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Sexual Violence and Legal Advocacy: Psychometric Evaluation of the Legal Advocacy Services Satisfaction Survey

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Abstract

Joanne Sparrow (304 words)

The Legal Advocacy Services Satisfaction Survey (LASSS; Gibbs, Agatonovic, & Bikos, 2011) is a nine-item self-report inventory developed to evaluate both the quality of the information provided by the legal advocate as well as the quality of the relationship the advocate has established with the client. This dissertation sought to address an important gap in the literature on sexual violence and the provision of legal advocacy services by examining survey data collected from adult (i.e., age 18 and over) female survivors working with legal advocates at an urban-based agency that provides multiple types of services to survivors of sexual violence and their families. Survey items were developed via consensual qualitative research (CQR: Hill Thompson, & Williams, 1997) and examined using confirmatory factor analysis (CFA). The items of the LASSS formed two lower-order factors comprised of four items reflecting *information* and five items reflecting *relationship,* (χ^2 [24; N = 181] = 132.714, $p < .001$; CFI = .929; RMSEA = .159). Further psychometric analyses demonstrated: (a) satisfactory convergent ($r = .467$, $p < .01$ [two-tailed]) and discriminant ($r = .387$, $p < .01$ [two-tailed]) validity; (b) good internal consistency (overall scale - T1 $\alpha = .948$; T2 $\alpha = .957$), and (c) robust temporal stability ($r = .794$, $p < .01$; two-tailed) of the measure. The LASSS demonstrates promise as both a screener and measure of client satisfaction with the provision of legal advocacy services; the measure can be completed by clients in less than 5 minutes and is easy for advocates to score and interpret. Information derived from the LASSS can be used by advocates to address aspects of service provision that may not be serving clients' needs effectively. Further validation of the measure and its potential use as a tool to support training and development, supervision, program evaluation and grant writing are discussed.

Keywords: sexual violence, legal advocacy, client satisfaction, training and development, program evaluation

Chapter I: Introduction and Review of the Literature

Introduction

Despite efforts by providers in the fields of health, human, and legal services, researchers have suggested that sexual violence (which encompasses rape, sexual coercion, unwanted sexual contact, non-contact unwanted sexual experiences, and being made to penetrate someone else; Smith et al., 2017) and intimate partner violence remain widespread problems that continue to plague our society and significantly undermine the physical and mental health of those who have been victimized (Macy, Giattina, Parish, & Crosby, 2010). Estimates from a nationally representative sample of adults living in the United States (US) suggest that at least 1 in 6 females and 1 in 33 males have experienced some form of sexual violence at some point during their lifetime (Choudhary, Smith, & Bossarte, 2012; Tjaden & Thoennes, 2006).[1] Unfortunately, incidents of sexual violence remain severely underreported for several reasons (Hellman, 2014;

[1] Sexual violence has long been viewed as an act of aggression involving a male perpetrator and female victim. Although research tends to support this view, a body of evidence suggests that members of all genders can be perpetrators and/or victims of sexual violence (Turchik, Hebenstreit, & Judson, 2016). In a 2011 study by Peterson, Voller, Polusny, and Murdoch, it was estimated that the prevalence of sexual assault among community samples of men ranged between 0.2% to 30%. Black and her colleagues (2011) reported that 1.4% (1 in 71) men reported having been raped at some point in their lifetime, while approximately 22% (1 in 5) men reported having experienced some form of sexual violence other than rape at some point in their lives. Various studies of female perpetrators have noted self-reported rates of sexual violence ranging between 2% and 24% (Fisher & Pina, 2013; Struckman-Johnson, Struckman-Johnson, & Anderson, 2003). High rates of sexual violence have also been reported by members of the LGBQ and transgender communities (Rothman, Exner, & Baughman, 2011; Stotzer, 2009). Although addressing sexual violence and the experiences of men and members of our LGBTQ communities is of great importance, these issues are part of a larger, urgently needed discussion which unfortunately goes beyond the scope of this dissertation. Given that the overwhelming majority of survivors of sexual violence are women (Parcesepe, Martin, Pollock, & Garcia-Moreno, 2015), and that the majority of the response data collected by the King County Sexual Assault and Resources Center (KCSARC) thus far has been from female survivors of sexual violence, this dissertation will focus exclusively on adult (ages 18 years and older) female survivors of sexual assault and their experiences with the KCSARC legal advocacy program.

Walsh, Zinzow, Badour, Ruggiero, Kilpatrick, & Resnick, 2016), suggesting that the rates reported by Tjaden and Thoennes (2006) possibly underestimate the severity of the problem. Researchers have estimated that between 2006 and 2010, 65% of the rapes that occurred in the US went unreported to the police, thus making rape the most underreported violent crime in this country (Langton, Berzofsky, Krebs, & Smiley-McDonald, 2012).

Contrary to the popular belief of the sexual perpetrator as the scary stranger in the park, most individuals who experience sexual violence know, and often have intimate relationships with, their abuser (Macy, Giattina, Sangster, Crosby, & Montijo, 2009). Studies demonstrate that close to 66% of sexual assaults are committed by an individual (i.e., a friend/acquaintance, relative or intimate partner) who is known to the survivor, and that almost 15% of these assaults may be carried out by a spouse or romantic partner (Ullman, Filipas, Townsend, & Starzynski, 2006). Regardless of the level of intimacy between the survivor and the perpetrator, the short- and long-term outcomes of sexual violence on survivors' physical and mental health have been well-documented and have been described as having a "radiating" impact (Riger, Raja, & Camacho, 2003, p. 184) which negatively affects the lives of survivors in multiple ways (Macy et al., 2009). In addition to the physical and mental health issues with which many survivors struggle, sexual violence has been found to negatively impact survivors' relationships with friends, children and family, and their ability to pursue education, work, and achieve career goals (Macy et al., 2009).

According to several researchers (Campbell, Sefl, Barnes, Ahrens, Wasco, & Zaragoza-Diesfeld, 1999; Macy et al., 2010; Macy et al., 2009; Sullivan & Bybee, 1999), domestic violence and sexual assault service agencies continue to fill critical gaps in several communities across the country. These agencies provide services to survivors that providers in other sectors

(i.e., health, human, and legal services) may not be able to offer due to a lack of training or the inability to provide the type of trauma-informed services required to adequately address the myriad problems associated with sexual violence. Although researchers have documented the effectiveness of domestic violence and sexual assault services by demonstrating improvements in survivors' safety, health, and well-being with their participation in services (Macy et al., 2009), reviews of the research on these services suggest that the existing studies tend to suffer from a lack of scientific rigor (Macy, Rizo, Johns, & Ermentrout, 2013). It has also been noted that agencies providing sexual/domestic violence support services rarely conduct rigorous evaluations of their programs (Macy et al., 2013). As a result, much remains to be learned about: (a) the structure, components, and content of the services offered to survivors; (b) the ways in which services are delivered to survivors, and (c) the ways in which they effect positive changes in the lives of survivors (Macy et al., 2009). In addition to the fact that providers working with survivors of sexual violence would like to know whether their services have been helpful (or not) and the extent to which their services make a difference in the lives of survivors, service providers and agencies continue to experience increasing pressure from funding agencies and policy makers to provide support services that are standardized and evidence-based, and track their outcomes (Macy, Ogbonnaya, & Martins, 2015).

Although efforts have been made by researchers to document recommended practices and conduct quasi-experimental evaluations of domestic violence and sexual assault services, the knowledge base regarding these practices and services is still in its preliminary stages (Macy, Johns, Rizo, Martin, & Giatinna, 2011). As a result, researchers wishing to conduct efficacy studies of the services provided to survivors of domestic and/or sexual violence find themselves facing significant gaps in the literature (Macy et al., 2011). In an effort to address these gaps,

researchers and service providers continue to engage in a dialogue regarding the types of outcome data required to evaluate the degree to which interventions provided by an agency have (or have not) been helpful (Bennett, Riger, Schewe, Howard, & Wasco, 2004; Sullivan, 2011; Wasco, Campbell, Howard, Mason, Staggs, Schewe, & Riger, 2004). Not only is it critical to determine the types of support required by survivors of sexual violence and how this assistance should be delivered, it is paramount that providers understand the ways in which survivors perceive the information and support they have received, and how they integrate these perceptions into the process of healing from their experiences (Simmel, Postmus, & Lee, 2016) so that service provision continues to improve and better meet the needs of current and future survivors seeking services.

Presently, little research is being done to examine survivors' perceptions regarding the usefulness of the resources and services they have received from an agency, and the ways in which this assistance may be associated with their mental health functioning (Simmel et al., 2016). This information is of vital importance for providers working with women with histories of multiple types of abuse who utilize community-based resources and services (Simmel et al., 2016), as it may be used to enhance service provision and reduce the possibility of survivors being unwittingly retraumatized by the professionals or paraprofessionals they turn to for support. In my dissertation, I seek to address an important gap in the literature regarding the outcomes of sexual violence service provision - specifically, legal advocacy - by examining survey data collected from adult female survivors of sexual violence working with legal advocates at the King County Sexual Assault Resource Center (KCSARC), an agency in Washington state designed to provide a variety of services to survivors of sexual violence and their families. Detailed information regarding the history of KCSARC and the services currently

offered to child and adult survivors of sexual assault and their families will be provided to the reader at a later point in this document.

More specifically, my dissertation will: (a) evaluate the factor structure of the Legal Advocacy Service Satisfaction Survey (LASSS; Gibbs, Agatonovic, & Bikos, 2011) – a nine-item, Likert-style self-report measure (that includes two additional questions regarding client satisfaction with services provided to family members) developed to evaluate client satisfaction with both the quality of the client-advocate relationship and the information provided by the advocate - via confirmatory and exploratory factor analysis (CFA and EFA) using structural equation modeling (SEM); (b) document the convergent and discriminant validity of the scale, and (c) document the internal consistency and test-retest reliability of the nine items that make up the scale. It is hoped that the information garnered from this study may then be used by KCSARC to support the training and supervision of its advocates, maintain (or improve) client satisfaction, reduce the potential for secondary victimization to occur, and inform program evaluation and development.

Sexual Violence: Definition and Prevalence Rates

As stated earlier, the term *sexual violence* is used to denote a number of sexual acts, including rape, sexual coercion, unwanted sexual contact, non-contact unwanted sexual experiences, and being made to penetrate someone else (Smith et al., 2017). Although several definitions of sexual assault exist, they share a number of commonalities and reference the following: (a) a sexual act by a person or persons committed upon another without that person's consent; (b) a sexual act occurring between persons of the same or opposite sex; (c) the existence or absence of a relationship between the perpetrator and survivor at the time of the sexual act, and (d) a list of behaviors that comprise the sexual act (Spohn & Tellis, 2012). For the purpose

of this dissertation, the terms *sexual violence* and *sexual assault* will be used interchangeably. Following Hellman's (2014) lead, the term *survivor(s)* will be used throughout this dissertation when referring to women who have experienced sexual violence, given that the term *survivor* is defined as "a person who continues to function or prosper in spite of opposition, hardship, or setbacks" (Dictionary.com, 2017) and thus carries with it the connotation of strength, fortitude and perseverance.[2]

Statistics reflecting rates of sexual violence vary widely across reporting agencies. In a recent telephone survey of noninstitutionalized English- and Spanish-speaking citizens living in 50 US states and the District of Columbia, the National Intimate Partner and Sexual Violence Survey (NISVS) gathered data regarding incidents of sexual violence, stalking, and intimate partner violence among adult women and men (ages 18 and older) using a dual-frame sampling strategy that included the use of both cellular telephones and landlines (Black, et al., 2011; Breiding, Smith, Basile, Walters, Chen, & Merrick, 2014; Smith et al., 2017). In 2011 (the second year of NISVS data collection), almost 13,000 interviews were completed and approximately 1,500 interviews were partially completed. Interviewers asked informants about

[2] According to Dictionary.com (2017), the term *victim* may be defined as: (1) "a person who suffers from a destructive or injurious action or agency;" (2) "a person who is deceived or cheated, as by [their] own emotions or ignorance, by the dishonesty of others or [an] impersonal agency," and (3) "a person (or animal) sacrificed or regarded as sacrifice." These definitions impart the message that the individual who has been assaulted/violated is objectified and depersonalized, made to be in a one-down (and often powerless) position, and may even be responsible for the aggressor's actions as a result of their own "emotions and ignorance." While individuals who experience sexual violence are often objectified and depersonalized, placed in positions of powerless by their abusers, and experience a variety of emotional reactions (including dissociation) in response to the trauma, the term *victim* (as defined by Dictionary.com) carries with it the added connotation of self-blame and self-recrimination and the idea that, in some way, the victim *brought the act of sexual violence upon themselves*. Given this subtle reference to victim-blaming and the implicit connotation that the survivor somehow *asked for it* because of their emotions or lack of knowledge, the term *survivor* will be used from this point on in this document.

their experiences with specific types of sexual violence including: (a) rape (completed or attempted forced penetration or alcohol- or drug-facilitated penetration); (b) sexual violence other than rape, (including being forced to penetrate the perpetrator); (c) sexual coercion (i.e., experiences of unwanted penetration in which physical force was not used); (d) unwanted sexual contact (such as kissing or fondling), and (e) noncontact unwanted sexual experiences (which included experiences like being flashed or forced to view sexually explicit media (Breiding et al., 2014).

The 2011 NISVS revealed that many survivors of sexual violence and intimate partner violence (IPV) were young girls and women when they were first sexually assaulted (Breiding et al., 2014). Among women who reported having experienced completed rape, close to 80% shared they were first raped before the age of 25; just over 40% of female respondents reported they were raped before age 18. Unfortunately, researchers have found that experiences of victimization as a child or adolescent increase the likelihood that such incidents will reoccur in adulthood (Breiding et al., 2014; Smith, White, & Holland, 2003).

In terms of the prevalence of sexual violence victimization of women, the 2011 NISVS revealed that almost 20% of respondents have been raped during their lifetimes, while close to 2% of the women interviewed reported they were raped in the 12 months preceding the survey. Approximately 44% of women who responded to the survey reported they had experienced other forms of sexual violence during their lifetimes, including: sexual violence other than rape (i.e., being made to penetrate the perpetrator), sexual coercion, unwanted sexual contact, and noncontact unwanted sexual experiences. In the 12 months preceding the survey, 5.5% of women interviewed reported they had experienced forms of sexual violence that included acts

other than rape, such as sexual coercion, unwanted sexual contact, and noncontact unwanted sexual experiences (Breiding et al., 2014).

The 2011 NISVS also revealed that approximately 9% of women reported they had been raped by an intimate partner during their lifetimes, and that close to 1% of women shared they had been raped by an intimate partner in the 12 months preceding the survey. Almost 16% of women interviewed reported they had experienced other forms of intimate partner sexual violence during their lifetimes, while just over 2% of female respondents acknowledged they had experienced other forms of intimate partner sexual violence in the 12 months prior to responding to the survey. Sadly, the overall pattern of results from the 2011 NISVS is consistent with the outcomes reported by previous studies and points to the fact that women are significantly impacted by sexual violence over the course of their lifetimes (Breiding et al., 2014).

Sexual Violence: Physical and Mental Health Outcomes

Several decades of research have demonstrated that sexual violence remains a significant public health issue associated with negative physical and mental health outcomes that have the potential to span the life course of the individual who has been victimized (Choudhary, Coben, & Bossarte, 2008; Choudhary et al., 2012; Messman-Moore, Brown, & Koelsch, 2005; Coker et al., 2002a; Norris & Feldman-Summers, 1981; Perilloux, Duntley, & Buss, 2012). In a study by Burgess and Holstrom (1978; as cited by Nadelson, 1989), half the women interviewed reported that it took several years to recover from their experiences of being sexually assaulted.

Sexual violence and physical health outcomes. When compared to individuals without a history of sexual violence, survivors who experience more frequent and severe forms of victimization appear to be at greater risk of developing a variety of health problems over the life span (Andersen, Hughes, Zou, & Wilsnack, 2014). It is also important to note that single-

incident experiences of sexual assault or rape have been shown to negatively impact the long-term physical health of survivors (Andersen et al., 2014). Researchers have documented that sexual violence victimization during adulthood has been linked to several health risks/problems, including: (a) more frequent and severe somatic symptoms (e.g., headaches); (b) sexual health issues (including chronic pelvic pain, gynecological problems, sexually transmitted diseases, and decreased interest in sexual intimacy/withdrawal from a partner); (c) higher rates of chronic disease (i.e., hypertension, obesity, Irritable Bowel Syndrome); (d) poorer health perceptions; (e) greater functional limitations, and (f) increased utilization of medical services (Andersen et al., 2014; Cole, Logan, & Shannon, 2005; Eadie, Runtz, & Spencer-Rodgers, 2008). Studies have also revealed that sexual violence may be linked with survivors' engagement in risky sexual behaviors, although the reasons behind this association remain unclear (Campbell, Sefl, & Ahrens, 2004; Wells et al., 2016).[3]

Sexual violence and physical health outcomes in the context of IPV. Bonomi, Anderson, Rivara, and Thompson (2007) have suggested that sexual violence within the context of intimate partner violence may increase the physical, mental, and social stress on women who find themselves in abusive relationships. Studies have demonstrated that when compared to women with no experience of abuse or physical intimate partner violence only, women experiencing intimate partner sexual violence were more likely to report chronic stress-related symptoms (e.g., high blood pressure, abdominal pain, loss of appetite) or central nervous system problems (e.g., headache, fainting, back pain, seizures; Bonomi et al., 2007). Several researchers (Bennice, Resick, Mechanic, & Astin, 2003; Cole et al., 2005; Eby, Campbell, Sullivan, & Davidson, 1995; Plitcha, 2004) have demonstrated that intimate partner sexual violence is

[3] Campbell and her colleagues hypothesize that increased distress resulting from the assault, self-blame and blame from society may contribute to survivors' engagement in greater risk-taking behavior.

associated with health issues and gynecological problems that cannot be explained by physical violence alone. In a study which explored spousal abuse, Campbell and Alford (1989) found that women attributed a variety of health issues (including bladder/urinary infections**,** vaginal and anal bleeding, dysmenorrhea**,** miscarriages**,** unwanted pregnancies and STDs) to their experiences of intimate partner sexual violence. Significant long-term health effects have also been observed for women experiencing intimate partner sexual violence (with or without intimate partner physical violence) long after the abuse ended (Bonomi et al., 2007).

Sexual violence and mental health outcomes. In addition to the physical effects experienced by adult survivors of sexual violence, a growing body of literature has demonstrated a strong association between sexual violence victimization and poor mental health outcomes (Choudhary et al., 2012; Hedtke et al., 2008; Mechanic, Weaver, & Resick, 2008; Ullman et al., 2006). Several researchers have reported that virtually all survivors of sexual violence in their samples experienced adverse psychological symptoms subsequent to the assault and that some survivors continued to experience symptoms years later (Dancu, Riggs, Hearst-Ikeda, Shoyer, & Foa, 1996; Kimerling & Calhoun, 1994; Parcesepe et al., 2015). In addition to experiencing an intense fear of death and dissociation during the assault, survivors often experience shock, confusion and denial, persistent fear and anxiety, and feelings of self-blame/guilt and low self-esteem after the assault (Morrison, Quadara, & Boyd, 2007).

Posttraumatic stress disorder (PTSD), anxiety and mood disorders, substance use disorders, and sexual and eating disorders are among the most frequently reported psychiatric sequelae of sexual violence for women (Faravelli, Giugni, Salvatori, & Ricca, 2004). Unfortunately, sexual violence also appears to lead to a consistently high prevalence of suicidal ideation and attempts among survivors (Parcesepe et al., 2015). In a review of studies examining

the outcomes of sexual violence, Campbell, Dworkin, and Cabral (2009) found that between 17% and 65% of survivors exhibited symptoms of PTSD, while 13% to 51% of survivors met the diagnostic criteria for depression. In addition, 13% to 49% of survivors demonstrated signs of alcohol dependence, while 28% to 61% reported illicit drug use.

In a study by Becker, Skinner, Abel, and Treacy (1982) of women who had been raped, the majority of survivors reported that they continued to experience issues regarding their sexual health (especially difficulty with arousal or desire and fear of sex) 12 months after the assault. In a study by Nadelson and colleagues (1982), 41 survivors of sexual violence were interviewed 15-30 months following their experiences of having been raped and reported that they continued to experience fleeting moments of terror and remained fearful and suspicious more often than not. At least 50% of the women interviewed reported that they continued to struggle with depression and various sexual difficulties, while more than 50% of respondents indicated that their sense of freedom to move about in the world was no longer what it had been prior to the assault. Considering the myriad ways in which sexual violence impacts women's mental health and quality of life, it is troubling to learn that close to 40% of all rape survivors may not seek professional support to address their mental health needs (Amstadter, McCauley, Ruggiero, Resnick, & Kilpatrick, 2008).

Sexual assault and mental health outcomes in the context of IPV. As stated earlier, most survivors of sexual violence know or have some kind of relationship with the perpetrator. In addition, contrary to popular belief, acts of violence against women often occur in private residences (as opposed to a darkened street or alley way) and do not usually involve the use of a weapon (Morrison et al., 2007). Studies examining the experiences of survivors of intimate partner sexual violence (ISV) have found associations between ISV and mental health issues.

Researchers have determined that experiencing sexual assault within the context of intimate partner violence is associated with an increase in depression, anxiety, and PTSD above levels that can be explained by physical violence alone (Campbell, Greeson, Bybee, & Raja, 2008a). According to Shields, Resick, and Hanneke (1990; as cited by Cole et al., 2005), women who were physically and sexually abused by their partners demonstrated significantly higher scores on several subscales (i.e., somatization, obsessive-compulsiveness, interpersonal sensitivity, hostility and paranoid ideation) of the Brief Symptom Inventory (BSI; Derogatis, 1993) when compared to women who were physically but not sexually abused by their partners. In a sample of 380 women experiencing intimate partner violence in their current relationships, Basile, Arias, Desai, and Thompson (2004) found that intimate partner sexual violence was positively associated with PTSD symptomatology. Similarly, Bennice and colleagues (2003) found that the severity of sexual violence perpetrated by an intimate partner was a significant predictor of PTSD even after controlling for the severity of physical abuse in a sample of 62 female survivors of intimate partner violence who were seeking support after being abused.

Researchers have determined that women who are raped by an intimate partner often experience high levels of fear, humiliation, guilt, and self-blame (Bonomi et al., 2007). In addition to feeling helpless and depressed, survivors who find themselves living in an environment that supports the use of sexual violence tend to isolate themselves socially (Campbell et al., 2008a). The unfortunate reality is that when women disclose their experiences of sexual violence, they often risk becoming stigmatized by friends, family and community (Bonomi et al., 2007). Remaining silent and shouldering the burden of their experiences can cause survivors to experience additional stress which has been linked to depression (Ahrens, 2006), substance use (Surrey, 1997), chronic pain (Bonomi et al., 2007) and suicide (Bonomi et

al., 2007; Campbell, Dworkin, & Cabral, 2009). Based on a survey of family practice clinics in the U.S., it was estimated that women who reported being sexually assaulted by an intimate partner were four times more likely to have made a suicide attempt than women who did not report sexual assault (Coker, Smith, Thompson, McKeown, Bethea, & Davis, 2002b; Parcesepe et al., 2015; Weaver et al., 2007).

The Radiating Impact of Sexual Violence

Research makes it abundantly clear that sexual violence takes its toll on multiple facets of a survivor's life. In addition to the short- and long-term physical and mental health outcomes associated with sexual violence, relationships with friends, family, intimate partners and the wider community are often negatively impacted (Crome & McCabe, 1995; Morrison et al., 2007). Survivors of sexual violence struggle with heightened fears of victimization and the inability to trust themselves (as well as others) after the assault, and often experience issues with intimacy (Billette, Guay, & Marchand, 2008; Herman, 2001, as cited by Hellman, 2014). In addition to the intangible costs of sexual assault related to the social, emotional, and psychological sequelae experienced by survivors, sexual violence has also been found to result in tangible financial costs to the survivor (in the form of loss of earnings/earning capacity/economic productivity, and expenses related to insurance, medical costs and counseling) and society (in the form of the costs associated with police investigations, criminal prosecutions and the correctional system; Mayhew & Adkins, 2003, as cited by Morrison et al., 2007). In a study estimating the financial losses associated with sexual assault in the state of Michigan, Post, Mezey, Maxwell, and Wibert (2002) determined that each incident of sexual violence cost the state US$108,447 (including quality of life costs). Based on prevalence data available at the time, Post et al. estimated the total cost of sexual assault in this country to be US$6.7 billion. Across several

studies, costs for mental health care and losses in productivity and quality of life were consistently found to be the costliest impacts of sexual violence.

Secondary Victimization

Given that survivors of sexual violence have extensive post-assault needs, they may approach a variety of social service systems (i.e., the police, legal and medical services, and mental health care providers) for assistance and support (Campbell, 2008b). Studies suggest that 26% to 40% of survivors report their experience of being assaulted to the police and pursue prosecution of the perpetrators through the criminal justice system (Campbell, 2008b). Between 27% to 40% of survivors seek medical forensic evaluations and care, while 16% to 60% obtain mental health services (Campbell, 2008b). Although researchers have suggested that seeking support from informal/formal sources and disclosing one's abuse experiences can help alleviate the long-term impact of abuse, studies demonstrate that not all support is the same and not all support is experienced as being helpful (Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010; Simmel et al., 2016).

When survivors of sexual violence break their silence and seek assistance and support, they risk experiencing disbelief/doubt, blame, being denied support from providers (Campbell, 2008b; Patterson, Greeson, & Campbell, 2009), and having their trust in these service systems violated. The ways in which systems and service providers respond to the needs of survivors can have significant implications for their recovery and well-being (Campbell, 2008b; Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). While service systems and providers can facilitate recovery from sexual violence by responding to the needs of survivors in ways that are supportive and empathic (Campbell, 2008b), the opposite is also true – a survivor's experience of

guilt, shame, and sense of powerlessness can be magnified by insensitive, unempathic service providers who do not provide their clients with the requisite services (Campbell, 2008b).

Secondary victimization refers to the survivor-blaming attitudes, insensitive comments, actions (and inaction), and practices demonstrated by systems and/or providers that result in additional traumatization/re-victimization of the survivor (Campbell et al., 2001; Laxminarayan, 2013). According to Campbell (2008b), secondary victimization is widespread and is experienced in varying degrees by most survivors seeking services. Campbell (2008b) also suggests that the ways in which services are provided also reflect broader social issues such as privilege and discrimination; according to Martin (2005; as cited in Campbell, 2008b) low socioeconomic and/or ethnic minority women have been found to experience even greater difficulty obtaining help. Unfortunately, myths regarding what constitutes actual rape (or "real rape"; Campbell, 2008b, p. 703) – an assault resulting in visible physical injuries, that is committed by a stranger wielding a weapon - continue to pervade our service systems as well as our society (Estrich, 1987, as cited in Campbell, 2008b); as a result, service systems pay the most attention to the above mentioned form of sexual violence despite the fact that 80% of assaults are committed by an individual who is known to the survivor, and that perpetrators often gain control over survivors using a variety of methods that exclude the use of weapons (Campbell, 2008b). Studies demonstrate that secondary victimization has been associated with a number of negative outcomes, including physical health symptoms, increased psychological distress, and sexual health risk-taking behaviors (Campbell, 2006).

Secondary victimization and the medical system. Unfortunately, survivors' experiences of secondary victimization after contact with providers in the medical system have been reported in the literature. Survivors of sexual violence are often left to wait for long periods

of time in hospital emergency departments, given that sexual assault is rarely an emergency health threat (Campbell, 2008b). So as not to destroy any physical evidence, survivors are not allowed to eat, drink or use the bathroom during this time (Campbell, 2008b; Littel, 2001). According to various researchers (Martin (2005); Parrot (1991), as cited in Campbell, 2008b), when survivors are finally seen, they often only receive a cursory explanation of what will occur, and many are often shocked to learn that they are required to undergo a pelvic exam after having been sexually assaulted. In a study by Campbell and Raja (1999), 58% of survivors of sexual violence reported becoming distressed by the questions doctors and nurses posed (e.g., inquiring about their sexual histories and behavior prior to the assault), and by the way they were treated during the exam process. Survivors have also described the medical care they received as "cold, impersonal, and detached" (Campbell, 2008b, p. 706). Given these reports, it is not surprising to learn that in a study by Ullman (1996), only 5% of survivors rated physicians as a helpful source of support.

Although comparative studies have suggested that survivors of sexual violence experience significantly fewer questions and comments that imply blame from medical service providers than from legal service providers, these questions and comments have a demonstrable negative impact of the survivors' mental health (Campbell, 2008b). As a result of their contact with doctors and nurses in the emergency department, most survivors reported that they felt: (a) badly about themselves (81%); (b) depressed (88%); (c) violated (94%); (d) distrustful of others (74%), and (e) reluctant to seek further help (80%; Campbell, 2005; Campbell & Raja, 1999. Studies have also demonstrated that negative responses from medical providers have been found to significantly exacerbate survivors' PTSD symptomatology (Filipas & Ullman, 2001; Starzynski, Ullman, Filipas, & Townsend, 2005; Ullman & Filipas, 2001a, 2001b). Campbell

and her colleagues (1999) found that survivors of non-stranger rape who received minimal medical assistance but who experienced high levels of secondary victimization demonstrated significantly elevated levels of PTSD compared to survivors who sought no medical assistance post-assault.

Secondary victimization and the legal system. Survivors' experiences of secondary victimization after contact with professionals in the legal system have also been reported in the literature. Survivors of sexual violence have reported that questioning by the police often includes asking about their prior sexual histories, what they were wearing at the time of the assault, and whether they responded sexually to the assault (Campbell, 2008b). A study by Campbell and Raja (1999) found that survivors rated questions such as these to be especially traumatizing. It should also be noted that the legal relevance of these types of questions is minimal, given that all states have laws that shield the survivor and limit the information that is allowed to be discussed in court (should the case reach that point in the legal process; Campbell, 2008b). If these questions hold no legal relevance, one wonders why they were raised to begin with. Logan and colleagues (2005) reported that survivors taking part in a focus group described their experiences with the legal system as "dehumanizing" (p. 603), and several group members shared they would not have reported the assault if they had known in advance what the experience would be like. Studies by Campbell (2005) and Campbell and Raja (1999) have revealed that as a result of their contact with legal system personnel, survivors felt: (a) badly about themselves (87%); (b) depressed (71%); (c) violated (89%); (d) distrustful of others (53%), and (e) reluctant to seek further help (80%).

Secondary victimization and the work of advocates. Advocates who work with survivors of sexual violence attempt to improve survivors' post-assault experiences by: (a)

helping survivors navigate the various service systems they may encounter; (b) working with service providers to ensure high-quality service delivery, and (c) making efforts to end secondary victimization (Campbell, 2006). Although only a handful of studies have examined the effectiveness of advocates and their work with survivors of sexual violence, the data appear promising (Campbell, 2008b), with survivors consistently rating advocates as informative and supportive (Campbell, 2008b; Golding, Sorenson, Burnam, & Stein, 1989; Wasco et al., 2004). In a study by Campbell and her colleagues (1999), survivors of domestic violence who worked with an advocate demonstrated significantly lower PTSD scores than survivors who dealt with the legal system without the help and/or support of an advocate. In a quasi-experimental design comparing experiences with the police, Campbell (2006) found that survivors who had an advocate available to them were significantly more likely to have a report taken by police and were less likely to be treated in a negative manner by law enforcement. Survivors who had the support of an advocate also reported experiencing significantly less emotional distress after their contact with the legal system (Campbell, 2006).

Advocacy: Support for Survivors of Sexual/Intimate Partner Violence

In response to the consciousness-raising efforts of the feminist movement during the 1970s and 1980s, female survivors of violence began to speak about their experiences; as the issue of violence against women garnered increased public attention, services began to be developed to address the needs of survivors. At the time, community-based advocacy played a vital role in supporting the expansion of legal protections for survivors and the creation of support services (Zweig & Burt, 2007). Since then, advocacy has become an established (and expanding) component of the criminal justice system's response to domestic/sexual violence (McDermott & Garofalo, 2004). In addition, evidence continues to support the finding that

community-based advocacy can increase survivors' access to much-needed resources (Allen, Bybee, & Sullivan, 2004; Sullivan & Bybee, 1999) and offer the assistance required to navigate the medical and legal systems which can be complicated, unwelcoming and unresponsive to their needs (Campbell, 1998; Macy et al., 2009).

According to Davies, Lyon and Monti-Catania (1998, p.2; as cited by Allen and her colleagues, 2004), an advocate is "anyone who responds directly to help abused women in an institutional context." Oftentimes, advocates are volunteers or paraprofessionals who work with survivors in ways that are respectful and collaborative, and who empower survivors to guide interventions in ways that are best suited to meet their individual wants and needs (Bybee & Sullivan, 2002). Advocacy tends to be classified as either *individual-based* (i.e. when advocates work directly with or on behalf of survivors to ensure their access to services and resources) or *systems-based* (i.e. when advocates work to change and improve the responses offered by institutions). As is often the case, many advocates are involved in providing direct support/assistance to survivors while, at the same time, working to effect change at a systems' level (Sullivan & Keefe, 1999).

Based on a survey of close to 400 advocacy programs in the U.S., Edelson (1993; as cited by McDermott & Garofalo, 2004) determined that while both individual- and systems-level advocacy were considered to be important and linked to the idea of empowering women who found themselves in violent relationships, most advocates reported their daily activities often involved providing direct services to survivors in the form of collecting information/making referrals, providing counseling, and meeting the survivors' needs for clothing and shelter, or representing survivors in one of the larger systems (e.g., explaining the criminal justice process; helping the survivor obtain an Order of Protection).

Regardless of the type of advocacy services (i.e., housing, legal, medical, social services, etc.) offered and the level at which advocates focus their attention, Knitzer (1976) has suggested that all forms of advocacy share the following six principles: (a) advocacy assumes that people have, or ought to have, certain basic rights; (b) advocacy assumes that rights are enforceable by statutory, administrative, or judicial procedures; (c) advocacy efforts are focused on institutional failures that produce or aggravate individual problems; (d) advocacy is inherently political; (e) advocacy is most effective when it is focused on specific issues, and (f) advocacy is different from the provision of direct services. In addition to these principles, Herbert and Mould (1992) suggested advocacy is not simply about providing a service to survivors, but that advocacy takes the requisite steps to ensure that services required by survivors are available and relevant to their needs. According to Herbert and Mould (1992), advocacy implies that providers are proactive in offering services to survivors that go a step beyond mandated service delivery. In addition to protecting survivors from secondary victimization, Macy and her colleagues (2009) reported that the primary focus of crisis-oriented advocacy services is to support survivors as they return to their pre-assault levels of functioning. The literature reviewed by Macy et al. (2009) also recommended that, in addition to providing nonjudgmental support (Berger, 1997; Resnick, Acierno, Kilpatrick, & Holmes, 2005), advocates should base their provision of services on the intention of helping normalize survivors' reactions to their experiences of sexual violence within the context of advocacy services (Daane, 1996; as cited by Macy et al.).

Advocacy within the context domestic violence services provision. Since the 1970s, residential and nonresidential programs that provide support and safety to survivors of domestic violence have established themselves in communities across the US (Goodman, Fauci, Sullivan, DiGiovanni, & Wilson, 2016)**.** Advocates who work in these programs often provide survivors

with a broad range of services, including safety planning, emergency and longer-term housing, legal assistance (i.e., by helping survivors obtain Orders for Protection and dealing with custody/visitation issues, survivors and advocates can work in conjunction with the court system to increase the likelihood of a positive legal outcome; Sullivan & Keefe, 1999), and employment support (Macy et al., 2009). In addition to the tangible supports and services offered, advocates are mindful of the ways in which they work with survivors, given the assumption that the relationships they form can revive survivors' sense of personal power and control, ultimately impacting the survivors' overall emotional well-being in a positive way (Kulkarni, Bell, & Rhodes, 2012). According to Weisz (1999), the provision of legal advocacy for survivors of domestic violence can be successful when it is responsive to women's relational needs, and when information and emotional support are offered in the physical presence of an advocate. In response to the lack of information regarding the effectiveness of advocacy services offered to female survivors of domestic violence, Sullivan and Bybee (1999) designed and evaluated a community-based advocacy intervention that was offered to women after they left a domestic violence shelter program. The intervention was designed to flexibly meet the unique needs of each survivor involved in the program and was intended to enhance the quality of survivors' lives by increasing the social support available to them in addition to improving their access to community resources (Bybee & Sullivan, 2002). Advocates (who were trained paraprofessionals) worked with the women in their natural environments to maximize the likelihood of creating lasting change (Bybee & Sullivan, 2002).

The advocacy intervention consisted of: (a) assessing the strengths and needs of each survivor; (b) obtaining information about community resources and sharing this knowledge with survivors as needed, and (c) taking an active role in joining with survivors and working to help

them acquire what they needed from their communities (Bybee & Sullivan, 2002). Advocates supported survivors by: (a) helping them complete employment applications; (b) visiting and vetting daycare centers together; (c) accompanying them to appointments with various agencies, and (d) accompanying them through the court process (Bybee & Sullivan, 2002). According to Bybee and Sullivan (2002), when compared to survivors who did not work with an advocate, survivors who worked with an advocate for 10 weeks following their exit from the shelter reported having more social support and experiencing greater efficacy accessing resources; they also reported experiencing a better quality of life and less re-abuse by an intimate partner. Survivors' reported improvement in quality of life remained relatively stable and was found to mediate a number of outcomes, including: (a) the intervention's positive impact on social support at 12-month follow-up; (b) survivors' access to resources at 24-month follow-up, and (c) re-abuse by an intimate partner at 24-month follow-up (Bybee & Sullivan, 2002).

In another study, Zweig and Burt (2007) found that when domestic violence and legal services agencies worked together to assist survivors, support staff demonstrated more positive and fewer negative behaviors. In addition, survivors reported that as their sense of control increased, their experiences of finding legal advocacy as helpful also increased.

Advocacy within the context of sexual assault services provision. The feminist social movement of the 1970s highlighted the issue of violence against women and supported the creation of community-based rape crisis centers (RCCs). Currently, there are more than 1,200 RCCs across the country where staff and volunteers who act as advocates provide various services to survivors of sexual violence, including crisis intervention, counseling, and medical and legal advocacy (Campbell, 2006). The work of advocates can be especially challenging, given that many survivors of sexual violence are often treated insensitively by medical providers,

police and representatives of the legal system, and do not receive the services they require (Campbell, 2006). Researchers have suggested that advocates provide several benefits when working with survivors of sexual violence and can prevent the onset of serious negative consequences (Campbell, 2006). Given that advocates appear to act as a protective factor in the lives of survivors, it is paramount that research and policy efforts continue to find ways to improve the availability and accessibility of advocates' services (Campbell, 2006) and ensure that the quality of services advocates provide continues to improve.

Wasco and colleagues (2004) completed a statewide evaluation of rape crisis center services and learned that survivors of sexual violence consistently rated advocates as informative and supportive. As Wasco and her fellow researchers (2004) also pointed out, however, positive perceptions do not necessarily reflect effective service delivery and the prevention of secondary victimization. Support for the effectiveness of advocates is reflected in a study by Campbell and Bybee (1997) of survivors of sexual violence who were assisted by an advocate while receiving care in a hospital emergency department. Campbell and her colleague (1997) found higher rates of medical and legal service delivery than what is typically reported in the literature. In addition to receiving information regarding pregnancy and STDs, almost 70% of survivors received an exam and STD preventive antibiotic treatment. Although only a third of survivors received emergency contraception, this rate is common for survivors who have the support of an advocate and is significantly higher than the rate for survivors who did not work with an advocate. Regarding the legal system, Campbell and her colleagues (2001) found that survivors who had the support of an advocate had reports taken by the police 59% of the time; this number is in contrast to previous research by Campbell et al. (2001) which found that police officers take reports from survivors approximately 50% of the time. It is also important to note that beyond

issues regarding service delivery, the majority of survivors who worked with an advocate reported less distress and secondary victimization by members of the medical and legal systems (Campbell, 2006).

Advocacy and Sexual Assault Nurse Examiner (SANE) programs. In collaboration with victim advocacy organizations and rape crisis centers, Sexual Assault Nurse Examiner (SANE) programs were created in the U.S. by the nursing profession in the 1970s and rapidly proliferated across the country during the 1990s and 2000s (Campbell, Patterson, & Bybee, 2012); currently, there are more than 700 of these programs in existence (Campbell, Bybee, Townsend, Shaw, Karim, & Markowitz, 2014b). Given the issues survivors often found themselves facing when they sought help from traditional emergency departments, including being treated insensitively by hospital staff (Campbell, Patterson, & Lichty, 2005), SANE programs attempted to circumvent these challenges by having specially trained nurses (as opposed to doctors) provide first-response care to sexual assault survivors (Campbell et al., 2012). Although 75% to 95% of SANE programs continue to be based in hospital emergency departments, a handful of programs (10% to 25%) may be found in community settings, such as rape crisis centers (Campbell et al., 2005; Logan, Cole, & Capillo, 2007). Virtually all SANE programs provide services to adolescents and adults, while approximately 50% provide services to pediatric survivors of sexual violence (Campbell et al., 2012).

SANE programs are staffed by specially trained registered nurses or nurse practitioners (Campbell et al., 2012) who simultaneously provide comprehensive medical, forensic, psychological and legal services to survivors of sexual violence (Campbell et al., 2008b; Campbell, Townsend, Shaw, Karim, & Markowitz, 2014a). In addition to providing crisis intervention and support, Sexual Assault Nurse Examiners (SANEs) are trained to offer survivors

of sexual violence health care (in the form of screening and prophylaxis of sexually transmitted infections [STIs], pregnancy testing and emergency contraception), detection and treatment of injuries, and state-of-the-art forensic medical evidence collection (Campbell et al., 2008b; Campbell et al., 2014a). SANEs also work in conjunction with the legal system and provide police and prosecutors with ongoing case consultation and testify as expert witnesses when a case goes to trial (Campbell et al., 2014b).

According to research by Young and her colleagues (1992), SANE programs attempt to maximize the probability of obtaining and preserving physical evidence for potential use in legal cases, while at the same time minimizing the physical and psychological trauma experienced by the survivor. By being mindful of survivors' psychological needs post-assault and treating them with respect and dignity, the possibility of re-traumatization during the examination phase is reduced (Campbell et al., 2008b). SANE programs often work in conjunction with local rape crisis centers and call on victim advocates to provide survivors with additional emotional support (Campbell et al., 2012; Hatmaker, Pinholster, & Saye, 2002; Littel, 2001). Given that several states have confidentiality laws in place which protect a survivor's communications with a sexual assault advocate, this delineation of roles is critically important given that SANEs may be called into court and asked to testify about their discussions with the survivor (Campbell, et al., 2012).

To date, the research literature on SANE programs has been largely qualitative – several articles have detailed information regarding how SANE programs have been created/administered, the challenges programs have encountered and the ways in which these challenges have been resolved, and issues regarding the technical aspects of collecting forensic evidence (Ahrens, Campbell, Wasco, Aponte, Grubstein, & Davidson, 2000; Hatmaker et al.,

2002; Lenehan, Aiken, & Speck, 1995; Rossman & Dunnuck, 1999). In addition to these more descriptive articles, numerous case studies and several longitudinal and quasi-experimental pre-post studies have been published which underscore the fact that SANE programs are an important resource to police and prosecutors and often lead to significant increases in arrest and prosecution rates (Campbell et al., 2014a). At present, academicians and policy makers continue to demonstrate an interest regarding the ways in which SANE programs may help to increase sexual violence prosecution rates within their communities (Campbell et al., 2014a).

Legal advocacy within the context of a law school/legal clinic. Although most often found embedded within domestic violence/sexual assault service programs, legal advocacy programs can also be found housed in prosecutors' offices, law schools, or law clinics (Allen et al., 2004). Currently, however, the only evaluation of a legal advocacy program embedded within a legal clinic is the quasi-experimental study of a legal advocacy program located in Washington, D.C., conducted by Bell and Goodman (2001). At six weeks post-intervention, Bell and Goodman (2001) stated that female survivors of domestic violence who worked with a professional or paraprofessional legal advocate reported a decrease in their experience of abuse and marginally higher emotional well-being compared to survivors who did not work with an advocate. In addition, survivors who worked with a legal advocate reported them as being both knowledgeable as well as supportive, while survivors who had not worked with advocates indicated the same kind of support would have been appreciated. Although these findings are promising in that they highlight the import role legal advocates play in the post-assault process, they should be interpreted with some caution given the lack of a control group (Macy et al., 2009; Sullivan, 2011).

To summarize, in their review of the domestic violence and sexual assault services literature, Macy and colleagues (2009) noted that much of the research reflects the fact that when survivors choose to report an assault, they are publicly scrutinized and experience significant challenges with the police and legal system. Survivors are often made to repeatedly provide detailed disclosures about their experiences with multiple individuals across multiple venues, including police, prosecutors, defense attorneys, and in the courtroom (Campbell,1998) and can experience the impact of secondary victimization as a result. Much of the literature indicates that advocates provide both informational and emotional support when they accompany survivors to legal appointments, interviews, trials and sentencing hearings (Macy et al., 2009). As a result, the goal of legal advocacy services appears to be multi-faceted and consists of: (a) providing survivors with information that will enable them to make decisions that are in their best interests; (b) supporting survivors as they attempt to manage the stress associated with navigating the medical and legal systems; (c) minimizing the experience of secondary victimization, and (d) helping survivors return to their level of functioning prior to the assault (Macy et al., 2009).

Program Evaluation

As stated previously, little is known about the outcomes of the important services provided to survivors of domestic/sexual violence by many domestic violence and sexual assault agencies within the U.S. Many of these agencies rarely conduct rigorous evaluations of their programs (Macy et al., 2015; Wasco et al., 2004), given that this type of research often poses significant challenges (e.g., maintaining confidentiality of the survivors who agree to participate in the research; Cole [2011]). A key question extensively discussed among researchers and service providers alike focuses on the type of outcome data that should be collected from survivors at the completion of service provision to assess how helpful the various interventions

provided by agencies have been (Bennett et al., 2004; Macy et al., 2015; Sullivan, 2011; Wasco et al., 2004).

As challenging as they may be, program evaluations serve a valuable purpose by providing service agencies with the opportunity to take stock of their progress. Program evaluations provide agencies with the opportunity to determine how well interventions are being implemented, and the ability to formulate ideas and methods to improve service delivery in the form of lessons that have been learned as a result of the process (Aubel, 1999). In keeping with the recommendations made by several researchers (Campbell et al., 2014b; Cousins & Chouinard, 2012; Torres & Preskill, 2001), participatory evaluation (PE) methods can serve a dual purpose by: (a) providing agencies with a useful strategy for assessing the impact of their work in the community, and (b) helping agencies develop their programmatic capacity.

Contrary to the more traditional approach to program evaluation whereby the evaluator functions as an independent outsider who plans and conducts the study with minimal input and involvement from agency staff members, PE incorporates feedback from staff (Campbell, et al., 2008b; Cousins & Earl, 1992). By engaging in PE, agency staff become involved at the start of the project (by helping to design the questions to be investigated) and remain involved throughout the phases of information collection, analysis, interpretation, formulation of lessons garnered by participation in the process and development of an action plan for future steps (Aubel, 1999). According to several researchers, program staff (including both the decision-makers and information users) often become deeply involved in the process which, in turn, tends to increase their interest and investment in the findings (Campbell et al., 2014b; Cousins & Chouinard, 2012; Torres & Preskill, 2001). Because program staff tend to see the results quickly (given that they are often the providers generating the data) and have forged connections with

and learned from other colleagues to bring the project to fruition, efforts at effecting changes in the program or service provision are made more easily (Campbell et al., 2014b; Cousins & Chouinard, 2012). It has also been suggested that the process of sharing information and learning stimulated at the group level can also contribute to learning at the organizational level (Aubel, 1999).

In general, program evaluations should accomplish two important goals. First, the results of the evaluation should provide agency managers/directors and funding agencies with: (a) feedback/information regarding program objectives (and answer the question "have the objectives been met?"); (b) details regarding the ways in which planned activities have been carried out, and (c) information about the ways in which resources have been utilized (Aubel, 1999). Second, program evaluation should lead to the development of lessons that will support staff in improving service provision and program implementation in the future. Unfortunately, while evaluations often provide agencies with information that helps support accountability, many do not generate lessons (Aubel, 1999) that could serve to support improvements in service provision and the experience survivors have with the agency in the future.

KCSARC: Evaluation of legal advocacy services. Although most agencies provide services to support both survivors of domestic violence and/or sexual assault (see Macy et al., 2010), the King County Sexual Assault Resource Center (KCSARC) is unique in that it is one of the few agencies in the country focused solely on providing services to improve the quality of life for survivors of sexual violence. KCSARC has been serving the needs of survivors of sexual assault and their families in the greater Seattle area since 1976 (http://www.kcsarc.org). The philosophy guiding the work of the agency underscores the importance of providing services to clients and their families in ways that are holistic and coordinated, so that survivors and the

individuals and/or networks that support them have access to information and the opportunity to develop skills that aid individuals in healing from sexual trauma (http://www.kcsarc.org). To this end, KCSARC service providers work collaboratively within and across a variety of disciplines, including advocacy, treatment, policy development and prevention to provide support, resources and direct services to victims and their families (http://www.kcsarc.org). The agency provides specialized resources that enable clients to transition from *victim* to *survivor* and has been recognized for its approaches to serving survivors and their families on both a regional and national level (http://www.kcsarc.org). KCSARC has also received recognition for its innovative prevention program, and has led the way in helping change beliefs, attitudes and behaviors about sexual violence through its best practice-based training and education programs (http://www.kcsarc.org). KCSARC's mission statement vows to "give voice to victims, their families, and the community; create change in beliefs, attitudes, and behaviors about violence; and instill courage for people to speak out about sexual assault" (http://www.kcsarc.org).

In following its mandate, KCSARC provides support and services to clients of all ages and backgrounds. Demographic data from 2015 indicate that 49% of the clients served by the center were under the age of 18, and that 79% of the clients served were female; less than 1% of the clients receiving services self-identified as transgender (http://www.kcsarc.org/factsfigures). Clients identifying as Caucasian (55.5%) represented the largest racial/ethnic group receiving services from the center, followed by individuals who self-identified as Hispanic or Latino (19.5%). Clients identifying as African American represented 9% of the clients receiving services, while the remaining 16% of clients identified as multi-racial/Asian-Pacific Islander/Native American and Alaskan Native or other (http://www.kcsarc.org/factsfigures). More than half (57%) of the clients receiving services were identified as being in the low- to

very low-income bracket, while only 8% earned enough money to be identified as being in the above moderate-income bracket. Data from 2015 regarding the relationship status of the offender to the victim indicate that 48% of offenders were family members, while an additional 41% were identified as acquaintances. Just over 10% of perpetrators were identified as strangers (http://www.kcsarc.org/factsfigures).

Funding for KCSARC programs and services is derived from municipal, county, state and federal sources, private donations, fee-for-service payments and donations from the United Way (http://www.kcsarc.org). In terms of the services offered to clients and their families, KCSARC provides: (a) a 24-hour resource line; (b) individual and group therapy; (c) parent education (when victims are children); (d) prevention and education programs; (e) community training; (f) CourtWatch - a program instituted in 2010 which assists judges in making fair and equitable decisions, ensures that survivors and their advocates better understand the legal process, and informs sexual violence legislation (http://www.kcsarc.org/courtwatch), and (g) legal advocacy.

Given that client satisfaction with the legal advocacy services provided by KCSARC is the focus of this dissertation, I felt it would be important to include more information about this component of the agency's service delivery. KCSARC has been providing legal advocacy services to its clients since 1976 (http://www.kcsarc.org). Currently, the agency is home to the largest, most comprehensive sexual assault legal advocacy program in the country (http://www.kcsarc.org). Demographic data from the past five years (2010 to 2015) indicate that advocates have seen a 40% increase in provision of support and services to victims of sexual assault and their families (http://www.kcsarc.org). KCSARC legal advocates serve a variety of populations, including: (a) children and youth; (b) victims of cybercrimes; (c) adult rape victims; (d) vulnerable adults; (e) children and youth who have been sexually exploited for commercial

gain, and (f) members of the LGBTQ community (http://www.kcsarc.org). KCSARC legal advocates provide information and support to victims and their families as they navigate the criminal justice and legal system and seek legal recourse against offenders (http://www.kcsarc.org). Given that the legal advocate is the only service provider whose sole focus is the survivor and their interests, the advocate can: (a) make the victim aware of their rights and discuss reporting options; (b) help the victim create safety plans and secure protection orders; (c) prepare the victim for what to expect, and accompany them to interviews and court/sentencing hearings, and assist in trial preparation; (d) act as a liaison and provide the client with legal updates; (e) speak on the client's behalf in court, if requested to do so, and help the client tell their story in the way they want it to be told, and (f) connect clients to other needed services, including emergency housing, counseling, parent education (when the victim is a minor) and employment (http://www.kcsarc.org).

Development of the Legal Advocacy Services Satisfaction Survey (LASSS). The larger project in which this dissertation is embedded began approximately seven years ago, when members of the Bikos Research Vertical Team (RVT) at Seattle Pacific University (SPU) were approached by KCSARC and invited to assist in developing a system that would enable the agency to evaluate its legal advocacy program on an ongoing basis (Gibbs et al., 2011). During the first phase of the project, a faculty member, graduate students, and a small group of KCSARC stakeholders (KCSARC executive director, staff members from the Legal Advocacy program, and a KCSARC board member) met to determine an appropriate method for designing a systematic process for program evaluation. Targeted outcomes developed at that time included determining: (a) the objectives of the project; (b) the way in which the evaluation would be designed; (c) the way in which data would be collected, and (d) the way in which data

interpretation and the final report would be managed (Gibbs et al., 2011).

Consensual qualitative research (CQR; Hill, Thompson, & Williams, 1997) analysis was chosen as the primary mechanism for addressing the project goals. Briefly, CQR utilizes open-ended questions and an inductive reasoning process to derive themes and core ideas from the information shared by the stakeholders being interviewed. The approach also requires that the research team (usually comprised of three to five researchers) reaches a consensus regarding the emerging themes and structure of domains and categories (Gibbs et al., 2011).[4] It was anticipated that the information derived from the CQR of KCSARC's legal advocacy program would be used to: (a) provide the agency with feedback regarding the services being provided to victims of sexual assault; (b) provide the agency with information about the way in which the program was functioning within the legal system, and (c) guide the selection, revision or creation of measures for use as part of the agency's mandate to engage in ongoing program evaluation (Gibbs et al., 2011).

Analysis of the qualitative information shared by the stakeholders revealed four themes (i.e. advocate role; outcomes; justice system/community and workload/resources) and 26 core ideas. According to Gibbs and colleagues (2011), many of the core ideas developed from the CQR related to either providing survivors of sexual assault with direct support or assisting in the creation of support for these individuals. These findings appeared to highlight the fact that the legal advocate is considered by many KCSARC stakeholders to be an important member of a survivor's post-assault social/emotional support system – even if the relationship between the survivor and their advocate is only a temporary one. In collaboration with the agency, it was decided that outcome measures utilized as part of an ongoing program evaluation would include:

[4] Given that a more in-depth discussion of the CQR method is beyond the scope of this project, it is recommended that interested readers review the work by Hill and colleagues (1997, 2005).

(a) an assessment of self-efficacy and an individual's ability to cope with sexual assault; (b) an assessment of the social/emotional support provided by the legal advocate, and (c) a survey evaluating client satisfaction with the services provided by the legal advocate (Gibbs et al.).

During the second phase of the project, the Legal Advocacy Services Satisfaction Survey (LASSS; Gibbs et al., 2011) was developed using information derived from the CQR to evaluate the level of client satisfaction with the advocacy services provided. Survey items were created using an iterative process; suggested wording for each of the items was sent from the Bikos RVT to members of the KCSARC leadership team for review before being sent back to the RVT. After much wordsmithing and several revisions (L.H. Bikos, personal communication, October 17, 2016), a nine-item Likert-style measure (including two additional questions referencing family members' experiences with the provision of legal advocacy services) was created that appeared to capture clients' satisfaction with the services they received from their legal advocate. Items were anchored by a Likert-type scale ranging from 1 (*Not at all*) to 5 (*To a very great extent)* and included questions such as "Did your advocate walk you through the legal process?" and "Was your advocate easily available to you?"

Purpose of This Dissertation

According to Sullivan (2011), the most helpful information regarding the extent to which a service delivery program has been effective is derived from comments and observations offered by the clients themselves. Although service providers may believe they have offered clients useful information, supported the development of new skills, and/or enhanced clients' sense of well-being in some way, only the clients themselves can provide feedback to support or refute the belief that services have been helpful (Sullivan, 2011). In an effort to determine the effectiveness of the legal advocacy services offered by the KCSARC, the Legal Advocacy

Services Satisfaction Survey (LASSS; Gibbs et al., 2011) was developed to evaluate the quality of the information provided by an advocate as well as the quality of the relationship the advocate was able to establish with the survivor. A nine-item questionnaire based on two factors/constructs (information and relationship) was developed for this purpose.

A multi-step process was followed in order to analyze the psychometric properties of the LASSS. First, I began by completing a confirmatory factor analysis (CFA) of the initial model. Second, I followed the *model generating approach* suggested by Jöreskog (1993) which allows for the initial two-factor model to be modified and retested several times using the same data, in the event the proposed model does not fit the given data. The goal of this model generating, exploratory factor analytic (EFA) approach was two-fold – it was hoped that a model that fit the data well from a statistical standpoint would be generated as a result of this process, and that each of the parameters of the model could be meaningfully interpreted (Jöreskog, 1993). Upon completion of the CFA and EFA, the third step in the process focused on exploring the convergent and discriminant validity of the LASSS. As a fourth step in this psychometric study, the internal consistency of the measure and its subscales was established by computing alpha coefficients. Lastly, the temporal stability (i.e., test-retest reliability) of the measure was evaluated by examining correlations between measures completed approximately 3 months apart.

CHAPTER II: Method

The purpose of my dissertation was to evaluate the factor structure and other psychometric properties of the nine-item Legal Advocacy Services Satisfaction Survey (LASSS). The LASSS was designed to assess client satisfaction among individuals who received services from the King County Sexual Assault Resource Center (KCSARC) between 2013 and 2017. The information derived from this survey is intended to inform and improve the agency's provision of legal advocacy services.

Participant Characteristics

Participants in this study sought services from the legal advocacy program offered by KCSARC. Given that demographic data specific to the legal advocacy program is currently unavailable, the following percentages reflect the age, ethnic background, socioeconomic status, and relationship status of the offender to the victim of all clients receiving services. Data from the KCSARC website (http://www.kcsarc.org/factsfigures) for 2015 indicate that 3,834 individuals received services from the center, and that close to half of these individuals were enrolled in the legal advocacy program. Almost half of the clients served by the center (49%) were under the age of 18. Most clients were female (79%), and less than 1% of the clients receiving services self-identified as transgender. Clients identifying as Caucasian (55.5%) represented the largest racial/ethnic group receiving services from the center, followed by individuals who self-identified as Hispanic or Latino (19.5%). Clients identifying as African American represented 9% of the clients receiving services, while the remaining 16% of clients identified as multi-racial/Asian-Pacific Islander/Native American and Alaskan Native or other (downloaded from http://www.kcsarc.org/factsfigures). More than half (57%) of the clients receiving services were identified as being in the low- to very low- income bracket, while only

8% earned enough money to be identified as being in the above moderate-income bracket. Data regarding the relationship status of the offender to the victim indicate that 48% of offenders were family members, while an additional 41% were identified as acquaintances. Just over 10% of perpetrators were identified as strangers (downloaded from http://www.kcsarc.org/factsfigures).

Demographic information reflecting the age, ethnicity, and income level of clients who participated in my study is limited but appears to reflect the data found on the KCSARC website. Of the 95 clients who listed their age (range 18 to 75 years), close to 40% were young women between the ages of 18 to 24. Of the 39 participants who provided information about their ethnicity, close to 70% identified as white/Caucasian, while approximately 13% self-identified as African American. Close to 40% of these 39 participants identified as being in the low- to very-low income bracket, while only 5% reported being in the above moderate-income bracket. The majority (56%) of participants had some high school, while an additional 21% had some college or technical training experience.

Sampling Procedures

Clients receiving services from the legal advocacy program were eligible to participate in the study, regardless of the amount of time they had been enrolled in the program. Information about the client's experience with their advocate was collected via survey method. Three separate measures evaluating client satisfaction, social/emotional support, and client self-efficacy were included in the survey packet and were to be administered by KCSARC staff approximately once every three months (i.e. one time per fiscal quarter); clients had the option to complete a maximum of three survey packets. Unfortunately, due to a variety of issues, this plan was not implemented with regularity. Clients were offered an incentive (in the form of a $10 digital gift card from Target for each completed survey) to participate in this study by the agency; therefore,

clients were eligible to receive a maximum of $30 for completing survey packets at each of the three time points. Client data were collected in one of two ways – either in-person at the KCSARC main office (with survey packets being provided to the client by their legal advocate), or via on online survey program (with the link being sent to the client by their advocate). Completed surveys were then de-identified and sent to the Bikos RVT via digital means.

Sample Size, Power, and Precision

In order to determine the appropriate sample size required for scale development, I reviewed the suggestions offered by Clark and Watson (1995) and determined that a minimum of 300 participants is recommended when attempting to validate a measure. To confirm this number, I utilized the approach presented by Westland (2010) and the calculator (i.e., A-priori Sample Size Calculator for Structural Equation Models) available on-line (https://www.danielsoper.com). Per the requirements needed to calculate sample size, I specified the number of latent variables to equal 2 and the number of indicator variables to equal 9 (the number of items making up the LASSS). In addition, I specified the minimum value to detect an effect at $d = 0.20$, significance at $p = .05$, and power at .80. Results of the computations indicated that a minimum sample size of 223 was required to detect an effect; sample size decreased to 90 when the value to detect an effect was set to $d = 0.30$. Thus, my sample of 180 participants appeared to be sufficient to detect a small effect size.

To determine the sample size required to power the analysis of the proposed two-factor model, I followed the widely accepted - yet often criticized – (Wolf, Harrington, Clark, & Miller, 2013) *rule of thumb* which recommends having at least 10 participants for each parameter that is to be estimated (Byrne, 2010; Kline, 2005). In my proposed model, 11 parameters (9 paths and 2

disturbances) needed to be estimated, requiring at least 110 participants. Hence, a sample consisting of 180 participants was deemed sufficient for the validation of the measure.

Measures

As stated earlier, three separate measures were included in each survey packet. Participants had the option of completing the measures via paper and pencil or an online survey, depending on their preferences, and could complete up to three survey packets over a 12-month period.

Legal Advocacy Services Satisfaction Survey. The Legal Advocacy Services Satisfaction Survey (LASSS; Gibbs et al., 2011) is a measure developed to assess client satisfaction with the quality of information and quality of the relationship the legal advocate is able to foster with the survivor. Clients are asked to rate nine items using a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*to a very great extent*). It is hypothesized that the measure is comprised of two factors – *information* (which reflects the type and quality of the information offered by the legal advocate) and *relationship* (which reflects the availability/accessibility of and perceived support provided by the advocate). Examples of items from the measure include questions such as "Did the advocate explain the legal process effectively?" (i.e. a question that reflects the quality of the information being provided by the advocate) and "Did your advocate maintain contact with you that met your needs?" (i.e. a question that reflects the quality of social support/relational component being offered by the advocate). In the study by Gibbs et al. (2011), alpha coefficients reflecting the internal consistency of the items were .89 and .94 at the first and second time points, respectively, while the test-retest correlation coefficient was .72. As the focus of my dissertation, I evaluated the factor structure of the LASSS to determine if it aligned with the two-factor (i.e., information, relationship), correlated, first-order structure that had been

hypothesized, a priori. In addition, I examined the measure's construct validity, internal consistency, and temporal stability.

Inventory of Socially Supported Behaviors. The Inventory of Socially Supported Behaviors (ISSB; Barrera, Sandler, & Ramsay, 1981) is a 40-item self-report questionnaire that assesses the perceived frequency of a variety of informal, socially supportive behaviors received by an individual during the previous month. Items on the ISSB are written in the second person (e.g. "expressed interest and concern in your well-being") and rated on a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*about every day*). A total score is created by summing the frequency ratings across all 40 items. In a study to assess the instrument's internal consistency reliability and test-retest reliability over a short interval (i.e. 48 hours), 71 undergraduate psychology students (female $n = 41$) took part in the research as an option for completing course requirements. Analysis of the data indicated that participants' total ISSB scores on first and second administration were substantially correlated ($r = .88$, $p < .001$). Coefficient alpha was calculated for each administration to determine the internal consistency of scale items and was found to be .93 and .94 at T_1 and T_2 respectively. The coefficient alphas reported by Barrera et al. (1981) are similar to the coefficient alpha reported in a study by Cohen and Hoberman (1983) in which the ISSB was utilized to examine the ways in which the perceived availability of social support and number of positive events acted as moderators of the relation between negative life stress and depressive and physical symptomatology in a group of college students ($N = 57$) enrolled in an introductory social psychology course. Cohen and Hoberman (1983) reported the internal reliability of the scale items as .92.

The ISSB was modified for use in an unpublished study by Gibbs et al., (2011) which evaluated a legal advocacy program for survivors of sexual assault. The modified ISSB

(MISSB; Gibbs et al., 2011) was developed by members of the Bikos RVT in collaboration with KCSARC service providers who served as subject matter experts. Fifteen items from the ISSB (Barrera et al., 1981) were chosen because: (a) they were identified during the CQR as reflecting some of the themes or core ideas derived from a review of the qualitative information derived from KCSARC stakeholders or (b) KCSARC service personnel felt the items captured the essence of the services provided to clients. The 15 ISSB items were then modified to: (a) highlight the fact that the support being offered to the client was being provided by the legal advocate and (b) reflect the quality/type of social support that a client could expect to receive from their advocate. Clients completing the survey were asked to rate the frequency of social support behaviors that "best represent how often your advocate responded to you in this way" (Gibbs et al., 2011) on a 5-point Likert scale ranging from 1 (*not at all*) to 5 (*about every day)*. In the study by Gibbs and colleagues (2011), internal consistency alpha coefficients were found to be .98 at both time points, while the test-retest reliability coefficient was calculated to be .51

Sexual Assault Coping Self-Efficacy Measure. The Sexual Assault Coping Self-Efficacy Measure (SACSEM; Gibbs et al., 2011) was adapted from the Domestic Violence Coping Self-Efficacy Measure (DV-CSE; Benight, Harding-Taylor, Midboe & Durham, 2004) and used as part of the evaluation of legal advocacy services provided to victims of sexual assault by KCSARC. The SACSEM was developed by members of the Bikos RVT in collaboration with KCSARC service providers who served as subject matter experts. Nineteen items from the DV-CSE (Benight et al., 2004) were chosen because they were identified as reflecting some of the themes developed during the CQR or because KCSARC service personnel felt the items were appropriate for use with the clients served by the agency. The phrases "since the most recent attack" and "since the latest assault" were deleted from the 19 DV-CSE items to

make them more sensitive/appropriate for use with the clients (who were survivors of sexual assault) taking part in the Gibbs et al. (2011) study. Twelve items were further modified to replace the qualifier "domestic abuse" with "sexual assault", and the words "abuser" or "abuse" with the words "assailant" or "assault" to make the items more relevant to the experiences of the KCSARC clients.

Clients completing the SACSEM are asked to indicate their ability or confidence (i.e. capability), since the sexual assault, to manage a variety of issues on a 5-point Likert scale ranging from 1 (*completely incapable*) to 5 (*completely capable)*; examples include items such as "Managing my housing, food, clothes and medical needs" and "Dealing with feelings of shame concerning the assault". The alpha coefficients reflecting internal consistency of the scale items was found to be .96 across three time points, while the test-retest reliability coefficients were calculated to be .76, .67, and .79 between T_1 and T_2, T_1 and T_3, and T_2 and T_3, respectively.

Research Design

Data utilized in my dissertation is a subset of the data collected as part of the ongoing evaluation of the KCSARC legal advocacy program evaluation. Data collection began in 2013, and an end-date for the project has yet to be determined. The research design for the overall program evaluation is longitudinal in nature and incorporates repeated measures for participants. Confirmatory factor analysis (CFA) utilizing structural equation modeling (SEM) was used to examine how well the proposed two-factor model fits the data. In order to determine the internal reliability of the LASS, Cronbach's coefficient alpha was calculated to determine the consistency of the items comprising each of the factors, and test-retest reliability was calculated to determine the degree to which results remained consistent over time. Convergent and discriminant validity

were determined using the modified version of the ISSB (Gibbs et al., 2011) and SACSEM, respectively, both of which are self-report measures.

CHAPTER III: Results

Participant Flow

Clients whose data were utilized for my dissertation sought services from the legal advocacy program offered by KCSARC at some point between 2013 to 2016. A basic demographic questionnaire and measures evaluating client satisfaction with legal advocacy services (i.e., LASSS), social/emotional support (i.e., MISSB), and self-efficacy (i.e., SACSEM) were included in the survey packets that were either completed in-person or on-line; the latter two measures included in the packet were used to assess the convergent and discriminant validity of the LASSS, respectively. A total of 181 clients completed a sufficient number of LASSS items to be included in the reliability analysis at Time 1; approximately 20% (n = 35) of these clients had sufficiently completed the survey to be included in the retest reliability analysis at Time 2.

Data Screening

Data screening began by ensuring that participants met two key criteria for inclusion in my study (i.e., participants were at least 18 years of age and female; male-to-female transgender clients were not included in these analyses). Given that a primary operational requirement of the AMOS SEM package is that each unit of analysis has complete data and that items missing data not be included in the analysis (Kaplan, 2009), data from participants who met the inclusion criteria were then screened for missing values.

Addressing Missing Data

Before estimating missing data, the available data were visually scanned for missing information; in addition, patterns of missing values were created and analyzed using SPSS 22. It was determined that my data set had very few missing values (i.e., less than 5%) and that the

pattern of missing data appeared to be haphazard. Managing missing data for the CFA was handled differently than the data used to develop the validity and reliability coefficients. Specifically, for the confirmatory factor analyses, missing data at the item level were estimated using single imputation (Enders, 2010). For the validity and reliability coefficients, multiple imputation (with 5 sets) was conducted at the item level. Correspondingly, pooled estimates of the output were reported.

Evaluating Structural Validity of the LASSS

Confirmatory factor analysis (CFA) was conducted on the a priori structural model of the LASSS using SPSS AMOS 22; data from 181 participants was used for this purpose. The model-generating (MG) approach as suggested by Jöreskog (1993) was used to evaluate the two-factor model (information [consisting of four items] and relationship [consisting of five items]) of client satisfaction with the legal advocacy services offered by KCSARC. According to Byrne (2010), the MG approach provides the researcher with the opportunity to continue exploring the initial, theoretically-derived, model (which has been rejected based on lack of fit with the sample data) in an attempt to locate possible sources of misfit. After modifying and re-estimating the model, it is hoped that this re-specified model will better describe the sample data and be statistically well-fitting as well as meaningful. In the case of the LASSS, modification indices (MI) were used to guide re-specification of the initial model while fit indices were used to compare the re-specified models in a nested fashion.

Parameter estimates, and fit indices were used to evaluate the fit of the initial first order two-factor model (Figure 1). Adequacy of the parameter estimates was assessed by: (a) examining the feasibility of the estimates; (b) determining the appropriateness of the standard errors, and (c) confirming that the parameter estimates were statistically significant. The indices

used to evaluate model fit included the Likelihood Ration Test statistic, commonly expressed as chi-square (χ^2), Comparative Fit Index (CFI) and root mean error of approximation (RMSEA) change indices. Briefly, the χ^2 value reflects the variances and covariances of the hypothesized model and the data set; the goal is to have a non-significant χ^2 value indicating that the proposed model and actual data set do not differ significantly from one another (Byrne, 2010). The CFI statistic evaluates sample size and provides a better estimate of covariation when sample sizes are small; a value of .95 is considered indicative of a good fit (Byrne, 2010). Lastly, the RMSEA statistic is sensitive to the complexity of the model and considers the error of approximation in the population (Byrne, 2010). A good fit of the model to the data is indicated by RMSEA values of .06 of less; values ranging from .06 to .08 suggest a reasonable fit, while values ranging from .08 to .1 suggest a mediocre fit. RMSEA values greater than .1 indicate a poor fit of the model to the data (Byrne, 2010). RMSEA values are computed along with a 90% confidence interval (CI); this interval indicates the precision of the RMSEA statistic in describing the model fit in the population. In an ideal situation, the upper end of the 90% CI should not exceed .06 (Byrne, 2010)

In the initial model, all regression weights were statistically significant and of reasonable magnitude. The fit indices used to evaluate this model suggested a moderate fit (C [26; N = 181] = 202.481, $p < .001$; CFI = .885; RMSEA = .194). In an attempt to improve the fit of the initial model, I evaluated the modification indices (Byrne, 2010) previously outlined in an effort to identify parameters that might be allowed to co-vary and, thus, improve the overall fit; it should be noted that re-specifications were made only when substantive rationale supported the parameter change. In the re-specified model in which error terms 8 and 9 were freed to covary, the fit indices indicated a statistically significant improvement in fit (χ^2 [25; N = 181] = 158.841,

$p < .001$; CFI = .913; RMSEA = .172). In the final re-specification of the model (Figure 2), error terms 7 and 8 (in addition to error terms 8 and 9) were freed to covary. Once again, the fit indices indicated a significant improvement in fit (χ^2 [24; $N = 181$] = 132.714, $p < .001$; CFI = .929; RMSEA = .159). At this point, the two-factor model was accepted, and the CFA was brought to a close.

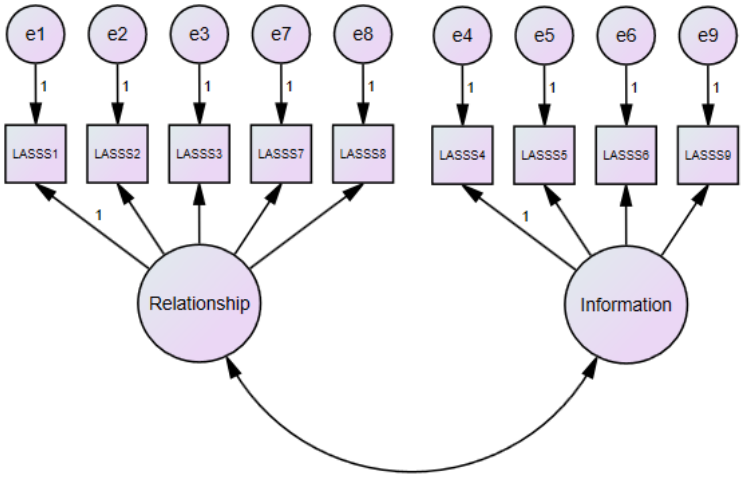

Figure 1. Hypothesized model of factorial structure for the Legal Advocacy Services Satisfaction Survey (Model 1).

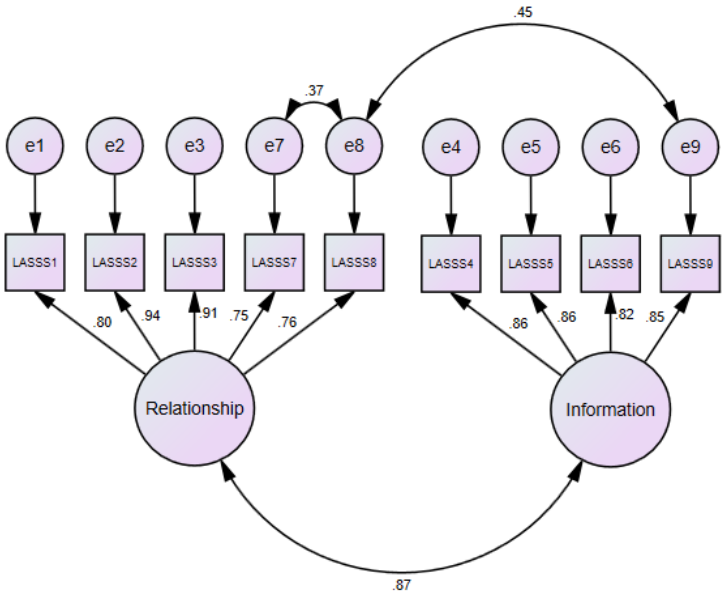

Figure 2. Hypothesized model of factorial structure for the Legal Advocacy Services Satisfaction Survey (Model 3).

Parameter estimates, and fit indices were also used to evaluate the fit of a proposed one-factor model (i.e., client satisfaction, comprised of all nine items of the LASSS; Figure 3); data from 181 participants was used for this analysis. In the initial one-factor model, all regression weights were statistically significant and of reasonable magnitude. The fit indices used to evaluate the model suggested a moderate fit (χ^2 [27; N = 181] = 253.033, $p < .001$; CFI = .883; RMSEA = .215). In an attempt to improve the fit of this model, I once again evaluated the modification indices in an effort to identify parameters that might be allowed to co-vary. In the re-specified model (Figure 4) in which error terms 2 and 3 were freed to covary, the fit indices indicated a significant improvement in fit (χ^2 [26; N = 181] = 166.922, $p < .001$; CFI = .908; RMSEA = .174). At this point, the one-factor model was accepted, and the CFA was terminated.

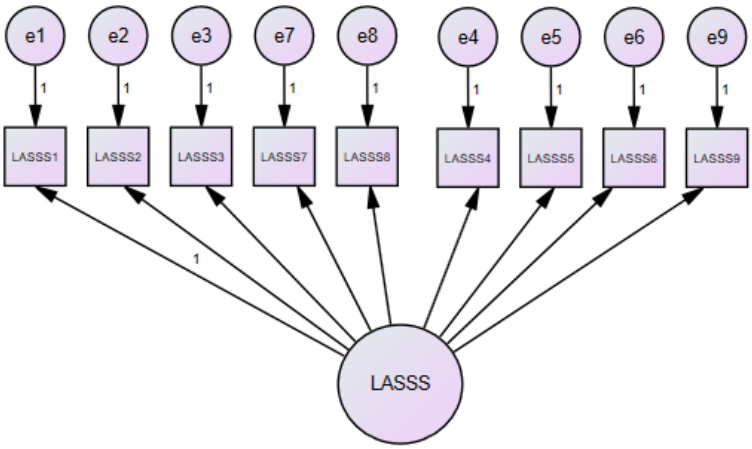

Figure 3. Hypothesized model of one-factor structure for the Legal Advocacy Services Satisfaction Survey (Model 1).

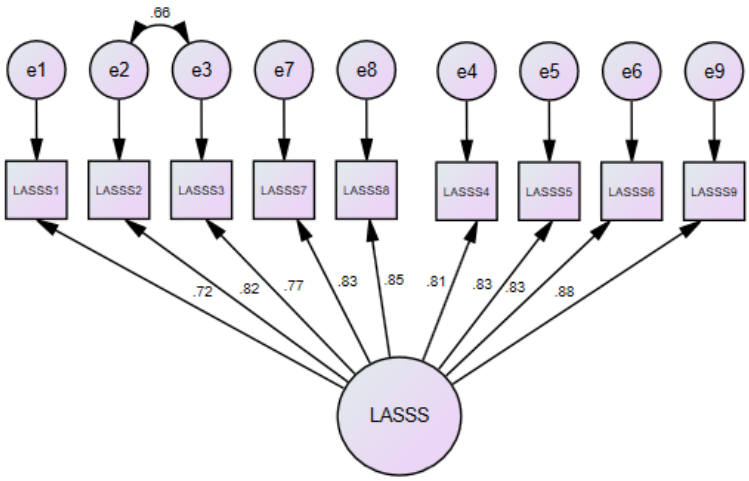

Figure 4. Re-specified model of one-factor structure for the Legal Advocacy Services Satisfaction Survey (Model 2).

Evaluating Construct Validity of the LASSS

To evaluate construct validity of the LASSS, I examined the measure's relationship with measures selected to assess convergent and discriminant validity (i.e., the MISSB and SACSEM, respectively). SPSS 22 was utilized to compute Pearson's correlations between the total scale mean scores of the LASSS (which assessed client satisfaction with social/informational support provided by the advocate), the MISSB (which assessed client's experience of social/emotional support offered by their advocate), and the SACSEM (which assessed client's sense of self-efficacy in coping with issues following the sexual assault). Referencing pooled data created

using multiple imputation, the LASSS and MISSB demonstrated a moderate (trending to strong) correlation ($r = .467$, $p < .01$ [two-tailed]). Although the LASSS and the SACSEM also demonstrated a moderate correlation ($r = .387$, $p < .01$ [two-tailed]), the strength of relatedness between these measures was less robust. Both correlation coefficients were consistent with the nomological net (or context within which the LASSS was developed – i.e., an agency providing services to victims of sexual violence), in that the relationship between measures reflecting similar constructs (i.e., support) was stronger than the relationship between measures reflecting dissimilar constructs (i.e., support versus self-efficacy).

Evaluating Internal Consistency Estimates

Given the psychometric support for both two-factor and single-factor models, I proceeded to analyze the internal consistency of the measure by calculating a series of Cronbach alpha coefficients. Alpha coefficients for the two-factor model at both the test (T_1) and re-test (T_2) waves are as follows: information subscale (4 items; T_1 $\alpha = .910$; T_2 $\alpha = .913$); relationship subscale (5 items; T_1 $\alpha = .917$; T_2 $\alpha = .915$), and overall scale (9 items; T_1 $\alpha = .948$; T_2 $\alpha = .957$). Further examination of the measure's internal consistency at Time 1 revealed that the deletion of any item would not improve the overall reliability of the scale; thus, in a manner consistent with the CFA results (in which no items were deleted to improve the factor structure of the measure), the final version of the scale contains nine items.

Evaluating Temporal Stability Estimates

I evaluated the temporal stability of the measure by comparing data from 35 participants collected approximately three months after the first administration of the LASSS. For this sample, the Pearson correlation coefficient for the information scale was .709 ($p < .01$; two-tailed), while the correlation coefficient for the relationship scale was .808 ($p < .01$; two-tailed).

The Pearson correlation coefficient for the total scale was .794 ($p < .01$; two-tailed). These significant correlations suggest a robust relationship between scores across time and indicate adequate test-retest reliability of the LASSS.

Chapter IV: Discussion

Researchers have consistently demonstrated that acts of sexual violence and intimate partner violence remain widespread social problems that significantly impact the physical and mental health of the individuals who have been victimized (Macy et al., 2010). Although researchers have documented the efficacy of services provided by agencies offering support to survivors of sexual assault and domestic violence by demonstrating improvements in survivors' safety, health, and well-being (Macy et al., 2009), more information is needed regarding: (a) the structure, components, and contents of the services offered to survivors; (b) the ways in which services are delivered, and (c) the ways in which services effect positive changes in the lives of survivors (Macy et al., 2009). In addition to the fact that providers would like to know whether their services have made a difference in the lives of survivors of sexual violence, service providers and agencies continue to experience increasing pressure from policy makers and funding sources to document their outcomes (Macy et al., 2015).

My dissertation sought to address a critical gap in the sexual assault literature regarding the outcomes of sexual assault service provision – specifically the provision of legal advocacy services and support – by evaluating the psychometric properties of a measure designed to assess such outcomes. Participants who took part in my study were adult (i.e., over age 18) female survivors of sexual violence working with legal advocates at the King County Sexual Assault Resource Center (KCSARC) in Washington state. The nine-item Legal Advocacy Services Satisfaction Survey (LASSS) was developed to evaluate both the quality of the information provided by the advocate as well as the quality of the relationship the advocate was able to establish with the survivor; the scale was then evaluated for structural and construct validity, internal consistency and test-retest reliability. Overall, the results of my dissertation indicated

that the newly developed LASSS scale is a psychometrically sound, two-factor, nine-item measure that may be utilized by providers and agencies working with survivors of sexual violence receiving legal advocacy services.

Scale Structural Validity

Confirmatory factor analysis (CFA), using AMOS SPSS 22, was conducted to examine the structural model of the LASSS which was hypothesized to consist of two factors (i.e., information and relationship). After determining that the a priori structure displayed a moderate fit, the model was modified slightly (by allowing two sets of error terms to covary) to better fit the data. Given that specific indices (i.e., χ^2, CFI, RMSEA) indicated a significant improvement in model fit at this point, the CFA was terminated and both original factors and all nine items comprising the LASSS were retained. Confirmatory factor analysis (using AMOS SPSS 22) was also conducted to evaluate the fit of a proposed one-factor model (i.e., client satisfaction). This a priori model also displayed a moderate fit and was modified slightly (by allowing one set of error terms to covary) to better fit the data. Once again, the same indices (i.e., χ^2, CFI, RMSEA) indicated a significant improvement in model fit and the CFA was terminated; all nine items comprising this one-factor version of the LASSS were retained.

Although analyses indicate that the LASSS can be considered a structurally-sound one- or two-factor measure, I recommend that the two-factor measure be used in applied settings (such as KCSARC), given that the two-factor measure allows service providers, supervisors and trainers to determine which specific facet of client satisfaction is being well supported and which facet may need to be improved upon. The two-factor measure also provides staff with targeted information that may be referenced to support ongoing program evaluation and program development.

Scale Construct Validity

I evaluated the construct validity of the LASSS by examining its relationship with two other measures specifically selected to assess convergent and discriminant validity. Pearson's correlation coefficient was calculated using the total mean score of the LASSS (which reflected overall client satisfaction with both informational and social support offered by the advocate) and the total mean score of the MISSB (which reflected the client's experience of emotional and social support offered by the advocate) to determine convergent validity. Pearson's correlation coefficient was then calculated using the total mean score of the LASSS and the total mean score of the SACSEM (which measured the client's sense of self-efficacy in coping with issues following sexual assault) to determine discriminant validity. Given that the relationship between measures reflecting a similar construct (i.e., support) was stronger than the relationship between measures reflecting dissimilar constructs (i.e., support versus self-efficacy), the LASSS appears to capture and reflect elements of a construct that represents a client's sense of satisfaction with the support they are receiving from their advocate.

Internal Consistency and Test-Retest Reliability

After evaluating the structural and construct validity of the LASSS, I evaluated the internal consistency and temporal stability (i.e., test-retest reliability) of the measure and its two subscales. Both subscales as well as the overall measure demonstrated good internal consistency. I also calculated alpha coefficients to determine the internal consistency of the scale and its subscales from data that were collected three months after the measure had been completed by clients for the first time. Once again, both subscales as well as the overall measure demonstrated good internal consistency.

The temporal stability of the LASSS was evaluated by comparing data from 35 participants who completed the measure for a second time, approximately three months after the first administration. Pearson's correlation coefficients for the measure and its two subscales were significant and suggested a robust relationship between scores across time and demonstrating adequate test-retest reliability. Given this finding, total and subscale scores should remain similar over time and reflect the stability of the client-advocate relationship. An increase or decrease in scores over time would be interpreted as change in the quality of one or both elements of client satisfaction as opposed to instability of the measure. High scores would suggest that the client feels satisfied with the services being provided and that the advocate is doing their job well, while low scores would suggest the opposite. In addition to providing feedback to elicit a discussion regarding ways in which the advocate might change their approach to providing services so that the client feels better informed and/or supported, LASSS scores could also be used by supervisors to individualize the training and support the needs of the advocates they supervise or mentor.

Implications for Practice and Research

My dissertation represents an attempt to address a significant gap in the literature on sexual violence by validating a measure of client satisfaction with the provision of legal advocacy services. As stated previously, no measure is currently known to exist that examines this aspect of legal advocacy support and intervention.

In terms of practical implications, the results of my dissertation demonstrate that the LASSS is a psychometrically-sound measure that can provide advocates, supervisors, program coordinators and agency directors with meaningful, client-generated information regarding satisfaction with specific aspects of service provision. Although an advocate may believe they

have provided the client with useful information or fostered a supportive relationship, only the client can verify whether this has been their experience or not. Comprised of nine items representing two domains (information and relationship), the LASSS can be completed by the client in less than 5 minutes and is easy for advocates to score and interpret; in addition, the measure demonstrated both good reliability with this specific sample of female survivors of sexual violence and satisfactory temporal stability. Information derived from the measure can be used by the advocate to address aspects of service provision that may not be working or serving the needs of the client well.

For example, research in the field of domestic violence has demonstrated that when programs serving female survivors fail to meet a client's need for information, the client often feels disconnected or at a loss - as she did during her relationship with the perpetrator (Weisz, 1999). By being able to evaluate whether they are meeting a client's need for information (i.e., explaining the legal process effectively; informing the client of the potential positive and negative outcomes stemming from the client's decisions; informing the client of the legal/judicial process, etc.), advocates can modify information delivery by providing the client with more information (or less, if the client is feeling overwhelmed) or alter the way in which information is being provided (e.g., augment discussions with written materials to reduce the possibility of taxing a client's memory) and thus decrease the potential for negative outcomes (i.e., a client feeling confused and/or disconnected). In addition, providing information that is clear, understandable, and accessible reduces the potential for secondary victimization by reducing the likelihood that the client will begin to question her ability to organize and make sense of the information being offered by the advocate. Feelings of disempowerment arise whenever knowledge and access to it are not shared in an egalitarian way.

In addition to providing the advocate with feedback regarding the type and quality of information being offered to the client, the LASSS can also provide the advocate with feedback regarding various aspects of the client-advocate relationship (i.e., availability of the advocate; whether the advocate provided consistent support throughout the process; whether the advocate supported the client to feel empowered to make her own decisions, etc.). Having the ability to track a survivor's sense of satisfaction with the client-advocate relationship appears to be especially important for female survivors of sexual violence, given that a woman's sense of self is organized and developed within the context of important relationships (Surrey, 1991; as cited by Weisz, 1999). Surrey's observation appears to be supported by research on the topic of women's development which underscores the importance that connectedness and caring hold for women (Weisz, 1999). Thus, it is not surprising to learn that results from a study examining the usefulness of an advocacy program for female survivors of domestic violence found that clients repeatedly referenced the importance of the bond they shared with staff (Allen, Larsen, Trotter, & Sullivan, 2013).

Given the significance that relationships hold for women, the LASSS has the potential to support the development and deepening of the client-advocate relationship by: (a) providing the traumatized client with the opportunity to safely share her thoughts/feelings about the advocacy process which she might otherwise be uncomfortable or reticent to share (especially in the early stages of the client-advocate relationship or if she feels her needs are not being met), and (b) providing the advocate with feedback to help them become increasingly more sensitive and attuned to the specific needs of their client. It is believed that information derived from the LASSS has the potential to reduce secondary victimization from occurring at both the individual and systems level by providing survivors a voice with which to offer feedback about their felt

experience of the client-advocate relationship, and the ways in which information and support are provided.

Research examining outcomes for female survivors of domestic violence have demonstrated that women who have the opportunity to work with advocates are more effective at seeking and accessing essential community resources, regardless of the specific needs they present with (Allen et al., 2004). Trauma researchers have also pointed out that feeling connected to their service providers helps restore a survivor's sense of agency and self-efficacy, and healing (Herman, 1997). Thus, results from the LASSS may be used in conjunction with other types of feedback to remind advocates of and reinforce the fact that the work they do is important, powerful and life-changing for many clients. Information of this kind may help reduce the possibility of provider burnout, which has been linked to feelings of reduced competence and personal accomplishment when work with clients is not always successful (Webster & Hackett, 1999).

Feedback from the measure can also be used to remind advocates of the important role they play in the lives of women who are marginalized (Sokoloff & Dupont, 2005). For example, women living in poverty experience a variety of mental health challenges (including depression, anxiety, posttraumatic stress, and substance use) at rates that exceed those of women who are more advantaged (Goodman, Glenn, Bohlig, Banyard, & Borges, 2009). In a study of racially and ethnically diverse, low-income women with depression working with student advocates in a domestic violence program, clients emphasized how important it was for their advocates to demonstrate their commitment, focus on their strengths, provide hope and encouragement, and anticipate their needs (Goodman, et al., 2009).

Lastly, results from the LASSS can be used during supervision to provide advocates with specific feedback about their work and targeted suggestions regarding ways to enhance the overall quality of the client-advocate relationship. Information from the LASSS can also be used to: (a) guide the training of paraprofessionals who are new to the field of legal advocacy; (b) support on-going program evaluation and program development, and (c) provide policy makers and funding sources with quantitative evidence, derived from a psychometrically validated measure of client satisfaction, to demonstrate that legal advocacy plays an important role in the lives of female survivors of sexual violence.

In terms of implications for research, the LASSS potentially serves as a building block for additional scale construction that will enable providers of legal advocacy services to better understand the needs of their clients. Expanding on a point made earlier regarding the client's actual experience of service provision and the beliefs an advocate may have about the usefulness of the information provided or the quality of the relationship, LASSS items could be reworded slightly to reflect the thoughts/experiences of the advocate (e.g., "I provided consistent support throughout the process"; "I supported the client to feel empowered to make her own decisions", etc.) regarding the quality of services they feel they have been providing. Responses from the advocate and the client could then be compared to determine how accurate the advocate's perceptions of service delivery are. This would allow for disparities in the responses to be addressed during supervision, likely resulting in a positive impact on the quality of the client-advocate relationship.

More specific to KCSARC, the LASSS provides the agency with the opportunity to engage in on-going program evaluation and quality assurance by: (a) documenting client satisfaction with service provision and (b) examining the ways in which client satisfaction is

related to advocates' fidelity to the model of support currently in use. By combining the results of the LASSS with results from measures that reflect client well-being, researchers may be able to support KCSARC stakeholders in developing a theory of client change to guide the work of advocates. The results may then stimulate further discussion regarding ways in which advocates form alliances and develop shared goals with their clients, and how the training, practice, and supervision needs of advocates are being met.

Limitations

Although the LASSS demonstrated good structural and construct validity, good internal consistency (with this specific sample of female survivors of sexual violence) and robust temporal stability as a measure of client satisfaction, readers of this dissertation are reminded to interpret the findings with a degree of caution, given the various limitations inherent to the study which will now be reviewed.

One of the first limitations of this study to be acknowledged pertains to the issue of sample. While the sample size was adequate to test (and confirm) the a priori hypothesis that the LASSS represents a two-factor structure (i.e., information and relationship), the characteristics of the sample may have confounded the results. An analysis of the demographic data available indicated that clients who responded to the survey were predominantly Caucasian (69%), younger (clients between the ages of 18 and 40 represented 83% of the sample) and had completed 12 years (or less) of education (56%). Thus, women of color/other minorities (e.g., disability status), women over the age of 40, and women with post-secondary education were considerably underrepresented in this study. In addition, it is not known how many women in the sample self-identify as queer, bisexual, transgender or gender non-conforming. It is possible that women representing these different demographic groups may respond to the measure

differently, especially if the advocate is not providing the client with information she feels is relevant or sensitive to her experience as a minority, or if she does not feel comfortable in her relationship with the advocate for various reasons (e.g. an older, non-cisgendered client sharing her experiences of being sexually assaulted with a younger advocate; a woman of color working with a Caucasian advocate, etc.). Thus, the results of this study cannot be generalized to encompass the experiences of women over the age of 40 (or female clients younger than age 18), women of color, women representing other minorities, women with post-secondary education, and women who identify as something other than heterosexual. It is also important to note that the results of this study cannot be generalized to male survivors (straight or gay) of sexual violence. This is unfortunate, given that researchers suggest that male (and LGBT) survivors: (a) face less understanding from providers regarding issues related to sexual violence that is not male to female; (b) experience more barriers to care, and (c) find fewer treatment resources available, including less advocacy (Turchik et al., 2016).

A second limitation of the study pertains to the issue of self-selection bias. Given that participation in the study was voluntary, it is possible that a certain type of client was more likely to complete the survey than another type of client. For example, based upon the fact that satisfaction scores for both subscales were high (i.e., scores of 4 and 5), with little variability, it is possible that clients who were more satisfied with their advocates and the services they were receiving were more motivated to complete the survey or felt more comfortable doing so. Anecdotally, legal advocates have reported that clients often feel frustrated with the lack of progress being made with their legal cases; as a result, some advocates have acknowledged feeling as though their clients transferred their frustrations to them and their work (Roberts, 2017). Therefore, it is possible that clients experiencing a sense of frustration with the legal

process and, by extension, their advocates opted not to complete the measure because they viewed this as yet another step in a process that appears to be broken and/or futile. Lastly, it is also possible that some clients may have found the idea of responding to a survey that might retrigger painful and/or traumatic memories too risky, and so chose not to respond (Campbell, Adams, Wasco, Ahrens, & Sefl, 2010). Unfortunately, clients who chose not to complete the measure are the very clients whose voices and opinions need to be heard so that the components of service delivery which do not appear to be serving their needs or serve as trauma triggers can be addressed and modified.

A third limitation of this study pertains to the fact that it was not designed to evaluate the content validity of the measure or its predictive validity. It is possible that that content of the questions and/or the way in which they were worded may need to be modified for use with clients representing the different demographic groups currently served by KCSARC in order to establish levels of satisfaction with the services being provided. In addition, it is not known how the quality of the information provided by the advocate and the quality of the client-advocate relationship may impact other important outcomes, such as: (a) client's self-esteem and ability to engage in greater self-advocacy; (b) client's level of anxiety and/or depression; (c) client's post-assault quality of life and reduction in the radiating impact of sexual violence; (d) a reduction in the client's experience of secondary victimization, and (e) successful prosecution rates.

A final limitation of this study relates to the fact that a number of variables that potentially impact client satisfaction in some way were not controlled for. For example, it is not known if the age, gender, sexual orientation, ethnicity of the advocate, their knowledge/understanding of the physical/emotional/psychic impact of trauma or years of experience in the field had an effect on clients' satisfaction scores. Similarly, it is not known if

client-specific variables (such as type of assault, relationship to the perpetrator, trauma history, length of time working with the advocate or matching with the advocate on age/ethnicity/sexual orientation) impact satisfaction ratings in some way.

Future Research

As stated earlier, my dissertation represents the first attempt at establishing the psychometric properties of a measure developed to assess client satisfaction with the provision of legal advocacy services. This study provides initial support and represents a starting point for future research on the use of the LASSS for such purposes. Further research, including cross-validation of the scale and its subscales, needs to be undertaken to examine the validity, reliability and temporal stability of the LASSS with clients representing different ethnic groups (and non-English speakers), disability groups, age groups, genders, sexual orientations and educational levels. It is possible that clients representing different demographic groups may: (a) assign more or less significance to different items of the measure; (b) require items to be reworded in ways that demonstrate the advocate's understanding of and sensitivity to specific issues facing various minority groups, or (c) require that other items be created to address informational and/or relational needs that are specific to the group.

For example, researchers have found that members of the LGBTQ community experience alarmingly high rates of sexual violence in comparison to the general population (Langenderfer-Magruder, Walls, Kattari, Whitfield, & Ramos, 2016). In a study by Balsam, Rothblum and Beauchaine (2005), more than twice as many lesbian and bisexual women (15.5 and 16.9%, respectively) reported being raped in adulthood than their heterosexual counterparts (7.5%), while 10% of gay and bisexual men reported being raped in adulthood (compared to 2% of heterosexual men who reported this experience). Sadly, members of the transgender community

appear to experience even higher rates of sexual violence, with approximately one in three transgender individuals reporting an experience of rape/sexual assault (Langenderfer-Magruder et al., 2016). Based on data from the Virginia Transgender Health Initiative study, close to 27% of participants reported histories of sexual assault beginning by age 13, with 89% of those participants reporting that stating their gender identity or expression appeared to be the primary motivator for the assault (Langenderfer-Magruder et al., 2016). Thus, it is possible that the LASSS may need to be modified to include items that reflect an advocate's understanding of the experience of individuals from marginalized communities living with the aftermath of sexual violence, whose shared historical narrative consists of stories of interpersonal violence, exploitation and oppression, and the challenges these clients may experience in developing trust in any kind of relationship as a result – even one that is intended to be non-judgmental, helpful, and supportive.

It is also important to note that satisfaction surveys are not synonymous with outcome evaluation surveys (Sullivan, 2011). Although a client may report feeling satisfied with the supports and services that have received from a program, they may also report that service provision was not effective for them (Sullivan, 2011; Ahrens, 2006). Therefore, the predictive validity of the LASSS combined with measures of self-efficacy/self-advocacy, and measures reflecting mental health issues (such as PTSD, depression, and anxiety) and quality of life/post-traumatic growth also needs to be explored. For example, researchers have suggested that older individuals are more negatively impacted by lack of support during the period in which they are recovering from their traumatic experience (Roberts, 2017). Therefore, it is possible that older clients may need even more support – or, perhaps, a different kind of support – from their advocates than younger clients in order to reduce the negative impact that sexual violence has on

the individual's health and well-being. Information derived from the LASSS can help advocates determine whether they are meeting the needs of their older clients and begin a dialogue regarding the kind of support the client may feel they need more of.

A final suggestion for future research with the LASSS pertains to the use of the measure to support the structural elements of service provision, including the training and supervision of advocates as well as program development/evaluation. The results of this study provide confirmation of and legitimacy to the fact that the informational and relational support offered by advocates are factors that impact client satisfaction with service provision. As such, data from this study may be used to underscore the importance of these factors as key to client satisfaction during the training of providers who are new to the field of legal advocacy. In addition, the LASSS provides supervisors with a way to track client satisfaction and provide positive feedback to advocates regarding the ways in which they are meeting the needs of their clients. The measure also provides supervisors with information that can be used to provide feedback and suggestions regarding specific ways in which support may be augmented to better meet the needs of the client. Lastly, quantitative data derived from a measure that has been psychometrically validated provides KCSARC with the opportunity to scientifically evaluate its legal advocacy program and determine whether elements of advocate training and service provision need to be addressed to better meet the needs of members of minority groups and improve client satisfaction. Results from this study may also be used by KCSARC to provide policy makes and funding agencies with data that supports the claim that legal advocacy is effective in meeting the informational and relational needs of clients and thus deserves to be a protected service that should receive on-going support and funding.

Conclusion

The goal of my dissertation was to complete a psychometric evaluation of a questionnaire (i.e., the LASSS) developed to measure client satisfaction with the provision of legal advocacy services offered by the King County Sexual Assault Resource Center (KCSARC). More specifically, the LASSS provides clients with the opportunity to rate: (a) the quality/usefulness of the information provided by the advocate and (b) the elements that factor into the quality of the client-advocate relationship. Confirmatory factor analysis (using structural equation modeling) was used to establish the structural validity of the LASSS. Results supported a two-factor (i.e., information and relationship), 9-item measure; various other measures were used to establish the measure's convergent and discriminant validity. Along with demonstrating good structural and construct validity, results indicated that the LASSS exhibits good internal reliability (with this sample of female survivors of sexual violence) and temporal stability.

Given the strong psychometric properties of the measure, my dissertation supports the on-going development and continued use of the LASSS as a measure of client satisfaction with the provision of legal advocacy services. In addition to providing advocates with client feedback, the LASSS also has the potential to support: (a) the training and supervision of advocates (and, by extension, reduce the probability of secondary victimization from occurring); (b) ongoing program evaluation, with a specific focus on the legal advocacy services offered by KCSARC, and (c) program development, grant writing, and other funding activities (e.g. donation requests).

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