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Rape Survivors' Experiences With the Legal and Medical Systems

Do Rape Victim Advocates Make a Difference?

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This study used a naturalistic quasi-experimental design to examine whether rape survivors who had the assistance of rape victim advocates had more positive experiences with the legal and medical systems compared to those who did not work with advocates. Eighty-one survivors were interviewed in two urban hospitals about what services they received from legal and medical system personnel and how they were treated during these interactions. Survivors who had the assistance of an advocate were significantly more likely to have police reports taken and were less likely to be treated negatively by police officers. These women also reported less distress after their contact with the legal system. Similarly, survivors who worked with an advocate during their emergency department care received more medical services, including emergency contraception and sexually transmitted disease prophylaxis, reported significantly fewer negative interpersonal interactions with medical system personnel, and reported less distress from their medical contact experiences.

Keywords: *rape; rape crisis centers; rape victim advocates; sexual assault*

One of the enduring legacies of the 1970s feminist social movement was the creation of community-based rape crisis centers (RCCs). There are now more than 1,200 RCCs in the United States, and their staff and volunteers provide numerous services to survivors of rape, such as crisis intervention, medical and legal advocacy, and counseling (Campbell & Martin, 2001; Martin, 2005). Of these three basic services, social system advocacy is perhaps the most challenging for RCC staff (Campbell, 1996; Martin, 1997, 2005). Rape victim advocates assist survivors in hospital emergency departments (ERs) and police departments by guiding them through the process of medical forensic evidence collection and legal prosecution. At the same time, rape victim advocates are trying to prevent "the second rape" or "secondary victimiza-

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tion"—insensitive, victim-blaming treatment from social system personnel that exacerbates the trauma of the rape (Campbell et al., 1999; Campbell & Raja, 1999, 2005; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Madigan & Gamble, 1991; Martin & Powell, 1994; Williams, 1984). The job of the rape victim advocate, therefore, is not only to improve service delivery but also to stop secondary victimization. Although RCCs have been providing legal and medical advocacy services for decades, there is little research evaluating the effectiveness of rape victim advocates. The purpose of the current study was to address this gap in the literature by comparing rates of service delivery and secondary victimization for rape survivors who did and did not work with rape victim advocates.

The work of rape victim advocates is challenging as existing research suggests that most rape survivors do not receive needed services and are often treated insensitively by social system personnel. Within the legal system, studies of rape case processing suggest that approximately 50% of the time law enforcement personnel either do not take victims' reports or never forward their reports for investigation, and only 22% to 25% of reported rapes are prosecuted, 10% to 12% of which result in some type of conviction (Campbell, 1998a; Campbell et al., 2001; Frazier & Haney, 1996). Case attrition is widespread and problematic; however, prior research has also found that postassault contact with the legal system can be revictimizing. For example, rape survivors report that they are asked about their prior sexual histories, questioned about how they were dressed or behaving at the time of the assault, and are encouraged not to report or prosecute the assault. Victims consistently report that these kinds of behaviors are highly distressing and revictimizing (Campbell et al., 1999; Campbell & Raja, 2005). Similarly, prior research has found that most survivors of rape report feeling guilty, depressed, anxious, distrustful of others, and reluctant to seek further help after their interactions with legal system personnel (Campbell et al. 1999; Campbell et al., 2001; Campbell & Raja, 2005).

Experiences of rape survivors with the medical system can also be difficult. When rape victims seek postassault emergency medical care, most receive a medical exam and forensic evidence collection kit (70%; Campbell et al., 2001), less than one half receive information on the risk of pregnancy (40% to 49%) (Campbell et al., 2001; National Victim Center, 1992), and between 20% and 43% are able to obtain emergency contraception to prevent pregnancy (Amey & Bishai, 2002; Campbell et al., 2001). Approximately one third of survivors of rape receive information about the risk of sexually transmitted diseases (STDs) and HIV from the assault (Amey & Bishai, 2002; Campbell et al., 2001; National Victim Center, 1992), and between 34% and 57% receive medication to treat and/or prevent STDs (Amey & Bishai, 2002; Campbell et al., 2001). In addition to these gaps in service delivery, secondary victimization from the medical system may also be a problem for survivors of rape (Martin, 2005; Martin & DiNitto, 1987). Campbell and Raja (2005) found that 58% of survivors in their sample reported that they were distressed by doctors' and nurses' questions about their sexual histories, behavior before the assault, and how they were treated during the exam process. Most women reported feeling violated, depressed, and anxious after their contact with medical professionals (see also Campbell et al., 2001).

These rates of legal case attrition and medical service delivery and secondary victimization come from studies of rape survivors who did not work with rape victim advocates, which raises the question: Can advocates make a difference? Are the experiences of rape survivors who have advocates any better? Few studies have explicitly tested this question. For example, in a statewide evaluation of RCC services, Wasco et al. (2004) found that survivors consistently rated advocates as supportive and informative. Yet being positively perceived does not necessarily mean that advocates are effective in promoting service delivery and preventing secondary victimization. More direct evidence of effectiveness comes from Campbell and Bybee's (1997) study of survivors of rape who had the assistance of an advocate during their hospital emergency department (ED) care. This study found higher rates of medical service delivery than what is typical in the literature: 82% received an exam, 70% information on pregnancy, 38% emergency contraception, 67% information on STDs, and 79% STD preventive antibiotic treatment. However, this study did not include a comparison group of survivors who did not work with advocates, which would have provided a more powerful test of advocates' effectiveness regarding service delivery. In a study of secondary victimization, Wasco, Campbell, Barnes, and Ahrens (1999) examined the relationship between social system contact and posttraumatic stress symptoms of rape survivors as a function of whether the victims had the assistance of an advocate. Although the number of victims in this study who had an advocate was quite small (21 in a sample of 102), they found that survivors who worked with advocates reported less distress after contacting the legal and medical systems. Taken together, the results of these studies suggest that rape victim advocates are beneficial; however, more direct comparison studies are warranted.

The purpose of the current study was to compare the service delivery and secondary victimization experiences of rape survivors who did and did not work with rape victim advocates to determine if survivors who worked with advocates received more services and had fewer negative interactions with social system personnel. Participants were recruited from hospital ERs because this is where most rape survivors receive immediate postrape medical care (Resnick et al., 2000). In addition, Resnick et al. (2000) found that victims who obtained medical care often did so after they had reported to the police and that law enforcement served as a conduit to medical care. Therefore, sampling in hospital EDs increases the likelihood that study participants would have contact with the legal and medical systems, which is consistent with the primary goal of the current study.

Two large, urban hospitals were selected for sampling that had several common characteristics. First, both were the primary hospital in their respective police precincts where law enforcement took rape victims for treatment (if the victim first presented to the police). Second, if a rape victim came to the hospital ED without prior contact with the police, both hospitals had policies to call the police, and then the survivor was given the choice of whether to talk to the police. These two features suggest that the sites sampled for the current study are typical with respect to how communities in other national studies respond to rape victims. Third, the hospitals were comparable with respect to (a) number of rape victims served per year, (b) having doctors

perform the rape exam and forensic evidence collection procedures (rather than sexual assault nurse examiner [SANE] nurses), and (c) serving a racially mixed population with high concentrations of patients who were Medicaid eligible. The primary difference between the two hospitals was that one had a policy to page rape victim advocates from a local RCC to come assist survivors of rape throughout their ER visit (Site #1) and the other did not (Site #2). This naturalistic quasi-experimental design allows for direct comparisons between the rape survivors who worked with a rape victim advocate (Site #1) and those who did not (Site #2).

The advocates serving the Site #1 hospital were paid staff and volunteers from an urban RCC. They had completed a 40-hour training program that included instruction on the psychological and physical health impact of sexual assault, victims' legal rights, the steps of legal prosecution, and the process of medical forensic evidence collection. In this training, the advocates also learned how to assess the survivors' needs for services and work on their behalf to obtain those resources if they were not forthcoming during the exam process. RCC staff also instructed the advocates to intercede when social system personnel engaged in behaviors or pursued lines of questioning that could be distressing to the survivors. The hospital ED staff at Site #1 paged the RCC as soon as they knew they had a victim seeking treatment and would typically wait until the advocate arrived before performing the rape exam. The advocates were usually present for the exam to support the survivor and clarify the information presented by the doctors and nurses. Survivors usually talked with the police after the exam and, hence, had the support of an advocate for that process as well.

To assess how advocates may influence the experiences of rape survivors with the legal and medical systems, victims in each hospital were interviewed right before their discharge about what had just happened in their contact with the medical and law enforcement personnel. Three domains were assessed: (a) service delivery: what services the survivors did or did not receive from legal and/or medical personnel. It is important to note that the use of the term *service delivery* in the context of victims' experiences with the legal system does not imply that all victims want complete trial process. Rather, the term refers to the actions taken by legal system personnel to process reported rape cases; (b) secondary victimization behaviors: whether victims encountered specific behaviors and/or actions from service providers that were distressing; and (c) secondary victimization emotions: whether survivors felt various forms of distress (e.g., self-blame, depressed, violated) after their contact with social system personnel. Rates of service delivery and secondary victimization were compared across sites to assess the effectiveness of rape victim advocates.

Method

Sample

In Site #1 (the hospital that worked with rape victim advocates), 38 rape survivors sought treatment during the 6-month period of time the current study was conducted, and 36 agreed to participate in the study (95% response rate). All 36 survivors from

Site #1 worked with a rape victim advocate. Of these victims, 17 also talked with police either before arriving at or during their hospital care. In Site #2 (the hospital that did not work with rape victim advocates), 46 victims sought treatment during the time of the current study, and 45 agreed to participate (98%). Of these 45 victims, 28 had contact with police. In sum, 45 survivors had contact with the legal system (17 from Site #1 and 28 from Site #2), and 81 had contact with the medical system (36 from Site #1 and 45 from Site #2). All 81 rape survivors in the current study were female, and more than one half were African American (52%), 37% were White, 8% were Latina, and 3% were multiracial. The average age was 26.12 years (*SD* = 3.45). Most of the women had a high school education (51%). Consistent with prior research, most of the assaults were committed by someone known to the victim (acquaintance, date, marital), did not involve the use of a weapon (74%), and did not result in physical injuries to the victim (62%). Of the women, 22% had been using alcohol at the time of the assault.

Procedure

The principal investigator (PI) worked collaboratively with the staff of both hospitals to develop uniform recruitment and data collection procedures that would ensure reliable access to rape survivors without interfering with their medical care. Consistent with the sites' normal protocols for responding to rape survivors, hospital staff would first call the police (if the police were not already accompanying the victim to the ER), then page a rape victim advocate (Site #1 only), and then page the research team. While the victim was receiving medical care and/or reporting to the police, the research team member who had been paged to the hospital waited at the nurses' station and did not have contact with the survivor or witness her interactions with system personnel. While the survivor was waiting for her discharge papers from the hospital, a nurse approached her and asked her if she would be willing to participate in a brief interview about her experiences in the ED. She was told the interview would be conducted by a female researcher who was not affiliated with the hospital or the police. If she agreed, only then was the researcher allowed to have contact with the victim. The interview was conducted with the rape survivor during the waiting time before discharge.

Measures

An orally administered checklist was used for data collection, and its administration was tape-recorded with the permission of the participants (100% agreed to tape recording). In addition to collecting basic demographic and assault characteristics, the checklist was designed to capture three kinds of information. First, service delivery was assessed: What services were provided to the rape survivors in their contact with the legal and/or medical systems? The PI reviewed police and hospital protocols and consulted with officers, doctors, nurses, and rape victim advocates to find out what services could be offered to rape survivors. In the current study, three steps in legal case processing were studied: whether a police report was taken, whether an investiga-

tion was or would be conducted, and whether law enforcement personnel provided referrals to survivors of rape for other community resources. There are other actions that could be taken by the legal system (e.g., arrest, prosecution); however, the informant groups reported that the three previously mentioned services were the only services that could be provided by the time data were collected. For the medical system, 16 services were examined (see Table 2 for a complete list). For each service (legal or medical), the survivors were asked, "Did (service) occur? Did you receive (service)?" and the respondents' answers were coded yes or no. If the participants responded no to a particular service, the interviewers were trained to probe further to find out whether the victim did not want the service (hence, not receiving it was consistent with the victim's wishes) or whether the victim wanted the service, but it was not provided. In the current study, when services were not provided, it was usually instances of the victim's wanting the service, but it was not provided (93% to 97% of the time, across all services).

Second, secondary victimization behaviors were assessed. Because current definitions of *secondary victimization* emphasize the behaviors of social system personnel, participants were asked whether they encountered specific actions. To generate this list of secondary victimization behaviors, formative research was conducted with multiple informant groups (Campbell, 1996, 1998b). Interviews and focus groups were conducted with police officers, prosecutors, doctors, nurses, RCC staff, rape victim advocate volunteers, and rape survivors to find out what specific behaviors of social system personnel might be upsetting to survivors of rape. In the current study, 14 behaviors were assessed for the legal system, 12 for the medical system. The questions were not the same across systems because the formative research revealed that assessment needed to be tailored to each system because of the inherent differences in the roles and functions of the legal and medical systems (see Tables 1 and 2 for a complete list). Consistent with prior studies on this topic (Campbell et al., 2001; Campbell & Raja, 2005), these behaviors were not labeled as secondary victimization during assessment; participants were simply asked whether the actions occurred. For each behavior, rape survivors were asked, "Did you experience (behavior)? Did this (behavior/action/comment) happen?" Answers were coded yes or no. To check whether it was reasonable to conceptualize these behaviors as secondary victimization, distress ratings were also collected from the survivors of rape. If a survivor reported that she encountered one of these behaviors, she was also asked to rate how distressing it was to encounter that behavior on a 1 to 5 scale (1 = not distressed, 2 = a little distressed, 3 = some distress, 4 = quite a bit of distress, 5 = a great deal of distress). All behaviors were rated as 3 or higher by all survivors who encountered them ($M = 4.22$, $SD = .47$).

Finally, secondary victimization emotions were assessed. Secondary victimization has been defined as insensitive and victim-blaming treatment by social system personnel that leaves victims feeling distressed. In the current study, eight secondary victimization emotions were assessed for the legal and medical systems, including feeling guilty, depressed, anxious and/or nervous, distrustful of others, and reluctant to seek further help as a result of contact with either the legal or medical systems. Rape survi-

vors were asked, "Did you feel (emotion) after your contact with the police officer/hospital staff? Did you feel this as a result of your contact with the police/hospital staff?" The participants' answers were coded yes or no.

Results

Legal Case Processing and Secondary Victimization

Differences in proportions tests, with Bonferroni corrections to control Type I error, were used to compare the endorsement rates of rape survivors for each service across the two sites (Downie & Heath, 1983). The differences in proportions test is quite conservative with sample sizes less than 100 (Downie & Heath, 1983), and coupled with a Bonferroni correction, Type I error may be adequately controlled, but at the risk of a Type II error. To balance these competing risks, the Bonferroni tests were grouped by substantive focus (Tabachnick & Fidell, 2001) (see Table 1). As Table 1 shows, police reports were significantly more likely to be taken in Site #1 where victims had the assistance of an advocate (59%) as compared to Site #2 (41%) (z [44] = 2.43, $p < .02$). Most reported cases were not investigated further or were not likely to be investigated (24% in Site #1, 8% in Site #2). A trend emerged suggesting that investigations were slightly more common in Site #1 than in Site #2 (z [44] = 2.02, $p < .05$). Most rape survivors were not given referrals by police officers to other community services: 6% in Site #1, 11% in Site #2 (no significant differences across sites).

Consistent with prior research on legal secondary victimization, some behaviors were commonly encountered, others were infrequent. Most rape survivors in both sites stated that they were discouraged from filing a police report; however, this was significantly more likely to happen in Site #2 (where rape victim advocates were not present): 81% in Site #2, 59% in Site #1 (z [44] = 2.42, $p < .01$). Similarly, many rape survivors reported that police officers were reluctant to take their report (although they did so); however, this was significantly more likely to happen in Site #2 as compared to Site #1: 79% vs. 35% (z [44] = 3.11, $p < .01$). It was less common for officers to refuse to take the report (e.g., officers stating that they would not take a report because they thought the victim was lying); however, again, this occurred more frequently in Site #2 where rape victim advocates were not involved: 43% versus 18% (z [44] = 2.39, $p < .01$). Most rape survivors who did not work with rape victim advocates (57%) were told by police officers that their cases were not serious enough to pursue further in the criminal justice system; the women who had the assistance of an advocate were significantly less likely to encounter this response (29%) (z [44] = 2.47, $p < .01$). In Site #2, it was typical for police officers to ask rape survivors if they had a prior relationship with the perpetrator (86%); however, this was less commonly asked in Site #1 (47%) (z [44] = 2.13, $p < .02$). Slightly less than one half of the rape survivors in Site #2 were asked about their prior sexual history by the police officers (46%), and this was significantly less common in Site #1 (12%) (z [44] = 2.83, $p < .008$). Finally, 31% of the women in Site #2 were asked by police officers if they had responded sexually to

the assault (e.g., asked whether they had an orgasm from the assault); this line of questioning was significantly less likely to occur in Site #1 (6%) (z [44] = 2.73, $p < .008$).

After their contact with the legal system, most rape survivors reported experiencing multiple kinds of distress. As can be seen in Table 1, almost all secondary victimization emotions had endorsement rates of more than 50%. Some emotions were nearly ubiquitous: 82% of the rape survivors in Site #1 and 93% of the victims in Site #2 stated that they felt violated after their contact with the legal system. Most also said that they felt disappointed (88% in Site #1 and 93% in Site #2). Some emotions, though still typical, were more likely to be reported by the women who did not work with a rape victim advocate. For instance, 83% of the survivors in Site #2 reported that they felt bad about themselves after their contact with the legal system. This was also common in Site #1 (60%) but was more typical in Site #2 (z [44] = 2.41, $p < .01$). Similarly, women in Site #2, who did not have the assistance of an advocate, were more likely to report feeling guilty (86%) or depressed (88%) than the survivors in Site #1 (59% and 53%, respectively) (z [44] = 2.36, $p < .01$; z [44] = 2.40, $p < .01$). Finally, most women in Site #2 stated that they were reluctant to seek further help after their experiences with the legal system (89%), which was significantly higher than those who reported this sentiment in Site #1 (61%) (z [44] = 2.33, $p < .01$).

Medical Service Delivery and Secondary Victimization

Differences in proportions tests with Bonferroni corrections were used to compare survivors' experiences with the medical system across the two sites. As can be seen in Table 2, some medical services were consistently provided to survivors, such as the rape exam, forensic evidence collection, and STD prophylaxis (medication for any treatable STDs that may have been contracted in the assault). However, several services were offered to less than one half of the rape survivors, including information on the risk of HIV from the assault, pregnancy testing, emergency oral contraception, testing for STDs and/or HIV, HIV prophylaxis, information on the health effects of rape, information on follow-up care, and community referrals. Some services were consistently more likely to be provided by medical professionals to survivors in Site #1, who had the assistance of a rape victim advocate. These women were significantly more likely to receive information on STDs (72% vs. 36%; z [80] = 2.67, $p < .008$), were somewhat more likely to receive information on the risk of HIV specifically (47% vs. 24%; z [80] = 2.09, $p < .05$), and were significantly more likely to receive STD prophylaxis (86% vs. 56%; z [80] = 2.50, $p < .008$) than were the women in Site #2 (who did not have an advocate). The victims who worked with advocates received more pregnancy-related services than the survivors who did not have the assistance of an advocate. Specifically, they were somewhat more likely to be tested for pregnancy (42% vs. 22%; z [80] = 2.01, $p < .05$) and were significantly more likely to receive emergency contraception to prevent pregnancy (33% vs. 14%; z [80] = 2.20, $p < .02$).

The rates of endorsement for the secondary victimization behaviors were generally low (most under 50%, see Table 2). For example, in only 24% of the cases in Site #1 and 36% of the cases in Site #2 did hospital staff refuse to conduct the medical exam

and/or forensic evidence collection. These refusals were not because of the medical provider's training and/or expertise (e.g., one provider refused so that someone with more or less training could do the exam) or his or her gender (e.g., one provider refused because the victim wanted a provider of the opposite sex). Exams and evidence collection were refused when hospital staff said that the assault occurred "too long ago," even though by the victims' accounts all sought services within 96 hours, which is within the time frame for forensic work (International Association of Forensic Nursing, 2005). During the exam process, the victims seen in Site #2 often reported that they were treated impersonally or coldly (69%), which was less commonly reported by the survivors treated in Site #1 (36%; z [80] = 2.51, $p < .01$). The women at Site #2 were somewhat more likely to be asked about how they were dressed at the time of the assault compared with the survivors treated at Site #1 (48% vs. 28%; z [80] = 2.24, $p < .05$). Most of the survivors in Site #2 were asked about their prior sexual histories (73%), which was also common, though statistically less likely in Site #1 (44%; z [80] = 2.47, $p < .008$). Of the survivors in Site #2, where no advocate was present, 20% were asked if they had responded sexually to the assault; this question was significantly less likely to be asked by the medical staff in Site #1 (3%; z [80] = 2.53, $p < .008$). The survivors' rates of endorsement for the secondary victimization emotions were quite high (72% or higher). The women treated in Site #2, without the assistance of a rape victim advocate, were more likely to report blaming themselves for the assault post-contact (82% vs. 54%; z [80] = 2.33, $p < .01$) and were significantly more likely to state that they were reluctant to seek further help (91% vs. 67%; z [80] = 2.40, $p < .01$) than were the women in Site #1.

Discussion

RCC staff and volunteers have been providing legal and medical advocacy for rape survivors for decades. However, there have been few empirical studies evaluating the effectiveness of the advocates' intervention. The current study used a naturalistic quasiexperimental design to compare the outcomes of victims who worked with rape victim advocates with those who did not. Rape survivors who worked with advocates reported receiving more services from the legal and medical systems. Previous research suggested that police officers take reports of rape survivors only 50% of the time (Campbell et al., 2001); however, the victims who worked with advocates had reports taken 59% of the time. Rates of medical care service delivery in this research were consistent with Campbell and Bybee's (1997) study of rape survivors who had the assistance of an advocate during their hospital ED care: Approximately 70% received an exam, information on pregnancy, information on STDs, and STD preventive antibiotic treatment. Most survivors did not receive emergency contraception (about one third); however, this rate is common for advocate-assisted cases and is significantly higher than for women who did not work with an advocate. Beyond service delivery, most survivors who worked with advocates reported less secondary victimization from legal and medical system personnel, and less post-system-contact dis-

Table 1
Rates of Legal Service Delivery and Secondary Victimization as a Function of Whether the Rape Survivor Worked With a Rape Victim Advocate (in percentages)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Legal—Services (3)		
Police report	59*	41
Investigation	24[a]	8
Referrals	6	11
Legal—Secondary victimization behaviors (14)		
Discouraged filing a report	59	81[b]
Reluctant to take a report	35	79[b]
Refused to take a report	18	43[b]
Told case was not serious enough to pursue	29	57[b]
Did not explain steps of reporting/prosecuting	18	21
Asked why with perpetrator	47	61
Asked if had prior relationship with perpetrator	47	86[b]
Questioned the way dressed	41	46
Questioned behaviors/choices	35	43
Questioned about prior sexual history	12	46[b]
Questioned why memories were vague or scattered	12	21
Questioned if resisted perpetrator	82	86
Questioned if responded sexually to the assault	6	31[b]
Asked if willing to take a lie detector test	6	18
Legal—Secondary victimization emotions (8)		
Felt bad about self	60	83[b]
Guilty and/or blame self	59	86[b]
Depressed	53	88[b]
Nervous and/or anxious	47	47
Violated	82	93
Disappointed	88	93
Distrustful of others	47	57
Reluctant to seek further help	61	89[b]

Note: For the three legal service delivery tests, only alpha levels $p < .02$ are considered statistically significant. For the legal secondary victimization tests, the five behaviors pertaining to the process of reporting and prosecuting a rape were grouped and alphas $p < .01$ are significant; the six behaviors relating to the survivors' behaviors at the time of the assault were grouped, alphas $p < .008$ are significant; and the three questions regarding the survivors' prior relationship with the assailant were grouped, alphas $p < .01$ are significant. For the legal secondary victimization emotions tests, the four emotions pertaining to guilt, depression, and anxiety were grouped, alphas $p < .01$ are significant; the four emotions relating to violation and reluctance to seek further help were grouped, alphas $p < .01$ are significant.

a. Denotes a trend difference.

b. Denotes a statistically significant difference.

tress than those who did not have the assistance of advocates. Secondary victimization has been linked with a variety of negative health outcomes, such as increased psychological distress, physical health symptomatology, and sexual health risk-taking behaviors (Campbell et al., 1999; Campbell et al, 2001; Campbell, Sefl, & Ahrens, 2004). Thus, a reduction in secondary victimization may have important long-term benefits for rape survivors. These findings regarding service delivery and secondary victimization provide some of the strongest evidence to date that RCC services are beneficial to rape survivors.

Whereas the design of the current study allowed for a direct comparison of victims' legal and medical system experiences as a function of whether they had an advocate, random assignment was not possible in this research. In the process of planning the current study, the PI met with staff from multiple hospitals in a major metropolitan city to explore design options. None would allow random assignment of advocates. Those that had policies to work with advocates felt it would be unethical to randomly assign victims in the ED to have the assistance of the advocate. Their perception was that advocates were tremendously helpful to survivors and that not providing this assistance would be a disservice to their patients. Hospitals that did not work with advocates were not interested in bringing them in to work with some patients, but not others. Without random assignment, either across sites or within sites, a quasi-experimental design was needed. It was also not possible to conduct a within-site quasi-experimental study as none of the hospitals used advocates only some of the time (they either consistently worked with advocates or did not). Yet it was discovered that two hospitals in this city were very similar on multiple characteristics (both were located in racially mixed neighborhoods, both served high concentrations of patients who were Medicaid eligible, and both had similar protocols for responding to victims of rape), except for their policies and practices regarding rape victim advocates: One routinely worked with rape victim advocates, the other did not. These similarities provided a solid methodological foundation for the current study; however, without random assignment, cross-site differences may be because of multiple factors, advocate involvement only one among many.

Therefore, it is important to explore what other factors, besides advocate involvement, could explain the differences in service delivery and secondary victimization rates across the sites (see Cook & Campbell, 1979). Four alternative explanations were examined. First, service providers' demographics, such as age, race and/or ethnicity, and education level, may influence how they respond to rape survivors, and if the hospitals varied significantly in provider demographics, this could account for site differences. To test this possibility, all social system personnel with whom the survivor interacted were also interviewed (see Campbell, in press), and there were no significant differences between sites with respect to their service providers' demographic characteristics. Thus, if providers' demographics influence their work with rape survivors, it appears that such effects would be consistent across sites.

Second, the degree of training legal and medical system personnel have had about sexual assault may influence their responses, as would their levels of experience working with rape survivors. In the interviews with system personnel, all participants were

asked to rate their perceived awareness of the issue of sexual assault and their experience working with rape survivors (Campbell, in press). Again, there were no significant differences across sites. To further explore the possible impact of training and experience, the directors of both hospital ERs were contacted to find out when their staff had last been trained on sexual assault and how many rape cases their staff had responded to within the past year. Both hospitals had not had training on sexual assault within the past 5 years, and there were no significant differences between the two sites with regard to the number of rape cases processed each year. Similar data were collected from the deputy chief of police who oversaw the two police precincts that served these hospitals. Again, there were no differences across sites with respect to police training or number of reported rapes the officers had responded to within the past year.

Third, it is possible that the policies and procedures for each hospital and each police precinct were fundamentally different, which would account for the varied experiences rape survivors had in each site. This issue was more difficult to examine as neither hospital nor police precinct had good written documentation explaining their response protocol for rape cases. Both hospitals' protocols stated that they followed state law regarding forensic evidence collection. As noted previously, Site #1 had a policy, unwritten but consistently followed, to page rape victim advocates to assist survivors in the ED, and this was the only identifiable difference between the sites. Both police precincts' operations manuals outlined a standard procedure for responding to victims of violent crime, and there was no other written evidence that suggested differential policies. Yet previous research has found that the decision-making processes of legal personnel are cultural and quite specific to their units (Frohmann, 1991, 1997, 1998; Kerstetter & Van Winkle, 1990; Martin & Powell, 1994), which may not be reflected in written policies, even if detailed versions existed. However, something was undoubtedly different between the two sites because one had a standing relationship with an RCC and engaged in what Martin and Powell (1994) termed *responsive processing* by providing victim-assistance resources. Previous research has shown that RCCs can create institutional change (Martin, DiNitto, Byington, & Maxwell, 1993; Schmitt & Martin, 1999), so it is possible that the rape victim advocates in Site #1 are representative of an ongoing institutional social cultural dynamic, rather than a force for change in individual encounters between victims and social system personnel.

Finally, it is possible that the victims themselves and/or the characteristics of the sexual assaults may have been different across the two sites. Perhaps one hospital treated more of some kinds of survivors or types of rape than the other, and such differences prompted alternative system responses. Demographic and assault characteristics were collected in the survivors' interviews, and cross-site comparisons yielded no significant differences. Taken together, these findings suggest that individual demographics, assault characteristics, system personnel's training and experience, and site policies and procedures were consistent across data collection sites and, thus, may not explain the differences in service delivery and secondary victimization rates across sites. However, one key alternative interpretation cannot be ruled out: The service pro-

Table 2
Rates of Medical Service Delivery and Secondary Victimization as a Function of Whether the Rape Survivor Worked With a Rape Victim Advocate (in percentages)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Medical—Services (16)		
Rape exam	89	76
Forensic evidence collection	89	76
Detection and/or treatment of injuries	61	56
Information on risk of pregnancy	72	56
Information on risk of STDs	72[b]	36
Information on HIV specifically	47[a]	24
Tested for pregnancy	42[a]	22
Emergency oral contraception	33[b]	14
Tested for STDs	14	13
Tested for HIV	8	13
STD prophylaxis	86[b]	56
HIV prophylaxis	19	16
Information on psychological effects of rape	6	4
Information on physical health effects of rape	6	4
Information on follow-up treatment	11	4
Referrals	14	7
Medical—Secondary victimization behaviors (12)		
Refused to conduct exam	24	36
Refused to do forensic evidence collection	24	36
Did not explain rape exam procedures	17	22
Impersonal and/or detached interpersonal style	36	69[b]
Asked why with perpetrator	44	58
Asked if had prior relationship with perpetrator	56	53
Questioned the way dressed	28	48[a]
Questioned behavior and/or choices	36	44
Questioned about prior sexual history	44	73[b]
Questioned why memories were vague or scattered	8	7

(continued)

viders in Site #1 simply told victims what they wanted to hear because of the presence of the rape victim advocate but did not actually follow through with more complete service. For example, law enforcement personnel may have said that a case would be investigated in the presence of the advocate; however, in fact, they did not pursue the case. Given the scope of the current study, it was not feasible to conduct follow-up assessments through police records, and this remains a limitation of the current work. In addition, it was not possible to identify the specific actions taken by the advocates

Table 2 (continued)

	Rape Survivors Who Worked With a Rape Victim Advocate	Rape Survivors Who Did Not Work With a Rape Victim Advocate
Questioned if resisted perpetrator	83	87
Questioned if responded sexually to assault	3	20[b]
Medical—Secondary victimization emotions (8)		
Felt bad about self	72	89
Guilty and/or blame self	54	82[b]
Depressed	81	93
Nervous and/or anxious	86	96
Violated	92	96
Disappointed	78	93
Distrustful of others	69	78
Reluctant to seek further help	67	91[b]

Note: For the Bonferroni corrections of the medical service delivery tests, the three services pertaining to the rape exam and injury treatment were grouped, alphas $p < .02$ are statistically significant; the three items related to pregnancy were grouped, alphas $p < .02$ are significant; the six questions regarding HIV/STDs were grouped, alphas $p < .008$ are significant; and the four items regarding health effects and follow-up treatment were grouped, alphas $p < .01$ are significant. For the medical secondary victimization tests, the four behaviors pertaining to rape exam were grouped and alphas $p < .01$ are significant; the six behaviors relating to the survivors' behaviors at the time of the assault were grouped, alphas $p < .008$ are significant; and the two questions regarding the survivors' prior relationship with the assailant were grouped, alphas $p < .03$ are significant. For the medical secondary victimization emotions tests, the four emotions pertaining to guilt, depression, and anxiety were grouped, alphas $p < .01$ are significant; the four emotions relating to violation and reluctance to seek further help were grouped, alphas $p < .01$ are significant. STDs = sexually transmitted diseases.

a. Denotes a trend difference.

b. Denotes a statistically significant difference.

that may have contributed to higher rates of service delivery and lower rates of secondary victimization across the sites. Nevertheless, the comparative data collected in the current study suggest that rape victim advocates and the RCCs they represent have had a positive impact on the experiences of rape survivors with the legal and medical systems.

In light of these findings, RCCs should continue to work toward widespread availability of rape victim advocates' services. Presenting evaluation data—either internal evaluations conducted by individual agencies or academic research studies—that speak to the effectiveness of rape victim advocates might help strengthen ties between RCCs and the legal and medical systems. It may also be useful to reexamine commonly used protocols for bringing advocates into hospital EDs to assist rape survivors. Several of the hospital ED directors contacted for participation in the current study mentioned that the so-called page-and-wait method for requesting an advocate was cumbersome, and this was a major deterrent to using RCC services. In addition to building stronger relationships with community service providers, RCCs may want to

reenergize their efforts to reach out directly to the women in their communities to publicize their services. Other research on postassault community help-seeking experiences of rape survivors has found that many women do not know about RCCs and do not work with rape victim advocates (Campbell et al., 2001; Wasco et al., 1999). Further efforts to advertise RCCs' services and their effectiveness could be beneficial so that survivors (or their family, friends, or significant others) could request advocacy services if they are not forthcoming. Rape victim advocates appear to provide numerous benefits and can prevent serious negative consequences for rape survivors, and it is important that future research and policy efforts continue to find ways to improve the accessibility and availability of advocates' services.

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