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PRACTICE ISSUES

Immediate Intervention for Sexual Assault: A Review with Recommendations and Implications for Practitioners

SUZANNE E. DECKER and AMY E. NAUGLE
Western Michigan University, Kalamazoo, Michigan, USA

Rape crisis centers provide vital early intervention services to sexual assault survivors. The history and current status of these services are reviewed in light of the current literature on early trauma intervention. The authors suggest approaches for rape crisis centers that are likely to be most effective and identify supporting evidence for these practices from the available literature. The role of other mental health practitioners in early sexual assault intervention is discussed, with recommendations for how practitioners may work with rape crisis services to coordinate delivery of the best service. Finally, a collaborative research agenda is proposed to further our knowledge and expertise in coordinating the delivery of immediate intervention for sexual assault.

KEYWORDS rape crisis centers, sexual assault, early intervention, trauma

Recently released data from the National Violence Against Women survey estimated that in the United States, one in six women has been raped at some point in her lifetime (Tjaden & Thoennes, 2006). Numerous studies have linked the experience of sexual assault to subsequent decline in

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Address correspondence to Amy E. Naugle, Department of Psychology, Western Michigan University, 1903 W. Michigan Avenue, Kalamazoo, MI 49008. E-mail: amy.naugle@wmich.edu

functioning, including post-traumatic stress disorder (PTSD; e.g., Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992), depression (e.g., Frank & Stewart, 1984; Kilpatrick, Resick, & Veronen, 1981), disruptions in sexual functioning (e.g., Burgess & Holmstrom, 1979) and increased suicidality (e.g., Masho, Odor, & Adera, 2005; Ullman & Brecklin, 2002). The negative effects of sexual assault have prompted many calls for immediate interventions for victims/survivors of sexual assault, with the goal of alleviating immediate distress and preventing longer-term problems (e.g., Campbell & Wasco, 2005; Koss, 1993; Rozee & Koss, 2001). The terms "victim" and "survivor" are used interchangeably throughout this paper.

RAPE CRISIS CENTERS

Immediate interventions for sexual assault often exist in the form of rape crisis centers (RCCs). The first RCCs in the United States developed in the early 1970s to address the "lack of adequate laws, policies, and services" available to survivors of rape (Kravetz, 2004, p. 10). A similar development has occurred more recently in the medical field with the development of Sexual Assault Nurse Examiner (SANE) programs (readers are referred to Campbell, Patterson, & Lichty, 2005, for a review of SANE programs). Early RCCs were typically based on a volunteer collective structure (Largen, 1985; New York Radical Feminists, 1974). Services offered by most RCCs included hotlines for sexual assault victims, individual counseling, group counseling or support groups, and referrals to mental health, medical, and legal services (Largen, 1985). A case history of one early RCC revealed emphases on victim services, social change, and advocacy for better services for each individual survivor (Kravetz, 2004), while a study of a different RCC conducted in the 1980s described efforts to collaborate with other agencies (e.g., the local hospital and police departments) to coordinate better care for the sexual assault survivor (Martin, DiNitto, Byington, & Maxwell, 1998).

Several authors have noted that RCCs have changed over time. Beginning in the mid-1970s, RCCs were eligible to apply for federal funds from sources such as the Law Enforcement Assistance Administration (Koss & Harvey, 1991) or United Way (Riger et al., 2002). Applying for such funds required RCCs to demonstrate organizational stability and community support (Koss & Harvey, 1991). Funding sources began to stress the importance of using professionally certified personnel as service providers (Matthews, 1994; Riger et al., 2002). During this time, many RCCs shifted from operating as volunteer collectives to using more traditional hierarchical organizational structures (Campbell & Martin, 2002; Riger et al., 2002), reflecting a shift towards increased professionalism in RCCs (Collins & Whalen, 1989).

Lack of Research to Guide RCCs' Development

Most RCCs developed as grassroots, community initiatives, basing their counseling and other service provision on retrospectively described needs of former survivors (Largen, 1985). In addition, little research or documentation existed to guide efforts of the first RCCs (Largen, 1985). A report supported by the Law Enforcement Assistance Administration provided descriptions of police, medical, and legal responses to sexual assault and provided a description of some early RCCs (Brodyaga, Gates, Singer, Tucker, & White, 1974). Another important publication included information on reactions to sexual assault exhibited by rape survivors who had visited a city hospital emergency room; this information was used to guide the development of a program which addressed the specific needs of rape survivors (Burgess & Holmstrom, 1974), and may have been used by developing RCCs as well. Whether other RCCs used these guides is not documented in the literature. While both publications included valuable recommendations and a wealth of supporting evidence, neither provided empirically tested procedures for handling the immediate effects of sexual assault.

Compounding the lack of research to guide the initial development of RCC services is the lack of research on current services. Nearly 1,100 RCCs exist in the United States; however, a comprehensive description of their services and activities is not available. Experts report that most RCCs currently offer crisis intervention and short-term counseling (Clemans, 2004). Crisis intervention is typically offered in the form of hotline counseling and medical or legal advocacy (Campbell & Martin, 2002). While many RCCs have been providing these kinds of services for decades, little evaluation research exists to describe the impact of RCC services on sexual assault survivors (Petrak, 2002; Resnick, Acierno, Kilpatrick, & Holmes, 2005; Zweig & Burt, 2002; Zweig, Burt, & Van Ness, 2004). Calls for research describing current services and evaluating their effectiveness have been made (e.g., Crowell & Burgess, 1996), but little research in this area has been published.

A few evaluation studies have been published in which interviews were conducted with rape survivors to document the impact of available services. While these studies provide valuable information about the preferences of those consuming RCC services, such studies have mostly been conducted in a small geographical area using a limited number of service agencies (e.g., Lievore, 2005; Lovett, Regan, & Kelly, 2004; Monroe et al., 2005; Williams & Holmes, 1981). In addition, these studies may be subject to selection bias, in that all participants sought services at an RCC or other agency and then agreed to participate in an interview about their experiences. These studies do not reflect the input of individuals who did not access RCC services or those who chose not to participate in an interview about their experiences. Findings from these evaluation studies suggest that rape survivors, in the immediate aftermath of a sexual assault, appreciate

having a supportive person with them (Monroe et al., 2005; Williams & Holmes, 1981) or accessible to them by telephone (Lievore, 2005), and appreciate being treated respectfully and having their stories believed (Lievore, 2005; Lovett et al., 2004; Monroe et al., 2005). Participants tended to rate services provided by RCC workers positively (Lovett et al., 2004; Monroe et al., 2005; Williams & Holmes, 1981). In a quasi-experimental study comparing experiences of rape victims who had access to RCC services and victims who did not have RCC services, Campbell (2006) found that rape victims who had an RCC advocate present with them in the emergency room were offered more services from legal and medical systems, experienced less secondary victimization or victim-blaming from legal and medical system representatives, and experienced less distress at emergency room discharge. Campbell's study is one of the first published empirical indicators of the value of RCC services and also includes input from individuals who did not access RCC services; however, this study has not been replicated in other communities.

A small number of experimental studies have been conducted to document the impact of immediate intervention for sexual assault on longer-term outcomes. In a particularly innovative project, rape survivors who received standard emergency room care, including the provision of a rape crisis worker, were compared to survivors who received a video describing the forensic evidence collection exam, explaining what survivors might experience, and offering advice on how to avoid the development of longer-term symptoms (Acierno, Resnick, Flood, & Holmes, 2003; Resnick et al., 2005; Resnick, Acierno, Holmes, Kilpatrick, & Jager, 1999). The video intervention was more successful at lowering post-forensic examination distress than the standard protocol, and recipients of the video intervention were less likely to use marijuana at six weeks post-intervention. In an earlier study, Ledray (1988) conducted a randomized controlled trial comparing the effects of four short-term, multi-session interventions that began when a sexual assault survivor was enrolled in the trial at the emergency room. Treatment arms included a goal-setting intervention, a supportive counseling intervention reportedly similar to services provided by RCCs, a combination of the two, and a no-treatment control group. Results revealed a significant treatment effect, with participants receiving any of the three forms of treatment improving more quickly on measures of depression. However, those who received no treatment also improved slightly over time, consistent with previous research on patterns of recovery from sexual assault (e.g., Atkeson, Calhoun, Resick, & Ellis, 1982; Frank & Stewart, 1984). While this study represents an intervention effort conducted across the first six months after a sexual assault, rather than a single-contact intervention that may be provided by RCCs, it is nonetheless one of the first intervention studies conducted with sexual assault victims to begin intervening in the immediate aftermath of assault.

Overall, results of limited available research suggest that immediately after sexual assault, survivors appreciate having a supportive person available, may wish to obtain medical, legal, or psychological intervention, and may prefer supportive and flexible advocacy to formal mental health intervention. Experts on contemporary RCCs suggest that most RCCs do provide hotline counseling (Clemans, 2004) as well as crisis intervention in the form of medical or legal advocacy (Campbell & Martin, 2002). As these are services identified as important in the studies reviewed above, despite a lack of evidence to guide their initial development, current RCC services appear designed to meet the identified needs of rape survivors. However, it should be noted that the small number of evaluation studies, spanning over 30 years, often represents individual centers in a specific geographic area, with the input of those individuals who chose to participate in research. In addition, these studies reflect only data that have been published in this area and unpublished work may either support or contradict these findings, or have obtained nonsignificant results. The results of these studies, while valuable, may not accurately reflect the experiences, needs, or wants of sexual assault survivors overall.

SUGGESTED APPROACHES FOR RAPE CRISIS SERVICES

Although evidence-based best practice guidelines for RCCs cannot be created at present due to a lack of literature evaluating immediate intervention for sexual assault, some suggestions for optimal service can be found by combining the sexual assault and trauma intervention literature. Based on available literature and the background of RCCs, it seems that RCC services should be conceptualized as a form of early intervention and support for survivors of sexual assault. Recent studies suggest that RCC early intervention services are provided by trained volunteers or staff, rather than exclusively by licensed mental health practitioners (e.g., Campbell, 2006), while formal mental health treatment (e.g., treatment for PTSD) is usually provided in the later stages of sexual assault recovery by licensed mental health practitioners. Approaches for RCC services may differ substantially from approaches to later psychotherapy or other recovery work, reflecting the different goals and needs of a sexual assault survivor in the acute aftermath of assault. Recommendations for RCC approaches, and supporting evidence for each recommendation, are presented below.

Suggested Approach for RCCs: Psychological First Aid

A systematic set of helping actions for those who have recently experienced a traumatic event was published recently by the National Center for PTSD and the National Child Traumatic Stress Network. This approach is called

Psychological First Aid (PFA) and is intended for use by first responders in a disaster and others who provide immediate assistance to survivors of trauma, including rape crisis center workers (Ruzek et al., 2007). Although this approach has gained more prominence recently, the term PFA was coined by Beverley Raphael (1977, 1986). PFA can be considered an umbrella approach that emphasizes the provision of support and meeting of basic needs in a survivor of trauma (Gibson et al., 2006). An international expert panel convened by the U.S. Department of Health and Human Services conducted a review of intervention approaches and concluded that in the first fourteen days after a mass disaster or trauma, PFA is the approach of choice (Gibson et al., 2006). Although PFA has not been rigorously empirically tested, it has been described as evidence-consistent (Gibson et al., 2006). A notable component of PFA is its non-interventionist stance. Rather than an emphasis on processing the trauma, PFA focuses on meeting the basic needs of a survivor and providing flexible support. PFA is designed for practical application and can be provided in any field setting (Ruzek et al., 2007), including places an RCC service provider may visit, such as an emergency room or police station.

A PFA approach appears to be consistent with the limited literature on existing RCC services. Service users at sexual assault referral centers in the United Kingdom did not request formal mental health intervention in the immediate aftermath of sexual assault, but appeared to prefer flexible and supportive counseling (Lovett, Regan, & Kelly, 2004). Burgess and Holmstrom (1974) found that women presenting to an emergency room after sexual assault requested a wide variety of services more related to meeting practical needs (e.g., medical attention, police intervention) than to processing of the trauma. Similarly, interviews with RCC service recipients in one community revealed that immediately after the assault, participants requested the provision of physical comforts like blankets, attention from medical providers or the police, and someone to provide emotional support; some participants also reported that they would have preferred to be left alone (Williams & Holmes, 1981). Based on the wide variety of needs of rape survivors, it appears that PFA may be an optimal approach for RCCs, with its emphasis on meeting survivors' physical needs, coordinating resources, and providing emotional support in the immediate aftermath of assault.

Recommendations for intervening with victims of any trauma emphasize the importance of assessing the victim's needs and acting on these needs rather than on the intervener's assumptions of what the victim needs (McNally, Bryant, & Ehlers, 2003; Raphael & Dobson, 2001). Similarly, in interventions with victims of sexual assault, an assessment of individual needs of the victim should be conducted and care provided based on those needs (Minden, 1991; Westefeld & Heckman-Stone, 2003). An early review of research on sexual assault recommended that well-intentioned help

should not be forced upon a victim and that the victim should determine her needs (Bard, 1976). Therefore, it is recommended that RCC service providers ask victims explicitly about their needs, and then provide the services or support requested in the style of PFA, with the knowledge that some victims may not need any assistance at all.

A final and noteworthy component of PFA is that because it is not a formal mental health intervention, it can be provided by individuals other than licensed mental health practitioners. Indeed, the international expert panel recommends that individuals in various fields as well as community members be trained in intervention for disaster and other traumas, noting that anecdotal reports after the events of 9/11/2001 suggested that some survivors preferred to receive help from trained individuals who were not part of the mental health field (Gibson et al., 2006). Further, use of trained and compassionate community members as service providers is in keeping with the grassroots origins of RCC services. While the immediate assistance provided by RCCs need not be provided solely by licensed or credentialed mental health professionals, it is recommended that individuals providing immediate assistance be trained and supervised by an individual who has experience in providing RCC services and has awareness of the potential mental health issues involved in recovery from sexual assault. Future studies of RCCs should examine what types of mental health professionals work with RCCs, and what services they provide.

Suggested Components of RCC Services

Assess immediate safety

Gray and Litz (2005) clearly state that assessing the safety of a person who has recently experienced a trauma should be the first priority. Similarly, many recommendations for early intervention with sexual assault survivors include assessing safety as the first priority (e.g., Bassuk, 1980; Green, 1988). Assessment targets should include whether the survivor is likely to encounter the perpetrator again, as well as the survivor's risk for self-harming behavior (Westefeld & Heckman-Stone, 2003). After assessing immediate safety concerns, many authors state that next priority should be to assist the survivor of sexual assault in recovering a sense of safety (e.g., Wiehe & Richards, 1995).

Assessing for and responding to suicidality

Trauma experts (e.g., Gray & Litz, 2005; Litz, Gray, Bryant, & Adler, 2002) suggest that immediate interventions for trauma of all varieties should include an assessment of suicidality. Recommendations for sexual assault immediate interventions contain similar suggestions (e.g., Daane, 2006; Littel,

2001; Minden, 1991). As increased risk for suicidality is a common phenomenon after sexual assault (e.g., Masho et al., 2005; Ullman & Brecklin, 2002), it is recommended that RCC service providers be trained to detect suicidality and to respond to suicidal ideation, or have the ability to refer suicidal clients to other trained service providers.

Help victims regain a sense of control

Most recommendations on immediate interventions for sexual assault stipulate that interveners should help the victim regain a sense of control, reflected in recommendations from disciplines such as crisis intervention (e.g., Daane, 2006; Kanel, 2007), medicine (e.g., Green, 1988; Mein et al., 2003), and community psychology (e.g., Campbell & Ahrens, 1998; Campbell et al., 2005). Litz and colleagues (2002) recommend that early interventions with victims of any kind of trauma promote agentic, in-control behavior, while Green (1988) recommends that medical providers encourage a sense of control by allowing victims to set the tone and pace of interviews. It is recommended that RCC service providers allow the victim to set the tone and pace of services as well. For example, RCC service providers can offer the victim the opportunity to talk about whatever she wants, rather than demanding that the victim discuss the assault or discuss feelings about the assault.

Offer options and promote informed decision-making

A practical way to restore a sense of control is to offer the sexual assault victim a full range of options from which to choose. Immediately after sexual assault, a victim may have the options of reporting the assault to the police, seeking medical care, receiving various forms of medical treatment, and so forth. Early interveners can promote informed decision-making by presenting the survivor with information on the options, then encouraging the survivor to make her own decisions (e.g., Johnson, 1998; Lievore, 2005; Littel, 2001; Westefeld & Heckman-Stone, 2003). Tsegaye-Spates (1985) stated that it is critical that victims be "given power as one of the early antidotes to the helplessness which accrues from the assault" (p. 41). In the hospital emergency room, victims should be informed of their right to refuse certain services (Daane, 2006; Vera, 1981) and their right to stop a medical exam at any time (Cantu, Coppola, & Lindner, 2003; McConkey, Sole, & Holcomb, 2001). As victims make decisions about involving the police, it is of special importance that service providers respect a victim's decision, regardless of a likely desire to see the crime reported (Clark, 1976).

It is recommended that RCC service providers present survivors with information about each potential decision, including "pros and cons" of each. Once a survivor has made decisions about the services she or he

chooses to receive, it is strongly recommended that the RCC service provider support the survivor's decisions and validate that the survivor is the best judge of her or his own needs, promoting in-control decision-making by the survivor that may contribute to regaining a sense of autonomy.

Coordinate provision of resources and services

After a victim has chosen what services they wish to receive, another aspect of PFA can be incorporated: helping survivors to obtain desired services. Many rape survivors do not receive services they need (Campbell, 2006). Some treatment options, such as emergency contraception, are not offered routinely to sexual assault survivors in emergency departments despite recommendations (Martin, Young, Billings, & Bross, 2007). Gray and Litz (2005) emphasize that victims of all forms of trauma should be provided with information on resources and similar recommendations have been made in the sexual assault literature (Daane, 2006; James & Gilliland, 2001; Kanel, 2007; Koss & Harvey, 1991; Westefeld & Heckman-Stone, 2003). It is recommended that the provision of information occur immediately and be provided in written form for later use. One early RCC team protocol was giving a handout to rape victims upon leaving the emergency room that included detailed information about further services that were available (Clark, 1976; Moynihan, 1983).

While coordinating services, advocate for respectful treatment

The finding that sexual assault survivors may be treated poorly by service providers such as physicians, nurses, or police officers, is well documented in research and anecdotal literature (Campbell, 2006; Campbell et al., 1999; Ullman & Filipas, 2001a). Negative treatment that may include victim-blaming has been termed "the second rape" or "secondary victimization," and may exacerbate the distress caused by sexual assault (Campbell et al., 1999). In a study comparing accounts of rape survivors and medical and legal personnel, service personnel were aware of secondary victimization behavior, but highly underestimated the amount of distress that survivors experienced (Campbell, 2005). Negative social reactions to disclosure of sexual assault have been linked to increased severity of post-traumatic stress symptoms (Campbell et al., 1999; Ullman & Filipas, 2001b). Preventing or reducing secondary victimization has been described as a high priority for contemporary RCC advocates (Campbell & Martin, 2002), and is recommended as a continued component of RCC service delivery. Further, detection of secondary victimizing behavior, and ways to respond effectively, should be included in training for RCC advocates.

Assess victim's social support and promote social support seeking

Litz et al. (2002) review the literature on social support and trauma recovery, and strongly recommend that early intervention for all trauma should include an assessment of the victim's level of social support. Similarly, Burgess and Holmstrom (1979) found in their early work that presence of supportive relationships was related to less distress in rape survivors. The converse to the proposed relationship between social support and distress has also been supported in research: In a sample of adult sexual assault survivors, negative social reactions to sexual assault disclosure were positively related to PTSD symptom severity and self-blame (Starzynski, Ullman, Filipas, & Townsend, 2005). In keeping with these findings, Westefeld and Heckman-Stone (2003) suggest that an assessment of the sexual assault survivor's social support network be conducted. Others suggest that anyone intervening shortly after sexual assault should emphasize to the survivor the importance of seeking social support (e.g., Brodyaga & Gates, 1982; Foley, 1985; Koss & Harvey, 1991; Resick & Mechanic, 1995, Westefeld & Heckman-Stone, 2003) or should attempt to increase the social support available to the survivor (Golding, Wilsnack, & Cooper, 2002). However, interveners should encourage survivors to seek support from sources likely to be supportive, not from individuals who may blame the survivor for the assault (Daane, 2006). To promote better support, early intervention may include the provision of education on sexual assault to the support network so that supportive individuals are less likely to hold victim-blaming attitudes (Green, 1988; Wiehe & Richards, 1995). Finally, many authors suggest that early intervention for sexual assault include direct service provision, such as counseling, to the survivor's support network (Brodyaga & Gates, 1982; Daane, 2006; Koss & Harvey, 1991).

Distribute information on common reactions

Distributing information on common reactions to trauma has been suggested for victims of all forms of trauma (Gray & Litz, 2005), including for victims of sexual assault (Kanel, 2007; Koss & Harvey, 1991; Lewis, DiNitto, Nelson, Just, & Campbell-Ruggaard, 2003) and victims of crime (Woods, 2001). The goal of providing this information has been described as normalizing common symptoms and preventing future misinterpretation of symptoms (e.g., "I'm going crazy"; Resick & Mechanic, 1995), consistent with some theories on PTSD development (Ruzek, 2006). While providing information about common reactions to trauma appears to be a widely recommended strategy, Rauch, Hembree, and Foa (2001) note that empirical support for this practice is mixed. In addition, some authors articulate concerns about inadvertent symptom prescription. In a study of video-based intervention with older victims of crime, Acierno, Rheingold, Resnick, and

Stark-Riemer (2004) provided information on common reactions with the goal of normalizing these symptoms without prescribing them; the video's narrator stated clearly that many people do not experience these symptoms. It is recommended that RCC service providers validate and normalize a victim's description of common reactions. Some RCC service providers may wish to open a discussion about common reactions by noting that "some" individuals experience these reactions. However, it is strongly recommended that this discussion emphasize the possibility, not the probability, that the client will experience these reactions, and that the short-term nature of common reactions is emphasized so as to avoid symptom prescription.

Recommend counseling

Many authors agree that counseling should be recommended to survivors of sexual assault (e.g., Daane, 2006; Green, 1988; Littel, 2001; Minden, 1991; Wilken & Welch, 2003). Research suggests that many individuals with high levels of posttraumatic stress symptoms do not seek mental health services, but little is known about how to encourage the use of services (Ruzek, 2006). In a guide written for law enforcement agents, Woods (2001) suggested that the suggestion of counseling be framed in terms of having seen other victims benefit from counseling in the past. As in the discussion of common reactions, it is recommended that the option of counseling is discussed by RCC service providers, but that service providers avoid making any implication that counseling is mandatory or necessary.

Recommend follow-up

Research has demonstrated that many survivors of sexual assault do not attend follow-up services. However, a survivor of sexual assault may benefit from follow-up medical care, particularly for treatment of injury or for concerns related to sexually transmitted infections or pregnancy. Therefore, many authors recommend that a follow-up appointment be suggested to survivors of sexual assault (e.g., Daane, 2006; McConkey et al., 2001; Minden, 1991; Wilken & Welch, 2003). Some recommend that follow-up appointments be scheduled to occur within 24–48 hours (Westefeld & Heckman-Stone, 2003), or that follow-up care be facilitated through telephone calls from service providers (Koss & Harvey, 1991). It is recommended that RCC service providers encourage the client to follow up with medical and legal providers, and provide written information on how to contact these providers. It is also recommended that RCCs offer the option of a follow-up phone call to clients or provide clear information on how the client can follow up with the RCC service.

Interveners should believe the victim's story and avoid judgment or intrusiveness

Many authors recommend that an immediate intervener for a victim of sexual assault believe the victim's story and avoid any questioning that could suggest an attitude of disbelief (e.g., Kanel, 2007; James & Gilliland, 2001; Wiehe & Richards, 1995). Likewise, attitudes of judgment (e.g., Cantu, Coppola, & Lindner, 2003; McConkey et al., 2001; Vera, 1981) or intrusiveness (Westefeld & Heckman-Stone, 2003) should be avoided. Daane (2006) notes that immediate interveners should anticipate the victim's potential need for privacy in the hospital emergency room and should, if necessary, advocate for increased privacy considerations. Based on reactions of help-seeking victims, Lovett, Regan, and Kelly (2004) emphasize the importance of interveners projecting attitudes of respect and sensitivity. It is therefore recommended that RCC service providers project attitudes of belief in the client's story and avoid any statements that could be interpreted as disbelieving or judgmental.

Interveners should be calm

In discussing the desirable attitudes of immediate interveners for sexual assault, many authors agree the intervener should present a calm demeanor (e.g., Cantu et al., 2003; Green, 1988; Kanel, 2007). The intervener maintaining a calm manner upon initial disclosure of sexual assault may lead to better rapport-building, promote the idea that problems are not insurmountable, and even serve as a corrective reaction to the potentially negative reactions of others (Resick & Mechanic, 1995). It is therefore recommended that while RCC service providers remain calm while providing reassurance and validation. To help RCC providers remain calm while hearing painful stories on a routine basis, support should be provided to RCC service providers by the RCC organization. In addition, it is recommended that training for RCC advocates include recommendations on self-care and avoiding burn-out.

Suggested Organizational Practice for RCCs: Coordination and Collaboration

Several authors state that immediate intervention for sexual assault is best provided when service provision groups, medical teams, and law enforcement agencies work together (e.g., Bard, 1976), and reports on early RCCs often emphasize the benefits of inter-agency coordination of services (e.g., Estabrook, Fessenden, Dumas, & McBride, 1978; Hardgrove, 1976). Inter-agency coordination has been described as helpful in avoiding the potential for systems to work at cross-purposes (Bard, 1976), avoiding duplication of services, facilitating referrals, and increasing awareness between agencies of

the needs and goals of other agencies (Hardgrove, 1976). In addition, some empirical data suggest that survivors in communities with high levels of service coordination are more likely to obtain desired services from medical, legal, and mental health systems when compared to communities with less service coordination (Campbell & Ahrens, 1998). Communities with high amounts of service delivery coordination often include programs involving multiple service providers, inter-agency training programs, and community-level reform groups (Campbell & Ahrens, 1998). A recent review of victim service groups receiving federal funding concluded that collaboration between service agencies and criminal justice agencies is vital and necessary to improved community response to violence (Burt et al., 2001).

To coordinate services and enhance collaborative refinement of services across agencies, a clear definition of the roles, duties, and responsibilities of each agency is recommended (Michigan Sexual Assault Systems Response Task Force, 2001). Cross-training between agencies to create understanding of the role of each agency and encourage collaboration for service planning and care for each individual client has also been identified as helpful (Estabrook, Fessenden, Dumas, & McBride, 1978). In a review of four communities, inter-agency task forces and networks, joint interviewing with victims, cross-training between agencies, and referral services were identified as organizational practices that enhanced the provision of care and the success of prosecution in cases of sexual assault. In addition, coordination between victim advocates and programs that assist traditionally underserved groups resulted in enhanced provision of translation, technical assistance, training, and funding for some advocacy groups (Epstein & Langenbahn, 1994). It is recommended that sexual assault programs periodically review the demographic status of their community and conduct needs analyses to ensure that their services are available and accessible to all members of the community (Michigan Sexual Assault Systems Response Task Force, 2001). Funded coordinator positions or specially designated staff are recommended to enhance inter-agency collaboration and communication (Burt, et al., 2001; Martin, 2007), and evaluation of the coordinating effort's efficacy is also recommended (Martin, 2007). Finally, it is recommended that RCCs seek to participate in creating joint inter-agency protocols for a variety of coordination efforts with other service agencies and service providers (Burt, Zweig, Schlichter, & Scarcella, 2000).

IMPLICATIONS FOR MENTAL HEALTH PRACTITIONERS

Mental health practitioners who do not work directly in RCC settings may seek to involve themselves in early intervention for sexual assault in several ways. Similar to the coordination between medical and legal systems and RCC services, clinical practitioners may wish to coordinate with RCC services

to enhance appropriate referrals (Pennsylvania Coalition Against Rape, 1996). This may be especially important for mental health practitioners who work in areas where the local RCC is not equipped to provide psychotherapy or other mental health services. Practitioners with special interest in trauma, sexual assault, or women's issues may especially wish to make contact with RCCs. Rape crisis service clients may be more willing to seek counseling if they are aware that the practitioner has interest or expertise in this area (Clark, 1976). Practitioners who receive referrals from RCC services should establish and maintain liaisons with the RCC and may wish to consider writing statements of reciprocal referral. In a statement of referral or other agreement, issues of confidentiality should be addressed (Pennsylvania Coalition Against Rape, 1996) with attention to the fact that both therapists and RCC service providers will wish to uphold high standards for confidentiality. As staff turnover may be high in RCC services due to limited funding (Ullman & Townsend, 2007), frequent regular contact initiated by the practitioner to the RCC may enhance the continued use of a referral list. To further enhance referrals, mental health practitioners may consider serving on a local sexual assault task force.

Practitioners who receive referrals from RCCs should keep in mind the issue of secondary victimization. A rape survivor who has received medical or legal attention may also have received secondary victimization from these services, which may compound the survivor's distress (Campbell et al, 1999). Mental health practitioners should assess for and treat distress related to secondary victimization as well as related to the assault itself. Finally, practitioners in the mental health community should be aware that in the immediate aftermath of sexual assault, a client may not be prepared for in-depth emotional processing of the assault (Gibson et al., 2006). Practitioners may wish to refer their own clients to the RCC service or to implement PFA with a client who reports experiencing a recent sexual assault.

Although there is little published literature describing the training methods used by RCCs, many centers may provide training in active listening, rapport-building, or other facets of clinical care that RCC advocates may engage in with clients. Clinical practitioners who wish to assist in RCC services may consider offering themselves as a training resource or an in-service trainer on these topics. Mental health practitioners may also be suited to providing training on avoiding vicarious traumatization and burnout, both of which have been documented in studies of RCC workers (e.g., Baird & Jenkins, 2003; Ullman & Townsend, 2007). Clinical practitioners with expertise in avoiding burnout or engaging in self-care may be valuable resources for RCC staff.

In collaborating with RCCs, mental health practitioners should be sensitive to power dynamics. A social psychology researcher described conducting interviews with mental health practitioners, whom she perceived to have higher power than herself, and rape crisis advocates, whom she perceived

to have lower power than herself (Ullman, 2005). The experiences of this researcher suggest that if this perceived power dynamic exists in other contexts, mental health practitioners may be perceived as having the "upper hand" in interactions with RCC staff. This power differential may be related to differences in education and occupation as well as potential differences in race, economic status, age, or gender. Practitioners attempting to collaborate or coordinate with RCCs should be sensitive to the potential for a perceived difference in power, and may need to do extra rapport-building to develop a working relationship with RCC staff that can enhance quality of care for sexual assault survivors.

PROPOSED RESEARCH AGENDA

Unfortunately, research on early intervention after sexual assault is limited, as is research on early intervention for other forms of trauma. Litz (2004) writes that while it is understandable for mental health professionals to want to help people in the aftermath of trauma, implementing interventions without empirical support could be, at best, a poor use of time and resources, and at worst, harmful to the natural recovery process. The example of single-session psychological debriefing for acute trauma is a reminder of how well-intentioned crisis interventions can prove to be ineffective (e.g., Rose, Brewin, Andrews, & Kirk, 1999) or even cause worsening of symptoms (e.g., Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou, Ehlers, & Hobbs, 2000). In order to serve survivors of sexual assault in the most effective ways possible, evaluation of existing services and implementation of any necessary improvements to services is recommended.

First, a description of RCC services as they exist currently is needed, so that current services can be compared to our growing knowledge about early intervention and best practice in that arena and new research questions can be formulated. Second, partnerships between researchers, mental health practitioners, and RCCs can seek to demonstrate which aspects of RCC service are most valuable to consumers, which aspects may result in better long-term outcomes, and which aspects of existing services, if any, are less helpful. Agency-academic partnerships have been suggested as a vital early step in implementing best practice in organizations (Johnson & Austin, 2006); such collaborative efforts may be especially fitting for the study of organizations for violence against women (Wasco et al., 2004). Researchers and practitioners can partner with RCCs to develop and conduct interdisciplinary research, with agendas that include input and research questions drawn from RCC staff and clients, as well as input from staff and clients on what outcome measures are most important (Gambrill, 2006; Riger, 1999). As in any collaborative effort to implement best practices in an organization, the organization's staff should be fully informed of the results of research

outcomes (Regehr, Stern, & Shlonsky, 2007); work in progress may also be presented to the organization to refine research questions or identify new ways of understanding emerging results (Gilfus et al., 1999).

Evaluation projects should be developed in collaboration with organizations so that organizations can begin to self-evaluate and adjust their service provision accordingly (Gotham, 2006). Riger and colleagues (2002) describe a model for "empowerment evaluation" for RCCs and domestic violence service agencies that includes teaching the organization's leaders to self-evaluate and fostering changes to program processes, outcomes, or both. In evaluation research, RCC advocates and center directors may fear that the results of an evaluation may result in fewer funding opportunities for the organization (Riger, 1999; Riger et al., 2002). To counteract these potential problems, researchers must fully communicate the intent of their projects, how the results of each project will be used, and how the results will be disseminated, and they must be willing to engage in collaborative decision-making about each of these processes. As Riger and colleagues note, explicit statements of collaboration may be created before evaluation research is designed to delineate goals and expectations. Such statements should be renegotiated throughout the project as results, goals, and expectations may change over time.

Potential for Collaboration between Practitioners, Researchers, and Rape Crisis Service Providers

Any research conducted with recently traumatized individuals should be conducted by trained staff in a sensitive manner. Practitioners who are interested in collaborating in research with RCCs may find that their clinical skills are uniquely suited to this kind of research. Some researchers have found benefit in using female, clinically trained individuals to conduct research interviews with women who have experienced gender-based violence, including sexual assault (Griffin, Resick, Waldrop, & Mechanic, 2003). During participation, participants should be continuously monitored for distress (Kavanaugh & Ayres, 1998), with careful attention to safety and to whether participation will further compromise safety or confidentiality (Riger, 1999). Mental health practitioners may be able to lend their skills to research efforts as collaborators in clinically focused research to enhance the provision of effective services.

CONCLUSIONS

The need for early intervention after sexual assault is clear, and RCC services have been designed to provide this early intervention. It is vital to begin collaborative examination of the existing RCCs in the nation to ensure

that services provided are optimal and reflect our growing understanding of the healing process. Although few researchers have addressed RCC services, it is clear that researchers can offer much to these services through collaborative research, with careful attention to respecting the wishes and needs of RCCs and their clients, and to soliciting the expertise of these individuals as collaborative partners in research. Practitioners can offer much to RCCs as sources of referrals, experts on sexual assault task forces, consultants to RCCs, and collaborators in sensitively designed research. Ultimately, such partnerships can result in enhancing the provision of helpful and effective services to the many Americans affected by sexual assault.

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