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# "YOU CAN STAY IF YOU WANT" -- WOMEN'S EXPERIENCES PROVIDING RAPE CRISIS MEDICAL ADVOCACY

Chandra N. Strange
*University of Kentucky*, cnstrange@me.com

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Chandra N. Strange, Student

Dr. Pamela P. Remer, Major Professor

Dr. Kenneth Tyler, Director of Graduate Studies

# “YOU CAN STAY IF YOU WANT” -- WOMEN’S EXPERIENCES PROVIDING RAPE CRISIS MEDICAL ADVOCACY

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DISSERTATION

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A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Education
at the University of Kentucky

By

Chandra N. Strange

Lexington, Kentucky

Director: Dr. Pamela P. Remer, Associate Professor of Counseling Psychology

Lexington, Kentucky

ABSTRACT OF DISSERTATION

"YOU CAN STAY IF YOU WANT" -- WOMEN'S EXPERIENCES PROVIDING RAPE CRISIS MEDICAL ADVOCACY

Many survivors of sexual trauma describe the forensic exam as a second rape (Campbell et al., 1999; Parrot, 1991). Rape crisis medical advocates (RCMAs) assist survivors through this time of vulnerability to retraumatization (Resnick, Acierno, Holmes, Kilpatrick, & Jager, 1999). Campbell (2006) stated that the primary role of the RCMA is to reduce victim-blame (VB), or the tendency to blame a victim for a crime. Survivors assigned RCMAs receive more medical and legal services and are less likely to feel revictimized (Campbell, 2006; Resnick et al., 1999), but the impact of the work on RCMAs has not been sufficiently examined. Previous research has shown that advocates experienced anger and fear in relation to the work (Wasco & Campbell, 2002), and that RCMAs who witnessed more VB reported less satisfaction with the work and commitment to the job (Hellman & House, 2006). Counselors who worked with trauma survivors reported higher vicarious trauma (VT) than those who did not (Schauben & Frazier, 1995). Counselors who worked with victims of sexual trauma endorsed more disruptive beliefs about self, others, and the world (Bober & Regehr, 2005). However, the appropriateness of generalizing results observed among counselors to RCMAs is unclear.

The purpose of this study was to examine predictors of RCMAs' VT and vicarious post-traumatic growth (VPTG). Since previous research has focused on individual-level variables like personality style and coping skills (Kelley, Schwerin, Farrar, & Lane, 2005; King, King, Fairbank, & Adams, 1998; Pearlman & Mac Ian, 1995), I examined the predictive ability of environmental/contextual/systemic variables on RCMAs ratings of VT and VPTG, including caseload, amount of supervision received, ratings of the psychosocial work environment, and perceptions of witnessing VB. One hundred and sixty-four RCMAs participated in this internet-based survey research. A series of hierarchical regressions demonstrated that higher ratings of VT were predicted by lower amounts of group supervision received, and lower ratings of the social community and the meaning of the work. Ratings of VPTG were significantly predicted by amount of individual supervision received. Interpretations and recommendations are provided to assist rape crisis agencies in supporting RCMAs in their work.

KEYWORDS: Rape Crisis Advocacy, Vicarious Traumatization,
Posttraumatic Growth, Victim-Blame, Work Environment

*Chandra N.Strange*
Student's Signature

*August 25, 2014*
Date

# "YOU CAN STAY IF YOU WANT" -- WOMEN'S EXPERIENCES PROVIDING RAPE CRISIS MEDICAL ADVOCACY

By

Chandra N. Strange

*Dr. Pamela P Remer*
Director of Dissertation

*Dr. Kenneth Tyler*
Director of Graduate Studies

*August 25, 2014*

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last year. Thank you for taking me with you, for keeping me here, for fighting every day until it was time to go, and reminding me to keep fighting after. I expect you to keep your promise to dance at my wedding.

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To Ryan and Vaneesa: Can you believe this? Seriously…wow. We actually made it out okay. More than okay, in fact. We created great lives. An adventurer, a mother, and a healer of wounded souls. All those people who hated on us in high school can suck it. Thank you for still being in my life after all these years. I will love you forever.

To my mother: How do I say thanks? How do I express my gratitude for my life? For all the pain, for all the joys, for always being so loved? For everything always being okay? How do I thank you for making my world, for showing me all its beauty, and for making me such a force to be reckoned with? I do not know how to thank you for making me the woman I am. I guess the best way might be to tell you that I finally like her. I like the woman I have become, and that woman is so much of you and because of you. A little hippie, a little witch, a little Black, a little White, a little gay, a little straight, and a whole lot radical feminist. All that diversity in the world that you embraced as a young woman is brought to bear in your child. I am the epitome of the beautiful mix of cultures you have always loved so much. You recreated that beauty in your child…and she is finally able to recognize that. Thank you for a job well done. Two against the world.

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## Chapter One: Introduction

I usually returned home well after dawn; sometimes it was still dark, and sometimes it was mid-afternoon, but usually the sun was still climbing upward, for some reason shining more brightly than it should, more brightly than I wanted it to. Those mornings seem unusually crisp and clear in my memory. I would climb into my car in the dark, damp hospital parking garage, and emerge to clear skies and radiant sunshine. I wanted rain. I felt like rain.

The phone had rung at two or three or four o'clock in the morning. I was on-call for the night shift. I would hit the quick-brew button on the coffee pot, grab my bag, and be out the door in ten minutes. Traffic was never a problem at that hour. By the time I arrived she[1] had been in the emergency room (ER) for hours. The police would be there, maybe family and friends, but maybe not. Nurses and doctors would scurry about. I would sit with her and hold her hand. Or I would just stand back, silently available should she need me. Sometimes she would ask me to leave, but usually she said "You can stay if you want." Later, she would grasp my hand with the strength of a warrior attempting to battle through an unwinnable challenge. Later, she would ask me why. Later, she would ask if it had happened to me. Later, she would try to heal. Now, in this moment, she was still trying to survive.

And then I would simply go home. I would exit the hospital, confront the offensively bright sky, and return to the home I shared with my mother and grandmother as if the world was still the same, as if I was still the same person who had departed just

[1] I have chosen to employ a generic "she" when referring to my own experiences, as all of my experiences have been with female victims of sexual violence. Research indicates that up to 10% of rape victims are male (National Institute of Justice & Centers for Disease Control & Prevention, 1998; U.S. Department of Justice, *2007).*

hours before, as if it were just a job that was now complete. But I was changed each time. The world as I knew it changed each time.

Sometimes, I returned home proud and triumphant, like the first night I was called to the ER. An elderly, homeless woman had been raped by a man she trusted. He passed out drunk after assaulting her, and she took his wallet out of his pocket before escaping. She was handing his wallet to the police as I arrived, and he was in jail before we left the ER.

Sometimes, I returned home sad, like the time a woman told me not to worry about her because she had been raped four times before and knew what to expect.

Sometimes, I returned home afraid for those involved, like the time I was sure a father and brother were going to kill the perpetrator. I stood in the ER hallway with them, in the middle of the night, trying to convince them not to kill this man when all I wanted to do was go kill him myself.

Sometimes I felt fear for myself, like when I gave a presentation to the University of Kentucky football team on the dynamics of sexual violence. I had heard of an advocate being assaulted at another school in a similar situation, and I was terrified someone was going to attack me on my way back to my car. I even had a male co-worker escort me to and from the presentation. Instead, as I left the room at the end of the presentation, with my head down and shoulders hunched in a terrified effort to protect myself from the imposing figures cast by these giants around me, I felt strong, yet strangely gentle, pats on my back. The players hugged me and thanked me for coming. And I cried, because sometimes I felt unexpectedly, indescribably valued, loved, and safe.

But usually I returned home angry, like the time I arrived at the ER to find a young woman of about twenty with ligature marks around her throat. By the time I got there she had already been told that the doctor would not see her, that the police would not take her report. Her friends were there, too, confused and concerned, begging me to do something, anything to make this right. Her friends told me what happened: a frat party, free alcohol, hours lost, and bruises gained. The ligature marks around the victim's throat told the story of her ordeal. She could have done nothing to deserve the treatment I was about to witness.

The nurse returned to the room we occupied, a small room off the waiting room that I had never been in before. In my four years as a rape crisis medical advocate (RCMA), I had always been directed to the Sexual Assault Response Team (SART) room, a specialized room where the victim would be met by a RCMA and a Sexual Assault Nurse Examiner (SANE). SARTs were created in the early 1970's, alongside rape crisis centers, as multi-disciplinary, multi-agency teams of professionals who worked collaboratively to provide services to victims of sexual violence (National Sexual Violence Resource Center, 2011), and they generally include medical, legal, and social service providers. In my area, when a victim of sexual violence reports to the ER or to police the SART is activated, dispatching police investigators, a SANE (a forensic nurse who specialized in treating victims of sexual violence, collecting physical evidence of the crimes, and testifying in court about the findings), and a RCMA to the ER. In all my previous experiences, the victim had already been examined by a physician, treated medically if necessary, and released to the SART team by the time I arrived. This young

woman had been offered none of those services, and for the life of me I could not figure out why she was where she was.

Eventually things became clearer. The nurse joined us, kneeled down in front of the victim, took her hand and said, in a sugary-sweet tone of voice meant to convey genuine concern, "You know, you really shouldn't have been at that party. You shouldn't be walking around campus at night. You shouldn't be drinking. It's your job to keep yourself safe. And this has happened to you before, hasn't it?" The victim nodded, apparently appropriately shamed. The nurse, with a look of something resembling certainty or assuredness on her face, informed the victim and her friends that they could leave. Everyone else looked to me for some kind of salvation, but I was at a loss. I felt like I was in the Twilight Zone, a parallel universe where things just were not as they should be. "I don't understand," I said to the nurse, "she hasn't been examined by a doctor, she wants to press charges, she needs a rape exam." The nurse took me by the arm and led me out of the room. "We do not have anyone available to conduct a rape exam on her." She then informed me that it was not my place to question her in front of her patient, and that I was acting outside the scope of my organization. So I called my organization and was told "Advocate for your client!"

And I tried. I tried so hard but, in the end, the only option was to have the victim's friends take her to another hospital, hours away, where we were promised she would get appropriate medical care and a rape exam. And I understand that she was treated with a decency and respect at the other hospital that one might not expect from the distant, rural place to which she was forced to travel. I did not witness this first-hand, however, as I was busy back at my organization trying to get somebody to do something.

And while my supervisors listened to my story, and agreed with me, and told me I was in the right for attempting to advocate for my client, I was never allowed back into that hospital as an advocate again. I tried to go once, on another crisis call, and was met at the door by the same nurse who informed me that I would not be allowed in if I was going to question her authority. I was never again to see a client at that hospital. In fact, I never again saw a client as a RCMA.

Even as I write this, almost ten years later, I can still feel echoes of the physical feelings I felt that night. My hands have gone cold and tingly as I type. My stomach is in knots. I am shaking slightly, so angry over the atrocity I witnessed, frustrated over my inability to change the horrific, re-traumatizing experience I watched unfold before me. I knew what that nurse's words were doing to my client; I feel it in my bones as much now as I did then. But at that time, I did not fully appreciate what lasting impacts the nurse's words would have on me.

**Statement of the Problem**

Rape crisis medical advocates (RCMAs) provide an important service to individuals who arrive at a medical facility for assessment, treatment, and/or forensic evidence collection in the aftermath of a sexual assault by proving emotional support, education about trauma, and advocacy for comprehensive and respectful services. During this time, survivors are particularly vulnerable to retraumatization (Resnick, Acierno, Holmes, Kilpatrick, & Jager, 1999; Worell & Remer, 2003). Campbell (2006) stated that the primary role of the RCMA is to reduce victim blame (VB; a tendency to blame the victim of a crime for the crime), thus improving the quality of services provided by medical personnel and police and reducing the extent of retraumatization of

survivors. The literature has consistently shown that survivors receive more medical and legal services when advocates are present (Campbell, 2006; Resnick et al., 1999; Wasco et al., 2004) and are less likely to experience victim-blame and re-victimization (Campbell, 2006).

However, few researchers have examined the impact of providing direct medical advocacy services on RCMAs. Hellman and House (2006) found that RCMAs who witnessed more VB reported less satisfaction with their work, and those who reported less satisfaction with their work reported lower levels of affective commitment to the job. In addition, ratings of satisfaction with the work and affective commitment to the job were both positively correlated with intent to remain an advocate. Wasco and Campbell (2002) found that many advocates experienced anger and fear in relation to the work. An unpublished study, designed to inform this dissertation research, found that RCMAs who perceived higher levels of VB by police tended to express lower levels of trust in police, medical personnel, social service providers, and people in general (Strange, Waldheim, & Tzou, 2011). This relationship was not observed for perceiving VB by medical personnel.

Given the limited number of research studies examining the impacts of providing rape advocacy on advocates, we are forced to extrapolate from research with professional counselors. This generalization may be inappropriate. Professional counselors tend to receive more advanced training and formal supervision than RCMAs, who are often volunteers. In addition, counselors are not generally present during forensic rape exams or other potentially re-traumatizing events. Jenkins and Baird (2002) described how advocates differ from professional counselors in role functions and exposure to clients,

and stated that "their unpaid status may sometimes mean that they do not receive the training and social support for stress management that paid staff do, which may raise their risk for trauma-related difficulties" (p. 431). Still, it seems important to consider that Schauben and Frazier (1995) found that professional counselors who worked with more trauma survivors "report more disrupted beliefs about themselves and others, more PTSD-related symptoms, and more 'vicarious trauma'" (p. 61). Pearlman and Mac Ian (1995) found that professional trauma therapists with the most symptoms tended to have the least experience, moderate exposure to clients' traumas, were not receiving formal supervision, and worked in hospitals. Fortunately, most research on counselors has detected low levels of distress (Elwood, Mott, Lohr, & Galovski, 2011; Jenkins & Baird, 2002), but Bober and Regehr (2005) found evidence that "working with victims of interpersonal violence…was associated with higher traumatic stress scores," and "working with victims of rape was associated with more disruptive beliefs" (p. 7). Way, VanDeusen, Martin, Applegate, and Jandle (2004) found that levels of vicarious trauma were in the clinical range for most of the trauma clinicians they surveyed.

**Purpose of the Present Study**

In this study I examined RCMAs' ratings of vicarious trauma (VT) and vicarious post-traumatic growth (VPTG). Additionally, since a great deal of the research on the effects of exposure to trauma focuses on individual-level contributions like coping skills, personality style, and history of victimization (Kelley, Schwerin, Farrar, & Lane, 2005; King, King, Fairbank, & Adams, 1998; Pearlman & Mac Ian, 1995), I attempted to add to the literature by examining the predictive ability of several systemic variables on RCMAs' ratings of VT and VPTG, such as caseload, amount of formal individual and

group supervision received, perceptions of social community at work, emotional demands of the work, meaning of the work, and the amount of VB RCMAs perceived by police and medical personnel in the course of their work with survivors. Additionally, because previous literature has indicated that VT may be developmental in nature (McCann & Pearlman, 1990), in this study I also examined the predictive ability of age, education level, and amount of experience as a rape crisis advocate on RCMAs' ratings of VT and VPTG. I hope that the results of the present study will increase our understanding of traumatization and post-traumatic growth in general, and VT and VPTG among RCMAs, specifically.

## Chapter Two: Literature Review

In this chapter I will define constructs utilized in this study; review previous literature related to secondary survivorship, or caring for traumatized-others; and cite research assessing for risk factors related to developing secondary or vicarious trauma reactions. I will also briefly review the literature related to rape victim-blame, theories proposed to explain the phenomenon of victim-blame, and the effects of exposure to victim-blame on trauma-related symptomology developed by victims. Finally, I will review previously observed effects of providing rape crisis advocacy services on advocates, and assess the strengths and weaknesses of the current literature-base. This chapter will conclude with the purpose and justification for the present study.

### Definition of Constructs

At present, our field lacks a definitive language for discussing sexual trauma, in general, and the impacts on those who care for trauma survivors in particular. As such, devoting some time to articulating the specific definitions of constructs that were utilized in this study is important.

**Defining rape.** Constructing a widely-acceptable definition of rape has proved elusive. The United States (US) Department of Justice (2003, 2007, 2009) maintains that rape is the full, forcible vaginal penetration of a woman over the age of 12, leaving untold numbers of victims unrepresented in national prevalence data. American legal statutes specified that rape could not be perpetrated within a marriage as recently as 1992 (National Center for Victims of Crime, 1999), and many states' statutes regard marital rape as less of a crime than stranger-rape (Bergen, 1999). To complicate matters even further, many victimized individuals themselves do not identify their experiences as rape.

Koss (1985) found that of the highly sexually victimized women she surveyed, only 57% identified their experiences as rape.

As I sat thinking about the depth, breadth, and historical context of discrepancies in defining rape, I realized I was futilely attempting to reconcile vastly different theories and observations from different fields (psychology, gender studies, interpersonal violence, etc.) about sexual trauma into the most *widely-accepted* definition of rape. I shifted my focus to identifying the most *widely-accessible* definition of rape to the lay-person. I asked myself, if I were someone with little knowledge of sexual violence, how would I go about deciding what rape meant? I would Google it! And, as expected, the first result returned was the Wikipedia page on rape.

The entry states:

> Rape is a type of sexual assault usually involving sexual intercourse, which is initiated by one or more persons against another person without that person's consent. The act may be carried out by physical force, coercion, abuse of authority or with a person who is incapable of valid consent. (Wikipedia, ¶ 1)

Upon further investigation, I found that this definition was based largely on the World Health Organization (2002) definitions of rape and sexual violence. The strengths of this definition are that it states rape usually involves sexual intercourse, but does not necessarily require it, and that consent is the pivotal determinant of whether a rape occurred or not. This definition also specifies that rape can result from force, coercion, or abuse of power, and that some people (such as those with physical, psychological, or intellectual disabilities, those who are under the influence of alcohol or drugs, or those under a legally identified age) can be incapable of providing consent to sexual acts.

***Rates of rape.*** As difficult as arriving at a consensus about what types of acts constitute rape has been, and maybe because we do not have a consensus about what definitively constitutes rape, gathering accurate data on the rates of rape has proved even more difficult. The U.S. Department of Justice's National Crime Victimization Survey (2007) documented about 213,000 rapes, attempted rapes, or sexual assaults of individuals reported to police in 2007. However, this survey defined rape as the full vaginal penetration of females over the age of 12, only counted assaults that resulted in prosecution, and each victim was only counted once per calendar year, regardless of number of events of rape. Other authors have argued that as many as one-in-three to one-in-six women and girls experience sexual abuse of one kind or another in their lifetimes (Koss & Harvey, 1991; Randall & Haskell, 1995; Ullman & Knight, 1992; United States Department of Justice National Crime Victimization Survey, 2007). If correct, that estimate would mean that of the approximately 155 million females residing in the US in 2009 (United States Census Bureau, 2009), between twenty-six and fifty-one million will experience sexual abuse of one kind or another during their lifetimes. In addition, Coxell, King, Mezey, and Gordon (1999) found that approximately 3% of the men they surveyed in the United Kingdom reported unwanted sexual experiences in adulthood, and 5% reported unwanted sexual experiences as children. Research in the U.S. indicated that up to 10% of rape victims were male (National Institute of Justice & Centers for Disease Control & Prevention, 1998; U.S. Department of Justice, 2007).

**Defining rape crisis.** The Rape, Abuse, and Incest National Network (RAINN) described rape trauma syndrome as "a common reaction to rape or sexual assault. It is

the human reaction to an unnatural or extreme event" (2014, ¶ 1). RAINN argued that, immediately following an experience of sexual trauma, victims may

> appear agitated or hysterical, may suffer from crying spells or anxiety attacks...[or] be without emotion and act as if 'nothing happened' and 'everything is fine [sic],' [they may exhibit] a strong sense of disorientation. They may have difficulty concentrating, making decisions, or doing everyday tasks. They may also have poor recall of the assault. (RAINN, 2014, ¶ 3)

This process is also often referred to as rape crisis. Worell and Remer (2003) argued that, in the immediate aftermath of sexual assault, survivors are

> often in a state of shock and feel helpless, out of control, ashamed, confused, and guilty. Their feeling reactions may vary from numbness to hysterical crying…During this stage she is especially vulnerable to negative, blaming reactions by others. Negative reactions revictimize the survivor. (p. 216)

This process of revictimization becomes "part of the rape trauma that needs to be healed" (p. 216), and for women who choose to undergo the forensic evidentiary exam, the revictimization can go on for hours or days or longer.

**Defining advocacy.** Advocates, in general, attempt to give voice to people and/or issues that might be otherwise silenced. "Fundamentally, advocacy is about speaking out and making a case for something important" (Nonprofit Action, 2005, ¶ 1). In many countries, the term advocate denotes a lawyer or barrister. In American culture, an advocate is generally considered to be a person who assists another navigate a difficult process or social, political, or judicial system. An advocate can also mean someone who supports a specific cause.

> Our lexicon for advocacy related concepts and actions complicates matters by using multiple words for the same actions as well as blurring understanding of what an organization is really doing. For example, the word "advocacy" is often used interchangeably with related words such as "lobbying," and "education." Some groups may use the word advocacy to define lobbying while others say they do advocacy work but an outsider is not certain whether they are engaged in public policy or advocating on behalf of clients or their mission in other ways. (Nonprofit Action, ¶ 2)

Advocates may function as lobbyists, educators, and/or social/political activists, or they may receive specialized training to provide very specific agency-related services directly to marginalized individuals.

**Defining rape crisis advocacy.** Rape crisis advocates are trained to provide crisis counseling and medical and legal advocacy services to survivors and their friends and families, both in person and via local and national rape crisis hotlines. They also provide education and information about sexual trauma to groups or individuals, and they frequently participate in activism and outreach activities. As a rape crisis advocate, I worked primarily as a rape crisis medical advocate (RCMA), supporting and assisting survivors during the forensic exam process.

**Defining the forensic exam.** The purpose of the forensic exam is to collect evidence of the sexual assault. In general, victims will have been examined and treated medically before beginning this process. To document the rape, a nurse or doctor will collect the victim's clothing, take swabs from anywhere on the victim's body that the perpetrator might have left bodily fluid, skin, or fibers, and examine the victim's body for

evidence of the use of force by the assailant and/or resistance by the victim. A survivor who wants to press charges may have his or her entire body examined, photographed, and swabbed; fingernails and toenails may be clipped, and pubic hair may be combed for evidence. The victim might also receive prophylactic treatment for sexually-transmitted diseases, and in some areas might have access to emergency birth-control. Police are often present throughout this process as they attempt to quickly collect information that might allow them to pursue the alleged perpetrator(s). Rape crisis medical advocates are often present, as well.

**Defining rape crisis medical advocacy.** RCMAs are present to support survivors emotionally through the forensic exam process, to educate them about the dynamics of trauma and trauma reactions, and to advocate for respectful and comprehensive services on their behalves. Our job is first and foremost to believe the victim, to help her retain whatever control she can over the exam process, and make sure she hears someone say that the assault was not her fault, that she did not deserve what happened to her, and that the things she was feeling were normal and did not make her crazy. Our job is to hold her hand, to stand by her side, to be her rock, if only for a few hours.

During my 40-hour training program to become a RCMA, the first thing my peers and I were told was that our job was primarily to sit with and hold another person's pain. That proved oddly true for me over the years. For all my training in counseling and psychotherapy, I seem to have the most impact on my clients simply by empathically engaging with them, hearing their stories, sitting with their pain, holding the pain, and

modeling that they can, and will, survive. Sharing such an empathic connection with a suffering-other is not easy, but is very simple.

Second, we were told that our job was to advocate for clients' rights to comprehensive and respectful medical treatment and investigation of the crime during the forensic rape exam. In fact, Campbell (2006) stated that the primary role of a RCMA is to reduce victim-blame (VB; a tendency to blame the victim of a crime for the crime or the circumstances leading up to it) and thus, improve service delivery by medical and legal personnel. The literature has consistently shown that having RCMAs present is beneficial for survivors (Campbell, 2006; Resnick et al., 1999; Wasco et al., 2004), as they receive more medical and legal services than survivors without RCMAs and are less likely to experience victim-blame and re-victimization in the immediate aftermath of the assault (Campbell, 2006). RCMAs enter a situation that has been described by many survivors as a second rape (Campbell et al., 1999), a situation with a high likelihood of resulting in further trauma to the victim (Resnick et al., 1999). The advocate is present to support and protect the victim through this process. I want to know what impact providing rape crisis medical advocacy services has on advocates.

**Secondary Survivorship**

The Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision (DSM-IV-TR; American Psychiatric Association [APA], 2000), defines an extreme traumatic stressor as either witnessing or experiencing an event involving "actual or threatened death or serious injury, or other threat to one's physical integrity…or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate," and states that symptoms of posttraumatic

stress disorder (PTSD) result from experiencing, witnessing, or being "confronted with" such an event that subsequently results in feelings of "intense fear, helplessness, or horror" (p. 467). Figley (2002) argued that this definition includes "the provision that one could be traumatized both by being in harm's way and by bearing the distress of others who are" (p. 1435). In this section, I will review the literature on the psychological outcomes of secondary exposure to trauma. I will discuss factors researchers have identified as related to the development of burnout, secondary traumatic stress (STS), compassion fatigue (CF), vicarious traumatization (VT), and posttraumatic growth (PTG). I will critique the literature for its strengths and weaknesses, and identify what future researchers need to address in understanding the impact of trauma work on rape crisis advocates.

**Burnout.** Maslach and Jackson (1982) described burnout as the emotional exhaustion stemming from the pressures of one's work, writing that burnout included experiences of emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment. Burnout is generally described as a process as opposed to a fixed condition, which may result in erosion of idealism and increased reports of detachment and cynicism (Cherniss, 1980). Evidence indicates that burnout may be distinctly different from the specific psychological effects of working with trauma survivors on therapists (Jenkins & Baird, 2002), as burnout seems more akin to a general emotional exhaustion resulting from work than to a state of being traumatized by one's work. Burnout might, theoretically, serve as a risk factor for developing CF.

**Secondary traumatic stress and compassion fatigue.** Figley (1983) conceptualized STS and CF as the normal emotional reactions of individuals who care

about someone who has experienced a traumatic event. He described STS as "the stress resulting from helping or wanting to help a traumatized or suffering person" (1995, p. 7), and CF as "a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, persistent arousal (e.g., anxiety) associated with the patient. It is a function of bearing witness to the suffering of others" (Figley, 2002, p. 1435). Thus, experiencing STS can lead to the development of CF.

Primary traumatic stress (PTS) and STS appear to differ only in that PTS describes what happens to the person who directly experienced a precipitating trauma, and STS describes what happens to the person who sees, hears, or learns about the precipitating traumatic experience (Jenkins & Baird, 2002, p. 424). Otherwise, the impacts are remarkably similar. Jenkins and Baird (2002) identified three domains of symptoms related to STS: arousal, avoidance, and "reexperiencing of the primary survivor's traumatic event" (p. 424). The DSM-IV-TR (APA, 2000) similarly describes the three major components of PTSD as reexperiencing of the trauma, avoidance of traumatic reminders, and heightened arousal (though this definition has been refined in the newly published DSM-V to include negative alterations in cognitions, which aligns nicely with theoretical underpinnings that informed the present study, this study was predicated upon the DSM-IV-TR definition of PTSD that was the standard at the time of data collection). Victims of both PTS and STS may reexperience painful memories or visualizations of the event, nightmares, and flashbacks (to the trauma or learning about the trauma); avoidance of reminders of the trauma or thoughts and feelings associated with the trauma; and problems with arousal, including sleep difficulties, irritability,

concentration problems, and hypervigilance. In fact, the only diagnostic difference between the two groups appears to be level of experiencing of the precipitating trauma. Those individuals who physically experience the precipitating event are called primary survivors, and those who did not physically experience the precipitating event, but who were impacted by the event nonetheless, are called secondary survivors. Hence, our attempts to differentiate the impacts on the two groups appear to focus more on the pragmatics of language than on the reality of the effects of traumatic experiences. In essence, CF equates to the development of symptoms of PTSD in response to a trauma suffered by another person.

**Vicarious traumatization.** Individuals who experience chronic (primary) traumas may develop what has been described as Complex-PTSD (C-PTSD). The conceptualization of C-PTSD is different from PTSD in that it captures the loss of sense of self, safety, and trust in others that seems to occur following prolonged or repeated traumatic experiences (Herman, 1997). These three core elements of C-PTSD are not part of the DSM-IV-TR (American Psychological Association, 2000) conceptualization of PTSD. Similar impacts have been observed, however, among counselors who chronically experience their clients' traumas (Bober & Regehr, 2005; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Way et al., 2004). When these three domains are impacted by their work with trauma survivors, counselors are described as having developed vicarious trauma (VT).

Jenkins and Baird (2002) conceptualized both CF/STS and VT as "reactions to the emotional demands on therapists…from exposure to trauma survivors' terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic

memories" (p. 423). They argue that CF/STS is closely related to VT, differing only in that the effects of CF/STS are in the emotional (intrusions and avoidance) and interpersonal realms, while the effects of VT are cognitive in nature (changes in beliefs about self, other people, and/or the world in general). VT may be analogous to C-PTSD, in that both seem to describe pervasive impacts on individuals' worldviews that can result from chronic (or extreme) exposure to trauma.

Pearlman and Mac Ian (1995), like Figley (2002), argued that empathy is the cornerstone of both providing effective trauma counseling and understanding the impact of providing trauma counseling on counselors.

> We define vicarious traumatization as the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae. Such engagement includes listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic reenactments. (Pearlman & Mac Ian, 1995, p. 558)

This ability to empathically engage, to put oneself in others' shoes while they tell you their horror story, can create an incredibly strong therapeutic alliance, but also puts counselors at risk for developing lasting changes in "enduring ways of experiencing self, others, and the world" (Pearlman & Mac Ian, 1995, p. 558).

Schauben and Frazier (1995) found that counselors who worked with more trauma survivors "report more disrupted beliefs about themselves and others, more PTSD-related symptoms, and more 'vicarious trauma'" (p. 61) than those who worked with fewer trauma survivors. Working with more survivors of trauma was not related to

burnout, but was related to VT, and specifically to ratings of emotional distress and changes in beliefs about the goodness of other people (and less so to changes in beliefs about the goodness of self and the world in general). Counselors in their study indicated that two of the most difficult aspects of working with survivors were psychic drain resulting from "hearing so much pain," and working through their own reactions to the abuse, including feeling helpless, powerless, fearful, sad, and angry. Other counselors mentioned difficulties hearing about the abuse and resulting changes in their own worldviews. One therapist stated that, to "hear the unimaginable and not be able to forget it," was challenging (Schauben & Frazier, p. 57). Pearlman and Mac Ian (1995) stated:

> It is not difficult to understand the loss of esteem for others as individuals are exposed, perhaps for the first time, to the horrors of people's capacity for cruel behavior against others. That which formerly may have been defended against can no longer remain unknown, unseen. (p. 564)

Collins and Long (2003) described the cognitive shifts that can occur among counselors as related to trust and chronic suspicion, safety and vulnerability, power and helplessness, and independence and loss of personal control or freedom. They also described counselors' experiences with witness guilt, akin to survivor guilt, in that it is the guilt individuals feel for not being able to protect someone from a traumatic, or lethal, event.

> Though it is nearly impossible to accomplish the task of taking away the client's pain, the practitioner may feel doubly guilty for not being able to do so…the practitioner must simply sit with the suffering and contain it, but not feel it as his or her own. (Rand, 2004, ¶ 1).

Fortunately, most research has detected only low levels of distress among therapists (Adams, Figley, & Boscarino, 2008; Adams & Riggs, 2008; Boscarino, Figley, & Adams, 2004; Elwood et al., 2011; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Some researchers even argue that "the extant research does not warrant systematic implementation of prevention and treatment recommendations" (Elwood et al., p. 34) for counselors. Bober and Regehr (2005), on the other hand, found evidence that "working with victims of interpersonal violence…was associated with higher traumatic stress scores," and "working with victims of rape was associated with more disruptive beliefs" (p. 7), and Way et al., (2004) found that levels of VT were in the clinical range for most of the trauma clinicians they surveyed, regardless of whether the clinician treated survivors of sexual assault or perpetrators.

**Vicarious posttraumatic growth.** In the previous sections, I reviewed several negative, or painful, outcomes of providing trauma-related mental health services on care-providers. Thankfully, not all of the outcomes observed among counselors are so negative. Schauben and Frazier (1995) found that trauma counselors were positively impacted by "watching clients grow and change…seeing victims become survivors…[and]…being a part of the healing process" (p. 57-58). Their participants found meaning in "the importance of the work and various characteristics of the work environment…([like] support from colleagues)" (p. 57-58). Calhoun, Cann, Tedeschi, and McMillan (2000) defined posttraumatic growth (PTG) as "the individual's experience of significant positive change arising from the struggle with a major life crisis" (p. 521). Tedeschi and Calhoun (1996) described the three major domains of PTG as perceived changes in self, perceived changes in relationships with others, and a

changed philosophy of life. The authors described individuals who experience PTG as having "a general tendency to experience difficult events in a way that produces perceptions of benefits" (p. 467). They also reported that PTG was associated with being extraverted, optimistic, and open to new experiences, though they admit telling if participants were extraverted, optimist, and open to new experiences before their traumatic experiences or if they were, in fact, changed in such ways by their experiences is not possible. Calhoun et al. found that posttraumatic growth was also significantly associated with both openness to religious change and "event-related rumination" (p. 525); the more participants thought about the event, the more growth they were likely to report. However, the authors also indicated that prolonged, negative, intrusive, ruminations led, expectedly, to distress.

**Summary.** Burnout, compassion fatigue/secondary traumatic stress, and vicarious trauma are all related to the toll caring takes on caregivers. Jenkins and Baird (2002) argued that burnout seems relatively unrelated to the emotional distress of those who care for individuals who have suffered trauma, as burnout is more of an emotional exhaustion from overwork than trauma resulting from one's work. They advocated, instead, for a focus on CF/STS as the cornerstones for understanding the overall impact of caring for traumatized-others, and identified four ways CF/STS and VT differ. First, they argue that descriptions of CF/STS focus on symptoms, while descriptions of VT focus on theoretical underpinnings of trauma reactions. Second, they argue that descriptions of CF/STS focus on behavioral symptoms of PTSD with rapid onset, while descriptions of VT focus on the context and etiology of trauma, as well as cognitive shifts and changes to belief systems that result over time. Third, CF/STS is described as

potentially impactful for professionals from multiple fields, while VT is most frequently observed among mental health professionals, and specifically those who work with victims of sexual trauma, such as rape, incest, or childhood sexual abuse. Finally, they argue a critical amount of exposure to trauma survivors results in different effects on professionals (i.e., CF/STS can result from one exposure to trauma; but VT results from repeated exposures over time). Because of these differences, the authors argue that CF should be the cornerstone for understanding overall the impact of caring for traumatized-others, as it focuses on PTSD-like symptoms among any helping professional who has been exposed to at least one client's trauma, as opposed to the more specific theoretical underpinnings related to changes in worldview experienced specifically by sexual trauma counselors with chronic exposure to their clients' traumatic material.

Pearlman and Saakvitne (1995) argued that while CF/STS includes descriptions of normal emotional reactions experienced by those who care about traumatized individuals, the cumulative effect of CF/STS can result in VT, or relatively permanent changes in individuals' world-views. They argue that exposure to others' traumas impacts cognitive schemas related to trust, safety, control, self- and other-esteem, and intimacy, as well as producing PTSD-like symptoms of intrusions and avoidance, resulting in the relatively permanent "transformation in the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" (p. 31), which results in changes in "identity, worldview, and spirituality…affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and…physical presence in the world" (p. 280). Thus, while CF/STS and VT differ in their impacts (with CF/STS impacting emotions,

behavior, and relationships, and VT impacting worldviews and beliefs about the self and others), VT appears to be an extension of CF/STS, much as C-PTSD is an extension of PTSD. Both describe normal reactions to trauma that, when experienced chronically (or extremely), result in similar changes to individuals' basic beliefs regarding trust, safety, and self- and other-esteem.

VT was determined to be the most appropriate outcome construct for examining the possible undesirable impacts of providing advocacy services on RCMAs in this study, largely because previous research has indicated that VT is more frequently observed among mental health professionals who repeatedly work with victims of sexual trauma (Jenkins & Baird, 2002; Pearlman & Saakvitne, 1995). CF/STS has been described as the potential, rapid-onset, PTSD-like symptoms that can develop in any caring-other after exposure to one trauma survivor's story (the cumulative effects of which might result in VT), as opposed to the enduring changes in cognitive schemas related to trust, safety, control, self- and other-esteem, and intimacy that develop over time, especially among mental health professionals who work with survivors of sexual violence. Pearlman and Mac Ian (1995) defined VT as "the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences" (p. 558), and empathic engagement as "witnessing and participating in traumatic reenactments" (p. 558). This seems particularly relevant to RCMAs, who are physically present to assist survivors during the acute rape crisis period, through the forensic exam, a process many sexual trauma survivors have described as a second rape (Campbell et al., 1999; Parrot, 1991), an established time of particular vulnerability and potential retraumatization of victims (Resnick, et al., 1999). Assessing RCMAs' ratings

of these different constructs was beyond the scope of this study. As such, assessing RCMAs' ratings of VT appeared to be the most appropriate choice for use in this study, as the established definitions of VT seem most relevant to individuals who provide direct services to sexual trauma survivors in the acute, rape crisis period as a regular part of their work. In addition, an unpublished study intended to inform this dissertation found that advocates who reported witnessing more victim-blame by police reported lower levels of trust in not only police, but also in medical service providers, social service providers, and people in general. While this finding did not hold for advocates who witnessed more victim-blame by medical service providers or social service providers, the results seem to indicate that advocates who witness victim-blame, a form of re-traumatization a victim may experience following the trauma (Campbell, 2006), may develop changes in basic beliefs about the goodness of other people and worldview shifts similar to the effects of VT documented in professional counselors.

Posttraumatic growth has been described in the literature as one potentially positive outcome of exposure to trauma. Schauben and Frazier (1995) documented the positive impacts on counselors of "watching clients grow and change…seeing victims become survivors...being a part of the healing process, [and finding] meaning in "the importance of the work and various characteristics of the work environment…([like] support from colleagues)" (p. 57-58). However, few data exist on the actual prevalence of VPTG among helping professionals, and none exists on the prevalence of VPTG among rape crisis advocates. Witnessing healing and client growth are probably key elements of what keeps most counselors doing the work. In this study I assessed RCMAs' ratings of VT and VPTG experienced in relation to advocacy work.

## Factors Related to the Development of Trauma Symptoms Among Counselors

The bulk of the research examining the impact of providing trauma counseling on counselors has attempted to discern what makes a therapist susceptible to CF/STS or VT (Adams & Riggs, 2008). The focus appears to be on reducing therapists' vulnerability to VT by attending to intrapersonal, intrapsychic contributions to trauma reactions. The research to date has focused primarily on the potential contributions of therapists' trauma histories, experience levels, caseloads, hardiness, resilience, and coping styles in predicting who might be most impacted by providing trauma counseling. Researchers have also begun to examine the impact of individuals' ratings of social support and experiences with negative social reactions on the development of trauma symptomology. In this section, I will review the findings related to risk- and protective-factors associated with the development of CF/STS and VT, and conclude with a review of one specific type of negative social reaction victims may experience, namely rape victim-blame, which appears to put both victims and care-providers at risk for increased trauma symptomology.

**Trauma histories.** Numerous researchers have attempted to evaluate the contribution of being a trauma survivor to the development of CF/STS and VT in therapists providing trauma counseling, with mixed results. Pearlman and Mac Ian (1995) found that counselors with a history of personal trauma "showed greater disruptions than those without a personal trauma history" (p. 563). On the other hand, Way et al. (2004) found that, despite the fact that 75% of the therapists they surveyed had a history of maltreatment, and over 50% reported multiple experiences with maltreatment, survivor status was not associated with intrusions or avoidance related to

providing trauma counseling. Similarly, Schauben and Frazier (1995) found no significant relationship between trauma histories and the subsequent development of trauma symptoms related to providing trauma counseling. These mixed results indicate that more research needs to be conducted before drawing conclusions about the impact of previous history of victimization on the development of trauma symptomology among care-providers. It could be that other, unexamined variables are moderating the effect of previous trauma on the development of symptomology among counselors.

**Experience.** Evidence that the negative effects of working with clients' traumas are more severe for those with less experience has been documented multiple times (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Way et al., 2004). Way et al. (2004) found that therapists who reported experiencing more intrusions and avoidance had been doing the work for a shorter period of time. Pearlman and MacIan (1995) surveyed trauma therapists about experiences working with clients. They found that trauma therapists with less experience were significantly more likely to display clinically significant symptom elevations on the Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1977), but that individuals "who had been doing trauma work longer experienced greater disruptions in self-intimacy and other-esteem" (p. 563), which may represent "a disconnection from one's inner experience, which may be the trauma therapist's way of not feeling as much pain related to the work" (p. 563). In other words, individuals in this study who had less experience seemed more likely to struggle with CF/STS, largely as a result of their inexperience working with traumatized-others, and those with more experience were more likely to suffer with VT and the resulting changes in worldview.

One-quarter of the graduate student therapists surveyed by Adams and Riggs (2008) indicated they had no formal training in trauma work prior to beginning work with trauma survivors. The authors argue that "deficits in trauma-specific training are broadly associated with a pattern of vicarious trauma symptoms independent of defense style" (p. 32). They observed no differences in VT between those with no training and those with a little training, indicating that low-level trauma training may not work to prevent trauma reactions.

**Caseload.** Many researchers have documented the impact of high trauma caseloads on counselors (Bell, Kulkarni, & Dalton, 2003; Bober & Regehr, 2005; Schauben & Frazier, 1995). Schauben and Frazier (1995) found that higher trauma caseloads were related to experiencing more negative psychological effects, specifically symptoms of PTSD, self-reported VT, and reduced other-esteem. Bober and Regehr (2005) found that more time per week providing trauma counseling was related to more trauma symptomology. They also found that years of experience were related to more "disruptive beliefs regarding intimacy with others…[suggesting] that degree of exposure has an impact on intrusions and avoidance symptoms" (p. 7). They concluded that disruptions to beliefs systems do not occur in the short-term, but may in the long-term. Bell et al. (2003) argued that diversity of case load can help "keep the traumatic material in perspective and prevent the formation of a traumatic worldview" (p. 466).

**Hardiness, resilience, and coping styles.** A significant amount of research on the development of trauma symptomology has focused on individual-level variables like hardiness, resilience, and coping styles. King et al. (1998) described hardiness as feeling in control, committed, and viewing change as a challenge and an opportunity for growth.

It is akin to resilience in that authors use the term to described individuals who seem to rise above the negative life events they experience, who manage to find a way to integrate and use those negative experiences positively. However, these concepts may have little to do with the impacts of contacts with suffering-others. For example, Bober and Regehr (2005) evaluated the use of coping skills among trauma therapists, and, while they found that participants listed useful coping skills such as self-care and leisure activities, they found no evidence that these coping strategies protected from or alleviated distress. Additionally, participants who were more likely to list such coping skills (proving they were aware of coping strategies) were not more likely to actually engage in the strategies they listed. The researchers also found that "participants with disrupted belief systems…were significantly less likely to engage in leisure activities" (p. 7), and they concluded that "it does not appear that engaging in any coping strategy recommended for reducing distress among trauma-therapists has an impact on immediate traumatic symptoms" (p. 7-8).

**Social support and psychosocial work environment.** Several researchers have shown that having more access to emotional support from friends, family, and colleagues was associated with lower levels of secondary trauma reactions among counselors (Boscarino et al., 2004). Schauben and Frazier (1995) documented relationships between amount of training, social support, advocate self-efficacy, experiences with victim-blame, ratings of job-satisfaction, and intent to remain advocates. Social support has been shown to be important for overall psychological well-being for survivors of domestic violence (Mitchell & Hodson, 1983), and lay-counselors conducting trauma therapy (Ortlepp & Friedman, 2002). Kristensen, Hannerz, Hogh, and Borg (2005) argued that

"the psychosocial work environment is generally considered to be one of the most important work environment issues," and assessing "psychosocial stressors at work, and the consequences, are believed to be very significant for workers, workplaces, and society" (p. 438). Researchers have reported that poorer psychosocial environments have been linked to "musculoskeletal disorders, cardiovascular diseases, mental disorders, stress, burnout, reduced quality of life, sickness absence, labor turnover, and decreased motivation and productivity" (Kristensen et al., p. 438).

However, other researchers have not observed similar results (Davis, Brickman, & Baker, 1991; Popiel & Susskind, 1985), and Ullman (1999) argued that, instead, the "negative aspects of social relations (e.g., negative social reactions)" (p. 343) have the most impact on victims of rape. Overall, the research seems to indicate that social support is good in a general way for psychological health, but whether social support is especially protective for those exposed to trauma and suffering is unclear. However, evidence that negative social reactions exacerbate the development of trauma symptomology among primary survivors (George & Martinez, 2002; Resnick et al., 1999; Ullman, 1999; Wasco & Campbell, 2002), as well as among advocates (Campbell et al., 1999; Hellman & House, 2006), is becoming increasingly clear.

**Exposure to rape victim-blame.** One type of negative social reaction a victim may face following a disclosure of sexual trauma is victim-blame. The Canadian Resource Center for Victims of Crime (CRCVC, 2009) defined victim-blaming as: "A devaluing act that occurs when the victim(s) of a crime or an accident is held responsible – in whole or in part – for the crimes that have been committed against them [sic]" (p. 2). The CRCVC stated that victim-blame is frequently experienced as "negative social

responses from legal, medical, and mental health professionals, as well as from the media and immediate family members or other acquaintances" (p. 2). These negative social reactions are often based on rape myths, or commonly accepted, but false beliefs about perpetrators, victims, and the dynamics of sexual violence. Several authors have documented the effects these negative social messages can have on victims, including feeling revictimized (Campbell et al., 1999; Worell & Remer, 2003), and endorsing higher rates of PTSD (Resnick et al., 1999) and a lower likelihood of reporting future crimes (George & Martinez, 2002). The documented effects on advocates include endorsing lower ratings of satisfaction with the work, which was in turn related to lower ratings of intent to continue advocacy work (Hellman & House, 2006). In this study I examined whether perceptions of witnessing victim-blame were associated with RCMAs' ratings of VT or VPTG. In the next section, I will define rape myths, which are thought to lead to the phenomenon of rape victim-blame, and review previous research examining the impacts of victim-blame on victims and caring-others in more detail.

***Rape myths.*** Rape myths are false, but widely held, beliefs about rape that stereotype victims and perpetrators and, often, provide justifications for sexual assault (Worell & Remer, 2003). Rape myths result in rape victim-blame. Payne, Lonsway, and Fitzgerald (1999) argued that rape myths generally revolve around common themes or cultural beliefs about masochism (the victim really wanted it), precipitation (the victim asked for it), victim characteristics (it was not rape, because…), fabrication (the victim lied), justification (the perpetrator did not mean it), trivialization (violent acts, specifically sexual assaults, are not harmful), and deviancy (perceiving rape as deviant or abnormal behavior, despite the normativity of sexual violence in women's lives).

Rape myths appear to serve several purposes. Payne, Lonsway, and Fitzgerald (1999) argued that rape myths mask the stark reality of the normativity of sexual violence in women's lives, justify that violence, and minimize the impact of sexual violence on victims. Worrell and Remer (2003) argued that rape myths "divert attention for the causes of rape from societal structures (e.g., patriarchy) by blaming the individual victim…when the victim is blamed, harmful societal (patriarchal) structures are not challenged or changed" (p. 207). Rape myths perpetuate sexual violence by justifying criminal behavior and blaming victims for the crimes committed against them. "Female reactions to trauma and their behavior are often pathologized by family members, friends, criminal justice personnel, and professionals alike...Male perpetrators in this myth are seen as helpless, sexually-frustrated beings, responding to sexually-provocative women" (CRCVC, 2009, p. 5).

Similarly, victimization has been described as a social process that portrays victims of crime as both responsible for the crime and powerless to prevent it (Weiss & Borges, 1977). Societal messages portray women as defenseless against men, needing to be protected from men by men, but also messages that make them ultimately responsible for men's behavior. "Society teaches women to accept responsibility for victimizing events that befall them, and teaches men to legitimize their sexual aggression against women" (Worell & Remer, 2003, p. 210). Thus, victims are reluctant to talk about their experiences for fear they will be blamed for their traumas.

In general, victims' attempts to make meaning of their assaults involve either blaming themselves for what happened or denying their experiences were assaults at all. "Led to believe that she is responsible for any sexual outcome and faced with an

unsupportive social environment…the woman experiences herself as having only the choice of responsibility and self-blame or denial" (Koss & Burkhart, 1989, p. 35). Recognizing that she was the random victim of someone else's violent behavior violates well-established beliefs about the nature of the world (the world is safe and just; good things happen to good people) and the goodness of other people. Changing theories about the self (I am good/I am bad; I did nothing wrong/It was my fault) is easier than changing theories about other people or society in general. Thus, victim-blame promotes self-blame along with minimization and denial of the consequences of sexual violence and social structures that perpetuate sexual violence. In the next section, I will review several theories that have been articulated in an attempt to explain how and why victims of crimes are portrayed as responsible for the crimes they have experienced.

***Theories of rape victim-blame.*** In this section I will review several theories have been developed in an attempt to explain why victim-blame occurs, including theories about just-world beliefs, attribution error, and invulnerability. Each of these theories attempt to explain how and why people go about concluding that victims are to blame for crime; that is, how they develop or acquire victim-blaming beliefs. After reviewing theories about how and why victim-blame occurs, I will describe the previously observed effects of rape victim-blame on survivors and those who care for them.

*Just-world beliefs.* The Just World Theory describes the tendency for individuals to assume that the world is fair and just, that good things happen to good people, and bad people get what they deserve (Idisis, Ben-David, & Ben-David, 2004; Johnson, Mullick, & Mulford, 2002). Most of us were raised to believe that if we studied hard enough and worked hard enough, then we could achieve anything we wanted. What comes around

goes around, after all. Just put your nose to the grindstone and pull yourself up by your boot-straps. Good things happen to good people, to people who work for them. According to the Just World mythology, the world is actually a safe place where you ultimately get what you earn or deserve. Our social systems are assumed to be fair, legitimate, and justifiable (Kay, Jost, & Young, 2005).

In reality, bad things happen to good people every day. However, if bad things happen to good people, then bad things could happen to any one of us at any time, which is an incredibly scary idea. Easier and psychologically safer is to view a victim as at fault, in control of or responsible for whatever the outcome, because then we can choose not to make those choices or behave in "that" way and can, thus, protect ourselves from violence and feeling the perpetual fear of being a victim of violence. This faulty logic provides an illusion of control over uncontrollable, random events. Perceiving victims, not as innocent and suffering, but rather as deserving of their fates (Kay et al., 2005), buffers the psychological effects of the harsh reality of violence in women's lives.

Lerner (1965) showed that an individual who was portrayed as having won the lottery was judged by others as working harder than his or her counterpart, who did not win the lottery. Lerner and Miller (1978) stated that "the sight of an innocent person suffering without possibility of reward or compensation motivated people to devalue the attractiveness of the victim in order to bring about a more appropriate fit between her [sic] fate and her character" (p. 1032). In other words, comprehending the suffering of an innocent person is so difficult that our brains automatically devalue the victim, making him or her less innocent, so that the suffering can be effectively integrated into our existing cognitive schemas about the goodness of the world. This self-protection comes

at a cost to victims and those who care about them, and results in victim-blame and the associated negative outcomes on victims and those who care for them.

*Attribution error.* Heider (1958) described attribution error as a human tendency to overemphasize internal (personal) attributions of victims over external (environmental) attributions of the situation. "So-called 'internal failings' take precedent over situational contributors" (CRCVC, 2009, p. 3). Individuals who make attribution errors tend to attribute others' struggles to internal characteristics of the individual, and their successes to external elements, such as the environment. Conversely, they attribute their own successes to personal characteristics, and their failures to external sources (Johnson et al., 2002). Again, this faulty attribution style seems to protect individuals from the psychological impact of the reality of their vulnerability to negative events. If the reason a woman was raped was because of something about her, then by not being like her one can avoid being raped. Attribution error negatively impacts fair and just treatment of victims of crime.

*Invulnerability theory.* Similar to elements of the previously mentioned theories related to just-world beliefs and attribution error, invulnerability theory highlights how innocent victims of violent crimes serve as reminders of our own vulnerability to life events, our own lack of control over negative life circumstances, and allows people to maintain a cognitive sense of safety from such events (Andrew, Brewin, & Rose, 2003). People conclude that victims were raped because of the way they were dressed or the way they were acting, so that as long as the individual does not behave in a similar manner, he or she will not experience that event. Invulnerability theory serves as yet another

example of the ways in which the human mind will create cognitive illusions of control over uncontrollable events.

*As social control.* The previous theories attempted to explain why people blame victims of crime for the events that befall them. I would like to extend these theories by proposing that rape victim-blame also serves as a highly effective method of social control, limiting the free movement and free expression of women, forcing them into subordinate life circumstances that prescribe constricting and constraining gender-roles. This process of subordination is achieved through instilling fear and shame in women (as well as in men who are deemed to have feminine qualities).

Fear of sexual violence, societal messages espousing victim-blame, and social rules designed to "protect" women from violent acts serve to tie women to the home (do not go out alone at night), instruct them in what they should wear (do not wear revealing clothing), how to behave (do not go to parties, and do not have or enjoy sex), and even what substances women are allowed to consume (do not drink alcohol or take drugs; do not leave your drink unattended as someone might poison it in order to rape you). These socio-cultural messages are very effective at forcing women to submit to traditional gender-roles by instilling fear of men who are erroneously portrayed by the cultural mythology as ferocious animals helpless to control themselves. Women are taught to protect themselves from violence, and failure to do so becomes a personal failing for which one is taught to feel ashamed.

Shame is a very powerful form of social control. Victims of sexual trauma almost universally feel both guilt and shame subsequent to their traumatic experiences. Fossum and Mason (1986) differentiate between guilt and shame by describing guilt as "a painful

feeling of regret and responsibility for one's actions," and shame as "a painful feeling about oneself as a person" (p. 5). Shame refers to an internal sense that one is somehow bad, and reflects fundamental alterations in basic beliefs about the goodness of the self. Shame has been used since the beginning of humanity to keep certain individuals, or certain groups of individuals, submissive. Benedict (1967) described how various cultures use shaming as social control, to encourage acceptable behaviors and discourage unacceptable ones. By blaming sexual trauma survivors, by shaming them, society teaches other young women how they are expected to behave.

***Effects of rape victim-blame on victims.*** Previous research has demonstrated that women who experience distressing events in the immediate aftermath of sexual trauma are more likely to develop more severe symptoms of posttraumatic stress disorder (Resnick et al., 1999). Experiences with victim-blame and revictimization may be most detrimental during the crisis period immediately following a sexual assault, which can range from the time right after the attack up to a year following. Victims in the crisis stage are **"**especially vulnerable to negative, blaming reactions by others. Negative reactions revictimize the survivor" (Worell & Remer, 2003, p. 216). This process of revictimization becomes "part of the rape trauma that needs to be healed" (Worell & Remer, 2003, p. 216), and for women who choose to undergo the forensic evidentiary exam, the revictimization can go on for hours or days.

Survivors who choose to participate in prosecution of the crime are expected to submit to extensive medical testing, to having their bodies photographed, their nails scraped, their body hairs plucked, and to having oral, vaginal, and anal swabs collected, as necessary. Many survivors describe the forensic evidence collection process as a

second rape (Parrot, 1991), even when done by compassionate, gentle professionals. All too frequently the exam is not conducted by compassionate professionals, and no alternative to this process exists for victims who want to press charges against the perpetrators. One survivor stated, "as if the rape weren't bad enough, I had to go through everything that I did with the police and doctors. It's just more rape. The rape just keeps on and on, like you just can't escape it" (Campbell et al., 1999, p. 855). Bohmer (1974) stated that "in criminal proceedings...there is a tendency to regard the rape victim as just another piece of evidence...[and]...victims frequently report that their encounters with police, district attorneys, and courtroom personnel were more traumatic than the rape incident itself" (p. 303). Another woman described her experience:

> They were raking me over the coals, making me feel like a slug, making me feel guilty for doing all the actions I did that day, and treating me like I was the one who raped, the offender, not the victim. (Campbell et al., p. 847)

In fact, Bohmer (1974) found that judges "appear to divide rape cases into three basic types, giving each category a different degree of credibility" (p. 304). She described these types as the genuine victim of a "stranger leaping out of the shadows in the dark alley situation;" the vindictive female who desires "to get even with a man;" and the child witness, who may or may not be able to "distinguish truth from falsehood and to comprehend the significance of swearing an oath on the Bible" (pp. 304-306). Bohmer added that older women are judged to be "better witnesses" than younger women, again highlighting the focus on the woman, herself, as a piece of evidence. Feild (1978), Findlay (1974), and Mathiasen (1974) all highlight the victim as offender paradigm.

Finally, Jackson and Sandberg (1985) showed how victim-blame impacted offender sentencing in cases of incest.

This message of women as evidence and objects for blame seems to be conveyed to survivors over and over again, in subtle behaviors and innuendos about how women should be. And it works to control individuals' behavior. Victims who have been previously blamed for their victimization have been shown to be less likely to report future crimes (George & Martinez, 2002), and the CRCVC (2009) stated that victim-blame can impact "a witness's willingness to testify, authorities' commitment in pursuing cases and prosecuting offenders, a jury's decision to convict, a prosecutor's decision to recommend incarceration, and a judge's decision to impose incarceration" (p. 6). In fact, rape shield laws were created specifically to protect rape victims from victim-blame during cross-examination; more specifically rape shield laws protect rape victims from being asked about their previous sexual experiences. In some cases such laws prevent attorneys from attacking the victim's reputation (Call, Nice, & Talarico, 1991). Rape shield laws are a good step toward offering justice to sexual trauma survivors. They also serve to legally invalidate the idea that some women are more deserving of rape because of their previous sexual experiences (i.e., that "good girls" are virgins and "good girls" do not get raped).

**Effects of Providing Rape Crisis Advocacy on Advocates**

Researchers have only recently begun to examine the experiences of rape crisis advocates providing advocacy. Wasco and Campbell (2002) found that all their participants noted experiencing both anger and fear in relation to their advocacy work. The fear-based reactions were generally rooted in either real or perceived danger, such as

from perpetrators or their families, and the anger-based reactions were generally directed at systems (i.e., the criminal justice system or the medical system). The authors concluded that rape victim advocacy was qualitatively different from the work done by counselors, as the anger and fear reported by advocates was "more often than not, experienced in response to systemic, institutional, environmental, and societal influence" (p. 124), and that "the emotional reactions to rape victim advocacy work may be a different phenomenon than the vicarious traumatization previously documented among different types of helping professionals" (p. 129). Similarly, Jenkins and Baird (2002) described how advocates differ from professional counselors in role functions and exposure to clients, and stated that "their unpaid status may sometimes mean that they do not receive the training and social support for stress management that paid staff do, which may raise their risk for trauma-related difficulties" (p. 431).

Hellman and House (2006) found that advocates who endorsed higher levels of job satisfaction also endorsed higher levels of affective commitment to the job, and both were associated with overall intent to remain an advocate. Advocates who perceived their training as more important were also more likely to report higher levels of overall satisfaction with their work. Advocates who reported experiencing victim-blaming behaviors were less likely to be satisfied with their work. The results gathered by Hellman and House seem to indicate that victim-blaming may have a significantly negative impact on the advocates who witness it. Victims who experience more victim-blame in the aftermath of rape are more likely to develop symptoms of PTSD (Resnick et al., 1999), and advocates who witness more victim-blame in the course of their work are less likely to be satisfied with their work and less likely to remain advocates (Hellman &

House, 2006). In an unpublished study, Strange and associates (2011) demonstrated that advocates who reported witnessing more victim-blame by police were less likely to trust not only police, but also medical service providers, social service providers, and people in general. This finding did not hold for advocates who reported witnessing higher levels of victim-blame by medical or social service providers, and seems to indicate that advocates who witness victim-blame by police, in particular, may develop changes in basic beliefs about the goodness of other people and worldview shifts similar to the effects of VT documented in professional counselors. A student once commented to me that she thought this was because police are viewed as "the gatekeepers of justice" (Harmon, personal communication, 2012), the first judges who decide who is responsible for a crime, or if a crime occurred at all, and if you learn you cannot trust them, then you assume you cannot trust anyone else.

Wasco, Campbell, and Clark (2002) argued that "rape has indirect effects on the lives of rape victim advocates" (p. 758), but these effects seem far from indirect. Advocates are often present, with victims, during a period of time that victims themselves describe as a continuing part of their rape trauma. This fundamental difference between the experiences of RCMAs and most counselors may limit our ability to generalize between these two groups, and as such, future research should continue to examine the impacts of providing advocacy services on advocates, specifically.

**Summary.** Despite the limitations cited above, utilizing previous research conducted with counselors provides the best foundation available for informing current research examining the experiences of advocates. Based on the findings discussed so far, caseload and amount of experience appear to be the most important contributors to the

development of secondary trauma reactions among counselors. Schauben and Frazier (1995) found elevated levels of VT, disrupted belief structures, and PTSD, but only among therapists with higher caseloads. They also argued that therapists' trauma-related symptoms are, in reality, vicarious, and not based on their own personal histories of exposure trauma. "Their symptomatology is related to the percentage of sexual violence survivors in their caseload [sic] but not to their own history of sexual victimization…Thus, counseling survivors is not necessarily more difficult for counselors who are themselves survivors" (p. 61). Pearlman and Mac Ian (1995) found that trauma therapists with the most symptoms tended to have the least experience, moderate exposure to clients' traumas, were in therapy, were not receiving formal supervision, and worked in hospitals. Bober and Regehr (2005) found no evidence that utilizing healthy coping strategies protected from or alleviated counselors' distress, and concluded that "it does not appear that engaging in any coping strategy recommended for reducing distress among trauma-therapists has an impact on immediate traumatic symptoms" (p. 7-8). The results of previous research examining the influence of social support on the development of trauma symptoms among counselors are mixed, and though it does appear clear that social support is good in a general way for overall psychological health, it is not clear if social support is especially protective for those exposed to trauma and suffering. Ullman (1999) argued that the negative social reactions victims may experience have more impact on the development of symptoms following rape. I am interested in whether these negative social reactions, such as witnessing victim-blame and revictimization, are involved in the development of symptomatology among rape crisis medical advocates, who are present to witness the revictimization, as well.

**Strengths, Weaknesses, and Future Directions**

Though the literature-base relating to professional counselors' experiences providing trauma therapy is robust, the literature on the experiences of rape crisis advocates is less so. We have descriptions of the effects of trauma work on therapists, risk factors for developing secondary trauma symptoms, and measures for evaluating trauma among counselors. To date, this literature base has been used to inform the advocacy field, but new research is showing that generalization may not be entirely appropriate. Several groups of researchers have begun to study the impact of advocacy on advocates more thoroughly, leading to a deeper understanding of the differences between the experiences of advocates and counselors.

Researchers need to evaluate levels of VT and VPTG among RCMAs. To date, we do not have estimations of the extent of the psychological impact of trauma work on advocates. We know that some advocates experience anger and fear in relation to their work (Wasco & Campbell, 2002), and that those who experience high levels of victim-blame are less satisfied with their work and do not expect to remain advocates long (Hellman & House, 2006). Researchers should begin to examine the extent of victim-blame witnessed by advocates, the impact witnessing those behaviors has on advocates, and the ways that organizations prepare advocates to respond to victim-blame and cope with the traumas to which they are exposed. Researchers should also begin to examine contextual, environmental elements that may contribute to advocates' positive and negative experiences with advocacy. Wasco et al. (2002), argued that the cultures of different rape crisis organizations (e.g., normalizing or pathologizing advocates' reactions to survivors) are linked to different patterns of advocate self-care. Bell et al. (2003)

similarly argued that "the values and culture of an organization set the expectations about the work. When the work includes contact with trauma, they also set the expectations about how workers will experience trauma and deal with it, both professionally and personally" (p. 466). The messages rape crisis agencies send about how advocates are expected to cope with the traumas to which they are exposed set the tone for how advocates will cope with the work on a daily basis. Examining if these messages influence the development of VT and/or VPTG is important to understanding the systemic contributions to the development of symptoms related to exposure to trauma. The present study attempted to contribute to the literature by addressing these questions.

**Purpose of the Present Study**

The purpose of this study was to examine possible predictors of RCMAs' ratings of VT and VPTG. In this study I examined the predictive ability of three individual-level variables (age, education level, and amount of experience), and eight systemic-level variables (caseload, amount of formal individual and group supervision, perceptions of the meaning of the work, the emotional demands of the work, social community at work, and perceptions of victim-blame by police and medical staff) on RCMAs' ratings of VT and VPTG. Selection of caseload and amount of education was based on previous research indicating their importance to the development of trauma symptoms in professional counselors, and age and education-level were included due to previous research highlighting the developmental nature of VT. The systemic-level variables of amount of formal individual and group supervision received from the agency, perceptions of the meaning of the work, the emotional demands of the work, and the social community at work were conceptualized as highlighting differing cultures of the rape

crisis organizations in an effort to examine if such systemic variables predict VT and/or VPTG beyond the individual-level variables. Perceptions of witnessing victim-blame by police and medical staff were conceptualized as variables assessing witnessing revictimization.

In this study I addressed the following empirical questions about the potential impact(s) of providing rape crisis medical advocacy work on RCMAs: Do individual variables, such as age, education level, and amount of experience as RCMAs predict ratings of VT and VPTG? Do systemic variables, such as caseload, amount of formal individual and group supervision received, and ratings of social community at work, meaning of the work, and emotional demands of the work predict RCMAs' ratings of VT and/or VPTG beyond the individual variables referenced above? Finally, do perceptions of witnessing VB by police or medical personnel account for additional variance in ratings of VT and/or VPTG beyond that of the other variables assessed?

## Chapter Three: Research Design and Method

This study was a cross-sectional, quantitative examination of rape crisis medical advocates' (RCMAs) ratings of vicarious trauma (VT) and vicarious posttraumatic growth (VPTG). I examined the predictive ability of several individual-level variables, namely advocates' age, education levels, and amount of experience as RCMAs on their ratings of VT and VPTG. I also attempted to attend to the contextual-, environmental-, and systems-level factors that may influence the development of VT and/or VPTG by collecting data on advocates' caseloads, amount of formal individual and group supervision received from their agencies, ratings of social community at work, emotional demands of the work, meaning of the work, and perceptions of witnessing victim-blame by police and medical personnel. Although both qualitative and quantitative data were solicited from participants, only quantitative data were analyzed for the purpose of this dissertation. The qualitative data collected were retained for future study. In this chapter I will describe the participants, measures, operational definitions of variables, hypotheses, study design, and procedure utilized in this study.

### Participants

I recruited ethnically diverse female RCMAs over the age of 18 from all 50 states to participate in this study. I limited participant recruitment to individuals identifying as female due to both the results of a preliminary study intended to inform this dissertation that indicated 99% of the rape crisis advocates surveyed identified as female (Strange et al., 2011), and previous research indicating that over 95% of rape crisis advocates were female (Jenkins & Baird, 2002). I also limited my sample to female advocates with experience providing rape crisis medical advocacy in an effort to narrow the focus to

individuals directly exposed to victims of sexual trauma in the immediate aftermath of the trauma and during the forensic evidence collection process. Tabachnick and Fidell (2007) suggested that the appropriate ratio of independent variables to cases in a regression should be equal to or greater than $50 + 8m$ (where $m$ is the number of independent variables), or $104 + m$ for testing individual predictors. This results in 138 and 115 participants needed, respectively, to conduct the hierarchical regressions in this study.

**Measures**

The independent and dependent variables included in this study were operationalized as scales and items validated through previous research. The one original measure, the Exposure to Victim-Blame Survey, can be found in Appendix A. Measures of demographic and independent variables can be found in Appendix B. Dependent variables can be found in Appendixes C and D. Three open-ended questions assessing the cultures of various rape crisis organizations can be found in Appendix E. These items were retained for analysis in a later study. The participant recruitment letter is included in Appendix F, and the informed consent form can be found in Appendix G. Demographic, independent, and dependent variables are delineated in Tables 3.1, 3.2 and 3.3, respectively.

**Measures of Independent Variables**

The independent variables collected for use in this study included a demographic questionnaire assessing participants' gender, race/ethnicity, employment status, age, education level, amount of experience as a rape crisis medical advocate, amount of caseload, and amount of formal individual and group supervision received from their rape

crisis agency, as well as independent variables assessing RCMAs' perceptions of their psychosocial work environment and witnessing victim-blame by medical personnel and police. The conceptualization of each of these variables is included below.

**Demographic questionnaire.** A demographic questionnaire was created to identify participants' gender, race/ethnicity, employment status, age, education level, amount of experience as a rape crisis medical advocate, amount of caseload, and amount of formal individual and group supervision received from their rape crisis agency. Gender was conceptualized as participants' self-identification as mostly male or mostly female, and was treated as a categorical variable. Race/ethnicity was conceptualized as participants' self-identification as of African origin, of Asian origin, of European origin, of Hispanic origin, of Native American origin, of multiple ethnic origins, or of other ethnic origin, and was treated as a categorical variable. Employment status was conceptualized as receiving monetary compensation for advocacy work or not, and was treated as a categorical variable. Age was conceptualized as a whole number of age in years, and was treated as a continuous variable in the regression. Education level was conceptualized as highest education received being grammar school, high school diploma or GED, some college, associate's degree, bachelor's degree, master's degree, or doctorate degree, and was treated as a categorical variable in the regression. Experience as a RCMA was conceptualized as total years and months participants had been providing rape crisis medical advocacy services, and was treated as a continuous variable in the regression. Caseload was conceptualized as a whole number representing the number of times participants reported to a medical facility *and* provided information and/or emotional support to a victim of sexual assault in the previous year, and was

operationalized as a whole number. Amount of formal individual supervision received was operationalized as the number of hours per month participants spent in formal one-on-one supervision related to their work as RCMAs, and was treated as a continuous variable in the regression. Amount of formal group supervision received was operationalized as the number of hours per month participants spent in formal group supervision related to their work as RCMAs, and was treated as a continuous variable in the regression. The demographic questionnaire is included in Appendix B.

**Psychosocial work environment.** One measure of the external environment that may impact RCMAs, and which has not been assessed previously, is the psychosocial work environment. Psychosocial work environment refers to the combined physical, social, and psychological atmosphere in which one performs job-related duties. "The psychosocial work environment is generally considered to be one of the most important work environment issues," and assessing "psychosocial stressors at work, and the consequences, are believed to be very significant for workers, workplaces, and society" (Kristensen et al., 2005, p. 438). Researchers have reported that poorer psychosocial environments have been linked to "musculoskeletal disorders, cardiovascular diseases, mental disorders, stress, burnout, reduced quality of life, sickness absence, labor turnover, and decreased motivation and productivity" (Kristensen et al., 2005, p. 438).

Few of the established measures for assessing workers' perceptions of their work environments assess ratings of the psychosocial aspects of work life. However, the Copenhagen Psychosocial Questionnaire (COPSOQ) was developed to do just that, and therefore, it was selected for use in this study, primarily because of its unique emphasis on ratings of psychosocial variables including perceptions of the emotional demands of

the work and ratings of the social community at work. In this section I will provide an introduction to the overall instrument, highlight scales selected for use in this study, and provide basic descriptive statistic for the scales selected for use in this study.

The COPSOQ was created at the request of the National Institute of Occupational Health in Denmark in the 1990's in an effort to create a standardized and validated assessment of psychosocial work environment (Kristensen et al., 2005). The Danish psychosocial work environment study was initiated to assess the most appropriate items to include in the final assessment. The final 141 items that were included in the 41 total scales that comprise the COPSOQ were selected based upon results obtained from a sample of 1858 Danish citizens between the ages of 20 and 60 years. The COPSOQ has since been utilized in research in at least six countries (Kristensen et al., 2005), including the United States, to assess workers' ratings of their psychosocial work environments. Three versions of the COPSOQ are available for public use: a short version intended primarily for practical use in small organizations, a medium version for use in larger organizations, and a long version intended primarily for use in research. All scales are limited to 3-4 items each to facilitate usage in both research and workplace contexts.

Kristensen et al. (2005) provided means, standard deviations, and Cronbach's alphas for each of the 41 scales included in the long version of the COPSOQ. Selection of scales for use in this study was based on established theory, previous research indicating which variables most directly address the questions asked in this study, psychometrics of the scales, and face validity for assessing the unique work demands of rape crisis medical advocates. Three of the 41scales from the long version were ultimately selected for this study: the social community at work scale ($M$ = 82.0, $SD$ = 17.4, Cronbach's alpha =

.80), the meaning of the work scale (*M* = 77.7, *SD* = 16.4, Cronbach's alpha = .77), and the emotional demands of the work scale (*M* = 37.8, *SD* = 25.5, Cronbach's alpha = .87). For the three scales selected, respondents were asked to rate items assessing their perception of their psychosocial work environments on 5-point Likert-type scales from 1 *never/hardly ever* to 5 *always*. Each item is scored 0-100 (0 *never/hardly ever*, 25 *seldom*, 50 *sometimes*, 75 *often*, 100 *always*), with the scale score being computed as the mean of the items in the scale, and higher scores indicating more of the construct assessed. The COPSOQ is not intended to be used as a total score. As such, and consistent with scoring criteria published by Kristensen et al. (2005), the mean scale scores for the three chosen scales were utilized in this study.

Kristensen, Hannerz, Hogh, and Borg (2005) conducted factor analyses, analyses of internal consistency, and analyses of response patterns to assess the reliability of the COPSOQ. The authors reported Cronbach's alphas ranging between .70 and .89 for the individual scales, and concluded that "the analyses presented in this article show that most of the COPSOQ scales have good internal reliability and that the correlations between the scales are moderate to low, and these levels of correlation indicate that the scales measure different aspects of the work environment or the well-being of workers" (Kristensen, et al., 2005, p. 446). This finding is consistent with previous articulations of the general parameters for acceptable levels of internal reliability (George & Mallery, 2003).

Construct validity of the COPSOQ was assessed by Bjorner and Pejtersen (2010) using differential item functioning (DIF), with most DIF being found for job type, and differential item effect (DIE), which "seemed to pertain to particular items, which

showed DIE in the same direction for several outcome variables" (Bjorner & Pejtersen, 2010, p. 90). Kristensen et al., (2005) concluded that "the COPSOQ concept is a valid and reliable tool for workplace surveys, analytic research, interventions, and international comparisons" (p. 438).

***Social community at work.*** The social community at work scale consists of three items that ask participants to rate the atmosphere between colleagues, cooperation between colleagues, and sense of feeling a part of the community of the agency. Scores on this scale can range from 0 to 100, and the average score observed among a sample of 1,850 Danish participants was 82.0 (*SD* = 17.4, Cronbach's alpha = .80).

***Meaning of the work.*** The meaning of the work scale consists of three items that ask participants to rate the meaningfulness of the work, the importance of the work, and their motivation toward the work. Scores on this scale can range from 0 to 100, and the average score observed among a sample of 1,850 Danish participants was 77.7 (*SD* = 16.4, Cronbach's alpha = .77).

***Emotional demands of the work.*** The emotional demands of the work scale consists of four items that ask participants to rate if their work puts them in emotionally disturbing situations, the extent to which they feel required to relate to other people's problems, how emotionally demanding their work is, and how emotionally involved they feel in their work. Scores on this scale can range from 0 to 100, and the average score observed among a sample of 1,850 Danish participants was 37.8 (*SD* = 25.5, Cronbach's alpha = .87).

**Exposure to victim-blame.** Witnessing victim-blame and retraumatization of survivors appears to be a unique aspect of RCMAs' psychosocial work environments that

cannot be captured by the COPSOQ, or other measures of work environment, which were designed for more general use in more typical work environments. As such, an additional measure of this unique aspects of RCMAs' experiences was needed to more fully assess RCMAs' psychosocial work environments. In this section I will provide the conceptualization of victim-blame utilized in this study and provide background on the measure selected to assess RCMAs' perceptions of victim-blame.

The Canadian Resource Center for Victims of Crime (CRCVC, 2009) defined victim-blaming as: "A devaluing act that occurs when the victim(s) of a crime or an accident is held responsible – in whole or in part – for the crimes that have been committed against them [sic]" (p. 2), and stated that victim-blame is frequently experienced as "negative social responses from legal, medical, and mental health professionals, as well as from the media and immediate family members or other acquaintances" (p. 2). Campbell (2006) described the role of the RCMA as "to prevent 'the second rape' or 'secondary victimization,' insensitive, victim-blaming treatment from social system personnel that exacerbates the trauma to the rape" (p. 30-31). Campbell and Raja (2005) found that the majority of rape survivors they surveyed were most distressed by questions about their behavior before the rape and questions about their previous sexual experiences. Campbell (2006) found that rape survivors who received the assistance of trained RCMAs were more likely to receive more services and to report less victim-blaming behaviors by medical staff and police.

For the purpose of this study, exposure to rape victim-blame was conceptualized as advocates' ratings of how frequently they witness or experience specific behaviors during the forensic rape exam, such as a victim being questioned about his or her sexual

history, being told he or she should not have been in the area where the assault occurred, or being told he or she should not have been associating with those sorts of people at the time of the assault. The exposure to victim-blame scale (see Appendix A) utilized in this study was created by Strange et al. (2011), who developed a 40-item scale intended to measure the frequency with which rape crisis medical advocates perceived witnessing rape victim-blame by police and medical personnel. The original scale items were developed based on previous literature (Campbell, 2006; Muldowney, 2009), the original authors' experiences providing rape crisis medical advocacy, and feedback from colleagues with experience in rape crisis advocacy and sexual trauma counseling. Strange et al. (2011) administered the 40 items derived from this process to 95 rape crisis medical advocates in a preliminary study designed to inform this dissertation. Items were rated on 4-point Likert-type scales, with responses ranging from 1 *never* to 4 *always.* Eight items (2, 6, 10, 14, 16, 17, 18, and 19) were reverse scored, resulting in a possible maximum score of 148. Higher scores indicated higher perceptions of witnessing victim-blame.

Strange et al. (2011) conducted paired samples t-tests on the twenty pairs of variables comprising the VB scales to evaluate whether differences existed between advocates' perceptions of the frequency of victim-blaming behaviors by medical and law enforcement personnel. Statistically significant differences between the means were observed on eleven of the twenty pairs of questions. The majority of the differences were observed in the direction of advocates experiencing police as being significantly more likely to engage in the queried behavior, though the rate of occurrence of most VB behaviors was low overall. Results revealed that advocates were significantly more

likely to indicate witnessing law enforcement personnel tell a victim that he or she should not have been in the area where the assault occurred, that she or he should not have been walking or traveling alone at night, and that he or she should not have been associating with those sorts of people. Advocates also indicated that law enforcement personnel were more likely to question a victim about why her or his memories of the assault are vague or disjointed, to ask the victim why she or he did not fight back, and to ask a victim if he or she was telling the truth. Advocates indicated that they perceived that the victim's previous history of victimization influenced the quality of services received from police more so than medical personnel, and that police were more likely to ask the advocate if he or she believed the victim. The data also indicated that advocates were more likely to witness medical personnel tell the victim she or he was believed 100%, provide equal treatment regardless of age, race, ethnicity, gender, sexuality, SES, religion, et cetera, and tell a victim he or she was not to blame for the assault.

**Measures of Dependent Variables**

This section will describe the two dependent variables assessed in this study, vicarious traumatization and vicarious posttraumatic growth, which can be found in Appendices C and D.

***Vicarious traumatization.*** Vicarious traumatization describes a process of loss of sense of self, safety, and trust brought about by chronic contact with others' traumas. The effects of vicarious trauma appear to result in changes in basic beliefs about the goodness of self, other people, and the world in general. Several authors have previously documented that counselors working with victims of sexual trauma report higher levels of traumatic stress, vicarious trauma, and disrupted beliefs (Bober & Regehr, 2005; Way et

al., 2004). The Trauma and Attachment Belief Scale (TABS; Pearlman, 2003; see Appendix C) was adapted to assess RCMAs' ratings of vicarious traumatization in this study.

The TABS is an 84-item self-assessment that measure changes in sense of safety, self-esteem, other-esteem, self-trust, other-trust, self- intimacy, and other-intimacy. The TABS is a revision of the Traumatic Stress Institute-Belief Scale (TSI-BS), one of the most widely-used measures of changes in basics beliefs resulting from traumatic exposure (Adams & Riggs, 2008; Bober & Regehr, 2005; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995). Respondents are asked to rate how strongly they agree with certain statements, such as "You can't trust anyone," and "Other people are no good," on 6-point Likert scales from 1 *disagree strongly* to 6 *agree strongly*. The TABS consists of 10 subscales assessing beliefs about self- and other-safety, self- and other-trust, self- and other-esteem, self- and other-intimacy, and self- and other-control. Pearlman (2003) reported excellent internal consistency (Cronbach's alpha = .96 for the total scale), and acceptable test-retest correlations ($r$ =. 75 for the total scale). She also argued that the content validity of the TABS appeared to be high, as the items were gathered from trauma survivors themselves. The author also argued that the assessment should be equally valid for clinical and non-clinical samples alike, that it has good discriminant validity, and that it is sensitive enough to detect differences between theoretically distinct groups. Unfortunately, most psychometric data were generated from the earlier TSI-BS, and normative data on diverse client populations are needed. Still, this measure is informed by established theory, is based on survivors' reports of their experiences

following trauma, and is one of the few measures to purport measuring VT, or cognitive shifts, among clinicians (Pearlman, 2003).

Total scores on the TABS were used to measure VT in this study. Only the full scale score was used in the analyses in the present study, with higher scores indicating more vicarious traumatization (Pearlman, 2003). Possible total scores range from 84 to 504, and the mean total score observed among the nonclinical standardization sample of 1,743 adults aged 17 to 78 was 187.2 (Pearlman, 2003).

***Vicarious posttraumatic growth.*** Posttraumatic growth has been defined as "the individual's experience of significant positive change arising from the struggle with a major life crisis" (Calhoun et al., 2000, p. 521). Tedeschi and Calhoun (1996) described three major domains of posttraumatic growth: Perceived changes in self, perceived changes in relationships with others, and a changed philosophy of life. Vicarious posttraumatic growth was conceptualized as the experience of such psychological growth from contact with traumatized-others.

An adaptation of the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) was used to assess psychological growth resulting from rape advocacy work (see Appendix D). The PTGI is a 21-item measure that evaluates openness to new possibilities, relating to others, personal strengths, spiritual change, and appreciation of life. For the purpose of this study, the wording of individual items was adapted to reflect changes experienced as a result of providing rape crisis medical advocacy services. Items on the PTGI are rated on a 6-point Likert-type scale 0 *none* to 5 *very great*. The authors indicated that "women tend to report more benefits than do men, and persons who have experienced traumatic events report more positive change than do persons who have not

experienced extraordinary events" (p. 455). The total score is determined by summing all items and higher total scores reflect higher levels of vicarious posttraumatic growth. Possible total scores range from 0 to 105.

The PTGI appears to be a valid and reliable measure of growth resulting from exposure to trauma. Tedeschi and Calhoun (1996) observed excellent internal consistency (Cronbach's alpha = .90) and good test-retest reliability ($r$ = .71) among a sample of college students, those with higher scores tending to report more severe traumas. Shakespeare-Finch and Enders (2008) found that significant-others of trauma survivors reported posttraumatic growth at levels very similar to those reported by their loved ones.

**Operational Definitions**

Operationalization of variables occurred as described in this section. Demographic variables were assessed with single items, independent variables were assessed with items and scales, and dependent variables were assessed with established measures.

**Descriptive variables.** The descriptive demographic variables of gender, race/ethnicity, employment status, age, education level, amount of experience, and caseload were assessed using the demographic questionnaire found in Appendix B. Gender was assessed with one item in which participants identified their gender as 0 *mostly male*, 1 *mostly female*, and was treated as a categorical variable. Race/ethnicity was measured with one item in which participants identified their race/ethnicity as 1 *of African origin*, 2 *of Asian origin*, 3 *of European origin*, 4 *of Hispanic origin*, 5 *of Native American origin*, 6 *of multiple ethnic origins*, 7 *other*, and was treated as a categorical

variable. Employment status was assessed with one item in which participants reported whether they receive monetary compensation for their work as advocates or not as 0 *no*, 1 *yes*, and was treated as a categorical variable. Age was assessed with one item in which participants reported their age in years and months and was converted to a whole number of age in total months before beginning the data analysis. Age was treated as a continuous variable. Education level was measured with one item in which participants reported their highest education level completed as 1 *grammar school*, 2 *high school or GED*, 3 *some college*, 4 *associate's degree*, 5 *bachelor's degree*, 6 *master's degree*, 7 *doctorate degree*, and was treated as a categorical variable. Amount of experience as a RCMA was assessed with a single item that asked participants to report how many years and months they have been working as RCMAs. This figure was then converted to total months experience providing medical advocacy services prior to beginning the data analysis. Amount of experience was treated as a continuous variable. Caseload was assessed with one item prompting participants to report the number of times they reported to a medical facility *and* provided information and/or emotional support to a victim of sexual assault in the previous year, and was treated as a continuous variable.

**Independent variables**. Independent variables were measured to determine which factors influence vicarious traumatization and vicarious posttraumatic growth for RCMAs (see Appendices A and B).

***Amount of individual supervision.*** Amount of formal individual supervision was assessed with one item, which asked participants to report how many hours per month they spend in one-on-one supervision related to their work as RCMAs.

***Amount of group supervision.*** Amount of formal group supervision was assessed with one item, which asked participants to report how many hours per month they spend in group supervision for their work as RCMAs.

***Social community at work.*** The social community at work was assessed with the 3-item social community at work scale from the COPSOQ (Kristensen et al., 2005). This measure was intended to assess RCMAs' perceptions of social support and social belongingness at work. Items were rated on a 5-point Likert-type scale from 1 *never/hardly ever* to 5 *always*. The average score of the three items in the scale was utilized in this study, consistent with scoring criteria delineated by Kristensen et al. (2005).

***Meaning of the work.*** The meaning of the work was assessed with the 3-item meaning of the work subscale from the COPSOQ (Kristensen et al., 2005). This measure was intended to assess RCMAs' perceptions of the importance and meaningfulness of the work. Items were rated on a 5-point Likert-type scale from 1 *never/hardly ever* to 5 *always*. The average score of the three items in the scale was utilized in this study, consistent with scoring criteria delineated by Kristensen et al. (2005).

***Emotional demands of the work.*** The emotional demand of the work was assessed with the 4-item emotional demands subscale from the COPSOQ (Kristensen et al., 2005). This measure was intended to assess RCMAs' perceptions of exposure to emotionally disturbing material and their emotional involvement with the work. Items were rated on a 5-point Likert-type scale from 1 *never/hardly ever* to 5 *always*. The average score of the three items in the scale was utilized in this study, consistent with scoring criteria delineated by Kristensen et al. (2005).

***Exposure to victim-blame by medical staff.*** RCMAs' perceptions of victim-blame by medical staff were assessed with the 20-item VB-M subscale of the VB questionnaire designed by Strange et al. (2011). This measure was designed to evaluate RCMAs' perceptions of victim-blaming behaviors exhibited by medical staff during the forensic medical exam (see Appendix A). Items were rated on a 4-point Likert-type scale where from 1 *never* to 4 *always*. Total score was determined by reverse scoring eight items (2, 6, 10, 14, 16, 17, 18, 19) and summing all items, resulting in a possible maximum of 80 for the VB-M subscale, with higher scores indicating higher perceptions of witnessing victim-blaming behaviors by medical personnel.

***Exposure to victim-blame by police.*** RCMAs' perceptions of victim-blame by police were assessed with the 20-item VB-P subscale of the VB questionnaire designed by Strange et al., (2011). This measure was designed to evaluate RCMAs' perceptions of victim-blaming behaviors exhibited by police during the forensic medical exam (see Appendix A). Items were rated on a 4-point Likert-type scale from 1 *never* to 4 *always*. Total score was determined by reverse scoring eight items (2, 6, 10, 14, 16, 17, 18, 19) and summing all items, resulting in a possible maximum of 80 for the VB-P subscale, with higher scores indicating higher perceptions of witnessing victim-blaming behaviors by police.

**Dependent variables**. Dependent variables were measured with established instruments, with instructions modified where necessary to measure vicarious traumatization and vicarious posttraumatic growth.

***Vicarious traumatization.*** Vicarious traumatization was assessed with the Full Scale score from the 84-item Trauma and Attachment Belief Scale (TABS; Pearlman,

2003; see Appendix C). Participants were asked to respond to statements about how individuals view themselves and others, selecting the response that best fits how they feel about themselves and their worlds. Possible scores range from 1 to 504. Only the full scale score, with higher scores indicating more vicarious traumatization, was utilized for the purpose of this study.

***Vicarious posttraumatic growth.*** Vicarious posttraumatic growth was measured with an adaptation of the 21-item Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996; see Appendix E). Participants were asked to respond to statements about changes in their lives in relation to their work with rape survivors. The total score was calculated by summing responses to all items, resulting in possible total scores ranging from 0 to 105, with higher scores indicating more vicarious posttraumatic growth.

**Hypotheses**

In this study I investigated the hypotheses described in this section (see Table 3.4). The purposes of this study were (a) to examine which variables might predict the development of VT and/or VPTG among RCMAs; (b) to determine if systemic-level variables, such as caseload, amount of formal individual and group supervision, perceptions of the social community at work, the meaning of the work, and the emotional demands of the work predict VT and/or VPTG beyond the individual-level variables of age, education level, and amount of experience as a RCMA; and (c) to determine if perceptions of witnessing victim-blame by police or medical staff predict VT and/or VPTG beyond the individual-level and other systemic-level variables. The unique contributions of the following variables on the development of VT and VPTG were assessed: age, education level, amount of experience as a RCMA, caseload, amount of

formal individual and group supervision, perceptions of the social community at work, the meaning of the work, the emotional demands of the work, and victim-blame by police and medical staff (see Table 3.4).

**Hypothesis 1.** Higher ages, experiences as a RCMA, caseloads, ratings of the emotional demands of the work, and ratings of victim-blame by police and medical staff will positively predict VT. Higher education levels, amounts of formal individual and group supervision, and ratings of social community at work and the meaning of the work will negatively predict VT.

***Hypothesis 1a.*** Higher age will significantly positively predict VT. McCann and Pearlman (1990) argued that the process of VT appears to be developmental in nature. To my knowledge, no research has examined the influence of age on the development of VT. As such, in this study I examined the predictive ability of age on ratings of VT.

H0: $\beta_{Age/VT} = 0$

H1: $\beta_{Age/VT} > 0$

***Hypothesis 1b.*** Higher amounts of education will significantly negatively predict VT. Previous research has shown that participants with higher educational levels demonstrated fewer symptoms of vicarious traumatization (Baird & Jenkins, 2003). As such, in this study I examined the predictive ability of educational achievement on ratings of VT.

H0: $\beta_{Edu/VT} = 0$

H1: $\beta_{Edu/VT} < 0$

***Hypothesis 1c.*** Higher amounts of experience providing rape crisis medical advocacy services will significantly positively predict VT. Evidence that the negative

effects, such as the development of PTSD-like symptomology, of working with clients' traumas are more severe for those with less experience has been documented multiple times (Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Way et al., 2004), but other authors have demonstrated that counselors who chronically experience their clients' traumas over time were more likely to develop specific changes in fundamental beliefs about self, others, and the world in general, or symptoms of VT (Bober & Regehr, 2005; Jenkins & Baird, 2002; Pearlman & Mac Ian, 1995; Schauben & Frazier, 1995; Way et al., 2004). Schauben and Frazier (1995) found that years of experience were related to more "disruptive beliefs regarding intimacy with others…[suggesting] that degree of exposure has an impact on intrusions and avoidance symptoms" (p. 7). They concluded that disruptions to beliefs systems do not occur in the short-term, but may in the long-term. Higher amounts of experience providing rape crisis advocacy services may be particularly relevant to the development of symptoms of VT. As such, in this study I examined the predictive ability of amount of experience on ratings of VT.

H0: $\beta_{Exp/VT} = 0$

H1: $\beta_{Exp/VT} < 0$

***Hypothesis 1d.*** Higher caseloads will significantly positively predict higher levels of VT. Schauben and Frazier (1995) found elevated levels of VT, disrupted belief structures, and PTSD, but only among therapists with higher caseloads of trauma survivors. They argued that counselors' "symptomatology is related to the percentage of sexual violence survivors in their caseload" (p. 61). Bober and Regehr (2005) found that more time per week providing trauma counseling was related to more trauma symptomology. Pearlman and Mac Ian (1995) found that trauma therapists with the most

symptoms tended to have higher rates of exposure to clients' traumas, and worked in hospitals. Amount of caseload may be particularly relevant to the development of symptoms of vicarious trauma among RCMAs, as it is the effects of chronic exposure to trauma that are thought to be associated with the development of vicarious traumatization. As such, in this study I examined the predictive ability of amount of caseload on ratings of VT.

H0: $\beta_{Case/VT} = 0$

H1: $\beta_{Case/VT} > 0$

***Hypothesis 1e.*** Higher amounts of formal individual supervision will significantly negatively predict VT. Pearlman and Mac Ian (1995) found that trauma therapists who were not receiving formal supervision were among those most likely to exhibit high levels of symptomology on measures of overall psychological functioning. As such, in this study I examined the predictive ability of amount of formal individual supervision received on ratings of VT.

H0: $\beta_{IndSup\ /VT} = 0$

H1: $\beta_{IndSup\ /VT} < 0$

***Hypothesis 1f.*** Higher amounts of formal group supervision will significantly negatively predict VT. Researchers have documented that therapists not receiving formal supervision show more impairment in overall psychological functioning than those who do receive formal supervision (Pearlman & Mac Ian, 1995), and that more emotional support is associated with fewer symptoms of secondary trauma (Boscarino et al., 2004). Formal group supervision might serve as another venue for advocates to process their

experiences providing advocacy. As such, in this study I examined the predictive ability of amount of formal group supervision received on ratings of VT.

H0: $\beta_{GrpSup\ /VT} = 0$

H1: $\beta_{GrpSup\ /VT} < 0$

***Hypothesis 1g.*** Higher ratings of the social community at work will significantly negatively predict VT. Previous research has shown that having more access to emotional support is important for overall psychological well-being for survivors of domestic violence (Mitchell & Hodson, 1983), and lay-counselors conducting trauma therapy (Ortlepp & Friedman, 2002). Other researchers have shown that having more access to emotional support from friends, family, and colleagues was associated with lower levels of secondary trauma reactions among mental health professionals (Boscarino et al., 2004). Bell et al. (2003) similarly argued that "the values and culture of an organization set the expectations about the work. When the work includes contact with trauma, they also set the expectations about how workers will experience trauma and deal with it, both professionally and personally" (p. 466). As such, in this study I examined the predictive ability of ratings of social community at work on ratings of VT.

H0: $\beta_{SocCom/VT} = 0$

H1: $\beta_{SocCom\ /VT} < 0$

***Hypothesis 1h.*** Higher ratings of the meaning of the work will significantly negatively predict VT. Hellman and House (2006) found that advocates who endorsed higher levels of job satisfaction also endorsed higher levels of affective commitment to the job, and both were associated with overall intent to remain an advocate. Advocates who perceived their training as more important were also more likely to report higher

levels of overall satisfaction with their work. As such, in this study I examined the predictive ability of ratings of the meaning of the work on ratings of VT.

H0: $\beta_{Meaning/VT} = 0$

H1: $\beta_{Meaning/VT} < 0$

***Hypothesis 1i.*** Higher ratings of the emotional demands of the work will significantly positively predict VT. Jenkins and Baird (2002) conceptualized both VT as "reactions to the emotional demands on therapists…from exposure to trauma survivors' terrifying, horrifying, and shocking images; strong, chaotic affect; and intrusive traumatic memories" (p. 423). Schauben and Frazier (1995) found that counselors in their study indicated that two of the most difficult aspects of working with survivors were psychic drain resulting from "hearing so much pain," and working through their own reactions to the abuse, including feeling helpless, powerless, fearful, sad, and angry. Wasco and Campbell (2002) found that all the advocates they surveyed reported experiencing both anger and fear in relation to their work. The fear-based reactions were generally rooted in either real or perceived danger, such as from perpetrators or their families, and the anger-based reactions were generally directed at systems (i.e., the criminal justice system or the medical system). The authors concluded that advocates reactions were "more often than not, experienced in response to systemic, institutional, environmental, and societal influence" (p. 124). As such, in this study I examined the predictive ability of ratings of the emotional demands of the work on ratings of VT.

H0: $\beta_{EmoDem/VT} = 0$

H1: $\beta_{EmoDem/VT} > 0$

***Hypothesis 1j.*** Higher ratings of victim-blame by police will significantly positively predict VT. Ullman (1999) argued that the negative social reactions victims may experience impact the development of symptoms following rape. Pearlman and Mac Ian (1995) argued that this ability to empathically engage, to put oneself in others' shoes while they tell you their horror story, can create an incredibly strong therapeutic alliance, but also puts counselors at risk for developing lasting changes in "enduring ways of experiencing self, others, and the world" (p. 558). Advocates are physically present to assist survivors during the acute rape crisis period, through the forensic exam, a process many sexual trauma survivors have described as a second rape (Campbell et al., 1999; Parrot, 1991), an established time of particular vulnerability and potential retraumatization of victims (Resnick et al., 1999). Negative social reactions seem to exacerbate the development of trauma symptomology among primary survivors (George & Martinez, 2002; Resnick et al., 1999; Wasco & Campbell, 2002; Ullman, 1999), as well as among advocates (Campbell et al., 1999; Hellman & House, 2006). Hellman and House (2006) found that advocates who witness more victim-blame in the course of their work are less likely to be satisfied with their work and less likely to remain advocates. They also found that advocates who witness more victim-blame in the course of their work are less likely to be satisfied with their work and less likely to remain advocates. Strange and associates (2011) demonstrated that advocates reported witnessing more VB by police than medical staff or social service providers, and that those who reported witnessing more victim-blame by police were less likely to trust not only police, but also medical service providers, social service providers, and people in general. This finding did not hold for advocates who reported witnessing higher levels of victim-blame by

medical or social service providers, and seems to indicate that advocates who witness victim-blame by police, in particular, may develop changes in basic beliefs about the goodness of other people and worldview shifts similar to the effects of VT documented in professional counselors.

H0: $\beta_{VB\text{-}P/VT} = 0$

H1: $\beta_{VB\text{-}P/VT} > 0$

***Hypothesis 1k.*** Higher ratings of victim-blame by medical staff will significantly positively predict VT. Similar to the previous argument, higher ratings of witnessing victim-blame have been shown to be associated with exacerbation of the development of trauma symptomology among primary survivors (George & Martinez, 2002; Resnick et al., 1999; Ullman, 1999; Wasco & Campbell, 2002), as well as among advocates (Campbell et al., 1999; Hellman & House, 2006). Several authors have documented the effects these negative social messages can have on victims, including feeling revictimized (Campbell et al., 1999; Worell & Remer, 2003), and endorsing higher rates of PTSD (Resnick et al., 1999) and a lower likelihood of reporting future crimes (George & Martinez, 2002). The documented effects on advocates include endorsing lower ratings of satisfaction with the work, which was in turn related to decreased intent to continue advocacy work (Hellman & House, 2006). Hellman and House (2006) found that advocates who witness more victim-blame in the course of their work are less likely to be satisfied with their work and less likely to remain advocates.

H0: $\beta_{VB\text{-}M/VT} = 0$

H1: $\beta_{VB\text{-}M/VT} > 0$

**Hypothesis 2.** Age, education level, amount of experience as RCMAs, amounts of formal individual and group supervision, ratings of the social community at work, the meaning of the work, the emotional demands of the work, and perceptions of victim-blame by police and medical staff will positively predict VPTG. Caseload will negatively predict VPTG.

***Hypothesis 2a.*** Age will positively predict VPTG. McCann and Pearlman (1990) argued that the process of VT appears to be developmental in nature, but to my knowledge, no research has examined whether VPTG shares a similar developmental-nature. Perhaps age brings a certain maturity to integrate painful experiences in a meaningful way. As such, in this study I examined the predictive ability of age on ratings of VPTG.

H0: $\beta_{Age/VPTG} = 0$

H1: $\beta_{Age/VPTG} > 0$

***Hypothesis 2b.*** Higher education level will significantly positively predict VPTG. Previous research has shown that participants with higher educational levels demonstrated fewer symptoms of vicarious traumatization (Baird & Jenkins, 2003), and those with more education may be more prepared with ways to cope with, emotionally process, and meaningfully integrate their experiences. As such, in this study I examined the predictive ability of educational achievement on ratings of VPTG.

H0: $\beta_{Edu/VPTG} = 0$

H1: $\beta_{Edu/VPTG} > 0$

***Hypothesis 2c.*** Higher amounts of experience as a RCMA will significantly positively predict VPTG. Advocates who remain advocates longer may be able to do so

because they experience more growth or other positive outcomes resulting from advocacy work, and/or may be more prepared with ways to cope with, emotionally process, and meaningfully integrate their experiences. To my knowledge, no research has examined whether VPTG is associated with amount of experience. As such, in this study I examined the predictive ability of amount of experience on ratings of VPTG.

H0: $\beta_{Exp/VPTG} = 0$

H1: $\beta_{Exp/VPTG} > 0$

***Hypothesis 2d.*** Higher caseload will significantly negatively predict VPTG. To my knowledge, no researchers have examined whether caseload is associated with the development of VPTG. Higher levels of exposure to suffering-others could decrease the emotional resources RCMAs have available to facilitate meaning-making and the development of other positive outcomes associated with working with trauma survivors. As such, in this study I examined the predictive ability of amount of caseload on ratings of VPTG.

H0: $\beta_{Case/VPTG} = 0$

H1: $\beta_{Case/VPTG} < 0$

***Hypothesis 2e.*** Higher amounts of formal individual supervision will significantly positively predict VPTG. Pearlman and Mac Ian (1995) found that trauma therapists who were not receiving formal supervision were among those most likely to exhibit high levels of symptomology on measures of overall psychological functioning. Those who receive more formal individual supervision might have more opportunity and/or encouragement to process their experiences as advocates more deeply, thus

resulting in more growth. As such, in this study I examined the predictive ability of amount of formal individual supervision received on ratings of VPTG.

H0: $\beta_{IndSup/VPTG} = 0$

H1: $\beta_{IndSup/VPTG} > 0$

***Hypothesis 2f.*** Higher amounts of formal group supervision will significantly positively predict VPTG. Formal group supervision might serve as another venue for advocates to process their experiences providing advocacy. Previous research seems to indicate that social support is important for overall psychological well-being (Mitchell & Hodson, 1983), and is associated with lower levels of secondary trauma reactions among mental health professionals (Boscarino et al., 2004) and lay-counselors conducting trauma therapy (Ortlepp & Friedman, 2002). Pearlman and Mac Ian (1995) found that trauma therapists who were not receiving formal supervision were among those most likely to exhibit high levels of symptomology on measures of overall psychological functioning. As such, in this study I examined the predictive ability of amount of formal group supervision received on ratings of VPTG.

H0: $\beta_{GrpSup/VPTG} = 0$

H1: $\beta_{GrpSup/VPTG} > 0$

***Hypothesis 2g.*** Higher ratings of social community at work will significantly positively predict VPTG. Previous research has shown that having more access to emotional support is important for overall psychological well-being for survivors of domestic violence (Mitchell & Hodson, 1983), and lay-counselors conducting trauma therapy (Ortlepp & Friedman, 2002). Other researchers have shown that having more access to emotional support from friends, family, and colleagues was associated with

lower levels of secondary trauma reactions among mental health professionals (Boscarino et al., 2004). Bell et al., (2003) similarly argued that "the values and culture of an organization set the expectations about the work. When the work includes contact with trauma, they also set the expectations about how workers will experience trauma and deal with it, both professionally and personally" (p. 466). As such, in this study I examined the predictive ability of ratings of social community at work on ratings of VPTG.

H0: $\beta_{SocCom/VPTG} = 0$

H1: $\beta_{SocCom/VPTG} > 0$

***Hypothesis 2h.*** Higher ratings of the meaning of the work will significantly positively predict VPTG. Hellman and House (2006) found that advocates who endorsed higher levels of job satisfaction also endorsed higher levels of affective commitment to the job, and both were associated with overall intent to remain an advocate. Advocates who perceived their training as more important were also more likely to report higher levels of overall satisfaction with their work. As such, in this study I examined the predictive ability of ratings of the meaning of the work on ratings of VPTG.

H0: $\beta_{Meaning/VPTG} = 0$

H1: $\beta_{Meaning/VPTG} > 0$

***Hypothesis 2i.*** Higher ratings of the emotional demands of the work will significantly positively predict VPTG. To my knowledge, no previous research has examined the association between ratings of the emotional demands of the work and the development of VPTG. Individuals who report higher levels of emotional demands, but who remain in their roles as RCMAs (i.e., those who were included in this study), may be able to remain in the role due to more effective meaning-making and integration of both

the positive and negative aspects of the work. As such, in this study I examined the predictive ability of ratings of the emotional demands of the work on ratings of VPTG.

H0: $\beta_{EmoDem/VPTG} = 0$

H1: $\beta_{EmoDem/VPTG} > 0$

***Hypothesis 2j.*** Higher ratings of victim-blame by police will significantly positively predict VPTG. Higher ratings of witnessing victim-blame have been shown to be associated with exacerbation of the development of trauma symptomology among primary survivors (George & Martinez, 2002; Resnick et al., 1999; Ullman, 1999; Wasco & Campbell, 2002), as well as among advocates (Campbell et al., 1999; Hellman & House, 2006). Other documented effects on advocates include endorsing lower ratings of satisfaction with the work, which was in turn related to decreased intent to continue advocacy work (Hellman & House, 2006). In an unpublished preliminary study designed to inform this dissertation, Strange et al. (2011) documented significantly higher ratings of witnessing victim-blame by police than by medical staff in a sample of female rape crisis advocates, and those who reported witnessing more victim-blame by police were less likely to trust not only police, but also medical service providers, social service providers, and people in general. Witnessing victim-blame could be conceptualized as a trauma advocates experience, an event they must somehow integrate into their identities and make meaning of in order to remain advocates, grow from their experiences, and continue in advocacy-work. Advocates who witness more victim-blame may have more opportunities to experience growth. As such, in this study I examined the predictive ability of ratings of witnessing victim-blame by police on ratings of VPTG.

H0: $\beta_{VB\text{-}P/VPTG} = 0$

H1: $\beta_{VB\text{-}P/VPTG} > 0$

***Hypothesis 2k.*** Higher ratings of victim-blame by medical staff will significantly positively predict VPTG. Similar to the argument above, higher ratings of witnessing victim-blame have been shown to be associated with exacerbation of the development of trauma symptomology among primary survivors (George & Martinez, 2002; Resnick et al., 1999; Ullman, 1999; Wasco & Campbell, 2002), as well as among advocates (Campbell et al., 1999; Hellman & House, 2006), and several authors have documented the effects these negative social messages can have on victims (Campbell et al., 1999; George & Martinez, 2002; Hellman & House, 2006; Resnick et al., 1999; Worell & Remer, 2003). As such, in this study I examined the predictive ability of ratings witnessing victim-blame by medical staff on ratings of VPTG.

H0: $\beta_{VB\text{-}M/VPTG} = 0$

H1: $\beta_{VB\text{-}M/VPTG} > 0$

**Study Design**

This study was a cross-sectional, internet-based research survey of RCMAs working for organizations providing rape crisis advocacy services.

**Procedure**

This study was approved by the University of Kentucky (UK) Institutional Review Board (#13-0415-P4S). Once approval was obtained, an introductory email (see Appendix G) was sent to rape crisis agency directors soliciting their assistance by forwarding the introductory email to their advocates via agency email lists. I attempted to identify as many rape crisis agencies as possible in all fifty states via internet search, literature review, and contacts within the field. I also implemented a snowball sampling

method by asking agency directors and participants to forward the introductory email to anyone they may have known with rape crisis medical advocacy experience. The introductory email contained a link to a description of the study and the online consent form (see Appendix H). Once participants provided consent, they were directed to the on-line questionnaire. Informal piloting before data collection began indicated that the entire questionnaire took approximately 30-45 minutes to complete. No identifying information was collected from participants, as IP addresses were scrubbed by the survey software.

I utilized the SurveyMonkey survey software to create this study. The first page provided a description of the study and potential risks and benefits involved in participation. Participants provided consent by clicking the "I Agree/Continue" button. The first question of the survey was used to verify that participants had experience as RCMAs, and to exclude those who did not from participating in this study, by asking participants to indicate if they had ever reported to a medical facility *and* met with a victim of sexual assault in an attempt to provide information and/or emotional support. The second question of the survey asked participants how many times they had reported to a medical facility *and* met with a victim of sexual assault in an attempt to provide information and/or emotional support in the previous year. Participants who responded 0 to either question were excluded from the data analysis, as only women currently working as RCMAs were included in the study. The survey was programmed in such a way that participants could not continue without providing responses to both of these items, but subsequent questions allowed participants to skip items or close the browser window at any time, indicating withdrawal from the survey. Participants were given the

instruments in the following order: professional experience variables, support and supervision variables, agency culture variables, the TABS, the PTGI, the victim-blame measures, and demographics. Presenting the fairly innocuous professional experience items first was intended to "warm-up" participants, slowly introducing questions that required more reflection on personal experiences. The victim-blame measure was placed last to prevent contamination of responses to other items by these questions. Participants were instructed to clear their internet browser history and restart their machines following completion of the survey. The raw data were transferred from the internet-based survey software to Microsoft Excel. From Excel, the data were imported into IBM SPSS Statistics 21 for data analysis.

**Data Analyses**

Preliminary analyses were conducted to test assumptions for regression. Participant demographic characteristics were examined, and any potential relationships between participants' demographic characteristics and the outcome variables were assessed. Patterns of missing data were examined, outliers were identified and removed, scales were checked for normality and transformed if necessary, and multicollinearity was assessed. Highly skewed variables were transformed using the logarithm transformations option in SPSS in order to guarantee the appropriateness of their inclusion in the regression analysis. Categorical variables were dummy-coded before being included in the regression and correlations between the variables were examined to ensure a low degree of correlation among the predictor variables. The data were then analyzed using a series of hierarchical linear regressions to examine which variables might significantly predicted vicarious traumatization and vicarious posttraumatic

growth. Both regressions included the same 11 independent variables entered in four steps with vicarious trauma as the dependent variable in the first regression and vicarious posttraumatic growth as the dependent variable in the second regression.

In the first step of each hierarchical regression, age, education, and experience as a RCMA were entered; in the second step, caseload, amount of formal individual supervision received, and amount of formal group supervision received were entered; in the third step the COPSOQ scale scores were entered; in the final step, perceptions of witnessing victim-blame by police and medical providers were entered. The individual-level variables of age, education, and experience were entered first to examine if the systemic-level variables accounted for variability above the individual-level variables. The agency-level variables of caseload and amount of formal individual and group supervision received were entered next to determine if they contributed to the variance accounted for beyond the individual-level variables. The work environment variables were entered in step three to determine if they accounted for variance beyond the individual-level variables and the single-items that assessed for caseload and amounts of formal supervision received. Ratings of perceptions of victim-blame were entered last to determine if these variables accounted for the variance in VT and VPTG beyond the other variables assessed.

Table 3.1

*Independent and Dependent Variables*

| Independent Variables | Dependent Variables |
|---|---|
| Age | Vicarious Traumatization |
| Education Level | Vicarious Posttraumatic Growth |
| Experience as a RCMA | |
| Caseload | |
| Amount of Individual Supervision | |
| Amount of Group Supervision | |
| Social Community at Work | |
| Meaning of the Work | |
| Emotional Demands of the Work | |
| Exposure to Victim-Blame by Medical Staff | |
| Exposure to Victim-Blame by Police | |

Table 3.2

*Research and Statistical Hypotheses*

| Research Hypotheses | Statistical Hypotheses |
|---|---|
| 1a. Higher age will significantly positively predict VT. | H0: $\beta_{Age/VT} = 0$<br>H1: $\beta_{Age/VT} > 0$ |
| 1b. Higher amounts of education will significantly negatively predict VT. | H0: $\beta_{Edu/VT} = 0$<br>H1: $\beta_{Edu/VT} < 0$ |
| 1c. Higher amounts of experience providing rape crisis medical advocacy services will significantly positively predict VT. | H0: $\beta_{Exp/VT} = 0$<br>H1: $\beta_{Exp/VT} < 0$ |
| 1d. Higher caseloads will significantly positively predict higher levels of VT. | H0: $\beta_{Case/VT} = 0$<br>H1: $\beta_{Case/VT} > 0$ |
| 1e. Higher amounts of formal individual supervision will significantly negatively predict VT. | $H_0$: $\beta_{IndSup\ /VT} = 0$<br>$H_1$: $\beta_{IndSup\ /VT} < 0$ |
| 1f. Higher amounts of formal group supervision will significantly negatively predict VT. | $H_0$: $\beta_{GrpSup\ /VT} = 0$<br>$H_1$: $\beta_{GrpSup\ /VT} < 0$ |
| 1g. Higher ratings of social community at work will significantly negatively predict VT. | H0: $\beta_{SocCom/VT} = 0$<br>H1: $\beta_{SocCom\ /VT} < 0$ |
| 1h. Higher ratings of the meaning of the work will significantly negatively predict VT. | H0: $\beta_{Meaning/VT} = 0$<br>H1: $\beta_{Meaning/VT} < 0$ |
| 1i. Higher ratings of the emotional demands of the work will significantly positively predict VT. | H0: $\beta_{EmoDem/VT} = 0$<br>H1: $\beta_{EmoDem/VT} > 0$ |

Table 3.2—*Continued.*

| Research Hypotheses | Statistical Hypotheses |
|---|---|
| 1j. Higher ratings of victim-blame by police will significantly positively predict VT. | H0: $\beta_{VB\text{-}P/VT} = 0$<br>H1: $\beta_{VB\text{-}P/VT} > 0$ |
| 1k. Higher ratings of victim-blame by medical staff will significantly positively predict VT. | H0: $\beta_{VB\text{-}M/VT} = 0$<br>H1: $\beta_{VB\text{-}M/VT} > 0$ |
| 2a. Higher age will significantly positively predict VPTG. | H0: $\beta_{Age/VPTG} = 0$<br>H1: $\beta_{Age/VPTG} > 0$ |
| 2b. Higher education level will significantly positively predict VPTG. | H0: $\beta_{Edu/VPTG} = 0$<br>H1: $\beta_{Edu/VPTG} > 0$ |
| 2c. Higher amounts of experience as a RCMA will significantly positively predict VPTG. | H0: $\beta_{Exp/VPTG} = 0$<br>H1: $\beta_{Exp/VPTG} > 0$ |
| 2d. Higher caseload will significantly negatively predict VPTG. | H0: $\beta_{Case/VPTG} = 0$<br>H1: $\beta_{Case/VPTG} < 0$ |
| 2e. Higher amounts of formal individual supervision will significantly positively predict VPTG. | H0: $\beta_{IndSup/VPTG} = 0$<br>H1: $\beta_{IndSup/VPTG} > 0$ |
| 2f. Higher amounts of formal group supervision will significantly positively predict VPTG. | H0: $\beta_{GrpSup/VPTG} = 0$<br>H1: $\beta_{GrpSup/VPTG} > 0$ |
| 2g. Higher ratings of social community at work will significantly positively predict VPTG. | H0: $\beta_{SocCom/VPTG} = 0$<br>H1: $\beta_{SocCom/VPTG} > 0$ |

Table 3.2—*Continued.*

| Research Hypotheses | Statistical Hypotheses |
|---|---|
| 2h. Higher ratings of the meaning of the work will significantly positively predict VPTG. | H0: $\beta_{Meaning/VPTG} = 0$<br>H1: $\beta_{Meaning/VPTG} > 0$ |
| 2i. Higher ratings of the emotional demands of the work will significantly positively predict VPTG. | H0: $\beta_{EmoDem/VPTG} = 0$<br>H1: $\beta_{EmoDem/VPTG} > 0$ |
| 2j. Higher ratings of victim-blame by police will significantly positively predict VPTG. | H0: $\beta_{VB\text{-}P/VPTG} = 0$<br>H1: $\beta_{VB\text{-}P/VPTG} > 0$ |
| 2k. Higher ratings of victim-blame by medical staff will significantly positively predict VPTG. | H0: $\beta_{VB\text{-}M/VPTG} = 0$<br>H1: $\beta_{VB\text{-}M/VPTG} > 0$ |

Table 3.3

*Hierarchical Regressions for Variables Predicting Vicarious Trauma and Vicarious Posttraumatic Growth*

| |
|---|
| Step 1: |
| Age |
| Education |
| Experience as a RCMA |
| Step 2: |
| Caseload |
| Amount of Formal Individual Supervision Received |
| Amount of Formal Group Supervision Received |
| Step 3: |
| Social Community at Work |
| Meaning of the Work |
| Emotional Demands of the Work |
| Step 4: |
| Perceptions of Witnessing Victim-Blame by Medical Providers |
| Perceptions of Witnessing Victim-Blame by Police |

*Note*. Each step includes all variables from the previous steps.

## Chapter Four: Results

Preliminary analyses were conducted to test assumptions for regression. Relationships between participants' demographic characteristics and the outcome variables were assessed, patterns of missing data were examined, outliers were identified and removed, scales were checked for normality and transformed using the logarithm transformations option in SPSS if necessary, and multicollinearity was assessed. Highly skewed variables were transformed in order to guarantee the appropriateness of their inclusion in the regression analysis. Categorical variables were dummy-coded before being included in the regression and correlations between the variables were examined to ensure a low degree of correlation among the predictor variables. The data were then analyzed using a series of hierarchical linear regressions to examine which variables might significantly predicted VT and VPTG. Both regressions included the same 11 independent variables entered in four steps with VT as the dependent variable in the first regression and VPTG as the dependent variable in the second regression.

### Participants

A total of 294 people consented to participate in this online survey. However, four participants did not answer any questions following providing consent, 47 did not answer any questions after endorsing the inclusion criteria of experience as a RCMA, 19 failed to meet inclusion criteria for working as a RCMA, and seven more did not answer the question. Thirty-seven participants either did not respond to the question assessing caseload in the previous year or answered 0. Sixty participants did not provide their ages, and eight responded that their gender was mostly male. This resulted in 129 participants being removed from the data analysis for failure to meet inclusion criteria (with some

participants meeting more than one exclusion criterion), and a final sample of 165 female participants over the age of 18 who had provided rape crisis medical advocacy services in the previous year, as specified for inclusion this study. However, one additional participant withdrew half-way through the survey, did not complete 80% of any dependent measure, and was subsequently dropped from the analysis. Subsequent analysis indicated that those who did not provide their ages also failed to complete 80% of the dependent measures, supporting that they would have been removed from the final analysis, most likely due to attrition due to the length of the survey, as age was one of the final questions presented to participants. The final sample consisted of 164 individuals who provided enough data (80% of items) to be included in the final analysis. Procedures for handling missing data will be addressed later.

**Descriptive Statistics**

**Participant characteristics.** The final sample consisted of 164 women who were predominantly White, in their mid-thirties, with a Bachelor's degree or higher, and who had about five years of experience providing rape crisis medical advocacy. The average age of participants was 38.26 (*SD* = 13.21). The majority of the sample identified as European American (81.1%), followed by of multiple ethnic origins (8.5%), of Hispanic origin (4.3%), of Native American origin (1.8%), of African origin (1.2%), and of Asian origin (.6%). An additional 1.8% of respondents selected the "Other Ethnicity" category. Most respondents endorsed having completed a Bachelor's degree (41.5%) or Master's degree (39.6%), with .6% having completed a terminal high school diploma or GED, 9.8% having attended some college, 4.3% having completed an Associate's degree, and 4.3% having completed a Doctorate degree. The average amount of experience as a

RCMA was 5.35 years (*SD* = 5.51), with a median of 3.46 years providing RCMA services. Overall, RCMAs' amount of experience ranged from .08 years to 39 years. Fifty-seven percent of RCMAs who participated in this study indicated that they received monetary compensation for their work as advocates. The mean caseload observed in this sample was 12.74 (*SD* = 26.78), with a median caseload of 6.00, and a range of one to 300 events of providing medical advocacy services in the previous year. Removing one extreme outlier who endorsed providing 300 cases of RCMA services in the previous year resulted in a mean of 10.98 (*SD* = 14.54), with a median of 6, and a range of one to 100 (see Table 4.1). This outlier was removed from subsequent analyses.

**Relation of participant characteristics to study measures.** Preliminary analyses were conducted to assess for relationships between participants' demographic characteristics and outcome variables before running the regressions. One-way ANOVA comparisons of categorical demographic variables with VT and VPTG are presented in Table 4.2. Significant mean differences between the level of the categorical variables and the study variables were identified using Tukey's HSD post hoc comparisons.

Product-moment correlations indicated that age was significantly negatively associated with ratings of VT ($r = -.33$, $p < .01$), and with ratings of VPTG ($r = -.16$, $p < .05$). Ratings of VT $F(4, 159) = 3.66$, $p < .01$ varied significantly by age. Post hoc comparisons demonstrated that participants aged 18-29 reported significantly higher ratings of VT (*M* = 177.96, *SD* = 45.84) than those aged 60 and above (*M* = 129.27, *SD* = 30.31). Ratings of VPTG $F(4, 159) = 3.80$, $p < .01$ also varied significantly by age. Post hoc comparisons demonstrated that participants aged 18-29 (*M* = 60.80, *SD* = 20.49) reported significantly more VPTG than those aged 30-39 (*M* = 45.69, *SD* = 23.83).

Participants reported education as highest level of education completed. Product-moment correlations demonstrated that education was mildly but significantly correlated with ratings of VPTG ($r$ = -.23, $p$ < .01), but not with ratings of VT. However, ratings of VPTG did not significantly vary by level of education $F(5, 158) = 2.01$, $p = .02$ in the ANOVA, but did demonstrate tendency toward a trend. Neither ratings of VT nor VPTG differed significantly by ethnicity.

**Missing Data Considerations**

Initial visual inspection of the complete data set of 294 revealed a large amount of missing data, which appeared to be attributable mostly to attrition, or participants closing their browser window before completing the entire survey, and hence failing to complete at least 80% of the dependent measures. In addition, the author was informed by several agency directors that they previewed the survey prior to distributing the link to advocates, without fully completing the survey themselves at that time. As such, missing data appears to be related to a combination of general attrition (withdrawing from the survey was as simple as closing the browser window) and previewing of the survey by agency directors to ensure appropriateness of distribution to advocates. Identifying participants who began the survey, did not complete it at that time, and later returned to complete the survey was not possible due to efforts to protect participants' identities by not collecting ip addresses or unique identifiers. After removing the 129 participants who did not satisfy all inclusion criteria as defined for this study, only one other participant failed to complete at least 80% of the dependent measures and was removed from the analysis. Subsequent analysis indicated that those who did not provide their age also failed to complete 80% of the dependent measures, supporting that they would have been removed

from the analysis for either of these two reasons. This overall pattern of missing data appeared to be the result of a high level of general attrition in this study.

Schlomer, Bauman, and Card's (2010) and Osborne's (2013) best practices for addressing missing data were used to guide this study. First, possible patterns of missing data were assessed. Little's Missing Completely at Random (MCAR) test (Schlomer et al., 2010) was used to assess the null hypothesis that missing data were due to completely randomness. Failure to reject the null hypothesis suggests participant oversight of an item or other act not related to the data. Missing items for posttraumatic growth ($\chi^2(100) = 89.89$, $p = .76$), emotional demands of the work ($\chi^2(2) = 2.49$, $p = .29$), meaning of work ($\chi^2(4) = 2.26$, $p = .69$), social community at work ($\chi^2(2) = .09$, $p = .96$), perceptions of witnessing victim-blame by medical staff ($\chi^2(257) = 269.72$, $p = .28$), and perceptions of witnessing victim-blame by police ($\chi^2(338) = 338.23$, $p = .49$) were found to be MCAR, as the null hypothesis on Little's MCAR was not rejected for the measure(s) assuming an alpha level of .05. However, missing data for vicarious trauma ($\chi^2(3378) = 3731.77$, $p = .00$) could not be considered MCAR, suggesting that missingness might be associated with other study variables.

I created a dummy code (0 *no missing data*; 1 *missing data*) to examine the pattern of missing data on the scale assessing ratings of VT and associations with demographic variables. Missingness varied significantly by ethnicity $F(6, 156) = 2.40$, $p < .05$. I created dummy codes for ratings of ethnicity to examine patterns of missing data across ethnic identification. Missing data on the measure of VT were significantly associated with ethnic identity as Latina ($F(1, 161) = 4.76$, $p < .05$) and Multiracial ($F(1, 161) = 4.73$, $p < .05$), indicating that individuals identifying with these ethnicities were

more likely to omit items in this measure, but not on the other measures utilized in this study. The following procedures for imputing missing data should have been able to address this pattern appropriately.

Responding to missing data was guided by Schlomer et al. (2010) and Osborne (2013). Pearlman (2003) suggested that cases with 20% or greater missing data be excluded from analyses for the measure assessing vicarious trauma. This threshold was adopted for both dependent measures. After removing the 129 participants who did not satisfy all inclusion criteria, only one other participant failed to complete at least 80% of the dependent measures and was subsequently removed from the analysis. Missing items in this study were imputed using multiple imputation (MI). Multiple imputation creates "multiple versions of the same data set...that explore the scope and effect of the missing data" resulting in estimates and confidence intervals that are more robust than simple (especially relatively weak) imputation" (Osborne, 2013, p. 125).

> The analyses are carried out on each data set, with the parameter estimates (e.g., factor loadings, group mean differences, correlations, regression coefficients) and their standard errors save for each data set. Final results are obtained by averaging the parameter estimates across these multiple analyses, which results in an unbiased parameter estimate...the final standard errors of these parameter statistics are based on both (a) the standard errors of the analysis of each data set and (b) the dispersion of parameter estimates across data sets. These combined standard errors from the multiply imputed data sets are used for significance testing and/or construction of confidence intervals around these parameter estimates. By accounting for the random fluctuations that occur between each

> imputation run, the MI procedure provides accurate standard errors and therefore accurate inferential conclusions. (Schlomer et al., 2010, p. 5)

Osborne (2013) argues that the advantage of MI is increased generalizability and replicability as a result of explicitly modeling the missingness and providing confidence intervals. Additionally, MI is one of the few procedures for imputing missing data that is appropriate for imputing data that are missing not at random (MNAR). In addition, MI is also appropriate for addressing any highly-biased MNAR-inverse relationships (Osborne, 2013; Schafer, 1999). Three to five imputations with MI are generally considered sufficient when presented with relatively low proportions of missing data (Osborne, 2013; Schafer, 1999; Schlomer et al., 2010). As such, five imputations were judged to be sufficient for use in this study, as adhering to the very conservative inclusion criteria resulted in a very low level of missing data in the final data set. The SPSS software presents the results of the MI as either pooled data or the result of the final imputation. As such, the pooled results were reported in this study where available, and results from the fifth and final imputation were reported if pooled results were not available.

**Scale Findings**

Analysis of scale descriptives in the present sample demonstrated moderate to high ratings of the emotional demands of the work ($M$ = 3.80, $SD$ = .60, range = 2.50), the social community at work ($M$ = 4.28, $SD$ = .68, range = 4.00), and the meaning of the work ($M$ = 4.54, $SD$ = .49, range = 2.67); moderate, or what Pearlman (2003) described as average, ratings of vicarious trauma ($M$ = 166.37, $SD$ = 43.71, range = 204.00); and moderate ratings of posttraumatic growth ($M$ = 53.31, $SD$ = 25.05, range = 102.00), perceptions of witnessing victim-blame by medical personnel ($M$ = 40.81, $SD$ = 6.17,

range = 33.00), and perceptions of witnessing victim-blame by police (*M* = 47.68, *SD* = 7.52, range = 41.00).

**Evaluation of Inferential Assumptions**

Measures of distribution, central tendency, dispersion, and internal consistency can be found in Table 4.3. Cronbach's alpha indicated adequate internal consistency for all scales. Normality was assessed for each scale. Scores on the emotional demands of the work, VT, VPTG, VBM, and VBP were normally distributed. Ratings of caseload, years of experience, amount of formal individual supervision, and amount of formal group supervision were positively skewed above 2.0, and ratings of the social community at work and meaning of the work were positively skewed above 1.0. Deviations from 0 suggest an asymmetrical distribution of scores, and skewness above 1.0 suggests an increased chance of committing a Type I or Type II error. Transforming highly skewed variables can reduce this risk. Ratings of caseload, years of experience, and amount of formal individual and group supervision were transformed for the analyses using the logarithm transformations option in SPSS. After transformation, all scales conformed to assumptions of normality. Ratings of the social community at work and meaning of the work were not transformed, resulting in a slightly leptokurtic distribution of scores.

Levene's (1960) test was used to assess for homogeneity of variance. Levene's (1960) test indicated that the variance between all variables was homoscedastic. Failing to reject the null hypothesis for Levene's (1960) test indicates that there were no significant deviations in the distribution of the variance across groups in this study.

**Inferential Statistical Analysis**

The alpha level for all tests was set at .05. Effect sizes for the model were reported as $R^2$, the amount of variance accounted for in the observed effect. The additional incremental variance accounted for at each step in the model was reported as $\Delta R^2$. SPSS 21 was used to conduct each analysis.

**Bivariate analysis.** Pearson's product-moment correlations (see Table 4.4) revealed that ratings of VT were significantly and negatively correlated with ratings of the social community at work and the meaning of the work. Ratings of VPTG were significantly and positively associated with amount of formal individual supervision received. Participants who reported higher ratings of VPTG also reported receiving significantly higher amounts of formal individual supervision. VBM was significantly and negatively related to social community at work, and positively related to amount of formal individual supervision received and ratings of VBP. VBP was significantly and positively related to experience, caseload, amount of formal individual supervision received, and ratings of VBM, and significantly negatively related to social community at work.

**Regressions for individual predictions.** Two hierarchical linear regressions were conducted to test the relative influence of the variables on ratings of VT and VPTG. Hierarchical linear regressions were performed to assess whether the two groups of the six systemic-level variables (caseload, amount of formal individual supervision, and amount of formal group supervision at step two; perceptions of the meaning of the work, the emotional demands of the work, and social community at work at step three), significantly added to the variance accounted for in the model after the variability

accounted for by the group of the three individual-level variables (age, education level, and amount of experience at step one) was determined. Finally, perceptions of witnessing victim-blame by police and perceptions of witnessing victim-blame by medical staff were included in the last step to assess for any additional variance in the model accounted for by witnessing what has been defined in this study as revictimization. Each regression was based on the same model, with the three individual-level variables of age, education level, and amount of experience entered in the first step; caseload, amount of formal individual supervision, and amount of formal group supervision in the second step, the COPSOQ subscales of the meaning of the work, the emotional demands of the work, and the social community at work entered in the third step; and perceptions of witnessing victim-blame by police and perceptions of witnessing victim-blame by medical staff in the fourth and final step. Findings by hypothesis are presented in Table 4.5.

***Prediction of ratings of vicarious trauma.*** Results of the regression to predict ratings of VT indicated that the model predicted VT at step 1 and step 3. Overall, the variables accounted for 24% of the variance in ratings of VT (see Table 4.6). Age ($t$ = -2.69, $p$ <.05) negatively predicted ratings of VT at step 1, amount of formal group supervision received ($t$ = -2.02, $p$ <.05) negatively predicted ratings of VT at step 2, and ratings of the social community at work ($t$ = -2.07, $p$ <.05) and meaning of the work ($t$ = -2.99, $p$ <.01) negatively predicted ratings of VT at step 3. No variables predicted VT at step 4. As such, hypotheses 1f, 1g, and 1h were supported, and hypotheses 1a, 1b, 1c, 1d, 1e, 1i, 1j, and 1k were not supported.

***Prediction of ratings of vicarious posttraumatic growth***. Results of the regression to predict ratings of VPTG indicate that the model predicted VT at step 1. The model did not predict ratings of VPTG at step 2, step 3, or step 4, though a trend toward significance was demonstrated at step 3. Overall, the variables accounted for 15% of the variance in ratings of VPTG (see Table 4.7). Age ($t$ = -2.14, $p$ <.05) negatively predicted VPTG at step 1. Educational achievement ($t$ = -2.17, $p$ <.05) negatively predicted ratings of VPTG at step 2, and amount of formal individual supervision ($t$ = 1.98, $p$ <.05) positively predicted ratings of VPTG at step 2. As such, hypothesis 2e was supported, and hypotheses 2a,2b, 2c, 2d, 2f, 2g, 2h, 2i, 2j, and 2k were not supported.

**Summary of Results**

Results of the analyses indicated that ratings of VT were significantly negatively predicted by amount of formal group supervision received, the social community at work, and the meaning of the work, with lower ratings of amount of formal group supervision received, the social community at work, and the meaning of the work predicting higher ratings of VT. Ratings of VPTG were positively predicted by amount of formal individual supervision received, with higher amounts of formal individual supervision received predicting higher ratings of VPTG. Despite the results observed in the regression analyses, age was not significantly predictive of VT, and neither age nor educational achievement were significantly predictive of VPTG, due to the observed effects occurring in the opposite directions than originally hypothesized.

Table 4.1

*Participant Demographics (n = 164)*

| Variable | *n* | % |
|---|---|---|
| Employment Status | | |
| Paid Employee | 94 | 57.3 |
| Volunteer | 70 | 42.7 |
| Race/Ethnicity | | |
| Of African Origin | 2 | 1.2 |
| Of Asian Origin | 1 | 0.6 |
| Of European Origin | 133 | 81.1 |
| Of Hispanic Origin | 7 | 4.3 |
| Of Native American Origin | 3 | 1.8 |
| Of Multiple Ethnic Origin | 14 | 8.5 |
| Other | 3 | 1.8 |
| Age ($M$ = 38.27, $SD$ = 13.22) | | |
| 18 to 29 years | 59 | 36.0 |
| 30 to 39 years | 49 | 28.0 |
| 40 to 49 years | 20 | 12.2 |
| 50 to 59 years | 21 | 12.8 |
| 60 years and greater | 18 | 11.0 |
| Education | | |
| Grammar School | 0 | 0.0 |
| High School or GED | 1 | 0.6 |

Table 4.1—*Continued.*

| Variable | *n* | % |
|---|---|---|
| Some College | 16 | 9.8 |
| Associate's Degree | 7 | 4.3 |
| Bachelor's Degree | 68 | 41.5 |
| Master's Degree | 65 | 39.6 |
| Specialist's Degree | 0 | 0.0 |
| Doctorate Degree | 7 | 4.3 |

Table 4.2

*One-Way Analysis of Variance Summary Table for Categorical Demographic and Study Variables (n = 164)*

| Outcome | Variable | *df* | *F* | *p* |
|---|---|---|---|---|
| VT | Age | 4 | 3.3** | .01 |
| | Education | 5 | .79 | .56 |
| | Ethnicity | 7 | 1.12 | .35 |
| VPTG | Age | 4 | 3.70** | .01 |
| | Education | 5 | 1.98 | .08 |
| | Ethnicity | 7 | .90 | .51 |

*Note*. Age was reported as a whole number. For the purpose of comparison, age was binned into 5 categories: 18 to 29 years, 30 to 39 years, 40 to 49 years, 50 to 59 years, and 60 years or greater. * $p < .05$; ** $p < .01$.

Table 4.3

*Summary of Inferential Assumptions Characteristics (n = 164)*

| | Distribution | | Central Tendency | | Dispersion | |
|---|---|---|---|---|---|---|
| Variable | Kurtosis (*SE*) | Skewness (*SE*) | Mdn | *M* | *SD* | *SEM* |
| Predictors | | | | | | |
| Experience | .92 (.38) | -.73 (.19) | .54 | .51 | .48 | .38 |
| Caseload | .34 (.38) | .43 (.19) | .78 | .81 | .46 | .04 |
| IND SUP | .57 (.38) | .89 (.19) | .30 | .37 | .37 | .25 |
| GRP SUP | - .28 (.38) | .70 (.19) | .30 | .32 | .33 | .29 |
| SOC | 2.77 (.38) | -1.22 (.19) | 4.33 | 4.29 | .68 | .05 |
| MEANING | 3.12 (.38) | -1.46 (.19) | 4.67 | 4.54 | .49 | .04 |
| EMO | -.57 (.38) | -.21 (.19) | 3.75 | 3.80 | .61 | .05 |
| VBM | .19 (.38) | .13 (.19) | 41.00 | 40.78 | 5.90 | .46 |
| VBP | .91 (.38) | .67 (.19) | 46.02 | 47.82 | 7.06 | .55 |
| Outcomes | | | | | | |
| VT | -.61 (.38) | -.10 (.19) | 53.50 | 53.24 | 24.59 | 1.92 |
| VPTG | 1.55 (.38) | .84 (.19) | 164.90 | 166.09 | 37.33 | 2.92 |

*Note*. IND SUP = Amount of Formal Individual Supervision Received, GRP SUP = Amount of Formal Group Supervision Received, SOC = Social Community at Work, MEANING = Meaning of the Work, EMO = Emotional Demands of the Work, VBM = Perceptions of Victim-Blame by Medical Providers, VBP = Perceptions of Victim-Blame by Police, VT = Vicarious Traumatization; VPTG = Vicarious Posttraumatic Growth.

Table 4.4

*Summary of Descriptive Statistics and Bivariate Correlations for Vicarious Traumatization and Posttraumatic Growth (n = 164)*

| | Variable | M | *SD* | Product-Moment Correlations | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 1. | Age | 38.27 | 13.22 | | | | | | | | | | | | |
| 2. | EDU | 5.23 | 1.01 | -.03 | | | | | | | | | | | |
| 3. | EXP | .51 | .48 | .51** | .12 | | | | | | | | | | |
| 4. | CASE | .81 | .46 | .10 | -.05 | .14 | | | | | | | | | |
| 5. | INSUP | .37 | .37 | -.00 | -.14 | -.09 | .01 | | | | | | | | |
| 6. | GRSUP | .32 | .32 | .05 | -.17* | .03 | .07 | 39** | | | | | | | |
| 7. | SOC | 4.30 | .68 | .04 | -.04 | -.05 | -.00 | -.11 | -.14 | | | | | | |
| 8. | MEAN | 4.54 | .49 | .01 | -.05 | .03 | .08 | -.17* | .15 | .50** | | | | | |
| 9. | EMO | 3.80 | .61 | -.02 | .01 | .09 | .02 | .06 | .16* | -.03 | .12 | | | | |
| 10. | VBM | 40.78 | 5.90 | -.11 | .05 | -.01 | .01 | .16* | .03 | -.22* | -.12 | .00 | | | |
| 11. | VBP | 47.82 | 7.06 | .18 | -.03 | 26** | .17* | .16* | .07 | -.16* | -.13 | -.06 | .38** | | |
| 12. | VT | 166.09 | 37.33 | -.27** | -.03 | -.19* | -.13 | .01 | -.08 | -.30** | -.32** | .07 | .13 | .00 | |
| 13. | VPTG | 53.24 | 24.59 | -.15 | -.21** | -.10 | .10 | .19* | .11 | .12 | .12 | -.09 | -.01 | -.01 | -.01 |

*Note*. EDU = Highest Education Received, EXP = Amount of Experience, CASE = Caseload, INSUP = Amount of Formal Individual Supervision Received, GRSUP = Amount of Formal Group Supervision Received, SOC = Social Community at Work, MEAN = Meaning of the Work, EMO = Emotional Demands of the Work, VBM = Perceptions of Victim-Blame by Medical Providers, VBP = Perceptions of Victim-Blame by Police, VT = Vicarious Traumatization; VPTG = Posttraumatic Growth. * $p < .05$; ** $p < .01$

Table 4.5

*Summary of Hierarchical Regressions for Variables Predicting Vicarious Traumatization (n = 164)*

| Predictor | *B* | *SE* | β | $R^2$ | $\Delta R^2$ | *F* |
|---|---|---|---|---|---|---|
| | | | Individual-Level Variables | | | |
| Step 1 | | | | .09 | .09** | 5.21** |
| Constant | 203.30*** | 17.58 | | | | |
| Age | -.76** | .25 | -.27 | | | |
| Education | -1.18 | 2.83 | .03 | | | |
| Experience | -3.65 | 6.90 | -.05 | | | |
| | | | Agency-Level Variables | | | |
| Step 2 | | | | .11 | .02 | 3.10** |
| Constant | 211.44*** | 19.23 | | | | |
| Age | -.76** | .25 | -.27 | | | |
| Education | -1.55 | 2.89 | -.04 | | | |
| Experience | -2.32 | 6.93 | -.03 | | | |
| Caseload | -7.35 | 6.16 | -.09 | | | |
| IND SUP | 3.55 | 8.64 | .04 | | | |
| GRP SUP | -1.25* | 1.10 | -.10 | | | |
| | | | Work Environment Variables | | | |
| Step 3 | | | | .24 | .14*** | 5.44*** |
| Constant | 317.13*** | 35.10 | | | | |
| Age | -.66** | .24 | -.24 | | | |
| Education | -2.99 | 2.71 | -.08 | | | |
| Experience | -4.22 | 6.51 | -.06 | | | |

Table 4.5—

*Continued.*

| Predictor | *B* | *SE* | β | $R^2$ | $\Delta R^2$ | *F* |
|---|---|---|---|---|---|---|
| Caseload | -5.98 | 5.76 | -.07 | | | |
| IND SUP | -.96 | 8.10 | -.01 | | | |
| GRP SUP | -2.13* | 1.04 | -.16 | | | |
| EMO DEM | 7.92 | 4.55 | .13 | | | |
| SOC COM | -9.62* | 4.47 | -.18 | | | |
| MEANING | -19.26** | 6.40 | -.25 | | | |
| | | Perceptions of Victim-Blame | | | | |
| Step 4 | | | | .24 | .00 | 4.45*** |
| Constant | 303.68*** | 45.19 | | | | |
| Age | -.61** | .24 | -.23 | | | |
| Education | -3.01 | 2.73 | -.08 | | | |
| Experience | -4.39 | 6.77 | -.06 | | | |
| Caseload | -5.94 | 5.84 | -.07 | | | |
| IND SUP | -1.72 | 8.32 | -.02 | | | |
| GRP SUP | -2.13* | 1.05 | -.16 | | | |
| EMO DEM | 7.89 | 4.61 | .13 | | | |
| SOC COM | -9.11* | 4.56 | -.17 | | | |
| MEANING | -19.38** | 6.46 | -.25 | | | |
| VBM | .33 | .51 | .05 | | | |
| VBP | -.42 | .44 | -.01 | | | |

*Note*. IND SUP = Amount of Individual Formal Supervision Received, GRP SUP = Amount of Formal Group Supervision Received, SOC COM = Social Community at Work, MEANING =

Meaning of the Work, EMO DEM = Emotional Demands of the Work, VBM = Perceptions of Victim-Blame by Medical Providers, VBP = Perceptions of Victim-Blame by Police.* $p < .025$; ** $p < .005$; *** $p < .001$.

Table 4.6

*Summary of Hierarchical Regressions for Variables Predicting Posttraumatic Growth (n = 164)*

| Predictor | *B* | *SE* | β | $R^2$ | $\Delta R^2$ | *F* |
|---|---|---|---|---|---|---|
| | | | Individual-Level Variables | | | |
| Step 1 | | | | .08 | .08** | 4.35** |
| Constant | 94.30*** | 11.67 | | | | |
| Age | -.31 | .17 | -.17 | | | |
| Education | -5.66** | 1.88 | -.23 | | | |
| Experience | 1.05 | 4.56 | .02 | | | |
| | | | Agency-Level Variables | | | |
| Step 2 | | | | .11 | .04 | 3.31** |
| Constant | 81.38*** | 12.62 | | | | |
| Age | -.32 | .16 | -.17 | | | |
| Education | -4.73* | 1.90 | -.19 | | | |
| Experience | .78 | 4.55 | .02 | | | |
| Caseload | 5.05 | 4.04 | .10 | | | |
| IND SUP | 10.41 | 5.67 | .16 | | | |
| GRP SUP | .27 | .72 | .03 | | | |
| | | | Work Environment Variables | | | |
| Step 3 | | | | .16 | .04 | 3.13** |
| Constant | 58.26* | 24.41 | | | | |
| Age | -.37* | .16 | -.20 | | | |
| Education | -4.27* | 1.88 | -.17 | | | |
| Experience | 1.86 | 4.53 | .04 | | | |
| Caseload | 4.73 | 4.01 | .09 | | | |

Table 4.6—

*Continued.*

| Predictor | *B* | *SE* | β | $R^2$ | $\Delta R^2$ | *F* |
|---|---|---|---|---|---|---|
| IND SUP | 11.71** | 5.64 | .17 | | | |
| GRP SUP | .67 | .73 | .08 | | | |
| EMO DEM | -5.31 | 3.17 | -.13 | | | |
| SOC COM | 3.31 | 3.10 | .09 | | | |
| MEANING | 5.93 | 4.46 | .12 | | | |
| | | | Perceptions of Victim-Blame | | | |
| Step 4 | | | | .16 | .00 | 2.53** |
| Constant | 63.21* | 31.47 | | | | |
| Age | -.37* | .17 | -.20 | | | |
| Education | -4.30* | 1.90 | -.18 | | | |
| Experience | 2.12 | 4.72 | .04 | | | |
| Caseload | 4.72 | 4.10 | .09 | | | |
| IND SUP | 12.01* | 5.80 | .18 | | | |
| GRP SUP | .67 | .73 | .08 | | | |
| EMO DEM | -5.38 | 3.21 | -.13 | | | |
| SOC COM | 3.20 | 3.18 | .09 | | | |
| MEANING | 5.90 | 4.50 | .12 | | | |
| VBM | -.04 | .35 | -.01 | | | |
| VBP | -.05 | .31 | -.01 | | | |

*Note*. IND SUP = Amount of Formal Individual Supervision Received, GRP SUP = Amount of Formal Group Supervision Received, SOC COM = Social Community at Work, MEANING = Meaning of the Work, EMO DEM = Emotional Demands of the Work, VBM = Perceptions of

Victim-Blame by Medical Providers, VBP = Perceptions of Victim-Blame by Police.* $p < .025$; ** $p < .005$; *** $p < .001$.

Table 4.7

*Results of Hypothesis Testing*

| Research Hypotheses | Statistical Hypotheses | Findings |
|---|---|---|
| 1a. Higher age will significantly positively predict VT. | H0: $\beta_{Age/VT} = 0$<br>H1: $\beta_{Age/VT} > 0$ | 1a. not supported |
| 1b. Higher amounts of education will significantly negatively predict VT. | H0: $\beta_{Edu/VT} = 0$<br>H1: $\beta_{Edu/VT} < 0$ | 1b. not supported |
| 1c. Higher amounts of experience providing rape crisis medical advocacy services will significantly positively predict VT. | H0: $\beta_{Exp/VT} = 0$<br>H1: $\beta_{Exp/VT} < 0$ | 1c. not supported |
| 1d. Higher caseloads will significantly positively predict higher levels of VT. | H0: $\beta_{Case/VT} = 0$<br>H1: $\beta_{Case/VT} > 0$ | 1d. not supported |
| 1e. Higher amounts of formal individual supervision will significantly negatively predict VT. | $H_0$: $\beta_{IndSup /VT} = 0$<br>$H_1$: $\beta_{IndSup /VT} < 0$ | 1e. not supported |
| 1f. Higher amounts of formal group supervision will significantly negatively predict VT. | $H_0$: $\beta_{GrpSup /VT} = 0$<br>$H_1$: $\beta_{GrpSup /VT} < 0$ | 1f. supported |
| 1g. Higher ratings of social community at work will significantly negatively predict VT. | H0: $\beta_{SocCom/VT} = 0$<br>H1: $\beta_{SocCom /VT} < 0$ | 1g. supported |
| 1h. Higher ratings of the meaning of the work will significantly negatively predict VT. | H0: $\beta_{Meaning/VT} = 0$<br>H1: $\beta_{Meaning/VT} < 0$ | 1h. supported |

Table 4.7—*Continued.*

| Research Hypotheses | Statistical Hypotheses | Findings |
|---|---|---|
| 1i. Higher ratings of emotional demands of the work will significantly positively predict VT. | H0: $\beta_{EmoDem/VT} = 0$<br>H1: $\beta_{EmoDem/VT} > 0$ | 1i. not supported |
| 1j. Higher ratings of victim-blame by police will significantly positively predict VT. | H0: $\beta_{VB\text{-}P/VT} = 0$<br>H1: $\beta_{VB\text{-}P/VT} > 0$ | 1j. not supported |
| 1k. Higher ratings of victim-blame by medical staff will significantly positively predict VT. | H0: $\beta_{VB\text{-}M/VT} = 0$<br>H1: $\beta_{VB\text{-}M/VT} > 0$ | 1k. not supported |
| 2a. Higher age will significantly positively predict VPTG. | H0: $\beta_{Age/VPTG} = 0$<br>H1: $\beta_{Age/VPTG} > 0$ | 2a. not supported |
| 2b. Higher education level will significantly positively predict VPTG. | H0: $\beta_{Edu/VPTG} = 0$<br>H1: $\beta_{Edu/VPTG} > 0$ | 2b. not supported |
| 2c. Higher amounts of experience as a RCMA will significantly positively predict VPTG. | H0: $\beta_{Exp/VPTG} = 0$<br>H1: $\beta_{Exp/VPTG} > 0$ | 2c. not supported |
| 2d. Higher caseload will significantly negatively predict VPTG. | H0: $\beta_{Case/VPTG} = 0$<br>H1: $\beta_{Case/VPTG} < 0$ | 2d. not supported |
| 2e. Higher amounts of formal individual supervision will significantly positively predict VPTG. | H0: $\beta_{IndSup/VPTG} = 0$<br>H1: $\beta_{IndSup/VPTG} > 0$ | 2e. supported |
| 2f. Higher amounts of formal group supervision will significantly positively predict VPTG. | H0: $\beta_{GrpSup/VPTG} = 0$<br>H1: $\beta_{GrpSup/VPTG} > 0$ | 2f. not supported |

Table 4.7—*Continued.*

| Research Hypotheses | Statistical Hypotheses | Findings |
|---|---|---|
| 2g. Higher ratings of social community at work will significantly positively predict VPTG. | H0: $\beta_{SocCom/VPTG} = 0$<br>H1: $\beta_{SocCom/VPTG} > 0$ | 2g. not supported |
| 2h. Higher ratings of the meaning of the work will significantly positively predict VPTG. | H0: $\beta_{Meaning/VPTG} = 0$<br>H1: $\beta_{Meaning/VPTG} > 0$ | 2h. not supported |
| 2i. Higher ratings of the emotional demands of the work will significantly positively predict VPTG. | H0: $\beta_{EmoDem/VPTG} = 0$<br>H1: $\beta_{EmoDem/VPTG} > 0$ | 2i. not supported |
| 2j. Higher ratings of victim-blame by police will significantly positively predict VPTG. | H0: $\beta_{VB\text{-}P/VPTG} = 0$<br>H1: $\beta_{VB\text{-}P/VPTG} > 0$ | 2j. not supported |
| 2k. Higher ratings of victim-blame by medical staff will significantly positively predict VPTG. | H0: $\beta_{VB\text{-}M/VPTG} = 0$<br>H1: $\beta_{VB\text{-}M/VPTG} > 0$ | 2k. not supported |

## Chapter Five: Discussion and Conclusions

In this chapter I will review the findings of the present research study and compare these findings with the established literature reviewed in the previous chapters. I will highlight the importance of these findings to the advocacy field and provide recommendations for how these findings can be utilized to improve the unique work-life experiences of RCMAs. I will review the strengths and limitations of the present study, and suggest future directions for subsequent research examining the impact of providing advocacy services on RCMAs, specifically focused on the influence of contextual variables on the development of VT and VPTG among RCMAs.

### Review of Results and Comparisons With Established Literature

Results of the present study indicated that higher ratings of VT were predicted by lower amounts of formal group supervision received, lower ratings of the social community at work, and lower ratings of the meaning of the work. Despite the results observed in the regression analysis, age could not be considered predictive of VT in this study, as the effect observed was in the opposite direction than originally hypothesized. Higher ratings of VPTG were predicted by higher amounts of formal individual supervision received. Despite the results observed in the regression analysis, neither age nor education could be considered predictive of VPTG in this study, as the effect observed was in the opposite direction than originally hypothesized.

**Predictors of vicarious traumatization.** Participants in this study reported experiencing what Pearlman (2003) described as average levels of VT, and actually endorsed slightly lower ratings of VT than the nonclinical standardization sample. The mean total score on the measure of VT observed among participants in the present study was 166.37, whereas the mean total score observed among the nonclinical standardization

sample was 187.2 (Pearlman, 2003). It could be that advocates in the present study were more adequately prepared to handle being confronted with trauma than the nonclinical standardization sample, thus protecting them from potentially negative impacts of the work. It could also be that participants in the present study were reluctant to report experiencing trauma reactions due to the stigma associated with helping professionals' painful reactions to their work. Future research should continue to examine advocates' reports of experiencing VT in relation to their work as advocates. Despite participants' relatively average ratings of symptoms of VT, higher ratings of VT were significantly predicted by lower amounts of formal group supervision received, lower ratings of the social community at work, and lower ratings of the meaning of the work.

Pearlman and Mac Ian (1995) found that trauma therapists with the most symptoms were not receiving formal supervision. As such, I initially hypothesized that higher amounts of both formal individual and group supervision received would predict lower ratings of VT. Results of the data analysis supported the hypothesis that amount of formal group supervision received would negatively predicted ratings of VT, but did not support the hypothesis that amount of formal individual supervision received would predict ratings of VT. It may be that formal group supervision served as a protective factor against the development of the negative impacts of exposure to others' trauma in a way that formal individual supervision did not for participants in this study. Amount of formal group supervision received was also significantly and positively correlated with ratings of the emotional demands of the work, perhaps indicating that participants who received more formal group supervision were more aware of the emotional demands of the work, and thus better able to cope with these demands. They may have had more

opportunity to process their experiences with the work with their colleagues than participants with fewer opportunities to engage in formal group supervision. This finding seems especially meaningful in light of the parallel finding that ratings of the social community at work also predicted ratings of VT.

Several researchers have shown that having more access to emotional support from friends, family, and colleagues was associated with lower levels of secondary trauma reactions among mental health professionals (Boscarino et al., 2004). Schauben and Frazier (1995) documented relationships between amount of training, social support, advocate self-efficacy, experiences with victim-blame, ratings of job-satisfaction, and intent to remain advocates. As such, I theorized that several contextual variables, including ratings of specific aspects of the psychosocial work environment, would be predictive of ratings of VT. Bell et al. (2003) argued that "the values and culture of an organization set the expectations about the work. When the work includes contact with trauma, they also set the expectations about how workers will experience trauma and deal with it, both professionally and personally" (p. 466). The messages rape crisis agencies send about how advocates are expected to cope with the traumas to which they are exposed set the tone for how advocates will cope with the work on a daily basis. As such, I predicted that ratings of the quality of social community at work would significantly negatively predict VT. The data analysis confirmed that higher ratings of VT were predicted by lower ratings of the social community at work for the women who participated in this study. Women in this study reported that they perceived a high degree of connection among colleagues, cooperation between colleagues, and feeling a sense of community at their rape crisis agencies, and such aspects of the social community at

work may serve to protect against the development of VT by providing advocates with safe and supportive environments where they feel connected to others and able to emotionally process their experiences providing advocacy. Such environments may facilitate emotional processing, normalization, and validation of advocates' emotional reactions to the often painful and difficult experiences engaging with people in the immediate aftermath of sexual trauma, thus reducing negative impacts such as VT.

Ratings of the social community at work were also significantly and positively correlated with ratings of the meaning of the work. I hypothesized that higher ratings of the meaning of the work would predict lower ratings of VT, and results of the data analysis supported this hypothesis. Participants in this study reported a high degree of meaningfulness of the work, importance of the work, and motivation toward the work. Both ratings of the social community at work and the meaning of the work appear to be important protective factors against the development of VT for women in this study, and these findings are consistent with previous research, especially Schauben and Frazier (1995), who found that the trauma therapists they surveyed found meaning in "the importance of the work and various characteristics of the work environment…([like] support from colleagues)" (p. 57-58). The results of the present study add further support to previous literature highlighting the importance of contextual/environmental contributions to the development of secondary trauma reactions among those who work with survivors of sexual trauma (Bell et al., 2003; Boscarino et al., 2004; Pearlman & Mac Ian, 1995).

**Predictors of vicarious posttraumatic growth.** Results of the present study indicated that participants reported experiencing moderate levels of VPTG, and that

higher ratings of VPTG were predicted by higher amounts of formal individual supervision received. No other variables significantly predicted ratings of VPTG. It could be that, where formal group supervision appeared to buffer against the development of secondary trauma reactions for women in this study, the individual attention received in formal individual supervision somehow helped advocates create positive meaning from their experiences and develop a sense of personal growth from engaging with people in the immediate aftermath of sexual trauma. In other words, formal group supervision appeared to buffer against the negative impacts of providing advocacy and formal individual supervision appeared to facilitate the positive impacts for women in this study. The results of the present study suggest that the types and amounts of formal supervision agencies provide to advocates can moderate the impacts of advocacy work on advocates.

Though no variables other than the amount of formal individual supervision received predicted ratings of VPTG, it is interesting to note that amount of formal individual supervision received was also significantly and positively correlated with ratings of witnessing victim-blame by police and medical staff. It could be that advocates who receive more formal individual supervision are better able to both identify victim-blaming behaviors and to process their experiences witnessing victim-blame in positive and meaningful ways that result in vicarious post-traumatic growth.

**Perceptions of witnessing victim-blame.** Ullman (1999) argued that the negative social reactions victims may experience impact the development of symptoms following rape, and I was interested in examining whether these negative social reactions, such as witnessing victim-blame and revictimization, were involved in the development

of symptomatology among rape crisis medical advocates, who are, at times, present to witness the revictimization. Pearlman and Mac Ian (1995) argued that this ability to empathically engage, to put oneself in others' shoes while they tell you their horror stories, can create an incredibly strong therapeutic alliance, but also puts counselors at risk for developing lasting changes in "enduring ways of experiencing self, others, and the world" (p. 558). Advocates are physically present to assist survivors during the acute rape crisis period, through the forensic exam, a process many sexual trauma survivors have described as a second rape (Campbell et al., 1999; Parrot, 1991), an established time of particular vulnerability and potential retraumatization of victims (Resnick et al., 1999). Several researchers have demonstrated that negative social reactions exacerbate the development of trauma symptomology among primary survivors (George & Martinez, 2002; Resnick et al., 1999; Ullman, 1999; Wasco & Campbell, 2002), as well as among advocates (Campbell et al., 1999; Hellman & House, 2006).

As such, I hypothesized that higher ratings of perceptions of witnessing victim-blame by police and medical care providers would significantly positively predict both VT and VPTG. However, results of the data analysis indicated that neither perceptions of witnessing victim-blame by police nor perceptions of witnessing victim-blame by medical care providers were predictive of ratings of VT or VPTG. However, ratings of perceptions of witnessing victim-blame by medical providers was significantly and positively correlated with amount of formal individual supervision received, which was itself predictive of the development of VPTG, and ratings of perceptions of witnessing victim-blame by medical providers was significantly negatively correlated with ratings of the social community at work, which was itself predictive of the development of VT.

Ratings of perceptions of witnessing victim-blame by police was significantly and positively correlated with amount of experience, caseload, and amount of formal individual supervision received, and was significantly and negatively correlated with ratings of the social community at work. Participants in this study who received more formal supervision, be it in individual or group formats, were more likely to report witnessing victim-blame, but ratings of witnessing victim-blame were not predictive of the development of VT or VPTG. It could be that participants who received more formal supervision were more attuned to perceiving victim-blaming behaviors, though this result does not appear to be related to or predictive of the development of either VT or VPTG. It could be that formal supervision facilitates advocates' awareness of victim-blaming behaviors but also buffers against any negative impacts of witnessing such behaviors. Formal supervision appears to help balance the positive and negative impacts of advocacy work on advocates.

**Summary**

The development of VT among RCMAs who participated in this study was predicted by lower amounts of formal group supervision received, lower ratings of the meaning of the work, and lower ratings of the social community at work. The development of VPTG among RCMAs who participated in this study was predicted by higher amounts of formal individual supervision received. Several systemic/contextual/environmental variables, namely amounts of formal supervision received and ratings of the social community at work, appear to be especially important to the development of VT and VPTG among RCMAs who participated in this study. Several researchers have shown that having more access to emotional support was

associated with lower levels of secondary trauma reactions among mental health professionals (Boscarino et al., 2004; Mitchell & Hodson, 1983; Ortlepp & Friedman, 2002; Schauben & Frazier, 1995). Having a safe space devoted to processing their experiences and receiving support for their work helps RCMAs create positive meaning from their experiences and grow when faced with the suffering of others. Contextual variables such as ratings of the social community at work and amounts of formal supervision received appear to help RCMAs experience their work in a way that minimizes negative impacts and maximizes benefits.

A major aim of this study was to assess the impact of witnessing victim-blame on the development of VT and VPTG among RCMAs. However, the results indicated that perceptions of witnessing victim-blame were not predictive of the development of VT or VPTG, though perceptions of witnessing victim blame by both police and medical staff were positively correlated with amounts of formal supervision received and negatively correlated with ratings of the social community at work. In light of the findings that lower ratings of the social community at work predict higher ratings of VT, rape crisis agencies should consider the relationship between RCMAs' perceptions of witnessing victim-blame and their ratings of the social community at work. Perceptions of witnessing victim-blame may contribute to advocates' perceptions of a less-than-supportive, or even hostile, work environment, which could then contribute to the development of VT in relation to advocacy work. Lacking a safe place to discuss experiences witnessing negative treatment of victims may exacerbate the negative impacts of the work on advocates. Agencies should consider this finding when attempting to balance the difficulties of providing comprehensive and sensitive services

to sexual trauma survivors, while at the same time protecting advocates from the negative impacts of advocacy work, itself, as well as from the impacts of exposure to negative responses to trauma survivors.

In conclusion, the results of this study indicated that several systemic/contextual/environmental variables impacted the development of VT and VPTG among RCMAs. Ratings of the amount of formal supervision received and the social community at work appear to be especially important factors to consider when designing advocacy programs and services that address the needs of survivors as well as the needs of service-providers. In addition, these agency/contextual-level variables are areas where agencies can exert a significant amount of control, unlike individual-level variables such as advocates' ages, amounts of experience, trauma histories, coping styles, hardiness, or resilience, over which agencies have little to no control.

We, as a community, are better able to care for survivors of sexual trauma when we care for those providing direct trauma-related services. This research shows that higher ratings of the social community at work and higher amounts of formal supervision received may protect advocates from the negative impacts of the work, such as developing changes in basic beliefs about the goodness of self, others, and the world. Future researchers should continue to examine the importance of contextual environments on RCMAs' ratings of VT and VPTG.

**Strengths, Limitations, and Future Directions**

Several strengths and limitation of the current study warrant consideration when interpreting the results observed. First, I limited data collection to women over the age of 18 who had experience providing rape crisis advocacy services in the past year. I

considered these conservative inclusion criteria strengths of the present study for several reasons. Previous research has indicated that the vast majority of rape crisis advocates are female (Jenkins & Baird, 2002; Strange et al., 2011), thus I limited my sample to individuals who identified as mostly female to simplify data analysis procedures. Examining differences observed between RCMAs of different gender identities was beyond the scope of this study. Future researchers should attend to these differences to examine whether gender identity or gender-role messages are associated with the development of VT and/or VPTG among RCMAs. I also limited data collection to women who had provided rape crisis medical advocacy services, as opposed to rape crisis advocacy in general, in an effort to examine the specific impacts of working with survivors in the immediate aftermath of sexual trauma during the forensic rape exam, a time of particular vulnerability to retraumatization for survivors (Resnick et al., 1999), in an effort to examine the impact of witnessing and participating in the forensic exam process on advocates. I suspect that different outcomes would be observed between advocates who provide telephone, legal, and/or medical advocacy services, due to differences in levels of contact with survivors (i.e., in person versus via telephone hotline; in the immediate aftermath of trauma versus later stages of processing). Future researchers should examine these differences. Finally, I only examined data from women who had provided medical advocacy services in the past year as a conceptualization of current status as an RCMA. Future researchers should examine potential differences between advocates who are currently providing services and those who have left their role as advocates. It might be feasible to recruit, via rape crisis agencies, previous

advocates who chose to leave the role in order to examine motivations for beginning and ending advocacy work. However, that analysis was beyond the scope of this study.

One possible limitation of this study was the small sample size. Various estimates of sample size indicated that I would need between 115 and 169 participants to achieve adequate power to detect effects in this study. Tabachnick and Fidell (2007) suggested that the appropriate ratio of independent variables to cases in a regression should be equal to or greater than $50 + 8m$ (where $m$ is the number of independent variables), or $104 + m$ for testing individual predictors, resulting in 138 and 115 participants needed, respectively, to conduct the hierarchical regressions in this study. A more conservative a priori power estimate using G*Power (Faul, Erdfelder, Buchner, & Lang, 2009) indicated a minimum sample size of 169 participants was needed to detect a .05 effect size. Mertler and Vannatta (2005) described an even more conservative method of determining the number of participants needed for a hierarchical regression: multiply the number of independent variables by 20, resulting in 220 participants needed to run hierarchical linear regressions with the eleven independent variables included in this study. The final sample size I obtained of 164 falls shy of the top-end, more conservative of these estimates (e.g., Mertler & Vannatta, 2005); thus a possible lack of power to detect borderline-significant effects should be noted when interpreting the results observed.

In addition, several variables in this study were not normally distributed, possibly violating assumptions of normality. Ratings of caseload, years of experience, amount of formal individual supervision, and amount of formal group supervision were positively skewed above 2.0, and ratings of the social community at work and meaning of the work were positively skewed above 1.0. Ratings of caseload, years of experience, and amount

of formal individual and group supervision were transformed for the analyses using the logarithm transformations option in SPSS. After transformation, all scales conformed to assumptions of normality. Ratings of the social community at work and meaning of the work were not transformed, resulting in a slightly leptokurtic distribution of scores. The leptokurtic distribution of scores should be taken into consideration when interpreting the results provided.

A major strength of this study was the attempt to attend to environmental/contextual/systemic variables that might impact the development of VT and/or VPTG among RCMAs. Future researchers should continue to examine the environmental contributions to the development of trauma symptomology in general, and to the development of the positive and negative impacts of providing trauma-related mental health services on care-providers, specifically. In addition, despite the strengths mentioned above, this research served as a simple snapshot of a complex phenomenon. For example, though this study provided a snapshot of RCMAs' rating of VT and VPTG, it did not assess RCMAs' experiences with burnout, compassion fatigue, or compassion satisfaction. It could be that other outcome variables are equally or more important to understanding the experiences of RCMAs. Future researchers should continue to examine the complex interplay between providing trauma-related mental health services and the development of both positive and negative outcomes. We should also continue to examine the dynamic relationships between advocates, medical service providers, and police, and the impacts of these relationships on both service-providers and those who utilize these services.

**Internal validity.** Internal validity refers to our ability to infer truth about relationships observed in the data we collect. One of the risks to the internal validity of this study was be our lack of ability to control the environments of participants at the time of testing. Some participants may complete the study in a quiet room, while others might complete the study in a public or noisy place. Fraenkel and Wallen (1996) described this lack of control over the testing environment as location threat, and it is inherent to internet-based research. Because of this lack of control, we have no way of assessing whether responses vary systematically based on differences in participants' environments. Also possible is that advocates who chose to participate in this study differ systematically from those who chose not to participate in this study, or that advocates who experience more VT, VPTG, or victim-blame are more likely (or less likely) to participate in such studies, skewing the results obtained. The possible risks of location threat and selection bias should be considered when drawing conclusions based on relationships observed among the data we collect. These weaknesses, while inherent in internet-based research, may limit generalizability of results obtained in this study. The present study is also limited by its cross-sectional nature, and the lack of established validity of the measure of victim-blame. Future researchers should begin to validate other measures to assess victim-blame, or revictimization, in order to continue informing the field about the importance contextual variables may play in the development of VT and VPTG among caring-others.

This study also has several strengths in regard to internal validity. Due to the cross-sectional nature of this research, no maturation or testing effects threatened the internal validity of the study. Additionally, the Trauma and Attachment Belief Scale

(Pearlman, 2003; see Appendix C), the Posttraumatic Growth Inventory (Tedeschi & Calhoun, 1996; see Appendix D), and the Copenhagen Psychosocial Questionnaire (Kristensen et al., 2005; See Appendix B) have all demonstrated high levels of internal consistency, supporting the overall reliability of the instruments. These strengths may be seen to increase the internal validity of the present study.

**External validity.** External validity refers to the apparent generalizability of the results obtained by a research study. I attempted to attain a high level of external validity in the present study by attempting to gather a representative sample of RCMAs by recruiting from all 50 states. Demographics obtained by sampling a large group of advocates from across the country may not reveal a nationally representative sample of individuals by gender, ethnicity, sexuality, et cetera, but should adequately reflect population demographics among RCMAs in the United States. The results of the present study revealed a fairly homogenous sample of mostly White, highly educated women. In addition, the results revealed that women who identified as Latina or Multiethnic missed more items on the assessment of VT, in a nonrandom manner, than women who identified with other identities. Thus, the generalizability to advocates beyond these descriptors may be limited. Also important to note is that data observed among RCMAs may not apply to different groups of mental health professionals; for example social workers, counselors, and rape crisis advocates who do not attend rape exams may not experience their work in the same way RCMAs do. We should only generalize between these groups cautiously without further research examining differences between these groups.

**Future Research Directions**

As stated above, this research provided a snapshot of the probably very complex experiences of rape crisis medical advocates, as well as the complex phenomenon of vicarious impacts of trauma. Future researchers should continue to examine the impacts of providing advocacy services on all types of advocates, including those who provide primarily telephone, hospital, and legal advocacy services, as well as on other first-responders, such as medical personnel and police. In addition, this research examined RCMAs' ratings of VT and VPTG, but it was beyond the scope of this study to examine RCMAs' ratings of other possible outcomes, such as ratings of burnout, compassion fatigue, and compassion satisfaction. Future researchers should examine the importance of these outcome variables to all first-responders, in an effort to ensure work-safety for all those who assist individuals in the immediate aftermath of trauma. Future researchers should also examine advocates' motivation for beginning advocacy work, and the potential impacts of those motivations on outcomes, as well as motivations observed among those who leave advocacy work. Understanding why advocates begin and end such work might help agencies increase work-safety and satisfaction with the work for current and future advocates.

Future researchers should also continue to attend to environmental/contextual influence on the development of trauma reactions. The present study demonstrated the importance of several environmental/contextual variables to the development of VT and VPTG, namely ratings of social community at work and amounts of formal supervision received. These are aspects of advocates' work experiences over which agencies can exert some control, and as such, are important places we as a community can intervene to

increase work-safety. Future researchers should examine how agencies that successfully provide regular and formal supervision, and have high ratings of social community, have been able to facilitate that process and overcome barriers. Future researchers should also begin to examine the impact of the dynamic relationships between agencies (i.e., the relationships between rape crisis agencies, police, and medical providers) on outcomes for both survivors of trauma and those providing trauma-related services, particularly first-responders, who are regularly exposed to the immediate effects of trauma on survivors.

**Conclusions and Implications for Advocacy-Work**

Despite the limitations cited previously, this study added to the literature concerning mental health professionals' experiences working with suffering-others by examining possible predictors of ratings of VT and VPTG among RCMAs. In addition, I also attempted to attend to several environmental variables that might influence both the positive and negative impacts of advocacy on advocates, such as ratings of the psychosocial work environment and exposure to victim-blame by police and medical staff. I hope that this focus on contextual variables will lead to improvements over previous studies in a number of ways.

First, the focus on environmental/contextual variables encourages researchers and clinicians to differentiate CF/STS from VT, which up until now, have largely been treated as interchangeable constructs. Research and theory have both consistently indicated that, while CF/STS and VT may be parallel constructs, they differ in their practical outcomes. CF/STS most closely resembles the construct of PTSD (including intrusions, avoidance, and hyperarousal), while VT described enduring changes to basic

beliefs about the goodness of self and others. Future researchers should attempt to examine the possible parallels between mental health professionals' experiences with VT and multiple-trauma survivors' experiences with what Herman (1997) described as Complex-PTSD.

Second, this study focused on organizational- or agency-level variables such as caseload, amount of formal supervision received, the psychosocial work environment, and perceptions of revictimization of survivors during the forensic rape exam. Attending to organizational-level variables encourages us to focus on larger societal structures that might serve to perpetuate the shaming and blaming of the victims of, and witnesses to, the devastating consequences of interpersonal violence. I named this dissertation "You Can Stay If You Want" because that is what so many survivors said to me; "you can stay if you want, but you don't have to," as if they were prepared to go through this experience alone, without support or comfort; without community. This research shows just how important that sense of community is to the advocates doing this work. Since the amount of formal group supervision received, ratings of the social community at work, and the meaning of the work negatively predicted VT, then organizational-level changes such as increasing the amount of formal supervision received, improving the social community at work, and highlighting the meaning of the work might increase work-safety for RCMAs. Since the amount of formal individual supervision received positively predicted ratings of VPTG, increasing the amount of time RCMAs spend in formal individual supervision might increase the positive impacts of the work. Since the amount of formal group supervision received predicted ratings of VT, increasing amounts of group supervision might protect advocates from the negative impacts of the work.

Formal supervision seems to be an especially important element of advocacy work that agencies can influence in efforts to reduce the negative impacts of the work on advocates and foster the positive. It seems important that we, as a community, find creative ways to facilitate advocates' participation in, and agencies' ability to provide, regular and formal group and individual supervision. Such efforts may seem, at first blush, to create further drains on often limited agency resources. Other advocates may need to cover crisis line or medical advocacy calls to facilitate their peers' engagement in supervision. Volunteers may be reluctant to commit more time to the agency for the purpose of supervision. Paid advocates may already feel drains on their time that make them reluctant to take on more obligations. Rape crisis agency directors should examine any additional barriers to providing and facilitating regular supervision for advocates working in their agencies, and work to distribute resources in such a way that facilitates participation in regular and formal supervision. Creative incentives, such as giveaways of simple and inexpensive gifts, providing free meals, financially compensating advocates for participating in supervision, highlighting the protective factors associated with participation in supervision, and creating a culture where attendance in supervision is an expectation of engaging in the work may facilitate such participation. Agency directors may be able to recruit volunteer supervisors, as necessary, from the local community and/or local educational institutions. The results of this study indicated that such engagement can increase work-safety by preventing the development of VT and enhancing the development of VPTG.

Another major finding of this study was how important the sense of community seems to be to ensuring the work-safety of RCMAs. The ideal community is comprised

of not only advocates, not only rape crisis agencies, but also other first-responders to trauma, survivors, and their loved-ones. Rape crisis agency directors might be able to increase work-safety for advocates by assessing the agency's relationships with other first-responder agencies. Combined trainings, debriefings, regular interdisciplinary meetings, and increased communication and cooperation between agencies might serve to improve or solidify these relationships and the sense of shared-community between agencies. Trainings offered or sponsored by rape crisis agencies, which might also incorporate survivors and their loved ones, might help dispel some of the rape myths that impact how police and medical providers interact with survivors and advocates. Taking an active role in shaping this community and how the community functions might help rape crisis agency directors protect advocates and survivors from rape victim-blame.

I hope that the results of this study will encourage other researchers to begin to systematically examine the impact of trauma work on first-responders. I hope that this research will inform the further study of rape crisis advocates' and survivors' experiences within the systems that are supposed to support them. I hope that this research will contribute to a shift from the narrow, and often blaming, focusing on individual-level contributors to trauma reactions to a wider perspective on system-level contributors to the positive and negative experiences of both sexual trauma survivors and those who care for them. We are a caring profession. We must remember to care for each other as we care for those we serve. The better we care for our advocates, the better they can care for survivors. And that is our shared goal. We are a caring community. This research highlights how important it is that our advocates know that.

Appendix A

Exposure to Victim-Blame Scale

The following questions ask if you have had specific experiences within medical and legal systems as a rape crisis medical advocate. Please read each of the following items carefully and rate the frequency with which you have or have not observed certain behaviors while working as a rape crisis medical advocate. In your work as a rape crisis medical advocate, how often have you observed…

1. A victim being asked about his or her sexual history?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

2. **A victim being told it was okay that he or she did not fight back?**

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

3. A victim being asked what he or she was wearing at the time of the assault?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

| | | | | |
|---|---|---|---|---|
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

4. A victim being asked if he or she had a relationship with the accused perpetrator?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

5. A victim being asked if she or he resisted the perpetrator during the assault?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

6. **A victim being told it was okay to be distressed following a sexual assault?**

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

7. A victim being told that she or he shouldn't have been in the area where the assault occurred?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

8. A victim being told that he or she shouldn't have been walking or traveling alone at night?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

9. A victim being told she or he shouldn't have been associating with those sorts of people at the time of the assault?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

10. **A victim being told that he or she was believed 100 percent?**

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

11. A victim being questioned about why her or his memories of the assault were vague or disjointed?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

12. A victim being asked if he or she was under the influence of drugs or alcohol at the time of the assault?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

13. A victim being asked why she or he did not fight back?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

14. **A victim being told it was okay that his or her memories of the attack are vague or distorted?**

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |

| | | | | |
|---|---|---|---|---|
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

15. A victim being questioned whether she or he is telling the truth?

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

16. **Equal treatment of victims regardless of age, race, ethnicity, gender, sexuality, socio- economic status, religion, etc?**

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

17. **A victim being encouraged to press charges against the perpetrator?**

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

18. **A victim being told that he or she was not to blame for the assault?**

| | | | | |
|---|---|---|---|---|
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |

| | | | | |
|---|---|---|---|---|
| | Never | Occasionally | Often | Always |
| 19. **A victim being told it was okay that he or she experienced arousal or orgasm?** | | | | |
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| 20. A victim's previous history of victimization influencing the quality of service received? | | | | |
| By medical staff | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |
| By police | 1 | 2 | 3 | 4 |
| | Never | Occasionally | Often | Always |

Note. Bold items indicate reverse scoring.

Table 5

*Factor Loadings for Victim-Blame by Medical Personnel Subscale (VB-M)*

| | Factor Loadings | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | Communalities |
| | DISBELIEF | SHOULDN'T | QUALIFIERS | BELIEF | |
| How often have you been asked if you believe the victim? | **.85** | .04 | -.06 | -.11 | .74 |
| How often have you been told that the victim was lying? | **.80** | .07 | .07 | -.20 | .68 |
| How often have you witnessed a victim being questioned about why his or her memories of the assault were vague or disjointed? | **.77** | .16 | .11 | .05 | .63 |
| How often have you witnessed a victim being asked why she or he did not fight back? | **.75** | .17 | .05 | -.22 | .64 |
| How often have you been told that you should not believe the victim? | **.72** | .25 | .23 | -.22 | .68 |
| How often have you witnessed a victim being questioned about whether she or he is telling the truth? | **.66** | .26 | -.02 | -.38 | .65 |
| How often have you witnessed a victim being told that he or she shouldn't have been walking or traveling alone at night? | .28 | **.89** | -.06 | .02 | .88 |
| How often have you witnessed a victim being told that she or he shouldn't have been associating with those sorts of people at the time of the assault? | .33 | **.80** | .19 | -.24 | .84 |
| How often have you witnessed a victim being told that she or he shouldn't have been in the area where the assault occurred? | .40 | **.80** | -.11 | -.14 | .83 |
| How often have you witnessed a victim being encouraged to press charges against the perpetrator? | -.22 | **.57** | .32 | .04 | .48 |
| How often have you witnessed a victim being asked if he or she had a relationship with the accused perpetrator? | .00 | .05 | **.89** | .05 | .79 |
| How often have you witnessed a victim being asked if she or he resisted the perpetrator during the assault? | .04 | .02 | **.78** | .19 | .65 |
| How often have you witnessed a victim being asked what he or she was wearing at the time of the assault? | .23 | .07 | **.77** | .14 | .67 |
| How often have you witnessed a victim being told that he or she was not to blame for the assault? | -.20 | -.08 | .11 | **.90** | .86 |
| How often have you witnessed a victim being told that he or she was believed 100% | -.14 | .07 | .18 | **.69** | .53 |
| How often have you witnessed equal treatment | -.29 | -.38 | .16 | **.68** | .71 |

| | | | | |
|---|---|---|---|---|
| of victims regardless of age, race, ethnicity, gender, sexuality, SES, religion, etc.? | | | | |
| Eigenvalue | 5.74 | 2.70 | 1.72 | 1.10 |
| % of Total Variance | 35.86 | 16.87 | 10.75 | 6.87 |
| Total Variance | | | | 70.35% |

*Note.* Extraction Method: Principal Component Analysis with Varimax Rotation and Kaiser Normalization. Bold items indicate factor groupings.

Table 6

*Factor Loadings for Victim-Blame by Police Subscale (VB-P)*

| | Factor Loadings | | | | | |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | Communalities |
| | SHOULDN'T | DISBELIEF | QUALIFIERS | HISTORY | BELIEF | |
| How often have you witnessed a victim being told that she or he shouldn't have been in the area where the assault occurred? | **.82** | .24 | .05 | .36 | -.05 | .87 |
| How often have you witnessed a victim being told that she or he shouldn't have been associating with those sorts of people at the time of the assault? | **.80** | .15 | .11 | .25 | -.09 | .75 |
| How often have you witnessed a victim being asked why she or he did not fight back? | **.78** | .06 | .31 | -.11 | -.06 | .72 |
| How often have you witnessed a victim being told that he or she shouldn't have been walking or traveling alone at night? | **.76** | .18 | .16 | .18 | .09 | .68 |
| How often have you witnessed a victim being questioned about why his or her memories of the assault were vague or disjointed? | **.62** | .34 | .37 | .02 | .13 | .65 |
| How often have you witnessed a victim being questioned about whether she or he is telling the truth? | **.59** | .51 | .23 | .08 | .11 | .68 |
| How often have you been told that you were acting outside of your training or organization's scope when you attempted to advocate for your client's right or well-being? | .03 | **.84** | .13 | .25 | -.09 | .80 |
| How often have you been told that the victim was lying? | .26 | **.80** | .28 | .21 | .05 | .84 |
| How often have you been asked if you believe the victim? | .21 | **.79** | .17 | .11 | .24 | .65 |
| How often have you been told that you should not believe the victim? | .22 | **.77** | .07 | .25 | -.05 | .72 |
| How often have you witnessed a victim being asked if she or he experienced sexual arousal or orgasm during the assault? | .20 | **.52** | .20 | -.05 | -.25 | .42 |
| How often have you witnessed a victim being asked if he or she was under the influence of drugs or alcohol at the time of the assault? | .14 | .15 | **.84** | .27 | .03 | .82 |

| | | | | | | |
|---|---|---|---|---|---|---|
| How often have you witnessed a victim being asked if he or she had a relationship with the accused perpetrator? | .22 | .18 | **.84** | .27 | .174 | .88 |
| How often have you witnessed a victim being asked if she or he resisted the perpetrator during the assault? | .31 | .14 | **.79** | .23 | -.01 | .79 |
| How often have you witnessed a victim being asked what he or she was wearing at the time of the assault? | .15 | .22 | **.74** | -.05 | .31 | .72 |
| How often have you witnessed a victim being distressed by the questions asked? | .21 | .38 | **.56** | .12 | .26 | .58 |
| How often have you witnessed a victim's previous history of victimization influencing the quality of services received? | .07 | .25 | .22 | **.73** | -.07 | .65 |
| How often have you witnessed a victim being encouraged to press charges against the perpetrator? | .39 | .11 | .21 | **.68** | .27 | .75 |
| How often have you witnessed a victim being questioned about his or her sexual history? | .24 | .38 | .27 | **.62** | .13 | .68 |
| How often have you witnessed a victim being told that he or she was not to blame for the assault? | .01 | .01 | .09 | .14 | **.83** | .72 |
| How often have you witnessed a victim being told that he or she was believed 100% | -.03 | -.06 | .27 | -.04 | **.80** | .71 |
| Eigenvalue | 8.74 | 2.30 | 1.80 | 1.22 | 1.12 | |
| % of Total Variance | 41.59 | 10.97 | 8.59 | 5.81 | 5.32 | |
| Total Variance | | | | | 72.29% | |

*Note.* Extraction Method: Principal Component Analysis with Varimax Rotation and Kaiser Normalization. Bold items indicate factor groupings.

Appendix B

Demographics and Independent Variables

**Caseload**

1. In the previous year, how many times did you report to a medical facility and meet with a victim in an attempt to provide information and/or emotional support in the aftermath of a sexual assault?

   _____

**Experience**

2. How many years and months have you worked as a rape crisis advocate?

   _____ Years, _____ Month

**Individual Supervision**

3. How many hours, per month, do you receive one-on-one supervision from your agency?_____

**Group Supervision**

4. How many hours per month do you receive group supervision from your agency?_____

**Psychosocial Work Environment**

5. Does your work put you in emotionally disturbing situations?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly | Seldom | Sometimes | Often | Always |

Ever

6. Do you have to relate to other people's personal problems as part of your work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

7. How often do you get help and support from your colleagues?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

8. How often are your colleagues willing to listen to your problems at work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

9. How often do your colleagues talk with you about how well you carry out your work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

10. Is there a good atmosphere between you and your colleagues?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

11. Is there good co-operation between colleagues at work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

12. Do you feel part of a community at your place of work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

13. Regarding your work in general, how pleased are you with your work prospects?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

14. Regarding your work in general, how pleased are you with the physical working conditions?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

15. Regarding your work in general, how pleased are you with the way your abilities are used?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

16. Regarding your work in general, how pleased are you with your job as a whole, everything taken into consideration?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

17. Is your work emotionally demanding?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

18. Is your work meaningful?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

19. Does your work have clear objectives?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

20. Is your work recognized and appreciated by the management?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

21. Are there good prospects in your job?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

22. Do you feel that the work you do is important?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

23. Do you know exactly which areas are your responsibility?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

24. Does the management at your workplace respect you?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

25. Do you get emotionally involved in your work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

26. Are you treated fairly at your workplace?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

27. Do you know exactly what is expected of you at work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly | Seldom | Sometimes | Often | Always |

Ever

28. Do you feel motivated and involved in your work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

29. Is your salary fair in relation to your effort at work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

30. Does the management trust the employees to do their work well?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

31. Can you trust the information that comes from management?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

32. Does the management withhold important information from the employees?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

33. Are the employees able to express their views and feelings?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

34. How often is your nearest superior willing to listen to your problems at work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

35. How often do you get help and support from your nearest superior?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

36. How often does your nearest superior talk with you about how well you carry out your work?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

37. To what extent would you say that your immediate supervisor makes sure that the individual staff member has good development opportunities?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

38. To what extent would you say that your immediate supervisor gives high priority to job satisfaction?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

39. To what extent would you say that your immediate supervisor is good at work planning?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

40. To what extent would you say that your immediate supervisor is good at solving conflicts?

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Never/Hardly Ever | Seldom | Sometimes | Often | Always |

**Demographics**

1. Please indicate your age in years and months: _____ Years, _____ Months

2. Please identify your gender as:

   0 Mostly male

   1 Mostly female

3. Please identify your race/ethnicity as:

   1 of African origin

   2 of Asian origin

   3 of European origin

   4 of Hispanic origin

   5 of Native American origin

6 of multiple ethnic origins

7 other

**Education**

4. What is the highest level of education you have completed?

1 Grammar school

2 High school or GED

3 Some college

4 Associate's degree

5 Bachelor's degree

6 Master's degree

7 Doctorate degree

**Professional Experience**

5. How many years and months have you worked as a rape crisis advocate?

_____ Years, _____ Months

Appendix C

Trauma and Attachment Belief Scale

This questionnaire is used to learn how individuals view themselves and others. As people differ from one another in many ways, there are no right or wrong answers. Please indicate the number next to each item which you feel most clearly matches your own beliefs about yourself and your world. Try to complete every item. Use the following response scale.

**1 = Disagree Strongly**

**2 = Disagree**

**3 = Disagree Somewhat**

**4 = Agree Somewhat**

**5 = Agree**

**6 = Agree Strongly**

1. I believe I am safe.

2. Even when I am with friends and family, I don't feel like I belong.

3. I never think anyone is safe from danger.

4. I can trust my own judgment.

5. People are wonderful.

6. I feel like people are hurting me all the time.

7. Some of my happiest times are with other people.

8. I could do serious damage to someone.

9. When I am alone, I don't feel safe.

10. Most people ruin what they care about.

11. I don’t trust my instincts.

12. I feel close to lots of people.

13. I can’t stop worrying about others’ safety.

14. I would never hurt myself.

15. I often think the worst of others.

16. I can control whether I harm others.

17. The world is dangerous.

18. I have a hard time making decisions.

19. I feel cut off from people.

20. The important people in my life are in danger.

21. I can keep myself safe.

22. People are no good.

23. I worry about what other people will do to me.

24. I like people.

25. Even if I think about hurting myself, I won’t do it.

26. I don’t feel much love from anyone.

27. I have good judgment.

28. I feel threatened by others.

29. When I am with people, I feel alone.

30. The world is full of people with mental problems.

31. I can make good decisions.

32. I am afraid of what I might do to myself.

33. When people I love aren’t with me, I believe they are in danger.

34. I feel safe when I am alone.

35. I often doubt myself.

36. Most people are good at heart.

37. I believe that someone is going to hurt me.

38. I do things that put other people in danger.

39. No one really knows me.

40. I don't respect the people I know best.

41. I can usually figure out what's going on with people.

42. I have physically hurt people.

43. I am afraid I will harm myself.

44. I feel left out everywhere.

Appendix D

Post-Traumatic Growth Inventory

Please rate the extent to which you experienced each of the following items as a result of your work as a rape crisis medical advocate.

**0 = I did not experience this change as a result of my work as a rape crisis medical advocate.**

**1 = I experienced this change to a very small degree as a result of my work as a rape crisis medical advocate.**

**2 = I experienced this change to a small degree as a result of my work as a rape crisis medical advocate.**

**3 = I experienced this change to a moderate degree as a result of my work as a rape crisis medical advocate.**

**4 = I experienced this change to a great degree as a result of my work as a rape crisis medical advocate.**

**5 = I experienced this change to a very great degree as a result of my work as a rape crisis medical advocate.**

1. My priorities about what is important in life.

2. An appreciation for the value of my own life.

3. I developed new interests.

4. A feeling of self-reliance.

5. A better understanding of spiritual matters.

6. Knowing that I can count on people in times of trouble.

7. I established a new path for my life.

8. A sense of closeness with others.

9. A willingness to express my emotions.

10. Knowing I can handle difficulties.

11. I'm able to do better things with my life.

12. Being able to accept the way things work out.

13. Appreciating each day.

14. New opportunities are available which wouldn't have been otherwise.

15. Having compassion for others.

16. Putting effort into my relationships.

17. I'm more likely to try to change things which need changing.

18. I have a stronger religious faith.

19. I discovered that I'm stronger than I thought I was.

20. I learned a great deal about how wonderful people are.

21. I accept needing others.

Appendix E

Qualitative Questionnaire

**Cultures of Rape Crisis Organizations**

1. What does the relationship between your organization and advocates look like?

   _____

   _____

   _____

2. What does the relationship between your organization and police look like?

   _____

   _____

   _____

3. What does the relationship between your organization and medical care providers look like?

   _____

   _____

   _____

Appendix F

Recruitment Letter


Dear Friends and Colleagues,

My name is Chandra N. Strange, and I am a doctoral candidate in Counseling Psychology at the University of Kentucky. I am currently conducting my dissertation research study, entitled "You Can Stay if You Want" – Women's Experiences Providing Rape Crisis Medical Advocacy. You have been identified as someone who may be a current rape crisis medical advocate (RCMA), and I am writing to you today to request your participation in my study.

RCMAs provide a valuable service to rape survivors during the forensic rape exam, but few researchers have examined the impact of this work on advocates. The survey/questionnaire will take about 30-45 minutes to complete, and will ask you to reflect on your experiences as an RCMA. You will not receive any rewards or payment for taking part in the study. However, I pledge to donate $1 to the Rape, Abuse, and Incest National Network for every one person who completes the survey (up to a maximum of $200).

I hope to receive completed questionnaires from about 200 people. As such, I would like to ask for your help in sending the link to RCMAs you may know, or to people who may come in contact with RCMAs. When more people participate in studies such as these, we are better able to determine the commonalities and challenges

advocates face in their work, in their personal lives, and possible ways to increase support for the people who do this very important work.

By following the link to the Internet survey, you will be provided further information to aid in your decision whether or not to take part in the study.

https://www.surveymonkey.com/s/Z92NYRJ

If you have questions about the study, please feel free to ask; my contact information is given below. If you have complaints, suggestions, or questions about your rights as a research volunteer, contact the staff in the University of Kentucky Office of Research Integrity at 859-257-9428 or toll-free at 1-866-400-9428.

I appreciate your help in considering participating in this study, and with recruiting other participants for this study. I hope that these results will help advocacy agencies train and support advocates in this valuable job, as well as help inform medical staff, social service workers, police, and the general public about rape crisis medical advocacy. Thank you for being an advocate. And thank you in advance for your help with this research project.

Sincerely,

Chandra N. Strange, MS, EdS

Department of Educational, School, and Counseling Psychology

University of Kentucky

859-619-2534

cnstrange@insightbb.com

## Appendix G

## Informed Consent

You are being asked to participate in a nation-wide research survey, conducted by researchers at the University of Kentucky, designed to examine the unique work and life experiences of female rape crisis medical advocates. This study is being conducted by Chandra N. Strange, M.S., Ed.S., under the supervision of Pamela Remer, Ph.D.

Your participation is voluntary. Your agency will have no knowledge as to whether you decided to participate in this study or not. All answers will be collected on-line and will be treated confidentially. No names are asked for or required, and web addresses will be deleted.

The survey will take approximately 30-45 minutes to complete. You may choose to exit at any time by simply closing the browser window. Closing your browser and rebooting your computer are also good practices when taking surveys, and help increase your privacy.

Your decision not to participate will not result in any penalty. Participating or not participating in the survey will not affect any rights to which you are otherwise entitled. For every one person who completes the entire survey, I pledge to donate one dollar to the Rape, Abuse, and Incest National Network (RAINN), up to a maximum of $200.

The risk of discomfort from participating in this study is minimal. Some people may feel uncomfortable after answering some of the questions. If you are more than moderately upset by the experience, we strongly suggest that you contact the researcher or seek help at your local mental health service providers.

We would also very much appreciate your help in sending the link to other rape crisis medical advocates you may know, or to people who may come in contact with rape crisis medical advocates. When more people participate in studies such as these, we are better able to determine the commonalities and challenges advocates face in their work, in their personal lives, and possible ways to increase support for the people who do this very important work.

If you have questions, suggestions, concerns, or complaints about this study, you can contact the investigator at 859-619-2534 or cnstrange@insightbb.com. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428, or toll-free at 1-866-400-9428.

If you wish to participate, please choose "Continue" and "Next", which is an indication of your informed consent. If you choose not to participate, you may press "Exit" and "Next" now.

The University of Kentucky is an Equal Opportunity University.

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advocates' self-care routines: The influence of organizational context. *American Journal of Community Psychology, 30,* 731-760. doi:10.1023/A:1016377416597

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**Vita**
**Chandra N. Strange**

## EDUCATION

| | |
|---|---|
| 2006-Present | **Ph.D. Student in Counseling Psychology**<br>Department of Educational, School, and Counseling Psychology<br>University of Kentucky<br>Lexington, KY<br><br>**Specialty Area:** Trauma Counseling<br><br>**Committee Chair:** Pam Remer, Ph.D.<br>**Dissertation Title***: "You can stay if you want" – Women's experiences providing rape crisis medical advocacy.*<br>**Defense:** August 15, 2014 |
| 2006 -2007 | **Education Specialist - Counseling Psychology**<br>Department of Educational, School, and Counseling Psychology<br>University of Kentucky<br>Lexington, KY |
| 2003-2006 | **Masters of Science in Education – Counseling Psychology**<br>Department of Educational, School, and Counseling Psychology<br>University of Kentucky<br>Lexington, KY |
| 1996-2002 | **Bachelor of Arts (Psychology)**<br>University of Kentucky<br>Lexington, KY |

## FACULTY APPOINTMENTS

| | |
|---|---|
| August 2014-May 2015 | **Visiting Assistant Professor**<br>**University of Southern Mississippi**<br>**Department of Psychology**<br>**Counseling Psychology Program** |

## CLINICAL AND SUPERVISION EXPERIENCE

| | |
|---|---|
| August 2013-July 2014 | **Psychology Intern**<br>**The Ohio State University** |
| August 2012-July 2013 | **Psychology Student Affiliate, Post-Masters Practicum**<br>**Eastern State Hospital, Lexington, KY** |
| Fall 2012 | **Assessment Supervisor, Post-Masters Practicum**<br>**Integrated Substance-Informed Survivor Therapy**<br>**University of Kentucky**<br>**Counseling Psychology Program** |
| January 2011-May 2012 | **Supervisor, Post-Masters Supervision Practicum**<br>**University of Kentucky Counseling Psychology Program** |
| January 2009-July 2009 | **Interpersonal Violence Counselor, Post-Masters Practicum**<br>**The Nest - A Center for Women, Children, and Families** |
| September-November 2008 | **Supervisor, Post-Masters Supervision Practicum**<br>**University of Kentucky Counseling Psychology Program** |
| August 2007-May 2008 | **Counselor, Post-Masters Practicum**<br>**University of Kentucky Counseling and Testing Center** |
| February-May 2007 | **Supervisor, Post-Masters Supervision Practicum**<br>**University of Kentucky Counseling Psychology Program** |
| August 2005-August 2006 | **Counselor, Masters Practicum**<br>**University of Kentucky Counseling Psychology Services Clinic** |
| January 2001-<br>December 2004 | **Volunteer Rape Crisis Advocate, Undergraduate Internship**<br>**Bluegrass Rape Crisis Center** |

## RESEARCH EXPERIENCE

| | |
|---|---|
| August 2007-August 2008 | **Research Assistant**<br>**Department of Educational, School, and Counseling Psychology**<br>**University of Kentucky** |

| | |
|---|---|
| June 2005-August 2005 | **Research Assistant**<br>**Center for Drug and Alcohol Research**<br>**University of Kentucky** |
| May 2001-August 2005 | **Research Assistant**<br>**Child Development Research Facility**<br>**University of Kentucky** |

## OTHER RESEARCH PROJECTS

| | |
|---|---|
| 2009-2011 | **Principal Investigator**<br>**Rape Crisis Advocacy Survey Project (A Dissertation Preliminary Study)**<br>**Counseling Psychology Program**<br>**University of Kentucky** |
| 2007 | **Principal Investigator**<br>**Sexual Harassment Social Justice Project**<br>**Counseling Psychology Program**<br>**University of Kentucky** |

## PUBLICATIONS

Flory, K., Hayden, A., Milich, R., Lorch, E., **Strange, C.**, & Welsh, R. (2006). On-line story comprehension among children with ADHD: Which core deficits are involved? *Journal of Abnormal Child Psychology, 34*, 853-865.

## POSTER PRESENTATIONS

**Strange, C. N.** (2006, February). *Mastering the art of effective study: Fostering academic success through an intensive, preventative study skills seminar.* Poster session presented at the Annual Conference on the First Year Experience, Addison, TX.

Flory, K., Milich, R., Lemberger, C., Whirley, K. S., Hayden, A., & **Strange, C. N.** (2003, April). *Why do children with ADHD have deficits in story production and comprehension?* Poster presented at the biennial meeting of the Society for Research in Child Development, Tampa, FL.

## TEACHING EXPERIENCE

| | |
|---|---|
| January 2013- May 2013 | **Instructor, EDP 303: Teaching Exceptional Learners in the Elementary Classroom** |

| | |
|---|---|
| | **Department of Educational, School, and Counseling Psychology**<br>**University of Kentucky** |
| January 2013- May 2013 | **Instructor, EDP 203: Teaching Exceptional Learners in the Regular Classroom**<br>**Department of Educational, School, and Counseling Psychology**<br>**University of Kentucky** |
| January 2012-May 2012 | **Co-instructor, EDP 661: Advanced Techniques of Counseling-II**<br>**Department of Educational, School, and Counseling Psychology**<br>**University of Kentucky** |
| August 2011-May 2012 | **Instructor, EDP 203: Teaching Exceptional Learners in the Regular Classroom**<br>**Department of Educational, School, and Counseling Psychology**<br>**University of Kentucky** |
| August 2008-May 2012 | **Instructor, EDP 202: Human Development and Learning**<br>**Department of Educational, School, and Counseling Psychology**<br>**University of Kentucky** |
| Summer 2007 | **Instructor, EPE 174: Theories of College Student Success**<br>**Academic Enhancement/Undergraduate Studies**<br>**University of Kentucky** |
| August 2006-May 2007 | **Seminar Coordinator, the Master Student Seminar**<br>**Academic Enhancement/Undergraduate Studies**<br>**University of Kentucky** |
| August 2005-May 2006 | **Teaching Assistant, PSY 100: Introduction to Psychology**<br>**Department of Psychology**<br>**University of Kentucky** |

## INVITED GUEST LECTURES

| | |
|---|---|
| Fall 2012 | **Psychodramatic Theory and Therapy,** Department of Rehabilitation Counseling**,** University of Kentucky |

| | |
|---|---|
| Spring 2011 | **Systems Theories and Therapies,** Department Of Rehabilitation Counseling**,** University of Kentucky |
| Spring 2011 | **Cognitive-Behavioral Therapies,** Department of Rehabilitation Counseling**,** University of Kentucky |
| Fall 2009 | **Empowerment Feminist Therapy**, Department of Rehabilitation Counseling**,** University of Kentucky |
| Spring 2009 | **Feminist Therapy,** Department of Rehabilitation Counseling**,** University of Kentucky |
| Fall 2008 | **Feminist Therapy**, Department of Rehabilitation Counseling**,** University of Kentucky |

## OUTREACH/SOCIAL JUSTICE ACTIVITIES

| | |
|---|---|
| November 2013 | **Co-Facilitator for The Ohio State University Annual Women of Color Retreat** |
| August 2011 | **Co-Facilitator of a Diversity Training/Ally Development Workshop**<br>**College of Education**<br>**University of Kentucky** |
| August 2010 | **Co-Creator and Co-Facilitator of a Diversity Training Workshop**<br>**College of Education**<br>**University of Kentucky** |
| January 2007-May 2008 | **Social Justice and Diversity Training Group Facilitator**<br>**Gatton College of Business and Economics**<br>**University of Kentucky** |
| September 2007 | **Violence Intervention and Prevention Center Research Task Force**<br>**University of Kentucky** |
| September 2007 | **Participant in the SEEDS Program**<br>**Violence Intervention and Prevention Center**<br>**University of Kentucky** |
| August 2007 | **Participant in the Humanity Academy**<br>**University of Kentucky** |

## AWARDS AND HONORS

| | |
|---|---|
| November 2012 | **Woman's Club Fellowship**<br>**University of Kentucky** |
| November 2012 | **Arvle and Ellen Thacker Turner Dissertation Research Grant**<br>**University of Kentucky** |
| 2007-2010 | **Lyman T. Johnson Fellowship**<br>**University of Kentucky** |
| 2004 | **United Way LOVE Award for Outstanding Volunteer Service Bluegrass Rape Crisis Center** |
| 2002 | **Graduate Magna cum Laude (undergraduate)**<br>**University of Kentucky** |
| 2002 | **Golden Key International Honor Society (undergraduate)**<br>**University of Kentucky** |
| Spring 2001-Fall 2002 | **Dean's List (undergraduate)**<br>**University of Kentucky** |

## PROFESSIONAL AFFILIATIONS

| | |
|---|---|
| 2007-present | **Member of the American Academy of Experts on Traumatic Stress** |
| 2006-present | **Student Affiliate of the American Psychological Association** |

## REFERENCES

Pamela Remer, Ph.D., Associate Professor
President, Division 35 – Society for the Psychology of Women
Counseling Psychology Program
University of Kentucky
251C Dickey Hall
Lexington, KY 40506-0017
(859) 257-4158
premer@email.uky.edu

Rory Remer, Ph.D., Professor
Director of Graduate Studies
Counseling Psychology Program
University of Kentucky
233 Dickey Hall
Lexington, KY 40506-0017
(859) 257-7877
rremer@uky.edu

Karen Taylor, PhD
Associate Director, Training Director
The Ohio State University
Counseling and Consultation Service
4th Floor, Younkin Success Center
1640 Neil Avenue
Columbus, OH 43201
614-292-5766
Taylor.45@osu.edu