Tools from: The Handbook on Sensitive Practice for Healthcare Practitioners: Lessons from Adult Survivors of Childhood Sexual Abuse

S A V E the situation

The acronym ***SAVE*** is a guide for responding effectively and compassionately in a variety of emotionally charged situations.
STOP
Stop what you are doing and focus your full attention to the present situation.
APPRECIATE
Try to appreciate and understand the person's situation by using the helping skills of empathy and immediacy. Empathy involves imagining the other person's experience (thoughts, feelings, body sensations) and communicating an understanding of that experience. Immediacy is verbalizing one's observations and responses in the moment, using present tense language. For example, 'Your fists are clenched and you look angry. What is happening for you?' or 'You seem upset' or 'I doubt there is anything that I can say that will make this easier. Is it okay with you if I sit here with you for a few minutes? If the patient is unable or unwilling to answer, the practitioner can shift the focus to determining possible ways to be helpful (e.g., "How can I help you?").
VALIDATE
Validate the other person's experience. For example, "Given what you have just told me, it makes sense that you feel angry."
EXPLORE
Explore the next step. For example, "Who can I call to come and stay with you?" or 'This has been difficult for both of us. I am not sure where to go from here. Can I call you tomorrow to see how you are doing?"

Common triggers

Sense	Trigger
Sight	• An individual who resembles the abuser or who has similar traits or objects (e.g., clothing, colouring, mannerisms). • A situation where someone else is being threatened or abused (e.g., a scowl, a raised hand, actual physical abuse). • The sight of an object that was part of the abuse or similar to such an object (e.g., a belt, rope, sex toys) or that is associated with the site where the abuse took place (e.g., a dark room, a locked door).
Sound	• Sounds associated with anger (e.g., raised voices, arguments, loud noises, objects breaking). • Sounds associated with pain or fear (e.g., sobbing, whimpering, screaming). • A situation in which the survivor is being reprimanded. • Sounds associated with the place or situation before, during, or after the abuse occurred (e.g., footsteps, a door being locked, a certain piece of music, sirens, birds chirping, a car door closing). • Anything that resembles sounds that the abuser made (e.g., particular words, phrases or tone of voice, whistling, cursing, groaning).
Smell	• Odours associated with the abuser(s) (e.g., cologne or after-shave, tobacco, alcohol, drugs). • Odours associated with the place or situation where the abuse occurred (e.g., mildew, petroleum products, food odours, outdoor smells).
Touch	• Any type of physical contact or proximity that resembles the abuse (e.g., touch on certain parts of the body, touch that comes without warning, standing too close, the sensation of breath on the skin, the manner in which someone approaches). • The sensation of any type of object that was used during abuse (e.g., ice, gel similar to lubricant or semen, the sensation of equipment that is reminiscent of restraints used during abuse).
Taste	• Any taste related to the abuse (e.g., certain foods, alcohol, tobacco).

Components of an effective response to disclosure

After hearing a disclosure of past abuse, the clinician should:

- Accept the information
- Express empathy and caring
- Clarify confidentiality
- Normalize the experience by acknowledging the prevalence of abuse
- Validate the disclosure
- Address time limitations
- Offer reassurance to counter feelings of vulnerability
- Collaborate with the survivor to develop an immediate plan for self care
- Recognize that action is not always required
- Ask whether it is a first disclosure

At the time of disclosure or soon after:

- Discuss the implications of the abuse history for future health care and interactions with clinician
- Inquire about social support around abuse issues

Responses to avoid after a disclosure

Survivors identified the following responses as clearly not helpful:

- Conveying pity (e.g., "Oh, you poor thing").
- Offering simplistic advice (e.g., "Look on the bright side," "Put it behind you," "Get over it," or "Don't dwell on the past.").
- Overstating or dwelling on the negative ("A thing like that can ruin your whole life").
- Smiling (while you may hope that your smile conveys compassion, a neutral or concerned expression is more appropriate).
- Touching the person without permission even if you intend it as a soothing gesture.
- Interrupting (let the individual finish speaking).
- Minimizing or ignoring the individual's experience of abuse, the potential impact of past abuse, or the decision to disclose (e.g., "How bad could it be?", "I know a woman that this happened to and she became an Olympic gold medalist," "Let's just concentrate on your back pain," or "What's that got to do with your sprained ankle?").
- Asking intrusive questions that are not pertinent to the examination, procedure, or treatment.
- Disclosing your own history of abuse.
- Giving the impression that you know everything there is to know on the subject.

If clinicians think that they have inadvertently responded to the disclosure in an inappropriate way, or if the patient's nonverbal feedback suggests a negative reaction to their initial responses, they should immediately clarify the intended message and check with the survivor for further reaction.

Adapted from: Schachter, C.L., Stalker, C.A., Teram, E., Lasiuk, G.C., Danilkewich, A. (2008). Handbook on sensitive practice for health care practitioner: Lessons from adult survivors of childhood sexual abuse. Ottawa: Public Health Agency of Canada https://www.integration.samhsa.gov/clinical-practice/handbook-sensitivve-practices4healthcare.pdf