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AVAILABILITY, UTILIZATION, AND PERCEIVED BENEFITS
OF TREATMENT SERVICES FOR SECONDARY
VICTIMS OF SEXUAL ASSAULT

A Thesis
Presented to the
Faculty of
California State University,
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Social Work

by
Steven Elliot McCraw

June 2002

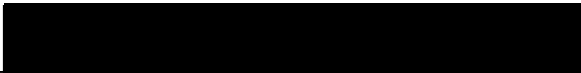
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by
Steven Elliot McCraw

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Approved by:


Dr. Matt Riggs, Faculty Supervisor
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5/9/02
Date


Dr. Rosemary McCaslin,
M.S.W. Research Coordinator

ABSTRACT

The purpose of this study was to examine and identify the current availability, utilization, and perceived benefits of treatment services for secondary victims (i.e. family members/significant others of sexual assault victims). Data was collected directly from participants (N = 400), which consisted of directors of rape crisis agencies. The participants were adults of diverse age, gender and racial/ethnic background. The procedure consisted of surveys mailed directly to the rape crisis agencies. 148 completed questionnaires were returned. 81.1 % of respondents reported offering services to secondary victims (e.g. crisis hotlines, referrals, family sessions including the victim, family sessions excluding the victim, support groups for the family members/significant others, and other services). However, services use by secondary victims appeared disproportionately low. (e.g. 40% of agencies offered support groups, 11% of offered support groups were utilized). All services received an average rating of beneficial or better. Respondents offered possible explanations for poor service use and provided strategies to improve service utilization by secondary victims.

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CHAPTER ONE

INTRODUCTION

Secondary trauma and vicarious victimization are relatively unexplored phenomena within social work and psychological research circles, with the one exception of secondary war trauma. However, trauma, a fundamental element and an inherent precursor of secondary trauma, is not limited to war related experiences. According to The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), trauma is analogous to, "... exposure to an extremely traumatic stressor involving personal experience or witnessing an event that involves actual or threatened death or serious injury, or other threats to the physical integrity of self or others" (DSM-IV; APA, 1994, pg. 424). Therefore, secondary trauma and related vicarious victimization can and should be applied to other traumatic events outside the realm of wartime experiences.

Another possible application of secondary trauma and vicarious victimization is in the field of rape, molestation, and other traumatic sexual assaults. The inclusion of secondary trauma and vicarious victimization in this area of research was, only until recently, scant

and void. What was known, however, was that sexual trauma is highly correlated with Post Traumatic Stress Disorder (PTSD). Likewise, PTSD is highly correlated with secondary trauma, which suggests a possible {if $A = B$ and $B = C$, then $A = C$ } association. Moreover, as in other forms of trauma, sexual trauma has a multitude of residual psychosocial effects on the sexual assault victim as well as the victim's family and significant others (Cwik, 1996; Feinauer, & Hippolite, 1987; Mio, & Foster, 1991; Mitchell, 1991).

However, possibly due, in part, to the lack of adequate research of secondary trauma and vicarious victimization in this area, the majority of the literature regarding rape, molestation, and other forms of traumatic sexual assault has traditionally focused primarily on the person who was assaulted (Cwik, 1996). Likewise, the majority of rape recovery, sexual assault, and crisis intervention services has traditionally been and is currently geared toward assisting solely the primary victim (Cwik, 1996). However, recent research suggests that the victim's family, and significant others may also be adversely affected by the traumatic sexual assault of their loved one via secondary trauma (Cwik, 1996; Feinauer, &

Hippolite, 1987; Mio, & Foster, 1991; Silverman, 1978). Although the traumatic sexual assault was not directly perpetrated against the victim's family/significant others, they are nevertheless vicariously effected through their association with the primary victims and therefore, become secondary victims. In addition, although not specifically addressing secondary trauma or vicarious victimization, several studies indicate that family involvement in the victim's treatment is vital to the victim's recovery as well as overall family adjustment (Emm, & McKenry, 1988; Figley, 1983; Mitchell, 1991). Unfortunately, despite these findings, the availability of treatment services specifically for or including sexual assault victims' families and significant others are, at best, scarce and inadequate, if not completely nonexistent.

Based on the aforementioned research, there is a definite need to identify the present availability of sexual assault recovery services designed to assist the families/significant others of sexual assault victims, the present rate of service use, and the perceived need and therapeutic value for these services. The difficulty, however, is determining which services are perceived as most beneficial, which services are adequately offered, and

what subsequent modifications or recommendations for service augmentation need to be implemented.

Nevertheless, comprehensive services are required in that there are a wide range of adaptive and maladaptive coping strategies used by the victim's family and significant others when attempting to come to terms with the sexual assault of their loved one that need to be addressed (Feinauer, & Hippolite, 1987). Furthermore, although there are not any predetermined reactions and each case, family, and individual is unique, there appears to be some predictable variability in possible psychological and behavioral reactions each family member/significant other, exhibits or experiences (Mio, & Foster, 1991). This variability is typically based on their age, gender, and relationship to the victim.

Male family members/significant others (i.e. fathers, husbands, boyfriends, brothers, adult and adolescent sons, and close male friends) often experience feelings of shame and guilt that a sexual assault has been perpetrated against their loved one and they were unable to protect her or prevent it (Rodkin, Hunt, & Cowan, 1982). Male family members may employ a variety of defense mechanisms including denial in the form of disbelief that the sexual

assault occurred, displacement in the form of feelings of anger toward themselves or the victim, and/or rationalization in the form of a distorted attempt to explain or justify the assault which often results in blame of the victim (Rodkin, Hunt, & Cowan, 1982). Therefore, they often become overprotective, too controlling, or inappropriately withdrawn and distant from the victim.

Female family members/significant others (i.e. mothers, sisters, adult daughters, and close female friends), on the other hand, frequently experience personal anxiety and fear as well as an undue sense of vulnerability (Cwik, 1996; Feinauer, & Hippolite, 1987; Mio, & Foster, 1991). They frequently become stifflingly sympathetic and therefore, controlling and overprotective of the victim as well.

In the case of minor children, especially the daughters of sexual assault victims, it is extremely important to be aware of the possible effects of the parent's (generally the mother's) traumatic experience on the children, (particularly daughters). Intergenerational transmission may lend itself to the transfer of trauma related norms and values transmitted from parent to child, mother to daughter, or grandmothers to mother to daughter,

which results in secondary trauma (Abrams, 1999). As these children grow up they may begin exhibiting maladaptive behaviors characteristic of the original trauma, although they only indirectly or vicariously experienced it. Therefore, the victims as well as the victims' families/significant others are in need of treatment.

This would be of particular interest to rape crisis centers and family therapy clinicians dealing with sexual assault victims and their families. Furthermore, this research would facilitate early detection and hopefully nip a potentially pervasive problem or disorder in the bud and hopefully facilitate the inclusion of treatment services for or including families/significant others of sexual assault victims. In addition, the research could bring to light a previously unrecognized disorder and assist those previously undiagnosed in receiving treatment.

Therefore, it is of the utmost importance to investigate how frequently families and significant others are included in the recovery process of traumatic sexual assault victims, what services are currently available and most often utilized by the victims' families and significant others, as well as the perceived benefit and need for such services. This is the basic underpinnings of

this current study and point of scientific inquiry. Stated more succinctly: the purpose of this study is to determine: the type and quantity of services currently offered to the families/significant others of sexual assault victims? How often are these services used by the victim's families/significant others? What are the practitioners' perceptions of the need and therapeutic value of treatment services for the victim's family/significant others?

CHAPTER TWO

LITERATURE REVIEW

The purpose of this study is to examine and identify the current availability and utilization of sexual assault recovery services by the families and significant others of sexual assault victims as well as to assess the need and benefit of family treatment services dealing specifically with traumatic sexual assault, secondary trauma, and the vicarious victimization of the family.

A similar study by Brookings, McEvoy, and Reed, (1994), examined the availability and utilization of rape crisis services among male significant others and the effects of male significant others' involvement in the sexual assault victim's recovery. The study found that male significant others who availed themselves of rape crisis services tended to be more supportive of the victim and aided the victim's recovery (Brookings, McEvoy, & Reed, 1994). Furthermore, the study reported a shortage of accessible services for male significant others and that men were reluctant to use the services that were available to them (Brookings, McEvoy, & Reed, 1994). However, the primary focus of the Brookings, McEvoy, and Reed, (1994),

study was on male influence on the victim's recovery and did not fully address how beneficial rape crisis/sexual assault treatment services were in assisting male significant others or additional family members/significant others coping with the sexual assault of a loved one.

Therefore, the current study will determine if the availability and utilization of rape crises/treatment services among male significant others reported in Brookings, McEvoy, and Reed, (1994) are generalizable across gender and/or relationship to the victim. Moreover, the current study will investigate the benefits and effectiveness of treatment services designed specifically to assist families and significant others in coping with the traumatic sexual assault of a loved one, secondary trauma, and vicarious victimization.

Family difficulties due to an extra-familial sexual assault of a loved one and the subsequent need for treatment services for families/significant others indirectly affected has gone largely unexamined. In contrast, It has been well documented that women who have been sexually assaulted typically suffer residual psychological and emotional effects, including, but not limited to, Post Traumatic Stress Disorder (PTSD),

Depression, Panic Disorders, Eating Disorders, Sleep Disorders, Somatoform Disorders, Brief Psychotic Disorder, or some combination thereof (Kelly, 1999; Frank, Turner, & Stewart, 1980). The most common presentation of these resulting effects is similar to or consistent with PTSD or PTSD related symptoms such as nightmares, flashbacks, heightened startle responses, hypervigilance, irritability or outbursts of anger, difficulty concentrating, marked avoidance of similar, representative stimuli, and extreme psychological and physiological reaction to that similar stimuli, (DSM-IV; APA, 1994). Other symptoms include pervasive feelings of vulnerability, intense shame and guilt, suicidal ideations, and a sense of worthlessness and low self-esteem. This is frequently accompanied by the fear that they are now visibly tainted or marked as "damaged goods" and therefore, easily identified as such, which, in turn, further perpetuates an unrealistic sense of ostracism and isolation (Bowie, Silverman, & Daniel 1990; Thelen, & Sherman, 1999).

However, these symptoms do not occur solely in the vacuum of a therapist's office. They are carried with the victim until successfully worked through. Thus anyone who has frequent and prolonged contact with the victim such as

the victim's family are potentially at risk of being adversely effected (Frank, Turner, & Stewart, 1980). Sexual trauma (i.e. rape, molestation, or other forms of traumatic sexual assault) tends to have short-term and long-term psychological and psychosocial effects on the victim as well as the victim's family/significant others (Cwik, 1996; Feinauer, & Hippolite, 1987; Mio, & Foster, 1991; Silverman, 1978). Consequently, the victim's family members/significant others may adopt similar reactions, beliefs, and misconceptions about themselves as a family or individually based on their age, gender or their relationship with the victim (Feinauer, & Hippolite, 1987; Mitchell, 1991). In other words, family members/significant others may also feel victimized and vulnerable, tainted and dirty, shame and embarrassed, or as if they are or will be ostracized by their social circle, neighbors, or community.

Furthermore, Sexual trauma can fundamentally alter family dynamics, family roles and family identity (Mio, & Foster, 1991). Caregiver roles often change in that the mothers, wives, and frequently daughters as well who used to act as family caregivers are now most in need of care and nurturing following a traumatic sexual assault. Therefore, family roles and responsibilities are frequently

modified and reassigned. New roles and responsibilities are placed on fathers, husbands, and children while others are taken away from the victim. This can be adaptive given that fewer responsibilities may lessen the victim's burden and allow her to focus on her recovery (Mio, & Foster, 1991). However, it can also place additional stress on the family in that family members/significant others may be unwilling or ill equipped to handle their new roles or responsibilities (Mio, & Foster, 1991). In addition, modifying family roles and responsibilities can also be maladaptive given that the victim may need her usual routine to maintain a sense of normalcy and aid her recovery (Mitchell, 1991). Moreover, as a consequence to the sexual trauma and subsequent changes, the focus of family importance, attention, and purpose often change as well, which, in turn, may further alter family identity (Mio, & Foster, 1991). These changes are typically unwanted and uncomfortable for the victim and the victim's family/significant others.

As families attempt to resist or adjust to these changes they may become over protective of the victim or may pretend as if nothing has happened, both of which are counterproductive to the victim's recovery as well as the

overall adaptive functioning of the family (Mitchell, 1991). This typically results in a myriad of adaptive and maladaptive coping strategies by the sexual assault victim's family/significant others (Feinauer, & Hippolite, 1987; Thelen, & Sherman, 1999). These coping strategies range from empathy and support of the victim to anger, blame, or over-identification with the victim (Mio, & Foster, 1991; Rodkin, Hunt, & Cowan, 1982).

Mio and Foster, (1993) found, through their work with male significant others of sexual assault victims, that a significant number of men had difficulty coping with the assault of a close female relative (i.e. wife, mother, sister). The male significant others (i.e. fathers, husbands, boyfriends, brothers, adult and adolescent sons, and close male friends) reported feeling uncomfortable and uneasy around their loved ones following a traumatic sexual assault (Mio, & Foster, 1991). The men also reported a sense of not knowing what to say or do or how to interact with the victim following a traumatic sexual assault (Mio, & Foster, 1991). Other male significant others reported feeling intense anger and rage at the perpetrator, themselves, and frequently the victim as well (Rodkin, Hunt, & Cowan, 1982).

The anger toward the perpetrator is probably most adaptive, yet without an identified assailant or means of resolution the anger can become self-consuming. Likewise anger toward themselves, usually for not being able to protect the victim or prevent the assault, is clearly unjustified, self destructive, and detrimental to the family (Rodkin, Hunt, & Cowan, 1982). Most awful, however, is anger felt or expressed toward the victim. This usually takes the form of blame and rejection, which, for the victim, is tantamount to revictimization (Brookings, McEvoy, & Reed, 1994). Moreover, blaming the victim can be disastrous to the victim's psyche, ego strength, and recovery in addition to the negative consequences on family cohesion and adjustment (Rodkin, Hunt, & Cowan, 1982).

These maladaptive and unsupportive behaviors are not only experienced and expressed by male family members/significant others. Female family members/significant others (i.e. mothers, sisters, adult daughters, and close female friends), also, frequently exhibit maladaptive coping strategies (Emm, & McKenry, 1988). Women are often either insensitive or oversensitive.

When insensitive, female family members/significant others have also been known to project and displace their

anxiety, anger, and hostility on to the victim (Emm, & McKenry, 1988). Possibly in an attempt to differentiate themselves from the victim, female family members/significant others may blame the victim for the traumatic sexual assault, based on her style of dress, not being aware of her surroundings, being in the wrong place at the wrong time, or not resisting enough. This may be a defense mechanism used to protect them from the realization that they could be victimized as well. Nevertheless, it is maladaptive and destructive to the victim and family's recovery and adjustment (Emm, & McKenry, 1988).

In contrast, oversensitive female family members/significant others often become, too compassionate, too considerate, too accommodating. They frequently attempt to create a surreal, trouble free environment for the victim, which the victim may find patronizing or stifling (Silverman, 1978). They may suffocate the victim with kindness or make inappropriate attempts to cheer her up, thus impeding the natural grieving process (Silverman, 1978). This may also prevent or delay the recovery process and closure for the victim and her family/significant others.

In addition, many female family members/significant others over-identify with the victim, develop feelings of intense fear and vulnerability, become hypervigilant, or experience many other symptoms congruent with having been traumatically victimized (Cwik, 1996; Feinauer, & Hippolite, 1987; Mio, & Foster, 1991).

Similarly, there are clear indications that children are highly influenced by the values, norms, and believe systems of their parents as well as the parent's subsequent behaviors and demeanor (Abrams, 1999). Children can then internalize these schemas and act them out via intergenerational transmission. Intergenerational transmissions aid the socialization of a child and are associated with the continuation of adaptive and maladaptive familial norms. Hence, many studies indicate a correlation between physical violence within the family of origin and domestic violence in subsequent adult relationships (Abrams, 1999). Other studies highly correlate prior intrafamilial and extrafamilial sexual abuse as a child with becoming an offender as an adult (Koverola, Proulx, Battle, & Hanna 1996; Stevenson, & Gajarsky, 1991). Furthermore, intergenerational transmission has been correlated with divorce, occupation,

social economic status, teenage pregnancy, welfare dependence, alcohol abuse, parenting styles, religion, and war trauma (Jennison & Johnson 1998; Margo, 1998; Myers 1996; Miller & Kramer 1997; Wolfinger, 1999) The premise of this theory is that norms and values, positive or negative, which determine how one functions in the world are passed from one generation to the next.

In the case of intergenerational transmission of secondary trauma, much of the research has focused on the transmission of combat trauma or holocaust traumas, resulting in secondary trauma and vicarious victimization in the children of or those closely involved with traumatized war veterans or Holocaust survivors (Motta, Joseph, Rose, Suozzi, & Leiderman, 1997).

However, traumatic experiences are not limited to combat trauma and Holocaust survivors, and therefore, secondary trauma and vicarious victimization can be further extrapolated or generalized beyond these two experiences. Sexual trauma, for example, may elicit similar responses in those closely involved with sexual assault victims. Stated succinctly: family members/significant others of sexual assault victims may indirectly or vicariously experience trauma as well as subsequent reactions and trauma related

effects in the, albeit, less intense, form of secondary trauma. Although the persons experiencing secondary trauma has not directly experienced the initial traumatizing event, they unwittingly appropriate a similar demeanor and life schema, including presenting symptoms and abreactions as the person who directly experienced the trauma (Motta et al., 1997, Frank, Turner, & Stewart, 1980). Based on this research it appears that the victim as well as the victim's family/significant others are in need of treatment services.

Therefore, it is important to investigate the current number and type of services offered, the frequency of service use, and the practitioners' perception of the need and therapeutic value of these services. Hence the purpose of this study is to identify: 1. the type and availability of treatment services for or including the victim's families/significant others, 2. the utilization of treatment services by the victim's families/significant others, 3. and the perceived need and benefits of these treatment services.

CHAPTER, THREE

METHOD

The purpose of this study is to examine and identify the current availability and utilization of sexual assault recovery services by the families and significant others of sexual assault victims as well as to assess the need and benefit of family treatment services dealing specifically with traumatic sexual assault, secondary trauma, and the vicarious victimization of the family. This study will focus on treatment services specifically intended for families/significant others of sexual assault victims (i.e. services/sessions in which the victim is not included) and family therapy services (i.e. services/sessions in which the victim is included). The study will conduct quantitative and qualitative research by way of a questionnaire (Refer to Appendix B). The purpose of using a combination of both quantitative and qualitative data is to elicit detailed quantifiable information about the type and function of existing services as well as to obtain wide-ranging comprehensive knowledge of why families/significant others do or do not use available services and what can be done to improve service use.

The limitations of this study are that this area of study has rarely been researched, and therefore, there is little reference material and limited resources available. Furthermore, due to confidentiality issues, neither sexual assault victims nor their children could be directly interviewed or surveyed. Therefore, the assessment of services as beneficial or non-beneficial are based solely on the perceptions of the directors of rape crisis centers and related agencies who are in frequent contact with the victims and their families. Therefore, further research, directly involving the victims families/significant others, will be needed to investigate various extraneous and underlying nuances before a final determination of how beneficial these services are can be made. Yet this study is intended to begin the journey of discovery, fill the gaps in information, and lay the foundation as it helps to determine how to best serve this population.

The data will be collected directly from Participants (N = 400), which would consist of the directors of rape crisis centers and related agencies. The participants will be adults of diverse age, gender and racial/ethnic background. The participants will be contacted/solicited through the Rape Recovery Terrashare national directory of

rape crisis centers via mail out surveys mailed directly to the rape crisis/sexual assault treatment service agency. All participants would be of normal/good physical and mental health.

Descriptive information regarding the type and frequency of services offered and utilized, the need and benefits of services rendered, reasons for current rate of service use, and ways to improve service use will be ascertained by way of a questionnaire (Refer to Appendix B). The study consists of 10 variables, which are designed to ascertain nominal and/or ratio data. The first variable identifies whether services are offered to family members/significant others. The second variable employs a check all that apply of fixed categories regarding the types of services offered. The third variable identifies the percentages of services used within each category. The fourth variable identifies the percentage of service use corresponding to the family member's/significant other's relationship to the victim. And the fifth variable identifies duration of service use. The next 3 variables employ a 4-point Likert scale ascertaining ordinal data assessing the perceived effectiveness and benefits of treatment services. The 2 additional variables consist of

qualitative open-ended questions designed to elicit narrative explanations of the present rate of service use and possible ways to increase service utilization.

Additional materials needed in the study include an informed consent sheet (Refer to Appendix A), a debriefing sheet (Refer to Appendix C), and a self addressed stamped envelope.

The researcher will mail questionnaires to the directors of various rape crisis centers listed in the Rape Recovery Terrashare national directory. The procedure would consist of participants filling out a questionnaire and thereby responding to the questions/variables therein. Each participant will receive an informed consent form to notify them of the research project dynamics, a questionnaire, a debriefing statement, and a stamped return envelope. The estimated time that each participant will need to complete the study is approximately 15 min.

All potential participants will be informed that they are volunteering for a research study concerning traumatic sexual assault and treatment service utilization. Participants will be informed about anonymity and confidentiality issues, and that they can discontinue their participation in the study at any time. No identifying

information will be taken from participants (i.e. names, telephone numbers, addresses) at any time.

There are not any foreseeable risks associated with participation in the study. The study (i.e. the questionnaire) will be completed at designated rape crisis/sexual assault treatment service agencies by the directors or licensed therapists of the agency who specialize and are trained in the treatment of traumatic sexual assault. However, therapists and other appropriate practitioner will be readily available if a participant finds the study disconcerting. In addition, if the participants have any concerns following involvement in the study. They can contact Dr. Rosemary McCaslin at (909) 880-5507. All participants will be treated in an ethical manner according to social work ethical guidelines as outlined in the NASW (1994).

Data analysis will utilize descriptive univariate statistics to describe the data, consisting of measures of central tendency and frequency distribution. In addition, questions ascertaining qualitative data (e.g. the reasons why families/significant others rarely utilize treatment services and what can be done to improve their service use?) will be assessed via content analysis. Subsequently,

the narrative data will be organized into categories generated by the data such as stigma related to sexual assault, perceiving the sexual assault as a problem only effecting the primary victim, and/or unaware of the availability of treatment services.

CHAPTER FOUR

RESULTS

A total of four hundred questionnaires were mailed to the directors/licensed therapists of various rape crisis agencies located throughout the United States. One hundred forty eight completed questionnaires were returned. One hundred twenty (81.1%) of rape crisis agency directors that responded reported that they offered treatment services to the family members/significant others of sexual assault victims (Refer to Figure 1.). Treatment services were defined as crisis hotlines, referrals, family sessions including the victim, family sessions excluding the victim, support groups for the family, and other services [Other services typically consisted of transportation and accompaniment to and from the police station, hospital, and court as well as victim and family advocacy]).

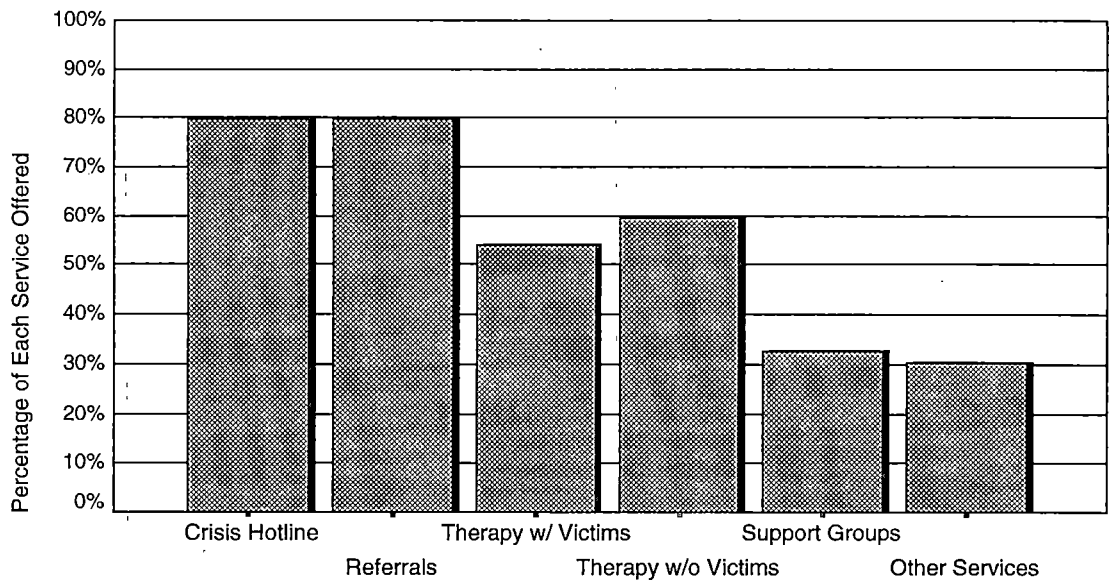


Figure 1. Percentage of Agencies Offering Services to Family Members and Significant Other's of Sexual Assault Victims

Eight rape crisis agencies (6.7%) offered two of the aforementioned services, twenty-six rape crisis agencies (21.7%) offered three of the aforementioned services, forty-four rape crisis agencies (36.7%) offered four of the aforementioned services, twenty-four rape crisis agencies (20.8%) offered five of the aforementioned services, and seventeen rape crisis agencies (14.2%) offered six or more of the aforementioned services to families/significant others of sexual assault victims in various combinations (Refer to Figure 2). The average number of services rape

crisis agencies offered was slightly over 4 services per agency ($M = 4.12$, $Mdn = 4$, mode = 4, $SD = 1.12$).

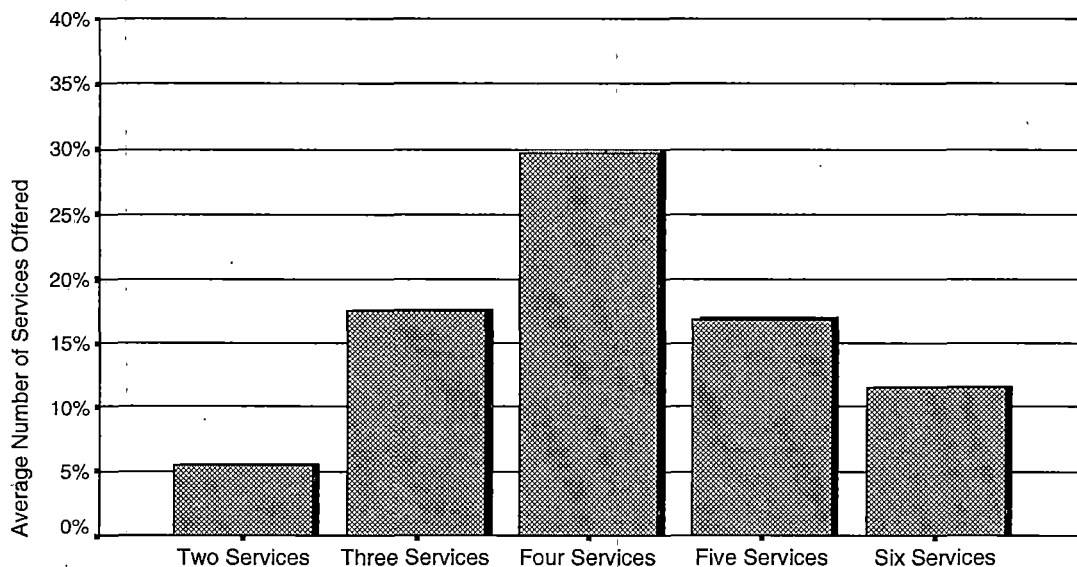


Figure 2. Average Number of Services Agencies Offered to Family Members and Significant Others of Sexual Assault Victims

However, services used by the family Members and significant others of sexual assault victims appeared disproportionately low (Refer to Figure 3). For example, 98.3% of rape crisis agency directors reported offering crisis hotline services, yet families/significant others only used an average of 42% of crisis hotline services ($M = .4244$, $Mdn = .4250$, mode = .50, $SD = .2360$). Likewise,

98.3% of rape crisis agency directors reported having referral services available for families/significant others. However, only 20% of referrals services were reportedly given to the victims' family members/significant others ($M = .2090$, $Mdn = .20$, mode = .10, $SD = .1332$).

Moreover, 77.3% of rape crisis agency directors reported offering family therapy/counseling sessions, which included the victim and 66.6% reported offering family therapy/counseling sessions, which excluded the victim. In contrast, rape crisis agency directors reported that family members/significant others participated in an average of 16% of available therapy/counseling sessions, which included the victim and participated in an average of 19% of available therapy/counseling sessions, which excluded the victim [$M = .1615$, $Mdn = .10$, mode = .10, $SD = .1572$] and ($M = .1990$, $Mdn = .16$, mode = .30, $SD = .1843$).

Furthermore, 40% of rape crisis agency directors reported offering support groups for the family/significant others. Conversely, only 11% of available support groups were reportedly utilized ($M = .1190$, $Mdn = .10$, mode = .10, $SD = .0890$). Other services were reportedly offered by 37.5% of rape crisis agencies. However, family members/significant others only used an average of 21% of these additional

available services ($M = .2112$, $Mdn = .20$, $mode = .05$, $SD = .1981$).

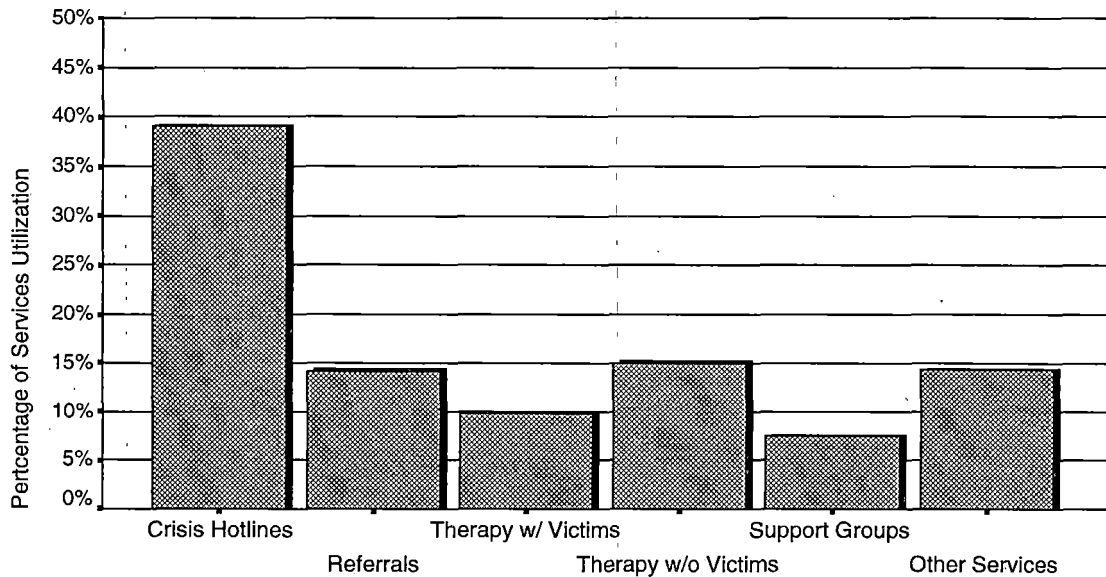


Figure 3. Percentage of Services Utilized by Family Members and Significant Others of Sexual Assault Victims

Utilization was also analyzed according to the family members'/significant others' relationship to the victim (e.g. mother, father, husband, boyfriend, sister, brother, victim's children, complete family, friends, and others). Several directors of rape crisis agencies that indicated that they offered services to the family members/significant others reported that certain specific relatives/significant others did not use their services.

Hence 3.4% of respondents reported that mothers, 17.8% of respondents reported that fathers, 18.6% of respondents reported that husbands, 24.6% of respondents reported that boyfriends, 33.9% of respondents reported that sisters, and 58.5% of respondents reported that brothers of sexual assault victims statistically did not use available services. Likewise, 63.8% of respondents reported that children, 65.3% of respondents reported that complete families, 21.2 of respondents reported that friends, and 60.2% of respondents reported that others (others typically included domestic partners and grandparents) of sexual assault victims statistically did not use available services.

Therefore, only rape crisis agencies that responded affirmatively that specific relatives/significant others used their services were included in the statistical analysis (Refer to Figure 4.). Nevertheless, mothers of sexual assault victims comprised an average of 43% of service use ($N = 114$, $M = .4351$, $Mdn = .40$, mode = .60, $SD = .2401$). Fathers of sexual assault victims comprised an average of 0.9% of service use ($N = 97$, $M = .09814$, $Mdn = .10$, mode = .10, $SD = .0629$). Husbands of sexual assault victims comprised an average of 14% of service use ($N = 96$,

M = .1472, Mdn = .10, mode = .10, SD = .1408). Boyfriends of sexual assault victims comprised an average of 11% of service use (N = 89, M = .1169, Mdn = .10, mode = .10, SD = .099). Sisters of sexual assault victims comprised an average of 0.7% of service use (N = 79, M = .0738, Mdn = .05, mode = .05, SD = .0636). Brothers of sexual assault victims comprised an average of 0.3% of service use (N = 49, M = .0351, Mdn = .02, mode = .01, SD = .0326). Children of sexual assault victims comprised an average of 10% of service use (N = 42, M = .1019, Mdn = .05, mode = .05, SD = .1830). Complete families of sexual assault victims comprised an average of 0.7% of service use (N = 41, M = .0736, Mdn = .05, mode = .10, SD = .063). Friends of sexual assault victims comprised an average of 16% of service use (N = 93, M = .1630, Mdn = .10, mode = .10, SD = .1321). Others comprised an average of 0.9% of service use (N = 47, M = .0917, Mdn = .05, mode = .10, SD = .0797).

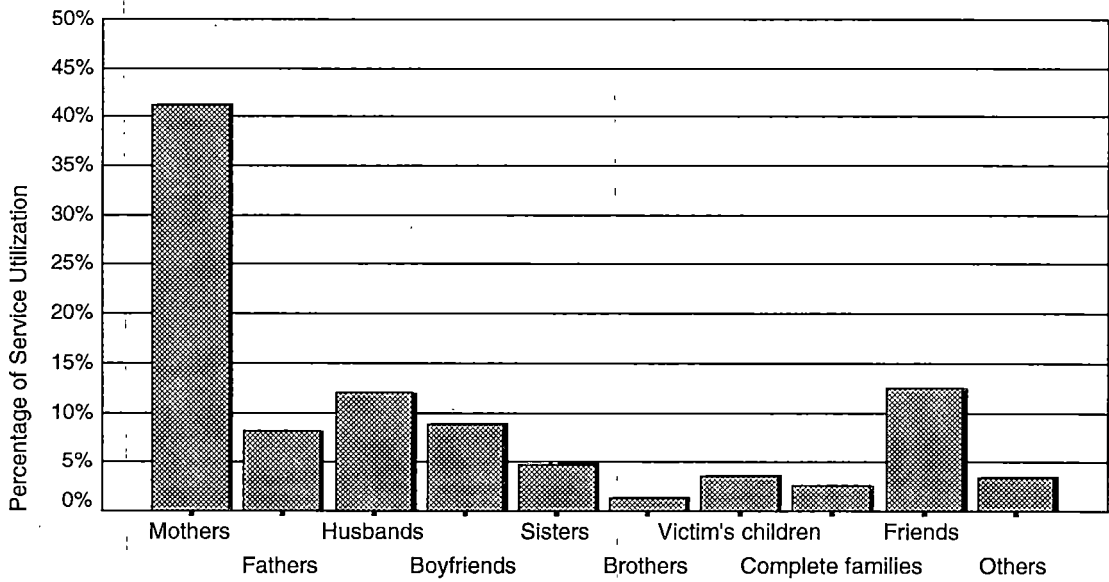


Figure 4. Percentage of Service Utilization According to the Significant Other's Relationship to the Primary Victim

In addition, rape crisis agency directors reported that the average duration of service use (e.g. number of contacts/sessions) per family members/significant others of sexual assault victims was slightly over three sessions ($M = 3.16$, $Mdn = 3$, mode = 5, $SD = 1.43$) (Refer to Figure 5.).

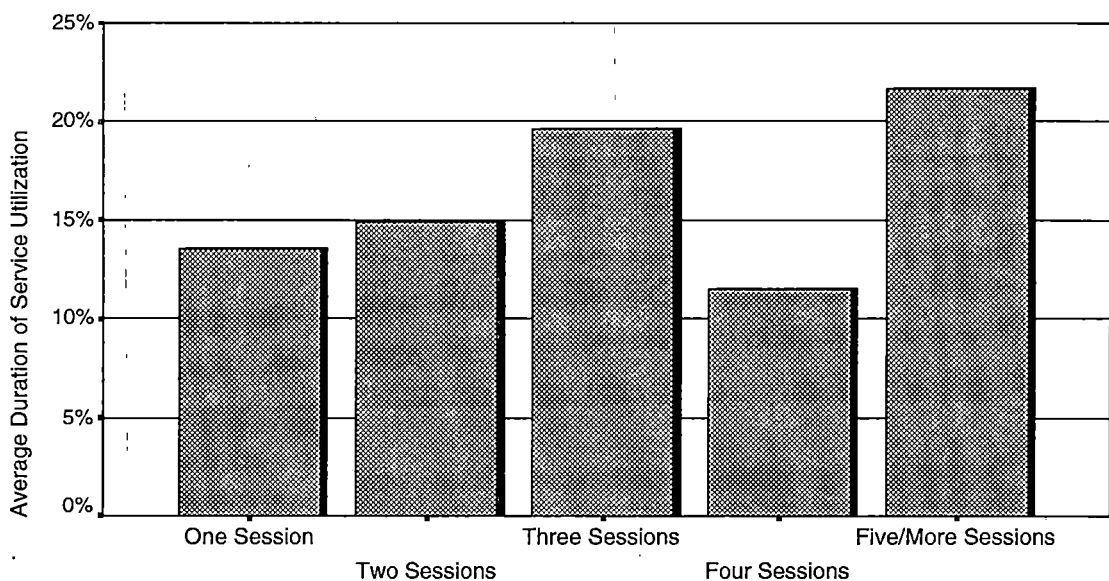


Figure 5. Average Duration of Service Utilization by Family Members and Significant Others of Sexual Assault Victims

Crisis agency directors also rated the perceived benefit of the aforementioned services with regard to family adjustment/coping skills and the victims' recovery associated with family service involvement. Services were rated on a 4-point Likert scale (i.e. 1 = not beneficial, 2 = moderately beneficial, 3 = beneficial, 4 = very beneficial) (Refer to Figure 6 and Figure 7). The directors of 10% of rape crisis agency directors rated crisis hotline services as moderately beneficial, 30.8% rated crisis hotline services as beneficial, and 59.2% rated crisis

hotline services as very beneficial to family adjustment/adaptive coping mechanisms ($N = 120$, $M = 3.49$, $Mdn = 4$, mode = 4, $SD = .67$). The directors of 2.6% of rape crisis agencies rated referral services as not beneficial, 11.2% rated referral services as moderately beneficial, 28.4% rated referral services as beneficial, and 37.8% rated referral services as very beneficial to family adjustment/adaptive coping mechanisms ($N = 116$, $M = 3.41$, $Mdn = 4$, mode = 4, $SD = .79$). The directors of 1% of rape crisis agencies rated family therapy including the victim as not beneficial, 18.6% rated family therapy including the victim as moderately beneficial, 47.1% rated family therapy including the victim as beneficial, and 33.3% rated family therapy including the victim as very beneficial to family adjustment/adaptive coping mechanisms ($N = 102$, $M = 3.13$, $Mdn = 3$, mode = 3, $SD = .74$). The directors of 1% of rape crisis agencies rated family therapy excluding the victim as not beneficial, 8.9% rated family therapy, excluding the victim as moderately beneficial, 39.6% of agencies rated family therapy excluding the victim as beneficial, and 50.5% rated family therapy excluding the victim as very beneficial to family adjustment/adaptive coping mechanisms ($N = 101$, $M = 3.40$, $Mdn = 4$, mode = 4, $SD = .69$). The

directors of 1.4% of rape crisis agencies rated support groups as not beneficial, 12.3% rated support groups and moderately beneficial, 34.2% rated support groups as beneficial, and 49.3% rated support groups as very beneficial to family adjustment/adaptive coping mechanisms (N = 73, M = 3.34, Mdn = 3, mode = 4, SD = .75). The directors of 5.9% of rape crisis agencies rated other service is as moderately beneficial, 17.6% rated other service is as beneficial, and 76.5% rated other service is as very beneficial to family adjustment/adaptive coping mechanisms (N = 34, M = 3.71, Mdn = 4, mode = 4, SD = .58).

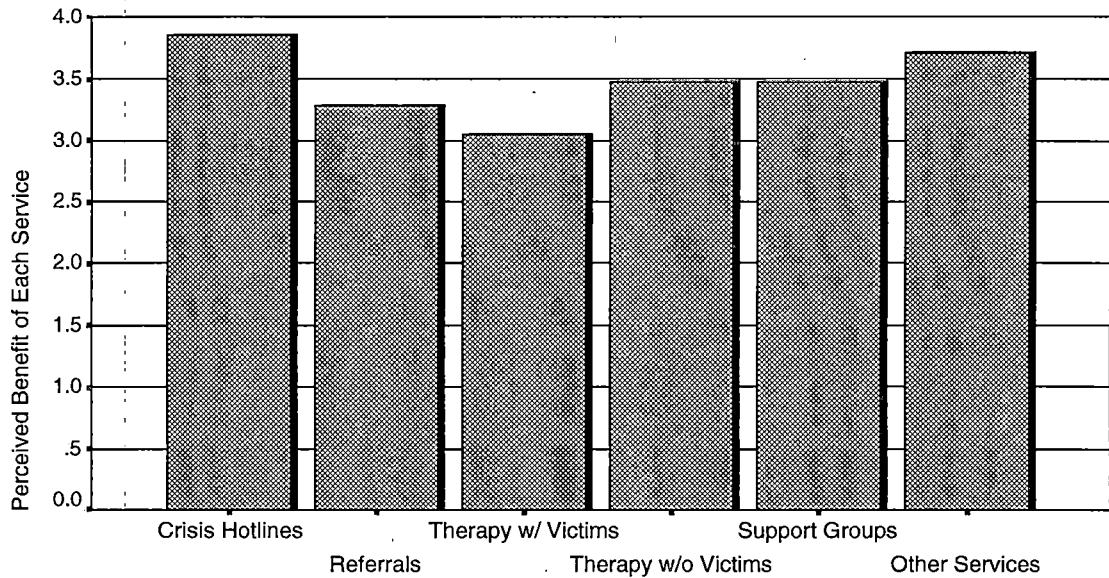


Figure 6. Perceived Benefits of Services Regarding Family Adjustment and Adaptive Coping Mechanisms

Furthermore, the directors of 11% of rape crisis agencies rated families/significant others with rape crisis hotline services as moderately beneficial, 30.5% rated families/significant others with rape crisis hotline services as beneficial, and 58.5% rated families/significant others with rape crisis hotline services as very beneficial to the victim's recovery ($N = 118$, $M = 3.47$, $Mdn = 4$, $mode = 4$, $SD = .69$). The directors of 0.8% of rape crisis agencies rated families/significant others with referral services as not beneficial, 11.9%

rated families/significant others with referral services as moderately beneficial, 32.2% rated families/significant others with referral services as beneficial, and 55.1% rated families/significant others with referral services as very beneficial to the victim's recovery ($N = 118$, $M = 3.42$, $Mdn = 4$, $mode = 4$, $SD = .73$). The directors of 1% of rape crisis agencies rated family therapy including the victim as not beneficial, 17.6% rated family therapy including the victim as moderately beneficial, 31.4% rated family therapy including the victim as beneficial, and 50% rated family therapy including the victim as very beneficial to the victim's recovery ($N = 102$, $M = 3.30$, $Mdn = 3.5$, $mode = 4$, $SD = .79$). The directors of 1% of rape crisis agencies rated family therapy excluding the victim as not beneficial, 6.9% rated family therapy excluding the victim as moderately beneficial, 34.7% rated family therapy excluding the victim as beneficial, and 57.4% rated family therapy excluding the victim as very beneficial to the victim's recovery ($N = 101$, $M = 3.49$, $Mdn = 4$, $mode = 4$, $SD = .67$). The directors of 1.3% of rape crisis agencies rated support groups for families/significant others as not beneficial, 12% rated support groups for families/significant others as moderately beneficial, 30.7%

rated support groups for families/significant others as beneficial, and 56% rated support groups for families/significant others as very beneficial to the victim's recovery ($N = 75$, $M = 3.41$, $Mdn = 4$, mode = 4, $SD = .76$). The directors of 2.8% of rape crisis agencies rated families/significant others with other services as not beneficial, 27.8% rated families/significant others with other services as beneficial, and 69.4% rated families/significant others with other services as very beneficial to the victim's recovery ($N = 36$, $M = 3.64$, $Mdn = 4$, mode = 4, $SD = .64$).

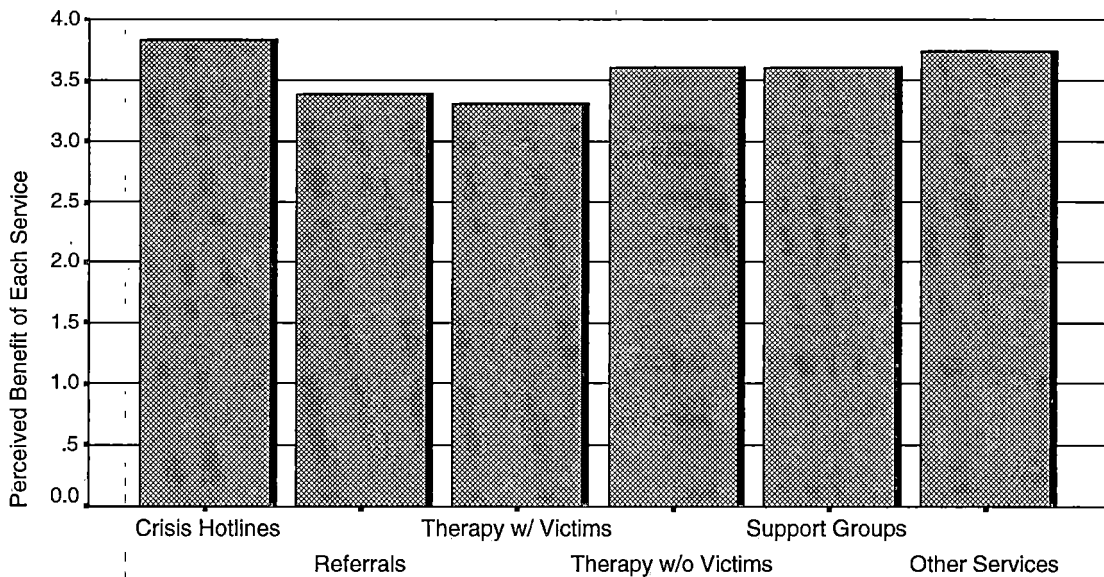


Figure 7. Perceived Benefits of Family Utilization of Services Regarding Victim Recovery

Similarly, the directors of 16.7% of rape crisis agencies rated the perceived benefit of existing and/or prospective support groups for families/significant others (excluding victims) as moderately beneficial, 35% rated existing and/or prospective support groups for families/significant others (excluding victims) as beneficial, and 48.3% rated existing and/or prospective support groups for families/significant others (excluding victims) as very beneficial to the victim's recovery ($N = 120$, $M = 3.32$, $Mdn = 3$, mode = 4, $SD = .74$) (Refer to Figure 8).

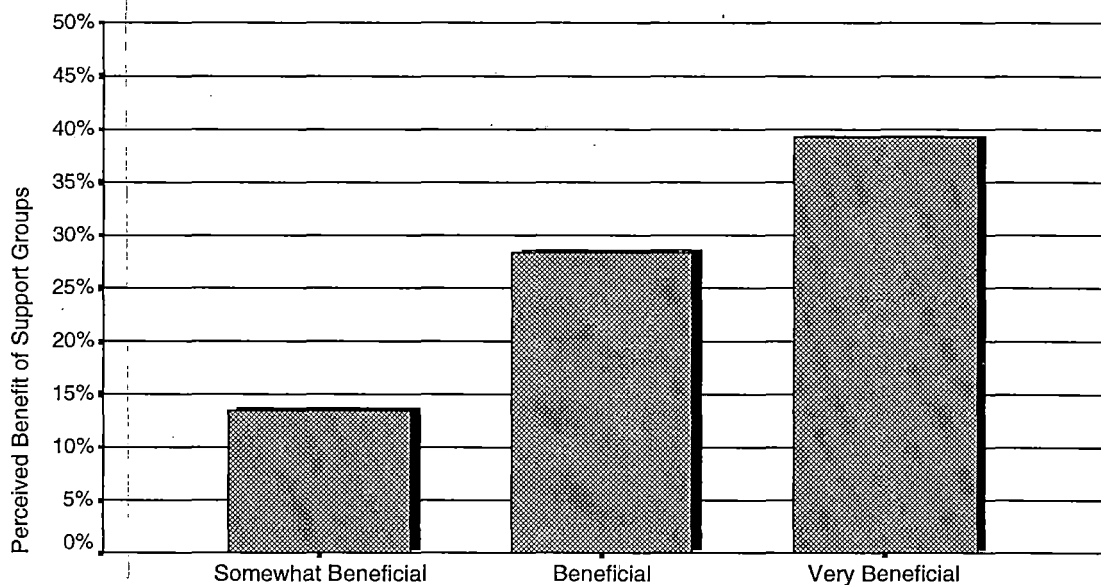


Figure 8. Perceived Overall Benefit of Support Groups Solely for Family Members and Significant Others of Sexual Assault Victims

Agency directors gave qualitative responses when asked to use their expertise as primary service provider of this population to identify the reasons for poor services use among family members/significant others of sexual assault victims and to provide plausible strategies to improve service use among family members/significant others of sexual assault victims. The qualitative data was assessed via content analysis, organized into categories generated by the data, statistically analyzed, and placed into tables (Refer to Appendix D and Appendix E).

CHAPTER FIVE

DISCUSSION

The rationale for conducting the current study was to seek and ultimately present information regarding the relationship between sexual violence and secondary trauma/vicarious victimization. Secondary trauma and vicarious victimization were relatively new, unstudied areas of research with little supporting empirical or clinical data. Consequently, a virtually unnoticed population was not being adequately served. Concern for this population, along with the opportunity to begin to rectify this situation was the incentive to research this area.

The goal of the study was to enhance understanding of the needs of secondary victims of sexual trauma by examining the availability, utilization and perceived benefits of various treatment services for this population. Secondary victims were defined as family members and significant others of sexual assault victims (e.g. mothers, fathers, husbands, boyfriends, sisters, brothers, victim's children, complete families, friends, and others closely associated with the victim). Sexual trauma was defined as

rape, molestation, or other forms of traumatic sexual assault. The study was designed to obtain information regarding existing treatment methods, what has proved to be productive and unproductive, and to present plausible strategies directly from primary service providers to include, improve, and establish services for family members/significant others of sexual assault victims.

It is clear from the present results that most directors of rape crisis agencies recognized the need to provide services for this population. Prior research also supports service provisions for family members/significant others of sexual assault victims (Cwik, 1996; Feinauer, & Hippolite, 1987; Mio, & Foster, 1991; Mitchell, 1991). As indicated in previous studies, the victim's family members/significant others are in need of treatment services in that they often adopt similar symptomatic presentations as the primary victim as well as experience perceived deterioration in family functioning subsequent to sexual trauma (Feinauer, & Hippolite, 1987; Mitchell, 1991). To briefly review, the victim's family members/significant others may feel shame, guilt, anxiety, depression, blame or anger toward themselves or the victim; they may become over protective, controlling,

hypervigilant, socially withdrawn; they may experience nightmares, sleep and appetite disturbances, heightened startle responses, irritability, identity and role confusion, difficulty concentrating, avoidance and psychological/physiological reaction to similar representative stimuli (Cwik, 1996; Feinauer, & Hippolite, 1987; Mio, & Foster, 1991; Mitchell, 1991). However, research has also shown that family involvement in the victim's treatment is instrumental in the victim's recovery, development of adaptive coping mechanisms, and overall family adjustment (Emm, & McKenry, 1988; Figley, 1983; Mitchell, 1991). These findings suggest that this population would benefit from treatment services. Nevertheless, the results indicated a shortage of available services and an apparent reluctance of family members/significant others to avail themselves of the few services that exist.

Therefore, it is necessary to implement the most promising and pragmatic strategies proposed by rape crisis agencies to augment services to best meet the needs of primary and secondary victims and lessen the gap between service availability and service use. True augmentation of services and implementation of agency proposals would

require change on a legislative, community, and individual agency/client basis. Two frequently occurring agency proposals that require legislative attention were to improve accessibility/availability of services (11.8% of total proposals) and a need for additional funding and resources (6.1% of total proposals). These two proposals overlap in that increased funding could provide additional facilities, more professionally trained counselors, and added materials, which in turn, would increase the availability of services as well as the number of clients that could be served. However, to accomplish this goal agency directors must first continually apply for existing grants and other subsidies (e.g. Violence Against Women Act fund and Victims of Crime Act fund). Agency directors may want to consider becoming proactive policy advocates, increasing their visibility and strength by forming alliances with prominent victims' rights groups, and proposing new or modifications to existing legislation to improve services and funding. Local, state, federal, and legislative representatives would need to be contacted and presented with clearly outlined policy objectives, statistical information regarding the benefits of

treatment, along with budgetary requirements, and a plan for resource allocation.

At the community level, two frequently occurring agency proposals to improve service awareness and utilization were positive community outreach (30.2% of total proposals) and Interagency collaboration (8% of total proposals). Positive community outreach, as described by agency directors comprised the enhancement of public knowledge of service availability, agency missions, populations served, and benefits of treatment. To operationalize and implement this strategy effectively rape crisis agencies need to publicize available services and explain what constitutes sexual violence and its impact on primary and secondary victims. This could be accomplished through presentations to local schools, churches, and community groups. Rape crisis agencies may also want to consider sponsoring and/or having pamphlets available at community events and facilities.

Similarly, to facilitate interagency collaboration rape crisis agencies could invite adjunct service providers (e.g. medical professionals, mental health counselors, social services providers, and law enforcement units) to agency produced educational seminars. Educational seminars

would present information regarding secondary victimization, statistics on the value of services, and the necessity for adjunct service providers to promote service use, have agency pamphlets accessible, and refer family/significant others to appropriate crisis agencies.

Agency proposed changes in practice or otherwise directly involving clients consisted of education of primary and secondary victims (11.3 % of total proposals) and increased training of employees (9.9% of total proposals). Use and continual training of degreed counselors/service providers is critical to providing adequate competent treatment. Counselors/service providers must have an in-depth understanding of psychosocial functioning, clinical assessment, intervention, and treatment planning. Hence specific clinical approaches for the psychological and emotional health of each victim group need to be provided.

Clinically, when treating traumatic sexual assault victims, their spouses/partners, and other family members, it is important to understand how secondary trauma may alter family/relational dynamics. Knowledge regarding the continuing effects of a traumatic sexual assault will help counselors/service providers to address and educate clients

about sexual trauma and vicarious victimization, assess the individual needs and issues of this population, and develop effective treatment plans to aid the recovery process for primary and secondary victims of sexual trauma.

Two additional proposals, which must also be mentioned, are to increase male staff (2.4% of total proposals) and develop support groups, and other services solely/specifically for family members/significant others of sexual assault victims (4.7% of total proposals). Brookings, McEvoy, and Reed (1994), reported a significant lack of male employees/volunteers working in rape crisis agencies, which they attributed to male significant others feeling uncomfortable or unwelcome and therefore not using services even when they are available. An easy remedy would be to encourage and recruit more male employees/volunteers. Another plausible solution would be to develop client or counselor facilitated support groups for male significant others (Brookings, McEvoy, and Reed, 1994).

The implementation of support groups for male significant others is a wonderful development in the treatment of secondary victimization. However, as proposed by agency directors in the present study, additional groups should be developed for all family members/significant

others of sexual assault victims. Although there is little research regarding support groups for family members/significant others of sexual assault victims, a similar model for such groups is found in Al-Anon, Nar-Anon, Alateen, and other Alcoholics Anonymous/Narcotics Anonymous family-oriented 12-step self-help groups. These groups provide structured support to secondary victims of alcohol and narcotics abuse from other family members and significant others who have had similar experiences (Read, 1995). It may prove beneficial to apply a similar model to groups for family members/significant others of sexual assault victims. In fact all the strategies proposed by the various rape crisis agency directors have the potential to increase service utilization and/or the availability of resources for family members/significant others of sexual assault victims. Therefore, each proposal warrants serious consideration, operationalization and implementation.

This study met its objective to identify: (1) the type and availability of treatment services for or including the victim's family members/significant others, (2) the utilization of treatment services by the victim's family members/significant others, (3) and the perceived need and benefits of these treatment services. The study was also

successful in identifying possible reasons of non-service use and presenting plausible strategies to improve availability and utilization of treatment services for secondary victims (i.e. family members/significant others of traumatic sexual assault victims).

One limitation, however, was the inability to directly survey secondary victims. Based on confidentiality issues and an understandable desire to protect primary and secondary victims of sexual trauma, permission to survey and/or other forms of direct contact with clients were ultimately denied. Therefore, assessment of services as beneficial or non-beneficial were based solely on the perceptions of the directors of rape crisis centers and related agencies who are in frequent contact with the victims and their families. Likewise, reasons for poor service utilization were garnered from the professional opinions of agency directors based on their interactions with the target population.

A second limitation or flaw was that sample size [returned questionnaires equaled 37% of total questionnaires mailed] may have been compromised in that rape crisis centers and related agencies identifying themselves as "crisis hotlines" were excluded from the

study. It appears that that may have been a poor decision in that the majority of hotline agencies offer additional services or may have added valuable information to the study. Another error in sampling/questionnaire construction was that agency directors that indicated that they did not offer services to the family members/significant others of sexual assault victims were directed to the end of the questionnaire. A better alternative would have been to have them answer the qualitative perception questions regarding reasons for poor service use and strategies to improve availability and utilization of services.

A third limitation or flaw was failure to include domestic partnerships in the family member/significant other category. An additional category for domestic partnerships among the list of family members may have provided important data for future research. Instead, to the dismay of some agency directors who fervently pointed out the design flaw in the margins of a few questionnaires, domestic partnerships were subsumed in the category of "others".

Nevertheless, this study provides informative research on secondary trauma, vicarious victimization, and various treatment options. This study is intended to begin the

journey of discovery. It serves to provide an initial endeavor from which future research can continue. Future research may focus on providing information regarding the development and various causal factors of secondary victimization, various relational dynamics affected by secondary trauma (e.g. marital dysfunction and parent-child conflict), or various clinical aspects such as assessment, intervention, and treatment planning. Future studies must continue the journey of discovery, fill the gaps in information, and continue to investigate how to best serve this population.

APPENDIX A

COVER LETTER/INFORMED CONSENT

Steven McCraw
Pegasus Day Rehabilitation Center
2310 North Sierra Way
San Bernardino, CA 92405
September 01, 2001

Program Director
Company
Address

Dear Sir or Madam:

I am an MSW student at California State University, San Bernardino working under the supervision of Dr. Matt Riggs, Ph.D. I am conducting an anonymous study regarding the availability, utilization, and perceived therapeutic value of sexual assault recovery services designed to assist the families/significant others of sexual assault victims. This study has been approved by the Department of Social Work Sub Committee of the Institutional Review Board at California State University, San Bernardino.

I respectfully ask that your agency/facility would participate and contribute to the study. This study does not request client participation or confidential client information. Preferred participants would be the director or licensed therapists of a rape crisis agency or an agency that offers rape crisis/sexual assault treatment services. Participants should also be at least 18 years of age.

This study involves the completion of a questionnaire regarding the type, use, application, and perceived benefits of treatment services. All information obtained in this study will be completely anonymous: this means that no information that could be used to identify you or your agency will ever be requested or reported. Your participation in this study will take approximately 15 minutes.

Your participation is completely voluntary. You are not obligated to answer any questions and you may discontinue your participation in the study at anytime without penalty. However, it is my hope that you will participate fully in this study in that I believe the results will be extremely beneficial. If you have any questions regarding the study please contact Dr. Rosemary McCaslin, Coordinator of MSW Research, at (909) 880-5507.

By placing a check mark in the space below, you acknowledge that you have been informed of the nature of this study and freely consent to participate and are at least 18 years of age.

Please make check mark here _____.

Sincerely,

Steven McCraw

APPENDIX B
QUESTIONNAIRE

*Utilization of Services by the families/significant others of sexual assault victims
Questionnaire*

1. Are services offered to the families/significant others of sexual assault victims?

- Yes (If Yes, please go to question 2.)
 No (If No, please skip to the end of the study)

**2. Which of the following services are offered to the families/significant others of sexual assault victims?
[Please check (all that apply]**

- Crisis Hotline Services.
 Referrals for the victim's family/significant others.
 Family Therapy (sessions including the victim and the victim's family/significant others).
 Individual or Family Therapy (sessions not including the victim).
 Support Groups for the victim's family/significant others (sessions not including the victim).
 Other _____?

3. Of the services listed above for family members/significant others of sexual assault victims, what is your estimate of how much each service is used?

[Note: percentages should equal 100 %]

- _____ % Crisis Hotline Services.
_____ % Referrals for the victim's family/significant others.
_____ % Family Therapy (sessions including the victim and the victim's family/significant others).
_____ % Individual or Family Therapy (sessions not including the victim).
_____ % Support Groups for the victim's family/significant others (sessions not including the victim).
_____ % Other _____?

4. Of the total number of family members/significant others who use the services offered above what is their typical relationship to the victim?

[Note: percentages should equal 100 %]

- _____ % Mothers _____ % Fathers _____ % Husbands _____ % Boyfriends _____ % Sisters
_____ % Brothers _____ % Victim's Children _____ % Entire Families _____ % Friends _____ % Others

5. What is the average duration of service use of families/significant others of sexual assault victims (not including referrals)?

- 1 Session 2 Sessions 3 Sessions 4 Sessions 5 or More Sessions

6. Please indicate from 1 to 4 how beneficial do you feel each of the following services are to the families/significant others of sexual assault victims in regards to family adjustment and adaptive coping mechanisms?

Not Beneficial	Moderately Beneficial	Beneficial	Very Beneficial
1	2	3	4

- Crisis Hotline Services.
- Referrals for the victim's family/significant others.
- Family Therapy (sessions including the victim and the victim's family/significant others).
- Individual or Family Therapy (sessions not including the victim).
- Support Groups for the victim's family/significant others (sessions not including the victim).
- Other _____?

7. Please indicate from 1 to 4 how beneficial do you feel providing each of the following services to sexual assault victims' families/significant others are to the victims' overall recovery?

Not Beneficial	Moderately Beneficial	Beneficial	Very Beneficial
1	2	3	4

- Crisis Hotline Services.
- Referrals for the victim's family/significant others.
- Family Therapy (sessions including the victim and the victim's family/significant others).
- Individual or Family Therapy (sessions not including the victim).
- Support Groups for the victim's family/significant others (sessions not including the victim).
- Other _____?

8. Overall, how beneficial do you feel support groups solely for the families/significant others of sexual assault victims (not including the victims) are or would be? [Please circle]

Not Beneficial	Moderately Beneficial	Beneficial	Very Beneficial
1	2	3	4

9. In your professional opinion, what are some of the reasons why victims' families/significant others do not readily seek treatment services?

10. In your professional opinion, what can be done to improve services used among families/significant others of sexual assault victims?

NOTE: Thank you for completing the study. Please place the completed questionnaire in the stamped envelope provided and mail back as soon as possible. Thank you

APPENDIX C

DEBRIEFING STATEMENT

Debriefing Statement

Thank you for completing the study. The purpose of this study was to examine and identify the current availability and utilization of sexual assault recovery services by the families and significant others of sexual assault victims as well as to assess the need and benefit of family treatment services dealing specifically with traumatic sexual assault, secondary trauma, and the vicarious victimization of the family. Additional objectives of the study were to identify plausible reasons for the current rate of service use among family members and significant others of sexual assault victims and to develop possible ways to increase service utilization.

If you are interested in the results of the study a copy of the results will be made available in the Pfau Library of California State University, San Bernardino after November 30, 2001.

If you have any concerns following involvement in this study or experience any discomfort in association with this study please contact Dr. Rosemary McCaslin, Coordinator of MSW Research, at (909) 880-5507.

Thank you again for your participation.

Steven McCraw

APPENDIX D
QUALITATIVE RESULTS TABLE 1. REASONS
FOR POOR SERVICE USE

Table 1: Reasons provided by rape crisis agency director for poor services use among secondary victims (i.e. family members/significant others of sexual assault victims).

Reasons for poor services	Statistics	
	Frequency	Percent
Secondary victims (i.e. family members/significant others) often do not recognize themselves as secondary victims/Denial that family members/Significant others need services.	46	14.8
Secondary victims (i.e. family members/significant others) are unaware that services are available to them	43	13.8
Shame, stigma, fear of societal blame for being a victim/related to a victim	40	12.9
Problem avoidance/denial of impact of assault to the family system	39	12.5
Guilt - family members/significant others undeservedly blaming themselves for not protecting/preventing the sexual assault	18	5.8
Lack of financial resources to pay for services	16	5.1
Secondary victims (i.e. family members/significant others) falsely believe they cannot seek services themselves because they must utilize all their energy supporting the primary victim	16	5.1
Lack of knowledge regarding the value of services	11	3.5
Private family issue - belief that the problem can be handled by family/significant others	11	3.5
Secondary victims (i.e. family members/significant others) may want to avoid their own past victimization/abuse issues	10	3.2
Lack of available/accessible	9	2.9
Fear of exposure/loss of confidentiality	8	2.6
Disbelief--blame of the victim--apathetic regarding services for themselves or supporting the primary victim	7	2.3
Family members/significant others may be reluctant to examine/change preexisting dysfunctional family/relational dynamics	7	2.3
Secondary victims (i.e. family members/significant others) falsely associate services with having a mental health issue or admission of incompetence	6	1.9
Don't know what to say/how to support to the primary victim	6	1.9
Primary victims are opposed/Family members/significant others don't know that a sexual assault	6	1.9
Re-victimization by poorly trained services providers	4	1.3
Preoccupied with others stressors, general life commitments prevent service use	4	1.3
Agencies are not culturally sensitive	3	1.0
Language barriers	1	.3
Total	311	100.0

Note: Some rape crisis agency directors provided 0-5 responses. Therefore, the number of reasons (311) do not equal the number of agencies that responded (148).

APPENDIX E

QUALITATIVE RESULTS TABLE 2. STRATEGIES
TO IMPROVE SERVICE USE

Table 2: Strategies provided by rape crisis agency director to improve services use among secondary victims (i.e. family members/significant others of sexual assault victims).

Strategies to improve services use	Statistics	
	Frequency	Percent
Positive community outreach to expand awareness of available services and to explain the impact of sexual violence on Family members/significant others as well as the necessity of family involvement in the victim's recovery	64	30.2
Improve accessibility/availability of services	25	11.8
Direct Education/Provide workshops and/or gender-neutral literature-pamphlets for secondary victims (i.e. family members/significant others) regarding the benefits of services	24	11.3
Training employees regarding secondary victims and the impact of family/significant others' involvement in the primary victim's recovery	21	9.9
Interagency collaboration -- Assist adjunct services agencies in understanding secondary victimization, having an adjunct service agencies promote service use and refer family/significant others to appropriate crisis agencies	17	8.0
More resources to assist family members/significant others (i.e agencies, counselors, materials, funding)	13	6.1
Have sliding scale/free services	12	5.7
Develop support groups, and other services solely/specifically for secondary victims (i.e.family members/significant others	10	4.7
Normalize family difficulties and secondary victimization/traumatization	6	2.8
Agency didn't know	6	2.8
Increase staffing/male staff	5	2.4
Maintain confidentiality	3	1.4
Have agency directors/counselors ask secondary victims (i.e. family members/significant others) how to improve services	3	1.4
Improve cultural sensitivity	2	.9
Assist secondary victims (i.e. family members/significant others) to understand intergenerational connections	1	.5
Total	212	100.0

Note: Some rape crisis agency directors provided 0-5 responses. Therefore, the number of strategies (212) do not equal the number of agencies that responded (148).

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