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What Really Happened? A Validation Study of Rape Survivors' Help-Seeking Experiences With the Legal and Medical Systems

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Much of what is known about rape survivors' experiences with the legal and medical systems has come from victims' accounts; rarely have researchers collected "the other side of the story" to find out what system personnel say did or did not happen in these interactions. In the current study, rape survivors who sought emergency medical care were interviewed before their hospital discharge about what services they received and how they were treated by social system personnel. Corresponding accounts were then collected from doctors, nurses, and police officers. There was significant interrater reliability between the survivors and legal and medical system personnel regarding what services were or were not provided ("service delivery") and if system personnel engaged in "secondary victimization" behaviors (i.e., statements/actions that could be distressing to victims). However, police officers and doctors significantly underestimated the impact they were having on survivors. Victims reported significantly more post-system-contact distress than service providers thought they were experiencing.

Keywords: rape; sexual assault; help-seeking; legal; medical; validity

After a sexual assault, rape survivors may need the assistance of both the legal and medical systems (Hazelwood & Burgess, 2001; Ledray, 1999). Victims may file a police report and pursue prosecution of the crime. They may also need postrape medical care, such as an injury exam and forensic evidence collection, as well as information and treatment options for pregnancy and sexually transmitted diseases. Understanding these victim-system interactions is an emerging focus in the rape victimology literature. Do victims receive the services they need? How are they treated by social system personnel in these contacts? What is the impact of these interactions on women's psychological well-being? Rape survivors' accounts of their experiences with the legal and medical systems suggest that many victims do not receive needed services and are often treated poorly by social system personnel (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Martin, 2005; Ullman & Filipas, 2001). Yet these issues are rarely studied from the perspective of community service providers, or better yet, from the point of view of both the survivors and system personnel. If a victim said she did not receive services and was treated poorly, what

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would the police officer, doctor, or nurse say happened? As literature on the community response to rape develops, it is important to understand, from multiple perspectives, the processes and outcomes of formal help seeking. The focus of the current study was to assess the degree to which rape survivors, police officers, doctors, and nurses agree about what happened in their interactions, thereby testing the accuracy of rape survivors' accounts of their experiences with the legal and medical systems.

Research on the community response to rape has focused primarily on two aspects of victim-system interactions: What services were or were not provided to survivors ("service delivery") and whether survivors were treated poorly by community service providers ("secondary victimization"). Legal service delivery—what "services" or steps of the prosecution process were initiated—is perhaps the most thoroughly investigated topic in this literature. Researchers have collected survivors' accounts (Campbell et al., 2001; Cluss, Boughton, Frank, Stewart, & West, 1983; Frazier & Haney, 1996), surveyed rape victim advocates who worked with the survivors as a proxy source of information (Campbell, 1998a; Sloan, 1995), interviewed criminal justice officials (Martin, 1997), conducted ethnographic observations of victim-system interactions (Frohmann, 1991, 1997, 1998), and reviewed official police/court records (incident reports, affidavits, closeout memoranda; Spohn, Beichner, & Davis-Frenzel, 2001). These studies have generated replicated, triangulated findings, which suggest that approximately 22% to 25% of reported rapes are prosecuted, 10% to 12% of which result in some type of conviction. Whereas it is clear that a small proportion of cases are prosecuted, few studies have examined the earlier stages of legal processing to find out how often police reports are taken, investigations are conducted, and arrests are made. Data collected from rape survivors suggest that approximately 50% of the time law enforcement personnel either do not take a report or never forward their reports for investigation (Campbell, 1998a; Campbell et al., 2001), but these rates have not been compared with accounts from police regarding what actions were/were not taken.

Survivors' experiences with the legal system are more complex than counting what services they receive—how they are treated by system personnel is also an important defining feature. For decades, advocates have expressed concerns that these interactions may be difficult for rape survivors, and indeed some researchers have found that legal contact can be revictimizing. These negative experiences have been termed "the second rape" (Madigan & Gamble, 1991), "the second assault" (Martin & Powell, 1994), or "secondary victimization" (Campbell & Raja, 1999; Williams, 1984). Secondary victimization has been defined as the victim-blaming attitudes, behaviors, and practices engaged in by community services providers, which result in additional trauma for rape survivors (Campbell & Raja, 1999). For example, questioning victims about their prior sexual histories, asking them how they were dressed, or encouraging them to not prosecute are actions system personnel may consider routine or necessary, but they may be upsetting for victims. Indeed, Campbell and Raja (in press) found that if rape survivors encountered these kinds of behaviors from system personnel, they consistently rated them as distressing and upsetting. This study also found that most rape survivors reported feeling guilty, depressed, anxious, distrustful of others, and reluctant to seek further help after their interactions with legal system personnel (see also Campbell et al., 1999, 2001). However, other researchers have not found evidence of secondary victimization. Frazier and Haney (1996) reported that rape survivors had generally positive attitudes toward law enforcement in spite of their frustration with the overall process of prosecution. To clarify these conflicting findings, more precise, behaviorally specific assessments of secondary victimization are needed from both survivors and system personnel.

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Understanding rape survivors' experiences with the medical system is no less complicated as victims have numerous health concerns that must be addressed. Previous research suggests that some services are routinely provided during postassault hospital emergency room care, but others are infrequently offered. For example, most rape survivors receive a medical exam and forensic evidence collection kit (70%) (Campbell et al., 2001). Yet only 40% of the survivors in the National Victim Center (1992) and 49% of the women in Campbell and colleagues' (2001) sample of urban rape survivors received information about the risk of pregnancy. With respect to emergency contraception to prevent pregnancy, accounts from victims indicate that 38% of women receive this service (Campbell et al., 2001), but analyses of hospital records have found lower rates, of 20% to 28% (Amey & Bishai, 2002; Uttley & Petraitis, 2000). Approximately one third of rape survivors receive information about the risk of STDs/HIV from the assault, and between 34% to 57% obtain medication to treat STDs (Amey & Bishai; Campbell et al., 2001; National Victim Center, 1992). To date, there have been no studies in this literature that have collected data from both survivors and hospital staff regarding what services were or were not provided during an ER visit. Such information would be helpful in teasing out whether these variable rates of service delivery are a function of poor documentation in hospital records, survivors' confusion about what happened during a highly stressful medical exam, or true gaps in service delivery.

Secondary victimization from the medical system may also be a problem for rape survivors. Researchers and advocates have noted that the process of the rape exam and forensic evidence collection can be traumatizing no matter how sensitively it is performed (Martin, 2005; Martin & DiNitto, 1987). For example, Campbell and Raja (in press) found that although endorsement rates for secondary victimization behaviors were lower for medical system contact than legal contact, 58% of survivors reported that they were distressed by doctors' and nurses' questions about their sexual histories, behavior before the assault, and how they were treated during the exam process. Most women reported feeling violated, depressed, and anxious after their contact with medical professionals. However, 47% of the rape survivors in Campbell and colleagues' (2001) study rated their contact with the medical system as healing, rather than hurtful. But those who did not receive needed services, such as emergency contraception or information about HIV, were significantly more likely to characterize their experiences as hurtful.

Current research suggests that many rape survivors do not receive needed services and are often treated insensitively by system personnel. However, such conclusions are based on reports from survivors, which may or may not be consistent with service providers' accounts of the same events. Therefore, the current study extends the work of Campbell and colleagues (2001) by surveying rape survivors as well as community service providers (police, doctors, and nurses). In the current study, rape survivors who sought emergency medical care were interviewed right before their hospital discharge about their contact with medical and law enforcement personnel. Corresponding accounts were then collected from the identified doctors, nurses, and police officers. Three domains were assessed: service delivery, secondary victimization behaviors, and secondary victimization emotions. For interpreting service delivery rates, it would be helpful to know if survivors and service providers identify the same gaps in services. Such validation data are even more important for understanding secondary victimization behaviors. It is one thing to agree on whether an event happened—for example, whether emergency contraception was given—but it is another to agree that a particular comment was made or question asked during a sustained interaction. It may also be useful to explore the emotional component of secondary victimization—What do survivors feel after system contact and do service providers know what survivors are feeling?

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There is no objective "fact" to triangulate here, but it is possible that system personnel may be unaware that their behaviors are upsetting to survivors. The survivors' and community service providers' accounts of service delivery, secondary victimization behaviors, and secondary victimization emotions were compared to determine whether there was significant interrater agreement regarding what happened in these interactions.

METHOD

Sample

Participants were recruited from hospital emergency rooms because this is where most rape survivors receive immediate postrape medical care and where many have their first contact with legal system personnel (Resnick et al., 2000). Two large, urban hospitals were selected for sampling that had several common characteristics. First, both had policies to call the police if a sexual assault victim presented at the emergency room, and then the survivor was given the choice whether to talk to the police. Such policies increase the likelihood that study participants would have contact with both the legal and medical systems. Second, the hospitals are comparable with respect to: (a) number of rape victims served per year, (b) having doctors perform the rape exam and forensic evidence collection procedures (rather than sexual assault nurse examiner (SANE) nurses), and (c) serving a racially mixed population with high concentrations of Medicaid-eligible patients. The primary difference between the two hospitals was that one had a policy to page rape victim advocates from a local rape crisis center to come assist rape survivors throughout their ER visit (Site #1) and the other did not (Site #2). (See Campbell [in press] for an examination of how the involvement of rape victim advocates affected service delivery and secondary victimization rates.) For the current study, there were no differences in interrater reliability between rape survivors and service providers as a function of data collection site; therefore, for the analyses reported in this article, data were collapsed across sites.

In Site #1, 38 rape survivors sought treatment over the 6-month period of time this study was conducted, and 36 agreed to participate (95% response rate). All doctors and nurses who treated these victims also agreed to participate in this study. Seventeen of these 36 survivors decided to talk to the police at the hospital. Validation data were also collected from these police officers. In Site #2, 46 victims sought treatment during the time of the study, and 45 agreed to participate (98%). Of these 45 victims, 28 had contact with the police at the ER. Complete validation data were collected from the doctors, nurses, and police officers (when applicable) for all cases. In sum, 45 cases were studied to validate victims' accounts of their experiences with the legal system (17 from Site #1 and 28 from Site #2). To validate victims' accounts of their interactions with the medical system, 81 cases were examined (36 from Site #1 and 45 from Site #2).

All 81 rape survivors were female, and over half were African American (52%), 37% were White, 8% were Latina, and 3% were multiracial. The average age was 26.12 years (SD = 3.45). Most of these women had a high school education (51%). Consistent with prior research, most of the assaults were committed by someone known to the victim (acquaintance, date, marital) (85%), did not involve the use of a weapon (74%), and did not result in physical injuries to the victim (62%). Twenty-two percent of the women had been using alcohol at the time of the assault. Twenty-six nurses worked with these 81 rape survivors. Most of the nurses were White (65%), 30% were African American, and 5% were Latina.

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The nurses' average age was 42.67 years old (*SD* = 4.32), and approximately one third had a college education in addition to their RN degree (31%). Eighteen doctors provided care to the 81 rape survivors. Most (88%) were White (12% Asian), and their average age was 45.52 (*SD* = 3.26). All had medical degrees (MD or DO); 44% were ER residents and 56% were attending physicians. The 45 rape survivors who had contact with the legal system worked with 22 police officers. Most officers were White (64%), 30% were African American, and 6% were multiracial. In addition to their police academy training, 36% had some college education. The officers' average age was 40.23 (*SD* = 3.89).

Procedure

The principal investigator worked collaboratively with the staff of both hospitals to develop uniform recruitment and data collection procedures that would ensure reliable access to rape survivors and service providers without interfering with the victims' medical care. Consistent with the sites' normal protocols for responding to rape survivors, hospital staff would first call the police, then page a rape victim advocate (if that was their policy), and then page the research team. While the victim was receiving medical care and/or reporting to the police, the research team member who had been paged to the hospital waited at the nurses' station and did not have contact with the survivor or witness her interactions with system personnel. While the survivor was waiting for her discharge papers from the hospital, a nurse approached her and asked her if she would be willing to participate in a brief interview about her experiences in the ER. She was told the interview would be conducted by a female researcher who was not affiliated with the hospital or the police. If she agreed, only then was the researcher allowed to have contact with the rape survivor. The research team member obtained the survivor's consent to participate and also completed release of information paperwork so that hospital staff and police officers could talk about the case with the victim's permission. The validation assessment was conducted with the rape survivor during the waiting time before discharge. After the survivor left the hospital, the researcher followed up with each of the parties with whom the survivor had contact to conduct validation assessments. Data were collected by one of three research team members, all of whom were female and had completed a 20-hour training program.

In 31 of the 45 cases with legal contact, validation data were collected from the police officers the same day as the assault occurred (69%): 20 of these were at the hospital after the victims were discharged, but before the officers left, and 11 were later that same day at the police station. In the remaining 14 cases, data were collected from the officers at the police station the day after the assault occurred. If validation data were obtained from police the day of the assault, the average time from the victims' hospital discharge to data collection was 4.34 hours (*SD* = 58.43 minutes). If data were collected the following day, average time from discharge to data collection was 31.93 hours (*SD* = 2.32 hours). For the 81 medical contact cases, validation data were collected from the nurses the same day as the assault occurred (on average 6.14 hours [*SD* = 2.23 hours] after victim discharge). In 60 of the 81 cases (74%), assessments were obtained from the doctors the same day as the assault occurred (average time to assessment was 7.35 hours, *SD* = 3.10 hours). In 21 cases, the researcher was not able to locate the doctor the day of the exam/assault, and had to complete the assessment the following day (or in two occasions, 2 days after assault). In these cases, average time from discharge to assessment was 35.72 hours (*SD* = 4.23 hours). Although most validation data were collected soon after the victims' discharge, analyses were performed to check whether agreement rates varied as a function of time to data

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collection. Cases were divided into two groups based on a median split, and agreement rates for service delivery, secondary victimization behaviors, and secondary victimization emotions were compared (analyses were conducted separately for the legal and medical systems). No significant differences emerged.

Measures

A verbally administered checklist was used for data collection, and its administration was tape recorded with the permission of the participants (100% of rape survivors and nurses, 94% of doctors, and 91% of police officers agreed to tape recording). In addition to collecting basic demographics and assault characteristics, the checklist measured three domains. First, "service delivery" was measured: what services were provided to the rape survivors in their contact with the legal and/or medical systems. The principal investigator reviewed police and hospital protocols and consulted with law enforcement personnel, doctors, nurses, and rape victim advocates to find out what services could be offered to rape survivors. In this study, three legal services were studied: whether a police report was taken, whether an investigation was or would be conducted, and whether law enforcement personnel provided referrals to rape survivors for other community resources. There are other actions that could be taken by the legal system (e.g., arrest, prosecution), but the informant groups reported that these were the only services that could be in progress by the time validation data were collected. For the medical system, 16 services were examined (see Table 2 for a complete list). For each service (legal or medical), the survivors were asked: "Did (service) occur? Did you receive (service)?" Police officers, nurses, and doctors were asked: "Did (service) occur? Did you provide (service) to the victim?" The respondents' answers were coded yes/no.

Second, "secondary victimization behaviors" were assessed. Because current definitions of secondary victimization emphasize the behaviors of social system personnel, participants were asked whether they encountered or engaged in specific actions. To generate this list of secondary victimization behaviors, formative research was conducted with multiple informant groups (Campbell, 1996, 1998a). Interviews and focus groups were conducted with police officers, prosecutors, doctors, nurses, rape crisis center staff, rape victim advocate volunteers, and rape survivors to find out what specific behaviors of social system personnel might be upsetting to rape survivors. In this study, 14 behaviors were assessed for the legal system, 12 for the medical system. The questions were not the same across systems because formative research revealed that assessment needed to be tailored to each system because of the inherent differences in the roles and functions of the legal and medical systems (see Tables 1 and 2 for a complete list). Consistent with prior studies on this topic (Campbell et al., 2001), these behaviors were not labeled as "secondary victimization" during assessment; participants were simply asked whether the actions occurred. For each behavior, rape survivors were asked: "Did you experience (behavior)? Did this (behavior/action/comment) happen?" The question for the police officers, nurses, and doctors was: "Did you say or do (behavior/action/comment)?" Answers were coded yes/no.[1]

Finally, "secondary victimization emotions" were assessed. Secondary victimization has been defined as insensitive and victim blaming treatment by social system personnel that leaves victims feeling distressed. In this study, eight secondary victimization emotions were assessed for both the legal and medical systems, including feeling guilty, depressed, anxious/nervous, distrustful of others, and reluctant to seek further help as a result of contact with either the legal or medical systems. Rape survivors were asked: "Did you feel (emotion) after your contact with the police officer/hospital staff? Did you feel this as a result of your

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contact with the police/hospital staff?" Police officers, nurses, and doctors were asked: "Do you think the victim felt (emotion) after her contact with you?" The participants' answers were coded yes/no.

RESULTS

Legal Service Delivery and Secondary Victimization

Across both data collection sites, there was 81% agreement between the victims and police for the three legal services examined in this study (see Table 1). This percentage was corrected for chance agreement with the kappa statistic (Cohen, 1960; Fleiss, 1971; Pett, 1997),

TABLE 1. Percentage of Rape Survivors Who Received/Experienced Each Legal Service or Secondary Victimization Behavior/Emotion According to Each Rater

	Endorsement Rate	
	Rape Survivor	Police Officer
Legal—Services (3)		
RS-P = 81% agreement ($\kappa = .85$)*		
Police report	48%	55%
Investigation	18%	27%
Referrals	9%	11%
Legal—Secondary Victimization Behaviors (14)		
RS-P = 73% agreement ($\kappa = .76$)*		
Discouraged filing a report	69%	60%
Reluctant to take a report	62%	49%
Refused to take a report	33%	29%
Told case was not serious enough to pursue	47%	40%
Did not explain steps of reporting/prosecuting	20%	0%
Asked why with perpetrator	56%	68%
Asked if had prior relationship with perpetrator	71%	84%
Questioned the way dressed	44%	38%
Questioned behaviors/choices	40%	40%
Questioned about prior sexual history	40%	38%
Questioned why memories were vague/scattered	17%	4%
Questioned if resisted perpetrator	84%	100%
Questioned if responded sexually to the assault	20%	13%
Asked if willing to take a lie detector test	13%	13%
Legal—Secondary Victimization Emotions (8)		
RS-P = 58% agreement ($\kappa = .39$)		
Felt bad about self	87%	60%
Guilty/blame self	73%	71%
Depressed	71%	38%
Nervous/anxious	62%	33%
Violated	89%	44%
Disappointed	91%	71%
Distrustful of others	53%	27%
Reluctant to seek further help	80%	22%

Note. RS = rape survivor; P = police officer.
$^{*}p < .05$.

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which was .85 for these three service delivery items. This value is considered "excellent" (Fleiss, 1971) and was statistically significant ($p < .05$), indicating that interrater agreement was significantly better than chance. For an additional assessment of agreement between raters, a differences in proportions test (Downie & Heath, 1983) was used to examine whether the percentages reported by the police officers were systematically higher or lower than those provided by the rape survivors. Although police officers tended to report slightly higher rates of service delivery than did the rape survivors, these differences did not reach statistical significance. Taken together, the results from the percent agreement calculations, kappa statistics, and proportion difference tests suggest that the rape survivors' account of what services were or were not provided by the legal system is consistent with the reports from the police officers themselves. As can be seen in Table 1, the survivors and officers agreed that approximately half of the rape survivors (48% by the survivors' accounts) had police reports taken, and only 18% were going to be investigated further. It was uncommon for police officers to refer victims to other community services (9%).

With respect to legal secondary victimization behaviors, there was also substantial agreement between the survivors and police officers as to whether these events occurred: 73% agreement ($\kappa = .76, p < .05$) across the two data collection sites. Endorsement rates for these 14 behaviors were collapsed and compared between the raters, and a differences in proportion test yielded no significant differences in reporting rates. When a rape survivor said that she did or did not encounter a specific secondary victimization behavior, most likely the police officer would also report that he/she did or did not engage in that behavior. As shown in Table 1, endorsement rates for the secondary victimization behaviors were quite variable. For example, most survivors reported that the officers discouraged them from filing a report (69%) or acted reluctant to take their report (62%). One third of survivors stated that the police refused to take their reports. Officers also commonly asked survivors why they were with the perpetrator (56%) and whether they had a prior relationship with him (71%). Forty percent of the survivors stated that police questioned them about their prior sexual histories, and 20% were asked specifically if they had responded sexually to the assault (i.e., if they had an orgasm).

The interrater agreement for legal secondary victimization emotions was substantially lower than for legal service delivery or secondary victimization behaviors: 58% agreement; $\kappa = .39$, *ns*. Rape survivors and police officers agreed on what happened—whether or not services were provided and how police officers interacted with victims—but they did not share a common view as to how rape survivors might feel after these experiences. Specifically, law enforcement personnel consistently underendorsed the secondary victimization emotions relative to the rape survivors' accounts (z [44] = 2.73, $p < .01$). In other words, the rape survivors often stated that they felt distressed after their interactions with police officers, but the officers did not think that the survivors felt such distress. After their contact with law enforcement personnel, survivors often reported feeling bad about themselves (87%) and blaming themselves for the assault (73%). Most also stated that they felt depressed (71%), violated (89%), and disappointed (91%). Eighty percent stated that they were reluctant to seek further help.

Medical Service Delivery and Secondary Victimization

There are a variety of services that medical staff could provide to rape survivors, and it appeared that there was some specialization in the roles and responsibilities of the emergency room nurses and doctors regarding these services. Some were performed exclusively

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by the nurses outside of the presence of the doctors (e.g., information on risk of pregnancy, STDs, HIV, psychological impact, physical impact, follow-up care, referrals), and consequently, the doctors could not consistently report on whether these services had been provided to the survivors. By contrast, the doctors' contact with the rape survivors always took place in the presence of the nurses. As a result, complete interrater data (i.e., rape survivor, nurse, and doctor) could be collected for only 9 services. Interrater data between the survivor and nurse could be obtained for all 16 services. Collapsing across the two data collection sites, there was 70% agreement between the rape survivors, nurses, and doctors for 9 of these 16 services ($\kappa = .78$, $p < .05$). The agreement between just the survivors and doctors for these 9 services was somewhat higher (85%) ($\kappa = .84$, $p < .05$). For all 16 medical services, the agreement between the survivors and nurses was 73% ($\kappa = .83$, $p < .05$). There were no significant differences in the proportions reported by each rater, indicating that there were no systematic underreporting or overreporting relative to the rates provided by the rape survivors. This pattern of results indicates that the rape survivors' accounts of which services they received in the emergency room are consistent with the doctors' and nurses' reports. As can be seen in Table 2, some services were routinely provided, such as the rape exam and forensic evidence collection kit (81%). Most survivors also received information about the risk of pregnancy and STDs from the assault (63% and 53%, respectively). However, only 35% received information specifically about the risk of HIV, and only 28% were given emergency oral contraception to prevent pregnancy. Most women received antibiotics to treat any STDs that may have been contracted in the assault (69%), but only 17% were given HIV

TABLE 2. Percentage of Rape Survivors Who Received/Experienced Each Medical Service or Secondary Victimization Behavior/Emotion According to Each Rater

	Endorsement Rates		
	Rape Survivor	Nurse	Doctor
Medical—Services (16)			
RS-N-D = 70% agreement ($\kappa = .78$)^{*a}			
RS-N = 73% agreement ($\kappa = .83$)*			
RS-D = 85% agreement ($\kappa = .84$)^{*a}			
Rape exam	81%	81%	81%
Forensic evidence collection	81%	81%	81%
Detection/treatment of injuries	58%	89%	89%
Information on risk of pregnancy	63%	71%	MS
Information on risk of STDs	53%	65%	MS
Information on HIV specifically	35%	49%	MS
Tested for pregnancy	31%	52%	54%
Emergency oral contraception (morning-after pill)	28%	28%	28%
Tested for STDs	14%	19%	19%
Tested for HIV	11%	15%	15%
STD prophylaxis	69%	69%	69%
HIV prophylaxis	17%	17%	17%
Information on psychological effects of rape	5%	26%	MS
Information on physical health effects of rape	5%	26%	MS
Information on follow-up treatment	7%	21%	MS
Referrals	10%	21%	MS

(Continued)

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TABLE 2. Continued

	Endorsement Rates		
	Rape Survivor	Nurse	Doctor
Medical—Secondary Victimization Behaviors (12)			
RS-N = 83% agreement ($\kappa = .84$)*			
RS-D = 79% agreement ($\kappa = .82$)*			
Refused to conduct exam	0%[b]/30%[c]	0%	30%
Refused to do forensic evidence collection	0%[b]/30%[c]	0%	30%
Did not explain rape exam procedures	20%[b]/20%[c]	0%	0%
Impersonal/detached interpersonal style	43%[b]/60%[c]	37%	56%
Asked why with perpetrator	50%[b]/52%[c]	56%	54%
Asked if had prior relationship with perpetrator	52%[b]/54%[c]	57%	59%
Questioned the way dressed	33%[b]/33%[c]	19%	23%
Questioned behavior/choices	33%[b]/41%[c]	27%	26%
Questioned about prior sexual history	50%[b]/65%[c]	63%	50%
Questioned why memories were vague/scattered	0%[b]/7%[c]	0%	7%
Questioned if resisted perpetrator	100%[b]/85%[c]	88%	100%
Questioned if responded sexually to assault	0%[b]/12%[c]	0%	14%
Medical—Secondary Victimization Emotions (8)			
RS-N-D = 58% agreement ($\kappa = .62$)			
RS-N = 79% agreement ($\kappa = .73$)*			
RS-D = 60% agreement ($\kappa = .55$)			
Felt bad about self	81%	63%	42%
Guilty/blame self	74%	56%	54%
Depressed	88%	74%	62%
Nervous/anxious	91%	79%	62%
Violated	94%	86%	84%
Disappointed	86%	67%	53%
Distrustful of others	74%	50%	41%
Reluctant to seek further help	80%	41%	27%

Note. RS = rape survivor; N = nurse; D = doctor; MS = substantial missing data.
[a]Computed on data for nine services. [b]From nurse. [c]From doctor.
*$p < .05$.

prophylaxis. It was quite uncommon for survivors to receive information about the psychological and physical health effects of rape and where and when to receive follow-up medical care.

The rape survivors were asked the medical secondary victimization behavior questions twice, first with respect to the nurses, then the doctors. Across the two data collection sites, the interrater agreement between the victims and nurses and between the victims and doctors was high: 83% ($\kappa = .84$, $p < .05$) and 79% ($\kappa = .82$, $p < .05$), respectively. No significant effects emerged in the differences in proportions tests (i.e., there was no evidence of systematic overrating or underrating). The endorsement rates for the secondary victimization behaviors were mixed. It was typical for doctors and nurses to ask the survivors why they were with the perpetrator and whether they had a prior relationship with him (50%/52% and 52%/54%, respectively). Most survivors were asked about their prior sexual histories (50%/65%), and 12% were asked by the doctors if they had responded sexually to the rape.

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Similarly to the police officers, it appears that some medical professionals were unaware of how rape survivors felt after their emergency room visits. The interrater agreement between the rape survivors, doctors, and nurses for the eight secondary victimization emotions was only 58%, which was not significantly better than chance ($\kappa = .62$, *ns*). A differences in proportions test revealed that the doctors consistently underrated these emotions in comparison to the rape survivors' data ($z\ [80] = 2.14, p < .05$). When victims stated that they felt various forms of distress, the doctors consistently reported that the rape survivors were not experiencing such emotions. By contrast, the nurses' accounts of the survivors' emotional states were generally consistent with what the survivors themselves said they were feeling. Across the two sites, the victim-nurse agreement was 79% ($\kappa = .73, p < .05$). As shown in Table 2, after their contact with the medical system, most survivors stated that they felt bad about themselves, guilty, depressed, anxious, violated, disappointed, distrustful of others, and reluctant to seek further help.

DISCUSSION

To date, most researchers who have studied victim-system interactions have typically collected data only from the survivors. These studies suggest that many rape survivors do not receive needed services and may be treated by system personnel in ways that are upsetting. Yet it was not yet known if community service providers had different recollections of what happened in these interactions. It was possible that their accounts would document much higher rates of service delivery and lower rates of secondary victimization. In this study, the stories of the victims and community service providers were compared. For service delivery and secondary victimization behaviors, in both the legal and medical systems, there was statistically significant interrater reliability between the survivors' and service providers' data. When a rape survivor said she did not receive a service, more often than not the police officer, doctor, or nurse agreed with this account. If a survivor said she encountered a specific secondary victimization behavior, such as being discouraged from filing a police report or asked about her prior sexual history by the ER doctor, the service provider usually agreed that indeed s/he behaved as such. These findings suggest that rape survivors' reports of their experiences with the legal and medical systems are indeed accurate and valid.

Whereas rape survivors and community service providers tended to agree on what events took place in their interactions, social system personnel often underestimated the potential negative impact they have on victims. The agreement rates for the secondary victimization emotions were generally quite low. Police officers and doctors consistently underrated relative to the survivors' data, indicating that they did not think victims were experiencing the kinds of distress that they reported enduring. If victims stated that they felt blamed or depressed after interacting with legal or medical system personnel, more often than not police officers or doctors did not think the survivors were feeling such distress. This effect was not found for the nurses, as they had significant interrater agreement with the survivors. These results indicate that some service providers may be unaware of how their behaviors are affecting rape survivors, and specifically, may not realize that their actions are distressing.

Yet the service providers may have considered their behaviors to be normal and proper given their roles and responsibilities. For example, questions about why a victim was with the perpetrator or whether she resisted the rape may be considered vital information for a thorough report. As noted previously, these items were generated by multiple informant

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groups, who stated that, however normative or necessary, these actions may be distressing to survivors. Indeed, the rape survivors in this study who encountered these behaviors consistently rated them as distressing, and they often spontaneously mentioned why they were upsetting. For instance, victims told the researchers that questions such as why they were with the perpetrator before the assault were distressing to them because they thought such a question implied that they shouldn't have been or that they used poor judgment, and therefore deserved what happened. Similarly, when asked if they resisted the attack, survivors often thought that meant that they were supposed to fight back and because in the end they were assaulted, they deserved to be raped. However, it is quite possible that service providers did *not* make such presumptions, hold such beliefs, or intend for their comments to be hurtful. In fact, during data collection, system personnel were rarely reluctant to answer these questions and rarely showed any indication that perhaps they "should" have done otherwise. Future research is needed on the motivation and intent behind community service providers' behaviors. In such work, it will be important to explore whether social system personnel such as police officers, doctors, and nurses experience vicarious trauma (VT) or burnout from their work with victimized populations and if those experiences are affecting their interactions with rape survivors (see Baird & Jenkins [2003] for exemplar research on VT with other violence against women service providers).

As with other studies in this literature, these findings suggest that rape survivors are quite distressed after their contact with legal and medical system personnel. Secondary victimization behaviors may be one mechanism through which this distress occurs, but such mediational hypotheses could not be tested with these data. In fact, the distress documented in this research could be attributable to the assault itself rather than postrape help-seeking experiences. Because independent assessments of general distress and posttraumatic stress were not administered, this possibility cannot be explicitly tested. In the measurement of the secondary victimization emotions, the survivors were specifically asked to reflect and frame their answers in regard to their social system contact—as a result of their experiences, did they feel this form of distress? Even though the question attempted to separate the distress of the rape from the potential distress of system contact, the respondents' answers may not have been divided accordingly.

It is also important to consider the limitations of the sample size in this study. To its benefit, this research collected data from multiple sources, but only 81 cases were analyzed to evaluate the medical system, 45 for the legal system. As such, it is possible that the nonsignificant differences in proportions tests (which explored whether there was systematic overreporting or underreporting relative to the rape survivors' data) could be due to insufficient power. With a larger sample size, these effects may have been significant, which would have indicated significant disagreement between the accounts of the rape survivors and social system personnel (and thereby call into question the validity of data collected only from rape survivors). Whereas this possibility cannot be ruled out, and hence the reader should interpret these results with some caution, it is also important to note that the kappa statistics were statistically significant. Their values, considered "good" or "excellent" in this study, ranged from .76 to .85; and values as low as .60 have still been characterized as acceptable in the literature (Fleiss, 1971).

Prior research has revealed that there are substantial problems with the community response to rape. Unvalidated reports of service delivery suggest that approximately half of the time law enforcement officers do not take victims' reports or forward their reports for investigation. In this study, validated data yielded similar findings, indicating that survivors' problems with the legal system do not begin at the stage of prosecution. Similarly,

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unvalidated reports of medical service delivery have indicated that few survivors are receiving emergency contraception and information on STDs/HIV, which was confirmed in this validation study. Moreover, system personnel reported engaging in behaviors that rape survivors find distressing, which raises questions for future research and policy regarding what is necessary to ask or tell survivors as part of law enforcement questioning or emergency room medical care.

Another indicator of the need for reform was highlighted by how many of the rape survivors responded during data collection for this study. They frequently stopped the researchers during the interview and asked questions: Was I supposed to get HIV medication? Was an investigation supposed to happen? Was the police officer allowed to ask about my sex life? It was challenging for the research team to know how to respond to these questions. To preserve the quality of the data, the researchers answered the victims' questions after the completion of the interview, providing information and referrals to address their lingering concerns. In effect, the research study became a supplemental resource for these women. That such a need was so consistently present further underscores the importance of continued efforts to improve the community response to rape.

NOTE

1. To check whether it was reasonable to conceptualize these behaviors as "secondary victimization," distress ratings were also collected from the rape survivors. If a survivor reported that she encountered one of these behaviors, she was also asked to rate how distressing it was to encounter that behavior on a 1 to 5 scale (1 = not distressed; 2 = a little distressed; 3 = some distress; 4 = quite a bit of distress; 5 = a great deal of distress). All behaviors were rated as a '3' or higher by all survivors who encountered them ($M = 4.22$, $SD = .47$).

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