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VICTIM SERVICES

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Paralleling the development of interest in the issue of rape fostered by the women's movement has been the concern for the special needs of sexual assault victims and the establishment of victim service programs. The changes began in response to criticism of the lack of appropriate services provided by law enforcement agencies, medical facilities, and other groups which deal with victims (e.g., Hayman, et al., 1967).

Treatment and control programs have developed as part of this growing awareness of issues surrounding the victimization of women. Changes in sexual assault legislation and in interpretations of existing laws have occurred, and there have been notable responses from many medical facilities, criminal justice agencies, community victim services, and education and prevention programs.

The natural channels through which most victims of violent crime seek help are hospitals and law enforcement agencies (Center for Women Policy Studies, 1975). Unfortunately, as Hilberman pointed out "most citizens trust neither one of these institutions to deal with rape" (Hilberman, 1976). There are few personnel selected and trained to work with rape victims as well as the powerful fears of victims relating to the decisions to report and prosecute. Consequently, in addition to public pressure to improve existing services,

there has been a push to implement community-based services provided by women for women.

These program developments began with concerned workers sharing information and support. While women's action groups focused public interest, often small groups of people associated with more formal organizations, particularly hospitals, implemented programs (Hayman et al., 1967; Burgess and Holmstrom, 1973; McCombie, et al., 1976). Emergency room personnel, particularly nurses, became aware of the need to change services and provide support for victims. Medical centers already had the facilities and much of the staff, as well as a tradition involving service to victims. All that was lacking was training and directions for change.

At the same time rape crisis centers were formed by groups of women who saw the need for crisis support for victims. This served as an alternative to treatment by institutions that held a victim-blame perspective. The final development in this victim service delivery process has been that of paid helpers employed by criminal justice agencies and medical centers. They include counselors working in police departments and emergency rooms, assistant district attorneys with special responsibility for rape cases, and lay advocates working in prosecutors' offices.

The literature on services provided victims can be grouped for examination on the basis of type of provider--hospital, police, prosecutor's office, or crisis center, as each is somewhat different in focus.

Hospital services. Much of the professional literature is written by (and directed to) hospital personnel. In addition to the literature described

elsewhere, there is an ever increasing number of articles dealing with counseling needs of victims (Burgess & Holmstrom, 1974b) and with particular treatments (Hilberman, 1976; Center for Women Policy Studies, 1975).

Articles in the literature on specialized rape treatment programs within hospitals emphasize these points:

-- A trained victim-support person is provided; this is either a nurse, a mental health professional, or a volunteer, who is incorporated into the emergency team.

-- There is a focus on training team members to be aware of the emotional trauma resulting from rape and to provide support for the victim. The most common approach is a general educational program for all personnel, including receptionists and physicians, coming in contact with victims.

-- There is an attempt to provide immediate services and privacy for the victim.

-- Hospitals should develop structured protocols for medical management.

-- Many programs provide for crisis intervention counseling; however, for the most part, counseling methods and procedures are not carefully outlined.

Such treatment programs tend to be complex and difficult to administer (e.g., McCombie, et al., 1976). The Center for Women Policy Studies report (1975) points out that most hospital programs represent primarily surface changes, adding support personnel to an already existing team, rather than

any in-depth attitudinal and procedural changes. Services tend to be provided in larger hospitals with relatively large staffs. There is little literature on changes instituted in smaller hospitals serving smaller cities or rural areas.

As treatment programs are expanded, follow-up services have been provided as part of hospital programs or by utilizing a referral process. The philosophy of hospital-based treatment for rape victims is that the hospital takes responsibility for insuring comprehensive care for every victim by organizing the diverse resources necessary to provide that care (Abarbanel, 1976).

Police and Courts. Although the previously frequent police attitude of indifference to rape is beginning to change, there are still great problems with police and criminal justice system reactions toward victims of sexual assault. "Raped women are subjected to an institutionalized sexism that begins with their treatment by the police, continues through a male-dominated criminal justice system influenced by pseudoscientific notions of victim precipitation, and ends with the systematic acquittal of many de facto guilty rapists" (Robin, 1977). The additional trauma experienced by victims who choose to prosecute is also documented (Burgess & Holmstrom, 1974a, 1975a). Police departments suffer from lack of personnel identified and trained to work with sexual assault victims. Thus Hilberman (1976) concludes: "Although there has been recent attention focused on the importance of law enforcement sensitivity to the victim's mental state and the management of victims in crisis, this is not the prevailing concern of most law enforcement agencies. Victim treatment may be impersonal and unsupportive if not frankly disbelieving and hostile."

Much is written on the need for police and courts to provide sympathetic services responsive to rape victims; however, with the exception of two thoughtful articles (Bard & Ellison, 1976; International Association of Chiefs of Police, 1975), few constructive suggestions for teaching supportive behaviors to police officers have appeared. The changes in law enforcement agencies generally have been those of an increased awareness of the suffering of the victim, and (in reaction to the pressures of women's organizations) becoming more responsive to her needs (Robin, 1977). One trend, seen in the last few years, is the increased interest expressed by law enforcement agencies in rape information (Chappell, 1976). Still, law enforcement agencies do not usually provide extensive or programmatic victim support services.

Services are occasionally provided by prosecutor's offices in which advocacy and support are extended throughout the adjudication process (Center for Women Policy Studies, 1975; Burgess & Laszlo, 1976). Such programs have been found to be effective, not only in helping victims, but in increasing prosecution and conviction rates (Haas, 1976).

Several recurring recommendations for improving the victim's interaction with the criminal justice system have been made by many writers (e.g., Blumberg & Bohmer, 1975; Center for Women Policy Studies, 1975; Chappell, 1976). These include:

-- Changing attitudes of personnel within the system, particularly in the direction of increasing acceptance of victims' perspectives

-- Increased use of women as police officers, investigators, and advocates

-- Improved procedures for informing the victim of the progress of her case

-- Eliminating the need for repeated questioning about the details of the assault

-- Changes in laws, particularly regarding issues of consent and credibility of the complainant

-- Acceptance of the changing status of victims and women (not only by police, prosecutors and judges, but also with the general public).

Rape crisis centers. In addition to services provided by traditional caregivers, this relatively new type of organization provides services especially for victims of sexual assault. Rape crisis centers often developed from the concerns of feminist groups, on the principle that a community sense of women helping women provides the best support for victims. This philosophy, although tempered over time, still is the cornerstone of the crisis center movement.

While some community rape crisis centers are routinely called by the police or by hospitals, most operate without close contact with the medical or criminal justice systems, frequently by choice. Some rape crisis centers are staffed entirely by volunteers, while others have professional staff. Almost

all share a similar origin, however, in their development in response to expressions of concern from women. In some cases it was pressure from nurses to develop better emergency room services (Hilberman, 1976; McCombie, et al., 1976), while in other cases, groups of women, most often already with ties to the women's movement, decided to develop community-based services (Schmidt, 1973; Connell & Wilson, 1974).

The earliest centers developed almost simultaneously in 1971 and 1972 in geographically diverse cities (Center for Women Policy Studies, 1975; Largen, 1976). Their success coincided with the growing national awareness of rape as an issue and led to the development of centers by women in other cities and smaller towns. There was little literature available at the time on victim's reactions or on helping victims, and information was distributed through an informal network of mimeographed newsletters, workshops, and visits to other centers. Much of this tradition is continuing, with the result that there are only a few articles in the professional literature on crisis center development. Most of these are fairly recent descriptions of the work of specific centers (Brady, et al., 1976; Walsh, 1976; "University of Texas students counsel rape victims," 1976; Price, 1975; Rape Crisis Center, Boston, Massachusetts, 1975).

The goals of most centers include: 1) to provide supportive services to victims in the forms of hotlines, counseling, anonymous reporting, and advocacy; 2) to reform institutions which deal with victims (improved court procedures and changes in emergency room handling of victims are common reform goals); 3) to provide education and information on sexual assault; and

4) to reform the law (Center for Women Policy Studies, 1975). The degree to which each of these goals is met varies among centers. Because of their organizational structure, the limits on available volunteer help, personal preferences of staff, and realistic limits in local situations, groups focus on selective, specific issues and objectives.

Several issues have become important as centers develop and become more sophisticated in their delivery of service. Until recently, selection of counselors was handled informally, in that most members were acquainted through work on other women's concerns. Most centers operated on the principle that no woman wishing to help other women should be refused the opportunity to become a counselor. Now, however, counselors themselves are becoming objects of study (Center for Women Policy Studies, 1975; Best & Kilpatrick, 1977), and in some centers counselor selection policies are being established. A second issue is the use of males as counselors. There had been the feeling that men should not be allowed to directly counsel victims, either because of the belief that victims would be upset having to face a male soon after the attack, or because of the orientation of some centers that the anti-rape movement is a women's self-help effort. Thus, while males had been active in support positions (Center for Women Policy Studies, 1975; Silverman, 1977), now there is interest in their participation as counselors.

As rape crisis centers have developed, training has become more formalized. Some centers, such as the ones in Ann Arbor, Michigan, and Washington, D.C., have long made training manuals available to new groups

(Connell & Wilson, 1974; Hilberman, 1976; Csida & Csida, 1974). New manuals developed for use with many such helping groups are being made available through the more formal channels of journals and commercial publications (e.g., Resnick, Hill, & Dutcher, 1976).

Questions are being raised about the patterns of client utilization of services of rape crisis centers, whether institutional (such as hospital-based) or community based. Community centers tend to serve fewer victims than hospitals and those who do seek help are likely to be middle class and white. It is possible that there is a lack of awareness of these centers; furthermore, certain groups of women may view their services as inappropriate for their needs, seeing the centers as too radical, for example. Community based groups may appeal more to women who perceive hospital or police services as unresponsive (Robin, 1977). On the other hand, large hospital programs tend to have an overrepresentation of minority women, particularly Black or Spanish-surnamed women, and women from lower income groups (Peters, et al., 1976).

Specialized services for child victims are not often reported in the literature. With the exception of interviewing techniques and some aspects of the medical examination, child victims are treated in the same programs as adults. Many authors have urged, however, that special care be taken when children are involved (Burgess & Holmstrom, 1974b; Capraro, 1967; Breen, Greenwald, & Gregori, 1972).

Programs are evolving both from small groups of women sharing a common ideology, and from more formal groups, often with ties to existing

community institutions. Women's crisis centers, pressured by the need to provide personnel and funding to meet increased demand for services, are becoming more structured (Center for Women Policy Studies, 1975). In other places, groups of paid crisis workers, often trained in mental health services, are being employed (Blacker, 1975). Some centers are beginning to work closely with other community agencies, such as hospitals, police, and prosecutors (Bryant & Cirel, 1977; Hardgrove, 1976), pursuing the aims summarized by Bard (1976):

> The multiple needs of the victim point to the necessity for an integrated and collaborative approach by all segments of the helping system. . . . The victim must be assured that at whatever point she opts to enter the system--emergency room, police, private physician, mental health agency, or women's group--she will receive sympathetic support and needed services. Fragmentation of the helping network can only impede optimum service delivery. Integration and humanization can serve the cause of the victim, criminal justice, and society as a whole. (Bard, 1976)

Institutionally based and professionally staffed programs are not necessarily preferred alternatives or replacements for volunteer community groups. Each type of program provides services to different victims, as well as providing different types of services. In addition to appealing to groups of women who may distrust the medical or criminal justice agencies, community rape crisis centers are able to provide consciousness-raising challenges to

status quo organizations that might not be feasible for a crisis group operating closely with within the organization under fire. On the other hand, quasi-professional groups working within the system may more easily bring about procedural change.

A special area of concern is how the victim perceives her treatment at the hands of societal institutions that are identified as providers of victim services. The studies carried out by service groups tend to show victims satisfied with crisis services (e.g., Solomon, 1974). Reports covering general victim responses to treatment by medical groups, and justice agencies are less positive, with the court system receiving the most criticism (Dutcher, 1974; Bart, 1975; Price, 1975; Copeland, 1976).

The literature on societal response through victim services does not necessarily reflect the impact of specific service groups, but rather the proclivities of certain groups of professionals to write of their observations and ideas. The workings of hospital rape crisis centers are well documented, probably reflecting the academic and professional orientations of these workers, the perceived need for dissemination of information, and the availability of records from which to gather data. The lack of community rape center literature probably reflects the orientation of center workers as doers rather than writers. Their writings appear much more in local mimeographed documents than in national publications. In addition, there may be organizational preferences for protecting the privacy of victims, and hence strong feelings against keeping records. As a result that data on which to base descriptions of center work are not available.

There is now a compelling need for more complete descriptions of treatment programs and for assessment of the outcomes of treatment. We know little about the evaluation of services: the training courses, the programs, and the methods of counseling which are most effective. As in other areas in sexual assault, the literature on service delivery to victims has included much data gathered through casual observation rather than controlled research. The information has been collected from discussions of self-reports from small numbers of sexual assault victims. Systematic studies of victims as consumers of services have to be undertaken, as companions to studies of the service providers. Victim crisis centers appear to have had great impact on individual victims and on societal reactions to rape, but have barely been able to document their own success. The changes that occur in justice agencies, in community centers, in medical programs, and in victim responses should be carefully observed and reported in ways that are replicable and broadly applicable.

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