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Sexual Assault Center Advocates and Psychotherapists: An Exploratory Study of Interventions

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Sexual Assault Center Advocates and Psychotherapists: An Exploratory Study of
Interventions

by

Rena E. Lockerby, B.A.

MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
in Partial fulfillment of the Requirements for the Degree of
Master of Social Work

Committee Members

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

In the following qualitative study, the researcher attempted to identify and compare the self-identified approaches taken by Sexual Assault Center (SAC) advocates (n = 4) and outpatient psychotherapists (n = 4) in working with adult survivors of sexual violence. Using grounded theory methodology, data from semi-structured interviews were coded using an open coding process. From this, six themes emerged from the interviews with SAC advocates and ten themes emerged from the interviews with psychotherapists, suggesting approaches used when providing crisis intervention and counseling to adult survivors of sexual violence. These themes and their corresponding subthemes are discussed in this report. The study demonstrated that when providing crisis intervention and counseling to adult survivors of sexual violence, SAC advocates and psychotherapists take many of the same approaches, but that the work of SAC advocates is structured to be more short-term and to meet the immediate needs of survivors of sexual violence, whereas the work of psychotherapists tends to be more long-term and with the use of specific therapeutic treatment interventions and assessment tools. Several implications can be drawn from this study. This study informs direct practice of and referrals made by social workers, service choices made by survivors, policy surrounding the funding of SACs, and future research related to crisis intervention and counseling approaches used with survivors of sexual violence.

Keywords: Sexual Assault Centers, Rape Crisis Centers, Psychotherapy, Advocacy, Sexual Trauma, Sexual Violence, Sexual Assault, Rape

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Sexual Assault Center Advocates and Psychotherapists: An Exploratory Study of Interventions

According to the 2011 *National Intimate Partner and Sexual Violence Survey*, approximately “19.3% of women and 1.7% of men have been raped [forced penetration] during their lifetimes” (Breiding et al., 2014, p. 1). Moreover, approximately 43.9% of women and 23.4% of men have experienced other forms of sexual violence, such as unwanted or coerced sexual touch (Breiding et al., 2014). Breaking these rates down further, 64.1% of multiracial women, 55% of American Indian/Alaskan Native women, 46.9% of non-Hispanic white women, 38.2% of non-Hispanic black women, 35.6% of Hispanic women, and 31.9% of Asian or Pacific Islander women have experienced some form of sexual violence in their lifetimes (Breiding et al., 2014).

Furthermore, rates of sexual violence victimization are higher among lesbian, gay, and bisexual people than among heterosexual people (Walters, Chen, & Breiding, 2013). Although there are no national studies estimating sexual violence committed against transgendered people (Testa et al., 2012), the rates still appear to be high (Clements-Nolle, Marx, & Katz, 2006). Additionally, Casteel, Martin, Smith, Gurka, and Kupper (2008) found that “women with severe disability impairments were four times more likely to be sexually assaulted than women with no reported disabilities” (p. 87). In a study that looked at homeless individuals within five U.S. states, 49% said they have experienced a violent attack while homeless and 15% said that this violent attack took the form of a sexual assault or rape (Meinbresse et al., 2014). Clearly, rates of sexual violence victimization are high among the entire U.S. population, but are even higher in minority groups, specifically. Sexual violence is not about love or attraction (National Sexual Violence Resource Center [NSVRC], 2010); rather, it is a tool of oppression, used to control others (Rape Abuse Incest National Network, 2009). It is maintained by this oppression and by

the acceptance of misinformation about sexual violence, such as the myth that the victim asked for it so it's the victim's fault (Campbell, Dworkin, & Cabral, 2009). A large reason for the differences between minority and majority populations in terms of their experiences with sexual violence, is that those who belong to minority groups, such as women; non-whites; people who identify as lesbian, gay, bisexual, and transgender (LGBT); people with low socioeconomic status (SES); people who have disabilities; etc. often experience high rates of oppression just by the nature of their identities. Because people belonging to oppressed groups typically lack power and are often vulnerable because of their lower social statuses, they are an easier "target" for sexual offenders (Pennsylvania Coalition Against Rape, 2007, p. 7). Therefore, sexual violence is a social problem, maintained by oppressive institutions and harmful social norms.

Each state defines terms such as sexual violence, rape, and sexual assault differently (Rape Abuse Incest National Network, 2009). The following definitions will be used in this report unless specified otherwise. According to Centers for Disease Control and Prevention (CDC)/National Center for Injury Prevention and Control's publication, *Sexual Violence Surveillance: Uniform Definitions and Recommended Data Elements*, sexual violence is defined as

a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. It includes: forced or alcohol/ drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; nonphysically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces

or coerces a victim to engage in sexual acts with a third party. (Basile, Smith, Breiding, Black, & Mahendra, 2014)

The Division of Violence Prevention, National Center for Injury Prevention and Control, and the CDC's definition of rape will also be used in this report and is stated as "completed or attempted forced penetration or alcohol- or drug-facilitated penetration" (Breiding et al., 2014). The following definition of sexual assault, provided by the U.S. Department of Justice, Office of Violence Against Women (2015), will be used: "any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities such as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape" (What is Sexual Assault? section, para. 1). The term sexual assault is differentiated from rape in that it includes any form of sexual contact, including rape. Sexual violence is a term that includes rape and sexual assault, as well as other forms of non-contact, non-consensual sexual experiences such as being forced to watch others engage in sexual activities. Childhood sexual abuse will refer to any act of sexual violence against a child. Essentially, sexual violence refers to any form of unwanted sexual activity and, therefore, will be used most frequently in this report. It should also be noted that the terms "victim" and "survivor" will be used interchangeably throughout this report.

Not only does sexual violence impact so many people, it can also cause serious emotional, psychological, and behavioral issues for survivors and their friends and families. Possible reactions to sexual violence can include, but are not limited to flashbacks; hypervigilance; anxiety; feelings of helplessness, shock, numbness, fear, anger, guilt, shame, and self-blame; denial; sleeping and eating difficulties; and self-esteem issues (NSVRC, 2010). Often, these reactions are exacerbated by a victim's encounter with medical or criminal justice

personnel. When seeking medical or law enforcement services after an assault, victims are often met with blame and are faced with the re-traumatizing task of having to defend themselves in front of powerful professionals such as police, doctors, and prosecutors (Campbell, 2008; Campbell et al., 2009; Murphy, Banyard, Maynard, & Dufresne, 2011). These difficult experiences may be even worse for marginalized populations, such as those with low SES, those who identify as LGBT, and racial minorities, because those who belong to these groups are often discriminated based on their identities alone (Campbell, 2008). Similar unsupportive reactions by friends and family; a victim-blaming, oppressive society; and the effects of multiple and/or historical trauma can also impact a victim's reaction to sexual violence, specifically by perpetuating self-blame (Campbell et al., 2009). Clearly, sexual violence and social and systemic responses to victims can seriously impact a survivor's reaction to this type of trauma.

Support from psychotherapists and other community providers can often alleviate some of these negative responses and help the victim cope adaptively after a crisis like sexual assault. Campbell (2008) noted that community mental health clinics, community-based support services such as rape crisis centers, and treatment studies are avenues in which sexual assault survivors can access mental health care. However, the focus of this report will be on workers within mental health clinics and rape crisis centers. As noted previously, sexual violence encompasses more than the traditional definition of rape, or non-consensual penetration by a body part or object; therefore, the term *rape crisis center* may not accurately represent all forms of sexual violence seen by these community-based agencies. In order to be more inclusive of all forms of sexual violence, the term *sexual assault center (SAC)* will be used throughout this report, even though the term *rape crisis center* was seen most frequently throughout the literature. The term "advocate" will be used to refer to a person who carries out the work of a SAC, whether on a

paid or volunteer basis. Not only do SAC advocates and psychotherapists provide care for one's mental health needs, they can also help protect the victim from the damaging impact of being blamed, judged, and questioned by medical and criminal justice providers and unsupportive loved ones (Campbell et al., 2009). Even after faced with poor systemic response, sexual assault victims can benefit from the services provided by mental health clinics (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Campbell et al., 2009; McDonagh et al., 2005; Nishith, Nixon, & Resick, 2005; Posmontier, Dovydaitis, & Lipman, 2010; Russell & Davis, 2007; Taylor & Harvey, 2009) and SACs (Campbell et al., 2001; Campbell, 2006; Campbell et al., 2009; Decker & Naugle, 2009; Wasco et al., 2004; Westmarland & Alderson, 2013).

Mental health care can be received at outpatient mental health centers or private practice clinics from a variety of licensed professionals. However, these traditional mental health services are not used by sexual assault survivors as much as they could be (Campbell, 2008; Starzynski, Ullman, Townsend, L.M. Long, Long, 2007). Stigma surrounding mental illness (Clement et al., 2015) and sexual violence may be barriers to seeking mental health services (Koss, Bailey, Yuan, Herrera, & Lichter, 2003). Traditional mental health clinics may be less popular than SACs because SACs often provide free mental health support and do not bill health insurance (Campbell, 2008). Additionally, licensed psychotherapists such as psychologists and clinical social workers are not typically present in the immediate aftermath of a sexual assault like other professionals; therefore, they do not make the immediate connection with victims to provide initial crisis intervention, potentially impacting the facilitation of future mental health care (Campbell, 2008). Despite these barriers, psychotherapists have a lot to offer victims of sexual violence in terms of treatment interventions to help alleviate the traumatic impact of sexual violence. These interventions will be discussed in the literature review.

Trained advocates from community-based SACs may be able to accommodate for some of the limitations the mental health system imposes on traditional psychotherapy. SACs are typically non-profit, community-based agencies that provide support and advocacy for victims of sexual violence as they navigate the medical, law enforcement, and legal systems. Many SACs provide 24-hour crisis intervention through hotline services. SAC's also offer support and education to friends and families of victims, provide community education about sexual violence, and engage in systemic change and prevention efforts (Barker, 2014; Campbell, 2008; Wasco et al., 2004). Additionally, many SACs provide counseling services (Campbell, 2008; Wasco et al., 2004). When providing medical advocacy, most SACs have advocates available 24-hours a day to respond to local hospitals when a victim seeks medical attention after a sexual assault (Martin, 2005). Here, advocates typically educate victims on what their options are and on what to expect based on their choices, as well as provide emotional support and crisis intervention as the sexual assault forensic exam or "rape kit" is completed. In terms of law enforcement and legal advocacy, SAC advocates often explain the criminal justice process and related options to sexual assault victims, provide support while the victim makes a police report and attends court, and advocate for sensitive and victim-centered treatment (Campbell & Martin, 2001; Campbell, 2006; Shaw & Campbell, 2011). In a study on sexual assault survivors' experiences with the medical and legal systems with and without the presence of a SAC advocate, Campbell (2006) found that medical and legal advocacy provided by SAC advocates led to less victim blaming and more services offered by medical and law enforcement personnel. SACs are another service option that victims can access in order to improve their emotional health and well-being after a sexual assault.

In addition to medical, law enforcement, and legal advocacy, many SACs also provide free counseling (Campbell, 2008) and 24/7 hotline-based crisis intervention services (Wasco et al., 2004). These two services, specifically, will be focused on in this study. Mental health services provided by SACs are typically easier to access than traditional mental health care (Koss et al., 2003) due to their low or no-cost (Campbell, 2008). SAC counseling and crisis intervention can be provided by licensed psychotherapists or non-licensed advocates who are not trained to administer psychotherapy (Decker & Naugle, 2009). Decker and Naugle (2009) found that sexual assault survivors may actually prefer SAC services over traditional mental health treatment. However, the problem with the crisis intervention and counseling offered by SACs is that several researchers note that there is very little research on the procedures used (Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012) and on the effectiveness of these services (Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009). Additionally, there is little research, in general, about effective immediate post-assault intervention for rape victims (Decker & Naugle, 2009). This is particularly problematic as the demand for the use of evidence-based practice continues. The potential impact of not having research to back interventions used with survivors of sexual assault is that survivors may not be getting the support and services they truly need. As professionals who may be referring sexual assault victims to SACs or outpatient mental health clinics, or working in either of these agencies, it is important for social workers to be aware of the crisis intervention and counseling procedures used in order to best serve their clients. That is why the focus of this exploratory study will be on identifying and comparing the self-identified approaches taken by SAC advocates and outpatient psychotherapists in working with adults who have experienced some form of sexual violence at any point in their lives.

Literature Review

Impact of Sexual Violence on Mental Health

Sexual violence can have serious impacts on a victim's mental health. Specifically, there is a high correlation between the experience of sexual assault and the development of Posttraumatic Stress Disorder (PTSD), depression, substance abuse, and comorbid disorders (Kaltman, Krupnick, Stockton, Hooper, & Green, 2005; Zinzow et al., 2012). Those who have experienced multiple sexual victimizations are at higher risk of developing these disorders than those who have experienced single incidents or who have no history of sexual assault. In looking at PTSD, specifically, Carper et al. (2015) found that sexual assault victims who tended to feel numb or experienced flashbacks early after the assault were more likely to develop PTSD at a later time. Although this study was the first of its kind and has yet to be replicated, it suggests a crucial area for intervention (Carper et al., 2015). Additionally, the development of dissociative disorders is also correlated with the experience of childhood sexual abuse (Foote, Smolin, Kaplan, Legatt, & Lipschitz, 2006; Loewenstein & Putnam, 1990). It should also be noted that transgender people experience high rates of violence, such as sexual assault, and have particularly high rates of suicide attempts and substance abuse following this sort of trauma (Testa et al., 2012). In summary, the literature states that PTSD, depression, substance abuse, dissociative disorders, suicidal ideation, and comorbid combinations of these disorders can develop after sexual assault.

Treatment Used by Psychotherapists

Because of their training in the diagnosis and treatment of mental illnesses, psychotherapists may be helpful in alleviating the psychological consequences of sexual violence. Specifically, psychotherapists can be very useful in treating the diagnoses commonly

associated with sexual violence, such as PTSD, depression, and substance abuse (Zinzow et al., 2012). Several treatment techniques have been studied to treat mental health disorders in rape victims, but findings have elicited mixed results. The research surrounding each of these approaches will be summarized in the rest of this section.

The Cognitive Behavioral Therapies have received much attention in their use with survivors of sexual violence. McDonagh et al. (2005), Russell and Davis (2007), and Taylor and Harvey (2009) found Cognitive Behavioral Therapy (CBT), as a whole, to be an effective approach for treating sexual-assault-related PTSD. However, McDonagh et al. (2005) found that CBT was not effective in treating the specific symptoms of dissociation, depression, or anger. The CBT techniques of Cognitive Processing Therapy (CPT; Nishith, Nixon, & Resick, 2005; Vickerman & Margolin, 2009), Prolonged Exposure (PE), and Stress Inoculation Training (SIT; Vickerman & Margolin, 2009) have also led to the improvement of symptoms associated with sexual violence. Despite these successes, one study noted that CPT was associated with better treatment outcomes and a larger reduction in the symptoms of trauma-related guilt than PE (Nishith, et al., 2005). Overall, the Cognitive Behavioral Therapies, as models to aid in the psychological healing of survivors of sexual violence, seem well supported by the literature; however, more research should be done to evaluate their use with survivors who present with multi-faceted symptom profiles.

In addition to the Cognitive Behavioral Therapies, other therapies have also demonstrated success in the treatment of symptoms related to sexual violence. Although not as effective as CBT, Present-Centered Therapy (PCT) was found to be beneficial for treating PTSD in adult survivors of childhood sexual abuse, likely because of its psychoeducational and problem-solving components (McDonagh et al., 2005). Eye Movement Desensitization and Reprocessing

(EMDR) is another intervention that has shown success in the treatment of traumatic memories associated with sexual violence (Edmond & Rubin, 2004; Posmontier, Dovydaitis, & Lipman, 2010; Rothbaum, 1997; C. Tarquinio, Schmitt, Tarquinio, Rydberg, & Spitz, 2012; Vickerman & Margolin, 2009). However, there is very little research in the last 10 years on EMDR's use with victims of sexual violence. Like the Cognitive Behavioral Therapies, PCT and EMDR are generally supported by the literature as effective treatments for victims of sexual violence. Still, more time-relevant studies on the use of these interventions with victims of sexual violence are needed.

History of Sexual Assault Centers

In addition to outpatient psychotherapy, going through a SAC is another route victims can take to receive care after sexual assault. SACs emerged in the early 1970s as a feminist response to the large number of women being sexually assaulted and the poor treatment of these victims by social systems, such as medical, law enforcement, and legal entities (Gornick, Burt, & Pittman, 1985). The development of SACs was truly a grassroots effort; women gathered, brainstormed, and responded to the needs of their communities by providing informal crisis intervention, often through the form of a free 24-hour telephone hotline, and political activism, which was aimed at challenging the sexist structures that fueled this form of violence against women (Gornick et al., 1985). Although activism and consciousness-raising were large pieces of the work of early SACs, the direct service component quickly expanded to include a “companion” service, called advocacy, in which SAC workers would accompany sexual assault victims to hospitals and police stations when seeking medical care or reporting the crime (Gornick et al., 1985, p. 250). Often, these workers were unpaid, lay people, many of which were also survivors of sexual assault (Gornick et al., 1985). Equality and consensus-based

decision-making was the structure of these early SACs (Gornick et al., 1985). Essentially, SAC services of the early 1970s were about women helping women.

The number of SACs quickly increased throughout the 1970s, from 400 in 1976 to 1,000 in 1979 (Largen, 1981 as cited in Gornick et al., 1985). In addition to this increase in centers, the late 1970s also brought about change in the structure and function of SACs. Increased media attention on rape, as well as the availability of federal, state, and local funding for SACs, pushed these centers to move towards a more formal, hierarchical organizational structure (Gornick et al., 1985). This change, as well as the mental health field's recognition of the psychological effects of sexual assault, led to the addition of paid staff to the SACs' workforces of unpaid volunteers (Gornick et al., 1985). Despite the rising attention of the mental health field to this issue and its medical-model-view of mental health problems (Gornick et al., 1985), many SACs resisted the medical model's tendency to convey a power differential between staff and client as well as the tendency to pathologize the psychological responses to rape (Woody & Beldin, 2012). Some SACs began to hire mental health professionals, such as social workers, to provide training to SAC staff and volunteers and to provide direct services to victims of sexual assault, while other SACs continued to employ non-mental health professionals to provide the counseling and other direct services to victims (Gornick et al., 1985; Woody & Beldin, 2012). By the early 1980s, activities and services varied between SACs throughout the nation (Gornick et al., 1985). Despite this variation, Gornick et al. (1985) found that SACs typically oriented to one of two groups: "direct services" or "community education and action" (pp. 253-254). The political activism intrinsic to the birth of SACs in the 1970s decreased in the early 1980s as direct services, such as 24-hour in-person assistance or telephone crisis intervention and referral, as well as individual and group counseling, increased (Gornick et al., 1985). The late 1970s and

early 1980s brought many changes to the original SAC model. However, the counseling provided at SACs was, and still is, about helping victims work through feelings unique to their individual situations, such as shame, self-blame, and anger (NSVRC, 2010), and assisting these victims as they process their experience in the context of their relationships with friends, family, and partners (Shaw and Campbell, 2011).

Moreover, although some changes have been made, reflections of the early years of SACs are still seen in these agencies today. According to Shaw and Campbell's (2011) personal communication with the National Sexual Violence Resource Center, there were over 1,200 SACs in 2010. Most SACs today still provide the following core services: medical, law enforcement, and legal advocacy; 24-hour crisis intervention; and counseling (Barker, 2014; Campbell, 2014; Wasco et al., 2004). These services are often provided by both paid staff members and trained volunteers (Shaw & Campbell, 2011). Additional services provided by some SACs also include organizational training, distribution of informational resources to survivors and their friends and families, community outreach, prevention education, social change work, and policy advocacy (Campbell & Martin, 2001; Shaw & Campbell, 2011).

It is important to note that today's SACs are integral in the creation of Sexual Assault Nurse Examiner (SANE) programs (Campbell & Martin, 2001; Ledray, n.d.) and Sexual Assault Response Teams (SART) in communities throughout the nation (Ledray, n.d.). A SANE "is a registered nurse, R.N., who has advanced education in forensic examination of sexual assault victims" (Ledray, n.d., p. 7). SANE programs were developed to enhance evidence collection for criminal cases and to decrease victim blaming, long wait times, and other forms of poor treatment often experienced by rape victims in emergency rooms (Hatmaker, Pinholster, & Saye, 2002; Ledray, n.d.). SANEs and SAC advocates typically respond together when a sexual

assault victim seeks medical attention. The SAC advocate typically provides support and tends to the emotional and other needs of the survivor while the SANE collects medical evidence (Ledray, n.d.). SACs also play a big role in the development maintenance of SARTs which are teams made up of SAC advocates, SANEs, law enforcement, and prosecutors and are aimed at coordinating community responses to victims of sexual assault (Ledray, n.d.). For example, they help ensure that victims only have to tell their stories once when working with these professionals (Ledray, n.d.). Even though SACs have changed since their inception in the 1970s, their focus on the best interests of the sexual assault survivor have remained constant over the years.

Crisis Intervention and Counseling Approaches Used by Sexual Assault Center Advocates

As mentioned in the previous section, SACs provide a diverse set of services and activities including crisis intervention and counseling. The SAC service of crisis intervention is often free and is provided by trained volunteer or paid staff advocates through the SAC's 24-hour phone line (Barker, 2014; Campbell, 2008; Wasco et al., 2004). Crisis intervention at SACs often involves "crisis counseling, information, and referrals to a wide variety of community resources" (Wasco et al., 2004). Like crisis intervention, the counseling provided at SACs is often offered at low or no cost (Campbell, 2008). SAC counseling can be in the form of individual meetings or support groups (Woody & Beldin, 2012) and is typically offered to victims, as well as to those close to the victims who are indirectly impacted by the sexual assault (Wasco et al., 2004). In the early years of SACs, this counseling was often provided by peer survivors (Woody & Beldin, 2012), but is currently provided by trained volunteers, trained paraprofessionals, or licensed practitioners (Wasco et al., 2004). Although crisis intervention and counseling are typically offered at SACs, this writer found very little research that described

the procedures used and the effectiveness of these services. This finding is echoed in the literature (see Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012). This is particularly problematic because this service is often provided by non-licensed volunteers and paraprofessionals (Wasco et al., 2004). Additionally, Woody and Beldin's (2012) position on the crisis intervention and counseling services provided by SACs is that the differences between these two services is unclear. The lack of published guidelines on SAC crisis intervention and counseling procedures is concerning as these services have been a hallmark of SACs for years.

Despite the lack of research informing the crisis intervention and counseling provided by SACs, the literature does offer some theoretical approaches and suggests some guidelines that can direct advocates as they do this work. As mentioned previously, evidence-based interventions for victims of sexual violence do not exist due to a lack of research in this specific area (Decker & Naugle, 2009); however, Decker and Naugle's (2009) review of the research suggest that "sexual assault and trauma intervention literature" should guide the intervention and support provided by SACs. Specifically, the results of their literature review prompted Decker and Naugle (2009) to suggest that SAC advocates include the following elements in their work with survivors of sexual violence:

- Assess immediate safety
- Assess and respond to suicidality
- Help victims regain a sense of control
- Offer options and promote informed decision-making
- Coordinate provision of resources and services
- While coordinating services, advocate for respectful treatment

- Assess victim's social support and promote social support seeking
- Distribute information on common reactions
- Recommend counseling
- Recommend follow-up
- Believe the victim and avoid judgement or intrusiveness
- Remain calm (pp. 425-430)

Similarly, in a qualitative study of SAC advocates, Ullman and Townsend (2008) found that most SAC advocates endorsed an empowerment approach to working with sexual assault victims. This victim-centered approach, where the victim takes the lead in the recovery process, encompasses helping the victim regain control and make choices, linking the victim with resources, assisting the client with safety planning, and facilitating the development of a non-blaming support system (Ullman & Townsend, 2008). The problem with this study, however, is that it did not define whether the SAC advocates interviewed were licensed psychotherapists or trained staff or volunteers. Unlike Ullman & Townsend (2008), Campbell et al.'s (2009) study suggested that SAC advocates take an ecological approach to assisting victims of sexual violence. The ecological approach suggests several areas for intervention and may be particularly helpful in reducing the shame often experienced due to the words and actions of victims by family and criminal justice and medical personnel (Campbell et al., 2009). The little research that guides the crisis intervention and counseling provided by SAC advocates suggests that approaches be based on the trauma intervention literature as well as on empowerment and ecological models.

In an attempt to build an evidence-base for the work of SAC advocates, several studies have introduced Psychological First Aid (PFA) as an approach to working with victims of sexual

assault (Campbell, 2008; Decker & Naugle, 2009; Ruzek et al., 2007; Woody & Beldin, 2012). According to the *Psychological First Aid Field Operations Guide, 2nd edition*, PFA is an evidence-informed technique aimed at helping people of all ages immediately after a mass disaster or terroristic event (Brymer et al., 2006). It consists of eight “core actions,” which are summarized by Brymer et al. (2006) in Table 1.

Table 1. *Psychological First Aid Core Actions and Goals*

1. Contact and Engagement

Goal: To respond to contacts initiated by survivors, or to initiate contacts in a non-intrusive, compassionate, and helpful manner.

2. Safety and Comfort

Goal: To enhance immediate and ongoing safety, and provide physical and emotional comfort.

3. Stabilization (if needed)

Goal: To calm and orient emotionally overwhelmed or disoriented survivors.

4. Information Gathering: Current Needs and Concerns

Goal: To identify immediate needs and concerns, gather additional information, and tailor Psychological First Aid interventions.

5. Practical Assistance

Goal: To offer practical help to survivors in addressing immediate needs and concerns.

6. Connection with Social Supports

Goal: To help establish brief or ongoing contact with primary support persons and other sources of support, including family members, friends, and community helping resources.

7. Information on Coping

Goal: To provide information about stress reactions and coping to reduce distress and promote adaptive functioning.

8. Linkage with Collaborative Services

Goal: To link survivors with available services needed at the time or in the future¹.

Ruzek et al. (2007) noted that little research exists regarding appropriate intervention techniques for use with survivors within the first 14 days after the crisis. Even though CBT is a well-supported intervention for those that have experienced a traumatic event, it has not been studied for use within the first 14 days post-trauma and may be too intense for those in crisis (Ruzek et al., 2007). Therefore, SAC advocates, who are often amongst the first-responders to cases of sexual violence, could benefit from training in PFA. In a sense, the use of PFA in SACs can bridge the gap between traditional psychotherapeutic techniques and the beneficial, yet not clearly defined, work of SAC advocates (Campbell, 2008).

Despite the findings of multiple studies that suggest there is little research on SAC crisis intervention and counseling procedures and their effectiveness (see Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012), there are many studies that support the work of SACs. Due to confidentiality policies and the psychological and physical crisis that victims are often in when seeking services from SACs, evaluating SAC services based on the victim's perspective can be difficult (Wasco et al., 2004). In an effort to address this issue and to begin to substantiate the counseling provided by SACs, Westmarland & Alderson (2013) created the *Take Back Control Scale* and used it to survey survivors of sexual violence. Westmarland and Alderson (2013) found that these participants

¹ Note: Taken from p. 19 of Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., . . . Watson, P. (2006). *Psychological First Aid: Field Operations Guide (2nd Ed.)*. Retrieved from http://www.nctsn.org/sites/default/files/pfa/english/1-psyfirstaid_final_complete_manual.pdf

improved on every item, with the biggest changes seen in feelings of empowerment and control, frequency of flashbacks, and existence of panic attacks (Westmarland & Alderson, 2013). The finding that sexual violence survivors improved most in the area of feeling empowered and in control of their lives (Westmarland & Alderson, 2013) is interesting in light of Decker and Naugle (2009) and Ullman and Townsend's (2008) conclusion that helping victims regain control is a significant element in the approaches taken by SAC advocates in their work with victims of sexual violence. Despite this evidence that supports the effectiveness of SAC counseling, it is unclear whether the counselors in Westmarland and Alderson's (2013) study were psychotherapists or trained non-psychotherapist staff or volunteers.

Additionally, based on sexual assault victims' self-report data, both Campbell (2006) and Wasco et al. (2004) found some of the first empirical evidence to support the effectiveness of the medical and law enforcement advocacy provided by SAC advocates. Similarly, Campbell and Martin's (2001) literature review revealed that SACs have consistently addressed systemic oppression over the many years of their existence, thus improving service delivery to and the wellbeing of victims of sexual violence. Furthermore, SAC advocates see their work with survivors as beneficial (Murphy et al., 2011). Although the level of professional training and the procedures employed by the SAC service providers were unclear, one study found victims' self-report of SAC counseling to be positive (Wasco et al., 2004). Given positive findings such as these, SACs and their services should continue to function and be presented as an optional resource for all survivors of sexual violence (Campbell, 2006; Campbell et al., 2009). Even though several studies noted that there is little research in the area of SAC crisis intervention and counseling (see Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009; Ullman &

Townsend, 2008; Woody & Beldin, 2012), this writer was able to find some literature that speaks to the value of SACs and the work accomplished therein.

Upon review of the literature surrounding the approaches used by psychotherapists and SAC advocates in working with victims of sexual violence, both similarities and differences have emerged. First, both types of providers focus their approaches on the individual survivor; however, SAC advocates also seem to intervene in areas beyond that of the individual victim. This is evidenced by the typical SAC services of medical, law enforcement, and legal advocacy; community education; and policy work (Barker, 2014; Campbell, 2014; Campbell & Martin, 2001; Shaw & Campbell, 2011; Wasco et al., 2004). Despite the broad scope that SAC advocates seem to take, their interventions appear to directly or indirectly help the individual survivor. Second, SACs differ from traditional psychotherapy in that their services can be provided by non-licensed advocates who are not trained in psychotherapy (Gornick et al., 1985; Woody & Beldin, 2012), whereas outpatient psychotherapy must be provided by licensed mental health professionals. Third, both SAC advocates and psychotherapists seem to work towards strengthening a survivors' psychological, emotional, and social wellbeing, as evidenced by the treatment techniques used by psychotherapists and the counseling and crisis intervention services provided by SAC advocates. Fourth, the evidence behind psychotherapy approaches seems stronger than that of SAC interventions. These similarities and differences suggested in the literature further support the need for studies, such as this one, to further identify and compare the approaches taken by SAC advocates and psychotherapists.

Summary

The literature on SAC advocates' and psychotherapists' work with victims of sexual violence is centered around the impact of sexual violence on mental health, the treatment used by

psychotherapists, the history of SACs, and the crisis intervention and counseling approaches used by SACs. Sexual violence impacts a survivor's mental health, as evidenced by the high rates of PTSD, depression, substance abuse, dissociative disorders, suicidal ideation, and comorbid disorders (Foote et al., 2006; Kaltman et al., 2005; Loewenstein & Putnam, 1990; Testa et al., 2012; Zinzow et al., 2012). Research shows that interventions often used by psychotherapists to address these psychological consequences of sexual violence include the Cognitive Behavioral Therapy techniques of Prolonged Exposure, Cognitive Processing Therapy, and Stress Inoculation Training as well as Present-Centered Therapy and Eye Movement Desensitization and Reprocessing. Despite the success of these treatments, there is not a lot of research identifying which psychotherapeutic approaches are best to use within the first few hours and days after a traumatic event, such as a sexual assault (Decker & Naugle, 2009; Ruzek et al., 2007).

SACs, which first grew out of the anti-rape movement of the early 1970s (Gornick et al., 1985), are another place where sexual violence victims can get support for their mental health and other needs. Many SACs provide medical, law enforcement, and legal advocacy; 24-hour crisis intervention; and counseling, among other services (Barker, 2014; Campbell, 2008; Wasco et al., 2004). Unfortunately, there is very little research on the specific procedures used in SAC crisis intervention and counseling, as well as on the effectiveness of these two services (Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012). Additionally, the few studies that *are* available that outline approaches used by SACs are not clear as to whether these practices are carried out by psychotherapists or non-psychotherapists, who are well-trained staff or volunteers. However, these approaches briefly discussed in the literature seem to be victim-centered and empowerment-based (Decker &

Naugle, 2009; Ullman & Townsend, 2008). Despite this lack of an evidence-base for the work of SAC advocates, there are studies that say this work is beneficial to victims (Campbell & Martin, 2001; Campbell, 2006; Murphy et al., 2011; Wasco et al., 2004). PFA was mentioned frequently in the literature as a possible evidence-informed set of guidelines to be used by SAC advocates. However, this approach has not yet been studied for use with sexual violence victims.

Given the psychological impact of sexual violence and the existence of traditional mental health clinics and SACs, it is important that direct service providers, such as social workers, and survivors of sexual violence be aware of the approaches taken by psychotherapists and SAC advocates in working with victims of sexual violence. The lack of time-relevant research specific to psychotherapeutic interventions for victims of sexual violence, as well as to the crisis intervention and counseling approaches used at SACs makes obtaining this awareness difficult. Therefore, using grounded theory methodology, the current study will attempt to answer the following research questions: When providing crisis intervention and/or counseling to adult victims of sexual violence, what are the approaches taken by SAC advocates and psychotherapists? How do these approaches compare to each other?

Conceptual Framework

The conceptual framework that guided this study was the ecosystems paradigm. Barker (2014) defines the ecosystems paradigm as a conceptual lens through which the social worker can note the systematic relatedness of case variables. The ecosystems perspective offers no prescription for intervention but as a meta-theory attempts to depict phenomena in their connectedness and complexity. This perspective permits multiple practice theories, approaches, and practitioner roles. (p. 135)

According to Forte (2007), the ecosystems paradigm is made up of two theories: the ecological perspective and the systems approach. As parts of the ecosystems paradigm, these components combined to inform the data analysis of this study.

The first component of the ecosystems paradigm is the ecological perspective.

According to the ecological perspective, people and the environments in which they live are inseparable; therefore, social workers and other direct service providers must focus on these two components simultaneously (Forte, 2007). Direct service providers who endorse an ecological approach to working with clients focus on the transactions between the unit of attention, or the individual client, family, or community, and that unit's environment (Barker, 2014; Forte, 2007). For the purpose of this study, the unit of attention was the individual client or survivor of sexual violence. "Positive transactions" between the client and a specific aspect of the environment or within aspects of the client's environment indicate a healthy, good fit where the needs of both the client and the environment are being met (Forte, 2007, p. 142). Conversely, "negative transactions" indicate an unhealthy, poor fit (Forte, 2007, p. 143). This is where direct service providers who endorse an ecological approach focus their interventions in order to help the client and the environment meet their full potentials (Forte, 2007). These concepts of the ecological perspective guided the current study.

The second component of the ecosystems paradigm is the systems approach. Barker (2014) defines the systems approach as "those concepts that emphasize reciprocal relationships between the elements that constitute a whole. These concepts also emphasize the relationships among individuals, groups, organizations, or communities and mutually influencing factors in the environment" (p. 423). Like the ecological perspective, the systems approach also necessitates that the direct service provider focuses simultaneously on the person and the

environment (Forte, 2007). According to the systems approach, the environment is made up of interacting, ever-changing systems (Forte, 2007). Systems of specific note are Bronfenbrenner's (1979) micro, meso, and macro systems. Macro-level systems include "society, communities, and organizations;" meso-level systems include "the client's network of personal settings and the interactions among them;" and micro-level systems include "the individual, family, or group and its small, immediate, and personal environmental setting" (Bronfenbrenner, 1979 as cited in Forte, 2007, pp. 191-192). Interaction of these systems can either be functional or dysfunctional depending on the goals of the client system. Accordingly, intervention is directed at the dysfunctional interactions. Important for intervention is the systems approach's assumption that changes in one system impact the other systems with which the client is interacting (Forte, 2007). The systems approach, a component of the ecosystems perspective, and its focus on the person within micro, meso, and macro systems was considered in the analysis of this study's data.

The ecosystems perspective can naturally be applied to the experiences of survivors of sexual violence and to the approaches taken by SAC advocates and psychotherapists in working with this population. When a person is sexually assaulted, the reactions and responses of micro, meso, and macro environmental systems will impact the victim's experiences associated with the aftermath of the sexual assault. At the macro-level, society's level of understanding of the dynamics of sexual violence as well as its position on sexual violence as a social problem (i.e. Does society endorse misconceptions about sexual violence, such as the victim is at fault for the assault?) will impact how victims view their own experiences. At the meso-level, whether or not the survivor's community is set up to appropriately and sensitively handle the needs of the survivor (i.e. Does the community have a SANE or SART program or a SAC? Are law

enforcement, medical, and mental health agencies equipped to meet the unique needs of sexual violence survivors and do these institutions approach survivors with sensitivity and compassion?) will impact the mental health of the survivor and may influence whether or not the survivor engages in the criminal justice system. Finally, at the micro-level, the reaction of the survivor's support system and the survivor's demographics, history of mental health issues prior to the assault, personal capacity to deal with stress, etc. will affect that survivor's mental health and wellbeing after the sexual assault. In terms of assessment and intervention, SAC advocates or psychotherapists could consider macro, meso, and micro factors and could intervene in several areas within the client's environment, such as in the areas of mental health, physical health, spirituality, family, friendships, housing, finances, school, work, social institutions, etc. Because the ecosystems paradigm suggests several areas for assessment and intervention, it was used as the conceptual framework that guides this study.

Methods

Research Design

This study used a qualitative research design to answer the following research questions: When providing crisis intervention and/or counseling to adult victims of sexual violence, what are the approaches taken by SAC advocates and psychotherapists? How do these approaches compare to each other? The purpose of this exploratory study was to identify and compare the self-identified approaches taken by SAC advocates and outpatient psychotherapists in working with adults who have experienced some form of sexual violence at any point in their lives. Therefore, the sample contained both SAC advocates and outpatient psychotherapists. Data were collected through in-person, semi-structured interviews and brief demographic email surveys containing mostly open-ended questions in order to align with the exploratory nature of this

study and to minimize the influence of the researcher. The semi-structured interview questions explored the experiences of participants providing counseling and/or crisis intervention services to adult survivors of sexual violence. Data were analyzed using an open-coding process based on grounded theory methodology and guided by the conceptual framework of the ecosystems paradigm.

Sample

The sample consisted of Minnesota-based SAC advocates and psychotherapists. A convenience sample of four SAC advocates was obtained from one Minnesota Coalition Against Sexual Assault member program. The researcher followed the following steps to obtain these participants: (1) the researcher used the *Rape Help MN* database (<http://rapehelpmn.org/find-help/>) to search for SAC's within a 200-mile radius from the researcher's residence. (2) Then, the researcher located a SAC that provided free crisis intervention and counseling services. (3) When choosing the SAC, the researcher gave preference to agencies that utilize paid, staff advocates who are not trained in psychotherapy to provide these services as it could be reasonably assumed that paid staff have the highest level of training amongst SAC advocates; however, unpaid interns and volunteers would have also been accepted as participants if they had provided crisis intervention and counseling services. (4) Next, the researcher made a phone call and sent an email to the identified SAC's executive director and requested permission to recruit participants from the agency (see Appendix A). After permission was granted, the researcher obtained an email on agency letterhead from the agency, indicating permission to recruit advocates for participation in the study (see Appendix B for a letter template). (5) The researcher called and/or emailed staff at the identified agency and asked them two screening questions to help ensure they provided both crisis intervention and counseling services to

survivors of sexual violence. The first screening question was, “Are you responsible for carrying out the following function of your agency: in-person, support counseling with adults?” The second screening question was, “Are you responsible for carrying out the following function of your agency: crisis intervention with adults?” SAC advocates who answered “yes” to both screening questions were invited, in accordance with the protection of human subjects as described in the next section, to participate in the study (see Appendix C).

This recruitment strategy resulted in four adult female participants from one Minnesota-based SAC. Three of the four SAC advocate participants were paid staff. One was a paid part-time staff member and volunteer. The experience of these participants in their roles as SAC advocates ranged from 1.5 years to 8 years. One participant had a Bachelor’s Degree, two participants had Masters Degrees, and one participant had a Doctoral Degree. Each SAC advocate participant identified as having a minimum of 40 hours of Minnesota-mandated sexual assault advocacy training

A convenience sample of four Minnesota-based, licensed psychotherapists from a variety of professional backgrounds were recruited from the public listings in the *Psychology Today* website (<https://therapists.psychologytoday.com/rms/>) to participate in this study. The researcher searched for psychotherapists whose offices were located within a 200-mile radius from the researcher’s residence. The researcher then initiated a two-part screening process to determine, based on self-reports, if the psychotherapists initially selected had experience providing psychotherapy to adult survivors of sexual violence. This two-step process is described as follows: (1) the researcher viewed profiles on *Psychology Today* and selected psychotherapists who indicated an area of practice that included issues such as, “sexual abuse” and/or “trauma.” (2) If the profiles included one or both of those terms, the psychotherapists were contacted by

phone and/or email and asked a screening question to better ensure experience with clients/survivors of sexual violence. The screening question was, “Do you have experience working with adult clients whose primary concerns are related to the direct impact of experiencing sexual violence?” If the answer to this screening question was “yes,” the psychotherapist was invited, in accordance with the protection of human subjects described in the next section, to participate in the study (see Appendix D).

This recruitment strategy resulted in four adult female psychotherapist participants. Two of the psychotherapist participants had a Master of Social Work degree and were Licensed Independent Clinical Social Workers. One of the psychotherapist participants had a Master of Arts degree in counseling psychology and was a Licensed Professional Clinical Counselor. The other psychotherapist participant had Master of Science Degree in Counseling Psychology (school counseling and community counseling), a Post-Graduate Certificate in Marriage and Family Therapy, and was a Licensed Marriage and Family Therapist. The experience of these participants in their roles as psychotherapists ranged from 3 to 23 years. Two of the psychotherapist participants were in private practice, one was in a small group practice, and the other was a program manager at a clinic.

Once participants initially agreed to participate in the study, a brief demographic survey was sent to them via email prior to the in-person, semi-structured interview. The survey consisted of the following four questions: (1) How many years have you been an advocate/psychotherapist? (2) What is your role within the agency in which you work (example: paid staff member, volunteer, private practice psychotherapist, community mental health center psychotherapist, other)? (3) What is your educational background (example: degree[s] and licensure[s])? (4) What kind of training did you receive to perform your current role as an

advocate/psychotherapist? The answers to these questions were collected after the consent form, indicating agreement to participate in the study, was signed.

Protection of Human Subjects

This study was approved by the Institutional Review Board (IRB) of the University of Saint Thomas (UST) prior to participant recruitment and data collection. The participants reviewed and signed the consent form prior to their interviews and the collection of their brief demographic survey responses. This consent form was created and presented based on the UST's IRB guidelines. It informed participants of the background, procedures, risks and benefits, and confidential and voluntary nature of the study (see Appendix E).

The researcher engaged participants in a discussion about informed consent prior to the signing of the consent form. The researcher notified participants that the interview would be audio-recorded, would last approximately one hour to one hour and 15 minutes, and that their responses would be transcribed and coded for the purpose of data analysis. The participants were also told that their responses would remain confidential. The researcher explained that data obtained from participant interviews and surveys would be shared in the form of a written, publically available research report, and in the form of an oral presentation for the purpose of dissemination of results. However, participants were assured that their names, the agencies they worked for, and any other identifying information would not be included in the study report or shared in the oral presentation. Additionally, participants were told that audio-recordings, transcripts, survey responses, signed consent forms, and letters of agency permission to recruit participants would be kept in a locked file cabinet and/or in a password protected file on the researcher's computer. They were also told that audio recordings would be deleted when transcription of the interviews was complete and that transcripts and survey responses would be

destroyed by June 1, 2017. Participants were told that the consent forms and The Letter of Agency Permission to Recruit Participants would be destroyed in three years after the completion of the study per federal regulations. The researcher also discussed the potential risks, precautions, and benefits of the study. Participants were given time to ask questions prior to the study and were informed that they could withdraw from the study at any time. Additionally, the researcher asked open-ended questions at the end of the informed consent discussion in order to check for comprehension. Informed consent was an ongoing discussion between the researcher and participant, even after the consent form was signed.

Data Collection Instrument and Process

Agreement to participate in this study was signified by each participant's signature on the consent form. At that time, the researcher collected answers from the brief demographic survey described previously. Once the consent form was signed, the researcher conducted a semi-structured interview, guided by an interview guide and completed in a confidential setting. The interview guide (see Appendix F) was informed by a review of the relevant literature and the conceptual framework of the ecosystems paradigm. It contained a face sheet where the researcher assigned an identification number to the participant (based on the type of participant and the order of the interview, i.e. *Psychotherapist 1*); documented the date, time, and location of the interview; and read relevant information before beginning the interview. The interview guide also contained 22 questions related to the main research questions of this study and included probes and prompts to clarify these questions and to add "depth and richness" to the content (Padgett, 2008, p. 111). Most of the interview questions were designed as open-ended to allow for open responses from the participants, to minimize the influence of the researcher, and to fit with the exploratory nature of this study. The interview guide was organized to include

questions about the assessment of clients who have experienced sexual violence at the beginning of the interview. The middle of the interview guide included questions about the perspectives of participants in providing counseling and crisis intervention to survivors of sexual violence. The end of the interview guide included questions about ending services with survivors of sexual violence.

The semi-structured interviews were audiotaped using a digital voice recorder for the purposes of data analysis. Due to the semi-structured nature of the interview, the researcher departed slightly from the interview schedule to ask unplanned questions in order to gain information that would not have been collected otherwise if only strict adherence to the interview guide was followed. Questions that departed from the interview guide related back to the initial research questions so that the integrity of the study was maintained.

Data Analysis Plan

The data obtained from the semi-structured interviews and demographic surveys was analyzed using grounded theory methodology. Additionally, the data analysis was informed by the conceptual framework of the ecosystems paradigm as described previously. Grounded theory is an inductive approach to data analysis that draws abstract codes, themes, and theories from raw data. Rather than following an exclusive, step-by-step process from data collection to the creation of themes and theory, grounded theory allows for a constant back-and-forth between each step of the data collection and analysis processes (Monette, Sullivan, Dejong, & Hilton, 2013). In this study, data analysis ended with the creation of themes rather than theories.

Each audiotaped interview and survey response was transcribed and analyzed. The data from each interview and survey was coded using open coding, which is a process where the coder goes through the data as many times as necessary to develop themes and categories that fit

the information presented (Monette et al., 2013). The researcher engaged in this open-coding process by reading each transcript and corresponding survey, highlighting phrases that appeared to be related to the research questions, writing memos that represented the thoughts of the researcher, noting key words used by the subject, and creating preliminary themes and subthemes based on the codes and memos produced by the researcher. These preliminary themes and subthemes were compared to the researcher's memos to make sure no codes were missed. Additionally, quotes from the interview transcript and survey were matched with the appropriate theme or subtheme in order to further refine and evaluate the appropriateness of these categories. Coding ended when saturation had been reached.

Findings

Using grounded-theory methodology, this study attempted to answer the following research questions: 1) When providing crisis intervention and/or counseling to adult victims of sexual violence, what are the approaches taken by SAC advocates and psychotherapists? 2) How do these approaches compare to each other? The findings will be separated by research question and presented in this section of the report.

In response to the first research question (When providing crisis intervention and/or counseling to adult victims of sexual violence, what are the approaches taken by SAC advocates and psychotherapists?), six themes were identified in the data obtained from the interviews with SAC advocates (n = 4). These themes were Peer/Community Advocacy Model, Regulate Mind and Body, Address/Build Support Network, Safety Planning, Provide Informed Referrals, and Address the Impact of the Social Context. The theme of Peer/Community Advocacy Model and Regulate Mind and Body were broken down into subthemes. These subthemes will be outlined later in this section. Ten themes were identified in the data obtained from the interviews with

psychotherapists (n = 4). These themes were Conduct Assessments; Survivor-Centered Approach; Empower; Validate, Normalize, and Support; Provide Psychoeducation; Teach Coping Skills; Treatment Interventions; Address Support Network; Safety Planning; and Provide Referrals. The theme of Treatment Interventions was broken down into five subthemes. Explanations of the themes and subthemes from each group of participants, as well as examples from the data that support these findings, will be described in the remainder of this section.

SAC Advocates

Peer/community advocacy model. With the exception of a wording difference, this theme was specifically mentioned by SAC advocate participants as an approach that SAC advocates take in working with survivors of sexual violence. It was said to encompass the following components, in which the researcher also found to be subthemes: Survivor-Centered and Driven Approach; Address Immediate Concerns/Triage; Provide Informed Options; Empower; Validate, Normalize, and Support; Provide Psychoeducation and Information; and Teach Coping Skills. Key phrases used by the participants to develop each of these subthemes will be highlighted as follows.

Survivor-centered and driven approach. This was identified as a subtheme of the Peer/Community Advocacy Model theme because SAC advocate participants frequently mentioned that the survivor leads the crisis intervention and counseling sessions that they provide:

It's entirely, again, driven by them as to what they want to work on.

Participants also mentioned that the survivor is the expert and that their work is centered on that survivor. This can be seen in these statements:

I rely on the techniques inherent to community advocacy, so very much about knowing that the person intuitively knows what's best for their lives.

What do you want to focus on? Because we are very person-centered and the person is their own best expert, so they get to guide what the topics are and the structure.

Additionally, SAC advocate participants noted that they meet the survivor where they are at and tailor services to meet the individual needs of each client.

We're really trying to meet, again, meet that person where they're at, let them decide where the conversation is going.

We see people of all identities and all experiences and so you're right, we do sometimes have to tailor a little bit depending on what happened to the person, what options that they have.

These examples from the data collected from SAC advocates show that the Survivor-Centered and Driven Approach, a subtheme of the Peer/Community Advocacy Model theme, developed out of codes about SAC advocate participants' approaches being survivor-led, focused on the survivor as expert, survivor-centered, aimed at meeting survivor where they are at, and tailored to the individual person.

Address immediate concerns/triage. Several statements made by SAC advocate participants stated that their approaches are like providing triage; they address immediate concerns then make a plan going forward. The following statements support this subtheme:

We're trained in triage. We bandage up the person, but if they have like a thyroid condition, we can't start going into that more in-depth care. We're here for like that broken bone or for that blood that needs to be taken care of right now. So if the person is talking about a relationship with a parent, we can be open to that to an extent but recognize that if they really need to go into like some deep relationship patterns or deep hurts or something like that, that's when we might make a referral to therapy and with the counseling sessions we're always trying to tie the topic to the sexual assault, is my understanding.

Because that's the reality of it, is one-on-ones are not sustainable, and they're not built to be sustainable, they're built to sort of be that triage between the immediate crisis and something more sustainable.

So working through that process of providing for those kinds of immediate concerns.

According to SAC advocate participants, SAC crisis intervention and counseling is analogous to medical triage and exemplifies the short-term, immediate nature of SAC advocate approaches within the Peer/Community Advocacy Model.

Provide informed options. This subtheme of the Peer/Community Advocacy Model theme encompassed statements made by SAC advocate participants that characterized their approaches to counseling and crisis intervention as providing survivors with information about their options and letting them decide what they want to do in light of those options.

The advocacy perspective is sort of laying out options and then letting them know that you can really pick whatever it is you want to pick and then we'll help you moving forward, whatever that looks like for you.

We aren't making decisions for people about what will heal them because we don't know that, we can only provide options in an accessible way and really providing information about those options.

Participants noted that providing survivors with information about their options was part of the Peer/Community Advocacy Model of SAC counseling and crisis intervention. Further analysis supported it as a subtheme of this model.

Empower. SAC advocate participants noted that empowering survivors to make their own decisions was a way of giving survivors power and control, two capacities that were taken away from the person during the sexual assault.

Advocacy model has been very useful because it allows people to feel empowered in their lives again after they have had their power taken away from them.

In our one-to-one peer advocacy, counseling is much more about empowering the individual, sharing knowledge and information as an equal, not as someone who is board certified or licensed.

The data revealed that empowering survivors was an approach used when employing the Peer/Community Advocacy Model to counseling and crisis intervention.

Validate, normalize, and support. The data showed that when providing counseling and crisis intervention, SAC advocate participants take a non-judgmental stance and validate, normalize, and support survivors' thoughts, feelings, behaviors, and experiences. This subtheme is supported by the following quotes from SAC advocate participants:

Really welcome and try to normalize and validate that whatever comes up might oscillate and change so frequently, too and that's normal and really trying to validate their experience, especially because the media only gives such narrow images of what is sexual assault and how someone responds and that really affects juries a lot too because the survivor is not acting like I think a survivor should and it can really affect the decision.

Folks really just need support and validation.

If they're feeling really escalated, validating the fact that they're feeling escalated and that their emotions are maybe all over the place, and that that's completely normal in terms of a reaction to a sexual assault. Any reaction is normal to a sexual assault; there's no typical reaction to a sexual assault, and I think validating that they're not crazy, that there's not something wrong with them and figuring out, once they can get to a safe place for themselves emotionally, figuring out what next steps would look like.

Other statements in this subtheme were about the SAC advocate participants conveying to survivors that they believe them. SAC advocate participants identified that, under the Peer/Community Advocacy Model, they validate, normalize, and support sexual violence survivors when providing counseling and crisis intervention.

Provide psychoeducation and information. Several codes were combined to form this subtheme. Some of the codes identified participant phrases that were focused on providing education on the definition and prevalence of sexual violence, as evidenced by the following quote:

It is education, information on prevalence of sexual violence, what sexual violence looks like, helping people name what has happened to them because for some folks they can't even come to terms with the fact that it was rape.

Other codes were about providing information about working with systems, such as the medical and criminal justice system.

We try to prepare them and give them the most accurate information possible about what they'll likely experience interacting with whatever systems professional that they are going to be interacting with. So, if they are going to be going into a police interview, we'll go with them, but we always kind of tell them what they'll potentially expect.

The rest of the codes identified areas in which psychoeducation was provided, such as in the areas of trauma, grief, self-esteem, healthy boundaries, communication, trust, and healthy relationships. Examples of some of these statements are as follows:

So when people can't quite remember or their memories are really scattered and they can't quite understand, talking through like when the brain...so thinking through like there are going to be parts you can't remember that's connected to this particular process in the brain. Your memory fragments because your pre-frontal cortex is no longer in charge. And so I call it like the logic brain versus the lizard brain.

People ask to talk about grief a lot, whether it's grief that they're experiencing from the assault. That's really common. It absolutely feels like a loss or a death of some part of people, many times, so dealing with it as grief is appropriate and so I think definitely working with that, so talking about and just educating around the fact that it's a healthy emotion to be having in this scenario so grief, self-esteem.

Provide Psychoeducation and Information is a multi-faceted subtheme of the Peer/Community Advocacy Model theme because it consists of codes about providing education on the definition and prevalence of sexual violence, information about working with systems, and psychoeducation on various areas of mental health.

Teach coping skills. SAC advocate participants identified that coping was part of the Peer/Community Advocacy Model approach to crisis intervention and counseling as evidenced by the following statements made in the SAC advocate interviews:

Finding alternative methods to help people cope with trauma, trauma/sexual violence. So things like coloring, for example, or providing fidgets so people have something to do with their hands as just a way to set themselves at ease.

Even with like self-harm, telling them to hold ice cubes instead of cutting.

What's worked for them in the past? If they can't think of anything, do you like to take hot showers, or do you like to craft or to knit? Even just taking a nap.

This subtheme revealed that when providing counseling and crisis intervention under the Peer/Community Advocacy Model, SAC advocate participants teach coping skills.

Regulate mind and body. The Regulate Mind and Body theme arose from codes that signified de-escalation techniques. It was broken up into two subthemes that represented the de-escalation techniques, Grounding and Mindfulness. Each of these subthemes will be described in this section.

Grounding. This subtheme represents comments made by SAC advocate participants about using exercises to ground survivors who are escalated or dissociated in the present moment when providing crisis intervention and counseling. Examples of these statements are as follows:

So when they have a moment of a flashback, they can't breathe, giving them grounding techniques that can help them get through that moment.

Connecting with their feet stable on the ground. Like five sense techniques, like asking them to name five things you see, four things you smell, three things you hear, kind of going like that down the five senses. Or asking the person, can you look around, you're here now, it's not happening again.

Several SAC advocate participants commented on techniques that ground the five senses, such as the technique described in the second of the two previous statements. SAC participants also spoke about the importance of grounding the survivor in reality. Therefore, these codes combined to form the Grounding subtheme of the Regulate Mind and Body theme.

Mindfulness. This subtheme represents statements made by SAC advocate participants that discuss using breathing, mindfulness, and meditation exercises to de-escalate a survivor when providing counseling and crisis intervention. The following statement represents the breathing exercises aspect of this subtheme:

Just doing some basic breathing exercises, maybe counting to five in the inhale, five on the exhale.

The next quote describes the mindfulness exercises that help make up this subtheme:

I use a lot of what I would call mindfulness stuff in session so I definitely ask people to sort of check in with the present moment as often as they can during their day.

This final quote gives an example of the meditation exercises mentioned in this subtheme:

We have some meditations that we do that are like imagining yourself on a beach, or if it's just like you need to ground a person, bringing them not exactly into the present moment, but into a space that can feel calming then after that, that can maybe bridge into the present moment because sometimes going from like a totally altered, heightened state to just like oh just feel your body, that is hard.

Meditation is a subtheme of the Regulate Mind and Body theme and consists of breathing, mindfulness, and mediation exercises that SAC advocate participants identified using in counseling and crisis intervention with survivors of sexual violence.

Address/build support network. As the name denotes, this theme encompasses codes that describe SAC advocate participants addressing and building the survivor's support system during counseling and crisis intervention sessions. Additionally, some of the codes under this theme also describe SAC advocate participants as intervening in a survivor's current support system, at the request of the survivor, if the support system was impeding on the survivor's healing. The following are examples of quotes that support this theme:

So to me it's always really important to address how friends and family are handling things because oftentimes that has been a source of either strength or strife for somebody, and if you aren't addressing their larger support network, you're missing a major opportunity to understand what's happening for them.

If family and friends do know and they're a really bad support system, then it's working with them to find a good support system that exists, whether that be with a support group, or another organization, or another group of friends...figuring out some support network with them.

Addressing and helping to build the survivor's support network developed out of the data as an approach SAC advocate participants use when providing counseling and crisis intervention services to adult survivors of sexual violence.

Safety planning. In this theme, SAC advocate participants described working with survivors to create both physical and emotional safety plans. This is evident in the following quotes from participants:

Safety- making sure that they're not only physically safe depending on the incident of the assault, whether it's in the house or by a stranger, a friend, but also emotional safety, so how can you take care of yourself as you're working through this.

So I really think assessing their physical safety. Do they feel safe going back to where they were? Do they need resources on like mental safety? If they are thinking about suicide, do they need to develop a safety plan or get them further support?

Safety planning emerged from the data as one of the approaches SAC advocate participants use when providing crisis intervention and counseling services.

Provide informed referrals. SAC participants described researching their referral resources before giving them to survivors, so that is why this theme was entitled, Provide *Informed Referrals*. SAC participants also described referring survivors to several different resources such as for therapy services, psychiatry services, legal services, medical services, cultural services, domestic violence services, shelter or housing services, and additional mental health crisis services. Key phrases of SAC advocate participants that support the creation of this theme are as follows:

Knowing your resources; you don't want to give someone a resource that you know is actually like a one year wait list or something like that.

I always try to provide referrals because to me, having a wider support network is never a bad thing. So if they're experiencing co-occurring sexual and domestic violence, referring them out to a domestic violence shelter to get them that resource. If they're experiencing very specific cultural considerations and they want assistance from a

cultural group, I have a list of a handful of places that can help them. If they are experiencing something that is beyond our capabilities, referring them out to trusted therapists. So just refer, refer, refer.

Although the participant in the latter of these two quotes mentioned providing referrals to build a “wider support network,” this quote was determined to be in support of the Provide Informed Referrals theme instead of the Address/Build Support Network theme because it was referring to building a survivor’s formal (i.e. professionals) rather than informal (i.e. family, friends, etc.) support network through referrals. Interviews with SAC advocate participants revealed that they make referrals to a variety of service providers when providing crisis intervention and counseling to adult survivors of sexual violence. This supports the development of the theme, Provide Informed Referrals.

Address the impact of the social context. SAC advocate participants identified several ways in which they address the influence of the social context on the survivor’s response to the sexual assault and subsequent healing process. Many participants described addressing the impact of “rape culture” on survivors by providing education on the subject and on how it can influence people’s reaction to sexual violence. The following quote shows evidence of this aspect of the theme:

Usually the approach is just to counteract that as much as possible, so just saying no and to explain that we live in a culture that perpetuates rape because we believe that victims do something to cause the rape and we do that because it scares us to think that there’s not an explanation for why that happened to somebody, then it could happen to any of us and that scares us so I think just explaining what rape culture is to people can make them understand why they may be treated that way by their loved ones.

As suggested in the above quote, SAC advocate participants defined rape culture as a set of oppressive messages woven into our culture that teach society that sexual violence is the fault of the victim. Additionally, SAC advocate participants identified the importance of recognizing the

influence of the cultural context when working with survivors of sexual violence. This is evident in the following quote:

So like I said, really respecting different cultures and different beliefs on how to have conversations, so like in the Somali community like healthy sex isn't talked about so how do you talk about sexual assault? So starting off by having general conversations or stories about how long have you been in Minnesota, what are the differences between here and your culture? Like sometimes you can open up like some of those differences can be laws and relationships and stuff like that and that can sometimes open the door a little bit, but reflecting the person's own language or what they're comfortable with.

The data within the theme, Address the Impact of the Social Context, suggest that SAC participants recognize that individual sexual assault is situated within a larger sociocultural context and that this dynamic is going to impact a survivor's response to and healing from their assault. The data further suggest that this impact is addressed by SAC advocates when providing counseling and crisis intervention services.

Psychotherapists

Conduct assessments. Each psychotherapist participant talked about conducting a thorough assessment when working with survivors of sexual violence. Some participants mentioned using specific assessment tools, such as the "PHQ-9," "GAD-7," and "WHODAS," while others mentioned using specific techniques, such as "motivational interviewing." In addition to these approaches, some psychotherapist participants noted observing client behavior as an approach taken when providing crisis intervention and counseling services to survivors of sexual violence. The following are examples of statements that formed this theme:

Intake and assessment helps me understand all of the characteristics and the traits and the diagnostic factors. That helps me know how to approach them.

I get some background information and I begin to ask them to tell their story of what happened.

Observing for different kinds of signs like are they disassociating, are they making good eye contact, what is their appearance, do they look like they're caring for themselves well.

Data analysis revealed that conducting assessments was a specific approach psychotherapist participants use when providing counseling and crisis intervention to adult survivors of sexual violence.

Survivor-centered approach. One of the aspects of the Survivor-Centered Approach theme was that counseling and crisis intervention sessions were found to be largely survivor-led or structured in a way that gives the survivor some control.

What I do is I sort of just lay out here are some of the approaches I use, this is kind of my style, and then I let them kind of pick what they feel drawn to.

Always giving them some control in the session because they didn't have control over everything else.

Another aspect of this theme is using a survivor-centered approach where interventions are tailored to the individual survivor.

Tailor your intervention to whoever is in front of you.

This theme also represented statements that show that psychotherapist participants meet the survivor where they are at.

I think this is sort of a social work thing is you start where the client is, not where you want them to be, I learned that, but start where the client is and what brought them here today is probably the first question I ask for anybody.

As the examples show, the Survivor-Centered Approach theme developed from codes about psychotherapist participants' approaches being survivor-led, focused on giving the survivor control, survivor-centered, and aimed at meeting the survivor where they are at.

Empower. As the name suggests, psychotherapist participants identified using an empowerment approach when providing crisis intervention and counseling with adult survivors of sexual violence. This is supported by the following examples:

I had a client who was treated poorly by law enforcement when she was having a panic attack, she does have sexual abuse in her history actually, and she was arrested, she was brought in that night and once she got into a more stable place, I encouraged her like use that fight, follow through with that fight instinct that you didn't get to do that was stuck and let's do that appropriately and call and find out who was on duty, talk to that supervisor, encourage that there's mental health training and do what you can to empower yourself if that's the direction you want to go.

I encourage them to find their voice.

Empower developed as a theme because many psychotherapist participants identified that they attempt to empower the survivors of sexual violence they work with when providing counseling and crisis intervention.

Validate, normalize, and support. Codes from interviews with psychotherapists revealed that, when providing crisis intervention and counseling to adult survivors of sexual violence, psychotherapist participants validate, normalize, and support thoughts, feelings, behaviors, and experiences. The following phrases support the creation of this theme:

Provide the support and sort of validation.

Hanging in there with them.

So they need support, they need validation, they need to hear that no means no, they need to hear that consent is consent and if you were drinking you could not give consent. They need to hear that everyone processes this differently and there's no right way and just a lot of normalizing the symptoms they're experiencing-the nightmares, the flashbacks, the self-blame.

Data analysis uncovered that psychotherapist participants validate, normalize and support sexual violence survivors' thoughts, feelings, behaviors, and experiences when providing counseling and crisis intervention.

Provide psychoeducation. Psychotherapist participants identified psychoeducation as a piece of the counseling and crisis intervention they provide. Some of the quotes that created this theme are as follows:

Psychoeducation would be another piece. Helping them understand trauma, you know, understand that they're not alone, this is very typical for someone who has experienced trauma, the fear, you know, the non-trust, the sort of flashbacks, the triggers.

This whole psych ed piece about you know people feel uncomfortable being powerless and so they feel if they can dress fine than this won't happen to them and with the best of intentions, I mean I don't think they're trying to make someone feel bad, but it's like that would never happen to my daughter because I make sure she doesn't leave the house in a short skirt kind of thing, until it happens to them. So I do think that the idea of yeah people think this way, it feels like they're blaming, but what it really is, is that they are scared and powerless and it's easier to be angry than it is to feel sad or powerless.

These quotes are very similar to other statements in this theme. Data analysis revealed that psychotherapist participants provide psychoeducation when working with adult survivors of sexual violence.

Teach coping skills. This theme was developed based on psychotherapist participants' comments about helping survivors build skills to cope with feelings. Writing was frequently mentioned as a coping skill taught by psychotherapist participants as evidenced by the following quotes:

I mean there are some people where journaling is very helpful. The idea that if they wake up in the middle of the night or if they have a nightmare, to have a pen and paper by the bed to be able to do that and then to bring that in and be able to process that.

It might be helping this client write a letter to this person and sometimes they send it and sometimes they tear it up.

A variety of other coping skills were also mentioned.

Giving them a lot of tools, self-soothe, taking baths, taking showers, a really, really cold shower if they need to knock themselves out of their head.

We might talk about, you know it sounds like you might have some anger you need to get out, what's a safe way to get that out, probably not calling that place over and over again and screaming and yelling or swearing in public, that kind of thing, but could you go home and make some snowmen and make some snowballs and throw them at some snowmen and have those thoughts and get it out in a healthy way.

The data revealed that psychotherapist participants teach coping skills when providing crisis intervention and counseling with adult survivors of sexual violence.

Treatment interventions. Data obtained from interviews with psychotherapist participants revealed that they employ specific treatment interventions when providing crisis intervention and counseling to adult survivors of sexual violence. Five specific treatment interventions were identified and, thus, developed as subthemes of the Treatment Interventions theme.

Narrative approach. As the title states, psychotherapist participants identified taking a narrative approach, at times, to working with survivors of sexual violence. This subtheme is supported by statements such as these:

I also do sand tray therapy. So I have a tray of sand and then they would come in and tell their story with different objects and symbols. And you can use this with metaphor and so they don't have to, again, talk directly because it can be very shaming and so the sand tray therapy, it's a narrative approach, but it more uses like symbols and archetypes and I've heard a lot of people say oh this feels really safe, then they can kind of work through their story and the subconscious works through what it is ready to work through so that's just a cool little trick to have up my sleeve.

I'll incorporate some narrative pieces, you know, let's re-story this. If we imagined re-writing that story, what would it be like? What would you like to have had happened?

Data analysis revealed that one of the approaches taken by psychotherapist participants in providing counseling and crisis intervention to adult survivors of sexual violence is a narrative approach.

Cognitive behavioral therapy and techniques. Psychotherapist participants identified using either Cognitive Behavioral Therapy (CBT) or cognitive behavioral techniques, such as in their approach to grounding the survivor in the present, in the counseling and crisis intervention provided to survivors of sexual violence. Statements that support this subtheme are as follows:

Sometimes I'll do cognitive stuff if they're a good fit for that, I would recommend that.

I have a list with columns of negative cognitions and positive cognitions and I give that to them. Either they can take it home or do it in the office setting, but for them to find the top three. Of course they can underline or circle all the ones that pertain to them, but I ask them to prioritize top three. Then we target them with Cognitive Behavioral Therapy or EMDR, either one.

These next statements describe how cognitive behavioral techniques were identified as sometimes being used by psychotherapist participants to help ground a person after being triggered into a flashback.

Grounding techniques when people have flashbacks to be able to make sure they are aware of the sensory kind of stimulants around them and ground them so they can go, ok I'm not there now, I am here and I am safe. I'm in my bed and in my house and I'm ok.

Well I do think there's sort of a lot of cognitive behavioral work that can be done; help them understand the distortion that not every man with a mustache is a bad person.

The subtheme, Cognitive Behavioral Therapy and Techniques, was characterized by statements about employing CBT with adult survivors of sexual violence and about using cognitive behavioral strategies to address triggers and ground the survivors in the present moment.

Dialectical behavioral therapy. Some psychotherapist participants identified using mindfulness and other Dialectical Behavioral Therapy (DBT) approaches when providing counseling and crisis intervention to survivors of sexual violence. The following quotes provide examples of statements that support this subtheme:

In DBT, we look at dialectics, that two opposing things can exist at the same time, we can be victimized in the world and still feel safe and find a way to be safe in the world, and so I would approach that.

DBT groups are really helpful for that, managing emotionality.

Data analysis revealed Dialectical Behavioral Therapy as a subtheme that characterizes psychotherapist participants' approaches to counseling and crisis intervention with adult survivors of sexual violence.

Somatic experiencing. Somatic Experiencing was mentioned frequently as either a therapy approach participants used or an approach that participants would recommend and subsequently provide a referral for if deemed appropriate. Examples of statements that support the creation of this subtheme are as follows:

In theory, with somatic experiencing, the trauma in people's lives gets stored in people's bodies when they are unable to complete their fight or flight responses and so clearly, and in sexual assault cases they're stuck in a freeze or they weren't able to fight or flight and so the theory would be, in session, we would work with their nervous system. So it's not about telling their story and I think that's cool because that can bring on a lot of shame for some survivors and I don't feel that I need to know those details so we work with the nervous system and so we do a lot of body tracking to see and then we may move into the freeze or they might be in an emotional flashback or in a memory of it, but they don't even have to talk about it, we just then work with the freeze in their body and then figure out what's the fight urge. They may want to push away so then we might stand up and push on my hands or push the wall. We do different things to activate that system to get them to complete the fight or flight response.

There are some times where people can benefit from somatic kinds of work if this is really impacting their functioning to the point of disability.

Using Somatic Experiencing therapy is one treatment intervention psychotherapist participants identified using when providing counseling and crisis intervention with adult survivors of sexual violence.

Eye movement desensitization and reprocessing. Some psychotherapist participants identified using Eye Movement Desensitization and Reprocessing (EMDR) as an approach to working with survivors of sexual violence. Examples of statements that support this subtheme are as follows:

I do EMDR and EMDR is just, it's not right for everyone, but when it is right for them, that's really what I prefer for people and helping to manage their anxiety or their PTSD responses with safe place.

I do some bilateral stimulation exercises, which is an EMDR intervention, to help them, you know, a lot of these individuals will have panic attacks, anxiety attacks and they don't understand it, it's very frightening to them.

EMDR is another treatment intervention psychotherapist participants identified using when delivering counseling and crisis intervention services to adult survivors of sexual violence.

Address support network. Psychotherapist participants stated that, when providing counseling and crisis intervention to survivors of sexual violence, they might identify and address the survivor's support network in terms of how the support network's response impacts that individual survivor; therefore, Address Support Network developed as a theme. This theme is supported by the following quotes from psychotherapist participants:

How will they, you know, handle family that may be overly concerned?

I encourage them to talk about it. If they feel judged or don't feel supported and examining what other people say for inaccuracies, you know, what's true to them?

What kind of support systems do they have in place currently?

According to analysis of the interviews with psychotherapists, addressing the survivor's support network is an approach that psychotherapists employ when providing crisis intervention and counseling to survivors of sexual violence.

Safety planning. Assisting sexual violence survivors in developing safety plans was mentioned frequently in the interviews with psychotherapists. Psychotherapist participants identified supporting clients in creating both physical safety plans and emotional safety plans.

They will continue to be possibly exposed to that person and so there's the safety planning in that way, but there's also the safety planning in going back to the same parking lot if that's where you worked or that sort of thing. Is there security, and who can you ask, and so many things?

Assess for suicidality, anything like that that may be immediate and then I would make sure that they have phone numbers.

Crisis safety planning.

Safety planning was identified as another approach used in psychotherapist participants' counseling and crisis intervention work with adult survivors of sexual violence.

Provide referrals. Psychotherapist participants described making referrals to resources such as to local SACs, support groups, other therapists, case managers, food shelves, financial resources, housing resources, hospitals, police stations, psychiatrists, and additional mental health care services. This theme is supported by the following phrases taken from the interviews with psychotherapists:

Sorting through and helping them understand that there is help available besides me.

The first thing, if it hasn't happened already, is to make sure that they seek medical attention just to rule out any kind of diseases. Sometimes if they can get to a medical appointment or have an exam sooner rather than later there might be some evidence yet if they want to prosecute.

A sexual assault center, if it's somebody on a campus they probably have some kind of support group, or you know depending on what the person's other needs are, whether they're male, female, you know, what other...but I think most campuses nowadays have sexual advocacy groups or victims of-type support groups, that kind of thing.

If I felt like it were out of my scope and if something were happening that I felt required something more intensive or perhaps somebody more qualified, I would definitely refer.

Psychotherapist participants talked frequently about making referrals, as necessary, when providing counseling and crisis intervention; therefore, it was made a theme that described approaches used when working with adult survivors of sexual violence.

Data analysis in response to the second research question (How do these approaches compare to each other?) revealed that there are both similarities and differences between the approaches of SAC advocate participants and the approaches of psychotherapist participants in

the crisis intervention and counseling provided to adult survivors of sexual violence. These similarities and differences can be found in Table 2.

Table 2. *Similarities and Differences of Themes and Subthemes between SAC Advocates and Psychotherapists*

Similarities	
SAC Advocates	Psychotherapists
Survivor-Centered and Driven Approach*	Survivor-Centered Approach
Empower*	Empower
Validate, Normalize, and Support*	Validate, Normalize, and Support
Provide Psychoeducation and Information*	Provide Psychoeducation
Teach Coping Skills*	Teach Coping Skills
Address/Build Support Network	Address Support Network
Safety Planning	Safety Planning
Provide Informed Referrals	Provide Referrals
Differences	
SAC Advocates	Psychotherapists
Peer/Community Advocacy Model	Conduct Assessments
Address Immediate Concerns/Triage*	Treatment Interventions
Provide Informed Options*	<ul style="list-style-type: none"> • Narrative Approach
Regulate Mind and Body	<ul style="list-style-type: none"> • Cognitive Behavioral Therapy and Techniques
<ul style="list-style-type: none"> • Grounding • Mindfulness 	<ul style="list-style-type: none"> • Dialectical Behavioral Therapy
Address the Impact of the Social Context	<ul style="list-style-type: none"> • Somatic Experiencing

	<ul style="list-style-type: none"> • Eye Movement Desensitization and Reprocessing²
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A description of the nuances of these comparisons can be found in the discussion section of this report. Similarities and differences also emerged between the results of the interviews with SAC advocates and psychotherapists when their respective themes and subthemes were viewed through the lens of the conceptual framework of the ecosystems paradigm. These similarities and differences can be seen in Table 3.

Table 3. *Themes and Subthemes of SAC Advocates and Psychotherapists Presented Within the Ecosystems Paradigm*

<u>SAC Advocates</u>	<u>Psychotherapists</u>
<p>Micro Systems</p> <p>1. Peer/Community Advocacy Model</p> <ul style="list-style-type: none"> • Survivor-Centered and Driven Approach • Address Immediate Concerns/Triage • Provide Informed Options • Empower • Validate, Normalize, and Support 	<p>Micro Systems</p> <p>1. Conduct Assessments</p> <p>2. Survivor-Centered Approach</p> <p>3. Empower</p> <p>4. Validate, Normalize, and Support</p> <p>5. Provide Psychoeducation</p> <p>6. Teach Coping Skills</p> <p>7. Treatment Interventions</p> <ul style="list-style-type: none"> • Narrative Approach • Cognitive Behavioral Therapy and Techniques

² Note. *Indicates a subtheme of the Peer/Community Advocacy Model theme.

<ul style="list-style-type: none"> • Provide Psychoeducation and Information • Teach Coping Skills <p>2. Regulate Mind and Body</p> <ul style="list-style-type: none"> • Grounding • Mindfulness <p>3. Address/Build Support Network</p>	<ul style="list-style-type: none"> • Dialectical Behavioral Therapy • Somatic Experiencing • Eye Movement Desensitization and Reprocessing <p>8. Address Support Network</p>
<p>Meso Systems</p> <p>4. Safety Planning</p> <p>5. Provide Informed Referrals</p>	<p>Meso Systems</p> <p>9. Safety Planning</p> <p>10. Provide Referrals</p>
<p>Macro Systems</p> <p>6. Address the Impact of the Social Context</p>	

The main similarity that was found when viewing the data in this way was that both SAC advocates and psychotherapists in this study addressed transactions between the individual survivor and micro and meso-level systems. Conversely, the main difference that was found was that SAC advocate participants tended to address the transaction between the survivor and the macro-level factor of the social context where psychotherapist participants did not appear to address transactions with macro-level systems. Analysis of the interviews with SAC advocates and psychotherapists revealed similarities and differences between the two sets of data.

Discussion

Interpretation of the Findings

Several themes developed from the data collected from both SAC advocates and psychotherapists in response to the research questions, 1) When providing crisis intervention and/or counseling to adult victims of sexual violence, what are the approaches taken by SAC advocates and psychotherapists? 2) How do these approaches compare to each other? Six themes emerged from the interviews with SAC advocates, suggesting that these are approaches that SAC advocates take when providing crisis intervention and/or counseling to adult victims of sexual violence. These themes were: Peer/Community Advocacy Model, Regulate Mind and Body, Address/Build Support Network, Safety Planning, Provide Informed Referrals, and Address the Impact of the Social Context. The theme of Peer/Community Advocacy Model consisted of the following seven subthemes: Survivor-Centered and Driven Approach; Address Immediate Concerns/Triage; Provide Informed Options; Empower; Validate, Normalize, and Support; Provide Psychoeducation and Information; and Teach Coping Skills. These represent the techniques employed by SAC advocates when providing crisis intervention and counseling under the Peer/Community Advocacy Model. Like the Peer/Community Advocacy Model theme, the Regulate Mind and Body theme also consisted of subthemes. The two subthemes that characterized this approach were Grounding and Mindfulness; therefore, it can be said that SAC advocates use grounding and mindfulness techniques to help regulate survivors' minds and bodies when providing crisis intervention and counseling. The themes and subthemes that emerged from the interviews with SAC advocates suggest that SAC advocates take several approaches to the crisis intervention and counseling they provide to adult survivors of sexual violence.

The findings also showed that several themes emerged from the interviews with psychotherapists. These ten themes included Conduct Assessments; Survivor-Centered

Approach; Empower; Validate, Normalize, and Support; Provide Psychoeducation; Teach Coping Skills; Treatment Interventions; Address Support Network; Safety Planning; and Provide Referrals. The theme of Treatment Interventions developed from the five subthemes of Narrative Approach, Cognitive Behavioral Therapy and Techniques, Dialectical Behavioral Therapy, Somatic Experiencing, and Eye Movement Desensitization and Reprocessing. These results suggest that psychotherapists approach crisis intervention and/or counseling with adult victims of sexual violence using these themes and subthemes as their methods.

The approaches used by SAC advocates and psychotherapists in the crisis intervention and counseling they provide to survivors of sexual violence are both similar and different. These approaches were similar in two significant ways. First, when viewing the results through the lens of the conceptual framework, ecosystems paradigm, as illustrated in Table 3, both SAC advocates and psychotherapists in this study addressed transactions between the individual survivor and micro and meso-level systems. Second, the findings revealed that when providing crisis intervention and counseling to survivors of sexual violence, many of the approaches taken by SAC advocates and psychotherapists are the same. Although the SAC advocate participants' theme of Regulate Mind and Body and psychotherapist participants' subthemes Cognitive Behavioral Therapy and Techniques and Dialectical Behavioral Therapy were ultimately determined to be different due to no explicit mention of CBT or DBT by SAC advocate participants, the actions taken by SAC advocates and psychotherapists (i.e. grounding techniques, trigger management skills, and mindfulness exercises) in relation to these constructs were very similar. This suggests that even though SAC advocates do not typically provide psychotherapy (Gornick et al., 1985; Woody & Beldin, 2012), they may be using therapeutic approaches similar to those used by psychotherapists. Additionally, with the exception of some

slight wording differences as described in the next paragraph, five of the subthemes (Survivor-Centered and Driven Approach; Empower; Validate, Normalize, and Support; Provide Psychoeducation and Information; and Teach Coping Skills) and three of the themes (Address/Build Support Network, Safety Planning, and Provide Informed Referrals) taken from the data on SAC advocate participants were similar to eight of the themes (Survivor-Centered Approach; Empower; Validate, Normalize, and Support; Provide Psychoeducation; Teach Coping Skills; Address Support Network; Safety Planning; and Provide Referrals) taken from the data on psychotherapist participants (see Table 2).

The wording difference between SAC advocate participants' Survivor-Centered and Driven Approach subtheme and psychotherapist participants' Survivor-Centered Approach is due to SAC advocate participants' emphasis on the survivor being the expert and therefore, "driving" the counseling and crisis intervention sessions. The wording difference between SAC advocate participants' subtheme of Provide Psychoeducation and Information and psychotherapist participants' theme of Provide Psychoeducation can be attributed to SAC advocates providing information about working with systems professionals (i.e. law enforcement, medical staff, etc.) in addition to the psychoeducation both they and psychotherapist participants provide. As for the differences between psychotherapist participants' theme of Address Support Network and SAC advocate participants' theme of Address/Build Support Network, psychotherapist participants did not explicitly identify focusing interventions on building the survivor's support network. It should be noted that it is possible that psychotherapist participants do help survivors build their support networks, if necessary, but this was not mentioned in the interviews. The final wording difference, which was between SAC advocate participants' theme of Provide Informed Referrals and psychotherapist participants'

theme of Provide Referrals was due to SAC advocate participants explicitly talking about researching community resources before sharing them with the survivors they are working with. Again, it is possible that psychotherapist participants do research their referral resources before sharing them, but this was not mentioned in the interviews. Despite these slight wording differences, many of the approaches taken by SAC advocates and psychotherapists are comparable, as evidenced by the eight theme/subtheme matches found in this study.

Not only were the approaches taken by SAC advocates and psychotherapists in the counseling and crisis intervention they provide to adult survivors of sexual violence similar in some ways, but they were also different in some ways. The first difference found in this study was that advocates tend to address the transactions between the survivor and macro-level systems where psychotherapist participants did not appear to address transactions at this level. The second difference found in this study was that psychotherapists tend to employ specific therapeutic treatment interventions (i.e. Cognitive Behavioral Therapy and Techniques, Somatic Experiencing, etc.) and conduct assessments, whereas SAC advocates employ more crisis-related or short-term approaches (i.e. Address Immediate Concerns/Triage, Regulate Mind and Body, etc.). This can be seen in Table 2. The findings show that, despite the similarities, the approaches taken by SAC advocates and psychotherapists differ in many ways, too.

Relation of the Findings to the Literature

Both similarities and differences were found between the current study's findings and the literature. The literature identified that psychotherapists primarily use Cognitive Behavioral Therapies (McDonagh et al., 2005; Nishith, et al., 2005; Russel & Davis, 2007; Taylor & Harvey, 2009; Vickerman & Margolin, 2009), Present-Centered Therapy (PCT; McDonagh et al., 2005), and Eye Movement Desensitization Reprocessing (EMDR; Edmond & Rubin, 2004;

Posmontier et al., 2010; Rothbaum, 1997; C. Tarquinio et al., 2012; Vickerman & Margolin, 2009) to alleviate the psychological consequences of sexual violence. The current study is consistent with the literature's findings about the use of Cognitive Behavioral Therapies and EMDR with adult survivors of sexual violence, but psychotherapist participants in the current study did not mention using PCT in their work with this population. Furthermore, the current study extends the literature by adding Somatic Experiencing, Dialectical Behavioral Therapy, and Narrative Therapy techniques to the therapeutic treatment interventions of the Cognitive Behavioral Therapies, PCT, and EMDR used by psychotherapists in treating sexual violence-related symptoms. Additionally, this study revealed other approaches not listed in the literature that psychotherapists use when providing crisis intervention and counseling to adult survivors of sexual violence, such as conducting assessments; using a survivor-centered approach; empowering the survivor; validating, normalizing, and supporting the survivor; providing psychoeducation; teaching coping skills; addressing the survivor's support network; safety planning; and providing referrals. In regard to crisis intervention and/or counseling provided by psychotherapists when working with survivors of sexual violence, both similarities and differences were found when this study's findings were compared to the literature.

Unlike the similarities and differences found between the results of this study regarding approaches taken by psychotherapists and the literature, only similarities were found between the results of this study regarding the approaches taken by SAC advocates and the literature. The literature identified that, despite the limited research on this subject (Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012), the approaches taken by SAC advocates in the crisis intervention and counseling they provide to adult survivors of sexual violence are based on the trauma intervention literature (Decker &

Naugle, 2009) as well as on empowerment (Ullman & Townsend, 2008) and ecological (Campbell et al., 2009) models. These findings are very similar to the findings in the current study. For example, most of Decker and Naugle's (2009) trauma and sexual violence research-related suggestions for SAC counseling and crisis intervention correspond with the themes and subthemes found in this current study. Additionally, Ullman and Townsend's (2008) empowerment model, which is made up of a survivor-centered approach that connects the survivor with resources, assists the survivor with safety planning, and aids in the development of a non-blaming support system, is consistent with the current study's SAC advocate participants' themes and subthemes of Empower, Survivor-Centered and Driven Approach, Provide Informed Referrals, Safety Planning, and Address/Build Support Network. It should be noted that Ullman and Townsend's (2008) empowerment approach is also very similar to some of the themes found in the data collected from psychotherapist participants in this study, such as Empower, Survivor-Centered Approach, Provide Referrals, Safety Planning, and Address Support Network. Moreover, the organization of the findings from SAC advocate participants into micro, meso, and macro-level approaches is consistent with Campbell et al.'s (2009) ecological approach to counseling and crisis intervention with survivors of sexual violence.

The findings generated from data collected from SAC advocates participants in this current study are also closely associated with the components of Psychological First Aid (PFA), an evidence-informed approach suggested in the literature for use by SAC advocates (Campbell, 2008; Decker & Naugle, 2009; Woody & Beldin, 2012; Ruzek et al., 2007). Although the phrasing is different, some of the themes and subthemes that developed out of the data collected from SAC advocates in this study matched with all eight of Brymer et al.'s (2006) "core actions" of PFA as demonstrated here: PFA's "Contact and Engagement" matches with SAC advocate

participants' Survivor-Centered and Driven Approach, PFA's "Safety and Comfort" matches with SAC advocate participants' Safety Planning, PFA's "Stabilization" matches with SAC advocate participants' Regulate Mind and Body, PFA's "Information Gathering: Current Needs and Concerns" matches with SAC advocate participants' Survivor-Centered and Driven Approach and Address Immediate Concerns/Triage, PFA's "Practical Assistance" matches with SAC advocate participants' Address Immediate Concerns/Triage and Provide Informed Options, PFA's "Connection with Social Supports" matches with SAC advocate participants' Address/Build Support Network, PFA's "Information on Coping" matches with SAC advocate participants' Teach Coping Skills and Provide Psychoeducation and Information, and PFA's "Linkage with Collaborative Services" matches with SAC advocate participants' Provide Informed Referrals (Brymer et al., 2006). This suggests that SAC advocates may already be implementing a form of PFA, although not true to the manual, in the crisis intervention and counseling they provide to adult survivors of sexual violence. Several similarities between the literature and the results of the current study regarding the approaches taken by SAC advocates in providing crisis intervention and counseling to adult survivors of sexual violence were found.

In addition to delineating approaches used by psychotherapists and SAC advocates independently, the literature also commented on the similarities and differences between the approaches of these professionals. These comparisons are fairly consistent with the similarities and differences found in the current study. Of special note is Gornick et al.'s (1985) and Woody and Beldin's (2012) conclusion that psychotherapists can provide psychotherapy to adult survivors of sexual violence and that SAC advocates, due to a lack of a licensure requirement, generally cannot. The current study extends this conclusion in two ways. First, this study extends the literature by demonstrating that although SAC advocates do not provide

psychotherapy (Gornick et al., 1985; Woody and Beldin, 2012), their techniques are often similar to those of psychotherapists, even with interventions typically designated as psychotherapeutic, such as CBT and DBT. Second, the current study extends Gornick et al.'s (1985) and Woody and Beldin's (2012) finding that SAC advocates do not provide psychotherapy by saying that SAC advocates tend to employ crisis-related or short-term approaches. Overall, results from the current study regarding the comparison of the crisis intervention and counseling approaches used by SAC advocates and psychotherapists with survivors of sexual violence are fairly similar to the findings in the literature about this comparison.

Strengths and Limitations

There are both strengths and limitations in the methodology of this study. The limitations of this study are centered on the sample. Because a convenience sampling strategy was used to recruit participants and because the sample sizes were small (SAC advocates, $n = 4$; psychotherapists, $n = 4$), the samples were not representative of the population and the results cannot be generalized beyond the scope of the study (Monette et al., 2013). Additionally, the sample of SAC advocates was taken from the same agency; therefore, results of the study may represent the crisis intervention and counseling approaches taken by that agency and not SAC advocates as a whole. It is also possible that the themes that developed out of the interviews with SAC advocates would also develop out of the interviews with psychotherapists and vice versa if larger samples were interviewed. Additionally, two of the psychotherapist participants eluded to having training in sexual assault advocacy and one of the SAC advocates mentioned she was also trained as a psychotherapist; therefore, the type of training participants had may have influenced the results. Due to these limitations, social workers and other clinicians should exercise caution when applying findings to practice.

Despite the limitations, there are several strengths of this study's methodology. One strength is that the results of this study provide areas for further research using larger, more representative samples. Another strength lies in the use of grounded theory as the data analysis approach. The literature on this research topic stated that there are few definite constructs that define the crisis intervention and counseling of SAC advocates (Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012) and psychotherapists (Decker & Naugle, 2009) in working with adult survivors of sexual violence; therefore, the inductive nature of the grounded theory approach to data analysis made it a good fit for this study as it suggested themes, or constructs, that may help in defining the crisis intervention and counseling services provided by SAC advocates and psychotherapists. Furthermore, findings from this study may aid in the development of formal procedures and guidelines, an area the identified in the literature as lacking (Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012), for SAC advocates and psychotherapists in working with adult survivors of sexual violence. A final strength of this research is that its results inform outpatient psychotherapists and SAC advocates on each other's work with survivors of sexual violence, thus aiding in informed referrals. These strengths suggest several implications for social work practice, policy, and research, which will be described in the following sections.

Implications for Social Work Practice

There are two implications for social work practice than can be drawn from this study. The first implication is that social workers and other professionals, as well as individual survivors, are now more informed about the approaches SAC advocates and psychotherapists take in providing crisis intervention and/or counseling with adult survivors of sexual violence.

The study showed that when providing crisis intervention and counseling to survivors of sexual violence, SAC advocates and psychotherapists do many of the same things, but that the work of SAC advocates is structured to be more short-term and to meet the immediate needs of survivors of sexual violence, whereas the work of psychotherapists has the capacity to be more long-term and to employ specific therapeutic treatment interventions. Low or no-cost SAC counseling and crisis intervention (Campbell, 2008) may appeal to survivors of sexual violence who do not want to receive a diagnostic label and the mental health stigma that may come with accessing traditional psychotherapy (Koss et al., 2003). Additionally, SAC counseling and crisis intervention services may appeal to referring professionals who do not want to convey that there is something pathological about their clients' psychological response to sexual violence (Woody & Beldin, 2012). Regardless, whether utilized individually or as complimentary services, both SAC advocacy and psychotherapy may be viable options for addressing the mental and emotional health of survivors of sexual violence. The results of this study inform social work practice by helping to define the approaches taken by SAC advocates and psychotherapists in providing crisis intervention and/or counseling with adult survivors of sexual violence; thus, informing service choices for survivors and informing referrals for professionals.

The second implication is that this study informs direct practice with survivors of sexual violence. It is interesting to note that in light of the literature's mention of Cognitive Behavioral Therapies (McDonagh et al., 2005; Nishith, et al., 2005; Russel and Davis, 2007; Taylor & Harvey, 2009; Vickerman & Margolin, 2009), PCT (McDonagh et al., 2005), and EMDR (Edmond & Rubin, 2004; Posmontier et al., 2010; Rothbaum, 1997; C. Tarquinio et al., 2012; Vickerman & Margolin, 2009) as therapeutic treatment interventions used by psychotherapists in working with survivors of sexual violence, this study revealed several other therapeutic treatment

interventions and guiding approaches used by psychotherapists in working with this population. This suggests that there are other avenues that psychotherapists can take when working with survivors of sexual violence that are not currently mentioned in the literature. Additionally, the approaches of SAC advocates in their crisis intervention and counseling work with survivors of sexual violence that were identified in this study can serve as guiding principles for other SAC advocates, especially because of the general lack of research in this area (Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012). Because social workers can occupy the role of a psychotherapist or SAC advocate, this study informs the crisis intervention and counseling work they provide with survivors of sexual violence. Therefore, another implication for social work practice is that the findings of this study inform direct practice with survivors of sexual violence.

Implications for Policy

Based on the implication for social work practice, the most salient implication for policy from this study is to increase and expand funding for the counseling and crisis intervention services of SACs. As mentioned previously, this study showed that SAC advocates do many of the same things that psychotherapists do with survivors of sexual violence in terms of crisis intervention and counseling. Based on this and the evidence found in the literature that mental health services provided by SACs are typically easier to access than traditional psychotherapy (Koss et al., 2003) due to their low or no-cost (Campbell, 2008) and that sexual assault survivors may actually prefer SAC services over traditional mental health treatment (Decker & Naugle, 2009), SACs may be a viable option for survivors of sexual violence who do not want traditional psychotherapy. Additionally, this study showed that SAC advocates provide more short-term counseling aimed at addressing more immediate or crisis-related concerns, an approach that may

not be provided by traditional psychotherapists. Therefore, this different, but unique and valuable approach that SAC advocates take to crisis intervention and counseling should be made accessible to all communities throughout the nation. Increasing funding to current SACs and expanding funding to communities without SACs can achieve this, thus making it an implication for policy.

Implications for Research

In addition to suggesting implications for social work practice and policy, this study also suggests an implication for research. As the literature pointed out, there is very little research on the specific procedures used in SAC crisis intervention and counseling, as well as on the effectiveness of these two services (Campbell, 2006; Campbell, 2008; Decker & Naugle, 2009; Ullman & Townsend, 2008; Woody & Beldin, 2012). Additionally, there is a lack of time-relevant research specific to psychotherapeutic interventions for survivors of sexual violence. The results of the current study fill these gaps and suggest further areas of study, such as replications of the current study with larger sample sizes and studies that focus solely on the counseling provided by SACs and psychotherapists, independently. Furthermore, future studies can build on the current study as well as on findings from past studies (see Campbell, 2008; Campbell et al., 2009; Decker & Naugle, 2009; Ruzek et al., 2007; Ullman & Townsend, 2008; Woody & Beldin, 2012) on SAC crisis intervention and counseling in order to work toward the creation of evidence-based guidelines for these services. Despite the addition of the current study to the literature, more research is needed on the approaches taken by SAC advocates and psychotherapists in the crisis intervention and counseling they provide to adult survivors of sexual violence.

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Appendix A

Agency Request for Participant Recruitment Letter

[Insert Date]

Greetings,

My name is Renae Lockerby and I am a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas. I am conducting a study about the intervention approaches used by sexual assault center (SAC) advocates and outpatient psychotherapists in working with victims of sexual violence. The title of this study is *Sexual Assault Center Advocates and Psychotherapists: An Exploratory Study of Interventions*. This study is being supervised by Dr. Lance Peterson and is being conducted between December 1, 2015 and May 16, 2016. I am writing you to request permission to recruit participants from your agency. Please read the rest of this email and ask any questions you may have before granting permission for me to recruit employees, interns, and/or volunteers from your agency.

The purpose of this study is to identify and compare the self-identified approaches taken by SAC advocates and outpatient psychotherapists in working with adults who have experienced some form of sexual violence at any point in their lives.

The research questions are: When providing crisis intervention and/or counseling to adult victims of sexual violence, what are the approaches taken by SAC advocates and psychotherapists? How do these approaches compare to each other?

I am looking for the following people to participate in this study: SAC advocates (employees, interns, and/or volunteers) who carry out your agency's in-person support counseling and crisis intervention services.

If participants agree to be in this study, they will be asked to do the following things: Complete a brief demographic survey and participate in a 1 hour to 1 hour and 15 minute audiotaped interview at a confidential location of their choosing. The brief survey will be sent to participants' emails prior to the interview. Participants will be instructed to email their responses to me after the consent form is signed at the time of the interview. I will transcribe and analyze their audiotaped interviews and survey responses. I will share findings from this and other interviews and surveys in the form of a written, publically available, research report and oral presentation. Participants' names, agency affiliations, and other identifying information will not be included in the survey response, transcript, written report, or oral presentation.

The study may have the following risks: First, participants may experience emotional distress if the stories they choose to share are traumatic, distressing, or personal in nature. Second, participants may experience emotional distress if they disclose confidential information about the clients they serve, such as names or identifying information. Third, participants may experience a confidentiality breach if they share information that meets the legal definition of child

maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting. Due to the nature of the interview questions, the likelihood of these events occurring is rare.

The following precautions will be taken to minimize each risk: First, participants will be told only to share what they are comfortable sharing. Second, participants will be told not to share confidential information in the interview. Should participants experience emotional distress, the interview will end and a phone number to a 24-hour mental health crisis line closest to their area will be given to them. If participants disclose confidential information about the clients they serve, such as names or identifying information, the interview will end and the audiotape will be destroyed. I will not share any of this information per the confidentiality statement below. Third, if participants share information that meets the legal definition of child maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting, the interview will end, the audiotape will be destroyed, and only what is required by law will be reported.

The study has no direct benefits.

The records of this study will be kept confidential. Research records will be kept in a locked file cabinet in my home office. I will also keep the electronic copies of the transcripts and the responses to the brief demographic survey in a password protected file on my computer. Participants' responses from the survey will be deleted from my email account. My research committee may see the transcripts of the interviews and the survey responses, but will not know who the participants are. I will delete any identifying information from the transcripts and the survey responses. Findings from the transcripts and surveys will be presented in the form of a written, publically available research report and presented in a public clinical research presentation. The audiotapes, transcripts, and survey responses will be destroyed by June 1, 2017. The consent form will be destroyed in three years of the completion this study per federal regulations.

Participation in this study is entirely voluntary. Participants may skip any questions they do not wish to answer and may stop the interview at any time. Your agency's decision (as well as the decision of individual participants) of whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If your agency grants permission to recruit participants, your agency and its participants are free to withdraw at any time without penalty. If individual participants decide to withdraw, data collected about them will not be used.

If you have questions, you may reply to this email or may contact me at 320-248-5838. You may also contact my research committee chairperson, Dr. Lance Peterson, at 651-962-5811 or the University of St. Thomas Institutional Review Board at 651-962-6035 with any questions or concerns.

In summary, I am writing to request permission from your agency to recruit employees, interns, and/or volunteers to participate in my research study. If you grant this permission, I will need a letter on agency letterhead, signed by a representative of your agency who is authorized to speak for the organization as a whole, indicating that this permission has been granted. Please note that this letter can be faxed, or sent as an email attachment, so long as it contains the agency letterhead.

I can provide a template with all the necessary information for this letter if your agency approves participant recruitment. Thank you for your consideration.

Sincerely,
Renaë Lockerby
Graduate Student with the School of Social Work
University of St. Thomas/St. Catherine University
320-248-5838

Appendix B
Agency Permission Letter Template

[Insert Date]

Rena Lockerby
[Researcher's Address]

Dear Rena Lockerby:

I have reviewed information regarding your research study, entitled *Sexual Assault Center Advocates and Psychotherapists: An Exploratory Study of Interventions*, and grant permission for you to recruit employees, interns, and/or volunteers from [Insert Agency Name]. It is understood that your study aims to identify and compare the self-identified approaches taken by sexual assault center advocates and outpatient psychotherapists in working with adults who have experienced some form of sexual violence at any point in their lives. It is further understood that:

- You are graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and that this study is being supervised by Dr. Lance Peterson. He can be contacted at 651-962-5811.
- Participation is completely voluntary and the participants and/or agency may withdraw from the study at any time throughout the research process without consequence.
- There are risks for participants of the study, including emotional distress if participants share traumatic, distressing, or personal information or if participants share identifying information about the clients they serve. Participants may also experience a confidentiality breach if they share information that meets the legal definition of child maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting. Due to the nature of the interview questions, the likelihood of these events occurring is rare.
- The following precautions will be taken to minimize risks: Participants will be told to only share what they are comfortable sharing, but not to share confidential information. If emotional distress is experienced, the interview will end, the audiotape will be destroyed, and a phone number to a 24-hour mental health crisis line closest to the participants' residences will be given. If information is shared that meets the definition of a mandated report of child maltreatment or vulnerable adult abuse, the interview will end, the audiotape will be destroyed, and only what is required by Minnesota law will be reported.
- Confidentiality of data will be maintained by removing any names, agency affiliations, and other identifying information from transcripts, survey responses, the written research report, and the oral presentation. All files related to this study will be kept in a locked file in the researcher's home office and/or computer.
- The study will begin on December 1, 2015 and end on May 16, 2016.

Sincerely,
[Insert Official Signature]
[Insert Name of Signer]
[Insert Title of Signer]

Appendix C

Script for Sexual Assault Center Advocate Participant Recruitment

Hello,

My name is Renae Lockerby and I am a graduate student with the School of Social Work at the University of St. Thomas/St. Catherine University. I am conducting a study about the intervention approaches used by sexual assault center advocates and outpatient psychotherapists in working with adult victims of sexual violence. You are eligible to participate in this study because of your role as a sexual assault advocate. I am contacting you to see if you would be willing to participate in a brief demographic survey and a one hour to one hour and 15 minute in-person, audiotaped interview to help me complete my study.

[If potential participant is interested:] Because I am focusing on crisis intervention and counseling provided by sexual assault center advocates and outpatient psychotherapists, I have to ask two screening questions to help ensure your appropriateness for this study. The first question is: “Are you responsible for carrying out the following function of your agency: in-person, support counseling with adults?” The second screening question is, “Are you responsible for carrying out the following function of your agency: crisis intervention with adults?”

[If the answer to both screening questions is “yes,” review the risks, precautions, and benefits:]. Before we set up the interview, I would like to review the potential risks and corresponding precautions of participation in this study. The potential risks are described as follows: First, you may experience emotional distress if the stories you choose to share are traumatic, distressing, or personal in nature. Second, you may experience emotional distress if you disclose confidential

information about the clients you serve, such as names or identifying information. Third, you may experience a confidentiality breach if you share information that meets the legal definition of child maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting. Due to the nature of the interview questions, the likelihood of these events occurring is rare. In order to manage these risks, I ask that you only share what you are comfortable sharing. Also, please do not share confidential information. Should you experience emotional distress, the interview will end and a phone number to a 24-hour mental health crisis line closest to your area will be given to you. If you disclose confidential information about the clients you serve, such as names or identifying information, the interview will end and the audiotape will be destroyed. I will not share any of this information. If you share information that meets the legal definition of child maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting, the interview will end, the audiotape will be destroyed, and only what is required by law will be reported to the appropriate authorities. This study has no direct benefits. Do you have any questions? Would you still like to participate in this study?

[If participant is still interested, set up the interview.] I have a four-question demographic survey to send to you via email prior to our interview. I will collect your responses at the time of the interview, after you sign the consent form. Your responses can be emailed or handed to me at that time. May I get your email address? I will send the demographic survey to you shortly. Would you also like me to email you a copy of the consent form to review prior to our interview? Do you have any other questions about the study? Should questions arise, feel free to contact me at 320-248-5838 or lee45003@stthomas.edu. Thank you and I will see you on *[date and time of interview]*.

Appendix D

Script for Psychotherapist Participant Recruitment

Hello,

My name is Renae Lockerby and I am a graduate student with the School of Social Work at the University of St. Thomas/St. Catherine University. I am conducting a study about the intervention approaches used by sexual assault center advocates and outpatient psychotherapists in working with adult victims of sexual violence. You are eligible to participate in this study because of your role as an outpatient psychotherapist. I am contacting you to see if you would be willing to participate in a brief demographic survey and a one hour to one hour and 15 minute in-person, audiotaped interview to help me complete my study.

[If potential participant is interested:] Because I am focusing on approaches used by sexual assault center advocates and outpatient psychotherapists in their work with adult victims of sexual violence, I have to ask one screening question to help ensure your appropriateness for this study. The screening question is: “Do you have experience working with adult clients whose primary concerns are related to the direct impact of experiencing sexual violence?”

[If the answer to the screening questions is “yes,” review the risks, precautions, and benefits:]. Before we set up the interview, I would like to review the potential risks and corresponding precautions of participation in this study. The potential risks are described as follows: First, you may experience emotional distress if the stories you choose to share are traumatic, distressing, or personal in nature. Second, you may experience emotional distress if you disclose confidential information about the clients you serve, such as names or identifying information. Third, you

may experience a confidentiality breach if you share information that meets the legal definition of child maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting. Due to the nature of the interview questions, the likelihood of these events occurring is rare. In order to manage these risks, I ask that you only share what you are comfortable sharing. Also, please do not share confidential information. Should you experience emotional distress, the interview will end and a phone number to a 24-hour mental health crisis line closest to your area will be given to you. If you disclose confidential information about the clients you serve, such as names or identifying information, the interview will end and the audiotape will be destroyed. I will not share any of this information. If you share information that meets the legal definition of child maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting, the interview will end, the audiotape will be destroyed, and only what is required by law will be reported to the appropriate authorities. This study has no direct benefits. Do you have any questions? Would you still like to participate in this study?

[If participant is still interested, set up the interview.] I have a four-question demographic survey to send to you via email prior to our interview. I will collect your responses at the time of the interview, after you sign the consent form. Your responses can be emailed or handed to me at that time. May I get your email address? I will send the demographic survey to you shortly. Would you also like me to email you a copy of the consent form to review prior to our interview? Do you have any other questions about the study? Should questions arise, feel free to contact me at 320-248-5838 or lee45003@stthomas.edu. Thank you and I will see you on *[date and time of interview]*.

Appendix E
CONSENT FORM
UNIVERSITY OF ST. THOMAS
GRSW682 CLINICAL RESEARCH PROJECT

Sexual Assault Center Advocates and Psychotherapists: An Exploratory Study of Interventions

I am conducting a study about the intervention approaches used by sexual assault center (SAC) advocates and outpatient psychotherapists in working with adult victims of sexual violence. I invite you to participate in this research. You were selected as a possible participant because of your role as an SAC advocate or outpatient psychotherapist. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Renae Lockerby, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas, and supervised by Dr. Lance Peterson. This study has been approved by the Institutional Review Board at the University of St. Thomas.

Background Information:

The purpose of this study is to identify and compare the self-identified approaches taken by Sexual Assault Center advocates and outpatient psychotherapists in working with adults who have experienced some form of sexual violence at any point in their lives.

The research questions are: When providing crisis intervention and/or counseling to adult victims of sexual violence, what are the approaches taken by SAC advocates and psychotherapists? How do these approaches compare to each other?

Procedures:

If you agree to be in this study, I will ask you to do the following things: Complete a brief demographic survey and participate in a 1 hour to 1 hour and 15 minute audiotaped interview at a confidential location of your choosing. The brief survey will be sent to your email prior to the interview. You will be instructed to email your response to me after this consent form is signed at the time of the interview. I will transcribe and analyze your audiotaped interview and survey response. I will share findings from this and other interviews and surveys in the form of a written, publically available, research report and oral presentation. Your name, agency affiliation, and other identifying information will not be included in the survey response, transcript, written report, or oral presentation.

Risks and Benefits of Being in the Study:

The study may have the following risks: First, you may experience emotional distress if the stories you choose to share are traumatic, distressing, or personal in nature. Second, you may experience emotional distress if you disclose confidential information about the clients you serve, such as names or identifying information. Third, you may experience a confidentiality breach if you share information that meets the legal definition of child maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting. Due to the nature of the interview questions, the likelihood of these events occurring is rare.

The following precautions will be taken to minimize each risk: First, you will be told only to share what you are comfortable sharing. Second, you will be told not to share confidential information in the interview. Should you experience emotional distress, the interview will end and a phone number to a 24-hour mental health crisis line closest to your area will be given to you. If you disclose confidential information about the clients you serve, such as names or identifying information, the interview will end and the audiotape will be destroyed. I will not share any of this information per the confidentiality statement below. Third, if you share information that meets the legal definition of child maltreatment or vulnerable adult abuse set forth by Minnesota statute on mandated reporting, the interview will end, the audiotape will be destroyed, and only what is required by law will be reported.

The study has no direct benefits.

Confidentiality:

The records of this study will be kept confidential. Written research records will be kept in a locked file cabinet in my home office. I will also keep the electronic copy of the transcripts and the responses to the brief demographic survey in a password protected file on my computer. Your response from the survey will be deleted from my email account. All research records, including the audio-recordings, will be kept in a lock box while traveling. My research committee may see the transcript of the interview and your survey response, but will not know who you are. I will delete any identifying information from the transcript and the survey response. Findings from the transcript and survey will be presented in the form of a written, publically available, research report and presented in a public clinical research presentation. The audio recording will be deleted as soon as the interview is transcribed. The transcript and survey responses will be destroyed by June 1, 2017. The consent form will be destroyed in three years of the completion this study per federal regulations.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. If you would like to withdraw, please notify me anytime in person or by phone at the number listed below. Should you decide to withdraw, data collected about you will not be used.

Contacts and Questions

My name is Renae Lockerby. You may ask any questions you have now. If you have questions later, you may contact me at 320-248-5838 or my research committee chairperson, Dr. Lance Peterson, at 651-962-5811. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. I am at least 18 years of age. My questions have been answered to my satisfaction. I consent to participate in the study and to be audiotaped.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix F

Interview Guide

Circle one: SAC Advocate / Psychotherapist

ID#: _____

Date of Interview: _____

Location: _____

Time begun: _____ Time ended: _____

Read to participant prior to interview: The following questions refer to your experiences working with adult clients who have experienced sexual violence at any time in their lives. The questions refer to clients' experiences as victims of sexual violence, not as offenders. For the purposes of this study, sexual violence will be defined as:

a sexual act that is committed or attempted by another person without freely given consent of the victim or against someone who is unable to consent or refuse. It includes: forced or alcohol/drug facilitated penetration of a victim; forced or alcohol/drug facilitated incidents in which the victim was made to penetrate a perpetrator or someone else; nonphysically pressured unwanted penetration; intentional sexual touching; or non-contact acts of a sexual nature. Sexual violence can also occur when a perpetrator forces or coerces a victim to engage in sexual acts with a third party. (Basile et al., 2014)

Sexual violence is a term that includes rape and sexual assault, as well as other forms of non-contact, non-consensual sexual experiences such as being forced to watch others engage in sexual activities. Essentially, sexual violence refers to any form of unwanted sexual activity.

1. How do you assess for history and recent experiences of sexual violence in your clients?
 - a. **Prompt:** Are there specific assessment tools you use, for example? If so, what are they?
2. How are goals set with clients who have experienced sexual violence victimization if working on their victimization is their primary concern?
 - a. **Probe:** Examples of goals that guide your meetings with client/victims
3. What are some examples of clients' needs in relation to sexual violence victimization?
4. If the sexual assault is more recent, how do you address immediate concerns?
 - a. **Probe:** safety concerns, medical concerns, legal concerns
5. Do you provide crisis intervention with clients who present with histories/recent experiences with sexual violence?
6. **If yes to item 5:** What does crisis intervention look like with this population?

Transition Statement: Unless otherwise specified, the rest of the questions will relate to general intervention with victims of sexual violence (not just crisis intervention as specified in the previous two questions).

7. What approaches (intervention techniques) do you use with clients who present with experiences with sexual violence?
8. How do you implement those approaches (intervention techniques)?
9. Do you follow a manual or set of guidelines when working with victims of sexual violence?
 - a. **Probe:** If so, please name and describe the manuals(s) and/or guidelines.
10. How, if at all, do personal characteristics of the client/victim influence your approaches with that person?

- a. **Prompt:** personal characteristics, meaning age, race, gender, income, personality characteristics, prior coping strategies, prior mental health diagnoses, etc.
11. How, if at all, does the client/victim's experience of multiple sexual victimizations influence your approaches with that person?
12. What are the differences, if any, in how you work with clients whose experience(s) with sexual violence is more recent than in the past?
13. How, if at all, do characteristics of the assault(s) influence your approaches with this population?
 - a. **Prompt:** characteristics of the assault, meaning the relationship of the offender to the victim, were there multiple perpetrators at once, at what age was the assault experienced, what was the nature of the assault (penetration or contact), alcohol or drug facilitated, etc.
14. How, if at all, do you address the impact of family and friend responses on the victim/client?
 - a. **Prompt:** How, if at all, do attitudes (beliefs) held by friends and family about sexual violence impact the victim of sexual violence? How do you address this with the victim?
15. How, if at all, do you address the impact of social attitudes (beliefs) about sexual violence on victims/clients?
16. How, if at all, do you address the impact of the responses of social institutions on the victim/client?
 - a. **Prompt:** social institutions meaning, the criminal justice system, medical system, mental health system, etc.

17. Do you typically provide referrals to victims of sexual violence for services in place of or in addition to your services?
 - a. **Prompt:** referrals to sexual assault centers/psychotherapists, support/therapy groups, medical care, law enforcement, housing assistance, social services, etc.
18. How do you know when a client/victim no longer needs counseling or ongoing support services?
19. How do you know when a client/victim no longer needs crisis intervention services?
20. How do you terminate (end) your work with client/victims?
21. In your opinion, what do professionals like yourself need to know to improve their work with victims of sexual violence?
22. Is there anything else you would like to add?

Read to the participants at the end of the interview: Thank you for completing this interview. Please remember to email me your responses to the brief demographic survey I sent to you prior to this interview. My email is lee45003@stthomas.edu. If you have your responses with you, you may hand them to me at this time. As a reminder, once I receive your responses, I will save them in a password protected file, remove your name and email address, and delete that email from my email account. Your name and identifying information will be kept confidential.