Staff may use grounding strategies to aid an individual who is overwhelmed by memories or strong emotions, or dissociating during intake. They help bring a client back to the present moment and reconnect their mind and body.

Here are a few techniques:

Guided Meditation. Ask the client to state what they observe in the present time.

- Guide the client through this exercise: "You seem to feel very scared/angry right now. You're probably feeling things related to what happened in the past. Right now, you are in a safe situation. Let's try to stay in the present. Take a slow deep breath, relax your shoulders, put your feet on the floor. Let's talk about what day and time it is. Today is day, month, year. It is approximately X time. You are here at the [Center] we are sitting in [interview room, Nest, meeting space]. Notice what's on the wall, etc. What else can you do to feel okay in your body right now?"

Help the client decrease the intensity of affect.

- "Emotional dial": A client imagines turning down the volume on his or her emotions.
- Clenching fists can move the energy of an emotion into fists, which the client can then release.
- Use strengths-based questions (for example, "How did you survive?" or "What strengths did you possess to survive the trauma?")

Ask the client to use breathing techniques.

- A particularly helpful technique is to exhale and expel all air from their chest. Keep lungs empty for a four-count hold. Then inhale through nose for four-counts. Hold the air in your lungs for four-counts. Exhale through your nose for four-counts and continue as needed. This breathing exercise for 2-5 minutes is a great grounding technique and helps calm and focus the survivor.
- Have the client place their hands on their abdomen, breathe in through the nose and out of the mouth. As breathing occurs, watch the hands go up and down while the belly expands and contracts (Center for Substance Abuse Treatment, 2014).

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Increasing Empowerment for Survivors

Staff can empower survivors by providing them with a deeper understanding of the trauma they have suffered and the physical, mental, and spiritual impacts it has had on their lives. Staff should encourage survivors to be active participants in deciding the services they access, when they are provided, by whom they are provided, and reassure survivors of their autonomy and right to control the process of receiving services and support (Edmund & Bland, 2011). Many times, empowering survivors begins with allowing them to be in charge of their healing process and the services they access. Staff should use trauma-informed and strength-based language during interactions with survivors. It is also important they be aware of their language, both verbal and non-verbal, in order to create a safe and non-judgmental space. Using a warm tone, maintaining appropriate eye contact, mirroring the survivor's body movements to show engagement, and appropriately leaning in and out during the conversation all help show understanding and engagement. By empowering survivors, validating their experience, and equipping them with the right resources Center staff can help survivors take steps towards safety and healing.

It is also critical that Centers build programs and policies that are non-judgmental, non-punitive, and flexible and programs that allow survivors to identify what they need rather than providing a cookie-cutter approach (Edmund & Bland, 2011). It is important to remember that we cannot judge the actions or inactions of survivors as they are the ones who understand their life best and have survived thus far. Leaving an abusive situation or oppressive environment may not always be the best solution to their problems. In these instances, staff can work on reducing harm, increasing safety and wellbeing, helping survivors establish goals, and creating a safe space where survivors can return once they are ready to move forward with other services. Staff must approach service delivery as a two-way street and work on reducing the power differential among staff and survivors.

Using Strength-Based and Hope-Centered Practices

In addition to understanding and addressing various victimizations, this Initiative and Tool seek to provide staff with a way to empower and increase hope in the lives of survivors. While understanding how past experiences have impacted survivors' current lives and decisions, there is also value for survivors in helping them plan and think about the future. Measuring and increasing hope for survivors, building coping skills, and increasing survivor empowerment and resiliency have been demonstrated as the best ways to mitigate the impact of trauma. Understanding the impact trauma has on a person's idea of themselves, their safety, autonomy, and justice are critical for staff to empower polyvictims (Edmund & Bland, 2011). Use of this Tool should be followed by comprehensive service delivery and a strength-based approach to setting positive survivor driven goals and seek to increase the hope of survivors.

A strength-based approach is focused on helping survivors identify the strengths and resources in their lives while simultaneously acknowledging and working to address the injustices that have taken place. It allows them to not only note the difficult events of their life but helps re-frame this conversation to how they have survived and thrived even in the midst of such difficulties. A strength based approach, "does not attempt to ignore the problems and difficulties, rather, it attempts to identify the positive resources (or what may need to be added) and strengths that will lay the basis to address the challenges resulting from the problems." (Hammond, 2010, p. 3). Working with a survivor to help them identify the strengths and resources they already possess can assist them in developing confidence and a deeper sense of appreciation for themselves. After utilizing the Tool to identify events and symptoms, users of the Tool should help take an inventory of the character traits, resources, skills, and people that have helped the survivor throughout their life.

The table below provides several examples of strengths a user of the Tool can help highlight in a survivor. Staff are encouraged to work with the survivors, as well as other service providers, to determine strengths and resources (Smith, 2006).

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Character Strengths

(VIA Institute on Character, 2018)

Wisdom	Creativity, curiosity, judgment, love-of-learning, and perspective
Courage	Bravery, honesty, perseverance, and zest
Humanity	Kindness, love, and social intelligence
Justice	Fairness, leadership, and teamwork
Temperance	Forgiveness, humility, prudence, and self-regulation
Transcendence	Appreciation of beauty, gratitude, hope, humor, and spirituality

Core Principles of Strength-Based Practice
(Resiliency Initiatives, 2010)

1. An absolute belief that every person has potential and it is their unique strengths and capabilities that will determine their evolving story as well as define who they are - not their limitations (not, I will believe when I see – rather, I believe and I will see).

2. What we focus on becomes one's reality – focus on strength, not labels – seeing challenges as capacity fostering (not something to avoid) creates hope and optimism.

3. The language we use creates our reality – both for the [service] providers and [survivors]

4. Belief that change is inevitable – all individuals have the urge to succeed, to explore the world around them and to make themselves useful to others and their communities.

5. Positive change occurs in the context of authentic relationships - people need to know someone cares and will be there unconditionally for them. It is a transactional and facilitating process of supporting change and capacity building– not fixing.

6. Person's perspective of reality is primary (their story)– therefore, need to value and start the change process with what is important to the person and not the expert.

7. People have more confidence and comfort to journey to the future (the unknown) when they are invited to start with what they already know.

8. Capacity building is a process and a goal – a life long journey that is dynamic as opposed to static.

9. It is important to value differences and the essential need to collaborate – effective change is a collaborative, inclusive and participatory process.

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Reiki Practitioner's healing practice, New Orleans Family Justice Center
Photo credit: Melanie Young

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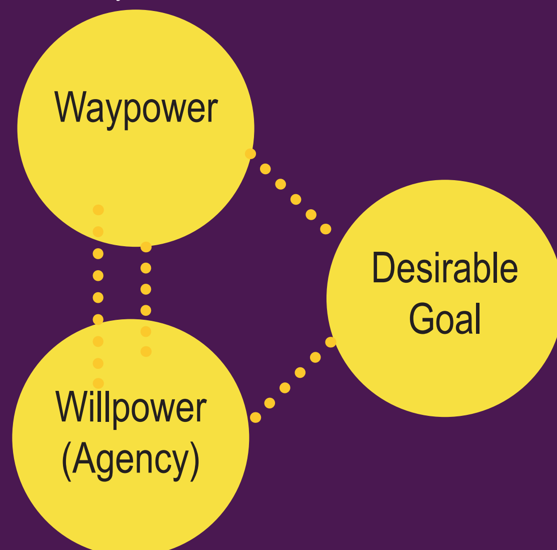
Increasing Hope

Of the 24-character strengths identified by positive psychologists, hope has been recognized as the best predictor of well-being (Snyder, 2001; Park et al., 2004; Marques, Lopez, Rose & Robinson, 2014; Gwinn & Hellman, 2018). Hope is the belief that your future can be brighter and better than your past, and that you have a role to play in making it better (Gwinn & Hellman, 2018). Hope is comprised of willpower, waypower, and goal setting. It is an important psychological strength that helps buffer the effects of adversity and stress, and serves as an important coping resource for both children and adults (Park et al., 2004; Hellman, 2011). Hope also predicts adaptive thoughts and behaviors and can be learned; therefore, intentional strategies and interventions can be used to increase hope in Centers (Parks et al., 2004; Gwinn, 2015).

Screening and intake at a Center should be accompanied and coupled with evidence-based treatment, long-term case management, a community of support, and goal setting. Psychologist Rick Snyder (2002), the leading researcher of Hope Theory, recommended using the statement, “You can get there from here,” when encouraging survivors to set, pursue, and achieve their goals. Increasing hope in the lives of trauma survivors often starts with caring people conveying a strong belief in survivors’ ability to have their future be different than their past.

Once immediate needs and crisis related needs have been met, staff are encouraged to help survivors think about short, medium, and long-term goals in order to increase hope. See Appendix X for more goal setting exercises. Those wanting to delve deeper into creating hope-centered organizations should contact the Alliance info@allianceforhope.com or visit the Hope Research Center at the University of Oklahoma



Using Information Gathered

While there is not a set number of "yes" answers in the Tool to trigger a specific Center response, Centers should work internally to identify the number of victimizations that could trigger a different response. Centers in this Initiative should identify a threshold for referral to support groups or therapy, without a wait, or prioritized access to resources and housing. According to the literature, survivors who experienced seven or more victimizations in the last year are at a higher risk of future victimizations and may be appropriate for a multi-disciplinary team (MDT) meeting. This meeting should include partners whom the survivor consented to work with after all confidentiality and information sharing agreements have been explained and signed. All confidentiality agreements, boundaries, and limitations should be followed according to Center, state, and federal law. This MDT meeting should help professionals better streamline, plan for, and organize services and survivor identified goals. In addition, survivors with seven or more victimizations should be provided long-term case management if desired.

As frontline staff use this Tool in their Centers with more survivors, they will begin to identify common experiences and symptoms throughout the intake process. Staff will also begin to identify survivors who are displaying greater levels of trauma-related symptoms and stress and may need further assessments, follow up, or specific interventions. It is critical the Center maintain clear policies and partnerships in order to meet the specific needs of survivors. Leadership should provide frontline staff with a process and voice in sharing the need for additional partners onsite to better serve the needs of survivors.

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Questions about Past Experiences: Ethical and Practice Issues

While the Tool is intended to organize and apply information staff have gathered during intakes, frontline staff and those utilizing the Tool may need to ask specifically about experiences listed in the Tool in order to provide appropriate services. Before asking survivors about a traumatic event, professionals should be clear about who they represent (agency and job title), what they will do with the information, and what would cause them to have to share the information with others. All professionals should be familiar with their jurisdiction's laws, the limits of confidentiality, and any mandatory reporting obligations. Information should not be gathered or shared if the professional believes this Tool could be used against the survivor or against their wishes in the future. The Family Justice Center model is a survivor-driven approach and all users of the Tool should become familiar with the Guiding Principles of the movement that focus on accountability to survivors for how services are provided (Alliance for Hope International, n.d.). It is important professionals administering the Tool weigh the benefit of gathering information as opposed to the harm of not gathering some or all of the required information (Pilnik & Kendall, 2012). This Tool is meant to help empower survivors and professionals in making choices, setting goals, and working collaboratively to create a service delivery plan that meets the needs of survivors.

Professionals should remember that some questions in the Tool could be distressing to survivors, in particular if this information has never been previously shared. It may take professionals several meetings to gather information, build rapport, and learn the extent of victimizations survivors overcame. Users of this Tool should not ask questions of survivors unless they have received appropriate training about strength-based interviewing techniques, de-escalation, and how to handle a crisis should it arise during intake. If a survivor experiences distress during intake, it is important staff have resources, tools, and support in helping survivors process these emotions. Sometimes it is cathartic and healing for survivors to tell their stories and it is important for staff to provide a safe space to do so, as long as the survivor guides this process and is aware of any confidentiality limitations and mandatory reporting issues prior to disclosure. This Tool provides users an opportunity to help survivors explore their past victimizations and help connect them with their current mental, emotional, and physical well-being.

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Sometimes it is cathartic and healing for survivors to tell their stories and it is important for staff to provide a safe space to do so, as long as the survivor guides this process and is aware of any confidentiality limitations and mandatory reporting issues prior to disclosure.

Staff Well-Being

Staff administering this Tool should also be aware of their own emotional well-being as it could affect their ability to use this Tool and perform intakes at their Center. Listening to traumatic experiences from survivors can take a toll and affect the user's ability to function either in a professional or personal capacity and this should always be taken into consideration. Leadership at Centers must be particularly attuned and prepared to implement this Tool, and ensure that the appropriate processes, activities, and protocols are in place to support staff. Training on vicarious trauma and its impacts should be conducted regularly at Centers. In addition, Centers should be responsible in facilitating, upholding, and modeling self-care practices. This could include designated debrief meetings, ongoing supervision and feedback, appropriate capacity building and staff appreciation events. Like survivors of trauma, vicarious trauma is common for professionals working on the front lines and they too may experience PTSD symptoms (Pilnik & Kendall, 2012). The increased scope of this Tool increases the chances of frontline staff experiencing secondary trauma, particularly during the beginning of implementation. As such, it is important Family Justice Centers and management staff provide ways to debrief and alleviate staff conducting intakes and also provide resources and ways to destress and promote staff well-being.

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Self-Care Tips for Intake Staff (Center for Substance Abuse Treatment, 2014):

- Peer support – creating systems of support with staff at the Center will help prevent isolation and depression.

- Supervision and consultation – leadership at Centers should develop systems for supervision and debrief with all intake staff in order to identify needs, gaps, or immediate issues. This should include everyone from receptionist staff, to advocates, and navigators. Staff should have a formal/informal mechanism for reaching out to mental health professionals to process their responses to clients, traumatic cases, and discuss strategies for self-care.

- Maintain a healthy life-work balance – leaving work at work, unplugging, and spending time doing things staff enjoy will help refresh staff and make them more resilient in managing difficult situations.

- Set clear boundaries with clients – it is natural for staff to want to help clients in any way they can but staff should be encouraged to define boundaries with clients and recognize they are doing the best that they can.

Practical Considerations

Family Justice Center staff often have high caseloads and limited resources and capacity. Professionals often find that even when they are able to identify the needs of survivors, the Center cannot always immediately provide it due to lack of funding, resources, or appropriate staffing. Staff utilizing this Tool may find that survivors have a broad array of needs that cannot be filled with current partners at the Center or due to resource scarcity. While this may prove to be a challenge for current clients and may require creative solutions, leadership at Centers should ensure that consistent gaps in service inform and create a feedback loop in order to bring in additional partners or services requested into the Center.

To address these circumstances, staff should be encouraged and empowered to:

1. Work with organizations outside of the Center to offer additional needs and services. These may include mental health providers who are trained in trauma assessment and treatment who can offer additional follow-up care or community-based organizations not already co-located in the Center.

2. Seek to utilize victim compensation or victim services funds to help pay for needed services.

3. Develop partnerships with universities and schools to bring graduate level professionals to the Center to provide additional services and build staff capacity at the Center.

4. Build partnerships with local hospitals or medical centers as they may be able to identify, provide treatment to, consult, or provide training to professionals on managing survivors with acute distress.

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5. Develop relationships with other community-based agencies not at the Center and develop offsite partnership agreements to fill the range of holistic needs of survivors including but not limited to: spiritual support, legal advocacy, health, housing, financial empowerment, job training and capacity building, education, etc.

6. Visit service providers in their community to better understand referrals outside of the agency and ensure capacity and services to which survivors are being referred.

7. Have a formal mechanism to provide feedback to Center leadership/partner leadership on the quality of services provided based on survivor feedback.

8. Spend time working on professional development.

Hope Rocks, One Safe Place

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Acknowledgments

It is only because of the innovative and extraordinary leadership of the six demonstration sites participating in this OVC National Polyvictimization Initiative that this Tool and Resource Guidebook were possible. The participating sites not only challenged their Centers and partner agencies to transform and rethink the way things are done, but have changed their communities in the process. We want to thank the Directors and all of the staff at the Family Justice Center Sonoma County, Stanislaus Family Justice Center, New Orleans Family Justice Center Alliance, Sojourner Family Peace Center, Tulsa Family Safety Center and the Queens (NYC) Family Justice Center for their tireless work and dedication to bringing HOPE to the lives of survivors in their communities. Special thanks to Diane Traversi, Kelsey Price, Carol Shipley, Erin Schubert, Tristan Gross, Janine Collier, Suzann Stewart, Jennifer DeCarli, and Eva Lessinger who served as our Points of Contact for this Initiative.

For assistance in implementing this Tool in other Family Justice Centers, please contact Alliance for HOPE International at info@allianceforhope.com for targeted training and technical assistance.

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Glossary

Animal Cruelty - Includes overt and intentional acts of violence towards animals and animal neglect or the failure to provide for the welfare of an animal under one's control. Many times, animal cruelty is used as a way to exert control over the owner and to cause emotional harm (RSPCA, 2017). Animal cruelty is not restricted to cases involving physical harm. Causing animals psychological harm in the form of distress, torment or terror may also constitute animal cruelty.

Anxiety - An overwhelming sense of apprehension and fear often marked by physical signs (such as tension, sweating, and increased pulse rate) (Merriam-Webster Dictionary 2017).

Assault - A violent physical or verbal attack. A threat or attempt to inflict offensive physical contact or bodily harm on a person that puts the person in immediate danger or in apprehension (Merriam-Webster Dictionary 2017).

Attachment problems - Refers to the ability to form emotional bonds and empathic, enjoyable relationships with other people, especially close family members. Attachment patterns are established in early childhood attachments and continue to function as a working model for relationships in adulthood. (Pilnik & Kendall, 2012).

Attention/Concentration Difficulties - Easily distracted/ inattentive leading to trouble forming strong friendships or completing work (Pilnik & Kendall, 2012).

Avoidance - Refers to the practice or an instance of keeping away from particular situations, activities, environments, individuals, things, or subjects of thought because of either (a) the anticipated negative consequences of such or (b) the anticipated anxious or painful feelings associated with those things or events. Psychology explains avoidance in several ways: as a means of coping- as a response to fear or shame- and as a principal component in anxiety disorders (Nugent, 2013).

Battery - Offensive touching or use of force on a person (Merriam-Webster Dictionary 2017).

Bullying - Unwanted, aggressive behavior that involves a real or perceived power imbalance. The behavior is repeated, or has the potential to be repeated, over time. Trauma can be a consequence of bullying, which can lead to mental health issues, substance use, and suicide, particularly if there is a prior history of depression or delinquency (SAMHSA, 2014).

Captivity - The state or period of being held, imprisoned, enslaved or confined (Dictionary, 2017).

Caretaker - A person who provides direct care (as for children, elderly people, or the chronically ill) (Merriam-Webster Dictionary 2017).

Community Violence - violence in the community, including exposure to gang-related violence, interracial violence, police and citizen altercations, and other forms of destructive individual and group violence is a recognized form of trauma (SAMHSA, 2014).

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Glossary

Conduct Problems - Aggressive behavior that causes or threatens harm to other people or animals, such as bullying or intimidating others, often initiating physical fights, or being physically cruel to animals. Non-aggressive conduct that causes property loss or damage, such as fire-setting or the deliberate destruction of others' property. Deceitfulness or theft, such as breaking into someone's house or car, or lying or "conning" others. Serious rule violations, such as staying out at night when prohibited, running away from home overnight, or often being truant from school (Mental Health America, 2017).

Cybercrime - Online identity theft, financial fraud, hacking, cyber-stalking, online child pornography and sexual exploitation, and information piracy and forgery (U.S. Department of Justice, Office of Justice Programs, and the Office for Victims of Crime, 2013).

Discrimination - The unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, or sex (Oxford Dictionaries 2017).

Dissociation - A mental process that causes a lack of connection in a person's thoughts, memory and sense of identity. Dissociation seems to fall on a continuum of severity. A defense mechanism—were survivors separate out of their memory things that they do not want to or cannot deal with. (Mental Health America, 2018).

Distant - Feelings of detachment or estrangement from others (Weathers et. al., 2015).

Emotional Abuse or Psychological Maltreatment - Acts of commission (other than physical or sexual abuse) against an individual. These kinds of acts, which include verbal abuse, emotional abuse, and excessive demands or expectations, may cause an individual to experience conduct, cognitive, affective, or other mental disturbances. These acts also include acts of omission against a minor such as emotional neglect or intentional social deprivation, which cause, or could cause, a child to experience conduct, cognitive, affective, or other mental disturbances (SAMHSA, 2014).

Family Justice Centers – Multi-agency collaboratives that bring services together under one roof – allowing survivors to access multiple services in one location. To be considered an affiliated Family Justice Center, by Alliance for HOPE International, a Center must, have a centralized intake process and an information sharing process with a minimum of the following full-time, co-located partner agencies: A community-based organization (at least one: DV or SA Program), Law enforcement investigators/detectives, Specialized prosecution unit, and civil legal services. Adhere to and demonstrate the implementation of Family Justice Center Guiding Principles in service delivery. Engage meaningfully with Alliance for HOPE's technical assistance team. Provide requested statistics and data to Alliance for HOPE International.

Fear of physical violence - Acting in a manner that makes someone feel afraid they may be physically hurt. The behaviors may include swearing, insulting, or humiliating someone (Felitti, et. al., 1998).

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Glossary

Health-risk behavior(s) - Any activity undertaken by people with a frequency or intensity that increases risk of disease or injury. Health risk behaviors might cluster together into a risky lifestyle. It can range from smoking, to use of drugs, to not wearing seatbelts or risky sexual practices (Steptoe & Wardle, 2004).

Historical Trauma – A form of trauma that impacts entire communities. It refers to the cumulative emotional and psychological wounding, as a result of group traumatic experiences, that is transmitted across generations within a community. Unresolved grief and anger often accompany this trauma and contribute to physical and behavioral health disorders. This type of trauma is often associated with racial and ethnic population groups in the United States who have suffered major intergenerational losses and assaults on their culture and well-being (SAMHSA, 2014).

Homeless - According to the United States Department of Housing and Urban Development Homeless is defined as (United States Department of Housing and Urban Development Homeless, n.d):

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Literally Homeless

1.Individual of family who lacks a fixed, regular, and adequate nighttime residence, meaning:

(I)Has a primary nighttime residence that is a public or private place not meant for human habitation;

(II)Is living in a publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

(III)Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

Imminent Risk of Homelessness

2.Individual or family who will imminently lose their primary nighttime residence, provided that:

(I) Residence will be lost within 14 days of the date of application for homeless assistance;

(II) No subsequent residence has been identified; and

(III) The individual or family lacks the resources or support networks needed to obtain other permanent housing

Homeless under other Federal Statutes

3.Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

(I) Are defined as homeless under the other listed federal statutes;

(II) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;

(III) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and

Glossary

(IV) Can be expected to continue in such status for an extended period of time due to special needs or barriers

Fleeing/Attempting to Flee DV

4. Any individual or family who:

(i) Is fleeing, or is attempting to flee, domestic violence;
(ii) Has no other residence; and
(iii) Lacks the resources or support networks to obtain other permanent housing

Hope – Is the belief that your future can be brighter and better than your past and that you have a role to play in making it better. Hope involves goal setting, agency (willpower to pursue goals), and pathways thinking (strategic ability to find ways to achieve goals even in the face of barriers or obstacles). Hope is measurable, malleable, and cultivatable (Snyder, 2002).

Human trafficking – Is a crime involving the exploitation of someone for the purposes of compelled labor or a commercial sex act through the use of force, fraud, or coercion. (SAMHSA 2014).

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Impulsivity – Has been defined as fast reaction without thinking and conscious judgment, acting without enough thinking, and a tendency to act with less thinking compared to the others who have similar levels of knowledge and ability (Bakhshani, 2014).

Intake Process – A process in FJCs which includes building a relationship and rapport with a client and orientation about the services available and identifying the professionals they wish to talk to within a Center. Intakes are usually conducted by an intake specialist. The Intake Specialist is usually responsible for assessing risk level and providing safety planning for every client. Intake Specialists may also provide individual support and crisis counseling when needed. Intake Specialist help create a link between the current symptoms a survivor is experiencing, their lived experiences, and how their beliefs impact their life. It is helpful for the Intake Specialist to have a clinical background or a masters level supervision (Family Justice Center – Alliance for HOPE International, 2016)

Irritable/Angry – Behavior or outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects. (Weathers et. al., 2015).

Jumpy – The state of being highly or abnormally alert to potential danger or threat. On guard, or constantly on the lookout for danger. Sometimes described as hypervigilance, this is common in trauma survivors (Merriam-Webster Dictionary, 2017).

Labor trafficking - The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery, (22 USC § 7102) (National Human Trafficking Hotline, n.d).

Glossary

Low Self-Esteem – Is a debilitating condition that keeps individuals from realizing their full potential. A person with low self-esteem feels unworthy, incapable, and incompetent. (UC Davis Health. Self-Esteem, n.d.).

Multi-Agency Center – To be considered an Affiliated Multi-Agency Center by Alliance for HOPE International, a Center must have at least three different co-located service providers; adhere to and demonstrate the implementation of Family Justice Center Guiding Principles in service delivery; engage meaningfully with Alliance's technical assistance team; and provide requested statistics and data to Alliance (Affiliation Process).

Natural or Man-made Disasters – Trauma can result from a major accident or disaster that is an unintentional result of a man-made or natural event. Disasters can occur naturally (such as tornadoes, hurricanes, earthquakes, floods, fires, mudslides, or drought) or be human-caused (such as mass shootings, chemical spills, or terrorist attacks) (SAMHSA, 2014).

Neglect – Is the most common form of abuse reported to child welfare authorities. However, it does not occur only with children. It can also happen when a primary caregiver fails to give an adult the care they need, even though the caregiver can afford to, or has the help to do so. Neglect also includes exposing someone to dangerous environments, abandoning a person, or expelling them from home (SAMHSA, 2014).

> Neglect may be:
> • Physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision)
> • Medical (e.g., failure to provide necessary medical or mental health treatment)
> • Educational (e.g., failure to educate a child or attend to special education needs)
> • Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs) (Child Welfare Information Gateway, 2013).

Numbing – Limited emotional range, avoiding thinking or talking about the future or goal setting, "feeling flat" (Pilnik & Kendall, 2012).

Partners – Entities and/or individuals who are onsite or offsite partners of the Family Justice Center and agree to provide services to those who come to the Center. In a Center, this includes governmental and non-governmental organizations and can provide crisis intervention to long term services such as civil legal support, mental health counseling, housing, or life skills (Gwinn & Strack, 2012, p. 71).

Physical Abuse or Assault - Defined as the actual or attempted infliction of physical pain (with or without the use of an object or weapon), including the use of severe corporeal punishment. Federal law defines child abuse as any act, or failure to act, which results in death, serious physical or emotional harm, sexual abuse, or exploitation of a child (SAMHSA, 2014).

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Glossary

Poverty – For purposes of this Tool poverty should be defined by the experiences of the survivor. Many times, this can include hunger, lack of shelter, being sick and not being able to see a doctor, not having access to school and not knowing how to read and/or not having a job. Can sometimes be described as fear for the future and living one day at a time. Most often, poverty is a situation people want to escape (Brunswick, 2010).

Robbery – Taking or attempting to take anything of value from the care, custody, or control of a person or persons by force or threat of force or violence and/or by putting the victim in fear (U.S. Department of Justice Federal Bureau of Investigation, 2010).

Sadness – Feeling down or unhappy in response to grief, discouragement, or disappointment. If ongoing, may indicate depression. Despair or regret.

School Violence – Is described as violence that occurs in a school setting and includes, but is not limited to, school shootings, bullying, interpersonal violence among classmates, and student suicide. (SAMHSA, 2014).

Self-blame – Thinking that one is responsible for bad things that happened, or for surviving when others did not. Feeling guilty for what you did or did not do, often connected to feelings of shame (U.S Department of Veterans Affairs, Common Reactions After Trauma, 2015).

Self-harming behaviors – Non-suicidal self-injury, often simply called self-injury, is the act of deliberately harming the surface of one's body, such as cutting or burning one's self. It is typically not meant as a suicide attempt. Rather, this type of self-injury is an unhealthy way to cope with emotional pain, intense anger and frustration. While self-injury may bring a momentary sense of calm and a release of tension, it's usually followed by guilt and shame and the return of painful emotions. Although life-threatening injuries are usually not intended, with self-injury comes the possibility of more serious and even fatal self-aggressive actions (Weathers et. al., 2015).

Sex Trafficking – Occurs when someone uses force, fraud, or coercion to cause a commercial sex act with an adult or causes a minor to commit a commercial sex act. A commercial sex act includes prostitution, pornography, and sexual performance done in exchange for any item of value, such as money, drugs, shelter, food or clothes (Shared Hope International n.d.).

Sexual Abuse or Assault - Unwanted or coercive sexual contact, exposure to age-inappropriate sexual material or environments, and sexual exploitation. The Department of Justice's (DOJ) Office on Violence Against Women defines sexual assault as "any type of sexual contact or behavior that occurs without the explicit consent of the recipient" (SAMHSA, 2014).

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Glossary

Sexual Harassment – Unwelcome sexual advances, requests for sexual favors, and other verbal or physical harassment of a sexual nature. Harassment does not have to be of a sexual nature, however, and can include offensive remarks about a person's sex. For example, it is illegal to harass a woman by making offensive comments about women in general. Both victim and the harasser can be either a woman or a man, and the victim and harasser can be the same sex (U.S. Equal Employment Opportunity Commission, n.d).

Sleep disturbance – Difficulty falling or staying asleep or restless sleep (Weathers et. al., 2015).

Stalking – A course of conduct directed at a specific person that involves repeated (two or more occasions) visual or physical proximity, nonconsensual communication, or verbal, written, or implied threats, or a combination thereof, that would cause a reasonable person fear." Stalking behaviors also may include persistent patterns of leaving or sending the victim unwanted items or presents that may range from seemingly romantic to bizarre, following the victim, damaging or threatening to damage the victim's property, defaming the victim's character, or harassing the victim via the Internet by posting personal information or spreading rumors about the victim (Office of Justice Programs - National Institute of Justice, 2007).

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Strangulation and/or positional asphyxia – Is pressure applied to the neck, by any means, that blocks airflow or blood flow. Asphyxia is deficiency of oxygen in the cells of the body including the brain. Strangulation is one of the most lethal forms of domestic violence and, often occurs in sexual assault, child abuse, and elder abuse cases. Positional asphyxia refers to pressure placed on a person's body that makes it difficult to inhale (bellows motion) in order to bring air into their lungs. Victims will refer to strangulation as "choking" and may not even know that pressure applied to their chest or body also causes asphyxia (Training Institute on Strangulation Prevention, 2017).

Losing Consciousness

Victims may lose consciousness by any one or all of the following methods: blocking of the carotid arteries in the neck (depriving the brain of oxygen), blocking of the jugular veins (preventing deoxygenated blood from exiting the brain), and closing off the airway, making breathing impossible.

Very little pressure (4-11 lbs. per square inch) on both the carotid arteries and/or veins for ten seconds is necessary to cause unconsciousness. However, if the pressure is immediately released, consciousness will likely be regained within ten seconds. To completely close off the trachea (windpipe), three times as much pressure (33 lbs.) is required. Brain death can occur in 1 to 2.5 minutes, if strangulation persists. Many victims suffer internal injuries including brain damage and are unaware unless informed by intervention professionals. Medical assessment should always be done if a strangulation victim has any signs or symptoms.

Glossary

Strong Negative Beliefs – Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad, “No one can be trusted, “The world is completely dangerous, “My whole nervous system is permanently ruined”) (Weathers et. al., 2015).

Substance Abuse - A maladaptive pattern of substance use leading to significant impairment or distress including a failure to fulfill major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

- Use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired)
- Substance-related legal problems (e.g. arrests for substance-related disorderly conduct)
- Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights) (LIFE, n.d).

System-induced trauma – Many systems that are designed to help individuals and families can actually cause trauma. For example, in child welfare systems, abrupt removal from the home, foster placement, sibling separation, or multiple placements in a short amount of time can re-traumatize children. In mental health systems, the use of seclusion and restraint on previously traumatized individuals can revive memories of trauma. Further, invasive medical procedures on a trauma victim can re-induce traumatic reactions (SAMHSA, 2014).

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Victim or Witness to Domestic Violence - According to DOJ’s Office on Violence Against Women, domestic violence is defined as: “a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone.” Domestic violence includes violence and abuse by current or former intimate partners, parents, children, siblings, and other relatives (SAMHSA, 2014).

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Appendices

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Flowchart on Trauma-Informed Actions: Immediate and Long-Term Steps

The Flowcharts below provide general guidance on immediate and long-term actions for follow-up based on services available at the Center. The specific responses may be considered after use of the Tool. This Flowchart is not meant to be exhaustive and only covers some potential disclosures. This Flowchart alone should not dictate action, users of the Tool should work with survivors to identify goals and discuss the possibility of accessing a variety of services from all Center partners. Staff must also discuss the benefits and possible detriments of sharing information with multiple partner agencies. Once confidentiality and information sharing agreements have been explained and signed by survivors, Center staff should take Flowchart recommendations below, and work to coordinate services offered, survivor goals, case management, and tailored service delivery based on the survivor's perceived and requested needs.

It is critical users of the Tool be aware of any Center protocol and practices specific for any, and all, events or symptoms presented in this Tool. Leadership of the Center should provide training and regular debriefings for staff on policies and protocols of the Center related to use of the Tool. It may also be necessary that leadership create new partnerships to support identified needs of survivors not currently addressed at the Center.

Best Practices

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The flowchart below assumes that some basic and foundational actions have been taken post disclosure regardless of the type of victimization. All survivors should be referred to relevant onsite and offsite partners who can support them with any of their needs; such as mental health services, legal providers, support groups etc. Similarly, this assumes staff are providing education and information to survivors about interpersonal violence. It is encouraged that all staff continue working through and reassessing any victimizations and symptoms during future visits. This flowchart is not meant to override any current actions at a Center, but rather to augment and supplement potential steps such as safety planning, triaging, and service delivery. As such, immediate and long-term actions below are very specific for the victimization or symptom disclosed and are not meant to be general actions.

Flowchart of Trauma-Informed Actions

Survivor discloses strangulation	**IMMEDIATE:** ● Refer survivor to emergency medical professionals on/offsite if any signs or symptoms are present. ● If survivor discloses a very recent incident where there has been urination or defecation following a strangulation assault, Centers should follow an approved strangulation assault protocol and strongly encourage the survivor to obtain immediate medical services. (For more information, go to www.strangulationtraininginstitute.com). ● Conduct a Danger Assessment with the survivor to assess for other lethality markers. **LONG-TERM:** ● Follow-up with questions from the Tool that address, when, number of times, any signs or symptoms from strangulation incident(s).

	● Connect survivor with law enforcement, legal services, medical, and mental health services as requested by the survivor. ● Develop a safety plan with survivor that includes physical and emotional safety for survivor and children, if applicable.

Survivor discloses sex or labor trafficking	**IMMEDIATE**:
	● Mandated reporting rules must be followed if survivor is a child or senior.
	● Follow-up questions should include asking if the survivor is currently being trafficked and any relevant information for current victimization and whether their safety is currently compromised.
	    ○ In situations of immediate, life-threatening danger, follow your Center's policies for reporting to law enforcement. Whenever possible, make an effort to involve the survivor in the decision to contact law enforcement.
	● Address any immediate needs such as access to food, clothing, emergency medical needs, family concerns, and language access.
	● Contact human trafficking services providers if they are not located in your Center; focus on having the providers come to the Center.
	● Develop a safety plan with the survivor that includes physical, emotional, and financial safety for the survivor and any children.
	● Establish follow-up strategies and next steps
	
	LONG-TERM:
	● Complete the Tool and assessment forms. Follow-up with questions such as sexual abuse/assault, financial abuse, substance abuse, and homelessness and any symptomology for appropriate referral to partner agencies.
	● Provide information and referral to medical needs such as TB and HIV testing for sex and labor trafficking and help schedule medical appointments or mental health appointments (Edmund & Bland, 2011).
	● Continue to assess and re-assess level of danger and adjust safety plan accordingly.
	● Connect survivor with: advocates/experts, law enforcement, legal services, and housing/shelter services as requested, spiritual services etc.
	● If survivor is or *was* a trafficking victim and has any criminal convictions because of their victimization – refer to appropriate post-conviction relief services if applicable in your state. For more information, click here.
	● Continue to meet with the survivor to develop goals and help them address their needs.
	    ○ Work with the survivor to help them find employment
	    ○ Connect survivor with professional development resources such as GED courses, certification courses, computer classes etc.
	    ○ Work with the survivor to help them build a community and network of people that they can trust that help serve as a protective factor and pull them out of harm's way

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	● Reassess any victimizations and symptoms present during future visits.
Client discloses being currently held against their will	**IMMEDIATE**: ● Mandated reporting laws must be followed if client is a child or senior. ● In situations of immediate, life-threatening danger, follow your Center's policies for reporting to law enforcement. Whenever possible, make an effort to involve the survivor in the decision to contact law enforcement. ● Address any immediate needs such as access to food, clothing, emergency medical needs, family concerns, and language access. ● Develop a safety plan with the survivor that includes physical, emotional, and financial safety for survivor and children. ● Establish follow-up strategies and next steps. ● Work with the survivor on grounding and breathing exercises that they can practice anywhere including at home, on the way to work etc. **LONG-TERM:** ● Complete the Tool with follow-up questions about other types of victimizations and symptoms they may be experiencing. ● Your Center should work with the survivor to update and reassess safety plans and connect them with housing options on/off-site. ● Connect survivor with: medical services, mental health services, law enforcement, and legal services as requested. ● Continue to meet with survivor to develop goals and help them address any needs. ● Reassess any victimizations and symptoms during future visits.
Client discloses substance use	**IMMEDIATE**: ● User should follow any reporting protocols at the Center as appropriate. Refer here for Federal Reporting Laws. ● Off-site partners who can come onsite and do intake with Survivors who want to pursue treatment ● Onsite support groups to address substance abuse ● Provide education around the ways that perpetrators may use substance use as a method of control ● Find providers locally accessible to survivors (in their zip code, etc.) ● Follow-up questions should include open-ended questions which include the duration of substance abuse, and if substance abuse is impairing the survivor's ability to live their day-to-day life, as well as any relevant information for appropriate connection with partner agencies. ● Ensure and safeguard privacy and communicate respect and trust with survivor. It is critical the survivor not feel judged or shamed for disclosure of current or past use. Ensure that survivor understands their rights and mandated reporting around disclosure. ● If the survivor is interested, provide connection with higher levels of care which might include mental health services and substance recovery programs.

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	LONG-TERM: ● Work with the survivor to feel empowered and find healthy coping mechanisms. ● Recommend support groups such as 12 step programs in your Center or through partner agencies (Edmund & Bland, 2011). ● Continue to meet with survivor to develop goals and help address any needs. ● Reassess any victimizations and symptoms during future visits.
Client discloses they are currently living in poverty and/or are homeless	**IMMEDIATE**: ● Identify the survivor's immediate needs (food, water, shelter, and medical services) and connect survivor with resources to meet their needs. o Specifically, if the client would like connect them to a local clinic that provides free to low-cost healthcare services. o Discuss any support networks they may have such as family or friends who may be able to provide some support. ● If the survivor is homeless, with their permission, connect them to on/offsite housing resources and provide them with resources that meet their identified immediate needs. ● Develop a safety plan with the survivor that includes physical, emotional, and financial safety for client and their children. ● Help survivor connect with support services such as Temporary Assistance for Needy Families, Women, Infants and Children Program, and Victims Compensation if applicable. **LONG-TERM:** ● Follow-up with questions in the Tool on homelessness, interpersonal violence, and financial abuse. ● Connect survivor with: medical services, transitional housing, mental health services and job training service providers as requested. ● Continue to meet with survivor to develop goals and help address any needs. ● Reassess any victimizations and symptoms during future visits.
Client discloses they are experiencing school violence or bullying	**IMMEDIATE**: ● Listen to story about incident without judgement or assumptions about the client's role in the bullying. ● Follow-up with survivor on whether they have any intentions to harm themselves or someone else, length and duration of bullying, and the type of violence as well as any symptoms they may be experiencing such as sadness, anxiety, low self-esteem, self-harming behaviors, and feeling distant. ● If survivor is a child, ask them if they are comfortable with the intake staff alerting their parents of the bullying.

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	● Work with parents and school administrators and teachers, if possible. ● Work with client to problem solve and empower child to think through solutions whether that includes walking away, using a buddy system, etc. ● Identify a support person for the child at school. **LONG-TERM:** ● Reassess any victimizations and symptoms during future visits. ● Connect survivor with age appropriate services as needed.
Client discloses experiencing and/or witnessing community violence	**IMMEDIATE**: ● Work with the survivor to identify the type of community violence they experienced or witnessed (physical assault/battery by a stranger; robbery, burglary, or mugging; victim of terrorist attack; identity theft; mass shootings; street riots; drive-by shootings; stabbings, beatings, heard gunshots, could also include cyberbullying or incidents committed online such as stalking or bullying, etc). ● VINE, specific agencies addressing bullying (particular to respective community), Anti-Bullying Coalition, Federal Agency that addresses victims of community violence (name will be found and shared) ● Work with the survivor to develop a safety plan (identifying safe streets, safe times to move-around, reporting gang violence to police, etc.) ● Provide education about potential mental health or physical symptoms they may experience due to stress or exposure to violence. **LONG-TERM:** ● Offer comprehensive services at the Center. ● Continue to meet with survivor to develop goals and help address any needs. ● Reassess any victimizations and symptoms during future visits.

Client discloses they have attempted suicide or are contemplating suicide	**IMMEDIATE**:
	● If someone has recently attempted suicide, do **<u>not</u>** leave that person alone. When contacting emergency services please let the client know before hand and explain to them step by step what is going to happen. Do NOT contact emergency services without first informing the client.
	● If someone has been thinking about suicide you, stay calm, be supportive and use trauma-informed language. Utilize a more extensive Suicide Assessment to identify potential risk. Some questions should include:
	    ○ Ask directly if they are thinking of harming themselves. Do not give advice or ask why (Nguyen, 2017).
	    ○ Ask survivor if they have a plan and assess the severity and immediacy of the situation.
	    ○ Ask if there are lethal means available to them, discuss ways to remove them and precautions that can be taken.

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	○ Phrases you can use when talking to a client (Berry, 2018): ▪ "Thanks for opening up to me ▪ "Is there anything I can do to help?" ▪ "I'm sorry to hear that. It must be tough" ▪ "I'm here for you when you need me?" ▪ "I can't imagine what you're going through" ▪ "How are you feeling today?" ● If someone discloses suicidal ideation but does not have a plan, stay calm, be supportive of the survivor and use trauma-informed language. It is important to note that many times suicidal ideation can be used as a coping mechanism for trauma. Therefore, it is critical to appropriately assess and identify the appropriate response. Utilize a more extensive Suicide Assessment to identify potential risk. ● With the survivor's permission, connect them with a crisis intervention counselor and follow your Center's suicide protocol. ○ Utilize a Suicide Risk Assessment ● Develop a safety and wellbeing plan with the survivor that includes physical, emotional, and financial safety for client and children. ● Establish follow-up strategies and next steps. **LONG-TERM:** ● Complete the Tool and assessment forms. Follow-up with questions on event-based trauma and any symptomology for appropriate referral to partner agencies. ● Provide information and connection to any other survivor identified needs. ● Continue to assess and re-assess level of danger and changes in behavior and symptomology. ● Continue to meet with survivor to develop goals and help address any needs. ● Reassess any victimizations and symptoms during future visits.
Client discloses self-harming behaviors	**IMMEDIATE:** ● Validate feelings and emotions and express concern about self-harming behavior in calm tones. It is critical to differentiate between suicidal behavior and self-harm. A client practicing self-harm does not intend to commit suicide. Self-harm is a coping mechanism (Berry, 2018). ● Do not characterize self-injury/harming as bad or inappropriate but rather a coping mechanism that is learned to cope with trauma (Ernhout & Whitlock, 2014). ● Follow-up questions should address when the self-harming behaviors began, how frequent it happens, and what triggers the self-harming behaviors. ○ Referral to clinicians should be made for further assessment. ● With the survivor's permission, connect them with a counselor/therapist for additional assessment and help in dealing with self-harming

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	behaviors. The counselor/therapist and the survivor should work together to identify and address the underlying causes of self-harming behaviors and work towards establishing healthy coping mechanisms. **LONG-TERM:** ● Complete the Tool and assessment forms. Follow-up with questions on event-based trauma and any symptomology for appropriate referral to partner agencies. ● Continue to meet with survivor to develop goals and help them address any needs. ● Provide services onsite around mindfulness, visualization, arts, etc. ● Reassess any victimizations and symptoms during future visits.
Answers YES to questions 1-9 on the symptomology section	● Referral to clinicians should be made for further PTSD assessment. ● Education around the pervasiveness of PTSD in trauma survivors should be provided. ● Tips and tools for emotional safety and healthy coping mechanisms should be shared with the client. ● Education and identification of triggers and potential safety planning for survivor and their children.
Client discloses experiencing discrimination	**IMMEDIATE:** ● Connect with community organizations relevant to specific form of discrimination ● Connect with legal partners onsite who can make referrals ● Validate the impact of discrimination and systemic discrimination ● Help survivor identify: ○ support network, and spiritual support if part of their life; ○ healthy coping mechanisms during time of stress and anxiety; ○ personal strengths and successes. ● Work with the survivor to develop a safety plan (documenting instances of discrimination at work, identifying allies, etc.) ● If survivor discloses discrimination in housing or their place of work help them complete the appropriate complaints and make connection with appropriate legal professionals. Including if discrimination from the police, specific mechanisms to report discrimination. **LONG-TERM:** ● Connect survivor with: mental health services, legal providers, support groups, community building programs, as requested. ● Continue to meet with survivor to develop goals and help them address any needs. ● Reassess any victimizations and symptoms during future visits.

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CROSS-CUTTING FACTORS:
HOPE
Resilience

ENABLING ENVIRORMENT:
Policy/Laws, Economics, Natural Envirorment

COMMUNITY:
City, Neighborhood, Town

INTERPERSONAL:

SELF
Mental Health Challenges, Low Self-Esteem
Self-Compassion, Mastery, Exercise, Meditation

Domestic Violence, Bullying, Child Abuse, Sexual Abuse, Neglect

Parents, Family, Friends, Peers, Spiritual Leaders, Teachers, Community Leaders

Community Violence: Gangs, Robberies, Shootings, Homicides, Assaults, Sexual Assaults

Camp HOPE, Religious Institutions, Family Justice Centers, Community Recreation Centers, Community Sports

Social Opression, Poverty, Racism, Discrimination, Natural Disasters, Terrorism

Disaster Relief Projects, Anti-Discriminatory and Anti-Racism Laws and Policies, Laws and Policies that produce equality and equity

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FACTORES TRANSVERSALES
ESPERANZA
Capacidad para Adaptarse
ENTORNO HABILITADOR
Política / Leyes, Economía, Entorno Natural
COMUNIDAD
Cuidad, Barrio, Poblacion
INTERPERSONAL
SI MISMO
Desafíos de Salud Mental, Baja Autoestima
Auto-Compasión, Maestría, Ejercicio, Meditación
Padres, Familia, Amigos, Compañeros, Líderes Espirituales, Maestros, Líderes de la Comunidad
Violencia Doméstica, Intimidación, Abuso Infantil, Abuso Sexual, Negligencia
Camp HOPE, Instituciones Religiosas, Centros de Justicia Familiar, Centros de Recreación Comunitaria, Deportes Comunitariosorganizations
Violencia en la Comunidad: Pandillas, Robos, Disparos, Homicidios, Asaltos, Asaltos Sexuales
Proyectos de Socorro en Casos de Desastre, Leyes y Políticas Antidiscriminatorias y Anti-Racistas, Leyes y Políticas que Generan Igualdad y Equidad
Opresión Social, Pobreza, Racismo, Discriminación, Desastres Naturales, Terrorismo
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Hope Introduction Discussion

The power of hope is based upon your capacity to understand the way things are right now, and to imagine a future for the way things could be.

Hopeful people are able to establish clear goals, determine multiple pathways toward their goals and dedicate mental energy toward those pursuits.

1. **Goals**: We all have varying number goals across the life domains. The important aspect in hope is that your goals have a level of desirability to harness your attention.
    a. **What happens with hope when goals are not clearly defined?**
    b. **Can agency overcome deficiency in pathways? "Where there is a will there is a way?"**
    c. **When your goal becomes blocked are you able to re-goal?**

2. **Pathways**: These are the mental road maps you develop in order to achieve your goals.
    a. **Imagination is the instrument of pathways. How many pathways can you conceive to your goals?**
    b. **If your pathway becomes blocked, can you imagine strategies to overcome the barrier?**

3. **Agency**: Think of this as the willpower or mental energy you have to pursue pathways. Agency is comprised of such things as: motivation, determination, self-control, confidence, etc.
    a. Being able to focus your willpower to YOUR goals is a critical component of achieving what you want in life.
    b. **What are some things that drain or detract your mental energy?**

4. Reflect back on a time in your life when you achieved a really important goal.
    a. **Can you describe the role of pathways?**
    b. **How would you describe your willpower?**
    c. **Did you have barriers that you had to overcome?**

5. Reflect on a time when someone wanted you to do something that wasn't very important to you (at that time).
    a. **Can you describe how having a goal that you don't desire impacts your motivation?**
    b. **In what other ways would you characterize your "hope"?**

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The Adult Hope Scale

Please read each item carefully. Using the scale shown below, please select the number that best describes you and put that number in the space provided.

	Item	Definitely False	Mostly False	Somewhat False	Slightly False	Slightly True	Somewhat True	Mostly True	Definitely True
1.	I can think of many ways to get out of a jam.	①	②	③	④	⑤	⑥	⑦	⑧
2.	I energetically pursue my goals.	①	②	③	④	⑤	⑥	⑦	⑧
3.	I feel tired most of the time.	①	②	③	④	⑤	⑥	⑦	⑧
4.	There are lots of ways around any problem.	①	②	③	④	⑤	⑥	⑦	⑧
5.	I am easily downed in an argument.	①	②	③	④	⑤	⑥	⑦	⑧
6.	I can think of many ways to get the things in life that are most important to me.	①	②	③	④	⑤	⑥	⑦	⑧
7.	I worry about my health.	①	②	③	④	⑤	⑥	⑦	⑧
8.	Even when others get discouraged, I know I can find a way to solve the problem.	①	②	③	④	⑤	⑥	⑦	⑧
9.	My past experiences have prepared me well for my future.	①	②	③	④	⑤	⑥	⑦	⑧
10.	I've been pretty successful in life.	①	②	③	④	⑤	⑥	⑦	⑧
11.	I usually find myself worrying about something.	①	②	③	④	⑤	⑥	⑦	⑧
12.	I meet the goals that I set for myself.	①	②	③	④	⑤	⑥	⑦	⑧

Draft

Agency: ___________

Add Scores on items: 2, 9, 10 and 12. Scores range from a 4 to a 32. Higher scores reflect higher agency.

Pathways: __________

Add scores on items: 1, 4, 6 and 8. . Scores range from a 4 to a 32. Higher scores reflect higher pathways thinking.

Total Hope Score: ___________ (Add Score for Pathways to the Score for Agency)

Scores of 40 – 48 are hopeful, 48 – 56 moderately hopeful, and 56 or higher as high hope.

Children’s Hope Scale

Directions: The six sentences below describe how children think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Place a check inside the circle that describes YOU the best. For example, place a check (√ or x) in the circle (☐) above "None of the time," if this describes you. Or, if you are this way "All of the time," check this circle. Please answer every question by putting a check in one of the circles. There are no right or wrong answers.

1. I think I am doing pretty well.

☐	☐	☐	☐	☐	☐
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

2. I can think of many ways to get the things in life that are most important to me.

☐	☐	☐	☐	☐	☐
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

3. I am doing just as well as other kids my age.

Draft

☐	☐	☐	☐	☐	☐
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

4. When 1 have a problem, I can come up with lots of ways to solve it.

☐	☐	☐	☐	☐	☐
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

5. I think the things I have done in the past will help me in the future.

☐	☐	☐	☐	☐	☐
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

6. Even when others want to quit, I know that I can find ways to solve the problem.

☐	☐	☐	☐	☐	☐
None of the time	A little of the time	Some of the time	A lot of the time	Most of the time	All of the time

Notes: The total Children's' Hope Scale score is achieved by adding the responses to the six items, with "None of the time" =1; "A little of the time" = 2; "Some of the time" = 3; "A lot of the time" = 4; "Most of the time" = 5; and, "All of the time" = 6. The three odd-numbered items tap agency, and the three even-numbered items tap pathways.

Hope Worksheet

This worksheet is intended to add detail and clarity to your pathways and agency. Those who are more hopeful will move through this worksheet with ease whereas less hopeful individuals will likely respond to this process with frustration and a focus on failure. It is important that you focus on the details of the goals – taking the time to identify them with patience and diligence. Do not rush through the worksheet. With each answer, spend time exploring more explanation and detail. The key to all these worksheets is to remember that imagination is the instrument of hope. Imagine your life differently if you can achieve your goals. What will it look like? Feel like? Be like? You should notice the ebb and flow of pathways and willpower focus as you move through the worksheet.

As you review the hope worksheet below, some explanation may be useful.

Item 1: Do not rush through this part of the worksheet. It is worth exploring each goal in terms of specific details, short term vs. long term, etc. The personal and professional goal worksheet may be useful in preparing for the full hope worksheet. A low hope person may struggle with describing specific details of a goal and might need help from a higher hope person. Don't be afraid to ask someone for help that seems to have higher hope in their life than you do.

Item 2: A person who does not desire the goal will struggle to complete the worksheet. It is important that the goal is desired by the person completing the worksheet. Finding a goal, no matter how small is often a great place to start if you are a low hope person.

Draft

Item 3: This item can help clarify the goal. For example, is the motivation to the goal intrinsic or extrinsic? Is it coming from within? Or is some outside force or person inspiring the goal? Goal motivation may start externally but sooner or later it must become internal. Intrinsic motivation is more likely to sustain you in the presence of barriers and adversity.

Item 4: After describing the goal, it is worth spending time relishing what success will feel like. This item is intended to reinforce willpower.

Item 5, 6, 7, & 8: Lower hope individuals will possibly struggle with these items. Don't be discouraged if you find yourself in that place. After considering the potential barriers, your willpower may be lower. Therefore, item 7 is intended to re-invigorate you to complete item 8.

Item 9: It is often helpful to break a goal into sub-goals or benchmarks. Sub-goals can also serve to help us determine if we are on the right pathway to our goals. Finally, breaking the goal into sub-goals helps you connect the future to the present – seeing how the small steps can get you to the goal eventually. Dream big, start small.

Item 10 & 11: These are intended to reinforce willpower and demonstrate the social resources available when pursuing our goals. You likely have far more resources available to you than you might think right now. It may take being honest with others by asking for help and it may take the time to find the right person to ask for help. But take it one step at a time.

Hope Worksheet

The purpose of this worksheet is to assist you in establishing a desirable goal using the language of hope. By describing your desirable goal in as much detail as possible you are likely to experience an increase in your motivation and interest. When you have described one or more possible strategies to your goal you are now on the pathway to rising and sustained hope.

1. **Describe your goal in as much detail as possible (Narrative)**

2. **How much do you desire this goal?** *A little* *Moderately* *A great amount*

3. **Describe why you want to achieve the goal. That is, describe what is motivating you.**

4. **Imagine you have just achieved your goal. Describe how you think you will feel in this future memory.**

Draft

5. **List the pathways (actions/strategies) you can use to achieve your goal.**

Pathway 1: ____________________

Pathway 2: ____________________

Pathway 3: ____________________

6. **Describe potential barriers for each pathway you listed.**

Pathway 1 Potential Barrier: ____________________

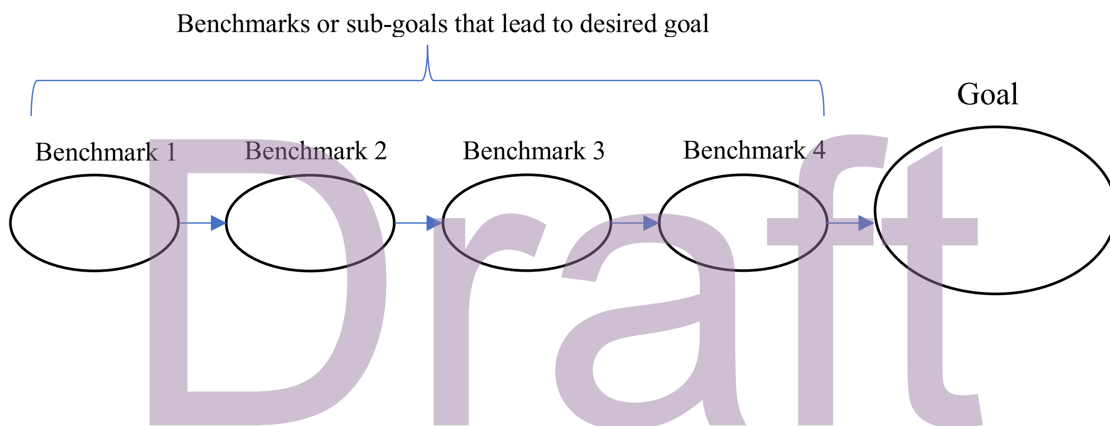
Pathway 2 Potential Barrier: ____________________

Pathway 3 Potential Barrier: ____________________

7. **Describe a time when you achieved a goal by overcoming barriers. That is, what were the barriers and how did you overcome them?**

8. **From points 5 & 6 above, choose the best pathway and describe how you will overcome the barriers to that pathway.**

9. **Describe benchmarks that you need to achieve to attain the goal. For example, what are two or three things that must be accomplished for you to attain your goal?**



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10. **Identify people and/or resources you can count on for support in pursuing your goal.**

11. **Describe something that motivates you (e.g., music, movie, person). Think of how you can use this inspiration to help you achieve your goal.**

Your Personal and Professional Goals Worksheet

Below write down three goals you set for yourself. These can be Personal Goals, Family Goals, and/or Professional Goals.

Goal 1: ____

Goal 2: ____

Goal 3: ____

Adding Detail to Your Goals

Specifics:	**Goal 1**	**Goal 2**	**Goal 3**
Approach vs. Avoidance:			
Degree of difficulty:			
Stretch vs. Mastery:			
Time to completion:			
Degree of change involved:			
Support Networks:			
Beneficiaries:			
Other Details:			

Draft

Overall, how successful do you think you will be in pursuing these goals?

1	2	3	4	5	6
Not at all successful	A little successful	Somewhat successful	Moderately successful	Mostly successful	Very successful

Goal 1: ______ Goal 2: ______ Goal 3: ______

Finding Hope

The most important thing we can do is lend our hope to others until they can find their own.

1. **Hope Modeling:** One way to help us think about hope (especially when we experience adversity) is to consider our own Hope Models.

    a. **Take a minute to think of the one adult role model in your life. Often, this is the person who, knowingly or not, made a profound impact on the direction of your life.**

    What impact did they have related to your goals, pathways, and agency?

    b. **Think about a leader you admire. Now list three words that describe this person.**

    1.
    2.
    3.

    c. **What story (movie, book, song, etc.) comes to mind that reflects hope?**

    d. **How do you model hope in your behaviors?**

Draft

2. Take a few minutes to think about a goal you have for yourself this week:

    a. Write down the goal: ____

    b. Describe a few of the barriers you will likely experience in pursuing your goal. Are you powerless to these barriers?

    c. Can you identify a cast of supporting "hope givers" and describe how they can help you achieve your goal?

    d. Identify one action you can take today to move toward your goal.

Appendix: Additional Resources

Aiding Survivors of Sex Trafficking

- Post-Conviction Relief for Human Trafficking Victims Convicted of Crimes Coerced by a Trafficker
    - Identifies crimes that a victim of human trafficking may be coerced into committing by a trafficker and provides information on how survivors can access post-conviction relief.
- National State Law Survey: Expungement and Vacatur Laws
    - Provides information on national state laws on expungement and vacatur laws.

Aiding Suicide Survivors and Clients with Suicidal Ideation

- Suicide Prevention Resource Center
    - Details resources for dealing with suicide prevention in a variety of environments from American Indian/Alaska Native Settings to workplaces.
- Suicide Risk Screening Tools
    - Provides access to the Columbia-Suicide Severity Rating Scale (C-SSRS) a questionnaire for suicide assessment and SAFE-T a suicide assessment five-step evaluation and triage.

Aiding Clients with Self-Harming Behaviors

- Cornell Research Program on Self-Injury and Recovery – Bringing Up Self-Injury With Your Clients
    - Provides techniques for working with clients who are practicing self-injury behaviors
- Cornell University College of Human Ecology: Self-Injury and Recovery Research and Resources (SIRRR)
    - Provides tools and assessments for self-injury as well as research on self-harm
- Self-Injury and the Role of the Human Service Professional
    - Equips staff with the tools they need to work with clients who practice self-injury in a non-judgmental and supportive manner.

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Motivational Interviewing Resources

- Motivational Interviewing Resources and Webinars
    - Provides access to tools on motivational interviewing based on the four guiding principles of expressing empathy and avoiding arguing, developing discrepancy, rolling with resistance, and supporting self-efficacy.

Building Cultural Competency

- A Treatment Improvement Protocol – Improving Cultural Competence
    - A toolkit that helps front line staff understand cultural competence and how to build cultural competence at their Centers.

Staff Self-Care and Vicarious Trauma Resources

- Compassion Fatigue Test for FJC Staff - The ProQol Measure in English and Non-English Translations
    - The ProQOL a tool used to measure the negative and positive effects of helping survivors and contains sub-scales for compassion satisfaction, burnout and compassion fatigue.
- Mindfulness Exercises
    - Mindfulness exercises and strategies that can downloaded in pdf and/or mp3 format.
- Confronting Vicarious Trauma
    - Provides information on understanding and dealing with vicarious trauma for front line staff

- Mindfulness-Based Stress Reduction Training Program
    - Empowers front line staff with knowledge on meditation, body awareness, and yoga to build mindfulness and reduce stress.

Working with Survivors of Natural Disasters

- Tips for Survivors of a Disaster or Other Traumatic Event: Coping with Retraumatization
    - Covers signs and symptoms of re-traumatization, resources for support, and resilience building.

Resources for Working Clients with Specific Symptoms

- Utilizing Trauma-Informed Approaches to Trafficking-Related Work
    - Provides trauma-informed approaches for working with clients who have been victims of trafficking and are experiencing specific symptoms.
- Advocate Training for Multi-Trauma Survivors
    - A toolkit that provides front line staff with in-depth techniques for working with survivors of multiple forms of trauma.

Resources for Working with Clients whose child/children were Abducted

- Federal Resources on Missing and Exploited Children: A Directory for Law Enforcement and Other Public and Private Agencies, Sixth Edition
    - Provides information on all federal agencies that assist in helping families locate their missing children.
- What About Me? Coping with the Abduction of a Brother or Sister
    - This document was developed by the Office of Juvenile Justice and Delinquency Prevention to support the siblings of children who were abducted.
- You're Not Alone: The Journey for Abduction to Empowerment
    - Provides survivors with support towards the journey of healing and empowerment after abduction.

Draft

Polyvictimization Assessment Tool

Name of Center: ______________________________ **Dates Utilized:** _______/ _________/ _________/ _________

Client Name: _________________________ **Client ID:**_________________________ **Over the age of 18? Yes** ☐ **No** ☐

Name of Staff Member(s): ____________________/ ____________________/ ____________________/ ____________________

New Client: ☐ **Returning Client:** ☐ **Number of sessions it took to gather the information below:** ______

The Polyvictimization Assessment Tool is an information integration tool. Please ensure confidentiality is explained and honored for each client. For each event below circle "Y" for yes or "N" for no in the boxes to the right as applicable for the different stages of the client's life (Child and Teen, Adult, and In the last year). In addition to "Y" and "N" user may circle other possible responses which include "A" for the **client did not respond** to the question; "B" for the **user did not ask** due to time constraints or other limitations; and "C" for the user did not ask since it was **not appropriate to ask.** For questions that are not applicable to all clients, an additional “Does not apply” response has been included. When marking an event "In the last year," please also mark the respective time period that it would fall under (Child and Teen OR Adult). Answers should be from the *client's perspective*. If the user has additional input or thoughts, particularly around minimizing, this should be included in the "Notes" section. The number of events calculated for "In the last year" is not a victimization score but should trigger a response at the Center.

Part A: Events

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
1. Assault/battery by parent, caregiver, partner, or relative (completed or attempted) (ex: with a gun, knife, or other weapon including fist, feet, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	**Note if parent, caregiver, partner, or relative:**
2. Strangulation and/or positional asphyxia (pressure applied by any means to the neck or anywhere that made it difficult to breathe) (ex: choking, use of body weight or arms, sitting on top of you, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
3. Sexual abuse/assault by parent, caregiver, partner, relative, friend, or other (completed or attempted) (ex: rape, made to perform any type of sexual act through force or threat of harm)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	**Note if parent, caregiver, partner, relative, friend, or other:**
4. Sex or labor trafficking (ex: being prostituted, forced involvement in sexual performances, forced pornography, involved in domestic servitude or other exploitative labor, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
5. Other forced/unwanted experience(s) related to your body not including abuse or assault (ex: touching, flashing, reproductive coercion such as forced abortions and family planning, revenge pornography, sexual remarks, sexual jokes, or demands for sexual favors by someone at work or school like a coworker, boss, customer, another student, teacher, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
6. Held against will (ex: being kidnapped, abducted, held hostage, held captive, prisoner of war, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
7. Emotional/verbal abuse by parent, caregiver, partner, relative, friend, or other (ex: putting down, fear of physical violence, name calling, mind games, humiliating, guilt trips, spiritual abuse, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	**Note if parent, caregiver, partner, relative, friend, or other:**
8. Financial abuse (ex: forbidden from working, given allowance, not allowed to access bank accounts, online financial fraud, other financial cybercrimes, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
9. Neglect by parent, caregiver, partner, relative, friend, or other (ex: being left unattended for long periods, lack of love or support system at home, very often feeling like not loved by family, malnutrition due to lack of adequate food/water, failure to provide necessary medical care that results in hospitalization, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	**Note if parent, caregiver, partner, relative, friend, or other:**
10. Substance use (ex: you, partner, or a close family member misuse prescription drugs, alcohol, or illicit drugs)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	**Note if client, parent, caregiver, partner, or relative:**
11. Stalking/inappropriate pursuit by parent, caregiver, partner, relative, friend, or other (ex: unwanted repeated contact in-person or via text messages, phone calls, social media, other online platforms including email, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	**Note if parent, caregiver, partner, relative, friend, or other:**
12. Poverty (ex: did not have enough food to eat, lack of basic needs such as clothes, shoes, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
13. Homeless (ex: transitional housing, shelter, hotel/motel paid by voucher, someone else's home, a vehicle, an abandoned building, anywhere outside, or anywhere not meant for people to live without having any other options)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
14. Severe physical injury/illness and/or mental illness resulting in hospitalization or incapacitation (ex: severe pain requiring treatment at home, due to an accident, mental health condition, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
15. Permanent or long-term loss (ex: of a spouse, romantic partner, child, parent or caregiver, due to incarceration, deportation, illness, suicide, death, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
16. Immigration related trauma (ex: separated from support network, language barriers, trouble finding a job, unfamiliar environment and food, deportation, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
	Does not apply ☐				
17. Separation from child(ren) or disrupted caregiving as a child (ex: the loss of custody, visitation, or kidnapping/abduction of a child; a change of custody among family members, numerous changes in foster care placements, or deportation as a child)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
	Does not apply ☐				
18. Jail/prison/probation/parole/detention time (ex: you, partner, close family member, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	**Note if client, parent, caregiver, partner, or relative:**
19. Bullying (ex: verbal or physical violence in-person or online via social media and other online platforms in the workplace, school, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
20. Chronic or repeated discrimination (ex: discrimiation based on race, ethnicity, where family comes from, gender, gender identity/expression, sexual orientation, ability/disability, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	
21. Community violence (ex: physical assault/battery by a stranger; robbery, burglary, mugging, or identity theft; victim of terrorist attack; mass shootings; street riots; drive-by shootings; stabbings; beatings; heard gunshots; etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Notes
22. System-induced trauma (ex: violent arrest situations, difficult experiences testifying against abuser at trial, police brutality, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	**Y N** **A B C**	**Y N** **A B C**	**Y N** **A B C**	
23. Seen someone who was dead, or dying, or watched or heard them being killed (in real life not on T.V. or in a movie, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	**Y N** **A B C**	**Y N** **A B C**	**Y N** **A B C**	
24. Natural and/or man-made disaster (ex: a hurricane, earthquake, flood, tornado, fire, train crash, building collapse, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	**Y N** **A B C**	**Y N** **A B C**	**Y N** **A B C**	
25. Animal cruelty (ex: abuse or threats to pet in attempts to create fear or manipulate)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	**Y N** **A B C**	**Y N** **A B C**	**Y N** **A B C**	
	Does not apply ☐				
26. Other (ex: anything really scary or very upsetting that occurred that is not included above or any other experiences that were not covered)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	**Y N** **A B C**	**Y N** **A B C**	**Y N** **A B C**	
Total lived victimizations by age group:					

Part B: Symptoms

For each symptom circle "Y" for yes or "N" for no in the boxes to the right as applicable for the different stages of the client's life (Child and Teen, Adult, In the last year, and Current Symptom). In addition to "Y" and "N" user may circle other possible responses which include "A" for the **client did not respond** to the question; "B" for the **user did not ask** due to time constraints or other limitations; and "C" for the user did not ask since it was **not appropriate to ask**. When marking a symptom as a "Current Symptom" and "In the last year," please also mark the respective time period that it would fall under (Child and Teen OR Adult). Answers should be from the *client's perspective*. If the user has additional input or thoughts, particularly around minimizing, this should be included in the "Notes" section. The number of symptoms for "In the last year" and "Current Symptoms" are calculated and should assist in guiding service delivery.

		Child and Teen (0-17)	Adult (18+)	In the last year	Current Symptom	Notes
1. Experiencing pain and/or physical symptom(s) that have not been diagnosed or are resistant to treatment	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
2. Suicide attempt, discussion, or thoughts of suicide	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
3. Self-harming behavior(s) (ex: cutting, eating disorder including overeating, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
4. Health-risk behavior(s) (ex: excessive use of drugs/alcohol, sharing needles, unprotected sex with multiple partners, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
5. Repeated disturbing memories, thoughts, or images of a stressful experience	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
6. Avoidance (ex: avoiding places, people or other stimuli associated with past trauma, feelings, or physical sensations that remind you of the trauma, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
7. Cut off (ex: feeling distant or isolated)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
8. Irritable/angry (ex: feeling irritable, having angry outbursts, or rage)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	

		Child and Teen (0-17)	Adult (18+)	In the last year	Current Symptom	Notes
9. Attention/concentration difficulties (ex: easily distracted/inattentive)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
10. Sleep disturbances (ex: night terrors, sleeplessness, excessive sleepiness, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
11. Anxiety (ex: overly tense, worried, or stressed to the point of withdrawal from activities, experiencing panic attacks, or needing excessive reassurances)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
12. Hypervigilance (ex: jumpy, startles easily, overly aware or concerned about potential dangers, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
13. Aggressive or violent behaviors, even if done so unintentionally or unexpectedly (ex: physically or verbally aggressive, destroys property, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
14. Impulsivity (sudden, strong, even irrational urge to engage in behavior without considering consequences first) (ex: stealing, truancy, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
15. Sadness (apathy/despair)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
16. Low self-esteem (ex: I am bad, there is something seriously wrong with me, self-blame for the experience, etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
17. Numbing, dissociating (ex: limited emotional range, avoiding thinking or talking about the future or goal setting, "feeling flat," etc.)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
18. Other (ex: any changes in behavior, physical well being, or mood that have occurred since the incident(s) that are not included above)	*Client did not respond = A* *User did not ask = B* *Not appropriate to ask = C*	Y N A B C	Y N A B C	Y N A B C	Y N A B C	
Symptoms Present In the last year and Current Symptoms:						