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Satisfaction and Use: Comparing First-time Victims and Victims of Multiple Sexual Assaults

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MS, Walden University, 2011

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Dissertation Submitted in Partial Fulfillment

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Abstract

Sexual assault advocacy services are intended to support and empower victims during the aftermath of an assault. This study's purpose was to identify sexual assault victims' use and satisfaction with victim advocacy services, and to compare those outcomes in first-time victims and victims of multiple sexual assaults. The goal was to determine if victims of multiple sexual assaults would seek services again due to satisfaction after receiving prior sexual assault advocacy services. Guided by empowerment theory, this study purported that victim satisfaction and seeking additional services would promote coping and empowerment for the victims and result in positive social change. Quantitative data were analyzed using the Inter-University Consortium for Political and Social Research with inclusion criteria of female, sexual assault victim, age 18 years or older, and being African American or Caucasian. The number of previous sexual assaults, use and satisfaction with victim advocacy services, and participant demographics were analyzed using inferential tests. A Chi-square test of independence examined the relation between victims of multiple sexual assaults and their use of victim advocacy services during the most recent assault, and revealed that victims of multiple sexual assaults were more likely to seek medical services during the most recent assault than they were to seek legal or sexual assault crisis center services. This finding suggests areas of improvement for victim advocacy services, specifically in improving the dissemination and collaboration of services among the medical, legal, and sexual assault crisis center communities. The findings from this study may help to evolve victim advocacy services, thereby increasing sexual assault victims' satisfaction with and use of services.

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Chapter 1: Introduction to the Study

Introduction

Victim advocates are human service professionals who help and guide sexual assault victims by helping them navigate available legal and medical options and by providing them with social support and other resources. Victim advocates are trained to anticipate the positive and negative aspects of victimization while strategizing with a victim (Kolb, 2011). There is much research on the efforts of the criminal justice system toward victims, but there is a knowledge gap in understanding how satisfied victims of sexual assault are with victim advocacy services and supports (Lonsway & Archambault, 2012; Kolb, 2011). This study sought to (a) determine the use and satisfaction levels of victims of sexual assault with victim advocacy services and supports, and (b) compare these findings for first-time victims of sexual assault to the findings for victims of multiple sexual assaults.

Background

The work of victim advocates is often not appreciated in a professional sense by the general population because many advocates do not have specialized credentials to signify their technical and skillful practice (Kolb, 2011). Nowadays, there are some credentialing programs available to victim advocates, such as those offered through the National Organization for Victim Assistance (NOVA, 2014) and various state resources such as Massachusetts Office for Victim Assistance (MOVA, 2014) and North Carolina Victim Assistance Network (NC-VAN, 2014). Even though the professional field is

expanding, the question remains: Are victims satisfied with victim advocacy services and supports?

Due to an increasing global rate of sexual assaults, there is a definite need for research on the appropriate levels of service for supporting victims of sexual assault (Kagumire, 2010). Patterson, Greeson, and Campbell (2009) reported that victims of sexual assault often do not seek services because they believe service providers will be unable to help and may cause increased psychological harm. However, Swim et al. (2011) conveyed the problem with exploring this crime is that the statistics are inaccurate due to lack of reporting and disclosure by victims because of fear of punishment. This is called secondary victimization. These findings are concerning and discouraging, which led to the need to identify victims' use of and satisfaction with victim advocacy services and supports. For the purposes of this study, victim advocacy services and supports were further divided into three types of services: medical, legal (i.e., police and prosecutor), and sexual assault crisis center based services (Weist et al., 2007).

Problem Statement

Victimology, a subfield of forensic psychology, is a growing concept. Much of the research on victims surrounds the context of domestic violence and help-seeking behaviors (Kaukinen, Meyer, & Akers, 2013). In searching the literature, there is a lack of focus on sexual assault and the supports available to victims of sexual assault. Victim advocacy services and supports should empower victims to gain back power and control, to expand their independence, and not cause secondary victimization. They should also educate victims on the courses of action and available resources (Rodino, 1985; Wasco &

Campbell, 2002). The resources offered to victims of sexual assault include medical, legal (i.e., police and prosecutor), and sexual assault crisis center based services (Rodino, 1985; Weist et al., 2007).

A review of the current literature offered much discussion of victims of domestic or intimate partner violence but lacked substantial discussion on victims of sexual assault. Further review offered a perspective of criminal justice professionals, victim advocates, sexual assault nurse examiners (SANEs), and how they all collaborate with each other (Rich & Seffrin, 2014; Nichols, 2013; Payne, 2007; Campbell et al., 2012). When reviewing research that included the victim's perspective, whether of domestic violence or sexual assault, the literature revealed a potential for disempowerment and secondary victimization when victims accessed resources and services (McDermott & Garofalo, 2004; Macy, Giattina, Parish, & Crosby, 2010; Long & Ullman, 2013; Paul, Gray, Elhai, & Davis, 2009; Backes, 2013). However, some sexual assault research noted positive victim experiences when interacting with SANEs, but only if the SANEs show care and compassion while concisely explaining choices to the victims (Fehler-Cabral, Campbell, & Patterson, 2011; Kaukinen & DeMaris, 2009). Therefore, this clearly revealed a knowledge gap in terms of sexual assault victimization and victims' perspectives on their use of and satisfaction with victim advocacy services and supports.

This study investigated the use of and satisfaction with victim advocacy services and supports among victims of sexual assault, to determine whether satisfaction was dependent upon victims' prior sexual assault history. There was an additional knowledge gap identified when it came to exploring first-time victimization versus multiple

victimizations. The literature search resulted in a few articles regarding youth and single versus multiple victimization, however only two articles surfaced in reference to adult victims of sexual assault and the focus was on a) risk of re-victimization (Casey & Nurius, 2005) and b) impact of re-victimization (Walsh, DiLillo, & Scalora, 2011) with regards to use and experiences with victim services.

Kaukinen and DeMaris (2009) reported that victim advocacy services and supports have the ability to increase coping capabilities among victims, but they can also result in a powerlessness state of mind. This study's examination of victims' use and satisfaction with victim advocacy services and supports could open the door for additional research on how victim services can provide care in a positive, supportive manner, rather than through negative approaches, which could lead to secondary victimization and/or re-victimization (McDermott & Garofalo, 2004; Casey & Nurius, 2005; Campbell & Raja, 2005).

Purpose of the Study

The purpose of this quantitative study was to investigate and explore sexual assault victims' use of and satisfaction with victim advocacy services and supports and to compare such rates among first-time victims and victims of multiple sexual assaults. Postmus, Severson, Berry, and Yoo (2009) studied victims' use and perception of services received and found that victim advocacy services and supports were not the most helpful. It resulted in what the providers thought was most important – emotional, legal, and psychological support, whereas the victims sought more tangible supports – financial, food, and housing assistance instead. Additionally, Robinson and Stroshine

(2005) studied domestic violence victims' satisfaction with police officers and found that satisfaction levels were determined by victims' expectations of the interactions. These findings align with the need and importance of studying the victims' perspective to identify their level of satisfaction.

The literature indicated a lack of empirical investigation on sexual assault victims' use of and satisfaction with victim advocacy services and supports including the victims' perspective (Macy et al., 2010; Campbell & Wasco, 2005), in addition to noting the potential for disempowerment by victim advocacy services and supports, which is not the intent of such services (McDermott & Garofalo, 2004; Russell & Light, 2006; Patterson et al., 2009). Moreover, there is a lack of comparative analysis in studying the use of and satisfaction with victim advocacy services and supports among first-time victims of sexual assault and victims of multiple sexual assaults.

The current literature also alluded to victims of sexual assault experiencing stigmatization and secondary victimization after use of victim advocacy services and supports. This lends to the expectation that victims of multiple sexual assaults would be less likely to use services again. However, this study hypothesized that victims of multiple sexual assaults are satisfied with victim advocacy services and supports thus using them again. That is why the phenomenon of first-time victims versus victims of multiple sexual assaults is further explored to identify potential perspective differences in service provision.

The independent variables were the number of previous sexual assaults (none vs. some). The four dependent variables in this study were as follows: the use of legal,

medical, and sexual assault crisis center victim advocacy services and supports, as well as victims' satisfaction with these services. The control variables included participants' age, race, and recruitment source.

Research Questions and Hypotheses

This study was guided by five research questions:

RQ1 – Are women with histories of multiple sexual assaults significantly more likely than first-time victims to use victim advocacy services and supports?

$H_0$1 – There are no differences in use of victim advocacy services and supports between women who have been sexually assaulted previously and first-time victims.

H_a1 – Women who have been sexually assaulted previously are significantly more likely than first-time victims to use victim advocacy services and supports.

RQ2 – Are women with histories of multiple sexual assaults significantly more likely than first-time sexual assault victims to use different types of sexual assault crisis center-based victim advocacy services and supports (e.g., individual counseling, group counseling, hotline, legal services, advocacy services, referrals)?

$H_0$2 – There are no differences in use of different types of sexual assault crisis center-based victim advocacy services and supports among women who have been sexually assaulted previously compared to first-time victims.

H_a2 – Women who have been sexually assaulted previously are significantly more likely than first-time victims to use the different types of sexual assault crisis center-based victim advocacy services and supports.

RQ3 – Are rates of satisfaction with victim advocacy services and supports significantly higher among women with histories of multiple sexual assaults than first-time sexual assault victims?

$H_0$3 – There are no differences in satisfaction levels with victim advocacy services and supports among women who have been sexually assaulted previously compared to first-time victims.

H_a3 – Women who have been sexually assaulted previously are significantly more satisfied with victim advocacy services and supports than first-time victims.

RQ4 – Among victims of multiple sexual assaults, are those who have used services before more likely than those who did not to use them in the present assault?

$H_0$4 – There are no differences in use of victim advocacy services and supports among victims of multiple sexual assaults.

H_a4 – Victims of multiple sexual assaults who have used services before are significantly more likely to use victim advocacy services and supports in the present assault.

RQ5 – Among victims of multiple sexual assaults, are those who have used services before more satisfied with services in the present assault?

$H_0$5 – There are no differences in satisfaction with victim advocacy services and supports among victims of multiple sexual assaults.

H_a5 – Victims of multiple sexual assaults who have used services before are significantly more satisfied with their use of victim advocacy services and supports in the present assault.

Theoretical Foundation

Lord and Hutchison (1993) discussed empowerment in terms of increasing awareness and exploring power and powerlessness, that is, lacking the means to gain greater control and resources in their lives. Empowerment theories (Lord & Hutchinson, 1993) recognize that power versus powerlessness is a result of society's failure to meet the needs of each member of society, viewed as not just blaming the victim. Thus, empowerment theories explicitly focus on the structural barriers that prevent people from accessing resources necessary for health and well-being, including an unequal distribution of power. Campbell's (2006) results indicated that victim advocate support and assistance increased victims' access to resources and services, and thus promotes empowerment. Further exploration of empowerment theory and how it supports the provision of victim advocacy services and supports to victims of sexual assault is discussed in Chapter 2.

Nature of the Study

This quantitative study used a quasi-experimental design. While it often looks like an experimental design, it does not offer random assignment. While viewed as inferior based on internal validity, quasi-experiments are implemented more frequently than randomized experiments (Trochim, 2006). An advantage of quasi-experimental designs is the ability to carry out a study within a natural setting which increases the probability of external validity. The disadvantages to using a quasi-experimental design are weakness in internal validity and inability to infer causation due to lack of random assignment (Frankfort-Nachmias & Nachmias, 2008).

This study analyzed secondary data from Weist et al. (2007). They studied participants' experiences after receiving victim advocacy services and supports. The data were collected using quantitative and qualitative methods, including face-to-face interviews. I completed an application to ICPSR to gain access to the identified data. Since the data were considered secondary or archival data, the population and sample are not considered a random sample.

The inclusion criteria were as follows: female, age 18 and over, either African American or European American (referred to as *Caucasian* in the Weist et al. (2007) study), a resident of the state of Maryland, and a victim of sexual assault. Interviews were conducted with 224 victims. Participants were recruited within the state of Maryland from: rape crisis centers; various community service providers; forensic nurse examiner programs; community outreach with rape crisis center educators; and three of the detention centers that housed female inmates.

This study investigated numerous related dependent variables; therefore, multivariate analysis was used. Identifying multiple relationships allows surveying of potential effects simultaneously along with the distinctive influences of each effect. An example of this is using multivariate analysis of co-variance (MANCOVA). It offers the ability to understand the effect of one or more independent variables on multiple dependent variables while controlling for the effects of other variables. So instead of doing multiple, individual ANCOVA tests with the different dependent variables, the variables can be combined into one test, which also helps control for Type I errors (Burkholder, 2012; Field, 2009).

This study conducted data analysis using a MANCOVA and testing via an *F*-test (Field, 2009). An *F*-test is used to test if variances from two populations are equal (i.e., first-time victims versus multiple victimizations). The one-tailed version is used to determine if the variance among first-time victims is greater or less than those who have experienced multiple victimizations (Field, 2009; StatSoft, Inc., 2014).

Definitions

Inter-University Consortium for Political and Social Research (ICPSR) – Requires membership to access secondary databases, publications, and training in quantitative literacy.

Re-victimization – A concept that explains that those who have been victimized once are more likely or at greater risk of experiencing future victimization (Anderson, 2004; Finkelhor, Ormrod, & Turner, 2007).

Victim - A victim is someone who has been adversely affected by force, often subjected to mistreatment, oppression, or a hardship.

Secondary Victimization – A concept that includes negative interactions with service providers such as victim blaming, questioning one's credibility, and other harsh treatment that may cause further traumatization (O'Sullivan & Fry, 2007).

Sexual Assault - Sexual assault involves non-consensual sexual contact that often involves the use of force by the offender. Often times the individual is incapacitated or incapable of giving consent or the offender may be in the position of authority.

Victim Advocate - A victim advocate works with victims to provide advocacy, support, and resources as well as act as liaison with collaterals such as the criminal justice

system, the court system, and military commands. Victim advocates are supportive and understanding, without showing bias or judgment, and provide empathy, no matter the decisions made by the victim.

Assumptions

The original data were collected by Weist et al. (2007) using face-to-face interviews with females who had been sexually assaulted. It was assumed that the willingness of the participants to volunteer in the Weist et al. (2007) study would not bias this study. It was also assumed that the participants in the Weist et al. (2007) study completed the questionnaires truthfully and to the best of their ability. It was further assumed that the original data were coded and entered correctly.

Based on two Institutional Review Board (IRB) approvals received by Weist et al. (2007), it was assumed that the participants were treated ethically and with fairness and respect. The assumptions of a MANCOVA include homogeneity of variances and covariances, which entails that the variances in different groups be identical and that the intercorrelations are homogeneous across cells (Field, 2009). Lastly, it was assumed that the 224 participants in the identified dataset would produce effective statistical results. This assumption was based on the G*Power analysis, further discussed in Chapter 3, which recommended a sample size of 54 participants (see Table 1).

Scope and Delimitations

This study sought to determine sexual assault victims' use of and satisfaction with victim advocacy services and support. Victim advocacy is victim centered, that is, it focuses on the victim rather than on what the advocate thinks or believes. Victim

advocates are supposed to be supportive and understanding, without showing bias or judgment; they are to provide empathy, no matter the choices or decisions made by the victims. Therefore, victim advocates need to know if the way they are providing service is efficient and warranted.

This study was delimited to the use of secondary data versus collecting primary data for analysis. Further delimitations include the participant criteria: female victims of sexual assault, age 18 and over, either African American or European American, who were residents of Maryland. Due to delimitations of secondary data, this study may only be generalizable to the specific participant criteria noted.

Limitations

In this study, secondary data were used for analysis, based on a study by Weist et al. (2007). Further analysis of this limitation entails the concept that the original data were intended for a particular purpose and there were no assurances that the identified data would be appropriate for this study or that it would answer the research questions and hypotheses (Babbie, 2013; Frankfort-Nachmias & Nachmias, 2008).). Additional limitations to using secondary data can include access to datasets and insufficient information about how the data were collected (Frankfort-Nachmias & Nachmias, 2008). The dataset was readily accessible, via application, on the ICPSR website (see Chapter 3) and Weist et al. (2007) offered great detail how their data were collected (see Chapter 3).

The other limitation involved the probability that the sample in the Weist et al. (2007) study was not random due to self-selection and referral bias. Participants were recruited within the state of Maryland from: rape crisis centers; forensic nurse examiner

programs; three detention centers that housed female inmates; various community service providers; and through community outreach conducted by rape crisis center educators. Due to the participant inclusion criteria of the Weist et al. (2007) study, the current study may not be generalizable to other populations. However, the intent is to reflect upon the results in terms of improving the provision of victim advocacy services and supports, which in turn creates positive social change.

Significance

This study is significant because of the way it advances practice. Individuals may be hesitant to discuss their most intimate moments, but add experiencing sexual assault victimization and that level of hesitation escalates. Victims may often avoid any situation that could cause them to re-experience the event, which could lead to re-victimization and/or secondary victimization. Therefore, it is critical to understand how victims use and respond to victim advocacy services and supports, and whether these vary by previous sexual assault experiences. With the rise of media coverage on sexual assault within the workplace, colleges, and the military, this study is instrumental at identifying a baseline of provisionary needs to support the fight against victimization.

This study compared the experiences of first-time victims of sexual assault with victims of multiple sexual assaults to see whether those who have been victimized more than once and used services would be likely to use these services again. This included medical and legal services, as well as services provided by the sexual assault crisis center, whose purpose is to support and empower the individual. Furthermore, victim advocates are trained to keep in mind what is in the best interest of the victim while reducing any

possible liabilities. It is expected that this study would (a) provide suggestions for how to reach first-time and multiple sexual assault victims in ways that increase their use of, and satisfaction with, victim advocacy services and (b) create an avenue for further research on victims' perspectives of the effectiveness of the service. Campbell and Wasco (2005) noted that efforts to refine and enhance response and intervention programs, services, and supports provided to victims of sexual assault may ultimately result in improvements to the larger society's treatment of sexual assault victims.

Summary

This study was conducted to understand how victims of sexual assault rate their use of and satisfaction with victim advocacy services and supports. The reason this study is important is that victim advocacy services and supports are meant to empower the victim throughout the medical and legal processes as well as to help the victim develop appropriate coping skills to gain back power and control. There is a definite lack of research when it comes to victims of sexual assault and their use of and satisfaction with victim advocacy services and supports.

Chapter 2 discusses the historical context of advocacy and the use of advocacy services for intimate partner violence and sexual assault. Additionally, Chapter 2 reviews empowerment theory and how it supports such a phenomenon. Chapter 3 discusses the quantitative nature of this study and the statistical analyses conducted. Chapter 4 reports the results of the MANCOVA, ANCOVA, and chi-square tests. Chapter 5 further discusses the findings of this study as well as the limitations, implications, and recommendations for a way ahead.

Chapter 2: Literature Review

Introduction

The purpose of this quantitative study was to (a) investigate sexual assault victims' use of, and satisfaction with, victim advocacy services and supports and (b) to compare these rates among first-time victims and victims of multiple sexual assaults. This chapter discusses sexual assault and reviews the scope of victim advocacy services and supports; it also discusses empowerment theory with respect to the use of, and satisfaction with, victim advocacy services and supports. Research on initial victimization and re-victimization is covered in this chapter as well as the potential for secondary victimization by service providers. For a balanced look at the literature, this chapter includes research that demonstrates both positive and negative outcomes associated with victim advocacy services and supports. It culminates with an explanation of how past research lacks in finding and influences this study.

Literature Search Strategy

The following databases were used to search the literature: Inter-University Consortium for Political and Social Research Datasets (ICPSR), ProQuest Dissertations and Theses, Google Scholar, LexisNexis Academic, PsycARTICLES, PsycINFO, PsycTESTS, SOCIndex, and SAGE Premier. In addition to the Walden Library, the keywords are searched to identify if any other educational facilities have information as well as government and non-profit agencies.

The following keywords were used in the searches: *victim, advocacy, sexual assault, coping, empowerment, experience, use, satisfaction, victimization, secondary*

victimization, re-victimization, first-time, multiple, adult, and *quantitative*. The literature search included peer-reviewed articles and journals authored within the last ten years, focusing on much of the research within the last five years. In searching the current literature on victim advocacy and victims of sexual assault, it was helpful to use a current article's reference list to search for similar, related articles. In addition, it was helpful to find other articles by the same authors, since many research and write about the same topics of interest multiple times, building upon the literature, for example, Campbell and Wasco (2005), Wasco and Campbell (2002).

Theoretical Foundation

The purpose of this study were to investigate sexual assault victims' use of and satisfaction with victim advocacy services and supports and further compare such among first-time victims and victims of multiple sexual assaults. Based on the provision that the intent of victim advocacy services and supports is to empower the victim to cope and take back power and control, empowerment theory was used in this study. Empowerment forms a summit of self-realization and identity. Those who are empowered often appear balanced and confident, while being self-aware and prepared (Kasturirangan, 2008).

Gupta and Kurian (2006) alleged that empowerment is a voluntary process that an individual seeks. For victims, this process entails an inside – out approach, focusing on themselves and attempting to cope and develop the necessary strength to attain power and control. Lord and Hutchison (1993) discussed empowerment in terms of power versus powerlessness, along with increasing awareness of one's self and their surroundings. Powerlessness is viewed as an objective phenomenon where individuals lack the ability

to aspire for superior control and better resources in their lives. Kasturirangan (2008) describes empowerment as an increase in control over relevant resources, in addition to understanding and participating in activities that create positive social change.

Campbell's (2006) depiction of empowerment involves a victim's ability to acquire access to resources and services with the support and assistance of a victim advocate, thus lending to the implication that victim advocacy services and supports promotes empowerment among those served. With this implication, the identification of use and satisfaction would be paramount, yet the current literature lacks evaluation of such. A further question emerges; does the implication of empowerment vary among first-time victims versus victims of multiple sexual assaults?

Empowerment theories recognize that power versus powerlessness is a result of society's failure to meet the needs of its members. Therefore, empowerment theories explicitly focus on the structural barriers that prevent people from accessing resources necessary for health and well-being, including an unequal distribution of power. Kasturirangan (2008) furthers that as victims engage in the process of empowerment, they often acquire mastery and control over their concerns thus creating an avenue to access necessary resources and services.

Kasturirangan's (2008) implication suggests that if first-time victims access services, they have the opportunity to acquire skills to become empowered, which in turn could reduce the risk of re-victimization or, if victimized again, may offer them more incentive to seek services again to increase the likelihood of further empowerment. Empowerment theory further alludes to personifying vast levels of self-efficacy among

victims of sexual assault who have participated in advocacy services and supports. Therefore, this study hypothesized that victims of multiple sexual assaults were more likely than first-time victims of sexual assault to use and be satisfied with victim advocacy services and supports through application of empowerment theory. It was further hypothesized, when applying empowerment theory, victims of sexual assault were more likely to use and be satisfied with sexual assault crisis center-based victim services as opposed to accessing legal-based or medical-based victim services due to rates of secondary victimization, as noted in the literature research and detailed below.

Literature Review

Sexual Assault

Violence against women is a serious violation of one's human rights. Violence against women can vary among countries but when it comes to sexual assault there are many similarities, especially the unequal levels of power and control (Ellsberg, 2006). Sexual assault involves non-consensual sexual contact that often comprises the use of force by the offender. Often times the individual is incapacitated or incapable of giving consent or the offender may be in the position of authority. The effect of sexual assault is often immediate as well as encompasses long-term consequences (Bloom, 2003). This study used secondary data from the Weist et al. (2007) study which identified sexual assault as forced vaginal, oral, and/or anal sex.

Rates of sexual assault vary amongst the literature however it averages from 15% to 40% among adults and children, females and males (Ellsberg, 2006; O'Sullivan & Fry, 2007). Planty et al. (2013) reported that males experienced lower rates of sexual assault

than females from 1995 to 2010. Additionally, O'Sullivan and Fry (2007) noted calculations that approximately 20% of those sexual assaulted will be re-victimized, which can include child sexual abuse victims who are re-victimized as adults or adult victims who experience sexual assault re-victimization. However, it is further suggested that 80% of women with disabilities will be re-victimized (O'Sullivan & Fry, 2007). It is identified that women age 34 or younger experience a higher rate of sexual violence at 3.7-4.1 per 1,000. Lastly, victims identified as White or Black experienced sexual assault at rates of 2.2-2.8 per 1,000, respectively (Planty et al., 2013). A highlight includes a 58% decline in sexual assault victimizations between 1995 and 2010 (Planty et al., 2013).

First-time victimization versus multiple victimizations. Victimization affects many individuals in similar ways resulting in some level of trauma; however when someone has experienced multiple victimizations, the level of trauma and needs of the individual may be greater than those of first-time victims. Davies (2007) developed a guide to address these differences and the challenges that surface. The purpose of the guide was to advise victim advocacy service and support professionals to explore various approaches and resources in order to enhance service provision. Davies (2007) identified three key issues in working with victims of multiple sexual assaults, which included the effect of policy on service provision; the development of complex trauma; and financial disadvantages.

When it comes to basic service provision, it is generally the same for everyone and seen as being beneficial. However, additional elements should be considered, including that services are to be victim-centered; that victim advocacy services and

supports should be collaborative and have community-focus; and that the approach to victim advocacy services and supports is universal because someone might not disclose multiple victimizations during the first meeting (Davies, 2007). Lastly, another consideration when working with victims of multiple sexual assaults is that service provision may take longer; be frequent or infrequent; and/or ever-changing based on need. Thus, it is critical to have detailed and concrete efficient training methodologies in place with regards to say the hotline phones, support groups, finding resources, collaborating with legal-based and medical-based services, and identifying basic human needs such as housing and financial constraints, to name a few (Davies, 2007). If we all do our part to positively impact and support the process, we can affect positive social change.

Re-victimization. Re-victimization is a term that offers explanation for increased risk of future victimization among those who have been previously victimized (Anderson, 2004; Finkelhor, Ormrod, & Turner, 2007). As the Bureau of Justice statistics confirm (Planty et al., 2013), there is an increased likelihood of sexual assault victimization upon those who have been sexually assaulted previously, either as a child or as an adult. Bloom (2003) reports the risk of re-victimization among child victims is almost double. Both Bloom (2003) and Planty et al. (2013) indicate high risk of re-victimization among college age women, whether the first occurrence was in adolescence or during college. Part of the education and resources provided by victim advocacy services and support is intended to help victims reduce their risk of re-victimization.

The Ahrens et al. (2007) study focuses on identifying satisfaction with services and supports while reducing re-victimization. The authors studied victim disclosure to informal supports versus formal supports including the decision to disclose such as help-seeking behavior or disclosure initiated by others. Disclosure generally occurred if the benefits outweighed the risks and the perceived support was seen as positive with no adverse reactions, while other forms of disclosure were initiated by services and supports on scene (Ahrens et al., 2007). Additionally, this study provides an avenue to explore differences in use of and satisfaction with victim advocacy services and supports among first-time victims and victims of multiple sexual assaults.

The study conducted by Walsh et al. (2011) focuses on emotional regulation and how the individual's ability to build and sustain emotional regulation can be impacted by sexual re-victimization. Their findings conclude that victims of multiple sexual assaults have significantly more difficulty with emotional regulation than first-time victims of sexual assault. The Casey and Nurius (2005) study sought to identify what increases the risk of re-victimization thus examining experiential and outcome differences among first-time victims and victims of multiple sexual assaults. Therefore, it is apparent that victimization can differ among first-time victims and those with multiple victimizations yet we still don't know if they are using the services and supports available and are satisfied (Paul, Gray, Elhai, & Davis, 2009).

Secondary victimization. What happens when the intended supportive services and supports backfires? It's called secondary victimization and it involves negative interactions with service providers to include victim blaming, questioning one's

credibility, and other harsh treatment that results in further traumatization (O'Sullivan & Fry, 2007). Campbell et al. (2001) reported that victims suffering from secondary victimization often do not receive the needed services, and their recurring trauma is exacerbated by the additional distress. The authors have also coined the experience as the "second rape" (p. 1239).

Additional research supports the concept of secondary victimization including McDermott and Garofalo (2004) with their twist on disempowerment; and Campbell and Raja (2005), Campbell (2006), and O'Sullivan and Fry (2007) furthering the exploration on secondary victimization. However, Campbell (2005) took a different approach and studied both the victim's experiences and the service provider's experiences. The results were underestimated by the service providers who thought their impact would be positive when in fact the victims reported that statements and actions by service providers were sometimes extremely distressing. This result describes secondary victimization. Lastly, Campbell et al. (1999) provides a historical perspective in which their results concur that victims experiencing victim-blaming have significant levels of increased distress as a result from secondary victimization.

Paul et al. (2009) further reported that sexual assault victims do not often report the crime to others, let alone seek services or treatment, for fear of secondary victimization. However, they suggest that coping and empowerment may be achieved through disclosure to victim advocacy services and supports. Yet Campbell and Raja (2005) studied sexual assault victims and their experience with secondary victimization and found that after receipt of legal-based and medical-based services many victims felt

re-victimized. They experienced victim-blaming, which made them feel guilty and anxious and exacerbated their trauma.

Additionally, this can lead to distrust and possible reluctance to seek further help but still does not identify use of and satisfaction with those services (Campbell & Raja, 2005). Again, as noted in previous reviews of the literature, these studies do not indicate variances based on first-time versus multiple victimizations. Consequently, the problem explored in this study is determining if in fact victims of sexual assault use and are satisfied with victim advocacy services and supports, and whether this satisfaction is dependent upon victims' prior sexual assault history.

In research conducted by McDermott and Garofalo (2004), occasions of victim disempowerment by victim advocates, even given the anticipated benefits of victim advocacy services and supports, are identified. The authors described the nature of disempowerment as meddling in the victim's life, telling the victim how to tell their story, a lack of confidence in the victim's ability to recognize best interests, and not allowing the victim to decide what collateral services to participate in (McDermott & Garofalo, 2004). Additional research by Campbell (2006) and O'Sullivan and Fry (2007) identified this experience as secondary victimization, which can lead to a resistance to seek assistance. Furthermore, victim advocacy services and supports should be victim centered and about what the victim chooses, not what the professional opines or thinks the victim should do or what should happen. So based on these findings, there is a knowledge gap in the literature because it is unknown if use of and satisfaction with

victim advocacy services and supports varies among first-time victims versus victims of multiple sexual assaults.

Patterson et al. (2009) sought to determine why victims of sexual assault do not seek formal assistance, such as medical, legal, mental health, and victim advocacy services and supports. Victims who did not seek services post-assault were interviewed about their reasoning for not reaching out for support. Findings indicated that victims believed the formal service providers would not be helpful and would actually cause more psychological harm, i.e., secondary victimization (Patterson et al., 2009). Importantly though, this study did not assess if these perceptions differed between first-time victims versus victims of multiple sexual assaults, resulting in an important knowledge gap.

Campbell (2008) studied victims' experience in seeking victim advocacy services and supports. This research indicates that while some experiences with victim advocacy services and supports are positive and helpful, there is a possibility of victims experiencing secondary victimization. Additionally, Campbell (2008) reports that some victims indicated that would not even seek help for fear of being treated poorly and that they wouldn't even receive help if sought. The secondary victimization is attributed to lack of prosecution, incomplete medical care, and lack of assistance in accessing necessary resources to become empowered (Campbell, 2008). These results provide an avenue for this study to determine if use of and satisfaction with victim advocacy services and supports varies among first-time victims and victims of multiple sexual assaults since this variable was not employed in the Campbell study.

Wasco and Campbell (2002) sought to understand the emotional reactions of victim advocates and how they may or may not play a role in their professional work with victims of sexual assault, i.e., secondary victimization. Victim advocates expressed more feelings of anger than fear, specifically directed towards institutional, systemic, environmental, and societal influences and towards societal responses to sexual assault (Wasco & Campbell, 2002). These findings lend to the need for positive social change in terms of sexual assault literature which this study seeks to advance.

Russell and Light (2006) sought to identify a link between criminal justice interventions and victim empowerment. Police personnel and victims of crime participated in focus groups and interviews. The interviews of police personnel identified opinions regarding the sufficiency of victim empowerment and any potential adjustments made to intensify victim empowerment within the criminal justice system. The victims of crime indicated during the interviews if the criminal justice system is helpful or not and provided recommendations on areas that require improvement within the criminal justice system (Russell & Light, 2006).

Police personnel who disclosed having provided assistance and intervention to victims of crime saw those victims worthy of such service, had received special training, and knew their role expectations. When the victim received service, these criminal justice actions often promoted victim empowerment (Russell & Light, 2006). This research aligns with the hypothesis that upon receiving services a victim is encouraged to become empowered which correlates to a higher rate of usage and satisfaction with services. In

addition, this study compares those rates among first-time victims and victims of multiple sexual assaults.

Historical context of victim advocacy services and supports. Victim services are meant to empower victims, allowing them to attain power and control, and foster independence (Rodino, 1985). Sexual assault crisis center-based services are a well-known intervention; however, they have not been widely evaluated because there is a great assumption they are good and helpful (O'Sullivan & Fry, 2007). Furthermore, there is much research on victim advocacy and the interconnection with domestic violence victims, however there is limited research about victim advocacy services for victims of sexual assault.

Rodino's (1985) discussion highlights and elaborates on the establishment of the Victims of Crime Act of 1984 by President Ronald Reagan, after he was victimized during a shooting and had difficulty with some of the legal aspects of his case (Hatten & Moore, 2010). It was at this time that his task force established the Victims of Crime Act of 1984, intended to provide support and assistance to victims (Rodino, 1985; Haynes, 2011; Hatten & Moore, 2010; Pyles et al., 2012). As such, the President's Task Force examined activities that the federal government could employ to assist victims of various crimes, i.e., robbery, homicide, sexual assault, domestic violence, and trafficking.

Rodino (1985) and Pyles et al. (2012) depict a vast array of victim services and supports, such as a 24-hour response hotline, including on scene crisis response and emergency relief; the ability to make referrals, provide consultation, and education, with translation assistance; the provision of transportation; and the conduct of mediation on

the victim's behalf. The intention and implementation of this act set a precedent for the necessity of victim advocacy services and supports and established their importance for victims. Additionally, in 1994 the Violence Against Women Act (VAWA) was enacted to combine the provision of victim services with increased offender accountability (WhiteHouse.gov, 2014).

VAWA has improved legal-based and medical-based victim services by ensuring that police respond and by increasing rates of prosecution, conviction, and sentencing, as well as mandating that victims do not bear the cost of forensic exams or protective orders. Additionally, victims and their families have full access to a myriad of services as well as being taken more seriously due to reform in state laws. Ultimately, since the passing of VAWA there has been an effect of positive social change (WhiteHouse.gov, 2014). However, Danis' (2003) research points out that many of the victim assistance programs across states were accessed and used by domestic violence victims, but there is little information regarding usage by sexual assault victims or victims of other various crimes. Therefore, this indicates a knowledge gap in terms of use of and satisfaction with victim advocacy services and supports by victims of sexual assault.

In the 1980's, landmark studies reported the prevalence of sexual assault and its impact on victims, yet there was a lack of reporting on victim use of and satisfaction with services as well as if any variance was due to first-time victimization or multiple victimizations. Campbell and Wasco (2005) extended this line of research beyond the victim's health and well-being to include significant others and the professionals who provide supportive services. They were interested in not only the effects on the victim but

also the effects and impact on victim advocates, legal, and medical professionals. Campbell and Wasco (2005) identified the effect sexual assault has on the victim to include secondary victimization and re-victimization. Moreover, they also described vicarious trauma that may occur to victim advocates, researchers, and other professionals. Despite these advances, the authors concurred that there is a lack of research regarding use, satisfaction, and level of victimization even though crisis centers emerged as early as the 1970's (Campbell & Wasco, 2005).

Macy et al. (2010) intended to supplement the identified dearth in sexual assault research with an exploratory study that included focus groups with sexual assault crisis center-based service agencies. Their research concurred that there is limited focus on examining sexual assault and that tension exists among various victim service agencies. They also identified a lack of hospitable and comprehensive services for victims. Macy et al. (2010) further reported that addressing and taking action against sexual violence is not always universal and such challenges may generate the opportunity for solution-focused alternatives. This implication supports this study in identifying the use of and satisfaction with victim advocacy services and supports among victims of sexual assault. It also provides for the examination of potential differences between first-time victims of sexual assault and victims of multiple sexual assault, which could lead to positive social change in the victim advocacy services and supports profession.

Victim advocacy services and supports. The intent of victim advocacy services and supports is to not only support and advocate for the victim, but also to educate them on resources and actions of recourse (Wasco & Campbell, 2002). The available resources

offered to victims of sexual assault can include crisis center-based services, legal-based victim services (i.e., law enforcement and the court system), and medical-based victim services (Rodino, 1985). Over a five year span it is estimated that 1 in 4 victims of sexual assault received assistance (Planty et al., 2013). However a dearth in the literature exists when it comes to studying use of and satisfaction with victim advocacy services and supports.

Sexual assault crisis centers. In crisis center-based services, victim advocates are supposed to be supportive, understanding, and empathetic, without showing bias or judgment, no matter the choices or decisions made by the victim. This can include providing support in the court room as a victim seeks a protective order or prepares to testify in a criminal hearing. It can entail a presence during an interview with law enforcement or during the forensic examination at the hospital. Additional positive attributes can involve identifying financial, educational, and emotional resources. As O'Sullivan and Fry (2007) indicate, there is a lack of evaluation of sexual assault crisis center-based services because the underlying assumption is that they are virtuous and helpful. With well over 1,200 crisis center-based programs across the United States (O'Sullivan & Fry, 2007; Campbell, 2006) investigating use and satisfaction is critical.

***Legal services*.** As for legal-based services, this can include law enforcement (police) and the court system (prosecutor). In the realm of sexual violence, law enforcement is tasked with responding to reports of sexual assault, interviewing the victim to obtain a statement, referring the victim to medical and advocacy services, and investigating. The investigation gets turned over to the courts to determine probable

cause, referrals for prosecution, and to work with victims in preparation for trial (Bartol & Bartol, 2008).

When it comes to reporting sexual assault to the police there has been a decline from 56% in 2003 to 35% in 2010, a similar level seen in the 1990s. Reasons for not reporting can include a feeling that the police would not do anything and fear of reprisal (Planty et al., 2013). Advocates can heed conflict with law enforcement when it comes to advocating for victims and attempts to prevent secondary victimization. Campbell (2006) reports that victims who had the assistance of an advocate were more likely to make a police report and not experience secondary victimization, yet there is no indication of their satisfaction with such services or if first-time versus multiple victimizations had an impact.

***Medical services*.** When it comes to medical-based victim services, treatment and care afforded to sexual assault victims has not always been commonplace. Sexual assault victims arrive in the emergency room and are not seen as urgent cases given that they often do not have overt physical injuries (Fehler-Cabral et al., 2011). However, Planty et al. (2013) reports that approximately 35% of victims received some form of treatment from medical services, and 80 % of those instances occurred in a hospital or emergency room.

Nowadays most major hospitals have SANE nurses on staff to attend to the immediate needs of sexual assault victims. These nurses are specially trained to treat victims in a sensitive and respectful manner. Campbell (2006) furthers that victims receiving medical services who are accompanied by an advocate are likely to receive

more medical care and less secondary victimization. Again, there is no indication of satisfaction with the services or any dependence on first-time versus multiple victimizations.

Collaboration among victim advocacy services and supports. Further review of the current literature focuses on victimization in terms of how victim advocacy, criminal justice, court, and medical systems interact and collaborate and from their point of view. Research from the victim's perspective is inadequate and is concentrated with regard to domestic violence and intimate partner victimization with minute discussion of sexual assault victimization. In addition to the positive intentions of victim advocacy noted above, the available research reveals that victim advocacy can disempower victims, by telling them how to tell their story, telling them how to feel and what to do, and by not letting them decide whether or not to participate in the prosecutorial process (McDermott & Garofalo, 2004).

Another highlight is that SANE nurses are appreciated when they show care and sensitivity rather than act cold and distant (Fehler-Cabral et al., 2011). When it comes to reporting the crime however, Kaukinen and DeMaris (2009) suggest that sexual assault victims prefer to report victimization to a friend or family member rather than going to the police to avoid trauma and secondary victimization. Therefore, the current literature alludes to a deficiency in the scholarship of sexual assault, specifically regarding the use of and satisfaction with victim advocacy services by victims of sexual assault (Macy et al., 2010; Long & Ullman, 2013).

In addition to limited discussion in the available literature regarding use and satisfaction, there is disparate research about first-time victimization versus multiple victimizations. There were a few articles about youth and single versus multiple victimization, however only two articles referenced single and multiple victimization among adult sexual assault victims. This study focuses on adult victims of sexual assault as the participant inclusion criteria includes being over the age of 18 per the secondary data collected by Weist et al. (2007).

Summary and Conclusions

Forensic psychology involves components of psychology and the legal system. Victimology and victim services are only one subspecialty of forensic psychology. Victimology does not discriminate based on gender, age, race, ethnicity, and/or socioeconomic status. It is essential for such professionals to understand components of both psychology and the legal system in order to advocate with the victim's best interests in mind.

Victims often struggle with trusting others and are thus often hesitant to discuss their victimization experiences and the consequences thereof. A victim advocate is supposed to provide support and advocacy to victims, including empathy, understanding, be kind and genuine in one's responses, as well as listen to them and believe them. The role of the victim advocate is to empower victims; to understand and respect the decisions that victims make, whether positive or limited; and show continued support without judgment or bias (Campbell, 2006). It is important to be able to identify multiple solutions along with consequences which lead to opportunities in developing the best

possible solution. The best possible solution should keep in mind what is in the best interest of the victim while reducing any possible liabilities.

Additionally, it is imperative to reduce stereotypical and victim-blaming attitudes of society so as to promote victim reporting and service provision and reduce secondary victimization and re-victimization. These situations impact forensic psychology professionals in helping to see a clearer picture of the areas of need. Professionals must work together, collaboratively, for the efforts of the victim, as we are only as strong and effective as the knowledge and services we provide. Lastly, identifying rates of use and satisfaction with victim advocacy services and supports, not only among first-time victims but also among victims of multiple sexual assaults, and understanding any variance between them, is imperative to carving out positive social change.

Chapter 3 describes the methodology used to study the research questions. This chapter discusses the use of MANCOVA and Chi-Square as a valid means to analyze the use of and satisfaction with victim advocacy services. This chapter also includes a description of the secondary data, i.e., population, recruitment, protocols, and instrumentation, and ethical considerations.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to (a) investigate sexual assault victims' use of, and satisfaction with, victim advocacy services and supports and to (b) compare such rates among first-time victims and victims of multiple sexual assaults. In this chapter, the following topics are covered: research design and rationale; methodology of the study to include – research questions and hypotheses, population (sampling, recruitment, interview protocol and data collection, and instrumentation and operationalization of constructs), and data analysis; as well as threats to validity including ethical procedures.

Research Design and Rationale

This quantitative study used a quasi-experimental design, which looks like an experimental design but does not use random assignment. Although seen as inferior, based on internal validity, quasi-experimental designs are often implemented more frequently than randomized designs (Trochim, 2006). One advantage of the quasi-experimental design is that it can be carried out in a natural setting and thus increase the probability of external validity. The design suffers from two disadvantages: weakness in internal validity and an inability to infer causation due to the lack of random assignment (Frankfort-Nachmias & Nachmias, 2008).

This study analyzed secondary data from the original study by Weist et al. (2007). They studied the participants' experiences after receiving victim advocacy services and

supports. The data were collected using quantitative and qualitative methods, including face-to-face interviews. The current study used only quantitative data in the analysis.

This study includes dependent, independent, and control variables. Independent variables are those that may cause, impact, or predict outcomes, that is, influence the dependent variables (Creswell, 2009). The independent variable for this study was the number of previous sexual assaults (none vs. some). A requirement to participate in the original study by Weist et al. (2007) was that the individual had experienced a sexual assault: forced vaginal, oral, and/or anal sex. The current study sought to determine if the participants' use of and satisfaction with victim advocacy services and supports was associated with having experienced one sexual assault versus multiple sexual assaults.

Dependent variables are those which depend on the independent variables for outcomes and effects, that is, they are influenced or predicted by the independent variables (Creswell, 2009). The dependent variables in this study were the use of legal, medical, and sexual assault crisis center-based victim advocacy services and supports, as well as satisfaction with these services.

Control variables are a special type of independent variable that is measured due to their potential influence on the dependent variables. Statistical procedures are used to control for these variables, which can include demographics (Creswell, 2009). The control variables in this study included age, race, and recruitment sources. The original study by Weist et al. (2007) included participants who were 18 years of age or older, of African-American and European American race, and were recruited from rape-crisis

centers, community education centers, and detention centers. Statistical analyses will be used to control for these variables.

Methodology

Research Questions and Hypotheses

This study was guided by five research questions:

RQ1 – Are women with histories of multiple sexual assaults significantly more likely than first-time victims to use victim advocacy services and supports?

$H_0$1 – There are no differences in use of victim advocacy services and supports between women who have been sexually assaulted previously and first-time victims.

H_a1 – Women who have been sexually assaulted previously are significantly more likely than first-time victims to use victim advocacy services and supports.

RQ2 – Are women with histories of multiple sexual assaults significantly more likely than first-time sexual assault victims to use different types of sexual assault crisis center-based victim advocacy services and supports (e.g., individual counseling, group counseling, hotline, legal services, advocacy services, referrals)?

$H_0$2 – There are no differences in use of different types of sexual assault crisis center-based victim advocacy services and supports among women who have been sexually assaulted previously compared to first-time victims.

H_a2 – Women who have been sexually assaulted previously are significantly more likely than first-time victims to use the different types of sexual assault crisis center-based victim advocacy services and supports.

RQ3 – Are rates of satisfaction with victim advocacy services and supports significantly higher among women with histories of multiple sexual assaults than first-time sexual assault victims?

$H_0$3 – There are no differences in satisfaction levels with victim advocacy services and supports among women who have been sexually assaulted previously compared to first-time victims.

H_a3 – Women who have been sexually assaulted previously are significantly more satisfied with victim advocacy services and supports than first-time victims.

RQ4 – Among victims of multiple sexual assaults, are those who have used services before more likely than those who did not to use them in the present assault?

$H_0$4 – There are no differences in use of victim advocacy services and supports among victims of multiple sexual assaults.

H_a4 – Victims of multiple sexual assaults who have used services before are significantly more likely to use victim advocacy services and supports in the present assault.

RQ5 – Among victims of multiple sexual assaults, are those who have used services before more satisfied with services in the present assault?

$H_0$5 – There are no differences in satisfaction with victim advocacy services and supports among victims of multiple sexual assaults.

H_a5 – Victims of multiple sexual assaults who have used services before are significantly more satisfied with their use of victim advocacy services and supports in the present assault.

Population

This study used secondary data (ICPSR, 2013) to analyze and report research findings. Weist et al. (2007) studied the participating clients' experiences after receiving victim advocacy services and supports. The data were collected using quantitative and qualitative methods that included face-to-face interviews. Interviews were conducted with 224 female participants who had previously experienced sexual assault. The study by Weist et al. (2007) had intended to reach about 500 study participants, however did not due to participant interest, number of interviewers versus logistics of interview sites, and the labor intensiveness of the interviews. This research study used only the quantitative data for analysis and reporting of research findings. I completed an application to ICPSR to gain access to the identified dataset.

Sampling and sampling procedure. Since the data is considered secondary or archival data, the population and sample is not considered a random sample. The participant inclusion criteria includes being: female, age 18 and over, either African American or European American (referred to as *Caucasian* in the Weist et al. (2007) study), a resident of the state of Maryland, and a victim of at least one sexual assault. Interviews were conducted on 224 victims of sexual assault. Two participants were dropped from the data set because one participant identified as mixed race and another did not identify race, resulting in a final sample of $N = 222$ (Weist et al., 2007). Using G*Power (Laureate Education, 2009g), a sample size has been computed, as seen in Table 1, based on a large effect size, a power of 0.80, and an alpha level of 0.05, which

includes 54 participants. Therefore, this dataset is expected to achieve effective statistical results.

Table 1

*Sample Size G*Power Analyses*

F tests – MANOVA: Global effects			
Options:	Pillai V, O'Brien-Shieh Algorithm		
Analysis:	A priori: Compute required sample size		
Input:	Effect size $f^2(V)$	=	0.30
	α err prob	=	0.05
	Power (1−β err prob)	=	0.80
	Number of groups	=	2
	Response variables	=	6
Output:	Noncentrality parameter λ	=	16.2000000
	Critical F	=	2.2989561
	Numerator df	=	6.0000000
	Denominator df	=	47.0000000
	Total sample size	=	54
	Actual power	=	0.8192133
	Pillai V	=	0.2307692

Recruitment. The avenues used for recruiting the participants included soliciting victims receiving services from one of the rape crisis centers within the state of Maryland; through various community service providers; from forensic nurse examiner programs; through community outreach with rape crisis center educators; and from three detention centers that housed female inmates. The rape crisis centers were educated about the study and asked to refer female victims for participant interviews. Similar recruitment strategies were used with community educators, i.e., notifying them about the study and participation if interested. Community service providers allowed fliers and posters to be displayed in offices and reception areas indicating the study and participation availability. With regards to forensic nurse examiners, similar strategies were employed in educating

staff about the study and how to proceed if interested in participating. As for the detention centers, a study representative attended the centers and gave a presentation about sexual assault followed by an educational brief about the study and how to participate if interested (Weist et al., 2007).

Interview protocol and data collection. The interviewers included four women, with bachelors or master's degrees in the field of human services, three were African American and one was Caucasian, with the race of the interviewer matching that of the interviewee. The interviewers were extensively trained including weekly meetings on "empathically conducting" interviews and "supporting victims" (Weist et al., 2007, p. 16). The interviews occurred at all of the 18 rape crisis centers throughout Maryland as well as three detention centers and various community sites. The interviews were conducted over an 18-month period and lasted anywhere from a little less than an hour to well over 2 hours, indicative of the interviewee's pace and potential needs. The researchers reported that none of the participants complained about the interview process or content, in fact some indicated it was supportive and some received additional services after participation. Additionally, the participants received $10 compensation for their time (Weist et al., 2007). The research was initially approved by the researchers' Institutional Review Board (IRB), and then received additional IRB approval after the detention centers were added as a recruitment site.

The data collected in the Weist et al. (2007) study were anonymous except for age and race, i.e., no other personal identifiers were retained in the dataset. This dataset was available for use on the ICPSR website (ICPSR, 2013). I have access to ICPSR website

through membership by Walden University as a Walden University student. The portion of data being accessed for this study included the quantitative dataset which initially did not require a formal permission letter as the dataset file was readily available on the website. However, when time came to access the data for analysis it did require an application, therefore I submitted the necessary documents to obtain access to the identified dataset in order to conduct the appropriate data analysis.

Instrumentation and operationalization of constructs. Weist et al. (2007) designed an interview instrument (see Appendix C) used with the identified dataset specifically for their study. The final instrument included 110 items in the following categories: Personal Demographics; Details of the Sexual Assault; Medical Care; Law Enforcement; Prosecution/Court Process; Sexual Assault Center Services; Other Counseling Services; and Recommendations for Improvement. The interview instrument includes open-ended questions as well as yes-no answers and Likert ratings (Weist et al., 2007). I will focus on the quantitative interview items for the purposes of this study. Question 19 provides a yes or no answer inquiring about a prior sexual assault experience and will be used to differentiate first-time victims from victims of multiple sexual assaults (Appendix C).

RQ1 – Are women with histories of multiple sexual assaults significantly more likely than first-time victims to use victim advocacy services and supports?

To test RQ1, item 20 (e.g. Did you ever seek help when you were sexual assaulted, molested, or raped before?) from the Details of the Sexual Assault section; Item 31 (e.g. Did you seek medical care in relation to the sexual assault?) from the

Medical Care section; Item 50 (e.g. Did you tell the police about the sexual assault?) from the Law Enforcement section; and Item 61 (e.g. Did you interact with the prosecutor's office?) from the Prosecution/Court Process section; and Item 72 (e.g. Did you receive services from a sexual assault crisis center?) from the Seeking Sexual Assault Services from a Sexual Assault Crisis Center section were analyzed.

RQ2 – Are women with histories of multiple sexual assaults significantly more likely than first-time sexual assault victims to use different types of sexual assault crisis center-based victim advocacy services and supports (e.g., individual counseling, group counseling, hotline, legal services, advocacy services, referrals)?

To test RQ2, Items 19-20 from the Details of the Sexual Assault section, and Items 81-86 (e.g. Did you receive individual counseling services at the sexual assault crisis center?) from the Seeking Sexual Assault Services from a Sexual Assault Crisis Center section were analyzed.

RQ3 – Are rates of satisfaction with victim advocacy services and supports significantly higher among women with histories of multiple sexual assaults than first-time sexual assault victims?

To test RQ3, Item 19 from the Details of the Sexual Assault section; Items 43-45 (e.g. How would you rate your satisfaction with the provision of the physical examination?) from the Medical Care section; Items 58-60 (e.g. How would you rate your satisfaction with how the police interviewed you regarding the assault?) from the Law Enforcement section; Items 68-69 (e.g. How would you rate your satisfaction with your interactions with the prosecutor's office?) from the Prosecution/Court Process

section; and Items 80-85, 88, and 92 (e.g. How would you rate the overall sexual assault services that you received from the sexual assault crisis center?) from the Seeking Sexual Assault Services from a Sexual Assault Crisis Center section were analyzed.

RQ4 – Among victims of multiple sexual assaults, are those who have used services before more likely than those who did not to use them in the present assault?

To test RQ4, Items 19 (e.g. Have you ever been sexually assaulted, molested, or raped before?) and 20 (e.g. Did you ever seek help when you were sexual assaulted, molested, or raped before?) from the Details of the Sexual Assault section; Item 31 (e.g. Did you seek medical care in relation to the sexual assault?) from the Medical Care section; Item 50 (e.g. Did you tell the police about the sexual assault?) from the Law Enforcement section; and Item 61 (e.g. Did you interact with the prosecutor's office?) from the Prosecution/Court Process section; and Items 72 (e.g. Did you receive services from a sexual assault crisis center?) and 81-85 (e.g. Did you receive counseling services at the sexual assault crisis center?) from the Seeking Sexual Assault Services from a Sexual Assault Crisis Center section were analyzed.

RQ5 – Among victims of multiple sexual assaults, are those who have used services before more satisfied with services in the present assault?

Lastly, to test RQ5, Item 20 (e.g. Did you ever seek help when you were sexual assaulted, molested, or raped before?) from the Details of the Sexual Assault section; Items 43-45 (e.g. How would you rate your satisfaction with the provision of the physical examination?) from the Medical Care section; Items 58-60 (e.g. How would you rate your satisfaction with how the police interviewed you regarding the assault?) from the

Law Enforcement section; Items 68-69 (e.g. How would you rate your satisfaction with your interactions with the prosecutor's office?) from the Prosecution/Court Process section; and Items 80-85, 88, and 92 (e.g. How would you rate the overall sexual assault services that you received from the sexual assault crisis center?) from the Seeking Sexual Assault Services from a Sexual Assault Crisis Center section were analyzed.

Data Analysis

Because this study investigated numerous related dependent variables, multivariate analysis was used. Identifying multiple relationships allowed us to survey potential effects simultaneously along with distinctive influences of each effect. An example of this was using a multivariate analysis of co-variance (MANCOVA). It offers the ability to understand the effect of one or more independent variables on multiple dependent variables while controlling for the effects of other variables. So instead of doing multiple, individual ANCOVA tests with the different dependent variables, the variables can be combined into one test, which also helps with controlling for Type I errors (Burkholder, 2012; Field, 2009).

This study conducted data analysis using MANCOVA and testing via an *F*-test (Field, 2009) for research questions 3 and 5. An *F*-test was used to test if variances from two populations are equal (i.e., first-time victims versus multiple victimizations). The one-tailed version was used to determine if there are significant differences between first-time victims and those who have experienced multiple victimizations. For example, if $F_{\text{calculated}} > F_{\text{critical}}$ then H_0 is rejected, whereas if $F_{\text{calculated}} < F_{\text{critical}}$ then H_0 cannot be rejected. The assumptions of this test include homogeneity of variances and covariances,

which entails that the variances in different groups are identical as well as the intercorrelations are homogeneous across cells. Additional assumptions include normally distributed dependent variables and independence of observations (Field, 2009; StatSoft, Inc., 2014). Descriptive statistics were examined to test for normality of the dependent variables. The Levene's test for homogeneity of variances in SPSS was used to test the assumption for homogeneity of variance.

For RQ 1, 2, and 4, a chi-square test was used, which determines if there is a relationship among categorical variables (Field, 2009). The chi-square statistic compares the categorical responses among two or more independent variables, i.e., the use of victim advocacy services and supports and comparison among first-time victims and victims of multiple sexual assaults. Chi-square is the sum of the squared difference between observed (*o*) and the expected (*e*) data (or the deviation, *d*), divided by the expected data in all possible categories (Field, 2009).

Chi-square tests are the most widely used nonparametric statistical test and unlike the parametric test discussed above they are designed for nominal data and do not require normal distribution or variance assumptions. With chi-square, a value is calculated from the data then compared to a critical value from a chi-square table with corresponding degrees of freedom. If the calculated value is equal to or greater than the critical value, then the null hypothesis is rejected. If the calculated value is less than the critical value, then the null hypothesis (*H*o) is accepted. The chi-square statistical procedures are similar to that used with the *F* test denoted above (Frankfort-Nachmias & Nachmias, 2008; Laureate Education, 2009i, Field, 2009).

Threats to Validity

Threats to validity include threats to internal validity and external validity. Threats to internal validity entail procedures, treatments, or experiences of the participants that threaten the researcher's ability to draw conclusions about cause and effect. Threats to external validity occur when researchers draw improper inferences among sample data to other groups or settings not under study and to past or future situations (Creswell, 2009). Babbie (2013) furthers the inquisition of validity with regards to secondary analysis in that the original data were intended for a particular purpose and there is no assurance that the identified data is appropriate for this study. However, I thoroughly reviewed the interview instrument and determined that it was feasible to answer this study's research questions and hypotheses with the identified secondary data originally collected by Weist et al. (2007). A thorough exploration of threats to internal and external validity is discussed next.

Threats to internal validity with regards to participants include history, maturation, regression, selection, and mortality. This study used secondary/archival data and in the original study by Weist et al. (2007), the types of threats to internal validity known as history and mortality are responded to in that all participants experienced the same external event (i.e., a sexual assault) and there was a significant sample size of 224 participants, which would account for possible drop outs. As for maturation and regression, there was no pre-scoring of participants in the original study and the age requirement for participation was 18 or older.

Threats to internal validity such as diffusion of treatment, compensatory/resentful demoralization, and compensatory rivalry are avoided in that there was no experimental treatment conducted and each participant received the same amount of compensation (Weist et al., 2007). With regards to testing and instrumentation, Weist et al. (2007) conducted the interview process in the same manner for all participants including the same interview instrument. All in all, threats to internal validity of the identified secondary data appear to be minimal.

Threats to external validity appear to be minimal as well. First, I have generalized the results to the identified participant groups and will not generalize the results of this study to other groups, such as male victims or victims of a race other than African American and European American or female victims younger than 18 years old. This study examined sexual assault victims' (females, African American and Caucasian, and age 18 and over) use of and satisfaction levels with victim advocacy services and supports; therefore, it is not indicative of specific timing and setting of the original study, only what the participants' experiences and responses were to the interview instrument (Appendix C).

Ethical Procedures

The original researchers went through an initial Institutional Review Board (IRB) process and received approval, then went through another IRB process when they added the detention center participants to the study parameters and received further approval to conduct research. The participant data includes no personal identifiers except for age, race, and other basic demographic information; therefore, the data are anonymous. When

the interviewers completed and turned in the interview paperwork, the informed consent was submitted separately from the interview documents so the responses remained anonymous (Weist et al., 2007).

Additionally, I received IRB approval (#06-25-14-0248992) to conduct research using secondary data. As the researcher, I was the main individual to have access to the dataset; however, my chair and committee member also had access. The data is stored on this researcher's computer and the files, including this analysis, will be retained for five years. Upon that time the data will be removed according to the pre-approved data storage and scrubbing agreement (Appendix A-B).

Summary

This study investigated the satisfaction levels of victims of sexual assault and their use of victim advocacy services and supports. The nature of this study was quantitative, using secondary data that was accessed from ICPSR. Multivariate analysis of covariance, analysis of covariance, and chi-square tests were conducted given there are numerous dependent variables. Ascertaining multiple relationships makes it possible to examine potential effects simultaneously along with distinctive influences of each effect. This analysis and findings are further discussed in Chapter 4.

Chapter 4: Results

Introduction

The purposes of this study were to (a) investigate sexual assault victims' use of and satisfaction with victim advocacy services and supports and (b) compare such rates between first-time victims and victims of multiple sexual assaults. In this chapter, the following topics are covered: data collection process and recruitment strategies used by Weist et al. (2007), population and demographics, variables of the sample, descriptive statistics, results (including statistical analyses using analysis of covariance, multivariate analysis of covariance, and chi-square tests), and a review of the hypotheses.

Research Questions and Hypotheses

This study was guided by five research questions:

RQ1 – Are women with histories of multiple sexual assaults significantly more likely than first-time victims to use victim advocacy services and supports?

$H_0$1 – There are no differences in use of victim advocacy services and supports between women who have been sexually assaulted previously and first-time victims.

H_a1 – Women who have been sexually assaulted previously are significantly more likely than first-time victims to use victim advocacy services and supports.

RQ2 – Are women with histories of multiple sexual assaults significantly more likely than first-time sexual assault victims to use different types of sexual assault crisis center-based victim advocacy services and supports (e.g., individual counseling, group counseling, hotline, legal services, advocacy services, referrals)?

$H_0$2 – There are no differences in use of different types of sexual assault crisis center-based victim advocacy services and supports among women who have been sexually assaulted previously compared to first-time victims.

H_a2 – Women who have been sexually assaulted previously are significantly more likely than first-time victims to use the different types of sexual assault crisis center-based victim advocacy services and supports.

RQ3 – Are rates of satisfaction with victim advocacy services and supports significantly higher among women with histories of multiple sexual assaults than first-time sexual assault victims?

$H_0$3 – There are no differences in satisfaction levels with victim advocacy services and supports among women who have been sexually assaulted previously compared to first-time victims.

H_a3 – Women who have been sexually assaulted previously are significantly more satisfied with victim advocacy services and supports than first-time victims.

RQ4 – Among victims of multiple sexual assaults, are those who have used services before more likely than those who did not to use them in the present assault?

$H_0$4 – There are no differences in use of victim advocacy services and supports among victims of multiple sexual assaults.

H_a4 – Victims of multiple sexual assaults who have used services before are significantly more likely to use victim advocacy services and supports in the present assault.

RQ5 – Among victims of multiple sexual assaults, are those who have used services before more satisfied with services in the present assault?

$H_0$5 – There are no differences in satisfaction with victim advocacy services and supports among victims of multiple sexual assaults.

H_a5 – Victims of multiple sexual assaults who have used services before are significantly more satisfied with their use of victim advocacy services and supports in the present assault.

Data Collection

Population

This study used secondary data (ICPSR, 2013) to analyze and report research findings. Weist et al. (2007) studied the participating clients' perspective after experiencing a sexual assault. The data were collected using quantitative and qualitative methods that included face-to-face interviews. This research study employed the quantitative data for analysis and reporting of research findings. I completed an application to ICPSR to gain access to the identified dataset. Since the data is considered secondary or archival data, the population and sample is not considered a random sample. The participant inclusion criteria included being: female, age 18 and over, either African American or European American (referred to as *Caucasian* in the Weist et al. (2007) study), a resident of the state of Maryland, and a victim of at least one sexual assault. Interviews were conducted on 224 victims. Two participants were dropped from the data set because one participant identified as mixed race and another did not identify race, resulting in a final sample of $N = 222$ (Weist et al., 2007).

Recruitment

The avenues used for recruiting the participants included soliciting victims receiving services within the state of Maryland from: a rape crisis centers; various community service providers; forensic nurse examiner programs; community outreach with rape crisis center educators; and three detention centers that housed female inmates. The rape crisis centers were educated about the study and asked to refer female victims for participant interviews. Similar recruitment strategies were used with community educators, i.e., notifying them about the study and participation if interested. Community service providers allowed fliers and posters to be displayed in offices and reception areas indicating the study and participation availability. With regards to forensic nurse examiners, similar strategies were employed in educating staff about the study and how to proceed if interested in participating. As for the detention centers, a study representative attended the centers and gave a presentation about sexual assault followed by an educational brief about the study and how to participate if interested (Weist et al., 2007).

The data collected in the Weist et al. (2007) study were anonymous except for age and race, i.e., no other personal identifiers were retained in the dataset. This dataset was available for use on the ICPSR website (ICPSR, 2013). I had access to ICPSR website through membership as a Walden University student. The portion of data being accessed for this study included the quantitative dataset which initially did not require a formal permission letter as the dataset file was readily available on the website. However, when time came to access the data for analysis it did require an application, therefore I

submitted the necessary documents to obtain access to the identified dataset in order to conduct the appropriate data analysis (Appendix A-B).

Demographics

The covariates or control variables in this study were participant age, race, and recruitment sources. The original study by Weist et al. (2007) required participants to be at least 18 years old, therefore the age range for the secondary data includes ages 18-70, with 41.7% of the participants being 34 or younger. The most frequent ages identified include 25 (5.4%), 26 (4.5%) 36 (4.9%), and 40 (4.9%) years old, each with 10-12 participants. The identified race of the participants was either African American or Caucasian, with 62.8% (140) identifying as African American and 37.2% (83) identifying as Caucasian. When it came to recruitment sources it included 24 different facilities where participants were interviewed with only one missing or unidentified. The facilities ranged from resource centers to crisis centers to detention centers. The sites where the most interviews were conducted include "My Sister's Place" and "PG County Detention Center" with 23.9% and 13.5%, respectively, of the participants.

Table 2

Means and Standard Deviation – Covariates/Control Variables

		Race	Center where interviewed	Age
N	Valid	223	222	223
	Missing	0	1	0
Mean		1.37	16.00	36.99
Median		1.00	19.00	36.00
Mode		1	19	25
Std. Deviation		.484	7.506	10.356
Variance		.235	56.339	107.257
Minimum		1	1	18
Maximum		2	26	70

Descriptive Statistics

The original study by Weist et al. (2007) indicated $N = 222$, however the SPSS dataset received from ICPSR provides $N = 223$. The independent variable was the number of previous sexual assaults (none vs. some). Of the 223 participants included in the Weist et al. (2007) study, 100 (44.8%) participants answered no to being sexually assaulted previously (i.e., before the most recent assault) while 119 (53.4%) participants answered yes and 4 (1.8%) responses of the 223 were missing.

Another independent variable was whether the participants had sought help when previously sexually assaulted or not. Of the 223 participants, 36 (16.1%) responded yes and 87 (39%) responded no to seeking help when sexually assaulted previously. The remaining 97 (43.5%) participants indicated N/A and 3 (1.3%) responses were missing.

Table 3

Frequency Tables – Sexually Assaulted Previously and Seeking Help When Previously Assaulted

		Sexually assaulted previously			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	100	44.8	45.7	45.7
	Yes	119	53.4	54.3	100.0
	Total	219	98.2	100.0	
Missing	Missing	4	1.8		
Total		223	100.0		

		Seek help when previously assaulted			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	87	39.0	70.7	70.7
	Yes	36	16.1	29.3	100.0
	Total	123	55.2	100.0	
Missing	N/A	97	43.5		
	Missing	3	1.3		
	Total	100	44.8		
Total		223	100.0		

The dependent variables were legal, medical, and sexual assault crisis center-based victim advocacy services and supports. Of the 223 participants, 129 participants had not sought medical care while 90 participants had sought medical care (4 of the 223 responses were missing). Of the 223 participants, 89 participants told police about the sexual assault while 131 participants had not (3 of the responses were missing). When it came to interacting with the prosecutor's office, only 36 participants indicated participation while 48 participants did not interact with the prosecutor's office (132 of the 223 responses were N/A and 4 of the 223 were missing). The codebook for the secondary data does not identify reasoning for the large amounts of missing data for the variable interact with prosecutor's office. For services sought at a sexual assault crisis center, 163 participants did not receive services while 57 participants did receive services (3 of the 223 responses were missing).

Table 4

Frequency Tables – Dependent Variables

		Sought medical care			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	129	57.8	58.9	58.9
	Yes	90	40.4	41.1	100.0
	Total	219	98.2	100.0	
Missing	Missing	4	1.8		
Total		223	100.0		

		Told police about sexual assault			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	131	58.7	59.5	59.5
	Yes	89	39.9	40.5	100.0
	Total	220	98.7	100.0	
Missing	Missing	3	1.3		
Total		223	100.0		

		Interacted with prosecutor's office			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	48	21.5	57.1	57.1
	Yes	36	16.1	42.9	100.0
	Total	84	37.7	100.0	
Missing	N/A	132	59.2		
	Missing	7	3.1		
	Total	139	62.3		
Total		223	100.0		

		Received services from a sexual assault crisis center			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	163	73.1	74.1	74.1
	Yes	57	25.6	25.9	100.0
	Total	220	98.7	100.0	
Missing	Missing	3	1.3		
Total		223	100.0		

(table continues)

Results

Research Questions and Hypotheses

RQ1 – Are women with histories of multiple sexual assaults significantly more likely than first-time victims to use victim advocacy services and supports? $H_0$1 – There are no differences in use of victim advocacy services and supports between women who have been sexually assaulted previously and first-time victims. H_a1 – Women who have been sexually assaulted previously are significantly more likely than first-time victims to use victim advocacy services and supports. The assumptions for chi-square tests have been met, including sufficiently large sample size (N=223), adequate expected cell counts, no more than 20% of the expected counts being less than 5 and all individual expected counts are 1 or greater, and one independent observation per subject.

Chi-square tests were performed with independent variable sexually assaulted previously and several dependent variables: sought medical care, told police about sexual

assault, interacted with prosecutor's office, and received services from a sexual assault crisis center. A chi-square test was performed, and no relationship was found between sought medical care and sexually assaulted previously, χ^2 (1, N = 215) = .01, p = .90. Another chi-square test was performed, and no relationship was found between told police about sexual assault and sexually assaulted previously, χ^2 (1, N = 216) = .01, p = .93. Similarly, no relationship was found between interacted with prosecutor's office and sexually assaulted previously, χ^2 (1, N = 83) = .78, p = .38. Chi-square testing also revealed no relationship between received services from a sexual assault crisis center and sexually assaulted previously, χ^2 (1, N = 216) = .68, p = .17. Based on the results of the chi-square tests, there was no relationship among first-time victims of sexual assault and victims of multiple sexual assaults when utilizing victim advocacy services and supports. Therefore, the null hypothesis is accepted for RQ1.

RQ2 – Are women with histories of multiple sexual assaults significantly more likely than first-time sexual assault victims to use different types of sexual assault crisis center-based victim advocacy services and supports (e.g., individual counseling, group counseling, hotline, legal services, advocacy services, referrals)? $H_0$2 – There are no differences in use of different types of sexual assault crisis center-based victim advocacy services and supports among women who have been sexually assaulted previously compared to first-time victims. H_a2 – Women who have been sexually assaulted previously are significantly more likely than first-time victims to use the different types of sexual assault crisis center-based victim advocacy services and supports. The assumptions for chi-square tests have been met, including sufficiently large sample size

(*N*=223), adequate expected cell counts, no more than 20% of the expected counts being less than 5 and all individual expected counts are 1 or greater, and one independent observation per subject.

Chi-square tests were performed with independent variable sexually assaulted previously and several dependent variables: received individual counseling at SACC, received group counseling at SACC, called sexual assault hotline at SACC, received legal services at SACC, received advocacy services at SACC, and referred to other agency for additional services. A chi-square test was performed and no relationship was found between received individual counseling at SACC and sexually assaulted previously, χ^2 (1, N = 55) = .79, p = .37. Another chi-square test was performed and no relationship was found between received group counseling at SACC and sexually assaulted previously, χ^2 (1, N = 55) = .87, p = .35. Similarly, a chi-square test was performed and no relationship was found between called sexual assault hotline at SACC and sexually assaulted previously, χ^2 (1, N = 53) = .16, p = .69.

A fourth chi-square test was performed and no relationship was found between received legal services at SACC and sexually assaulted previously, χ^2 (1, N = 53) = 1.82, p = .18. A fifth chi-square test was performed and no relationship was found between received advocacy services at SACC and sexually assaulted previously, χ^2 (1, N = 52) = .54, p = .46. Final chi-square testing also revealed no relationship was found between referred to other agency for additional services and sexually assaulted previously, χ^2 (1, N = 53) = .43, p = .51. Based on the results of the chi-square tests, there was no relationship among first-time victims of sexual assault and victims of multiple

sexual assaults when utilizing different types of sexual assault crisis center-based victim advocacy services and supports. Therefore, the null hypothesis is accepted for RQ2.

RQ3 – Are rates of satisfaction with victim advocacy services and supports significantly higher among women with histories of multiple sexual assaults than first-time sexual assault victims? $H_0$3 – There are no differences in satisfaction levels with victim advocacy services and supports among women who have been sexually assaulted previously compared to first-time victims. H_a3 – Women who have been sexually assaulted previously are significantly more satisfied with victim advocacy services and supports than first-time victims.

Sexual Assault Crisis Center (SACC). An analysis of covariance was conducted with independent variable sexually assaulted previously, dependent variable rate of overall services at SACC, and covariates: age, race, and recruitment source. The assumptions have been met as the variances across groups are not different, as indicated by Levene's test, with a significance value of .75, which is greater than the criterion of .05, and is therefore considered not significant ($F(1, 51) = .10$, $p > .05$). Additionally, descriptive statistics were examined and noted normality of dependent variable distribution.

The main effect of being sexually assaulted previously was not significant, ($F(1, 48) = .11$, $p > .05$, $\omega 2 = .00$), demonstrating that the rate of overall services at the SACC is not dependent on being sexually assaulted previously. The covariates were not significant as well, age ($F(1, 48) = 2.19$, $p > .05$, $\omega 2 = .00$), race ($F(1, 48) = 1.11$, $p > .05$, $\omega 2 = .00$), and recruitment source ($F(1, 48) = 1.66$, $p > .05$, $\omega 2 = .00$). Ultimately, these

results support a decision to accept the null hypothesis as there was not a significant difference among being a first-time victim and being sexually assaulted previously with the rate of satisfaction with overall services at the SACC.

Table 5

Means and Standard Error – Rate overall services at SACC

Dependent Variable: Rate overall services at SACC				
Sexually assault previously	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
No	4.447[a]	.179	4.086	4.807
Yes	4.530[a]	.169	4.189	4.870

Note: Covariates appearing in the model are evaluated at the following values: Race = 1.47, Center where interviewed = 10.38, Age = 38.77.

Medical. A multivariate analysis of covariance was conducted with independent variable sexually assaulted previously; dependent variables: satisfaction with physical examination, satisfaction with testing for STDs, and satisfaction with info about emergency contraception; and covariates: age, race, and recruitment source. The assumptions have been met as the variances across groups were not different, as indicated by Box's M, with a significance value of .99, and Levene's test, with a significance value of .85, .60, and .35, respectively, which is greater than the criterion of 0.05, and is therefore considered not significant. Additionally, descriptive statistics were examined and noted normality of dependent variable distribution.

There were no statistically significant differences between women who were first-time victims and those who had been previously sexually assaulted on satisfaction with medical services, ($F(3, 45) = .68$, $p > .05$; Wilk's $\Lambda = 0.96$, partial $\eta^2 = .04$. The covariates were not significant as well: age ($F(3, 45) = 1.86$, $p > .05$, $\omega 2 = .00$), race ($F(3, 45) = .28$, $p > .05$, $\omega 2 = .00$), and recruitment source ($F(3, 45) = 1.07$, $p > .05$,

$\omega 2 = .00$). Ultimately, these results support a decision to accept the null hypothesis as there was not a significant difference among being a first-time victim and being sexually assaulted previously with the rate of satisfaction with overall medical services.

Table 6

Means and Standard Error – Medical Services

Dependent Variable	Sexually assault previously	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Satisfaction with physical examination	No	3.291[a]	.206	2.877	3.705
	Yes	3.114[a]	.182	2.748	3.480
Satisfaction with testing for STDs	No	3.414[a]	.195	3.022	3.807
	Yes	3.327[a]	.173	2.979	3.674
Satisfaction with info about emergency contraception	No	3.025[a]	.272	2.477	3.573
	Yes	2.497[a]	.241	2.013	2.982

Note: Covariates appearing in the model are evaluated at the following values: Race = 1.25, Center where interviewed = 15.46, Age = 36.85.

Police. A multivariate analysis of covariance was conducted with the independent variable sexually assaulted previously, the dependent variables: satisfaction with police interview, satisfaction with how police handled case, and satisfaction with overall interactions with police; and covariates: age, race, and recruitment source. The assumptions have been met as the variances across groups were not different, as indicated by Box's M, with a significance value of .67, and Levene's test, with a significance value of .60, .53, and .39. Additionally, descriptive statistics were examined and noted normality of dependent variable distribution.

There were no statistically significant differences between women who were first-time victims and those who had been previously sexually assaulted on satisfaction with police services, ($F(3, 64) = .36$, $p > .05$; Wilk's $\Lambda = 0.98$, partial $\eta^2 = .02$. The covariates were not significant as well, age ($F(3, 64) = .89$, $p > .05$, $\omega 2 = .00$), race ($F(3, 64) = .44$,

p >.05, $\omega 2$ = .00), and recruitment source ($F(3, 64) = .53$, $p > .05$, $\omega 2$ = .00). Ultimately, these results support a decision to accept the null hypothesis as there was not a significant difference among being a first-time victim and being sexually assaulted previously with the rate of satisfaction with overall police services.

Table 7

Means and Standard Error – Police Services

Dependent Variable	Sexually assault previously	Mean	Std. Error	95% Confidence Interval Lower Bound	Upper Bound
Satisfaction with police interview	No	2.761[a]	.219	2.325	3.198
	Yes	2.550[a]	.203	2.144	2.955
Satisfaction with how police handled case	No	2.731[a]	.221	2.289	3.173
	Yes	2.497[a]	.206	2.086	2.907
Satisfaction with overall interactions with police	No	2.682[a]	.212	2.259	3.106
	Yes	2.565[a]	.197	2.172	2.959

Note: Covariates appearing in the model are evaluated at the following values: Race = 1.35, Center where interviewed = 14.35, Age = 37.27.

Prosecutor. A multivariate analysis of covariance was conducted with independent variable sexually assault previously dependent variables: satisfaction with prosecutor's office and overall satisfaction with court process, and covariates: age, race, and recruitment source. The assumptions have been met as the variances across groups were not different, as indicated by Box's M, with a significance value of .22, and Levene's test, with a significance value of .39 and .61. Additionally, descriptive statistics were examined and noted normality of dependent variable distribution.

There were no statistically significant differences between women who were first-time victims and those who had been previously sexually assaulted on satisfaction with prosecutor services, ($F(2, 21) = .07$, $p > .05$; Wilk's $\Lambda = 0.99$, partial $\eta^2 = .01$. The covariates were not significant as well, age ($F(2, 21) = 1.54$, $p > .05$, $\omega 2 = .00$), race

($F(2, 21) = .58$, $p > .05$, $\omega 2 = .00$), and recruitment source ($F(2, 21) = .29$, $p > .05$, $\omega 2 = .00$). Ultimately, these results support a decision to accept the null hypothesis as there was not a significant difference between first-time victims and those who has previously experienced a sexual assault regarding the rate of satisfaction with overall prosecutor services.

Table 8

Means and Standard Error – Prosecutor Services

Dependent Variable	Sexually assault previously	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Satisfaction with interaction with prosecutor's office	No	2.882[a]	.317	2.224	3.540
	Yes	2.974[a]	.330	2.289	3.658
Overall satisfaction with court process	No	2.372[a]	.356	1.633	3.111
	Yes	2.292[a]	.371	1.523	3.061

Note: Covariates appearing in the model are evaluated at the following values: Race = 1.30, Center where interviewed = 11.70, Age = 37.63.

RQ4 – Among victims of multiple sexual assaults, are those who have used services before more likely than those who did not to use them in the present assault? $H_0 4$ – There are no differences in use of victim advocacy services and supports among victims of multiple sexual assaults. $H_a 4$ – Victims of multiple sexual assaults who have used services before are significantly more likely to use victim advocacy services and supports. The assumptions for chi-square tests have been met, including sufficiently large sample size (N=223), adequate expected cell counts, no more than 20% of the expected counts being less than 5 and all individual expected counts are 1 or greater, and one independent observation per subject.

Chi-square tests were performed with independent variable seek help when previously assaulted and several dependent variables: received individual counseling at SACC, received group counseling at SACC, called sexual assault hotline at SACC, received legal services at SACC, received advocacy services at SACC, sought medical care, told police about sexual assault, interacted with prosecutor's office, and received services from a sexual assault crisis center.

Sexual Assault Crisis Center (SACC). A chi-square test was performed and no relationship was found between received individual counseling at SACC and seek help when previously assaulted, χ^2 (1, N = 29) = .29, p = .59. Another chi-square test was performed and no relationship was found between received group counseling at SACC and seek help when previously assaulted, χ^2 (1, N = 29) = .41, p = .52. Similarly, a chi-square test was performed and no relationship was found between called sexual assault hotline at SACC and seek help when previously assaulted, χ^2 (1, N = 28) = 2.67, p = .10. A fourth chi-square test was performed and no relationship was found between received legal services at SACC and seek help when previously assaulted, χ^2 (1, N = 29) = .68, p = .41. Final chi-square testing revealed no relationship was found between received advocacy services at SACC and seek help when previously assaulted, χ^2 (1, N = 28) = 1.25, p = .26.

Legal. A chi-square test was performed and no relationship was found between told police about sexual assault and seek help when previously assaulted, χ^2 (1, N = 121) = 2.07, p = .15. Similarly, a chi-square test was performed and no relationship was found between interacted with prosecutor's office and seek help when

previously assaulted, χ^2 (1, N = 47) = .47, p = .50. Chi-square testing revealed no relationship was found between received services from a sexual assault crisis center and seek help when previously assaulted, χ^2 (1, N = 121) = 1.51, p = .22.

Medical. A chi-square test was performed and a significant relationship was found between sought medical care in the most recent assault and seek help when previously assaulted, χ^2 (1, N = 121) = 5.08, p = .02. Results indicated that women who previously sought help after a sexual assault were more likely to seek medical care after the most recent assault in that 57.1% sought medical care and 42.9% did not. The opposite pattern was demonstrated by women who did not see help for prior assaults: 65.1% did not seek medical care for their most recent assault, while 34.9% did seek medical care. Thus, women who did not seek help for the prior assaults were also not likely to seek medical care for their most recent assault.

Based on the results of the chi-square tests, there is no relationship among victims of multiple sexual assaults in terms of previous use of services when utilizing services in the present assault except when it comes to seeking medical care. Therefore, the null hypothesis is rejected when seeking medical care and the null hypothesis is accepted when seeking legal and sexual assault crisis center-based services.

RQ5 – Among victims of multiple sexual assaults, are those who have used services before more satisfied with services in the present assault? $H_0$5 – There are no differences in satisfaction with victim advocacy services and supports among victims of multiple sexual assaults. H_a5 – Victims of multiple sexual assaults who have used

services before are significantly more satisfied with their use victim advocacy services and supports.

Sexual Assault Crisis Center (SACC). An analysis of covariance was conducted with independent variable seek help when previously assaulted, dependent variable rate of overall services at SACC, and covariates: age, race, and recruitment source. The assumptions have been met as the variances across groups are not different, as indicated by Levene's test, with a significance value of .68, which is greater than the criterion of .05, and is therefore considered not significant ($F(1,26) = .18$, $p > .05$). Additionally, descriptive statistics were examined and noted normality of dependent variable distribution.

The main effect of seeking help when previously sexually assaulted was not significant, ($F(1, 23) = .08$, $p > .05$, $\omega 2 = .00$), demonstrating that the rate of overall satisfaction with services at the SACC is not dependent on having previously sought help when sexually assaulted. The covariates were not significant as well, age ($F(1, 23) = 2.83$, $p > .05$, $\omega 2 = .00$), race ($F(1, 23) = .67$, $p > .05$, $\omega 2 = .00$), and recruitment source ($F(1, 23) = .63$, $p > .05$, $\omega 2 = .00$). Ultimately, these results support a decision to accept the null hypothesis as there was not a significant difference in overall satisfaction with SACC services between those who sought help when previously sexually assaulted and those who did not.

Medical. A multivariate analysis of covariance was conducted with the independent variable seek help when previously assaulted; the dependent variables: satisfaction with physical examination, satisfaction with testing for STDs, and

Table 9

Means and Standard Error – Rate overall services at SACC

Dependent Variable: Rate overall services at SACC				
Seek help when previously assaulted	Mean	Std. Error	95% Confidence Interval	
			Lower Bound	Upper Bound
No	4.540[a]	.225	4.074	5.006
Yes	4.428[a]	.311	3.784	5.072

Note: Covariates appearing in the model are evaluated at the following values: Race = 1.39, Center where interviewed = 10.11, Age = 39.71.

satisfaction with info about emergency contraception; and covariates: age, race, and recruitment source. The assumptions have been met as the variances across groups were not different, as indicated by Box's M, with a significance value of .61, and Levene's test, with a significance value of .34, .75, and .76, respectively. Additionally, descriptive statistics were examined and noted normality of dependent variable distribution.

There were no statistically significant differences in seeking help when previously sexually assaulted and the current assault on satisfaction with medical services, (*F*(3, 24) = .45, $p > .05$; Wilk's $\Lambda = 0.95$, partial $\eta^2 = .05$. The covariates were not significant as well, age (*F*(3, 24) = .57, $p > .05$, $\omega 2 = .00$), race (*F*(3, 24) = .49, $p > .05$, $\omega 2 = .00$), and recruitment source (*F*(3, 24) = .69, $p > .05$, $\omega 2 = .00$). Ultimately, these results support a decision to accept the null hypothesis as there was not a significant difference in overall satisfaction with medical services between those who sought help when previously sexually assaulted and those who did not.

Police. A multivariate analysis of covariance was conducted with the independent variable seek help when previously assaulted; the dependent variables: satisfaction with police interview, satisfaction with how police handled case, and satisfaction with overall interactions with police; and the covariates: age, race, and recruitment source.

Table 10

Means and Standard Error – Medical Services

Dependent Variable	Seek help when previously assaulted	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Satisfaction with physical examination	No	3.190[a]	.269	2.638	3.743
	Yes	3.032[a]	.356	2.300	3.764
Satisfaction with testing for STDs	No	3.254[a]	.250	2.741	3.767
	Yes	3.264[a]	.331	2.585	3.944
Satisfaction with info about emergency contraception	No	2.308[a]	.322	1.646	2.970
	Yes	2.845[a]	.426	1.969	3.722

Note: Covariates appearing in the model are evaluated at the following values: Race = 1.19, Center where interviewed = 14.84, Age = 39.23.

The assumptions have been met as the covariances across groups were not different, as indicated by Box's M, with a significance value of .50. The Levene's test indicated that variances were equal across the groups for satisfaction with police interview and overall satisfaction with police services (p's > .05); however, variances were unequal for the variable regarding satisfaction with how the police handled the case ($F(1, 38) = 5.48$, $p < .05$). However, MANCOVA is robust to violations of the equality of variance assumption when cell sizes are equal (Tabachnick & Fidell, 2007). Additionally, descriptive statistics were examined and noted normality of dependent variable distribution.

There were no statistically significant differences in seeking help when previously sexually assaulted and the current assault on satisfaction with police services, ($F(3, 33) = .07$, $p > .05$; Wilk's $\Lambda = 0.99$, partial $\eta^2 = .01$. The covariates were not significant as well, age ($F(3, 33) = 1.53$, $p > .05$, $\omega 2 = .00$), race ($F(3, 33) = .85$, $p > .05$, $\omega 2 = .00$), and recruitment source ($F(3, 33) = 1.37$, $p > .05$, $\omega 2 = .00$). Ultimately, these results support a decision to accept the null hypothesis as there was not a significant

difference in overall satisfaction with police services between those who sought help when previously sexually assaulted and those who did not.

Table 11

Means and Standard Error – Police Services

Dependent Variable	Seek help when previously assaulted	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Satisfaction with police interview	No	2.564[a]	.245	2.066	3.062
	Yes	2.453[a]	.345	1.752	3.154
Satisfaction with how police handled case	No	2.557[a]	.246	2.058	3.056
	Yes	2.466[a]	.346	1.764	3.168
Satisfaction with overall interactions with police	No	2.611[a]	.223	2.159	3.063
	Yes	2.437[a]	.313	1.800	3.073

Note: Covariates appearing in the model are evaluated at the following values: Race = 1.25, Center where interviewed = 15.10, Age = 39.30.

Prosecutor. A multivariate analysis of covariance was conducted with the independent variable seek help when previously assaulted; the dependent variables: satisfaction with prosecutor's office and overall satisfaction with court process, and the covariates: age, race, and recruitment source. The assumptions have been met as the variances across groups are not different, as indicated by Box's M, with a significance value of .99, and Levene's test, with a significance value of .55 and .53. Additionally, descriptive statistics were examined and noted normality of dependent variable distribution.

There were no statistically significant differences in seeking help when previously sexually assaulted and the current assault on satisfaction with prosecutor services, ($F(2, 8) = 2.21$, $p > .05$; Wilk's $\Lambda = 0.65$, partial $\eta^2 = .36$. The covariates were not significant as well, age ($F(2, 8) = 1.39$, $p > .05$, $\omega 2 = .00$), race ($F(2, 8) = 2.60$, $p > .05$, $\omega 2 = .00$), and recruitment source ($F(2, 8) = .26$, $p > .05$, $\omega 2 = .00$). Ultimately, these

results support a decision to accept the null hypothesis as there was not a significant difference in overall satisfaction with prosecutor services between those who sought help when previously sexually assaulted and those who did not.

Table 12

Means and Standard Error – Prosecutor Services

Dependent Variable	Seek help when previously assaulted	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Satisfaction with interaction with prosecutor's office	No	1.673[a]	.619	.273	3.074
	Yes	4.041[a]	.619	2.641	5.442
Overall satisfaction with court process	No	1.569[a]	.727	-.076	3.214
	Yes	2.859[a]	.727	1.214	4.505

Note: Covariates appearing in the model are evaluated at the following values: Race = 1.14, Center where interviewed = 11.43, Age = 38.07.

Summary

Assumptions were met for all of the statistical analyses. The chi-square statistical analysis did not support alternative hypothesis 1 as there was no significant difference found for use of victim advocacy services and supports among first-time victims of sexual assault and victims of multiple sexual assaults. The chi-square statistical analysis also did not support alternative hypothesis 2 as there was no significant difference found for use of different types of sexual assault crisis center-based victim advocacy services and supports among first-time victims of sexual assault and victims of multiple sexual assaults. The analysis of covariance and multivariate analyses of covariance did not support alternative hypothesis 3 as there was no significant difference found for satisfaction with victim advocacy services and supports among first-time victims of sexual assault and victims of multiple sexual assaults.

The chi-square statistical analysis supported a portion of alterative hypothesis 4; therefore, the null hypothesis was rejected when it came to victims of multiple sexual assaults and seeking medical care during the present assault. The chi-square statistical analysis did not support the remaining components of alternative hypothesis 4 as there was no significant difference found among victims of multiple sexual assaults and use of legal-based and sexual assault crisis center-based victim advocacy services and supports during the present assault. The analysis of covariance and multivariate analyses of covariance did not support alternative hypothesis 5 as there was no significant difference found for satisfaction with victim advocacy services and supports among victims of multiple sexual assaults in the present assault.

The following chapter will summarize the study and present conclusions about the findings. Chapter 5 will also discuss the social change implications, the limitations of this study, and future recommendations for continued research in this area.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to investigate sexual assault victims' use of and satisfaction with victim advocacy services and supports. There was a lack of focus on sexual assault, including victims, and victim advocacy services and supports in the current literature (Macy et al., 2010; Campbell & Wasco, 2005). The literature also lacked empirical evidence in findings related to use of and satisfaction with such services. With regards to use of and satisfaction with victim advocacy services and supports, the literature displayed a knowledge gap regarding potential differences between first-time victimization versus multiple victimizations. Therefore, in addition to studying use and satisfaction with victim advocacy services and supports, this study further compared such among first-time victims of sexual assault and victims of multiple sexual assaults.

This quantitative study used a quasi-experimental design in analyzing secondary data from an original study by Weist et al. (2007). They studied the participants' experiences after receiving victim advocacy services and supports. The data originally consisted of quantitative and qualitative methods, including face-to-face interviews. However, the current study analyzed only the quantitative data.

For RQ1, 2, and 4, I intended to analyze the data using chi-square tests. For RQ3 and RQ5, I intended to analyze the data using a MANCOVA, because it makes it possible to understand the effect of one or more independent variables on multiple dependent variables while controlling for the effects of other variables. However, when conducting the analysis, I noted that the frequency of the SACC services variables was considerably

low and resulted in errors. Therefore, the data analysis was revised to include separate tests for each service type: a MANCOVA for medical and legal services, while an ANCOVA was run for SACC services, for both RQ3 and RQ5.

Key Findings

The results of the chi-square statistical analyses included no significant findings except when it came to seeking medical care. For Hypothesis 1, there was no difference between first-time victims of sexual assault and victims of multiple sexual assaults in their use of victim advocacy services and supports, whether legal, medical, and sexual assault crisis center-based. For Hypothesis 2, there was no difference between first-time victims of sexual assault and victims of multiple sexual assaults in their use of different types of sexual assault crisis center-based victim advocacy services and supports. Statistical significance was found for Hypothesis 4 with use of medical services among victims of multiple sexual assaults during the present assault. However, for that same group, there were no differences in the use of legal and sexual assault crisis center-based victim advocacy services and supports.

The results of the analyses of covariance and multivariate analyses of covariance included no significant findings. For Hypothesis 3, there was no difference in satisfaction levels with victim advocacy services and supports among first-time victims of sexual assault and victims of multiple sexual assaults. For Hypothesis 5, there was no difference in satisfaction with victim advocacy services and supports in the present assault among first-time victims of sexual assault and victims of multiple sexual assaults.

Interpretation of the Findings

Sexual assault involves non-consensual sexual contact that often comprises the use of force by the offender. The effect of sexual assault is often immediate as well as encompasses long-term consequences (Bloom, 2003). Research from the victim's perspective is inadequate and highly concentrated on domestic violence and intimate partner victimization rather than sexual assault victimization. Additionally, the Ahrens et al. (2007) study provided an avenue to further explore use of and satisfaction with victim advocacy services and supports and to compare such among first-time victims and victims of multiple sexual assaults. Therefore, this study used data that contained the experiences of victims of sexual assault with victim advocacy services and supports, to include legal, medical, and sexual assault crisis center-based services, as well as if the participant was sexually assaulted previously.

The research identified that women age 34 or younger experienced a higher rate of sexual violence at 3.7-4.1 per 1,000, while victims identified as White or Black experienced sexual assault at rates of 2.2-2.8 per 1,000, respectively (Planty et al., 2013). The demographics of this study indicated that 42% of the sample was age 34 or younger and 67% identified as African American while 37% identified as Caucasian. These findings correlate with the statistics provided by Planty et al. (2013). O'Sullivan and Fry (2007) noted that approximately 20% of those sexually assaulted will be re-victimized, which can include child sexual abuse victims who are re-victimized as adults or adult victims who experience sexual assault re-victimization. Of the participants in the secondary dataset (N = 223), 219 responded yes or no when asked about being sexually

assaulted previously with approximately 55% indicating yes to being sexually assaulted previously. Therefore, these calculations correlate with the O'Sullivan and Fry (2007) findings as well.

Campbell (2005) studied victim's experiences and service provider's experiences in which case the service providers had underestimated their impact on victims as the victims reported that some experiences were extremely distressing. These findings should be further explored given the lack of significance found by this study with regards to use of and satisfaction with victim advocacy services and supports both among first-time victims of sexual assault and victims of multiple sexual assaults. What was significantly found by this study was that among victims of multiple sexual assaults they were more likely to seek medical care during the present assault. This finding is aligned with Fehler-Cabral et al. (2011) who noted that the medical services of SANE nurses were appreciated when victims experienced care and sensitivity versus cold and distance at the hospital, i.e., the victims had positive experiences during previous assaults thus they are seeking medical services again for the present assault. Therefore, this finding also differs from Campbell and Raja's (2005) results which point to a reluctance to seek further help.

Paul et al. (2009) further reported that sexual assault victims often do not report the crime to others, let alone seek services or treatment, for fear of secondary victimization. However, they suggest that coping and empowerment may be achieved through disclosure to victim advocacy services and supports. These findings should continue to be explored and researched as this study did not indicate significant differences regarding use of and satisfaction with victim advocacy services and supports

both among first-time victims of sexual assault and victims of multiple sexual assaults. Furthermore, future research should investigate the possible mechanisms underlying greater use of medical services by victims of multiple sexual assaults during the present assault compared to first-time victims. These findings were consistent with the Patterson et al. (2009) and Campbell (2008) studies. Given the low frequency of participation in SACC services it appears coping and empowerment was not applicably achieved in this study. With regards to McDermott and Garofalo's (2004) findings of disempowerment, this study did not evaluate the qualitative results of this dataset, therefore this study cannot confirm or deny such findings; however it would be a direction to explore for possible future research.

Empowerment theory was utilized in this study and Kasturirangan (2008) describes empowerment as an increase in control over relevant resources while Campbell (2006) depicts empowerment as an ability to acquire access to resources and services. Empowerment theories recognize that power versus powerlessness is a result of society's failure to meet the needs of its members. Therefore, empowerment theories explicitly focus on the structural barriers that prevent people from accessing resources necessary for health and well-being. Kasturirangan (2008) furthers that as victims engage in the process of empowerment, they often acquire mastery and control over their concerns thus creating an avenue to access necessary resources and services.

As noted in the results section of this study, the concept of empowerment is confirmed in terms of victims of sexual assault seeking medical care. There was a significant difference found between first-time victims of sexual assault and victims of

multiple sexual assaults when it came to seeking medical-based victim advocacy services and supports during the present assault. Victims of multiple sexual assaults were more likely to seek medical services during the present assault than were first-time victims. Although the nature of the current data do not allow for investigation of the mechanisms underlying this finding, several possibilities should be considered. It may be that victims of multiple assaults are more likely to seek out medical services during the most recent assault due to prior positive experiences with medical-based services. Alternatively, perhaps victims who experience multiple assaults tend to have more severe assaultive experiences than first-time victims resulting in a greater need for medical attention. Although speculative, future research investigating such possibilities could ultimately affect positive social change in the field of Victimology.

Regarding the use of services for sexual assault crisis center-based services and legal-based services, there were no significant differences between first-time victims of sexual assault and victims of multiple sexual assaults. The lack of significant results may be due to low statistical power given the low service utilization rates. With regards to satisfaction with services, all null hypotheses were accepted as no significant differences were found between first-time victims of sexual assault and victims of multiple sexual assaults. Given the lack of significant differences, these findings provide no evidence of secondary victimization among first-time victims of sexual assault and victims of multiple sexual assaults with regards to victim advocacy services and supports.

Limitations of the Study

First and foremost, a limitation of this study was that secondary data were used for analysis instead of primary data. To further explore this limitation, the original data were intended for a particular purpose and there was no assurance that the identified data were appropriate for this study or that it would answer the research questions and hypotheses (Babbie, 2013; Frankfort-Nachmias & Nachmias, 2008). Secondly, another limitation includes the probability that the sample in the Weist et al. (2007) study was not random due to self-selection and referral bias. Weist et al. (2007) recruited participants within the state of Maryland from a rape crisis center; from forensic nurse examiner programs; from three detention centers that housed female inmates; through various community service providers; and through community outreach conducted by rape crisis center educators. Lastly, due to the specific participant inclusion criteria, this study is not generalizable to all populations. However, the intent was to reflect upon the results in terms of improving the provision of victim advocacy services and supports after exploring use of and satisfaction with such as well as comparing among first-time victims and victims of multiple sexual assaults, thus lending towards positive social change that impacts a societal level.

Recommendations

While this research study adds to the literature of sexual assault victimization, the lack of significant findings suggests that first-time victims of sexual assault and victims of multiple sexual assaults may not experience differences in their help-seeking behavior or their perceptions of the help they do receive. Therefore recommendations for future

research include duplicating this study with the collection of primary data versus the use of secondary data as well as conducting a qualitative study on victims of sexual assault and their experiences with victim advocacy services and supports. Further research should also be explored in terms of first-time victimization versus multiple victimizations given that this study found no significance through the use of the identified secondary dataset. Future research could explore these issues through both quantitative and qualitative approaches. Additionally, future research could try to identify a larger sample size, possibly across multiple states, to increase statistical power as well as the generalizability of the findings. Given the extreme dearth in literature with regards to first-time victimization and multiple victimizations in adults, this would be an avenue to explore and identify possible comparative results.

While use of and satisfaction with victim advocacy services and supports should be further explored through additional studies, this baseline study also provides for an opening to explore victims experiences in terms of helpfulness, importance, etc., i.e. effectiveness. This next level of research would investigate whether victim advocacy services and supports actually do what they intend to, such as empower, assist, and support the victim. This level of research is important because if the services and supports do not accomplish what they intend to then the purpose needs to be reviewed, redefined, and reapplied for future effectiveness.

Implications

The significance of this study stemmed from a definite gap in the literature. The gap includes a lack of research regarding victims of sexual assault, victim satisfaction

with victim advocacy services and supports, the victim's perspective, and first-time victims and victims of multiple sexual assaults and comparing such. Furthermore, individuals are often hesitant to discuss their most intimate moments, but when you add experiencing sexual assault victimization and that level of hesitation escalates. The level of traumatized experienced often leaves victims avoiding any opportunity to re-experience the causal event, such as through re-victimization or secondary victimization (Paul et al., 2009). Therefore, it is crucial to understand how victims use and respond to victim advocacy services and supports, and whether it varies by previous assault experiences.

This study failed to achieve significant results except in terms of seeking medical care and as such would not be useful in implicating policy changes or affecting significant change in societal views. However, the social change impact of this study was intended to improve the provision of victim advocacy services and supports. This study's results can affect improvements upon the provision of services and supports in terms of highlighting an opportunity to reevaluate and revamp the approach. With all this said, the result of this study, whether significant or not, did achieve positive social change by adding to the literature, providing direction for future research, and impacting at a societal level by pointing out victim advocacy services and supports could only do better (Campbell & Wasco, 2005).

Conclusion

The intent of this research study was to understand if victim advocacy services and supports were being used, and if so, the satisfaction level of the participants.

Although this study was limited by the use of secondary data, differences were identified regarding victims of multiple sexual assaults and their use of medical-based services during the present assault. Future research should investigate the mechanisms underlying these differences, as well as explore use of and satisfaction with victim advocacy services and supports in a variety of sexual assault victim populations. Understanding what services and supports a victim uses and is satisfied with are necessary for creating a path of positive social change within victim services. Knowledge is power and with collaboration, purpose, and meaning, the outcomes are absolutely endless.

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Appendix A: Dataset Approval from ICPSR

[NACJD Access Request:21881] Are victims of sexual assault satisfied with victim advocacy services and supports thus promoting coping and empowerment? Access Request Approved

Christin Cave
Aug 8

to Kristen.Beyer, me

Dear Kristen Beyer,

Your request for access to data for Are victims of sexual assault satisfied with victim advocacy services and supports thus promoting coping and empowerment? has been approved. We will contact you shortly with information about accessing the files you requested.

To view the approved agreement, order additional data, add researchers, or update your security plan, you may use this link:

Please contact Christin Cave if you have any difficulty with this process.

Thank you,
Christin Cave
Inter-university Consortium for Political and Social Research
University of Michigan
P.O. Box 1248
Ann Arbor, MI 48106

Appendix B: Dataset Access from ICPSR

ICPSR\NACJD restricted data

Arun Mathur Aug 12

to me, Kristen.Beyer, Christin

Dear Dr. Beyer,

Your request for access to the restricted data from the African American Experience of Sexual Assault in Maryland, 2003-2006 has been approved. I will shortly be sending you a temporary URL from which you can download the files. Once you have done so please move them to wherever specified in your Data Protection Plan before emailing me for the password to un-encrypt them

Best regards,

Data package includes

1) quantitative and qualitative data/SPSS
2) interview instrument by Weist et al. (2007) (Appendix C)
3) corresponding codebooks

Appendix C: Interview Instrument by Weist et al. (2007)

Subject ID # _____
Interviewer Initials _____
Date _____
Subject race _____
Center _____

INTERVIEW

First, I want to honor the fact that you are here to tell me about your experience of sexual assault. By sharing your story, you will be helping other survivors of sexual assault. I also want to acknowledge that talking about your experience may be difficult for you or might bring up difficult feelings. I want to assure you that you are in a safe environment. You can take a break at any time during this interview. Counselors are available here at the center if you think if may be beneficial to speak with one. You also can decline to answer any question that you do not want to answer.

Are you ready to begin?

PERSONAL DEMOGRAPHICS – First, I am going to ask you some demographic questions.

1. What part of Maryland do you reside in?

1 Western
2 Central
3 Eastern
4 Southern

2. How would you describe where you live?

1 Urban
2 Suburban
3 Rural

3. What is your age? _____

4. What is your marital status?

1 Single
2 Married
3 Living in a committed relationship
4 Separate/Divorced
5 Widowed

5. What is the highest education level you completed?

1 Some high school
2 High school graduate or GED
3 Technical or Trade School

4 Associate's degree
5 Bachelor's degree
6 Master's degree
7 Doctoral degree

6. What is your annual household income? _____

7. Do you receive any form of public assistance? 1 Yes 0 No

IF NO, SKIP TO QUESTION 8.

What form of public assistance do you receive? *(Circle all that apply.)*
1 WIC
2 Medical Assistance (Medicare, Medicaid)
3 Housing Assistance
4 Income Assistance
5 Other _____

DETAILS OF THE SEXUAL ASSAULT – Now I will ask some questions about the sexual assault.

8. How long ago did the sexual assault take place? _____
(If individual indicates that more than one sexual assault took place, ask the person to focus on the most recent assault.)

9. What was the relationship of the person who assaulted you?
1 Friend
2 Acquaintance
3 Spouse
4 Relative
5 Boyfriend
6 Girlfriend
7 Ex-spouse
8 Ex-boyfriend or girlfriend
9 Stranger
10 Date
11 Teacher
12 Boss
13 Friend of the family
14 Co-worker
15 Other, specify _____

10. What was the ethnicity of the person who assaulted you?
1 White
2 African-American
3 Asian/Pacific Islander
4 American Indian/Alaska Native
5 Hispanic

6 Other (specify): _____
7 Unknown

11. Was the person who attacked you under the influence of drugs and/or alcohol at the time of the assault?
1 Yes 0 No 7 Unknown

12. Did the person who attacked you persuade you to use drugs and/or alcohol or put drugs into your drink prior to the assault?
1 Yes 0 No 7 Unknown

13. When you were assaulted, which of the following occurred? *(Circle all that apply.)*
1 Vaginal penetration with a penis
2 Vaginal penetration with a finger or foreign object
3 Oral sex
4 Anal penetration with a penis
5 Anal penetration with a finger or foreign object
6 Sexual touching
7 Other _____

14. Did you receive any other physical injuries in addition to the rape/sexual assault? 1 Yes 0 No

IF NO, SKIP TO QUESTION 16.

15. Please describe the physical injuries.

_____
_____
_____
_____

16. Did the person who assaulted you use a weapon? 1 Yes 0 No

IF NO, SKIP TO QUESTION 17.

What type of weapon was used?
1 Firearm
2 Knife
3 Blunt instrument
4 Other

17. Where did the assault take place? _____

18. Had you been stalked by the person who assaulted you? By stalking, I mean that the attacker followed you, made unwanted phone calls, or sent you letters or e-mails for an extended period of time.
1 Yes 0 No

19. Have you ever been sexually assaulted, molested, or raped by someone before this incident?
1 Yes 0 No

IF NO, SKIP TO QUESTION 21

20. Did you ever seek help when you were sexually assaulted, molested, or raped before? 1 Yes 0 No

21. How long after the sexual assault was it before you told someone about it? *(Fill in the appropriate blank below.)*

_____ hours or _____ days or _____ months or _____ years

IF INDIVIDUAL NEVER TOLD ANYONE, SKIP TO QUESTION 31 UNDER MEDICAL CARE.ON PAGE 5

22. Who was the first person that you told about the sexual assault?

1 Mother
2 Father
3 Sister
4 Brother
5 Other Relative _____
6 Friend
7 911
8 Police
9 Medical Professional (doctor/nurse/hospital staff)
10 Attorney
11 Rape Crisis Center
12 Spouse
13 Hairdresser
14 Clergy
15 Therapist/counselor
16 Teacher
17 Co-worker
18 Other _____

23. Why did you choose that person? _____

24. How did that person react when you told them? _____
_____
_____
_____

25. Based on the person's reaction, did it appear that they believed you? 1 Yes 0 No

What made you think that they did or did not believe you?
_____
_____

26. Have you told anyone else? 1 Yes 0 No

IF NO, SKIP TO QUESTION 31 UNDER MEDICAL CARE ON PAGE 5.

27. Who else did you tell? *(Circle all that apply.)*

1 Mother
2 Father
3 Sister
4 Brother
5 Other Relative _____

6 Friend
7 Police
8 Medical professional (doctor/nurse/hospital staff)
9 Attorney
10 Hairdresser
11 Clergy
12 Therapist/Counselor
13 Teacher
14 Co-worker
15 Other _____
16 Other _____

28. How did each person react when you told them?
(If there is more than one person, write number (e.g.1), then the response for that person)
_____
_____
_____

29. Based on the person's reaction, did it appear that they believed you? 1 Yes 0 No

30. What made you think that they did or did not believe you?
_____
_____

MEDICAL CARE - Now I am going to ask some questions about medical services.

31. Did you seek medical care in relation to the sexual assault? 1 Yes 0 No

IF YES, SKIP TO QUESTION 33.

32. Why did you not seek medical care?
_____

SKIP TO QUESTION 50 UNDER LAW ENFORCEMENT ON PAGE 7.

33. How long after the assault did you have a medical examination? _____

34. What prompted you to seek care at a medical facility? *(Circle all that apply.)*
1 Injuries
2 Possible sexually transmitted disease
3 Possible pregnancy
4 Family suggestion
5 Friend suggestion
6 Police officer
7 Wanting to get evidence
8 Other (specify) _____

35. Did you tell the medical professionals that your visit/injuries had to do with being sexually assaulted?
1 Yes 0 No

36. Where did you receive medical treatment for the sexual assault?
1 Hospital
2 Clinic (Planned Parenthood, Community Health Clinic)
3 Doctor's office (Family Practitioner, GYN)
4 Other_____

37. `In what county did you receive the medical treatment services?
County: _____

38. Who performed the medical examination? *(Circle all that apply.)*
1 Physician
2 Nurse/Nurse practitioner
3 SAFE/SANE examiner
4 Don't know

39. Was a rape kit completed (collections of evidence)? 1 Yes 0 No

40. Did someone at the hospital tell you about forms of emergency contraception, such as the morning-after pill or Plan B, that were available? 1 Yes 0 No

IF NO, SKIP TO QUESTION 42.

41. Did you take emergency contraception? 1 Yes 0 No

42. Were you tested (and if necessary treated) for any sexually transmitted diseases? 1 Yes 0 No

43. How would you rate your satisfaction with the provision of the physical examination?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

44. How would you rate your satisfaction with the provision of the testing service for sexually transmitted diseases?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

45. How would you rate your satisfaction with the delivery of information about the availability of emergency contraceptives?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

46. Please rate the importance to you of the following medical services:

a) Testing for and treating sexually transmitted diseases

1 Very Important 2 Somewhat Important 3 Not At All Important

b) Medical treatment for injuries

1 Very Important 2 Somewhat Important 3 Not At All Important

c) Offering emergency contraception (morning-after pill, Plan B)

1 Very Important 2 Somewhat Important 3 Not At All Important

d) Collection of evidence

1 Very Important 2 Somewhat Important 3 Not At All Important

47. Who paid for the medical services (such as examination, treatment for sexually transmitted diseases, or emergency contraception) you received?

1 Insurance 2 Out-Of Pocket 3 No Charge 4 Other _____

48. Are you aware that in the state of Maryland you are not to be charged a fee from the hospital for medical treatment related to sexual assault services if you report the assault to the police? 1 Yes 0 No

IF NO, SKIP TO QUESTION 49.

If you were aware of this policy, did this influence your decision to report the assault to the police? 1 Yes 0 No

49. Have you ever received a bill from the hospital for services related to a sexual assault even though you reported the assault to the police? 1 Yes 0 No

LAW ENFORCEMENT – I am going to ask some questions about interactions with the law enforcement system.

50. Did you tell the police about the sexual assault? 1 Yes 0 No

IF YES, SKIP TO QUESTION 52.

If not, why not? _____

51. Do you plan to tell the police (make a police report)? 1 Yes 0 No

IF YES, SKIP TO QUESTION 72 UNDER SEEKING SERVICES FROM A SEXUAL ASSAULT CRISIS CENTER ON PAGE 9.

If not, why not? _____

SKIP TO QUESTION 72 UNDER SEEKING SERVICES FROM A SEXUAL ASSAULT CRISIS CENTER ON PAGE 9

52. How long after the sexual assault did you tell the police? _____

53. Do you think the police believed you? 1 Yes 0 No

54. What made you think that the police did or did not believe you?
_____

55. Have criminal charges been filed against the person who assaulted you? 1 Yes 0 No

IF YES, SKIP TO QUESTION 57

If not, why not? _____

56. Do you plan to initiate criminal charges against the person who assaulted you? 1 Yes 0 No

IF YES, SKIP TO QUESTION 57

If not, why not? _____

SKIP TO QUESTION 58

57. Was the person who assaulted you arrested? 1 Yes 0 No

58. How would you rate your satisfaction with how the police interviewed you regarding the assault?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

59. How would you rate your satisfaction with how the police handled/pursued your case?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

60. How would you rate your satisfaction with your overall interactions with the police?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

PROSECUTION/COURT PROCESS

61. Did you interact with the prosecutor's office? 1 Yes 0 No

IF YES, SKIP TO QUESTION 62.

If not, why not? _____

SKIP TO QUESTION 72 UNDER SEEKING SERVICES FROM A SEXUAL ASSAULT CENTER ON PAGE 9.

62. How often did you speak with the prosecutor? _____

63. Do you think the prosecutor believed you? 1 Yes 0 No

64. What made you think that the prosecutor did or did not believe you?
_____

65. Were you assigned a victim advocate in the prosecutor's office? 1 Yes 0 No

66. Were you informed of the availability of victim assistance funds? 1 Yes 0 No

67. Was your case prosecuted? 1 Yes 0 No

IF YES, SKIP TO QUESTION 68

If not, why not? _____

68. How would you rate your satisfaction with your interactions with the prosecutor's office?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

69. How would you rate your overall satisfaction with the court process?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

70. Was the perpetrator convicted? 1 Yes 0 No

IF NO, SKIP TO QUESTION 71.

Did the perpetrator serve jail time? 1 Yes 0 No

71. Who paid for any legal assistance services you received?

1 Out-Of Pocket 2 No Charge 3 Other _____ 4 Didn't Use

SEEKING SEXUAL ASSAULT SERVICES FROM A SEXUAL ASSAULT CRISIS CENTER – I am going to ask you some questions about receiving services to help you deal with the sexual assault.

72. Did you receive services from a sexual assault crisis center? 1 Yes 0 No

IF YES, SKIP TO QUESTION 73

If not, why not? _____

SKIP TO QUESTION 94 UNDER SEEKING OTHER COUNSELING SERVICES SECTION ON PAGE 13

73. Prior to victimization, did you know about the sexual assault crisis center? 1 Yes 0 No

74. Did you have any problems finding a sexual assault crisis center? 1 Yes 0 No

IF NO, SKIP TO QUESTION 75.

What problems did you have?
_____

75. How did you learn about the sexual assault crisis center where you went? *(Circle all that apply.)*
1 Newspaper advertising
2 Telephone book
3 Word of mouth
4 Friend
5 Relative
6 Therapist
7 Health care professional
8 Clergy (Pastor, Minister)
9 Police
10 Hospital
11 School
12 Television
13 Other_____

76. In what county was the sexual assault crisis center where you received services?
County: _____

77. How long after you were assaulted did you come to the sexual assault crisis center?
1 Within 24 hours of incident
2 Within 1 week
3 Within 1 month
4 Within 2 – 6 months
5 Within 6 – 12 months
6 More than 1 year

IF 1, SKIP TO QUESTION 78.

What prevented you from going for services sooner?
_____

78. What prompted you to seek care at the sexual assault crisis center? *(Circle all that apply.)*
1 Family suggestion
2 Friend suggestion
3 Referral from police officer

4 Referral from hospital
5 Felt anxious or depressed (bad feelings that wouldn't go away)
6 Wanted to talk with someone who understood what you had been through
7 Relationship problems
8 Nightmares/flashbacks
9 Trouble at work
10 General hard time functioning
11 Something similar happened to your child
12 Other, specify:_____

79. What was your first point of contact with the sexual assault crisis center?
1 Hotline
2 Victim advocate at hospital
3 Other _____

80. How would you rate the overall sexual assault services that you received from the sexual assault crisis center?
1 Very poor 2 Poor 3 Adequate 4 Good 5 Excellent

81. Did you receive individual counseling services at the sexual assault crisis center? 1 Yes 0 No

IF NO, SKIP TO QUESTION 82.

How many individual counseling sessions did you attend per week? _____
How long did you receive individual counseling? _____
How would you rate your satisfaction with the provision of individual counseling service?
1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

82. Did you receive group counseling services at the sexual assault crisis center? 1 Yes 0 No

IF NO, SKIP TO QUESTION 83.

How many group counseling sessions did you attend per week? _____
How long did you receive group counseling? _____
How would you rate your satisfaction with the provision of group counseling service?
1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

83. Did you call the sexual assault hotline at the sexual assault crisis center? 1 Yes 0 No

IF NO, SKIP TO QUESTION 84.

How would you rate your satisfaction with the provision of the sexual assault hotline service?
1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

84. Did you receive legal services at the sexual assault crisis center? 1 Yes 0 No

IF NO, SKIP TO QUESTION 85.

How would you rate your satisfaction the provision of legal services?
1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

85. Did you receive advocacy services, such as accompaniment for police interviews, hospital visits, and/or court appearances, from the sexual assault crisis center? 1 Yes 0 No

IF NO, SKIP TO QUESTION 86.

How would you rate your satisfaction with the provision of advocacy services?
1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

86. Were you referred to another agency for additional services? 1 Yes 0 No

IF NO, SKIP TO QUESTION 90.

87. What additional services were you referred for? *(Circle all that apply.)*
1 Legal assistance
2 Medical services
3 Mental health counseling
4 Social services
5 Substance abuse counseling
6 Domestic violence counseling
7 Other_____

88. How would you rate your satisfaction with the provision of the referral service?

1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

89. Who paid for other referred services you received?
1 Insurance 2 Out-of pocket 3 No charge 4 Other _____

90. How important were the following to you?

1 Helping you cope with difficult feelings
1 Very Important 2 Somewhat Important 3 Not At All Important

2 Helping with legal matters
1 Very Important 2 Somewhat Important 3 Not At All Important

3 Helping you decide how to tell people you think need to know
1 Very Important 2 Somewhat Important 3 Not At All Important

4 Helping you create a support system
1 Very Important 2 Somewhat Important 3 Not At All Important

5 Confidentiality
1 Very Important 2 Somewhat Important 3 Not At All Important

91. Did you receive a statement of confidentiality from the sexual assault crisis center? 1 Yes 0 No

92. On a scale of 1 to 10, with 1 being not sure at all and 10 being very sure, how confident are you that your discussions were kept confidential at the sexual assault crisis center?

Not sure at all Very sure
1 2 3 4 5 6 7 8 9 10

93. Who paid for counseling services you received?
1 Insurance 2 Out-of pocket 3 No charge 4 Other _____

SEEKING OTHER COUNSELING SERVICES

94. Did you get counseling services from a place other than a sexual assault crisis center? 1 Yes 0 No

IF NO, SKIP TO QUESTION 103 UNDER RECOMMENDATIONS FOR IMPROVEMENT SECTION ON PAGE 14

95. Where did you receive counseling services for sexual assault other than a sexual assault crisis center? *(Circle all that apply.)*
1 Church/pastor
2 Therapist/counselor
3 Hospital
4 Other (specify) _____

96. How long after you were assaulted did you receive counseling services?
1 Within 24 hours of incident
2 Within 1 week
3 Within 1 month
4 Within 2 – 6 months
5 Within 6 – 12 months
6 More than 1 year

IF ANSWER WAS 1, SKIP TO QUESTION 97.

What prevented you from going for services sooner?
_____

97. What prompted you to seek counseling services? *(Circle all that apply.)*
1 Family suggestion
2 Friend suggestion
3 Police officer
4 Hospital referral
5 Felt anxious or depressed (bad feelings that wouldn't go away)
6 Wanted to talk with someone who understood what you had been through
7 Relationship problems
8 Nightmares/flashbacks
9 Employee assistance program
10 General hard time functioning
11 Something similar happened to your child
12 Other, specify:_____

98. Did you receive individual counseling services? 1 Yes 0 No

IF NO, SKIP TO QUESTION 99.

How many individual counseling sessions did you attend per week? _____
How long did you receive individual counseling? _____
How would you rate your satisfaction with the provision of individual counseling services?
1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

99. Did you receive group counseling services? 1 Yes 0 No

IF NO, SKIP TO QUESTION 100.

How many group counseling sessions did you attend per week? _____
How long did you receive group counseling? _____
How would you rate your satisfaction with the provision of group counseling services?
1 Very Dissatisfied 2 Somewhat Dissatisfied 3 Somewhat Satisfied 4 Very Satisfied

If dissatisfied, explain why. _____
_____

100. Who paid for counseling services you received?
1 Insurance 2 Out-of pocket 3 No charge 4 Other _____

101. Did you receive a statement of confidentiality from the person you received counseling services from?
1 Yes 0 No

102. On a scale of 1 to 10, with 1 being not sure at all and 10 being very sure, how confident are you that your discussions were kept confidential?
Not sure at all Very sure
1 2 3 4 5 6 7 8 9 10

RECOMMENDATIONS FOR IMPROVEMENT – I am now going to ask you some questions about your overall experience in receiving services for sexual assault.

103. Looking back, what was the biggest problem or difficulty you had in your sexual assault treatment experience?

_____
_____

104. What service or experience was the most helpful to you?

_____
_____

105. What are the strategies you used in coping with the aftermath of the sexual assault?

_____
_____

106. Do you think your race/ethnicity was a factor in how people responded to you? 1 Yes 0 No

If yes, why or how? _____
_____

107. Do you think race/ethnicity of the perpetrator was a factor in how people responded to you? 1 Yes 0 No

If yes, why or how? _____
_____

108. What would you recommend to your community as ways to improve how it responds to people who have been sexually assaulted?

_____
_____

109. If you could make one recommendation to the state for improvement of the sexual assault treatment service in Maryland, what would it be?

_____
_____

110. Is there anything you would like to say?

_____
_____

That is all the questions I have. Thank you for taking the time to be interviewed for this study.

Addendum to the Interview Instrument
Questions 28 through 30

Person told (number from question 27) _____

How did that person react when you told them? _____
_____
_____
_____

Based on the person's reaction, did it appear that they believed you? 1 Yes 0 No

What made you think that they did or did not believe you? _____
_____
_____
_____

Person told (number from question 27) _____

How did that person react when you told them? _____
_____
_____
_____

Based on the person's reaction, did it appear that they believed you? 1 Yes 0 No

What made you think that they did or did not believe you? _____
_____
_____
_____

Person told (number from question 27) _____

How did that person react when you told them? _____
_____
_____
_____

Based on the person's reaction, did it appear that they believed you? 1 Yes 0 No

What made you think that they did or did not believe you? _____
_____
_____
_____

Curriculum Vitae
Julie Lindahl

Education

2012 – 2015	Ph.D., Psychology, Forensic Psychology Specialization Walden University Dissertation: *Satisfaction and Use: Comparing First-time Victims and Victims of Multiple Sexual Assaults*
2010 – 2011	MS in Forensic Psychology, Mental Health Applications Walden University
2003 – 2004	BS in Psychology Double Minor: Criminal Justice/Public Law & Government Eastern Michigan University

Experience

2014 – present	SHARP Program Manager Department of the Army, Huntsville, AL
2014	Regional Sexual Assault Response Coordinator SAPR Program, Department of the Navy, Norfolk, VA
2013 – 2014	Installation Sexual Assault Response Coordinator SHARP Program, Department of the Army, Natick, MA
2011 – 2013	Victim Advocate Program Specialist FAP/SAPR Prgms, United States Marine Corps, Jacksonville, NC
2010 – 2011	Co-facilitator Adult Sex Offender Treatment Group, Greenville Counselors, Greenville, NC
2008 – 2011	Adjunct Instructor Psychology Department, Pitt Community College, Winterville, NC

Certifications

2013 – 2015	D-SAACP Advocate Level II #XY-0612-3061

Volunteer

2014 – present	Advisory Council Member National Sexual Violence Resource Center, Enola, PA
2004 – 2007	Response Team Advocate SafeHouse Center, Ann Arbor, MI