# Violence Against Women

http://vaw.sagepub.com


## Barriers to Working With Sexual Assault Survivors: A Qualitative Study of Rape Crisis Center Workers

Sarah E. Ullman and Stephanie M. Townsend

*VIOLENCE AGAINST WOMEN* 2007; 13; 412
DOI: 10.1177/1077801207299191

The online version of this article can be found at:
http://vaw.sagepub.com/cgi/content/abstract/13/4/412

Published by:

http://www.sagepublications.com

**Additional services and information for *Violence Against Women* can be found at:**

**Email Alerts:** http://vaw.sagepub.com/cgi/alerts

**Subscriptions:** http://vaw.sagepub.com/subscriptions

**Reprints:** http://www.sagepub.com/journalsReprints.nav

**Permissions:** http://www.sagepub.com/journalsPermissions.nav

**Citations** http://vaw.sagepub.com/cgi/content/refs/13/4/412

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

**Violence Against Women**
Volume 13 Number 4
April 2007 412-443
© 2007 Sage Publications
10.1177/1077801207299191
http://vaw.sagepub.com
hosted at
http://online.sagepub.com

# Barriers to Working With Sexual Assault Survivors

## A Qualitative Study of Rape Crisis Center Workers

Sarah E. Ullman
Stephanie M. Townsend
*University of Illinois at Chicago*

To better understand barriers service providers may face when advocating for survivors, a study using grounded theory and qualitative, semistructured interviews was conducted of rape victim advocates ($N = 25$) working in rape crisis centers in a large metropolitan area. Broader societal attitudes framed and were reflected in institutional responses to victims and in barriers faced by advocates working with survivors. Organizational barriers noted by advocates related to resources, environmental factors, professionalization, and racism. Staff burnout was a major barrier affecting advocates' ability to help survivors. Finally, the most salient direct service barrier was secondary victimization by criminal justice and medical or mental health systems.

***Keywords:*** *barriers to service; rape victim advocates; sexual assault survivors*

Rape crisis centers are uniquely situated to respond to the physical, emotional, and social needs of survivors. Their services focus on three critical areas: 24-hour crisis hotlines, individual and group counseling (often on a short-term basis only), and legal and medical advocacy (Campbell & Martin, 2001). Although there have been few explicit studies on the benefits of receiving rape crisis services, there is evidence that rape crisis center advocates do help victims obtain services from the legal, medical, and mental health systems. In a study of survivors' postassault experiences, Campbell et al. (1999) found that survivors who worked with a rape crisis center advocate experienced significantly less distress than those who did not. In community studies, rape crisis centers are rated as most helpful of a range of support sources by victims seeking help after assault (Filipas & Ullman, 2001; Golding, Siegel, Sorenson, Burnam, & Stein, 1989). A recent study of more than 1,000 sexual assault survivors recruited from

**Authors' Note:** This article was partially written while the first author was a faculty scholar at the University of Illinois at Chicago, Great Cities Institute. Earlier portions of this article were presented at the 2003 and 2004 American Society of Criminology meetings. We thank anonymous reviewers of this article for helpful comments.



Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

the community in a large metropolitan area showed that 16% sought rape crisis services and 79.3% rated them as helpful—a higher percentage than any of 10 informal and formal support sources assessed (Ullman, Filipas, Townsend, & Starzynski, in press). Despite the potential benefit of crisis services, only 1 in 5 survivors in their sample received these services. Similarly, the numbers of survivors accessing the legal, mental health, and criminal justice systems are also low. Representative community data show that only 11.0% have contact with the legal system, 9.3% seek medical care, and 16.1% obtain mental health services (Golding et al., 1989). Recent convenience samples show higher rates of contact, with 20% to 39% contacting the legal system, 20% to 43% seeking medical care, and 39% to 60% obtaining mental health care (Campbell et al., 1999; Ullman, 1996; Ullman et al., in press). Even the highest of these estimates reflects a relatively low proportion of survivors accessing services that can potentially benefit from them in coping with the physical and psychological effects of sexual violence. This raises questions about whether there are barriers to services that could be mitigated. Specific services for rape victims can be obtained from mental health, medical, and police or legal sources following the crime. Martin (2005) has provided a detailed description of all formal service providers and their roles in relation to serving rape victims. Martin argues that some service providers pose barriers for victims and their advocates because of unique organizational goals that conflict with the goal of enhancing victim recovery. For example, Martin has shown how organizational goals such as police and prosecutors' need for victims to serve as credible witnesses and hospital personnel's treatment of victims as patients with physical injuries lead them to treat victims in an unresponsive manner. Other work with rape survivors shows that they experience harmful treatment from medical and legal institutions that often revictimize them with negative social reactions (Campbell, 1998; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). This evidence suggests that organizational or system barriers lead to harmful responses to victims and likely a lack of therapeutic services. The existence of barriers is further supported by Logan, Evans, Stevenson, and Jordan's (2005) recent focus groups with 30 female clients from rural and urban rape crisis centers that showed barriers of lack of access, availability, and knowledge of services and unacceptable and/or revictimizing experiences with service providers (e.g., lack of sensitivity by mental health, medical, and criminal justice personnel). These findings regarding secondary victimization are consistent with many other studies of sexual assault victims showing that survivors report a variety of negative social reactions both from informal and especially from formal support providers. Furthermore, studies show these reactions have harmful effects on psychological symptoms of survivors, including posttraumatic stress disorder (PTSD; Campbell et al., 1999; Davis, Brickman, & Baker, 1991; Ullman, 1996; Ullman et al., in press; Ullman & Filipas, 2001).

Reports from victims are an important source of information regarding barriers to accessing support. An alternative approach is to seek the perspectives of advocates whose role is both to provide direct support and to help victims access resources from other systems. Advocates may be a useful source of information in at least three

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

ways. First, they can help to identify barriers victims face. This approach was used by Campbell (1998), who interviewed rape crisis advocates about their most recent case. Advocates were asked about victims' experiences with the legal, medical, and mental health systems, including what actions were taken by each system, whether those actions fit what the victim wanted, and how readily available the services were. Analyses indicated that there were three patterns in victims' experiences. One group had positive experiences with all three systems, a second group had positive experiences only with the medical system, and a third group had difficult experiences with all three systems. This study revealed differential patterns of responses based on community-level, assault-related, and individual-level variables. It also demonstrated that advocates could be an important source of information about the experiences victims have when seeking support services.

Second, advocates may also be important sources of information about the challenges service providers face when assisting survivors. Burnout and vicarious trauma have been documented as problems in past studies of rape crisis workers (Baird & Jenkins, 2003; Ghahramanlou & Brodbeck, 2000; Schauben & Frazier, 1996) and crime victim support workers generally (see Salston & Figley, 2003, for a review). Yet most research has only studied these psychological symptoms in relation to worker characteristics and client caseloads. It is also important to understand organizational and system-related barriers from the vantage point of those who interface with many survivors during long periods. Social service providers' perspectives in their own words can provide additional insights into the institutional barriers that limit the availability and efficacy of services. Such information may help in understanding the larger context of rape crisis work that contributes to vicarious trauma and burnout in workers.

Third, understanding the perspectives of service providers on service-related barriers can help researchers who are attempting to do collaborative research on sexual violence. Collaborative methods for research and evaluation are especially appropriate when working with violence against women organizations because of the fact that workers in such organizations possess critical knowledge about issues such as client safety and confidentiality (Wasco et al., 2004). It is also beneficial for practitioners who cite benefits of collaboration that include identification of promising practices, validation of local program experiences, obtaining data to support funding requests, and evaluation of client services and programs, whereas researchers cite benefits of gaining new perspectives, generating research ideas, improving project design, and interpreting research findings (National Violence Against Women Prevention Research Center, 2001). However, there are numerous challenges to collaboration between researchers and service providers, including differing priorities, different organizational cultures, and a diversity of professional backgrounds, that give rise to different terminologies (Riger, 1999). Overcoming these challenges and negotiating tensions first requires that researchers understand the context in which service providers work. To foster effective collaborations, it is particularly important that researchers understand the barriers that service providers may face in their work. This can sensitize

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

researchers to the complexities of service provision, thereby allowing for better communication and collaboration.

In summary, although some research has documented barriers faced by survivors to getting help (Campbell, 1998; Campbell et al., 2001; Martin, 2005), further work is needed from service provider perspectives on the barriers they face in advocating for survivors. Therefore, a qualitative interview study was conducted of victim advocates from various rape crisis centers in a large urban area. This was a grounded theory, exploratory study to identify barriers advocates face in their work and how those barriers affect survivors' ability to receive support. Implications for future research and practice with sexual assault survivors are discussed.

# Method

## Sample

The sample was composed of 25 women who were current or former rape victim advocates working at rape crisis centers in a large Midwestern metropolitan area. This sample is part of a larger study of both clinicians and advocates working at a variety of social service agencies, including rape crisis centers (see Ullman, 2005, for a description of the first author's experience doing these interviews). Participants were recruited using multiple methods. Letters were sent to 60 people working in agencies in the metropolitan area who were listed as participants at the most recent national conference on sexual violence prevention. All persons who called the researcher or responded to the researcher's phone calls did participate in the study. In response to these letters, 14 interviews were conducted (a 23% response rate). Although the sexual violence conference is a selective source to sample, many eligible participants could be easily identified from that list with contact information for many metropolitan area rape crisis workers who attended the conference. In addition, 10 interviewees were identified by participants referring the interviewer to other people who have worked in the rape crisis field in the area, and one person was located by a chance meeting at a professional function. This resulted in a total sample of 25 advocates, representing 10 distinct agency locations, with an average of 2.80 persons interviewed per location. Nineteen participants were currently working as advocates doing advocacy, referral, and/or crisis counseling at rape crisis centers. Six were former advocates who had worked at rape crisis centers, generally within the past year. Most advocates had done medical advocacy and/or crisis counseling. Two had done primarily legal advocacy, one had done health education, and six had also done administrative work (e.g., volunteer coordinator, director, supervisor) in addition to advocacy. Eight rape crisis centers were freestanding organizations, two programs were contained within a larger social service agency or community mental health center, and one participant worked both on a rape crisis hotline and in a university counseling and advocacy setting. All

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

women had experience working with sexual assault survivors, ranging from 1.5 to 16 years of experience, with an average of 5.14 years of experience (s = 3.83). Eleven workers also had mental health experience doing crisis counseling or other types of therapy with sexual assault survivors, with an average of 3.64 years of experience (s = 6.00). Participants were asked to indicate if they had any or all of four types of training (sexual assault, domestic violence, child abuse, violence against women). Thirteen had all 4 types of training, and 12 had from 1 to 3 types of training. All had training on sexual assault. No further detail was specifically asked about the nature and extent of participants' training. In terms of practice location, 4 worked in suburban locations, 19 worked in the city, and 2 worked in both city and suburban settings. Women were asked to check off all applicable items in a checklist that characterized their treatment orientation. Seventeen endorsed a feminist orientation in their approach to working with survivors, whereas 12 endorsed various other treatment orientations such as client-centered and cognitive behavioral. All participants were women. In terms of education, 1 had a PhD, 7 had master's degrees, 14 had bachelor's degrees, and 3 had some college or an associate's degree. Most women were White ($n = 12$), followed by Hispanic ($n = 6$), Black ($n = 5$), Asian ($n = 1$), and multiracial ($n = 1$). Women's average age was 33.04 years (s = 9.20 years). Most women ($n = 12$) were in their 20s, with a range of 25 to 58 years. Two had incomes of $10,000 to $20,000, 11 had incomes from $20,000 to $30,000 per year, 8 earned $30,000 to $40,000 per year, 3 had incomes of $60,000 or more, and 1 refused to provide her income.

## Agencies

Services for rape victims in the area from which participants were sampled include a 24-hour hotline for the entire metropolitan area that is run out of the largest rape crisis center in the city. The hotline is coordinated by full-time employees and staffed by trained volunteers 24 hours a day. Other services provided by the area's rape crisis centers include medical and legal advocacy, crisis counseling and referral to other social and mental health services, prevention education, and training to other agencies including police and state's attorneys. Agencies where workers were employed included two large rape crisis centers, one of which had satellite offices in both city and suburban locations. Both of these rape crisis centers had administrative and supervisory staff, advocates, and counselors, with a smaller core of paid, full-time staff and a larger core of volunteer victim advocates who typically went on emergency room calls when rape victims were taken there by police following an assault.

Some workers mainly did crisis counseling and gave referrals to survivors of sexual assault, whereas others did longer-term therapy with survivors or administrative work and supervision of other employees in their agencies. Most advocates did crisis counseling and medical advocacy, with two advocates primarily doing legal advocacy and prevention education to area schools and colleges. Typically, those doing mostly counseling also worked on advocacy needs with clients, some of whom

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

were also receiving therapy from mental health professionals outside of the rape crisis center. Smaller agencies were typically more mental health focused and were often part of community mental health centers, although they still identified as rape crisis centers. They provided the same advocacy and counseling services, but the larger organizations where they were housed also served other populations, such as child victims or clients with general mental health needs. Agencies varied in geographic location and both provider and client demographic characteristics, partially reflecting the agency, its philosophy, and the client population of the specific agency location. For example, agencies in predominantly Black or Hispanic neighborhoods had more staff with similar ethnic backgrounds, whereas agencies located in the downtown central city had a greater proportion of White staff.

Obviously, our study is limited by a small sample from a subset of centers in one metropolitan area, some of whom were former advocates with negative experiences that may have motivated them to participate. No rural advocates were included in this study, which is a limitation because rape crisis center services are much more limited in rural areas (Martin, 2005), and barriers that advocates and victims face may differ in rural areas (Logan et al., 2005). In addition, only a couple of open-ended questions were asked about barriers advocates faced in working with survivors and in their organizations specifically, which were followed up with probes. Detailed questions were not asked about a predetermined list of specific barriers, which may have led to underreporting of certain barriers or more discussion by advocates of the most salient barriers they face. Because only the first author conducted these interviews, age and race matching with advocates was not possible. The first author is a White, middle-aged female, which may have led to fewer or poorer quality data from advocates with different age and ethnic characteristics (see Ullman, 2005, for a discussion of her perceptions of how this may have affected interviews with older, ethnic minority women, in particular).

## Procedure

Participants completed in-person interviews at a time and location convenient for them. Most interviews were conducted at their work offices (20) at a convenient time for the women, but 5 preferred to be interviewed at other locations. Interviews were conducted from November 2002 through May 2003 by the first author. Interviews ranged from 45 minutes to 1 hour and 20 minutes in length, with the average interview length of 65.36 minutes ($s = 13.36$ minutes), and a modal interview length of 1 hour.

Semistructured interviews asked about women's training and work experience with survivors of sexual assault and other relevant work experience, how disclosures of sexual assault tended to occur, how interviewees typically respond to disclosures, difficult and rewarding aspects of working with survivors, barriers to working with survivors and to survivors' obtaining services, and solutions that might improve services to this population. Participants were also asked about their views about the role

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

of mental health professionals in working with sexual assault survivors. Only the data on barriers were analyzed in the current study.

## Analysis Strategy

A grounded theory approach was used for data analysis. Four stages of analysis were used. The first stage consisted of open and axial coding (Strauss & Corbin, 1998). Open codes emerged from the text to break the data into discrete parts. Axial coding extended the analysis from the textual level to the conceptual level. The second stage of analysis involved construction of a meta-matrix, which is a master chart that compiles descriptive data from each case into a standard format (Miles & Huberman, 1994). Column headings identified key variables and each row represented a program. This process allowed for the identification of themes that were common to many programs and those that were unique to a small number of programs. The third stage of analysis was the manipulation of the meta-matrix to create submatrices that were conceptually ordered according to key variables (Miles & Huberman, 1994). This process allowed for identification of patterns between variables. The final stage was the creation of analysis forms that summarized the submatrices. In completing these forms, both within-case and cross-case analyses were done, in which the content of codes within and then across cases were compared. The goal was to identify and interpret any themes or patterns that could answer the research question of what barriers interfere with survivors receiving help following a sexual assault. The results as described in the following section were based on the final stage of analysis.

# Results and Discussion

Advocates identified multiple barriers to their work with survivors at their organizations and in the social systems (e.g., medical, criminal justice) from which survivors seek help. In the sections that follow, each barrier is described by advocates reporting them and how the barrier affected advocates' ability to work with survivors and help them access needed services. To frame the organization of these barriers, Figure 1 shows how these themes may be organized hierarchically to show their interrelationships.

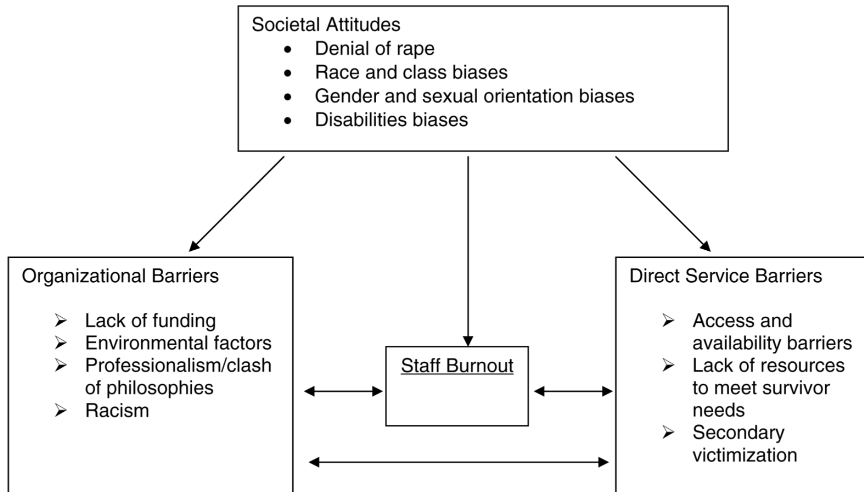
Broader societal attitudes discussed first can be viewed as influencing several subgroups of barriers occurring at levels of the (a) organization, (b) staff, and (c) direct services.[1]

## Societal Attitudes

Barriers to service provision exist within a larger societal context. At the macro level, it is important to consider how societal attitudes may be reflected in the

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

**Figure 1**
**Organization of Barrier Themes Identified by Rape Victim Advocates**




responses that societal institutions make to rape survivors. Some advocates (36%) spoke about attitudes toward rape manifested in system responses that interfered with advocacy. For example, one advocate discussed the larger barrier of societal denial of the problem of rape:

> We still haven't reached a point in our society where you can even acknowledge this problem for what it is and that's why people can't get over it. I don't care if they're sitting in an office an hour a week and somebody says, yes you have a right to all these feelings, everything else in the world, tells them that they don't. Until we acknowledge that, that's never gonna happen! (Advocate 36)

Race and class biases are also societal barriers reflected in organizations, including rape crisis centers and in institutions that respond to survivors' needs. These types of biases were noted by 56% of participants.

> So it's all based on the story that night what's the story? How credible is the witness? the victim? How credible is the perp? Well, you know racism plays into account, classism plays into account, I mean you name it, it's there. Sexism plays a role, too. (Advocate 3)

> There's always this doubt. I've never heard a person who wasn't of color told: "Well, you can take it back if you want, you know if you tell me that you made it up, then we'll let you go if you try to press charges." They bully young people and particularly young

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> people of color by saying, "I'm giving you a chance to take this back." Police say I'm giving you a chance to tell me the truth, if you're not telling me the truth then you know, you can take it back now, but if we go through with this and we try and prosecute and we find out that you're lying, then you're gonna go to jail, you know? It's like a script. I haven't heard like an older person told that, I've never heard a person who wasn't of color asked those things so, and when I say older, I mean like people in their 40's or 50's unless there was a situation where maybe they were mentally ill or they were a substance abuser. It's always people who are disenfranchised in some form or fashion who are completely silenced and not believed. (Advocate 25)

One participant continued to explain further the ways survivors are treated differently based on gender and sexual orientation:

> It's even sexist because male survivors are treated horribly. They don't even take it seriously and act like they deserve it. The impression I've gotten is not as if they're saying that it didn't happen, it was just they deserved it or they must have been doing something to condone it or they must be homosexual so it's because of their lifestyle. I've seen survivors who were not homosexual openly say, well you know, I'm not gay, but all the questioning was geared around that. Did you know the guy, were you in a relationship with him? Why does that matter so? People still have in their minds what the ideal rape victim looks like, behaves like, what type of lifestyle they have. It's amazing to me that we haven't gotten past that. I think it's partly the media and it's partly about just wanting to remain in your comfort zone. (Advocate 25)

Another advocate spoke of problems that survivors with disabilities and immigrants have in getting appropriate responses from service systems:

> I think the hardest work that I've done is with people with any type of disability and with elder people and not because they put up a barrier. It's hard also to work with people with mental illness because it's hard to work with them, and it's hard to make the system to understand them and respect them and their rights. It's also hard with immigrants for the same reason and because law enforcement doesn't cooperate with them and thinks what they're saying or what they think is because of their ethnicity. (Advocate 32)

Clearly, these attitudes make it even more difficult for advocates to help survivors from marginalized groups who suffer from multiple sources of stigmatization and devaluation in the eyes of social institutions that deal with rape victims. It is much more difficult for advocates to combat not only rape stereotypes affecting all rape survivors but also additional stereotypes about "less deserving" rape victims who because of age, race, sexual orientation, occupation, mental illness, or immigration status are viewed as unworthy of the system's attention or response. These attitudes about specific groups of people are ingrained in all members of society to varying degrees and may be more unconscious and well accepted. This may make them even harder for advocates to challenge than rape stereotypes, which probably are less socially acceptable to admit adhering to. These broad societal attitudes undergird

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

specific barriers that are seen at the levels of the organization and staff, and they contribute to barriers that victims face when seeking direct services.

## Organizational Barriers

The high prevalence of rape in combination with widespread denial of this problem contributes to the underresourcing of agencies that serve victims. As a result, rape crisis centers face organizational-level barriers to providing an adequate response to victims' needs. Barriers at this level include a lack of funding and environmental stressors. In the effort to obtain more funding and resources, agencies have come under pressure to adopt organizational practices that are seen as more professional but that in some cases redefine the agencies' focus on advocacy. In addition, organizations are not immune from societal attitudes such as racism that may be manifest in their own practices. Each of these barriers was articulated by participants in this study.

### Lack of Funding

The lack of funding was an issue mentioned by 64% of participants. Some described funding as precluding advocates from making a long-term commitment to rape crisis work. This may directly contribute to staff turnover and, therefore, to lower quality services for survivors.

> It's hard to think about making a RCC [rape crisis center] a career for a long time, cause it's impossible, it's very hard to imagine spending the rest of your life working for no more than $35,000 a year and that's after being at an agency for a long time. Especially, I mean I remember that they just made a decision that nobody was going to advance, they were only going to have supervisors that had master's degrees, so everybody that had a BA or BS, that was sort of then the ground level. Some were sort of faced with this dilemma, because there's obviously nowhere else to advance in the agency without having a master's degree but the money and time it would take to get a master's degree and then come back, even the supervisory level is really only going to make $4,000 more. But I went for my master's last year, it would be financially prohibitive even in a supervisory position. So I think that they can also value sort of experience in the field. (Advocate 35)

> I know I'm glad we're getting money, I'm glad to have this done but it's just I think there were some of the people at [Agency X] who left because they had children and the agency doesn't provide child care, you know you can't bring your child, too. I understand that, and so it's cheaper to stay at home with your children than to have day care and work at [Agency X]. The pay is that low for some of the positions, and I don't understand how in a feminist organization why people have to leave a job. (Advocate 35)

In addition to low salaries, which may contribute to staff turnover, the lack of funding also raises the possibility of competition between agencies for available funds. This

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

was a concern of 16% of participants. One advocate spoke of this in relation to the competition between domestic violence and sexual assault providers for the same dollars:

> I think sometimes you run into that sort of change in focus [from rape to domestic violence], I think other times it's really just vying for the same funding. I think the whole DV/sexual assault thing is that domestic violence has always just been sort of ahead of the ball in terms of getting the funding, the awareness, and getting more people to recognize it as an issue. Plus, I think just in general it's [domestic violence] easier for people to talk about than anything that has to do with sex. That kind of puts you down a couple of notches in terms of who's gonna want to talk to you about it, fund you, and let you into their schools to talk about it. So I think that there has always sort of been that challenge distinguishing sexual assault from domestic violence and getting sexual assault recognized, also a very serious concern that needs attention. (Advocate 10)

The scarcity and competitiveness of funds was also discussed in terms of how it shapes the approaches agencies take to doing their work. One such effect is that agencies may take on new projects because they fear losing the support of grantors, even though the new projects are beyond the scope of what the agency can handle. For example, an advocate complained of a situation when her agency director agreed to provide advocacy to more area hospitals, when advocate resources were already stretched to the limit in covering their existing contracts:

> I'm sure it has to do with funding, but I think that there's also a way in which we, as in "we" as a part of this agency get so scared that we're gonna lose funding or not be able to expand services that we start agreeing to things that are not helpful to the agency. (Advocate 35)

Part of the problem may be that grantors do not recognize the larger context of providing services or the preliminary steps needed to launch an initiative. This can create a mismatch between grantors' expectations and what is actually necessary to carry out community initiatives. One advocate explained this in the context of outreach she did to the [Ethnic group name] community:

> The [Ethnic group name] services program was funded when I started working at the agency and they had staff that was funded by [the state coalition], but the funding was strictly for counseling, and the entire time that I was there, they had a total of 3 or 4 clients, because the outreach had not been done. You can't just open your doors and expect that people are gonna come. What ended up happening with that program was that everyone was aware that we were in danger of losing that funding, and so the manager asked me to come in and make a last minute push to try and drum up some clients. But it was a little late, and actually that was a time when I felt like I was ready to transition into something else anyway, so I said okay, fine, but the more I started working on that, the more I felt like this is just not something that I care to save, because this program was of course conceived in a way that had no consideration or respect for the communities that it was presuming to serve. If the funding was really what it should be,

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> it should be funded to be purely outreach and that's it. We shouldn't even have been funded for counseling at that point in time, which they would have known if they had talked to anybody within those communities. (Advocate 37)

A former advocate with many years in the field explained her broader view of funding in relation to other government priorities. She spoke of federal changes in terms of a shift from funding victim services to funding criminal justice and prosecution-based strategies and a wholesale shift of funds away from violence against women toward issues of gangs and drugs:

> There's so many different levels to that because nationally there's nothing available because the funding has been diverted over the last 5 years from victim services into prosecution. And so there's less and less money available to victim services, so a lot of the money comes from things like the Violence Against Women Act and some other kinds of victims' services. But in order to deal with the crime, the current administration strategy is to shift away putting victim services money into prosecution. But the problem is that prosecution money has been transferred into prosecution of gangs and drugs, so the prosecution level of sexual assault, domestic violence, or child sexual abuse has not necessarily increased in correlation with extra money they put into prosecution. (Advocate 38)

She also spoke of the problematic structure of services where duplicate services have been developed in parallel, instead of having centralized services, where common resources can be shared by many different constituencies. Her comments on this matter are especially notable because they contrast with other participants who expressed more concern with maintaining their own agencies' programs and services. This former advocate, however, proposed a centralization of services as a way to make better use of limited funds:

> Right now is there are a lot of dollars spent on duplication of services, but what I would like to see is an actual kind of centralization of services that a lot of these violence against women agencies need, so you have a centralization of services that offer legal advocates so that not everybody has these positions. You could have a centralized database where you allow common resources to be funded commonly and collectively and then people can utilize the resources. So if you've got a curriculum development person who's actually being funded from eight different agencies, each of those agencies has to spend less money, but they can all utilize the curricula developed by that kind of a practice system. I think it's what's necessary and I think it's the next part of the maturation process of these agencies. (Advocate 38)

## Environmental Factors

Limited funding may also lead to less than ideal settings in which to provide services. Environmental factors within rape crisis centers were cited as barriers to

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

providing services by 8% of advocates. This problem may be greater, however, at smaller agencies and satellite offices. Those mentioning positive environmental characteristics of their work settings (e.g., spacious, peaceful, welcoming) all worked in larger agencies, whereas most of the small number of participants mentioning problems with the work environment (3 out of 4) worked in these smaller settings. Specifically, they talked about problems with lack of privacy and limited space for doing advocacy in their workplace. For example,

> In terms of counseling, I've only had about 3 clients coming into the office for legal advocacy where there's no real privacy. I have the cubicle where I sit, but there's no real privacy for a client to come in and talk to me. (Advocate 22)

A related issue regarding the physical work environment was safety concerns, mentioned by one advocate working at a larger agency in the city:

> For the first month I was working there, there was no lock on the office door, so I couldn't even lock myself in, and I just remember being terrified at night and being told by the agency that we don't have enough money and there's too many people coming in and out to deal with this problem. (Advocate 35)

Although few advocates in this study mentioned environmental factors, likely because they were not specifically asked about these factors, they seemed important to mention because they may affect advocates in their work with victims. Martin (2005) notes that smaller agencies, particularly rape crisis centers, may be less able to be responsive to victims' needs generally because of their limited resources.

## Professionalization of Rape Crisis Centers

Another important organizational characteristic that may affect the ability of advocates to help survivors is the professionalization of rape crisis centers, which was mentioned by 16% of advocates. Research has documented that as many rape crisis centers have become more institutionalized, they have focused more on counseling and advocacy for individual survivors and less on political action and institutional advocacy, as in the past (Campbell, Baker, & Mazurek, 1998). In this study, a major barrier raised by some advocates was professionalization of rape crisis centers. Professionalization and standardization of services has its benefits, such as ensuring that survivors receive quality treatment (e.g., counseling) by well-trained professionals who have specific educational credentials. However, it may also have disadvantages, such as minimizing the traditional feminist or social change perspective, that may be important for challenging systems that fail to meet victims' needs.

Advocates presented two conflicting views on the impact of professionalization of rape crisis centers on survivors receiving their services. Three advocates argued that professionalization (e.g., requiring specific educational credentials) was harmful

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

because it (a) excluded many women who had a vital contribution to make helping rape survivors and (b) led rape crisis centers to hire professionals who were nonfeminist or even antifeminist in their orientation. Another perspective voiced by one advocate in particular was that professionalization (defined as appropriate professional training and demeanor) is important to encourage in rape crisis centers, so that survivors are appropriately treated and the field is taken seriously and supported by external funders. However, this approach may also narrow the range of people whose skills are employed in the field. In this sample, concerns about professionalization were noted more by those workers endorsing a feminist orientation. The advocates quoted below described the manifestation of professionalization of rape crisis work occurring at the organizational level:

> There's a lot of issues like professionalization of the movement that I think is a big problem. Everything is so focused on services. You have people at [Agency X], they had this awesome very powerful woman working there, she'd been doing the work for several years and she was let go, they got rid of her position. We had heard it was because she doesn't have a college degree and that's [Agency X's] formal policy is you have to have a college degree to do the work. I think that just excludes a lot of very amazing people. (Advocate 29)

> There are ways that agencies could think more about how they are marketing their services, who their staff are, what their priorities are in terms of staffing and where centers and satellites are going to be located, but I think that's not the kind of thing that happens. This is where I start to get really angry because I feel as though I've seen the agencies get more and more professionalized and become more of a system. They all work together more, so they become more and more alike, and it's frustrating because there's this move to say we want all of our counselors to have master's degrees. On the one hand, yeah you would like your sexual assault survivors to get sort of the best kind of counseling that they can, but the master's is not always the best measure of who's best able to provide 10 weeks of crisis counseling. (Advocate 35)

This latter point is likely valid given research showing no correlation of professional training with psychotherapeutic effectiveness (Luborsky et al., 1986; Stein & Lambert, 1984). Professional technical expertise and knowledge do not necessarily predict success. Instead, effective therapists and other support sources have qualities of warmth, empathy, and genuineness (Frank & Frank, 1991), which may not come from professional training or certification.

Limiting staff to those with graduate degrees can also narrow the focus of rape crisis centers. Specifically, the need for activism and social advocacy, not simply counseling, was identified as important for empowering survivors:

> We have to move toward thinking about social advocacy and making change. I see a lot more counselors who are just trained as counselors and don't think about activism. If

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> you're in there empowering your clients, think about how much they can advocate for themselves. Not just with family members or partners, but society. . . . Writing a letter to the editor can be a part of the counseling or therapy, but that gets lost when they're more traditional, and that's not being stressed in the training. (Advocate 35)

Unfortunately, as agencies professionalize and require more educational credentials, they lose a broader activist focus, which is critical for fighting rape and for empowering survivors, and end up with a narrower, apolitical, individual counseling approach.

Another advocate described the problem of supervisors with clinical credentials who are nonfeminist and yet are hired at rape crisis centers that traditionally espoused and often still espouse a feminist commitment to addressing violence against women:

> They hired a clinical supervisor who was not a feminist, who said that she doesn't understand what feminism's about. But how can you work in a RCC and not be a feminist? I remember one time she came to talk to me about a client she had. She said the woman had gone to make a phone call at like three in the morning, and this woman said, "Well don't you just think that was stupid, I mean that was just asking to get raped." And I said, "I cannot believe you are the clinical supervisor at this agency!" (Advocate 35)

Clearly, such statements are problematic coming from a leader in an organization devoted to eradicating violence against women and sensitive treatment of rape survivors. This may not only affect survivors who have contact with the staff person but also communicate a negative and demoralizing message to advocates about how their organization's leaders view sexual assault survivors.

Although these concerns about professionalization and especially about the hiring of staff based on narrow criteria were shared by many of the advocates, an alternative view was also expressed. An advocate who had left rape crisis work to work on behalf of rape victims in another arena presented a very different view of professionalization. She argued for a "professionalism" that referred to the need for professional behavior in rape crisis centers. This was distinct from the issue of professionalization of rape crisis centers by requiring workers to have advanced degrees:

> A controversial thing that I've said before, and people get mad at me all the time, is I think a lot of victim service agencies adopt a victim mentality of "woe is us, there's nothing we can do, there's too much to be done, we can't do it all, we're stressed out." There is a lack of professionalism in these agencies. . . . I think part of it is, you've gotta professionalize the profession in a way that it hasn't been. I mean we just have not done it and I don't think it has to be that damn stressful as people make it out to be. I think there is a way to do this and I think it has to do with leadership. One of the things I have fought very hard for at [Agency X] is to say, look, if it stresses you out that much, don't do it! (Advocate 38)

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

I asked how this kind of professionalism differed from the negative side of professionalization of agencies that other advocates expressed to me. She elaborated on the problem:

> Sometimes you hear these young, passionate people are very feminist or who have very strong politics who feel like the model is very apolitical or very service oriented and doesn't have that kind of analysis. But the thing about it is, and maybe this is just me getting older too, is that passion that you find in the college age population. . . . You can't build a workforce on that, cause guess what, those kids grow up and when they hit 25, they quit cause they wanna make more money. I think the problem is people want to build a lot on trying to harness that energy, but that is a fleeting kind of energy, it is not a permanent energy, and so what you have to do is you have to create a channel in which you capture that energy but that can't be the permanent fuel that you run on. The permanent fuel that you run on has to be based on professionals who are in it for the long haul. (Advocate 38)

This quote suggests that both conditions of the work (e.g., low pay) and who it attracts (e.g., young feminists) may lead to staff turnover because of lack of career advancement opportunities in rape crisis centers. She spoke of how she envisioned developing services to address specific functions that agencies sought to fulfill and that such a model would lead to long-term growth instead of functioning in survival mode in the context of limited government resources directed at the problem.

> We need staff people to fulfill these functions. What are the functions that should be fulfilled from a staff perspective, what are the functions from a volunteer perspective and how can we professionalize the whole process so that we're putting appropriate responsibilities on staff, appropriate responsibilities on volunteers, appropriate responsibilities on the boards of directors, appropriate responsibilities on leadership, and we've created some really strong selection tools, retention tools, leadership development tools, so that people in these positions are people who wanna be in these positions for the long haul, and we're actually developing the skills necessary for them to become better as they go along. . . . It's a difference between surviving and thinking about long-term growth. I think the way that these organizations are constructed right now is all based on a survival model. I absolutely think this issue [rape] is one of the most underfunded issues in our country, and it's one of the most prevalent issues in our country, and we don't deal with it. But until the rest of the world comes around, we have to do better with what we have. (Advocate 38)

## Racism in Rape Crisis Centers

Racism is an issue that has been critically important in the contemporary women's movement generally and in relation to the issue of rape and rape crisis centers specifically (Campbell et al., 2001; Matthews, 1994; Scott, 1998). Racism is not only an issue that must be confronted in the broader society. It must also be confronted within rape crisis centers themselves. If left unaddressed, it undermines an

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

agency's ability to provide quality services to victims of color and replicates within the agency dynamics of oppression that are related to the cultural causes of violence against women. Racism was spontaneously noted to be a problem in rape crisis organizations by 24% of advocates in this study:

> I think the whole rape crisis center thing is still a "White feminist" women's movement thing, and I think it's still painfully obvious. Especially at a center like X which for the most part is White women. (Advocate 30)

Another advocate voiced her perception that her organization tried to be nonracist by sponsoring events related to women of color, but that action was not tantamount to a thorough organizational critical self-examination and attempt to be truly nonracist in everyday practices:

> We just had this event focused on women of color, which I think is good, but I think in some way it's almost like, well you know, we did that event kind of a thing like, we're not racist, we did that event! (Advocate 29)

Another advocate discussed a systemic issue that she perceived affected workers in her satellite office. The workers all happened to be women of color and were treated with distrust by the manager at the main office of the organization who was White:

> There was, in my mind, a ridiculous conflict with our manager who had a basic lack of trust in people in our office, many of whom had conflicts with her in the past. A lot of us perceived that this was related to the fact that everyone who worked in our office were people of color. (Advocate 37)

Another more structural manifestation of racism was the geographic distribution of services, which resulted in disproportionately poorer access to rape crisis services for women living in predominantly ethnic minority neighborhoods.

> Downtown and the north side is where most services are! There are less on south side, yet huge populations reside there. There are not enough funds to publicize resources or to understand what people want or need. Many White feminists in the field who are college educated need to not "poo-poo" religion. We don't understand different cultural responses. (Advocate 33)

> Another former advocate who was an administrator and worked for many years in the [city] rape crisis movement explained the larger context of racism in rape crisis centers. The civil rights movement and the feminist movement really were on parallel but unconnected charts, whether it's the NAACP or the Urban League and the victims' organizations. Different institutions came out of the civil rights movement and civil rights history and then there's sexual assault and domestic violence that really came out of the feminist movement. So now you've got these organizations that are trying to go back and deal with some of these issues. Because they were segregationist in their thinking, which translated into a lot of segregation in their practices. They're trying to heal some of that, but a lot of Black women in their communities don't want to have

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> anything to do with you, because they say: you have not been here for us when we needed you. (Advocate 38)

Although the issue of racism was not mentioned by the majority of advocates in terms of how they were treated by rape crisis centers or as a barrier to their work with survivors, it was mentioned by a few White and ethnic minority women despite the fact that no questions in the interview focused on this topic specifically. This suggests that issues of racism are likely of concern for many advocates working in rape crisis centers. Some women perceive that their organizations have not dealt with this issue fully, which is likely a reflection of the larger context in which racism continues to afflict society and the feminist movement more generally. Insofar as racism alienates ethnic minority women advocates and causes them job stress in working at their organizations, this is a problem that may lead to burnout for these workers and may also indirectly negatively affect their ability to help survivors.

## Staff Burnout

Both organizational barriers and the nature of rape crisis centers' work may affect advocates' ability to help survivors by causing stress and burnout. Research has shown vicarious traumatization and burnout are problems for many counselors and advocates working with sexual assault survivors (Baird & Jenkins, 2003; Ghahramanlou & Brodbeck, 2000; Schauben & Frazier, 1995; Wasco & Campbell, 2002), although existing studies have not examined how organizations may specifically contribute to these problems. Not surprisingly, 44% of advocates, particularly ex-advocates (4 out of 6), mentioned factors associated with stress and burnout among workers that were caused by their agency's working conditions.

> There's burnout and that can be difficult. But I think that's in any social service setting required to witness everybody else's pain and the impact of that. (Advocate 25)

> I think it starts at the top. Funders want you to do as much as you can with as little. And they certainly don't want you to have downtime. They don't see that downtime is actually recovery time so that you can sustain it long term. I think that the way that the jobs are set up is to do this 100% of the time and not to take part time stuff. And I think that's why people get into private practice, because they're so sick of this nonprofit stuff where you just burn your workers out. You exploit either their sense of giving, their naivete or their age. I think young idealistic workers get easily crapped on because they are so passionate. I was so passionate and now I'm like totally cynical and rekindling my passion, but only because I've had a year off already to sort of recover and think about this. (Advocate 31)

Multiple causes of burnout were identified by the advocates. First, a number of them, especially those who had left their agencies because of burnout, cited inadequate supervision as a factor contributing to burnout.

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> I think it's because there's a lot of supervision problems in rape crisis work and we have supervisors who don't know what our jobs are. Maybe they've done medical [advocacy]. A lot of the executive directors in [city] haven't done any direct service work. My supervisor has done medical, but she has not done legal [advocacy]. There's low accountability in the centers, you have people who are super burnt out and not fired. There are legal advocates who don't do anything, there's a lot of people who don't do anything. Counselors who don't do anything, don't see anyone, you know. (Advocate 29)

> I just feel how much can they care about survivors when the frontline people working directly with survivors are treated with blatant disregard for their well-being. I mean that's sort of my cynical perspective at this point. . . . They would say, "Yeah we hear what you're saying and we're working on it," which was the response for 2 years during which they were not working on it. I never felt like I was blamed necessarily, but it certainly was not like, "Oh you're right, we're gonna fix this tomorrow, because this is a problem and you know we see that." It was never like that. Everything was this huge long process, and most things that were addressed were never taken care of or fixed. (Advocate 30)

Other organizational problems that may be related to staff burnout raised mostly by former advocates included lack of adequate pay, lack of support, lack of accountability for work, and even outright abuse of workers that may actually characterize inadequately funded human service agencies in general (Glisson, 2000; Webster & Hackett, 1999).

> I don't have to have somebody who's exploiting me, disempowering, abusing me basically, not paying me anything, I mean the money is a part of that too because nobody wants to work for crap. We tell clients we're trained to empower people, but who do we as social workers empower, everybody but ourselves. We're just these little doormats for everybody, and we're encouraged to be that way, because when we speak out, our agencies don't want to hear it. I think there's a problem with social work as a whole that the people who are in the nonprofit and advocacy/victim services are sort of qualitatively poorer than they could be. (Advocate 31).

> I mean I don't really know how to frame it, but there are problems of not like getting support, and when people aren't supported, you have a lot of people who don't like their jobs. For instance, someone called and she said, "I tried to work with the legal advocate at this other center on the north side, she had no idea what I was talking about, so can you help me?" I gave her a bunch of information and she asked: "What are you talking about?" Who is talking to this legal advocate and finding out why she doesn't know what her job is? I mean it's because she's not getting training or support. Why isn't someone addressing it? I think training and support would create better advocacy skills and reduce burnout. (Advocate 29)

> When the executive director first came to the agency, she said, I'm gonna do this, this, and this. And we were like, great! And then nothing changed. She didn't do any of what she said she was gonna do. I've said the relationship with the agency, it's like an abusive relationship. The agency's the abuser and the worker is the victim. I felt like there was so

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> many times where I thought, am I crazy? Is it me? It takes a long time to leave and realize that you deserve better! It was so similar, it's really scary looking back at it, it was like a cycle of violence. (Advocate 30)

Organizational factors such as time constraints imposed by rigid work demands and inflexibility in rape crisis centers were also cited as a barrier to advocates' own professional development and their ability to sustain themselves in doing such stressful work. One advocate who had burnt out and left her agency noted,

> There's this national women of color against violence conference, and we were told that time volunteering there couldn't be work time which was frustrating because we were networking. It's sort of an inflexibility that became more institutionalized on the grant-making level. You have to count how everyone's time is being spent, but that fails to count how workers sitting around chatting for 2 hours is an important part of self-care and sustaining morale. . . . I just think that there are ways in which the agency doesn't always want to be flexible in terms of hours, yet they expect you to be flexible. They need someone that's gonna stay until 8:00, but they're the same people saying that you can't come in when it's convenient for you. (Advocate 35)

Although past research has suggested that supportive organizations may directly and indirectly promote workers' self-care (Wasco, Campbell, & Clark, 2002), which may reduce stress and burnout, researchers have not directly studied workers' perceptions of how organizations may be unsupportive. This may be partially because of past studies recruiting workers through their organizations (e.g., via executive directors), whereas in this study, workers were recruited directly, not through their organizations, as were former advocates who, not surprisingly, were more negative about their former employers.

It is very important to note that despite these negative aspects of agencies raised by workers, rape crisis centers do extremely positive work with few resources. Comments such as those noted here would likely be reflective of workers' perceptions in any human services organization. These issues may in fact be common yet unlikely to be voiced by workers who are still in the field, as evidenced by the fact that only one current advocate in this study (who was working off site at a hospital doing advocacy) clearly raised these negative criticisms about her organization. This led to interviews with former advocates, all of whom more fully elaborated on this theme. It is not surprising that current workers, most of whom were interviewed at their agencies, would be hesitant to raise these controversial issues.

## Barriers to Direct Services

Although societal attitudes, organizational-level variables, and staff burnout affect the availability and quality of services, their effects may not always directly affect individual victims. However, there are barriers to service provision that

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

directly affect individual victims who may be in need of or who may seek services from rape crisis centers and from the legal, medical, and mental health systems. Barriers that occur in the course of providing direct services to victims include limited access to services, the unavailability of specific services, a lack of resources to meet victims' needs, and secondary victimization when services are sought.

## Access and Availability of Services to Meet Survivor Needs

The ability to access support services is the starting point for victims to get formal help in coping with sexual assault. However, barriers to survivors' connecting with existing services were noted by many (44%) of the advocates interviewed. These barriers included stigma of receiving services, geographic location, cost of services, and inadequate availability of services. Some of these barriers appeared to be related to race and geographic location, suggesting that they may differentially affect subgroups of survivors. For example, the stigma of seeking mental health services and geographic location of services were noted as barriers for ethnic minority women. In discussing how ethnic minority women might perceive her agency, one advocate explained,

> Why do I want to come downtown to some ritzy, all White counseling center where they're gonna tell me I'm crazy? You know the stereotype. Well, counseling doesn't mean you're the crazy one. Just because we're downtown doesn't mean we're ritzy or we're all Caucasian or all straight or whatever it may be. Many people of communities that are oppressed do not want to come to the services, they want the services to come to them. So we must go out to their communities and meet them on their turf, go into their schools and show that I'm not afraid to come meet you where you're at. I'm not afraid as a White woman to come into your neighborhood. (Advocate 3)

Clearly, if ethnic minority women perceive that going to services means they could be labeled mentally ill or that the service providers will be White, middle-class women who will not identify with them or understand their concerns, this may be enough of a barrier to prevent them from accessing available services. In addition, there may be practical difficulties associated with traveling to organizations that provide services outside survivors' neighborhoods, especially for women who rely on public transportation.

Another frequently cited barrier was the availability of affordable or free services:

> One of the most obvious barriers for many survivors is needing resources that are affordable or free. We're really fortunate that all of our services are free because it makes sense that somebody who's the victim of a crime shouldn't have to pay. That's a big worry to survivors that I've worked with—how am I gonna pay for this? Fortunately, in the emergency rooms we can tell them that the law [Sexual Assault Survivors Emergency Treatment Act] pays for your care through the [state] Department of Public Aid. We tell them, if you get a bill, call me, we'll fix it. (Advocate 8)

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

Unfortunately, advocates also noted that many victims do not realize that rape crisis services are available free of charge, so they may not seek help believing they would have to pay for services they cannot afford. Inadequate availability of services was cited with regard to basic rape crisis services for specific subpopulations and for related needs extending beyond rape crisis including bilingual services and services for disabled women. For example, the lack of bilingual services prevents some women from being able to access formal support, as one advocate described:

> The other [barrier] that comes up immediately is living in a city as diverse as [city] is the limited language capabilities that we have and so we serve clients obviously in English. We do have sort of a backup system. And there are several other agencies that do bilingual . . . we have crisis intervention services. So we feel pretty well equipped to handle calls that are monolingual Spanish speakers. But [city] has a large population of Latino people and Polish people and we just can't serve them. (Advocate 6)

The pressing need for bilingual services to serve survivors and their family and friends is clear from the area's demographics. According to the 2000 census, 26% of this urban area's population was Hispanic. In addition, the area has a very large Polish-speaking population. However, rape crisis services in languages other than English are not widely available.

Several advocates also noted the limited services for disabled survivors:

> There are limited resources available for people with disabilities. There is the deaf and hard of hearing community that some people describe as disabled. Some people don't see that as a disability, but certainly the resources available for that community are very limited. (Advocate 6).

> I am surprised for such a big city there are not rape crisis centers with a focus on disabilities. I just surely thought that there would be all these great programs. I think there was a grant out there a couple of years ago, but the program failed and I don't know why. I think that's sad. (Advocate 1)

The limited availability of services for disabled survivors is particularly notable in light of data showing that disabled persons are at equal or greater risk of sexual victimization than others (Young, Nosek, Howland, Chanpong, & Rintala, 1997).

## Resource Barriers That Reduce Direct Services

Resource issues mentioned by 28% of advocates that affect rape crisis centers' capacity to provide direct services included funding constraints, agency inefficiency in using funds, and paperwork required by funders. In addition, the scarcity of resources appears to have resulted in problems with the way organizations are structured and how they treat employees, both of which affect their ability to serve survivors. These

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

organizational issues included poor supervision, unresponsiveness to employees' needs, and inflexibility of organizations.

The most commonly mentioned resource barrier, noted by all of those interviewed, was the sheer lack of funding for rape crisis centers. As one advocate put it,

> It really comes down to funding. I mean we can't expand our programs any further. We have waiting lists of hospitals that want us in. We have waiting lists of high schools and colleges that want us doing our prevention programs. We don't have enough people to go out to police stations and be a face that the police officers recognize. We don't have enough people in courthouses that are court watchers to know how judges are ruling, so that we could know who to vote in or vote out. If we had more funding to expand some of our programs, we could make a bigger impact for all victims as a whole. (Advocate 3)

Another frequently cited (52%) problem was that the funding restricts the range of activities in which rape crisis centers can engage. This may mean that survivors in certain areas are unserved or that necessary work is not funded:

> One of the biggest barriers is definitely how funding is set up. For your funding to have a boundary is very frustrating. Even for just basic mental health counseling, you can't see anybody past [a certain street]. But if there's really nothing there for those people, where do they go? There have been times when I've wanted to do a little more community outreach, but my funding only lets me do 1% so it gets a little frustrating, so I think more flexibility would be good. (Advocate 16)

> I think the expectation is higher than what can be provided in the amount of time that the funds allot for it. They don't provide enough up front time for advertising, getting the word out, going into the community before you're supposed to be showing results. Then you're not successful and they take the money away, give it to someone else, and then they run into the same problem. So I think it's sort of a two-fold problem. One coming from the funder's restrictions and then the other just trying to be creative, thinking outside the box of different ways of providing the service. (Advocate 10)

External funding also requires accountability and reporting to the funder. Although only a couple of advocates mentioned burdensome paperwork, they aptly described how it could conflict with efforts to provide crisis advocacy to survivors:

> There was an argument always between the street staff and management (who had to actually answer to funders), and they want to know exactly what this victim's age was, and what that relationship is—if that information is not available. There's a four-page form that you have called an intake form and on there you put the exact time you spent with them, all the medication that they were given—you know just things that you have to know. I understood the need for it but, my other need was greater [i.e., to be there for her client]. (Advocate 36)

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> I know one of their biggest frustrations is time and the sheer amount of paperwork you have to do for a client. I've had a couple of them tell me, if I didn't have to go and do all that paperwork, I could probably see an extra client a day. . . . I think funders are too concerned about numbers. They always want to know how many people? How much money? How many hours? And it doesn't always boil down to that and I think they just don't seem to get that. (Advocate 16)

## Secondary Victimization

The final direct services barrier affecting victims noted by advocates was secondary victimization. Because sexual violence has emotional, medical, and legal ramifications, survivors often come into contact with multiple community systems. Navigating these systems can be challenging and, at times, retraumatizing. Often, a main function of advocates is to work on behalf of survivors to ensure that their rights are respected and that they receive all of the assistance to which they are entitled. Consequently, advocates face barriers to working with survivors not only in the context of their own agencies and funders but also in their interactions with other systems. A major barrier mentioned by most (72%) of those interviewed was that survivors experience negative or revictimizing reactions, such as being blamed or disbelieved when telling other people about the assault or seeking formal services. Hospitals were frequently cited as a common first contact for survivors and as a place where they may face unpredictable responses:

> There are certain hospitals in this city that are wonderful. I mean I haven't dealt with very many yet, but I've heard the stories. I mean there are certain ERs that if I had a friend that was raped, I would probably send them to that ER first, even if it was 5 miles out of the way because their staff is compassionate, they're prepared to deal with this issue, they just take a good approach to it. And then you have other hospitals—it just depends on the luck of the draw. I mean if you've got a physician that's tired or cranky or doesn't want to deal with this or feels like this person has lied or the victim happens to be a prostitute. (Advocate 7)

> Certainly one of the barriers is how people treat people who've been sexually assaulted and all the myths that they come to the table with. If the victim's first interaction with whomever they're disclosing to is negative, then that could sort of stop them from seeking other help. If their first contact is the hospital ER and a nurse or a doctor is rude or inappropriate or doesn't believe them, that could just end it right there. They're not gonna want to get help in any other way, they'll forget it, not want to tell anybody else feeling that no one will believe me. If it's the police who respond negatively initially, maybe they won't go on to get medical help. That's a huge barrier. (Advocate 10)

> When you do encourage survivors to get help, you're sort of sending them into the lion's den almost. I mean this is a scary thing to go to the hospital and it's kind of a gamble, whether or not the experience is going to go well. It's even worse to have your case taken into the legal system and frankly, I don't know. If I were raped right now, I don't know if I would go to the hospital. I certainly would not prosecute and there's no

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> way I would go to court. So I was beginning to feel while I was there even [at the agency]—how can I be doing this work, telling people what they should do with their case when I wouldn't do it myself? (Advocate 30)

> A lot of times they [formal support sources] don't say things in front of the [victims]. But out of the room, nurses and law enforcement would make comments to me that always are out of line, they say too much to me and that's when I get really frustrated. It happens a lot of times where nurses are revictimizing my clients, saying, "Girl, what are you thinking? What were you doing like at 9:00 at night up there?" (Advocate 32)

These reactions to victims by the medical system make it difficult for advocates because they often are unable to protect survivors from further trauma following the rape caused by these negative social reactions from service providers, which research shows are associated with greater PTSD symptoms in survivors (Campbell et al., 1999; Ullman & Filipas, 2001). Because victims need these systems' services and advocates have less power than medical personnel, advocates are put in a bind if they try to confront personnel making negative reactions to victims. Advocates have to work with service providers on an ongoing basis, and although they may try to educate them as best they can, they must walk a fine line in doing so, as they can receive defensive reactions and hostility from these personnel. Even worse, providers' hostility may be taken out on survivors who may subsequently be treated even more poorly. Clearly, this problem adds to advocates' burden because they have to try to support survivors regarding not only the rape and its effects but also the revictimization they are experiencing from system personnel.

Because of problems of secondary victimization within the medical system, advocates also suggested that training of medical personnel was needed. However, pointing this out to those providers often led to anger or denial by personnel who did not appreciate advocates' viewpoints about system responses to survivors.

> I mean the hospital situation could also be equally frustrating with people not really knowing how to do exams very well and doctors and nurses that just weren't really trained in how to do these things and didn't really have the bedside manner that we would have liked. We have contracts with various hospitals and we would try to go into hospitals and do trainings with folks in ERs and not only is it hard to do trainings, but when you get there, they're like, "We know how to do our job, we don't need you people having to tell us how to do our jobs." And we would say well actually, we have all these cases where evidence was tampered with or a client is saying that this happened. That shouldn't have happened. So we knew that stuff was happening. And that was often frustrating too. (Advocate 30)

As a consequence of these attitudes, advocates are often unable to effectively ensure that victims' rights are fulfilled and that they get appropriate medical care and proper collection of forensic evidence in the rape kit.

The legal and criminal justice systems were also identified as sources of secondary victimization for survivors.

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> I think another huge barrier is just the mythology that's out there and is so pervasive. Victim blame is, in my perception, the number one barrier to prosecution that victims face. If they're willing and want to prosecute, what law enforcement looks at primarily is how credible is this person and how credible is their story? Because if they're not credible, this isn't going to stand up in court and we don't want to take it. And there are 101 billion ways to discredit somebody, and I've seen and heard them all. What we know is that people are targeted [for rape] because of their vulnerability and their inability to be credible or tell the story in the way that law enforcement needs it to be told. (Advocate 8)

> I get very frustrated with felony review in the state's attorneys office in the sense that unless there is a statement from the offender, we can't charge this individual. The system doesn't like to give options. I've been in with state's attorneys who want the case to go a certain way and they don't give victims all their options and that is one of my jobs—to make sure they're aware of all their options. But sometimes that doesn't sit well with the state's attorneys office. (Advocate 20)

> I promised her that she doesn't have to see him [the offender]. She didn't want to press charges, she didn't want him in her life. They had already put him out of the house. He had snuck in. We go to the police station, there's a woman detective who I already knew, I had a history with her, she was awful, awful. She questioned the woman [survivor] in the same room with the suspect handcuffed to a piece of wood on the wall. So we're at the other end of this conference table and he's right there the whole time. It was so unnecessarily abusive. (Advocate 36)

> The court system is really awful. If you get a good state's attorney, and there are some out there, that's fine. But most of the time and especially with sexual assault, they don't want to deal with it. We've been training people in the state's attorneys office, but they didn't even want to sit through the training. (Advocate 16)

A former advocate summarized the problems with entering the legal system for rape survivors most clearly:

> We still have a system where it's extremely tough for women to come out and allege a rape, let alone go through the process of a trial. . . . I understand the profound expectations people have when they press charges and I know 9 times out of 10 it'll be plea-bargained out and you don't get your moment in court. If it does go to trial, you don't ever get to tell your story the way you want to, so I think expectations women have of what it means to go to court are derived from our popular cultural ideal of standing up in court, pointing at somebody and saying he raped me and that of course does not happen. I've said, you know your job as a survivor now is to get stronger and here are all the different options you can use to get stronger. Don't let anybody tell you that the only way to get stronger is through the legal system, cause it will probably not be the result. So, I'm much more brutally honest with them and I think there's a lot of advocates who kind of feed into the mythology of what it means to press charges and that you have to press charges to get rapists off the streets. We're not gettin em off the street! If we do get em off the street, it will be for 5 to 6 months and from what I've seen chances are if a man

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

> rapes women, he is either going to participate as a rapist or be victimized by sexual assault in jail. When he gets back on the street, he's a much more dangerous rapist than he was before. I have no faith in the legal system to solve this issue. (Advocate 38).

In summary, secondary victimization from police and legal personnel makes it difficult for advocates to help survivors get any kind of real justice or accountability from the criminal justice system. Advocates can try to support survivors who choose to pursue a criminal case by helping keep them informed about their case and going to court with them, but they have little control over whether a case will be deemed credible and worthy of the prosecutor's time and effort in the first place. Police may also poorly treat survivors, violate their rights, and retraumatize them when they perceive that certain survivors have less value, such as young, ethnic minority women. This makes it extremely difficult for advocates whose goal is to try to empower survivors within an inherently antivictim criminal justice system.

## Conclusions and Study Implications

This study identified a number of barriers that workers in rape crisis centers perceive that survivors face getting services. Consistent with past research on survivors, advocates noted numerous problems with access, availability, affordability, and acceptability of services (Campbell, 1998; Campbell et al., 2001; Logan et al., 2005; Martin, 2005). Our sample of rape crisis center workers mentioned barriers of access and availability to services, funding and resource problems at both organization and system levels, and secondary victimization or insensitivity of service providers, notably medical and criminal justice system personnel. Many interviewees mentioned problems of underfunding of rape crisis centers and difficulty securing help among women in disadvantaged groups such as the homeless, prostitutes, the disabled, and mentally ill. Some barriers also varied by workers' demographic or treatment orientation. Those with higher degrees reported fewer problems with services being insensitive or structural barriers generally. Workers with less formal education cited more structural barriers and services insensitivity and fewer survivor-related barriers. It is unclear if these perceptions were because of the jobs of workers in the organization or differences in individuals with these different degrees. Views about the causes of social problems may also differ for those who elect to gain higher degrees, who may have a greater investment and belief in the system than those who do not.

Most advocates mentioned the problems of secondary victimization by the systems that are supposed to help women obtain medical treatment and justice. However, workers doing primarily advocacy were more likely than those doing counseling to mention racism and sexism as barriers and service providers' insensitivity toward minorities specifically. Not surprisingly, those endorsing a feminist orientation were more likely to mention barriers related to race, class, and gender bias, professionalization of

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

rape crisis centers, rape myths or societal denial of rape, language barriers, and lack of culturally competent services than were those endorsing nonfeminist treatment orientations. Although both Whites and minorities mentioned issues of racism generally as barriers, ethnic minorities were more likely to mention racist biases of the system specifically, particularly if they were young, compared to Whites. In addition, Latinas mentioned language barriers and familial, cultural, or immigration issues more than others. This finding is consistent with past studies of sexual assault victims who frequently note problems of receiving negative social reactions when seeking help from formal systems (Campbell et al., 1999, 2001; Ullman, 1996; Ullman & Filipas, 2001). In our study, workers also identified barriers associated with language, ethnic minority race, family or culture, immigration, disability, mental illness, prostitution, and young age to be associated with poorer access to services and more secondary victimization by formal service providers, especially medical and criminal justice personnel. Racism was noted in our study as a barrier particularly for younger women in how they were treated as rape victims. Young, ethnic minority women were viewed as being subject to greater police harassment and secondary victimization by medical and criminal justice system personnel.

Although Logan et al.'s (2005) sample mentioned bureaucratic problems and staff incompetence as barriers for women seeking services, these were discussed in relationship to medical and criminal justice systems, not rape crisis centers themselves. Other research by Campbell and Martin (Campbell et al., 2001; Martin, 2005) has also documented problems, particularly with the medical and criminal justice or legal systems' responses to rape victims. Survivors in Logan et al.'s study did not mention any of the numerous problems found in our study, noted by advocates we interviewed in these organizations. This may be because of a number of factors. They may not have had awareness of these problems, given that their contact is more limited than employees of centers studied here. The women were recruited by rape crisis centers, and the focus groups were conducted at the centers, which may have made any problems that arose with those agencies less likely to be mentioned. Women with negative experiences may also have been less likely to have been referred to the study by rape crisis center staff. Finally, their study did not ask women about problems with getting help from rape crisis centers specifically.

However, our study found that various organizational barriers to doing advocacy were professionalization, racism, inflexibility of rape crisis centers, physical space limitations, structure of programs, burnout, and vicarious trauma related to poor supervision, and lack of accountability and caretaking of staff by agencies, corruption, lack of respect for clients in one agency, and paperwork demands. Past research has clearly documented the serious problem of vicarious trauma and burnout in those who work with traumatized populations, including sexual assault survivors (Salston & Figley, 2003; Schauben & Frazier, 1995; Wasco & Campbell, 2002). Racism has also been documented by others studying rape crisis centers (Campbell et al., 2001; Matthews, 1994; Scott, 1998). Professionalization has been noted by other

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

researchers who study rape crisis centers as leading to changes in these organizations (Campbell et al., 1998), such as being less political, which were noted as negative by a number of younger advocates in this study. Clearly, some of the organizational problems noted are related to funding limitations, but others, such as racism, may be associated with professonalization.

These problems did not characterize all agencies, and the worst problems were mentioned by former advocates who likely felt freer to talk about problems in their past work settings but also may have had worse experiences than other employees. Clearly, the small convenience sample of metropolitan area advocates studied presents biases that may not reflect what a random sampling of rape crisis center employees and former employees might report. Further research is needed to determine how widespread these perceptions are and how these issues may be better addressed in rape crisis centers in the future. We caution that these findings should not be taken to mean that rape crisis centers are not doing extremely positive work on behalf of survivors of sexual assault in the community. These problems more likely reflect widely shared, yet often unspoken, experiences of workers in low-paid human service organizations, all of whom provide critically needed services without adequate funding and societal support (Glisson, 2000; Webster & Hackett, 1999).

Community studies suggest that rape crisis centers are typically rated as one of the most helpful support sources by sexual assault survivors (Filipas & Ullman, 2001; Golding et al., 1989), compared with other formal sources such as mental health, medical, and criminal justice, which are typically rated less favorably. In addition, a recent preliminary descriptive evaluation of rape crisis services in Illinois found that they were an effective use of taxpayer money (Wasco et al., 2004). Despite the findings here of problems in these organizations, some of which were noted to a greater extent by former advocates in the sample, it does not necessarily imply that many survivors are not receiving excellent help from these agencies. Human service agencies, including rape crisis centers, typically receive less funding than needed to serve their client populations and often cannot afford to pay or support workers as much as they ideally would like to. Although efficient use of limited resources is one way to overcome such limitations, clearly sheer amounts of funding and support for providing such services to a population in crisis is a major task that cannot simply be managed by better fiscal management.

More attention is needed to addressing problems related to less-than-optimal resources and support for advocates in particular working in rape crisis centers, and these problems are unlikely to be limited to centers in the metropolitan area studied here. However, it is known that this line of work is related to high burnout, and many current employees mentioned the problems of high turnover in these agencies that offer little chance for promotion or pay increases. Future research on secondary trauma and burnout in rape crisis workers should go beyond studying worker characteristics, training, and work roles and also study organizational characteristics that may also contribute to these negative outcomes.

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

Martin (2005) has persuasively argued that organizational constraints and goals often result in secondary victimization of rape victims because workers in medical and criminal justice systems follow rules required to do their jobs, which entails practices that often conflict with the needs of rape victims. This implies that organizational change, not only training or education of service system personnel, will be needed to improve rape victims' treatment. Clearly, this exploratory study suggests that more research is needed to understand how rape crisis workers may be better supported in their organizations and in their advocacy efforts generally for survivors in the systems with which they interface. Researchers need to be aware of the stresses faced by rape crisis centers and their workers if they wish to collaborate with them in work that may help to respond to rape in the community. This study's results may also help researchers to better understand the larger context in which survivors attempt to get help from rape crisis centers, the medical system, and the criminal justice system. Without an understanding of the larger context of survivors' help-seeking experiences from both survivors' and service providers' perspectives, researchers may be less able to fully understand how survivors navigate their recovery and their support-seeking experiences following sexual assault. The findings suggest many barriers that rape crisis centers need to address to enhance their advocates' ability to help rape survivors. However, increased resources to these organizations are urgently needed to enable them to make these changes. This is vital given that rape crisis centers are the only support system whose goal is to help victims navigate their recovery and to obtain help from other service systems. Beyond this, the larger societal context of rape and other organizations that deal with rape victims (e.g., hospitals, criminal justice) also need to be adapted or transformed in some way to improve responses to victims following sexual assault.

## Note

1. We thank an anonymous reviewer for this suggestion of how to organize the themes identified in this study.

## References

Baird, S., & Jenkins, S. R. (2003). Vicarious traumatization, secondary traumatic stress, and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, *18*, 71-86.

Campbell, R. (1998). The community response to rape: Victims' experiences with the legal, medical, and mental health systems. *American Journal of Community Psychology*, *26*, 355-379.

Campbell, R., Baker, C. K., & Mazurek, T. L. (1998). Remaining radical? Organizational predictors of rape crisis centers' social change initiatives. *American Journal of Community Psychology*, *26*, 457-483.

Campbell, R., & Martin, P. Y. (2001). Services for sexual assault survivors: The role of rape crisis centers. In C. M. Renzetti, J. L. Edelson, & R. K. Bergen (Eds.), *Sourcebook on violence against women* (pp. 227-241). Thousand Oaks, CA: Sage.

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

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., 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.

Davis, R. C., Brickman, E. R., & Baker, T. (1991). Effects of supportive and unsupportive responses of others to rape victims: Effects on concurrent victim adjustment. *American Journal of Community Psychology*, *19*, 443-451.

Filipas, H. H., & Ullman, S. E. (2001). Social reactions to sexual assault victims from various support sources. *Violence & Victims*, *16*, 673-692.

Frank, J. D., & Frank, J. B. (19991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Ghahramanlou, M., & Brodbeck, C. (2000). Predictors of secondary trauma in sexual assault trauma counselors. *International Journal of Emergency Medicine*, *2*, 229-240.

Glisson, C. (2000). Organizational climate and culture. In R. Patti (Ed.), *Handbook of social welfare administration* (pp. 195-218). Thousand Oaks, CA: Sage.

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.

Logan, T. K., Evans, L., Stevenson, E., & Jordan, C. (2005). Barriers to services for rural and urban rape survivors. *Journal of Interpersonal Violence*, *20*, 591-616.

Luborsky, L., Crit, S., Christoph, P., McLellan, A. T., Woody, G., Piper, W., et al. (1986). Do therapists vary much in their success? Findings from four outcome studies. *American Journal of Orthopsychiatry*, *56*, 501-512.

Martin, P. Y. (2005). *Rape work: Victims, gender, and emotions in organization and community context*. New York: Routledge.

Matthews, N. (1994). *Confronting rape: The feminist anti-rape movement and the state*. London: Routledge.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.

National Violence Against Women Prevention Research Center. (2001, May). *Fostering collaborations to prevent violence against women: Integrating findings from practitioner and researcher focus groups*. Charleston, SC: Author.

Riger, S. (1999). Working together: Challenges in collaborative research on violence against women. *Violence Against Women*, *5*, 1099-1117.

Salston, M., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress*, *16*, 167-174.

Schauben, L. J., & Frazier, P. A. (1995). Vicarious trauma: The effects on female counselors of working with sexual violence survivors. *Psychology of Women Quarterly*, *19*, 49-64.

Scott, E. K. (1998). Creating partnerships for change: Alliances and betrayals in the racial politics of two feminist organizations. *Gender & Society*, *12*, 400-423.

Stein, D. M., & Lambert, M. J. (1984). On the relationship between therapist experience and psychotherapy outcome. *Clinical Psychology Review*, *4*, 127-142.

Strauss, A. L., & Corbin, J. M. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* Newbury Park, CA: Sage.

Ullman, S. E. (1996). Do social reactions to sexual assault victims vary by support provider? *Violence and Victims*, *11*, 143-156.

Ullman, S. E. (2005). Interviewing clinicians and advocates who work with sexual assault survivors: A personal perspective on moving from quantitative to qualitative methods. *Violence Against Women*, *11*, 1-27.

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009

Ullman, S. E., & Filipas, H. H. (2001). Predictors of PTSD symptom severity and social reactions in sexual assault victims. *Journal of Traumatic Stress*, *14*, 369-389.

Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (in press). Psychosocial correlates of PTSD symptom severity in sexual assault survivors. *Journal of Traumatic Stress*.

Wasco, S. M., & Campbell, R. (2002). Emotional reactions of rape victim advocates: A multiple case study of anger and fear. *Psychology of Women Quarterly*, *26*, 120-130.

Wasco, S. M., Campbell, R., & Clark, M. (2002). A multiple case study of rape victim advocates' self-care routines: The influence of organizational context. *American Journal of Community Psychology*, *30*, 731-760.

Wasco, S. M., Campbell, R., Howard, A., Mason, G., Staggs, S., Schewe, P., et al. (2004). A statewide evaluation of services provided to rape survivors. *Journal of Interpersonal Violence*, *19*, 252-263.

Webster, L., & Hackett, R. K. (1999). Burnout and leadership in community mental health systems. *Administration and Policy in Mental Health*, *26*, 387-399.

Young, M. E., Nosek, M. A., Howland, C. A., Chanpong, G., & Rintala, D. H. (1997). Prevalence of abuse of women with disabilities. *Archives of Physical Medicine and Rehabilitation*, *78*(Suppl.), S34-S38.

**Sarah E. Ullman** is professor of criminal justice at the University of Illinois at Chicago. She received a PhD in social/developmental psychology at Brandeis University and completed postdoctoral training in health psychology at University of California, Los Angeles. Her research interests concern the impact of sexual assault and traumatic life events on women's health and substance abuse outcomes, cognitive and behavioral factors associated with recovery from trauma, and situational and behavioral correlates of rape avoidance. Her current research integrates quantitative and qualitative methods to better understand formal and informal support seeking in sexual assault survivors.

**Stephanie M. Townsend** is visiting assistant professor of psychology at Dominican University. She received a PhD in community and prevention psychology at University of Illinois at Chicago. Her research interests include evaluation of sexual assault prevention programs, provision of social support and health care services to sexual assault survivors, and the role of victim advocates and rape crisis centers in assisting rape survivors.

Downloaded from http://vaw.sagepub.com at NATL SEXUAL VIOL RESRC LIB on February 11, 2009