

APRIL 2007

A Room of Our Own: Sexual Assault Survivors Evaluate Services

**A Research Report
from the New York City Alliance
Against Sexual Assault**



A Room of Our Own: Sexual Assault Survivors Evaluate Services

By Deborah Fry



**New York City Alliance
Against Sexual Assault**

Published by the
New York City Alliance Against Sexual Assault

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First printing: April 2007
Editor: Jennifer Tierney
Report design: Scott Santoro, Worksight

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Foreword

Victim-centered care after an assault is vital for recovery from the trauma inflicted by sexual violence. Services that provide important medical and psychological care can start the recovery process by strengthening victims to attend to their immediate needs. Furthermore, a survivor has the option of reporting the assault to law enforcement and working with the criminal justice system to hold the perpetrator accountable. The New York City Alliance Against Sexual Assault holds a value that it is crucial to ask survivors what they thought of the care they received and how they think we can improve the system to better meet their needs.

A Room of Our Own: Survivors Evaluate Services reveals in their own voices the experiences adult survivors have when they seek care after a sexual assault. Many of the survivors who participated in this study talked about their experiences of not being believed, not being treated in a caring manner or not being heard in their interactions with service providers after an assault. When compared to those survivors who felt well taken care of, we can no longer tolerate inadequate care. While there are many model programs in NYC to work with sexual assault survivors such as the Sexual Assault Forensic Examiner (SAFE) and Sexual Assault Response Team (SART) programs in emergency departments, the city's rape crisis programs, the NYPD's Special Victims Division and the Sex Crimes Bureaus at each of the five District Attorney's offices, there is still much work that needs to be done to ensure that *all* survivors have access to the best care in New York City.

The New York City Alliance Against Sexual Assault has played a leadership role to ensure that all New Yorkers have access to quality sexual assault services and interventions, should they need them. We are one of two NYS Department of Health-certified SAFE training program in the NYC area and

we train close to 200 health professionals a year to provide specialized, quality care to survivors in the acute care setting. We also provide training for rape crisis counselors through our Rape Crisis Training Institute and coordinate a Criminal Justice Collaboration Project to work with our colleagues in the law enforcement and criminal justice sectors.

The Alliance's innovative research seeks to provide baseline evidence regarding the treatment of sexual assault survivors in NYC with one goal in mind to improve care. The companion research report *How SAFE is NYC?: Sexual Assault Services in Emergency Departments* documents what is and is not being done for survivors in the acute care setting. Together these two reports highlight the tremendous strides that NYC has made to improve services and the work that still needs to be done to ensure that all survivors, no matter what borough, no matter what age, no matter what sexual orientation or physical ability, have access to the best services available.

We hope you will take the findings of these reports to heart and join us in our goals.



Harriet Lessel, Executive Director
New York City Alliance Against Sexual Assault
June 2006

Acknowledgements

This study was conducted through the Research Department of the New York City Alliance Against Sexual Assault led by Deborah Fry (Research Director). The online component of this study was developed by Sam Nelson (Web Manager) for the Alliance.

We would like to thank all the women and men who participated in this study. We hope your courage in participating and allowing us to learn from your experiences will help improve the system for others. We would also like to thank the women who participated in the focus groups at the beginning of this project to help design the survey, your input was very helpful and much appreciated. Much gratitude goes to the many stakeholders and survivors who reviewed the various survey drafts and provided incredible input for improving the survey.

A special thanks goes to the Survivor Survey Outreach Committee, a group of dedicated volunteers who sought to spread the word high and low about this research project across NYC: Keri Walden, Lynn Frederick Hawley, Vivian Lew, Linda Juste, Traci Shoemaker, Christine Borges, Melanie Lynn and Mandi Larsen. A big thank you to Christy Banister, a dedicated volunteer who finalized the references and bibliography for this report.

A warm thank you goes to the 13 participating rape crisis program sites and their staff for working with the Alliance on the often cumbersome Institutional Review Board protocols, training and data collection process. Your tireless effort to improve services for survivors is to be applauded.

The Alliance thanks the key stakeholders from the four sectors: hospital services, rape crisis programs, law enforcement and criminal justice services who met with us to review the report and provide comments and feedback.

Appreciation also goes to the 2004–2006 NYC Alliance Against Sexual Assault Research Advisory Committee for their guidance on the Alliance’s research projects and their comments on this report: Cari Olson, MPH (Director of Research, Injury Epidemiology Unit, Bureau of Epidemiology Services, NYC Department of Health and Mental Hygiene); Catherine Stayton, MPH, DrPH (Director of the Injury Epidemiology Unit, Bureau of Epidemiology Services at the NYC Department of Health and Mental Hygiene); Larry Busching (Chief, Family Court Division of the NYC Law Department and a member from the Alliance’s Board of Directors); Karen Terry, PhD (Deputy Executive Officer, Program of Doctoral Studies in Criminal Justice at the John Jay College of Criminal Justice); Marielis Rivera, MPH (Health Educator at the South Bronx Health Center for Children and Families); Victoria Frye, MPH, DrPH (Research Investigator at the NY Academy of Medicine); Susan Xenarios, LCSW (Director of the Crime Victims Treatment Center at St. Luke’s-Roosevelt Hospital and a member of the Alliance’s Board of Directors); and Donna Gaffney, MA, Msc, RN, DNSc, (Associate Professor, Seton Hall University).

Special thanks also goes to the following Alliance staff: Tamara Pollak (Training and Education Director); Jenn Tierney (Communications Director); Daisy Deomampo (Research Associate); Christine St. John (Community Organizer); Deiderie Armstrong (Assistant Director); Tamika Johnson and Tamecca Phillips (Administrative Assistants); and a special thanks to Harriet Lessel (Executive

Director) for her vision and support of this research project. Additional thanks goes to Mel Schneiderman, PhD, (member of the Alliance Board), for his thoughtful comments on the draft report. Warm thanks go to all of the Alliance's Board members who commented on the drafts of the report and thoughtfully discussed the dissemination and linkage of the report to our advocacy goals.

A big thank you goes to Dr. Rebecca Campbell who reviewed the final draft of the report. We are continually impressed and applaud your service-based research efforts to improve care and measure the outcomes of improved care for sexual assault survivors.

This research and publication was funded by grants from the New York City Council and the New York State Department of Health. The Alliance would like to thank these two funders for their contributions to defining and developing evidence-based best care for sexual assault survivors in NYC. The dissemination of this report was funded through the New York State Division of Criminal Justice Services, a leader in funding programs to improve their response to sexual assault victims in NYC.

About the Author

Deborah Fry is the Research Director at the New York City Alliance Against Sexual Assault. At the Alliance, Deborah works on citywide research projects, all geared to helping improve service delivery for survivors in NYC and evaluating current prevention and intervention programs. Current projects include this study and *How S.A.F.E. is NYC? Sexual Assault Services in Emergency Departments*. In addition to conducting primary research, Deborah also provides research technical assistance to the NYC rape crisis programs. Deborah has a Masters of Arts degree from the Maxwell School of Citizenship and Public Affairs at Syracuse University and her Masters in Public Health from Columbia University. Deborah was also a Fulbright Research Scholar from 2001 to 2002.

Table of Contents

Foreword	i	Chart 11. Percentage of Respondents Who Received Information About the Criminal Justice Process	46
Acknowledgments	ii	Table 1. Overview of Survivor Recommendations	52
Executive Summary	1	Table 2. Sample Distribution	54
Chapter 1. Introduction	5	Survivor Voices	
Chapter 2. Hospital Services	13	What Was the Best Thing About Going to the Hospital?	18
Chapter 3. Rape Crisis/Victim Assistance Programs	25	What Was the Worst Thing About Going to the Hospital?	21
Chapter 4: Law Enforcement	33	What Was the Best Thing About Going to a Rape Crisis Program?	28
Chapter 5: Criminal Justice	43	What Was the Worst Thing About Going to a Rape Crisis Program?	30
Chapter 6: Implications	51	What Was the Best Thing About Going to the Police?	36
Appendix A: Methodology	53	What Was the Worst Thing About Going to the Police?	40
Appendix B: Survey Instrument	59	What Was the Best Thing About Going to the District Attorney's Office?	47
References	67	What Was the Worst Thing About Going to the District Attorney's Office?	49
Charts and Tables		Quality of Care Case Studies	
Chart 1. Age When Sexual Assault Occurred	9	Providing Care to Survivors with Mental Illness	20
Chart 2. Borough of Residence, Assault and First Services Contacted	10	LGBT Survivors: Navigating Through Heterosexist Systems	29
Chart 3. Respondents (%) Referred to Other Services From First Point of Contact	11	Male Survivors of Sexual Assault: The Hidden Epidemic	39
Chart 4. All Services Contacted After Assault	11	Providing Quality Services to Survivors with Physical Disabilities	48
Chart 5. Victim Advocate Services	17		
Chart 6. Treatment by Doctor/Nurse	17		
Chart 7. Why Respondents Felt Poorly Treated at the Hospital	19		
Chart 8. Percentage of Respondents That Felt Their Rape Crisis Counselors Knew How to Help Them	27		
Chart 9. Reasons for Feeling Poorly Treated by the Police	37		
Chart 10. Satisfaction with Treatment by Uniformed and Non-Uniformed Officers	38		

Executive Summary

Every year the New York City Alliance Against Sexual Assault hosts a Sexual Assault Yearly Speak Out (SAY SO), a day-long reading of survivors' stories. SAY SO is an important event to empower survivors, to hear their stories, to get the larger NYC community to talk about sexual violence and to *change* the environment from one of tolerance to intolerance of sexual violence. The opening ceremony of the 2006 SAY SO event featured Karen Carroll, the Associate Director of the Bronx Sexual Assault Response Team. Karen, a survivor of marital rape, talked about her experiences with the hospital staff after *her* sexual assault. This experience eventually led her to become a Sexual Assault Forensic Examiner to help other survivors as they seek care after their assault.

It was a Saturday morning. I opened the bedroom door and he was standing there. In his right hand was a knife and in his left hand two black ropes. My memory of the rape is like I was a spectator. I remember thinking, 'Watch everything.' He's going to jail but I need evidence. I was lucky that the detective who showed up at the hospital was compassionate and asked appropriate questions. But I had a horrible rape exam. The doctor didn't even say hello. He walked over to the rape kit and started reading directions. I had been an ER nurse long enough to know that if you don't collect evidence the right way, it might not be used in court. I had to show the doctor how to do my rape kit.

Survivors of sexual violence can turn to a variety of services after an assault. They may seek medical care, counseling services, report the assault to the police and/or work with prosecutors on a legal case. Often survivors are treated poorly by the very systems set up to help them. Secondary victimization has been defined as the victim-blaming attitudes, behaviors, and practices engaged in by community service providers that result in additional trauma for rape survivors. Examples include asking victims how they were dressed, questioning

them about their sexual histories, asking if they were sexually turned on by the assault or encouraging them not to prosecute (Campbell et al., 1999; Campbell & Raja, 2005 as cited in Campbell 2006). Such treatment increases rape survivors' feelings of stress, guilt, depression, and distrust and reluctance to seek further help (Campbell et al., 1999; Campbell et al., 2001; Campbell & Raja, 2005 as cited in Campbell, 2006).

A recent study compared victims' accounts of what happened during service delivery with those of doctors, nurses and police officers. Police officers and doctors significantly underestimated the impact they were having on survivors. Victims reported experiencing more distress about their contacts with the medical and criminal justice systems than service providers thought they were experiencing (Campbell, 2005).

One of the main reasons for embarking on this research is to provide a forum for survivors' voices and use those experiences to start a dialogue about systems change. Having an opportunity to express one's voice is especially important after experiencing one of life's most disempowering violations—sexual violence.

The Alliance is in a unique position to conduct this research *and* implement the recommendations posed by survivors. The Alliance is one of the few survivor advocacy organizations with a strong research department. Using the public health model, the Alliance seeks to find out the 'how, where, by whom and how we can stop it' of sexual violence. The Alliance conducts this research both to inform the prevention of sexual violence but also to ensure that *all* survivors have access to the best care. Currently, we are one of two New York State certified Sexual Assault Examiner Training Programs serving the 63 emergency departments in NYC—this means that we train all the doctors, nurses, nurse practitioners and physician assistants in the city

that want to provide specialized care to sexual assault patients. The Alliance also provides trainings to all the sectors involved with responding to sexual assaults: hospitals, rape crisis programs, law enforcement, and criminal justice.

New York City offers several sources of public assistance to sexual violence survivors including: specialized hospital services including forensic evidence collection, free and confidential rape crisis counseling (both associated with hospitals and community-based programs), and specialized police and criminal justice response. This report reflects the quality of these services from the survivors' perspective.

An anonymous survey was provided to survivors of adult sexual violence (violence that occurred when they were 18 or older) who had sought services for that assault in NYC. Recruitment of participants (18 and older) for this study included the general NYC public through a web-based survey and advertising in both English and Spanish through print media and radio and through rape crisis programs. A total of 77 respondents filled out the survey; 12 of these did not meet the study criteria and were excluded from the study leaving a total sample size of 65 respondents.

With this report, the Alliance takes the evaluation of service provision to a participatory level by including feedback from the very people who use these services. It is important to include survivors' voices in this field and remember that a responsible sexual assault response includes interdisciplinary collaboration and feedback from victims. This is the *first* ever citywide report that includes the survivor perspective in both the experiences of services and also in the recommendations for service improvement. Chapter 1 defines the response to sexual violence and the services that are available to survivors in New York City and the challenges of measuring 'satisfaction' in this field. Chapter 2 describes survivors' experiences seeking hospital

care. Chapter 3 examines survivors' satisfaction with rape crisis programs. Chapter 4 examines the experiences survivors have with the police and Chapter 5 describes the interactions with the criminal justice system. Every chapter concludes with survivor recommendations for improving the city's response to sexual violence and to improve services. Lastly, Chapter 6 describes the implications of the findings and concludes with a call for dialogue and questions that should be addressed.

Key Findings:

Survivors are more satisfied with care they receive at hospitals that have a Sexual Assault Forensic Examiner (SAFE) Program.

Survivors were more likely to be satisfied with the medical care they received at the hospital if they went to a New York State Department of Health-certified Sexual Assault Forensic Examiner (SAFE) Center of Excellence. These programs were specifically developed to ensure that sexual assault survivors are provided with competent, compassionate, victim-centered and prompt medical care, while at the same time enabling forensic evidence collection and preservation if the survivor wishes at any point to go forward in the criminal justice process. As of May 2006, there were 17 SAFE Centers of Excellence among the 63 emergency departments in NYC. *Where* you go for care will likely impact the *quality* of care you receive after a sexual assault. There is, however, no communication campaign in place to let the general public know which hospitals are designated as SAFE Centers of Excellence.

Volunteer rape crisis advocates are an important component of survivor care.

The presence of a volunteer (not part of hospital staff) victim advocate had a statistically significant impact on the survivors' satisfaction with the care they received at the hospital. Survivors who had the help of a victim advocate during their hospital visit reported being 'very satisfied' or 'satisfied' with their care at the hospital more often than survivors who did not have the help of a victim advocate. The victim advocates gave survivors information about counseling and reporting to the police. Furthermore, more than three-quarters of survivors reported that the victim advocate gave them the support they needed during the hospital visit and helped explain components of the medical exam to them.

Many survivors did not receive adequate medical care and follow-up from the hospital.

Less than a third of survivors reported that their doctor or nurse asked if they had a safe place to go after leaving the hospital or made follow-up medical appointments for them. Just a little over half of the respondents reported that they were given information about HIV post-exposure prophylaxis, when appropriate, or information about sexually transmitted infections. A larger percentage (68%) of survivors reported being given information about emergency contraception, when applicable. These percentages are in contrast to what hospitals report doing in our companion piece *How SAFE is NYC? Sexual Assault Services in Emergency Departments*. In this report, *all* of the hospital representatives interviewed reported *always offering* emergency contraception and nearly all reported offering HIV post-exposure prophylaxis when indicated.

Standard of care is low for certain populations across all sectors.

Each chapter of this report highlights experiences of the substandard care received by vulnerable populations—survivors with mental illness, male survivors, disabled survivors, and lesbian, gay, bisexual and transgender (LGBT) survivors. Their experiences inform broader questions regarding quality of care. Dialogue, training, protocol development, monitoring and evaluation are needed to ensure that *all* survivors receive the best care.

Out of all the sectors, survivors were most satisfied with the care they received at rape crisis programs.

This is likely due to the fact that the mandate of rape crisis programs is to deliver victim-centered care to promote the healing and recovery from trauma after a sexual assault. Other victim services sectors may operate under different mandates (such as providing medical care, enforcing the law and ensuring community safety). Regardless of the overarching mandate, all sectors can and should utilize a victim-centered approach.

“I felt in control again, I felt like I was doing everything I could.”

—34-year-old female

Chapter 1: Introduction

Defining Sexual Violence

When we talk about *sexual violence* we mean:

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or [acts] otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work (World Health Organization [WHO], 2002).

For this study, we did not give survivors a set definition of *sexual assault* or *sexual violence*, instead we relied on their self-defined meaning of the word. No matter how we define it, if they sought services for the assault, they should be delivered in a sensitive and victim-centered manner.

Throughout this report we use the words *survivor* and *victim* interchangeably in order to recognize and validate the seriousness of the act against the person while at the same time focusing on the person's ability to recover from this trauma.

Defining Satisfaction with Services

Client satisfaction studies are a recognized tool to improve the quality of services. Patient or client satisfaction is increasingly highlighted as an important objective of health care and other human service sectors, a key determinant of service quality and a useful indicator of outcome (Stallard, 1996). Various researchers have viewed satisfaction as the degree of discrepancy between expectation and experience (Oliver, 1979 as cited in Stallard, 1996). This means that dissatisfaction would occur when experience fails to achieve expectations.

Other researchers, however, have viewed these models as too simplistic and focused on the concept and nature of expectations. They ask: do people have realistic expectations of services about which they have no knowledge or only limited contact? Limited knowledge about services may result in clients without standards who will perceive any

service as satisfactory. We find, however, that this is not the case when clients are asked to evaluate services after a sexual assault, since survivors are likely to be familiar with emergency hospital care, counseling, and possibly the police. It is less likely that they will have had any previous experience with the criminal justice system through the District Attorney's office.

Some current research looks at what the meaning of 'satisfaction' and 'dissatisfaction' mean and how they can be measured. A study on dissatisfaction found that the concept of 'personal identity threat' was a key variable in understanding dissatisfaction with health care. Threats to personal identity included perceptions of being dehumanized, objectified, stereotyped, disempowered and devalued (Coyle, 1999). The opposite end of the spectrum is a definition that satisfaction is 'the extent to which treatment gratifies the wants, wishes, and desires of clients' (Lebow, 1982 as cited in Stallard, 1996). Whatever the underlying theoretical models, it is clear that clients do evaluate and make judgments about the services they receive.

Most satisfaction assessments consist of a survey covering major domains of service delivery. Open-ended questions within this format elicits more critical comments, enabling analysis of both satisfaction and dissatisfaction. The current study employed the use of open-ended questions for each service sector by asking **1)** Was there anything that prevented you from going to [service sector, such as hospital, rape crisis program, police or District Attorney's office], **2)** What was the best thing about going to [service sector], **3)** What was the worst thing about going to [service sector], and **4)** What recommendation do you have to improve these services for other survivors?

Client satisfaction is a key objective for service delivery. Research has shown that if a service is unacceptable to its users, it will be under-used regardless of how effective it might be (Holland,

1983 as cited in Stallard, 1996). Satisfaction is also often used as an outcome indicator for assessing services, especially where other outcomes (such as therapeutic change) are hard to identify and quantify (Fitzpatrick, 1991 a; Stallard, 1994 as cited in Stallard, 1996). One strength of satisfaction studies is that they map out service quality over time to see if interventions have been effective. Thus, it is possible that this study could serve as a baseline, with future studies conducted in five to ten years after the survivor recommendations are implemented.

When is the most optimal time to assess satisfaction with services: directly after they are received, a short time later, or two to three years later? This is a key question for researchers. The current study did not set a time limit for when services were accessed. While the majority of respondents accessed services within the last year, there are a few respondents who accessed services more than a decade ago. A primary objective of this study was to provide survivors with a forum to discuss their experience of services for sexual assault since each one can provide valuable lessons and learning opportunities for service providers in this field. Further, smaller sample sizes are the norm in this field of research, and it was felt if the timeframe was limited that fewer respondents would have the opportunity to give feedback.

One drawback to having an open timeframe is the increased probability that changes in service provision have occurred. This, however, seems to affect the analysis little because very few respondents sought services outside of the last three years and upon closer examination, the levels of satisfaction varied very little between those who sought services more than three years ago versus those who experienced services within the last three years.

The issue of whether questionnaire respondents are more or less satisfied than non-respondents has received little attention and yet is of central importance to analyzing results and implementing service change. Due to the length of the survey and the subject matter, it is hypothesized that those who were either very satisfied or very dissatisfied were more likely to fill out the survey than those

who were not at either extreme. Thus, the levels of 'satisfaction' and 'dissatisfaction' may be underestimated in the current study.

What is an acceptable level of satisfaction? Studies have found that 90% satisfaction is a good criterion for overall satisfaction; this criterion might drop to 80% when evaluating specific components of service delivery (Bucknall, 1994; Godin et al., 1987; Gowers & Kushlick, 1991; Stallard et al., 1992 as cited in Stallard, 1996). This means that in other studies an expected dissatisfaction percentage is approximately 10-20% of users. Focusing on those aspects with the highest levels of dissatisfaction is often more effective for systems change.

Satisfaction studies inform service improvements. We hope our findings serve to transform services for survivors of sexual violence into a more victim-centered approach. Key stakeholders from each of the service sectors were involved in the conceptualization and design of the survey. They also provided feedback and comments on this study. Chapter 6 makes a call for dialogue based on the findings and the recommendations from survivors themselves.

Findings on Assault Characteristics

Survivors were asked several questions about the assault for which they sought services. Specifically, if they had ever experienced prior sexual violence, their age at the time of the assault, whether they knew the perpetrator and the gender of the perpetrator.

Nearly half of the respondents (49.2%) said they had been sexually assaulted before this time. Several studies have shown a relationship between child sexual abuse, adolescent sexual violence and later revictimization as an adult. The following text box shows the most current literature in this field. While understanding the current research on revictimization is important, it is also necessary to remember that no one asks for, causes, invites or deserves to be assaulted. Prevention of sexual violence lies with potential or past rapists, not potential or past victims.

Sexual Revictimization: Examining Risk Factors for Repeat Victimization

Sexual abuse early in life has been implicated in vulnerability to repeat sexual victimization. There is a growing literature on this relationship, the risk factors and psychological correlates, and interventions. In the 1980s a seminal study uncovered the correlation between childhood sexual abuse (CSA) and rape in adulthood (Russell, 1986). In a retrospective study of 152 women who had experienced intrafamilial sexual abuse (incest) before the age of 14, 63% also experienced rape or attempted rape after the age of 14.

Subsequent studies have found that women who experienced sexual assault in childhood were two to three times more likely to be raped or sexually assaulted after the age of 16 (Gidycz et al., 1993; Kilpatrick et al., 1997; Tjaden & Thoennes, 2000; Siegal & Williams, 2003). Recently, Classen and colleagues (2005) reviewed 90 empirical studies focused on the prevalence of and risk factors for sexual violence revictimization and confirmed the elevated risk of sexual assault among child sexual abuse survivors. Desai et al. (2002) found rates of sexual reassault were even higher for male survivors of childhood sexual abuse: they were 5.5 times more likely to be revictimized in adulthood.

Sexual abuse in childhood also increases the risk of sexual victimization in adolescence. A New Zealand study followed a birth cohort that represented 83% of the births in a 4.5-month period in 1977. When the cohort turned 18, the researchers inquired about their childhood and adolescent sexual experiences. Six percent reported rape in childhood, and 7.5% reported rape or attempted rape between the ages of 16 and 18 (Fergusson, 1997).

However, there have been inconsistent results across studies as to whether sexual victimization in childhood alone is a risk factor for revictimization in adulthood or whether childhood sexual abuse *and* adolescent sexual abuse increases the risk for sexual assault in adulthood and why this relationship occurs. For example, both studies in the National Institute of Justice's Research in Brief, *Violence Against Women: Identifying Risk Factors* (USDJ, 2004), despite describing very different populations—primarily white college students in one study and mostly black urban women in the other—found

that experiencing sexual abuse in childhood and adolescence significantly predicted revictimization in adulthood, but neither childhood nor adolescent sexual abuse alone significantly increased the risk of rape in adulthood.

Several studies have shown that more severe sexual abuse in childhood—including the use of force, penetration, closer relationship to the perpetrator and longer duration—increases the risk of revictimization (Fergusson, 1997; Kessler & Bieschke, 1999; Humphrey & White, 2000; Arata, 2000). The underlying reason may be that trauma has a cumulative impact on development and coping that increases the risk of revictimization (Jankowski et al., 2002; Moeller et al., 1993). One line of research has examined the mediators that underlie the relationship between sexual assault in childhood or adolescence and revictimization. For example, it has been found that alcohol abuse in itself increases the risk of sexual assault, and also that there is a high rate of alcohol abuse among survivors of CSA and adolescent sexual abuse. Similarly, CSA survivors often have multiple sexual partners and have sex with people they know less well, as a result of what Finkelhor and Browne (1985) term “traumatic sexualization,” and the number of sexual partners increases risk of sexual assault. Finally, a symptom of traumatic stress that children are particularly likely to develop is dissociation, or detachment from the self, during stress. Dissociation can decrease the ability both to recognize danger and to defend oneself from sexual assault.

A recent study tested three theoretical models for explaining revictimization among college women and found that self-blame, posttraumatic stress and number of sexual partners did not mediate repeated experiences of sexual victimization (Wasco, 2004). Other studies have focused on using an ecological framework to better understand the ‘why’ of sexual revictimization. This model looks at factors outside of the victim, including childhood factors, such as family environment, contextual factors including the behavior of the perpetrator, and societal and cultural factors that impact revictimization (Messman-Moore & Long, 2003).

Findings from National and Global Studies on Non-Stranger Sexual Violence

The National Violence Against Women Survey (NVAWS), conducted with a random sample, found that 15% of US women over the age of 17 reported having been raped (Tjaden & Thoennes, 2000).

Two-thirds of the rapes of victims over the age of 12 were committed by someone known to the victim. A friend or acquaintance of the victim committed nearly half the rapes; an intimate partner committed 17% and another relative 3% (Catalano, 2005). Men are more likely to be raped by strangers (29%) than women (17%) (Tjaden & Thoennes, 2006). Attackers of college women are even more likely to be known to the victim. The National College Women Sexual Victimization Survey found that 90% of the offenders were known to their victims (Fisher, Cullen & Turner, 2000).

For adult women, the highest risk of rape comes from an intimate partner. A Canadian study found that 30% of women who were raped in adulthood were assaulted by their intimate partners (Randall & Haskell, 1995). In the US, for 46% of women who have experienced rape or attempted rape the perpetrator was a spouse or ex-spouse, a current

or former cohabiting partner, a date or a boyfriend or girlfriend, with over half by a current or former spouse or cohabiting partner (Tjaden & Thoennes, 2000). Most of these intimate partner assaults of women (69%) occurred during the relationship; 25% occurred both during the relationship and after the relationship ended (Tjaden & Thoennes, 2000).

Rape of women by male intimate partners is a global problem. In a ten-country study of violence against women, the World Health Organization (WHO) found that rates of sexual violence perpetrated by male partners ranged from a low of 6% in Japan to a high of 59% in Ethiopia (WHO, 2005). The WHO study provides one of the first cross-country examinations of patterns of partner violence. In most of the countries in the study, from 30% to 56% of women who had experienced any violence by an intimate partner reported both physical and sexual violence (WHO, 2005). This pattern did not hold true for all sites, however: across Thailand and in provincial Bangladesh and Ethiopia, a large proportion of women experienced sexual violence only.

“Many people [interviewed me], none took me seriously; really a nightmare I will never forget, worse than the actual sexual molestation.”

—43-year-old female

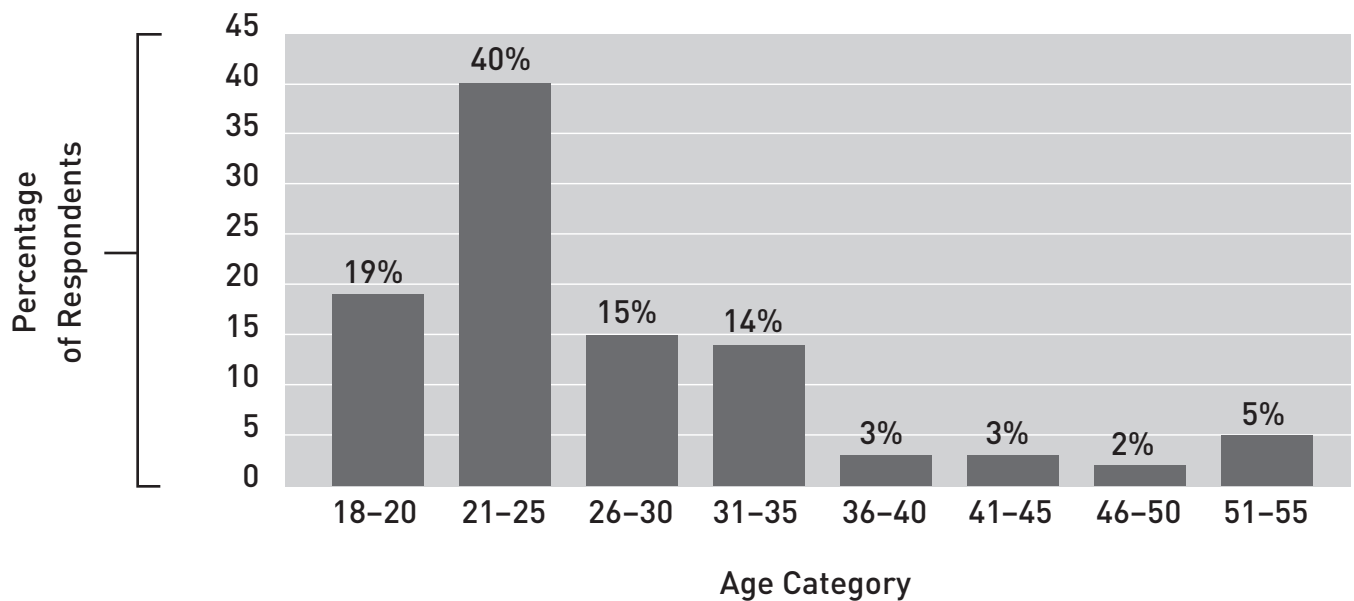
Chart 1 highlights the age at which the assault took place. For 40% of the respondents the assault took place when they were 21-25 years old. Overall, 59% of the sexual assaults took place between the ages of 18-25. Another 14% of respondents reported that the sexual assault took place when they were between the ages of 31-35 years old. Twenty-eight was the average age at the time of the assault (range was 18 to 54).

The majority (93.9%) of the perpetrators of sexual violence in this study were male. This is consistent

with other studies that show that sexual violence is most often perpetrated by men against all victims: men, women and children.

In this study, 60% of respondents knew their attacker and 40% reported the attacker was a stranger. For many respondents the person was a friend (31.7%), dating partner (19.5%), someone the respondent had seen before but was not friends with (17.1%), a person of authority (7.3%) such as a boss, teacher, commanding officer, etc., or someone they had met on a blind date or at a bar (7.3%).

chart 1: Age When Sexual Assault Occurred



Findings on Help-Seeking Behavior

Respondents who participated in this study, all of whom accessed services, were asked about their help-seeking behavior following the assault. Specifically, they were asked which service they contacted first, in which borough this service was located, how long after the assault did they seek help from this place, if this first point of contact referred them for further services, and the total number of services they sought after the assault.

This study only surveyed survivors who had accessed services after their assault. When asked which place they contacted first after the sexual assault, 27.7% responded that they called 911. Another 20% contacted security or the police, and 15.4% went to a hospital first. A smaller percentage contacted a counselor first at either a rape crisis/victim assistance program (12.3%) or through a private counselor (10.8%).

We can see from Chart 2 that survivors are more likely to seek services in the borough where the assault happened as evidenced by the case of Brooklyn. In Brooklyn, we see that more respondents in this study were assaulted outside of the borough in which they live and instead of seeking services in their borough of residence, they sought services in the borough in which they were assaulted. This is likely due to the fact that ambulances will transport victims to the nearest hospital facility, law enforcement will come from the nearest precinct and the case must be prosecuted in the borough in which

the assault took place. Rape crisis services, however, can be sought in any borough.

Of the sixty-two respondents who answered the question of when they sought help, the vast majority contacted the first service within a day of the assault occurring (56.5%) or within three days of the assault (19.4%). Although it is also common that survivors contact services much later, only 6.5% or 4 respondents, sought help more than one year after the assault.

chart 2: Borough of Residence, Assault and First Service Contacted

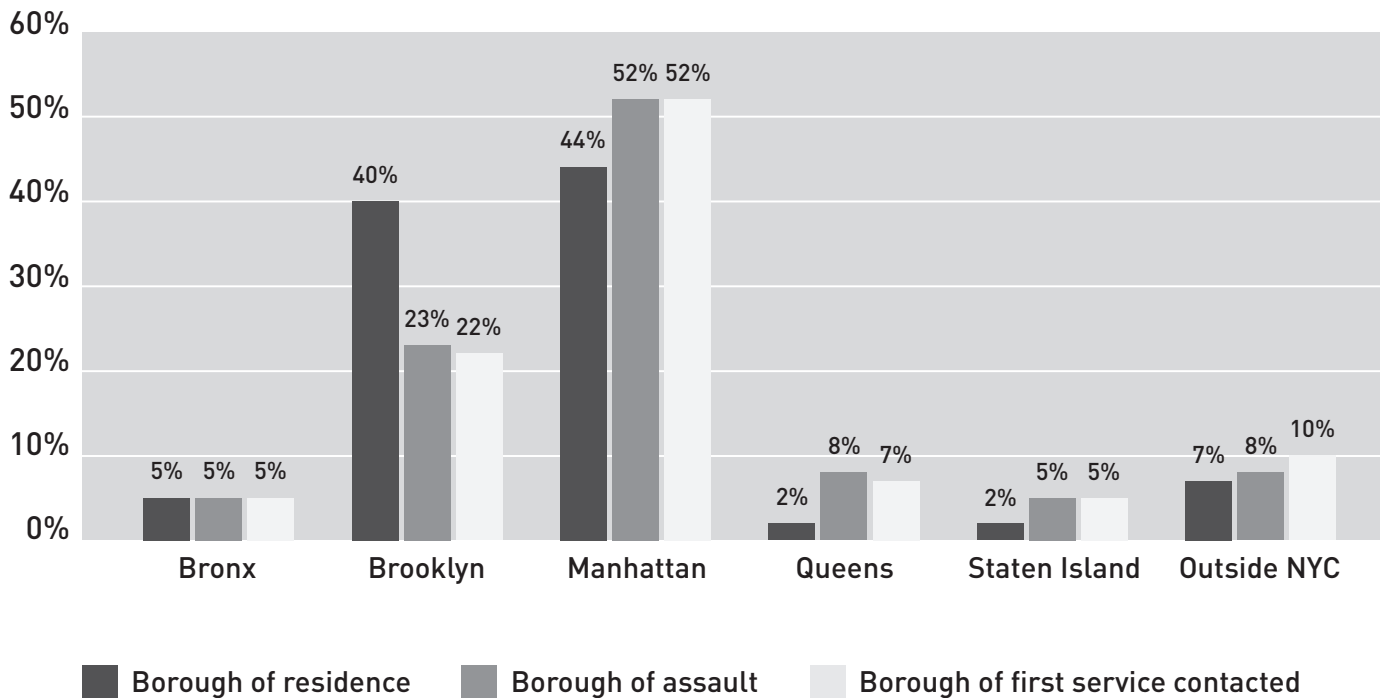


Chart 3 shows that for nearly half of the respondents (41.9%) the first service contacted did *not* advise them to go for further services. Despite this low referral percentage, 61% of respondents contacted three or more services after the sexual assault.

Chart 4 shows all the services that were contacted after the assault; a large number of respondents (67.7%) contacted rape crisis/victim assistance programs often in conjunction with other services. It should be noted that recruitment for survey respondents took place in rape crisis programs and on the web (see Appendix A for more details). A little over half of the respondents contacted security/police and just under half went to the hospital after the assault. Much smaller percentages called a hotline (15.4%) or went to a church or faith-based organization after the assault (10.8%). Other services contacted include primary health clinicians, gynecologists and a public advocate.

Survivors told the details of their sexual assault to a median of four people (average seven people with a range from 1-60) including doctors, nurses, police officers, counselors, etc.

chart 3: Respondents (%) Referred to Other Services from First Point of Contact

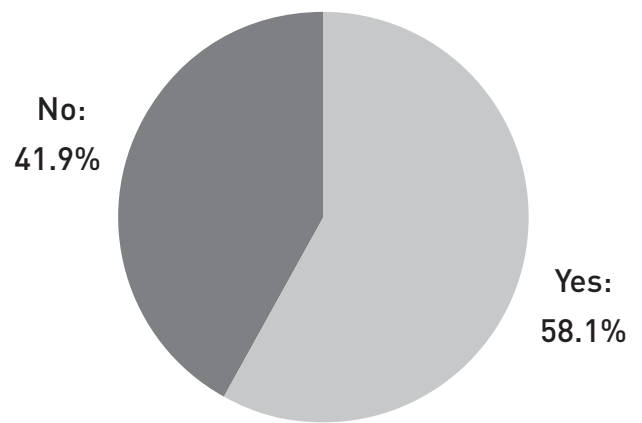
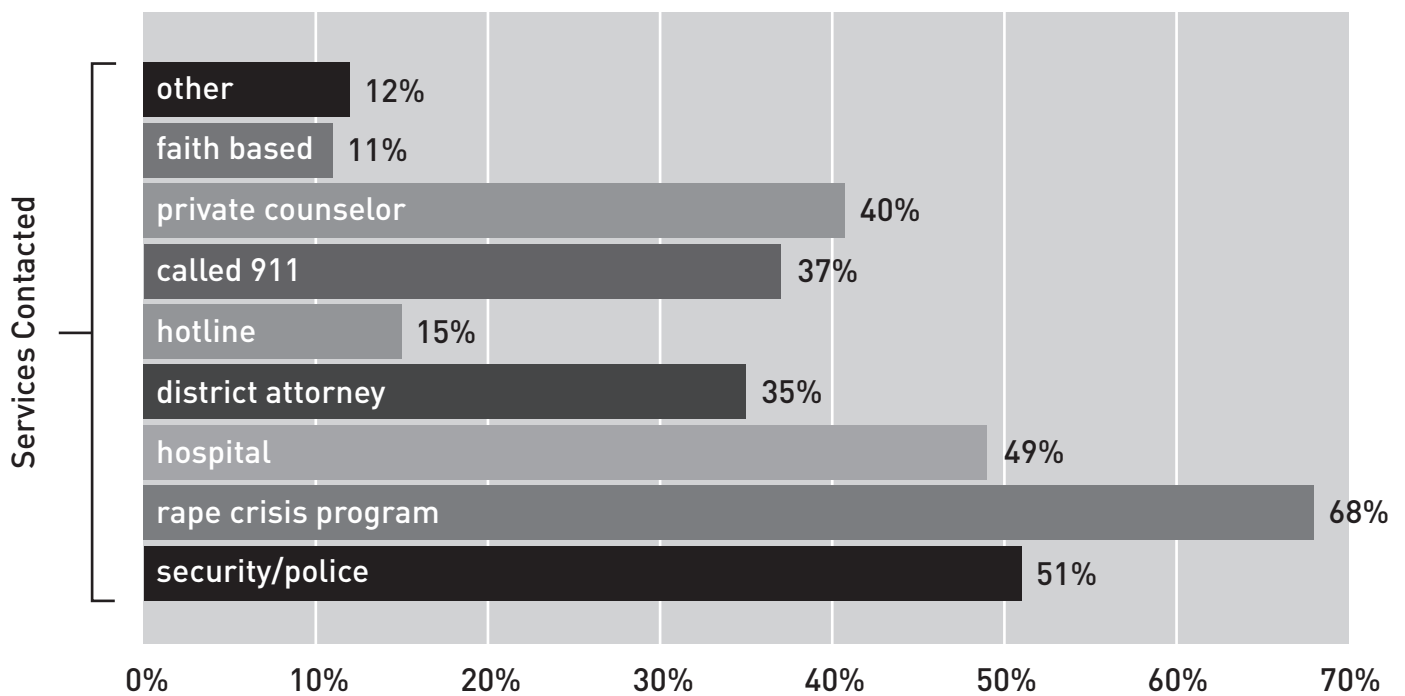


chart 4: All Services Contacted After Assault



“The environment [hospital] was not at all comforting. Again, I would suggest that they have trained, sensitive advocates readily available.”

—21-year-old female

Chapter 2: Hospital Services

Many survivors choose to go to a hospital after a sexual assault to receive care for injuries, as well as for preventive treatment for sexually transmitted infections including HIV and emergency contraception. Once they present at the hospital, patients are also offered psycho-social support for acute trauma, and the option of forensic evidence collection.

This study assessed the following concerns about hospital services: **1)** what prevents survivors from going to the hospital; **2)** experiences with clinicians; **3)** satisfaction with services, **4)** the positive and negative aspects of going to the hospital and **5)** recommendations for improving hospital services for sexual assault survivors. This chapter also includes information on an underserved population identified in the study: survivors with mental illness.

Hospital Care for Sexual Assault Survivors in NYC

Every hospital in New York State must ensure that all victims of rape or sexual assault who present at the hospital are provided with care that is comprehensive and consistent with current standards of practice. By Public Health Law entitled Treatment of Sexual Offense Victims and Maintenance of Evidence in a Sexual Offense (2002), every hospital in New York State must provide treatment to victims of a sexual offense and be responsible for:

1. Maintaining sexual offense evidence and chain of custody, and
2. ‘contacting a rape crisis program or victim assistance organization, if any, providing victim assistance to the geographic area served by the hospital to establish the coordination of non-medical services to sexual offense victims who request such coordination and services.’

By law, the patient must be told about the local rape crisis services and that a rape crisis advocate can accompany him/her during the exam if s/he wishes.

In 2000, Governor Pataki signed into law the Sexual Assault Reform Act (SARA) which mandated that SAFE programs be available throughout the state. The NYS Department of Health promulgated standards under SARA for SAFE Centers of Excellence. SAFE programs and clinicians aim to ensure that sexual assault survivors are provided with competent, compassionate, victim-centered and prompt care, while at the same time ensuring forensic evidence collection and preservation. SAFE program philosophy is based upon the belief that providing a specialized standard of medical care, advocacy and evidence collection to victims of sexual assault will support recovery and prevent further injury or illness arising from victimization, and may increase the successful prosecution of sex offenders for victims who choose to report the crime to law enforcement (NYS DOH, 2004.).

All hospitals, regardless of whether they are a SAFE program, are required to provide medical care to patients reporting a sexual assault. In 2003, a new law required hospitals that treat sexual assault patients to provide information on emergency contraception. The Department of Health was charged with developing and producing informational materials on emergency contraception to be used by all hospitals in New York State. These materials are currently available in eight languages. If requested by the victim, the hospital must directly provide emergency contraception.

In New York State, the Department of Health (DOH) publishes a *Protocol for the Acute Care of the Adult Patient Reporting Sexual Assault* (2004) that details the standard for treatment of survivors in emergency departments throughout the state. To become a Sexual Assault Forensic Examiner, a doctor, nurse, nurse practitioner or physician assistant must attend a NYS DOH-certified training program, such as the training program offered through the NYC Alliance Against Sexual Assault, for a five-day comprehensive course on medical and forensic treatment. These clinicians must then complete

a preceptorship or 'mentoring' with a certified examiner to complete the process. If a doctor, nurse, nurse practitioner or physicians assistant received training in another state or through the International Association of Forensic Nurses (IAFN), their training would be reviewed by a DOH-certified training program, and they would be able to apply to DOH to become a certified SAFE clinician.

To become a specialized SAFE Center of Excellence, a hospital or other center must meet the following criteria that are above and beyond what is required by state law:

1. Maintain a designated and appropriately equipped private room in or near the hospital's emergency department to meet the specialized needs of sexual assault patients. Accommodations must include access to a shower and be handicap accessible.
2. Maintain a supply and provide an initial supply to patients, as medically indicated, of prophylaxis for HIV.
3. Establish an organized program/service specifically to carry out and oversee the provision of sexual assault services. This would include the development and implementation of policies and procedures detailing staffing requirements, initiating and conducting community outreach programs, participating in an organized data collection system, and routinely following-up with patients/law enforcement officials and crime laboratory personnel regarding the credibility of evidence collection activities.
4. Designate a program coordinator to exercise administrative and clinical oversight for the program.
5. Ensure that the program includes a cohort of specially trained Sexual Assault Forensic Examiners (SAFEs) who have been prepared through an intensive classroom and preceptor training program and have been certified by NYSDOH to conduct sexual assault exams.

6. Establish/participate in an interdisciplinary taskforce that includes local rape crisis centers and other service agencies, and law enforcement representatives/local prosecutors to develop services that meet community needs and to ensure that quality victim services are available.
7. Maintain Sexual Assault Forensic Examiners on-site or on-call available to the patient within 60 minutes of arriving at the hospital, except under exigent circumstances.
8. Routinely use the New York State Evidence Collection Kit, if the patient consents to having evidence collected.
9. Coordinate outreach activities in the community and with other hospitals to share best practices, provide training opportunities and promote the availability of programs, to the extent feasible.
10. Participate in regional and statewide quality assurance initiatives designed to measure program effectiveness and meet reporting requirements (NYS DOH, 2004).

As of May 2006, 15 hospitals representing 17 emergency departments have earned the NYS DOH designation SAFE Centers of Excellence in NYC (NYS DOH, 2006). This number represents 27% of the emergency departments in the city. Many hospitals may have some SAFE services available to survivors but may not have met all of the criteria to be designated as a SAFE Center of Excellence or may be in the process of accreditation (For a more detailed examination of what services are offered in NYC's Emergency Departments, consult the Alliance's companion report entitled *How SAFE is NYC? Sexual Assault Services in Emergency Departments*). In addition, Mayor Bloomberg mandated the creation of Sexual Assault Response Teams (SART) at the Health and Hospital Corporation (HHC) facilities (the public hospitals). Currently there are SART programs in the Bronx, Brooklyn, Manhattan and Queens. The HHC SARTs operate similarly to SAFE Centers, except that the medical provider and advocate can travel to any of the HHC hospitals within a specific borough to provide care.

Measuring satisfaction with hospital services

Measuring satisfaction with acute care services is a developed field in patient satisfaction research. Satisfaction surveys are common procedure for quality assurance in most hospitals throughout the city. The constructs for measuring satisfaction are clear—the patient enters with a complaint and the clinicians work to ensure the well-being of the patient. Clear guidelines are laid out in the *New York State Protocol for the Acute Care of the Adult Patient Reporting a Sexual Assault* about what procedures should be followed, what should be provided to the patient, and how the patient should be informed throughout the whole process.

Research Questions and Findings

What prevents survivors from going to the hospital?

In this study, over half (56.1%, n=26) of survivors went to the hospital after the sexual assault. For those that did not go to the hospital, we asked “Was there anything that prevented you from going to the hospital?” Twenty-one respondents identified five major themes for not going to the hospital after the sexual assault:

- **Too traumatized and fearing for safety and well-being**

“All I can remember is laying on the floor balled up in a knot, extremely traumatized, very terrified, cold, shaking, I felt wet, dirty, disgusted, shamed...not able to move...balled myself up in the fetal position, thought I was dying.”
—41-year-old female

“I was just trying to protect my children and myself first. I did not think of it right away.”
—31-year-old female

“I was afraid and did not know what to do.”
—27-year-old female

“The person was a work supervisor threatening the livelihoods of others, is violent and has a history of retaliating against people.”
—respondent, age unknown

- **Thought it was their fault/embarrassed to seek care**

“I felt that I brought it on myself, who would believe what had happened, it would have been consensual at first but then things just went all wrong.” —21-year-old female

“Went to the doctor 2 to 3 months after the incident. Did not want to be embarrassed in front of others. I didn’t have any evidence, I felt I washed it away. I felt very dirty, then, the time of the month came 2 days later. I felt who would want to examine me like this. I had finally got coverage but had a pediatric Dr., got this straightened out then didn’t know what Dr. that accepted my coverage would see me. It was the worst time of my life. Not having a Dr. when most needed.”
—35-year-old female

“I don’t have health insurance and I was drunk when the incident occurred and I thought it was my fault.” —37-year-old female

- **There were no physical injuries**

“What happened to me did not require medical attention.” —32-year-old female

- **Sexual assault did not include intercourse**

“My sexual assault didn’t involve intercourse, but oral sex. I didn’t feel like I had to go to the hospital afterwards.” —34-year-old female

“There wasn’t full penetration.”
—25-year-old female

At the hospital, what services do survivors find helpful?

Victim Advocates

Victim advocates provide emotional support to a victim of sexual assault in the hospital setting. In New York City, victim advocates are usually either community volunteers who complete a 40-hour training administered by their local rape crisis program and overseen by the NYS DOH, or they are hospital social workers. There is at least one hospital in NYC that trains ancillary emergency room staff (patient care technicians) to serve as patient advocates.

The 2004 *National Protocol for Sexual Assault Medical Forensic Examinations* outlines the role of patient advocates. Advocates may accompany victims from the initial contact and the actual exam through to discharge and follow-up. In particular, they:

- Assist in coordination of victim transportation to and from the exam site;
- Provide victims with crisis intervention and support to help cope with the trauma of the assault and begin the healing process;
- Actively listen to victims to assist in sorting through and identifying their feelings;
- Let victims know that their reactions to the assault are normal and dispelling misconceptions regarding sexual assault;
- Advocate that victims' self-articulated needs be recognized and their choices be respected;
- Advocate for appropriate and coordinated response by all involved professionals;
- Support victims in voicing their concerns to other service providers;
- Respond in a sensitive and appropriate manner to victims from different backgrounds and circumstances, and reduce barriers to communication;
- Serve as an information resource for victims (e.g. answer questions, explain the importance of prompt law enforcement involvement if the decision is made to report, explain the value of medical and evidence collection procedures, explain legal aspects of the exam, help them understand STIs, HIV and pregnancy treatment options, and provide referrals);
- Provide replacement clothing when clothing is retained for evidence, as well as toiletries;
- Aid victims in identifying individuals who could support them to heal (e.g. family members, friends, counselors, religious or spiritual counselors/advisors, and/or teachers);
- Help victims' families and friends cope with their reactions to the assault, providing information and increasing their understanding

of the type of support victims may need from them; and

- Assist victims in planning for their safety and well-being (USDOJ, 2004).

Volunteer victim advocates are a crucial component of the care of survivors in the hospital. In this study, survivors were asked if a volunteer victim advocate assisted them in the hospital setting. The question was worded as follows: "Sometimes survivors have a counselor who helps guide them through the visit at the hospital. This counselor is called a victim advocate (also known as a rape crisis advocate or rape crisis counselor) and is not part of the hospital staff. Did you have a victim advocate at the hospital?" 50% (n=13) of those who went to the hospital said they had a victim advocate at the hospital. For those respondents, the majority were very satisfied (50%) or satisfied (28.6%) with the victim advocates.

On the importance of rape crisis advocates, one survivor noted:

"Hospitals need to acknowledge that people who were raped before rape advocates evolved, were considered the instigators and this is something we will always live with...even though we know now, it isn't true, it affected our relationships with family and friends and how we've developed socially..." 50-year-old female

Chart 5 shows many of the services offered by volunteer victim advocates to survivors in the hospital setting. Nearly all of the survivors who had victim advocates stated that they received:

- information about counseling (93%),
- the support they needed during the hospital visit (79%),
- information about reporting to the police (71%) and
- an explanation of the components of the medical exam from the victim advocate (79%).

Overall, the impact of victim advocates is a very positive one. In fact, the presence of a victim advocate had a statistically significant impact on the

survivor's satisfaction with the care they received at the hospital ($p < .05$). Survivors who had the help of a victim advocate report being 'very satisfied' or 'satisfied' more than survivors who did not have the help of the victim advocate.

How do survivors feel about their experiences with clinicians?

Exactly half of the respondents said they waited a long time to see a clinician (Doctor, Nurse, Physician Assistance, Nurse Practitioner) when they went to the hospital after the sexual assault. One respondent said:

"No one bothered to speak to me. I was there with my 12 year old sister and her 14 year old friend. Not ONE person spoke to us. We had to wait for

family to get there. I was also an employee of one of the doctors there. There was ZERO counseling. We were put in a room and couldn't even get a nurse to stay with us." 32-year-old female

Among those seeking care at a hospital ($n=32$), one-third reported that the clinician made a follow-up medical appointment (38%) and slightly fewer were asked by a clinician if they had a safe place to go after leaving the hospital (34%) or were given information about reporting to the police (34%). More respondents were given information about emergency contraception when appropriate (68%), were given information about sexually transmitted infections (STI's) including HIV (59%) and a little over half were given information about medicine to help prevent the HIV infection (post exposure prophylaxis).

chart 5: Victim Advocate Services

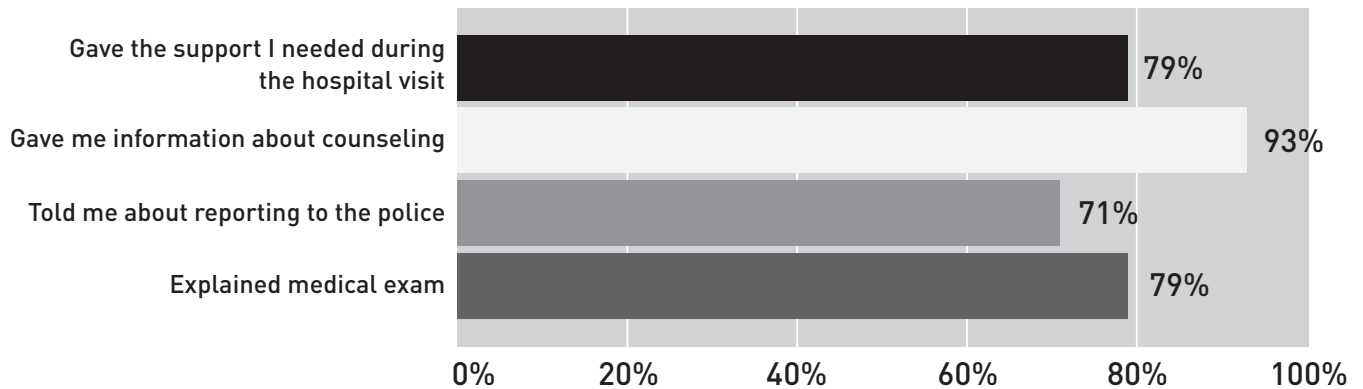
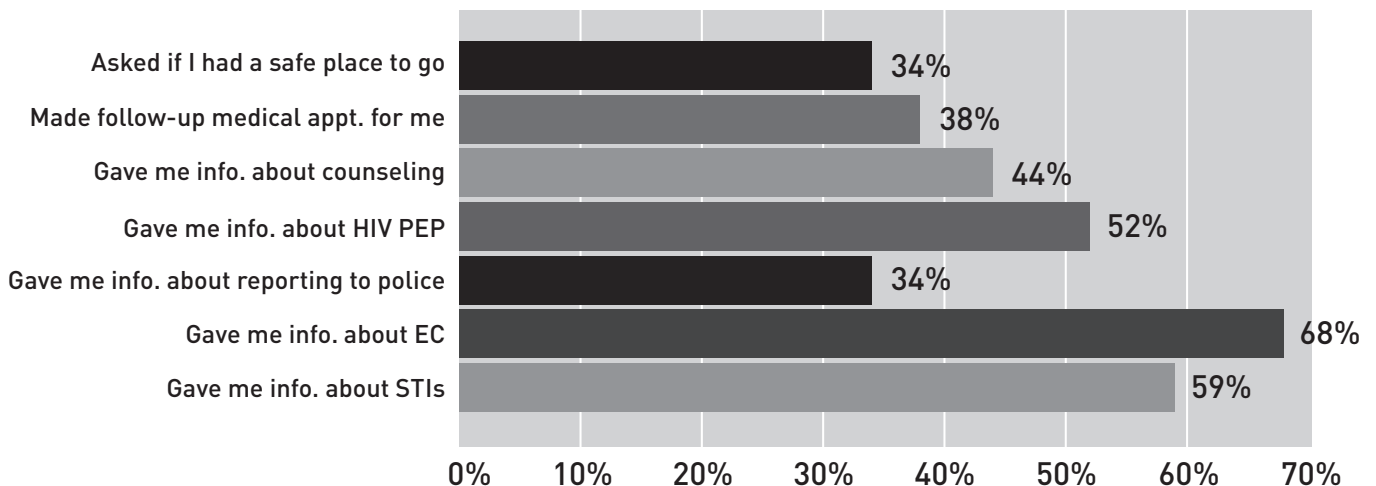


chart 6: Treatment by Doctor/Nurse



Survivor Voices:

What was the best thing about going to the hospital?

“Feeling more secure after getting the tests/medication I needed.”

—21-year-old female

“The victim advocate who arrived while I was there and receiving medication to prevent any disease.”

—33-year-old female

“I felt in control again, I felt like I was doing everything I could.”

—34-year-old female

“Immediate rape kit and drug test were performed. Female officer supportive and with me [the] whole time. Special Victim’s Unit agent came. Rape advocate supportive and necessary. Phone calls to family.”

—24-year-old female

“I was checked for diseases, also somebody listened, but only about ‘that rape’”

—50-year-old female

“I knew that I was doing everything to prevent/treat STDs and HIV.”

—23-year-old female

“The staff realized the importance of listening and working with the patient for their well-being, and refused to disclose my personal information to my mother...”

—36-year-old female

“I was taken by the paramedics that the police patrol that came to apartment called.”

—30-year-old (gender not given)

“It eased my worries about STDs and HIV.”

—28-year-old female

“My injuries were noted and attended to. In addition, my medical examination provided the essential evidence.”

—57-year-old female

“Learning I was okay physically.”

—25-year-old (gender not given)

“Precautionary measures were taken against STDs and pregnancy.”

—26-year-old female

“The validation.”

—26-year-old female

“The victim’s advocate and a small sense of empowerment.”

—25-year-old female

“They gave me STD shots and believed me.”

—54-year-old male

“I was able to do rape evidence kit with enough evidence to have a more definite conviction.”

—32-year-old female

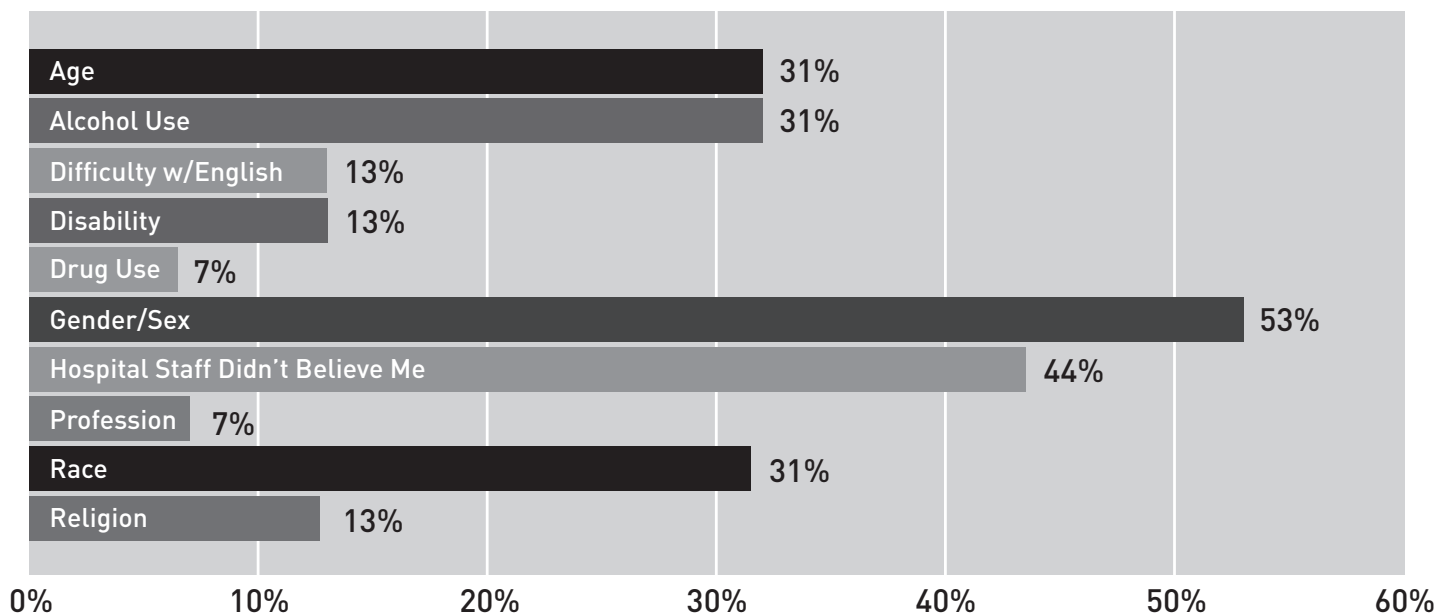
“Counseling, feeling safe.”

—44-year-old female

Of respondents who went to the hospital after the assault, 60% went within the last three years. Among the survivors visiting the hospital in the past three years, a higher percentage were asked if they had a safe place to go to after leaving the hospital (44%), more follow-up medical appointments were made (40%), more information was given about HIV PEP (61.5%), more information was given about EC (67%) and STIs (67%) where appropriate. For more recent hospital visits, fewer respondents were given information about other services such as reporting to the police (33%) and counseling (38.8%).

Half of the survivors surveyed reported feeling treated poorly at the hospital (n=16). Chart 7 shows the main reasons why respondents felt clinicians treated them poorly. Overwhelmingly, of those that felt poorly treated, respondents felt that their gender biased clinicians against them. Importantly 44 percent of these respondents felt like hospital staff did not believe their disclosure of sexual assault. Unfortunately data limitations prevent further exploration of these reasons, showing a clear area for additional research.

chart 7: Why Respondent Felt Poorly Treated at the Hospital



The respondents were asked to provide any other reasons they felt they were treated poorly at the hospital:

"I was behaving badly; I was somewhat hostile and often tearful." —37-year-old female

"The doctor suggested I should date and forgive my boss for raping me because he was wealthy and 'gentle.' This made me feel embarrassed about being angry for being physically forced to have unwanted intercourse with him." —23-year-old female

"They were not experienced with date rape victims and [there was] very little communication between the internist, attending and ob/gyn."

—26-year-old female

"was brought to the PEDIATRICS ER — TOTALLY OUT OF LINE!!!"

—32-year-old female (emphasis original)

Providing Care to Survivors with Mental Illness

“Once we have labeled a woman as suffering from a major mental illness, whether that label is an accurate assessment or not, we view her reports of sexual and physical abuse through the colored lens of her diagnosis...The stigma of her diagnosis is often sufficient to call her account into question.” (Harris & Landis, 1997)

Sexual violence in the lives of both men and women with mental illnesses is widespread. A two-state study found that 26% of men and 64% of women with severe mental illness had been sexually assaulted at some point in their lives (Mueser et al., 1998). In a recent study, 782 men and women with severe mental illness were interviewed. In this study, 20.3% of the women and 7.6% of the men reported a sexual assault within the past year and 57.1% of the women and 24.5% of the men experienced a sexual assault during adulthood (Goodman et al., 2001).

Emerging research focuses on adult survivors of sexual violence who have a mental illness and their treatment by service providers. A recent study conducted in New Zealand found that when sexual abuse was disclosed to service providers at a community mental health center that these staff noted the abuse in their clients files but did very little if nothing to address the violence. Only 33% of the treatment plans mentioned the abuse and only 22% of the abused clients received abuse-focused therapy. None of the assaults were reported to the police (Agar & Read, 2002).

A chilling and thoughtful article written by the mother of a daughter who was sexually abused as a child and suffered from chronic mental illness tells of the retraumatization of her daughter in the mental health system. The account underscores how early childhood trauma experiences are mimicked

in common mental health institutional practice (Jennings, 1994). Other research has also reflected on the practices of working with mental health patients such as using coercion, constraints and involuntary treatment that may cause retraumatization to survivors of sexual violence (Clark et al., 2005).

All service providers need to be cognizant of the stigmatization that is associated with mental illness and provide victim-centered care that does not blame the victim. One survivor in the current study spoke of her experiences in the hospital setting:

“The doctor walked in the ER just looked at the notes and looked at the meds I take- I have a mental illness and he looks at me and ask me how do I know I was raped? And from there on it felt like it was going to happen again so my agenda switched and it was just to get out of there as quickly as possible.”

When asked what the worst thing was about going to the hospital, she responded:

“That I went to seek treatment- I was scared anyway...I called my mentor and I told her. She demanded me to go to the hospital and to make sure I did she had spoke to my mom and had my mom take me- but the experience there reinforced my fears-and now simple things that I would have went for I can't anymore.”

Recommendations for changing the hospital system:

“That people who are survivors of sexual assault wouldn't be 'punished', as I have, by going to a mental hospital after their attack(s).”

Survivor Voices:

What was the worst thing about going to the hospital?

"I felt like I wasn't believed, I wasn't informed about what was necessary medically vs. legally." —23-year-old female

"Having to expose myself in an uncomfortable way again so soon after the attack. Having to answer questions...the mental energy it took to think logically at that point."

—28-year-old female

"The confusion. First, I saw the internist who was going to perform the kit. However, she did not know what to do. When she came back in she told me that in order to perform the kit, the police would have to be involved. An hour later the social worker showed up and clarified the situation because I did not want police involvement. Then the attending came in and told me he could not answer my questions, but that the ob/gyn would be in to perform the kit. Several hours later the ob/gyn came in with a female doctor and another doctor who observed. They were kind and respectful, but without the attending ob/gyn, they would have not known what to do. I walked in at 8pm and walked out of the hospital at 4am the following morning. The hospital was very quiet that night."

—26-year-old female

"The doctor and nurse in the emergency room, in my opinion, weren't emotionally supportive of me." —41-year-old female

"The expense, the time wasted, the further insult to my body, my spirit, my mind, and the emotional aftermath of being treated so cruelly by everyone I came into contact with. Many of the people working at the hospital would not look me in the eye and they would not answer my questions. And when I cried, it terrified them. They did not know what to do with a person who had tears flowing down her cheeks. They panicked and looked

for ways to isolate me and deprive me of my freedom (such as being able to leave the hospital)." —37-year-old female

"I was very weary and needed to clearly recount details many times."

—57-year-old female

"The long waits, the educational video about HIV playing over and over in the lobby as I waited to be tested for HIV, the lack of comfort or understanding of the doctors and counselors, feeling like I was a number, being made to feel guilty for my sexual choices and for the assault by the counselors." —21-year-old female

"Having to explain everything so many times."

—25-year-old (gender not stated)

"They charged me a lot of money after promising I wouldn't have to pay for the visit. They couldn't figure out how to work the camera to take photographs so I was stuck sitting naked on the exam table for an hour. They were training someone on how to do the exam. It didn't seem like anyone knew what they were doing." —26-year-old female

"It is embarrassing and a little scary, I just wanted to start forgetting."

—34-year-old female

"Was not offered emergency contraception, did not offer info about HIV prevention, did not talk to me much, was not sensitive to my situation, made follow-up appt. too far from treatment. Told me morning after pill would not be offered to me by them. Told me they wouldn't give me HIV prevention cocktail, to follow-up with primary care health provider if I was interested." —24-year-old female

Survivors' Recommendations

Twenty-four survivors gave their recommendations to help make hospital services better for other survivors.

1. Provide rape crisis advocates

Many respondents mentioned that the best way to improve services at the hospital is to provide trained rape crisis advocates.

"Have counselors and advocates readily available (let people know that the services are available so they don't have to ask) that are trained to be sensitive and not to blame the survivor, to be with the person throughout the whole process if they are asked to be. The examinations felt very violating...one doctor was talking to a nurse freely while he gave me a pap smear and didn't tell me what he was going to do and did it all very fast. The environment was not at all comforting. Again, I would suggest that they have trained, sensitive advocates readily available."
—21-year-old female

"Counseling follow-up."
—30-year-old (gender not stated)

"Have rape counselors available 24/7...There must be some sort of counseling for victims as well as a comfortable place to sit or lay down, not a cold dismal examining room." —32-year-old female

2. Provide comprehensive treatment

Several survivors mentioned that comprehensive treatment should be provided, and that when a hospital is unable to provide this treatment, a referral should be made to a hospital that can provide appropriate treatment.

"Emergency contraception should be offered and available on site. Pictures should be taken. HIV prevention cocktail should be available, explained and prescribed. Follow-up appt. should be made within 72 hours. If none of the above mentioned is possible, immediate referrals/transfers to other facility should be arranged."
—24-year-old female

"...A GHP [sic] and Rhophynol [sic] test should have been performed. I had to call the nurse the following day to see if I was tested. It was not the attending's choice to decide if that should have been performed..." —26-year-old female

3. Screening for sexual violence should occur in the ER

Several respondents stated that in order to make services better, it is important for the hospital to screen patients for sexual violence, both verbally and through their intake forms.

"When a girl comes in with broken ribs and says the injury happened while she was on a blind date, and then she starts sobbing, you might take her aside and ask her if she was sexually assaulted. I went to three different hospitals and not one person asked me that..."
—37-year-old female

"They should have a section especially for victims of violence and sexual abuse on their intake forms, and hire skilled doctors and counselors in this area." —36-year-old female

4. Better training for clinicians that handle sexual assaults

Many respondents mentioned that the attitudes of the clinicians needed to change in order to make the hospital a better place. Specifically, survivors mentioned making sure the victim feels believed, working with clinicians to make sure they are comfortable with handling sexual assault cases and providing training for interacting with survivors. All of these respondents were seen at a hospital that was *not* a NYS Department of Health certified SAFE Center of Excellence.

“I would have female doctors available to do the physical exams, and I would be sure the staff made the victim feel believed.” —25-year-old (gender not stated)

“More comfortable attending doctors and more privacy.” —33-year-old female

“Nurses and doctors should be more careful and sensitive to the patient’s needs, including how they talk to the patient (tone of voice)...”
—24-year-old female

“The doctor should be more patient and explain what she’s doing and not make it seem like I am stupid for reporting a rape when there wasn’t excessive physical damage.” —23-year-old female

“Someone, somewhere needs to make sure that women who say they were crime victims on city/state/federal jobs get real help and investigations and care.” —43-year-old female

5. Decrease the wait time in the ER

It was mentioned that one thing that could be improved for other survivors is to decrease the overall wait time experienced by victims in the ER.

“Decrease the wait time. My whole visit took 4 and a half hours. Which was torture...not being able to bathe, lying around half naked for hours alone just waiting and thinking.” —28-year-old female

6. Have more specially trained clinicians

It was also mentioned that having more doctors and nurses to work exclusively with sexual assault victims would be an improvement at the hospital.

“The nurse and doctor were very busy and seemed very overworked. The nurse was somewhat short with me and the doctor had to keep going back and forth between patients. I would hire more doctors or nurses to handle these cases.”
—25-year-old female

“I felt heard and understood when I really needed help.” —34-year-old female

Chapter 3: Rape Crisis Programs

Many survivors seek services from rape crisis or victim assistance programs to receive emotional support and begin the healing process from the trauma of sexual violence. Survivors seek care from these programs shortly after the assault or even many years later. Most programs in NYC offer short-term individual and group therapy at no cost to the survivor.

This chapter covers the services provided by rape crisis and victim assistance programs in NYC. This study measured the following aspects of rape crisis programs: **1)** what prevents survivors from going to a rape crisis program, **2)** experiences with rape crisis counselors, **3)** satisfaction with services, **4)** the positive and negative aspects of going to a rape crisis program and **5)** recommendations for improving rape crisis services for sexual assault survivors. This chapter also includes information on lesbian, gay, bisexual and transgender (LGBT) survivors.

Rape Crisis/Victim Assistance Programs in NYC

Rape crisis programs are the longest-standing community-based interventions for sexual assault. Rape crisis programs began in the 1970s, when volunteer activists received training on the crisis response and were on-call to come to the side of a rape victim wherever she was, and to accompany her to the hospital or police, or neither. As there were few women police officers when this movement was born, the police sometimes contacted the advocates to come and talk to and comfort a rape victim. Now, there are more than 1200 rape crisis programs in the United States (Campbell & Martin, 2001; Martin, 2005 as cited in Campbell, 2006) and over 20 rape crisis programs in New York City.

Rape crisis programs are now mainly located in hospitals, with a small number located in community-based or university institutions. Most programs have paid staff that can provide short-term, confidential, individual and group counseling to survivors, regardless of how long ago the assault

took place or where it occurred. Most of these programs also offer their counseling services for free. Increasingly, many programs are offering specialized services for adolescents, males, LGBT and non-English speaking survivors.

Volunteers are still an integral component of rape crisis programs and serve as rape crisis advocates to provide support to patients who go to the emergency department after an assault. These volunteers are carefully selected and receive 40 hours of training on crisis intervention, quality care, working with co-survivors and the hospital, law enforcement and criminal justice systems of NYC, and are often on-call once or twice a month.

A recent evaluation study that interviewed victims and reviewed records found that survivors who had the assistance of an advocate were more likely to have police reports taken and were less likely to be treated negatively by police officers (Campbell, 2006). Survivors who worked with an advocate during their emergency department care received more medical services, including emergency contraception and sexually transmitted disease prophylaxis, and reported significantly fewer negative interpersonal interactions with medical personnel than survivors who did not have an advocate (Campbell, 2006). Furthermore, survivors reported less distress from their emergency department visit when they had an advocate present (Campbell, 2006). While this initial research is important, it is also crucial to examine the impact of both counseling services and the rape victim advocate on the long-term health outcomes of survivors.

Measuring satisfaction with counseling services

Measuring satisfaction with counseling services is also common procedure for quality assurance and program improvement in many counseling centers throughout the city. All of the rape crisis programs operate under clear guidelines regarding patient care, privacy and confidentiality. The more

difficult construct is measuring satisfaction *across* programs, as each program is different and may have a different counseling approach. In this study, the satisfaction measurement is subjective; we asked survivors if they felt better as a result of their counseling experience. We did not ask survivors to reflect on the method of counseling; rather we asked them how the counseling and the approach made them feel.

Research Questions and Findings

What prevents survivors from going to a rape crisis program?

In this study, 70.6% (n=36) of survivors went to a rape crisis or victim assistance program after the sexual assault. More respondents reported contacting a rape crisis program (n=44) than those who reported going to a program (n=36). More survivors went to a rape crisis program than any other service. For those that did not go to a rape crisis program, we asked “Was there anything that prevented you from going to a rape crisis or victim assistance program?” Fourteen respondents identified the main reasons for not going to a rape crisis program after the sexual assault:

- **Accessibility**

Several survivors mentioned that accessibility was a major reason they did not go to a rape crisis program.

“Lack of wheelchair accessibility.”
—55-year-old female

“I am looking for a counselor, which seems to be difficult to find.” —26-year-old female

- **Prior negative experience with service providers**

Several respondents mentioned that prior bad experiences with service providers, such as the police or hospital staff, led them to not want to go to a rape crisis program.

“All I can remember is that I was so disgusted and humiliated after the way I was treated by NYPD I did not have the will or the strength to go on any further.” —41-year-old female

- **Fear**

A few respondents mentioned that fear played a role in not seeking help from a rape crisis program.

“Afraid to even leave the house.”
—25-year-old female

“For more than 10 years threats [from perpetrator] including jail threats and thugs hired to threaten me.” —49-year-old, gender not stated

- **Seeking counseling services elsewhere**

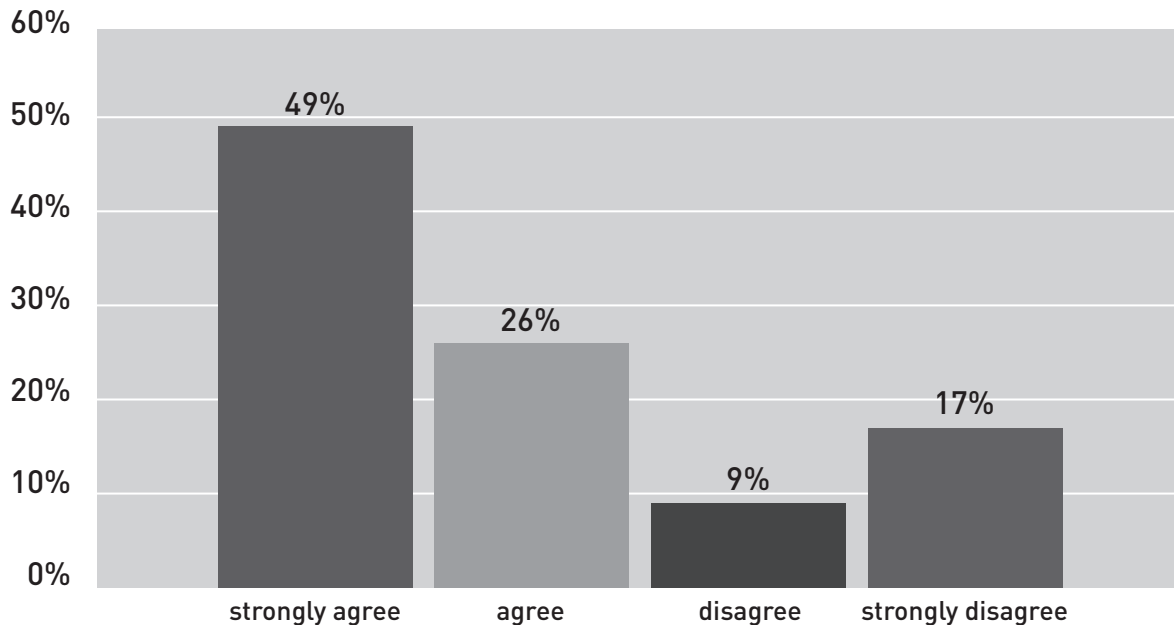
Survivors stated that since they were seeking counseling elsewhere, this prevented them from going to a rape crisis program.

“I had a counselor already, not rape crisis.”
—34-year-old female

Experiences with rape crisis counselors

Similar to other service sectors, just over half of respondents (53%) who sought services from a rape crisis/victim assistance program did so within the last three years. All survivors who sought services at a rape crisis program were asked a number of questions about their experiences with both the program and the rape crisis counselors. Most of these respondents (80.6%) ‘strongly agreed’ or ‘agreed’ that they could trust their counselor. Furthermore, Chart 8 shows the percentage of respondents that felt their counselor knew how to help them.

chart 8: I Felt My Counselor Knew How To Help Me



Respondents were asked if they were satisfied with the advice given to them on how to speak to their partners about the assault. Approximately half of the respondents said they were not satisfied with the advice given to them and a full third said that they were not given any advice when appropriate.

The majority of respondents (52.4%) said their counselors also gave them information about what to expect from the police, when this is a course of action they sought or considered seeking. A smaller percentage (42.1%) reported that their counselors gave them information about what to expect from the District Attorney, where applicable.

Survivors were also asked how comfortable they felt talking to the counselor about their experiences. The majority felt comfortable 'all of the time' or 'most times' (61.1%) with a small percentage (16.7%) stating that they 'never' felt comfortable speaking to their counselor.

As with other service sectors, survivors were asked if at any point they felt treated poorly at the rape crisis or victim assistance program and 22.9% (n=8) said they had. The top reasons for why they felt treated poorly were gender/sex, age and their difficulty in speaking English.

"I just felt that she didn't care. I was [a teen]...I don't think she had the knowledge or experience to deal with that." —32-year-old female

"lack of cultural competencies around alternative sexualities..."
—32-year-old transgender female to male (FTM)

"It was primarily for women" —54-year-old male

Overall, the overwhelming majority (74.3%) of survivors said they felt better as a result of their counseling experience. The majority of respondents (65.7%) felt 'very satisfied' or 'satisfied' with the emotional support that was provided by the counselor. Overall, a high percentage (68.5%) of the survivors in this study were 'very satisfied' or 'satisfied' with the rape crisis or victim assistance program they visited.

Survivor Voices:

What was the best thing about going to a rape crisis program?

“All of the support, sympathy, careful talking, kindness from all the staff...My counselor’s availability to me...overall relationship with my counselor and the office manager/secretary.”

—24-year-old female

“I feel like I’m taking steps to heal.”

—25-year-old female

“Being told what to do to receive treatment and assistance. [My program] was very helpful, supportive, and I really appreciate everything they did for me.”

—23-year-old female

“I felt heard and understood when I really needed help.”

—34-year-old female

“Designing a program or structure with my counselor as a guide. Not only talking about the incident but also talking about me and my life to apply strength and confidence to areas that were weakened by the event and led up to the event. [My counselor] is the best! She is really good at what she does.”

—30-year-old female

“They understand your history and are sensitive to your needs.”

—36-year-old female

“Having someone to talk to and to help me through the process of working with the police, detectives and receiving compensation/coverage as I was uninsured at the time.”

—33-year-old female

“My feelings and experiences were validated and I was comforted and reassured.”

—57-year-old female

“I received the help I needed and the counseling sessions went deeper than the sexual assault. It helped me to see it wasn’t my fault and that I am worthy of unconditional love.”

—43-year-old female

“It was a safe space. Nothing I said, did or felt would shock them. My counselor knew about what I was feeling and what I would feel as time passed from the experience.”

—28-year-old female

“Group counseling.”

—31-year-old female

“How supportive and cared for I felt. This was the first time I felt like I could trust telling someone about my experiences and I also felt like I was really being helped.”

—20-year-old female

“To let my feelings out and being able to vent and cry without being embarrassed or uncomfortable.”

—53-year-old female

“The people really cared about my mental state and how I was feeling. They were also passionate about trying to change university policy. Although the rape crisis center was helpful, the office on campus (where sexual assault is reported and tried) was not.”

—25-year-old female

Lesbian, Gay, Bisexual and Transgender (LGBT) Survivors: Navigating Through Heterosexist Systems

“The [Rape Crisis Program] did a great job. I found at the other programs that people were not able to deal with the particulars of the abuse, and my sexual orientation and gender identity.”

—32-year-old transgender female to male (FTM)

The institutional level of heterosexism, built upon cultural norms, is high in our society. Given the invisible nature of heterosexism to heterosexuals, it usually comes as a surprise to realize how widespread it is (Girshick, 2002).

Homophobia, biphobia and heterosexism have major implications for service providers. Many social workers are not considering the full range of issues for their clients because they are not comfortable disclosing their sexual orientation (Appleby & Anatas, 1998 as cited in Girshick, 2002). Furthermore, survivors may perceive that therapists and other service providers are not open to sexuality issues or that they are insufficiently trained about human sexuality. Likewise health care providers and other service providers may make assumptions about heterosexuality and stigmatize patients by asking inappropriate questions. LGBT survivors may be further stigmatized by the false yet common belief that previous (especially childhood) sexual abuse resulted in their sexual orientation.

Rape, sexual assault, and related terms have the power to label some acts negatively, while ignoring and, by implication, condoning other acts. How these terms are defined affects how people label, experience, evaluate, and assimilate their own sexually coercive incidents. In addition, the definition of these terms convey numerous assumptions about power and coercion, sexuality, and gender. (Muehlenhard et al., 1992 as cited in Girshick, 2002).

In New York State, rape is defined as engaging in sexual intercourse by forcible compulsion or by engaging in such action with a person who is incapable of consent. “Sexual intercourse” has its *ordinary* meaning which is penis to vagina penetration and occurs upon any penetration, however slight. One of the major legal problems lesbians, bisexuals and gay men face is that oftentimes the state defines their sexual behaviors as illegal or deviant. Regardless of how these laws and definitions are enforced, that these “blue laws” are still on the books adds to the ‘hostile environments in the courts’ —(Hodges, 2002 as cited in Girshick, 2002).

Overall, heterosexism in the legal system can be found: in how sexual acts are defined and sometimes criminalized even when consensual; in gender neutral language that is not necessarily sexual orientation neutral; and when rape is not a charge applied for LGBT survivors and when it is, only at misdemeanor level (Girshick, 2002). This atmosphere discourages LGBT survivors from seeking protection and bringing the perpetrators to justice.

“Treat men who are raped the same way women are treated...it WAS rape even if I was not penetrated in the vagina...special sensitivity is needed to LGBT issues (hate crimes) and someone to talk to you and comfort you.”

—54-year-old male

“I’m a sex researcher, and SM activist and a bisexual woman, and he was a bisexual man. We are both black. The DA’s office doesn’t give a shit about black women, particularly black women who won’t be victims..” —44-year-old female

Survivor Voices:

What was the worst thing about going to a rape crisis program?

“Dealing with the reality of the crime.”

—44-year-old female

“I felt judged.” —26-year-old female

“Having to face what happened to me.”

—26-year-old female

“I didn’t have an advocate to help me get through this pain of how to talk to the police or detective about the rape.”

—35-year-old female

“It was primarily for women.”

—54-year-old male

“It’s difficult to disclose information to strangers about something so personal and traumatic.”

—25-year-old female

“The fact that it was short-term.”

—20-year-old female

“Lack of understanding, lack of culturally competent services.”

—32-year-old transgender female to male (FTM)

“They never followed up.”

—31-year-old female

“It is only short term...a year at the most. If you want to continue therapy you have to find a new counselor.”

—28-year-old female

“Naturally it was difficult to talk about.”

—57-year-old female

“Getting there...I’d procrastinate and put off appointments.” —24-year-old female

“The limits people put on assistance due to lack of paperwork, i.e. police reports, hospital reports, RO’s, etc. When my life would be threatened and possibly terminated if these reports were obtained against my attackers.”

—36-year-old female

“She didn’t care. No one seemed to. It was as though it was a joke to people.”

—32-year-old female

“Probably that I had to pay a fee...”

—41-year-old female

“They did not seem to have much information. I emailed [a women’s organization] and they never responded, so I gave up on organizations.”

—28-year-old female

“Rehashing all the terrible details/memories.” —25-year-old female

Too hurried, too rushed, my problem and/or situation was too enormous or better yet too profound for her to handle. I was treated with an impatient, disinterested attitude” —41-year-old female

Survivors' Recommendations

Twenty-three survivors gave recommendations to help make rape crisis and victim assistance programs better for other survivors.

1. More training for counselors

Several survivors mentioned that more training should be provided to the rape crisis counselors to better help survivors.

"Better trained staff and assistants who are prepared to handle such case sensitive clients and information. People who lack empathy have no business working in areas of such sensitive nature." —41-year-old female

"Have better understanding counselors..." —32-year-old female

"More services for transgender clients, more awareness about alternative sexualities including BDSM." —32-year-old transgender female to male (FTM)

"...not to make male-on-male rape taboo." —54-year-old male

2. Have connections to and provide other services for survivors

Many respondents mentioned that there need to be referrals and connections made from rape crisis programs to other services, especially safe housing.

"Add legal services." —23-year-old female

"Immediate safe shelter/housing set aside for victims of violence and sexual abuse. Based on counseling history, which is often free and confidential and does not impose an immediate vulnerability attack to victims such as myself." —36-year-old female

"Need to have a connection to help victims of domestic violence and make housing better than it is. You stay in Tier II too long or Tier I

too long and people go back to their batterer. This isn't good!" —53-year-old female

"[There is a] lack of shelters and safe houses that are accessible..." —55-year-old female

3. More group therapy

One recommendation for improving services was to offer more group therapy for survivors of sexual violence.

"Group therapy could be valuable and interesting." —30-year-old female

"More group sessions throughout the year." —26-year-old female

4. Offer long-term counseling

Many respondents mentioned that one way to improve services for other survivors would be to have more long-term counseling.

"I would make sessions longer." —20-year-old female

"The program is an excellent program, maybe more time and more sessions." —43-year-old female

5. Offer free services

It was mentioned that one thing that could be improved for other survivors is to offer counseling services at no charge to survivors.

"That they would accept medical insurance or give free services for financially challenged survivors of sexual assault." —41-year-old female

“The officer was helpful and took me seriously.” —44-year-old female

Chapter 4: Law Enforcement

One option available to sexual assault survivors after an assault is to report to the police. Many survivors report the crime to the police to apprehend the perpetrator in order to feel safer and more empowered. Many survivors also choose not to report to the police.

This study assessed the following with regard to law enforcement: **1)** what prevents survivors from going to the police, **2)** the specifics details of their contact the police, **3)** experiences with the police, **4)** treatment by uniformed officers, **5)** treatment by non-uniformed officers, **6)** satisfaction with the police, **7)** the positive and negative aspects of reporting to the police after a sexual assault, and **8)** recommendations for improving the law enforcement response to sexual assault. This chapter also includes information on male survivors of sexual violence as an underserved population.

Law Enforcement

All police officers of the New York City Police Department (NYPD) are trained how to respond to sexual assault cases. Furthermore, specialized response is available through the Special Victims Division. In 1972, the NYPD started the Rape Hotline to respond to cases of sexual violence. A couple of years after the Rape Hotline was initiated, each borough instituted Sex Crimes Units to work on these cases locally. Only in January 2003 was a Special Victims Division created, with each borough squad reporting to a citywide command that works directly under the Chief of Detectives. Staten Island does not have a Special Victims Squad at this time but detectives assigned to the borough receive the same training. 911 operators also receive training by the Special Victims Division on telephone communications, rape trauma syndrome, domestic violence, and counseling resources available to survivors.

Detectives in the Special Victims Division all attend a week-long Sex Crimes and Child Abuse Investigation Course given by the Special Victims

Division that is accredited by the State University of New York. The course consists of approximately 25 lessons from leaders in the field of investigating and prosecuting sex crimes, and always opens with a compelling story of a survivor to emphasize the need for empathy. Each year five or more Special Victims detectives are invited to attend the Sex Crimes Course given by the New York State Troopers, and when available investigators attend other related conferences.

According to the NYPD Academy, the role of the first-response uniformed police officer in a sexual assault case is not investigative. They are there primarily to provide aid to the victim (Police Academy, 2006). The Recruit Training Section Student Guide explains that the first police officer on the scene of a sex crime plays an important part in minimizing the trauma and in maximizing the chances of successful prosecution. In the sex crimes cases, police officers are taught to recognize that the victim is probably suffering the most traumatic experience of his/her life and to therefore, demonstrate extreme patience, compassion, and understanding in these encounters.

A uniformed police officer is often called in first response on a case of sexual assault. The detectives, regular or Special Victims, are called in later and often arrive at the hospital emergency room after the survivor's arrival. In cases where uniformed officers are not involved, the police may be notified by the hospital if the survivor wishes to report. When this happens the detectives may be the first response officers. In either case, the role of the detective is in many ways quite different from the role of the uniformed officer. One of the primary goals in the investigation of an adult sex crime is the identification and arrest of the perpetrator.

In the Detective Bureau, investigators are given the Executive Laws that require that a private setting be used for an interview with a sex crime victim,

and that allow a rape crisis counselor (advocate) to be present during an interview, unless the victim objects. The detective procedure includes fifteen points (prior to apprehension) beginning with the interview of the first responders as well as the victim, and obtaining medical attention for the victim. The other points are concerned with the proper collection and handling of evidence (Lt. S. Clark, personal communication, September 4, 2006).

Since the police officers work in direct contact with victims, it is important for them to have the capacity to understand multiple languages. In March 2004, the Language Line Program was launched, which equips all police precincts with direct, instant access to language interpreters 24 hours a day. Each precinct stationhouse has special dual-handset telephones with access to interpreters in over 150 different languages. Now victims who do not speak English can tell their stories to the police and get the help they need. Since the inception of the program, Language Line phones have been used over 1,000 times in over 30 languages including: Arabic, Bengali, Cantonese, Farsi, Greek, Haitian-Creole, Hindi, Japanese, Korean, Mandarin, Punjabi, Russian, Spanish and Urdu (OCDV, 2004).

The implementation of a Special Victims Division and other services such as the Language Line are important enhancements for survivors of sexual violence during an investigation.

Examining satisfaction with the police

Recently, policing research has focused more on improving community relations and improving citizen satisfaction with police services. In a National Institute of Justice study, *Satisfaction with Police—What Matters?*, authors found that three factors influenced satisfaction: **1)** encounters with the police, **2)** perceived neighborhood quality of life (including feelings of safety), and **3)** neighborhood context (Reisig & Parks, 2002). While police can do little to directly change the perceived neighborhood quality of life, which varies between individuals, administrators are focusing more on citizen interactions with the police as a quality improvement measure.

One study found that people were more satisfied when officers were respectful and met or exceeded service expectations, such as explaining their course of action (Furstenburg, 1973 as cited in Reisig & Parks, 2002). As with measuring satisfaction in other service sectors, satisfaction most often results when expectations are met or exceeded. The question then becomes, what are survivors' expectations when interacting with the police after a sexual assault? Previous research has shown that most citizens expect police to behave in a professional manner, specifically avoiding sarcasm and acting courteously and respectfully (Reisig & Parks, 2002). Several questions were asked in this study to measure satisfaction with interactions with the police. It is clear from this study that survivors expect to be kept informed about the process of their case and what to expect. Furthermore, survivors expected explanations for why certain questions needed to be asked.

Research Questions and Findings

What prevents survivors from reporting to the police?

To better understand the decision-making process, survivors who did not go to the police were asked, "Was there anything that prevented you from going to the police?" Fourteen survivors mentioned several main themes about why they did not go to the police.

- **Afraid of how police officers would treat them**

Survivors expressed that fear of how they would be treated was a deterrent to seeking help with the police.

"I'm hesitant to file a report, because I'm afraid to be asked questions that make me uncomfortable. I have selective memory of the night of my assault and am missing essential minutes, where I don't know what happened. I'm afraid the police won't believe me. The person who assaulted me lives in my neighborhood, and knows where I live; and I see him on the street every now and then. I'm afraid to have to face a confrontation with him, if I file a report." —34-year-old female

"...the domestic violence, fear of prejudice against LGBT folks, fear that they would remove children,

just wanting to get out of the abusive situation.”
—32-year-old transgender female to male (FTM)

“..because I just wanted to get a medical examination and also because I was afraid I would be treated as an instigator...”
—50-year-old female

- **Past negative experience with the police**

Survivors expressed that having past negative experiences with the police also prevented them from seeking help from the police after a sexual assault or continuing to seek help from the police.

In the survey, respondents were asked about prior negative experience with the police. The responses were split fairly evenly between those who did not (57.6%) and those who did 42.4%. However, prior negative experiences did not significantly impact satisfaction with the police response by either the uniformed or non-uniformed officers.

“I did call the police the night I was attacked. However, when the police arrived at my apartment that very same night, one of the officers promised that my underwear I was wearing at the time of my assault would be picked up the next day by another officer at my neighborhood precinct. The officer, however, failed to show up for some reason or other, so I didn’t bother to go to that police precinct.” 41-year-old female

“My attacker was a police officer.”
—20-year-old female

- **Not wanting to get involved in the criminal justice process**

Survivors expressed that not wanting to get involved in the criminal justice process prevented them from going to the police after the sexual assault.

“I didn’t want to arrest my best friend.”
—26-year-old female

“I did not want to get embroiled in anything legal. I did not feel the assault was dire enough to report, I suppose.” —21-year-old female

- **The trauma of the sexual assault**

For some survivors the trauma of the sexual assault and the characteristics of the assault prevented them from going to the police.

“I was confused about my assault. I had been drinking. However, now I know I was slipped a date rape drug.” —26-year-old female

“In the beginning I was catatonic, frozen in shock, hurting, cold, severely traumatized and in extreme pain, and since there was such a violent counter-attack I was very much afraid as well.”
—41-year-old female

- **Other reasons**

Several other reasons for not reporting to the police mentioned included lack of knowledge and access.

“Didn’t know it was my right.”
—25-year-old female

“Wheelchair access and nobody taking me seriously.” —55-year-old female

Help-Seeking Behavior

Over half (49.2%, n= 32) of the respondents contacted security or police after the sexual assault. For those that did report to the police after the sexual assault, questions were asked about how they contacted the police. The police were most likely to be contacted by the survivor themselves (64.3%), as opposed to a friend (14.3%), family member (7.1%) or stranger (7.1%). Most often the police were contacted through dialing 911 (81.5%) and a smaller percentage were contacted through going to a local police station (14.8%).

The majority of respondents who contacted the police did so within a day of the assault (77.4%) and a much smaller percentage contacted the police within two weeks after the assault (12.9%). For nearly two-thirds of the respondents, the police were called during the day (from 8am to midnight) and a smaller percentage (30%) was contacted during the night (between midnight and 7:59am) when it is more likely that the nightwatch will be the first responders. Several respondents didn’t recall when the police were called.

Survivor Voices:

What was the best thing about going to the police?

“They were the best. I will always remember [the two detectives]. They worked their butts off on this case. They truly cared. And I will thank them EVERYDAY for that.” (emphasis original)

—32-year-old female

“Addressed crime quickly...rapist immediately arrested, DA contacted immediately, she called me that weekend. Uniform female officer [was] extremely supportive and non-judgmental.”

—24-year-old female

“Being free to speak my mind about what had happened to me.”

—41-year-old female

“They believed me and were basically nice to me.” —54-year-old male

“Feeling safe.” —44-year-old female

“It helped me to gain a sense of control and safety. And 8.5 years later, as a result of a DNA match that wouldn’t have been collected if I had not gone to the hospital/police, we just put him away!”

—33-year-old female

“They told me exactly what I could do.”

—31-year-old female

“..A detective went the extra mile to make me comfortable. He is the best! They really responded to catch him after I spotted him 3 weeks later. They did instruct me at the time of the incident to keep

my eyes out for him, and I listened and caught him 3 weeks later.”

—30 year old female

“The officer was helpful and took me seriously.” —44-year-old female

“The police were very helpful to me. They also drove me home from the station and picked me up the next morning to go to get a restraining order against the man who assaulted me. I also ran into the arresting officer later in the subway when he was in plainclothes. It made me feel good to see him.” —32-year-old female

“They arrested the guy.”

—26-year-old female

“They drove me home from the scene. I felt safe and I felt like maybe they could prevent a similar incident from taking place with another person.”

—34-year-old female

“They called the ambulance to take me to the hospital.” —36-year-old female

“They really worked hard to try and find the perpetrator. I felt safer when they arrested him.” —25-year-old female

“They were kind when taking my statement.” —23-year-old female

“They treated me with respect and sensitivity.” —female (age not given)

Experiences with the police

Survivors were asked several questions about their experiences and interactions with the police. On average survivors recounted the details of the sexual assault to three police officers, ranging from telling one officer to talking to 12 police officers. For some people, recounting details over and over again can be very traumatizing.

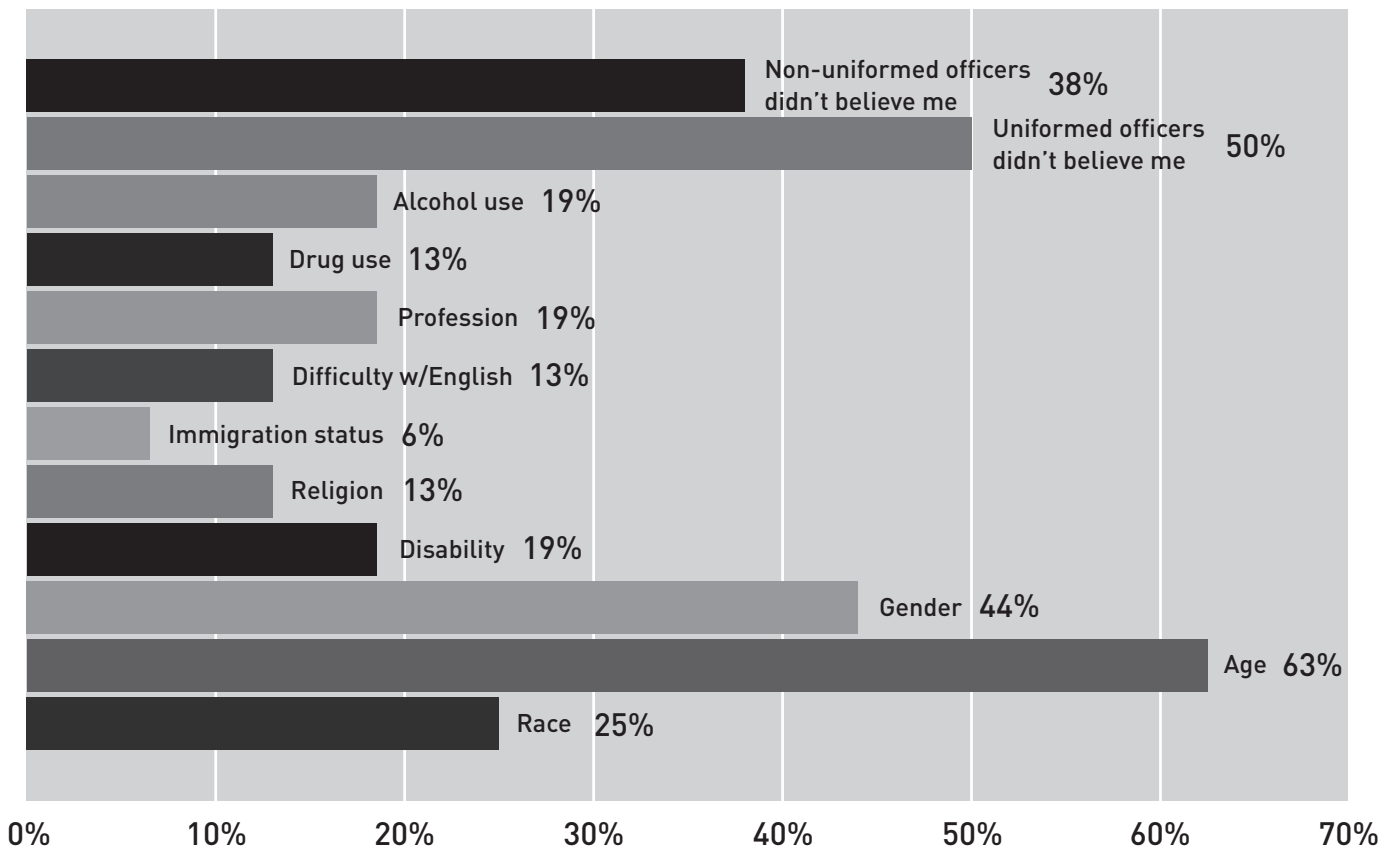
There were also very few referrals to counseling services, support groups or rape crisis programs. Only 29% of survivors said that any police officer gave them this information. Referrals for services such as counseling are very important to address the continuum of care and ensure that holistic care is being provided.

Survivors were also asked if they felt treated poorly by the police at any time. Just slightly over half (51.6%) or sixteen respondents said they did feel

poorly treated at some time. However, the majority of respondents were either 'satisfied' or 'very satisfied' with both their treatment by uniformed officers (78%) and by non-uniformed officers (57%). Chart 9 shows several reasons these survivors thought contributed to their being poorly treated by the police.

For these survivors, age was the main reason cited (62.5%). These responses came from a wide age range of survivors but were mostly concentrated in women in their 20's and 30's. Survivors also felt that the uniformed officers did not believe them (50%) much more than the non-uniformed officers (37.5%). Many felt that their gender also contributed to poor treatment (43.8%). While data limitations prevented further analysis of these answers, one area for future research is to explore these feelings in greater depth.

chart 9: Reasons for Feeling Treated Poorly by the Police



Treatment by Uniformed Officers

The survey made the distinction between uniformed officers and non-uniformed officers. Uniformed officers tend to be the first responders and on-duty police officers. Non-uniformed officers tend to be detectives and undercover police officers. A distinction was made to offer more detail to the accounts and recommendations.

Of those who went to the police, 87.5% (n=28) spoke with an officer in uniform. Overall, the majority (70.3%) of respondents felt 'satisfied' or 'very satisfied' with the explanation given to them by the officer in uniform about why certain questions were being asked. Furthermore, nearly half of the respondents felt that the officer in uniform made efforts to address their safety concerns (46.4%).

Treatment by Non-Uniformed Officers

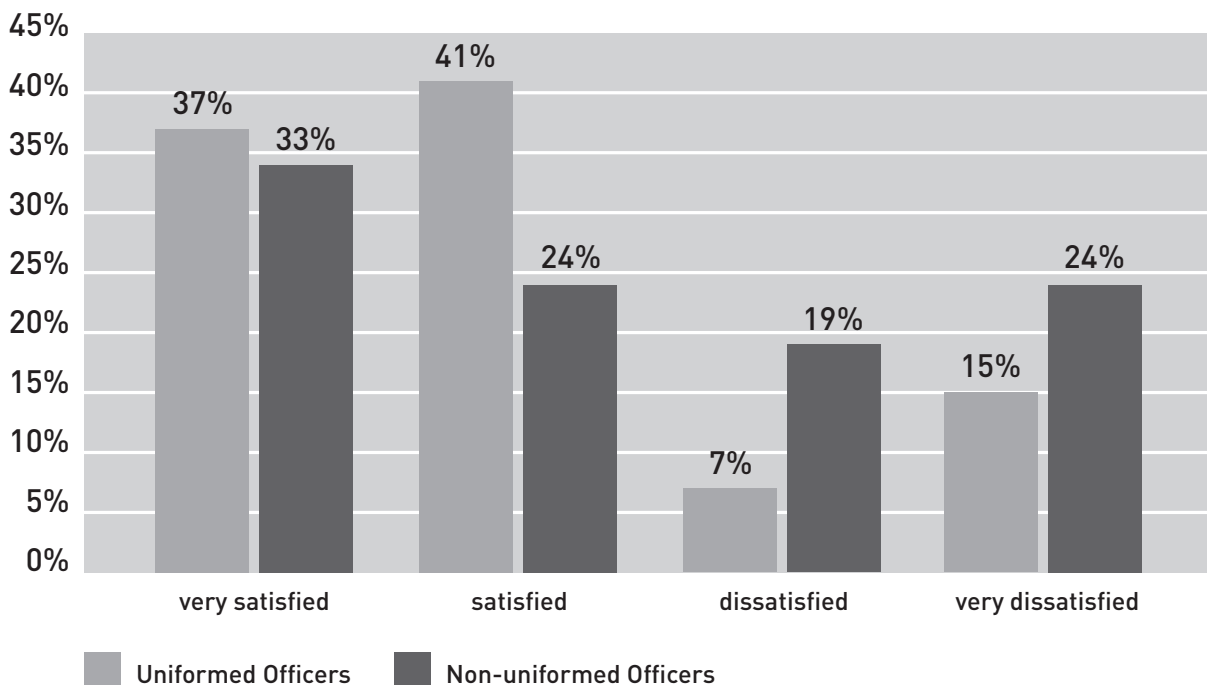
Fewer respondents who went to the police reported speaking with a non-uniformed officer (65.6%) after the sexual assault. Among them, over half (60%) reported feeling 'satisfied' or 'very satisfied' with the explanation given to them by non-uniformed offi-

cers about why certain questions were being asked; however, a quarter of the respondents felt 'very dissatisfied' about the explanation given to them by the non-uniformed officers. A similar percentage of non-uniformed officers (47.6%) reportedly made efforts to address the survivors' safety concerns as that of uniformed officers (46.4%).

Chart 10 shows the respondents' satisfaction with the way they were treated by uniformed and non-uniformed police officers. The majority of respondents were either 'satisfied' or 'very satisfied' with both their treatment by uniformed officers (78%) and by non-uniformed officers (57%). A higher percentage of respondents were either 'dissatisfied' or 'very dissatisfied' with their treatment by non-uniformed officers (43%) than by uniformed officers (22%).

Nearly two-thirds of respondents (61.9%) who worked with non-uniformed officers felt that the officer did not make efforts to keep them informed as the investigation continued. Furthermore, a little over half of the survivors (52.4%) felt that the non-uniformed officer did not give them information about what to expect during the investigation.

chart 10: Satisfaction with Treatment by Uniformed and Non-Uniformed Officers



Case Study: Male Survivors of Sexual Assault: The Hidden Epidemic

"We are primed and ready to recognize male perpetrators but turn a blind eye to male victims." —from "The Male Survivor: The Impact of Sexual Abuse by Mendel (1995, pg.4).

All men are potential victims of sexual assault (Lipscomb et al., 1992). According to national statistics, 2.8 million men in the United States were forcibly raped at some time in their lives. The majority of male victims (70%) were raped before their 18th birthday. Male victims tend to be raped by acquaintances, regardless of their age at the time of the victimization (Tjaden & Thoennes, 2006).

Help Seeking Behavior

Male rape and sexual assault is even more underreported than female rape. Researchers and practitioners believe this results from: **1)** social beliefs that men are expected to be able to defend themselves against assault (McMullen, 1990; Ashworth, 1995 as cited in Rentoul & Appleboom, 1997), **2)** the survivor's fear that his sexual orientation may come under critical scrutiny, **3)** reporting male sexual assault is distressing (Groth & Burgess, 1980 as cited in Rentoul & Appleboom, 1997), and **4)** the 'male ethic', which emphasizes self-reliance among men (Stank & Hobdell, 1993; Mendel, 1995 as cited in Rentoul & Appleboom, 1997). Furthermore, male victims of rape and sexual assault feel poorly understood and find it very difficult to report the crime and seek help (King, 1995; Mezey & King, 1987; Holmes, 1989 as cited in Rentoul & Appleboom, 1997).

When they do seek help, men are most likely to go to a rape crisis or victim assistance program. A study that examined agencies that treated men for sexual assault found that 61% of the agencies were rape crisis programs and the second highest

number of survivors was seen at victim services in the District Attorney's office (Isely & Gehrenbeck-Shim, 1997). Male survivors are likely to contact these services much later after the assault. A study conducted with a male-focused counseling program in London found that the average time from assault to contact with the counseling program was 16.4 years (King & Woollett, 1997). In the current study when asked about their experiences with rape crisis programs, two male survivors wrote:

"It was primarily for women."

"It was not expected that a man would seek counseling for rape."

In a study of 3,635 male sexual assault survivors, it was found that when men sought medical treatment, only 23% revealed the sexual nature of their assaults to the medical personnel. In this same study, very few men (15%) reported the assault to the police —(Isely & Gehrenbeck-Shim, 1997).

Men are often prevented from seeking help because they feel they will not be believed. It is particularly important for service providers to recognize that the events occurred and to accept the survivor and provide support. When asked what he would change about the hospital system to make it a better place for other survivors, one man said:

"privacy, information, referral...AND IT WAS RAPE EVEN THOUGH I AM A MAN."
(emphasis original)

Another respondent mentioned:

"Treat men who are raped the same way women are treated...it WAS rape even if it was not penetrated in a vagina." (emphasis original)

Survivor Voices:

What was the worst thing about going to the police?

"I had to answer questions that I was not comfortable with." —34-year-old female

"It was very uncomfortable. When I called 911 I spoke with a woman, who was not very nice. When I went to the station, I had to speak with a man."

—25-year-old female

"I was not believed. No attempt to help me really came. No information on my case. Detective did not keep me informed on what's going on. I felt like I had been victimized all over again."

—35-year-old female

"Telling the story of what happened. It was intimidating." —24-year-old female

"...the treatment I received from NYPD was reprehensible; I was verbally abused and highly disrespected to the point of severe insult and humiliation."

—41-year-old female

"fear of rejection." —44-year-old female

"I was lied to about the action not being taken against the rapist. They promised to make an appointment for me with a DA and failed to do so." —23-year-old female

"The abuser is a police officer that was defended by the department."

—36-year-old female

"They took like 20 minutes and I felt unsafe, they didn't want to drive me home..." —22-year-old female

"crime victims on city jobs need protection and rights about making police complaints..someone outside city jurisdiction who does not work for DC37 needs to be monitoring and protecting us."

—43-year-old female

"...the sense that you were being a nuisance when calling for information on the investigation. Having to discuss very personal details with strange men."

—28-year-old female

"Their inability by choice to take me to the emergency room that night because the rape was incomplete." —41-year-old female

"They called it sodomy at the hospital in a public place and in a loud voice without sensitivity."

—54-year-old male

"They made me feel like I put myself in the position to be assaulted, they were somewhat condescending."

—25-year-old female

"...no female detective; it would have been easier to speak to a gay or lesbian officer. That said, this experience made me think much more highly of the police than I had before." —44-year-old female

"...They made promises they did not keep regarding evidence, gave me the run-around, did not return calls, [and] would not communicate with the DA. I felt like my case [was] unimportant compared to others." —28-year-old female

Survivors' Recommendations

Twenty-five survivors gave recommendations to help make the police response better for other survivors.

1. More training for police officers

Overwhelmingly, survivors recommended more training for police officers on interacting with survivors. Specifically, it was mentioned that police officers should receive training in interviewing skills that include victim sensitivity, handling emotions, and general interpersonal communication skills. Also, a recommendation was made for police officers to use the manuals from the National Organization on Disability on the Uniform Duties to Disabled Persons law.

"Detectives need to be better trained to handle emotion." —26-year-old female

"They need to have officers, especially the men, trained in sensitivity...for victims of sexual abuse and violence, and ask that upon interviewing people they present this as their first form of communication." —36-year-old female

"The police should be better educated, and they should be required to take classes in ethics and psychology." —37-year-old female

2. Provide referrals for other services

Many survivors mentioned that to make police services better for other survivors, it was important that police provide referrals and information for other services such as counseling.

"That they should listen to survivors' requests for help of their choosing and accede to it." —41-year-old female

"They could have ...offered me the location of a support group or number..." —28-year-old female

3. Treat sexual assaults as a serious crime

Several respondents stated that in order to make services better, it is important for police officers to treat sexual violence as a serious crime and act more concerned when interacting with survivors.

"...calling it rape and not treating it as just businesslike." —54-year-old male

"They could have seemed more concerned...and treated this like a serious crime." —28-year-old female

"...make them nicer for Christ's sake I was almost raped!!! And they acted like it was nothing. I know it happens everyday, but I'm still a human being." —22-year-old female

4. Police officers should ensure more privacy for survivors

Many survivors mentioned instances involving a lack of privacy when disclosing details about the sexual assault. Police should interview victims in private.

"They yelled out sodomy at the hospital in a routine way." —54-year-old male

"Remove perpetrator from room..." —53-year-old female

5. Have more female officers handle sexual assault cases

Many survivors mentioned that having female officers and detectives would make the experience better for other survivors.

"More female detectives would be nice." —44-year-old female

"First of all, I would not have male officers handling female rape victims before [or] after, they have no respect or regard to the handling of these cases." —41-year-old female

"More female police officers to handle this situation...it's difficult and embarrassing to discuss this with a male stranger." —32-year-old female

“I wanted to press charges and did. Even though I felt it was a lost cause. I felt that I needed to do it for me and for the progression of this fight.”

—25-year-old female

Chapter 5: Criminal Justice

Prosecuting perpetrators of sexual violence is, unfortunately, a very difficult process for both the prosecutor and for the victim. Navigating the criminal justice process often occurs after a survivor of sexual assault has already accessed other services. It is very rare that the criminal justice system is the first point of contact for survivors of sexual assault. As a result, a smaller percentage of the sample in this study (34%, n=22) went to the District Attorney's office. Due to the small numbers it is difficult to draw reliable conclusions, thus results should be interpreted with caution.

This study assessed the following with regard to the criminal justice system: **1)** what prevents survivors from going through the criminal justice process, **2)** case characteristics of survivors in this study, **3)** experiences with prosecutors, **4)** satisfaction with criminal justice system, **5)** the positive and negative aspects of going through the criminal justice system, and **6)** recommendations for improving the criminal justice system for other sexual assault survivors. This chapter also includes information on survivors with physical disabilities as an underserved population.

Criminal Justice Services

Each borough in New York City has a District Attorney's (DA's) office that has the responsibility and authority to investigate and prosecute crimes in that borough. Sexual assaults are among the most under-reported crimes in the United States (NYDA, 2006). The prosecution of such cases is difficult and demands considerable expertise. In 1974, the New York County District Attorney's Office, recognizing the need to dedicate resources and special attention to crimes of sexual violence, became the first prosecutor's office in the nation to establish a sex crimes prosecution unit (NYDA, 2006). A Sex Crimes Unit now exists in each of the DA's offices in the five boroughs.

In addition to prosecutorial process, members of each of these units spend a great deal of time training medical personnel about protocols for victim examinations, providing training to police about case investigation techniques, and informing the public about sex crimes (NYDA, 2006). Prosecutors all over the state and country have followed the Sex Crimes Unit model that was started in NYC.

Each of the Sex Crimes Units work closely with the NYPD's Special Victims Squad, frequently interacting with detectives from the moment a rape case is reported to the police. Furthermore, DNA technology has revolutionized the investigation of sexual assault cases. DNA databanking has the potential to solve scores of cases in which investigators were initially unable to identify the rapist.

Each of the DA's offices also offers counseling services to survivors of sexual assault both for the initial crisis and through the often difficult components of the criminal justice process. In addition, many of the DA's offices provide additional specialized services for adults. The Kings County District Attorney's office in Brooklyn has instituted three such programs:

Barrier Free Justice, started at the Kings County (Brooklyn) District Attorney's Office in 2000, assists survivors of any crime with psychiatric, physical, or cognitive disabilities to navigate the criminal justice system. A network of involved social workers, case managers, and attorneys provide guidance, support, and concrete services to facilitate the victims' steps toward safety (Barrier Free Justice, 2006).

Project Shield is a collaborative effort between the Brooklyn District Attorney's Office and YAI/National Institute for People with Disabilities. The aim of project shield is to educate professionals about the sexual assault of individuals with Mental Retardation/Developmental Disabilities (MR/DD). This training project has a goal of facilitating more effective investigations and prosecutions of sex crimes involving individuals with MR/DD through collaboration between criminal justice professionals, social service providers and community groups (Project Shield, 2004).

The Brooklyn **E.P.I.C. (Ending Prostitution in our Communities)** is a six-week alternative-to-incarceration program for individuals arrested for prostitution-related offenses in Brooklyn. The E.P.I.C. program is offered to individuals twenty-two years old and over arrested out of the 60th and 72nd precincts. The current program goals are to reduce the number of people engaging in prostitution and to decrease recidivism; increase economic self-sufficiency; and improve physical and mental health (K. Kramer., personal communication, July 28, 2006). While this program does not specifically focus on sexual violence, it does recognize that prostituted women often need rape crisis and related medical services. There is also a similar program called S.T.A.R. which was developed by District Attorney Charles J. Hynes to assist teens to abandon prostitution by providing them with concrete alternatives and solutions (Brooklyn DA, 2007).

Measuring satisfaction with criminal justice services

Measuring satisfaction with the criminal justice system is challenging. Unlike some sectors, the DA's office does not provide direct services to the client; instead they represent the state in a case against the perpetrator. The mandate of the

criminal justice system is to fairly adjudicate criminal applicants, promote community safety and uphold the law. The role of an attorney in a civil case differs from that in a criminal case; in civilian cases, there is direct client representation.

Since satisfaction is measured as exceeding expectations, the question becomes what do survivors expect from prosecutors in the DA's office? Going through the criminal justice system is no easy task and to provide survivor support, many of the DA's offices have set up victim advocacy services. While this study asked about survivors interactions with victim advocates at the DA's office, the small number of respondents precluded their inclusion in this report.

Similar to the police sector, there is little prosecutors can do to change satisfaction with the outcomes of the case. They can, however, behave in a professional manner and act respectfully toward survivors. Understanding survivor expectations will help prosecutors to develop victim advocacy services and educate the public about their role in sexual assault cases.

Research Questions and Findings

What prevents survivors from seeking criminal justice services?

To better understand barriers to accessing the criminal justice system, survivors were asked "Was there anything that prevented you from going to the District Attorney's office?" Four main themes emerged from their responses:

- **Lack of information about the criminal justice process**

Survivors mentioned that they did not know that going to the District Attorney's office might have been an option for them.

"I didn't know anything about this. That I could talk to or contact the District Attorney's office."
—35-year-old female

"I don't know how, and it's too late to prosecute the rapist. All the physical evidence is gone."
—37-year-old female

"Not given the option." —54-year-old male

- **The perpetrator was never caught**

Many survivors said the fact that the perpetrator was never caught prevented them from going to the District Attorney's office.

"Because the man who violated me was a total stranger whom I didn't know by name (although I had a fairly good description of what he had worn as well as where the attack occurred the night the attack happened). Furthermore, because the assault was incomplete, I figured that the District Attorney couldn't do much as I had encouraged the police to try to find the guy and when they couldn't after about a month, I just gave up on the case." —41-year-old female

"Couldn't find the perpetrator and not suggested."
—54-year-old male

- **Charges were not filed against the perpetrator**

Survivors expressed that one of the main reasons they did not go to the District Attorney's offices was that they either did not know charges needed to be filed or they did not want charges to be filed against their attacker.

"I called the DA's office in NYC to ask for advice. They told me I needed a docket number to speak with an assistant DA. I again asked if I could seek advice and they told me that I had to file charges." —26-year-old female

"I didn't want to file charges against my best friend." —26-year-old female

"...no report was taken. So no report [was sent to] the District Attorney." —55-year-old female

- **Difficulties in contacting District Attorney's office**

Some survivors experienced difficulties when trying to reach the District Attorney's office, either through an intermediary or directly.

"I was given the phone number of a DA, and we left messages on each other's cell phone, but never got to talk to each other in person."
—34-year-old female

"Police said they'd set up an appointment for me, and then would not do so, I was given no contact information." —23-year-old female

Case Characteristics

Only 34% of respondents in this study went through the criminal justice system after the sexual assault (n=22). Of those, the majority went to the DA's office within a week of the assault occurring (52.6%) and over a quarter went within a month (26.3%).

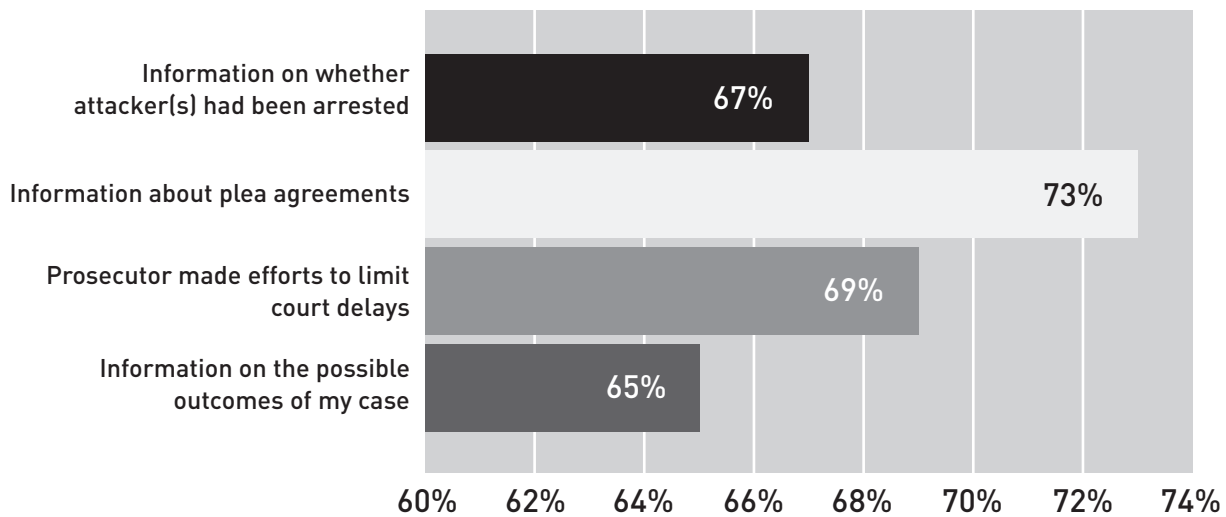
For those who reported going through the prosecution process, the timeline for prosecuting the cases for the majority of respondents was less than six months (44%), between six months and one year (31%), and longer than a year or ongoing (12.5% each). When asked about the final outcome of the case, 38.1% ended in convictions (28.6% plead guilty and 9.5% by trial). Nearly a quarter (23.8%) of cases were dropped or dismissed, and 19% are pending. One respondent mentioned the outcome of her case:

"Defendant was deemed mentally incompetent to stand trial and reprimanded [sic] to social services." —32-year-old female

Experiences with the prosecutors

Survivors were asked several questions about their experiences and interactions with the prosecutors at the District Attorney's office. The majority of respondents (65%) were either 'very satisfied' or 'satisfied' with the way they were treated during the first interview. Chart 11 shows whether the respondent received information on various aspects of the

chart 11: Information Received About the Criminal Justice Process



criminal justice process. Nearly three-quarters of the respondents received information about plea agreements (73%) and reported the prosecutor made efforts to limit court delays (69%). The majority of survivors also reported that they were given information whether their attacker(s) had been arrested (67%) and information on the possible outcomes of their case (65%).

A small percentage of respondents (36.4%) testified in court against their attacker. Of those that testified, 60% were 'very satisfied' with the information given to them about testifying in court and 77.8% felt well-prepared to testify.

Five respondents wanted to press charges but felt that after going to the District Attorney's office that they could not. When asked why they felt this way, several survivors responded:

"The DA basically told me there was not enough evidence to prosecute and this made me feel like the perpetrator had won and nobody believed me and all my efforts to empower myself were in vain." —25-year-old female

"The DA kept trying to talk me out of it, saying that because there were no witnesses, and because of the defense attorney's experience, they would make me look like a fool."

—29-year-old (gender not given)

"The first DA that I spoke with interrogated me as if I were a criminal and asked me why I did not fight back harder, why did I let this guy do this to me. SHE was very insensitive and rude, basically reduced me to tears, and kept leaving the office and interrupting our interview with phone calls and other appointments, even though she had made an appointment with me."

—28-year-old female (emphasis original)

Survivors were asked if they felt poorly treated at the District Attorney's office and the reasons they felt this way. Ten respondents, or less than half of the survivors (45%) who reported going to the District Attorney's office, said that at some point they felt poorly treated. Of these survivors, the major

reason reported for poor treatment was they felt that their prosecutor did not believe them. Several respondents explained other reasons why they felt treated poorly:

“The A.D.A. told me she was too busy with more important cases.” —26-year-old female

“She didn’t give a damn. She plea-bargained the case without notifying me that she was going to do so, and she let a known stalker loose so he could become a counselor.” —44-year-old female

“Insensitive/stoic behavior all around.”
—36-year-old female

Survivor Voices:

What was the best thing about going to the District Attorney’s office?

“The chance to make this crime known.”
—36-year-old female

“Prosecutor was serious, organized, detailed, determined, honest and professional. I was compensated for my time and reimbursed for doctors/hospital bills. Pictures of bruises were taken.”
—24-year-old female

“Justice.” —44-year-old female

“That even though they weren’t punished fairly and were treated like privileged white men, they were still held accountable and publicly plead to the charge.” —25-year-old female

“She [the ADA] knew what she was doing.”
—53-year-old female

“They were just like the police—very helpful and caring. I will always be forever grateful to [my prosecutors] for all their hard work.”
—32-year-old female

“My DA. She is incredible. So thorough and solid—she prepares you, calms you and works so hard.” —33-year-old female

“The first assistant DA I worked with was very responsive and informative.”
—32-year-old female

“Honestly, I can’t think of anything positive that has come of it but for the fact that my attacker has had to deal with lawyers since the week he assaulted me, and that is a punishment I wouldn’t wish on anyone. Also, restraining orders have been issued and renewed, so that is good.” —28-year-old female

“My DA. [She] was awesome! She is a great lady, very professional.”
—30-year-old female

“I wanted to press charges and did. Even though I felt it was a lost cause. I felt that I needed to do it for me and for the progression of this fight.”
—25-year-old female

Providing Quality Services to Survivors with Physical Disabilities

"People think I am a wheelchair with a person attached rather than a PERSON in a wheelchair."
—55-year-old female (emphasis original)

It is estimated that more than 70% of women with a wide variety of disabilities (both physical and developmental) have been victims of sexual violence at some point in their lives (Stimpson & Best, 1991 as cited in Elman 2005). The majority of the violence is perpetrated by someone the victim knows. A large majority of the perpetrators are male caregivers, followed by male family members and only a small percentage are strangers (Sobsey & Doe, 1991 as cited in Elman, 2005).

Help Seeking Behavior

Although most people with disabilities live independently, there is still a reliance on others for care, and this makes it difficult to report those very people as abusers since it might trigger the end of a relationship and loss of essential care. Some abusers may be so controlling that those they victimize have no way to disclose the abuse to others. Furthermore, there are many obstacles for people with disabilities that make it difficult for them to access services. These can include the absence of accessible reporting devices (e.g. TTY's), assistance personnel (e.g. interpreters for the deaf), comfortable examination equipment, accessible transportation and building spaces.

The following quotes from a survivor highlights the frustration over not receiving quality care:

"Somehow law enforcement and hospitals think we have no reality as real people and that the last thing they want to do is deal with sexual issues in someone who has mobility limits."

"...Seems people go into a brain buzz when asked if they have ever dealt with disabled persons."

"The system is broken for disabled persons"

"Persons with physical disabilities are treated badly and not given any credibility. Even with materials brought nobody took it seriously. The only medical information I received and got was a bowel resectioning because of the beating I endured and the sexual issue was trivialized and not taken into account at all. I still have the DNA and nobody took it or took me seriously to this day. If the statute of limitations on rape is ever gotten rid of I have the DNA evidence to get this guy put in jail. But no report was ever taken and nothing was ever done to help."

Successful programs that provide services to survivors with disabilities are able to address the scope of the problem, adopt policies to ensure programs are accessible, facilitate an ongoing dialogue between victim service programs and disability programs, and use a community approach by including other key stakeholders in the development and ongoing service provision process.

Navigating law enforcement and the criminal justice system can also be very difficult.

Survivor Voices:

What was the worst thing about going to the District Attorney's office?

"the feeling that what I was doing was not going to make a difference and that no one believed me. I felt like just a number. I would not recommend to any victim that they go through the justice system."

—26-year-old female

"Embarrassment of telling my case to grand jury, but [my prosecutor] made me comfortable! She rocks!"

—30-year-old female

"It lasted forever. I had to keep reliving the situation over and over. The defendants went to the same college as I did and it was really hard to go through the process and have to see them all the time."

—25-year-old female

"Hard to get her when I needed questions [answered]."

—53-year-old female

"When my case was transferred to another assistant DA, he did not follow up on the case and I had to call him to find out what the outcome was."

—32-year-old female

"Feeling like nobody believed me, feeling like I was responsible for the crime, feeling helpless and out of options."

—25-year-old female

"The apathy—insensitivity to victims... which resulted in more mental pain/anguish and hopelessness regarding help and safety."

—36-year-old female

"...She [the prosecutor] listed four charges that would be brought against the attacker. I asked several times that he be forced to attend therapy sessions. She said this was a definite possibility. She seems to be doing everything in her power NOT to go to trial, because it would be a waste of her time. She offers the criminal the same GREAT deal every month, and every month he turns it down. At what point will we go to trial? She does not tell me what is happening at any point."

She has told me that I cannot attend court proceedings because I would be in violation of the restraining order, and she has now informed me that her office does not deal out sentences of therapy because they are an office of punishment, not a "holistic" office. She said it's either community service or jail. I told her I wanted him to go to jail then if that was the only option, and she thought that was very funny, laughed and said that "would not happen." Now the charges they are offering him are not even close to what we started with, they're not even sexual anymore. I mentioned that I wanted him to register as a sex offender, and she laughed and said that that would only happen when children are involved."
(emphasis original)

—28-year-old female

"Re-telling the story...and being in the DA's office was tedious and intimidating..."

—24-year-old female

Survivors' Recommendations

Seventeen survivors gave recommendations to help make the criminal justice system better for other survivors.

1. Provide sensitivity training for prosecutors

Similar to recommendations for improving law enforcement, survivors recommended more training for prosecutors on interacting with survivors. Specifically, it was mentioned that prosecutors should receive sensitivity training for working with victims of sexual violence. Also, a recommendation was made for educational manuals about disabled persons and the Uniform Duties to Disabled Persons Act to be enforced.

"Get people who care about the rights of victims not defend their own people."
—36-year-old female

"...I think that entire office could use some sensitivity training." —44-year-old female

2. Better communication

Many survivors felt that the criminal justice system would improve if there were better communication between the prosecutors and victims.

"Better communication, especially if the person who you are dealing with is transferred off the case." —32-year-old female

"Just trying to reach her—she has a tight schedule." —53-year-old female

3. Implement and connect with other support services

Several respondents stated that in order to make the criminal justice response better that it is important to implement support services or to connect with already existing support services, such as safe housing/shelter and to provide this information to survivors in a useful way.

"I think I was really lucky and worked with an ADA who was amazing. She really cared and motivated me to keep going with the case. She has since been promoted and works in the US Supreme Court now. It would be more helpful if service information was provided to a victim, maybe in a packet or something. In my experience I was in a daze and it was difficult to process all the info."
—25-year-old female

"Safe housing/shelter. Relocation assistance programs. Counseling services in public NYC schools. Publication in ads in popular newspapers and websites about organizations in all five boroughs. Employment training/education programs." —36-year-old female

Chapter 6: Implications

Sexual assault is prevalent in our city. National surveys estimate that at least 17.6% of adult women and 3% of adult men have been raped (attempted and completed) during their lifetime (Tjaden & Thoennes, 2006). If these proportions are applied to NYC, approximately 1.3 million women and over 200,000 men have been raped at some point in their lives. In the last year alone in NYC, it is estimated that over 22,000 women and nearly 7,000 men were raped. These are numbers of staggering proportions. For those that have experienced rape, we know that very few will seek help. From July 2004 to June 2005, 1,339 adult survivors sought counseling services at NYC's rape crisis programs (NYS DOH, 2005). Furthermore, only 1,498 cases of rape were reported to the NYPD in 2006 (NYPD, 2006), representing less approximately 5% of the estimated rapes that are actually occurring.

Sexual violence has serious implications for individuals and society as a whole. This epidemic significantly and negatively impacts the physical and mental health of its victims both in the immediate aftermath and throughout the lifespan. In the Commonwealth Fund's 1998 Survey of Women's Health, women who experienced sexual violence by someone they knew were 2.8 times more likely to rate their health as fair or poor than women who had not experienced any violence (Plichta & Falik 2001). Furthermore, those who have experienced sexual violence by an intimate (partner, friend, relative, spouse) were 3.5 times more likely to report disabilities (self-assessment as having any condition that keeps her from participating fully in life activities) than those who have not experienced sexual violence (Plichta & Falik 2001).

While we know that few survivors seek care, for those who do the quality of care they receive and how they are treated is important for their recovery from the trauma of the assault. What is clear from this study is that while many survivors are receiving adequate care in a respectful manner, many are

not. One survivor who is treated poorly or not given proper care is one too many. As service providers, advocacy organizations, city agencies and committed individuals, we need to work together to ensure that NYC provides the best care for survivors of sexual violence.

Dialogue is the first step to ensuring that *all* sexual assault survivors in NYC are receiving quality care. The point is to not merely avoid negative feedback but to foster a climate of change within institutions and throughout New York City that supports, rather than revictimizes, survivors of sexual violence when they seek help.

Some important questions to consider:

- Since findings show that survivors are more likely to be satisfied with the care they receive at the hospital if it is a SAFE Center of Excellence, what infrastructure will ensure that *all* survivors are able to access a SAFE Center? How many SAFE programs are still needed in NYC? What is the best way to let the public know about these SAFE and SART programs?
- What infrastructure will ensure that *all* survivors who present at an emergency department in NYC have access to volunteer rape crisis advocates?
- What standards will ensure that survivors receive quality care and how can we ensure that these standards are, in fact, being implemented?
- How can we ensure that training of service providers, law enforcement and criminal justice responders is incorporated into the institutional structure? Since there is a high turnover in all of these service sectors, how can we ensure that everyone is on the same page regarding the expected standard of care?

- What needs to be in place to develop and implement cultural competency training in working with underserved populations, as well as removing specific barriers to services and improving services to these populations?
 - What specifically needs to be done to make sure that the issue of quality care is addressed for the following populations:
 - survivors with mental illness
 - male survivors
 - disabled survivors
 - LGBT survivors
 - What needs to happen so that all four sectors—hospital, rape crisis programs, police and DA’s offices are working collaboratively and ensuring appropriate referrals and follow-up is taking place?
 - How can we limit the number of times a survivor has to tell the details of the assault?
 - How can we include survivors in all of our planning, trainings and implementation for program improvement across the sectors?
 - How can we ensure that 911 dispatchers are appropriately trained to handle sexual assault cases?
 - What is the best way to move forward on the survivor recommendations? (See Table 1 for summary of all recommendations)
 - How do we ensure that *all* survivors have access to the best quality care and response in NYC?
- Providing quality care for sexual assault survivors in NYC demands action. Talking openly about the strengths *and* weaknesses in service provision to survivors in NYC is necessary to create an atmosphere that is supportive and victim-centered.

Table 1: Overview of Survivor Recommendations

Hospitals	Rape Crisis Programs	Police	District Attorney’s Offices
More training for service providers and responders	More training for service providers and responders	More training for police officers and responders	More training for prosecutors and responders
Provide Rape Crisis Advocates	Provide referrals for other services	Provide referrals for other services	Provide referrals for other services
Screen for sexual violence in the ED	Offer long-term counseling	Treat sexual assault as a serious crime	Improve communication with victims
Provide comprehensive treatment	More group therapy	Ensure privacy for survivors	
Decrease the wait time in the ED	Offer free services	Have more female officers available to handle sexual assault cases	
Have more specially trained clinicians			

Appendix A: Methodology

Overview

This study employed a cross-sectional, pilot-tested survey design to measure survivors' satisfaction with service providers and first responders after a sexual assault. The survey was open to adult (18 years and older) who experienced a sexual assault and sought services for that assault in NYC. The assault for which they sought services must have occurred when they were an adult.

There were two recruitment arms to this study: **1)** through rape crisis programs and **2)** a general online survey that was advertised widely across NYC through community-based organizations, newspaper ads, and support services for survivors. Survivors who were currently seeking services at one of the thirteen rape crisis programs that participated in this study were invited to take the survey. Survivors recruited through rape crisis programs were given an option of completing either a paper survey or the online version. Only 20% of this convenience sample completed a paper survey, the other 80% completed the online version. Due to the sampling method, participation rates could not be calculated.

The survey was made available in both Spanish and English. This study was approved by the Institutional Review Boards of eight organizations—St. Luke's-Roosevelt, Harlem Hospital, Safe Horizon, Long Island College Hospital, Mt. Sinai, St. Vincent's Catholic Medical Centers, Beth Israel Medical Center, and the NYC Gay and Lesbian Anti-Violence Project.

Sampling and Subject Selection

Table 2 details the distribution of the sample in this study. A total of 77 respondents filled out the survey; 12 of these did not meet the study criteria and were excluded from the study leaving a total sample size of 65 respondents. The most common reasons for exclusion from the study included either respondents under the age of 18 or respondents who were assaulted when they were under the age of 18. This study was limited to survivors ages 18 and over, and we see a much larger percentage of respondents in the 20–30 age range. However, all of the age ranges are represented in the study. Most of the respondents are female.

Hispanics are underrepresented in the study, despite the survey being available in Spanish and advertisements placed in Spanish speaking organizations and newspapers. Future research should be conducted to assess the satisfaction with services among this group. Asian and Pacific Islanders are also underrepresented in this study. The respondents in this study lived primarily in Brooklyn or Manhattan despite citywide advertising about the study. A concentrated effort should be given to recruiting participants from the Bronx, Queens and Staten Island in future studies.

Table 2: Sample Distribution — Total Sample: 65*

Gender	% of sample	Education Level	% of sample
Female	91	No School	—
Male	7	Grade School	—
Transgendered (FtM)	2	Some High School	5
		High School Diploma	14
		Two-year College	24
		Undergraduate	40
		Graduate Degree	17
		Borough of Residence	
		Bronx	5
		Brooklyn	40
		Manhattan	44
		Queens	2
		Staten Island	2
		Outside NYC	7
Age			
18–20	5		
20–30	48		
30–40	23		
40–50	15		
50–60	9		
Race/Ethnicity			
African American/Black	25		
Asian or Pacific Islander	5		
Hispanic	12		
Native American/Alaskan Native	3		
White	55		
Sexual Orientation			
Heterosexual/Straight	84		
Gay	5		
Lesbian	—		
Bisexual	9		
Undecided	2		

* Missing data excluded
 — No one in sample

Formative Research

To inform the design of the survey, key stakeholder interviews were held with service providers regarding the best way to sample the survivor population and ways to reach special populations. In the fall of 2003, interviews were conducted with 18 key stakeholders representing each of the four sectors, and also including other organizations that have conducted survivor satisfaction surveys. The interviews focused on four major themes:

1. Defining Satisfaction

To understand the concept(s) of satisfaction and access as they are understood by service providers. To

this end, service providers were asked to describe the details of the services available to rape survivors. Their responses helped us assure that our survey will indeed ask survivors to provide feedback on the entire spectrum of services available to them (recognizing that some survivors may encounter a larger array of services than others).

2. Understanding the context or environment of providing care for survivors.

Key stakeholders were asked about the feasibility and appropriateness of fielding the survey in various locations and at different times.

3. Order of Events

Speaking with both service providers/stakeholders and survivors helped us understand the way that events unfold after a person reports that (s) he was sexually assaulted. The service providers were very helpful in outlining the work they each do and in explaining the spectrum of agencies that offer sexual assault survivor services.

4. Special Circumstances

The interviews were useful to anticipate special circumstances. For example, we spoke with service providers about how to reach out to marginalized populations—such as the elderly, men, gay men, lesbians, transgendered persons, and undocumented immigrants. The service providers offered useful ideas on how to reach out to these groups when distributing the survey.

A focus group was conducted with survivors in February 2004 to review the survey and to elicit ideas for survey changes. Participants were recruited by flyers placed at local rape crisis programs and through the Alliance's website. Survivors examined the survey question-by-question and suggested changes; these changes are reflected in the survey that was utilized for this study. Focus group participants helped elucidate the path survivors take when navigating the system.

The survey was conducted at rape crisis programs and as an online survey through the Alliance's website. These locations were decided based on the following factors:

- Stakeholders and survivors indicated that the ED is not the ideal place to conduct a satisfaction survey that looks at a range of services, as the ED is usually the first point of contact with this system of services. Furthermore, they cautioned that administering a survey in this circumstance might be too traumatic for survivors.
- Stakeholders highlighted that the organizational capacity for giving a survey to survivors upon contact with the NYPD was also not realistic. Furthermore, the counseling component would not be present if the survey brought up painful memories.

- Many stakeholders felt that rape crisis programs present a good location to field the survey. The location provides counseling opportunities if the survey brings up any issues that the survivor may want to talk about.
- The survey was also available on the Alliance's website and through print and radio media. This was done to recruit respondents who were not currently involved with a rape crisis program but had sought help from one of the other sectors in NYC.

Spanish Translation

Since an English language pilot that focused on the survey format and wording was already conducted, it was determined that the Spanish pilot should focus on the correct translation of the survey. The Principal Investigator organized a conference call between our Spanish Translator and several Spanish-speaking rape crisis counselors across the city. The items discussed included appropriate translation of key words (such as victim advocate, sexual assault) and making sure the translation was appropriate for all key dialects of Spanish.

The Spanish-speaking rape crisis counselors represented the Puerto Rican, Dominican and Chilean Spanish but were also knowledgeable about other dialects of Spanish spoken since they serve clients from almost every Spanish speaking country. The rape crisis counselors and the translator went question by question in the survey and came to a consensus on all the translations.

Limitations in Study Design

Due to the difficulties in sampling survivors of sexual violence, a non-random convenience sampling methodology was utilized. The consequence of using a nonprobability sampling strategy is that an unknown portion of the population is excluded. Because some members of the population (adult survivors in NYC that have accessed services for the assault) have no chance of being sampled, the extent to which this sample represents the entire

population cannot be known. Despite these limitations, the study provides tremendous insight into the experiences of sexual assault survivors as they access services in NYC and will be useful for program improvement.

Validity

Internal Validity

A study is valid if its questions actually measure what they claim to, and if there are no logical errors in drawing conclusions from the data. "Threats to internal validity" means that variables other than those being studied may impact the satisfaction of services. Several threats to internal validity were examined and addressed.

One threat to internal validity is the '*Hawthorne Effect*,' which asks if the expectation or actions of the investigator contaminate the outcomes of the study? Does having a counselor administer the consent form or taking the survey in the counseling office impact the respondents' responses to being satisfied with that service provider? This threat has been minimized by not having the counselor administer the survey (only giving the consent form) and by assuring the respondent that no one will be able to link the survey back to him or her.

A second threat to internal validity that was addressed in this study is selection bias. This is a concern; the respondents who actively seek counseling services may differ significantly from survivors who do not access these services. Plus, those who responded to the survey may differ from survivors who did not. An attempt has been made to minimize this bias by providing the web-based survey.

Another form of selection bias may occur due to the higher literacy level needed to fill out the survey. Efforts have been made to lower the literacy level of the survey including using both the Frye Formula and the SMOG test. At the beginning of survey development, both formulas revealed that the survey was college level reading. After several changes and rewording, explaining words that may be dif-

ficult to understand and also shortening sentences, the reading level is currently at 9th grade level. Due to the language needed to cover the satisfaction with services and the mode of data collection (web-based), this survey will exclude both survivors with very low literacy levels but also homeless survivors or survivors with a low socio-economic status (due to the computer use) unless they are currently in counseling services. Future studies are needed in which one-on-one interviews or an Audio Computer Assisted Self-Interviewing (ACASI) system is used. Unfortunately, this is a recognized bias in this study.

Closely tied with selection bias is the *maturation bias* meaning it is possible that the survivors survey in community-based and counseling programs differ in maturation or the passage of time since their assault than survivors who only access hospital or law enforcement services. We are uncertain the effects this will have on satisfaction levels.

External Validity

In addition to internal validity, studies should also be concerned about external validity which is concerned with any possible biases in the process of generalizing conclusions from a sample to a population, to other subject populations, to other settings, and/or to other time periods. The population for this study was survivors who sought services in NYC for the assault. The largest weaknesses in this study occur with external validity, primarily due to the non-random sampling technique and the small sample sizes. Due to these limitations, results from this study are not generalizable to the survivor population of New York City.

Despite considerable threats to external validity, efforts were made to minimize the effect of these biases on study results. An attempt was made to minimize this bias by ensuring that participating programs ask *all* of their clients if they would be interested in participating.

The training of service providers also helped minimize external validity by ensuring that all survivors are approached in a similar manner.

Due to the nature of the satisfaction survey, it may be that survivors who were very dissatisfied with the care they received were more likely to fill out the survey than survivors who were in the middle of the spectrum. Study results do show that survivors were more likely to fall at either end of the spectrum (very dissatisfied or very satisfied). While this is an important limitation, it is useful to understand dissatisfaction for program improvement purposes.

The web-based survey also presents a threat to external validity since there is no control over the sample distribution. An attempt was made to minimize this bias by ensuring that outreach for the web-based survey was wide-reaching and covered all types of communities.

Since the sampling design was not probabilistic, external validity was not going to be strong; nonetheless, our sampling design was intended to reach as many survivors who sought services as possible.

Construct Validity

Like external validity, construct validity is related to generalizing. But, where external validity involves generalizing from the study context to other people, places or times, construct validity involves generalizing from the measures or questions to the *concept* of the measures or questions. Construct validity may be thought of as a “labeling” issue. When we measure “satisfaction” is that what we are really measuring? Any threats to construct validity have been minimized by ensuring that the survey instrument was “focus-grouped” with survivors of sexual assault and through a careful examination of the literature and discussions with key stakeholders.

Satisfaction, though an ambiguous construct, is generally accepted and widely used.

Web-based Survey

The web-based survey component of the survivor survey is an exciting avenue for the Alliance to take in this research project. Web-based surveys hold great potential for surveying survivors who are not present in counseling type settings. Web-based surveys also show potential for surveying on sensitive topics. The web-based survey was open to all participants in the study and was the only method of survey implementation to reach the general NYC population. The Web Manager worked closely with the Principal Investigator to develop the web-based survey which was identical to the paper-based survey and also included the appropriate information to consent to participate in the study.

Web-based Survey Design

Several design items were developed and deemed as important for the web-based survey, these items include:

- The ability to support multiple platforms and browsers
- The ability to prevent multiple submissions (i.e. the inclusion of a time stamp)
- Providing the feedback ‘thank you’ upon completion of the survey
- The ability to export the data directly into a database (excel)
- Sequential screens to avoid download time
- Links available at the beginning and end of the survey to a list of support service information
- Web-based specific instructions (how to erase a check mark etc.)
- Introductory page (similar to approach script used by counselors)

It is important to protect the respondents' privacy and confidentiality for both the paper and web-based surveys. Methods that helped ensure the privacy and confidentiality for the web-based survey included:

- Using temporary cookies
- Certifying privacy through a 3rd party
- Using hypertext links for long disclosures
- Explanation in the introduction about the confidentiality of the survey (conditions of release, use, retention and disposal of personal data and sampling procedures)
- Collecting data through web pages versus e-mail (more secure)

The web-based survey design was piloted with computers that had different processing powers, internet service providers, internet access, operating systems and browsers to ensure that the web-based design would work consistently, given the varying types of computers systems and connection speeds. The pilot also checked the web-based design for ease in filling out the survey (large enough text boxes, skip responses, checking and unchecking answers, and coding).

Analysis

All quantitative data was analyzed using the Statistical Program for the Social Sciences (SPSS) 11.5 for Windows. Frequencies were calculated and presented for all the variables in the study. Independent sample t-tests were used to determine statistical significance for difference between means and are reported at the .05 confidence level, unless otherwise indicated.

The narrative data was obtained from several open-ended questions on the surveys, specifically for each service section the following questions were asked: **1)** was there anything that prevented you from going to [service sector, such as hospital, rape crisis program, police or District Attorney's office], **2)** what was the best thing about going to [service sector], **3)** what was the worst thing about going to [service sector], and **4)** what recommendation do you have to improve these services for other survivors?

The analysis used emergent categories to code the data using cross-case analysis, rather than using preconceived categories. After the first level coding, the data was pattern coded as a way of grouping those summaries into a smaller number of themes or constructs to examine the patterns, reoccurrences or "repeatable regularities" (Miles & Huberman 1994). This was done to help us better understand what prevents survivors from accessing services and what should change to improve services. Several outlying experiences were identified in the study: these included survivors who had very negative experiences across all the services they encountered. These narratives are presented in each chapter and are important for confirming the conclusion that the standard of care is low for certain populations across all sectors.

Code-recode reliability was conducted by coding on one day and then recoding the data three days later and checking the reliability which was high (over 90%). The qualitative and quantitative analysis as presented in this report was also reviewed by the Alliance's Research Advisory Committee.

Appendix B: Survey Instrument

* This survey is copyrighted. Please do not replicate the survey in whole or part without prior permission from the New York City Alliance Against Sexual Assault (contact research@nycagainstrape.org)

Satisfaction with Services in New York City

This survey is for adult survivors of sexual assault who have gone to services in New York City for the assault (hospital, counseling, police or the District Attorney's office).

This survey will help the New York City Alliance Against Sexual Assault improve services for survivors in New York City.

The information you provide is completely anonymous and no one will be able to link this survey back to you. It is important that you answer the questions to the best of your ability. You may skip any questions. Your participation is voluntary and you can choose to stop filling out the survey at any time. After each question, please mark the box that best matches your answer or opinion.

Please answer the questions about the **most recent** sexual assault.

1. When did the most recent sexual assault take place?
Year: _____
2. Where did the most recent sexual assault take place?
 Bronx Brooklyn Manhattan Queens
 Staten Island Outside New York City
3. How old were you when this assault happened?
Age: _____
4. Had you ever been sexually assaulted before this time? Yes No
5. What was the sex/gender of the person(s) who assaulted you?
 Man Woman Transgendered
6. Was the person who assaulted you a stranger?
 Yes No
If no, what was his/her relationship to you?
 person of authority (boss, teacher, commanding officer etc.) friend parent other relative
 dating partner husband wife
 someone I had seen before but was not friends with
 other (please specify _____)
7. Which of the following people/places did you contact first after the sexual assault?
 security/police
 rape crisis program/victim assistance program
 hospital prosecutor/District Attorney
 hotline called 911
 private counselor (not at a rape crisis program)
 church/religious organization
 other (please specify _____)
8. This place is in... Bronx Brooklyn Manhattan
 Queens Staten Island Outside New York City
 I don't know
9. How long after the assault did you contact this place?
 Within 1 day within 3 days within a week
 within 1 month within 6 months within 1 year
 more than 1 year later
10. This organization advised me to contact another place for more services.
 Yes No
11. Please check all the people/places you contacted after the most recent sexual assault:
 security/police rape crisis program/victim assistance program hospital
 prosecutor/District Attorney hotline called 911
 private counselor (not at a rape crisis program)
 church/religious organization
 other (please specify _____)
12. In total, how many people interviewed you about your most recent sexual assault? (including nurses, doctors, police, counselors, District Attorney's and others) 'Interview' means that these people asked you about the details of the assault so that they could help you, but not including family and friends.
_____ people

Section 1: Hospital Services

- 1.1. Did you go to a hospital after the most recent sexual assault?
 Yes (If yes, go to Question 1.3) No
- If no, was health insurance one reason why you did not go to the hospital?
 Yes No
- 1.2. Was there anything that prevented you from going to the hospital? Please explain. **(now go to Section 2)**
- 1.3. What was the name of the hospital?
Hospital (ex.: St. Maria's Hospital) _____
_____)
- 1.4. What year did you visit the hospital?
Year: _____)
- 1.5. Sometimes survivors have a counselor who helps guide them through the visit at the hospital. This counselor is called a **victim advocate** (also known as a rape crisis advocate or rape crisis counselor) and is not part of the hospital staff. Did you have a **victim advocate** at the hospital?
 Yes No (If "no", go to question 1.11)

If yes, please answer the following questions.

Victim Advocate:

- 1.6. The advocate explained the medical exam to me.
 Yes No
- 1.7. The advocate told me about reporting to the police.
 Yes No
- 1.8. The advocate gave me information about counseling.
 Yes No
- 1.9. The advocate gave me the support I needed during the hospital visit.
 Yes No
- 1.10. Overall, how satisfied were you with the advocate?
 very satisfied satisfied dissatisfied
 very dissatisfied

Other Hospital Staff:

Please answer yes or no for the following questions.

- 1.11. I waited a long time to see a doctor or nurse.
 Yes No
- 1.12. My doctor/nurse gave me information about sexual transmitted diseases (STDs) including HIV.
 Yes No
- 1.13. My doctor/nurse gave me information about emergency contraception to prevent pregnancy (also known as the 'morning after pill').
 Yes No Does not apply
- 1.14. My doctor/nurse gave me information about reporting to the police.
 Yes No
- 1.15. My doctor/nurse gave me information about medicine to prevent HIV.
 Yes No Does not apply
- 1.16. My doctor/nurse gave me information about photographing my injuries.
 Yes No Does not apply
- 1.17. My doctor/nurse told me who would see the photos.
 Yes No No photos were taken
- 1.18. Sometimes clothes are given to a survivor when they are at the hospital. Did you receive any clothes at the hospital?
 Yes No Does not apply
- 1.19. My doctor/nurse gave me information about going to a rape crisis center, counseling or support group.
 Yes No
- 1.20. My doctor/nurse made a follow-up medical appointment for me.
 Yes No Does not apply
- 1.21. My doctor/nurse asked if I had a safe place to go after leaving the hospital.
 Yes No
- 1.22. At any point, did you feel treated poorly at this hospital?
 Yes No **(If 'no' go to Question 1.23)**

If "Yes," please help us understand why by checking any of the reasons you feel may have caused you to be treated poorly.

- | | |
|---|--|
| My race
<input type="checkbox"/> Yes <input type="checkbox"/> No | My difficulty speaking English
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My age
<input type="checkbox"/> Yes <input type="checkbox"/> No | My profession
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My gender/sex
<input type="checkbox"/> Yes <input type="checkbox"/> No | My drug use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My disability
<input type="checkbox"/> Yes <input type="checkbox"/> No | My alcohol use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My religion
<input type="checkbox"/> Yes <input type="checkbox"/> No | The hospital staff didn't believe me
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My sexual orientation
<input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> other (please specify)
_____ |
| My immigration status
<input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Please check the answer that best describes your experience.

- 1.23. My doctor/nurse tried to make me comfortable during the physical exam.
 strongly agree agree disagree
 strongly disagree does not apply
- 1.24. My doctor/nurse explained what was going to happen every step of the exam.
 strongly agree agree disagree
 strongly disagree does not apply
- 1.25. My doctor/nurse explained the side effects of my HIV medication in a way I could understand.
 strongly agree agree disagree
 strongly disagree does not apply
- 1.26. Overall, how satisfied are you with the care you received at the hospital after the most recent sexual assault?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 1.27. The best thing about seeking medical care was:

1.28. The worst thing about seeking medical care was:

1.29. What would you add or change to make this hospital a better place for yourself and other survivors?

Section 2: Rape Crisis and Victim Assistance Programs

If you went to more than one program, please answer for the most recent place you visited.

- 2.1. Did you go to any rape crisis or victim's assistance program after the last sexual assault?
 Yes **(If yes, go to question 2.3)** No
- 2.2. If no, was there anything that prevented you from going to a rape crisis or victim's assistance program? Please explain.

(now go to section 3)

- 2.3. What was the name of the program you visited?
Program Name: _____
- 2.4. What year did you first visit this program?
Year: _____

Please answer if you agree or disagree with the following statements:

- 2.5. I felt I could trust my counselor.
 strongly agree agree disagree
 strongly disagree
- 2.6. I felt my counselor knew how to help me.
 strongly agree agree disagree
 strongly disagree

Please answer yes or no for the following questions:

- 2.7. My counselor gave me information about what to expect from reporting to the police.
 Yes No Does not apply
- 2.8. My counselor gave me information about what to expect from the District Attorney.
 Yes No Does not apply
- 2.9. My counselor spoke to the police for me.
 Yes No I did not want them to speak to the police Does not apply

- 2.10. My counselor spoke to the District Attorney for me.
 Yes No I did not want them to speak to the District Attorney Does not apply
- 2.11. Did you fill out a form to get money back for what you spent on the hospital visit? This form is also called a crime victims' compensation form.
 Yes No Does not apply (I didn't go to hospital)
- 2.12. If yes, did your counselor help you fill out this form?
 Yes No
- 2.13. I was satisfied with the advice given to me on how to speak with my partner about the assault. By partner, we mean your boyfriend, girlfriend, husband or wife.
 Yes No Was not given any advice
 Does not apply (I did not have a partner at the time)
- 2.14. Overall, I feel better as a result of my counseling experience.
 Yes No
- 2.15. I felt comfortable speaking with the counselor about my experiences.
 all of the time most times sometimes
 rarely never
- 2.16. At any point, did you feel treated poorly at this rape crisis or victim assistance program?
 Yes No **(If 'no' go to Question 2.17)**

If "Yes," please help us understand why by checking any of the reasons you feel may have caused you to be treated poorly.

- | | |
|---|--|
| My race
<input type="checkbox"/> Yes <input type="checkbox"/> No | My difficulty speaking English
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My age
<input type="checkbox"/> Yes <input type="checkbox"/> No | My profession
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My gender/sex
<input type="checkbox"/> Yes <input type="checkbox"/> No | My drug use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My disability
<input type="checkbox"/> Yes <input type="checkbox"/> No | My alcohol use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My religion
<input type="checkbox"/> Yes <input type="checkbox"/> No | The counselors staff didn't believe me
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My sexual orientation
<input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> other (please specify) _____ |
| My immigration status
<input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Please answer how satisfied you were with the following services.

- 2.17. How satisfied were you with the emotional support provided to you by your counselor?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 2.18. Overall, how satisfied were you with the rape crisis or victim assistance program?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 2.19. The best thing about going to a rape crisis center or victim assistance program was:
- 2.20. The worst thing about going to a rape crisis center or victim assistance program was:
- 2.21. What would you add or change to make this program a better place for yourself and other survivors?

Section 3: Police

- 3.1. Did you ever go to the police after the last sexual assault?
 Yes **(if yes, go to question 3.3)** No
- 3.2. If no, was there anything that prevented you from going to the police? Please explain. **(now go to section 4)**
- 3.3. Who contacted the police?
 I did family friend the hospital staff
 my husband/wife/boyfriend/girlfriend
 stranger other (specify _____)
- 3.4. How were the police contacted?
 911 phone call at the hospital
 at a police station
 Other (specify _____)

- 3.5. Have you ever had a bad experience with the police before this most recent sexual assault?
The officers in uniform didn't believe me
 Yes No
- 3.6. How long after the most recent sexual assault were the police contacted?
 Within 1 day 2-14 days after 2-4 weeks later
 1-3 months more than 3 months later
- 3.7. What time of the day were the police contacted?
 Between 8am and midnight
 Between midnight and 7:59am I don't know
- 3.8. How many police officers did you speak with about the most recent sexual assault?
_____ officers
- 3.9. Did any police officer give you information about going to a rape crisis center, counseling or support group?
 Yes No Does not apply
- 3.10. At any point, did you feel treated poorly by the police?
 Yes No **(If 'no' go to Question 3.11)**

If "Yes," please help us understand why by checking any of the reasons you feel may have caused you to be treated poorly.

- | | |
|--|--|
| My race
<input type="checkbox"/> Yes <input type="checkbox"/> No | My profession
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My age
<input type="checkbox"/> Yes <input type="checkbox"/> No | My drug use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My gender/sex
<input type="checkbox"/> Yes <input type="checkbox"/> No | My alcohol use
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My disability
<input type="checkbox"/> Yes <input type="checkbox"/> No | The officers in uniform didn't believe me
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My religion
<input type="checkbox"/> Yes <input type="checkbox"/> No | The non-uniformed officers didn't believe me
<input type="checkbox"/> Yes <input type="checkbox"/> No |
| My sexual orientation
<input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> other (please specify)
_____ |
| My immigration status
<input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| My difficulty speaking English
<input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

The following questions are about the type of police officer(s) you spoke with. Some of the officers wear a uniform (patrol officers) and others are not in a uniform (detectives).

Officers in Uniform

- 3.11. After the most recent sexual assault, did you speak with an officer in uniform?
 Yes No **(if 'no' go to question 3.15)**
- 3.12. How satisfied were you with the way the officer in uniform treated you?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 3.13. How satisfied were you with the explanation given to you by the officer in uniform about why certain questions were asked?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 3.14. Did the officer in uniform make efforts to address your safety concerns?
 Yes No I did not have any safety concerns

Non-Uniformed Officers

- 3.15. Did you speak with a police officer not in uniform (in plain clothes including detectives)?
 Yes No **(If 'no' go to question 3.21)**
- 3.16. How satisfied were you with the way you were treated by the non-uniformed officers assigned to your case?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 3.17. How satisfied were you with the explanation given to you by the non-uniformed officer about why certain questions were asked?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 3.18. Did the non-uniformed officer make efforts to address your safety concerns?
 Yes No I did not have any safety concerns
- 3.19. Did the non-uniformed officer give you information about what to expect during the investigation?
 Yes No Does not apply
- 3.20. Did the non-uniformed officer make efforts to keep you informed as the investigation continued?
 Yes No Does not apply

Other Police Questions:

- 3.21. The best thing about going to the police was:
- 3.22. The worst thing about going to the police was:
- 3.23. What would you add or change about the police to make the services better for yourself and other survivors?

Section 4: District Attorney's Office

- 4.1. Did you seek services from a District Attorney after the most recent sexual assault?
 Yes (If yes, go to question 4.3) No
- 4.2. If no, was there anything that prevented you from going to a District Attorney? Please explain. **(now go to section 5)**
- 4.3. I went to the District Attorney's office in...
 Bronx Brooklyn Manhattan Queens
 Staten Island Outside NYC
- 4.4. What year did you go to the District Attorney's office?
Year: _____
- 4.5. How long after the most recent sexual assault did you go the District Attorney's office?
 within a week within 1 month
 within 6 months within 1 year
 more than 1 year later
- 4.6. How satisfied were you with the way you were treated during the first interview?
 very satisfied satisfied dissatisfied
 very dissatisfied

Please answer yes or no for the following:

- 4.7. Information was given to me about the possible outcomes of my case.
 Yes No Does not apply
- 4.8. My lawyer/prosecutor made efforts to limit court delays.
 Yes No Does not apply
- 4.9. My lawyer/prosecutor gave me information about plea agreements.
 Yes No Does not apply
- 4.10. My lawyer/prosecutor gave me information about whether my attacker(s) had been arrested?
 Yes No Does not apply
- 4.11. Did you receive counseling at the District Attorney's office?
 Yes No **(If no, go to question 4.17)**
- 4.12. My counselor at the District Attorney's office gave me information about what to expect from the prosecution process.
 Yes No
- 4.13. My counselor at the District Attorney's office spoke to the District Attorney for me.
 Yes No
- 4.14. My counselor at the District Attorney's office helped me fill out a form to get money back for what I spent on the hospital visit. Also called a crime victims' compensation form.
 Yes No I did not go to the hospital
- 4.15. How satisfied were you with the emotional support provided to you by the counselor at the District Attorney's office?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 4.16. Overall, how satisfied were you with the counseling program at the District Attorney's office?
 very satisfied satisfied dissatisfied
 very dissatisfied
- 4.17. Did you testify in court?
 Yes No **(If no, go to question 4.20)**
- 4.18. If yes, how satisfied were you with the information given to you about testifying in court?
 very satisfied satisfied dissatisfied
 very dissatisfied does not apply

4.19. If yes, did you feel well-prepared to testify?

Yes No

4.20. Did you want to press charges but after going to the District Attorney's office felt that you could not?

Yes No (if no, go to question 4.22)

4.21. If yes, why did you feel this way?

4.22. At any point, did you feel treated poorly at District Attorney's office?

Yes No (If 'no' go to Question 4.23)

If "Yes," please help us understand why by checking any of the reasons you feel may have caused you to be treated poorly.

My race

Yes No

My age

Yes No

My gender/sex

Yes No

My disability

Yes No

My religion

Yes No

My sexual orientation

Yes No

My immigration status

Yes No

My difficulty speaking English

Yes No

My profession

Yes No

My drug use

Yes No

My alcohol use

Yes No

The District Attorney didn't believe me

Yes No

The counselors didn't believe me

Yes No

other (please specify)

4.23. Overall, how satisfied were you with the services you got from the District Attorney's office?

very satisfied satisfied dissatisfied

very dissatisfied

4.24. What was the timeline for prosecuting your case?

Amount of time spent: _____

Does not apply

4.25. What was the final outcome of the case?

conviction acquittal dropped/dropped

plea agreement case sealed still pending

other (specify _____)

4.26. The best thing about going to the prosecutor/District Attorney was:

4.27. The worst thing about going to the prosecutor/District Attorney was:

4.28. What would you add or change about the prosecutor/District Attorneys office to make the services better for yourself and other survivors?

Section 5: Information about you

5.1. What is your year of birth?

Year (example: 1973) _____

5.2. My sex/gender is:

Female Male Transgendered (MTF)

Transgendered (FTM)

5.3. My sexual orientation is:

straight/heterosexual gay lesbian

bisexual not sure

5.4. My racial/ethnic background is... (check all that apply)

African American/Black Hispanic/Latino

Asian/Pacific Islander American/Alaskan Native

White Other (specify _____)

5.5. My highest level of education is:

no school grade school some high school

high school diploma two-year college

undergraduate degree graduate degree or more

5.6. I live in:

Bronx Brooklyn Manhattan Queens

Staten Island Outside NYC

Thank you for taking time to complete this survey.

“When a girl comes in with broken ribs and says the injury happened while she was on a blind date, and then she starts sobbing, you might take her aside and ask her if she was sexually assaulted. I went to three different hospitals and not one person asked me that...”

—37-year-old female

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“Treat men who are raped the same way women are treated...it WAS rape even if I was not penetrated in the vagina...special sensitivity is needed to LGBT issues (hate crimes) and someone to talk to you and comfort you.” —54-year-old male



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