

# The Impact of Post-Sexual Assault Services on Survivors

---

■ By Katie Parker

Sexual assault service providers know the value of their programs through the gratitude of the survivors and their significant others for their dedication, constant support, and encouragement. Funders, on the other hand, are often looking for measurable outcomes and concrete numbers to justify services provided. In addition, evidence of the effectiveness of programs that help sexual assault survivors through the process of recovery and provide medical care and legal advocacy can be used to instill support in the community for these services and to rationalize further funding.

While measuring the effectiveness of programs set in place to provide sexual assault survivors with desperately needed services is important, it can be a particularly daunting task when staff time and funds for evaluation are scarce. Many survivors' contact with formal organizations post-sexual assault is limited, if it occurs at all, and due to concerns about protecting a survivor's right to confidentiality, safety, and privacy, as well as a desire to promote healing, evaluations of existing programs can be extremely difficult to conduct. Even so, brief satisfaction surveys and client comments provide valuable feedback that can be used to tailor programs to the needs of survivors. Agencies offering services to sexual assault survivors can look to current research for guidance when designing programs in accordance with evidence-based, best practices and to supplement program evaluations to confirm that services are making a considerable, long-term difference in the lives of survivors.

**Advocacy** services, while not able to completely eradicate all forms of secondary victimization and stigmatization, have been shown to significantly increase the quality of care provided to sexual assault survivors and reduce the amount of distress experienced after contact with the medical and legal systems. Campbell (2006), in her study of two urban hospitals without Sexual Assault Nurse Examiner (SANE) programs, found that survivors were less likely to blame themselves for the assault after interacting with an advocate (54% of the time as opposed to 82% when an advocate was not present). Furthermore, when an advocate was not present, survivors were likely to voice reluctance to seek further help 91% of the time compared to only 67% of the time when the survivor had the support of an advocate. While survivors often reported feeling discouraged to file a police report and felt the police officer was reluctant to take a report, these events occurred less frequently when an advocate was available. The presence of advocates also seemed to diminish the incidence rates of law enforcement personnel asking about a survivor's prior sexual history, if the survivor had a previous relationship with the assailant, or if the survivor had responded sexually to the attack. During the medical exam, survivors were likely to receive information on STDs 72% of the time when an advocate was present (compared to only 36% when an advocate was not present), were more likely to receive information on HIV (47% of the time compared to 22% without an

---

*Continued on next page*

## *The Impact of Post-Sexual Assault Services on Survivors continued...*

advocate), were increasingly likely to be tested for pregnancy (42% of the time compared to 22% with no advocate present), and received access to emergency contraception at more than twice the rate (33% compared to 14% when an advocate was not with the survivor). Reducing these types of negative interactions may lead to improved long-term outcomes for sexual assault survivors as “secondary victimization has been linked with a variety of negative health outcomes, such as increased psychological distress, physical health symptomatology, and sexual health risk-taking behaviors” (Campbell, 2006, pg. 40).

Many advocacy services stem from community-based **rape crisis centers**, which also provide sexual assault survivors with crisis intervention hotlines, group and individual counseling, and legal advocacy. One study found that of those seeking services at 19 rape crisis centers in Maryland, 40.5% recommended more services and centers be made available to survivors (Monroe, Kinney, Weist, Dafeamekpor, Dantzler, & Reynolds, 2005). When participants were asked what they liked best about the centers, survivors commented “that staff were non-judgmental, believed victims, and promoted recovery and/or coping skills and feelings of safety and comfort” (Monroe et al., 2005, pg. 771).

Studying the effectiveness of **crisis intervention hotlines** can be extremely difficult since service providers do not want to take focus away from the crisis at hand by conducting an evaluation survey and because calls are confidential and generally brief. Wasco, Campbell, Howard, Mason, Staggs, Schewe, and Riger (2004), in their study of 33 sexual assault programs in Illinois, conducted a short phone interview with those calling sexual assault crisis hotlines. They found that

56.8% of responding callers reported gaining “a lot more information” after the call and another 27.4% said they gained “somewhat more” information. In addition, 73.4% of callers reported feeling that “a lot” of support was provided by the staff person answering the phone. While there is limited research in this area, it is important to note that addressing the psychological needs of a survivor immediately following the assault is especially important as delayed care increases the risk of health problems in the future (Campbell, Patterson, Adams, Diegel, and Coats, 2008).

**Group counseling** has been found to be one of the most effective methods of therapy for sexual assault survivors once the time of crisis has passed. Working within a group of others who have been sexually assaulted allows survivors to normalize their own reactions and reduces feelings of alienation and isolation (Roth, Dye, & Lebowitz, 1988). Group therapy can also provide survivors with a sense of hope through connecting with others, which VanDeusen and Carr (2003) found to be the single most helpful factor as identified by college-aged women in their study of sexual assault survivors in Michigan. They also noted that women who participated in the group feared revictimization and being alone less and had an increased sense of personal safety and of trust in others. Matching scores for 76 women pre- and post-counseling, Wasco et al. (2004) were able to show that counseling can decrease symptoms of posttraumatic stress disorder including feeling low in energy, having repeated unpleasant thoughts, having sleep that is restless or disturbed, feeling bad about oneself, having feelings of guilt, and feeling like injuring or hurting oneself. The same study of Illinois sexual assault programs found that counseling

---

*Continued on next page*

## *The Impact of Post-Sexual Assault Services on Survivors continued...*

also significantly increased participants feelings of having someone to turn to for advice, having someone who can help in times of trouble, trusting one's ability to solve difficult problems, having confidence about the decisions one makes, being in control of one's own life, being able to help oneself when troubled, knowing the assault was not the survivor's fault, and being able to talk about thoughts and feelings about the assault.

In an effort to offer more survivor-centered care, **Sexual Assault Nurse Examiners** (SANEs) provide forensic evidence collection and post-assault physical and emotional care as an alternative to long waits in the emergency department, physicians and nurses who have not been specially trained, and staff who may be insensitive and victim-blaming. Most (85%) of sexual assault survivors who received care from a Minneapolis SANE program "identified the nurses listening to them as one thing that helped them the most during their crisis period" (Malloy, 1991 cited by Campbell, Patterson, & Lichty, 2005). In addition, Ericksen et al. (2002) found survivors who utilized a Canadian sexual assault service felt they were "respected as a whole person," "felt the presence of the nursing staff," "felt safe," "appreciated how they were physically touched-the nurses held their hands during the exam," "felt in control," "felt reassured," "felt believed and supported by the staff," "felt they were cared for by people with expertise," "felt informed," and that "they felt cared for beyond the hospital" (cited by Campbell et al, 2005, pg. 319-320). Comparing hospital emergency departments pre- and post-SANE program implementation, Derhammer, Lucente, Reed, and Young (2000) found that survivors were only given a complete physical exam 11% of the time before the SANE program. That number jumped to 95% of the time post-implementation.

SANE programs also increased the rate with which pregnancy testing, emergency contraception, and STD prophylaxis were provided to survivors (Crandall and Helitzer, 2003 as cited by Campbell et al., 2005).

Several studies (Cornell, 1998; Littel, 2001; Ledray and Simmelink, 1997) noted that the implementation of SANE programs has increased the quality of **evidence collection**, reduced the number of errors, and maintained the chain of custody at a higher rate than when physicians completed forensic evidence kits. Specifically, Sievers, Murphy, and Miller (2003) found that SANE-collected evidence kits scored significantly higher on 9 out of 10 quality control criteria than those collected by doctors. Sexual assault nurse examiners are also able to act as expert witnesses in court, and Crandall and Helitzer (2003) found that police filed more charges against perpetrators, the conviction rate rose from 57% to 69%, and that sentences were longer (5.1 versus 1.2 years) after a SANE program was implemented in New Mexico.

These research studies will not replace the importance of conducting regular program evaluations; however, they do offer examples of tested practices and the knowledge that existing programs are improving the physical and psychological well-being of sexual assault survivors, as well as giving them the necessary resources to work toward desired long-term outcomes. Many studies have shown the benefits of advocacy services, crisis intervention hotlines, group counseling, rape crisis centers, and SANE Programs and agencies can use these resources to ensure that they are developing the most effective programs for sexual assault survivors and their families.

---

*Continued on next page*

## The Impact of Post-Sexual Assault Services on Survivors continued...

### References

- Campbell, R., Patterson, D., & Lichty, L. F. (2005). The effectiveness of sexual assault nurse examiner (SANE) programs: A review of psychological, medical, legal, and community outcomes. *Trauma, Violence, & Abuse, 6*, 313-329.
- Campbell, R. (2006). Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference? *Violence Against Women, 12*, 30-45.
- Campbell, R., Patterson, D., Adams, A. E., Diegel, R., & Coats, S. (2008). A participatory evaluation project to measure SANE nursing practice and adult sexual assault patients' psychological well-being. *Journal of Forensic Nursing, 4*, 19-28.
- Cornell, D. (1998). Helping victims of rape: A program called SANE. *New Jersey Medicine, 2*, 45-46.
- Crandall, C. & Helitzer, D. (2003). *Impact evaluation of a sexual assault nurse examiner (SANE) program* (NIJ Document No. 203276). Washington, DC: National Institute of Justice.
- Derhammer, F., Lucente, V., Reed, J., & Young, M. (2000). Using a SANE interdisciplinary approach to care of sexual assault victims. *The Journal on Quality Improvement, 26*, 488-495.
- Ericksen, J., Dudley, C., McIntosh, G., Ritch, L., Shumay, S., & Simpson, M. (2002). Clients' experiences with a specialized sexual assault service. *Journal of Emergency Nursing, 28*, 86-90.
- Ledray, L. E. & Simmelink, K. (1997). Efficacy of SANE evidence collection: A Minnesota study. *Journal of Emergency Nursing, 23*, 75-77.
- Littel, K. (2001). Sexual assault nurse examiner programs: Improving the community response to sexual assaults victims. *Office for Victims of Crime Bulletin, 4*, 1-19.
- Monroe, L. M., Kinney, L. M., Weist, M. D., Dafeamekpor, D. S., Dantzler, J., & Reynolds, M. W. (2005). The experience of sexual assault: Findings from a statewide victim needs assessment. *Journal of Interpersonal Violence, 20*, 767-776.
- Sievers, V., Murphy, S., & Miller, J. (2003). Sexual assault evidence collection more accurate when completed by sexual assault nurse examiners: Colorado's experience. *Journal of Emergency Nursing, 29*, 511-514.
- VanDeusen, K. M. & Carr, J. L. (2003). Recovery from sexual assault: An innovative two-stage group therapy model. *International Journal of Group Psychotherapy, 53*, 201-223.
- Wasco, S. M., Campbell, R., Howard, A., Mason, G. E., Staggs, S. L., Schewe, P. A., & Riger, S. (2004). A statewide evaluation of services provided to rape survivors. *Journal of Interpersonal Violence, 19*, 252-263.

---

*Katie Parker, BS, is a Research Assistant for the Crime Victim Services Commission Technical Assistance Project at the Michigan Public Health Institute.*