

community outcomes. *Trauma, Violence, & Abuse: A Review Journal*, 6, 313–329.

Campbell, R., & Raja, S. (1999). The secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence and Victims*, 14, 261–275.

Campbell, R., & Raja, S. (2005). The sexual assault and secondary victimization of female veterans: Help-seeking experiences in military and civilian social systems. *Psychology of Women Quarterly*, 29, 97–106.

Campbell, R., & Salem, D. A. (1999). Concept mapping as a feminist research method: Examining the community response to rape. *Psychology of Women Quarterly*, 23, 67–91.

Campbell, R., Sefl, T., & Ahrens, C. E. (2004). The impact of rape on women's sexual health risk behaviors. *Health Psychology*, 23, 67–74.

Campbell, R., Sefl, T., Barnes, H. E., Ahrens, C. E., Wasco, S. M., & Zaragoza-Diesfeld, Y. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology*, 67, 847–858.

Campbell, R., Sefl, T., Wasco, S. M., & Ahrens, C. E. (2004). Doing community research without a community: Creating safe space for rape survivors. *American Journal of Community Psychology*, 33, 253–261.

Campbell, R., Townsend, S. M., Long, S. M., Kinnison, K. E., Pulley, E. M., Adames, S. B., & Wasco, S. M. (2005). Organizational characteristics of Sexual Assault Nurse Examiner programs: Results from the national survey of SANE programs. *Journal of Forensic Nursing*, 1, 57–64.

Campbell, R., Townsend, S. M., Long, S. M., Kinnison, K. E., Pulley, E. M., Adames, S. B., & Wasco, S. M. (2006). Responding to sexual assault victims' medical and emotional needs: A national study of the services provided by SANE programs. *Research in Nursing & Health*, 29, 384–398.

Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the "second rape": Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence*, 16, 1239–1259.

Koss, M. P., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M., Ullman, S., West, C., & White, J. (2007). Re-

vising the SES: A collaborative process to improve assessment of sexual aggression and victimization. *Psychology of Women Quarterly*, 31, 357–370.

The Psychological Impact of Rape Victims' Experiences With the Legal, Medical, and Mental Health Systems

Rebecca Campbell
Michigan State University

This review article examines rape victims' experiences seeking postassault assistance from the legal, medical, and mental health systems and how those interactions impact their psychological well-being. This literature suggests that although some rape victims have positive, helpful experiences with social system personnel, for many victims, postassault help seeking becomes a "second rape," a secondary victimization to the initial trauma. Most reported rapes are not prosecuted, victims treated in hospital emergency departments do not receive comprehensive medical care, and many victims do not have access to quality mental health services. In response to growing concerns about the community response to rape, new interventions and programs have emerged that seek to improve services and prevent secondary victimization. The contributions of rape crisis centers, restorative justice programs, and sexual assault nurse examiner programs are examined. Strategies for creating more visible and impactful roles for psychologists and allied professionals are also discussed.

Keywords: rape, sexual assault, legal, medical, mental health

Sexual violence is a pervasive social problem: National epidemiological data indicate that 17% to 25% of women are raped in their adult lifetimes (Fisher, Cullen, & Turner, 2000; Koss, Gidycz, & Wisniewski, 1987; Tjaden &

Editor's Note

Rebecca Campbell received the Award for Distinguished Early Career Contributions to Psychology in the Public Interest. Award winners are invited to deliver an award address at the APA's annual convention. A version of this award address was delivered at the 116th annual meeting, held August 14–17, 2008, in Boston, Massachusetts. Articles based on award addresses are reviewed, but they differ from unsolicited articles in that they are expressions of the winners' reflections on their work and their views of the field.

Thoennes, 1998). Rape is one of the most severe of all traumas, causing multiple, long-term negative outcomes, such as posttraumatic stress disorder (PTSD), depression, substance abuse, suicidality, repeated sexual victimization, and chronic physical health problems (Kilpatrick & Acierno, 2003; Koss, Bailey, Yuan, Herrera, & Lichter, 2003).¹ Rape victims have extensive postassault needs and may turn to multiple social systems for assistance. Approximately 26% to 40% of victims report the assault to the police and pursue prosecution through the criminal justice system, 27% to 40% seek medical care and medical forensic examinations, and 16% to 60% obtain mental health services (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Ullman, 1996a, 1996b, 2007; Ullman & Filipas, 2001a). When victims reach out for help, they place a great deal of trust in the legal, medical, and mental health systems as they risk disbelief, blame, and refusals of help. How these system interactions unfold can have profound implications for victims' recovery. If victims are able to receive the services they need and are treated in an empathic, supportive manner, then social systems can help facilitate recovery. Conversely, if victims do not receive needed services and are treated insensitively, then system personnel can magnify victims' feelings of powerlessness, shame, and guilt. Postassault help seeking can become a "second rape," a secondary victimization to the initial trauma (Campbell & Raja, 1999; Campbell et al., 2001).

Victims' postassault help seeking experiences are not uniformly bad or retraumatizing (Campbell et al., 2001; Ullman, 1996a, 1996b; Ullman & Filipas, 2001a). But there is reason—many reasons, actually—to be concerned about what happens to victims when they seek community help. Although some victims have positive experiences, secondary victimization is a widespread problem that happens, in varying degrees, to most survivors who seek postassault care. Who gets services, and how they get them, reflects privilege and discrimination. Ethnic minority and/or low socioeconomic status (SES) women, for instance, are more likely to have difficulty obtaining help (Martin, 2005). Furthermore, our social systems do not treat all rapes equally. Persistent, stubborn myths remain about what constitutes "real rape"—stranger assaults committed with a weapon, resulting in visible physical injuries to victims (Estrich, 1987). Social systems respond to these assaults with the highest attention. Yet, prevalence studies consistently demonstrate that nonstranger rape is far more typical (approximately 80% are committed by someone known to the victim) and that assailants use a variety of tactics—not just weapons—to gain control over their victims (Koss et al., 1987, 2007). Our social systems are least likely to respond to the most common kinds of assaults.

At a time of tremendous vulnerability and need, rape victims turn to their communities for help and risk further hurt. The trauma of rape extends far beyond the actual assault, and intervention strategies must address the difficul-

ties rape survivors encounter when seeking community help. Although prevention efforts to eliminate rape are clearly needed, it is also important to consider how we can prevent further trauma among those already victimized. A growing literature is emerging on postassault help seeking and its impact on victims' mental health outcomes. The purpose of this article is to review the extant research on rape victims' experiences with legal, medical, and mental health systems and how those interactions affect survivors' psychological well-being.² The contributions of rape crisis centers, community-based agencies that work as advocate intermediaries between victims and social systems, are examined throughout. In response to growing concerns about the community response to rape, new interventions and programs have emerged that seek to improve services and prevent secondary victimization. These innovative alternatives are also reviewed to explore strategies for creating more consistently positive, postassault help seeking experiences for all rape victims.

The Legal System

Victims' Help-Seeking Experiences

Rape prosecution is a complex, multistage process, and few cases make it all the way through the criminal justice system (Bouffard, 2000). Most victims' first contact will be with a patrol officer, which will be the first of numerous times victims will be asked to describe the assault. Typically, a detective is then assigned to investigate and decide whether the case should be referred to the prosecutor. Detectives have considerable discretion in conducting investigations, and what happens during this process can be quite upsetting for victims. Many victims report that law enforcement personnel actively discouraged them from reporting (Campbell, 2005, 2006; Campbell & Raja, 2005; Filipas & Ullman, 2001; Ullman, 1996b). Police may graphically portray the personal costs involved for victims should they pursue prosecution, such as repeated trips to court or humiliating cross-examination (Kerstetter & Van Winkle, 1990; Madigan & Gamble, 1991). Detectives issue

¹ First, to clarify the meaning of key terms used in this article (adapted from Koss & Achilles, 2008), *rape* refers to an unwanted act of oral, vaginal, or anal penetration committed by the use of force, the threat of force, or when the recipient of the unwanted penetration is incapacitated; *sexual assault* refers to a broader range of contact and noncontact sexual offenses, up to and including rape. The focus of this review is rape, but because sexual assault can include rape, selected research on sexual assault was also included when appropriate. Second, the terms *victim* and *survivor* are used interchangeably in this article. The term *survivor* conveys the strength of those who have been raped; the term *victim* reflects the criminal nature of this act.

² There is a parallel literature on victims' experiences disclosing to informal sources of support (e.g., family and friends) and the resulting impact on survivors' psychological health. The focus of this article is formal systems (legal, medical, and mental health systems and rape crisis centers), but see Ullman (1999, 2000) for reviews on informal support.

warnings of impending prosecution, not to assailants, but to victims, threatening them that they will be charged if at some point in the investigation doubt emerges about the accuracy of their claims (Logan, Evans, Stevenson, & Jordan, 2005). Victims are questioned about elements of the crime (e.g., penetrations, use of force, or other control tactics) over and over again to check for consistency in their accounts, which can be emotionally unsettling and, given that trauma can impede concentration and memory (Halligan, Michael, Clark, & Ehlers, 2003), cognitively challenging as well. Many victims report that this questioning strays into issues such as what they were wearing, their prior sexual history, and whether they responded sexually to the assault (Campbell, 2005, 2006; Campbell & Raja, 2005; Campbell et al., 2001). Victims rate these questions as particularly traumatic (Campbell & Raja, 2005), and their legal relevance is minimal at best because all states have rape shield laws that limit information about the victims from being discussed in court, should the case reach that far (Flowe, Ebbesen, & Putcha-Bhagavatula, 2007). In spite of rape shield laws, law enforcement personnel confirm that these are typical investigational practices (Campbell, 2005). The police investigation is designed to weed out cases, and to that end, it is very effective: Most reported rapes never progress past this stage. Approximately 56% to 82% of all reported rape cases are dropped (i.e., not referred to prosecutors) by law enforcement (67% on average; Bouffard, 2000; Crandall & Helitzer, 2003; Frazier & Haney, 1996).

If a case progresses past the investigation stage, prosecutors often conduct their own interviews with the victims prior to deciding whether to file criminal charges (Martin & Powell, 1994). Again, what happens in this process is largely unknown, but Frohmann's (1997a, 1997b) ethnographic research revealed that prosecutors require victims to go through the details of the rape again multiple times. If prosecutors are disinclined to charge the case, then they engage in a lengthy exploration of any discrepancies in victims' accounts and press victims for explanations and proof. If prosecutors are inclined to press charges, they cover much of this same ground but try to coach victims, grooming them for how to respond to and withstand such questioning. Either way, victims go through a punishing process of reliving the assaults and defending their characters (Koss & Achilles, 2008). More cases drop out of the legal system at this stage: On average, approximately 44% of the cases referred by law enforcement to prosecutors for further consideration are dismissed by the prosecutors, and about half on average (56%) move forward (Frazier & Haney, 1996; Spohn, Beichner, & Davis-Frenzel, 2001).

For the cases that are accepted for prosecution, victims must prepare for a series of court hearings (e.g., preliminary hearings, trials, plea hearings, sentencing). Research is limited on these end-stage processes, perhaps because they

are relatively rare occurrences. Through extensive recruitment efforts, Konradi (2007) interviewed 47 victims whose cases made it to trial or plea bargaining. Approximately one third of these women felt inadequately prepared by the prosecutors: Although they had been questioned repeatedly, they were given very little information about the procedural process and felt thrown into the hearings with little understanding of what to expect. Most victims did receive extensive preparation, but it was grueling: reading and re-reading police reports, practicing how to tell what happened in the rape, simulating cross-examination, and figuring out how to dress, speak, show emotion, or not show emotion in court. If a case makes it this far, more often than not, it results in a guilty verdict or a guilty plea bargain. Of prosecuted cases, 76% to 97% end with guilty verdicts or pleas (88% on average; Frazier & Haney, 1996; Spohn et al., 2001). These cases were carefully selected, and these victims were tested and then groomed, so that what went forward through the system had good odds for conviction.

But overall, case attrition is staggering: For every 100 rape cases reported to law enforcement, on average 33 would be referred to prosecutors, 16 would be charged and moved into the court system, 12 would end in a successful conviction, and 7 would end in a prison sentence (Bouffard, 2000; Crandall & Helitzer, 2003; Frazier & Haney, 1996; Spohn et al., 2001). Successful prosecution is not random: It is more likely for those from privileged backgrounds and those who experienced assaults that fit stereotypic notions of what constitutes rape. Younger women, ethnic minority women, and women of lower SES are more likely to have their cases rejected by the criminal justice system (Campbell et al., 2001; Frohmann, 1997a, 1997b; Spears & Spohn, 1997; Spohn et al., 2001; cf. Frazier & Haney, 1996). Cases of stranger rape (where the suspect was eventually identified) and those that occurred with the use of a weapon and/or resulted in physical injuries to victims are more likely to be prosecuted (Campbell et al., 2001; Frazier & Haney, 1996; Kerstetter, 1990; Martin & Powell, 1994; Spears & Spohn, 1997; Spohn et al., 2001). Alcohol and drug use by the victim significantly increases the likelihood that a case will be dropped (Campbell et al., 2001; Frohmann, 1997a, 1997b; Spears & Spohn, 1997; cf. Frazier & Haney, 1996).

These data suggest that the odds of a case being prosecuted are not good, and the treatment victims receive from legal system personnel along the way is not much better. Across multiple samples, 43% to 52% of victims who had contact with the legal system rated their experience as unhelpful and/or hurtful (Campbell et al., 2001; Golding, Siegel, Sorenson, Burnam, & Stein, 1989; Filipas & Ullman, 2001; Monroe et al., 2005; Ullman, 1996b). In qualitative focus group research, survivors described their contact with the legal system as a dehumanizing

experience of being interrogated, intimidated, and blamed. Several women mentioned that they would not have reported if they had known what the experience would be like (Logan et al., 2005). Even victims who had the opportunity to go to trial described the experience as frustrating, embarrassing, and distressing, but they also took tremendous pride in their ability to exert some control in the process and to tell what happened to them (Konradi, 2007).

These experiences of secondary victimization take a toll on victims' mental health. In self-report characterizations of their psychological health, rape survivors indicated that as a result of their contact with legal system personnel, they felt bad about themselves (87%), depressed (71%), violated (89%), distrustful of others (53%), and reluctant to seek further help (80%) (Campbell, 2005; Campbell & Raja, 2005). The harm of secondary victimization is also evident on objective measures of PTSD symptomatology. Ullman and colleagues found that contact with formal help systems, including the police, was more likely to result in negative social reactions, which were associated with increased PTSD symptomatology (Filipas & Ullman, 2001; Starzynski, Ullman, Filipas, & Townsend, 2005; Ullman & Filipas, 2001a, 2001b). In a series of studies dealing directly with victim/police contact, Campbell and colleagues found that low legal action (i.e., the case did not progress or was dropped) was associated with increased PTSD symptomatology, and high secondary victimization was also associated with increased PTSD (Campbell et al., 2001; Campbell & Raja, 2005). In tests of complex interactions, Campbell, Barnes, et al. (1999) identified that it was the victims of nonstranger rape whose cases were not prosecuted and who were subjected to high levels of secondary victimization who had the highest PTSD of all—worse than those who chose not to report to the legal system at all. It is interesting that when victims who did *not* report to the police were asked why they did not pursue prosecution, they specifically stated that they were worried about the risk of further harm and distress; their decision was a self-protective choice to guard their fragile emotional health (Patterson, Greeson, & Campbell, 2008).

Alternatives and Innovations: Restoring Survivors

Rape is a felony crime, and the take-home message should not be that prosecution is a futile, psychologically damaging endeavor. What can be done to change the legal system's response to rape victims? Since the beginning of the antirape movement in the 1970s, rape crisis centers have led multiple successful efforts for legal reform (e.g., repealing marital exemption laws, enacting rape shield laws; see Matthews, 1994). But there is the law as written and the law in practice—and changing the latter has required the daily dedication of rape victim advocates. Most rape crisis centers have legal advocacy programs whereby

trained paraprofessional advocates help victims navigate their contacts with the criminal justice system (see Campbell & Martin, 2001, for a review). Advocates explain the legal process to victims and inform them of their rights, and in many communities, advocates can be present for the police and prosecution interviews as well as accompany victims to court. The advocates' job is to watch, witness, and advocate on behalf of victims to improve case processing and prevent secondary victimization.

Few studies have examined the effectiveness of rape victim advocates, but the limited studies on this topic are promising. Survivors consistently rate advocates as supportive and informative (Campbell et al., 2001; Golding et al., 1989; Wasco et al., 2004). Wasco, Campbell, Barnes, and Ahrens (1999) found that survivors who worked with advocates had significantly lower PTSD scores than those who had legal system involvement without the help of advocates. Pursuing this issue further, I (Campbell, 2006) used a naturalistic quasi-experimental design to compare the experiences with police of victims who had a rape crisis center victim advocate available to them and those who did not. Rape survivors who had the assistance of an advocate were significantly more likely to have police actually take a report and were less likely to be treated negatively by law enforcement (e.g., less likely to be discouraged from reporting, less likely to be questioned about their sexual histories). These victims also had significantly less emotional distress after their contact with the legal system. Rape victim advocates continue to provide support and advocacy through the later stages of trials or plea bargains (Martin, 2005), and the victims in Konradi's (2007) qualitative study noted that advocates provided useful information about their rights, helped them prepare for making their victim impact statements at the offenders' sentencing hearings, and supported them by attending the hearings. However, not all communities have rape crisis centers, so many victims do not have the option of working with an advocate (Campbell & Martin, 2001).

Although rape crisis centers have been instrumental in changing the legal culture of rape prosecution, many victims have little faith that justice is possible (Logan et al., 2005; Patterson et al., 2008). Sarason's (1972) theory of alternative settings suggests that interventions which step outside of existing systems may be more effective: Creating something altogether different is often more successful than tinkering with existing settings. In that vein, restorative justice programs for sexual assault victims have emerged as a promising alternative to traditional justice systems (Koss, 2006).³ Restorative justice programs oper-

³ Sexual Assault Nurse Examiner (SANE) programs, which were developed within the medical system, may also have positive effects on the legal system. These programs are reviewed later in this article.

ate outside of the criminal justice system but are often developed by community-wide teams that include victims/survivors, rape crisis center advocates, and representatives from the legal, medical, and mental health systems. These programs work from the fundamental position that the needs of the victims, as well as their significant others, friends, family, and all others who were hurt by the rape, are paramount and that offenders need to accept responsibility for that harm and make amends (Koss, 2006; Koss & Achilles, 2008). The philosophy and operation of restorative justice programs are multidisciplinary in nature (see Koss, 2006, for a review), but psychology and allied professions have been clearly influential, as these interventions strive to create an empowering experience for survivors, prevent psychological distress, and promote social support from the survivors' families and communities (Koss, Bachar, Hopkins & Carlson, 2004).

In the context of sexual assault, restorative justice programs often use conferencing methods, whereby the victim, the offender, and their families agree to prepare for a meeting, at which time the offender will publicly take responsibility for the assault. Detailed procedures are developed to prevent secondary victimization in the conference and to provide a respectful environment (see RESTORE Overview Manual, 2006). At the conferences, specially trained facilitators cue offenders to make a statement accepting responsibility for their actions, and then the victims (and others) have the opportunity to describe how they have been affected by the assault. The offenders then have to verbally acknowledge that they have heard what has been said about the harm caused by their actions. A redress plan is then developed that outlines how the offenders will repair the harm and make amends. In the United States, only one operational restorative justice program for sexual assault exists, codeveloped by Koss and multiple stakeholders in Pima County, Arizona (see Koss et al., 2004). Victims who initially report to the criminal justice system are offered the opportunity to participate in the RESTORE program if their cases meet eligibility criteria (the offender is 18 years old or older, is a first-time offender, is accused of raping someone known to him, or is charged with a misdemeanor sex offense; RESTORE Overview Manual, 2006). Evaluation of RESTORE is in progress, but preliminary findings suggest that offenders who successfully completed the program exhibited positive changes in their understanding of the harm they had caused to the victim and others (Koss & Achilles, 2008).

The Medical System

Victims' Help-Seeking Experiences

Rape victims have extensive postassault medical needs, including injury detection and care, medical forensic examination, screening and treatment for sexually transmitted infections (STIs), and pregnancy testing and emergency

contraception. Although most victims are not physically injured to the point of needing emergency care (Ledray, 1996), traditionally, police, rape crisis centers, and social service agencies have advised victims to seek treatment in hospital emergency departments for a medical forensic exam (Martin, 2005). The survivor's body is a crime scene, and due to the invasive nature of rape, a medical professional, rather than a crime scene technician, is needed to collect the evidence. The "rape exam" or "rape kit" usually involves plucking head and pubic hairs; collecting loose hairs by combing the head and pubis; swabbing the vagina, rectum, and/or mouth to collect semen, blood, or saliva; and obtaining fingernail scrapings in the event the victim scratched the assailant. Blood samples may also be collected for DNA, toxicology, and ethanol testing (Martin, 2005).

Victims often experience long waits in hospital emergency departments because rape is rarely an emergent health threat, and during this wait, victims are not allowed to eat, drink, or urinate so as not to destroy physical evidence of the assault (Littel, 2001; Taylor, 2002). When victims are finally seen, they get a cursory explanation of what will occur, and it often comes as a shock that they have to have a pelvic exam immediately after such an egregious, invasive violation of their bodies (Martin, 2005; Parrot, 1991). Many victims describe the medical care they receive as cold, impersonal, and detached (Campbell, 2005, 2006; Campbell & Raja, 2005). Furthermore, the exams and evidence collection procedures are often performed incorrectly (Martin, 2005; Sievers, Murphy, & Miller, 2003). Most hospital emergency department personnel lack training in rape forensic exams, and those with training usually do not perform exams frequently enough to maintain proficiency (Littel, 2001; Plichta, Vandecar-Burdin, Odor, Reams, & Zhang, 2006).

Forensic evidence collection is often the focus of hospital emergency department care, but rape survivors have other medical needs, such as information on the risk of STIs/HIV and prophylaxis (preventive medications to treat any STIs that may have been contracted through the assault). The Centers for Disease Control and Prevention (2002) and the American Medical Association (1995) recommend that all sexual assault victims receive STI prophylaxis and HIV prophylaxis on a case-by-case basis after risk assessment. Yet analyses of hospital records have shown that only 34% of sexual assault patients are treated for STIs (Amey & Bishai, 2002). However, data from victims suggest much higher rates of STI prophylaxis: 57% to 69% of sexual assault patients reported that they received antibiotics during their hospital emergency department care (Campbell, 2005, 2006; Campbell et al., 2001; National Center for Victims of Crime & National Crime Victims Research and Treatment Center, 1992). But not all victims are equally likely to receive STI-related medical services.

Victims of nonstranger rape are significantly less likely to receive information on STIs/HIV or STI prophylaxis (Campbell & Bybee, 1997; Campbell et al., 2001), even though knowing one's assailant does not mitigate one's risk. In addition, one study found that Caucasian women were significantly more likely to get information on HIV than were ethnic minority women (Campbell et al., 2001).

Postassault pregnancy services are also inconsistently provided to rape victims. Only 40% to 49% of victims receive information about the risk of pregnancy (Campbell et al., 2001; National Center for Victims of Crime & National Crime Victims Research Center, 1992). The American Medical Association (1995) and the American College of Obstetricians and Gynecologists (1998) recommend emergency contraception for victims at risk for pregnancy, but only 21% to 43% of sexual assault victims who need emergency contraception actually receive it (Amey & Bishai, 2002; Campbell, 2005, 2006; Campbell & Bybee, 1997; Campbell et al., 2001). To date, no studies have found systematic differences in the provision of emergency contraception as a function of victim or assault characteristics, but hospitals affiliated with the Catholic church are significantly less likely to provide emergency contraception (Campbell & Bybee, 1997; Smugar, Spina, & Merz, 2000).

In the process of administering the forensic exam, STI services, and pregnancy-related care, doctors and nurses ask victims many of the same kinds of questions as do legal personnel regarding their prior sexual histories, sexual responses during the assault, what they were wearing, and what they did to "cause" the assault. Medical professionals may view these questions as necessary and appropriate, but rape survivors find them upsetting (Campbell & Raja, 2005). Comparative studies suggest that victims encounter significantly fewer victim-blaming questions and statements from medical system personnel than from legal personnel (Campbell, 2005, 2006; Campbell & Raja, 2005; Campbell, Barnes, et al., 1999, 2001), but this questioning still has a demonstrable negative impact on victims' mental health. Campbell (2005) found that as a result of their contact with emergency department doctors and nurses, most rape survivors stated that they felt bad about themselves (81%), depressed (88%), violated (94%), distrustful of others (74%), and reluctant to seek further help (80%; see also Campbell & Raja, 2005). Only 5% of victims in Ullman's (1996b) study rated physicians as a helpful source of support, and negative responses from formal systems, including the medical system, significantly exacerbated victims' PTSD symptomatology (Filipas & Ullman, 2001; Starzynski et al., 2005; Ullman & Filipas, 2001a, 2001b). Victims who did not receive basic medical services rated their experiences with the medical system as more hurtful, which has been associated with higher PTSD levels (Campbell & Raja, 2005; Campbell et al., 2001). Specifically, nonstranger rape victims who received minimal medical services but encountered high secondary victimization appeared to be the most at

risk: These women had significantly higher levels of PTSD symptoms than victims who did not seek medical services at all (Campbell, Barnes, et al., 1999).

Alternatives and Innovations: A SANE Approach

The conclusion cannot be that victims should not seek postassault medical care. Forensic evidence may be crucial for a successful legal case (Frazier & Haney, 1996; Spohn et al., 2001), but even more important is the fact that there are significant long-term health consequences for untreated injuries and STIs/HIV (Aral, 2001). Rape crisis centers have been instrumental in improving postassault medical care, including leading efforts to create standardized rape kits and providing medical advocates on a 24/7 basis to help victims in hospital emergency departments (Martin, 2005). Unfortunately, not all hospitals work with rape crisis centers, which may compromise victim care. In a quasi-experimental study, I (Campbell, 2006) compared victims' medical forensic exam experiences in two urban hospitals that were highly similar (e.g., number of victims served per year, patient sociodemographic characteristics) except that one had a policy of paging rape crisis center advocates to assist victims, and the other did not work with advocates. Victims who had the assistance of an advocate were significantly more likely to receive comprehensive medical care and were less likely to experience secondary victimization. Although these differences cannot be solely attributed to the efforts of the rape crisis center advocates, this study suggests that victims may benefit from some assistance in navigating the chaos of hospital emergency departments.

Alternatively, it may be more effective to change the postassault medical care delivery system entirely, which was the founding premise of Sexual Assault Nurse Examiner (SANE) programs. SANE programs were created by the nursing profession in the 1970s and rapidly grew in numbers during the 1990s (Ledray, 1999; Littel, 2001; U. S. Department of Justice, 2004). These programs were designed to circumvent many of the problems of traditional hospital emergency department care by having specially trained nurses, rather than doctors, provide 24/7 crisis intervention and medical care to sexual assault victims in either hospital emergency department or community clinic settings (Campbell, Patterson, & Lichty, 2005). Influenced by psychiatric and community mental health nursing, as well as clinical psychology, SANE programs place strong emphasis on treating victims with dignity and respect in order to decrease postassault psychological distress (Ledray, 1992, 1999; Taylor, 2002). Many SANE programs work with their local rape crisis centers so that victim advocates can be present for the exam to provide emotional support, which combines the potential benefits of both service programs (Littel, 2001; Taylor, 2002).

The medical forensic exams and the evidence collection kits provided by SANE programs are more thorough than

those victims receive in traditional emergency department care. Most SANE programs utilize specialized forensic equipment (e.g., a colposcope), which allows for the detection of microlacerations, bruises, and other injuries (Ledray, 1999). Even though the exam is more lengthy, *how* it is performed is qualitatively different. SANE programs provide a full explanation of the process *before* the exam begins and then continue to describe what they find throughout the exam, giving patients the opportunity to reinstate some control over their bodies by participating when appropriate (e.g., combing their own hair). In an evaluation of a midwestern SANE program, victims gave strong positive feedback about their exam experiences: All patients indicated that they were fully informed about the process and that the nurses took their needs and concerns seriously and allowed them to stop or pause the exam if needed (Campbell, Patterson, Adams, Diegel, & Coats, 2008). This patient-centered care also seems to help victims' psychological well-being, as survivors reported feeling supported, safe, respected, believed, and well-cared for by their SANE nurses (see also Ericksen et al., 2002).

With respect to STI/HIV and emergency contraception care, national surveys of SANE programs find service provision rates of 90% or higher (Campbell et al., 2006; Ciancone, Wilson, Collette, & Gerson, 2000). As with traditional emergency department medical care, SANE programs affiliated with Catholic hospitals are significantly less likely to conduct pregnancy testing or offer emergency contraception (but they do so at higher rates than non-SANE, Catholic-affiliated emergency departments; Campbell et al., 2006). In a quasi-experimental longitudinal study, Crandall and Helitzer (2003) compared medical service provision rates two years before to four years after the implementation of a hospital-based SANE program and found significant increases in STI prophylaxis care (from 89% to 97%) and emergency contraception (from 66% to 87%).

In addition to beneficial effects on victims' health, SANE programs may be instrumental in increasing legal prosecution of reported cases. Multiple case studies suggest that SANE programs increase prosecution, particularly plea bargains, because when confronted with the forensic evidence collected by the SANE programs, assailants will plead guilty (often to a lesser charge) rather than face trial (see Littel, 2001). When cases do go to trial, the SANE programs' expert witness testimony can help obtain convictions (see Ledray, 1999). Quasi-experimental pre-post designs have found that police referral and prosecution rates have increased significantly after the implementation of SANE programs (Campbell, Patterson, & Bybee, 2007; Crandall & Helitzer, 2003). Key informant interviews suggest this happens because SANE programs help centralize what is often disjointed, fragmented care for victims, which improves working relationships between the legal and medical systems. The development and launch of SANE programs are often accompanied by formal and informal

cross-agency trainings to improve communication, collaboration, and coordination. These trainings typically emphasize strategies for establishing rapport with victims, which may prevent secondary victimization and increase victims' engagement in the prosecution process (Campbell et al., 2007; Crandall & Helitzer, 2003). Although more research on SANE programs is clearly needed, it appears that changing postassault victim care practices in one social system can have positive ripple effects in other systems as well.

The Mental Health System

Victims' Help-Seeking Experiences

The mental health effects of rape have been extensively studied, yet it is still difficult to convey just how devastating rape is to victims' emotional well-being (Campbell, 2002). Many women experience this trauma as a fundamental betrayal of their sense of self, identity, judgment, and safety (Janoff-Bulman, 1992; Koss et al., 1994; Moor, 2007). Between 31% and 65% of rape survivors develop PTSD, and 38% to 43% meet diagnostic criteria for major depression (for reviews, see Kilpatrick & Acierno, 2003; Kilpatrick, Amstadter, Resnick, & Ruggiero, 2007; Koss et al., 2003). These sequelae are largely due to the trauma of the rape itself, but as noted previously, negative responses from the legal and medical systems exacerbate victims' distress. Clearly, victims may *need* mental health services, but there has been comparatively less research on what services they actually receive and whether that care improved their psychological health. Victims may obtain mental health services in myriad ways (e.g., treatment outcome research, community clinics/private practice, specialty agencies such as rape crisis centers), and their experiences vary considerably as a function of treatment setting.

First, some victims receive mental health services by participating as research subjects in randomized control trial (RCT) treatment outcome studies (e.g., Foa, Rothbaum, Riggs, & Murdock, 1991; Krakow et al., 2001; Resick et al., 2008; Resick, Nishith, Weaver, Astin, & Feuer, 2002). This option is available only to rape survivors who live in communities where such research is being conducted and who fit eligibility criteria. However, this kind of research is not intended to provide large-scale services; the goal is to establish empirically supported treatments (ESTs) that can then be disseminated for wider-scale benefit (American Psychological Association, 1995; American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006). Indeed, the results of these trials suggest that cognitive-behavioral therapies, such as cognitive processing therapy and prolonged exposure, are effective in alleviating PTSD symptoms (Foa, Keane, & Friedman, 2000; Russell & Davis, 2007). The victims who participate in these trials receive high-quality treatment and benefit tremendously, but this is not the experi-

ence of the typical rape victim seeking postassault mental health services (Koss et al., 2003).

A second, and more typical, way victims receive postassault mental health services is through community-based care provided by psychologists, psychiatrists, or social workers in private or public clinic settings. More victims receive mental health services in these settings than in treatment outcome studies, but these settings are still highly underutilized and have serious accessibility limitations. Most victims who seek traditional mental health services, for example, are Caucasian (Campbell et al., 2001; Golding et al., 1989; Starzynski, Ullman, Townsend, Long, & Long, 2007; Ullman & Brecklin, 2002). Ethnic minority women are more likely to turn to informal sources of support (e.g., friends and family; Wyatt, 1992) and may not necessarily place the same value on formal psychotherapy (Bletzer & Koss, 2006). Victims without health insurance are also significantly less likely to obtain mental health services (Koss et al., 2003; Starzynski et al., 2007).

When victims do receive community-based mental health services, it is unclear whether practitioners are consistently using empirically supported treatments. Two statewide random sample studies of practitioners suggest it is unlikely. Campbell, Raja, and Grining's (1999) survey of licensed mental health professionals in a midwestern state found that most (52%) reported using cognitive-behavioral methods with victims of violence (including, but not limited to sexual assault victims), but almost all practitioners stated that they rarely use a single approach and intentionally combine multiple therapeutic orientations and treatments. Sprang, Craig, and Clark's (2008) study of mental health practitioners in a southern state also found high use of cognitive-behavioral interventions with trauma victims (including, but not limited to sexual assault survivors), but again, these were not in exclusive use. Exposure therapy, a cognitive-behavioral therapy approach with strong empirical support (Foa et al., 2000), was rarely cited as a preferred treatment (see Ruscio & Holohan, 2006). These studies suggest that cognitive-behavioral therapy approaches are often used by community practitioners, but without in-depth data on how the services were implemented, it would be a stretch to conclude that most victims receive empirically supported care in traditional, community-based mental health services. As is often the case in the efficacy-effectiveness-dissemination research cycle, it can take quite a while for evidence-based practice to become standard care (Huppert, Fabbro, & Barlow, 2006; Kazdin, 2008; Ruscio & Holohan, 2006; Sprang et al., 2008; Westen, Novotny, & Thompson-Brenner, 2004).

Few studies have examined if and how victims benefit from community-based mental health services. In general, victims tend to rate their experiences with mental health professionals positively and to characterize their help as useful and supportive (Campbell et al., 2001; Ullman, 1996a, 1996b). Whether positive satisfaction results in demonstrable

mental health benefit is largely unknown, although Campbell, Barnes, et al. (1999) found that community-based mental health services were particularly helpful for victims who had had negative experiences with the legal and/or medical systems. Victims who encountered substantial difficulty obtaining needed services and experienced high secondary victimization from the legal and medical systems had high PTSD symptomatology; but among this high-risk group of survivors, those who had been able to obtain mental health services had significantly lower PTSD, which suggests that there may have been some benefit from receiving such services. In this same sample, however, 25% of women who received postassault mental health services rated this contact as hurtful (with 19% characterizing it as severely hurtful; Campbell et al., 2001). Indeed, some mental health practitioners have expressed concern about whether their own profession works effectively with sexual assault victims: 58% of practitioners in a statewide study felt that mental health providers engage in practices that would be harmful to victims and questioned the degree to which victims benefit from services (Campbell & Raja, 1999).

A third setting in which victims may obtain mental health services is specialized violence against women agencies, such as rape crisis centers and domestic violence shelter programs. Rape crisis centers help victims negotiate their contact with the legal and medical systems, and they also provide individual and group counseling (Campbell & Martin, 2001). These agencies are perhaps the most visible and accessible source for mental health services for rape victims (Koss et al., 2003), as they provide counseling free of charge and do not require health insurance. As with traditional mental health services, there is still evidence of racial differences in service utilization, as Caucasian women are significantly more likely to utilize rape crisis center services than are ethnic minority women (Campbell et al., 2001; Martin, 2005; Wgliski & Barthel, 2004).

Little is known about the therapeutic orientations and treatment approaches used in rape crisis centers, but current data indicate a strong feminist and/or empowerment theoretical orientation (e.g., shared goal setting, focus on gender inequalities, identification of rape as not only a personal problem but a social problem too; Edmond, 2006; Goodman & Epstein, 2008; Howard, Riger, Campbell, & Wasco, 2003; Ullman & Townsend, 2008; Wasco et al., 2004). In a national survey of rape crisis centers and domestic violence shelters,⁴ approxi-

⁴ Domestic violence shelters are included in studies of community-based mental health services for rape/sexual assault victims because some communities do not have free-standing rape crisis centers and instead have combined sexual assault/domestic violence programs (Campbell, Baker, & Mazurek, 1998; National Sexual Violence Resource Center, 2006). Domestic violence programs are also included in such research because irrespective of their organizational linkages to rape crisis centers, these agencies provide counseling services to victims of marital rape/intimate partner rape (Howard et al., 2003).

mately 70% of the agencies reported using cognitive-behavioral methods—in combination with other methods (e.g., client-centered and feminist; Edmond, 2006). With respect to counseling outcomes, Wasco et al. (2004) and Howard et al. (2003) compared self-reported PTSD symptoms pre- and post-counseling among victims receiving rape crisis center counseling services and found significant reductions in distress levels and self-blame over time and increases in social support, self efficacy, and sense of control. Because these studies did not examine the content of services or include comparison groups, it is unclear whether these observed improvements are attributable to the services provided.

Alternatives and Innovations: Mental Health Services Sooner and Better

Victims have extensive postassault mental health needs, and several researchers/practitioners have called for increased use of empirically supported treatments in rape crisis centers and other community-based mental health services settings (Edmond, 2006; Russell & Davis, 2007; Sprang et al., 2008). Future work in this arena can benefit from the large, multidisciplinary literature on the adoption of evidence-based practice in community settings. Miller and Shinn's (2005) extensive review of the science–practice gap across multiple social issues highlights several challenges that may be particularly relevant for improving mental health services for rape victims (see also Kazdin, 2008). Making providers aware of evidence-based practice and/or empirically supported treatments is a necessary first step (Sprang et al., 2008), but knowledge is rarely sufficient for innovation adoption (Miller & Shinn, 2005). Changing existing practice requires that individuals and organizations have the training, expertise, and funding to adopt the innovation. Training may be a particularly salient resource because most mental health professionals do not receive adequate instruction on working with victims (Goodman & Epstein, 2008; Campbell, Raja, & Grining, 1999; Ullman, 2007). In response to this situation, several national/federal research agendas on interpersonal violence have called for more training of mental health workers (Koss, 2008). Ullman (2007) argued that such training must focus on teaching professionals how to inquire in a sensitive manner about women's histories of victimization; survivors may be reluctant, and understandably so, to disclose abuse, and yet the underlying reason for their distress may be a history of victimization. As Resick (2004) aptly noted, "Treatment needs to focus on processing the core traumas, not just on symptoms" (p. 1292). Training is an important first step in ensuring that mental health professionals are responding appropriately to the needs of victimized women.

But Miller and Shinn (2005) found that even with adequate training and resources, practitioners can be resistant to evidence-based practice if they perceive that the innova-

tion is incongruent with their values. In the context of mental health services for rape victims, this seems quite possible given that rape crisis centers' roots stem from the antirape social movement, which is a markedly different historical context than that of the mental health profession. The limited empirical data on rape crisis centers' mental health services suggest a strong valuing of feminist, empowerment-focused approaches (Edmond, 2006; Wasco et al., 2004), which could be perceived as incongruent with therapeutic approaches that do not emphasize the broader social context of rape (Goodman & Epstein, 2008). Similarly, non-rape-crisis-center-affiliated mental health practitioners specifically favor integrating multiple therapeutic orientations and approaches (Campbell, Raja, & Grining, 1999; Sprang et al., 2008), which could be viewed as antithetical to the adoption of manualized interventions. Kazdin (2008) noted that mental health practitioners' skepticism of evidence-based practice may run even deeper. Participant samples and treatment success are often narrowly defined in efficacy research, leaving clinicians to question whether such treatments can create meaningful improvement in clients' everyday life functioning. Research on clinical decision making is clearly warranted to understand how rape crisis center counselors' and other community-based mental health providers' beliefs and values shape their choice and implementation of treatment approaches.

Miller and Shinn's (2005) analysis also invites critical examination of the presumptive advantage of empirically supported treatments. There is a well-documented "pro-innovation bias" in the social sciences: the notion that evidence-based practice and/or empirically supported treatments are widely considered to have benefits over indigenous practices that have not been studied and indeed may prove effective if studied (Mayer & Davidson, 2000; Rogers, 1995). Miller and Shinn (2005) advocated for more research that seeks to understand what is being offered in community settings, to identify indigenous strategies that are effective, and to capture local knowledge and expertise, because closing the research–practice gap requires partnerships with the "agencies, organizations, and associations that are the lifeblood of the community" (p. 179). In that vein, translational research projects with rape crisis centers and other community-based mental health services are needed to evaluate current services, assess the need for adoption of empirically supported treatments, and disseminate effective clinical practice (see National Institute of Mental Health, 2004, 2006).

A more fundamental innovation for improving mental health services for rape victims is reconceptualizing the role of mental health professionals in postassault care. When victims obtain mental health services it is usually after the fact. Psychologists and allied professionals are largely absent in the immediate, postassault community

response to rape, which is unfortunate because during this vulnerable time, victims encounter substantial secondary victimization from the legal and medical systems. Bringing trained mental health professionals in earlier could make a significant difference in victims' well-being, and a promising, empirically informed model of early intervention is psychological first aid. Based on years of research on crisis intervention techniques, psychological first aid was developed for working with victims of disasters, violence, and other traumas in their immediate aftermath (Everly & Flynn, 2005; Parker, Everly, Barnett, & Links, 2006; Ruzek et al., 2007). The goal of psychological first aid is to accelerate recovery and promote mental health through eight core goals and actions: (1) initiate contact in a nonintrusive, compassionate, helpful manner; (2) enhance safety and provide physical and emotional comfort; (3) calm and orient emotionally distraught survivors; (4) identify immediate needs and concerns and gather information; (5) offer practical help to address immediate needs and concerns; (6) reduce distress by connecting to primary support persons; (7) provide individuals with information about stress reactions and coping; and (8) link individuals to services and inform them about services they may need in the future (Ruzek et al., 2007).

Ruzek and colleagues (2007) examined how and why these eight principles of psychological first aid can curb posttrauma distress. Focusing on psychological and physical safety can interrupt the biological mechanisms of posttrauma stress reactions (see Bryant, 2006) and can challenge cognitive beliefs about perceived dangerousness (see Foa & Rothbaum, 1998). Grounding techniques that focus individuals on the relative safety of the present time can also be effective in interrupting processes that begin to link nonthreatening persons, places, and things to the original trauma event (see Resick & Schnicke, 1992). Trying to calm victims can significantly decrease the likelihood that their immediate anxiety will generalize to other situations (see Bryant, 2006) and can reduce high arousal levels, which, if prolonged, can lead to acute stress disorder (and later PTSD) as well as significant somatic symptoms (see Harvey, Bryant, & Tarrier, 2003). Mobilizing resources to respond to victims' immediate needs and linking them to services in the community have been found to reduce distress and increase long-term quality of life (see Sullivan & Bybee, 1999). Providing information about effective coping strategies can foster self-efficacy, which can help victims set realistic expectations for the long-term recovery process (see Benight & Harper, 2002). Strengthening social support and coping can help with practical and material resource needs but also provides additional outlets for emotional processing of the traumatic events (see Norris, Friedman, & Watson, 2002). Each of the individual components of psychological first aid has good empirical support, but there has been limited research on how the *combined* set of

intervention strategies can curb posttrauma distress (Ruzek et al., 2007). However, a recent meta-analysis of multistrategy crisis intervention methods for medical patients found that these techniques can significantly mitigate PTSD, depression, and anxiety symptoms (Stapleton, Lating, Kirkhart, & Everly, 2006). Future research is needed to examine how the full complement of psychological first aid components can prevent distress among diverse groups of trauma survivors.

Given these promising findings regarding the effectiveness of psychological first aid, it is worth considering how this intervention could be used to assist rape survivors in the immediate postassault aftermath. Psychological first aid was purposively designed for simple, practical administration wherever trauma survivors are, including hospitals, shelters, and police departments (National Child Traumatic Stress Network and National Center for PTSD, 2006). Psychological first aid can be performed by mental health professionals, but another role for psychologists and allied professionals is to provide training to public health workers and other first responders so that they can also offer psychological first aid (Parker, Barnett, Everly, & Links, 2006). Mental health professionals could work with hospital emergency departments, SANE programs, and police departments—either as providers of psychological first aid or as training consultants. Similarly, because the medical and legal advocacy provided by rape crisis centers includes crisis intervention, mental health professionals could partner with these centers to ensure that advocates are trained in all psychological first aid core competencies.

Conclusion

Rape victims encounter significant difficulties obtaining help from the legal, medical, and mental health systems, and what help they do receive can leave them feeling blamed, doubted, and revictimized. As a result, survivors' posttrauma distress may be due not only to the rape itself but also to how they are treated by social systems after the assault. The community response to rape is not haphazard: Certain victims and certain kinds of assaults are more likely to receive systemic attention. Ethnic minority and/or low-SES victims and those raped by someone they know are at particularly high risk for having difficult postassault help-seeking experiences. Some victims are virtually missing in the research on this issue and indeed may be missing in our social systems as well. What happens to immigrant victims, to survivors living in rural areas, to lesbian, bisexual, and transgendered victims, and to survivors with disabilities is largely unknown, but given that privilege and discrimination so strongly influence system response, there is more than enough reason to be concerned about highly marginalized and vulnerable victims.

This review has highlighted the experiences of victims who sought help from formal social systems and the diffi-

culties they encountered. But one must remember that many victims, indeed most, do not seek help from the legal, medical, and mental health systems. When these survivors are asked why they do not, they say that they are concerned about whether they would even get help and that they are worried about being treated poorly. Unfortunately, empirical research suggests that this apprehension is probably warranted. At the same time, for some victims, social system contact is beneficial and healing. The challenge, then, is to address the underlying problems in our social systems so that good care is more consistently provided to all victims, who have survived all kinds of assaults. We need interventions and programs that victims will trust and that will help them through the healing process.

Several promising innovations have emerged to improve the community response to rape. For the legal system, SANE programs seem to be making a positive difference in prosecution rates, but the criminal justice system remains inherently adversarial—as it was designed and intended to be. Restorative justice programs offer a way to “restore survivors” (Koss, 2006) by creating an alternative setting that focuses on victims’ needs to speak of the assault and to be heard and recognized. Offenders are held accountable for their actions and must make amends. This is what many survivors say they want, and it can be done without a grueling, drawn-out court battle (Koss & Achilles, 2008). Although legal issues still garner a great deal of attention from researchers, practitioners, and policymakers, the medical and mental health needs of victims are also paramount. A founding goal of SANE programs was to provide more comprehensive medical care and to do so in a way that addressed victims’ emotional needs for respect, privacy, and control. Emerging data suggest that these programs are successful in these aims, but there is still a need for more focus on victims’ mental health needs. Developing central roles for psychologists and allied professionals in the immediate postassault community response to rape could be instrumental in preventing secondary victimization and preventing further distress. Psychological first aid provides one approach for creating linkages between the mental health community, victims, and other social system personnel. Collaborative, multisystem innovations, informed by social science research, are changing the community response to rape. The trauma associated with negative postassault help seeking can be prevented, and our communities can be more effective in helping survivors heal from rape.

Author’s Note

I thank Debra Patterson for her assistance with the preparation of this manuscript and Deb Bybee, Kelly Klump, Cris Sullivan, and Sarah Ullman for their helpful comments on drafts of this manuscript.

Correspondence concerning this article should be addressed to Rebecca Campbell, Department of Psychology, Michigan State University, 127 C Psychology Building, East Lansing, MI 48824-1116. E-mail: rmc@msu.edu

References

- American College of Obstetricians and Gynecologists. (1998). Sexual assault (ACOG educational bulletin). *International Journal of Gynecology and Obstetrics*, *60*, 297–304.
- American Medical Association. (1995). *Strategies for the treatment and prevention of sexual assault*. Chicago, IL: Author.
- American Psychological Association. (1995). *Template for developing guidelines: Interventions for mental disorders and psychosocial aspects of physical disorders*. Washington, DC: Author.
- American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*, 271–285.
- Amev, A. L., & Bishai, D. (2002). Measuring the quality of medical care for women who experience sexual assault with data from the National Hospital Ambulatory Medical Care Survey. *Annals of Emergency Medicine*, *39*, 631–638.
- Aral, S. O. (2001). Sexually transmitted diseases: Magnitude, determinants, and consequences. *International Journal of STD & AIDS*, *12*, 211–215.
- Benight, C. C., & Harper, M. L. (2002). Coping self-efficacy perceptions as a mediator between acute stress response and long-term distress following natural disasters. *Journal of Traumatic Stress*, *15*, 177–186.
- Bletzer, K. V., & Koss, M. P. (2006). After rape among three populations in the Southwest: A time for mourning, a time for recovery. *Violence Against Women*, *12*, 5–29.
- Bouffard, J. (2000). Predicting type of sexual assault case closure from victim, suspect and case characteristics. *Journal of Criminal Justice*, *28*, 527–542.
- Bryant, R. A. (2006). Cognitive behavior therapy: Implications from advances in neuroscience. In N. Kato, M. Kawata, & R. K. Pitman (Eds.), *PTSD: Brain mechanisms and clinical implications* (pp. 255–270). Tokyo: Springer.

- Campbell, R. (2002). *Emotionally involved: The impact of researching rape*. New York: Routledge.
- Campbell, R. (2005). What really happened? A validation study of rape survivors' help-seeking experiences with the legal and medical systems. *Violence & Victims, 20*, 55–68.
- Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? *Violence Against Women, 12*, 1–16.
- Campbell, R., Baker, C. K., & Mazurek, T. (1998). Remaining radical? Organizational predictors of rape crisis centers' social change initiatives. *American Journal of Community Psychology, 26*, 465–491.
- Campbell, R., Barnes, H. E., Ahrens, C. E., Wasco, S. M., Zaragoza-Diesfeld, Y., & Sefl, T. (1999). Community services for rape survivors: Enhancing psychological well-being or increasing trauma? *Journal of Consulting and Clinical Psychology, 67*, 847–858.
- Campbell, R., & Bybee, D. (1997). Emergency medical services for rape victims: Detecting the cracks in service delivery. *Women's Health, 3*, 75–101.
- Campbell, R., & Martin, P. Y. (2001). Services for sexual assault survivors: The role of rape crisis centers. In C. Renzetti, J. Edleson, & R. Bergen (Eds.), *Sourcebook on violence against women* (pp. 227–241). Thousand Oaks, CA: Sage.
- Campbell, R., Patterson, D., Adams, A. E., Diegel, R., & Coats, S. (2008). A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients' psychological well-being. *Journal of Forensic Nursing, 4*, 19–28.
- Campbell, R., Patterson, D., & Bybee, D. (2007, October). *Prosecution rates for adult sexual assault cases: A ten year analysis before and after the implementation of a SANE program*. Paper presented at the International Forensic Nursing Scientific Assembly, Salt Lake City, UT.
- Campbell, R., Patterson, D., & Lichty, L. F. (2005). The effectiveness of sexual assault nurse examiner (SANE) programs: A review of psychological, medical, legal, and community outcomes. *Trauma, Violence, & Abuse: A Review Journal, 6*, 313–329.
- Campbell, R., & Raja, S. (1999). The secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence & Victims, 14*, 261–275.
- Campbell, R., & Raja, S. (2005). The sexual assault and secondary victimization of female veterans: Help-seeking experiences in military and civilian social systems. *Psychology of Women Quarterly, 29*, 97–106.
- Campbell, R., Raja, S., & Grining, P. L. (1999). Training mental health professionals on violence against women. *Journal of Interpersonal Violence, 14*, 1003–1013.
- Campbell, R., Townsend, S. M., Long, S. M., Kinnison, K. E., Pulley, E. M., Adames, S. B., & Wasco, S. M. (2006). Responding to sexual assault victims' medical and emotional needs: A national study of the services provided by SANE programs. *Research in Nursing & Health, 29*, 384–398.
- Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the "second rape:" Rape survivors' experiences with community service providers. *Journal of Interpersonal Violence, 16*, 1239–1259.
- Centers for Disease Control and Prevention. (2002). Sexual assault and STDs—Adults and adolescents. *Morbidity and Mortality Weekly Report, 51* (RR-6), 69–71.
- Ciancone, A., Wilson, C., Collette, R., & Gerson, L. W. (2000). Sexual Assault Nurse Examiner programs in the United States. *Annals of Emergency Medicine, 35*, 353–357.
- Crandall, C., & Helitzer, D. (2003). *Impact evaluation of a Sexual Assault Nurse Examiner (SANE) program* (Document No: 203276). Washington DC: National Institute of Justice.
- Edmond, T. (2006, February). *Theoretical and intervention preferences of service providers addressing violence against women: A national survey*. Paper presented at the Council on Social Work Education Conference, Chicago, IL.
- Ericksen, J., Dudley, C., McIntosh, G., Ritch, L., Shumay, S., & Simpson, M. (2002). Clients' experiences with a specialized sexual assault service. *Journal of Emergency Nursing, 28*, 86–90.
- Estrich, S. (1987). *Real rape: How the legal system victimizes women who say no*. Cambridge, MA: Harvard University Press.
- Everly, G. S., & Flynn, B. W. (2005). Principles and practice of acute psychological first aid. In G. S. Everly & C. L. Parker (Eds.), *Mental health aspects of mass disasters: Public health preparedness and response* (pp. 79–

- 89). Baltimore, MD: Johns Hopkins Center for Public Health Preparedness.
- Filipas, H. H., & Ullman, S. E. (2001). Social reactions to sexual assault victims from various support sources. *Violence & Victims, 16*, 673–692.
- Fisher, B. A., Cullen, F. T., & Turner, M. G. (2000). *The sexual victimization of college women* (NCJ 182369). Washington, DC: U.S. Department of Justice, Office of Justice Programs.
- Flowe, H. D., Ebbesen, E. B., & Putcha-Bhagavatula, A. (2007). Rape shield laws and sexual behavior evidence: Effects of consent level and women's sexual history on rape allegations. *Law and Human Behavior, 31*, 159–175.
- Foa, E. B., Keane, T. M., & Friedman, M. J. (Eds.). (2000). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford Press.
- Foa, E. B., & Rothbaum, B. O. (1998). *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York: Guilford Press.
- Foa, E. B., Rothbaum, B. O., Riggs, D. S., & Murdock, T. B. (1991). Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioral procedures and counseling. *Journal of Consulting and Clinical Psychology, 59*, 715–723.
- Frazier, P., & Haney, B. (1996). Sexual assault cases in the legal system: Police, prosecutor and victim perspectives. *Law and Human Behavior, 20*, 607–628.
- Frohmann, L. (1997a). Complaint-filing interviews and the constitution of organizational structure: Understanding the limitations of rape reform. *Hastings Women's Law Journal, 8*, 365–399.
- Frohmann, L. (1997b). Discrediting victims' allegations of sexual assault: Prosecutorial accounts of case rejections. *Social Problems, 38*, 213–226.
- Golding, J. M., Siegel, J. M., Sorenson, S. B., Burnam, M. A., & Stein, J. A. (1989). Social support sources following sexual assault. *Journal of Community Psychology, 17*, 92–107.
- Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health, and justice*. Washington, DC: American Psychological Association.
- Halligan, S. L., Michael, T., Clark, D. M., & Ehlers, A. (2003). Posttraumatic stress disorder following assault: The role of cognitive processing, trauma memory, and appraisals. *Journal of Consulting and Clinical Psychology, 71*, 419–431.
- Harvey, A. G., Bryant, R. A., & Tarrier, N. (2003). Cognitive behavior therapy for posttraumatic stress disorder. *Clinical Psychology Review, 23*, 501–522.
- Howard, A., Riger, S., Campbell, R., & Wasco, S. M. (2003). Counseling services for battered women: A comparison of outcomes for physical and sexual abuse survivors. *Journal of Interpersonal Violence, 18*, 717–734.
- Huppert, J. D., Fabbro, A., & Barlow, D. H. (2006). Evidence-based practice and psychological treatments. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet* (pp. 131–152). Washington, DC: American Psychological Association.
- Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.
- Kazdin, A. E. (2008). Evidence-based treatment and practice: New opportunities to bridge clinical research and practice, enhance the knowledge base, and improve patient care. *American Psychologist, 63*, 146–159.
- Kerstetter, W. (1990). Gateway to justice: Police and prosecutor response to sexual assault against women. *Journal of Criminal Law & Criminology, 81*, 267–313.
- Kerstetter, W., & Van Winkle, B. (1990). Who decides? A study of the complainant's decision to prosecute in rape cases. *Criminal Justice and Behavior, 17*, 268–283.
- Kilpatrick, D. G., & Acierno, R. (2003). Mental health needs of crime victims: Epidemiology and outcomes. *Journal of Traumatic Stress, 16*, 119–132.
- Kilpatrick, D. G., Amstadter, A. B., Resnick, H. S., & Ruggiero, K. J. (2007). Rape-related PTSD: Issues and interventions. *Psychiatric Times, 24*, 50–58.
- Konradi, A. (2007). *Taking the stand: Rape survivors and the prosecution of rapists*. Westport, CT: Praeger.
- Koss, M. P. (2006). Restoring rape survivors: Justice, advocacy, and a call to action. *Annals of the New York Academy of Sciences, 1087*, 206–234.

- Koss, M. P. (2008, February). *Interpersonal violence agendas: Past and future*. Paper presented at the American Psychological Association Summit on Violence and Abuse in Relationships, Bethesda, MD.
- Koss, M. P., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M., et al. (2007). Revising the SES: A collaborative process to improve assessment of sexual aggression and victimization. *Psychology of Women Quarterly, 31*, 357–370.
- Koss, M., & Achilles, M. (2008). *Restorative justice responses to sexual assault*. Retrieved March 3, 2008, from http://www.vawnet.org/category/Main_Doc.php?docid=1231
- Koss, M. P., Bachar, K. J., Hopkins, C. Q., & Carlson, C. (2004). Expanding a community's justice response to sex crimes through advocacy, prosecutorial, and public health collaboration. *Journal of Interpersonal Violence, 19*, 1435–1463.
- Koss, M. P., Bailey, J. A., Yuan, N. P., Herrera, V. M., & Lichter, E. L. (2003). Depression and PTSD in survivors of male violence: Research and training initiatives to facilitate recovery. *Psychology of Women Quarterly, 27*, 130–142.
- Koss, M. P., Gidycz, C. A., & Wisniewski, N. (1987). The scope of rape: Incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology, 55*, 162–170.
- Koss, M. P., Goodman, L. A., Browne, A., Fitzgerald, L. F., Keita, G. P., & Russo, N. F. (1994). *No safe haven: Male violence against women at home, at work, and in the community*. Washington, DC: American Psychological Association.
- Krakow, B., Hollifield, M., Johnston, L., Koss, M., Schrader, R., Warner, T. D., et al. (2001). Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: A randomized control trial. *Journal of the American Medical Association, 296*, 537–545.
- Ledray, L. (1992). The sexual assault nurse clinician: A fifteen-year experience in Minneapolis. *Journal of Emergency Nursing, 18*, 217–222.
- Ledray, L. (1996). The sexual assault resource service: A new model of care. *Minnesota Medicine, 79*, 43–45.
- Ledray, L. E. (1999). *Sexual assault nurse examiner (SANE) development & operations guide*. Washington, DC: Office for Victims of Crime, U.S. Department of Justice.
- Littel, K. (2001). Sexual assault nurse examiner programs: Improving the community response to sexual assault victims. *Office for Victims of Crime Bulletin, 4*, 1–19.
- Logan, T., Evans, L., Stevenson, E., & Jordan, C. E. (2005). Barriers to services for rural and urban survivors of rape. *Journal of Interpersonal Violence, 20*, 591–616.
- Madigan, L., & Gamble, N. (1991). *The second rape: Society's continued betrayal of the victim*. New York: Lexington.
- Martin, P. Y. (2005). *Rape work: Victims, gender, and emotions in organization and community context*. New York: Routledge.
- Martin, P. Y., & Powell, R. M. (1994). Accounting for the "second assault": Legal organizations' framing of rape victims. *Law & Social Inquiry, 19*, 853–890.
- Matthews, N. A. (1994). *Confronting rape: The feminist anti-rape movement and the state*. New York: Routledge.
- Mayer, J. P., & Davidson, W. S. (2000). Dissemination of innovation as social change. In J. Rappaport & E. Seidman (Eds.), *Handbook of community psychology* (pp. 421–438). New York: Plenum Press.
- Miller, R. L., & Shinn, M. (2005). Learning from communities: Overcoming difficulties in dissemination of prevention and promotion efforts. *American Journal of Community Psychology, 35*, 169–183.
- Monroe, L. M., Kinney, L. M., Weist, M. D., Dafeamekpor, D. S., Dantzler, J., & Reynolds, M. W. (2005). The experience of sexual assault: Findings from a statewide victim needs assessment. *Journal of Interpersonal Violence, 20*, 767–777.
- Moor, A. (2007). When recounting the traumatic memories is not enough: Treating persistent self-devaluation associated with rape and victim-blaming myths. *Women & Therapy, 30*, 19–33.
- National Center for Victims of Crime & National Crime Victims Research and Treatment Center. (1992). *Rape in America: A report to the nation*. Arlington, VA: National Center for Victims of Crime.
- National Child Traumatic Stress Network and National Center for PTSD. (2006). *Psychological first aid: Field operations guide* (2nd ed.). Retrieved March 3, 2008, from: http://www.nctsn.org/nctsn/nav.do?pid=typ_terr_resources_pfa

- National Institute of Mental Health. (2004). *Bridging science and service: A report by the National Advisory Mental Health Council's Clinical Treatment and Services Research Workgroup*. Bethesda, MD: Author.
- National Institute of Mental Health. (2006). *The road ahead: Research partnerships to transform services: A report by the National Advisory Mental Health Council's Workgroup on Services and Clinical Epidemiology Research*. Bethesda, MD: Author.
- National Sexual Violence Resource Center. (2006). *Directory of sexual assault centers in the United States*. Enola, PA: Author.
- Norris, F. H., Friedman, M. J., & Watson, P. J. (2002). 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry, 65*, 240–260.
- Parker, C. L., Barnett, D. J., Everly, G. S., & Links, J. M. (2006). Expanding disaster mental health response: A conceptual training framework for public health professionals. *International Journal of Emergency Mental Health, 8*, 101–110.
- Parker, C. L., Everly, G. S., Barnett, D. J., & Links, J. M. (2006). Establishing evidence-informed core intervention competencies in psychological first aid for public health personnel. *International Journal of Emergency Mental Health, 8*, 83–92.
- Parrot, A. (1991). Medical community response to acquaintance rape—Recommendations. In A. Parrot & L. Bechhofer (Eds.), *Acquaintance rape: The hidden crime* (pp. 304–316). New York: Wiley.
- Patterson, D., Greeson, M. R., & Campbell, R. (2008). *Protect thyself: Understanding rape survivors' decisions not to seek help from social systems*. Manuscript submitted for publication.
- Plichta, S. B., Vandecar-Burdin, T., Odor, R. K., Reams, S., & Zhang, Y. (2006). The emergency department and victims of sexual violence: An assessment of preparedness to help. *Journal of Health and Human Services Administration, 29*, 285–308.
- Resick, P. A. (2004). A suggested research agenda on treatment-outcome research for female victims of violence. *Journal of Interpersonal Violence, 19*, 1290–1295.
- Resick, P. A., Galovski, T. E., Uhlmansiek, M., Scher, C. D., Clum, G. A., & Young-Xu, Y. (2008). A randomized control trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76*, 243–258.
- Resick, P. A., Nishith, P., Weaver, T. L., Astin, M. C., & Feuer, C. A. (2002). A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology, 70*, 867–879.
- Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*, 748–756.
- RESTORE Overview Manual. (2006). Retrieved March 3, 2008, from http://restoreprogram.publichealth.arizona.edu/process/RESTORE_Overview_Manual.pdf
- Rogers, E. M. (1995). *Diffusion of innovations* (4th ed.). New York: Free Press.
- Ruscio, A. M., & Holohan, D. R. (2006). Applying empirically supported treatments to complex cases: Ethical, empirical, and practical considerations. *Clinical Psychology: Science and Practice, 13*, 146–162.
- Russell, P. L., & Davis, C. (2007). Twenty-five years of empirical research on treatment following sexual assault. *Best Practices in Mental Health, 3*, 21–37.
- Ruzek, J. I., Brymer, M. J., Jacobs, A. K., Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). Psychological first aid. *Journal of Mental Health Counseling, 29*, 17–49.
- Sarason, S. B. (1972). *The creation of settings and the future societies*. San Francisco: Jossey-Bass.
- Sievers, V., Murphy, S., & Miller, J. (2003). Sexual assault evidence collection more accurate when completed by sexual assault nurse examiners: Colorado's experience. *Journal of Emergency Nursing, 29*, 511–514.
- Smugar, S. S., Spina, B. J., & Merz, J. F. (2000). Informed consent for emergency contraception: Variability in hospital care of rape victims. *American Journal of Public Health, 90*, 1372–1376.
- Spears, J., & Spohn, C. (1997). The effect of evidence factors and victim characteristics on prosecutors' charging decisions in sexual assault cases. *Justice Quarterly, 14*, 501–524.

- Spohn, C., Beichner, D., & Davis-Frenzel, E. (2001). Prosecutorial justifications for sexual assault case rejection: Guarding the "gateway to justice." *Social Problems, 48*, 206–235.
- Sprang, G., Craig, C., & Clark, J. (2008). Factors impacting trauma treatment practice patterns: The convergence/divergence of science and practice. *Journal of Anxiety Disorders, 22*, 162–174.
- Stapleton, A., Lating, J., Kirkhart, M., & Everly, G. S. (2006). Effects of medical crisis intervention on anxiety, depression, and posttraumatic stress symptoms: A meta-analysis. *Psychiatric Quarterly, 77*, 231–238.
- Starzynski, L. L., Ullman, S. E., Filipas, H. H., & Townsend, S. M. (2005). Correlates of women's sexual assault disclosure to informal and formal support sources. *Violence & Victims, 20*, 417–432.
- Starzynski, L. L., Ullman, S. E., Townsend, S. M., Long, D. M., & Long, S. M. (2007). What factors predict women's disclosure of sexual assault to mental health professionals? *Journal of Community Psychology, 35*, 619–638.
- Sullivan, C. M., & Bybee, D. (1999). Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology, 67*, 43–53.
- Taylor, W. K. (2002). Collecting evidence for sexual assault: The role of the sexual assault nurse examiner (SANE). *International Journal of Gynecology and Obstetrics, 78*, S91–S94.
- Tjaden, P., & Thoennes, N. (1998). *Full report of the prevalence, incidence, and consequences of violence against women: Findings from the National Violence Against Women Survey*. Washington, DC: National Institute of Justice.
- Ullman, S. E. (1996a). Correlates and consequences of adult sexual assault disclosure. *Journal of Interpersonal Violence, 11*, 554–571.
- Ullman, S. E. (1996b). Do social reactions to sexual assault victims vary by support provider? *Violence and Victims, 11*, 143–156.
- Ullman, S. E. (1999). Social support and recovery from sexual assault: A review. *Aggression and Violent Behavior, 4*, 343–358.
- Ullman, S. E. (2000). Psychometric characteristics of the Social Reactions Questionnaire: A measure of reactions to sexual assault victims. *Psychology of Women Quarterly, 24*, 169–183.
- Ullman, S. E. (2007). Mental health services seeking in sexual assault victims. *Women & Therapy, 30*, 61–84.
- Ullman, S. E., & Brecklin, L. R. (2002). Sexual assault history, PTSD, and mental health service seeking in a national sample of women. *Journal of Community Psychology, 30*, 261–279.
- Ullman, S. E., & Filipas, H. H. (2001a). Correlates of formal and informal support seeking in sexual assault victims. *Journal of Interpersonal Violence, 16*, 1028–1047.
- Ullman, S. E., & Filipas, H. H. (2001b). Predictors of PTSD symptom severity and social reactions in sexual assault victims. *Journal of Traumatic Stress, 14*, 369–389.
- Ullman, S. E., & Townsend, S. M. (2008). What is an empowerment approach to working with sexual assault survivors? *Journal of Community Psychology, 36*, 1–14.
- U. S. Department of Justice. (2004). *A national protocol for sexual assault medical forensic examinations: Adults/adolescents*. Washington, DC: Author.
- Wasco, S. M., Campbell, R., Barnes, H., & Ahrens, C. E. (1999, June). *Rape crisis centers: Shaping survivors' experiences with community systems following sexual assault*. Paper presented at the Biennial Conference on Community Research and Action, New Haven, CT.
- Wasco, S. M., Campbell, R., Howard, A., Mason, G., Schewe, P., Staggs, S., & Riger, S. (2004). A statewide evaluation of services provided to rape survivors. *Journal of Interpersonal Violence, 19*, 252–263.
- Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130*, 631–663.
- Wgliski, A., & Barthel, A. K. (2004). Cultural differences in reporting of sexual assault to sexual assault agencies in the United States. *Sexual Assault Report, 7*, 84; 92–93.
- Wyatt, G. E. (1992). The sociocultural context of African American and White American women's rape. *Journal of Social Issues, 48*, 77–91.

