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Reimaging safety after sexual violence: A qualitative exploration of survivors' experiences with formal and informal crisis response networks.

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REIMAGINING SAFETY AFTER SEXUAL VIOLENCE:

A QUALITATIVE EXPLORATION OF SURVIVORS' EXPERIENCES WITH FORMAL AND INFORMAL CRISIS RESPONSE NETWORKS

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A Dissertation Approved on

March 29, 2024

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Katherine Lorenz, PhD, MA

DEDICATION

This dissertation is dedicated to:

Ruth Decker,

Jean Lewis,

Carolyn Dennis,

and

All victims and survivors of sexual violence.

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ABSTRACT

REIMAGINING SAFETY AFTER SEXUAL VIOLENCE: A QUALITATIVE EXPLORATION OF SURVIVORS' EXPERIENCES WITH FORMAL AND INFORMAL CRISIS RESPONSE NETWORKS

Hallie R. Decker

March 29, 2024

Sexual violence (SV) is a highly prevalent public health and human rights concern impacting communities across the United States. SV is associated with a myriad of adverse physical, reproductive, sexual, mental, behavioral, financial, and social health outcomes which may be acute or chronic. Health challenges associated with post-traumatic stress and post-traumatic stress disorder are particularly common among victims and survivors of SV. Engagement in early psychological/psychosocial intervention strategies may prevent or reduce PTSD-related symptomatology after experiencing an SV encounter. Despite the availability of crisis response and support options to support individuals who have experienced SV, significant barriers exist across social ecology to meaningful access and engagement, leading to significant underreporting of SV, as well as underutilization of available crisis response services and resources. Lived experience perspectives from individuals who have experienced SV are critical for learning more about how to overcome barriers to care and crisis response engagement, and to address adverse health outcomes after SV.

This qualitative descriptive study engaged adults who identified as having experienced contact SV (n=20) in semi-structured narrative interviews to learn more about their experiences with and perspectives regarding formal and informal crisis response and support networks. Interviews were analyzed using reflexive thematic analysis methods.

Three manuscripts were developed based on qualitative data collected. The first manuscript explored survivors' experiences with post-assault crisis care delivered by nonprofit human services organizations (NPHSO) and leveraged lived experience to make targeted recommendations for improving access to and quality of crisis response services. The second manuscript reported on findings specific to survivors' experiences with crisis response services offered by criminal justice systems (CJS). The third manuscript considered how social responses to SV disclosures from informal social support providers may support or obstruct survivors' recovery trajectories.

The findings of this study indicate that crisis response services frequently fail to align with the priorities, objectives, and immediate needs experienced by survivors following a violent encounter. Participants expressed a significant lack of confidence in crisis response services, particularly those associated with the criminal justice system (CJS), to deliver compassionate, understanding, and supportive care. Consequently, many survivors opted not to engage with law enforcement, emergency departments, or crisis counseling altogether. To restore this eroded trust, participants proposed a variety of recommendations for enhancing crisis response services, ranging from improving communication strategies and outreach efforts to implementing substantial policy reforms and systems transformations. As individuals with lived experience, survivors of SV offer

invaluable insights into the effective strategies for supporting individuals in urgent need of post-assault care.

This dissertation follows a three-manuscript format and has seven chapters. Chapter one introduces the topic and provides a brief background. Chapter two offers an extensive review and synthesis of the literature. Chapter three explains the methodological approaches used, as well as theoretical, conceptual, and epistemological underpinnings of the study. Chapters four through six present three distinct manuscripts developed with the findings of the study. Finally, chapter seven discusses the three manuscripts, as well as presents implications for policy, practice, and future research directions.

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CHAPTER I

INTRODUCTION

The wounds of trauma are not merely those caused by the perpetrators of violence and exploitation; the actions or inactions of bystanders—all those who are complicit in or who prefer not to know about the abuse or who blame the victims—often cause even deeper wounds. These wounds are part of the social ecology of violence, in which crimes against subordinated and marginalized people are rationalized, tolerated, or rendered invisible. If trauma originates in a fundamental injustice, then full healing must require repair through some measure of justice from the larger community.

In the course of their recovery, survivors inevitably confront many complicated questions about justice: Can they dare to tell their stories in public, and if so, can their truth be recognized by the community? Can the harm be repaired, and if so, what would that require? How can survivors and offenders go on living in the same community? What would it mean to hold offenders accountable? Is reconciliation something to be desired, and if so, how can it be achieved? How can the community provide public safety and prevent future harm?

I propose that survivors of violence, who know in their bones the truths that many others would prefer not to know, can lead the way to a new understanding of justice. The first step is simply to ask survivors what would make things right—or as right as possible—for them. This sounds like such a reasonable thing to do, but in practice, it is hardly ever done. Listening, therefore, turns out to be a radical act.
Judith Herman, Truth & Repair (2023)

Introduction

Sexual violence (SV) remains a global crisis, despite ongoing coordinated efforts to mitigate violence rates and address harms committed. SV is associated with a wide array of adverse physical and psychological health outcomes and remains highly prevalent worldwide (Borumandnia et al., 2020).

Current crisis response options for people who have experienced SV are largely offered as formal, institutionalized pathways for reporting a violent incident and pursuing prosecution for the perpetrator. Healthcare institutions partner with law enforcement agencies and the judicial system to provide a reporting protocol that uses bio-evidence to identify and prosecute a perpetrator. Nonprofit human services organizations established to support survivors of SV, such as rape crisis centers (RCCs) or sexual assault resource centers (SARCs), provide various stabilization and support services, such as crisis hotlines, brief therapeutic interventions, and legal advocacy, among other services.

Despite the collaborative institutional efforts to provide these pathways to "safety after SV" for survivors, a significant justice gap exists between reports filed and perpetrators convicted. This gap demonstrates a systemic failure to hold perpetrators meaningfully accountable for harms committed, and a lack of justice experienced by victims (Lonsway & Archambault, 2012).

Many people who have experienced SV intentionally choose not to report their experiences with SV for a variety of complex reasons. Among individuals who do report, many describe experiencing additional traumatization during the process of engaging with crisis care services (Hockett et al., 2016; Venema, 2016). Presently, people who have experienced SV, as well as those who commit SV, do not experience "justice" as it has been currently imagined. Without meaningful accountability measures, SV continues to plague communities globally.

The purpose of this dissertation study is to explore the experiences and perspectives of survivors of SV with various formal and informal crisis response intervention networks. This will allow for the identification of critical gaps in knowledge, practice, and service provision.

In chapter one, I provide a brief overview of the problem, as well as discuss the many drivers and outcomes of SV. I will define how SV will be conceptualized throughout this study and provide introductory definitions to the many moving parts that make up the systems of SV and SV crisis response. Finally, I will contextualize the issue of SV in the Commonwealth of Kentucky and discuss the unique policy landscape and cultural norms that shape access to post-SV crisis care in the state.

Chapter two provides an extensive literature review of the topic. The chapter will begin with a thorough introduction of SV as a public health problem and will then delve into literature examining how historical approaches to SV crisis response have influenced SV response today. The chapter will additionally consider the many barriers to engagement in crisis response services experienced by survivors of SV today.

Chapter three overviews the methods to be used for data collection and analysis for the proposed research, including an overview of qualitative thematic analysis and grounded theory, as well as a detailed proposal for the data collection and analytic approach of the study.

Chapters four through six contain three distinct manuscripts developed using the study findings. Findings will align with three unique research questions developed with the experiences of post-assault crisis response experiences in mind.

Finally, chapter seven will thread together each of the manuscripts with a discussion, and will discuss implications for policy and practice, as well as directions for future research.

Crisis response interventions are developed with the intention to serve people who have experienced SV, charge perpetrators, and mitigate overall rates of SV. Existing literature suggests that these interventions may have unintended adverse impact by perpetuating the very systems of violence they attempt to address. By soliciting and examining the lived experiences of survivors of SV in Kentucky, this study will determine where critical gaps in service provision are occurring, how those gaps may be perpetuating unintended consequences and further harm, and how people with lived experience reimagine pathways to safety after SV.

Gathering community-engaged data on lived experience with SV crisis response will also provide unique insight into innovative approaches to address violence and support victims of SV. This study will interrogate historical and contemporary conceptualizations of SV to understand how they have led to current crisis intervention practices, as well as to envision novel opportunities for meaningful change.

Defining Sexual Violence

Sexual violence (SV) is an all-encompassing term to refer to a broad range of sex- and interpersonal power-based acts including, but not limited to, rape, assault, molestation, intimidation, humiliation, harassment, stalking, and technology-facilitated violence (e.g., “revenge porn,” AI-generated deepfake images, online intimidation, and blackmail). SV is a public health crisis of epidemic magnitude. Often understood as only referring to interpersonal acts, SV may also refer to systemic operationalization of sexual or coercive violence, such as human trafficking for sexual exploitation, child marriage, forced abortion and sterilization, forced birth and other reproductive violence, and rape as a systematized weapon of war (WHO, 2002, p. 149).

Prevalence of SV in the United States

Prevalence and incidence data on SV are difficult to measure, as recorded rates vary between reports. The CDC asserts from available data that as many as one in three adult women and one in 38 adult men have experienced attempted or completed rape within their lifetimes in the United States (CDC, 2021). SV is prevalent in childhood as well, with available data demonstrating that one in three girls and one in 13 boys will be affected (CDC, 2021). Available data from the Rape, Abuse, and Incest National Network (RAINN) indicates that in the US, a person is sexually assaulted every 68 seconds (RAINN, 2021).

SV disproportionately impacts structurally marginalized communities (Prevention Institute, 2021). Black, Indigenous, and people of color (BIPOC), lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, individuals with disabilities, and other historically oppressed populations experience higher rates of SV, in addition to having less access to intervention and/or protective services (NSVRC, 2019).

Though these statistics demonstrate a high prevalence of SV experiences across populations in the US, it is widely acknowledged that available data on SV significantly underestimates the true prevalence of sexual coercive violence. For example, the US

Department of Justice estimates that as many as 80% of rapes are not reported to law enforcement or healthcare agencies (Morgan & Kena, 2018). The National Sexual Violence Resource Center similarly reports that approximately 63% of sexual assaults are never reported, naming rape the “most underreported crime” (NSVRC, 2015).

Health Outcomes of Sexual Violence

SV and coercive victimization are associated with a range of adverse physical, sexual, reproductive, psychological, mental, and behavioral health outcomes. Health outcomes following an incident of sexual coercive violence may be temporary or lifelong. Health outcomes after SV may also manifest as acute issues that, without appropriate and timely intervention, have the potential to become chronic health conditions. SV is also associated with economic disparity, as trauma from experiencing violence may impact a person’s capacity to work or remain employed over time (Basile, DeGue, et al., 2016).

Relative to other traumatic events, individuals who have experienced SV have an increased risk of meeting diagnostic criteria for post-traumatic stress (PTS), as well as for demonstrating relative severity of PTS-related symptomatology (DiMauro & Renshaw, 2021). PTS-related symptomatology includes but is not limited to depression, anxiety, as well as more serious psychiatric mood disorders; adverse behavioral health outcomes such as hopelessness, inability to develop trust for others, perceived powerlessness, as well as risky sex and substance use behaviors; adverse sexual health outcomes including sexual dysfunction or painful sexual intercourse (Black et al., 2011; Machado et al., 2011) (WHO, 2012). Notably, literature demonstrates that individuals who are exposed to intentional acts of interpersonal violence, such as SV, are more likely to develop PTS-related symptoms than individuals who experience traumatic events that are accidental or disaster-related (Johansen et al., 2022; Sareen, 2014).

As prevalence of SV is high globally and across populations and many adverse health outcomes are associated with experiencing violence, SV is an important area of study within the discipline of public health.

Interventions for Sexual Violence

In this section, I introduce and discuss current intervention strategies offered to address and mitigate SV. Present day interventions that seek to address SV largely fall into three categories: primary prevention, secondary prevention, and tertiary prevention, or long-term efforts to address lasting impacts of violence after violence has occurred, as well as perpetrator and sex offender treatment interventions (CDC, 2004). Prevention efforts are introduced and discussed further below.

Primary Prevention

Primary prevention efforts for SV include universal interventions offered to general populations, as well as more specialized interventions for populations at higher risk for experiencing SV and are most often offered as community or organizational-level policies or programs (DeGue et al., 2014). Primary prevention interventions for SV attempt to prevent perpetration in addition to victimization of SV (DeGue et al., 2014).

Primary prevention interventions include bystander intervention training, comprehensive sexual health education for youth and adolescents, women's empowerment programming, and the implementation of policies in schools and workplaces that seek to create a protected environment from sexual harassment and sexually inappropriate interaction (Basile, DeGue, et al., 2016). These interventions, rooted in social normalization and gender equality theories, aim to shift broadly accepted social norms to discourage perpetration of SV, or to encourage bystanders to intervene when risk factors for perpetrating or experiencing SV become apparent (Basile, DeGue, et al., 2016).

Secondary Prevention

Secondary prevention to address SV are intervention efforts to support people who have experienced violence and identify/apprehend perpetrators after violence has occurred (CDC, 2004), otherwise referred to throughout this dissertation as crisis response services. Crisis response services are services available to a person who has experienced SV that are intended to respond to the immediate physical, psychological, legal, and social needs of the victim. SV crisis response involves the interorganizational collaborative contributions of law enforcement organizations, healthcare institutions, and often, non-profit human services organizations.

Law Enforcement and Prosecution

The primary goal of law enforcement in responding to SV is to collect evidence to identify and prosecute a perpetrator. Law enforcement officers may collect evidence from the person impacted by violence, the person accused or suspected of perpetrating violence, the scene of the crime, as well as testimony from witnesses or secondary parties (NYSCASA, 2003; Hunter, Cewe & Mills, 1998) (McQueen & Murphy-Oikonen, 2023).

A key element to build a compelling case to prosecute a perpetrator of SV is DNA from the victim that is collected in forensic examination, which are typically collected in an emergency department or healthcare institution.

Emergency Departments & Healthcare Response

The forensic exam is the main purpose for engaging with healthcare institutions following an experience with SV, “demonstrat[ing] the intersectionality between medicine and law” (Ladd & Seda, 2020) by providing critical bio-evidence with which to identify and prosecute a perpetrator more accurately.

Most commonly, evidence collection following an experience with SV is conducted in hospital emergency departments, but sometimes also in urgent-care, primary care offices, or OB/GYN departments (Ladd & Seda, 2020). When available, sexual assault forensic examinations are performed by Sexual Assault Nurse Examiners (SANEs) or Sexual Assault Forensic Examiners (SAFEs), though SANE/SAFE programs are not available/accessible in every emergency department nationwide, particularly in rural areas (Thiede & Miyamoto, 2021).

Nonprofit Human Services Organizations

Services commonly provided by nonprofit human services organizations, such as RCCs or SARCs, include crisis intervention, 24-hour hotline services, referral services, short-term therapeutic interventions, community education and violence intervention trainings, legal counseling and advocacy, support groups, as well as free accompaniment to hospital visits and forensic exams following an assault (Bein, 2010; Gunther, 2021).

Unlike law enforcement and healthcare institution arms of crisis response to SV, services provided by nonprofit human services organizations do not wholly center legality and prosecution. Rather, RCCs largely provide short-term crisis intervention and mental health stabilization services to victims and survivors. As of 2021, there were about 1,300 RCCs serving the US nationally (Bein, 2010; Gunther, 2021).

Tertiary Prevention

Tertiary prevention efforts are long-term intervention plans that aim to prevent death or disability associated with violence (Kirk et al., 2017). Tertiary prevention efforts largely consist of long-term psychotherapy options to help survivors navigate and mitigate trauma after experiencing violence, or of intervention efforts to rehabilitate sex offenders or perpetrators of violence (CDC, 2022). This dissertation project will not thoroughly explore tertiary prevention efforts but may refer to them throughout.

Intervention Impact

Though each of these interventions and crisis response services boast some degree of efficacy in seeking justice for victims, SV continues to plague communities around the world at rates that are seemingly untouched by attempts at intervention. Issues of SV thus experience a phenomenon known as the “justice gap,” wherein the rate of conviction for offenders is far below the rate of victimization (Lonsway & Archambault, 2012)

Literature demonstrates that out of every 100 rapes committed, only between five and 20 are ever reported to the police: 0.4 - 5.4 are ever prosecuted, 0.2 - 5.2 ever end in conviction, and of that, only 0.2 - 2.8 perpetrators are ever incarcerated (Lonsway & Archambault, 2012). Put differently, RAINN reports that only 25 out of every 1,000 perpetrators will be incarcerated on conviction of felony sexual assault or rape (RAINN, 2022). These numbers suggest that law enforcement and legal prosecution of SV has not demonstrated powerful efficacy in addressing or preventing the widespread epidemic of SV. The concept of the justice gap serves to make known the lack of accountability perpetrators of sexual assault are likely to face in the US and globally - so little, that feminist advocates have recently begun to ask the question: “Is rape a crime?” (Bowdler, 2020).

Furthermore, literature and popular culture alike suggest that many survivors report negative experiences and even re-traumatization while engaging with crisis response providers (McQueen et al., 2021). Experiencing secondary traumatization while seeking care after SV may exaggerate immediate and long-term adverse health impacts related to SV, increase perceived barriers to care, and impact institutional trust among survivors of SV (McQueen et al., 2021). These experiences, shared widely since the viral #MeToo social media movement, may discourage engaging in continua of care or dissuade others from engaging with crisis response services (Whiting et al., 2021).

Sexual Violence in Kentucky

SV occurs everywhere in the world. For the purposes of this study, however, I focus on SV crisis response in the state of Kentucky, a state positioned between the Midwest and South regions of the US. Kentucky’s proximity to the “Bible Belt,” wealth disparity between urban and rural regions of the state, and conservative political representation in local and federal government (at the time of this dissertation project) create a unique political environment that shapes not only policies regarding response to SV, but also cultural attitudes and worldviews that inform practice frameworks of crisis response. In this section, I will briefly introduce information about the general prevalence of SV in Kentucky, as well as some state-level policy responses to provide context to the issue.

Prevalence

SV is highly prevalent in the state of Kentucky. The 2010-2012 National Intimate Partner and SV Survey conducted by the Centers for Disease Control and Prevention reports on the prevalence of five types of SV in each state: rape, being made to penetrate someone else, sexual coercion, unwanted sexual contact, and non-contact unwanted sexual experiences (Smith et al., 2017; Smith et al., 2018). The survey combines each of these five types of SV in one aggregated measure, named “Contact SV.” Nationally, lifetime prevalence of contact SV was above 30% for women, and over 10% for men. In Kentucky, the lifetime prevalence for contact SV is between 38.6% and 47.5% for women, representing the highest rates in the Midwestern region of the US. This percentage estimates that 668,000 women reported lifetime experience with contact SV in Kentucky between the years of 2010 and 2012. At the time of this survey, Kentucky averages were higher than national averages in all five measurements of SV (Kentucky Association of Sexual Assault Programs, 2012).

Though state-level data from the 2016-2017 NISVS are not yet available, aggregated data from the Federal Bureau of Investigation offers insight into more contemporary trends in SV in Kentucky. Based on those data, contributors to the Kentucky Sexual Assault Response Team (SART) Advisory Committee report that one in two women in Kentucky will experience sexual assault in her lifetime; one in five Kentucky men will experience sexual assault in his lifetime; and that historically marginalized groups, including BIPOC, LGBTQ+, and disabled communities, experience the highest rates of SV (Second Annual SAFE Act Report, 2019). BIPOC and LGBTQ+

populations also have some of the lowest rates of care seeking after experiencing SV in Kentucky (SAFE Act Report, 2021).

Policy Response in Kentucky

Laws relevant to SV vary by state, shaping access and opportunities to crisis response and support. In Kentucky, first degree rape is defined as "[engaging] in sexual intercourse with another person by forcible compulsion" or with a person who is physically helpless or younger than 12 years old" (KRS 510.040). "Forcible compulsion" is defined as: "physical force or just a threat of force, expressed or implied, that makes the victim fear immediate death, physical injury to self or 3rd person, fear of kidnap, or fear of any offense under this Chapter. Proof of physical resistance by the victim is NOT required to meet the definition," (KRS 510.010). "Physically helpless" is defined as: "the victim is either unconscious or otherwise physically unable to communicate unwillingness, including as a result of the influence of a controlled substance or legend drug," (KRS 510.010).

In Kentucky, rape of the first degree is considered a Class B Felony punishable by 10 to 20 years in prison. It becomes a Class A felony when the victim is under 12 years old or suffers from "serious physical injury," (KRS 510.010). As a felony, there is no statute of limitations on rape in Kentucky. Kentucky also terminates parental rights of the rapist parent when a child is born of rape if a conviction for felony sexual offense has been acquired (KRS 510.010).

SAFE Act

In 2015, an audit discovered a backlog of almost 3,000 sexual assault forensic exams, or "rape kits," sitting untested in forensic labs and in evidence rooms of law enforcement agencies, creating a state-wide controversy (Klibanoff, 2019). To address the backlog, the Kentucky state legislature, with contributions from the Kentucky Association for Sexual Assault Programs, passed the Sexual Assault Forensic Evidence (SAFE) Act in 2017.

The SAFE Act implemented an interdisciplinary advisory board to oversee efforts to eliminate the backlog of unsubmitted and untested sexual assault kits (SAFE Act Report, 2019). By 2018, the backlog had been cleared, but challenges with testing forensic exams remain. The SAFE Act requires a forensic exam to be submitted by law enforcement if a survivor of sexual assault decides to report the event, which has led to an increase of forensic exams sent to labs by almost 100% (Klibanoff, 2019). Furthermore, forensic labs have experienced high rates of lab staff turnover, contributing further to the slow return of kits. The SAFE Act stipulates that all kits submitted to forensic laboratories be returned in 90 days, but the current average time kits are being returned is around 220 days (Klibanoff, 2019).

Beyond the efforts to address the backlog, the SAFE Act ignited sweeping policy reform to address several other elements of Kentucky's response to acts of SV. The SAFE Act introduced mandatory training on sexual assault for Kentucky state police, new duties for law enforcement regarding sexual assault cases, data collection protocols, a centralized database and timelines for data analysis, new duties of hospitals to comply with law enforcement in sexual assault cases, designations for "SANE-ready hospitals," and more (SAFE Act Report, 2019). Currently, the Kentucky SART Advisory Committee is advocating for increased funding to enact a new pilot project on rapid DNA testing, an emerging technology that can produce a DNA profile for comparison to a named subject to be searched in the state database in only 90 minutes (SAFE Act Report, 2019).

Despite aggressive efforts put forward by the SART Advisory Committee and the SAFE Act to address SV in Kentucky, SV continues to impact Kentuckians disproportionately. Efforts to mitigate SV, while earnest and well-intentioned, seem to make virtually no significant impact on trends of SV over time – and may even produce unintended adverse consequences. For these reasons, it is critical to engage in deep listening with Kentuckians with lived experience with SV to learn more about how to best support victims and survivors.

Study Purpose

For victims and survivors of SV, “safety” is often primarily conceptualized and packaged as formalized engagement with criminal justice systems: identifying, convicting, and incarcerating a perpetrator. Beyond this, “safety” may also be presented as engagement in individual counseling and therapy, engaging in recovery journeys that emphasize the privacy and confidentiality of experiencing a deeply stigmatized phenomenon.

However, as evidenced by the justice gap of SV, the significant underreporting of experiences with SV, and reports from survivors claiming to have experienced re-traumatization during the process of engaging with crisis response services, it can be deduced that existing intervention frameworks to address SV have failed to meaningfully protect communities and to meaningfully support people who have experienced SV, creating and contributing to lasting adverse population health outcomes.

Despite aggressive efforts to address SV in Kentucky, such as efforts put forward by the SAFE Act, prevalence remains high and engagement with crisis response remains comparatively low. For structurally minoritized communities in Kentucky, barriers to crisis response services and pathways to safety after experiencing SV exacerbates known health inequities by obstructing access to trauma-informed care and healing.

In response to this identified gap in research and practice, this qualitative study will explore the experiences of victims and survivors of SV in Kentucky. Analyzing this data will yield critical information for how to intervene to generate positive outcomes for people who have experienced SV, as well as mitigate rates of ongoing violence.

Conducting interviews with Kentuckians who have lived experience with SV will yield critical information about perspectives and lived realities of engaging with SV crisis response services. Analyzing these data will help identify gaps in care, as well as areas for growth and leverage points for intervention.

Finally, in alignment with participatory action research frameworks, I propose that the end goal of this study include actionable steps, as defined by community, to implement meaningful change for the affected populations.

Research Questions

This dissertation study aimed to explore the following overarching research questions:

RQ1: Based on their interactions with KY-based NPHSOs, how do survivors of sexual violence imagine best practices for offering community-based care?

RQ2: How do people who have experienced sexual violence experience, engage with, and perceive criminal justice responses to sexual violence?

RQ3: How can peers, families, and communities support people who have experienced sexual violence?

To respond to these questions, this study aimed to:

1. Gain nuanced perspective on the experiences of survivors of SV.
2. Identify critical gaps in services available and accessible to survivors of SV.
3. Imagine innovative preventative and crisis care approaches to individual and community safety.

To accomplish these aims, this study employed a qualitative approach. Approaching this issue qualitatively is necessary as these nuanced concepts are not easily quantifiable. Methods are outlined in further detail in Chapter 3.

CHAPTER II

LITERATURE REVIEW

Introduction

In this chapter, I present a thorough literature review spanning relevant topics to be explored and addressed throughout this dissertation study. The chapter will begin with discussion around sexual violence (SV) definitions, prevalence, and epidemiology. Next, the chapter will present an in-depth overview of crisis response services available to address SV, including law enforcement agencies, healthcare institutions, and nonprofit human services organizations. In this section, I also discuss the "unintended consequences" of these services, including the secondary traumatization of survivors seeking care and the phenomenon of underreporting to illustrate available crisis response as "band-aid" solutions incapable of mitigating systemic violence. Next, this section will present a discussion of how data collection efforts, as they occur mainly through the channels of crisis response services, mischaracterize SV and perpetuate ineffectualness of crisis response by perpetuating incomplete conceptualizations of violence. I will then discuss the impact of "band-aid" crisis care strategies on structurally marginalized communities experiencing SV to illustrate the immediacy of evaluation and change.

Finally, this chapter will present a deep dive into various "mental models," or personally constructed internal representations of reality, that have influenced SV discourse and intervention historically and contemporarily. The section will first introduce the concepts of mental, cultural, and instituted models. Next, I introduce several prominent cultural models that have significantly informed SV discourse and practice, including gender, legality, racism, carceralism, and rape mythology. The impact of these mental models on SV discourse and practice will then be discussed. This section ends with critical information to inform the chosen method of this dissertation project, which is introduced and discussed in full in Chapter 3.

The chapter will conclude with a synthesis of information presented, as well as a concise problem statement to inform Chapter 3.

Defining SV

Sexual violence (SV) is defined by the World Health Organization (WHO) as "...any sexual act, attempt to obtain a sexual act, unwanted sexual comments, advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work," (WHO, 2002, p. 149). The act of coercion can assume multiple expressions, including but not limited to physical force, psychological intimidation, blackmail, threat of physical harm, or threat of withholding critical resources, such as preventing or terminating employment, (WHO, 2002, p. 149).

Sexual Violence Prevalence in the United States

The World Health Organization reports that as many as one in three women – or 736 million – experience lifetime SV globally (WHO, 2020). In the US, it is estimated that around 43.6% of women have experienced lifetime SV, and approximately one in five women (21.3%) have experienced attempted or completed rape at some point in their lifetime (NISVS, 2015). Similarly, the CDC asserts from available data that as many as one in three adult women and one in 38 adult men in the US will experience attempted or completed rape (CDC, 2021). Available data from the Rape, Abuse, and Incest National Network (RAINN) indicates that in the US, a person is assaulted every 68 seconds (RAINN, 2021). SV is prevalent in childhood as well, with available data demonstrating that 1 in 3 girls and 1 in 13 boys will be affected (CDC, 2021).

The CDC collected data in the National Intimate Partner and SV Survey of 2010 to demonstrate that one percent of women in the US had experienced forcible rape in the past 12 months; findings that equate to about 1.3 million women who are raped each year in the US (Black et al., 2011). This is a large discrepancy from findings from the Department of Justice's National Violence Against Women Survey that reported 0.3 percent of women and 0.1 percent of men had experienced rape or forcible sexual assault in the previous 12 months, findings that equate to approximately 302,091 women and 92,748 men who experience rape annually (Tjaden, 2000). According to the CDC's NISVS survey (2010), one in two women and one in five men reported experiencing sexual victimization other than rape at least once in their lifetimes (Black et al., 2011).

As evidenced by the various prevalence reported here, SV is notoriously difficult to measure. It is broadly acknowledged that available data grossly underestimate true prevalence and incidence rates. This phenomenon is explored in depth later in the chapter.

Notably, trends of SV across populations are observed to increase during times of crisis, such as war or pandemics. A recent trend analysis reports that though rates of SV have slowly declined in many countries around the world, rates should still be much less than they currently are: "Given the high economic and social burden that SV has on victims and societies, the rate of SV in most countries does not seem to have dropped remarkably and requires special attention by relevant policymakers" (Borumandnia et al., 2020). The same analysis reports that "the SV prevalence rate is highly heterogeneous among world countries which may be due to the definitions and tools used, and more importantly, the culture norms" (Borumandnia et al., 2020).

Sexual Violence as a Public Health Crisis

Described as "devastatingly pervasive" (WHO, 2020), SV is prevalent worldwide. It is committed and experienced at all social-ecological levels of health and is widespread enough to be deemed an "epidemic" by top health organizations and institutions globally (CDC, 2021).

Impact of Sexual Violence on Health

SV and victimization are associated with a range of adverse physical, sexual, reproductive, psychological, mental, and behavioral health outcomes (WHO, 2012). Health outcomes following an incident of sexual coercive violence may be temporary or lifelong, or may manifest as acute issues that, without appropriate intervention, may become chronic health conditions.

Common physical health outcomes associated with experiencing SV include acute or immediate physical injury following assault, such as bruises, lacerations, and broken bones, as well as more serious physical injuries, such as traumatic brain injury or abdominal trauma (WHO, 2012). Physical injuries sustained during assault may lead to disability or chronic pain conditions (WHO, 2012). The most serious physical health outcome related to experiencing SV is death.

Sexual and reproductive health outcomes associated with experiencing SV include unintended or unwanted pregnancy, sexually transmitted infections, transmission of HIV, vaginal bleeding, chronic vaginal or pelvic infection, urinary tract infection, traumatic fistula, sexual dysfunction, or painful sexual intercourse related to trauma (WHO, 2012).

Mental health outcomes include, but are not limited to anxiety, depression, sleeping and eating disorders, poor self-esteem, various somatic disorders, as well as self-harm and suicidality (WHO, 2012). Experiencing SV can have a severe psychological impact on survivors and may permanently change belief systems and ability to trust others (Breiding et al., 2014). Behavioral health outcomes common after experiencing SV include substance use and disorders, sexual dysfunction, high-risk sex behaviors, and other high risk social behaviors (WHO, 2012). Behavioral outcomes may be present immediately after a violent event or may become patterned into lifelong behaviors.

Individuals who have experienced SV are at an increased risk of meeting diagnostic criteria for post-traumatic stress (PTS) and developing associated subsequent health outcomes relative to other traumatic and adverse events (DiMauro & Renshaw, 2021). Literature demonstrates that individuals who are exposed to intentional acts of interpersonal violence, such as SV, are more likely to develop PTS-related symptoms than individuals who experience traumatic events that are accidental or disaster-related (Johansen et al., 2013; Sareen, 2014). Experiences of SV, through pathways of PTS and allostatic load, are also associated with higher risk of developing chronic disease and conditions (Basile et al., 2021).

SV additionally bears a significant financial burden on individuals, with the average occurrence of SV incurring a lifetime cost of $122,461 per person (Peterson et al., 2017). This cost is reflective of medical costs, criminal justice costs, damages costs, and lost productivity costs related to long-term physical and mental health impacts commonly experienced after SV. Given the high prevalence of SV, the estimated population economic burden of SV in the US is nearly $3.1 trillion dollars over the lifetimes of individuals who experience SV (Peterson et al., 2017).

Sexual Violence Crisis Response Services

This section will provide a brief overview of the roles each component of crisis care play in supporting survivors of SV and in contributing to preventive measures.

A formal pathway of crisis response services is available to individuals who have experienced SV. Crisis response interventions to SV involve collaborative efforts between law enforcement organizations, healthcare institutions, and often, non-profit rape crisis organizations.

Primary goals of SV crisis response include ensuring the immediate physical safety of the survivor of violence, as well as to identify and prosecute the perpetrator of violence. The interventions are largely interconnected, as the justice system's ability to prosecute perpetrators relies heavily on bio-evidence collected in healthcare visits following an assault (Ladd & Seda, 2020).

Law Enforcement and Prosecution

The primary goal of law enforcement in responding to SV is to collect evidence to identify and prosecute the perpetrator of the crime. Law enforcement officers may collect evidence from the person impacted by violence, the person accused or suspected of perpetrating violence, the scene of the crime, as well as testimony from witnesses or secondary parties (NYSCASA, 2003; Hunter, Cewe & Mills, 1998) (McQueen & Murphy-Oikonen, 2023). The evidence collection process may include interviews, photographing visible wounds, bruises, or lacerations, as well as photographing or collecting physical evidence at the crime scene (clothing, bedding, toilet tissue, condoms, etc.).

Prosecutions of sexual assault are often generalized into one of two classifications: “identity” cases, where the motivation of the investigation is to determine the identity of the perpetrator (also known as “stranger rape” cases), and “consent” cases, where the motivation of the investigation is to determine whether consent was obtained before an alleged act of SV perpetrated by a known offender (Hunter et al., 1998; McQueen & Murphy-Oikonen, 2023). Evidence collected to prosecute “identity” cases will typically include descriptions from the victim, descriptions on the offender’s “method of operation,” and forensic evidence from the victim. Evidence collected to prosecute “consent” cases, however, will typically include “Evidence of force or threat of force, victims' resistance efforts (if any), words used by victim to dissuade offender, details concerning victim's submission, evidence regarding victim's fear of offender, evidence regarding victim's fear of environment or situation, any evidence of physical injuries on victim's body,” (Hunter et al., 1998; McQueen & Murphy-Oikonen, 2023). Bio-evidence is collected for the sole purpose of identifying and convicting the alleged perpetrator of violence.

Law enforcement is conceptualized as the primary point of contact in seeking institutional support after experiencing violence, and thus can act as gatekeepers, “who select which sexual assault cases are deemed worthy of subsequent formal processing, investigation, and referral to prosecution" (Garza & Franklin, 2021).

Healthcare Institutions

The key element to build a compelling case to prosecute a perpetrator of SV is DNA collected from a forensic examination, which is typically collected in a hospital environment or healthcare institution (Ladd & Seda, 2020).

The forensic exam, or "rape kit," consists of 15 official steps, each of which serve to thoroughly collect evidence from the body of the victim of a sexual assault. The process is often time-consuming and invasive; however, a significant emphasis is placed upon the availability of forensic DNA to move forward with prosecuting acts of SV (Ladd & Seda, 2020). DNA samples are stored in hospital or state laboratories until the prosecution is ready to begin. Though the stabilization and welfare of the victim are also taken into care and consideration during hospitalization following sexual assault, the primary focus of engaging the emergency department following SV is to conduct the forensic exam to aid in building a convincing legal case to prosecute the offender.

Nonprofit Human Services Organizations

Though advocacy for victims and survivors of SV has existed for as long as acts of SV have been committed, efforts to organize and standardize a caring response to victims and survivors after an assault officially began in the 1960s and 1970s (Gunther, 2021). Rape crisis centers (RCCs), borne out of women's rights and civil rights activism escalating at that time, began as informal and unfunded grassroots efforts to support survivors and bring political attention to the prevalence of SV against women (Gunther, 2021). The early RCCs were often run by survivors themselves, commonly without physical offices, and tailored to the specific needs of the communities they served. Over time, RCCs have grown and become more accessible as regional and national rape crisis coalitions have "formed an organizing force for local rape crisis centers" (Gunther, 2021).

Unlike law enforcement and healthcare institution arms of crisis response to SV, services provided by RCCs do not wholly center legality and prosecution. Instead, services provided by RCCs are more likely to center the needs of the survivor as the primary priority, regardless of whether they choose to prosecute.

Services commonly provided by nonprofit organizations may include crisis intervention, 24-hour hotline services, referral services, short-term therapy, community education and violence intervention trainings, legal counseling and advocacy, support groups, as well as free accompaniment to hospital visits and forensic exams following an assault (Bein, 2010) Gunther, 2021). These organizations largely provide short-term crisis intervention and mental health stabilization services to victims and survivors (Bein, 2010) Gunther, 2021).

As survivor-serving nonprofit organizations were originally formed by feminist advocates in response to mainstream feminist and women's rights movements happening in the 1970s and 1980s, it remains common even today for the driving theory and motivation behind these organizations' missions to reflect common conceptualizations of SV as "violence against women." Though many organizations have contemporarily changed their name and/or mission statement to reflect the reality of SV of impacting individuals of all genders, underlying narratives about who experiences SV remain common (Violence, 2020).

Informal Social Support Networks

In lieu of formal support, many victims of SV opt to disclose their experiences and receive support from informal support networks, such as friends, family members, or significant others (Ahrens et al., 2007; Filipas & Ullman, 2001; Kirkner et al., 2021; Lorenz et al., 2018). While evidence suggests that individuals who have experienced SV perceive responses from informal social supports more positively than from formal supports (i.e. law enforcement, health providers, etc.) (Lorenz et al., 2018), negative reactions from informal social supports are still common, and may have a significant impact on future support seeking behaviors (Lorenz et al., 2018; Relyea & Ullman, 2015). Overtly negative reactions, such as reactions suggesting the victim was responsible for the violent encounter, or even well-intentioned reactions, such as those that acknowledge the experience but do not offer support, have been associated with negative perceptions on the part of the victim, which may have a significant impact on their subsequent ability to reach out for additional support from others, or to engage with formal support services (Lorenz et al., 2018; Relyea & Ullman, 2015). Alternatively, positive responses from informal social supports may have the impact of encouraging victims of SV to pursue additional support and recovery services, further increasing their likelihood of mitigating distress and SV-PTS related adverse health outcomes.

Summary

Crisis response services attempt to support survivors mainly by providing formal and institutionalized pathways of reporting and prosecution of a perpetrator. Law enforcement and healthcare institutions work together to create a process survivors can engage with to report SV as a crime and collect bio-evidence with which to support that claim in court. Nonprofit organizations provide more survivor-centered services, such as crisis line support, advocacy services, and short-term and group therapy options. Many survivors forgo engagement with formal crisis response support entirely, choosing instead to rely on support from informal social support networks.

Despite the ongoing collaborative efforts of these organizations, rates of SV continue to trend, and crimes continue to occur unreported. As a deeply complex and multifaceted issue, SV is challenging to meaningfully measure and address.

Challenges of Measuring and Addressing Sexual Violence

Data on SV in the US largely comes from three major streams: police data, clinical and hospital data, and self-report survey data (WHO, 2002). These data streams rely on self-report from survivors for data collection. However, it is broadly acknowledged that available data on SV significantly underestimates true prevalence and incidence. In this section, I explore the challenges of collecting accurate SV data to demonstrate how stigma, institutional trust, and trauma impact the ability of institutions to engage meaningfully with survivors.

Law Enforcement Data

Law enforcement data are based on reports made to police. Law enforcement cannot collect data on instances of SV that are not reported. Law enforcement data are collected from three major streams: the survivor (often the person making the report), environmental evidence taken from a crime scene, and bio-evidence from a forensic exam (Hunter et al., 1998; McQueen & Murphy-Oikonen, 2023).

Police data are skewed, as many survivors of SV do not report their experiences to the police. Rape and instances of SV represent the most violent crimes that are reported and prosecuted the least (Hockett et al., 2016). This occurs for an array of reasons. Survivors may feel that their experience was not “legitimate” enough to warrant a legal or criminal investigation, or that they will not be believed as a “genuine” or “credible” victim of SV for a myriad of possible reasons – both narratives that are rooted in “rape mythology,” or deeply held and prominent stereotypes, prejudices, and false narratives rooted in white supremacy and misogyny about SV that serve to excuse aggression, construct hostile perspectives towards victims, and bias criminal investigations to the benefit of the perpetrator (Du Mont et al., 2003; O’Neal, 2019; Venema, 2018). Survivors may also fear getting involved in the legal justice system, retaliation from perpetrators, peers, or larger community, facing rejection, dismissal, or insensitivity from police, or may not wish to have the perpetrator arrested or engaged in legal justice systems (Jones et al., 2009).

Furthermore, minoritized communities including Black, Indigenous, and people of color (BIPOC) and LGBTQ+ communities may resist reporting incidents of SV to police due to existing community mistrust of police, discomfort with becoming involved in the legal justice system, or fear of especially brutal punishment of perpetrators, who–across populations–are often family members, peers, colleagues, and acquaintances (Decker et al., 2019). Survivors of SV who are already involved in the criminal justice system, who work in criminalized gig economy work or sex work may be especially reluctant to engage with police or in legal justice systems (Sloss & Harper, 2010).

Fears of not being believed by police when reporting SV discourages formal reporting, a common phenomenon that may further skew data in SV prevalence. Many survivors of SV share this fear, with police perceptions acting as a common determinant in victims' decisions to not report their experiences (Lorenz et al., 2021).

Survivors of SV who do not fit the paradigm of "perfect" or "ideal" victim, i.e., a (white, cisgender, and heterosexual) woman who is "credible," physically assaulted by a stranger, and has sustained a physical injury (Quinlan, 2016; Sleath & Bull, 2017) often fear not being believed or taken seriously by police (Ricciardelli et al., 2021). Unfortunately, these fears are grounded in truth: literature demonstrates that police deem as many as one in five reports of SV as "unfounded," indicating that dismissing SV has become common practice within law enforcement crisis response (McQueen et al., 2021).

Experiencing dismissal or disbelief when reporting to law enforcement may cause secondary victimization and/or secondary traumatization, phenomena that are linked to exacerbated adverse health outcomes and that may discourage survivors from seeking further legal or healthcare assistance after the event (Ahrens, 2006; Murphy-Oikonen, McQueen, et al., 2022; Patterson, 2011).

Finally, legal definitions impact how data on SV is collected through law enforcement and legal justice channels (see "Legal History of SV").

Clinical Data

Most clinical data on SV are collected during forensic examination, a time-consuming 15-step process of: recounting the details of the event; a toxicology report; blood and saliva tests; fingernail shavings collection; head and pubic hair collection; clothing collection, locating and photographing bruises; lesions, and injuries; and genital and anal swabs (Ladd & Seda, 2020). The purpose of the forensic exam is to collect and document evidence for litigation purposes (Ladd & Seda, 2020). Survivors who are not interested in or are fearful of participating in legal justice systems following an assault may delay or refuse medical care to bypass the forensic exam. Furthermore, it is not uncommon for completed forensic exams to go untested for long periods of time, impacting validity of prevalence data (Campbell et al., 2017).

Clinical data are also often inaccurate. Available clinical data are largely biased towards the most violent incidents of forcible assault and rape, as many survivors do not require or desire medical attention for less physically violent experiences of sexual coercion (World Health Organization, 2002; Even survivors who do experience physically violent events may delay or refuse medical attention for a variety of nuanced reasons. It is speculated that only between 18% and approximately half of all SV survivors seek healthcare following a violent event (Hullenaar & Frisco, 2020; Munro-Kramer et al., 2017).

Survivors of SV may experience similar feelings around engaging with healthcare systems following an assault: fears of not being believed, fears of not appearing as a "perfect victim," fears of secondary traumatization, fears of participating in legal justice processes, and more (Munro-Kramer et al., 2017). Stigma associated with receiving sexual assault health services and cost and availability of services were also identified as significant barriers to accessing healthcare after assault (Munro-Kramer et al., 2017; Sable et al., 2006).

Survey Data

Self-report survey data, even when conducted by prominent health organizations such as the CDC and the World Health Organization, may be unreliable as well as they rely on respondents' accessibility to the survey, often conducted via house-phone (RDD) or, more contemporarily, via internet. For this reason, many surveys do not account for incidents of SV enacted on children and adolescents, individuals living in group facilities (rehabilitation centers, senior living communities, inpatient hospital facilities, etc.), individuals experiencing homelessness or between addresses, households without telephones and/or internet access, non-English speaking individuals, individuals living in poverty, and more (Tjaden, 2000).

Furthermore, many surveys may only collect data on specific violent acts under the SV umbrella (e.g., date rape), in specific communities (e.g., sexual assault on college campus), or may only account for acts of sexual coercion as defined per survey instructions (e.g., may account for data on completed rape prevalence, but not attempted) (Jones et al., 2009).

Finally, all the streams of data collection to measure SV may be inherently flawed because of their reliance on self-report structures. Many survivors of SV choose not to report their experiences, and for many reasons. As previously mentioned, common reasons to not report an experience with SV include shame, guilt, or embarrassment; fears of not being believed or treated with dignity by first responders or healthcare providers; not wanting friends or family members to know; fears of being retaliated against by perpetrators or others; fears of engaging in the legal justice system; and more (Sable et al., 2006). Furthermore, individuals who have experienced SV may not recognize their experiences as SV because of internalized misconceptions about what counts as “real” SV, among other reasons.

As data about SV can only be collected from self-report measures, and as SV remains a highly stigmatized and politicized subject, data collected do not likely represent the actual prevalence of the problem.

Summary

In this section, I have highlighted many of the challenges that prevent survivors of SV from meaningfully engaging with the pre-determined institutional pathways currently available to attain justice and healing after having experienced violence. Challenges with availability and accuracy of SV data may exacerbate inadequacy of SV crisis response by reinforcing notions of who survivors are and what services they are desire participating in.

Sexual Violence and Historically Marginalized Communities

SV disproportionately impacts structurally minoritized communities (Smith et al., 2017). Not only is general prevalence of SV significantly higher among historically marginalized groups than in socially privileged populations, but access to support services and crisis response is also limited (Wooten, 2017).

In this section, I discuss the experiences of SV among several historically marginalized communities in the US: Black communities, Indigenous communities, LGBTQ+ communities, and disability communities. This section will introduce and discuss some common experiences of these groups to demonstrate the failures of SV support services to meaningfully address and protect these groups from violence, to mitigate levels of violence experienced in these communities, and to demonstrate the failure of a “one-size-fits-all” universalist approach to SV crisis care (Wooten, 2017). The list of minoritized communities that experience heightened rates of SV presented here is not exhaustive nor comprehensive, and each paragraph serves only as an introduction to the complex and innumerable experiences of structural oppression and violence. Throughout this section, language of “violence against women” is used frequently, as a reflection of how SV is framed in the public health literature presented here.

Black Communities and Sexual Violence

SV disproportionately impacts Black communities (Slatton & Richard, 2020). The US Department of Justice reports that on average, one in five Black and African American women are survivors of rape, and 38% of Black women report experiencing SV other than rape during their lifetimes (Black et al., 2011; Slatton & Richard, 2020).

Black women are also among the least likely to report their experiences with SV, and report receiving little-to-no support when they do: “The Department of Justice (DOJ) reports, “for every one Black woman that reports her rape, at least 15 will not report…These numbers are in stark contrast to white women, where for every one woman who reports a rape, only five women will not come forward” (Hart & Rennison, 2003; Slatton & Richard, 2020). Slatton and Richard’s article “Black Women's experiences of sexual assault and disclosure: Insights from the margins” (2020) explores how the unique social and cultural positionality of Black women “present fundamentally unique challenges for disclosure due to their societal marginalization, resulting in differences ‘in the quality of resources available to Black survivors, their willingness to access those resources, and the treatment they receive when they do seek help’” (Slatton & Richard, 2020; Tillman et al., 2010).

The racist historical intersection of SV and law in the US continues to inform Black women's experiences with SV today. Historically, white colonizers in the US had defined enslaved African people as "property" – who, as such, did not have personal autonomy and thus, could not be raped (Slatton & Richard, 2020). Black women, characterized as hypersexual, were often held responsible for their own victimization; a trend that has continued into present day:

> *As victims of a tumultuous and painful past and present, Black women are bombarded with societal messages that represent sexual abuse as an occupational hazard…They learn that their believability as a victim will be inherently compromised, that they will be blamed for their own victimization, and that they will receive very little support from society. (Slatton & Richard, 2020)*

Racist media stereotypes today continue to perpetuate "Jezebel" stereotypes, or those of Black women as hyper-sexual or promiscuous. These stereotypes may exacerbate risk of experiencing violence or having reports of violence not be taken seriously (Zounlome et al., 2019).

Furthermore, Black women are more likely than white women to be targeted for SV enacted by police officers, deepening the historical and contemporary mistrust between Black communities and law enforcement (Slatton & Richard, 2020).

Wooten (2015) and Zounlome et. al (2019) discuss how white supremacy informs the frameworks that make up SV prevention efforts on university campuses, a location where SV is rampant nationwide (Wooten, 2017; Zounlome et al., 2019). Zounlome et al. discuss the development of SV prevention programs utilizing majority white sampling frames, biasing the data towards white experiences and understandings of violence. The authors then discuss how the lack of Black representation in SV prevention research concretizes systemic barriers to seeking care and justice after surviving SV:

> *This long pattern of violence, combined with historical stereotypes of Black women as hypersexual and sexually aggressive, resulted in societal structures that normalize SV against these women…These systemic inequities coupled with the lack of legal access, unequal legal treatment, and media underrepresentation of Black women result in the SV perpetrated against them being perpetuated, but being ultimately ignored in society. (Zounlome et al., 2019)*

Wooten (2015) argues that because SV response has only historically prioritized the experiences of white women and upheld white supremacy through systematized sexual exploitation, victimization, and intentional neglect of Black women, that "Black women are the antithesis of the ideal rape victim due to centuries of racist and sexist ideology aimed at protecting White supremacy" (Wooten, 2017).

Black survivors who are not believed or protected by "justice" or healthcare systems after enduring violence, and whose experiences of violence are diminished in favor of white "perfect victims' experience exacerbated adverse health outcomes, many of which stem from grief, shame, and post-traumatic stress (Slatton & Richard, 2020; Wooten, 2017; Zounlome et al., 2019).

Indigenous Communities and Sexual Violence

Indigenous and First Nations women experience rates of sexual victimization up to three times higher than that of general populations and are disproportionately represented as victims of all violent crime (Black et al., 2011; Murphy-Oikonen, Chambers, et al., 2022). A survey conducted by the Urban Indian Health Institute surveyed 148 Indigenous women experiencing homelessness or living in low-income areas and reported that 94% of survey participants had experienced rape or another form of SV in their lifetimes (Urban Indian Health Institute, 2022). Among them, 49% reported misusing substances after the experience, 42% had experienced suicidal ideation or had attempted suicide, and 86% reported being affected by historical trauma (Urban

Indian Health Institute, 2022). Only 8% of respondents reported that their experience had led to a conviction of the perpetrator.

Indigenous communities experience a disturbing intersection of SV and other violent crime, such as kidnapping and/or homicide. For example, the National Crime Information Center reports that in 2016, the US Department of Justice's federal missing person database listed 116 missing persons cases, though during that same year 5,712 reports of missing American Indian and Alaska Native women and girls were made (Lucchesi & Echo-Hawk, 2018). These statistics demonstrate a consistent neglect of violence towards Indigenous communities. Though dismaying, these statistics are consistent with the rates of violence Indigenous people have been subject to since the colonization of the US and Canada (Murphy-Oikonen, Chambers, et al., 2022).

Indigenous survivors of violence disproportionately do not engage with law enforcement to report their experiences, and cite being not believed or trusted by police, and even feeling threatened by police while reporting a violent experience (Murphy-Oikonen, Chambers, et al., 2022). They directly associated their poor experiences with law enforcement with their nationalities and Indigeneity (Murphy-Oikonen, Chambers, et al., 2022). This barrier to care exacerbates health outcomes related to trauma and contributes to mistrust of law enforcement among Indigenous communities (Murphy-Oikonen, Chambers, et al., 2022).

Negative stereotypes of American Indian people may contribute to law enforcements' lackadaisical response to SV in Indigenous communities. Andrea Smith's paper "Not an Indian Tradition: The Sexual Colonization of Native Peoples" explores the history of SV towards Indigenous people. She argues that "SV does not simply just occur within the process of colonialism, but that colonialism is itself structured by the logic of SV", and that colonial patriarchal "norms" deemed Indigenous people "dirty," "sinful," and "impure," and thus, "rape-able" (Smith, 2003). It is clear from the lack of support for murdered and missing Indigenous women that these violent colonial perspectives remain intact today.

Indigenous women, at the center of racist, colonial, and misogynist cultural crossfire, experience an enormous burden of violence. The phenomenon of violence towards Indigenous communities is so prevalent, a movement called "Murdered and Missing Indigenous Women (MMIW)" was formed to call attention to the scale of violence experienced by Indigenous women, as well as to make a statement about the lack of institutional pathways of support for Indigenous survivors of violence. MMIW is symbolized by a red handprint over a person's mouth and chin, representing the "all the missing sisters whose voices are not heard. It stands for the silence of the media and law enforcement in the midst of this crisis. It stands for the oppression and subjugation of Native women who are now rising up to say #NoMoreStolenSisters" (Native Hope, 2022). The MMIP movement, or Missing and Murdered Indigenous People, acknowledges that not only women but also men and two-spirit Indigenous people are disproportionately impacted by sexualized violence (NativeHope, 2022).

LGBTQ+ Communities and Sexual Violence

Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) populations also experience disproportionate risk of sexual victimization. Though empirical prevalence and incidence data about SV experienced in LGBTQ+ communities are sparse and unreliable, several studies demonstrate high rates of incidence for all forms of SV within LGBTQ+ populations (Guadalupe-Diaz, 2015; Rothman et al., 2011).

Lifetime prevalence for experiencing all forms of SV was reported to be between 12% and 54% for gay and bisexual men, and between 16% and 85% for lesbian and bisexual women; the median estimate for lifetime sexual assault among gay and bisexual men is reported as approximately 30%, and 43% for lesbian and bisexual women (Rothman et al., 2011). The CDC 2010 National Intimate Partner Violence and SV Survey reports that "approximately one in eight lesbian women (13%), nearly half of bisexual women (46%), and one in six heterosexual women (17%) have been raped in their lifetime. This translates to an estimated 214,000 lesbian women, 1.5 million bisexual women, and 19 million heterosexual women" (Walters et al., 2013). The NIPVSV survey also reports 40% of gay men and 47% of bisexual men experiencing SV in their lifetimes, compared with one in five heterosexual men (Walters et al., 2013).

Rates of SV among transgender individuals is particularly high; between 50% and 64% of transgender people reporting having experienced SV within their lifetimes (Office for Victims of Crime, 2014), with 13% reporting having experienced SV motivated by transphobia (James et al., 2016). Bisexual and transgender individuals, including individuals who are both bisexual and transgender, experience disproportionate risk of experiencing lifetime SV compared with heterosexual and cisgender populations, and also with LGQ populations (Flanders et al., 2020; Rosenberg, 2019; Stotzer, 2009).

In addition to experiencing disproportionate incidence of various forms of SV, including same-sex/same-gender intimate partner violence, LGBTQ+ individuals are uniquely subject to experiencing particular forms of violence, such as "corrective rape," group rape, SV enacted as fetishization, and SV due to anti-queer or anti-trans bias (Doan-Minh, 2019; Guadalupe-Diaz, 2015). "Corrective rape" is a term originally coined to refer to SV enacted by heterosexual/ cisgender men towards lesbians to "correct" or "cure" their homosexuality (Doan-Minh, 2019). Corrective rape is "political, systemic, group-based violence…defined by the distribution of power in society and not by individualized relationship dynamics or personal antagonism between the rapist and victim" (Doan-Minh, 2019) that specifically targets LGBTQ+ individuals whose sexuality or gender expression/experience challenge commonly held norms around traditional masculinity, femininity, and heterosexuality in society.

Disability Communities and Sexual Violence

Adults with physical and intellectual disabilities experience violent sexual victimization at rates up to three times higher than those without, and children with physical and intellectual disabilities experience sexual abuse more than 5 times more than their non-disabled peers (Harrell, 2017; Smith & Harrell, 2013) in what has been deemed by disability justice activists and public health professionals as a "silent epidemic" (Basile, Breiding, et al., 2016). Literature also demonstrates that people with disabilities are more likely to suffer from longer periods of extended violence and abuse when compared to non-disabled populations (Plummer & Findley, 2012). There is also a large discrepancy between rates of SV experienced by people with disabilities versus how many reports are made, suggesting that the violence they experience is vastly underreported (Willott et al., 2020).

Historically and contemporarily, people with disabilities have been marginalized in the US and globally: "Researchers suggest that cultural biases and negative societal views toward those with disabilities that include such behaviors as dehumanizing, depersonalizing, and devaluating adds to the continuation of abuse of these individuals" (Plummer & Findley, 2012). Additionally, people with disabilities are often infantilized, and characterized as dependent (i.e. not having personal autonomy) and asexual (Plummer & Findley, 2012). This has led to cultural attitudes of neglect and dismissal towards the experiences of SV reported by people with disabilities.

Survivors with disabilities experience a lack of accessible resources after experiencing SV, and report being met with insensitive or dismissive behavior by first responders and/or healthcare professionals (Swedlund & Nosek, 2000). Gilson et al. (2001) argues that "[l]ack of attention to abuse in the disabled population on all levels, including policy, theory, and practice, causes an environment that not only creates barriers to services but actually enables the abuse of individuals with disabilities" (Gilson et al., 2001)

Intersectionality and Sexual Violence

Structurally marginalized populations experience disproportionate rates of SV, a phenomenon that is additionally reflected in communities and individuals who hold intersectional experiences of identity. Intersectionality refers to a framework to describe how systems of power and oppression overlap to create distinct experiences for people with multiple identity categories (Crenshaw, 1997). Because SV does not happen in a vacuum and is interconnected with other forms of systemic violence, its impact is felt differently based on a person's lived experience and positionality while navigating systems of power. Thus, individuals with intersectional experiences of identity may experience unique and distinct challenges when navigating crisis care after SV. To illustrate this concept, the example of communities living at the intersection of racist and homophobic/transphobic systems of oppression is explored below. As possibilities of intersectional experience are endless, and each incredibly nuanced, this example is far from a comprehensive analysis, but may still provide clarity about how intersections of identity may impact experiences navigating crisis care after SV.

For example, individuals who are BIPOC and LGBTQ+ face discrimination based on racial identity as well as on sexual orientation and/or gender identity. BIPOC and LGBTQ+ individuals who experience SV may experience perceived or actual lack of access to crisis response or medical services following the assault for fear of discrimination, harassment, or lack of culturally responsive services and/or providers (Slatton & Richard, 2020). Understanding how dynamics of societal power and oppression cultivate cultural norms, healthcare and service barriers, and socioeconomic constraints that render minoritized groups more vulnerable to sustained violence, activists have asserted that approaches to preventing and addressing harms of SV be in intentional acknowledgment of multiplicative harms experienced in individuals holding multiple marginalized identities, and that approaches to SV response that acknowledge intersectionality of identities may be most efficacious (McCauley et al., 2019).

A growing body of literature also demonstrates significant evidence for the progressive relationship between chronic life stress and chronic disease and illness and increased mortality (Beckie, 2012). This relationship may be especially robust among vulnerable and marginalized populations who experience diminished agency because of systemic oppression and historical neglect. LGBTQ+ and BIPOC individuals are particularly vulnerable to traumatic stress. Minority stress theory (MST) posits that "differential exposure to minority stressors among sexual minority individuals, such as prejudicial events (e.g., heterosexism) and expectations of rejection lead to poor mental health outcomes," (Meyer, 2003). Additionally, accumulative psychological distress associated with experiencing racism has been well-documented as a risk factor for poor health outcomes broadly (Bailey et al., 2017).

In navigating white supremacist, heteropatriarchal, and hetero/cis-normative society, BIPOC LGBTQ+ people experience higher rates of mental health concerns and psychosocial stress (Budge et al., 2013), as well as experiences with harassment and discrimination, interpersonal and SV, bias-related violence and hate crimes, (Shipherd et al., 2011) and collective economic marginalization compared to their white, heterosexual, and cisgender counterparts. The constant exposure to marginalization and persistent threat of victimization based on racial or LGBTQ+ identity may contribute to allostatic overload (Alessi et al., 2018; Meyer, 2003) and potentially contribute to the onset of acquired chronic illness and/or disability.

Summary

Each of the experiences discussed in this section introduces how SV response services have failed to meaningfully support survivors from structurally marginalized communities. A key theme throughout each of these experiences is how conceptualization and development of SV prevention and response services have not included diverse representation of experience, and thus have been informed by incomplete data, which, in turn, perpetuate inaccessible and inequitable service. This phenomenon can be more thoroughly explained with a discussion of "mental models," and how they collectively impact service provision and delivery.

Mental & Cultural Models

Throughout this dissertation, I will refer to “mental models,” or personally held worldviews that drive perception and subsequent behavior (Doyle et al., 2001; Westbrook, 2006). Mental models are referred to as “models” because they are simplified representations of reality that humans negotiate to create meaning and sense of endlessly complex experiences and phenomena: “...the conceptual frameworks that individuals form, based on experience and formal knowledge acquisition, which allow them not only to predict the results of explicit behaviors but also to interpret and understand their environment” (Westbrook, 2006). A person’s “mental database,” thus, is made up of a set of mental models that are comprised of beliefs, ideas, assumptions, and inferences that may come together, consciously, or unconsciously, based on a person’s education, experiences, culture, family dynamics, political alignment, and more (Westbrook, 2006).

Because personal mental models are influenced by society and culture, the opposite is also true: society and culture are influenced by mental models. Mental models thus also exist collectively as the product of shared ideas and beliefs via avenues of culture. Collective mental models can thus be understood as cultural models (Shore, 1996). Though cultural models are constructed as mental representations in the same way that personal mental models are, they are driven by one significant exception: “...the internalization of cultural models is based on more socially constructed experiences…cultural practices that constrain attention and guide what is perceived as salient are not left open to much personal choice but are closely guided by social norms” (Shore, 1996). Shared mental models, or cultural models, thus generate and perpetuate dominant social norms, which drives group decision making, including how societal problems are conceptualized and addressed.

A key characteristic of mental models is that they inherently and significantly simplify reality. As it is impossible to know all the details of the world at once, mental models are what humans use to make understanding the world more accessible and approachable (Westbrook, 2006). The effect of sharing simplified cultural models is that limitations of models are perpetuated, validated, and codified into law and conduct, obstructing meaningful change.

Cultural Models about Sexual Violence

SV can be understood through a variety of deeply held mental and cultural models. To understand how interventions to address SV operate, it is important to understand the mental and cultural models that inform them. In this section, I will introduce several concepts and phenomena that have historically and contemporarily contributed cultural models that inform how SV is responded to today.

First, I will introduce the concept of rape mythology, and discuss how rape myths surrounding "perfect victims" create significant barriers to service engagement for survivors of SV. Next, I will discuss several prominent concepts that are informed by rape mythology, including gender, racism, legality, and carceralism. Finally, I will synthesize this information to describe the impact of these mental models on crisis response and primary prevention approaches to SV today.

Rape Myths and "The Perfect Victim"

In this section, I will introduce the concept of the "rape myth." Rape myths are mental models that inform other mental models previously discussed in this section and have great sociocultural power over SV discourse today.

Rape myths significantly inform and are informed by shared mental models of SV. The term rape myth is coined by Martha Burt in her 1980 article "Cultural myths and supports for rape," and is defined as: "prejudicial, stereotyped, or false beliefs about rape, rape victims, and rapists" (Burt, 1980). Burt notes that rape myths are deeply entrenched in culture and are institutionalized in law. Rape myths are upheld by cultural constructs of "sex role stereotyping, sexual conservatism, adversarial sexual beliefs, and acceptance of interpersonal violence" (Burt, 1980).

Rape myths serve to excuse sexual aggression and create hostility toward victims of SV by normalizing the questioning of the victim's integrity, shaming the victim for being "deserving" of violence, minimizing the legitimacy of violence experienced, and by blaming the victim for their own victimization (Hockett et al., 2016). Common rape myths include (but are not limited to): that only "bad" women are raped; that women frequently lie about experiencing SV; that the clothing choice of a victim may be reason for sexual assault; that a woman who truly does not want to be raped will be able to physically resist/escape; or that men cannot be held responsible for their sexual desires or cannot "control themselves," thus blaming the sexual assault on the victim who allowed for the encounter to "go too far" (Burt, 1980; Hockett et al., 2016). Rape myths facilitate (and are facilitated by) traditional attitudes towards gender and sexuality: "...some feminist theories suggest that when women fail to conform to their traditionally submissive gender role, men—whose traditional gender roles are characterized by dominance—may consequently perceive heterosexual relationships as adversarial. Because of this perception, both men and women may view sexual domination of women via rape as 'a potential consequence of not fulfilling one's sex role'" (Hockett et al., 2016).

Rape myth endorsement, or the widespread acceptance of rape myths as valid within institutions, occurs at individual and institutional levels and impacts the ability of first responders to engage meaningfully with survivors: "Rape myth endorsement has created an environment, often termed a 'rape supportive culture,' that accepts and justifies SV, particularly against women" (Garza & Franklin, 2021).

Among the most powerfully accepted rape myths in legal institutions, as well as in popular discourse, is that of the "perfect victim:" "...a person, or category of individuals who, when victimized, are most readily attributed the complete and legitimate status of being a victim," (Ricciardelli et al., 2021). As deemed an illegal act, SV is commonly conceptualized as a criminal offense. Therefore, SV is commonly discussed through the lens of criminology, legal justice, and binary narratives of "victims" and "perpetrators." As such, legal parlance significantly informs the commonly held mental models about SV.

The construct of the "perfect victim" is purposefully fashioned to meet all of the requirements to best be able to successfully try a criminal case:

> *The legitimate status of the victim is contingent upon, inter alia, the social, cultural, and economic background of the victim as well as the legal circumstances surrounding their experience of victimization. As such, the concept of ideal victim points to the intersectional components of how some individuals in society, for instance adult women and racialized populations who experience structural inequalities, are denied victim status. (Ricciardelli et al., 2021)*

The concept of the “perfect victim” is deeply rooted in commonly held sociocultural beliefs about SV and gender expectations, and significantly informs cultural narratives regarding who is “deserving” of trust and subsequent justice following an experience with SV. Rooted in rape myth, as well as in white supremacy, misogyny, and conservative religious norms, “perfect victim” narratives dominate and are dominated by collective mental models of SV - so much so that they often dictate how SV is addressed, what programs are constructed, how perpetrators are treated, and who among the victimized will be trusted or sympathized with.

The “perfect victim” rarely exists, if at all. Perfect victim narratives, in their powerful chokehold on legalized SV crisis response, create significant barriers to care for all victims who do not fall into this accepted model – and even for those who (mostly) do: “...it is plausible that the low conviction rate for rape offenders, as compared with other violent crime offenders may also be related to the expression…of bias against rape victims in the criminal justice system” (Hockett et al., 2016).

Gender and Sexual Violence

Any act of SV can be experienced or perpetrated by anyone regardless of gender, sexuality, age, nationality, race, ability, and more. However, the disproportionate impact of SV on women globally has constructed a widespread understanding of SV as synonymous with “violence against women,” phraseology adopted commonly in federal, state, and local government institutions, global health organizations, healthcare institutions and research, and in the nonprofit sector (CDC, 2021).

Global ideological, structural, and cultural forces, such as capitalism, patriarchy, and the historic ordering of the institutions of marriage and the nuclear family have resulted in the phenomenon where women have experienced significantly less power in society throughout history and have overwhelmingly experienced violence and abuse that reflects and reinforces traditional gender roles (Goldscheid, 2015). Because of this, SV is also commonly characterized as “violence against women” in public discourse, government organizations, and legal definitions -- all of which inform the practices and objectives of SV crisis response services.

The terminology of “violence against women” is largely synonymous with “sexual violence,” suggesting that women are the sole targets and victims of sexually violent acts. This language, despite its clear directionality of violence being committed towards women, still begets women’s responsibility for preventing and protecting themselves from SV, rather than linguistically directing the responsibility of violence elsewhere. The use of the term “violence against women” effectively erases abuses experienced by men, as well as abuses committed by women, and furthermore, socially and legally solidifies and validates gender roles and stereotypes about who experiences and who commits violence (Goldscheid, 2015). At the same time, this language also suggests that men are never the targets or victims of SV – only perpetrators – and that women are only victims and never perpetrators of SV.

While statistics may demonstrate that cisgender boys and men do not experience SV at the same rates of women and girls, it is untrue and misleading to suggest that they are wholly immune to experiencing SV (Weiss, 2010). Available data on boys’ and men’s experiences with SV may be vastly misrepresenting the reality of the issue, as social and cultural systems (including the gender-specific framing and feminization of SV) may deter boys and men from naming their experiences as SV, or subsequently reporting their experiences with SV to any official body or organization that could meaningfully capture these data (Weiss, 2010).

Racism and Sexual Violence

SV, as well as prosecution practices for sex-based criminal acts, played a critical role in the justifications for slavery and the subsequent Jim Crow laws enacted following the end of the Civil War. Enslaved women, considered property, were not included as potential victims protected by common law.

SV was legally weaponized against enslaved African people as a reinforcement of slavery commonly (Davis, 1983). Sexual coercion was an important part of slave ownership, as rape was used systematically as a way of communicating ownership and dehumanization of enslaved Black women.

Prominent scholar, activist, and Black feminist theorist Angela Davis notes the use of sexual coercion and rape as mechanisms for enforcing white supremacy. Rape charges of white women by Black men were one of the most powerful tools used to justify lynching of Black men: "The myth of the black rapist of white women is the twin of the myth of the bad black woman -- both designed to apologize for and facilitate the continued exploitation of Black men and women," (Davis, 1983). Davis describes how society largely excused the actions of white rapists by perpetuating the image of Black women as "immoral," " promiscuous," "less than human," and by separating from the category of “woman” (Davis, 1983).

The racist reasons for outlawing rape – as destruction of a white man’s “property,” rather than the violation of a person’s bodily autonomy – have founded present-day mental models of feminism, which serve as the primary political motivation to address SV (as SV is conceptualized most as violence against women). These mental models thus provide foundations of SV, of who commits SV, and of who is a probable "victim" or survivor of SV.

These mental models undergird present-day policy approaches to and sociocultural understandings of SV, which ultimately determine how prevention and crisis efforts are allocated to victims and survivors of violence. Racism remains a large, looming, and unwelcome presence in SV discourse: "It is only when white women are violated or even imagined to be violated by nonwhite men that white society suddenly seems to find its moral compass," (Hamad, 2020).

Legal History of Sexual Violence Definitions

SV, an umbrella term referring to a vast continuum of actions, behaviors, and attitudes, all occurring at varying frequencies and levels of perceived severity, is notoriously difficult to define comprehensively. On this, Zelewski and Runyan write:

> *Despite the clear identification of violence, even the most 'obvious' violence can slip out of grasp quickly, both theoretically and legislatively. Though, perhaps, it is the very grasping at violence and grappling with it that reproduces violence through (inevitable) failures to maintain clear and sharp boundaries around what counts as a violent deed. (Zalewski & Runyan, 2013)*

Throughout history, legislative definitions of what "counts" as SV have greatly influenced how SV is addressed and understood, which in turn, circles back to reinforce cultural narratives of violence (Tracy et al., 2012).

Legal and cultural definitions of SV are heavily informed by shared schemas, or collective mental models, on what kind of acts could be defined as sexually violent. Legal definitions of SV govern what is prosecutable as SV, as well as how justice is pursued. Though definitions of SV have become more progressive and inclusive over time, legal definitions of SV continue to dictate how victims and perpetrators of violence are treated and allowed to access healing and rehabilitation. Because legal definitions of SV may vary state by state in the US, victims of SV may have differential access to care based on the geographic region they reside in or were assaulted in.

Historically, legal definitions of rape have centered on female victimization committed solely by male perpetrators. The very first mention of the illegality of rape is widely accepted as appearing the Code of Hammurabi in Babylon, which dictated that "if a man forces sex upon another man's wife or if a man forces sex upon a virgin woman that 'is living in her father's house,' then 'that man should be put to death'" (Gold & Wyatt, 1977). This definition is believed to have set the precedent for all proceeding legal definitions of SV, even contemporarily. This definition, beyond claiming a unidirectional movement of violence and a set of gendered expectations and roles, additionally frames the crime of SV not as one of immorality or bodily harm, but rather as one of property damage. By framing the definition of a "victim" of SV as a woman who is married to a man, or a virgin woman living with her father, the language implies that the damage done is not towards the woman herself but is done by "damaging" the "property" of the husband/father. This framework can be observed in future legal definitions of SV in the US.

In the colonial US, common law legally defined rape as "the carnal knowledge of a woman, 10 years or older, forcibly and against her will." Suffragist activists successfully advocated for the legal age of consent to be raised from 10 years old to between 14 and 18 years old, depending on the state - a legal framework that remains today (Bishop, 2018). In 1927, the law was modified to remove the age altogether, simply declaring an act of rape to be “the carnal knowledge of a woman forcibly and against her will” (Bishop, 2018). The common law definition of rape remained intact until 2013, when it was officially changed to “the penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim,” (Department of Justice, 2012). Marital rape was not made illegal until 1993, but many argue that this law is not meaningfully upheld today, a phenomenon related to deeply held misconceptions of SV (See: Rape Myths, pg. 38) (Onyango, 2019).

Beginning in 2013, the Federal Bureau of Investigations Uniform Crime Reporting (UCR) program began collecting data on incidence of rape using the revised definition of rape than what had been encoded in law since 1927. The common law definition of rape was updated in 2013, but the original definition was still in use for data collection purposes until 2017 (FBI, 2019). Though the new definition removes gendered expectations, “force,” and the necessity of penile penetration from legal interpretation of what counts as rape, it may still be too narrow a definition to capture true prevalence of SV in its focus on penetration and interpersonal contact.

Carceralism and Sexual Violence

Crisis response to SV today revolves around carceral ideologies. “Carceral feminism” refers to “a reliance on policing, prosecution, and imprisonment to resolve gendered or SV,” (Terwiel, 2020). Carceral feminism is a political ideology that began during the antirape movements of the 1960s and 1970s and relies upon white feminist politics that seek to utilize criminalization and legal recourse to eradicate SV (here, very intentionally conceptualized as “violence against women”) (Sweet, 2016).

Involvement with the state, judicial system, and law enforcement represent a survivor's one path towards receiving "justice" after an experience, with the sole goal of defining "justice" as the imprisonment of the perpetrator. Other crisis interventions for survivors of violence also aid in working towards this goal: healthcare institutions provide the forensic exam to be used as evidence in the court, and other than counseling and support, many rape crisis centers offer free legal advice to survivors to guide their decision making surrounding the prosecution process. Other than via engagement with the criminal legal system and the American prison state, victims of SV are offered no recourse to safely confront or escape their abuser (Kim, 2020).

SV conceptualization, legislation, and intervention have centered SV as an illegal act more so than an immoral act, and center legal retribution as the main goal of justice after an experience with violence. Because SV is such a stigmatized and reprehensible set of acts, there is little motivation for funding health and social services to rehabilitate perpetrators, and instead, a fervent desire to remove them from society via incarceration (Quinn et al., 2004).

Black and Indigenous community and spiritual traditions inspire alternative approaches to justice for SV survivors, noting the failure of white feminist approaches to reducing violence by weaponizing further violence. Anti-carceral approaches to justice include community-based responses to violence, community accountability practices, transformative justice, and restorative justice approaches (Kim, 2020; Sweet, 2016). These approaches to justice de-center the criminal justice system, and are grounded in three common principles:

> *The first is the understanding that interpersonal forms of violence are rooted in or are not separable from the structural violence of ableism, classism, racism, sexism, heterosexism, transphobia, xenophobia, ageism, Christian supremacy, and the multiple permutations of oppression that are ill-contained by the words available to us in the English language. A second feature has been the recognition of the carceral state as the primary institution perpetuating violence, largely targeting oppressed racial, class, gender, and other subjects, thereby motivating a commitment to locate politics and practice outside of the criminal justice system and the related institutions of immigration control and child welfare; along with this has been the project to recognize and challenge the "cops in our heads" that can mimic punitive, retributive approaches. Third, we turn then to our own communities, however indecipherable, divided, imperfect, and embedded in violence, as the very sources for emancipatory legacies and futures. (Kim, 2020)*

Community-based responses to violence, transformative justice, and restorative justice approaches to addressing SV encourage community-based interventions that protect the victim/survivor, hold the perpetrator accountable by facilitating behavior modification interventions, hoping to facilitate healing for all parties involved. These practices acknowledge that many perpetrators of violence are also survivors of violence and facilitate healing dialogue so that the victim/survivor may reclaim power and safety and not go on to perpetrate themselves, and the perpetrator can heal from whatever trauma or thought pattern causes them to harm and not continue to harm (Kim, 2020).

Though alternative approaches to justice for survivors of SV have taken root in some communities in parts of the US, carceral approaches to justice remain the most prominently accepted cultural model of how justice is defined for this issue.

Impact on Crisis Response and Primary Prevention

In this section, I have introduced several prominent concepts and phenomena that have informed mental and cultural models, and thus approaches to practice regarding response to SV throughout history. In this section, I will further discuss how these collective mental and cultural models have impacted crisis response and primary prevention practices today, and how those impact survivors in need of care. This section will explore the impact of collective mental models informing SV response on LGBTQ+ communities and BIPOC communities, as well as how white feminist and carceral feminist thought have influenced response practice today.

White Feminist Approaches to Sexual Violence Response

Black feminist theory draws attention to the abandonment of race issues by mainstream feminists (Davis, 1983; Lorde, 2012). “White feminism” is a contemporary term for a line of feminist thought that declares patriarchy the sole enemy of all women without consideration to the confounding factors of race and class. White feminism, ever present today, found its beginnings with the women’s suffrage movement, as the suffragettes believed that inclusion of race and class discourse in feminist theory would detract from the ultimate goal of ending gender-based oppression (Davis, 1983). Black feminist theorists have critiqued and problematized common mental models of SV as neglecting critical perspectives of Black women, LGBTQ+ individuals, working-class and impoverished individuals, and instead building public narratives about SV that are rooted in white experience. Black feminists also criticize mainstream (read: white) feminists for their attempts to define “universal experiences of womanhood” without direct acknowledgment that many experiences historically associated with Black womanhood negate or exist in opposition to many characteristics claimed by white feminists to be universal experiences of all women (Lorde, 2012).

More directly, white feminism is explicitly rooted in anti-Blackness and white supremacy. Attempts to universalize “womanhood” as synonymous with whiteness have historically excluded Black women, Indigenous women, and women of color from the category “woman” altogether. Given this historical framing, mental models depicting SV as “violence against women” inherently exclude the lived experiences and theories of BIPOC women, instead favoring the “universal” (read: white) experience of women to dictate and delineate how SV is approached and understood. This is further fleshed out by “perfect victim” narratives that equate whiteness with innocence, and do not offer the same empathy to BIPOC survivors.

In her article “Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color,” scholar Kimberlé Crenshaw problematizes the impact that white feminism has had on SV crisis response practices, and how they may routinely fail Black women and women of color. She uses the example of rape crisis centers reporting that “counselors who provide rape crisis services to women of color report that a significant proportion of the resources allocated to them must be spent handling problems other than rape itself. Meeting these needs often places these counselors at odds with their funding agencies, which allocate funds according to standards of need that are largely white and middle-class,” (Crenshaw, 1997). This phenomenon occurs because funding for RCCs often reflects the values, needs, and mental models of white fundraisers and donors who have envisioned the purpose of the nonprofit through mental models of violence that are also influenced by whiteness. When services are envisioned and created without the intentional acknowledgment of intersectionality and how the lived experiences of non-white populations differ, a new kind of structural violence is enacted.

Applying Black feminist critique of mental models informing SV prevention and crisis response has significant utility for understanding how BIPOC individuals are failed by existing frameworks. The explicit exclusion of Black women from theoretical frameworks to describe SV, as well as from SV protections and crisis response services is a tool of white supremacist and colonial violence that systemically and structurally oppresses BIPOC communities.

Sexual Violence Response for LGBTQ+ Survivors

LGBTQ+ communities experience barriers to care when seeking help or justice after having survived an experience with SV. The language of "violence against women" is additionally problematic in its oversimplification of gender-based violence by its insistence on a gender binary.

The language of "violence against women" – or even language to convey the role of men (i.e., "men's violence against women," "SV against men," etc.) - does not meaningfully account for the fact that people of all genders commit and are impacted by SV globally. Additionally, the gender-specific framing of SV as only impacting one of the two recognized binary genders, "violence against women" not only excludes cisgender men, but also people across the gender spectrum. As such, the experiences of many victims and survivors who are LGBTQ+ are erased and invalidated, effectively "exclud[ing] them from services as well as from legal and other forms of redress" (Goldscheid, 2015).

The "violence against women" framework thus serves as a barrier to care for LGBTQ+ survivors. By allowing only some experiences with SV to be legitimized and given compassion, other experiences are prevented from receiving that same dignity—instead, normalizing their erasure. It simplifies entire systems of violence and trauma as a unidirectional movement of violence, committed by one group of people towards another, and draws boundaries around gender expectations, legitimizing gender stereotypes and roles.

The relegating of SV to a gender-specific frame harms victims and survivors of violence who fall outside of this mental model. For example, the language of “violence against women” not only delegitimizes violence experienced by non-women, but also violence committed by non-men, and additionally imbues gender stereotypes into perceptions of who is a “victim,” and who is a perpetrator. These mental models may thus exclude experiences of SV committed in same-sex or same-gender pairings, obstructing access to care for non-heterosexual survivors or survivors attacked by a person of the same sex and/or gender: “Framing…SV as violence committed by men against women…excludes the complexities of the experiences of lesbian, gay, and trans survivors, which may involve different dynamics of coercion and control, which may challenge dominant Western gender-role stereotypes, compounding barriers to obtaining services” (Goldscheid, 2015).

Upholding mental and cultural models that frame SV as “violence against women” may generate the unintended consequence of perpetuating violence by only validating certain, gender-based experiences of violence.

Carceral Approaches to Justice Impact on Sexual Violence Response

By conceptualizing SV through a legalized and carceral framework, mental models of SV thus primarily center on acts of violence as criminal acts, rather than immoral acts or manifestations of structural, societal, and cultural illness (Tracy et al., 2012). This perspective forces narratives to include distinct “protagonists” and “antagonists;” clear and unequivocal representations of the victimized and the victimizer:

“Legal requirements about evidence and demonstrating ‘beyond reasonable doubt’ to secure convictions ensure these [perfect victim] frameworks guide officers’ interpretations of sex crime victims” (Ricciardelli et al., 2021).

The necessity for legal straightforwardness erases nuance and perpetuates oversimplification of SV, which ultimately serves to facilitate justification of rape myths; particularly in the form of “perfect” victims and perpetrators.

Carceral approaches to justice after SV rely heavily on the trust and participation of survivors of violence. For many populations who experience pre-existing mistrust with law enforcement and legal frameworks, such as BIPOC, LGBTQ+, undocumented immigrants, sex workers, people with previous engagement with legal systems, and people who are abused by members of law enforcement, may perceive no meaningful pathway to receiving legal justice after abuse.

Given the racist history of not only policing in the US, but also the role of white feminism and rape as a scapegoat “crime” used by the criminal legal system to target and incarcerate Black men and men of color, carceral feminism has provided a powerful theoretical justification for the disproportionate rate of incarceration of BIPOC in the US (Terwiel, 2020).

Carceral feminism has inspired many “tough-on-crime” policies in the name of protecting women from SV, but the impact has proven to be different than the intention: “...rather than diminish gendered and SV, these measures have expanded the hold of the punishment apparatus over racially and economically marginalized people of all genders” (Terwiel, 2020). Often, women and girls of color who are survivors of violence are themselves made to engage in the legal justice system, or are incarcerated themselves, rather than receive “justice.” Given the lack of success in eradicating or even reducing SV, carceral feminist approaches have only been successful in contributing to further violence by weaponizing legal systems - systems imbued with white supremacy that disproportionately target and sentence BIPOC. Carceral feminism, itself a white feminist movement, only seeks to protect “perfect victims” of violence – and is not particularly successful even at that.

“Rape Myth” Impact on Sexual Violence Response

Literature has demonstrated that rape myths have significant influence over the perspectives of professionals involved in SV response services, including jurors and judges, law enforcement officers, investigative agencies, and healthcare professionals such as doctors, nurses, social workers, and counselors (Garza & Franklin, 2021). Operating from a set of mental models that uphold rape myths, survivors face disbelief or dismissal when reporting their experiences to crisis response providers: “Such expressions of disbelief and blame by the groups socially and legally responsible for the well-being of rape victims may result in a secondary victimization for some rape victims, an experience that can negatively influence their recovery” (Hockett et al., 2016).

Rape myths are particularly insidious because they are socially conditioned and internalized. Individuals who have sustained violence may internalize rape myths, further obstructing access to care and healing after an experience with SV (Mortimer et al., 2019). These powerful societal falsehoods have great impact over not only the victims of SV, but also over the very systems designed to maintain societal order, including the judicial system. Because these societal beliefs are so dominant, omnipotent, and readily accepted, SV experienced by anyone other than a "perfect victim" is often subject to scrutiny via rape myth.

Summary

Current practices of secondary prevention efforts for SV have failed to meaningfully reduce rates of SV or support survivors in achieving justice or health after SV. I posit that the failure is because, in part, they rely upon shared mental models informing practices that are rooted in sexism, heterosexism, carceralism, white supremacy, and gender essentialism – all of which are informed by the instituted model of Christian Evangelical colonialism.

Survivors of SV who have engaged in crisis response services have critical experiential knowledge from which new, more inclusive, and equitable, mental models of violence can be generated. Minoritized survivor populations, disproportionately impacted by SV and excluded from most SV research and practice, may especially have much to offer to address these failings, as their unique experiences may highlight gaps in service and discourse.

Gaps in Knowledge and Practice

Despite ongoing primary and secondary prevention efforts, SV remains rampant in the US. Because of this, SV can be considered a truly wicked problem. True prevalence of SV is difficult to know, as measurement is based fully on self-report in a society where reporting an experience with SV is often treated as taboo and dangerous. Historically and structurally marginalized populations are at particularly high risk of experiencing SV, and additionally have limited access to institutionalized pathways to healing and justice after surviving a violent experience. Crisis response interventions to address SV include multiple contributors and working partners across multiple institutions and sectors, each of whom have their own perspectives and "agendas" regarding who is granted access to safety, healing, and justice after an experience with SV.

Current crisis response efforts rely heavily on trust in and vulnerability with institutions that have long played a significant role in the oppression of marginalized populations, and thus have perpetuated and contributed to structural SV by only offering a narrow pathway to justice rife with pre-determined mental models of what defines a "real" experience with SV. Crisis response solutions to address SV are created in a universalist approach to violence and are informed by collective cultural models rooted in historical and contemporary white feminism and supremacy, as well as carceralism, heterosexism, and religious ideals of sex and "purity."

Without access to meaningfully engage in pathways to safety, healing, and justice following an experience with SV, adverse health outcomes associated with SV will continue to be perpetuated. As SV impacts so many people across the nation and worldwide, intervention efforts to address SV must be prioritized in public health scholarship and practice.

CHAPTER III

METHODS

Introduction

To address the identified gap in literature and public health practice, I conducted a qualitative study to more thoroughly understand lived experiences that inform adverse health behaviors and outcomes among survivors of SV, as well as to identify plausible alternatives or additions to existing crisis response frameworks to improve care access and options following experiences with SV.

The purpose of this chapter is to introduce and outline the methodological approach taken for this study. By conducting a nuanced comparative examination of how survivors perceive, experience, and imagine best practices for responding to SV, this approach allowed for the identification of gaps in practice, as well as for the collection of robust evidence to guide development of novel and innovative intervention strategies grounded in lived experience. This study investigated three research questions:

RQ1: Based on their experiences with KY-based SV crisis response services, how do people who have experienced SV imagine best practices for offering person-centered care?

RQ2: How do people who have experienced sexual violence experience, engage with, and perceive criminal justice responses to sexual violence?

RQ3: What is the role of informal social support and community care in improving health and wellbeing for survivors of sexual violence?

To respond to these questions, this study aims to:

1. Gain nuanced perspective on the experiences of survivors of SV.
2. Identify critical gaps in services available and accessible to survivors of SV.
3. Imagine alternative approaches to individual and community safety.

Each of the research questions were investigated using a qualitative descriptive approach and reflexive thematic analysis methods by analyzing qualitative interviews with members of the affected populations.

Methodological Approach

To address the identified study aims, I employed a qualitative descriptive approach using reflexive thematic analysis methods.

Qualitative Inquiry

Qualitative inquiry is an intentional choice of approach for this dissertation. A strength of qualitative research is the ability to capture nuance in public health data, as well as deeply situate data in context – a unique benefit to the chosen methodological approach that is not similarly achievable with quantitative methods.

Qualitative methods allow for the collection of rich and thick data on a topic not very well understood or researched. As the topics examined in this dissertation study (such as SV, crisis response services, and personal experiences and decision-making strategies, among others) are each complex topics, their convergence will involve analysis of concepts not easily quantifiable or understood through a positivist approach. Finally, qualitative methods provide a unique opportunity for the amplification of the voices of historically neglected communities. Using qualitative methods, theory can be developed utilizing narratives of the lived experiences and bodily epistemology of populations at the center of the issue. This perspective is essential for addressing the harms experienced and the needs of affected populations.

Qualitative Description

Qualitative description (QD) is an approach that provides a comprehensive summary of an event in the everyday terms of those events" (Sandelowski, 2000, 2010). Though QD approaches are still interpretivist, this approach is characterized by lower levels of interpretation than are high-inference qualitative approaches such as phenomenology or grounded theory and require a less "conceptual or otherwise highly abstract rendering of data" (Sandelowski, 2000, 2010). Researchers using qualitative description "stay closer to their data and to the surface of words and events" than many other methodological approaches (Bradshaw et al., 2017; Sandelowski, 2000). Despite this, these approaches offer plenty of opportunity for layering additional hues, tones, and textures from other prominent qualitative approaches to strengthen the rigor of the approach.

Reflexive Thematic Analysis

The primary strategy for qualitative inquiry that was employed for this dissertation study is thematic analysis. Reflexive thematic analysis is an interpretivist method first described by Braun & Clarke in 2006, and later updated in 2019, for analyzing qualitative data that centers the identification and analysis of recurring ideas in transcripts, or themes (Braun & Clarke, 2006, 2019; Riger & Sigurvinsdottir, 2016). While conducting thematic analyses, researchers will inductively derive themes, which may be implicit or explicit ideas identified within datasets. Themes generally are ideas that are reflect recurrent patterns among multiple interviews, as well as emerge multiple times within interviews. Finally, themes should be representative of ideas that are salient and true to participants (Riger & Sigurvinsdottir, 2016).

Reflexive thematic analysis takes part in six overarching steps: data familiarization, initial code generation, generating initial themes, theme review, theme defining and naming, and report production (Braun & Clarke, 2006, 2019; Campbell et al., 2021). Notably, these phases are iterative in nature and do not need to take place in exact order. Braun & Clarke emphasize in their updated methodology report that themes are actively generated and organized by the researcher; they are not emergent or lie dormant waiting to be uncovered. The active role of the researcher as the organizer and storyteller of the data is a key feature of reflexive thematic analysis (Braun & Clarke, 2019; Campbell et al., 2021).

Braun and Clarke (2006, 2019) emphasize the embracing of reflexivity in thematic analysis. In fact, subjectivity is conceptualized as at the core of reflexive thematic analysis, and the acknowledgment of the researcher's role in knowledge generation is key for engaging in quality thematic analyses (Braun & Clarke, 2019; Joy et al., 2023).

Unlike similar qualitative inquiry methods, such as grounded theory, reflexive thematic analysis does not rely upon any pre-determined theory or epistemology: "This independence from a specific theoretical framework permits broad, and flexible application of the analytic approach across a range of epistemologies - including essentialist and constructionist paradigms" (Braun & Clarke, 2014, 2019; Campbell et al., 2021). As a method independent of grounding theory or epistemology, reflexive thematic analysis relies upon the researcher to pair the method with appropriate, relevant, and robust theoretical underpinnings to guide the research (Braun & Clarke, 2019; Campbell et al., 2021). It thus also becomes the responsibility of the researcher to ensure that reflexive thematic analysis pairs well with chosen theoretical and epistemological approaches.

Theoretical, Epistemological, & Conceptual Foundations

Theory informs and shoulders the entire research process. From the formulation of research questions to address identified problems, to the frame of analysis and method of dissemination, theory's role is to provide a critical lens through which a researcher can construct meaning from data and develop conclusions: "Theories arrange sets of concepts to define and explain phenomena, enabling us to move beyond basic description to in-depth description, interpretation, and explanation" (Kelly, 2010). Beyond the characteristics that make up my positionality as a researcher, this research is grounded in two critical theories: intersectional feminist theory and systems theory. Intersectional feminist theory served as a sensitizing concept to the chosen approach to this study, while socioecological theory was chosen to help frame the conceptualization of survivors and their access to care as deeply embedded within social and cultural contexts.

Intersectional Feminist Theory

This study was informed by intersectional feminist theory as a sensitizing concept, or as a foundational concept informing the chosen direction of the research. In tradition with constructivist grounded theory methods (See: Chapter Three), sensitizing concepts "offer ways of seeing, organizing, and understanding experience" (Charmaz, 2000), and may inform the "departure from which to study the data" (Bowen, 2006; Charmaz, 2000).

In contrast to traditional feminist theory, intersectional feminist theory argues for a political epistemology - one that is always “interpretive and partial,” as “all humans bring their own histories, biases, and subjectivities with them to a research space or project, [thus,] it is naïve to think that the written product of research could ever be considered neutral” (Freeman, 2019). Intersectional feminist theory centers researcher positionality and reflexivity as a critical tenet, and asserts the inevitability of “standpoint epistemology,” which “posits that knowledge comes from one’s particular social location, that it is subjective, and the further one is from the hegemonic norm, the clearer one can see oppression” (Freeman, 2019). This approach to knowledge is opposite to many Enlightenment theories in its clear assertion that there is no objective truth that can define all of humanity’s experiences. Standpoint epistemology, rooted in feminist theory, asserts that “the personal is political,” and that experiential knowledge, particularly that of marginalized people, is critical to advancing scientific research. Feminist theory, in its focus on position, space, and location, centers knowledge as residing in the body. This theoretical approach is thus critical when interviewing survivors of sexual and power-based violence whose experiences and perspectives have historically been scrutinized and neglected.

Traditional feminist theories employ varying approaches the problem of SV. Liberal feminism considers rape and sexual coercion “a gender-neutral assault on individual autonomy, likening it to other forms of assault and/or illegitimate appropriation, and focusing primarily on the harm that rape does to individual victims,” (Whisnant, 2009). More radical feminist theory supports the concept of sexual coercion as a pillar of patriarchy and male social domination over women. Sexual coercion is thus a systemic problem stemming from social power, not merely an individual act of interpersonal violence. As women and girls are disproportionately impacted globally by sexual coercion and rape, the issue cannot be considered gender neutral.

Traditional feminist theory thus centers patriarchy as the root of sexual coercive violence:

> … a social system in which men disproportionately occupy positions of power and authority, central norms and values are associated with manhood and masculinity (which in turn are defined in terms of dominance and control), and men are the primary focus of attention in most cultural spaces.” (Whisnant, 2009)

Radical feminist theory posits women as targets of systemic sexual coercive violence in the context of (female) gender and sexuality to uphold and maintain patriarchal dominance in society. Feminists regard rape as systemic deprivation of women’s bodily autonomy to restrict women’s sexual, reproductive, and cultural freedom.

Feminist theory has been critiqued for being overly influenced by whiteness and white supremacy, and for not being responsive to race and to the lived realities of Black, Indigenous, and other women of the global majority; capitalism and the lived realities of class struggle among poor and working women; or gender as a non-binary phenomenon and the lived realities of individuals who also experience gendered discrimination and harm.

Intersectionality theory was coined by Kimberlé Crenshaw to refer to how the experience of interlocking mechanisms of oppression create unique experiences of oppression for those who hold multiple minoritized or marginalized identities (Crenshaw, 1997). Crenshaw notes that when identity politics are used to further social justice agendas, such as feminist political movements advocating for women’s rights or antiracist political movements advocating for liberation of people of color, the intragroup differences are often ignored or bylined:

> The failure of feminism to interrogate race means that the resistance strategies of feminism will often replicate and reinforce the subordination of people of color, and the failure of antiracism to interrogate patriarchy means that antiracism will frequently reproduce the subordination of women. These mutual elisions present a particularly difficult political dilemma for women of color." (Crenshaw, 1997)

Crenshaw thus defines intersectional feminism as "the view that women experience oppression in varying configurations and in varying degrees of intensity…cultural patterns of oppression are not only interrelated, but they are bound together and influenced by the intersectional systems of society" (Crenshaw, 1997).

Intersectional feminist theory can be extended to include the experiences of populations whose marginalization or oppression cannot be wholly explained by patriarchal violence. People who experience multiple forms of domination or marginalization related to race, class, gender, sexuality, ability, and more, experience reduced access to healthcare, heightened adverse health outcomes, and reduced autonomy to experience health and quality of life to its fullest potential due to systemic and structural oppression and neglect. Thus, for these health inequities to be meaningfully mitigated, it is critical that these multi-dimensional and multi-directional phenomena are directly acknowledged at every step of public health research and practice (Rogers & Kelly, 2011). Intersectional feminist theory, in its overt acknowledgment of the impact of the "complex dimensions of inequality and power structures that create roles of domination and subordination" (Rogers & Kelly, 2011) is thus a critical frame with which to examine the experiences of diverse survivors of SV seeking care and/or justice via available crisis response frameworks.

In his article “Reconstructing the landscape of health disparities research: Promoting dialogue and collaboration between feminist intersectional and biomedical paradigms,” Weber (2006) outlines several principles of feminist intersectionality and how they are applicable and beneficial to health research with a focus on social justice (Weber, 2006). They are summarized in Table 1.

Intersectional feminist theory lends itself to qualitative methods and provided a beneficial framework from which to approach the experiences of survivors of SV in accessing crisis care after a violent event. Depending on the intersections survivors have with racial identity, ability, and socioeconomic class, they will have variable access to crisis response options after SV. Intersectional feminist theory explicitly acknowledges this inequity, and thus provides a critical lens through which to conduct this research.

Table 1. Intersectional Feminist Theory Applicability to Health Inequities Research (Adapted from Weber, 2006).

Principle 1: Active researcher engagement	Intersectional approaches to health research seek to rectify social injustices. To accomplish this, the researcher must actively engage and collaborate with communities, and must engage with research with subjectivity, rather than objectivity.
Principle 2: Social construction	Research variables, including the research process itself, are socially constructed in time and place. Thus, there is no objective “truth” to be “found” as a result of the research process – only stories to be told.
Principle 3: Power relationships	Power relationships drive social systems and structures, as well as interpersonal relationships. Power is a present variable at all social ecological levels of health. Power is used by dominant groups to obtain and hoard resources (e.g., wealth, education, healthcare).
Principle 4: Intersectionality	“Social inequalities are interdependent, mutually constituted, and integrally connected systems. Oppression created by more than one subordinate position based on difference is multiplicative not additive, is not reducible to one dimension or factor for individuals or groups and is unique. There are differences both within and between groups” (Rogers & Kelly, 2011).

Social Ecological Model

This research was additionally grounded in social ecological approaches, first described by Urie Bronfenbrenner (1977), and later shaped to be specifically applicable to health promotion efforts by McLeroy, Bibeau, Steckler, & Glanz (1998) (McLeroy et al., 1988). The Social Ecological Model (SEM) developed by McLeroy et al., (1998) is illustrated as a series of five nesting circles, each representative of levels of influence on a person's health and wellbeing. The five circles are defined as 1). Intrapersonal factors, or characteristics of an individual, such as attitudes, knowledge, behaviors, and self-concept; 2). Interpersonal processes and primary groups, or the informal and formal social networks an individual is part of; 3). Institutional factors, or social institutions with organizational characteristics, as well as formal and informal rules and regulation for operation; 4). Community factors, or relationships among institutions, organizations, and informal networks within defined community boundaries; and 5). Public policy, or laws and polices existent at the local, state, and national levels (McLeroy et al., 1998). The imagery of the SEM as concentric circles represents the levels of influence as not distinct from one another, but rather, integrated and informed by one another.

Social ecological approaches are critical to framing public health in that they provide a framework for understanding how individuals and their environments mutually impact one another (McLeroy et al., 1988). Particularly useful for complex public health issues such as SV, social ecological approaches may aid researchers in understanding different levels of influences and their relationship to one another. As systems models, SEMs can additionally convey complexity by demonstrating multiple levels of influence inherent in health experiences, as well as health decision-making processes.

Social ecological approaches are additionally useful for embedding individuals in context of their social environments, highlighting that health behaviors, experiences, and decisions are shaped and informed by determinants at every level of the SEM. For these reasons, utilizing social ecological frameworks to ground this research is key for understanding the experiences of SV survivors with crisis response services, in acknowledgement that every person's decision to engage or not with support will be shaped and informed by their personal beliefs, knowledge, and attitudes about SV, the response and support of their formal and informal social networks, the community norms in place that either foster or prevent a sense of access and safety to engage with crisis support services, the organizations proximal or available to the person in crisis and their available services, and the policies and laws that inform the kinds of crisis response services are made available.

Study Sample

Each of the research questions was investigated using qualitative interviews with individuals with lived experience of sexual violence.

Sampling Frame and Recruitment Process

To thoroughly examine each of the research questions, a robust sample of 20 interviews was required. Interview participants met several eligibility requirements to participate in this study. To participate in this study, interview participants needed to be:

1. Be 18 years of age or older.
2. Identify as a survivor of SV (defined broadly) of an event(s) experienced in adulthood or adolescence.
3. Be willing to speak about their experiences in depth.

For the purposes of this study, eligible participants will have experiences with SV and associated crisis response services in adulthood. Though Kentuckians additionally experience disproportionate rates of childhood sexual abuse (CSA) (Children's Bureau of US Dept. of Health and Human Services, 2022), the researcher believes that the two phenomena (CSA and SA in adulthood) are different enough to warrant separate attention. Ideal participants should have engaged with at least one type of SV crisis response services but may also have engaged with all. However, prior engagement with crisis response services was not required for eligibility for participation. It was not a requirement that an interested participant have filed a police report against a perpetrator.

To allow for the engagement of the most diverse sampling frame possible, interviews were recruited for held virtually. Recruitment took place primarily on social media (Facebook and Instagram), and additionally through targeted solicitation of identified community centers and rape crisis counseling centers statewide.

Due to the sensitive nature of the study topic, snowball sampling and referrals of participants from participants were accepted and encouraged. Additionally, to fairly compensate individuals for sharing sensitive and difficult information, all participants were offered an incentive for their time and participation.

A digital recruitment flyer providing basic information about the purpose of the study, eligibility criteria, and incentive descriptions was created to recruit interviewees (see Appendix B). The recruitment flyer included intentionally diverse imagery to demonstrate population interest and inclusion. The flyer included a brief researcher positionality statement (i.e., "A survivor-led study") to demonstrate solidarity and shared experience as a means of establishing psychological safety. Interested parties were offered a link and QR code to a Qualtrics survey on digital recruitment flyers where they filled out eligibility information to participate in the interviews (see Appendix C). The eligibility survey asked interested parties to provide basic demographics information, as well as an email address at which they may be contacted to participate in an interview if chosen. The format of the eligibility survey was largely open-ended to allow interested parties to self-define their racial, socio-economic, sexuality, and gender identities.

The eligibility survey additionally included a PDF of an IRB-approved informed consent document, as well as some accessible language to ensure participants understand consenting to participation (see Appendix D). In addition, the eligibility survey asked for interested parties to digitally agree to participate in the study, having read and understood the informed consent document before the survey information can be sent to the researcher.

The researcher screened recruitment surveys for eligibility and directly contacted eligible participants with the provided contact information to schedule the virtual interviews. The researcher intentionally sought to interview a sample that was racially, ethnically, geographically, and socio-economically diverse, and a sample of individuals representative of intersectional identities. Eligibility and contact information collected from screening surveys were organized in an Excel spreadsheet that also included information regarding interview scheduling, completion of interview, and where recordings and transcriptions were stored. This spreadsheet, as well as all eligibility surveys, was be kept confidential and stored in an encrypted and password-protected cloud server.

Interviews were conducted, recorded, and transcribed on Microsoft Teams. Scheduling emails additionally included basic instructions for how to use Teams to access the virtual interview. This process continued until a final number of 20 interviews was conducted.

Final Sample

The final sample reflected diversity of race, gender, sexual orientation, socioeconomic status, and disability experience. Demographics of the final sample are described here, as well as in Appendix E.

Eight participants reported being between 18 and 25 years of age; seven were between 26 and 35; two were between 36 and 45; one participant was between 46 and 55, and one was between 56 and 65 years old.

The sample also reflected diversity of socioeconomic status. Three participants reported earning less than $10,000 per year; four reported earning between $10,000 and $25,000 annually; three reported earning between $26,000 and $35,000; two earning between $36,000 and $45,000 annually; two earning between $46,000 and $55,000 annually; three earning between $56,000 and $65,000 per year; one earning between $66,000 and $75,000 per year; one earning between $96,000 and $105,000 per year; and one earning more than $106,000 annually.

Fifteen participants identified as white or Caucasian, two identified as Black or African American, and three identified as mixed-race or biracial. Most participants identified as female or woman (n=14), one identified as man or male, two identified as non-binary, and three participants identified as transgender men. Regarding sexual orientation, seven participants identified as heterosexual, with the remaining participants identifying as queer (n=3), bisexual (n=5), pansexual (n=2), and gay (n=1). One participant did not include information about sexual orientation. Among the participants who reported a heterosexual orientation, two self-described as “heterosexual-ish” or “straight-ish.” Finally, eleven participants disclosed living with a disability or chronic illness, defined broadly, with several participants offering living with chronic mental illness. A table demonstrating demographics information of the final sample is presented in Appendix II.

Data Collection

Primary Data Collection Methods

The primary data collection method was semi-structured qualitative interviewing. The process of conducting in-depth interviews allowed for a rich and nuanced exploration of how survivors of SV experience existing frameworks of crisis response and intervention available via mechanisms of law enforcement, forensic health examinations, litigation processes and rape crisis counseling - all institutions whose responses to SV are historically (and contemporarily, to varying degrees), based in hetero-patriarchal norms of “violence against women.” Interviewing diverse survivors of SV inherently challenges hetero-patriarchal norms of SV, thus allowing for novel opportunities to build and generate evidence and theory that could be impactful in influencing more inclusive, appropriate, and impactful crisis response actions.

Interviews were chosen as a primary data collection method to investigate R1 largely to protect the target demographic of informants. Interviews, rather than focus groups, may allow survivors a greater sense of psychological safety, trust, and confidentiality when disclosing sensitive and potentially triggering information.

Interviews were semi-structured and followed a pre-prepared interview guide, which were approved by the dissertation committee and University IRB. Interviews were scheduled for 60 minutes but ultimately followed the comfort level and availability of the interviewee. A sample interview guide is included in Appendix A.

Interviews were held virtually and were recorded and transcribed verbatim. Microsoft Teams was used to create an audio file of the interview, which were then be uploaded to OtterAI for transcription. The researcher then thoroughly reviewed the AI generated transcriptions and cleaned the data for confidentiality and accuracy. All recorded and transcribed interviews were anonymized during data cleaning and were kept confidential in a secure encrypted web-based and password-protected cloud file.

Data Analysis Methods

Data were analyzed in tradition with reflexive thematic analysis methods, an interpretivist method for analyzing qualitative data that centers the identification and analysis of recurring ideas in transcripts, or themes (Braun & Clarke, 2006, 2019). Themes are ideas that are found in recurrent patterns across multiple interviews, as well as within interviews. Themes also reflect ideas or concepts that are salient and true to participants.

Reflexive thematic analysis involves a six-step process: data familiarization, initial code generation, the generation of initial themes, theme review, theme defining and naming, and report production. Each of the six steps are described in depth below.

Data Familiarization

The first step in engaging in reflexive thematic analysis is familiarizing oneself with the data. As the interviews are transcribed, the researcher will familiarize herself with the data by re-listening to the audio recordings of the interviews, as well as thoroughly reading each transcript. Thoroughly familiarizing oneself with the data will prepare the researcher to engage in the next step, initial code generation.

Initial Code Generation

Initial coding first took place with the first five collected transcripts. Coding the first five transcripts, or about 1/4th of the total sample of transcripts, allowed for an initial direction with which to pursue ongoing data collection and analysis.

Initial coding was approached by coding each sentence of each transcript, line-by-line. During line-by-line coding, the researcher employed techniques such as applying gerunds and using "in-vivo" coding to thoroughly analyze the data. Initial coding allows for the researcher to begin immersing themself in the data and learning about the possible theoretical directions of the project. Initial codes are largely based on actions, perspectives, feelings, and behaviors described by interview participants in interview transcripts. The researcher used initial coding to accomplish these goals, and to begin "form[ing] the link between collecting data and forming an emergent theory to understand and account for these data" (Charmaz, 2014). By engaging in initial coding, the researcher induced theory from the data, and allowed the data to guide learning and further analysis (Charmaz, 2014).

This process is antithetical to quantitative methods, which applies preconceived categories or notions to data. However, the researcher approached initial coding with social justice theories, such as intersectional feminist theory, as sensitizing concepts, or concepts to provide a starting point for initiating analysis but that does not ultimately determine its content (Charmaz, 2014).

Focused Coding and Categorizing

After five of the final sample of transcripts was collected and line-by-line coded, an analytic direction allowed for focused coding and categorizing to begin. The process of focused coding involves developing synthesis and categories based on emergent themes in the data and applying them to the remainder of transcripts to not only accelerate the analysis process, but also to "synthesize, analyze, and conceptualize larger segments of data," (Charmaz, 2014). In tradition with the method of constructivist grounded theory, focused codes may take prominence based on applicability of emergent themes or may become less relevant throughout the analysis process. The researcher followed, rather than forced, the data.

Focused coding involves an ongoing process of conceptualizing, defining, and applying emergent themes to data based largely on frequency and conceptual significance (Charmaz, 2014). The act of categorizing thus becomes inherent in this process, as emergent themes have become apparent enough to be deemed categories. During this process, categories begin to emerge and will be defined. Initial definitions of themes, subject to change, were written during this time.

Generating Initial Themes

The researcher generated initial themes based on salient and recurrent ideas present within and across interviews. Initial themes reflected ideas constructed during the process of focused coding. The process of generating initial themes was helped along by diagramming, mapping, or other strategies for visually accounting for and organizing data (Campbell et al., 2021).

Theme Review

Braun & Clarke (2006) describe two levels of theme review. The first is a review of coded data from individual transcripts, and the second is a process of reviewing the entire dataset (Braun & Clarke, 2006; Campbell et al., 2021). At this stage, descriptions were generated for each theme. Descriptions may be brief or thorough and may explain the main message of each theme as well as differentiate themes from one another.

Theme Defining & Naming

Finally, Braun & Clarke (2006) suggest choosing eye-catching and thoughtful names for defining and naming themes constructed from the data (Braun & Clarke, 2006, 2019; Campbell et al., 2021). In this stage, the researcher weaved together themes constructed from the data to tell a story that reflects the voices of interview participants related to the research questions. To accomplish this, the researcher went between the data and the identified themes to organize the story into a “coherent and internally consistent account” (Braun & Clarke, 2006). To further illustrate the overall narrative of the project, the researcher engaged in a more thorough analysis of the data to exemplify and provide “evidence” for each theme. The researcher used exemplifying quotes to illustrate the story of each theme, as well as the broader story told by threading together all themes.

Constant Comparison Method

As qualitative descriptive approaches allow for “hues, tones, and textures” from other qualitative methodological approaches to enhance the rigor of data collection and analysis, the researcher additionally used the constant comparison method associated with grounded theory methods (Glaser & Strauss, 2017; Sandelowski, 2000). The constant comparison method is a method of analysis that “generates successively more abstract concepts and theories through inductive processes of comparing data with data, data with code, code with code, code with category, category with category, and category with concept” throughout the ongoing data collection and analysis process, (Charmaz, 2014) as well as with relevant scholarly literature. Engaging in constant comparison deepened my analytic ability, as well as challenge my own biases and initial conclusions as I move through the analysis process.

Study Rigor

Establishing rigor is a critical step in conducting qualitative research. Rigor was established using several strategies. The use of accurately transcribed and full transcripts throughout the entire coding process is an essential first step for establishing reliability (Thorogood & Green, 2018).

Rigor was also established using peer debriefing strategies. Peer debriefing establishes rigor in qualitative research by requiring researchers to “disclose their personal and methodological processes during the research to a disinterested peer, with the purpose of making explicit aspects of the work that might remain implicit within the researcher’s mind” (Barusch et al., 2011; Lincoln & Guba, 1985). By engaging in peer debriefing, the researcher was exposed to different interpretations of data, as well as diverse worldviews and ideologies, that encouraged the researcher to consider data from new perspectives and challenges inherent biases (Henry, 2015).

Furthermore, I engaged in memo writing throughout the data collection and analysis process, to “provide ways to compare data, to explore ideas about the codes, and to direct further data-gathering," (Charmaz, 2014). This process also supported reliability in that it helped to record and reflect upon any biases that come up during the research process, or emotions that may cloud my judgment or analytic prowess.

Another step taken to enhance rigor is to engage in a deep practice of reflexivity by acknowledging and making apparent my own beliefs, experiences, and biases with a researcher positionality statement (see: Researcher Positionality & Reflexivity Statement, pg. 63). Acknowledging and reflecting critically on the social, cultural, and political forces that shape my interpretation and analysis of data will ground my findings in context and will prevent the findings from making grand or sweeping claims about generalizability of results (Barusch et al., 2011).

Throughout each phase of the project, rigor was demonstrated by using the aforementioned strategies, as well as utilizing think-aloud peer review techniques throughout the analysis process with the dissertation committee, and by analyzing the data to saturation (Thorogood & Green, 2018).

Researcher Positionality / Reflexivity Statement

In tradition with intersectional feminist theory, as well as reflexive thematic analysis methodology, researcher positionality and reflexivity are apparent and influential in all stages of the research process. Charmaz (2014) writes: "If, instead, we start with the assumption that social reality is multiple, processual, and constructed, then we must take the researcher's position, privileges, perspective, and interactions into account as an inherent part of the research reality," (Charmaz, 2014).

As the primary researcher on this study, my worldview is thus inherent in the aims and framing of this research. As a queer woman, my experience is one that often challenges the heteronormative and patriarchal scripts prescribed to inform collective mental models of how things “are” or “should be” naturally. However, perhaps most relevant to the subject matter of this research is my own lived experience with sexual violence.

As a person with identities and experiences that I seek to reflect in my research, and as a researcher, I occupy an “insider-outsider” position. Dr. Alissa Ackerman has coined the term “survivor-scholar” (Sardina & Ackerman, 2022) to refer to a person who is both a survivor of SV or harm, and a researcher who studies SV. I adopted this identity in this research and wear it proudly. I also offered to share this identity to any participant involved in this study.

As survivors, we occupy a space related to an experience that is often used to shame, humiliate, discredit, and gaslight us. The claiming of this identity as one of great knowledge is critical to this work – both for me, and for the target participant population of this work.

Conclusions

The proposed study identified gaps in critical crisis response services for survivors of sexual assault in Kentucky, and through the collection and analysis of rich data from multiple perspectives, will be able to recommend a set of best practices for future care provision. This research informs future crisis response interventions for marginalized populations and inspires a new conceptualization from which to operationalize community-based trauma-informed care following SV.

CHAPTER IV

REIMAGINING SUPPORT AFTER SEXUAL VIOLENCE: SURVIVORS' RECOMMENDATIONS FOR NONPROFIT SUPPORT ORGANIZATIONS

Introduction

Sexual violence (SV) impacts individuals and communities worldwide. SV is an umbrella term to refer to a range of power-based and coercive acts of interpersonal violence, including but not limited to rape, sexual assault, molestation, sexual intimidation, sexual harassment, stalking, and technology-facilitated violence (e.g. “revenge porn” or AI-generated “deepfake” pornography) (WHO, 2002). The CDC asserts from available data that as many as one in three adult women and one in 38 adult men will experience attempted or completed rape within their lifetimes in the United States (CDC, 2021). SV is prevalent in childhood as well, with available data demonstrating that one in three girls and one in 13 boys will be affected (CDC, 2021).

SV disproportionately impacts structurally minoritized communities (Prevention Institute, 2021). Black, Indigenous, and people of color (BIPOC), lesbian, gay, bisexual, transgender, and queer (LGBTQ) individuals, individuals with physical, intellectual, and developmental disabilities, and other historically marginalized populations experience higher lifetime risk of experiencing SV, in addition to having less access to intervention and/or protective services due to barriers caused by existing social and structural inequities (NSVRC, 2019).

Though these statistics demonstrate a high prevalence of SV experiences across populations in the US, it is widely acknowledged that available data on SV significantly underestimates the true prevalence. For example, the US Department of Justice estimates that as many as 80% of rapes are not reported to law enforcement or healthcare agencies (Morgan & Kena, 2018). SV and victimization are associated with a range of adverse physical, sexual, reproductive, psychological, mental, and behavioral health outcomes (WHO, 2012).

Sexual Violence as a Widespread Public Health Issue

Health outcomes following an SV event may be temporary or lifelong, or may manifest as acute issues that, without appropriate intervention, may develop into chronic health conditions. Health outcomes associated with SV experiences may be physical, reproductive, mental, psychological, and behavioral, with co-morbidities being common (Breiding et al., 2014; Cloutier et al., 2002; Santaularia et al., 2014).

Though SV may lead to adverse physical and reproductive health outcomes, SV is most highly associated with mental, psychological, and behavioral health challenges related to post-traumatic stress (PTS). PTS refers to a heightened stress state commonly experienced after witnessing or experiencing a traumatic or life-threatening event, such as a car crash, a natural disaster, or interpersonal acts of violence, such as SV. PTS is not a diagnosable disorder and resolves for most individuals who experience it with appropriate intervention. However, without intervention, PTS may advance to post-traumatic stress disorder (PTSD), a clinically diagnosed condition recognized by the Diagnostic and Statistical Manual of Mental Disorders (Dworkin et al., 2023).

Relative to other traumatic events, individuals who have experienced SV have an increased risk of meeting diagnostic criteria for post-traumatic stress (PTS), as well as for demonstrating relative severity of PTS-related symptomatology (DiMauro & Renshaw, 2021; Dworkin et al., 2023). While many survivors of SV recover from SV-PTS symptomatology after a few weeks or months, as many as 10% - 40% affected victims develop persistent post-traumatic stress disorder (PTSD) lasting many years, or even for life (Johansen et al., 2022; Sareen, 2014).

Common mental health outcomes related to SV-PTS may include, but are not limited to anxiety, depression, sleeping and eating disorders, poor self-esteem, various somatic disorders, as well as self-harm and suicidality (WHO, 2012). Experiencing SV can have a severe psychological impact on survivors and may permanently change belief systems and ability to trust others (Black et al., 2011). Prevalent behavioral health outcomes common after experiencing SV include substance use and disorders, sexual dysfunction, high-risk sex behaviors, and risk of entering and participating in abusive intimate partnerships (WHO, 2012). Behavioral outcomes may be present immediately after a violent event or, without appropriate and timely intervention, may become patterned into lifelong behaviors.

Experiences of SV, through pathways of chronic stress and allostatic load associated with PTS and PTSD, are also associated with higher risk of developing chronic disease and long-term conditions (Basile et al., 2021; Beckie, 2012). As SV is highly correlated with the development of PTSD (Scott et al., 2018), early identification and intervention of SV incidents is important to prevent long-term health outcomes associated with PTS development (Dworkin & Schumacher, 2018; O'Donnell et al., 2008). Though every person experiences trauma and related health outcomes differently, failure to engage in early (or any) intervention significantly increases risk of long-term adverse health outcomes, as well as risk of re-victimization (Jaffe et al., 2023).

The public health implications of SV go beyond mental, psychological, and behavioral health. SV commonly has a devastating financial impact, with many survivors experiencing disrupted employment, income, and earning power while managing PTS related to an SV event, a phenomenon that may have long-term or permanent impact on survivors' employment and career trajectories (Loya, 2014). SV is also associated with housing, food, and healthcare insecurity (Basile et al., 2021; Clough et al., 2014; Fedina et al., 2022).

Crisis Response Services to Support Survivors of Sexual Violence

Literature suggests that access to early psychosocial/psychological intervention after experiencing a traumatic event may be effective for reducing the long-term impact of post-traumatic stress (PTS) and related symptomatology, including post-traumatic stress disorder (PTSD) (Dworkin & Schumacher, 2018; Dyregrov & Regel, 2012; O'Donnell et al., 2008; Roberts D Clin Psy et al., 2009; Scott et al., 2018). As such, various crisis response options are made available to individuals who have experienced SV to help immediately connect them to resources and begin a process of recovery.

Crisis response service needs of people who have experienced SV are extensive, and encompass a broad range of physical, psychological, behavioral, social, and legal supports (Bach et al., 2021). Formal crisis response interventions for people who have experienced SV involve collaborative efforts between law enforcement organizations, healthcare institutions (emergency departments), and often, non-profit human services organizations (NPHSOs) with specific missions to support survivors of SV. The interventions are largely interconnected, as the justice system's ability to prosecute perpetrators relies heavily on bio-evidence collected in healthcare visits following an assault, as well as the victim's comprehensive testimony (Ladd & Seda, 2020).

Nonprofit Human Services Organizations

NPHSOs included in SV crisis response may include rape crisis centers (RCCs), sexual assault resource centers (SARCs), victim advocacy programs, or similar programs (Bein, 2010). Services commonly provided by NPHSOs may include 24-hour hotline services, legal counseling and advocacy, support groups, as well as free accompaniment to hospital visits and forensic exams following an assault and community education programs, community engagement and outreach activities, housing, financial, and employment empowerment services, and violence intervention trainings (Bein, 2010). A primary focus of these organizations is often to provide immediate crisis response, short-term therapeutic intervention, and mental health stabilization services to victims and survivors (Bein, 2010).

As the only crisis response service option that offers low-to-no cost, evidence-based, and specially trained therapeutic and stabilization support, NPHSOs may be best positioned to support the immediate PTS-related health needs of survivors of SV (Decker & Naugle, 2009). By deploying early intervention strategies, NPHSOs may have a unique opportunity to resolve any PTS-related mental, psychological, or behavioral challenges before they develop into PTSD or similar long-term or lifelong health condition.

Barriers to Crisis Response Engagement

Despite the ongoing collaborative efforts of these organizations, crisis response options, including NPHSOs, remain critically underutilized by victims of SV. The National Sexual Violence Resource Center reports that approximately 63% of sexual assaults are never reported, naming SV the “most underreported crime” (NSVRC, 2015). Reasons for underutilizing of services after experiencing SV are broad and diverse and reflect multiple barriers to engaging in services.

Barriers to engaging in crisis response care may be related to psychological safety or may be barriers to access based on structural and social barriers. Common reasons to not disclose or seek services following an experience with SV include shame, guilt, or embarrassment; fears of not being believed or treated with dignity by support providers; not wanting friends or family members to know; fears of being retaliated against by perpetrators or community members; fears of being pressured to engage in the legal justice system; and the perception that services will not or cannot help (Anderson & Overby, 2021; Bach et al., 2021; Carson et al., 2020; Sable et al., 2006; Zinzow et al., 2022). Common structural barriers include, but are not limited to, lack of transportation, costs, perceived costs, and availability of services, having to take time off work to access services (Anderson & Overby, 2021; Zinzow et al., 2022). Finally, victims of SV may choose not to engage in crisis care because they do not recognize their own experiences as SV, internalizing common misunderstandings about what defines “real” SV is and who is impacted (Wood & Stichman, 2018).

SV crisis response services, including NPHSOs, are most significantly underutilized by structurally minoritized populations, who disproportionately experience structural inequities that create barriers such as cost-barriers, transportation barriers, and barriers related to discrimination, harassment, and victim-blaming behaviors from service providers (Bach et al., 2021; Kennedy et al., 2012). Literature demonstrates that most individuals who are served by formal crisis response services are white, youthful, urban, English-speaking, non-disabled cisgender women (Koss et al., 2017).

Barriers to engaging in crisis response services may also be related to a fundamental mismatch between available service provisions and survivors' desires and expressed needs. Reflecting the underutilization of available services, Koss, White, & Lopez report that survivors "often say their available options mismatch their objectives, present accessibility challenges, disempower their pursuit of what justice means to them, and fail to offer concrete responses to basic needs," (Koss et al., 2017).

Survivor-Led Approaches to Care

Connecting survivors to resources and care is critical to interrupt the pathway from post-traumatic stress to long-term and chronic adverse health conditions, and yet many barriers exist to engagement with crisis response services offered by NPHSOs (Koss et al., 2017). To address these barriers, the White House, among other critical violence prevention organizations, have issued a call for "survivor-centered" and "survivor-led" approaches to care after experiences with sexual violence (The White House, 2023).

To mitigate long-term harms associated with SV experiences, early intervention is suggested as best practice (Dworkin & Schumacher, 2018; O'Donnell et al., 2008; Roberts D Clin Psy et al., 2009; Scott et al., 2018). Between available crisis response options, NPHSOs are best positioned to provide early intervention strategies to survivors, as they offer evidence-based therapeutic and mental health stabilization services, as well as services targeting structural determinants of health, such as employment, food, and housing. However, these services remain underutilized, reflecting various barriers to engagement.

Approaches to post-SV crisis support that are imagined by individuals with lived experience present a powerful opportunity to meaningfully address commonly experienced and perceived barriers to care, allowing for greater access to care, higher-impact services, reduced discrimination, shame, and stigma, and a significant impact on public health. Centering the voices and experiences of individuals with lived experience in the envisioning and development of crisis response approaches may offer innovative insights and nuanced perspectives otherwise inaccessible to interventionists without lived experience. Towards this aim, this study centers the voices of survivors of SV in envisioning new crisis response approaches, offering innovative insights and nuanced perspectives otherwise inaccessible to interventionists without lived experience.

Methods

Individuals who disclosed lived experience with SV were recruited to participate in this qualitative descriptive study (n=20). Participants were invited to share their experiences and perspectives regarding crisis response options available to them in semi-structured in-depth narrative interviews. As SV remains a highly stigmatized experience in all communities, a study design that emphasized the confidentiality, privacy, and psychological safety of participants was developed.

Recruitment

Participants were recruited via flyers shared on popular social media sites (Facebook and Instagram). Information shared on social media flyers included the version of the study title (Reimaging Safety after Sexual Violence: A Survivor-Led Study), the IRB number (IRB #22.1070), a brief discussion of the interview, eligibility criteria, a description of the financial incentive for participation, as well as a QR code and link to a pre-screening eligibility survey. The recruitment flyers featured gender-neutral imagery, as well as images featuring diversity of human experience, in attempts to counter the often whitewashed and heavily gendered nature of common SV discourse.

If interested in participation, participants filled out a brief pre-screening survey that assessed eligibility for participation based on inclusion and exclusion criteria, and captured some basic demographic information. The eligibility questionnaire utilized open-text response options to allow interested parties to use their own language to self-define information regarding their identities and experiences. Demographic information was not required to submit a request for an interview.

Participants who met the eligibility criteria were then invited to provide their name and contact email to participate in an interview. Members of the research team contacted participants directly to invite them to complete a one-on-one virtual interview, as well as to provide an additional copy of the unsigned informed consent document. All participants were compensated with a $50 Amazon gift card. All study procedures were approved by the Institutional Review Board at the University of Louisville.

Data Collection

Data were collected through two mechanisms. First, key participant information was collected as part of the screening process with a brief questionnaire through an online survey platform (Google Forms) to ensure that they met inclusion criteria.

Next, recorded interviews were facilitated using a semi-structured interview guide. Interviews were held virtually using an online video conferencing program (Microsoft Teams). The interviews were guided by an interview guide (Appendix A) to discuss the participants' perspectives and lived experiences as individuals who have experienced SV. The interviews were transcribed, reviewed for accuracy, and deidentified before data analysis.

Data Analysis

Audio recordings of interviews were transcribed using OtterAi. The AI-generated transcripts were then thoroughly cleaned by the researcher to ensure accuracy and confidentiality. Next, a process of line-by-line coding to determine a set of initial thematic codes (i.e., a codebook) for the data was begun. A codebook was developed and utilized to analyze a different subset of transcripts in-depth. De-identified interview transcriptions were uploaded into a qualitative analysis software (Dedoose) for thematic analysis. The researcher met with committee members frequently to discuss discrepancies and refine the set of codes. A revised codebook was then used to code all transcripts in Dedoose. The excerpts were reviewed by the investigators to identify themes across interviews.

Several measures were taken to ensure reliability and validity during this study. Transcripts were recorded and transcribed verbatim to ensure accuracy in analysis. Initial code applications generated by the researcher were presented to two experts unaffiliated with the study to engage in a process of peer debriefing. Finally, the researcher engaged in a practice of deep reflexivity to critically consider the role of pre-existing biases, assumptions, and expectations.

Results

Participants included adults living in the state of Kentucky who were over the age of 18. Additional eligibility criteria included identifying as having experienced SV and being willing to talk in depth about their experiences and decision-making strategies related to engagement with crisis response services. Exclusion criteria included individuals who were not yet 18, and individuals who had not experienced SV. For the purposes of this study, SV was defined broadly to include a vast array of experiences that could be categorized as SV. Participants were not required to have formally reported their experiences with SV or to have engaged with any crisis response services to be eligible for participation in this study.

The final sample reflected diversity of race, gender, sexual orientation, socioeconomic status, and disability experience. Eight participants reported being between 18 and 25 years of age; eight were between 26 and 35; two were between 36 and 45; one participant was between 46 and 55, and one was between 56 and 65 years old.

The sample also reflected diversity of socioeconomic status. Three participants reported earning less than $10,000 per year; four reported earning between $10,000 and $25,000 annually; three reported earning between $26,000 and $35,000; two earning between $36,000 and $45,000 annually; two earning between $46,000 and $55,000 annually; three earning between $56,000 and $65,000 per year; one earning between

$66,000 and $75,000 per year; one earning between $96,000 and $105,000 per year; and one earning more than $106,000 annually.

Fifteen participants identified as white or Caucasian, two identified as Black or African American, and three identified as mixed-race or biracial. Most participants identified as female or woman (n=14), one identified as man or male, two identified as non-binary, and three participants identified as transgender men. Regarding sexual orientation, seven participants identified as heterosexual, with the remaining participants identifying as queer (n=3), bisexual (n=5), pansexual (n=2), and gay (n=1). One participant did not include information about sexual orientation. Among the participants who reported a heterosexual orientation, two self-described as “heterosexual-ish” or “straight-ish.” Finally, eleven participants disclosed living with a disability or chronic illness, defined broadly, with several participants offering living with chronic mental illness.

Interviews with survivors of SV uncovered several perceived and experienced barriers to meaningfully engaging in crisis response services offered by NPHSOs. Participants identified several recommendations for improving access to and quality of post-SV care based on lived experience that fell into the following three overarching themes: Survivor-Centered Services, Expanded Organizational Outreach, and Enhanced Organizational Service Offerings. Each of the identified major themes are more fully described by several sub-themes.

Survivor-Centered Services

A particularly salient theme across participant interviews was the importance of providing services that center the survivor and their expressed needs in all crisis care decisions. Survivor-centered services were additionally described as services that reflect the identities, circumstances, and lived experiences of survivors. Sub-themes within this theme include Person-Centered Care, Representation & Inclusion, Language & Imagery, and Accessibility.

Person-Centered Care

Participants frequently spoke about the importance of centering the survivor of SV in all crisis support care decisions and treatment choices. Especially after having experienced SV, an event where autonomy and agency are violently taken away from a person, allowing a person complete control and agency in how and when they access care is a critical aspect of NPHSO services. Expounding on this concept, one participant offers: "*There's just so much power even in just having choice. And I feel like so much of what victims experience is not having a choice. Their choices have been ripped away in so many different ways"* (Participant 17).

Another person echoed this sentiment, discussing the importance of allowing a person complete agency over how they decide to access care or engage with crisis response services following an experience with SV:

> *I mean, I guess the thing that I would say is like, no matter what you decide to do, this is your situation to deal with. I mean, this is your situation; you get to choose how it's handled. And as you move through that, and do seek help, the way you feel might change, and that's okay. And it's always your choice to do what make what you feel best about."* (Participant 4)

A third participant added to the discussion, adding that individuals who have experienced SV may require an array of various services or supports following a traumatic event, and though they should be made aware of the kinds of supports that exist for them, they should ultimately be in control of their own care:

> *And then, from that point, just going back to survivor-led care, giving them back the control that they lost. It would look like following their needs, wherever those may lead. So, whether it be like talking about it, or… just providing them support and comfort they need. Maybe that would be like physical resources. And maybe they need pregnancy tests and STD tests, things like that. And making sure that they know what they have access to, and that they can make informed choices about their care.* (Participant 6)

Other participants conceptualized the need for agency in accessing care to take a person-by-person approach, acknowledging that different people will have different support needs. One participant described honoring each person's unique crisis support needs as a form of "safety:" "*I think that safety could definitely be more focused on an individual, person-by-person basis*" (Participant 14).

Finally, one participant described approaching the unique care needs of diverse individuals as "needs assessments:"

> *I wonder if it could be like, what do you need? Because I think needs assessments are really important, period. But I wonder if it could be like, what do you need? And maybe various funding [is] set aside for this person to sleep in a hotel. Or, you know, like, what do you need from us?...Like, we need to make sure you have new clothes right now. Like, you need new underwear right now…I just think asking the person what they need, because somebody might not be able to go home. Or may be scared to go home, you know. And so, I just think, or what does that look like? Do you need to stay at the hospital? Also making sure that stuff is in place as soon as you leave. Like, let's make sure we get therapy in place. Let's make sure X, Y and Z is already in place, because this person has been through a lot in the probably the last 24 hours…. I just think having things in place those resources in place and just not a list of phone numbers. That's not enough.* (Participant 10)

This participant imagines engaging in crisis support services as a truly person-centered and comprehensive experience where a person's immediate and long-term needs are addressed with care and efficiency but are also being driven by consent and the needs of the person who had experienced SV. Participants shared that crisis support services should support people who have experienced SV with a "survivor-led" approach as a means of building trust and establishing psychological safety as an early intervention to allow a person a better chance of recovery.

Representation & Inclusion

An additional significant sub-theme related to providing survivor-centered care was ensuring survivors had appropriate representation in NPHSO care. Participants reported that lack of representation of racial, gender, and sexual orientation diversity in NPHSOs that created barriers to engagement in crisis response or support. Participants who were BIPOC and/or LGBTQ+ discussed feeling neglected, isolated, and underrepresented in SV support services.

Participants who did not identify as women discussed feeling that crisis support services were unprepared to support them based on their identities. As SV is commonly gendered and discussed as a "woman's issue," participants who were not women shared about the isolation they experienced as a result. One participant shared that they noticed that services were heavily gendered towards supporting cisgender women, causing them to feel isolated from accessing care:

> *Mostly, like, the thing that I've run into is like, super, like gendered services…feel very, like isolating. And just like… if a place is not outspokenly, like queer friendly or trans friendly… I'm going to assume, in order to protect myself, that that is not a safe space.* (Participant 6)

Another participant offers a related sentiment, sharing that gendered language and imagery in SV discourse commonly referred to by NPHSOs isolates survivors who do not fall under commonly expected gender dynamics of SV:

> *…the gendered language around it is really big, because…I feel like, people are constantly like, well, one gender is usually the person who is abusive, or the perpetrator. And that's not true. And that's really harmful and creates more shame…and that's also really isolating…Because I think people usually think it's*

> *like men perpetrating females. Yes. And that's so harmful, because it leaves so many people out.* (Participant 11)

Another participant, a transgender man, discussed feeling grateful for the support of the advocate sent by a local NPHSO while he engaged in post-SV care at the emergency department, but that he wished the advocate who was sent was more able to relate to his lived experiences:

> *But I think that as far as like, having an advocate...I'm glad that exists…I would have definitely felt more comfortable having a queer person there…I think it's really important, especially when…you've come from a situation where maybe…you are sort of taken advantage of. But when you're trying to briefly build trust with somebody else…it probably helps to have like instant things to relate to them with and so if the person had been queer…that would have really helped me out.* (Participant 4)

In addition to discussing using representation as a means of swiftly building rapport, trust, and psychological safety, this participant highlights the significance having the agency to choose what kind of advocate he would have wanted to join him would have had for him as he navigated an extremely emotionally vulnerable situation. Another participant shared his sentiment, offering that she wishes crisis response services were "*also diverse, like, I would hope that people would look like you when you need help. I think that that does help*" (Participant 10).

This same participant, a Black woman, expounded upon her thoughts by ruminating on how NPHSOs isolate individuals whose experiences don't align with "ideal victim" narratives about SV:

> *I think I'd like -- it's not diverse…And a lot of times, it's white women. That's like, this white woman got raped or this white girl was assaulted walking back to college. It's like, this shit happened to me. And this not just happening to white people."* (Participant 10)

This participant suggests that she doesn’t see herself, or Black women generally, represented in SV crisis response care or discourse surrounding SV. As such, she discussed not feeling safe engaging in care, suggesting that these services were not developed with her experiences in mind.

Demonstrating the importance of NPHSOs adopting intersectional approaches to SV support, one participant shared that he did not seek out therapeutic services because he did not believe that he would be able to access care or support that was knowledgeable about his identities as a person who is Black and queer: “*I think having somebody or resource that clearly articulates that they are educated on the experience of where people, most specifically, Black queer people, because those are often the most violated with sex crimes”* (Participant 16).

Participants also discussed positive experiences with representation they have had while engaging with NPHSOs after SV. The same participant discussed a positive experience he had when he called a nonprofit crisis line to receive support after experiencing SV:

> *They were understanding, they didn't dismiss because of my identity. They didn't dismiss anything. I felt like they would they take it as seriously as they would have if my white counterpart had called. And they had the training, they had the knowledge, to support in that moment, what to say what to do and how to consult somebody in that moment.”* (Participant 16)

Here, in this participant’s reflection that the organization took him as seriously as “if his white counterpart called,” he describes feeling surprised to have received support despite not being a white person, calling attention to perceived racism and anti-Blackness in NPHSOs. While he is sharing an overall positive experience, he is also acknowledging surprise at the good experience, highlighting larger barriers experienced by non-white people seeking care.

Another participant shared a positive experience they had while engaging with services offered by nonprofit organizations:

> *And my therapist was really amazing. Because like, part of my identity is I'm polyamorous. And so that was really a big part of the work we did as well. ...And it was very, like affirming of my gender and like, [she was] just a badass, just like a really great therapist."* (Participant 11)

This participant shares that they were able to retain engagement in care post-SV precisely because their therapist with the NPHSO they reached out to was gender-affirming and took an active interest in their polyamorous identity, rather than shaming or neglecting that aspect of their identity and experience.

Finally, a participant shared that honoring a person's identities and experiences was the "only way" crisis support providers could establish trust with people who have experienced SV:

> *Yeah, I definitely think it would look like a completely judgment free and survivor-led process, it would kind of start... without any assumptions of what a survivor is. Whether that's like demographically, like it would make so everybody felt comfortable seeking that care whether they were, whatever their gender was, whatever their sexuality, the circumstances of the violence, they wouldn't feel minimized or turned away at any point. And I think that's like the only way it could start."* (Participant 6)

Overall, participants shared a desire for NPHSOs to increase diversity and representation not only in their staffing, but also in the ways they conceptualize, approach, and address experiences of SV as they impact different communities and individuals with intersecting identities. For many participants, a perceived lack of representation in services acted as a significant barrier to the decision to engage in care after experiencing SV. Participants who felt that their experiences with services were representative of their identities and experiences felt supported.

Language & Imagery

While use gendered language was presented as an issue of representation, participants also highlighted additional language commonly used in SV discourse by NPHSOs that made them feel unsafe, misunderstood, or unheard. Exemplifying this, one participant shared that she found language commonly used in SV discourse "insensitive to victims:" "*You know, I think so much of so much of the language that surrounds sexual violence is not victim centered in an appropriate way. It's very insensitive to the victims*" (Participant 17).

For many participants, the word "rape" was particularly unpleasant, or brought about particularly difficult emotions. One participant shared that she didn't believe the word "rape" did justice to the experience she survived: "*Like, yes, I was violently raped. If you're going to use the word 'rape' I'd rather use I was 'violently raped.' I was afraid for my actual living life*" (Participant 14). The word "rape" was problematic and painful for other participants, who shared their thoughts on the word and on how SV is spoken about broadly:

> *Yeah, I mean, it has always bothered me when, when even like organizations surrounding this stuff, or look, resources or whatever…uses the word 'rape'… it feels really sharp…And it's really upsetting to me. I just really hate it…And I'm just like, man, there's so many other ways to say that, and like, you just didn't have to do that."* (Participant 4)

Another participant shares this sentiment, commenting that the word "rape" is triggering and uncomfortable to use or hear: "*I…think we're moving away from…the word 'rape.' I just don't like the word 'rape,' you know. I will tend to use 'sexual assault'* *now...But I like it so much better now. That's the only thing that really hits me"* (Participant 7).

Considering the ways NPHSOs utilize imagery to connect with possible clients and advertise services, one participant shared that she felt uncomfortable with some of the ways NPHSOs depict victims of SV:

> *…obviously there's clinics out there, and they have always pictures of like a woman who just looks at her most depressed state ever. And I'm like, that's not always what it looks like…So, for me, I just hate those… when I was younger, I would see those pictures and just think like, is that me now? Is that what I look like?"* (Participant 3)

This participant discusses feeling misrepresented or patronized for being meant to resonate with an image of a sad and depressed person, and shares that seeing images such as these as a younger person who had experienced SV was deeply uncomfortable, even stopping her from accessing services for fear of being pitied or felt bad for.

A participant who currently works in an SV prevention NPHSO shared her sentiments on language commonly used to connect with survivors:

> *… the other language that makes me so angry is when there's language around, like brokenness or shattered... it's a model of nonprofits that is used across the board, because so much of it is like engaging that ethos of sorrow and sympathy, which is actually just creating those straight levels of oppression again. Like, let me show that I am better than you by helping you, or by fixing you…And I think a lot of that language like really is just creating more of that; structures of oppression and hierarchy. Because you're saying, you are broken, therefore I have to take care of you. Let me care for you. Let me tell you what to do.* (Participant 9)

Finally, participants shared disparate perspectives on terms commonly used to refer to people wo have experienced SV - "victim" and "survivor." While one participant expressed preference for the term "survivor," many other participants reported dislike for the term. One participant discussed the term "survivor" as feeling disempowering:

> *I don't find the word 'survivor' particularly empowering…Because I do think that like, calling someone a 'victim' has its negative connotations, but it also kind of holds them harmless or blameless, like I can be held blameless for what happened to me. And so, I think identifying myself as a victim of a crime was actually very helpful in being like, no, actually, this has nothing to do with the choices you made, or something flawed about you or wrong about you. This is just a thing that happens.* (Participant 15)

Another participant shares this perspective, offering that, in her perspective, the term "victim," rather than "survivor," conveys the seriousness of the experience:

> *But I feel like 'survivor' makes it sound like there was a good thing that came from that. Like, you lived through that; you overcame that. I can understand why people would want to not be called a 'victim,' but for me personally, like that is the jargon that I would use to describe myself.* (Participant 18)

The experiences of these participants highlight the importance of engaging in deep listening and mirroring the language used by victims. Language and imagery are key considerations of providing trauma-informed care post-sexual violence and may act as a barrier or facilitator to care.

Accessibility

Finally, the provision of survivor-centered care was also associated with accounting for accessibility of services. Several participants discussed wishing NPHSOs were more accessible for people with various support needs related to various disabilities. One participant suggested crisis support providers be prepared to work with people who have various physical abilities or needs:

> *Yeah, I think it has a lot to do with, like, accessibility for like different, like disabilities or other emergencies. Like, people are not going to have the same physical needs for the situation…Like if somebody needs to, like, stand up or pace or, you know, two different types of their mind settle.* (Participant 6)

Another participant shared that they wished that they had known about or had access to a web-based option to engage with crisis support services, rather than using a phone call or visiting an in-person clinic:

> *Probably some sort of, if there was like an online sort of chat room type thing. I feel like that would have helped us that made sense because I was too scared to call someone. I don't know if that was available, to be honest. But if there was some sort of online chat room was someone that could help. Maybe that would have helped.* (Participant 20)

Participants discussed being more willing to engage in NPHSO support services if they perceived that they would be able to engage in ways that made them feel most comfortable.

Expanded Organizational Outreach

A second recurrent theme within and across survivor interviews was the desire for expanded organizational outreach. As they reflected on their encounters with SV, participants recall lacking awareness of services offered by NPHSOs, or misunderstanding the target population for services. Participants describe how more thorough communication regarding services, as well as expanded educational outreach to dispel common SV misunderstandings could help more victims of SV access care through NPHSOs. Subthemes within this theme include Lack of Awareness of Services, Transparency, Communication, and Outreach, and Education and Health Promotion.

Lack of Awareness of Services

Participants discussed a major barrier to being able to seek out support services at NPHSOs following their experiences with SV: a lack of awareness of the existence of such services. Illustrating this, one interviewee admits: "*Well, I knew in one instance, that what was going on was completely wrong. But I just I just didn't know who or how to* *reach out to anyone for help or what to do about it*" (Participant 3). Another participant shared a similar experience:

> *And at the time, I wasn't aware at all of like any services. So, I think that definitely impacted my decision to or not to engage in these services. Because I had no knowledge of any services that we're available in the area, whether through the university or in the community.* (Participant 9)

Finally, one participant discusses feeling that their age prevented them from being able to know what services were available to them, or how to access them on their own:

> *…when it happened to me, I was 18… And I just I didn't really know how to access that care. And I was scared, and I didn't have like anyone else there to tell me how to do that, I guess it didn't feel…accessible to someone as young as me. Or like, I just didn't know how, really.* (Participant 20)

Participants' demonstrated lack of awareness of available NPHSO services to support survivors of SV highlight the need for expanded organizational outreach activities and trainings to ensure that all individuals are aware of these services.

Transparency, Communication, & Outreach

Another common theme across participant interviews related to organizational outreach was a perceived lack of transparency about what services NPHSOs offer, how to engage with them, and what kinds of information they can expect to have to disclose in order to engage in care or report an experience with SV. Many participants discussed not feeling equipped to engage in NPHSO services simply because they did not know what making that decision would mean for them, or what they would be required to do.

A few participants discussed choosing not to engage with NPHSO services because they perceived services only being available for "serious" experiences with SV:

> *Maybe the messaging of a resource like that being a little bit different. Because right now, again, like I kind of view that type of resource as something that's…for really serious things that have happened, for women that are in danger, not necessarily for just like, any type of sexual assault.* (Participant 12)

This same participant continues:

> *So, I guess just like an overall like normalizing these types of resources and messaging around them that like they're for anybody who's gone through anything that's even like, any type of sexual assault, no matter the degree or what had happened, or where happened, anything like that. And then just making them available to like all the different communities.* (Participant 12)

Here, this participant is commenting on how crisis support services are perceived and portrayed as only being available to people who have experienced very "serious" and dangerous experiences with SV.

Another participant echoes this sentiment, sharing that they didn't want to engage in services for fear of "taking away" from others who may have needed services more:

> *I have friends who have gone through very serious situations, and I wouldn't want them to think that I am co-opting their language, or taking away from their resources for something that I don't equate in my mind to what they went through.* (Participant 6)

Another participant expounded upon these perspectives, also suggesting that services offered by NPHSOs feel "dramatic," but for different reasons:

> *I think that as a survivor, the services that are available feel very dramatic – is the word that comes to mind… like by meeting with anyone, you're kind of solidifying what happened to you. It can feel really scary and like you're already dealing with a lot of things that are happening. And so, this is just another meeting or another thing you have to deal with that feels really unfair. It also can feel really like intimidating. We know that like as survivors of violence, one of the reasons why it is so traumatizing is that you no longer have choice and autonomy. And so, by then going into a space where you don't know what to expect, or what questions they're going to ask, or how they may or may not be labeling your experience…that can feel really intimidating.* (Participant 9)

This participant highlights that she was reluctant to engage in care because she was unsure of what it would mean to engage in crisis support care, and also in order to receive care, she would be made to admit to herself that her experience was indeed SV, a realization she may not have been ready to make.

One participant shares that while she knew about NPHSO services to support survivors of SV, she wasn't aware of the kinds of services that were available, or what to expect if she did decide to pursue support:

> *...if it wasn't for friends, I wouldn't have known that the rape crisis center was free, didn't have any strings attached to insurance or didn't have any strings attached to reporting, like it wasn't mandated…those kinds of things would have been really awesome to know ahead of time.* (Participant 19)

For some participants, the desire for transparency was connected to desires for knowledge and autonomy. Some participants connected the lack of clarity around what is required of them in order to engage with NPHSO services to a lack of autonomy. Illustrating this perspective, one interviewee shared that they hesitated to engage with NPHSO services because they were concerned they would be pressured by service providers to press legal charges:

> *I think there was a lot of fear before I went to the [crisis center], because I was afraid people were going to coerce or pressure me to like, go to the police…And I knew that it would be more traumatizing for me to do that."* (Participant 11)

To rectify these concerns, one participant suggested that there be a resource made prominently available by NPHSOs that clearly describe and walk through options that are available to survivors as they are making the decision whether or not to seek support:

> *And I think like maybe having a conversation before you get to that point to be like, hey, you can say that you've been raped without having to go through that process. Like if you decide like, hey, I actually don't want to press charges, I just need someone to talk to…* (Participant 1)

For many participants, not knowing what crisis response services are available, not knowing about the kinds of SV experiences are "worth" seeking care after, or not knowing what they are "allowed" to disclose, acted as significant barriers to engaging in

NPHSO services that could be overcome with greater transparency around service eligibility, offerings, and confidentiality statements.

Education & Health Promotion

An additional theme across participant interviews related to expanded organizational outreach was a desire for increased educational efforts to teach people broadly about sexual health, relational health, consent, and violence. Many participants shared these desires as they themselves did not have access to sexual health education, an experience that they associated with their experiences with SV. One participant shared that she felt like not having access to comprehensive sexual health education was a "missed opportunity:"

> *Knowledge, essentially…it would have been great, as being someone who was raised in the south, to have some sort of sex ed that included consent...Or at least having access to that before being halfway through college… there's so many missed opportunities from that.* (Participant 19)

Another interviewee shared that she may have been able to better identify unhealthy or dangerous sexual experiences and relationships if she had had access to comprehensive sexual health education:

> *So, I've thought about this a lot, actually…my brain goes towards…how could it have been better. And I think the first place is sex education. I was a teenager, and my sex education was not comprehensive. It was very abstinence-based, very, like, 'you'll get pregnant and die' type shit. And so…I honestly didn't even realize what had happened to me for…several years. And I think that's an education thing. Like, I knew that sexual assault happened. But my perception of what that looks like, was very different. Because I never learned about consent formally.* (Participant 18)

A third participant echoed this sentiment, sharing that having access to comprehensive sexual health education may have helped her be able to better identify sexual harm and be able to know to reach out for help:

> *If that information had been in front of my face…I think I probably would have been more inclined to reach out for help. But coming from…the school that I went to, and the people that I was around, like, you just didn't talk about these things. You know what I mean? You didn't. There just was no outreach for anything like this. So for me, it just would have been more helpful.* (Participant 3)

Many participants emphasized the importance of being taught about these topics from very young ages, instead of high school or beyond. For many participants, they believed that having access to age-appropriate sexual and relational health information would have allowed them to be able to not only identify when sexual harm was occurring, but also be able to prevent it: "*Because I think that we're just trying to hit it with adults….Um, but I think that it could just be taught earlier*" (Participant 10). Another participant shared these sentiments, discussing how access to comprehensive sexual health education from a young age would allow for greater awareness of sexual harm from every angle:

> *But I think like giving people the education about how like nuanced like sexual harm can be, from a really young age, will help people…hopefully stop like sexually harming people, because they'll have that information… And to be able to identify it when it does happen.* (Participant 1)

For many participants, educational outreach was the single most impactful intervention they advocated for to not only be able to identify sexually harmful or dangerous situations, but also to be able to prevent them. Education and outreach are key for preventing sexual violence, as well as for educating about what support services exist, what they are for, and what they require. Education and outreach should combat stereotypes or media expectations of what constitutes as sexual violence – many people were unlikely to recognize their own experiences as violent because they did not match media portrayals.

Participants also discussed desiring increased educational efforts about the nuances of SV not commonly reflected in popular media narratives or stereotypes. Many participants discussed not realizing that they had even experienced SV until many years after the fact, because their experience did not match up with media narratives about SV, because their experiences did not feel as "dramatic" as SV is commonly portrayed to be. For example, one participant recalled that she was unable to discern her experience as SV because she did not believe that violence could occur within a romantic relationship:

> *And I didn't know. And, and even though…I knew that I felt like that's what had happened to me, I sort of talked myself out of it because of the context. This isn't -- I'm in a relationship with this person…But it you know, in my teenage mind, at the time, it was like, well, rape happens, you know, from a stranger, it doesn't happen in the context that it happened to me.* (Participant 17)

Another participant shared that they had difficulty identifying their experience as SV because it similarly did not happen within the common narrative of SV:

> *Besides the fact that it can happen to anyone, and anyone can do it. Honestly, family members even could, the close ones to you. So, I think everyone should be aware of it and know what it looks like. Because I didn't know I even was [assaulted] until later…Like, I feel like consent should be taught more to...Just like being aware of someone that might hurt you. And someone that could have hurt you.* (Participant 20)

One participant called for more educational outreach from SV-focused nonprofit organizations as a means of providing education for people who may not be able to recognize their experience as SV because it was different than preconceived notions:

> *Now, with all these new technologies, I feel like it should be. It should be on all the platforms, and it should be in the schools, and it should be on the TV, it should be, you know… I feel like it should just be so accessible. And I know it costs money. But like, isn't that isn't that worth investing in?* (Participant 3)

For these participants, increased education from crisis response services about what SV is and the range of experiences SV can refer to would have helped them be able to identify their experiences as SV earlier, allowing them increased opportunity to access care.

Enhanced Organizational Service Offerings

The final major theme identified by participants was enhanced organizational service offerings, and expanding organizational capacity to be able to serve all people who are in need of care. Subthemes within the theme of organizational support included environment, capacity and structural supports.

Environment

Participants described the importance of NPHSOs offering a comfortable, warm, and welcoming environment in which to engage in support services. For several participants, the comfort of the environment was directly associated with their ability to feel psychologically safe and comfortable enough to verbally process their SV experiences in a therapeutic environment. Exemplifying this, one participant shared:

> *I would say like a living room, like someone's living room…for me, specifically, like just having a couch like it feeling cozy, it feeling warm, feeling like you're stepping into someone's space, and not like something as sterile as a hospital.* (Participant 1)

Another participant described the importance of a physically comforting environment for him to be able to establish psychological safety while engaging in care:

> *Um, I think it can definitely be a lot about the physical environment...And I have felt actually felt the most safe when I went to a place that was usually child's therapist, even though I was an adult. But they had a lot of like, fidget toys. They had a very like comfortable, cozy, blankets available. They had a comfortable chair. They had like options for art therapy and music therapy…And with like, yeah, just to feel physically comfortable. And that gives me that sort of mental comfortability because I'm not really going to be able to go to a space where I feel like I can share and be vulnerable if I'm like, sitting in like a stiff chair.* (Participant 6)

Participants discussed the importance of a comfortable and safe physical environment to facilitate a sense of psychological safety and preparedness to engage in difficult and vulnerable disclosures of SV experiences.

Capacity

Several participants discussed experiencing disappointment that NPHSOs did not have the adequate capacity to be able to provide many of the critical supports that victims of SV may need immediately and in the long-term. Exemplifying this, an interviewee who currently works in a NPHSO supporting survivors of SV herself, reflects on the services that are currently offered by NPHSOs and worries that they are not meeting the full range of needs of people who have experienced SV: "*...a lot of folks really needed more support...coming in meeting with me for an hour, every week or every other week wasn't really helping the challenges that they were facing*" (Participant 9).

An additional participant recalled about when a local NPHSO did not have adequate capacity to take her and her children in after experiencing SV at home, she was forced to return to a dangerous environment:

> *I knew that [crisis center] couldn't take us in, and like they didn't have any beds. But I wish that somebody did. I wish that there was somebody that could have took me in, even if that was like temporary...I needed to be anywhere but home by myself with my baby...I think having somewhere to go that was safe, would have been so helpful.* (Participant 10)

This participant highlights that the lack of capacity for her local NPHSO to either take her in or help her arrange for a safe place to stay the night put her in the position of having to return to the home she shared with the perpetrator of SV, placing both herself and her child in danger.

Finally, another participant discussed the possibility of expanding capacity of NPHSOs by opening more locations or organizations that can provide crisis stabilization care in multiple areas in a given city or town:

> *...I would say having like, physical locations in multiple parts of a city…the if something's happened in a different part of [city], that's, you know, scary or traumatic to go through...So just having like multiple places around town that are safe…I think it would help it with it.* (Participant 12)

Acknowledging transportation as a potential barrier for many victims of SV to be able to access in-person care at NPHSOs, this participant calls for service expansions to make these critical services more accessible.

In their observations of the limited capacity of NPHSOs to meet all the various crisis response needs of diverse survivors, these participants acknowledge that services provided by these organizations are in dire need of additional funding and support to be able to meet the demand of victim support needs.

Structural Supports

Participants recognized that SV impacts individuals in many areas of their lives, and thus they may require support that goes beyond traditional service offerings provided by NPHSOs. Structural support, or support with finances, housing, employment, etc. One participant shared that more than counseling or victim advocacy, what would have helped her most was financial support to be able to take time off from work for a few weeks to focus on recovery:

> *Being able to collect some kind of monetary compensation… I needed to take some time off work because I was too terrified to be anywhere…So if I knew that I would be able to keep eating and keep like paying the rent…while I got my shit under control…Yeah, that would have been the most immediate thing.* (Participant 15)

Another participant questioned why there weren't more housing initiatives for people who experienced SV:

> *And like, especially like college campuses, it gets really hard. Like, I've known friends who were assaulted by people who lived in their dorms. And then when they filed their case, they still lived in their dorm, their dorm building. Why can't they be moved?* (Participant 14)

Participants acknowledged that for many victims of SV, a successful recovery may involve access to physical safety away from a perpetrator, time away from work, and other structural supports. Safety after SV could not only be accessed through mental health support.

Discussion

SV is a significant public health and human rights concern that is "devastatingly pervasive," impacting as many as one in two women and one in three men in the United States (CDC, 2022). SV is associated with a range of adverse physical, mental, sexual, reproductive, psychological, and behavioral health outcomes that may impact a victim for a few weeks or a lifetime (Black et al., 2011). Notably, SV is associated with a high risk of experiencing PTS, as well as developing PTSD, a diagnosable disorder that may not resolve without proper health intervention (Dworkin et al., 2023). Early intervention following a traumatic event demonstrates efficacy in reducing symptoms associated with PTS, and interrupting PTS from developing into PTSD or similarly chronic or life-altering conditions (Dworkin & Schumacher, 2018).

As primary points of entry for many survivors into recovery care, and vital connectors to resources, NPHSOs are uniquely positioned to meet victims in immediate aftermath of a SV encounter and provide critical therapeutic and stabilization support. Despite this positioning, many barriers spanning social ecological levels exist to survivor's meaningful engagement with services (Anderson & Overby, 2021). To best protect the long-term health and wellbeing of survivors of SV, it is critical to understand these barriers to be able to reduce and overcome them.

This study contributes to the literature by offering victims and survivor's perspectives and lived experiences with NPHSO services after experiencing SV. As individuals with lived experience engaging with (or considering engaging with) these services, the embodied wisdom of survivors of SV is critical for holistically understanding the nuances of service provision and barriers to care. Individuals with lived experience offer critical perspectives that may be otherwise inaccessible to health interventionists or service providers. The perspectives shared in this study, based on lived experience, offer key recommendations for NPHSOs supporting survivors of SV to reduce barriers to engagement and meaningfully meet the service needs of this vulnerable population.

Participants emphasized the importance of providing support services utilizing a survivor-centered approach. Survivor-centered approaches acknowledge that the survivor is the expert of their own experiences and care needs, which are influenced by each survivor's unique identity, context, and circumstances (Jumarali et al., 2021). Kulkarni et al., (2015) provide six key elements of engaging in survivor-centered care, all of which participants in the present study reflected across interviews:

> 1) increasing opportunities for survivors to exercise meaningful choices;
> 2) listening deeply and amplifying survivors' voices;
> 3) engaging in collaborative partnerships which seek to minimize power differentials;
> 4) crafting individualized solutions that build on survivors' strengths;
> 5) providing validation and support of survivors' experiences; and
> 6) addressing systemic elements that limit survivors' opportunities and access to resources and justice. (Kulkarni et al., 2015)

For the participants in this study, “survivor-centered” referred to honoring the autonomy and individual care needs of each survivor while conducting care activities, but also referred to ensuring that diverse survivors of SV were represented and included in services, services were accessible to victims with physical, intellectual, and cognitive disabilities, and language that honored the survivors’ preferences of inclusion, self-perception, and naming violence was honored.

As a key feature of providing “survivor-centered services” was practicing person-centered care, or care strategies that center empowerment of survivors through ensuring opportunities for exacting autonomous choice and self-determination (Cattaneo et al., 2021). Participants emphasized the importance of honoring the autonomy of the victim in all care and crisis response decision-making, a strategy that has been well-established in literature to bolster self-efficacy and trust after experiencing SV (Cattaneo et al., 2021; Davies & Lyon, 2013; Goodman, Fauci, et al., 2016; Goodman, Thomas, et al., 2016; Kirkner et al., 2021; Kulkarni et al., 2015; Kulkarni et al., 2012; Nichols, 2013). Survivor-centered approaches to care have demonstrated efficacy in positively impacting health outcomes following SV, including greater survivor satisfaction with crisis response systems, fewer depressive symptoms, and greater quality of life over time (Bennett Cattaneo & Goodman, 2010; Jumarali et al., 2021). Goodman et al. (2016) have also found that survivors report greater confidence in community-based services and resources that are tailored to their individual, specific care goals (Cattaneo et al., 2021; Goodman, Thomas, et al., 2016). Mirroring and exemplifying this literature, participants advocated for person-centered approaches as they felt strongly that restoring the self-efficacy and determination that had been compromised in the SV experience.

The participants interviewed for this study represented a diversity of race, gender, sexual orientation, disability status, age, socioeconomic status, and circumstances of violence. Reflecting this, a salient theme across interviews was the desire for increased representation of diversity and meaningful inclusion in NPHSO services. Though SV impacts all communities, the burdens of violence, as well as of reduced access to care and diminished quality of care, are felt disproportionately by populations that are socially and structurally minoritized, including BIPOC populations, queer and transgender populations, individuals with disabilities, as well as women and girls (Bach et al., 2021; Koss et al., 2017).

Participants in this study discussed the many ways in which they felt isolated from NPHSOs established to support survivors of SV. Participants of color reported feeling as if sexual violence resource centers were unprepared to meet the unique challenges of BIPOC survivors, or as if they prioritized the experiences of white victims. Racial discrimination, harassment, and lack of culturally responsive providers experienced by BIPOC SV survivors seeking care in NPHSO environments are unfortunately well documented (Slatton & Richard, 2020; Wooten, 2017; Zounlome et al., 2019). Furthermore, these perspectives are evidenced in a significant body of literature demonstrating a historical and contemporary neglect of issues of racism, white supremacy, and other structural forms of systemic oppression within NPHSOs that exacerbate risk of violence, as well as health outcomes associated with violence, experienced by Black and Indigenous survivors, as well as survivors of color and immigrant survivors (Cayir et al., 2021; Mehrotra et al., 2016; Violence, 2020). Scholars, advocates, and survivors alike have increasingly been calling attention to issues of inclusion and representation within NPHSOs to support survivors of SV (Cayir et al., 2021; Koss et al., 2017; Montesanti & Thurston, 2015; Richie, 2015; Slatton & Richard, 2020; Wooten, 2017). As white women hold the majority of leadership and staff positions in a majority of NPHSOs established to support survivors of SV, organizational decisions made regarding resource allocation, workplace culture, service provisions, and hiring staff may inadvertently perpetuate an organizational culture that caters to whiteness and white experience (Cayir et al., 2021; Crenshaw, 1997). Moreover, organizations that do not meaningfully cultivate cultures of equity and inclusion risk harming survivors of violence, as well as staff members who represent structurally marginalized communities, perpetuating harmful and ineffective service (Bach et al., 2021; Cayir et al., 2021; Chow & Austin, 2008).

Similarly, participants who identified as queer and/or transgender in this study recognized several ways in which NPHSOs supporting survivors of SV have isolated them from care by centering cisgender women as the primarily target clientele. Cis-essentialism and anti-transgender bias are common in NPHSO responses to SV, demonstrated by patterns of discrimination and harassment reported by gender diverse and transgender survivors (Jordan et al., 2020). These experiences are additionally reflected in literature demonstrating that transgender and gender diverse survivors of SV frequently avoid seeking formal care in anticipation of anti-trans mistreatment and may even consider these services irrelevant to their unique experiences (Jordan et al., 2020).

As structurally minoritized communities experience higher risk of SV, re-victimization, and adverse health outcomes following SV that may additionally be compounded due to societal trauma such as systemic racism or transphobia, NPHSOs must adopt a broader social justice approach to SV response, and meaningfully consider the ways in which systemic violence shapes and reinforces interpersonal violence to meet the unique needs of diverse survivors of SV and provide culturally relevant and appropriate care approaches (Cayir et al., 2021; Richie, 2015). A powerful step towards realizing this critical goal is hiring staff that is representative of all communities served, and fostering an organizational culture that supports equitable voice and participation among staff members (Cayir et al., 2021; Kolivoski et al., 2014; Mitra et al., 2022; Richie, 2015).

Finally, participants identified particular usages of language and imagery as either facilitators or barriers to engagement in NPHSO services post-assault. For many participants, the word “rape” was particularly uncomfortable and did not inspire psychological safety. Furthermore, participants had various perspectives regarding how to self-label as either “victims” or “survivors.” Though the term “survivor” is commonly presented as best practice in strengths-based approaches to trauma-informed care (Cullen et al., 2023), many participants suggested that they would actually prefer to self-label as “victims,” as they felt the term reduced expectations of them to have moved on from the event, or to have “fought.” This discussion highlights the importance of listening to victims’ and survivors’ language and labelling preferences and mirroring them.

The importance of mirroring label language cannot be understated, as language has the power to perpetuate social inequities, particularly surrounding stigmatized issues such as SV, that may force the individual who has experienced violence to contend with powerful social narratives like rape myths (O’Shea et al., 2024). Labelling theory offers further context to the significance of language, and states that “labels are societally shared ideas about an experience that creates mental representations of people; consequently, people who have been assigned or operate under the conditions of these labels internalize these representations, causing the label to become a part of their identity," (Moradi et al., 2012; O'Shea et al., 2024). For these reasons, the labelling of individuals who have experienced SV has critical social, political, and cultural implications (O'Shea et al., 2024). For example, though many associate the label "victim" with powerlessness, weakness, or vulnerability, and the label "survivor" with empowerment, strength, and resilience, the participants in this study demonstrate that these narratives do not resonate with every victim and survivor (O'Shea et al., 2024; Papendick & Bohner, 2017). To best support the ongoing health and wellbeing of individuals who have experienced SV, labelling language should be approached intentionally and should reflect the personal preferences of the person in crisis.

An additional salient theme across interviews was a desire for expanded organizational outreach. Participants in the present study reported being unaware of the existence of services to support survivors of SV, a significant barrier to care that prevented them from accessing these critical supports, sometimes for many years. Literature demonstrates that awareness of services is a common barrier to engaging in SV support services (Nasta et al., 2005; Stoner & Cramer, 2019; Walsh & Bruce, 2014). One study measuring high schoolers' awareness of SV services in Cleveland, Ohio, found that students that demonstrated greater awareness of SV support services were also more knowledgeable about SV generally, suggesting that individuals who receive targeted education or information about SV may be aware of local resources for SV support (Lee et al., 2015). This finding is emphasized in Schulze & Perkins (2017) article that found that male students, LGBTQ+ students, and BIPOC students surveyed generally demonstrated less awareness of SV support services than heterosexual, cisgender, and white counterparts (Schulze & Perkins, 2017). These findings, in conjunction with findings presented in this study, have significant implications for the need for NPHSOs to target diverse populations in health promotion and service awareness campaigns, and for how individuals and communities receive information regarding service availability in their communities. Related to this was a perceived lack of transparency regarding NPHSO services, and reluctance to engage with care services for a lack of understanding of what engaging in services would require them to do. For example, one participant shared feeling hesitant to engage with their local NPHSO for fears that they would be pressured to formally report their experience to police. To combat these barriers to care, NPHSOs supporting survivors of SV can increase awareness efforts through community events and social media campaigns and can create accessible resource guides that walk potential clients through available services, as well as address frequently asked questions.

Finally, participants acknowledged the ways in which they perceived their SV experiences to be associated with their lack of comprehensive, evidence-based, and inclusive sexual health education. Comprehensive sexual health education provided to school-aged youth has demonstrated efficacy in reducing risk of SV perpetration and victimization (Foshee et al., 2004; Goldfarb & Lieberman, 2021; Makleff et al., 2020; Schneider & Hirsch, 2020). As public schools in Kentucky and many other states in the Southeastern United States do not require comprehensive sexual health education, many students may not have reliable access to this critical information (Secor-Turner et al., 2017). However, findings from this study demonstrate a high desire from SV survivors for education about sexual health, consent, and other topics related to SV experiences. As experts in SV who are not affiliated with the same policies that prevent public schools from offering this education, NPHSOs may be uniquely positioned to provide educational materials to communities on topics related to SV (Fisher et al., 2012; Ott et al., 2011; Stauss et al., 2012). NPHSOs may create educational materials that can be presented and disseminated online in webinars or on social media platforms (Manduley et al., 2018). NPHSOs may also develop and present educational sessions to be presented in community spaces in partnership with community centers and local businesses.

A final overarching theme discussed by participants in this study was a desire for enhanced organizational service offerings, in acknowledgement that many survivors of SV require additional support beyond the scope of what many community-based NPHSOs are traditionally able to offer. Participants reported that SV impacted many facets of their lives beyond their mental and emotional health, and that access to structural supports, such as moving away from a house shared with a perpetrator, employment programs that would allow them paid time off from work or being able to access services closer to their homes, would have had powerful impacts on their ability to recover from SV. Many NPHSOs offer housing and economic support to survivors (Schrag & Edmond, 2018). Understandably, many NPHSOs supporting survivors of SV are limited in their capacity to engage in structural support services by limited funding opportunities, workforce issues, and other challenges of nonprofit sector work (Maier, 2011). However, NPHSOs may work to build strong collaborations with community partners that may be able to help with housing, employment, and workforce issues.

Exemplifying such a partnership, the Kentucky Coalition Against Domestic Violence offers survivors economic empowerment services, such as micro loans and individual development grants, and has partnered with the Kentucky Housing Corporation to establish and operate a rapid rehousing program (Safe Housing Partnerships, 2020). To best support the health, wellbeing, and recovery of survivors of SV, NPHSOs should be intentional in their acknowledgement of the multi-level impact of SV on victims' lives and strive to collaborate with community partners who can support victims structurally.

A prominent feature of these findings lies in the emphasis on the empowerment of survivors through systems transformation, rather than through individual behavioral change. While previous research has extensively documented the internal obstacles that victims may encounter that bar access to care, the present study predominantly emphasizes learning from lived experiences to inform how NPHSOs could enhance their support for survivors of SV. This perspective underscores the need for holding systems accountable at a structural level, rather than perpetuating the onus of change onto survivors. Although interviewees in this study did acknowledge their own internalized barriers to accessing services, such as feelings of shame, guilt, or difficulty recognizing their experiences as SV, they ultimately advocated for systems to be held responsible for shaping these internalized beliefs, rather than attributing the responsibility solely to themselves.

Overall, the findings of this and similar studies point to the benefits of NPHSOs partnering with victims and survivors of SV to learn more about strategies for overcoming barriers to service engagement (Kirkner et al., 2021; Koss et al., 2017; White et al., 2019). The lived experiences of victims and survivors of SV offer critical insight and benefit to all support intervention services and may offer distinct advantages to reducing barriers to service utilization and support that exist across social ecological levels.

Limitations

While this study provides valuable insights into the experiences and perspectives of survivors of SV and the role of NPHSOs in supporting them, several limitations warrant acknowledgment. There may be limitations associated with the recruitment strategy employed in this study. For instance, participants may have been more likely to volunteer if they had particularly positive or negative experiences with NPHSOs, potentially biasing the sample towards extreme viewpoints and overlooking more nuanced perspectives. Additionally, the interview guide did not include questions specific to experiences associated with social positionality or identity, and therefore may have missed key information related to unique and intersectional identities. Furthermore, the study focused primarily on survivors' perspectives and experiences, with limited exploration of the viewpoints of NPHSO staff or other stakeholders involved in supporting survivors. This narrow focus may provide an incomplete understanding of the dynamics at play within survivor support systems. Lastly, qualitative research inherently emphasizes depth over breadth, and while this study offers rich insights into the experiences of survivors and the role of NPHSOs, it may not capture the full complexity of survivorship experiences or the multifaceted nature of support systems.

Despite these limitations, this study contributes valuable qualitative data to the existing literature on survivor support systems and highlights areas for future research and intervention efforts aimed at improving support services for survivors of SV.

Conclusion

Existing literature demonstrates that SV crisis response services offered by NPHSOs are critically underutilized, despite high rates of SV impacting communities across the state. Early intervention after a violent and/or traumatic event may prevent individuals from developing long-term or chronic adverse physical, behavioral, and/or psychological health outcomes associated with PTSD, as well as help survivors overcome systemic obstacles associated with SV experiences. Individuals with lived experience offer unique perspectives that can contribute to the "reimagining" of support NPHSOs can offer survivors of sexual violence.

CHAPTER V

“HE WENT TO JAIL. BUT IS THAT JUSTICE?”

SEXUAL VIOLENCE SURVIVORS’ PERSPECTIVES ON JUSTICE, ACCOUNTABILITY, AND REPAIRING SEXUAL HARM

Introduction

Sexual violence (SV) remains a pervasive public health concern impacting as many as one in three women and one in six men across communities in the United States according to available data (CDC, 2021). SV may be conceptualized as an umbrella term to refer to a broad array of power-based and coercive acts of interpersonal sexualized violence, including but not limited to rape, sexual assault, molestation, sexual intimidation, sexual harassment, stalking, and technology-facilitated violence (e.g. “revenge porn” or explicit AI-generated “deepfake” images) (WHO, 2002). SV is significantly associated with a myriad of adverse health outcomes spanning social ecological levels, including but not limited to physical injury, sexually transmitted disease and/or infection, mental and psychological disorders, and commonly, post-traumatic stress disorder (PTSD) (WHO, 2012; (Scott et al., 2018). SV impacts all populations, but disproportionately impacts women and girls, Black, Indigenous, and people of color (BIPOC), LGBTQ+ populations, individuals with disabilities, student populations, individuals living and working in economically disadvantaged areas, and other structurally marginalized populations (Bach et al., 2021).

As a primary entry point to crisis response services available to support individuals, many individuals engage with law enforcement and the criminal justice system (CJS) following an SV encounter. Law enforcement may support the individual to report the incident as a crime and begin an investigation to identify and/or apprehend the perpetrator, as well as refer victims to support resources and necessary healthcare options.

Despite the availability of crisis response services to support victims of SV, law enforcement response to SV is underutilized. Literature demonstrates that a minority of victims formally report SV to law enforcement, with many victims choosing to never formally report (Hockett et al., 2016). The National Sexual Violence Resource Center offers that approximately 63% of sexual assaults are never reported to police, making SV the “most underreported crime” (NSVRC, 2015). Reasons for underutilizing of CJS services, as well as underreporting, after experiencing SV are broad and diverse, and reflect multiple barriers to service engagement and utilization.

Barriers to Reporting Sexual Violence

The decision to report SV is highly complex and involves deep consideration of many interpersonal, collective, and societal factors (Lorenz & Jacobsen, 2021). Common reasons reflected in contemporary literature for not reporting SV to law enforcement include fear of engaging with the legal justice system; retaliation from perpetrators, peers, or community members; facing rejection, dismissal, or insensitivity from police, or wishing to protect the perpetrator from being arrested or engaged in legal justice systems (Jones et al., 2009).

Engaging with law enforcement and CJS after SV may present additional barriers to members of marginalized and minoritized communities. These barriers include but are not limited to language barriers, lack of knowledge about or unfamiliarity with existing services, mistrust of any formal agencies, fears of deportation, and cultural ideals and norms that prevent individuals from disclosing vulnerable information (Koss et al., 2017; White et al., 2013). Minoritized communities including Black, Indigenous, and people of color (BIPOC) and LGBTQ+ communities may additionally resist reporting incidents of SV to police due to existing community mistrust of police, or fear of especially brutal punishment of perpetrators, who–across populations–are often family members, peers, colleagues, and acquaintances (Decker et al., 2019). Survivors of SV who are already involved in the criminal justice system, who work in criminalized gig economy work or sex work may be reluctant to engage with police or in legal justice systems (Deering et al., 2014).

An additional barrier to survivor engagement with CJS may be the difficulty of successfully convicting a perpetrator of SV. Exemplifying this is a phenomenon known as the "justice gap," wherein the rate of conviction for offenders is far below the rate of victimization (Lonsway & Archambault, 2012). Literature demonstrates that out of every 100 rapes committed, only between five and twenty are ever reported to the police: 0.4 - 5.4 are ever prosecuted, 0.2 - 5.2 ever end in conviction, and of that, only 0.2 - 2.8 perpetrators are ever incarcerated (Lonsway & Archambault, 2012). The concept of the "justice gap" demonstrates the lack of legal accountability perpetrators of SV are likely to face in the US and globally (Lonsway & Archambault, 2012; Temkin & Krahé, 2008). This gap is multifaceted, encompassing systemic failures such as underreporting, victim blaming, inadequate investigative procedures, and lenient sentencing practices. Survivors of SV who are aware of the "justice gap" may be discouraged from formally reporting their experiences to CJS (Mengeling et al., 2014).

Rape Myth Acceptance and Criminal Justice Systems

Survivors of SV may additionally minimize their experiences, and express that their experience was not "legitimate" enough to warrant a legal or criminal investigation, or that they will not be believed as a "genuine" or "credible" victim of SV, referring to commonly believed rape myths (Du Mont et al., 2003; Maiorano et al., 2023; Quinlan, 2016; Sleath & Bull, 2017). Rape myths are deeply held and prominent stereotypes and misconceptions that serve to excuse aggression, construct hostile perspectives towards victims of SV, and bias criminal investigations to the benefit of the perpetrator (Du Mont et al., 2003; O'Neal, 2019; Venema). Common rape myths declare that only certain acts of SV constitute "real" SV, and that only certain individuals are "real" or "credible" victims of SV (Du Mont et al., 2003; Maiorano et al., 2023). Rape myths regarding "real" SV include certain characteristics of the circumstances and environment in which an SV encounter has taken place, including characteristics of the victim and perpetrator (Maiorano et al., 2023). Common circumstances associated with "real" SV include an attack occurring at night; the attack occurring in a public place; physical force being used by the perpetrator; indicators of a physical fight (bruises, lacerations, etc.); the presence of a weapon; proof of penetration; evidence of physical and verbal resistance; and injury procured in resistance (Du Mont et al., 2003; Hine & Murphy, 2019; Hockett et al., 2016; Maiorano et al., 2023). Common characteristics of "real" and "credible" victims of SV include individuals who are young, female, white, heterosexual, and single, with no prior documented mental health challenges or conditions, no prior criminal record, no drug or alcohol usage prior to the assault, who appear emotionally and physically distressed while reporting, and who formally report immediately after the assault has taken place (Du Mont et al., 2003; Maiorano et al., 2023; Parratt & Pina, 2017; Sleath & Bull, 2017; Van der Bruggen & Grubb, 2014).

Literature demonstrates that police treatment of SV reports are frequently informed by rape myth acceptance among officers, or the degree to which law enforcement accept and endorse rape myths (Garza & Franklin, 2021; Hine & Murphy, 2019; Lorenz & Jacobsen, 2021; McMillan, 2018; O'Neal, 2019; Ricciardelli et al., 2021; M. Smith et al., 2016; Venema, 2016). While contemporary quantitative studies report mixed results on prevalence of rape myth acceptance among law enforcement officers, several studies still report higher rape myth acceptance when engaged in qualitative studies or open-ended survey questions (Dellinger Page, 2010; Venema, 2016; Venema, 2019).

Criminal Justice Systems and Secondary Victimization

Furthermore, literature and popular culture alike suggest that many survivors report negative experiences while engaging with CJS (McQueen et al., 2021). Experiencing dismissal, disbelief, or discrimination when reporting SV to law enforcement and/or CJS may cause secondary victimization and/or secondary traumatization, (Campbell, 2008; Garza & Franklin, 2021; Maddox et al., 2012; Monroe et al., 2005; Patterson, 2011). Secondary victimization is a phenomenon that may occur when victims of SV are made to endure further harm by way of negative social, institutional, or societal reaction in consequence of the primary victimization (Orth, 2002).

The Present Study

Despite CJS efforts to address SV, prevalence remains high and engagement with CJS and law enforcement remain comparatively low. As evidenced by the significant underreporting of experiences with SV, the "justice gap" between SV reports and perpetrator convictions, and reports from survivors claiming to have experienced institutional betrayal and re-traumatization during the process of engaging with crisis response services, existing CJS intervention frameworks to address SV are failing to meaningfully support people who have experienced SV, and in many cases, may even have adverse impact on public health outcomes associated with SV.

Survivors of SV "often say their available options mismatch their objectives, present accessibility challenges, disempower their pursuit of what justice means to them, and fail to offer concrete responses to basic needs," (Koss et al., 2017). In response to this mismatch, this study explored the experiences and perspectives of survivors of SV who either reported or considered reporting their SV encounters to law enforcement and CJS. Learning from individuals with lived experiences with CJS services offers critical insight for services improvement and/or systems transformation to address institutional betrayal and reduce associated adverse health outcomes.

Methods

Individuals who identified as victims and survivors of sexual violence were recruited to participate in this qualitative descriptive study (n=20). Participants were invited to share their experiences and perspectives regarding experiences with CJS crisis response options in in-depth semi-structured narrative interviews. Interviews were held virtually in April of 2023.

Recruitment

Participants were recruited via flyers shared on popular social media sites (Facebook and Instagram). Information shared on social media flyers included a version of the study title that included a brief researcher reflexivity statement (Reimaging Safety after Sexual Violence: A Survivor-Led Study). The flyer also contained the IRB number (IRB #22.1070), a brief discussion of the interview process, several eligibility criteria, a description of the financial incentive for participation, as well as a QR code and link to a pre-screening eligibility survey.

Interested parties were instructed to fill out a brief pre-screening survey on Google Forms that assessed eligibility for participation based on inclusion and exclusion criteria, and also captured some basic demographics information. As part of the eligibility survey, participants were invited to fill out a brief demographics survey to ensure a sample that was diverse in identity and experience. Though it was encouraged, participants were not required to disclose any demographics information in order to submit a request for an interview.

Participants who met the eligibility criteria were then invited to provide their name and contact email to participate in a virtual interview. The researcher then contacted participants directly to invite them to a virtual interview, as well as to provide an additional copy of the unsigned informed consent document. All interviewees were compensated with a $50 Amazon gift card for their participation. All study procedures were approved by the Institutional Review Board at the University of Louisville before interview commencement.

Data Collection

Data were collected through two mechanisms. First, the research team collected key participant information as part of the screening process with a brief questionnaire through an online survey platform (Google Forms) to ensure that they met inclusion criteria.

Next, recorded interviews were facilitated. The interviewer used an interview guide to discuss the participant's perspectives and lived experiences as individuals who have experienced SV. Interviews were held virtually using an online video conferencing program (Microsoft Teams). The interviews were transcribed, reviewed for accuracy, and deidentified before data analysis.

Data Analysis

Audio recordings of interviews were transcribed using OtterAi and were thoroughly cleaned by the researcher to ensure accuracy. The researcher engaged in a process of line-by-line coding to determine a set of initial thematic codes (i.e., a codebook) for the data. De-identified interview transcriptions were uploaded into a qualitative analysis software (Dedoose) for thematic analysis. Next, the codebook was applied to analyze additional transcripts. The researcher met with committee members frequently to discuss discrepancies and refine the set of codes. A revised codebook was then used to code all transcripts in Dedoose. The excerpts were reviewed by the investigators to identify themes across interviews.

Several measures were taken to ensure reliability and validity during this study. Transcripts were recorded and transcribed verbatim to ensure accuracy in analysis. Initial code applications generated by the researcher were presented to two experts unaffiliated with the study to engage in a process of peer debriefing. Finally, the researcher engaged in a practice of deep reflexivity to critically consider the role of pre-existing biases, assumptions, and expectations.

Results

Participants included adults living in the state of Kentucky who were over the age of 18. Additional eligibility criteria included identifying as having experienced SV and being willing to talk in depth about their experiences and decision-making strategies related to engagement with crisis response services. Exclusion criteria included individuals who were not yet 18, and individuals who had not experienced SV. For the purposes of this study, SV was defined broadly to include a vast array of experiences that could be categorized as SV. Participants were not required to have formally reported their experiences with SV or to have engaged with any crisis response services to be eligible for participation in this study.

The final sample reflected diversity of race, gender, sexual orientation, socioeconomic status, and disability experience. Eight participants reported being between 18 and 25 years of age; seven were between 26 and 35; two were between 36 and 45; one participant was between 46 and 55, and one was between 56 and 65 years old.

The sample also reflected diversity of socioeconomic status. Three participants reported earning less than $10,000 per year; four reported earning between $10,000 and

$25,000 annually; three reported earning between $26,000 and $35,000; two earning between $36,000 and $45,000 annually; two earning between $46,000 and $55,000 annually; three earning between $56,000 and $65,000 per year; one earning between $66,000 and $75,000 per year; one earning between $96,000 and $105,000 per year; and one earning more than $106,000 annually.

Fifteen participants identified as white or Caucasian, two identified as Black or African American, and three identified as mixed-race or biracial. A majority of participants identified as female or woman (n=14), one identified as man or male, two identified as non-binary, and three participants identified as transgender men. Regarding sexual orientation, seven participants identified as heterosexual, with the remaining participants identifying as queer (n=3), bisexual (n=5), pansexual (n=2), and gay (n=1). One participant did not include information about sexual orientation. Among the participants who reported a heterosexual orientation, two self-described as "heterosexual-ish" or "straight-ish." Finally, eleven participants disclosed living with a disability or chronic illness, defined broadly, with several participants offering living with chronic mental illness.

Participants discussed their experiences and perspectives regarding CJS service provision for survivors of SV. Results from participant interviews fell into three major themes that broadly encompassed salient and recurrent ideas shared within and among interviews. The first theme, Mistrust of Criminal Justice Systems, explores perspectives and opinions about with law enforcement and the courts shared by participants that informed deep mistrust for CJS to handle SV reports compassionately and respectfully. The second overarching theme, Secondary Victimization with Criminal Justice Systems, reports on participants' lived experiences with CJS that contributed to mistrust, including experiences navigating officer rape myth acceptance. The final theme, Reimagining Justice after Sexual Violence, explores interviewees' desires, ideas, and recommendations for mitigating harms caused by CJS to survivors of SV, and reimagines how justice could be meaningfully conceptualized in alignment with survivors' values and objectives.

Mistrust of Criminal Justice Systems

Among participants, a deeply felt mistrust for CJS was shared. Characterizing this mistrust were several sub-themes. Subthemes include Lack of justice, structurally marginalized communities and CJS, carceral justice "doesn't work for most folks," and cynicism towards CJS.

Lack of Justice

Participants described deeply rooted mistrust of CJS to protect individuals who have experienced SV, as well as to guide individuals who have experienced SV to justice. When asked about justice, one participant shared that justice was something "rarely seen": "*...there's not justice for it. And so, I don't know necessarily what that would look like if there was [justice], because it's something we rarely see*" (Participant 19). Another participant shared this perceived lack of justice for victims of SV by describing her perception of the magnitude of SV that is unaddressed by CJS efforts:

> *So anyway...that's why I laughed initially, when you asked 'is there justice,'...it used to be a week did not go by without there being some reporting of some assault on a woman being beaten up by her partner, being killed by her partner, or strangers, you know.* (Participant 5)

A common theme amongst interviewees was that there was a lack of justice for victims of SV because CJS were unable to hold perpetrators meaningfully and appropriately accountable. One participant described this perception by sharing: "*But I think because of the way that we treat victims…the way that we treat perpetrators, or…we see that they rarely get any …punishment or anything from doing those things to people*" (Participant 1). For some participants, prominent SV cases featured in media affected their trust for CJS. Exemplifying this, one participant shares that the lack of accountability for perpetrators in high-profile cases communicates a prioritization of the support of the perpetrator to victims of SV, ultimately discouraging CJS engagement:

> *...a lot of what we see in the media as a whole lot of victim-blaming and like, you know, accusing people of false accusations. Like, for instance, the Brock Turner case, or Brett Kavanaugh, like those things, were just very supportive of the rapist and not supportive of the victim.* (Participant 18)

This participant highlights recent high-profile SV cases, specifically People v Turner and the Kavanaugh hearings, which received substantial media coverage and were widely perceived as failures in holding sexual abusers accountable for the harms they inflicted.

Structurally Marginalized Communities and Criminal Justice Systems

Apart from harboring a general mistrust towards the CJS, participants articulated an increased awareness of how structural power dynamics intensify the lack of trust between survivors of SV and CJS. One participant characterizes this heightened mistrust by describing CJS as "broken," and highlighting the perceived mistreatment of structurally marginalized communities who seek assistance from CJS:

> *And I just think it's really hard to come to that trust after it's been so…thoroughly broken. And that's just like a small piece of this whole conversation, a small piece of the puzzle of the problems with the criminal justice system…Like there's major problems with how they treat transgender people, how they treat people of color, people with mental illnesses, disabilities, and…It just sort of builds into this system that I can't trust and I know a lot of people around me can't trust.* (Participant 6)

The same participant expounds upon this thought by calling attention to the upholding of white supremacy in CJS:

> *Yeah, I think we've seen it like time and time again, of the criminal justice system. Not protecting survivors in the way they need to, and protecting or glossing over perpetrators, especially if you're thinking of like white wealthy men.* (Participant 6)

Participants felt especially unable to trust CJS with their experiences of SV if they belonged to marginalized or minoritized communities, highlighting existing mistrust between communities and CJS that additionally translated into CJS responses to SV.

Another participant demonstrates mistrust for CJS by sharing an anecdote of their reporting experience as a nonbinary person. The participant reported that they felt forced to present as a woman to have a better chance of being heard and taken seriously by law enforcement and the judicial system:

> *I knew very early on that if I – I could choose my non-binary identity, or I could get justice because I did not need one more variable that was going to work against me…And I think a lot of people even I thought, well, that's silly. But in reality, I knew that if I wanted justice in this very traditional legal sense, I needed to conform with things as much as possible."* (Participant 13)

Here, this participant is suggesting that they understood that crisis response systems would have less respect for them if they chose to disclose their nonbinary identity, so they felt pressured to hide a key aspect of their identity in order to safely engage with these services.

Carceral Justice "Doesn't Work for Most Folks."

Another participant described their perspective of CJS as "fucked up," and pushing a narrative of justice that "doesn't work for most folks:"

> *I think we currently, like, often like push people to the only form of justice that we're familiar with. And that's the SVU version. Yes. And that doesn't work for most folks. Also, because like those systems are kind of fucked up. So like, they*

> *don't actually like yield anything except for re-traumatization for the survivor.* (Participant 9)

Exemplifying this perspective, several participants expressed mistrust for CJS to procure justice after SV because they felt as if justice after SV, as it is currently conceptualized, was not possible. One participant who did engage with CJS after her experience with SV expressed anger at the lack of justice she felt was the outcome of her experience: "*... like, my rapist went to jail for nine months. Went to jail for nine months, got out, got married, has a kid. Like, what the fuck?...how is that fair?*" (Participant 14). For this participant, the lack of justice she experienced after her encounter with CJS significantly contributed to a sense of mistrust for CJS abilities broadly to support any person who had experienced SV.

Other participants felt that "justice" delivered through the CJS was not possible, and thus "irrelevant," because it would not take away from the long-lasting impact of having endured SV. About CJS pathways to justice after SV, one participant stated: "*And so, I actually don't think you can get that. Right?*" (Participant 15). The same participant continues, "*...what justice means to me is like, kind of irrelevant, because I think you cannot have back -- the person who I was before this is never coming back*" (Participant 15). Another participant shared this sentiment, questioning if carceral "justice" after SV is possible or truly meaningful:

> *Because now, I live with this, like, I carry it with me. And yes, I can, like, you know, go to therapy and work through it and surround myself with people that are safe, and that I love and that can protect me and care about me. But it's still something I think about, you know, 10 years later…And so does justice really exist in this type of situation?* (Participant 12)

For these participants, the avenues to achieve "justice" offered by the CJS lacked sufficient potency or inspiration to counterbalance or alleviate the harms inflicted by the experience of SV.

Cynicism towards Criminal Justice Systems

Further demonstrating mistrust for CJS, several participants demonstrated what can be considered cynicism or a lack of faith in CJS to appropriately and compassionately respond to SV cases, a phenomenon that discouraged formal reporting. Exemplifying this, one participant mused:

> *And, you know, if I think if our judicial system were fairer to victims, if the way that police handled things were a lot more sensitive, if there was just more, you know, it all just comes down to it…* (Participant 17)

Another participant echoes this sentiment, wondering about the efficacy of training to increase the sensitivity of officers responding to SV reports: "*And I think that it's the real easy answer for justice to say, well, I wish law enforcement had more training… because the individuals, like I have seen that are gonna respond first, are not specially trained"* (Participant 13). By contending that first responders lack sufficient training to address reports of SV, this participant demonstrates skepticism regarding the CJS's ability to effectively and compassionately respond to individuals who have undergone SV experiences.

Another participant expressed deep cynicism of CJS's ability to appropriately support individuals who have experienced SV by suggesting that engaging with police after a violent encounter would be her "last instinct:"

> *I would say the police department or [local police force], absolutely would not do anything…maybe a report would be filed. But like, that's it, I don't even know if they would connect…somebody going through that with the proper nonprofit*

> *organization or resources. So, I think my last instinct would be to call [local police force].* (Participant 12)

One interviewee echoes this instinct, and emphasizes her mistrust for CJS by reflecting on the decision she made not to report her experience with SV to law enforcement, further highlighting institutional mistrust and the belief that victims' narratives are frequently dismissed:

> *And I think now, would I react any differently? I don't know that I even would, simply because it feels a lot like nothing's going to be done anyway. It's my word against his, you know, it's even there's, there's nothing that I can do for any recourse now. It's my word against his, he would never admit that. That's what he did. He would never acknowledge it, he would deny that 100% and have, there's no way to prove it.* (Participant 17)

For this participant, the complete reliance on anecdotal evidence as the sole basis for prosecuting SV cases undermined her confidence in the ability of the institution to impartially adjudicate such cases.

Participants collectively expressed profound distrust in CJS methods for securing justice following incidents of SV. This skepticism extended across all tiers of CJS, encompassing experiences and perspectives pertaining to law enforcement agencies and judicial systems. The lack of perceived justice for both them and others who have encountered SV—either personally known to the participants or encountered through media narratives—fueled this mistrust, leading to a sense of cynicism among participants regarding the efficacy of CJS initiatives in addressing SV.

Secondary Traumatization Experiences with Criminal Justice Systems

Mistrust experienced by participants was also related to experiences with secondary traumatization while attempting to engage in crisis response services.

Additionally, participants discuss their decisions not to engage or limit their engagement with CJS based on anticipated secondary traumatization.

Experiences with Criminal Justice Systems and Law Enforcement

Several participants who did choose to formally report their SV encounters, or who had previous interactions with police or CJS unrelated to SV, described experiences with secondary victimization. These experiences created and contributed to mistrust for crisis response services, and impacted participants' willingness to engage with crisis response services, including CJS.

Representing this phenomenon, one participant shares an experience of being directly invalidated at the time of making a formal disclosure of SV to police: *"And I had tried to call the police and they kind of laughed in my face and said, like, that sucks for you. I was like, oh, okay*" (Participant 13). This same participant later reported that this experience significantly informed her decision to not engage CJS after she experienced an additional SV encounter: "*And so I was under the impression, well, if they didn't take it seriously, the first time, they have no reason to take it seriously the second time*" (Participant 13).

Another participant shared about a previous negative experience with police that damaged her trust by insinuating she was having a mental health crisis after calling for help following a home invasion:

> *...they just made it seem like I...was having a mental health crisis. And didn't help me, and just kind of like, chalked it up to like, this is nothing...And they just like, kind of like brushed it off. Like it wasn't anything. And that was it....so that's why I just don't get police involved, even in situations that are harmful.* (Participant 1)

For these participants, the experience of being invalidated by a helping professional, whether through passive neutrality or though more direct invalidation, significantly harmed their ability to trust CJS.

Participants recalled their experiences with forensic interviewing, a process in which victims provide statements as part of a formal report, and many described the experience as “traumatizing” and “horrible.” One participant recounted the experience of giving a verbal report of SV to a police officer and being made to feel “unwelcome:” “*...one of the officers just kind of stood there and just was stoic, very, like, neutral face…And so, I didn't necessarily take that as a welcoming response*” (Participant 19). For this participant, the officer’s perceived lack of compassion or validation made her feel uncomfortable and uncared for in a highly vulnerable moment. Another participant describes being asked multiple times about the sexual positions she was in during the time of the violent encounter; jarring questions that were justified to her as what she would be expected to respond to in court:

> *So, most of the questions…he told me he was asking me them because they were questions that the cross examiner…would ask me in a courtroom, to try and like, get me down. So, some of the questions he asked me like ten different questions that were asking the same thing. Like, were there any times when you were on top of him? Were there any times when he was behind you? Were there any times when he was on top of you? ...And most of those questions I said, I don't know. I don't know. I don't know. Because my brain blocked most of it out.* (Participant 2)

Another participant recalls a similar experience, where she was unable to answer “basic” questions about her experience with SV during a forensic interview, and felt that the officers could have demonstrated more sensitivity to her inability to recall details of the encounter:

> *And they're like…did this take an hour? Or did it take two minutes? I don't know... How did you get home? I actually don't really have an answer that*

> *question. Because I was so traumatized…And so, they had all of these questions for me. If I had had somebody who had known how to ask questions to someone who is currently traumatized…* (Participant 15)

Another participant who currently works as a therapist with clients who have experienced SV also spoke to the difficult nature of the forensic interviewing process with CJS which often retraumatized individuals who report their experiences with SV, and create mistrust:

> *I mean, I've been in interviews with like, really, really, really wonderful law enforcement folks, or prosecutors, or Title IV folks who are asking questions in a really compassionate way. But they still have to ask those questions. And so that is just the nature of that system. Yeah. And even if like they want to do differently, like they don't have other options, and totally, sometimes, oftentimes, like that survivor is going to be, it's really just going to add more doubt into their mind of like, why did this happen? Why didn't I do that? Which can be really, really traumatizing.* (Participant 9)

This participant recognizes that even when interviews are conducted in a sensitive manner, the questions posed during the forensic interviewing process frequently evoke doubt and shame among individuals reporting SV. For many participants, these encounters engendered a perception of being scrutinized, amplifying feelings of doubt and mistrust. As one participant describes, this experience led him to feel like a "criminal" as he completed a police report:

> *And so, my experience to sum that up was, I would say really thorough, and really like, I don't know, like investigatory. You know what I mean? I almost felt like I was being investigated. And I definitely felt like I wasn't really believed by police officers. And it was also strange, because, I mean, I don't know, I just, I didn't feel like a person anymore. I didn't even feel like a victim. I just felt like someone else…I sort of felt like a criminal somehow.* (Participant 4)

This participant associated the experience of being made to feel "like a criminal" and as if he were the subject of investigation directly with the perception that the officers receiving the report did not believe his account of SV. He emphasizes: "*And, I mean, I don't think* *that those officers believe me. Yeah. I mean, I really don't.*" (Participant 4). Being invalidated while sharing such vulnerable information, and in a vulnerable state, was described as significantly re-traumatizing.

Finally, another participant spoke out about the consequences of not being believed by CJS after reporting an experience with SV as she recounted her experience in court:

> *But I remember when I didn't get granted anything when it was all dismissed, and we were leaving. And she said…I don't have any proof of sexual assault. Now, it's like – I'm telling you…I didn't get EPO, I didn't get anything...And I like remember, I was like…somebody's gonna die. People are gonna die… women are gonna die. People and women are not gonna talk. Because you are not taking them seriously.* (Participant 10)

These participants aptly highlight a phenomenon that contributes significantly to the "justice gap" and the critical underreporting of SV.

Anticipation of Re-Traumatization

Participants additionally described hesitation to engage with CJS due to anticipation or expectation of not being treated well or experiencing further harm. For many participants, the expectation of being treated poorly if and/or when they reported their SV experiences to law enforcement were prominent, and a major barrier to engagement.

One participant suggested that she did not wish to engage with CJS after her experience with SV because she feared it would only cause her "emotional issues:"

> *And also, I didn't want to go through the judicial system, because I also know that that sucks. And I just kind of felt like, either way, I didn't think much would come of it. Except for just more emotional issues for me, just based on what I know about the system.* (Participant 18)

Another participant describes the relief she felt when she learned that she would not be pressured by a nonprofit organization to support survivors of SV to engage with police or CJS:

> *Um, I think there was a lot of fear before I went to the [crisis center], because I was afraid people were going to coerce or pressure me to like, go to the police, which…That's basically that's just not useful for me, I would say. And I knew that it would be more traumatizing for me to do that.* (Participant 11)

Finally, a third participant echoes this anticipation of re-traumatization if they were to report their experience to law enforcement and CJS:

> *And so, it just kind of makes me feel like, why would I go through that trouble? Potentially, like re-traumatizing myself having to relive this to not be heard or for nothing to come of it potentially like put myself in more danger if this person I'm like, making report on is around me or knows I'm doing this? Why would I take those risks for something that isn't actually going to do anything?* (Participant 12)

For these participants, the prominent anticipation or expectation of encountering secondary victimization and re-traumatization was a significant deterrent from seeking involvement with formal crisis response services subsequent to their experiences with SV. Participants reported significant apprehension that formal reporting of their SV encounters to the CJS would likely result in mistreatment rather than receiving compassionate care, exacerbating traumatic stress.

Officer Rape Myth Acceptance

A prominently highlighted experience among interviewees was secondary victimization specifically related to anticipation of or experiences with officer rape myth acceptance. These participants described hesitance to engage with CJS because they perceived aspects of themselves and/or their experiences to be something CJS would cast doubt over. For these participants, feeling as if they did not fall into the paradigm of a “perfect victim” discouraged them from feeling safe to report their SV experiences to law enforcement or engage with CJS.

Several participants described feeling unwilling to engage with CJS because of the perception that they would be blamed for their own victimization. Exemplifying this, three participants shared:

> *I think there's, you get called into question, your integrity gets called into question. You know, it's, it's so much blame shifting that happens…Oh well, she was raped, but look at her lifestyle!…all that stuff gets brought out, that somehow the victim has done something to initiate this. And that's, that's the justice system.* (Participant 17)

> *…when you do get the court system involved, a lot of times you're like, put… your character is put on the stand, kind of thing. And just, I didn't want that -- that would be more dramatic and just, no.* (Participant 11)

> *Yeah. Because I mean, when you when you think about, like, what a investigation looks like, from law enforcement side, like a detective is going to ask a lot of why questions. Why were you there? What were you doing? Where did you go? Who were you with? Why did you pick up your underwear off of the floor? Why didn't you just immediately run? Why didn't you yell? While they're trying to do their job…those questions are reinforcing all of these ideas that the survivor already has of like, they messed up, they should have done things differently.* (Participant 9)

Other participants felt as if they would not be taken seriously by police or CJS because their experiences fell outside of what they perceived CJS would consider “real SV,” reflecting common rape myths. One participant shared that she did not report because she felt that the fact that she was drinking would be held against her:

> *And I also think that like, I know what I know about having dealt with the police and dealt with a legal system with this. There's a 0% chance that if I had taken him out to the police, they would have even brought charges, because I went to him willingly. And I had been drinking, not heavily, but I've been drinking. And I had been to court with women who did press charges. And they would get every single man you ever had sex with to get up there, and like, prove that you're a fucking slut. And like, this is just you regretting this one, right?* (Participant 15)

Another participant echoed her concerns, reporting that she did not consider reporting because she feared that the nature of her experience would be used against her in court:

> *Um, when reasons that I maybe didn't consider it so much…I was assaulted in the context of a relationship, but it was the context of a sadomasochistic relationship...To make it even more complicated, the day that he did assault me, I had let him tie me up, with the intention of just playing around. And so, I know now that he intentionally tricked me into allowing him to tie me up. And he just really terribly beat me and raped me.* (Participant 7)

These participants' anticipation of being confronted with dismissal or disbelief by law enforcement or CJS if they were to formally report were related to the belief that law enforcement would not consider their circumstances to fall under the category of "real" SV.

Finally, some participants spoke to the experience of fearing not being taken seriously by law enforcement or CJS because of aspects of their identity:

> *Well, I am a biracial, gender non-conforming gay man in rural eastern Kentucky. My kind is not predominant here already. And a lot of the times our experiences and problems are not taken seriously because we don't fit the standard of cis, white, straight. So that's why I already get the vibe that we're not taken seriously. And so, I don't expect cops to take anything we experience seriously either.* (Participant 16)

Commonly upheld rape myths are strongly shaped by white supremacy, misogyny, transphobia, ableism, and other structures of power and oppression. As most individuals who experience SV may not conform to societal notions of "perfect victims," there is apprehension that their experiences may be disbelieved or turned against them. The anxiety about potentially encountering rape myths among law enforcement officers while seeking legal assistance following SV illustrates a form of institutional betrayal.

Reimagining Justice after Sexual Violence

In acknowledgement of their demonstrated deep mistrust for CJS, participants offered their perspectives on how they imagined justice after SV. Participants considered what they believed the role of CJS should be in responding to SV, emphasized the importance of perpetrator accountability, and imagined how restorative approaches to accountability might yield more beneficial outcomes for survivors and perpetrators of SV than punitive measures.

Reimagining Criminal Justice System Involvement

For many participants, mistrust of CJS was so great that they fundamentally questioned the role of law enforcement and CJS in SV crisis response, or to frame conceptualizations of how justice is offered after SV. One participant suggested that police not be involved "at all" in reporting SV:

> *I think the only time that police should be involved is when it's time to like arrest the person. Yeah. That, but I don't think…that they should be a part of the investigation. I don't think they should be in part of the like, the conversation, the initial conversation; I don't think the police should be involved at all.* (Participant 1)

Another participant echoed this sentiment, suggesting that in a perfect world, there would be no need to stand trial to procure justice after SV: "*...in a perfect world…I feel like there wouldn't be a trial. Because the idea of having to stand up in front of my perpetrator and like, tell my story seems really awful and weird to me*" (Participant 18).

Participants considered the possibility of SV crisis response that didn't rely upon or include CJS or law enforcement:

> *Yeah, I mean, I kind of I kind of wish that police weren't involved. You know? I don't know, maybe in a perfect world…it's not like you...even have to talk to a police officer at all, maybe it's more like you're given the opportunity to speak to*

> *either a single person or like a group of people who have experienced the same thing or are willing to chat with you about it.* (Participant 4)

Other participants dreamed about how justice after SV is defined, and how it could shift to better reflect the desires of survivors. One participant suggested that even if the systems necessary to provide individuals who have experienced SV with real justice may not exist yet, they still hoped future justice conceptualizations would move away from police:

> *But also, I think it gets really tricky for me, because I identify as like an abolitionist…And so my hope for the future is that there are systems in place where like, you don't have to go to the police for that kind of stuff. Because they never believe you really.* (Participant 11)

Another participant discussed a desire to reconsider justice after SV as only focusing on CJS:

> *…there's often like a black and white like view of what justice is supposed to be like, it's like through the criminal justice system. Like, a perpetrator has to be held criminally accountable for a survivor to get justice. But I don't think it is like that simple at all…And I don't think that's where we need to turn for our sense of justice in these situations.* (Participant 6)

Accountability and Carceral Punishment

Among the participants in this study, the attainment of perpetrator accountability through the CJS was frequently perceived as unlikely or unattainable. A considerable number of participants found that the CJS's conceptualization of accountability did not align with their own vision of accountability, one that they believed would be more likely to contribute to their sense of safety and wellbeing. Evidencing this, numerous participants expressed the sentiment that the incarceration of SV perpetrators did not align with their ideals of justice.

One participant acknowledged that while particularly violent or repeat offenders should not have ready access to the public, she did not believe that incarceration was the answer:

> *And then we can talk about…what justice looks like, because…while I feel like there are some people who are like, really nasty, and like, are really harmful, and do some really heinous, like, incredibly sexually violent things…that don't need to have access to the public, I don't believe in the carceral system.* (Participant 1)

Another participant shares that she doesn't believe that incarceration of perpetrators of SV is not a solution that will ultimately protect others from dangerous behavior: "*So I think that's what justice looks like… I don't need somebody sitting in a four-by-four cell. That's not what I need. I need other people to be safe"* (Participant 14). For these participants, an important feature of justice was the protection of others from harm.

Some participants contemplated the rationale behind incarceration, considering that it ultimately does not diminish the impact of the violence endured. One participant shares that it "wouldn't have made him feel better" if the person who perpetrated SV against him went to jail:

> *I'm not sure what that would feel like to me. Like, if I would have been the one to put that guy in jail…it wouldn't have made me feel any better. I don't think it would have felt like justice to me. I mean maybe a little bit, but it didn't change the fact that things like that had happened to me, you know what I mean?* (Participant 4)

Another participant shares a similar perspective, emphasizing that incarceration of the person who perpetrated SV against her would not have made her feel "safer:"

> *Let's say we'd gone to court, let's say, I had secured a conviction, I wouldn't have felt…I would still have had PTSD, I would still wake up, I would still be afraid of men, I would still be like afraid to…. Like it wouldn't have done anything different for me…Like, I wouldn't have felt safer in any way. And so, I thought about that a lot. Like…would him going to jail… really have solved anything for me?* (Participant 15)

For these participants, traditional pathways to justice and accountability that are presented by CJS did not resonate with their needs and sense of safety after experiencing SV.

Restorative Justice Approaches to Accountability

Participants discussed the desire for personal accountability obtained through more restorative frameworks of justice. One participant discussed how meaningful a personal apology from the perpetrator of her SV experience would have been:

> *I just wish that he would have been like, yeah, I took advantage you in that situation. Just like to acknowledge it. Yeah. Um, or to acknowledge, like, hey, I thought that like, this was okay. I realized that like, your response to this makes me understand now that it's not okay. And I'm sorry. I don't know.* (Participant 1)

Another participant reflects the significant impact restorative paths to justice had on her ability to recover from SV because she did receive a personal apology from her attacker: "*The first time I…ended up receiving acknowledgement and an apology from the perpetrator. Which I think actually was like incredible. And really helped me be able to, like move forward and deal with what had happened*" (Participant 9). This participant continues,

> *And like, I think I was really lucky that I genuinely think that this person didn't know anything about consent…didn't know that he what he was doing was wrong until afterwards, and was actually able to like apologize and own it, of his own accord, which was really incredible. I think that it was some of that like, restorative justice work that was able to happen that we didn't have like a framework for, but he was able to just do that.* (Participant 9)

For this participant, the meaningful apology she received from the individual who committed SV against her allowed her to perceive him in a more humane light. This gesture played a crucial role in enabling her to transcend the harm inflicted upon her and move on from the experience.

Restorative Justice & Rehabilitation as Accountability

For many participants, the single most powerful form of accountability to hold perpetrators to after committing SV was not incarceration, but rather rehabilitation. Participants felt that ensuring perpetrators received rehabilitative counseling was a powerful potential means of protecting others from experiencing what they had endured and creating lasting justice after SV. Demonstrating desire for perpetrators to be offered rehabilitative options, one participant asks "*But I'm wondering if the perpetrator – like what needs to be in place for them so this doesn't happen again?…Are you seeking the therapies that you need to seek?…are we making sure these things are in place?*" (Participant 10).

Another participant shares: "*I don't believe that there's not a perpetrator out there who can't be rehabilitated...you want to say all these people are monsters, but don't really believe that they all are*" (Participant 7). Another participant shares a similar sentiment, considering how individuals who perpetrate SV may frequently have also experienced SV, and may be more likely to stop harmful behaviors if root causes of violence were addressed in counseling:

> *And it's often not for very long, but I really doubt how much…if there is such a thing, rehabilitative counseling is offered to them. Seems to me, like there just has got to be at a minimum, even if it only stops one out of five of them from going out and doing it again…I wonder and think so often about the causes of sexual violence. And I know that its often people do it, who've had it perpetrated upon them. And they need treatment and help too. They've often been abused, whether sexually or in some way. So, justice…God, when you talk about justice, it feels like the whole world needs to be rehabbed….and have some sort of compassion and empathy from others so that we can break the cycle of the bad things that have happened to us.* (Participant 5)

Another participant contemplates the enduring consequences of incarcerating perpetrators of SV without providing a rehabilitative trajectory, examining how this approach may inadvertently heighten the likelihood of recurrent SV perpetration upon their release:

> *I'm not sure that that really changes anything because…it's not like they're being asked to reflect on like what they've done, or I mean they kind of are, but like I seriously doubt that they do that, you know what I mean? And they're not being helped to change their ways or like their thoughts or anything. And then, they're probably around other people who have done the same thing. So…it sort of perpetuates this culture that inspired this to begin with.* (Participant 4)

An additional participant shares a similar perspective, offering hope that perpetrators of SV would be offered resources to help them address "underlying issues" that may have led them to commit harm:

> *But it would be awesome if people who have committed these things are given resources and help to sort of like work through and understand why what they've done is wrong. And why they did it…There's got to be some underlining issues here as to why someone would do something like that…But it would be great for someone to have to be faced with that. And having to like, own up to the fact that they messed up, and take actual steps to become a better person and to not assault anybody else.* (Participant 12)

For the participants in this study, the most impactful means of safeguarding others from SV and ensuring accountability for SV perpetrators, involved a shift in focus towards offender rehabilitation as opposed to prioritizing legal justice and incarceration.

Visions of Justice

Participants in the present study did not feel that CJS provided them with a pathway to justice that resonated with them. For individuals who have experienced SV, the concept of "justice" prioritized safeguarding others from SV, participating in community accountability practices and restorative justice frameworks, and rehabilitating perpetrators, rather than emphasizing incarceration and societal removal. Participants in the present study offered different visions of justice than what is commonly presented as "justice after SV."

On the topic of what justice means after SV, one participant offered:

> *I think when there is harm that has been caused, our goal is to utilize justice to gain peace again. But oftentimes, right now, the way that our culture exists is that we don't have a lot of capacity for creative justice, like, what justice could look like. It's only through like the legal justice process.* (Participant 9)

This participant emphasizes that "justice" through the CJS may not be the pathway to justice that resonates with individuals who have experienced SV.

Another participant highlighted that "justice" after SV would be a perpetrator acknowledging the full extent of the harm they have committed:

> *I guess to summarize, justice for me would be… somebody's grasping with the fact that they have…like completely altered a life essentially, you know, and I don't know what that would look like or anything but I also don't think that putting someone in jail of fixes.* (Participant 4)

Finally, one participant emphasized the significance of addressing the underlying causes of SV perpetration as a more effective means of preventing SV than incarceration:

> *Is that is that really justice? Is that really justice for the person who got harmed that knowing that he's out there, and …there was probably no steps that were really put in place for him to understand and not shame, so that he can understand and process it in a healthy way. So he can know not to do that anymore. Most of the time, when people are met with shame and guilt, they just avoid the situation. So that means that he's possibly avoiding the healing that he could be doing and potentially will continue to hurt people because of it…he went to jail. But is that justice?* (Participant 1)

Discussion

Participants discussed encountering a range of barriers to formally reporting their experiences to CJS and law enforcement that are reflected in the literature. One primary barrier stemmed from fears of encountering disbelief or victim-blaming attitudes by law enforcement (Lorenz et al., 2021). Additionally, concerns about privacy, confidentiality, and fear of retaliation from the perpetrator or social repercussions can dissuade survivors from formally reporting (Orchowski et al., 2022). Institutional factors such as perceived and experienced systemic biases, including misogyny, transphobia, or racial discrimination, may further erode trust in CJS and act as a barrier to reporting (Decker et al., 2019). Moreover, past negative experiences or lack of confidence in law enforcement's ability to effectively investigate and prosecute sexual assault cases can deter survivors from seeking police involvement (Lorenz, 2023). Finally, socio-cultural factors, including stigma, shame, and cultural norms surrounding SV, may also contribute to survivors' reluctance to engage with CJS. Among others, these barriers collectively underscore the complex interplay of individual, interpersonal, institutional, and societal factors that shape survivors' decision-making processes regarding reporting sexual assault to law enforcement agencies (Lorenz & Jacobsen, 2021; Orchowski et al., 2022; Sable et al., 2006).

A particularly prominent barrier described by participants in this study was a deeply held mistrust for CJS. Participants in the present study demonstrated a significant mistrust for law enforcement and CJS to be able to bring perpetrators of SV to justice, as well as to offer any benefit to victims of SV. The mistrust described by participants in this study was powerful enough to discourage participation in CJS after SV. A perceived lack of justice displayed by CJS for individuals who experience SV was a powerful contributor of mistrust. The “justice gap,” a phenomenon where rates of perpetrator conviction remain significantly lower than rates of reported SV (Lonsway & Archambault, 2012) was referenced multiple times by participants who reported mistrust in CJS to be able to do anything.

Perceptions of and trust in law enforcement and CJS are shaped by police and interactions with individuals who have experienced SV (Lorenz, 2023; McQueen et al., 2021; Murphy-Oikonen, McQueen, et al., 2022). In alignment with what is reported in contemporary literature, most participants in this study did not formally report their SV experiences to law enforcement or CJS (Lorenz et al., 2021). Participants who did not disclose SV experiences to law enforcement or CJS demonstrated a significant existing mistrust for these institutions, and frequently cited this as a core reason for choosing to not report. Poor perceptions of what CJS can offer to individuals who have experienced SV were facilitated by adverse personal experiences with law enforcement and/or CJS, as well as by popular media narratives surrounding high profile SV cases, such as the infamous People v. Turner case and the Kavanaugh hearings, as well as via social media discourse, where victim-blaming and other rape myth narratives may be publicly amplified (Anderson & Overby, 2021).

Participants who engaged with CJS after SV reported adverse experiences that exacerbated traumatic impact of the event, contributing to mistrust for law enforcement and CJS, and undermining their ability to recover from the violent encounter, a phenomenon that is frequently reflected in literature (Lorenz, 2023; Lorenz et al., 2021; McQueen et al., 2021; Stewart et al., 2023).

The concept of institutional betrayal, defined by Dr. Jennifer Freyd, is useful for further contextualizing the experiences described by participants (Smith & Freyd, 2014). Institutional betrayal, an extension of betrayal trauma theory, describes the experience of an institution upon which an individual is dependent upon in some capacity mishandling a traumatic experience through a failure to prevent or respond supportively following a disclosure of a traumatic or violent event, (Smith & Freyd, 2014). Institutional betrayal refers to a phenomenon wherein institutions, such as CJS, “create hostile environments which normalize sexual violence, make it difficult to report the experience, mishandle the complaint, attempt to cover up the experience, or retaliate against survivors" (Pinciotti & Orcutt, 2021; Smith & Freyd, 2013, 2014). Experiences with institutional betrayal has been linked to exacerbated adverse health outcomes, including an increased risk of developing depression, dissociation, anxiety, sexual dysfunction, and poor physical health (Pinciotti & Orcutt, 2021). Furthermore, experiencing institutional betrayal while reporting SV may further discourage survivors from seeking further legal or healthcare assistance after the event, further compounding health outcomes after SV (Ahrens, 2006; Murphy-Oikonen, McQueen, et al., 2022; Patterson, 2011; Patterson et al., 2009; Pinciotti & Orcutt, 2021).

The characterization of the adverse experiences of individuals who have experienced SV when disclosing to law enforcement and the CJS as institutional betrayal underscores the reliance individuals have upon these systems, especially given the absence of clear alternatives for reporting or seeking justice following a violent encounter. Moreover, the systemic inability to deliver justice to those who have experienced SV, a phenomenon reflected in the "justice gap," illustrates how institutional betrayal occurs across various social-ecological levels, contributing to collective trauma and fostering a pervasive sense of mistrust among victims of SV.

Participants in this study described experiences with secondary traumatization, as well as institutional betrayal, that eroded their trust in institutions designed to protect and support them after experiencing violence. Even participants who had not directly experienced institutional betrayal were hesitant to engage with CJS for fears of experiencing secondary traumatization. As demonstrated in contemporary literature, and as reflected in the present study, the anticipation of experiencing poor treatment serves as a barrier to care (Lorenz, 2023; Lorenz et al., 2021; Lorenz & Jacobsen, 2021).

A particularly salient typology of institutional betrayal experienced and anticipated by participants were betrayals associated with officer rape myth acceptance. Rape myths, first described by Brownmiller (1975) and Burt (1980) describe deeply entrenched stereotypes, beliefs, and ideologies regarding what defines “real” SV, who “legitimate,” “genuine,” or “credible” victims of SV are and what characteristics they have (Acquaviva et al., 2022; Burt, 1980; Davies et al., 2022). Despite their being rooted in patriarchal stereotypes and false narratives, rape myths have long been accepted and even endorsed by CJS and have had problematic implications for legal decision-making regarding SV cases (Acquaviva et al., 2022; O’Neal, 2019; Ricciardelli et al., 2021). Rape myths thus may inadvertently influence what incidents of SV become formal reports, what charges are listed on the report, what investigative resources are directed towards identifying and/or arresting a suspect, and whether a case will be prosecuted in court (Acquaviva et al., 2022; O’Neal & Spohn, 2017). Exemplifying this, literature demonstrates that law enforcement are more likely to respond favorably to incidents of SV that most closely align with “perfect victim” narratives commonly shared as rape myths, such as incidents that involve physical force or serious injury, are perpetrated by a stranger, that do not involve drugs, alcohol, or a prior criminal record, and that align with gender stereotypes of SV (a man perpetrating SV against a young woman), among other characteristics (Pinciotti & Orcutt, 2021; Ricciardelli et al., 2021; Venema, 2016).

As a first point of contact with CJS for many individuals who choose to report SV, law enforcement officers’ endorsement of rape mythology may have a particularly dangerous impact on legal decision-making, as officer discernment greatly impacts report processing and prioritization (Acquaviva et al., 2022; Murphy-Oikonen, McQueen, et al., 2022; Ricciardelli et al., 2021). For many individuals who experience SV, officer rape myth acceptance is a significant barrier to reporting (Davies et al., 2022; Lorenz et al., 2021; Ricciardelli et al., 2021). Many participants in the present study describe choosing not to report their experiences to law enforcement for fears that something about their identity or circumstance would prevent them from being believed. For some participants, this was because they were in romantic relationships with the offenders; others had consumed alcohol and other substances at the time of the attack; and others still feared reporting because of their race, sexual orientation, or gender.

Officer rape myth acceptance is tied to social and structural inequality, and often perpetuates white supremacist, patriarchal, hetero/cissexist and ablest norms about how "innocence" is constructed, conceptualized, and mobilized in CJS (Wooten, 2017). BIPOC individuals who have experienced SV have reported racist and humiliating treatment while disclosing SV to law enforcement (Decker et al., 2019). Black survivors who are not believed or protected by "justice" or healthcare systems after enduring violence, and whose experiences of violence are diminished in favor of white "perfect victims'" experiences (Slatton & Richard, 2020; Wooten, 2017; Zounlome et al., 2019). Additionally, LGBTQ+ individuals who experience SV may be at higher risk of experiencing institutional betrayal via officer rape myth acceptance (Goldscheid, 2015; Mortimer et al., 2019). The gender-specific framing of SV as only impacting one of the two recognized binary genders, "violence against women" not only excludes cisgender men, but also people across the gender spectrum. As such, the experiences of many victims and survivors who are LGBTQ+ are erased and invalidated, effectively "exclud[ing] them from services as well as from legal and other forms of redress" (Goldscheid, 2015).

Officer rape myth also perpetuates social and structural inequality, privileging the access to services of populations most likely to align with "perfect victim" narratives (i.e. young, white, cisgender, heterosexual women) (Hockett et al., 2016; Sleath & Bull, 2017). Participants in the present study demonstrate mistrust for CJS and law enforcement based on the perception that they would not be believed or treated with care because they believed that aspects of their identity or experience made them "imperfect victims."

Participants in this study who formally reported SV encounters to CJS described poor experiences, resulting in worsened stress and exacerbated mistrust. Mistrust for CJS associated with institutional betrayal, characterized by a perceived lack of justice and officer rape myth acceptance, has significant implications for the health and wellbeing of individuals who have experienced SV. Psychological distress and traumatic stress stemming from the original SV encounter are exacerbated when individuals receive harmful responses to SV disclosure while seeking legal support (Christl et al.; Lorenz, 2023; Smith & Freyd, 2013). Experiences with institutional betrayal have been associated with exacerbated adverse health experiences following SV, including but not limited to heightened risk of dissociative disorders, anxiety, depression, sexual dysfunction, substance use, and other manifestations of traumatic stress (Smith & Freyd, 2013). Institutional betrayal experiences that are rooted in perceived discrimination based on identity or circumstance additionally has been associated with exacerbated adverse health outcomes, many of which stem from grief, shame, and post-traumatic stress (Gómez, 2022; Gómez & Gobin, 2020; Smidt et al., 2021; C. P. Smith et al., 2016).

Secondary victimization experiences may further impact health by discouraging victims from accessing any additional support or disclosing the SV encounter elsewhere (Ahrens, 2006; Campbell, Wasco, et al., 2001; Lorenz, 2023; Patterson, 2011). Experiencing harmful responses while disclosing SV may reduce the likeliness of any future engagement with CJS or law enforcement (Lorenz & Jacobsen, 2021) and may even increase risk of SV revictimization (Miller et al., 2011).

Though choosing to report SV to CJS is an incredibly personal and complex decision, widespread mistrust for CJS creates several missed opportunities to provide victims with resources or referrals to care, collect accurate data regarding SV prevalence, and to prevent perpetrators from reoffending (McQueen et al., 2021; Murphy-Oikonen, McQueen, et al., 2022). The perspectives and experiences of participants in this study highlight the critical need for alternative strategies for disclosing SV experiences that foster safety, inclusion, and trust. To better support the health, wellbeing, safety, and recovery of individuals who have experienced SV, alternative strategies to envisioning and interacting with “justice” are warranted. As experts of their own experiences, individuals who have experienced SV are best positioned to be able to define justice after SV (Koss et al., 2017).

Exemplifying the powerful mistrust for CJS demonstrated in this study, many survivors were unsure if procedural pathways to justice presented by CJS aligned with their desires for justice based on lived experience. The findings of this study are in alignment with a burgeoning body of literature that asserts that existing CJS strategies for procuring justice do not align with the immediate and long-term wants or needs of victims and survivors (Burns & Sinko, 2023; Daly, 2014; Koss et al., 2017; McGlynn & Westmarland, 2019).

Participants in the present study considered the possibility of restorative justice (RJ) and community accountability approaches to justice rather than punitive or carceral justice approaches. Restorative justice, as an evolving paradigm within legal and social frameworks originating in Indigenous peacekeeping tradition (Gavrielides, 2018), intersects with public health by offering a holistic and community-centered approach to address harm and conflict. In contrast to punitive models, restorative justice emphasizes healing, reconciliation, and rebuilding relationships between individuals, communities, and institutions (Cowan et al., 2022; Koss et al., 2003). This approach aligns with public health principles by recognizing that the repercussions of harm extend beyond individual victims to impact the overall well-being of communities (Cowan et al., 2022; Long et al., 2022). By engaging stakeholders in dialogue and collaborative decision-making, restorative justice interventions strive to identify and address the root causes of harm, thereby contributing to the prevention of future incidents. The emphasis on empowerment, empathy, and community involvement in restorative justice processes aligns with public health goals, fostering resilience, social cohesion, and mental well-being within communities (Koss, 2014). Integrating restorative justice principles into public health frameworks holds the potential to create a more comprehensive and effective approach to addressing and preventing harm, emphasizing a collective responsibility for the health and safety of communities.

RJ approaches to address SV may feature a perpetrator's apology and acknowledgement of harm, establishing of physical, social, mental, and spiritual safety, and perpetrator rehabilitation through counseling (Decker et al., 2022). While literature on utilization of RJ approaches to address harm after SV is burgeoning and often contentious, a recent systematic review found that while RJ approaches may need to be slightly adjusted to meaningfully address the extent of harm that is committed in SV, RJ approaches offer utility in meeting needs expressed by victims "to seek safety, to seek information, to speak and be heard, to vent emotion, to seek accountability, to feel empowered, and ultimately to find a different meaning around the event that would better allow them to move forward" (Bolitho, 2015; Burns & Sinko, 2023). Additional studies have demonstrated that RJ approaches may more appropriately align with the goals and justice desires of survivors of SV (Decker et al., 2022; Koss et al., 2003; Marsh & Wager, 2015; McGlynn et al., 2012).

More than anything else, participants felt strongly about the aspect of RJ approaches that center perpetrator rehabilitation through counseling. For many participants, the arrest and incarceration perpetrators of SV was not prioritized in their visions of justice. Some participants acknowledged the immediate sense of physical safety incarceration could provide, however fleeting. However, a majority of participants described unsureness or cynicism that carceral justice approaches could meaningfully address root causes of violence or prevent perpetrators from reoffending, and may even exacerbate risk, a perspective that is additionally reflected in literature (Decker et al., 2022).

Participants acknowledged the humanity of perpetrators of SV, and considered the possibility that many perpetrators of SV may themselves be victims of SV. Participants felt that RJ approaches centering rehabilitative counseling may be efficacious in helping perpetrators address reasons for committing sexual harm, and thus be more efficacious in preventing them from re-offending and harming others in the community. Novel restorative frameworks for SV encompass approaches aimed at addressing the necessity for remorse and accountability. These approaches involve facilitated face-to-face accountability sessions, wherein offenders actively acknowledge and take responsibility for the harm caused, as well as the provision of written acknowledgments of harm and apologies (Iovanni et al., 2017; Koss, 2014). Further research is essential to comprehensively ascertain the enduring safety implications and rehabilitative efficacy of these emerging models (Decker et al., 2022).

Survivors of SV interviewed for this study prioritized accountability, rehabilitation, and the protection of others in the community in their self-expressed definitions of justice. For these participants, these characteristics were not observed or experienced in CJS pathways of procedural justice. These findings highlight the critical need for innovative, victim-centered, community-based, and restorative approaches to defining and working towards justice after SV.

By redirecting victims away from inefficient, unpredictable, and often, harmful approaches to justice, reimagining justice to better align with the expressed priorities, goals, and objectives of survivors of SV may have significant implications for the health and wellbeing of survivors of SV.

Limitations

While this study provides valuable insights into the experiences and perspectives of survivors of SV and the role of CJS in supporting them, several limitations warrant acknowledgment. There may be limitations associated with the recruitment strategy employed in this study. For instance, participants may have been more likely to volunteer if they had particularly positive or negative experiences with CJS, potentially biasing the sample towards extreme viewpoints and overlooking more nuanced perspectives. Furthermore, the study focused primarily on survivors' perspectives and experiences, with limited exploration of the viewpoints of CJS stakeholders or others involved in supporting survivors. This narrow focus may provide an incomplete understanding of the dynamics at play within survivor support systems. Lastly, qualitative research inherently emphasizes depth over breadth, and while this study offers rich insights into the experiences of survivors and the role of CJS, it may not capture the full complexity of survivorship experiences or the multifaceted nature of support systems.

Despite these limitations, this study contributes valuable qualitative data to the existing literature on survivor support systems and highlights areas for future research and intervention efforts aimed at improving support services for survivors of SV.

Conclusion

Survivors of SV interviewed for this study demonstrated prominent mistrust for law enforcement, CJS, and carceral conceptualizations of justice after sexual violence. Mistrust is deeply rooted in prominent cultural and media narratives, perceived lack of justice for victims of SV, adverse personal and community experiences with these institutions often characterized by officer rape myth acceptance. Each of these aforementioned phenomena constitute elements of institutional betrayal, a construct to describe the impact of being harmed by systems individuals are dependent upon for support and protection following a traumatic event. Experiences with secondary victimization are positively associated with exacerbated adverse health experiences that disproportionately burden marginalized/minoritized populations. To better support the health, wellbeing, safety, and recovery of individuals who have experienced SV, accountability strategies that center their voices and lived experiences are critical. Justice goals that center safety, accountability, rehabilitation, and community protection via restorative justice approaches are identified by participants as priorities in new definitions of "justice after SV."

CHAPTER VI

ISOLATION PERPETUATES VIOLENCE: THE ROLE OF INFORMAL SOCIAL SUPPORT AND COMMUNITY CARE IN IMPROVING HEALTH AND WELLBEING AFTER SEXUAL VIOLENCE

Introduction

Sexual violence (SV) is a pervasive public health and human rights issue that is prevalent across all communities. SV is an umbrella term to refer to acts of sexualized, power-based, and coercive interpersonal violence such as rape, sexual assault, molestation, sexual harassment, stalking, and technology-facilitated SV (i.e. “revenge” or “deepfake” AI pornography). Though SV impacts all communities regardless of racial, gender, or sexual identity, socioeconomic status, or educational attainment, communities made vulnerable by social and structural inequities are disproportionately impacted (Bach et al., 2021).

Prevalence and incidence data on SV are difficult to accurately measure, as recorded rates vary between reports. The CDC asserts from available data that as many as one in two adult women and one in three adult men will experience some form of contact SV within their lifetimes in the United States (CDC, 2021). Though these statistics demonstrate a high prevalence of SV experiences across populations in the US, it is widely acknowledged that available data on SV significantly underestimates the true prevalence of SV, especially among groups that may experience additional societal and structural barriers to disclosure and self-reporting (Bach et al., 2021; Breiding et al., 2014).

Relative to other traumatic events, individuals who have experienced SV have an increased risk of meeting diagnostic criteria for post-traumatic stress (PTS), as well as for demonstrating relative severity of PTS-related symptomatology (Alarcon et al., 2012; Birkeland et al., 2021; DiMauro & Renshaw, 2021). PTS refers to a heightened stress state commonly experienced after witnessing or experiencing a traumatic or life-threatening event, such as a car crash, a natural disaster, or interpersonal acts of violence, such as SV (Sparks, 2018). However, without intervention, PTS may advance to post-traumatic stress disorder (PTSD), a clinically diagnosed condition recognized by the Diagnostic and Statistical Manual of Mental Disorders (Dworkin et al., 2023; Sparks, 2018).

PTS-related symptomatology includes but is not limited to depression, anxiety, as well as more serious psychiatric mood disorders; adverse behavioral health outcomes such as hopelessness, inability to develop trust for others, perceived powerlessness, as well as risky sex and substance use behaviors; adverse sexual health outcomes including sexual dysfunction or painful sexual intercourse (Black et al., 2011; Machado et al., 2011) WHO, 2012). Notably, literature demonstrates that individuals who are exposed to intentional acts of interpersonal violence, such as SV, are more likely to develop PTS-related symptoms than individuals who experience traumatic events that are accidental or disaster related (Johansen et al., 2013; Johansen et al., 2022; Sareen, 2014).

PTS-related behavioral health outcomes may be present immediately after a violent event or may become patterned into lifelong behaviors (Santaularia et al., 2014).

Experiences of SV, through pathways of trauma and allostatic load, are additionally associated with higher risk of developing long-term or chronic disease and conditions (Basile et al., 2021; Santaularia et al., 2014).

PTS related health outcomes following an incident of SV (SV-PTS) may be temporary or lifelong, or may manifest as acute issues that, without appropriate intervention, may become chronic health conditions (Johansen et al., 2013; Johansen et al., 2022; Sareen, 2014). While many survivors of SV recover from PTS symptomatology after a few weeks or months, as many as 10% - 40% affected victims develop persistent post-traumatic stress disorder (PTSD) lasting many years, or even for life (Sareen, 2014).

Given the epidemiological magnitude of SV, as well as the high risk of long-term or chronic adverse health outcomes related to SV experiences, it is critical that victims of SV have access to meaningful support expeditiously following a violent encounter. Evidence suggests that adverse health outcomes and distress related to SV-PTSD may be mitigated with early intervention (Dworkin & Schumacher, 2018; Regehr et al., 2013). Individuals who receive compassionate, judgement-free, and survivor-centered psychological or cognitive-behavioral support demonstrate clinical significance in reduced distress and other SV-PTSD related symptoms than those who do not receive support (Dworkin & Schumacher, 2018; O'Donnell et al., 2008; Regehr et al., 2013). Notably, evidence suggests that access to formal support services, such as therapeutic interventions or services offered by nonprofit human services organizations, as well as informal supports such as positive social support from friends, family, and loved ones, are both efficacious in reducing distress after SV and bolstering recovery (Dworkin & Schumacher, 2018).

It is common that individuals who have experienced SV never formally report their experiences to institutions such as law enforcement or emergency departments (Lorenz & Jacobsen, 2021). More frequently, victims of SV will disclose their experiences to informal sources of social support, such as family members, friends, significant others, and other close loved ones (Ahrens et al., 2007; Filipas & Ullman, 2001; Lorenz et al., 2018). While evidence suggests that individuals who have experienced SV perceive responses from informal social supports more positively than from formal supports (i.e. law enforcement, health providers, etc.) (Lorenz et al., 2018), negative reactions from informal social supports are still common, and may have a significant impact on future support seeking behaviors (Lorenz et al., 2018; Relyea & Ullman, 2015). Overtly negative reactions, such as reactions suggesting the victim was responsible for the violent encounter, or even well-intentioned reactions, such as those that acknowledge the experience but do not offer support, have been associated with negative perceptions on the part of the victim, which may have a significant impact on their subsequent ability to reach out for additional support from others, or to engage with formal support services (Lorenz et al., 2018; Relyea & Ullman, 2015). Alternatively, positive responses from informal social supports may have the impact of encouraging victims of SV to pursue additional support and recovery services, further increasing their likelihood of mitigating distress and SV-PTS related adverse health outcomes.

Given the increased likelihood that victims of SV will disclose their experiences to informal social support providers rather than formal support services, as well as the significance that reactions from informal social supports hold in terms of bolstering wellbeing and encouraging or discouraging the pursuit of further health intervention, more information is needed to learn about how to best leverage social support to facilitate recovery and wellbeing after SV. While a significant body of research explores the impact of informal social support on recovery trajectories after SV, relatively fewer studies have engaged individuals with lived experience. Learning from individuals who have experienced SV is critical for understanding the nuances of helpful versus harmful social reactions to SV disclosures, as well as what kinds of social reactions may encourage or discourage future recovery behaviors in victims of SV.

Methods

Individuals who identified as victims and survivors of SV were recruited to participate in this qualitative descriptive study. Participants (n=20) shared their experiences and perspectives regarding experiences with social support associated with their SV experiences in semi-structured narrative interviews. As SV is a vulnerable and stigmatized subject, a study design that emphasized the confidentiality, privacy, and psychological safety of participants was developed.

Recruitment

Participants were recruited via flyers shared on popular social media sites, including Facebook and Instagram. Information shared on social media flyers included a version of the study title that included a brief researcher reflexivity statement (Reimaging Safety after Sexual Violence: A Survivor-Led Study). The flyer also contained the IRB number (IRB #22.1070), an invitation to the interview process, several eligibility criteria, a description of the financial incentive for participation, as well as a QR code and link to a pre-screening eligibility survey.

The recruitment flyers featured gender-neutral imagery, as well as images featuring diversity of race, religion, ability, sexual orientation, and gender. These images were chosen to communicate an inclusive message to interested participants, as well as to dispel myths surrounding who "real" victims of SV are. If interested in participation, participants were instructed to fill out a brief pre-screening survey on Google Forms that assessed eligibility for participation based on inclusion and exclusion criteria. The eligibility survey also captured some basic demographics information, including questions about race, gender, sexual orientation, disability status, and socioeconomic status. The eligibility questionnaire utilized open-text response options to allow interested parties to use their own language to self-define information regarding their identities, circumstances, and SV experiences. Participants were not required to disclose any demographics information in order to submit a request for an interview.

Participants who met the eligibility criteria were then invited to provide a name and contact email to participate in a virtual interview. The researcher contacted interested participants who met eligibility criteria directly to invite them to a virtual interview, as well as to provide a copy of the unsigned informed consent document. For their participation, all interviewees were compensated with a $50 Amazon gift card. All study procedures were approved by the Institutional Review Board at the University of Louisville before interview commencement.

Data Collection

Data were collected through two mechanisms. First, the key participant demographics information was collected as part of the screening process with a brief questionnaire through an online survey platform (Google Forms).

Next, recorded interviews were facilitated. The interviewer used a semi-structured interview guide to facilitate an interview regarding the participant's perspectives and lived experiences as individuals who have experienced SV. Interviews were held virtually using an online video conferencing program (Microsoft Teams). The interviews were transcribed, reviewed for accuracy, and deidentified before data analysis.

Data Analysis

Audio recordings of interviews were transcribed using OtterAi and were thoroughly cleaned by the researcher to ensure accuracy. The researcher engaged in a process of line-by-line coding to determine a set of initial thematic codes (i.e., a codebook) for the data. De-identified interview transcriptions were uploaded into a qualitative analysis software (Dedoose) for thematic analysis. Next, the codebook was applied to analyze additional transcripts. The researcher met with committee members frequently to discuss discrepancies and refine the set of codes. A revised codebook was then used to code all transcripts in Dedoose. The excerpts were reviewed by the investigators to identify themes across interviews.

Several measures were taken to ensure reliability and validity during this study. Transcripts were recorded and transcribed verbatim to ensure accuracy in analysis. Initial code applications generated by the researcher were presented to two experts unaffiliated with the study to engage in a process of peer debriefing. Finally, the researcher engaged in a practice of deep reflexivity to critically consider the role of pre-existing biases, assumptions, and expectations.

Results

In semi-structured narrative interviews, participants discussed their experiences and perspectives on the impact of informal social support on SV recovery and support seeking behavior.

Participants included adults living in the state of Kentucky who were over the age of 18. Additional eligibility criteria included identifying as having experienced SV and being willing to talk in depth about their experiences and decision-making strategies related to engagement with crisis response services. For the purposes of this study, SV was defined broadly to include a vast array of experiences that could be categorized as SV. Exclusion criteria included individuals who were not yet 18, and individuals who had not experienced SV. Participants were not required to have formally reported their experiences with SV or to have engaged with any crisis response services to be eligible for participation in this study.

The final sample reflected diversity of race, gender, sexual orientation, socioeconomic status, and disability experience. Eight participants reported being between 18 and 25 years of age; seven were between 26 and 35; two were between 36 and 45; one participant was between 46 and 55, and one was between 56 and 65 years old.

The sample also reflected diversity of socioeconomic status. Three participants reported earning less than $10,000 per year; four reported earning between $10,000 and $25,000 annually; three reported earning between $26,000 and $35,000; two earning between $36,000 and $45,000 annually; two earning between $46,000 and $55,000 annually; three earning between $56,000 and $65,000 per year; one earning between

$66,000 and $75,000 per year; one earning between $96,000 and $105,000 per year; and one earning more than $106,000 annually.

Fifteen participants identified as white or Caucasian, two identified as Black or African American, and three identified as mixed-race or biracial. A majority of participants identified as female or woman (n=14), one identified as man or male, two identified as non-binary, and three participants identified as transgender men. Regarding sexual orientation, seven participants identified as heterosexual, with the remaining participants identifying as queer (n=3), bisexual (n=5), pansexual (n=2), and gay (n=1). One participant did not include information about sexual orientation. Among the participants who reported a heterosexual orientation, two self-described as "heterosexual-ish" or "straight-ish." Finally, eleven participants disclosed living with a disability or chronic illness, defined broadly, with several participants offering living with chronic mental illness.

Findings from the present study are organized into three overarching themes: *Barriers of Sexual Violence Disclosure to Informal Sources of Social Support, Informal Social Support Experiences after SV Disclosure,* and *Peer Support as a Powerful Tool for SV Recovery*. Each of the three identified themes include several subthemes that add further nuance to the findings.

Barriers to SV Disclosure to Informal Sources of Social Support

Many participants described encountering barriers to disclosing SV to informal sources of social support. For a few participants, intentional decisions not to disclose SV experiences to informal social supports were made. These participants described the reasons for not disclosing their SV experiences to informal social supports, highlighting critical needs for the establishment of social and psychological safety to disclose vulnerable experiences to others. Subthemes describing participants' experiences with lacking sufficient social support include *Nondisclosure* and *Stigma and Shame Related to Disclosure.*

Nondisclosure

Several participants made an intentional decision not to disclose their SV experiences to friends, family, or other informal support providers. As one participant describes: "*I kept it very tight inside, didn't tell anybody about it*" (Participant 12). Another participant describes experiencing multiple violent encounters, and not disclosing any of those experiences to informal support providers: "*...nobody else knew, no one. I didn't tell anyone else at that time. And then, with the additional instances, again, I didn't really tell anyone*" (Participant 9). A third participant describes a common experience among participants, wherein they did decide to disclose their experiences with SV to informal support providers, but not until a significant duration of time had passed from the original event: "*I mean, after the fact…but at the time, I don't even think I told anyone until like much later*" (Participant 18). One participant even shares that she didn't see any point in disclosing her experience to friends or family members because she felt that there wasn't anything that they would be able to do: "*So, I just didn't see the use in it. Like, why am I gonna drag other people into this? Like, there's really not much that there is to do*" (Participant 12).

These participants describe the common response to choose not to disclose experiences with SV to friends, family, or other close loved ones at the time of the violent encounter or at all.

Shame/Stigma Related to Disclosure

A few participants who decided not to disclose their SV experiences to informal support providers describe feelings of shame, as well as fear of encountering stigma as reasons for making this decision. One participant shared an experience wherein she and her best friend had experienced SV at a party as adolescents, but never spoke of the experience with one another in the years since:

> *...my best friend and I...I don't think we ever even talked about it. Maybe once after that, yeah...I don't think I don't even think I told my mom…I was so embarrassed and ashamed that I put myself in that, you know, as a child thinking, I put myself in that position. So, I never really talked about it to anybody.*" (Participant 3)

This participant describes feeling responsible for not only her own victimization, but also her friends', contributing to a deep shame and sense of self-blame. While she notes that the shame related to self-blame was her perspective at the time ("*as a child thinking*..."), she still admits that she never disclosed the experience to any other informal social supports.

Another participant shares that she never disclosed her SV experiences to any informal social support providers because she was in a romantic relationship with the perpetrator and wanted to protect his image:

> *...I didn't reach out to anybody. And I'm in this relationship, and I'm sort of fighting for this relationship to work. And I didn't want people who were sort of warning me about it – I didn't want them to be proven right…I just think that that was the biggest reason I didn't even realize.* (Participant 17)

This participant describes experiencing SV within the context of a romantic relationship, an experience that made it difficult for her to understand violent experiences as SV despite concern from loved ones in her life. Because she couldn't recognize her experiences as SV, and because she wanted to protect her significant other's reputation from other loved ones in her life, she chose not to disclose any SV experiences to informal social support providers.

Finally, a third participant shares that she chose not to tell any informal supports about her SV experience because she had been drinking and felt worried that she would not be believed or taken seriously:

> *I think that I didn't tell any of my friends – like, the initial thing that happened when I was a freshman. I had been drinking; I was at a frat house, like, there were all of these confounding factors that made me believe that people wouldn't believe what happened or that I didn't want what happened.* (Participant 9)

Each of these participants describe experiencing shame and self-blame related to their experiences with SV for different reasons. Though their reasons were different, they were each related to commonly held misconceptions about what constitutes “real” SV, or rape myths (for example, a person cannot experience SV in the context of a romantic relationship or they are not a reliable informant of their own experiences if they had been drinking). For these participants, shame and embarrassment over the event, feelings of self-blame or responsibility, and fear that they would not be believed or treated with care, prevented them from disclosing their experiences to informal support providers and being able to receive social support in that capacity.

Informal Social Support Experiences after Sexual Violence Disclosure

Participants who did decide to disclose their SV experiences to informal support providers shared experiences and perspectives that demonstrated the critical significance of social support to bolster recovery following an SV encounter. Subthemes related to participants’ experiences with informal social support following SV disclosure include *Importance of Social Support following SV Disclosure, Positive Examples of Social*

Reactions, Negative Examples of Social Reactions, and *Social Reactions and Support Seeking Behaviors.*

Importance of Social Support Following Sexual Violence Disclosure

Most participants recognized the importance of social support in being able to safely recover from a violent encounter. Several participants described the significance of being able to talk about their experiences with their romantic partners and friends, and how sharing the experience with their community helped them to process and heal following the encounter:

> *So, I mostly just relied on community support. The support of my partners, the support of my friends…And yeah, just kind of sort of talking that out and kind of actually beginning to process what happened to me. And yeah, that's probably the only resource I would say that I took.* (Participant 6)
>
> *I think, community…I have strong community around me, who I can be open with, you know, I can just be open about it.* (Participant 17)

These participants emphasize the ability to "be open with" community about their experiences with SV was critical to their ability to "process what happened." They also discuss "relying" upon community support after experiencing SV, highlighting the significant role social support can provide in recovery from SV.

In considering the role of social support in a recovery process, participants additionally recognized the experience of SV as not being an individual or interpersonal phenomenon, but rather one that is embedded in larger, community contexts. Speaking to this, one participant connects the role of social support and community to a larger conceptualization of SV occurring in self-perpetuating systemic behavior:

> *And I think what is so unfortunate is that the ways to prevent violence are often community based. And then the ways to recover and heal from violence are community based. And when you have folks that don't have either, like they're not able to have the community in order to prevent the violence, and then after the*

> *violence occurs, they're not able to help the community to heal from the violence.* (Participant 9)

Each of these participants discusses the importance of social support in helping them process the violent encounter and being able to get the experience off their chest and receive support and care in a vulnerable time. In recognizing the significant role social and community-based support plays in supporting individuals who have experienced SV, participants also drew connections to the ability of social support to interrupt self-perpetuating cycles of violence that are emboldened when social support offered in informal support networks is not available.

Supportive Examples of Informal Social Reactions to SV Disclosure

Participants shared several examples of how supportive social reactions to SV disclosure can demonstrate support and be beneficial in recovery efforts. Positive examples of social support included listening and being present, offering validation, and supporting survivors with their immediate needs in the time right after a violent encounter.

Listening and Being Present. Several participants discussed examples of how informal support providers supported them in their recovery after SV by listening to their experiences and being present with them. One participant offered the example of community support as a kind of "doula-ing:" "*...community groups, just like holding space and sitting with them, which is like a really big thing. Like, even if we're just like, watching SNL, funny videos, or like, things like that…it becomes like doula-ing…You know what I mean?*" (Participant 11). This participant evokes the role of a doula, or a support professional charged with the physical, emotional, and spiritual care of another person while they navigate significant transitions in life, such as childbirth or death, to describe the kind of support they received from their community that helped them recover from SV.

Another participant considers Brene Brown's popular work on the utility of vulnerability to combat shame to describe the importance of listening as support for healing after SV:

> *I also try to tell people about it…because that helps with a variety of ways, but it's also good to just have that thing be known… Brene Brown talks about how the solution to shame is vulnerability. It's tempting to feel shame about this thing that happened to you, but talking about it with people who will support you and love you is very, very helpful.* (Participant 8)

For this participant, sharing her story and being heard was a way of being vulnerable and combatting any shame she felt attached to her SV experiences.

A third participant, who previously shared that at the time of her SV experience she did not disclose to any informal social supports, discussed the importance of being present and listening to process the event with informal support providers:

> *I think for a long time, I just didn't open up. I just kind of like, kept these things inside, hid them away, and just hoped they would go away. And now realizing like, if I'm having a bad day, if I'm having a day where for some reason, like these things are triggering in my mind…talking to my husband about it or talking to my best friend about it being like, hey, like, can we go for a walk?…I just want to like, talk through this, or walk through this. And that's really helped a lot.* (Participant 12)

Each of these participants discuss the value of sharing their stories with others, and the value of feeling heard and held in community. For these participants, social support was defined by being present with them and listening to their stories.

Affirmation & Validation. Several participants noted the importance of validation as a key feature of providing social support to a loved one after SV. One participant shared about the experience of receiving validation from friends after a violent encounter:

> *It definitely felt kind of freeing. Like I was, like, letting go of something inside of me. And I was, like, just finally being able to like, face what happened to me and like, come to like the realization like, it's not my fault. There's no, there's no sense in like dwelling and like going back to what I could have done differently and blaming myself for the situation. And just, yeah, being able to talk with somebody else about that that took my situation seriously helped me take it more seriously. Because the beginning of those conversations would usually be like…I would just try to brush it off myself, like, you know, it's not that big of a deal…And then when other people started taking it seriously…That kind of made me made me actually, like sit with that and work through it in a way that I don't think I would have been able to do on my own.* (Participant 6)

This participant shares that receiving validation about their SV experience with informal support providers allowed them to not only validate themselves and recognize the severity and impact of the event on their life and wellbeing, but also to process the event in a healthy way and move away from self-blame. This participant shares that the support they received from friends helped them process and heal in ways they don't believe they could have done on their own, speaking to the critical impact of positive social reactions and support to SV disclosure on a survivor's ability to recover.

An additional participant shares a similar experience:

> *And my friends honestly helped the most, like with figuring out that that was sexual assault…I was so in shock. I didn't really notice or understand or really, so they helped me with that.* (Participant 20)

For this participant, validation from friends helped him recognize the violent encounter for what it was, catalyzing him to seek out further support.

As SV is a highly stigmatized form of interpersonal violence, many survivors may anticipate experiencing invalidation, or attempts to convince them that their experiences did not actually happen or were not as violent or severe as they were experienced by the survivor. Because of these common reactions to SV disclosures, providing affirmation and validation is a key way of providing social support after SV.

Supporting Immediate Needs. Another example of supportive social reactions to SV disclosure was the ability to support the survivor by helping them with some immediate needs, which may be as simple as help with household chores. One participant recalls:

> *I was pregnant after the assault, and one of my friends cleaned my cat's litter boxes for me because when you're pregnant, you're not supposed to clean litter boxes. So that was really nice...my best friend…after I had the abortion, she drove to stay with me for a couple of days. So that was really nice.* (Participant 2)

This participant speaks about receiving support with immediate needs, as well as having someone be present with her to support her in an extremely vulnerable time.

Another participant shares about how she was able to support a friend of hers who was assaulted at a bar by helping with her immediate needs, whatever they may be:

> *And you just got to listen to what they need. And it could change like, it could shift. But in that moment, she just needed the morning after pills. She needed me to help her pack for a trip. Yeah. And that was it. Like she didn't need me to go into hyper-vigilante, let's go to his house, and let's tell all his neighbors. And so, I think just being there for folks is helpful.* (Participant 10)

This participant describes supporting her friend by listening to what her most immediate needs were and supporting her to pursue those without pressuring her to do anything else. Here, she describes that every person's response to violence will be different, and therefore every survivor's needs will be different.

These participants' experiences and perspectives highlight the importance of meeting survivors where they are, and providing support by helping them navigate everyday life while they may be in a state of shock or experiencing PTS. These participants additionally highlight the importance of listening to what those immediate needs may be, and not assuming that all survivors will want to immediately or ever engage with formal support or crisis response services.

Unsupportive Examples of Informal Social Reactions to SV Disclosure

Many participants also described experiences with social reactions to their SV disclosures that they perceived as negative and harmful to their recovery process. Subthemes of negative examples of informal social reactions to SV disclosure included peer pressure, angry or aggressive reactions, invalidation, and buy-in to rape myths.

Peer Pressure. Participants described experiences where they were peer pressured into engaging in services or taking actions they did not want to take or did not feel prepared to take. One participant discussed being pressured by family members and friends into making a police report after his experience with SV, an act that he felt "took his power away:"

> *I kinda feel like my power was kind of taken away from me by other people being like, well, it's your responsibility to do something for other people, you know what I mean? When in reality, like, I was at, sort of gave up my power by doing some that I didn't want to do.* (Participant 4)

This participant described the impact of being pressured into engaging with formal support services by informal support providers, an experience that ultimately made him feel as if his agency and power were taken from him all over again by robbing him of the opportunity to make his own decision of if or when to formally report the experience.

Another participant recalls an experience of having to establish a new faith community for herself after members of her previous church pressured her to forgive the perpetrator of her SV encounter:

> *I remember I stopped being friends with a lot of girls that I knew who I went to church…Um, I just remember a lot of the girls just saying, like, you really need to forgive him. Like, if you want to be a really good Christian, you really need to forgive him. I was like, that's not my job. Like my job is not to forgive somebody*

> *else for what they did, like, like, that's not…I was like, I can't sleep at night. I was like, I was like, I'm fear of grocery stores.* (Participant 14)

For this participant, the pressure from others in her faith community to forgive her assailant or else not be a "good Christian" made her feel invalidated, misunderstood, and isolated, ultimately leading to the end of those relationships.

Angry, Aggressive Reactions. Several participants discussed managing angry or aggressive reactions from friends or family after disclosing their SV experiences. One participant recalls her mother bringing a weapon when she came to visit her after her SV experience at college: "*I was really pissed at my mother, who, who came down the next day, and she packed a butcher knife in her suitcase. And it infuriated me. It's like, what the hell are you doing?*" (Participant 5). Another participant describes his father's reaction to learning of his SV encounter from another family member:

> *And so, I think that she essentially told my dad, who apparently like, fell to his knees and like, immediately, and was just like, crying out. And immediately was like, where's my gun? You know what I mean? Like, he was going to try to kill this man, which is part of the reason why I agreed to sort of pursue charges on this guy, 'cause I was like, if my dad found out, like he's a dead man, I mean, literally, you know? I mean, I come from a rough bunch, we'll just put it like that. And so I think…when I heard that, it was really upsetting. And, you know, the next time I saw him, I felt like that was all he could think about. And I didn't even feel like a feel like an individual anymore. You know, I didn't feel like myself at all around hardly anyone.* (Participant 4)

This participant describes how his father's aggressive reaction to learning of his SV experience pressured him into reporting the encounter before he was ready for fear of what further damage his father's anger might cause.

For these participants, being met with anger or aggression following an SV disclosure was "infuriating" and "upsetting," despite the anger and aggression being directed towards the perpetrator of violence. Ultimately, these participants describe being made to manage the aggressive emotions of others, an interaction that contributed further to their distress rather than reducing it.

Invalidation. Participants also described experiences with being met with invalidation of their SV disclosures. One participant shared the impact of being invalidated after disclosing her SV experience to a significant other:

> *I remember talking to an on-and-off-again boyfriend…And telling him the situation...I explained to him what happened, and he was like, oh, well, I don't consider that rape. And so, then I just kind of dropped it and never talked about it again.* (Participant 1)

This participant then conveyed that this exchange inhibited her from seeking additional support from either informal sources or formal services for an extended period, as her partner's response led her to believe that others would similarly not take her experiences seriously.

Another participant shares a perspective based on an experience where she disclosed an SV encounter perpetrated by a co-worker to their manager, who took no further action:

> *...it was someone that I worked with, and I remember just taking it to my manager and being like, I can't work with this person. You know, every time I look at him…I see pain, I'm angry…I told my manager what happened. And nothing, nothing was done. He wasn't even fired…nothing was done. So, to me, it was just kind of like, well, he's not even getting fired from his job…* (Participant 3)

For this participant, the inaction on the part of her boss after her SV disclosure communicated that her experience was not significant or severe enough to take any punitive or protective action, ultimately leading her to feel invalidated in her experience. She continues, “*It's hard to validate your feelings sometimes when someone else is telling you that what happened to you wasn't traumatic*” (Participant 3).

Rape Myths. Participants additionally described encountering rape myths, or commonly accepted falsehoods about SV, when disclosing their experiences to informal social support providers. Because rape myths generally place blame upon the victim of violence for their own victimization, as well as minimize the harm of SV, participants describe these experiences as harmful. One participant describes her family's reaction focusing on the actions she took that placed her in the position to be sexually assaulted:

> *I wish that my family had been more supportive…They were just like…why did you put yourself in that situation? Why did you do that? …or, it was like, why are you acting like this? And not are you okay, what can I do to help you? Yeah…I think would have been more beneficial.* (Participant 18)

Another participant shares an experience where she was met with rape myths when disclosing her experience to a close friend many years after the violent encounter:

> *Even 15 years later, my friend was still like. Was that what happened? Like, you weren't held at knifepoint or something?...So yeah, it was interesting to be like reaffirmed on why I hadn't told anyone because of the responses that I would get…But I think that was just a really good example of the environment that I was in at the time. And even now, carrying through, some people still have those beliefs.* (Participant 9)

This participant describes the impact of experiencing a negative social reaction to her SV disclosure 15 years after the event as validating of her decision to not disclose her experience at the time of the original encounter.

For these participants, reactions rooted in rape mythology were particularly harmful as they minimized the harm of SV, as well as placed blame upon the victim for their own victimization, demonstrating a lack of understanding and empathy for their experiences.

Social Reactions and Support Seeking Behaviors

Participants discussed the ways in which supportive or unsupportive social reactions to SV disclosure may encourage or discourage further support seeking behaviors, such as pursuing therapy or filing an official police report. One participant, whose friends' reaction to her SV disclosure left her feeling invalidated, shared:

> *...so for a really long time…I really struggled with like feelings of like, well, then why do I feel so weird about it? Why do I feel so uncomfortable? Whether this person's name gets mentioned or when, you know, like, I'm afraid that this person is going to show up somewhere? And it wasn't until like, years later that I realized that like, no, [I] was right. And I just didn't go to the right people for help.* (Participant 1)

This participant describes second guessing herself about her experience, a phenomenon that was in part due to her friends' unsupportive reactions to her SV disclosure. Another participant shared:

> *This is how I think the whole situation could have turned out really different. If somebody had told me to go to the police…if someone had given me that validation to know that people would believe that that's what had happened to me, I think I would have done it…I think had somebody just sat me down and said, look, you were raped, go to the police, I think I probably would have.* (Participant 7.

These participants describe experiencing a lack of meaningful social support from informal support providers in their lives at the time of their SV encounters, a phenomenon that ultimately led to delayed care-seeking and crisis response engagement.

Adversely, several participants discussed experiences in which positive support from informal support providers encouraged them to engage in recovery interventions. One participant shares discusses how disclosing her SV experience to her friends allowed her to learn critical information about support resources that she wasn't otherwise aware of: "*And so, if it wasn't for friends, I wouldn't have known that the rape crisis center was* *free, didn't have any strings attached to insurance, or didn't have any strings attached to reporting, like it wasn't mandated*" (Participant 19). For this participant, who otherwise wouldn't have reached out to a crisis response organization for fears of having to pay for services or being pressured into formally reporting her experience, a conversation with a friend allowed her to learn more about available resources, which catalyzed her decision to seek further support.

Another participant describes how listening to her friends' experiences with SV allowed them to understand their own experiences with a new perspective: "*And then…a friend told me an experience they had had. And it just, like, triggered that for me. And putting it into the concept that like what had happened [to me] was actually rape"* (Participant 11). For this participant, providing validation for similar experiences with informal support providers allowed them to validate their own experience, and begin a recovery journey in therapy.

Social Support a Powerful Tool for Sexual Violence Recovery

Participants describe the importance of social support for bolstering recovery after SV. Subthemes within this theme include Insufficiency of formal support, impact of social support, social reactions can encourage or discourage further support seeking, and formal leveraging of a peer support model to support SV recovery.

Insufficiency of Formal Support Services

Participants discussed the importance of having social support to bolster recovery after SV, considering the limited impact of formal support services to fully carry the full recovery: "*Because you can't be in therapy for forever, like, you have to go home at some point. And like, what do you do with that? Right? That's when I think community support* *is really important*" (Participant 11). Another participant echoes this sentiment, recognizing that many survivors may require more support than what formal support services can reasonably offer:

> *You know, like, otherwise, it's just okay, well, call this number, go home…You know, it's just anything that feels like this person is not sort of thrown out and left to figure this out on their own, or has to go find everything themselves.* (Participant 10)

Another participant, who currently works in a nonprofit organization supporting survivors of SV, observes that challenges associated with SV are often more systemic than what support services can meaningfully work with:

> *...a lot of folks really needed more support, like in their, in their life, like with friends and family and needed to be able to be supported in the life that they lived, like coming in meeting with me an hour, every week or every other week wasn't really helping the challenges that they were facing.* (Participant 9)

She continues:

> *And I think that I mean, I think that like support services…can only do so much. I think that it is really like a cultural thing that needs to be shifted, is because we are like, so lonely as a whole. We're so lonely. And we're so isolated, which just allows for violence to be…continually perpetuated.* (Participant 9)

Each of these participants recognized that while crisis support services play a critical role in stabilizing victims after SV, social support experienced in everyday life is crucial for helping survivors combat shame and recover in the long-term from SV.

Informal Social Support: A Safer Option than Formal Support

Several participants acknowledged that for many survivors whose identities or circumstances do not align with common narratives of SV that are most frequently validated by formal support services, informal social support may be a safer option for receiving support than engaging in formal systems. Acknowledging harms committed by formal crisis response systems to survivors of SV, one participant observes:

> *So I feel like having the police there, especially for survivors of color, or survivors with like physical disabilities that are visible, or like mentally ill survivors, or just survivors that are more vulnerable to police violence, that might be more traumatizing if the police were present… I think that you definitely need like your friends, and if you're comfortable your family, you need support from people in your life.* (Participant 2)

Another participant, who identifies as a queer and biracial man, reports: "*I've entered into therapy. That's about it. I mean, I've talked with my friend about it a lot, but I have been able to find an adequate therapist that was experienced with queer people in the queer experience*" (Participant 16). For this participant, a lack of representation in formal support services meant that the only source of support available to him was through informal support providers.

For these participants, formal crisis response services, including law enforcement, hospitals, and nonprofit human services organizations offering therapeutic interventions to survivors of SV, could not be trusted to provide compassionate and safe care to diverse survivors. Formal crisis response services may not be inclusive enough to seem or be welcoming to survivors of SV who are not young, white, cisgender and heterosexual women. For diverse survivors, informal social support may feel like the only option available for receiving support at all following an encounter with SV.

Formal Leveraging of Peer Support Model

Given the acknowledged importance of social support for SV recovery, many participants desired more peer support options as service offerings complementing formal support services. Expanding on this idea, one participant suggested:

> *Yes…peer support. I've had people who knew, and that was it. So if there had been like, hey, we have volunteers here, who, you know, have been through something similar, or are trained to be your friend, if you need just somebody to walk with me to the cafeteria, because you're afraid of running into him, something like that. So maybe some kind of peer support.*

Another participant discussed wishing he had a social-support resource, such as a peer support mentor or support group, to be able to rely on for ongoing support: "*...something that would be really beneficial of like, yeah, we're not just here for like, right after this has happened to you, like, you can call me up or like, come to this like, ongoing, like group support thing*" (Participant 4). Sharing a similar sentiment, another participant described a desire for more support groups for survivors of SV:

> *...when people are ready to talk, knowing you're not alone is so critical. And knowing that other people have experienced what you have experienced, I think just helps with the healing process. And so having support groups for people who can who are ready and want to talk about them.* (Participant 17)

In acknowledgement of the critical importance of social support in recovering from SV, these participants discussed desiring more peer-centered options, such as peer support mentors or group therapy options, to be offered as part of formal support services that could be available to survivors of SV.

Survivor-Led Peer Support Approach

Participants found particular merit in receiving social support from others who have also experienced SV. Several participants who did not receive support from others who had experienced SV discussed how they believe knowing of others who had shared that experience might have helped them feel less alone:

> *…when I look back in retrospect, I was so isolated…it brings you and lifts you out of the darkness, you know, to recognize that there are others. It helps us I think, to recognize our own strength and hearing from others' traumas too, you know… there is, I think, a natural sort of [response] that comes with that for you to look at your situation…with more compassion.* (Participant 5)

Other participants who did experience support from others who had experienced SV discussed the significant impact it had on their ability to share their experiences with someone who could relate, and who “understood,” helping them feel hopeful for the future:

> *I was recently talking to a friend of mine who had just actually experienced sexual violence. And I let her know my history. And…it gave her hope to see me in a healthier, happier place. And to know that I've been there.* (Participant 8)

> *And also, I don't know, sort of feel good to know that. Like, I wasn't alone in that, and a lot of ways, you know, learning that experiences, obviously, I'm not like, but yeah, just sometimes hearing other people's stories makes me feel better. And I sort of hate that it is like a pathway of connection, because like, that's awful. But it also still is like, sometimes it's nice to know that however terrible it is, to know. It's, it's comforting to know that like, I'm not the only person who feels this way, because sometimes, you know, sometimes those things can feel really isolating and terrifying. And it can help to feel less alone.* (Participant 4)

> *I think like, I'm really, I don't want to say lucky because that's so weird word to, but I'm very grateful that I had friends who got it. Unfortunately, I hate that they got what happened to me, but I didn't feel isolated in that way. Because I knew there were people I could trust and talk about with what happened to me.* (Participant 11)

For these participants, the social support they received from others who had experienced SV was invaluable to their ability to not feel alone in their recovery journey.

Discussion

This study contributes to a growing body of literature advocating for increased informal social support as being imperative to mitigating risk of PTS and associated adverse health outcomes after experiencing SV (Ahrens et al., 2009; Ahrens et al., 2007; Campbell, Ahrens, et al., 2001; Campbell et al., 2012; Edwards & Ullman, 2018; Edwards et al., 2022; Filipas & Ullman, 2001; Jacques-Tiura et al., 2010; Kirkner et al., 2021; Lorenz et al., 2018; Scoglio et al., 2022). However, relatively few studies have been conducted with survivors of SV to learn more about what kinds of social support would be or have been most beneficial to their recovery after SV.

Most SV survivors disclose their SV experiences to informal support providers, such as friends, family members, significant others, and other loved ones, before engaging with formal support or crisis response services. Many SV survivors never formally report their SV experiences, choosing instead to rely wholly on social support from their communities. Most survivors will disclose their SV experiences to at least three informal support providers across their lifetimes (Filipas & Ullman, 2001).

Literature demonstrates that informal social support providers are more likely than formal support providers to react supportively to the disclosure (Ahrens et al., 2009; Ahrens et al., 2007; Filipas & Ullman, 2001). However, SV survivors still receive high levels of both positive and negative reactions to SV disclosure from informal support providers, with the most recent findings reporting that between 74 and 97% of survivors receive at least one positive reaction, and between 80 and 98% of survivors receive at least one negative reaction (Ahrens et al., 2009; Campbell, Ahrens, et al., 2001; Filipas & Ullman, 2001).

Notably, previous research has found that negative reactions to SV disclosure are more damaging to the health and wellbeing of SV survivors than positive reactions are beneficial (Dworkin & Schumacher, 2018; Orchowski & Gidycz, 2015; Orchowski et al., 2022; Scoglio et al., 2022). This is critical, because literature also demonstrates that survivors may receive negative reactions more frequently than positive reactions (Filipas & Ullman, 2001). Furthermore, benefits from positive reactions to SV disclosure from informal support providers may be negated by negative reactions, and up to 20% of survivors have reported regretting disclosing their SV experiences to informal support providers (Ahrens et al., 2010; Jacques-Tiura et al., 2010; Orchowski & Gidycz, 2015).

Negative responses to disclosure of SV could inhibit survivors from future disclosures, thereby depriving them of access to both formal and informal support networks and social support integral to their recovery process. This delay in seeking support may prolong the recovery period or defer the initiation of the recovery journey, potentially exacerbating post-traumatic stress (PTS) symptoms over time (Campbell et al., 2012; Scoglio et al., 2022). In addition to discouraging survivors from further disclosing their experiences, negative social reactions to SV disclosure may lead to loss of relationship (Scoglio et al., 2022). For some survivors, this phenomenon may cause a complete restructuring of their social network, especially if negative reactions are received from multiple members of a survivor's informal support network (Jaffe et al., 2023).

Literature demonstrates an association between negative reactions to SV disclosure from informal social supports and presence of PTS-related health outcomes (Borja et al., 2006; Brewin et al., 2000; Campbell, Ahrens, et al., 2001; Filipas & Ullman, 2001; Jacques-Tiura et al., 2010; Johansen et al., 2013; Kirkner et al., 2021; Ozer et al., 2003; Relyea & Ullman, 2015; Ullman et al., 2007) and similarly, an association between positive reactions to SV disclosure and lessened risk of PTS-related symptoms (Cénat et al., 2020; Fuller-Thomson et al., 2020; Hirai et al., 2020; Littleton, 2010; Machisa et al., 2018). Critically, individuals who never disclose SV experiences to any informal social support providers experience higher rates of PTS than those who do disclose the experience to someone, further demonstrating the importance of positive social support to recovery (Ahrens et al., 2010). For survivors of SV, the presence of positive social support from informal social support providers is key for mitigating risk of developing PTS-related symptoms.

The findings of this study further demonstrate the importance of positive social support from informal support providers to the health, wellbeing, and recovery of individuals who have experienced SV. Aligning with contemporary literature, the participants in the present study who received positive social support from informal support providers noted the significant role it played in their ability to heal and recover from the violent encounter. Participants in the present study described examples of both positive and negative reactions to SV disclosure, many of which mapped on to Ullmans' (2000) seven distinct types of social reactions to SV disclosure: emotional support, tangible aid, blame, taking control, distraction, treating differently, and egocentric reasons (Ahrens et al., 2009; Ullman, 2000). Several participants discussed reactions that combined several elements these types, such as reactions that combined emotional support and tangible aid, or reactions that combined taking control with treating differently. Positive reactions described in the present study also aligned with Scoglio et al.'s (2022) findings that positive reactions fit into three overarching themes: 1). validation and compassion, 2). offering choices, and 3). naming the violence (Scoglio et al., 2022). The alignment of findings in this study with previous research may lend to the salience of these established constructs of social reactions after SV, offering further evidence with which to base future research, interventions, and policy goals.

Positive reactions to SV disclosure from informal support providers may encourage or discourage further disclosure and support-seeking behaviors, and thus may play a "gatekeeping" role in survivors' recovery journey. Because negative reactions to SV disclosure remain common, programs that support the psychoeducation of community members may be a particularly impactful way to increase support seeking behaviors and decrease epidemiology of SV related PTS. Community education programs such as bystander intervention training support SV-prevention efforts by empowering community members to identify the signs of violence and redirect potentially violent situations (Bush et al., 2021). Similarly, community conversations surrounding how to support a friend or family member following a SV encounter have begun taking place on select college campuses around the nation, in attempts to bolster recover yfo SV survivors by empowering community members with knowledge of how to positively respond (Edwards & Ullman, 2018; Edwards et al., 2022). Finally, viral social media campaigns such as #MeToo and #TimesUp have brought attention to the ways survivors seek support and acknowledgement online. Organizations such as metoo. Global have incorporated virtual resources, including support groups and sharing circles, to their resource offerings, highlighting the desire for such interventions.

Acknowledging the power of positive social support they received, or reflecting on the impact positive social support would have made on their recovery if they had received it, participants in the present study described a desire for peer support as a formal offering of crisis response services to better support survivors in their recovery journey. Peer support, a key principle of a trauma-informed approach, is defined by SAMHSA as “a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both. This mutuality—often called ‘peerness’—between a peer support worker and person in or seeking recovery promotes connection and inspires hope” (SAMHSA). Peer support approaches engage individuals with lived experiences similar to those in recovery to provide non-clinical, strengths-based support rooted in the experiential knowledge of their own recovery journeys. Peer support models may involve elements of listening, providing psychoeducation, tutoring, mentoring, advocacy and activism, and are grounded in the concepts of mutual nuanced understanding and greater empathy and respect for survivors (Gregory et al., 2022).

Participants described a desire for peer-centered support options including support groups, having a “sponsor” or mentor-type peer to engage with and check in with them, and being able to meet and talk with others who have experienced SV, as meaningful options to complement existing support services. The benefits of peer-led or peer-centered support options described by participants in the present study align with benefits of peer support described in literature, including opportunities to feel genuinely seen and understood, to acknowledge and accept the reality of the SV experiences, increased social connectedness, and opportunities to learn about additional resources, coping strategies, and opportunities for further support (Gregory et al., 2022; Konya et al., 2020). As non-hierarchical approaches, peer support approaches to recovery care may also disrupt power dynamics that may exist between formal providers and survivors, allowing a greater opportunity for sharing, mutual trust, and reciprocity, and centering peer support as “solidarity, not charity” (Bakshi, 2021; Gregory et al., 2022; Watson, 2017). Finally, as SV is a highly stigmatized and misunderstood experience, peer support approaches to recovery care may offer unique utility in combatting shame, self-blame, and guilt associated with rape myths, or commonly held falsehoods about who should be held responsible for SV, as well as to disrupt social isolation and disruption that may occur within survivors’ informal support networks following SV disclosure (Cody et al., 2023; Heard & Walsh, 2023; Menon et al., 2020).

Peer support options may present unique benefit for survivors of SV who do not meet expectations of “perfect victims” of SV, or who may not be offered benefit of the doubt by formal crisis response services due to structural and systemic racism, hetero/cis-sexism, and ableism present in legal justice institutions. Peer support approaches may be especially impactful for BIPOC, LGBTQ+, disabled, mentally ill, non-English speaking individuals, and other communities that are disproportionately impacted by violence, as well as neglected by formal crisis response institutions. Peer support mentors may thus provide culturally relevant and empathetic support where formal systems fail (Bakshi, 2021; Corrigan et al., 2015): “Because peers often “speak the same language” (both literally and socioculturally), trusted companionship of empathetic peers more effectively validates experiences of structural oppression, marginalization, and exclusion” (Bakshi, 2021; Faulkner & Basset, 2012; Repper & Watson, 2012). Furthermore, peer support approaches may be more effective in relating to and normalizing the experiences of diverse survivors in ways that challenge stigma and strengthen community networks (Bakshi, 2021). Echoing this, several studies have demonstrated a preference for peer support approaches from individuals with marginalized and minoritized identities, as peer support more effectively honored culturally specific coping mechanisms and narratives (Bakshi, 2021; Corrigan et al., 2015; Grier-Reed, 2013).

Participants in the present study described particular benefit stemming from recovering in community with others who have also experienced SV. This phenomenon is similarly established in literature, with previous research establishing that survivors reported a preference for being supported by other individuals with an SV history for the increased opportunity to feel believed, heard, listened to, validated, respected, understood, and not judged (Gregory et al., 2022; Robotham et al., 2019). Recovering alongside and with the guidance of others who have experienced SV may additionally offer a unique opportunity to provide blueprints of hope in nuanced ways that cannot be similarly accomplished by working with individuals who have not experienced SV. Survivors have noted the benefits of working with peer support mentors who are also survivors of SV as offering support that is normalizing of their experiences, relatable, credible and authentic, as well as translatable (Cody et al., 2023).

The literature on the efficacy and appropriateness of peer-led support models for survivors of SV is limited, but burgeoning (Gregory et al., 2022; Konya et al., 2020; Littleton, 2010; Robotham et al., 2019). Peer support models are slightly more established in mental health and addiction recovery services, and peer support approaches to support SV survivors may draw on established literature in these fields (Du Plessis et al., 2020; Myrick & Del Vecchio, 2016; Scannell, 2022; Shalaby & Agyapong, 2020; Tracy & Wallace, 2016).

Given the high risk of developing long-term or chronic health outcomes following an experience with SV, the mistrust survivors report for formal support and crisis response services, as well as the sheer magnitude of SV prevalence, it is critical that informal support providers be equipped to provide SV survivors with compassionate, validating, and judgement-free support to best protect the health and wellbeing of the public. The findings of the present study reinforce the critical need to reconceptualize recovery after SV as embedded within a larger social ecological context rather than as an individualistic effort.

Limitations

While this study provides valuable insights into the experiences and perspectives of survivors of SV and the role of informal social support providers in supporting them, several limitations warrant acknowledgment.

There may be limitations associated with the recruitment strategy employed in this study. For instance, participants may have been more likely to volunteer if they had particularly positive or negative experiences with informal social support, potentially biasing the sample towards extreme viewpoints and overlooking more nuanced perspectives. Furthermore, the study focused primarily on survivors' perspectives and experiences, with limited exploration of the viewpoints of friends, family members, or others involved in supporting survivors. This narrow focus may provide an incomplete understanding of the dynamics at play within informal support systems. Lastly, qualitative research inherently emphasizes depth over breadth, and while this study offers rich insights into the experiences of survivors and the role of social support, it may not capture the full complexity of survivorship experiences or the multifaceted nature of support systems.

The themes identified and constructed for this study were emergent and were constructed using data collected to answer a different research question. For this reason, several opportunities to ask additional or clarifying questions regarding pre-existing relationship dynamics, the specific types of group-based support interventions survivors would be interested in, the differences in informal support victims experienced with friends versus family members, etc., were missed. Future research should more intentionally consider nuanced dynamics of social support to gain more thorough information to inform policy and practice.

Despite these limitations, this study contributes valuable qualitative data to the existing literature on survivor support systems and highlights areas for future research and intervention efforts aimed at improving support services for survivors of SV.

Conclusion

Informal social support plays a pivotal role in the recovery journey of survivors of sexual violence, offering unique benefits that complement formal support services. Through the provision of empathy, validation, and companionship, informal support networks offer survivors a sense of belonging and understanding that may be lacking in formal settings. Moreover, informal support can be more readily accessible, flexible, and tailored to the individual needs of survivors, fostering a greater sense of empowerment and agency in their healing process. Additionally, informal support networks can serve as crucial buffers against the negative impacts of social stigma, isolation, and self-blame commonly experienced by survivors. By acknowledging and harnessing the power of informal social support, policymakers, practitioners, and researchers can enhance the effectiveness and inclusivity of support services for survivors of sexual violence, ultimately promoting their health, resilience, and well-being.

CHAPTER VII

DISCUSSION, PRACTICE AND POLICY IMPLICATIONS, & CONCLUSION

Purpose of the Study

Sexual violence (SV) represents a widespread public health and human rights concern that affects diverse populations globally. Despite impacting every and all communities, the burden of SV is disproportionately felt by structurally marginalized and minoritized groups, including women & girls; individuals who are Black, Indigenous, and people of color (BIPOC); individuals within lesbian, gay, bisexual, transgender, & queer (LGBTQ+) communities; people with disabilities; and individuals working and/or living in impoverished and economically disadvantaged areas, among others. SV is highly prevalent, impacting as many as one in three women across the life course, and one in six men (CDC, 2020).

SV is associated with a range of adverse physical, reproductive, sexual, psychological, mental, and behavioral health outcomes (WHO, 2012; (Black et al., 2011). Notably, individuals who have experienced SV are at an increased risk of meeting diagnostic criteria for post-traumatic stress (PTS) and developing associated subsequent health outcomes relative to other traumatic and adverse events (DiMauro & Renshaw, 2021). Literature demonstrates that individuals who are exposed to intentional acts of interpersonal violence, such as SV, are more likely to develop PTS-related symptoms than individuals who experience traumatic events that are accidental or disaster-related (Johansen et al., 2013; Sareen, 2014).

Given the high prevalence of SV, as well as the high risk of developing serious and chronic adverse health outcomes following a violent encounter, it is critical that individuals who experience SV have meaningful and urgent access to compassionate, culturally relevant, trauma-informed, and evidence-based care. Literature suggests that access to early psychosocial/psychological intervention after experiencing a traumatic event may be effective for reducing the long-term impact of post-traumatic stress disorder (PTSD) and related symptomatology (Dworkin & Schumacher, 2018; Dyregrov & Regel, 2012; Roberts D Clin Psy et al., 2009; Scott et al., 2018). As SV is highly correlated with the development of PTSD and related mental, physical, and behavioral health concerns (Scott et al., 2018), early identification and intervention of SV encounters is critical to interrupt potential long-term health outcomes (Dworkin & Schumacher, 2018). Though every person experiences trauma and related health outcomes differently, failure to engage in early (or any) intervention significantly increases risk of long-term adverse health outcomes, as well as risk of re-victimization (Jaffe et al., 2023).

Multi-organizational crisis response services are available to survivors of SV to support their various post-assault safety needs related to physical health, psychological and mental health, legal support, and protection from further harm. Formal crisis response interventions for survivors of SV involve collaborative efforts between law enforcement organizations, healthcare institutions (emergency departments), and often, non-profit human services organizations, such as rape crisis centers (RCCs) or sexual assault resource centers (SARCs). The efforts of these formal crisis response services are largely interconnected, as the justice system's ability to prosecute perpetrators relies heavily on bio-evidence collected in healthcare visits following an assault, as well as the victim's comprehensive testimony (Ladd & Seda, 2020). Formal crisis response services largely center the criminal justice system (CJS) and attempt to support individuals impacted by SV by providing formal and institutionalized pathways of reporting and prosecution of a perpetrator (Koss et al., 2017; Ladd & Seda, 2020). Law enforcement and healthcare institutions work together to create a process survivors can engage with to report SV as a crime and collect bio-evidence with which to support that claim in court. Nonprofit human services organizations provide more person-centered services, offering support services such as crisis line support, advocacy services, and short-term and group therapeutic options, among others (Bein, 2010).

Despite the ongoing collaborative efforts of these organizations, crisis response services remain critically underutilized by individuals who have experienced SV. The National Sexual Violence Resource Center reports that approximately 63% of sexual assaults are never reported, naming SV the "most underreported crime" (NSVRC, 2015). Reasons for underutilizing of services after experiencing SV are ranging and reflect multiple complex barriers to engaging in services spanning social ecological levels. For example, barriers to engaging in crisis response services may be related to psychological safety, such as experiencing feelings of guilt or shame, or may be barriers to access based on structural and societal determinants, such as lack of transportation or childcare.

Furthermore, literature demonstrates that most individuals who are served by formal crisis response services are white, youthful, urban, English-speaking, non-disabled cisgender women, reflecting dominant cultural narratives about "perfect victims" of SV

(Koss et al., 2017). Crisis response services are most significantly underutilized by structurally minoritized populations, who in addition to be being disproportionately burdened by SV, additionally disproportionately experience structural inequities that create barriers such as cost-barriers, transportation barriers, and barriers related to discrimination, harassment, and victim-blaming behaviors from service providers (Bach et al., 2021; Kennedy et al., 2012).

In lieu of formal support, many victims of SV opt to disclose their experiences and receive support from informal support networks, such as friends, family members, or significant others (Ahrens, 2006; Filipas & Ullman, 2001; Kirkner et al., 2021; Lorenz et al., 2018). While evidence suggests that individuals who have experienced SV perceive responses from informal social supports more positively than from formal supports (i.e. law enforcement, health providers, etc.) (Lorenz et al., 2018) negative reactions from informal social supports are still common and may have a significant impact on future support seeking behaviors (Lorenz et al., 2018; Relyea & Ullman, 2015). Overtly negative reactions, such as reactions suggesting the victim was responsible for the violent encounter, or even well-intentioned reactions, such as those that acknowledge the experience but do not offer support, have been associated with negative perceptions on the part of the victim, which may have a significant impact on their subsequent ability to reach out for additional support from others, or to engage with formal support services (Lorenz et al., 2018; Relyea & Ullman, 2015). Alternatively, positive responses from informal social supports may have the impact of encouraging victims of SV to pursue additional support and recovery services, further increasing their likelihood of mitigating distress and SV-PTS related adverse health outcomes.

Connecting survivors to resources and care is critical to reduce risk of long-term, chronic, or lifelong adverse health conditions commonly associated with sexual violence (SV), yet multiple barriers exist across social ecological levels that often prevent meaningful engagement in crisis response systems, leading to significant underutilization of available crisis response services (NSVRC, 2015). To address barriers to care and crisis response engagement, the White House, among other critical violence prevention organizations, have issued a call for "survivor-centered" and "survivor-led" approaches to care after experiences with SV (The White House, 2023).

Crisis response service needs of victims of SV are extensive, and encompass a broad range of physical, psychological, behavioral, social, and legal supports (Bach et al., 2021). Reflecting the underutilization of available services, people who have experienced SV have expressed that "their available options mismatch their objectives, present accessibility challenges, disempower their pursuit of what justice means to them, and fail to offer concrete responses to basic needs," (Koss, White, & Lopez, 2017). While literature on post-SV crisis response interventions is well-established, less is known about the experiences with and perspectives on crisis response services from individuals with lived experiences.

To further explore this expressed "mismatch," this study sought to engage with survivors of SV to learn more about their experiences, perspectives, and suggestions regarding crisis response services offered by nonprofit human services organizations and criminal justice systems, as well as how they experience support in informal social networks. The following three questions guided this research:

RQ1: Based on their interactions with KY-based NPHSOs, how do survivors of sexual violence imagine best practices for offering community-based care?

RQ2: How do people who have experienced sexual violence experience, engage with, and perceive criminal justice responses to sexual violence?

RQ3: How can peers, families, and communities support people who have experienced sexual violence?

The findings of this study indicate that crisis response services provided to survivors of SV frequently fail to align with the priorities, objectives, and immediate needs experienced by survivors following a violent encounter. Participants expressed a significant lack of confidence in crisis response services, particularly those associated with the criminal justice system (CJS), to deliver compassionate, understanding, and supportive care. Consequently, many survivors opted not to engage with law enforcement, emergency departments, or crisis counseling altogether. To restore this eroded trust, participants proposed a variety of recommendations for enhancing crisis response services, ranging from improving communication strategies and outreach efforts to implementing substantial policy reforms and systems transformations. As individuals with lived experience, survivors of SV offer invaluable insights into the most effective strategies for supporting individuals in urgent need of post-assault care.

In this chapter, I will briefly discuss salient and recurrent themes present across each of the manuscripts developed for this dissertation study, as well as consider implications for policy and practice that reflect the identified objectives of participants interviewed for this study. Finally, I will make several recommendations for future research directions based on study findings.

Discussion

Though each of the manuscripts included in this dissertation study individually identified distinct findings that contribute to the public health literature regarding nonprofit human services organizations' service provision, criminal justice responses to SV, and the role of informal social support networks in supporting the health and wellbeing of SV survivors, several salient themes were present across all three manuscripts. Three overarching themes that were identified in all three manuscripts were: Mistrust for Crisis Response Services, Navigating Rape Myths in Sexual Violence Crisis Response, Lack of Culturally Appropriate Care Options, and Centering Autonomy & Survivor-Centered Care. Each of these themes are explored in depth below.

Mistrust for Crisis Response Services

In each of the manuscripts related to the three research questions, participants demonstrated a significant mistrust for crisis response services. Mistrust was primarily directed towards crisis response services affiliated with criminal justice systems (CJS) but was additionally expressed towards all facets of crisis response networks, including services offered at emergency departments and nonprofit human services organizations. Mistrust directed towards CJS was largely centered around perceived mistreatment and lack of compassion directed to survivors of SV, as well as around a perceived inefficiency and inability of procedural justice systems to be able to successfully convict a perpetrator of violence.

Participants felt that many services offered by crisis response systems did not have their best interests as survivors at heart, and at worst, even believed crisis response systems were actively disinterested in supporting them. Interviewees expressed fears of not being believed or taken seriously, and anticipated being treated poorly by police, especially if they were members of structurally marginalized and minoritized populations. For some participants, these beliefs were rooted in experience with formally reporting or engaging in crisis response services, however, many participants who did not formally engage in services shared similar fears. Related to this expressed mistrust, participants demonstrated reluctance towards engaging in crisis response services after experiencing SV.

The salience of this theme across all manuscripts demonstrates a critical importance for repairing trust in crisis response services in order to protect health and wellbeing of survivors, whether that occurs through service improvements or system transformation.

Navigating Rape Myths in Sexual Violence Crisis Response

In every manuscript developed based on interview data collected for this dissertation study, participants described confronting and navigating rape myths after their experiences with SV. Participants experienced internalized rape myths, or harmful beliefs related to responsibility for victimization directed at the self. Participants also described encountering rape myths from crisis response service providers, such as law enforcement officers, as well as from informal support providers, such as peers and family members. Common rape myths participants encountered included feeling that they were somehow responsible for their own victimization; that their victimization had not been "legitimate" because it had occurred within the context of a romantic relationship, or because they were not attacked with a weapon; that they would not be believed because they had been drinking or using drugs; or they would not be taken seriously because of attributes of their identity, such as being male or a member of the LGBTQ+ community. Many participants who had internalized rape myth ideology ultimately did not choose to report their experiences with SV or reach out for therapeutic support.

The prominent recurrence of the presence of rape myths in the findings of this dissertation study demonstrates that rape myth ideology may act as a significant barrier to deciding to engage in care or to make a formal report of the SV encounter. The significant recurrence of this theme also highlights the frequency of rape myth acceptance in contemporary culture, despite SV being more visible in present day cultural zeitgeist.

Lack of Culturally Appropriate Care Options

Across manuscripts, participants spoke to critical gaps in availability and existence of crisis response services that were culturally appropriate, relevant, or competent. Participants discussed perceiving that crisis response services were most available to victims whose identities, experiences, and circumstances were most aligned with narratives of "perfect victimhood," and were white, young, non-disabled, English-speaking, cisgender, and heterosexual. Participants who identified as BIPOC, part of LGBTQ+ communities, or disabled discussed experiencing barriers to meaningful and effective crisis response care based on these minoritized identities, and that those barriers existed across multiple social ecological levels. Barriers based on identity were experienced while engaging in crisis response services, and additionally were experienced anticipatorily, as many participants shared avoiding crisis response services altogether for fears that aspects of their identity or social positionality would prevent crisis responders from engaging with them compassionately. Even participants who did identify with more privileged social positionality acknowledged the ways in which their privilege benefitted them in navigating the complexity of existing crisis response and support services to support victims and survivors of SV.

The prominence of this theme within all three manuscripts is demonstrative of significant inequities existent across crisis response networks. Inequities in crisis response networks directly translate to exacerbated inequities in health outcomes associated with SV experiences.

Centering Autonomy & Survivor-Centered Care

In each of the manuscripts developed as a part of this dissertation study, participants underscored the imperative of re-imagining crisis response services to prioritize autonomy and cater to the needs, desires, and comforts of survivors. Participants emphasized that interpersonal coercive violence, such as SV, often leads to a profound sense of diminished autonomy and control. Therefore, prioritizing autonomy and embracing survivor-centered approaches to care were deemed essential for cultivating a truly trauma-informed ethos of care. Additionally, participants expressed the belief that many of the perceived discrepancies between the services provided and the needs of survivors could be mitigated through active listening and collaborative engagement with individuals who have lived experience of SV.

Recognizing lived experience as invaluable wisdom for shaping requisite adaptations to crisis response interventions holds promise in incentivizing more survivors to seek essential care following experiences of sexual violence (SV), consequently mitigating population health repercussions stemming from the pervasive prevalence of SV.

Each of these themes were related to the overarching objective of this study, which was to reimagine how safety is formally and informally presented, offered, and accessed after sexual violence. While participants expressed discontentment with crisis response services broadly, they were not without hope for how system improvements and/or transformations could better support victims and survivors.

Implications for Policy & Practice

This dissertation study contributes to a growing body of evidence regarding the perceived utility, effectiveness, and reliability of crisis response services aimed at assisting survivors of SV in the immediate aftermath of a violent encounter. By engaging in deep listening with individuals with lived experience, this study presents a series of impactful intervention recommendations, policy reforms, and systemic overhauls across the entirety of the crisis response continuum.

By listening to and implementing intervention suggestions grounded in lived experience, this dissertation hopes to reimagine safety after sexual violence. Specifically, the three manuscripts included in this dissertation gleaned perspectives from survivors of SV based on their experiences with services offered by nonprofit human services organizations, with criminal legal system responses to SV, and with social and peer support following a violent encounter. Each manuscript highlights survivor experiences that yield invaluable insights for substantially enhancing health outcomes associated with SV through avenues of practice improvement and policy reform. Specific implications and recommendations for policy and practice based on findings are presented below.

Manuscript 1: Reimagining Support after Sexual Violence: Survivors' Voices on Improving Nonprofit Support Services

The first manuscript included in this dissertation gathered perspectives from survivors of SV on how nonprofit human services organizations can adopt more inclusive, transparent, and person-centered policies to better support all survivors of SV, regardless of their experience, circumstance, or identity. The recommendations identified in this manuscript are organized into three overarching themes: Survivor Centered Services, Expanded Organizational Outreach, and Enhanced Service Offerings. The suggestions made by participants in the first manuscript included in this dissertation have significant implications for policy and practice that, if adopted, could allow for tangible differences in service utilization and health outcomes among individuals who have experienced SV.

Implications for Policy and Practice

Participants described a desire for increased representation of diverse experiences, circumstances, and identities in nonprofit support services, in acknowledgment that SV support services have historically catered primarily to the experiences of young, white, and heterosexual cisgender women (Wooten, 2015; Crenshaw, 1991). A critical means for increasing trust and service utilization among individuals who have experienced SV is meaningfully increasing representation of diverse populations, identities, and experiences in service provision, promotional materials, social media presences, and discourse generally. Though SV has long been conceptualized as a "women's issue," SV impacts communities and individuals regardless of gender, sex, or sexuality, and the gendered approach to SV service provision isolates and neglects the care needs of individuals who are not cisgender women. To rectify this, nonprofit support organizations may adopt gender neutral language to refer to survivors and perpetrators of SV, as well as to the violence itself. Additionally, crisis response services have historically been more accessible and available to white women, contributing to deep isolation of BIPOC individuals and communities who experience SV, despite rates of SV being higher among BIPOC communities. Nonprofit organizations may consider the unique needs of BIPOC survivors and create specific spaces and opportunities where BIPOC survivors may seek support.

Related to representation, participants also discussed preferences for language that services can adopt to project a more welcoming and safer environment. Participants discussed how certain language commonly used by nonprofit support organizations, including binarily gendered or solely feminized language ("women's shelters," "violence against women," etc.),, language choices to refer to violent encounters (i.e. "rape," "sexual assault," etc.), or language choices to describe how a person identifies themselves following SV (i.e. "victim," "survivor," "perpetrator," etc.), may encourage or prevent psychological safety felt by the individual seeking services. Language can serve as a significant barrier to engagement in care, as language can cause people to believe that they are unwelcome in certain spaces, that their experiences "don't count" or are not serious enough to warrant crisis support or can force people to self-identify in ways that contribute to traumatization and PTSD. Crisis response services can reconsider how they use language to be more inclusive of all people who experience SV, and to be more welcoming of people who experience varying "degrees" of SV.

Participants also spoke to a desire for increased transparency of what services are offered by nonprofit support organizations, and what kinds of engagement they ask of survivors in order to meaningfully participate. Crisis support services should increase transparency of what services are made available to people who have experienced SV, how to access them, and what will be required of people to meaningfully engage. For example, nonprofit organizations should be transparent about not being required to file a police report to engage with a support group run though the organization or can create a "What to Expect" page easily accessible on organizational websites. Organizations can also produce comprehensive resource guides and community specific maps that thoroughly outline service requirements and offerings, so that individuals can learn about what to expect before deciding to engage in care.

Participants noted that a common barrier to seeking support from NPHSOs was difficulty in identifying their own experiences as SV. This challenge may have stemmed from a lack of nuanced representation of SV in media, popular culture, or educational contexts, which contributed to a lack of awareness and recognition among survivors. Organizations can adopt story-telling approaches to demonstrate the variety of ways SV can look and impact people to foster greater recognition of violent dynamics among the public. These activities may take place as community-based events featuring skits or service walkthroughs or may be made available online on organizational webpages or social media accounts.

Moreover, participants highlighted the perceived advantage of developing and disseminating community-based education and awareness initiatives, which could serve not only to provide crucial evidence-based and comprehensive sexual health education to youth, but also to communicate information about the complexities of SV to the broader public through their platforms. Though political challenges bar comprehensive sexual health education programs from taking root in Kentucky school systems, NPHSOs can use their platforms to provide sexual health education to the public. Creating educational promotional materials, community-based education programs, developing educational media such as podcasts and social media presences, can increase awareness of SV. This proactive and accessible approach to community education could address common misconceptions related to SV experiences and help community members in being able to better identify and address SV.

Participants discussed the importance of providing person-centered care, or care options that are deeply grounded in the self-professed needs and wants dictated by the survivor, without additional external pressures to engage in any kind of formal or informal support service for any reason. NPHSOs can demonstrate a person-centered approach by creating and utilizing mini needs assessments to be conducted with every person who discloses having experienced SV. Needs assessments can gauge immediate and long-term needs and can help service providers connect individuals to appropriate resources based on responses. The direction of care should follow the desires and considerations of the person seeking care, and the provision of a mini-needs assessment could provide a standardized “menu” of care survivors could use to assess and identify their own individual support priorities.

Finally, participants observed several structural, organizational, and policy changes nonprofit organizations could adopt or advocate for to better support survivors of sexual violence. In acknowledgement of NPHSOs being the most likely point of entry for many individuals who have experienced SV, policymakers can advocate for increased funding and capacity for survivor-serving organizations to be able to provide greater supports for survivors' economic, housing, and employment-based needs.

Manuscript 2: "*He went to jail. But is that justice?*" Sexual violence survivors' perspectives on justice, accountability, and repairing sexual harm

The second manuscript included in this dissertation investigated survivors' experiences with the criminal justice system (CJS), in acknowledgment of how police interactions can either facilitate or prevent further help seeking behaviors after SV, impacting long-term health outcomes. Participants shared their experiences making formal reports of their SV encounters, as well as their perspectives and opinions on CJS interactions with survivors of SV broadly. A key finding of this manuscript was the immense mistrust experienced by survivors of SV for law enforcement and other representatives of CJS, either citing poor personal experiences with police, recalling poor experiences of loved ones who have engaged with CJS after SV, or referencing media portrayals of police and survivor interactions. Survivors interviewed for this study overwhelmingly did not feel safe or comfortable engaging with law enforcement or CJS as a crisis response option to turn to after experiencing SV, and described experiencing or anticipating institutional betrayal if they did engage. Many participants ascribed this phenomenon to officer rape myth acceptance. Because of this mistrust, interviewees chose to reimagine justice after SV, and consider alternative means of what justice after a violent encounter could look like and mean to them.

Participants emphasized the significance of holding perpetrators accountable for committing sexual harm and highlighted the notable disparity between reports of SV and actual convictions. This discrepancy underscores the necessity for innovative approaches to ensure genuine perpetrator accountability, as existing systems were perceived to be inadequate in this regard. However, participants did not feel that incarceration of perpetrators was holding them accountable.

Exemplifying this, interviewees described the potential utility of restorative justice (RJ) approaches to justice, or approaches that feature a perpetrator's apology and acknowledgement of harm, establishing of physical, social, mental, and spiritual safety, as well as perpetrator rehabilitation through counseling (Decker et al., 2022). The findings of this study highlight a critical need for innovations in how pathways to "justice" can be conceptualized and provided to survivors of SV to better support their long-term health and wellbeing.

Implications for Policy and Practice

Key findings from this manuscript point to severed trust between survivors of SV and CJS, including law enforcement officers and formal forensic reporting processes. Policymakers and practitioners may utilize these findings to support alternative crisis response models to support survivors of SV that may divert from police to behavioral support professionals or crisis counselors employed by nonprofit human services organizations with specific missions to support survivors of SV.

Instead of depending solely on law enforcement for conducting forensic interviews, this responsibility could potentially be shifted to social workers, crisis triage workers, or crisis counselors who could undergo specialized training by law enforcement. These professionals may be better positioned to elicit comparable information from survivors while mitigating mistrust and reducing stigma. Forensic interviews could be facilitated by social workers or crisis counselors either in collaboration with law enforcement or independently, leveraging specialized training in trauma-informed and culturally relevant interviewing techniques. This approach may capitalize on the diverse skillsets and training requirements of social workers and crisis counselors to enhance the quality and effectiveness of forensic interviews in cases of sexual violence for survivors who do wish to formally report their experiences, but who may feel uncomfortable directly communicating with police.

An additional opportunity for providing accessible mental health support could potentially be developed in partnership with efforts to establish a national behavioral health crisis hotline (988). Rape crisis counselors may be cross trained as 988 crisis responders, and survivors of SV may have the opportunity to receive behavioral health support without law enforcement response by calling or texting the national crisis support line (988) in efforts to consolidate and streamline opportunities to access mental health support following a traumatic event.

Several other innovative reporting mechanisms that do not involve direct interaction withs law enforcement may be explored to remove trust barriers between SV survivors and police. Anonymous online reporting of SV may allow for greater opportunity for perpetrators of SV to be held criminally accountable, without relying on direct testimony and legal participation of survivors, a process that has been demonstrated in literature and popular culture alike as deeply biased and traumatizing for SV survivors (Powell, 2015). Other anonymous online interventions that utilize “matching systems” to allow survivors to connect with others who have been harmed by repeat perpetrators may demonstrate efficacy in building confidence to encourage survivors to report, as well as build an online database of survivor-reported repeat perpetrators. Project Callisto, an innovative program available in San Francisco, California, offers a “proprietary Matching System, is the first and only tool that utilizes cryptography to provide a secure alternative to a whisper network to determine if others were harmed by the same perpetrator” (Project Callisto, 2024). Innovative programs such as this may empower survivors to report their experiences without the added pressure of having to decide to press charges before they are ready, while simultaneously helping other survivors build a stronger case for seeking accountability of repeat offenders. Non-police centered and anonymized reporting options may encourage more survivors to come forward with their experiences.

Another key finding from this manuscript was the desire of participants to engage in RJ approaches to justice, contributing to a rapidly growing body of literature demonstrating utility of these approaches for victims of interpersonal power-based violence. Implementing restorative justice approaches to address SV holds promise as a transformative policy initiative. Restorative justice frameworks prioritize healing, accountability, and community involvement, offering a departure from traditional punitive measures. By centering the needs and voices of survivors, restorative justice policies aim to empower survivors while meaningfully holding perpetrators accountable for their actions. These approaches often involve facilitated dialogues between survivors and perpetrators, providing opportunities for acknowledgment of harm, apology, restitution, and reconciliation. Additionally, restorative justice processes can facilitate community healing and prevent recidivism by addressing underlying causes of violence and promoting rehabilitation, a prominent point of interest for participants interviewed for this study.

However, successful implementation requires careful consideration of survivor safety, consent, and access to support services, as well as comprehensive training for facilitators and stakeholders involved in the process. Practitioners interested in adopting and offering RJ mediations to survivors of SV may engage in specialized trainings or learn from existing professionals in this field. As a first step in being able to safely facilitate RJ mediations, practitioners may also develop a comprehensive safety plan for all parties, including safety considerations for the victim, perpetrator, and mediator. Practitioners may access further resources or pursue professional membership with national associations such as the National Association of Community and Restorative Justice to begin adopting and offering RJ support options to survivors of SV.

Manuscript 3: Isolation Perpetuates Violence: The role of informal social support and community care in improving health and wellbeing after sexual violence

The third manuscript included in this dissertation examined survivors of SV's perceived role of peer and social support in long-term recovery after experiencing a violent encounter. Key findings of this study found that regardless of whether participants had or had not received meaningful social support following their SV disclosures, they agreed that it was an important feature of successful recovery. The manuscript highlighted several supportive and unsupportive examples of social reactions to SV disclosure based on lived experience perspectives and made recommendations for providing meaningful social support to individuals who have experienced SV. Finally, a key finding of this study was survivors' desire for nonprofit support services to leverage peer support options, such as support groups and peer support counselors, as formal offerings to support survivors of SV.

Implications for Policy & Practice

The present study highlighted several significant implications for policy and practice. A key finding from the study was the critical role that social support and connectedness play in preventing and mitigating PTS symptoms and long-term adverse health outcomes in survivors of SV. Policymakers and practitioners can utilize these findings to advocate for the development of more peer-led and peer-centered recovery programs to support individuals post-SV, as well as to advocate for community-based education programs and materials targeting friends and family members of SV victims.

Community education programs targeting informal support providers of survivors of SV may be particularly beneficial for empowering individuals to positively support survivors of SV. Programs that use narrative storytelling approaches, such as skits, community discussion groups, and more, may be particularly effective in their ability to provide distinct examples of positive and negative reactions to SV disclosure, as well as trying these reactions to underlying cultural norms and possible health outcomes. Community education of supportive social responses to SV disclosure may also take the form of blog posts, social media posts, and online resource guides. Acknowledging that anyone may be impacted by SV, community-based education initiatives should target diverse populations and engage in a wide breadth of outreach.

The most significant findings from this study centered around the importance of supportive social networks to bolster recovery after SV. Practitioners in the field may leverage this information by creating more group-based support opportunities for victims, and also for friends or family members who may benefit from navigating supporting an SV survivor among others. Support groups may be held in-person or could be facilitated online via virtual video conferencing programs.

Among the findings was the finding that individuals who have experienced SV glean particularly meaningful support from others who have experienced SV. Practitioners may utilize these findings to support the development of programs that leverage the lived experience wisdom of individuals who have experienced SV to support survivors, such as peer mentors or peer support counselors. Practitioners interested in leveraging this kind of paraprofessional support should ensure a fair and living wage for peer support mentors and should hire support mentors who are representative of diverse identities and circumstances. Notably, while existing literature on peer-support models for survivors of SV demonstrate value in these approaches, they also suggest caution that peer-support models may create more opportunities for survivors to experience secondary traumatization or overexposure to violent narratives and unintentionally creating harm (Gregory et al., 2022; Watson et al., 2019). These safety considerations, as well as considerations for the safety, wellbeing, and responsibility of peer support providers, and especially peer support providers with lived experience, should be carefully considered before implementing social support and peer-led support programs.

To extend the reach and accessibility of social support and peer support models, practitioners may investigate the use of online, virtual, and telehealth options. Practitioners and policymakers should investigate Medicaid reimbursement and insurance coverage for engaging in peer-centered care to ensure that services can be accessed by all who may require them.

To best be able to empower survivors of SV to reach out and utilize peer-support options, as well as to empower survivors to become peer support mentors themselves, social norming public health campaigns challenging rape myths and other harmful common narratives surrounding SV may be efficacious. Health promotion campaigns featuring diverse subjects may normalize the reality that SV can impact anybody, regardless of their identity, circumstance, or experience, and encourage victims to seek support if they have been harmed. Health promotion campaigns may also feature messages of hope and positivity, modeling for victims that help is available, and that it will get better.

Directions for Future Research

This dissertation study identified several directions for future research. Future research should examine the development, implementation, and evaluation of survivor-led programs hosted by NPHSOs to test the efficacy and sustainability of the recommendations provided in this study. Quantitative and evaluative studies are necessary to further investigate the efficacy and scalability of suggested practice and policy changes that reflect the recommendations of survivor participants. Presenting the ideas that have been suggested in this study to a larger audience may provide further evidence for the benefits of supporting survivor-led programs.

Additional research efforts should investigate the experiences of structurally marginalized individuals and communities who have experienced SV to learn more about the unique barriers to service utilization and engagement. Research engaging individuals from various racial groups, sexual and gender minority communities, disability communities, age ranges, among other identity-based groups, as well as research considering intersectionality of identities, is critical to gain culturally appropriate and specific suggestions about overcoming or removing those barriers to meaningfully create access to care and reduce health inequities associated with SV.

Finally, it is necessary to conduct similar studies in diverse geographical locations, in acknowledgement of how stark policy differences between states in the United States may lead to varying levels of trust and engagement with crisis response services among survivors of SV. To learn more about how state-based policy and cultural norms facilitate or prevent service utilization and experiences, studies employing a range of methods should be conducted in each state.

The findings from this study additionally highlight a critical need for victim-centered and led initiatives to reframe justice processes after SV. Future research is necessary to learn more about how victim-centered justice frameworks may be operationalized and implemented. Research that examines the long-term satisfaction of survivors of SV with RJ approaches to justice associated with mental and emotional health outcomes is necessary to learn more about the efficacy of these approaches. Additionally, future research on best practices for and efficacy of rehabilitative programs for perpetrators of SV is critically needed to support victim-centered approaches. Qualitative studies engaging perpetrators of violence who have entered RJ mediations would be beneficial for learning more about the rehabilitative efficacy of these approaches.

Finally, while the findings from this study aligned with contemporary literature on the role of social support after experiencing SV, additional research is necessary to learn more about the impact of social support on health trajectories, as well as about best practices in the development, implementation, and evaluation of peer support mentoring for survivors of SV. An increased research focus on the role of community in facilitating or thwarting recovery after SV is critical for understanding support seeking behaviors of survivors. Quantitative studies examining the association between positive and negative informal social support experienced after SV encounters, support seeking behaviors, and subsequent health outcomes are necessary to draw more solidified conclusions regarding this reported correlation.

More research is called for on the appropriateness of peer support models, and the best ways to utilize social support without causing further harm to clients or peer support mentors or specialists. Studies conducted in collaboration with lived experience peer support specialists are critical for understanding the impact of peer-support models on paraprofessionals.

Most peer support literature specifically related to SV focuses on white women's experiences (Lorenz et al., 2018). Additional research is necessary on the specific social support wants and needs of diverse populations.

Conclusion

While each manuscript included in this dissertation contributes independently to the existing literature, collectively they offer targeted, actionable, and survivor-centered recommendations for enhancing crisis response services tailored to support individuals in the immediate aftermath of sexual violence. This research has the potential to inform nonprofit human services organizations in developing new policies, programs, or decisions regarding outreach and marketing strategies, thereby creating an environment where survivors of SV feel more welcomed, heard, and safe when accessing these services. Furthermore, the findings of this research shed light on shortcomings within criminal justice systems that have contributed to significant mistrust, paving the way for innovative justice processes to be implemented alongside or in lieu of traditional approaches. Lastly, for the family, friends, and significant others of survivors, the insights gleaned from this research can promote positive responses to SV disclosures that effectively support the long-term recovery of survivors of SV.

Survivors of sexual violence (SV) deserve systems of care that not only effectively address their needs but also honor their narratives and prioritize their concerns. The findings of this dissertation study leverage the voices and embodied wisdom of survivors to envision a reimagining of safety after sexual violence.

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APPENDIX A. INTERVIEW GUIDE

[*The following interview guide is meant to direct a semi-structured interview with a participant. Given the stigmatized and vulnerable nature of the interview content, it is recommended that the interviewer abide by the participants' comfort level, even if that means certain questions are unaddressed. The interview should follow the pace, comfort, and perspectives of the interviewee.*]

[*Include information in the beginning about informed consent. Ask again for verbal consent to proceed with the interview.]*

[Include information in the beginning about nature of interview; ensure participants understand their right to skip questions they do not want to answer or exit the interview at any time. Ensure participants understand they do not have to disclose anything they do not wish to. Ensure participants understand that the nature of the interview is NOT about an experience with a violent event, though if they want to disclose that information, they may. The interview is about experiences with crisis response services.]

[Include information about confidentiality in the beginning. THIS IS CRITICAL. Ensure the participant understands their name, age, race, profession, or any potentially identifying feature will not be included in the final results unless they give permission otherwise to include details. Ensure they understand they will not be identifiable to any authority or person.]

Sample Intro Script:

Thank you so much for being here today; I greatly appreciate it. There are just a couple of things I need to go over before we start the interview. The first thing I'll go over is the informed consent process. The eligibility survey you participated in offered a link to the informed consent document, and I will also send it to you by email or text if you are interested. By participating in the eligibility survey, you are demonstrating your informed consent to participate in this study. I will walk you through what that means really quick just so we are all on the same page.

There is a risk of psychological harm in participating in this study, as the nature of the study is kind of a hard and difficult topic. I want to be clear that you are not required to disclose any information you are not comfortable disclosing, and especially about personal experiences with violence. This interview is mainly about your perspectives and decision-making processes about engaging with crisis response services. If you want to, and are comfortable talking about more personal topics, I welcome that and have space for that – I have experienced sexual violence myself, so there is nothing you could say that would make me uncomfortable or would make me judge you - but I will never require you to talk about anything you don't want to. That also means if we come up on a question and you don't want to answer it, you do not have to – you can say, "skip," or "I am not comfortable answering that," and I will not pressure you to respond. Also, if at any point you feel like you no longer want to participate in the interview, you may leave at any time at will – you are not stuck here.

Finally, this interview is completely confidential. That means I will never say anything to anyone about your participation in this study, and that your name or any other identifiable information will not be published alongside any of the data collected. No other members of the research team have access to your information and will only receive de-identified transcripts to work with. Additionally, after this study is completed, I will delete all records of your information so that it isn't accidentally made available down the line or anything like that.

Do you have any questions for me before we begin?

Do I have your consent to begin the recording?

The interview will take place in 3 sections – the first is a short, introductory section. Next, we will talk about your experiences or decision-making processes regarding crisis response services. The last section is the "reimagining" section, where I'll ask some more theoretical questions about what could be changed to make something better. So that's a more creative and expansive and forward-thinking section.

If you are ready, let's go ahead and get started!

Introduction

1. To begin, will you tell me a little bit about yourself, and what made you feel interested in participating in this interview?

Experience with Crisis Response

2. What crisis response services do you have experience engaging in? Filing a police report, going to the hospital, calling a crisis line or going to a crisis center, anything like that?
    1. How would you describe the experience?

Sample follow up questions:

1. What stands out about that experience to you? This can be anything at all.
2. Do you feel that you were treated with respect throughout the experience?

        → If not, what behaviors made you feel disrespected?
        → If so, what behaviors made you feel respected?
    3. Did you feel safe engaging with these services?
        → If not, what could have been done to make you feel safer?
        → If so, what about the experience made you feel safe?
    4. How did your experience impact your trust with these services? (law enforcement, healthcare, legal justice, nonprofit sector)?

  2. What factors impacted your decision to reach out to crisis response services?

No Experience with Crisis Response

1. Tell me about how you made your decision not to engage with crisis care services after your experience.
    a. What factors impacted your decision?
    b. Was your decision informed by anyone else's experience, whether a friend or family member, a community member, or a public case?
    c. What are your perceptions of crisis care services? (Of law enforcement? Of healthcare institutions? Of nonprofits?)
    d. Are these services you feel safe in engaging in or reaching out to?
        i. If so, what about them helps you to feel safe and welcomed?
        ii. If not, what about them makes you feel unsafe or unwelcomed?
    e. Did you utilize any other resources to assist you during your time of crisis? Resources can mean other services, community members, family, etc.
        i. If so, what was that experience like?
        ii. If not, what would have made you feel safe and cared for in that time? What could have been done?

Action Imagining and Planning (All participants)

2. How do you imagine "safety" after sexual violence?
3. How do you imagine "justice" after sexual violence?
4. What do you believe best practices should be for survivors of SV? In a perfect world, what would that process look like to you?
5. If you had to give advice to a friend about engaging with these services, what advice would you give?
6. Is there any language that you find upsetting or triggering when you see it being used by crisis response services or service providers?

7. What additional support would be helpful, or would have been helpful, during that time?
8. How have you been caring for yourself since having this experience?
9. Is there anything that I haven’t asked about that you want to share with me about these experiences?

[*Discuss incentive, resources for future care, and thank them for their time. Discuss following-up with them should the researcher need future clarification or expounding*].

APPENDIX B. STUDY RECRUITMENT IMAGES

Reimagining Safety after Sexual Violence: a Survivor-Led Study

If you live in the state of Kentucky and have ever experienced sexual violence,

we want to learn from you.

Help us reimagine how crisis care services can support people after sexual violence.

If selected, you will be compensated **$50** for a 1-hour confidential interview.

To learn more:

https://bit.ly/RS-Study

Sexual violence impacts everybody. People from all backgrounds, identities, and experiences are encouraged to apply.

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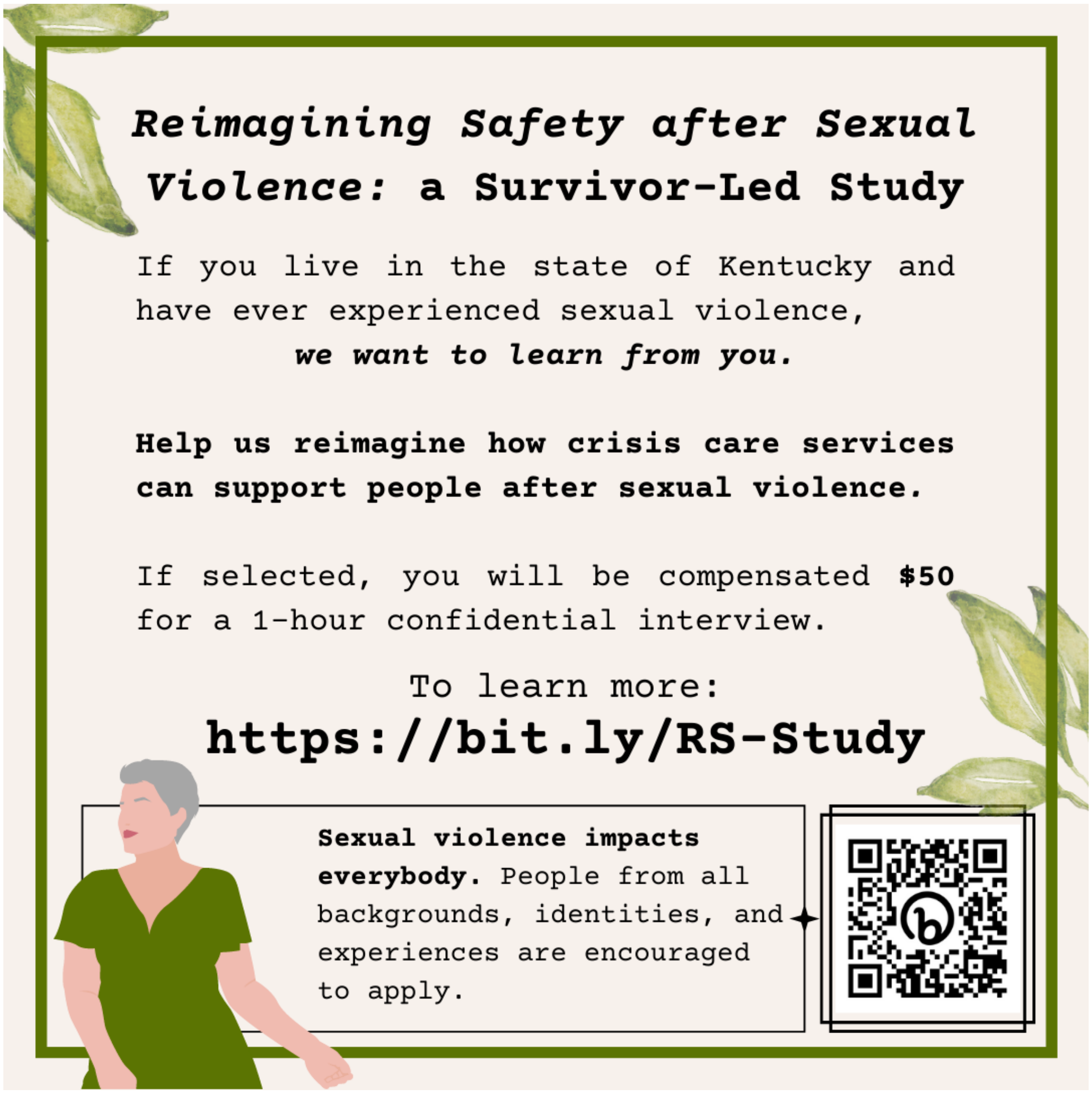

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APPENDIX C. ELIGIBILITY SURVEY

Reimagining Safety after Sexual Violence (RS) Study
Recruitment Screening Questions

Thank you for your interest in participating in the Reimagining Safety after Sexual Violence (RS) Study. This survey is to determine your interest and eligibility for taking part in this research. If you are selected, you will be contacted by a member of the research team to schedule an interview. Your interview will last between 60 and 90 minutes, and you will be compensated with a $50 gift card for your time and expertise. The information provided in this survey will be kept confidential.

Please read the following PDF about informed consent and your rights for participation in research.
[Insert unsigned Informed Consent PDF]

1. Are you over the age of 18?
    a. Yes
    b. No

    [If yes, move to question 2.]
    [If no, display Final Prompt 2.]

2. Are you currently, or have you ever been, a resident of Kentucky?
    a. Yes
    b. No

    [If yes, move to question 3.]
    [If no, display Final Prompt 2].

3. Since turning 18, have you ever experienced an event you would consider as sexual violence? Sexual violence is defined broadly and may include experiences of rape, assault, molestation, stalking, technology-facilitated violence (online intimidation or distribution of “revenge porn”).
    a. Yes
    b. No

    [If yes, move to question 4.]
    [If no, display Final Prompt 2.]

4. After your experience, did you contact or engage with any crisis response service, e.g. law enforcement agencies, healthcare institutions, or nonprofit agencies?
    a. Yes
    b. No

    [If yes, move to question 5.]
    [If no, move to question 5.]

    [Insert eligibility statement here]

Thank you! If you are seeing this message, you are eligible to participate in the Reimagining Safety study. In order to capture a diverse range of experiences, please fill out the following demographics information. Text-boxes are used to allow you to self-identify using language that you decide. Responses are mandatory, as they help this research capture a wide diversity of experience. Responses will not be used to impact eligibility for participation or for receiving an incentive award.

5. What is your current age?
    [Open text box]

6. What is your race?
    [Open text box]

7. What is your gender?
    [Open text box]

8. How would you define your sexual orientation?
    [Open text box]

9. Do you have a disability or live with chronic illness?
    a. Yes
    b. No

10. How would you describe your current personal annual income?
    a. <10,000/year
    b. 10,000 - 25,000/year
    c. 26,000 - 35,000/year
    d. 36,000-45,000/year
    e. 46,000-55,000/year
    f. 56,000 - 65,000/year
    g. 66,000-75,000/year
    h. 76,000-85,000/year
    i. 86,000-95,000/year
    j. 96,000-105,000/year
    k. <106,000/year

11. Are there any other identities that feel important to you, or that you believe should be represented in sexual violence research?

    [Open text box]

[Final Prompt 1]

Thank you so much for filling out this eligibility survey. You are eligible for participation in this study. Please enter your name (can be first name only) and a safe email address or phone number you are comfortable with being contacted at, and a member of the research team will reach out shortly to schedule your interview.

Name

[Open text box]

Email or phone number

[Open text box]

If you have provided a phone number, would you prefer to receive a text or a phone call?

1. Phone call
2. Text

[Final Prompt 2]

Thank you so much for filling out this eligibility survey. At this time, your answers have indicated that you are not eligible for participation in this study. If you believe you are receiving this message mistakenly, please contact Hallie Decker, at hallie.decker@louisville.edu.

APPENDIX D. INFORMED CONSENT DOCUMENT

Reimagining Safety after Sexual Violence Study

Informed Consent Information

Dear participant,

You are being invited to participate in a study exploring survivors of sexual violence's experiences of and decision-making processes regarding various crisis response services to learn more about service accessibility, appropriateness, and inclusivity. For this study, we will be conducting virtual interviews. The purpose of this study is to learn from individuals who have experienced sexual violence to better understand how to approach crisis care. We are especially interested in the experiences of individuals who have engaged with crisis care services after experiencing violence; however, you do not need to have done so in order to be eligible for this study.

This research is being conducted by Hallie Decker, MSSW, PhD(c) at the School of Public Health and Information Sciences at the University of Louisville. This research is being conducted to fulfill the requirements of the dissertation process to complete the doctoral degree.

There are minimal risks for your participation in this research study. You may experience psychological distress while completing this interview. The information collected may not benefit you directly. The information learned in this study may be helpful to others. The information you provide may help improve crisis response services for survivors of sexual violence. Your completed interview will be stored in secure university cloud servers. The recorded interview will take between one hour and 90 minutes to complete. The recordings will be transcribed for analysis.

You will be paid either a $50 Amazon gift card or a $50 prepaid card (depending on your preference) for your time, inconvenience, or expenses while you are in this study. Because you will be paid to be in this study, the research team may collect your name, address, social security number, and keep records of how much you are paid. You may or may not be sent a Form 1099 by the University. This will only happen if you are paid $600 or more in one year by the University. This will not include payments you may receive as reimbursement for actual expenses based on receipts or actual miles traveled. We are required by the Internal Revenue Service to collect this information and you may need to report the payment as income on your taxes. You can still be in the study even if you do not want to be paid.

Individuals from the University of Louisville Health Promotion & Behavioral Sciences department, the Institutional Review Board (IRB), the Human Subjects Protection Program Office (HSPPO), and other regulatory agencies may inspect these records. In all other respects, however, the data will be held in confidence to the extent permitted by law. Should the data be published, your identity will not be disclosed.

Taking part in this study is voluntary. By answering the screening questions you agree to take part in this research study. You do not have to answer any questions that make you feel uncomfortable. You may choose not to take part at all. If you decide to be in this study you may stop taking part at any time. If you decide not to be in this study or if you stop taking part at any time, you will not lose any benefits for which you may qualify.

If you have any questions about your rights as a research subject, you may call the Human Subjects Protection Program Office at (502) 852-5188. You can discuss any questions about your rights as a research subject, in private, with a member of the Institutional Review Board (IRB). The IRB is an independent committee made up of people from the University community, staff of the institutions, as well as people from the community not connected with these institutions. The IRB has reviewed this research study.

If you have any questions, concerns, or complaints about the research study, please contact:
Hallie Decker, MSSW, at hallie.decker@louisville.edu.

If you have concerns or complaints about the research or research staff and you do not wish to give your name, you may call 1-877-852-1167. This is a 24 hour hot line answered by people who do not work at the University of Louisville.

Thank you,

Hallie R. Decker, MSSW (*she/her/hers*)
University of Louisville
Research Manager | Ph.D. Candidate
School of Public Health and Information Sciences
Office of Research and Innovation | Health Equity Innovation Hub
515 W. Market St. Louisville KY 40202

APPENDIX E. FINAL SAMPLE CHARACTERISTICS

Age Range
18 - 25: 8
26 - 35: 8
36 - 45: 2
46 - 55: 1
56 - 65: 1

Gender
Cisgender Woman: 14
Cisgender Man: 1
Nonbinary: 2
Transgender Man: 3

Race
White/Caucasian: 15
African American/Black: 2
Biracial: 3

Sexual Orientation
Straight/Heterosexual: 7
Bisexual/Pansexual: 8
Queer: 3
Gay: 1

Disability or Chronic Condition
Yes: 11
No: 9

Socioeconomic Status Range
<$10,000/year: 3
$10,000 - $25,000/year: 4
$26,000 - $35,000/year: 3
$36,000 - $45,000/year: 2
$46,000 - $55,000/year: 2
$56,000 - $65,000/year: 3
$66,000 - $75,000/year: 1
$76,000 - $85,000/year: 0
$86,000 - $95,000/year: 0
$95,000 - $105,000/year: 1

> $105,000/year: 1

After your experience, did you contact or engage with any crisis response service? For this purpose, crisis response service will refer to law enforcement agencies, healthcare institutions, or nonprofit agencies.

Yes: 10
No: 5
Considered, but did not contact or engage: 5

APPENDIX F. RESOURCE GUIDE

Reimagining Safety after Sexual Violence Study – Sexual Violence Resources

Kentucky:
Interactive map of sexual violence services in Kentucky: https://www.kasap.org/help-for-survivors

Crisis Text Line:
Text “KY” to 741741

Region 1: Lotus Children’s Advocacy & Sexual Violence Resource Center
P.O. Box 8506, Paducah, KY 42002
(800) 928-7273
hopehealgrow.org

Region 2: Sanctuary, Inc.
P.O. Box 1165
Hopkinsville, KY 42241
(800) 766-0000 | sanctuaryinc.net

Region 3: New Beginnings Sexual Assault Support Services
1716 Scherm Rd.
Owensboro, KY 42301
(800) 226-7273
nbowensboro.org

Region 4: Hope Harbor, Inc.
913 Broadway Ave.
Bowling Green, KY 42101
(270) 846-1100
hopeharbor.net

Region 5: Silverleaf Sexual Trauma Recovery Services
751 S Provident Way
Elizabethtown, KY 42701
(877) 672-2124 | silverleafky.org

Region 6: The Center for Women & Families
P.O. Box 2048, Louisville, KY 40201
(844) BE-SAFE-1 | (844) 237-2331
thecenteronline.org

Region 7 & 8: The Ion Center for Violence Prevention
835 Madison Ave.
Covington, KY 41011
(859) 491-3335 (Northern Kentucky)
(606) 564-6708 (Buffalo Trace)
ioncenter.org

Region 9 & 10: Pathways, Inc.(Ashland & Morehead)
P,O. Box 790, Ashland, KY 41101
(800) 562-8909 | pathways-ky.org

Region 11: Mountain
Comprehensive Care Center's Healing Program for Survivors of Sexual Assault & Domestic Violence
104 South Front Ave.
Prestonsburg, KY 41653
(800) 422-1060 | mtcomp.org

Region 12: The Rising Center
637 Morton Blvd., Hazard, KY 41701
(800) 375-7273 | therisingcenter.org

Region 13: Cumberland River
Victims Services
P.O. Box 568, Corbin, KY 40701
(606) 528-5286 | crvsky.org

Region 14: Adanta Sexual Assault
Resource Center (ASARC)
259 Parkers Mill Rd.
Somerset, KY 42501
(800) 656-HOPE (4673) | adanta.org

Region 15: Ampersand Sexual
Violence Resource Center of the Bluegrass
P.O. Box 1603, Lexington, KY 40588
(859) 253-2511
ampersandky.org

National:

National Sexual Assault Hotline (RAINN):
1-800-656-4673

RAINN Online Counseling: https://ohl.rainn.org/online/

Sexual Abuse Crisis Text Line:
Text HOME to 741741

Love is Respect Hotline
1-866-331-99474 (24/7) or Text “loveis” 22522

The Anti-Violence Project– serves people who are LGBTQ
Hotline 212-714-1124 Bilingual 24/7

LGBT National Help Center
National Hotline (1-888-843-4564) or National Youth Talkline (1-800-246-7743)
Online Peer Support Chat (https://www.glbthotline.org/peer-chat.html) or Weekly Youth Chatrooms (https://www.glbthotline.org/youthchatrooms.html)

National Domestic Violence Hotline
1-800-799-7233
Text LOVEIS to 22522

Ujima – National Center on Violence Against Women in the Black Community
Ujima is in the process of developing a culturally-specific services resource directory, which identifies organizations across the country that provide unique services tailored to survivors on violence across the African diaspora. While the resource directory is being finalized, contact Ujima at 1-844-77-UJIMA for information on resources currently available.
If you need immediate assistance, always dial 9-1-1

FORGE– serves transgender and gender nonconforming survivors of domestic and sexual violence; provides referrals to local counselors

The Network La Red– serves LGBTQ, poly, and kink/BDSM survivors of abuse; bilingual
Hotline - 617-742-4911
National Suicide Prevention Lifeline

1-800-273-TALK (8255)
suicidepreventionlifeline.org

National Domestic Violence Hotline
1-800-799-SAFE (7233)
thehotline.org

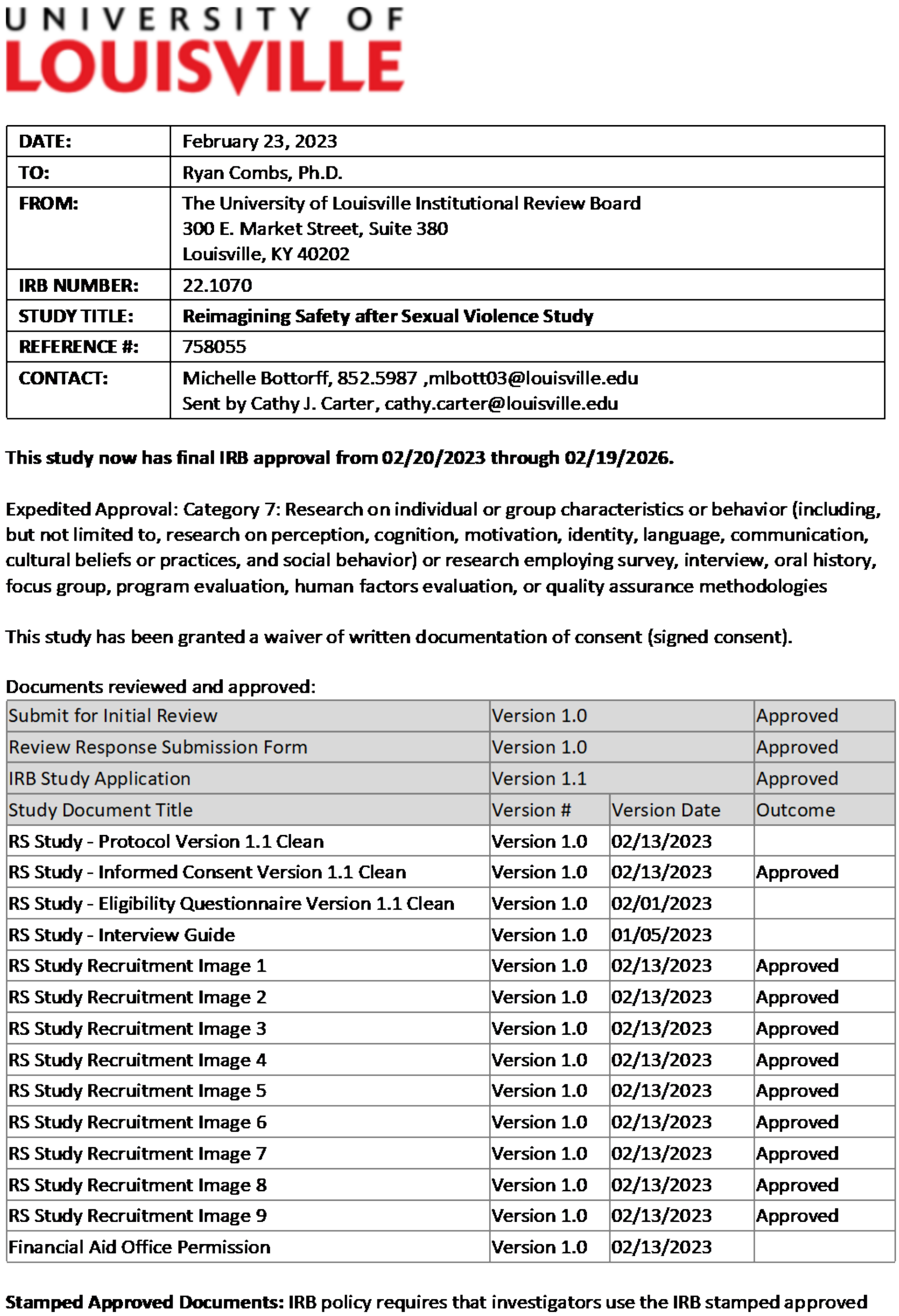
Operating around the clock, seven days a week, confidential and free of cost, the National Domestic Violence Hotline provides lifesaving tools and immediate support to enable victims to find safety and live lives free of abuse. Callers to The Hotline at 1-800-799-SAFE (7233) can expect highly trained, experienced advocates to offer compassionate support, crisis intervention information, educational services and referral services in more than 200 languages.

National Deaf Domestic Violence Hotline
855-812-1001
thedeafhotline.org
The National Deaf Hotline, partnered with National Domestic Violence Hotline, strives to make sure there is access for survivors, friends, and family members to reach out anytime by providing services that run 24 hours and 7 days a week. The services are to support survivors of domestic violence and/or sexual assault within the Deaf, DeafBlind, DeafDisabled, and Hard-of-Hearing community.

StrongHearts Native Helpline
1-844-7NATIVE (762-8483)
Chat: strongheartshelpline.org
StrongHearts Native Helpline is a culturally-appropriate, anonymous, confidential and free service dedicated to serving Native American and Alaska Native survivors, and concerned family members and friends affected by domestic, dating and sexual violence. Dial or text 1-844-7NATIVE (1-844-762-8483) or click on the chat now icon at strongheartshelpline.org 24/7. Connect with knowledgeable advocates who can provide lifesaving tools and immediate support to enable survivors to find safety and live lives free of abuse. StrongHearts Native Helpline is a project of the National Indigenous Women's Resource Center and the National Domestic Violence Hotline. Learn more at strongheartshelpline.org.

National Human Trafficking Hotline
1-888-373-7888 / Text: 233733
humantraffickinghotline.org
The National Human Trafficking Hotline is a national anti-trafficking hotline serving victims and survivors of human trafficking and the anti-trafficking community in the United States. The toll-free hotline is available to answer calls from anywhere in the country, 24 hours a day, 7 days a week, every day of the year in more than 200 languages.

APPENDIX F. INSTITUTIONAL REVIEW BOARD OUTCOME LETTER



UNIVERSITY OF LOUISVILLE

DATE:	February 23, 2023
TO:	Ryan Combs, Ph.D.
FROM:	The University of Louisville Institutional Review Board 300 E. Market Street, Suite 380 Louisville, KY 40202
IRB NUMBER:	22.1070
STUDY TITLE:	**Reimagining Safety after Sexual Violence Study**
REFERENCE #:	758055
CONTACT:	Michelle Bottorff, 852.5987 ,mlbott03@louisville.edu Sent by Cathy J. Carter, cathy.carter@louisville.edu

This study now has final IRB approval from 02/20/2023 through 02/19/2026.

Expedited Approval: Category 7: Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

This study has been granted a waiver of written documentation of consent (signed consent).

Documents reviewed and approved:

Submit for Initial Review	Version 1.0		Approved
Review Response Submission Form	Version 1.0		Approved
IRB Study Application	Version 1.1		Approved
Study Document Title	Version #	Version Date	Outcome
RS Study - Protocol Version 1.1 Clean	Version 1.0	02/13/2023	
RS Study - Informed Consent Version 1.1 Clean	Version 1.0	02/13/2023	Approved
RS Study - Eligibility Questionnaire Version 1.1 Clean	Version 1.0	02/01/2023	
RS Study - Interview Guide	Version 1.0	01/05/2023	
RS Study Recruitment Image 1	Version 1.0	02/13/2023	Approved
RS Study Recruitment Image 2	Version 1.0	02/13/2023	Approved
RS Study Recruitment Image 3	Version 1.0	02/13/2023	Approved
RS Study Recruitment Image 4	Version 1.0	02/13/2023	Approved
RS Study Recruitment Image 5	Version 1.0	02/13/2023	Approved
RS Study Recruitment Image 6	Version 1.0	02/13/2023	Approved
RS Study Recruitment Image 7	Version 1.0	02/13/2023	Approved
RS Study Recruitment Image 8	Version 1.0	02/13/2023	Approved
RS Study Recruitment Image 9	Version 1.0	02/13/2023	Approved
Financial Aid Office Permission	Version 1.0	02/13/2023	

Stamped Approved Documents: IRB policy requires that investigators use the IRB stamped approved version of informed consents, assents, and other materials given to research participants. The IRB applies an approval stamp to the top right hand corner of the document. For instructions on locating the IRB stamped documents in iRIS visit: https://louisville.app.box.com/s/oh7a7ccyjlsyqxa1goibbgf3rx5jle8v

Please note: The file format of your recruitment materials did not allow for the placement of the IRB approved stamp on the document. (This also generally happens on, for instance, an Excel spreadsheet.) The attached versions WERE approved – as reflected on this letter.

Continuation Requirements: **Your study has been set with a three-year expiration date.** If you complete your study prior to the expiration date, you are required to submit a study closure amendment.

You are responsible for submitting a continuation request approximately 30 days prior to the expiration date of your research study. If a study lapse occurs, this is considered non-compliance and may prompt a HSPPO audit.

Human Participants & HIPAA Research training are required for all study personnel. It is the responsibility of the investigator to ensure that all study personnel maintain current Human Participants & HIPAA Research training while the study is ongoing.

Study Site Approval: Permission from the institution or organization where this research will be conducted **must** be obtained before the research can begin (e.g., UofL Health, Norton Healthcare, Jefferson County Public Schools, etc.).

Amendments **(Making Changes to the Study)**: Prior to making changes to the study, the investigator must submit an amendment to the IRB and receive approval. If the change is being made to ensure the immediate safety and welfare of the participants, refer to the amendments link above for more information.

Reportable Events: The investigator is responsible for reporting certain study events to the IRB within 5 working days.

You are required to follow all University of Louisville policies and procedures related to conducting human subjects research and managing research data. For more information visit: Human Subjects Protection Program Policies.

The committee will be advised of this action at a regularly scheduled meeting. Thank you,

Paula Radmacher

Paula Radmacher, Ph.D., Vice Chair, Biomedical Institutional Review Board

We value your feedback; let us know how we are doing: https://www.surveymonkey.com/r/CCLHXRP

CURRICULUM VITAE

Hallie R. Decker, MSSW, PhD(c)
hallie.decker@louisville.edu | hallieruthdecker@gmail.com |
linkedin.com/in/halliedecker

Research Interests

Health equity • Social and structural determinants of health • Multi-level health intervention • Social Ecology • Violence prevention • Systems thinking • Qualitative Methods • Grounded Theory • Community-based participatory research • Community-based system dynamics • Gender equity • Sexuality and sexual health • Mental health • Healthcare access and trust • Research Justice

Education

2018-2024	**PhD**	University of Louisville, School of Public Health and Information Sciences, Department of Health Promotion and Behavioral Sciences Dissertation Title: *Reimagining Safety after Sexual Violence: A Qualitative Exploration of Survivors' Experiences with Formal and Informal Crisis Response Networks*
2017-2018	**MSSW**	University of Louisville, Raymond A. Kent School of Social Work and Family Sciences
2009-2013	**BA**	University of Kentucky, College of Arts and Sciences, Department of Chinese Language and Literature, Minor in International Studies

Academic Employment

2023 – Present	**Associate Director of Research**	State-University Partnership with Kentucky Cabinet for Health & Human Services - *Understanding the Behavioral Health Landscape and Feasibility of Mobile Crisis Intervention (MCI) in Kentucky: Assessing and Addressing Behavioral Health in Kentucky*

2023 - Present	**Research Manager**	Jewish Heritage Fund: *Increasing resilience in LGBTQ+ adolescents: mitigating the impact of trauma by planning and implementing an educational curriculum for healthcare providers.*
2022 – Present	**Managing Editor**	Family & Community Health Journal
2021 - 2023	**Research Manager**	Health Equity Innovation Hub
2020 - 2021	**Graduate Research Assistant**	Centers for Disease Control: Youth Violence Prevention Research Center
2018-2021	**Graduate Research Assistant**	University of Louisville School of Public Health and Information Sciences

Teaching Experience

2021-2022	**Instructor**	Health Equity (PHPB 301)

Invited Guest Lectures

2023	University of Illinois at Chicago: IPHS 401 – Determinants of Health	Lecture Title: *Gender, Sexuality, & the Social Determinants of Health*
2023	University of Illinois at Chicago: IPHS 401 – Determinants of Health	Lecture Title: *Gender, Sexuality, & the Social Determinants of Health*
2023	University of Louisville: PHPB 312 – Social Justice Practice in Public Health	Lecture Title: *Using System Dynamics to Identify Leverage Points for Change*
2023	University of Louisville: PHPH 301 – Global Public Health	Lecture Title: *Gender, Sexuality, & Health: Conceptualizing constructs of gender and sex to better understand gender-based health experiences and inequities.*
2022	Health Equity Innovation Hub	Lecture Title: *Community-Based System Dynamics Applications to Public Health*

2022	University of Louisville: PHPH 301 – Global Public Health	Lecture Title: *Gender, Sexuality, & Health: Conceptualizing constructs of gender and sex to better understand LGBTQ+ health experiences and inequities.*
2021	University of Louisville: PHPH 300 – Social and Behavioral Foundations of Public Health	Lecture Title: *LGBTQ+ Population Health and Disparities: Why Pronouns are Health Promotion*
2020	University of Louisville: PHPH 301 – Global Public Health	Lecture Title: *LGBTQ+ Population Health and Disparities.*

Scholarships, Certificates, & Awards

2023	University of Louisville Graduate School Dissertation Research Scholarship
2022	University of Louisville Student Champion Award
2021	Research! Louisville Third Place Winner of Best in Health Disparities Research
2019	Kent School of Social Work Third Place Winner for Evidence-Based Practice Award

Publications

Decker, H., Combs, R., Cowand, A., Noonan, E., Weingartner, L., Harris, L., Williams, S. Shared social identity and social safety as health promoting factors for transgender individuals with a chronic illness and/or disability. Under review at *Disability & Health.*

Middleton, J., Harris, L., **Decker, H**., Revill, S. "He Lived in a Tent, and I was Homeless…So I Became his Girlfriend": Coping Strategies Among Survivors of Childhood Sex Trafficking. In preparation.

Combs, R., **Decker, H**., Noonan, E., Weingartner, L., Bohnert, C. Gender Minority Portrayal in Patient Simulation: Transgender and Non-binary Healthcare Providers Consider the Priorities and Ethics of Practice. Accepted in *International Journal of Healthcare Simulation*.

Decker, H., & Wendel, M. (2023). Applications of Participatory System Dynamics Methods to Public Health: A Systematic Review. *Family & Community Health*, *46*(Suppl 1), S6-S21.

Garney, W. R., Wendel, M. L., **Decker, H. R**., & Flores, S. A. (2023). Advancing the Systems Science Paradigm in Public Health Through Intervention and Evaluation. *Family & community health*, *46*(Suppl 1), S2-S5.

Naifeh, M. M., Stevenson, M. D., Abramson, E. L., Aston, C. E., Combs, R. M., **Decker, H**. R., & Li, S. T. T. (2023). The Early Effects of the Coronavirus Disease-19 Pandemic on Pediatric Resident Education: A National Assessment. *Academic Pediatrics*, *23*(5), 993-1000.

Noonan, E. J., Combs, R., Bohnert, C., **Decker, H. R**., Black, C., & Weingartner, L. A. (2022). Perspectives of Transgender and Nonbinary Health Care Providers on Gender Minority Patient Simulation. *Academic Medicine*, *97*(11S), S139.

Decker, H., Combs, R. M., Noonan, E. J., Black, C., & Weingartner, L. A. (2022). LGBTQ+ Microaggressions in Health Care: Piloting an Observation Framework in a Standardized Patient Assessment. *Journal of Homosexuality*, 1-17.

Weingartner, L. A., Combs, R. M., Bohnert, C. A., **Decker, H. R**., & Noonan, E. J. (2022). Epistemic Peerhood as a Model To Improve Gender-Affirming Care in Medical Education. *Teaching and Learning in Medicine*, 1-10.

White, K. B., Combs, R. M., **Decker, H. R**., & Schmidt, B. M. (2021). Gender-Based Perspectives on Professional Healthcare Chaplaincy Board Certification. *Journal for the Scientific Study of Religion*, *60*(4), 871-889.

White, K. B., Combs, R. M., & **Decker, H. R**. (2022). Board certification of professional chaplains: a qualitative study of stakeholder perspectives. *Journal of Health Care Chaplaincy*, *28*(4), 443-466.

Research Posters & Conference Presentations

2023	**International Human Trafficking & Social Justice Conference** University of Toledo's Human Trafficking and Social Justice Institute *Toledo, Ohio*	Presented "He Lived in a Tent, and I was Homeless…So I Became his Girlfriend": Coping Strategies Among Survivors of Childhood Sex Trafficking" Oral session
2022	**Research!Louisville** University of Louisville *Louisville, Kentucky*	Presented "Application of Participatory System Dynamics Methods to Public Health Research: A Systematic Review"
2022	**International Systems Dynamics Society Conference (ISDC 2022)** International Systems Dynamics Society *Frankfurt, Germany*	Presented "Community-Based Systems Dynamics and Group Model Building Application to Public Health: A Systematic Review"

2021	**Research!Louisville 2021** University of Louisville *Louisville, Kentucky*	Presented "Effects of an Inclusive Clinical Skills Training on Medical Student LGBTQ+ Microaggressions."
2020	**American Public Health Association (APHA) Conference – "Creating the Healthiest Nation: Preventing Violence"** American Public Health Association *San Francisco, California*	Presented "The development of the LGBTQ microaggressions in healthcare scale (LGBTQ-MHCS)" Oral session
2020	**Kentucky Public Health Association (KPHA) Conference – "2020 Transformation - A Clear Vision for a Healthy Kentucky"** *Covington, Kentucky*	Presented "Embrace the Journey: An LGBTQ+ Adolescent Health Campaign" Poster
2019	**Transformation in Transition: Building Affirming Community in Rural Spaces Conference** Big Sandy Safe Zone *Pikeville, Kentucky*	Co-facilitated "The eQuality Toolkit: Practical Skills for LGBTQ and DSD-Affected Patient Care" Workshop
2019	**LGBT Mental Health Conference** Eastern Kentucky University *Richmond, Kentucky*	Co-facilitated "Evidence-Based Practical Skills for LGBTQ and DSD-Affected Patient Care" Workshop
2019	**2019 AAMC Central and Southern GSA/OSR Joint Regional Spring Meeting: Navigating Evolving Pathways** OMNI Louisville Hotel *Louisville, Kentucky*	Presented "eQuality: Project Overview and Clinical Resources from LGBT Medical Curricula" Poster
2019	**National LGBTQ Health Conference – Bridging Research & Practice** Emory Conference Center and Hotel *Atlanta, Georgia*	**"Gender and Sexual Minority Adolescent Health in Louisville, Kentucky"**

2018	**2018 Social Justice Research Symposium** Cooperative Consortium for Transdisciplinary Social Justice Research *Louisville, Kentucky*	Presented “Gender and Sexual Minority Adolescent Health in Louisville, KY” Poster
2018	**Research!Louisville 2018** University of Louisville *Louisville, Kentucky*	Presented “eQuality: Project Overview and Clinical Resources from LGBT Medical Curricula” Poster

Community Service

2023 -- present	Community Equity Committee Member	Planned Parenthood Great Northwest, Hawai’i, Alaska, Indiana, Kentucky