

Community Services for Rape Survivors: Enhancing Psychological Well-Being or Increasing Trauma?

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This research examined how contact with the legal, medical, and mental health systems affects rape survivors' psychological well-being. Although community services may be beneficial for some victims, there is increasing evidence that they can add trauma, rather than alleviate distress (termed *secondary victimization*). This study examined how secondary victimization affects rape survivors' posttraumatic stress (PTS) symptoms. Adaptive and snowball sampling were used to recruit a sample of 102 rape survivors. Victims of nonstranger rape who received minimal assistance from either the legal or medical system, and encountered victim-blaming behaviors from system personnel, had significantly elevated levels of PTS. This high-risk group of rape survivors had PTS levels significantly higher than all other victims in this study, including those who did not seek community assistance posttrauma. However, for these high-risk rape survivors, receiving sustained mental health services after these negative experiences was associated with a significant decrease in PTS.

"They were raking me over the coals, making me feel like a slug, making me feel guilty for doing all the actions I did that day, and treating me like I was the one who raped, the offender, not the victim."

—A rape survivor on filing a police report

"Worst experience ever. And it was because of the doctor. He was very rough. And he was saying, 'Open your legs. Stay still. Open them further.' I'm saying, 'Excuse me?' I feel like saying, 'I have just been raped!' He was just so crass, so rude about it. Really cold... And then when he scraped [taking the vaginal swabs], I jumped, and he says, 'You gotta stay still!'"

—A rape survivor on the medical rape exam

"My therapist kept talking about my need for attention. How I made bad choices in life because of my need for attention. How I got myself raped for attention. Those words hurt as much as the rape itself."

—A rape survivor on mental health counseling

These rape survivors' narratives speak to the detrimental effect community services may have on women's psychological well-being.¹ To date, the rape victimology literature has focused primarily on assessing the prevalence of rape and its impact (e.g., Atkeson, Calhoun, Resick, & Ellis, 1982; Golding, 1994; Kil-

patrick et al., 1985; Kimerling & Calhoun, 1994; Koss, 1993; Koss, Gidycz, & Wisniewski, 1987; Riggs, Kilpatrick, & Resnick, 1992), as well as developing effective therapeutic interventions (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Frank et al., 1988; Resick & Schnicke, 1992; Rothbaum, 1997). Nevertheless, as these narratives suggest, rape survivors' experiences with the legal, medical, and mental health systems may "hurt as much as the rape itself." The trauma of rape, therefore, may extend far beyond the actual assault, and intervention strategies must address the difficulties rape survivors encounter when seeking community help.

A growing body of research suggests that survivors are often denied help by their communities, and what help they do receive may often leave them feeling revictimized (Campbell, 1998; Campbell & Bybee, 1997; Frohmann, 1991; Madigan & Gamble, 1991; Martin & Powell, 1994; Matoesian, 1993; Williams, 1984). These negative experiences have been termed the *second rape* or *secondary victimization* (Madigan & Gamble, 1991; Martin & Powell, 1994; Williams, 1984). Analysis of these interactions between victims and social systems may uncover ways to promote a community response to rape that is psychologically beneficial to victimized women.

Sexual assault has widespread effects on women's psychological and physical health (see Koss, 1993), and as a result, rape victims may contact several community agencies for assistance, such as the legal, medical, and mental health systems (Campbell, 1998). The services provided by these systems are often difficult to access and potentially stressful for rape survivors.

Most rape survivors never get their day in court. Only 25% of reported rapes are accepted for prosecution, 12% of defendants are actually found guilty, and 7% of all cases result in a prison term (Frazier & Haney, 1996). In addition, Campbell (1998) found that even for survivors who had the assistance of an advocate, 67% had

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¹ The quotations are from rape survivors interviewed in this study.

their legal cases dismissed; more than 80% of the time, this decision was made by legal personnel and contradicted the victims' wishes to prosecute. Nevertheless, a small proportion of rape victims do have their cases prosecuted, but it is unclear whether this assistance is actually helpful to survivors. For example, both Matoesian (1993) and Sloan (1995) concluded that the procedures of prosecution are harmful to women's well-being. Similarly, Cluss, Boughton, Frank, Stewart, and West (1983) found that rape victims whose cases were prosecuted were more distressed than those whose cases were not prosecuted. By contrast, Frazier and Haney (1996) reported that survivors held positive attitudes toward investigating officers but were frustrated by the overall response of the criminal justice system. These findings suggest that the type of help offered to some rape victims by the legal system may not be perceived as "help" but instead as stressful and traumatic.

Rape is not only a criminal event but also a health risk. As a result, many rape survivors turn to the medical system for assistance (e.g., a physical exam to detect and treat injuries, forensic evidence collection, screening and treatment for STDs, and pregnancy testing and prevention; Campbell & Bybee, 1997). Despite these diverse medical needs, current research suggests that many survivors are not receiving adequate care. More than 50% of female rape victims are not advised about pregnancy testing and prevention, and only 40% are given information about the risk of STDs (Campbell & Bybee, 1997; National Victim Center, 1992). Even if rape survivors are able to obtain needed medical care, there has been some concern in the literature that the services themselves may be quite traumatizing. The physical intrusiveness of the rape exam procedures often leaves many women feeling violated and reraped (Parrot, 1991). The services provided by the medical system, like those offered by the legal system, may provide assistance to some rape survivors but, for others, may actually increase trauma.

Because of the trauma associated with rape, mental health workers are also called on to help victims and those close to them who are also traumatized by the rape (e.g., family, friends, and marital or relationship partners). A variety of successful clinical interventions have been supported in the literature (e.g., Foa et al., 1991; Frank et al., 1988; Resick & Schnicke, 1992; Rothbaum, 1997), suggesting that mental health services are quite beneficial to rape survivors. However, not all mental health providers use these established successful techniques, and some feminist therapists have argued that traditional psychotherapy may be victim blaming (e.g., Brown, 1994; Wyche & Rice, 1997). Thus, in contrast to the legal and medical systems, there is less evidence to suggest that mental health services can be revictimizing to rape survivors, although this possibility is worthy of empirical investigation.

The goal of the present study was to examine how contact with social systems affects rape survivors' psychological well-being. Consistent with the rape victimology literature, posttraumatic stress (PTS) symptoms were used as the index of well-being (see Foa, Steketee, & Olasov, 1989; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). The conceptual model guiding this research compared the psychological health outcomes of rape survivors who sought community-based services (legal, medical, and/or mental health) with those who did not seek such services (i.e., a nonequivalent control-group design; Cook & Campbell, 1979).² Table 1 summarizes the purpose of this study, its conceptual questions, and its analytic plan into a three-phase model of inquiry.

In Phase I of this study, the primary goal was to understand the impact of social system contact on rape survivors' well-being (PTS symptoms), controlling for individual-level and rape-related variables. Time since the assault occurred was controlled in all analyses. Demographic control variables included age at assault, race/ethnicity, marital status, and education level. Characteristics of the rape may also affect survivors' PTS symptoms and must be accounted for as well: type of rape (stranger vs. nonstranger rape), the presence of physical injuries, the use of a weapon, and alcohol use by the victim. These variables have been demonstrated in prior research to affect either posttraumatic stress disorder (PTSD) or service providers' perceptions of rape victims (see Campbell, 1998; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). After the effects of these control variables have been established, measures of system contact can be evaluated. Two elements of community contact were assessed: (a) the services provided (or denied) by each system (i.e., what forms and how many services were received) and (b) victims' experiences of secondary victimization with each system (i.e., what behaviors and how many negative experiences were endured; see Williams, 1984, for an operational definition of secondary victimization).

In Phase II of the analyses, the type of rape was examined because it can affect how service providers respond to victims (see Estrich, 1987). Victims of nonstranger rape (acquaintance, date, and marital rape) have been found to experience more difficulty obtaining community services and may be more at risk for negative, victim-blaming treatment (Campbell, 1998; Kerstetter, 1990). Thus, the type of rape may function as a moderator of victims' outcomes, not a direct effect. In other words, if a survivor was a victim of stranger rape, rather than nonstranger rape, are there differential relationships between social system contact and PTS symptoms?

Finally, the literature suggests that contact with the legal and medical systems may be particularly difficult for rape survivors, but there has been less concern raised about the mental health system. In Phase III of this study, the goal was to understand the impact of social system contact on PTS symptoms as moderated by type of rape and contact with helpful social systems, such as the mental health system. It is possible that mental health services may "undo" some damage associated with negative experiences from other community agencies.³

Method

Sampling Design

A variety of techniques has been used in previous research to obtain samples of rape victims (see Campbell, Ahrens, & Sefl, 1999, for a review). Two of the more commonly used strategies—random digit dialing

² Although conceptually this study follows a nonequivalent control-group design, the analytic plan does not include simple group contrasts. Rather, the goal was to obtain a sample of rape survivors with diverse community experiences (those with and without system contact) so as to maximize variability on measures of system contact.

³ All of the rape survivors in this study who had contact with the mental health system did so after contact with the legal and/or medical systems. So, although this study used a cross-sectional design, rather than a longitudinal design, it is possible to conduct these exploratory analyses on how mental health contact buffers the effects of other social systems (Phase III).

Table 1

Phases of Data Analysis to Assess Impact of Social System Contact on Rape Survivors' Posttraumatic Stress (PTS)

Phase	Conceptual question	Analytic plan ^a
I	To understand impact of social system contact on PTS, controlling for individual-level and rape-related variables ^b	Equation 1: Individual-level variables: Age at assault, race, marital status, education level Rape-related variables: Type of rape, injuries, weapon, alcohol use System contact variables: Legal services, legal SV, medical services, medical SV, mental health services, mental health SV
II	To understand impact of social system contact on PTS, as moderated by type of rape, controlling for individual-level and rape-related variables as needed ^c	Equation 2 (legal): Legal services, legal SV, type of rape, all two-way interactions, three-way interaction Equation 3 (medical): Medical services, medical SV, type of rape, all two-way interactions, three-way interaction Equation 4 (mental health): Mental health services, mental health SV, type of rape, all two-way interactions, three-way interaction
III	To understand impact of social system contact on PTS, as moderated by type of rape and buffered by contact with helpful social systems, controlling for individual-level and rape-related variables as needed ^d	Equation 5 (legal and mental health): Four-way interaction (Legal Services \times Legal SV \times Type of Rape \times Mental Health Services) Equation 6 (medical and mental health): Four-way interaction (Medical Services \times Medical SV \times Type of Rape \times Mental Health Services)

Note. Given the increased complexity of the analyses in Phases II and III, each social system (legal, medical, and mental health) is examined in separate equations. SV = secondary victimization.

^a In all equations, a control variable (time since assault) is entered first in its own block before entering the predictor variables. PTS is the dependent variable. ^b No moderators were included in Phase I to understand the effect of system contact in its own right. ^c Nonsignificant variables in Phase I are not carried over into Phases II and III. ^d Nonsignificant variables in Phase II are not carried over into Phase III.

and recruitment through social systems (e.g., hospital emergency rooms and police department rape crisis centers)—were not used in this study. There has been some concern in the literature that the invasive nature of these methods may be incompatible with survivors' needs to reinstate control and personal boundaries after the violation of the assault (see Campbell et al., 1999). Furthermore, in this study, systems-based techniques are not methodologically appropriate. Given that the primary goal of this study was to examine how contact with social systems affects rape survivors' psychological well-being, the target sample needed to include victims who did and did not have contact with community agencies. Recruiting through social systems would locate only some of the participants to be studied (those with system contact) and would require the use of other sampling techniques to locate rape survivors who did not have contact with social systems. The use of two recruitment strategies would confound sampling protocol with the group contrast (system contact vs. no system contact).

Therefore, a new sampling strategy was developed for the present study, which was designed to maximize both sampling rigor and responsiveness to the needs of rape survivors in recovery (see Sefl, Campbell, Wasco, Barnes, & Ahrens, 1999, for details of the sampling rationale and methods). This recruitment protocol was modeled after the techniques of adaptive sampling (Thompson & Seber, 1996). Adaptive sampling has been used primarily in the natural sciences to sample migratory animals and requires that researchers systematically sample locations in which the target population may congregate. Such locations may shift over time, so sampling must occur in a variety of settings (breadth) and frequently within high concentration settings (depth). In applying this logic to the recruitment of rape survivors, settings and locations with high concentrations of women would be appropriate targets for locating rape survivors.

The city of Chicago and its two closest suburbs were divided into regions on the basis of zip codes; this sampling unit was selected because it is possible to obtain census information stratified by zip code. To ensure adequate breadth of coverage, we targeted zip codes representing women of varying races and socioeconomic statuses (SESs; according to the 1990 U.S. Census) for recruitment efforts. To ensure adequate depth of coverage and representation of women of Color, we invested intensive recruitment in

certain zip-code areas. In each zip code, requests for participation in this study were made using posters, fliers, and in-person presentations to groups of women. The content of these requests was designed to be responsive to the needs of rape survivors in recovery and to facilitate trust; three key points were emphasized: (a) Many women have been sexually assaulted, but it is difficult to talk about such experiences; (b) this study's all-female research team would like to hear from women who have talked about such experiences before, as well as those who have never discussed the assault before, when they feel ready to do so; and (c) the research team ensures a safe, comfortable, and respectful interview environment.

In contrast to previous studies, the placement of posters and fliers and the locations for in-person presentations were not based on convenience but were instead systematically plotted. Detailed records were kept indicating the exact location in the city where each poster or flier was placed and each presentation was conducted. The type of settings targeted within each zip code varied but included places where women may be living, working, or passing through as part of their daily activities (the "daily round"), including public transportation sites, grocery stores, currency exchanges, Laundromats, schools, coffee shops, bookstores, gyms, spas, nail and beauty salons, social service agencies, libraries, and churches.

Recruitment was conducted between September 1997 and April 1998, and during that time 2,916 recruitment materials (fliers, posters, and in-person presentations) were distributed: 33% to nail and beauty salons, 17% to daily round locations (e.g., public transportation sites, grocery stores, currency exchanges, Laundromats, and schools), 15% to Chicago public libraries (main and branch sites), 13% to social service agencies, 9% to bookstores, 7% to churches, and 5% to special bookstore events throughout Chicago. These recruitment efforts were spread throughout the Chicago area: Of the 69 zip codes within the city and two closest suburbs, 61 zip codes received at least one recruitment and 37 received 10 or more distributions of information. Recruitment activities were both broad (88% of all zip codes were covered) and intense (61% were targeted for multiple distributions).

As a result of this distribution of information throughout the city, the project office received 186 calls from women requesting participation in the study. Of those calls—some of which were answered immediately by

project staff and some of which were placed after-hours—we were able to establish contact with 157 women (84%) but were unable to reach 29 women (e.g., no phone number to call back, changed numbers, or missed calls) despite numerous attempts to do so. Of the 157 women we could contact, 112 women (71%) were eligible to participate: They were 18 years of age or older at the time of the assault and were assaulted by a stranger, acquaintance, dating partner, or husband.⁴ The 45 women who screened out were given a comprehensive packet of community referrals. Of the 112 women who were eligible to participate, completed interviews were conducted with 102 participants (91%); the remaining 10 women did not complete an interview because of missed appointments and unsuccessful attempts at rescheduling.

To gauge the effectiveness of this new sampling protocol, we asked the 102 participants how and where they heard about the study. In 82 cases (80%), it was possible to trace a woman's involvement in the study to a specific recruitment technique and zip-code location (i.e., 82 "traceable" participants). The remaining 20 cases were obtained through snowball sampling—these women heard about the study through a variety of untraceable sources. The recruitment settings that proved most successful were targeting the daily round (57% of the traceable participants were recruited through daily round settings). Of the 61 city zip codes in which recruitment was conducted, 27 zip codes (44%) yielded a traceable participant. Of the 37 zip codes that received intensive recruitment efforts, 73% yielded a traceable participant.

To assess the representativeness of these 27 zip codes vis-à-vis characteristics of the Chicago metropolitan area as a whole, we compared these zip codes with citywide data using 1990 U.S. Census information (age, race, marital status, education level, and employment). These 27 zip codes were comparable with the larger metropolitan area with respect to age, marital status, and employment status. However, the 27 zip codes that yielded traceable participants for this study had a significantly higher representation of African American women, $\chi^2(1, N = 69) = 7.33, p < .05$, and a significantly lower representation of White women, $\chi^2(1, N = 69) = 6.07, p < .05$. These differences are not surprising, given our extensive efforts to recruit women of Color.

To assess the representativeness of the 82 traceable participants vis-à-vis the other women in those zip code areas, we compared our participants' demographics with 1990 U.S. Census data for the female residents of these 27 zip codes. Results indicated no significant differences in age, race, marital status, education level, and employment between the participants of this study and the adult female residents of these 27 zip codes. Thus, in contrast to previous studies of rape survivors in Chicago (e.g., Bart & O'Brien, 1984), the sample in the study is representative of the regions of Chicago from which the participants were recruited.

Participants

One hundred two female rape survivors participated in this study. The average current age of this sample was 34.29 years ($SD = 10.05$, range = 18–64); average age at the time of the assault was 26.68 years ($SD = 8.67$, range = 18–52).⁵ In contrast to many studies in the rape victimology literature, this sample was not primarily White: 51% were African American, 37% were White, 6% were Latina, 5% were multiracial, and 1% were Asian American. Almost one third of the sample (30%) was currently married, and 53% had children. Most women (82%) had a high school education (24% were college graduates), and 61% were currently employed.

Consistent with previous research, most of the rape survivors in this sample were assaulted by someone they knew (acquaintance, date, or partner; 66%) and most were raped by a single assailant (94%). Thirty-eight percent were not physically injured in the attack, but of those who were injured, 86% experienced bruising, 49% were cut during the assault, 21% experienced some type of head injury (e.g., blow to the head or broken blood vessels in eyes and face from being choked), 5% contracted an STD from the assault, and approximately 1% were permanently disabled from the assault. Most women did not have a weapon used against them (70%),

and most were not under the influence of alcohol (70%). On average, the rape had occurred 8.25 years prior to the conducting of this interview.

Procedure

Interviews were conducted in person, with a mean duration of 2.27 hr ($SD = 54.96$ min, range = 45 min–5.5 hr). Each participant was paid \$30 and given public transportation tokens to reimburse them for transportation expenses. The tape-recorded interviews were conducted by the six authors and five additional undergraduate research assistants, who received course credit for their participation in the project. To assess interrater reliability, a second interviewer listened to a random sample of 25% of the interviews to code the entire interview. Interrater agreement was 96%, which was corrected for chance agreement ($\kappa = .88$).

Measures

Measures of social system contact. We used three measures to collect data about each of the three main social systems with which the victims may have had contact: legal, medical, and mental health. First, each survivor was asked whether she had "any contact at all" with each system (0 = no, 1 = yes). Contact percentages were quite comparable across systems: 39% of the sample had contact with the legal system, 43% with the medical system, and 39% with the mental health system.

Second, for each system with which a victim had contact, she was asked which services she received from a list of all the possible services that could have been provided by that system (list provided by two rape crisis centers and verified by one police department, two hospitals, and three mental health agencies): The legal system provided six services (e.g., police report was taken and an investigation was conducted), the medical system provided nine services (e.g., rape exam and evidence collection and STD screening), and the mental health system provided two services (short- and long-term counseling). To distinguish victims who received a great deal of help from a social system from those who received minimal or no help, we computed a summed scale for each system to reflect the number of services provided to each victim. (See Table 2 for the psychometric properties of the Services Received Scales.)

Third, an exploratory approach was used to develop scales assessing secondary victimization of rape survivors because there are no established measures from which to work. To create scales that were similar, conceptually and methodologically, to the Services Received Scales, the research team sought to identify a list of behaviors that social system personnel may

⁴ Our recruitment materials used both the terms *rape* and *sexual assault*, given that previous research has found that many victims do not use the term *rape* to describe their experiences (Koss et al., 1987). We did not feel it was necessary to provide a uniform definition to the rape survivors in the screening process because our staff inquired about the type of assault the callers experienced. In all cases accepted for inclusion in this study, the victim (a) was at least 18 years old; (b) reported to us that she experienced vaginal, anal, and/or oral penetration (including penetration by an object) by a stranger, acquaintance, dating partner, or husband; and (c) reported to us that this penetration was committed by the use of force or the threat of force. These elements are common in most legal definitions of rape (see Berger, Searles, & Neuman, 1988). Because the focus of this study was how social systems respond to rape victims, incest survivors were not interviewed. Previous research has indicated that the response of the criminal justice system, in particular, is quite different in cases of incest, as compared with adult sexual assault (Russell, 1984).

⁵ We were required by our institutional review board to limit participation to survivors who were at least 18 years old currently and were at least 18 years old at the time of the assault. These criteria very likely produced an older sample of rape victims than in other reports in the literature.

Table 2
Measures of Social System Contact and Interscale Correlations

Scale	Psychometrics				Interscale correlations					
	<i>M</i>	<i>SD</i>	CITC	α^a	1	2	3	4	5	6
Services Received Scales										
1. Legal Services Received	0.93	1.71	.55-.86	.89	—	.55**	.06	.18	.38*	.10
2. Medical Services Received	1.69	2.66	.36-.75	.85		—	.06	.24*	.29*	.05
3. Mental Health Services Received	0.38	0.58	.11	.40			—	.12	.31*	.31*
Secondary Victimization (SV) Behaviors Experienced Scales										
4. Legal SV	1.20	2.38	.40-.79	.91				—	.14	.35*
5. Medical SV	1.01	1.43	.41-.84	.83					—	.26*
6. Mental Health SV	0.23	0.77	.50-.80	.78						—

Note. CITC = corrected item-total correlation.

^a The items in these scales were dichotomously coded (received service: 1 = yes, 0 = no), so it is to be expected that alphas for these scales will be lower.

* $p < .05$. ** $p < .01$.

exhibit in their interactions with rape survivors that could be distressing for rape survivors. Such lists (one list for each system studied: legal, medical, and mental health) were generated through reading published narratives of rape victims' experiences with social systems; the research team members' experiences as rape victim advocates; and consultation with rape crisis center staff, police officers, prosecutors, emergency room nurses, and mental health counselors. Just as the number of services that could be provided by each system varied, so too did the number of secondary victimization behaviors: For the legal system, there were 10 possible behaviors (e.g., police told you your case was not serious enough to pursue); for the medical system, there were 7 behaviors (e.g., medical personnel performed the rape exam without explanation); and for the mental health system, there were 4 behaviors (e.g., mental health personnel asked you for physical evidence of the rape).

In administering these scales, we asked the participants who had contact with a particular system if any of its personnel engaged in each behavior. If the survivor responded affirmatively to a behavior, she was then asked to rate how distressing this behavior was to her (1 = *none*, 2 = *a little*, 3 = *some*, 4 = *quite a bit*, 5 = *a great deal*) because it is quite possible that behaviors upsetting to some survivors may not be to others. Only if the behavior was rated as somewhat distressing (Level 3) or higher was that behavior coded as a "1"—she encountered the behavior, and it was distressing to her. If the survivor did not encounter the behavior, or if she did encounter it but was not distressed by it, then that behavior was coded as a "0." In other words, each secondary victimization behavior was coded as either a 1 (experienced and was distressed by behavior) or 0 (did not experience or did not experience behavior as distressing) for each participant. To distinguish victims who were subjected to many revictimizing behaviors from those who were not, we computed a summed scale for each system (legal, medical, and mental health) to reflect the number of secondary victimization behaviors each victim experienced. (See Table 2 for the psychometric properties of the Secondary Victimization Behaviors Experienced Scales.)

It is important to note that there are many scaling approaches that could have been used to score both the Services Received Scales and the Secondary Victimization Behaviors Experienced Scales. Our goal was to capture the "amount" of services received and secondary victimization experienced; hence, we used a dichotomous coding system with summed scaling. This approach, however, cannot distinguish between cases in which services were received but no secondary victimization occurred (Secondary Victimization Behaviors Experienced Scale score = 0) and cases in which no services were received; therefore, no secondary victimization could have occurred (secondary victimization scale score also = 0).

However, the purpose of this study was to explore the link between secondary victimization and PTS symptoms, so capturing the amount of secondary victimization experienced was critical. Although a score of 0 on the secondary victimization scales could occur under different circumstances, it always means that survivors did not encounter distressing behaviors from social system personnel. This method seemed more accurate in reflecting the amount of secondary victimization experienced than substituting a mean score (another scaling approach). Even though some women in this sample had scores of 0 on both the Services Received Scales and the Secondary Victimization Behaviors Experienced Scales, the interscale correlations (see Table 2) suggest that multicollinearity was not a serious issue (all correlations were below .55, with most less than .30). Therefore, multicollinearity did not influence the presence or strength of the effects observed in this study.

Measure of psychological well-being. Previous literature has established that PTS, which includes both depressive and anxious symptoms, is quite common among rape victims (Foa & Rothbaum, 1998; Goodman, Koss, & Russo, 1993). Therefore, a measure of PTS was used to assess the participants' psychological well-being. Saunders, Arata, and Kilpatrick's (1990) version of the Symptom Checklist-90—Revised, Crime-Related PTS scale, was used, which consists of 28 items (e.g., "feeling suddenly scared for no reason" and "repeated unpleasant thoughts that won't leave your mind"; see also Arata, Saunders, & Kilpatrick, 1991). The participants rated how frequently they experienced each symptom within the past 7 days on a 5-point scale (0 = *not at all*, 1 = *a little bit*, 2 = *moderately*, 3 = *quite a bit*, 4 = *extremely*). The items were averaged to create a scale score of psychological distress (the Crime-Related PTS scale; $M = 1.24$, $SD = 1.00$; $\alpha = .96$; range of corrected item-total correlations = .51-.82).

Results

We used hierarchical multiple regression to test the relationships between social system contact and rape survivors' psychological well-being (see Aiken & West, 1991; Cohen & Cohen, 1983). Data analysis unfolded in three phases to examine how community experiences affect victims' PTS symptoms, as moderated by type of rape and experiences with helpful community agencies, controlling for individual-level and rape-related variables (refer to Table 1, third column, for the analytic plan).

Phase I: The Impact of Social System Contact on PTS

The focus of the first phase of data analysis was to understand how contact with social systems affects rape survivors' PTS scores, controlling for the effects of individual-level and rape-related variables. In Equation 1, four blocks of independent variables were entered hierarchically to predict the dependent variable (PTS). In the first block, the primary control variable, time since assault, was entered but was not significant, $F(1, 92) = 0.11$, ns ($R = .03$, $R^2 = .001$). In the second block, the individual-level variables were considered: age at assault, victim's race, marital status, and education level. This block of variables was also not significant, and none of the univariate tests were significant, $F(5, 88) = 1.34$, ns ($R = .27$, $R^2 = .07$, $\Delta R^2 = .07$, ns). The third block tested whether characteristics of the rape itself predicted the survivors' PTS scores: type of rape, presence of physical injuries, use of a weapon, and victim's use of alcohol at time of assault. This block was also not significant, $F(9, 84) = 1.08$, ns ($R = .32$, $R^2 = .10$, $\Delta R^2 = .03$, ns); all univariate tests were not significant. Finally, in the fourth block, the system contact variables were considered: legal services, legal secondary victimization, medical services, medical secondary victimization, mental health services, and mental health secondary victimization. This block was statistically significant, $F(13, 78) = 2.17$, $p < .05$ ($R = .53$, $R^2 = .28$, $\Delta R^2 = .18$, $p < .05$). Significant univariate tests emerged for legal secondary victimization, $\beta = 0.23$, $t(93) = 2.43$, $p < .05$, and medical secondary victimization, $\beta = 0.22$, $t(93) = 2.84$, $p < .01$. In both of these tests, higher levels of secondary victimization were associated with higher PTS scores. Thus, the results of Phase I indicated that individual-level and rape-related variables were not predictive of PTS; nevertheless, negative experiences with the legal and medical systems were associated with increased PTS.

Phase II: Type of Rape as a Moderator of the Impact of Social System Contact on PTS

In Phase II of data analysis, the goal was to understand the impact of social system contact on rape survivors' PTS scores as moderated by type of rape. In other words, if a survivor was a victim of stranger rape, rather than nonstranger rape, are there differential relationships between social system contact and PTS? Given the increased complexity of this question, victims' experiences with the legal, medical, and mental health systems were each considered in separate equations. In all of these analyses, the categorical variable in the interaction term (type of rape) was dummy coded (see Aiken & West, 1991).⁶

The focus of Equation 2 was to test whether type of rape moderates the relationship between victims' experiences with the legal system and their PTS scores. The control variable, time since assault, was entered in the first block and was not significant, $F(1, 98) = 0.04$, ns ($R = .02$, $R^2 = .001$). In the second block of variables, the main effects were entered: legal services, legal secondary victimization, and type of rape. The overall block was significant, $F(4, 95) = 2.02$, $p < .05$ ($R = .30$, $R^2 = .20$, $\Delta R^2 = .20$, $p < .01$), because of the strong univariate effect for legal secondary victimization, $\beta = 0.27$, $t(95) = 2.60$, $p < .01$. All other main effects were not significant. In the third block of variables, the interactions were entered: two-way interactions (Type of Rape \times Legal Services, Type of Rape \times Legal Secondary Victimization, and Legal Services \times Legal Secondary Victimization),

and a three-way interaction (Type of Rape \times Legal Services \times Legal Secondary Victimization). This block of variables was significant, $F(8, 91) = 2.05$, $p < .05$ ($R = .50$, $R^2 = .33$, $\Delta R^2 = .13$, $p < .01$). Two of the two-way interactions were significant: Type of Rape \times Legal Services, $\beta = 0.20$, $t(95) = 1.99$, $p < .05$, and Type of Rape \times Legal Secondary Victimization, $\beta = 0.29$, $t(95) = 2.02$, $p < .05$. Victims of nonstranger rape who received fewer services from the legal system had elevated levels of PTS, as did victims of nonstranger rape who experienced more secondary victimization from the legal system. The three-way interaction between type of rape, legal services, and legal secondary victimization was also significant, $\beta = 0.19$, $t(95) = 1.99$, $p < .05$. Victims of nonstranger rape who received minimal help from the legal system, but were subjected to high levels of secondary victimization in the brief contact they did have with legal personnel, exhibited significantly elevated levels of PTS.⁷

Equation 3 is similar in structure to Equation 2, except that it tests how type of rape moderates the relationship between victims' experiences with the medical system and PTS outcomes. Again, the control variable, time since assault, was not significant (Block 1), $F(1, 98) = 0.12$, ns ($R = .04$, $R^2 = .01$). The block of variables containing the main effects was significant (Block 2), $F(4, 95) = 2.10$, $p < .05$ ($R = .33$, $R^2 = .22$, $\Delta R^2 = .21$, $p < .01$). The main effect for medical secondary victimization was again significant, $\beta = 0.30$, $t(95) = 2.81$, $p < .05$. In the third block, the interaction terms were entered and were found to be significant, $F(8, 91) = 2.03$, $p < .05$ ($R = .56$, $R^2 = .37$, $\Delta R^2 = .25$, $p < .01$). Two two-way interactions were significant: Type of Rape \times Medical Services, $\beta = 0.23$, $t(95) = 2.03$, $p < .05$, and Type of Rape \times Medical Secondary Victimization, $\beta = 0.32$, $t(95) = 2.17$, $p < .05$. Victims of nonstranger rape who received fewer services from the medical system had elevated levels of PTS, as did victims of nonstranger rape who experienced more secondary victimization from the medical system. The three-way interaction between type of rape, medical services, and medical secondary victimization was also significant, $\beta = 0.19$, $t(95) = 2.01$, $p < .05$. Victims of nonstranger rape who received very few services from the

⁶ Aiken and West (1991) recommended centering variables before computing cross-products to reduce multicollinearity (i.e., compute so interaction term is independent/uncorrelated with the component measures). Nevertheless, this procedure is recommended when both terms of the interaction are continuous. In our study, the interactions were cross-products of a categorical variable (type of rape) and continuous variables (Services Received Scales and Secondary Victimization Behaviors Experienced Scales). In this case, choosing the appropriate coding system for the categorical variable in the interaction term is the key issue. As Aiken and West (1991) stated, "When the interactions involve a categorical variable and a continuous variable, dummy coding produces immediately interpretable contrasts with the comparison group, whereas simple effect coding does not. Hence, if there is interest in contrasts between pairs of groups, dummy variable coding will be more efficient" (p. 129). Thus, in our study, type of rape (the categorical variable) was dummy coded before computing the cross-products.

⁷ In Phase II, the significant two-way and three-way interactions are not described in full detail because of a significant four-way interaction that emerges in Phase III of the analyses. Following Keppel's (1991) recommendations, the highest order interaction should be the focus of the analyses and subsequent description.

medical system, but were subjected to high levels of secondary victimization, had elevated levels of PTS.

In Equation 4, the focus was whether type of rape moderates the relationship between victims' experiences with the mental health system and their PTS outcomes. The control block (time since assault) was not significant (Block 1), $F(1, 98) = 0.03$, ns ($R = .01$, $R^2 = .001$). In the second block, the main effects were entered: type of rape, mental health services, and mental health secondary victimization. This block was not significant, $F(4, 95) = 0.62$, ns ($R = .10$, $R^2 = .06$, $\Delta R^2 = .06$, ns). In the third block, all interactions were entered; this block was not significant, and all univariate tests were likewise not significant, $F(8, 91) = 0.86$, ns ($R = .21$, $R^2 = .09$, $\Delta R^2 = .03$, ns).

The results of Phase II further suggest that negative experiences with the legal and medical systems can have a detrimental effect on rape survivors' PTS scores. More specifically, evidence of a moderator emerged: Nonstranger rape victims who received minimal help from either the legal or medical system, but were nevertheless subjected to a high degree of secondary victimization, experienced significantly elevated PTS scores. However, in Phase II, no effects emerged for the mental health system. It is not clear whether contact with the mental health system has no effect on survivors' well-being or if its impact transcends a straightforward direct relationship. It is possible that contact with the mental health system may also moderate how contact with the legal and medical systems influences rape survivors' well-being. This hypothesis was examined in Phase III of the analyses.

Phase III: Multiple Moderators—One System Undoing the Harm of Contact With Other Systems

In Phase III, the interrelationships among social systems were explored. Two equations were tested: Equation 5 focused on the interrelationships between the legal and mental health systems, and Equation 6 examined the interrelationships between the medical and mental health systems. In Equation 5, the first block (time since assault) was not significant, $F(1, 95) = 0.04$, ns ($R = .04$, $R^2 = .001$). In the second block, the significant effects found in Phases I and II were included (legal secondary victimization, Type of Rape \times Legal Services, Type of Rape \times Legal Secondary Victimization, and Type of Rape \times Legal Services \times Legal Secondary Victimization), $F(5, 91) = 3.24$, $p < .01$ ($R = .42$, $R^2 = .18$, $\Delta R^2 = .17$, $p < .01$). Thus, in the third and final block, when the four-way interaction was included, the significance of the ΔR^2 indicated whether this complex interaction accounted for a significant portion of variance in the outcome variable (PTS) beyond what was already accounted for by the significant main effects and the two-way and three-way interactions. Indeed, this was the case, $F(6, 90) = 2.25$, $p < .05$ ($R = .53$, $R^2 = .28$, $\Delta R^2 = .10$, $p < .05$); the beta for the interaction term Type of Rape \times Legal Services \times Legal Secondary Victimization \times Mental Health Services was 0.23, $t(97) = 2.13$, $p < .05$.⁸

Interpreting a significant four-way interaction is typically aided through visual representation of the data (Aiken & West, 1991; see Figure 1). First, a median split was used to separate the participants' scores on the Legal Services, Legal Secondary Victimization, and Mental Health Services scales (from high to low). Low legal services tended to represent cases in which the victims' reports were dropped very early in the prosecution process, pro-

viding a conceptual grounding for this split. There was virtually no action taken by the legal system to prosecute these cases. High legal services, by contrast, indicated cases in which the assault report received some attention from the criminal justice system (e.g., investigation or arrest), but only a handful of cases were actually successfully prosecuted (four cases were convicted at trial and five accepted a guilty plea). Cases characterized as low legal secondary victimization involved minimal negative contact with the legal system (fewer than three distressing behaviors experienced). In high legal secondary victimization cases, the survivors were subjected to multiple distressing behaviors from criminal justice system personnel. The median split for the Mental Health Services scale differentiated low services (no counseling or minimal counseling; e.g., a couple of crisis intervention sessions) from high services, where sustained contact with a mental health provider was established for counseling.

Second, the median splits on these three variables, along with the fourth variable in the four-way interaction (type of rape), were combined to form the 16 "subgroups" that compose this data set (i.e., nonstranger rape victims with low legal services, low legal secondary victimization, low mental health services; nonstranger rape victims with low legal services, low legal secondary victimization, high mental health services; etc.). The mean PTS score for each of these 16 subgroups is plotted along a horizontal axis in Figure 1. From these calculations, it becomes readily apparent which participants are at highest risk: nonstranger rape victims who received very little help from the legal system but who were subjected to a great deal of secondary victimization in their attempts to prosecute. These women had the highest PTS scores. Nevertheless, what appears to make the critical difference is whether these rape victims were able to obtain sustained mental health services after this rather disastrous contact with the legal system. Of this high-risk group, survivors who received high mental health support had lower PTS scores than those who did not have as much contact with the mental health system (mean PTS scores of 2.51 vs. 3.71). Thus, in cases of nonstranger rape in which contact with the legal system had gone very poorly, subsequent contact with the mental health system may have "undone some damage," as exhibited by significantly lower PTS scores.

A similar pattern of results emerged for two other subgroups of nonstranger rape victims. Some survivors of acquaintance, date, or marital rape did have their cases pursued by the criminal justice system (high legal services) but were nevertheless subjected to numerous secondary victimization behaviors (high legal secondary victimization). Among these survivors, those who received substantial contact with a mental health provider had lower PTS scores than those who did not (mean PTS scores of 2.23 vs. 2.50). Thus, this significant four-way interaction suggests that contact with the mental health system can make a critical difference in how nonstranger rape victims are impacted by difficult experiences with the legal system. The assistance provided by the mental health system is associated with a significant decrease in PTS.

In Equation 6, the relationships between type of rape and contact with the medical and mental health systems were explored. The

⁸ There are many approaches to structuring hierarchical regression models that could have been used for Equations 5 and 6. Given the exploratory purpose of the analyses in Phase III, only significant terms from Phases I and II were carried over into Phase III to maximize power.

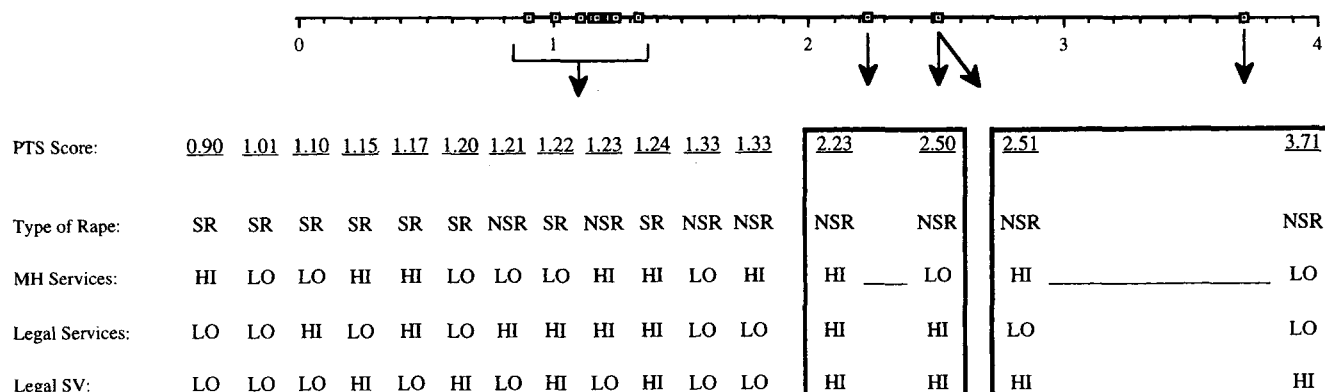


Figure 1. Reduced posttraumatic stress (PTS) among rape survivors who sought mental health (MH) services after contact with the legal system: The four-way interaction. The benefit of MH services was significant reduction in PTS among high-risk participants (NSR victims with high SV whose legal cases were dropped) if they received MH services. SV = secondary victimization; SR = stranger rape; NSR = nonstranger rape; HI = high; LO = low.

control variable was not significant (Block 1), $F(1, 95) = 0.04$, ns ($R = .03$, $R^2 = .001$). In the second block, the significant effects found in Phases I and II were included (medical secondary victimization, Type of Rape \times Medical Services, Type of Rape \times Medical Secondary Victimization, and Type of Rape \times Medical Services \times Medical Secondary Victimization), $F(5, 91) = 3.01$, $p < .01$ ($R = .39$, $R^2 = .17$, $\Delta R^2 = .16$, $p < .01$). In the final block, the four-way interaction (Type of Rape \times Medical Services \times Medical Secondary Victimization \times Mental Health Services) produced a significant change in the R^2 , indicating that it predicts unique variance in the survivors' PTS scores, $F(6, 90) = 2.14$, $p < .05$ ($R = .48$, $R^2 = .25$, $\Delta R^2 = .08$, $p < .05$); the beta for this interaction term was 0.21, $t(97) = 2.10$, $p < .05$.

Figure 2 depicts the significant four-way interaction between type of rape, medical services, medical secondary victimization, and mental health services. The nonstranger rape victims who

received very little help from the medical system (typically, the rape exam only, with no additional services for pregnancy and STD prevention), but were subjected to a great deal of secondary victimization, had the highest PTS scores. However, those rape survivors who had obtained mental health services after this rather difficult contact with the medical system exhibited significantly lower levels of PTS than those who obtained no help or very minimal help from mental health professionals. In addition, nonstranger rape victims who received substantial assistance from the medical system (typically, rape exam plus information and resources for pregnancy and STD prevention), but nevertheless experienced high secondary victimization, also had relatively elevated levels of PTS. But within this group of nonstranger rape victims, those who received subsequent mental health support had lower PTS than those who did not. Once again, it appears that contact with the mental health system is associated with lower PTS scores.

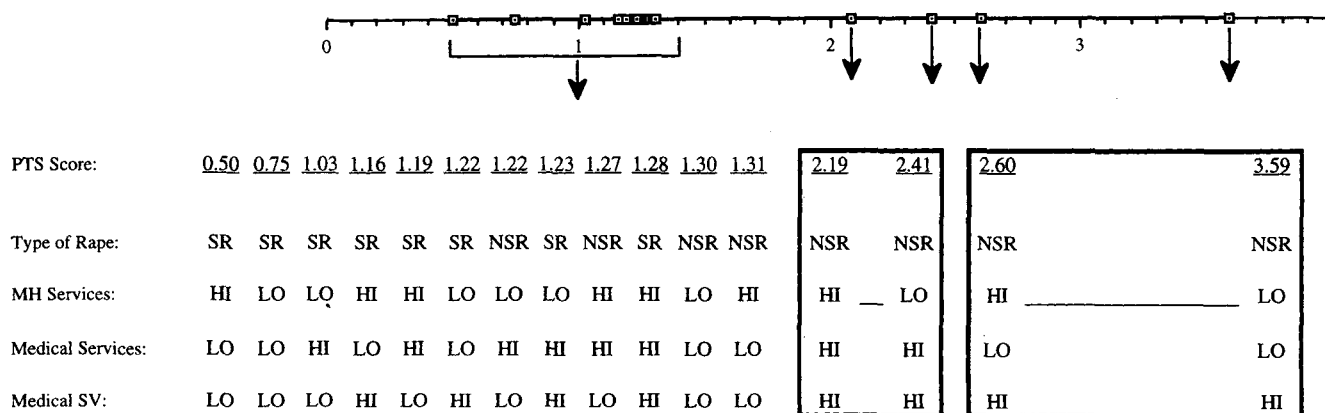


Figure 2. Reduced posttraumatic stress (PTS) among rape survivors who sought mental health (MH) services after contact with the medical system: The four-way interaction. The benefit of MH services was significant reduction in PTS among high-risk participants (NSR victims with high SV who received minimal medical care) if they received MH services. SV = secondary victimization; SR = stranger rape; NSR = nonstranger rape; HI = high; LO = low.

Discussion

Rape is quite devastating to women's psychological and physical health. Although there is still a great deal to be learned about how the violation of the assault itself impacts victims, it is also important to consider the trauma of rape more broadly. Since the beginning of the antirape movement and academic research on sexual assault, there has been concern that society in general, and our social systems in particular, may not be responsive to the needs of rape survivors (see Estrich, 1987). However, empirical research on how community involvement affects recovery has been lacking. The focus of this research project was to begin to fill this void in the literature—to link our understanding of the potential risks and benefits of seeking community services to survivors' recovery outcomes. Some rape victims have positive experiences with social systems, and their involvement with the community facilitates recovery. Nevertheless, for many other survivors, particularly victims of nonstranger rape (which is far more common than stranger rape), contact with social systems adds to their trauma. As one rape survivor in this study stated, "As if the rape weren't bad enough, I had to go through everything that I did with the police and doctors. It's just more rape. The rape just keeps on and on, like you just can't escape it."

In this study, a sampling protocol new to the rape victimology literature was used to recruit 102 rape survivors. These methods involved community outreach throughout the Chicago metropolitan area to identify women of varying races/ethnicities and SESs who have experienced sexual assault. These zip code-based recruitment strategies proved quite successful, given that our sample's characteristics were equivalent to the 1990 U.S. Census data for women in Chicago. Although this technique assesses representativeness quite differently than the methods of random digit dialing, the message of our recruitment efforts seemed important to these women: The control to disclose and participate is very much in the women's hands. As survivors struggle to rebuild their sense of control postassault, psychologists can aid that process by creating research environments that foster those feelings of control without sacrificing methodological rigor.

However, it is important to note two potential drawbacks of this sampling approach. First, those individuals who respond to "calls for research participation" may be different from the general population of rape survivors. In addition, we do not know how many rape survivors saw our recruitment materials but elected not to participate in our study. Nevertheless, the women who responded to our recruitment efforts were at the very least similar to other women in those Chicago neighborhoods (see Campbell et al., 1999, for a more detailed discussion of the current debates in the literature on sampling rape victims). Second, by sampling postassault, the retrospective nature of this study introduces the possibility of memory biases. Although retrospective studies are quite common in the violence-against-women literature (e.g., survivors often will not discuss the assault immediately postrape), more prospective studies that are respectful of survivors' healing processes are needed to understand memory effects.

Although none of the women we interviewed felt that their experience with community systems was worse than the rape itself, many discussed how negative encounters compounded the effects of the assault. Of the 40% of this sample who had contact with the legal and/or medical systems, most received only minimal services from these agencies. Very few cases in the legal system went

beyond the stage of filing a police report; the detectives and prosecutors did not pursue these cases, even though the rape victims wanted to press charges. In the medical system, rape survivors received more services than in the legal system but were still infrequently advised about STD testing, pregnancy testing, and methods of preventing pregnancy (i.e., administering the morning-after pill). Of the women who had contact with the mental health system, most were able to obtain either short- or long-term counseling. No direct relationship (main effect) between services received (in any of the three systems studied) and PTS outcomes was substantiated. These nonsignificant results may be partly due to the restricted range on the Services Received Scales used in the present study because most women received minimal help.

Nevertheless, contact with social systems involves not only service delivery but also rape survivors' experiences interacting with system personnel in their attempts to obtain help. There has been growing concern in the literature that the behaviors and practices of community system personnel may be retraumatizing to rape survivors. This study provides one of the first empirical tests of secondary victimization by assessing its effects on survivors' psychological well-being. In developing the secondary victimization scales, community system personnel were consulted to create a list of behaviors and practices that may be traumatic for rape survivors. On a positive note, most survivors in this study did not endorse a high number of these items, but most women who had contact with the legal and/or medical systems experienced at least two secondary victimization behaviors. Most commonly, victims were told by system personnel that their stories were unbelievable or that their cases were not serious enough to pursue.

Whereas the overall endorsement rates for the items in the secondary victimization scales were low, the effect of those two to three distressing behaviors appears quite detrimental. If a rape survivor reported the assault to the police or a doctor and was told by those community personnel that they did not believe her, it is unfortunately all too easy to imagine how hurtful those actions may be to a victim. The results of this study support that notion: Significant main effects were found for the relationship between legal secondary victimization and PTS and for the relationship between medical secondary victimization and PTS. The more distressing revictimizing behaviors the survivors were subjected to, the higher their PTS symptomatology. This study provides quantitative support that the actions of community system personnel can affect rape survivors' outcomes; experiencing behaviors that doubt and blame victims was associated with increased psychological distress.

The relationships between service delivery, secondary victimization, and psychological well-being may be more complex than what can be described in simple main effects. Our results suggest that type of rape significantly affects how community contact impacts well-being. Victims of stranger rape do not have the same experiences as those who survived nonstranger rape. In both the legal and medical systems, a significant three-way interaction between type of rape, services received, and secondary victimization was supported. Victims of nonstranger rape who received minimal assistance, but nevertheless experienced a higher degree of secondary victimization, had significantly elevated levels of PTS (means of 2.50–3.70 vs. the overall sample mean of 1.24). These results identify a high-risk group of rape survivors: nonstranger rape victims who received minimal help from their com-

munities and had negative experiences with system personnel. These women were at substantial risk for elevated PTS.

The results of this study present one strategy for assisting these at-risk rape survivors. Obtaining sustained mental health services was associated with significantly lower levels of PTS. A significant four-way interaction was supported in both the legal and medical systems between type of rape, services received, secondary victimization, and mental health services received. Among the nonstranger rape victims who received minimal help, but higher levels of secondary victimization, later contact with the mental health system was associated with a significant drop in PTS as compared with at-risk survivors with no mental health intervention. Given the cross-sectional nature of this study's design, it is not possible to conclude that mental health assistance caused the significant drop in PTS. Nevertheless, the survivors in this study described how the validation and support they received from their counselors about both the rape and the negative experiences following the rape were extremely important in their recovery. The results of this study suggest a promising role for mental health providers in assisting not only with the trauma of rape but also with the trauma sometimes associated with seeking community services.

In all of these analyses examining the effects of services and secondary victimization on rape survivors' PTS, several control variables were also considered. In this sample, time since assault, victim demographics, and characteristics of the rape (e.g., type, weapon use, injuries, and victim's alcohol use) were not predictive of survivors' PTS. These results differ from other reports in the field that link severity with elevated victim distress (e.g., Kilpatrick et al., 1989; Resnick et al., 1993). However, there was considerable variability in this sample as to how long ago the assault occurred. Prior research has substantiated that PTS is most burdensome to rape survivors within 1 year postassault (Foa, Riggs, & Gershuny, 1995; Kilpatrick et al., 1989; Rothbaum et al., 1992). For most women in this sample, the rape was more than 1 year ago. This restriction of range on the dependent variable could explain why no relationships were found between demographics, characteristics of the rape, and PTS outcomes.

Another important limitation of this study is its relatively small sample size. Approximately 40% of the sample had contact with one of these three community systems (approximately 40 cases), creating a substantial reduction in power. In particular, the tests of the four-way interactions should be viewed with some caution because it is possible that the small sample sizes compared in these analyses produced unstable means and chance effects. Replication of these effects with larger samples is needed. However, in this research it was appropriate to include survivors with and without system contact so as to tease out the differential experiences for "system contact" survivors and "no system contact" survivors. Whereas this study cannot definitively answer the question whether it was "better" or "worse" to have system contact or no system contact, by drawing a sample with considerable variability on these measures, we were able to identify a high-risk group of rape survivors (nonstranger rape victim, low services, high secondary victimization). These survivors had significantly elevated levels of PTS as compared with all other groups of participants, including those survivors with no system contact.

As with all studies that rely on self-report data, it is important to note the limitations of such methodological approaches. In this study, we did not have verification from community system per-

sonnel as to whether services were in fact provided or whether the secondary victimization behaviors were exhibited. Although our measures cued women to the specific events that happened in their contact with system personnel, as opposed to their impressions and reactions to those events, self-report bias on the secondary victimization scales remains a threat to the results of this study.

Similarly, the self-report measure assessing PTS was not supplemented with more sophisticated diagnostic tools administered by mental health professionals. Thus, we cannot conclude whether these women were experiencing clinical levels of PTS. The 28 items in the Saunders et al. (1990) measure were rated on a 0–4 scale, and the overall sample mean was 1.24. This value is somewhat low, suggesting that as an overall group, these women were somewhat unlikely to meet clinical criteria for PTSD. However, for the high-risk rape survivors, whose mean PTS scores were above 3.00, it is possible that with additional diagnostic tools we may have been able to establish whether they did in fact meet the criteria for clinical PTSD. The focus of this research, however, was to establish if there was any link between community contact and elevated levels of PTS, which makes the use of self-report instruments a reasonable choice.

Finally, the challenges of self-report data are further complicated by the nature of PTS itself. PTS often includes symptoms of estrangement, alienation, and feeling misunderstood, in combination with elevations in irritability and anger. It is therefore possible that women who developed PTS as a result of the rape may be more likely to perceive secondary victimization than women who did not experience PTS. In our study, we used self-report measures of both PTS and secondary victimization, which does not allow us to disentangle these effects. Future work in this area should further clarify these interrelationships between PTS and secondary victimization using both self-report and more objectively based measures. However, previous research with nonvictim samples (e.g., service providers and rape victim advocates) suggests that victim-blaming treatment is not just something survivors "perceive" (Campbell & Raja, in press; Campbell & Salem, 1999; Frohmann, 1991). Secondary victimization is perceived, and perceived as problematic, by multiple stakeholders.

The results of this study highlight the importance of continued education efforts with community system personnel who work with rape survivors. It is entirely possible that police, prosecutors, doctors, nurses, and mental health professionals may be unaware of how their behavior impacts rape survivors—both positively and negatively. Although members of the legal and/or medical systems may not typically focus on the mental health effects of their procedures and practices, our results suggest that these actions do indeed have a psychological impact. These postrape interactions can be experienced as the continuation of the rape, not as helpful assistance alleviating the trauma of the assault. Rather than limiting our focus to treating secondary victimization once it has occurred, the prevention of secondary victimization must be a long-term goal. Many victim advocacy groups provide regular training for system personnel on violence against women, and these programs can offer one medium for education about the mental health effects of system practices. The Long Island College Hospital and Junior League of Brooklyn (1998) issued an instructional video, *Restoring Dignity: Frontline Response to Rape*, designed to teach service providers about the beneficial and detrimental effects they may have on rape survivors. These training resources may be helpful in communicating the broader message

of these research results: Telling victims, especially nonstranger rape victims, that their stories are not believable and what happened to them is not serious enough for further attention by our social systems is harmful and should not be general practice.

With respect to clinical interventions, these findings alert mental health practitioners to the risks rape survivors face in seeking community assistance. Although secondary victimization by mental health providers can also occur (see Campbell & Raja, in press), this study did not find substantial evidence for its occurrence. Rather, our findings suggest how helpful mental health providers can be in counseling survivors of rape about both the assault itself and their community experiences postassault. Although most current models of rape counseling do not specifically recommend cognitive and affective exploration of the topic of secondary victimization, our results suggest that rape survivors may be quite distressed by all of the events surrounding the rape. A broader therapeutic approach that considers not only the distress caused by the rape but also the distress associated with society's response to rape would be useful to rape survivors.

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