Although prevention efforts aimed at eliminating the occurrence of sexual assault are clearly needed, it is also important to consider how we can prevent further trauma among those already victimized. Prior research suggests that rape survivors may experience victim-blaming treatment from system personnel (termed secondary victimization *or* the second rape*). This research examined how postassault contact with community systems exacerbated rape victims' psychological and physical health distress. Findings revealed that the majority of rape survivors who reported their assault to the legal or medical system did not receive needed services. These difficulties with service delivery were associated with both perceived and objective measures of negative health outcomes. Contact with the mental health system, rape crisis centers, or religious communities was generally perceived by victims as beneficial. This study suggests that the trauma of rape extends far beyond the assault itself, as negative community responses can significantly elevate distress.*

Preventing the "Second Rape"

Rape Survivors' Experiences With Community Service Providers

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Within the past 25 years, the issue of violence against women has gained substantial recognition in both public arenas and academic research (Koss et al., 1994). The magnitude of this problem is staggering: At least 17% of women will be victims of sexual violence in their lifetimes (Koss, Gidycz, & Wisniewski, 1987; Russell, 1984; Tjaden & Thoennes, 1998). In response to this problem, psychologists have examined how sexual assault affects women's mental health (Atkeson, Calhoun, Resick, & Ellis, 1982; Kilpatrick

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et al., 1985) and developed effective treatment practices that alleviate victims' distress (see Foa & Rothbaum, 1998). Yet, rape does not occur in cultural isolation: Society's response to this crime can also affect women's well-being. Rape survivors may turn to a variety of community agencies for assistance, such as the police, prosecutors, hospitals, mental health clinics, and rape crisis centers (Campbell, 1998). These community services can be quite helpful for some victims, but for others, quite distressing.

A growing body of research suggests that rape survivors are often denied help by their communities, and what help they do receive often leaves them feeling blamed, doubted, and revictimized (Campbell, 1998; Campbell et al., 1999; Cluss, Boughton, Frank, Stewart, & West, 1983; Frohmann, 1991; Konradi, 1996; Madigan & Gamble, 1991; Martin, 1997; Martin & Powell, 1994; Matoesian, 1993; Sloan, 1995; Spencer, 1987; Williams, 1984; Williams & Holmes, 1981). These negative experiences have been termed *the second rape* (Madigan & Gamble, 1991), *the second assault* (Martin & Powell, 1994), or *secondary victimization* (Campbell & Raja, 1999; Campbell et al., 1999; Williams, 1984). Consequently, victims' well-being may be affected not only by the violence itself but also by help-seeking interactions postassault. The trauma of rape extends far beyond the actual assault, and intervention strategies must address the difficulties rape survivors encounter when seeking community help. Although prevention efforts to eliminate sexual assault are clearly needed, it is also important to consider how we can prevent further trauma among those already victimized.

When rape victims' needs are not addressed by the very organizations they turn to for assistance, the effects can be quite devastating. Secondary victimization has been defined as the victim-blaming attitudes, behaviors, and practices engaged in by community service providers, which further the rape event, resulting in additional trauma for rape survivors (Campbell & Raja, 1999; Campbell et al., 1999; Williams, 1984). Drawing on the theoretical work of Martin and Powell (1994), Campbell and Raja (1999) noted that the risk of secondary victimization may stem from three sources. First, research on rape myth acceptance suggests that system personnel may be treating victims in an insensitive manner. Across several studies, police, prosecutors, judges, and doctors have been found to ascribe to victim-blaming attitudes, such as believing women provoke rape and often lie about the occurrence of rape (Best, Dansky, & Kilpatrick, 1992; Campbell & Johnson, 1997; Ward, 1988). But, rape myth acceptance does not necessarily constitute or produce secondary victimization. Yet, reports of victims' accounts have indicated that a substantial number of survivors have been directly told by service providers that they were not believable or credible, and even in the absence of such

direct communication, many women still felt doubted in their interactions with system personnel (Campbell, 1998; Frohmann, 1991; Madigan & Gamble, 1991; Russell, 1984).

Second, secondary victimization may occur not only because of what service providers do but also because of what they do not do. Not providing assistance is quite common, which can cause additional stress for rape survivors. A recent study by Campbell (1998) found that even for survivors who had the assistance of a rape victim advocate, 67% had their legal cases dismissed, and more than 80% of the time, this decision was made by legal personnel and contradicted the victims' wishes to prosecute the assault. A similar picture has emerged for the medical system. Most rape victims are not advised about pregnancy and STD/HIV risk during the emergency room medical exam (National Victim Center, 1992), and only 20% receive information about the health effects of sexual assault (Campbell & Bybee, 1997). Victims wanted these services, but system personnel did not provide them. These difficulties obtaining needed resources may be another factor contributing to the secondary victimization of rape survivors.

Finally, for those rape victims who are able to obtain desired services, it is not known if this assistance is actually helpful. The research addressing this issue is mixed. For example, both Matoesian (1993) and Sloan (1995) concluded that the procedures of legal prosecution are often harmful to women's well-being. Similarly, Cluss et al. (1983) found that rape victims whose cases were prosecuted were more distressed than those whose cases were not prosecuted. By contrast, Frazier and Haney (1996) found that survivors held positive attitudes toward investigating officers but were frustrated by the overall response of the criminal justice system. Less research has been conducted in the medical system, although Parrot (1991) noted that the physical intrusiveness of the rape exam procedures often leaves many women feeling violated and re-raped. Although this evidence is far from conclusive, it appears that for some rape survivors, the type of help offered to them may not be perceived or experienced as beneficial.

The focus of this study, therefore, was to examine how contact with a variety of community systems affects rape survivors' psychological and physical health well-being. Given the already substantial body of research documenting service providers' attitudes toward rape victims, our aim was to explore less studied aspects of secondary victimization. Consequently, the purpose of this study was to interview a survivor population with regard to their experiences seeking postrape community services. Specifically, three questions were explored in this work: (a) Did this sample of rape survivors obtain needed community resources, and are there demographic or assault charac-

teristics that differentiate those who did and did not receive services; (b) did survivors experience their contact with community system personnel as helpful or hurtful (perceived secondary victimization), and how do these perceptions vary as a function of their service delivery outcomes; and (c) how do both service delivery outcomes and perceived secondary victimization relate to objective measures of psychological and physical health outcomes? To date, the limited research on secondary victimization has concentrated on victims' experiences with the legal and medical systems; in this study, we expanded the scope to consider multiple community systems, not just legal and medical, but also mental health, rape crisis centers, and religious groups.

METHOD

Participants

To obtain a sample of adult rape survivors, our recruitment protocol was modeled after the techniques of adaptive sampling (Thompson & Seber, 1996; see also Campbell et al., 1999, and Campbell, Sefl, Wasco, & Ahrens, 2001, for a more detailed description of the sampling procedures). Adaptive sampling has been used primarily in the natural sciences to sample migratory animals and requires that researchers systematically sample locations in which the target population may congregate. Such locations may shift over time, so sampling must occur in a variety of settings (breadth) and frequently within high concentration settings (depth). In applying this logic to the recruitment of rape survivors, settings/locations with high concentrations of women would be appropriate targets for locating rape survivors. The city of Chicago and its two closest suburbs were divided into regions based on zip codes; this sampling unit was selected because it is possible to obtain census information stratified by zip code. To ensure adequate breadth of coverage, zip codes representing women of varying races and socioeconomic statuses (according to the 1990 U.S. Census) were targeted for recruitment efforts. To ensure adequate depth of coverage and representation of ethnic minority women, certain zip code areas received intensive recruitment.

In each zip code, requests for participation in this study were made via posters, fliers, and in-person presentations to groups of women. The content of these requests was designed to be responsive to the needs of rape survivors in recovery and to facilitate trust; three key points were emphasized: (a) Many women have been sexually assaulted, but it is difficult to talk about such experiences; (b) this all-female research team would like to hear from

women who have talked about such experiences before, as well as those who have never discussed the assault before—when they feel ready to do so; and (c) the research team ensures a safe, comfortable, and respectful interview environment.[1]

In contrast to previous studies, the placement of these posters/fliers and the locations for in-person presentations were not based on convenience but were instead systematically plotted. Our research team kept detailed records indicating the exact location in the city where each poster/flier was placed and each presentation was conducted. The type of settings targeted within each zip code varied but included places where women may be living, working, or passing through as part of their daily activities, including the following: public transportation, grocery stores, currency exchanges, laundromats, schools, coffee shops, bookstores, gyms, spas, nail and beauty salons, social service agencies, libraries, and churches. These recruitment efforts were spread throughout the Chicago area: Of the 69 zip codes within the city and two closest suburbs, 61 zip codes received at least one recruitment, and 37 received 10 or more distributions of information. Recruitment activities were both broad (88% of all zip codes were covered) and intense (61% were targeted for multiple distributions).

As a result of our recruitment throughout the city, 186 women requested participation in the study (over an 8-month period). Of the 157 women we were able to contact, 112 women (71%) were eligible to participate (18 years old, assaulted by a stranger, acquaintance, dating partner, or husband). Completed interviews were conducted with 102 participants (91%). In 82 cases (80%), it was possible to trace a woman's involvement in the study to a specific zip code location (the remaining 20% of the sample was obtained through snowball sampling). There were no significant differences in age, race, marital status, education level, and employment between these participants and the adult female residents of these zip codes (based on 1990 Census data). Thus, in contrast to previous studies of rape survivors in Chicago (e.g., Bart & O'Brien, 1984), the sample in the study is representative of the regions of Chicago from which the participants were recruited.

The average age of this sample was 34.29 ($SD = 10.05$), and most participants were women of color: 51% were African American, 37% White, 6% Latina, 5% Multi-racial, and 1% Asian American. Almost one third of the sample (30%) was currently married, and 53% had children. Most women (82%) had a high school education, and 61% were employed. Consistent with previous research, most participants were assaulted by someone they knew (acquaintance, date, partner) (66%), and most were raped by a single assailant (94%). Thirty-eight percent were not physically injured in the attack.

Most women did not have a weapon used against them (70%), and most were not under the influence of alcohol (70%). On average, the rape had occurred 8.25 years prior to the conducting of this interview. In comparison to the National Violence Against Women Survey (NVAW) results (Tjaden & Thoennes, 1998), our sample was older (NVAW revealed most rapes happen between the ages of 12 and 17; we were limited to studying assaults committed after age 17); had a higher proportion of African American women (NVAW lifetime prevalence rates for African American women was 19%; we specifically recruited for ethnic minority women); and had a higher proportion of stranger rapes (NVAW indicated that 14% of rapes are stranger assaults). It is important to note, however, that the purpose of our study was not to assess prevalence or incidence of rape in the Chicago metropolitan area. Thus, comparisons of our data to other studies (especially those national in scope) should be viewed with some caution. Nevertheless, this information sheds some light on how different sampling strategies may recruit different subgroups within the population of rape survivors.

Procedure

Interviews were conducted in person with a mean duration of 2.27 hours (*SD* = 54.96 minutes; Range = 45 minutes to 5.5 hours). Each participant was paid $30 and given public transportation tokens to reimburse her for transportation expenses. The tape-recorded interviews were conducted by the five authors and six additional female undergraduate research assistants who received extensive training on violence against women (prevalence, incidence, impact), community resources (legal and medical procedures, rape crisis center services), research methodology, feminist interviewing techniques, and self-care strategies for during and after the interviews. The undergraduate interviewers also received course credit for their participation in the project. To assess interrater reliability, a random sample of 25% interviews was listened to by a second interviewer to code the entire interview. Interrater agreement was 96%, which was corrected for chance agreement (kappa = .88).

Measures

The interview combined questions written specifically for this study with established measures of psychological and physical health outcomes. Following introductory material and questions, participants were asked to tell their stories of the assault in their own words. The length of these narratives

varied considerably and was the primary factor determining the overall length of the interview, but our research team felt it was important to allow the participants to describe what happened to them in their own ways. For this study, assault characteristics were coded from the survivors' narratives (type of rape, injuries, weapon use, alcohol use by victim) (interrater agreement on these specific codes was 100%).

After these open-ended questions, participants were guided through a series of structured questions pertaining to their postassault community help seeking (organized by each community system with which they had contact). Each survivor was asked whether she had any postassault contact with five social systems: legal, medical, mental health, rape crisis centers, or religious communities. To assess service delivery outcomes, for each system with which a victim had contact, she was asked which services she received from a list of all possible services that could have been provided by that system (list provided by two rape crisis centers and verified by one police department, two hospitals, and three mental health agencies). To assess overall perceived secondary victimization (i.e., the degree to which they had hurtful experiences with service providers during the provision of/refusal of services), survivors were asked to rate how contact with each system affected them on a 7-point scale (1 = *very healing*, 2 = *moderately healing*, 3 = *a little healing*, 4 = *neither healing nor hurtful*, 5 = *mildly hurtful*, 6 = *moderately hurtful*, and 7 = *severely hurtful*).

The final sections of the interview included administrations of standardized measures of health outcomes and demographics. Previous literature has established that posttraumatic stress (PTS) and depression are quite common among rape victims (Atkeson et al., 1982; Kilpatrick et al., 1985). Therefore, the Symptom Checklist 90 Revised, Crime-Related PTS scale (Saunders, Arata, & Kilpatrick, 1990) and the Center for Epidemiological Studies Depression Scale (CESD) (Radloff, 1977) were used to assess psychological distress. Due to substantial intercorrelation between the PTS and CESD scales ($r = .87$, $p < .01$), a combined index of psychological health was created. Items were standardized prior to computing an averaged scale score (standardized alpha = .97, corrected item-total correlations = .24-.80). A modified version of the Cohen-Hoberman Inventory of Physical Symptoms (CHIPS) was administered to assess the survivors' physical health (Eby, Campbell, Sullivan, & Davidson, 1995). Of the 35 health symptoms (the original CHIPS items with additional items assessing gynecological symptoms), 4 had low corrected item-total correlations in our sample (< .30) and were dropped. The final 31 items had an alpha of .94 (corrected item-total correlations = .34-.79).

RESULTS

Postassault Community Help Seeking: Service Delivery Outcomes

To understand rape survivors' postassault help-seeking experiences, we performed two sets of analyses. First, we examined what percentage of victims (in our total sample) turned to each of the five social systems (legal, medical, mental health, rape crisis centers, religious communities) and whether seeking help from each of the systems varied as a function of victim characteristics (age, education level, race) and assault characteristics (type of rape, injuries, weapon use, alcohol use). These analyses revealed that approximately one third of the rape survivors we interviewed sought community assistance postassault: 39% reported the assault to the police and attempted legal prosecution, 43% sought rape-related medical care, 39% obtained mental health services, 21% contacted a rape crisis center, and 18% turned to their religious community for support. In addition, it appears that some victims were more likely than others to turn to specific community systems postassault. Comparing the survivors who did and did not report to the legal system, we found that stranger rape survivors were more likely to seek assistance from the legal system than were nonstranger rape survivors: $\chi^2(1, N = 102) = 15.70$ ($p < .001$) (57% versus 43%, respectively). No other victim or assault characteristics differentiated those who sought legal assistance from those who did not report the assault to the criminal justice system. Similarly, comparisons between those who did and did not seek medical care revealed that stranger rape victims were also more likely than nonstranger rape victims to seek this kind of assistance: $\chi^2(1, N = 102) = 17.39$ ($p < .001$) (58% versus 42%, respectively) (no other variables were significant). Whether victims sought mental health services postassault varied as a function of race: 69% of the women who contacted a mental health professional for assistance were White, and only 31% were ethnic minority women: $\chi^2(1, N = 102) = 5.10$ ($p < .05$). This effect was even more pronounced for contacting a rape crisis center, as 91% of the survivors who had contact with such centers were White, and only 9% were ethnic minority women: $\chi^2(1, N = 102) = 8.51$ ($p < .01$). No other variables distinguished those who did and did not seek help from mental health professionals or rape crisis centers. None of the victim or assault characteristics differentiated those who contacted their religious communities for assistance postassault.

To further explore survivors' service delivery outcomes, our second set of analyses focused on just the subsamples of victims who reported to each of the five community systems. Thus, among those who contacted the legal sys-

tem (or medical, mental health, rape crisis center, religious community), which specific services were obtained and were there differences between those who did and did not obtain those services? Table 1 summarizes these results. Given the small sample sizes for these exploratory analyses, expected cell frequencies occasionally dropped below 5 (particularly in the analyses for rape crisis center services and religious community services), but nevertheless, some reliable effects emerged.[2] Survivors experienced the most difficulty with the legal system: 25% of the cases that were reported to the legal system were prosecuted, but 75% of the reported rapes resulted in no prosecution at all.[3] Ten percent of the reported cases were tried but the rapist was not convicted at trial, 10% were tried and convicted, and 5% were resolved by a guilty plea from the assailant. The cases that were and were not prosecuted differed in several respects. Prosecution was attempted more frequently for White women than for ethnic minority women: 70% of prosecuted cases had White women victims, and 30% were ethnic minority victims. Assaults that fit a more "classic rape" profile (e.g., stranger rape, physical injury, and weapon use) were also more likely to be prosecuted: 80% of the prosecuted cases involved stranger rapes, and 20% were nonstranger rapes.

Victims who sought medical attention postrape were able to access many of the services they desired. Most survivors received the medical rape exam and evidence-collection procedures. However, if the victim had showered or bathed postassault, hospital staff would typically not perform the exam. Less than half of the victims received information about the risk of pregnancy, the morning-after pill to prevent pregnancy, or information on STDs and HIV. However, most survivors were given preventive antibiotics to treat any curable STDs that could have been contracted in the assault. It appears that hospital staff were fairly routinely providing antibiotics as part of the exam procedures but were not talking with the survivors specifically about STD risk. Furthermore, White women were more likely than ethnic minority women to receive HIV information, and victims of stranger rape were also more likely to be told of HIV risk and testing options than victims of nonstranger rape.

Victims who contacted mental health professionals, rape crisis centers, or their religious communities did not experience similar gaps in service delivery. It is important to note that these services are qualitatively different from legal and medical interventions as they are often self-initiated, voluntary services. Virtually all of the survivors who sought counseling services were able to obtain either short-term or long-term therapy. Rape crisis centers provided information about rape, community-based advocacy, and referrals to all women who sought their assistance. Finally, all of the victims who wanted to discuss the assault with a member of their church community were able to do so.

TABLE 1: Community Services for Rape Survivors: Who Did and Did Not Receive Specific Services?

Specific Service	*% Who Received Service*	*Differences Between Victims Who Did/Did Not Receive Service*	*% Differences*
Legal system ($n = 40$)			
Case prosecuted[a]	25%	White women more likely to have their cases prosecuted than minority women $\chi^2(1, n = 40) = 7.18, p < .001$	Of prosecuted cases: 70% were White women, 30% were ethnic minority women
		Victims of stranger rape more likely to have their cases prosecuted than victims of nonstranger rape $\chi^2(1, n = 40) = 3.97, p < .05$	Of prosecuted cases: 80% were stranger rapes, 20% were nonstranger rapes
		Victims physically injured were more likely to have their cases prosecuted than nonphysically injured victims $\chi^2(1, n = 40) = 5.02, p < .05$	Of prosecuted cases: 65% involved injuries, 35% did not involve injuries
		Rapes involving weapons were more likely to be prosecuted than rapes that did not involve weapon use $\chi^2(1, n = 40) = 4.82, p < .05$	Of prosecuted cases: 70% involved weapons, 30% did not involve weapons
Medical system ($n = 44$)			
Rape exam & evidence collection	70%	none	
Pregnancy information	49%	none	
Morning-after pill	43%	none	
Information on STDs	39%	none	
Information on HIV	32%	White women more likely to receive HIV information than minority women $\chi^2(1, n = 26) = 5.77, p < .05$	Of women who received HIV info: 60% were White women, 40% were ethnic minority women

		Victims of stranger rape more likely to receive HIV information than victims of nonstranger rape $\chi^2(1, n = 26) = 6.01, p < .001$	Of women who received HIV info: 73% were stranger rapes, 27% were nonstranger rapes
STD antibiotics	57%	none	
Mental health system ($n = 40$)			
Short-term therapy	65%	none	
Long-term therapy	38%	none	
Counseling for significant others	5%	none	
Referrals to other services	5%	none	
Rape crisis centers ($n = 21$)			
Information about rape (for self)	100%	N/A	
Information about rape (for significant others)	2%	none	
Individual counseling	3%	none	
Group counseling	4%	none	
Community-based advocacy	100%	N/A	
Referrals to other services	100%	N/A	
Religious communities ($n = 18$)			
Pastoral counseling	100%	N/A	
Referrals to other services	3%	none	

a. The interview included questions with regard to preprosecution legal services, such as having a police report taken, investigation conducted, arrest made, and so on. However, to simplify our presentation of the results, we focus on the specific service of whether the assault was prosecuted as the other services ultimately lead up to this outcome.

Rape Survivors' Experiences of Secondary Victimization in Postassault Community Help Seeking

The second major research question for this study examined whether survivors perceived their contact with community system personnel as helpful or hurtful (perceived secondary victimization) and whether those perceptions varied as a function of their service delivery outcomes. For each social system with which victims had contact, participants rated how that experience affected them on a 7-point scale ranging from *very healing* to *very hurtful*. Table 2 summarizes those ratings and the results linking perceived secondary victimization and service delivery outcomes. In these analyses, a series of 3×2 chi squares were performed: secondary victimization rating (three categories: healing, hurtful, neither healing nor hurtful)[4] by specific service delivery outcomes (two categories: obtained service, did not obtain service). Significant 3×2 tables were then partitioned into smaller tables to locate and interpret the significant effects (see Pett, 1997; Siegel & Castellan, 1988).

Contact with the legal system was experienced as hurtful for at least half of the survivors in this study (52%). Victims who did not have their cases prosecuted were more likely to rate their contact with the legal system as hurtful. Almost half of the victims who sought medical attention postassault found this contact to be healing (47%), but nearly one third experienced it as hurtful. Victims who did not receive the morning-after pill were more likely to rate their contact with the medical system as hurtful as were victims who did not receive HIV information. Survivors overwhelmingly rated their contact with mental health professionals, rape crisis centers, or religious communities as healing (70%, 75%, and 85%, respectively). There were no significant associations between perceived secondary victimization and service delivery outcomes for mental health, rape crisis centers, or religious community services. This lack of findings is not surprising given the restriction of range on the service delivery outcomes and perceived secondary victimization for these systems and services.

Service Delivery Outcomes, Secondary Victimization, and Health Outcomes

The final set of analyses examined our third research question: How do service delivery outcomes and perceived secondary victimization relate to objective measures of psychological and physical health outcomes? The cross-sectional nature of this study prohibits drawing causal inferences, but significant associations among variables can be identified (see Table 3 for a

TABLE 2: Rape Survivors' Experiences of Secondary Victimization (SV)

System	*SV Category Rating*	*Association Between SV & Service Delivery Outcomes*
Legal		
	35% healing 13% neither heal/hurt 52% hurtful	SV (3) × Prosecution (2): $\chi^2(2, n = 27) = 6.03, p < .05$ Victims who did not have their cases prosecuted rated their contact with the legal system as hurtful: $\chi^2(1, n = 27) = 4.31, p < .05$
Medical		
	47% healing 21% neither heal/hurt 29% hurtful	SV (3) × Rape Exam (2): NS SV (3) × Pregnancy Info (2): NS SV (3) × Morning-After Pill (2): $\chi^2(2, n = 43) = 8.38, p < .05$ Victims not able to get the morning-after pill rated their contact with the medical system as hurtful: $\chi^2(1, n = 43) = 4.05, p < .05$ SV (3) × Info on STDs (2): NS SV (3) × Info on HIV (2): $\chi^2(2, n = 43) = 10.61, p < .05$ Victims who did not receive HIV information rated their contact with the medical system as hurtful: $\chi^2(1, n = 43) = 3.94, p < .05$ SV (3) × STD Antibiotics (2): NS
Mental health		
	70% healing 5% neither heal/hurt 25% hurtful	SV (3) × Short-Term Therapy (2): NS SV (3) × Long-Term Therapy (2): NS SV (3) × Counseling for Significant Others (2): NS SV (3) × Referrals (2): NS
Rape crisis centers		
	75% healing 13% neither heal/hurt 12% hurtful	SV (3) × Info For Self (2): NS SV (3) × Info for Others (2): NS SV (3) × Individual Counseling (2): NS SV (3) × Group Counseling (2): NS SV (3) × Community-Based Advocacy (2): NS SV (3) × Referrals (2): NS
Religious community		
	85% healing 15% hurtful	SV (3) × Pastoral Counseling (2): NS SV (3) × Referrals (2): NS

TABLE 3: Service Delivery Outcomes, Secondary Victimization (SV), and Health Outcomes

System	*Service Delivery & Health Outcomes*	*Secondary Victimization & Health Outcomes*
Legal		
	Prosecution & psychological health ($r_{pb} = -.42, p < .05$)	Legal SV & psychological health $F(6,37) = 3.91, p < .05$
	Prosecution & physical health ($r_{pb} = -.40, p < .05$)	Legal SV & physical health $F(6,37) = 4.02, p < .05$
Medical		
	Morning-after pill & psychological health ($r_{pb} = -.33, p < .05$)	Medical SV & psychological health $F(6,43) = 4.23, p < .05$
	Morning-after pill & physical health ($r_{pb} = -.37, p < .05$)	Medical SV & physical health $F(6,43) = 4.41, p < .05$
	HIV info & psychological health ($r_{pb} = -.37, p < .05$)	
	HIV info & physical health ($r_{pb} = -.35, p < .05$)	

summary of these analyses). To examine the connections between service delivery outcomes and health outcomes, partial point-biserial correlations were performed. Partial correlations were used to control for the effects of victim race and rape characteristics (type, injuries, weapon use) because prior analyses suggested that these variables influence service delivery outcomes; point-biserial correlations were selected because service delivery outcomes were dichotomous and health outcomes were continuous scales (see Pett, 1997). To examine the relationship between perceived secondary victimization and health outcomes, a series of ANCOVAs were performed; the categorical recoding of secondary victimization (healing, hurtful, neither) was used as the independent variable and health outcomes as the dependent variable, with victim race and rape characteristics included as covariates.

Significant partial point-biserial correlations revealed that victims who did not have their cases prosecuted exhibited higher psychological and physical health distress. Similarly, ANCOVA results suggested that victims who rated their contact with the legal system as hurtful exhibited higher psychological and physical health distress. For victims who sought medical care postassault, associations between the provision of some services and health outcomes were also supported. Significant partial point-biserial correlations indicated that victims who did not receive HIV information exhibited higher

psychological and physical health distress. In addition, victims who did not receive the morning-after pill exhibited higher psychological and physical health distress. ANCOVA results revealed that victims who rated their contact with the medical system as hurtful exhibited higher psychological and physical health distress. Victims who contacted mental health professionals, rape crisis centers, or their religious communities were usually able to receive the services they desired and rated this contact as healing. However, the point-biserial correlations between service provision and health outcomes were nonsignificant, as were the analyses between impact ratings and health outcomes. Given the relative uniformity of positive experiences with these community systems, minimal variability and restriction of range likely contributed to the nonsignificant findings.

DISCUSSION

When women go public with their stories of rape, they place a great deal of trust in our social systems as they risk disbelief, scorn, shame, and refusals of help. How these interactions with system personnel unfold can have profound implications for victims' recovery. Our results suggest that negative community contacts are associated with poorer health outcomes. Therefore, a key focus in violence against women research and interventions must be the prevention of secondary victimization. This study revealed substantial gaps in legal and medical service delivery. Ethnic minority women and victims of nonstranger rape are at particular risk for experiencing difficulty when trying to obtain needed services. Addressing the rates of service provision must be one goal of preventive strategies. In addition, many survivors reported that their contact with system personnel during the provision of services (or lack of provision) was hurtful in its own right. Thus, preventive interventions must also address how service providers treat victims who come forward for assistance. Based on our findings, three prevention approaches are recommended: (a) increased involvement in service provision by rape crisis centers; (b) increased training for all service providers; and (c) development of multisystem coordinated care service programs.

Consistent with the findings of other empirical studies and comprehensive reviews (see Campbell & Martin, 2001, for a review), our results revealed that rape crisis centers are an underutilized service by victims. This is unfortunate because rape crisis centers can be effective agents in assisting victims to negotiate system contacts, providing vital crisis intervention and advocacy services (Campbell, 1998; Campbell, Baker, & Mazurek, 1998; Campbell & Martin, 2001; Schmitt & Martin, 1999). It appears that many women, partic-

ularly ethnic minority women, may not know about rape crisis centers and how they can be of help immediately postassault. Rape crisis centers should consider focusing more of their organizational attention toward increasing public awareness about their services, particularly in communities of color. Our results do not necessarily indicate that rape crisis centers need to expand their current services, which could be quite costly and create difficulties with other community service providers; rather, our findings suggest that many women may not be familiar with what rape crisis centers have to offer. Local and national efforts to publicize rape crisis centers may need to be increased.

Second, our findings highlight the need for additional professional training for service providers. Instruction on issues of violence against women is perfunctory in police academies and medical schools (Lonsway, 1997). Service providers must be aware of the variety of services that they should be offering rape victims, and they must be challenged on their implicit beliefs that only certain victims need particular services. In addition, system personnel may be unaware of how their behaviors impact victims. Lonsway's (1997) evaluation of a training intervention with police academy recruits suggested that additional instruction on sexual assault and victim interviewing techniques improved recruits' skills, which was positively received by the interviewees. In addition, resources such as The Long Island College Hospital and Junior League of Brooklyn (1998) instructional video, "Restoring Dignity: Frontline Response to Rape," are designed to teach service providers about the beneficial and detrimental effects they may have on rape survivors. Such resources should be an integral part of training programs.

Finally, secondary victimization may be prevented by redefining the larger context of service delivery. Selected communities throughout the United States have developed coordinated care programs, which bring together police, prosecutors, doctors, nurses, social workers, and rape victim advocates to work as an integrated team in assisting rape survivors. Models for building community coordination have been developed for domestic violence services (e.g., Shepard & Pence, 1999), which may provide useful examples for sexual assault programs. Similarly, Boles and Patterson (1997) developed a general eight-step model for developing community response protocols that is applicable to a variety of crimes, including sexual assault (see also Patterson & Boles, 1992). In 1994, the U.S. Department of Justice reported that "in an increasing number of communities, law enforcement and social service agencies have formally coordinated their response to the crime of rape . . . [these] changes have helped [them] maintain a successful stance against rape" (p. xi). The focus of the study was to describe four communities in the United States that have coordinated service programs for rape victims.

Although outcome evaluation was not a primary goal, this exploratory work indicated that these programs were helpful to survivors. Taking this work a step further, Campbell and Ahrens (1998) compared victims who lived in these innovative communities to those who lived in cities without such programs and found that rape victims who received coordinated assistance were more likely to obtain needed resources that facilitated their recovery from the assault. A specific type of coordinated service program, the Sexual Assault Nurse Examiner (SANE) Program, is growing in number and shows considerable promise in facilitating service delivery that is consistent with rape survivors' needs (Ahrens et al., 2000; Ledray, 1999). All of these prevention recommendations are built on a common foundation that emphasizes improved communication and coordination among service providers. It may be difficult, impractical, and unreasonable for any one service sector to be able to provide all the services a rape survivor needs—and to do so in a healing, respectful manner. However, working together as a team, varied service providers may be better able to address the variety of legal, medical, and mental health needs of rape survivors.

NOTES

1. Our recruitment materials used both the terms *rape* and *sexual assault*, given that previous research has found that many victims do not use the term *rape* to describe their experiences (Koss, Gidycz, & Wisniewski, 1987). We did not feel it was necessary to provide a uniform definition to the rape survivors in the screening process because our staff inquired about the type of assault potential participants experienced. In all cases accepted for inclusion in this study, the victim (a) was at least 18 years old; (b) reported to us that she experienced vaginal, anal, and/or oral penetration (including penetration by an object) by a stranger, acquaintance, dating partner, or husband; and (c) reported to us that this penetration was committed by the use of force or the threat of force. These elements are common in most legal definitions of rape (see Berger, Searles, & Neuman, 1988). Because the focus of this study was how social systems respond to rape victims, incest survivors were not interviewed. In addition, we were required by our IRB to limit participation to survivors who were at least 18 years old currently and were at least 18 years old at the time of the assault.

2. Although some expected cell frequencies dropped below 5, less than 20% of the cells overall had $f_e < 5$ (see Pett, 1997, and Siegel & Castellan, 1987).

3. The interview included questions concerning preprosecution legal services, such as having a police report taken, investigation conducted, arrest made, and so on. However, to simplify our presentation of the results, we focus on the specific service of whether the assault was prosecuted, as the other services ultimately lead up to this outcome.

4. Although the questions pertaining to secondary victimization were asked on a 7-point scale, the variable distributions revealed that participants answered in three primary categories (healing, hurtful, neither). As a result, we categorized these variables for these analyses.

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