Best-practices in methods for evaluation of crisis and counseling services provided to rape victims

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What does research tell us about best practices in evaluating services provided for rape victims?
Why is it important to conduct evaluation of services provided to rape victims?

- Rape victims who report positive experiences when seeking post-assault care through various services offered have better prospects for long term recovery than those who report negative experiences.
- Rape victims who report negative experiences, including being unable to obtain the needed services or being treated insensitively by service personnel are more likely to perceive the experience as a second rape which magnifies the victims’ powerlessness, guilt and shame (1, 2).

What are the potential risks and benefits associated with rape victims' participation in research?

- An emerging body of research indicates that writing or talking about trauma is perceived as therapeutic and more likely to be beneficial than to do harm.
- In general, traumatized research participants report favorable perceptions of their experiences.
- Although some participants found it emotionally distressing to recount details of the traumatic event, most reported that they would be willing to participate in similar research in the future.
- A small number of participants do report experiencing strong negative emotions or more distress than anticipated during the research protocol, however, the majority of trauma-focused research participants who experience strong emotional reactions do not regret their participation, nor do they negatively appraise their research participation experience (7, 8, 9, 10).

Why do rape victim participate in research?

- They hope it will be beneficial for themselves
- They hope it will be beneficial for others
- To support sexual assault researchers
- To receive a financial incentive (2,4)

What distinguishes emotional discomfort from a re-traumatizing experience for rape victims participating in research?

- The crucial feature that distinguishes one circumstance from the other is the uncontrollability that characterizes traumatic experiences.
- Crisis service providers and evaluators should be trained to inform survivors of their ability to exert control over the data collection situation by opting out of participation at anytime with no repercussions (7, 8, 9).

What are the most important factors that must be considered by rape crisis service evaluators?

- Victims seeking hotline or advocacy services are likely to be in crisis and emotionally upset; therefore, evaluation questionnaires should be kept brief.
- Victims seeking hotline or advocacy services are not required to provide their private contact information which makes follow-up data collection (by phone or e-mail, for example) very difficult, therefore collecting evaluation data immediately post-service may be necessary.
- Collecting data using electronic devices may increase survivors' perception of anonymity and may help to reduce pressure on the victim to give a positive evaluation (1,3,4,5).

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Introduction

It is well established that whether a sexual assault victim is able to attain the needed services and whether she is treated in an empathic, supportive manner in interactions with service-providing systems has profound implications for her recovery. For example, some victims who report positive experiences when seeking post-assault care through various services offered may have better prospects for long term recovery, however, when victims are not able to receive needed services or if they are treated insensitively by personnel the help-seeking experience may be perceived as a second rape which magnifies the victims’ powerlessness, guilt and shame (1, 2). Additionally, some studies indicate that when a victim who seeks postassault care in a local emergency rooms is provided with a medical advocate to see to the victim’s immediate emotional needs and to help her understand what her needs and options are in all elements of the postassault care (including making a police statement, evidence collection, as well as information about how to obtain follow-up medical, legal, or mental health services) she is more likely to receive comprehensive medical care and less likely to report the experience as a secondary violation (1).

The Madison Office of Community Services is seeking evidence-based recommendations regarding best practices for conducting evaluation of the services provided to sexual assault victims through the Dane County Rape Crisis Center (RCC). Their information needs fall into 3 distinct categories. (A) What are the potential risks and benefits of participating in research for rape victims? (B) What are best practices for outcomes measures of sexual assault crisis services? (C) What are the best practices in
collecting evaluation data from sexual assault survivors, bearing in mind their needs and vulnerability as a traumatized population?

**Potential risks and benefits of participating in trauma-focused research**

Rape victims are considered a hard-to-find, traumatized, or vulnerable population. As such, there are a variety of methodological and ethical challenges involved that must be grappled with by any researchers, practitioners, or evaluators, that may work in this domain. Notwithstanding, there is enough empirical evidence to inform best practices in terms of the types of services that can be offered by community organizations in order to maximize victims likelihood of recovery. For a detailed review of empirically supported best practices and innovations in post sexual assault services please see Campbell's 2006 article “Rape survivors' experiences with the legal and medical systems: Do rape victim advocates make a difference?” (1).

A central concern in collecting data from vulnerable, traumatized populations for evaluation of services is that it is important to distinguish between distress resulting from a re-traumatizing experience, and emotional distress that is the natural result of recalling a traumatic event that involved intense fear or powerlessness, or horror. The crucial feature that distinguishes one circumstance from the other is the uncontrollability that characterizes traumatic experiences. In contrast, researchers and crisis service providers are well trained to inform survivors of their ability to exert control over the data collection situation by opting out of participation at anytime (7, 8, 9).

Research examining the potential for harm shows that participants in trauma-based research are in fact not excessively distressed by participation. Specifically,
participation in research is often viewed as an interesting and valuable experience; and that when participants’ needs are respected, they are not too fragile to participate in research in the acute aftermath of a traumatic experience. An emerging body of research indicates support for the idea that writing or talking about trauma is perceived as therapeutic and generally more likely to be beneficial than to do harm (7, 8, 10).

In the past several years, a growing number of studies have found that in general, traumatized research participants report favorable perceptions of their experiences. Although some participants found it emotionally distressing to recount details of the traumatic event, most reported that they would be willing to participate in similar research in the future, indicating that recounting the assault does not lead to prolonged or overwhelming distress (7, 8, 9). However, a small number of participants do report experiencing strong negative emotions or more distress than anticipated during the research protocol. A limited body of evidence suggests certain victim characteristics may be associated with increased likelihood of unexpected levels of distress in trauma-related protocols including preexisting distress, younger and older age, a history of multiple trauma exposure, social vulnerability, and greater physical injury severity (8). Of particular interest is the finding that the majority of trauma-focused research participants who experience strong emotional reactions do not regret their participation, nor do they negatively appraise their research participation experience (7, 8).

Why do rape survivors participate in research? (2) conducted a meta-study of victims’ reasons for research participation. Findings indicated 4 primary reasons why rape victims were willing to participate in a face-to-face interview: (A) they hoped their participation would help other survivors understand that they are not alone, and that other
women have also survived sexual assault, (B) they hoped their participation would be
helpful in their own recovery, (C) they chose to participate citing support for research on
rape/sexual assault, and (D) they were motivated to participate in order to receive
financial compensation/incentive (2).

Evaluation of sexual assault services presents challenges that are distinct from
those that accompany basic institutional research. Most of the services offered sexual
assault agencies like the Dane County RCC are short-term and focus on the needs of a
victim in crisis or in danger. As such, the service evaluation design must take into account
the safety, confidentiality, and privacy of rape victims in order to facilitate her recovery.

**Best practices for outcome measures of sexual assault crisis services**

In 2004 a team of researchers and service providers collaborated in a statewide
evaluation of services provided by 33 sexual assault agencies in Illinois (11). The services
they evaluated were similar to those provided by the Dane County RCC: crisis hotline,
advocacy, and post-assault counseling services for survivors, and sometimes their family
members. The authors stated, “the purpose of the evaluation was to generate 'numbers'
that the state legislature could use to determine whether funds were being used effectively
and to provide information to service providers so that they could modify their services.”

Evaluation methods for the hotline and advocacy services took the form of brief
interviews conducted by the service provider immediately post-service (in the case of
hotline or advocacy) and self-report questionnaires given to incoming counseling clients
(in case they previously received hotline or advocacy services). The outcome measures
for hotline and advocacy used a likert-scale responses to assess whether services provided
information, support, and in the case of medical or legal advocacy, help with decision making. (The exact wording of these items was unavailable, but they asked the participant to rate on a 5-point scale, the amount of information gained, the amount of emotional support they received, etc.) The method of surveying counseling clients who previously used hotline or advocacy services showed that these clients reported receiving significantly less support than those who were surveyed in person (or by phone) by the service provider. There were no significant differences in ratings of information received for these 2 survey methods. The immediate post-service outcome methods showed that in general, service providers in hotline and advocacy were meeting the desired goals (they generally got positive ratings).

Counseling services were evaluated by means of a self-administered questionnaire filled out at the beginning of counseling services and at the end of a series of counseling appointments. Items assessed indicators of distress and used likert scale rating to assess services. These questionnaires contained 2 sub scales: A Counseling Outcome Index (COI) and a Post-traumatic Stress Index (PSI). The COI consisted of 8 items examining the participant's perceived ability to identify and address her postassault socio-emotional needs. (For example, “I have someone I can turn to for helpful advice about a problem,” “I have ways to help myself when I feel troubled,” “I am able to talk about my feelings and emotions regarding the assault.”) The PSI consisted of 6 items assessing the frequency with which participants experienced symptoms of Post-traumatic stress syndrome. (for example, “Over the past 7 days, how much have you been bothered by feeling low in energy?” “...Sleep that is restless or disturbed?” “...Feelings of guilt?”) These surveys indicated that most participants received individual counseling for a prolonged period
(48% reported receiving 10 or more sessions). Post counseling surveys showed a significant increases on the COI ratings and significant decreases in the PSI ratings (11).

This study indicates that in most cases rape service agencies were able to meet many clients' needs and facilitate recovery which lends support to such services being a well-justified use of tax-payer money. Despite challenges and limitations, such as a low response rate (many hotline and advocacy service recipients reported being too upset to answer evaluation questions) it provides a useful example of how service evaluation questions can be worded to gather at least a minimal amount crucial information with respect to the extremely difficult circumstances that accompany postassault care and services.

**Best practices in collecting evaluation data from sexual assault survivors**

Although only a few empirical studies exist that examine the best practices employed by community-based-organizations in data collection methods for evaluation of sexual assault services, there are still some very useful findings emerging. Campbell, Adams & Patterson (3) compared response rates and client feedback on 3 methods of collecting evaluation data on traumatized victims seeking post-assault services: (A) on-site, in-person data collection immediately post-services, (B) data collected by telephone survey, 1 week post-services, and (C) on-site, self administered, immediately post-services.

The first method, on-site, in-person administration of service evaluation questionnaire yielded the highest overall response rate, 88%, followed by the self-administered on-site method, 41% rate of responses, and the telephone follow-up method yielded the lowest response rate of 17%. This study also collected data comparing clients'
responses across all 3 data collection methods and found that clients' responses were consistent across all 3 methods, indicating that the data collection method did not seem to correlate with positive or negative service ratings (3, 6).

Anonymity and confidentiality are primary considerations for rape victims; they are not required to give their name to service providers. This is particularly problematic for the telephone follow-up survey method. Even in those cases where a survivor does provide contact information, calling her a week later may violate her privacy or her safety if she happens to live with her assailant. The lower response rate for self-administered on-site method compared to the in-person survey method may be due in part to fatigue after the medical examination, and police interview. Most likely, even after having agreed to fill-out an evaluation survey, the task of reading and responding to questions may simply feel overwhelming (3, 6).

Although the in-person survey method had the highest response rate, that method relied on a partnership between a SANE program and an advocate program where the advocate conducted the survey evaluating SANE services (3). If inter-program collaborative evaluation is not an option, an in-person survey evaluating services provided by the interviewer may pressure the service recipient to give positive responses. It is also possible that the in-person interview style, and the self-administered paper pencil method each raised privacy or confidentiality concerns for the survivor. Computer-based administration of surveys have been shown to help traumatized participants feel less inhibited in their responses to survey items because they perceive that their confidentiality or anonymity is better protected; computer-based surveys did not lead to increased confusion for the survey participants (5, 10).
Conclusions and Recommendations

**Outcome measures in rape crisis service evaluation**

In terms of best practices for outcome measures for evaluating post-assault services, there are very few studies that provide details of their outcome measures. However, the few existing studies (3, 11) indicate that these surveys should be brief in order to avoid exacerbating a rape victim's post-assault circumstances such as being emotionally upset or fatigued. The evaluation questionnaire that was used to evaluate hotline and advocacy services consisted of 2 items: one which asked the client to rate the amount of *information* they received, and the amount of *emotional support* they felt they received. Additionally, in the case of advocacy services, a third item asked clients to rate how much help they received in making decisions regarding post-assault services and coping (3, 11). Counseling services were evaluated by administering pre- and postcounseling questionnaires asking the client to report on her levels of post-traumatic stress and her ability to cope with the assault or to find support (3, 11).

**Best practices in service evaluation data collection with rape victims**

We know that rape victims report the hope that their participation will help themselves, as well as other rape victims (2). However, we also know that certain contextual constraints regarding the circumstances in which rape services are provided, make collecting service evaluation data very difficult. For example, hotline and advocate service recipients are likely to be in crisis, and many may be too upset to answer additional questions immediately post-service. Furthermore, service recipients are not required to provide their private contact information which makes follow-up data collection (by phone or e-mail, for example) very difficult. In addition to this, we know
that those rape victims who agree to participate in an evaluation questionnaire immediately post-services are more likely to give positive evaluations; those who filled out an evaluation questionnaire at a later time were more like likely to report being dissatisfied with the services they received (3, 4, 5, 6, 11).

There are several ways that these challenges can be addressed. First, some agencies have had success administering questionnaires evaluating hotline or advocacy services to clients who receive counseling services. These clients are often referred to counseling services after receiving services from either the hotline or in-person advocacy. Secondly, hotline workers or advocates could invite service recipients to call back at a later time to do an evaluation on the phone, or invite them to visit the agency's website, and provide a link to an online evaluation questionnaire.

In the case of advocacy services, because service recipients are often given a packet of resources, including an insert which invites clients to evaluate the services received on the agency's website would be helpful in collecting more meaningful evaluation data. The packet could also include brief information about how survivors have found participation in research to be beneficial, and offer options for them to opt in to longer-term follow up interview that may be mutually beneficial to survivor and service provider. Hotline workers and advocates will be able to get some data by asking service recipients to take a survey immediately, by providing options to fill out an evaluation at a later time, either on-line, on the phone, or from counseling clients, an agency can increase the likelihood of getting valid, balanced data while respecting the clients immediate emotional needs.

An additional possibility for collecting on-site evaluation data is the use of
electronic devices for data collection. Using electronic devices to collect evaluation data seems to enhance clients' perception of anonymity. Therefore, by providing a small laptop or electronic device to ER advocates, then a brief evaluation survey could be administered immediately post-service. This may serve to avoid the positive response bias that may accompany the in-person post-service survey method.

It is important when considering all of this information that we use caution before drawing conclusions due to the limited body of published research examining evaluation of rape crisis services. However, as discussed above, there are still a variety of ways in which we can use what information there is to make small, but meaningful improvements in order to facilitate positive recovery for rape survivors.
References


