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Rape Crisis Victim Advocacy: A Systematic Review

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Abstract

While rape crisis center (RCC) advocacy is generally regarded as valuable, there are no prior systematic reviews of the advocacy literature. This review examined RCC advocacy service provision, perceptions and impact of advocacy, and challenges and facilitators to effective service provision. Databases related to health and social sciences were searched including Academic Search Complete, PsychINFO, PubMed, CINAHL, ProQuest, Science Direct, OAlster, WorldCat, and MEDLINE. Empirical articles written in English that examined RCC advocacy service provision and/or impact in the US were included. The researchers reviewed abstracts and titles, and then full texts. Forty-five articles met criteria, were summarized, and double checked. Findings demonstrate advocacy is multi-faceted, beneficial, and challenging. Advocates work directly with survivors and interact with other responders on behalf of survivors. Specifically, advocates provide emotional support, safety plan, support survivors in making decisions, and assist them in navigating other systems. While advocates are generally regarded positively by survivors and responders, some responders have concerns about advocates. In addition, advocates sometimes report victim-blaming and being ill-equipped to meet survivors' needs. Finally, advocates face specific challenges in their work with survivors and responders. Future research using diverse methodological approaches is needed to understand advocacy utilization and reach; survivors' perceptions of advocacy; marginalized survivors' experiences; connections between specific services, implementation, and outcomes; and effective strategies for advocates' interactions with other responders. Additional resources to help advocates serve all survivors effectively and equitably; to support evaluator-practitioner partnerships; and to share unpublished data on advocacy may help contribute to improvements in advocacy practice.

Keywords

intervention, sexual assault, reporting/disclosure, support seeking, mental health and violence

Rape Crisis Victim Advocacy: A Systematic Review[1]

Sexual assault (SA) is associated with a variety of negative consequences for survivors' physical and mental wellbeing (Pemberton & Loeb, 2020). The trauma and impact of SA may be exacerbated when survivors are met with negative reactions upon disclosure (e.g., Martin, 2005) Rape crisis centers (RCCs) were developed in the 1970s through grassroots efforts to improve the response to SA (Shaw & Campbell, 2011). Rape crisis centers initially aimed to both support survivors and demand social change to eliminate rape. Today, RCCs typically offer crisis hotlines, advocacy, long-term counseling, and support groups (Bein, n. d.). Rape crisis centers may also participate in multidisciplinary efforts to coordinate how formal systems respond to SA, such as Sexual Assault Response Teams (SARTs; Greeson & Campbell, 2015). Many RCCs also lead community education efforts to prevent and raise awareness of sexual violence (Office on Violence Against Women, 2017). Through these efforts, RCCs strive to prevent SA, and make systems more accessible and responsive to survivors. Advocacy is one of the core services provided by rape crisis centers (Macy et al., 2013) and is widely viewed as best practice (Office on Violence Against Women, 2013). However, there have been no holistic examinations of the evidence-base on RCC advocacy. A systematic review of the research on RCC advocacy can guide policy, practice, and future research directions. Therefore, this systematic review examines RCC advocacy service provision, perceptions of and impact of advocacy, and challenges and facilitators to effective service provision.

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Advocacy involves acting with or on behalf of an individual (or individuals) and may focus on creating change at multiple levels of analysis (e.g., individuals, systems, communities, etc., (Sullivan & Goodman, 2019; Toporek et al., 2009). Agencies that serve victims of gender-based violence provide advocates to help meet survivors' needs (Macy et al., 2013). These advocates may be staff or highly trained volunteers (Maier, 2011). Advocates interact with survivors and with others (e.g., other systems personnel) on the survivor's behalf (Sullivan & Goodman, 2019). To date, there is no one definition or framework for conceptualizing RCC advocacy. However, the literature on intimate partner violence advocacy provides useful guidance that can be extended to the context of RCC advocacy. Sullivan and Goodman (2019) note that advocacy is distinct from other forms of support for survivors because advocacy involves "partnering with (survivors) to represent their rights and interests while linking them to concrete resources, protections, and opportunities" (abstract). In this way, advocacy seeks to empower survivors by centering their goals, interests, and rights (Rivas et al., 2019; Sullivan & Goodman, 2019; Wood, 2015). Advocacy is distinct from other services because advocacy is not merely referrals or case management, but also involves representing survivors' interests to others, to ensure survivors can access concrete resources (Sullivan & Goodman, 2019).

Drawing from these frameworks, we define RCC advocacy as working in a formal capacity (as a trained volunteer or employee of a RCC) with or on behalf of a sexual assault survivor to support them in accessing resources to address their post-assault needs. Specifically, this includes providing survivors information about their options, rights, and resources; supporting survivors as they attempt to obtain resources and/or interact with other systems; interacting with others on a survivor's behalf to help them access services or other resources; providing emotional support; and safety planning (e.g., Shaw & Campbell, 2011; Wilt, 2019). This does not include formal therapeutic services.

In this paper, we are focused on advocacy provided by RCCs. Often, RCC advocacy focuses on legal advocacy (i.e., helping survivors who are interested learn about and access resources from the civil and criminal legal systems), and medical advocacy (i.e., helping survivors who are interested learn about and access medical and forensic services post-assault). Advocacy focused on sexual assault survivors also occurs in other contexts, not just rape crisis centers. For example, police departments and prosecutor's offices offer victim advocates that help sexual assault survivors progress through various criminal legal processes (see OVW, 2017). However, unlike RCC advocacy, these forms of advocacy are limited to the criminal justice system and do not focus solely on advocating for survivors' interests. Therefore, these distinct forms of advocacy are excluded from the focus of this review.

In addition, sexual assault co-occurs with intimate partner violence for many survivors. Survivors who experience intimate partner violence that includes sexual violence may seek services and receive advocacy from an agency that focuses on intimate partner violence, not a RCC. Although intimate partner violence and RCC advocacy are both guided by similar principles (e.g., empowerment, helping survivors access resources; Sullivan & Goodman, 2019; Shaw & Campbell, 2011; Ullman & Townsend, 2008; Wood, 2015), they are also distinct. Intimate partner violence advocacy is provided in residential and nonresidential settings and tends to focus more on meeting survivors' material needs (e.g., housing, employment, etc.; Allen et al., 2004, Bennet et al., 2004; Macy et al., 2009). Rape crisis center advocacy focuses less on these topics, and does focus on medical advocacy, particularly accompanying survivors to medical/forensic exams (Shaw & Campbell, 2011). Additionally, while both types of advocacy focus on the legal system, laws, protections (e.g., protective orders), and evidence differ with respect to intimate partner violence and non-intimate partner sexual assault. As a result, legal advocates in intimate partner violence versus sexual assault cases play different roles with respect to the legal system. Thus, while there may be similarities in intimate partner violence advocacy and advocacy focused uniquely on sexual assault survivors, there are also meaningful differences. Therefore, this review focuses on advocacy services that are specifically designed for sexual assault survivors, provided by rape crisis centers.

Rationale

The purpose of this systematic review is to examine research on RCC advocacy. The medical and legal systems are two major systems through which survivors commonly seek services. However, these systems frequently retraumatize survivors and fail to provide comprehensive services (Long, 2018; Maier, 2012a). Thus, advocates play a critical role in mitigating further trauma and helping survivors access needed services (Shaw & Campbell, 2011). In recognition of the importance of this role, advocacy services are routinely offered by RCCs in the U.S. (Bein, n. d.). While there is no exact data on the scope of medical and legal advocacy, a 2016 OVW report found that, in a 6-month span, Violence Against Women Act funded grantees provided crisis intervention services (including advocacy) to over 38,000 primary victims (Office on Violence Against Women, 2016).[1] In addition to being widespread, offering RCC advocacy services to SA survivors is considered best practice (e.g., OVW, 2013).

While these services are clearly valuable, there is also recognition that the field needs to further examine the evidence base behind them (National Advisory Committee on Violence Against Women, 2013). A deeper understanding of the research on advocacy can provide guidance for practice and future research. For one, advocates need to ensure medical and legal personnel meet survivors' needs. Examining research on these relationships may help guide how advocates should approach other disciplines. In addition, advocacy involves multiple types of intervention (e.g., emotional support, working with other responders, etc.). Reviewing the research can help to examine different services advocates provide, as well as implementation and impact of services. This can help demonstrate which advocacy practices are most and least effective for survivors, as well as the circumstances under which they are more or less effective (e.g., for diverse groups of survivors; see Rivas et al., 2019 for an examination of these issues within intimate partner violence advocacy). This in turn can be used to inform funding, training, technical assistance, and supervision. In addition, advocates themselves report advocacy is challenging (Ullman & Townsend, 2007). By examining challenges as well as facilitators to service provision, we can identify interventions to help support advocates in providing services more effectively. Finally, an examination of the research on RCC advocacy can help demonstrate gaps in the evidence base, which can guide priorities for future research and evaluation.

While these topics have been examined successfully within the context of intimate partner violence advocacy (e.g., Rivas et al., 2019), they have yet to be examined within RCC advocacy. Again, these forms of advocacy, while similar, are also distinct. To best evaluate the evidence on the implementation and effectiveness of advocacy services and ultimately inform practice, we believe that it is most useful to have a narrower focus on one context: advocacy designed for sexual assault survivors. Therefore, the purpose of this systematic review was to examine the literature on advocacy services provided by RCCs. Specifically, we examined: (1) service provision (what advocates do and how they do it); (2) perceptions of advocacy (by survivors and other SA responders) and the impact of advocacy; and (3) challenges and facilitators that influence the provision of advocacy services.

Methods

Search Strategy

The following databases were searched for peer-reviewed articles in English: Academic Search Complete, PsychINFO, PubMed, CINAHL, ProQuest, and Science Direct. In addition, the following databases were searched via the DePaul University library database: OAlster, WorldCat.org, MEDLINE, ERIC, and Social Sciences. We searched using the keywords: advoca* AND (“sexual assault” OR “sexual violence” OR “sexual abuse” OR rape). When databases allowed, search phrases were specified for only titles, abstracts, or key words. This yielded 530 results from the DePaul University database, 519 results in Academic Search Complete, 477 from PsychINFO, 468 from PubMed, 304 from CINAHL, 227 from ProQuest, and 111 from Science Direct. Ultimately, 1475 unique articles were identified and screened for eligibility. No date range was used to limit the search.

Article Review

The review only examined original empirical articles. Articles were eligible for the review if they examined provision and/or impact of RCC advocacy services in the United States. If a study examined both RCC advocacy and another type of advocacy (e.g., intimate partner violence advocacy), it was retained, to ensure all studies of RCC advocacy were captured. However, studies that only examined intimate partner violence programs providing advocacy to survivors who experienced sexual intimate partner violence were excluded. Studies examining advocates’ experiences, but not provision or impact of advocacy services, were excluded. Additionally, included articles were limited to studies that directly empirically examined service provision and/or the impact of advocacy on survivors and other systems. To limit the scope of review, studies that examined issues previously empirically linked to advocate service provision, such as burnout and vicarious trauma, were only included if the studies in question provided direct empirical links to service provision. Finally, studies only examining hotline services were excluded.

Research assistants reviewed abstracts and titles, and when necessary, screened full texts. Weekly meetings were held to monitor screening accuracy and consistency. Ultimately, a total of 45 articles met inclusion criteria and were reviewed and double checked by multiple authors to ensure accuracy. Appendix 1 describes attributes of the articles and Appendix 2 lists methodological details for each article. We organized findings into the following themes: (1) advocacy service provision; (2) perceptions of the quality and impact of advocacy; and (3) challenges and facilitators to effective service provision.

Results

Advocacy Service Provision

Thirty studies addressed advocacy service provision, that is, what services are provided and how (see Table 1). Overall, studies showed advocates are survivor-centered, provide nonjudgmental emotional support (with occasional exceptions), provide information and support survivors’ choices and agency, safety plan, and accompany survivors during interactions with the medical and CJ systems. They attempt to maintain collaborative relationships with medical and CJ personnel, but also intervene to ensure survivors receive needed services and are treated well. To organize the results, the remainder of this section is divided into: guiding approaches to how advocates provide services; how advocates provide services directly to survivors; and how advocates work with other responders.

Guiding Approaches. Several studies of advocates and agency staff addressed the broader values, goals, and approaches that guide rape crisis advocates. Across qualitative and mixed method studies, advocates reported adopting a survivor-centered, trauma-informed lens that emphasizes survivor empowerment (Kolb, 2011b; Murray et al., 2016; Ullman & Townsend, 2008). Advocates also reported valuing cultural

Table 1. Advocacy Service Provision Findings.

Citation	Finding
Patterson & Campbell, 2010[a,c]	Survivors stated that advocates support survivors' decisions to report and participate in the CJ process.
Wasco et al., 2004 [a,d]	Survivors reported that advocates provide information, support, and help in decision making.
Bhuyan & Velagapudi, 2013 [b,c]	Advocates emphasized the need for bilingual service delivery and to better serve immigrants (including undocumented immigrants).
Campbell & Bybee, 1997 [a,d]	Advocates reported taking action when a survivor did not receive services they wanted. Generally, ER staff do not arrange follow-up care without advocate involvement. Advocates are highly involved in survivors receiving emergency contraception and information on STIs and physical/psychological health effects. Medical staff usually carry out the rape exam and treatment for injury without advocate involvement.
Corrigan, 2013 [a,c]	Advocates reject the strategy of public conflict with police, encourage a collaborative approach, with the belief that relationships ultimately facilitate better results for victims. While advocates approach their work differently from police officers and SANEs, they expressed a willingness to collaborate and belief that they could successfully work together.
Gmelin et al., 2018 [b,c]	Advocates expressed discomfort around sexual topics and harm reduction. Training increases advocate's willingness to discuss harm reduction for sex/pregnancy, refer to family planning clinics, and talk to clients about their health (including reproductive health). Advocates identified "warm referrals" as a method for creating a formal partnership with reproductive health providers.
Kolb, 2011a [b,c]	Advocate strategies to maintain sympathy when working with "difficult" clients: deflecting blame (e.g., to abuser), reconstructing victim-biography to better understand behavior. Advocates sometimes refuse sympathy to difficult clients when they feel offering unlimited sympathy becomes problematic/unhelpful to the client. Maintaining friendly, egalitarian relationships with clients help advocates derive meaning, satisfaction from their work. They also are more likely to accept inappropriate emotional displays from clients versus an outsider.
Kolb, 2011b [b,c]	Advocates use empowerment to help clients so they can help themselves, which allow clients to direct the conversation flow and intensity. Advocates described negative results in terms of clients' empowerment. Empowerment makes it so advocates do not have to be an expert. Advocates had an easier time saying what empowerment was *not* than saying what it is.
Kolb, 2011c [b,c]	Two domains of advocate work: care work (listening to clients, giving clients control, empathy) and legal work (informing clients on legal options). Advocates valued care work and viewed legal advice as a form of caring, and felt their paralegal skills received more respect than their emotional skills.
Logan & Walker, 2018a [b,c]	Advocates stated they engage in safety planning strategies such as starting where the victim is, creating safe space, focusing on strengths, assessing resources/referrals, and planning for emotional safety. Common pitfalls to avoid in safety planning: Being judgmental about victims' decisions and dictating a plan versus collaborating with victims.
Logan & Walker, 2018b [b,c]	Advocates' views of safety planning training and supervision: Advocates receive some training, but mostly learned on-the-job. Supervision occurs as needed, during group meetings, or is limited due to paid supervisor shortages. Some advocates felt more ongoing training was needed, especially with SA.
Long, 2018 [a,c]	Advocates reported challenging police officers' assumptions about rape and survivors. Advocates balance challenging officers with supporting and caring for survivors. Several advocates balance challenging officers while establishing working relationships. Some advocates discussed how they supported officers who were emotionally impacted by SA response by comforting them, suggesting counseling.
Maier, 2008 [a,c]	Advocates said they try to prevent survivor revictimization and restore survivor agency by: believing survivors, emphasizing it was not their fault, allowing them to make their own decisions, comforting them, staying with them during exam or while talking to police (when protocol allows/victim wants it), informing them of the different steps of the response process, getting them food/drink, and requesting other responders be more sensitive.
Maier, 2012b [a,c]	Most advocates did not express victim-questioning attitudes, but some placed responsibility for prevention on survivors. Some advocates suggested rape may be due to miscommunication. Advocates reported gender socialization, power differences, and societal factors cause rape. No advocate felt women deserve rape. Advocates with victim-questioning attitudes would not express them to survivors or treat survivors differently.
Patterson & Pennefather, 2015 [a,c]	Advocates perceived nurses value advocacy less, felt nurses treated them like assistants, and felt they were often interrupted or misunderstood by nurses.

(continued)

Table 1. (continued)

Citation	Finding
Ullman & Townsend, 2008 [a,c]	All advocates discussed empowerment and allowing clients to be in control. Advocates endorsed using empathy and an intersectional approach that considers other factors/needs (e.g., finances). Advocates use safety planning and social support as empowerment tools.
Wasco & Campbell, 2002 [a,c]	Some advocates reported anger and fear (related to treatment of survivors and rape culture) influenced their desire to continue their work.
Cole & Logan, 2008a [a,c]	SANE program directors stated strategies to prevent/resolve conflict between SANEs and advocacy included maintaining open communication, clear roles/boundaries, and recognizing each other's work.
Harrison et al., 2010 [a,c,d]	RCC directors stated part of the advocate's role is to provide information, and answer questions about emergency contraceptives (ECs) in a non-judgmental way. Two directors said advocates are trained to empower survivors to make their own decisions. All directors said their advocates have positive attitudes about providing information about ECs and a potential advocate would not be hired if they expressed disapproval of ECs.
Macy et al., 2011 [b,d]	Medical advocacy goals (according to agency directors): Emotional support, legal/medical accompaniment, legal/medical information, safety planning, victim's compensation, violence information, community referrals, social support, self-care strategies. Legal advocacy goals: Emotional support, legal/medical information, victim's compensation, medical/legal accompaniment, safety planning, violence information, community referrals, social support, self-care strategies. Stand-alone SA agencies prioritized: Emotional/social support strategies, promotion of self-esteem, self-care, development of relationships with other survivors more highly, and safety planning and provision of violence information less highly, than dual DV/SA agencies.
Macy et al., 2013 [b,d]	Agency directors reported legal and medical advocacy services should be available immediately 24/7, 365 days a year.
Patterson, 2014 [a,d]	Nurses and advocates agreed it was inappropriate to discuss conflict in front of survivors. Advocates tend to resolve conflict indirectly (e.g., reporting to supervisor); nurses tend to resolve conflict directly (e.g., discussing concerns with advocates). Factors influencing conflict resolution strategy: Desire to avoid tension, perceived likelihood of successful outcome, urgency of issue, and perceived role responsibility to address issues.
Patterson & Tringali, 2015 [a,c]	Nurses and advocates reported advocates should not convince survivors to participate in the CJS, but rather support survivors' decisions regarding CJS participation, provide information, and accompany survivors throughout the process.
Cole & Logan, 2008b [a,c]	Members of SARTs said few advocates provide information/resources for substance use. Hypothetical common response: Validate that the victim's intoxication did not excuse assault. Advocates typically do not test for substance abuse during the first response.
Greeson & Campbell, 2015 [a,d]	SART members rated offering victims the opportunity to have an advocate accompany them to court hearings as one of the most common coordinated activities. Offering victims the opportunity to have an advocate present for detective interviews was the least common.
Perry et al., 2015 [a,c]	A sample of patients and professionals from RCCs and reproductive health agencies reported care providers believe/support survivors, truly care about patients, are concerned about retraumatization, and recognize survivors' healing is not linear.
DiNotto et al., 1989 [a,c,d]	A sample of survivors and SA responders reported advocates aim to ensure fair treatment of survivors in the CJS; in doing so, advocates may create conflict with other responders. Advocates accompany survivors to meetings with law enforcement, state attorney, and courts; and inform survivors what to expect in the CJS.
Murray et al., 2016 [b,c,d]	SA/DV providers reported that values of advocacy include: Cultural competence, empowerment, trauma-informed, and survivor driven. Additionally, advocacy organizations should address their own forms of bias.
Lewis et al., 2003 [a,c,d]	Of nurses who called the RCC, 57 (73%) indicated that an advocate responded in 76%–100% of SA cases.
Herz et al., 2007 [b,d]	In a study of mental health workers, advocates were more likely than other groups to think their DV and SA training was adequate and less likely to be interested in additional training. Advocates generally identified important short-term interventions as the assurance of victim safety (physical, emotional, etc.) and report guidance.

[a] Examines SA advocacy only.
[b] Examines SA and DV advocacy.
[c] denotes qualitative methodology.
[d] denotes quantitative methodology.

competence (Murray et al., 2016). Survivors are often treated poorly by other responders; quantitative and qualitative studies of advocates and agency directors indicated that primary motivations of advocates include mitigating harm, restoring survivor agency, and preventing retraumatization following the trauma of SA (Macy et al., 2011; Maier, 2008; Ullman & Townsend, 2008). In qualitative interviews, advocates described feeling angry due to witnessing the poor treatment of survivors by CJ and medical professionals, which in turn motivates them to continue striving to protect survivors (Wasco & Campbell, 2002). Finally, one quantitative study revealed advocates typically feel well-trained and prepared (Herz et al., 2007).

Work with Survivors. Only one study examined how often advocates respond to survivors. A mixed method study found that most medical professionals who contacted RCCs to dispatch support to a survivor reported advocates respond in 76–100% of cases (Lewis et al., 2003).

Other studies focused on what advocates do when serving survivors. Several studies of advocates, agency directors, and other SA responders described advocates as nonjudgmental sources of emotional support for survivors. In quantitative surveys, agency directors reported that advocates emphasize goals of providing emotional and social support, believing survivors, and promoting survivor self-esteem and self-care (Macy et al., 2011). In a qualitative study, advocates described caring about the survivors with whom they work and supporting them through the healing process (Perry et al., 2015). In open-ended surveys, members of three SARTs in one state reported advocates provide emotional support by validating what happened to the survivor was a crime and was not their fault, regardless of alcohol usage (Cole & Logan, 2008b). In another qualitative study, advocates reported utilizing empowerment values in their work by showing empathy to survivors (Ullman & Townsend, 2008). Finally, one qualitative study showed advocates do not endorse victim-questioning attitudes, and typically understand the broader structural forces that contribute to sexual violence (Maier, 2012b).

However, several studies raised issues related to advocates as a nonjudgmental source of support. In Maier's (2012b) qualitative study of advocates, some participants suggested that, at times, survivors they work with could have or should have prevented the assault. Despite holding these beliefs internally, advocates stated they would never share these feelings with survivors or treat them differently, because they support all survivors unconditionally. An ethnographic study of a dual RCC and domestic violence shelter also showed advocates hold negative feelings toward some survivors (Kolb, 2011a). Advocates may struggle internally with maintaining empathy for clients who they feel are "difficult." Advocates managed these feelings via various strategies, including deflecting blame toward more culpable others (e.g., perpetrators), and reconstructing their understanding of a survivor's situation to better understand a survivor's behavior. However, on occasion, advocates "withheld sympathy" from survivors when they felt sympathy was problematic (e.g., breaking agency rules) or not helping the survivor.

The literature also demonstrated advocates provide survivors with information, and support their decision making. Quantitative and qualitative data from advocates, agency directors, and other responders, demonstrate that advocates provide referrals to other resources, information on alcohol intoxication (e.g., intoxication does not excuse the perpetrator's actions), medical information (e.g., emergency contraceptives, other health information), what to expect from the legal process (e.g., dealing with police, prosecutors, courts) and how survivors can exercise legal options (Cole & Logan, 2008b; DiNotto et al., 1989; Harrison et al., 2010; Kolb, 2011c; Macy et al., 2011; Maier, 2012a; Patterson & Tringali, 2015; Wasco et al., 2004). Studies also demonstrated advocates emphasize survivor choice. In a qualitative study, advocates reported they emphasize survivor agency in order to empower survivors (Ullman & Townsend, 2008). Similarly, in a qualitative study of SANEs and advocates, participants reported the goal of advocates is not to convince survivors to participate in the criminal justice system (CJS), but rather, to support survivors' decisions regarding the CJS (Patterson & Tringali, 2015).

Advocates also use safety planning to assist and empower survivors (Ullman & Townsend, 2008). In qualitative interviews, advocates described how they primarily learn about safety planning "on the job" through court advocacy, shelter, case management, therapy, and hotlines (Logan & Walker, 2018a; 2018b). In safety planning, they establish goals, create a safe space, focus on their strengths through validation and empowerment, assess resources, and refer for additional services (Logan & Walker, 2018a). Advocates also noted the importance of not being judgmental or controlling with survivors during safety planning (Logan & Walker, 2018a).

In addition to what advocates are doing, some articles showed what stakeholders believe advocates should be doing, or are not doing. Two studies focused on what advocates *should* do. A quantitative study of agency directors indicated advocacy services should be available at all times, 365 days a year (Macy et al., 2013). In a mixed methods study, agency directors reported advocates should express positive attitudes and be nonjudgmental sources of information for survivors (e.g., emergency contraceptives; Harrison et al., 2010). Three studies noted things advocates are *not* doing. Site leads for an advocate training program discussed in qualitative interviews that advocates were not always willing to discuss harm reduction and sexual topics due to discomfort (Gmelin et al., 2018). In open-ended surveys, SART members reported few advocates provide general information or referrals to community resources for substance use, and that advocates do not test for substance abuse during the first response (Cole & Logan, 2008b). Last, in qualitative focus groups, advocates relayed more of their services need to be tailored for immigrant, undocumented, and bilingual survivors (Bhuyan & Velagapudi, 2013).

Work with Other Systems and Responders. In addition to direct care work with survivors, advocates regularly engage with medical and CJ professionals. Too often, medical and CJ personnel deny survivors services and treat them in an insensitive manner. Therefore, advocates accompany survivors during medical forensic exams and CJS processes (e.g., filing a report, court hearings), and interact with medical and CJ system personnel to help survivors get their needs met (Campbell & Bybee, 1997; DiNotto et al., 1989; Greeson & Campbell, 2015; Macy et al., 2011).

In qualitative interviews, advocates described balancing challenging other responders while establishing positive relationships and providing care for survivors (Long, 2018). In another qualitative study, advocates reported employing a collaborative approach to working with other responders in hopes of increasing successful outcomes for survivors (despite advocates' frustrations with the other responders; Corrigan, 2013). Research also revealed advocates' work requires intervening with other responders to ensure survivors' needs are met. For example, a nationally representative quantitative study of RCCs found advocates are highly involved to ensure medical staff provide appropriate care and information for survivors related to medical forensic exams, STIs, injury treatment, and emergency contraceptives (Campbell & Bybee, 1997). Advocates also strive to ensure survivors are treated fairly in the CJS (DiNotto et al., 1989). Furthermore, qualitative studies of advocates showed advocates challenge other responders' negative views of survivors (Long, 2018), and suggest ways for responders to be more sensitive when working with survivors (Maier, 2008). A mixed methods study of advocates and other SA responders concluded that by challenging other responders to help survivors, advocates may inadvertently create adversarial dynamics between themselves and other responders (DiNotto et al., 1989). As a result, advocates also engage in strategies to resolve or prevent conflict with other responders. A qualitative nationally representative study of SANE program directors found that open communication, establishing clear boundaries and roles, and recognizing the contributions of other responders to the collaborative response effort can help prevent and resolve conflict between SANEs and advocates (Cole & Logan, 2008a). In a qualitative study of advocates' work with SANEs in one RCC, advocates reported engaging in indirect conflict resolution (e.g., bringing concerns to advocacy supervisors) and discussing issues away from survivors when possible (Patterson, 2014).

In some instances, advocates may also serve as a source of support for others in doing the difficult work of responding to SA. In qualitative research by Long (2018), advocates described building rapport and providing emotional support to officers who were emotionally impacted by cases. Qualitative research has also identified the importance of advocates' referrals to facilitate partnerships between advocates and reproductive health service providers (Gmelin et al., 2018).

Last, research suggested ways advocates could expand their work with other responders to improve their scope of work. Focus groups with advocates highlighted the need for greater collaboration between rape crisis advocacy and immigrant advocacy to inform public policy around issues of immigration and violence against women (Bhuyan & Velagapudi, 2013).

Perceptions of and Impact of Advocates

Overall, 14 articles examined survivors' and responders' perceptions of the quality of advocacy and/or the impact of advocacy services (see Table 2). Results indicated advocates improve service provision, decrease retraumatization, and may assist other responders in their work. Some responders also reported that working with advocates can pose challenges to their work. First, we will review the literature on survivors' perceptions of the quality of advocacy, and the impact of advocacy on survivors, followed by the literature on other responders' perceptions of the quality of advocacy and the impact on their work.

Survivors' Perceptions of Advocacy and Impact of Advocacy on Survivors. Notably, only two studies examined survivors' perceptions of advocacy. In a statewide quantitative evaluation of rape crisis services, the majority of survivors reported that advocates provide a good amount of information, support, and assistance in decision-making (Wasco et al., 2004). A second qualitative study by Patterson and Campbell (2010) asked survivors how (if at all) advocates influenced their participation in the CJS. They found that survivors who initially chose to participate in the CJS feel supported in continuing the CJ process because advocates make them feel more comfortable and confident in their decisions.

Other studies of survivors and SA responders revealed advocates have a positive impact on medical and CJ system responses. A nationally representative study of RCCs found advocates improve the provision of additional medical services to survivors by intervening when services were not provided by medical staff (Campbell & Bybee, 1997). Similarly, a quasi-experimental study found survivors who are accompanied by advocates in the hospital are more likely to receive arrangements for follow-up care; receive information on sexually transmitted infections (STIs) and physical and psychological health effects; and be offered emergency contraception (Campbell, 2006). Additionally, in open-ended surveys, prosecutors reported advocates increase referrals for therapy (Gaines & Wells, 2017).

Advocates also influence how the CJS responds to survivors. A quasi-experimental study found that survivors who have an advocate at the hospital are more likely to have a police report taken (Campbell, 2006). Additionally,

Table 2. Perceptions of Advocacy and Impact.

Citation	Finding
Campbell, 2006[a,d]	Survivors with advocates reported experiencing: More police reports taken, less negative treatment by police officers and negative interactions with medical providers, less reported distress after contact with legal and medical systems, and more medical services provided.
Patterson & Campbell, 2010 [a,c]	Survivors felt encouraged to continue with the CJ process when responders, including advocates, made them feel more comfortable and confident in their decision to report and participate in the criminal justice process.
Wasco et al., 2004 [a,d]	Majority of survivors expressed advocates provide a good amount of information (61.9%), support (79.4%), and help in decision making (53.7%) during service provision.
Campbell & Bybee, 1997 [a,d]	According to advocates, ER staff generally did not arrange follow-up care without advocate involvement. Advocates are highly involved when survivors receive information on STIs and physical and psychological health effects; advocates are also highly involved in survivors receiving the morning after pill. Advocates reported medical staff usually carry out the rape exam and treatment for injury without advocate involvement.
Logan & Walker, 2018b [b,c]	Most advocates shared they do not receive formal feedback from victims, those who did gain it from surveys/evaluations. Others gain informal feedback during or after sessions with victims (e.g., witnessing victims feel more in control/empowered; victims returning to thank them) or via victim follow through on the safety plan. Some advocates felt victims did not follow through on plans, others were not sure how many followed through, others felt more evaluation was needed to assess if plans were effective.
Patterson & Tringali, 2015 [a,c]	Advocates and nurses expressed advocates' empowering work with survivors may influence survivors' participation in the CJS because advocates make survivors feel more comfortable and confident in their decisions.
Lewis et al., 2003 [a,c,d]	Of 72 nurses who rated advocates, 86% rated them as good or excellent.
Patterson & Pennefather, 2015 [a,c]	Some nurses expressed feeling disrespected when advocates misunderstood them or tried to instruct nurses on the exam. Some nurses value advocacy as important, or more important, than evidence collection and use advocates' assistance to speed up the response for the survivor.
Cole & Logan, 2008a [a,c]	SANEs rated working relationships with advocates as mostly positive. 76.6% rated as excellent, 13.4% rated as good, 5.2% rated as poor.
Maier, 2012a [a,c]	54% of SANEs reported positive relationships with advocates, 38% reported positive and negative relationships, 3% reported negative relationships, 5% did not respond. Positive nurse-advocate relationships are related to open communication, appreciation, and role understanding. Advocates' focus on the survivor makes nurses' work easier by allowing them to focus on medical response. Advocates overstep boundaries when they question SANEs' work, push survivors, interrupt/rush SANEs.
Downing & Mackin, 2012 [a,c]	Some SANEs view advocates as a proxy for the caring role that they usually hold as a nurse that allows for them to take a more forensic role. Some SANEs expressed difficulties with relying on quiet advocates because they felt like they do not provide the care that patients needed.
Gaines & Wells, 2017 [a,c]	Prosecutors' views of advocates: Generally positive, helpful, effective, help survivors better understand court cases and with emotional support, help refer them to therapy, help to make them easier to approach and prepare for trial. Investigators said advocates improve communication, help with supporting survivors/families, and provide assistance during court proceedings. Investigators felt advocates would be unhelpful in some cases due to conflicting objectives, unbalanced approach, confidentiality concerns, and over-involvement/role boundary issues.
Rich & Seffrin, 2014 [a,d]	Police reported mostly positive perceptions of advocates. Female police officers are significantly more engaged with advocates than male officers and feel more positively about advocates.
Patterson, 2014 [a,c]	Conflict between nurses and advocates arises from concerns with how the other responder interacts with survivors and role misunderstandings.

[a] Examines SA advocacy only.
[b] Examines SA and DV advocacy.
[c] denotes qualitative methodology.
[d] denotes quantitative methodology.

prosecutors reported in open-ended surveys that advocates are helpful in preparing survivors for court, communicating, supporting survivors and their family, and providing assistance through court proceedings (Gaines & Wells, 2017). Like survivors, SANEs also reported that advocates influence survivors' engagement in the CJS. This qualitative study found that advocates focus on supporting survivors' choices and do not push them to participate in the CJS (Patterson & Tringali, 2015).

Finally, advocates also mitigate harm inflicted by the medical and CJ systems (i.e., secondary victimization). Campbell's (2006) quasi-experimental study asked survivors how they were treated by police and medical personnel. Though survivors were not asked directly about their experiences with advocates, survivors who are accompanied by advocates in the hospital reported less negative treatment by police officers and medical personnel, and less overall distress following contact with the CJ and medical systems. Thus, advocates work makes survivors' help-seeking experiences more positive and less traumatizing.

Despite research that underscores the utility of advocacy, advocates themselves may receive limited direct feedback from survivors on their work. One qualitative study examining advocates' safety planning found most advocates do not receive formal feedback from survivors, aside from occasional surveys or evaluations (Logan & Walker, 2018b). However, they may receive informal feedback such as witnessing survivors gaining control and feeling empowered, having survivors return to thank them, or learning survivors followed through on their safety plans. Nevertheless, advocates emphasized the need for additional evaluation and feedback to ascertain the effectiveness of safety planning (Logan & Walker, 2018b).

Responders' Perceptions of Advocacy and Impact of Advocacy on Responders. Advocates' work on behalf of survivors necessitates interactions with other responders; thus, research has also explored how nurses, police, and others perceive the work of advocates. Research with nurses suggested SANEs typically view their relationships with advocates positively (Cole & Logan, 2008a) and value the contributions of advocacy (Maier, 2012a). In a nationally representative study of SANE program coordinators, 90% rated working relationships with advocates as excellent or good (Cole & Logan, 2008a). A qualitative study of SANEs from one program revealed that some perceive advocacy as equally important, or even more important, than evidence collection (Patterson & Pennefather, 2015). Additionally, a mixed methods statewide study explored the perceptions of nurses who had worked with an advocate during a medical forensic exam (Lewis et al., 2003). Of nurses who rated an advocate's response, 86% rated the advocate as either good or excellent. According to qualitative interviews with SANEs, advocates also lighten nurses' workload by fulfilling the principal care role for a survivor, thus allowing nurses to focus on evidence collection and medical response (Downing & Mackin, 2012; Maier, 2012a). Advocates may also aid SANEs by offering to assist with errands to help expedite the process for a survivor (e.g., making copies; Patterson & Pennefather, 2015).

In contrast, research has also identified SANEs having some mixed or negative experiences with advocates. In a nationally representative study of SANE program directors, 5.2% rated their working relationships with advocates as poor (Cole & Logan, 2008a). In a qualitative study, some SANEs reported difficulties with relying on advocates who they feel do not provide sufficient care to a survivor (Downing & Mackin, 2012). A qualitative study conducted with advocates and SANEs from one RCC identified sources of conflicts between these two disciplines regarding how the other responder worked with a survivor and role misunderstandings (Patterson, 2014). Moreover, in qualitative research, SANEs reported feeling advocates have a negative impact on nurses when they question, interrupt, or rush their work (Maier, 2012a); push survivors to make certain decisions (Maier, 2012a); or direct nurses in evidence collection (Patterson & Pennefather, 2015). Specifically, these behaviors frustrate SANEs and make them feel disrespected.

While research on perceptions of advocates and their impact predominantly concentrates on nurse advocacy relationships, two studies captured CJ professionals' perceptions of advocates. In both studies, advocates were regarded mostly positively although, again, some concerns were raised. In quantitative surveys of police, Rich and Seffrin (2014) found police had mostly positive perceptions of advocates, but female officers reported more positive perceptions of and engagement with advocates than male officers. In another study, qualitative interviews with investigators revealed they typically perceive advocates positively, but also have concerns about collaboration when advocate and police objectives conflict, or when advocates overstep role boundaries by being overly involved (Gaines & Wells, 2017). Finally, in open-ended surveys, prosecutors typically considered advocates to be positive, helpful, and effective (Gaines & Wells, 2017).

Challenges and Facilitators to Advocacy Work

In total, 17 articles discussed challenges and facilitators that influenced advocacy service provision (see Table 3). Overall, challenges were discussed to a much greater extent than facilitators, and emerged in the context of work with survivors and work with other responders.

Work with Survivors. As discussed in the Advocates Service Provision section, advocates' work with survivors often includes acting as nonjudgmental sources of emotional support, and providing survivors with information to help support problem-solving and decision-making, including when they interact with other system responders (ex. medical, legal). Eight articles discussed challenges that affect advocates' direct work with survivors, including lack of necessary training, support, and skills among advocates; lack of necessary tangible resources; and survivors' lack of awareness of available services. Through qualitative interviews, focus groups, and surveys employed across five studies, some advocates reported a lack of training, preparedness, and self-efficacy related to responding to survivors (Carlyle & Roberto, 2007;

Table 3. Challenges and Facilitators to Advocacy.

Citation	Findings
Bhuyan & Velagapudi, 2013[b,c]	Advocates identified barriers to service and collaboration as language and lack of resources for bilingual advocates, concerns about police collaboration leading to deportation, and bias from other providers.
Carmody, 2006 [b,c]	Advocates' barriers to work: territorialness across systems, negative interactions with police, funding constraints for training, exclusion from police interviews of survivors, lack of resources, language and cultural barriers to SA services, inadequate staffing particularly at rural sites. Barriers to survivor access (according to advocates): Lack of uniformity between counties and municipalities, systems not believing survivors, legal loopholes.
Logan & Walker, 2018a [b,c]	Advocates identified barriers to safety planning as: substance use/abuse; gun threats; survivor wanting gun for safety; stalking; threats to friends and family; lack of resources; working within the justice system; victim expectations unrealistic or beyond advocate role; caseload limits and time restrictions; and lack of protocols for high-risk situations.
Logan & Walker, 2018b [b,c]	Advocates' safety planning challenges: Lack of training, maintaining boundaries; letting worry for victims spill into their personal lives; personal triggers; working with diverse populations (e.g., immigrants, LGBT community, individuals with disabilities, or elderly populations); avoiding victim-blaming language. Advocates said more formal feedback and research was needed to determine best practices and effectiveness of strategies.
Murphy et al., 2011 [b,c]	Advocates identified rocky relationships with other agencies and absence of collaboration among service providers (e.g., isolation of sexual assault) as affecting their ability to help survivors negotiate the CJS.
Payne, 2007 [a,c]	Barriers to working with health providers (according to advocates): Isolated, rural hospitals not having sufficient resources; boundaries being overstepped; other providers not seeing sexual assault as a health concern; communication problems. Barriers to working with mental health providers (according to advocates): Role ambiguity; issues with referrals; funding concerns; lack of SA training.
Payne & Thompson, 2008 [a,c]	Barriers to collaboration with police, from advocates' perspective: Police isolating advocates from process; lack of respect for RCCs and collaboration; poor attendance at SART meeting; police viewing advocates as problems, not collaborators.
Sudderth, 2006 [b,c]	Advocates and police reported barriers to collaboration as clash of values/protocols, issues with power differentials and control, lack of protocols for resolving conflict, and differences in empathy for victims.
Ullman & Townsend, 2007 [a,c]	Advocates' reported barriers to work: societal rape myths; biases regarding survivors based on race, gender, sexuality, disability, and/or immigration status; lack of funding; issues with space/safety within organizations; racism in RCCs; staff burnout; secondary victimization. Advocates' barriers to direct service provision: Access/availability of services for different survivors, lack of information about services, lack of resources for advocates.
Cole & Logan, 2010 [a,c,d]	SART members reported challenges to collaboration as: victim's behavior, substance use, demographics (e.g., experiencing homelessness), relationship to perpetrator, lack of evidence of force.
Cole & Logan, 2008a [a,c]	SANE coordinators discussed sources of SANE-advocate conflict included independence/control (80%), role conflict/ambiguity (44.3%), different values/perspectives (12.9%), lack of advocate training (8.6%), personality conflicts (8.6%), team commitment (4.3%), and confusion (2.9%).
Patterson, 2014 [a,c]	Nurses and advocates recommend building relationships between nurses and advocates to help with resolving conflict and discussing concerns.
Patterson & Tringali, 2015 [a,c]	Challenges to collaboration from advocate perspective: Nurses devaluing advocacy, disrupting advocacy work, not understanding advocate role, and not being as committed, advocates being treated as assistants.
Cole, 2011 [a,d]	58.2% of SART members reported victim confidentiality is not a challenge to coordination, 10.1% neutral, 31.7% reported it is a challenge. Advocates were more likely to report this as a barrier to coordination than other SART members.
Perry et al., 2015 [a,c]	A sample of patients and professionals from RCCs and reproductive health agencies identified lack of funding, lack of opportunity to prosecute, and negative encounters with police as barriers to services.
Rich & Seffrin, 2013 [a,d]	When controlling for other variables, police SA training significantly predicted willingness to work with advocates. Police reported reluctance to work with advocates due to role confusion, wanting sole control of case, and perceptions of advocates' negative attitudes toward police.
Carlyle & Roberto, 2007 [a,d]	Advocates reported communication anxiety negatively related to, and communication competence positively related to, subdimensions of counseling self-efficacy.

[a] Examines SA advocacy only.
[b] Examines SA and DV advocacy.
[c] denotes qualitative methodology.
[d] denotes quantitative methodology.

Carmody, 2006). Advocates reported specific challenges in being trained and prepared to: engage in safety planning (Logan & Walker, 2018b), work with diverse groups (e.g., on the basis of race, gender, sexuality, disability, immigration status, and age; Logan & Walker, 2018b; Ullman & Townsend, 2007), and adapt to survivors' unique needs (e.g., navigating perpetrator threats; Logan & Walker, 2018a). Advocates also reported challenges related to appropriately managing negative emotions related to their work and letting worry for clients spill over into their personal lives while experiencing burnout (Logan & Walker, 2018b; Ullman & Townsend, 2007). The lack of training and preparedness reported by advocates was also reported by SANE program coordinators. In a nationally representative qualitative study, Cole and Logan (2008a) found that one-in-10 SANE coordinators perceived a lack of preparedness and training among volunteer advocates. In addition to a lack of training, lack of tangible resources also presented as a challenge in working with survivors.

Across four qualitative studies that relied on interviews and focus groups with advocates, patients, and other professional staff, participants reported that agencies often had limited funds, space, and staffing, which was repeatedly identified as negatively affecting advocates' abilities to serve survivors (Bhuyan & Velagapudi, 2013; Carmody, 2006; Perry et al., 2015; Ullman & Townsend, 2007). Participants specifically mentioned how funding constraints related to lack of training for advocates and agencies' inabilities to staff bilingual advocates, or advocates at rural sites (Bhuyan & Velagapudi, 2013; Carmody, 2006). Finally, advocates also reported a key challenge in serving survivors related to access and availability of services for different survivors. Specifically, advocates interviewed by Ullman and Townsend (2007) reported that survivors sometimes lack information on availability and eligibility for services. Notably, the papers in this review included only limited discussions or mentions of burnout, secondary trauma, and vicarious trauma as key challenges in working with survivors. This is likely due to the inclusion criteria employed for this review (e.g., papers include a direct empirical examination of service provision).

If lack of training and funding are considered challenges to serving survivors, we might assume ample training and funding are facilitators. Only one study empirically probed factors facilitating advocates' work with survivors. Carlyle and Roberto (2007) quantitatively examined relationships between communication and counseling self-efficacy among volunteer RCC advocates. They found communication competence was positively related to advocates' counseling self-efficacy. That is, if advocates felt competent in being able to communicate effectively, they believed they were capable of being effective advocates.

Work with Other Responders. In addition to facing challenges in working with survivors directly, advocates also face challenges in working with other responders. 13 articles discussed challenges advocates face working with other responders, including disparate values, commitments, and worldviews; advocates and other responders not fully understanding, respecting, and distinguishing between each other's roles; and weak working relationships. Several studies explored the negative impact of disparate values, commitments, and worldviews between advocates and other responders on coordination. Across three qualitative studies, advocates reported a clash of values or perspectives, as other disciplines endorse rape myths, discriminate against survivors, disbelieve survivors, lack empathy for survivors, or do not see SA as a pervasive problem (Carmody, 2006; Sudderth, 2006; Ullman & Townsend, 2007). As suggested by two studies with non-advocate responders, advocates may be more aware of such value and commitment clashes than other responders. In a national qualitative study of SANE program coordinators, only about one-in-ten participants identified differences in values and perspectives as a source of conflict between SANEs and advocates (Cole & Logan, 2008a). A second quantitative study of SART members found advocates were more likely to point to confidentiality as a challenge to coordination than other SART members (Cole, 2011). Different values and commitments have significant implications for survivors' experiences with responders. Across interviews and focus groups, advocates reported how other responders' tendencies to disbelieve survivors result in the use of polygraphs with survivors, and exploitation of legal loopholes that make it difficult to provide advocacy services (Carmody, 2006).

A second set of challenges in working with other responders related to collaborators not fully understanding, respecting, or distinguishing between each other's roles. Several studies that interviewed or surveyed police, nurses, or advocates reported role ambiguity as a key challenge. SANEs, mental health providers, and police often did not understand the role of the advocate or were confused about who should complete which tasks (Cole & Logan, 2008a; Payne, 2007; Patterson & Tringali, 2015; Rich & Seffrin, 2013). This same set of studies also found a lack of respect for RCCs and collaboration, and a tendency for other responders to view advocates as a problem (Payne & Thompson, 2008). Qualitative interviews of advocates and SANEs found some nurses devalue advocacy and treat advocates as assistants (Patterson & Tringali, 2015), while surveys conducted with police demonstrated some police hold negative views of advocates and believe advocates have negative attitudes toward police (Rich & Seffrin, 2013).

The final set of challenges was weak working relationships, often defined by a lack of trust and unwillingness to work together. Based on interviews, focus groups, and surveys with advocates and police, there is sometimes a lack of trust between disciplines and a reluctance to work with one another (Carmody, 2006; Rich & Seffrin, 2013). This sometimes occurs due to issues of control and power (Sudderth, 2006). For example, police reported wanting to have sole control of the case (Rich & Seffrin, 2013). Advocates perceived police as being territorial, and that advocates were sometimes excluded from interviews (Carmody, 2006). Advocates reported anxiety related to communicating with other providers, and that such rocky relationships directly affect their abilities to help survivors navigate the CJS (Carlyle & Roberto, 2007; Murphy et al., 2011). Such challenges were exacerbated further due to a lack of protocols for resolving interdisciplinary and personal conflicts (Cole & Logan, 2008a; Sudderth, 2006). Interviews with a range of SART members also revealed specific victim and case characteristics (e.g. victim behavior, substance use, demographics, relationship with perpetrator, and lack of evidence of force) often make collaboration more challenging (Cole & Logan, 2010).

Much like advocates' work with survivors, the literature did not often empirically examine what facilitates advocates' work with other responders. In one qualitative study of SANEs and advocates, participants recommended building relationships between SANEs and advocates so they could discuss concerns and resolve emerging conflicts (Patterson, 2014).

Discussion

This was the first systematic review of research on RCC legal and medical advocacy. Forty-five articles examined service provision, perceptions and impact of advocacy, and challenges and facilitators to effective advocacy service provision. Overall, the review reveals several strengths and limitations of the empirical literature on legal and medical advocacy.

Strengths of the Literature

First, empirical examination of rape victim advocacy is growing over time. This is an encouraging step in better understanding the impact of advocacy services, as well as how to improve services. Second, studies in the review support the field's investment in advocacy services (although replication studies in more diverse contexts are warranted). Advocates exist to serve survivors, and generally survivors find advocates to be informative, supportive, and helpful to their decision-making (Patterson & Campbell, 2010; Wasco et al., 2004). Furthermore, studies of SA responders and service provision show advocates increase referrals; increase survivors' chances of having a police report taken and receiving medical/forensic services; promote a less traumatizing response; and help survivors (who wish to do so) participate in the CJS (Campbell, 2006; Campbell & Bybee, 1997; Gaines & Wells, 2017; Patterson & Tringali, 2015).

Third, the literature demonstrates advocates' work is multifaceted and challenging. Advocates provide nonjudgmental emotional support; provide information, referrals, and support with decision-making; safety plan; accompany survivors during their interactions with medical and legal systems; attempt to foster collaborative relationships with other responders; and intervene when systems are not meeting survivors needs (e.g. Campbell & Bybee, 1997; Logan & Walker, 2018a; Long, 2018; Maier, 2012a). However, at times, they have to manage victim-blaming and other negative feelings toward survivors (Kolb, 2011a; Maier, 2012b). This also occurs in contexts where some advocates are underprepared, with limited support and tangible resources, fear that services are not accessible to all survivors, and challenging interactions with other responders (e.g., Carmody, 2006; Ullman & Townsend, 2007).

Table 4. Implications for Future Research, Policy, and Practice.

Implications for Research	Implications for Policy and Practice
•Need for more studies of advocacy from the perspective of survivors •Need for more studies that attend to utilization and reach of advocacy •Need to report demographics and attend to diversity among survivors while examining service delivery, perceptions of advocacy, and impact of advocacy (particularly multiply marginalized survivors) •Need to test theory of change of advocacy that examines links between specific advocacy practices, implementation, distal and proximal outcomes •Need for studies that guide advocate on how to overcome challenges in working with other responders, without sacrificing survivor care •Need for more methodological diversity and rigor (e.g., more quasi-experimental, longitudinal research, quantitative research in large generalizable samples) •Need for more reporting on context and to examine advocacy in more diverse contexts •Need to distinguish between RCC and domestic violence advocacy and when combined, compare the two	•Conduct replication studies to strengthen the body of evidence on the effectiveness of advocacy •Increase resources to RCCs to allow staff to provide more supervision and training to advocates related to meeting diverse survivors •Increase resources to help advocates with self-care and vicarious trauma •Provide technical assistance to RCCs to help them diversify their staff and make services more accessible to marginalized groups •RCCs should work together with groups pursuing methods of addressing support, healing, and justice for survivors outside of the medical and CJS and advocate for medical and CJS reform for marginalized groups •Increase support for evaluator-practitioner partnerships that help agencies to conduct meaningful evaluation to improve advocacy practice •Allow agencies to share evaluation findings in a de-identified manner so that the field can identify and learn from patterns in advocacy

Limitations of the Literature and Directions for Future Research

In addition to strengths, the literature also has notable limitations (see Table 4). Thus far, only one study examined utilization and reach of medical and legal advocacy (Lewis et al., 2003). Many important questions remain. What proportion of survivors receive advocacy services? What groups are under-represented or under-served by RCCs? Are advocates called and do they respond in a timely fashion? Both case studies of specific RCCs, as well as statewide and national samples would be beneficial for answering these questions.

There is also very little research linking specific facets of advocacy services and implementation with survivors' outcomes. In other words, there is not a well-supported theory of change that demonstrates how exactly advocacy works. Which advocacy practices do survivors think are most/least effective? Which facets of implementation are most salient to survivors? How do survivors believe advocates' victim-centered, empowerment philosophy shows up in their work and how do they feel about that? The literature demonstrates the impact of accompanying survivors during medical exams. What are the impacts of emotional support, providing information and supporting choices, and safety planning? Some settings provide legal advocacy for issues outside of the CJ system (e.g., assistance with landlords, civil legal assistance; Green, 2018; Wilt, 2019): what does this entail and what are the outcomes? What are the mechanisms by which advocates influence others to respond more positively to survivors? Does advocacy affect survivors' long-term outcomes? Such information is necessary for identifying which facets of advocacy are most important for positive outcomes. Thus, future theory of change work and mixed methods research that links specific advocacy practices with distal and proximal outcomes will be particularly beneficial.

Likewise, there is an important body of literature on rape crisis center advocates' experiences in providing advocacy, particularly around vicarious traumatization and burnout. Certainly, advocacy burnout and vicarious trauma are valuable outcomes in their own right, and in addition, are likely to have important ramifications for service provision for survivors. However, this literature was primarily excluded from the review because it did not provide empirical evidence of the links between advocates' negative outcomes and the implementation and quality of service provision. Thus, more research is needed to demonstrate how the emotionally taxing and under-resourced nature of rape crisis advocacy affects the implementation and quality of services for survivors.

In addition, there is a glaring absence of research that addresses survivors' perceptions of advocacy. Advocacy is survivor-centered, but research has focused much more on other stakeholders' perspectives. Only two studies asked survivors about their experiences with advocates. One statewide evaluation asked survivors to rate the extent to which advocates are supportive, provided information, and helped with decision-making, while the other study asked how advocates influence the survivors' participation in the CJS (Patterson & Campbell, 2010; Wasco et al., 2004). There were no published studies that offered survivors an opportunity to identify comprehensively what they find helpful about advocacy, or to provide constructive feedback on how advocates could improve. This is a remarkable gap, as advocacy exists to serve survivors. Future small scale qualitative studies for survivors to give in-depth feedback about what was most important to them, as well as larger statewide and national quantitative studies to draw generalizable conclusions, are sorely needed. Furthermore, funding is needed to support both qualitative and quantitative research that addresses these pressing questions.

Additionally there is a glaring lack of attention to diversity and multiply marginalized survivors. Basic demographics were reported infrequently (e.g., 38% of the 45 studies reported on race/ethnicity). In addition, many pressing questions need to be asked. When survivors do access advocacy services, are there disparities in receipt of services across groups? Are perceptions and impact of advocacy consistent for different groups? How, if at all, are advocacy services being tailored to the unique needs and cultures of different groups of survivors? Do survivors benefit from working with an advocate from a similar gender identity or racial background? In particular, there is a need for focused attention on help-seeking experiences of oppressed groups (McCauley et al., 2019). Rape crisis centers have been criticized for racism (e.g., Ullman & Townsend, 2007), heteronormative and transphobic practices (e.g., Seelman, 2015), and lack of accessibility to other marginalized groups (e.g., Bhuyan & Velagapudi, 2013). We especially need to be examining the experiences of survivors of color, sexual and gender minorities, survivors with disabilities, immigrant survivors, survivors of diverse ages, survivors living in poverty, male survivors (and others) with advocacy. This is necessary to understand how to address survivors' unique needs; how to provide services equitably; and whenever possible, to help survivors of all identities feel like advocacy is accessible to them (McCauley et al., 2019). Again, funding is needed to support this type of research.

Another limitation concerns research to inform advocates' interactions with other responders. Despite mostly positive perceptions, medical and CJ staff also hold some negative views of advocates. We found advocates face a variety of challenges in collaborating with CJ and medical staff. However, findings to date provide much less guidance on *overcoming* these problems. Future research that provides case studies of strong multidisciplinary relationships; examines how different methods of working with responders influence survivors' experiences; or gives advocates more specific strategies for how to intervene with other responders, while trying to cultivate positive relationships whenever possible, will be particularly useful.

Finally, there is a need for more methodological diversity and rigor. To date, there is only one quasi-experimental study examining the impact of advocacy on survivors' experiences and there have been no studies of the impact of advocacy on survivors after leaving the medical and CJ systems. Although experimental research is unlikely to be feasible due to the widespread availability of advocacy services, quasi-experimental approaches that compare different approaches to advocacy may be beneficial. Similarly, longitudinal studies would be valuable to more fully understand how advocacy affects survivors long term. Furthermore, there is a need for more work in diverse contexts. Both studies of survivors' perceptions of advocacy occurred in the Midwest. Much of the work that collected data from advocates or examined interactions with other responders utilized qualitative methodology within small geographic contexts (e.g., one county). In addition, all research on nurse and advocacy interactions has focused on highly trained SANEs. Advocacy challenges and service provision, including interactions with other responders, may be influenced by various contextual features (e.g., RCC organizational context, the presence and quality of a SART, policy, etc.). Thus, it is unclear the extent to which these studies of advocates' work are generalizable to settings with different contextual features. More research with diverse contexts and/or representative quantitative samples will yield new insights. In addition, we encourage researchers conducting small-scale qualitative research to provide detailed descriptions of the context where their study was conducted, to help readers understand to what settings their findings may be generalizable. Finally, many studies examined SA advocacy at the same time as domestic violence advocacy. Their services and approaches are overlapping and similar, and yet also distinctive. In the future, researchers could focus on one type of advocacy or directly discuss how findings do or do not apply to both types of advocates.

Limitations of the Review

This review only examined published, peer-reviewed articles. We did not capture book chapters, or unpublished evaluations. This is a limitation, as unpublished evaluations may provide unique insight into survivors' perceptions of advocacy. However, the review accurately represents published literature available to practitioners, policymakers, and researchers to learn from and use to guide policy and practice. In addition, in order to provide a comprehensive look at the literature, the review examined all studies of RCC legal and medical advocacy. However, at times, studies examined RCC advocacy alongside other providers (e.g., domestic violence advocates). In addition, this review was limited to studies that directly empirically examined service provision and/or the impact of advocacy on survivors and other systems. Therefore, empirical articles examining advocates' occupational experiences (e.g., burnout and vicarious trauma) that did not also empirically link these experiences to service delivery were excluded. However, the review accurately represents research that does empirically link occupational experience to service delivery. Future reviews should examine the full body of literature on advocates' experiences of advocacy. Finally, this review was limited to studies of rape victim advocacy in the U.S., published in English. Further review of advocacy research in other nations may provide insight into how advocacy operates in diverse legal and sociocultural contexts.

Implications for Policy and Practice

The review has several important implications for policy and practice. The review identified a variety of challenges that were explicitly linked to influencing advocates' ability to provide services effectively to their clients. While one study found that advocates generally felt prepared (Herz et al., 2007), in other studies, advocates described how lack of preparation and resources negatively influenced their work, especially with marginalized populations (e.g., Bhuyan & Velagapudi, 2013). Furthermore, advocates noted that the emotional aspect of the role and burnout affected their work (Logan & Walker, 2018b; Ullman & Townsend, 2007). Increasing resources to RCCs, such as funding, could allow staff to provide more supervision and training to advocates including how to adapt to the unique needs of specific survivors, and addressing their vicarious trauma. Additionally, paying for external training and self-care opportunities for advocates, could lead to improvements in advocates' work with survivors. RCCs may also benefit from diversifying their staff and from technical assistance resources to help them adapt their work to make it more accessible and responsive to marginalized populations. Finally, the CJS and medical systems have caused disproportionate harm to marginalized groups including people of color, people living in poverty, undocumented immigrants, and LGBTQ people (to name a few). As a result, some people from these groups may not ever desire legal and medical advocacy services, because the CJ and medical systems are not helpful to them. Therefore, RCCs should join movements to identify and provide alternate strategies for survivors to access support, justice, and healing that operate outside these systems (e.g., transformative justice), while also advocating for CJS and medical system reform for marginalized groups (McCauley et al., 2019).

In addition, the review noted the many ongoing challenges to advocates' work with medical and CJ personnel. Advocates balance maintaining positive working relationships with other responders, while also intervening to ensure the survivor gets what they need (Long, 2018). RCCs would benefit from additional resources to provide or support training that explicitly identifies and discusses the many challenges that may arise when working with other providers, helps advocates anticipate when such challenges are most likely to come up, and equips advocates with specific tools and skills to respond (e.g., conflict resolution). Rape crisis centers should also provide mechanisms for advocates to bring concerns related to working with other providers to the attention of RCC leadership (e.g., case feedback forms) in a timely way. By having clear, visible mechanisms in place for volunteer advocates to raise concerns to RCC staff, RCC staff can bring such concerns to multidisciplinary spaces so that they can be resolved.

Finally, we recommend further support for evaluation. Funders require RCCs to evaluate their services. However, RCCs frequently lack formal training in evaluation. Resources are needed to support evaluator-practitioner partnerships that help RCCs to rigorously evaluate their services, and answer the questions that are most timely and useful in their context. Furthermore, a national clearinghouse could allow agencies to share their evaluation data (without identifying their program), so that practitioners and researchers can identify important trends in advocacy (e.g., what is most and least helpful; how well different types of clients are served etc.).

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Notes

1. This number is not specific to advocacy, and does not capture advocacy not funded by VAWA, but it does suggest that crisis intervention services—which includes advocacy—are widespread.

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Appendix 1

Characteristics of the 45 Reviewed Manuscripts

		Number of articles (%)
Population	Includes survivors	5 (11%)
	Includes advocates/rape crisis center staff	35 (78%)
	Includes other professionals	20 (45%)
Type of Advocacy[a]	Sexual assault only	31 (69%)
	Sexual assault and domestic violence	14 (31%)
Setting[a]	Single site	9 (20%)
	Local (city, county)	5 (11%)
	State	18 (40%)
	Multi-state/regional	7 (16%)
	National	5 (11%)
	Unspecified	1 (2%)
Participant Demographics Reported	Race and/or ethnicity	17 (38%)
	Gender	22 (49%)
	Markers of socioeconomic status (e.g., income, education)	14 (31%)
Methodology[a]	Quantitative	12 (27%)
	Qualitative	28 (62%)
	Mixed-methods	5 (11%)
Time Period Published[a]	Before 2000	2 (4%)
	2000–2010	19 (42%)
	After 2010	24 (53%)
Included in Which Findings Table	Advocacy service provision	30 (67%)
	Perceptions of advocacy and impact	17 (38%)
	Challenges and facilitators to advocacy work	13 (29%)

[a] Denotes exclusive categories.

Appendix 2

Article Methods, Sample, and Demographics

Study	Method, sample, and demographics
Campbell, 2006 [a]	Quasi-experimental study with quant interviews to compare experiences of 81 survivors with and without advocates. Demographics: Race, age, education, gender, whether survivors knew perpetrator.
Patterson & Campbell, 2010 [a]	Qual interviews with 20 female SA survivors who received a medical forensic exam from a Midwest SANE program and filed a report to police (1999–2007). Demographics: Gender, race/ethnicity, age, relationship to perpetrator.
Wasco et al., 2004 [a]	Quant surveys: Workers from 33 Illinois RCCs administered surveys to 281 survivors following survivors' experiences with advocates. Demographics: Type of advocacy received, gender.
Bhuyan & Velagapudi, 2013 [b]	Qual focus groups with 24 advocates from a mostly rural Southern state coalition (11 advocates had follow-up interviews). Demographics: Gender, race, languages spoken, role.
Campbell & Bybee, 1997 [a]	Quant interviews with 147 advocates from nationally sampled RCCs who recently had a case in which a victim sought ER services. Demographics: Participant gender, age, race, education; most recent case: survivor race, age, education; perpetrator familiarity, # of perpetrators, assault type, degree of injury.
Carmody, 2006 [b]	23 individual qual interviews and 3 focus groups with advocates from SA and DV agencies in a Southern state. Demographics: Type of agency, type of victim served.
Corrigan, 2013 [a]	Qual interviews of 167 advocates at 112 RCCs in Colorado, Kansas, Michigan, New Jersey, South Carolina, and Washington. Demographics: Race.
Logan & Walker, 2018a [b]	Qual focus groups with 37 advocates from SA & DV agencies in one state. Demographics: Gender, work setting, race/ethnicity, age, education.
Logan & Walker, 2018b [b]	Qual focus groups and surveys with 37 advocates from DV & SA agencies in one state. Demographics: Work setting, gender, race/ethnicity, age, education.
Long, 2018 [a]	Qual interviews with 23 female advocates from RCCs in a large Midwestern city. Demographics: Gender, race/ethnicity, age, number of calls advocates responded to, length of service.
Maier, 2008 [a]	Qual interviews with 47 advocates from RCCs in 4 East Coast states who interacted with police and/or medical. Demographics: Gender, age, race, years' experience, SA history
Maier, 2012b [a]	Qual interviews with 58 advocates from RCCs in several East Coast states. Demographics: Gender, years of experience, age, race, lived experience of sexual assault, employment status.
Murphy et al., 2011 [b]	Qual interviews with 14 advocates from RCCs in a Northeastern state. No advocate demographics. Population served demographics: Gender, response rate, referral type.

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Study	Method, sample, and demographics
Payne, 2007 [a]	Qual interviews with 44 advocates from RCCs in Virginia. No demographics.
Payne & Thompson, 2008 [a]	Qual interviews with 44 advocates sampled from a statewide meeting and conference in Virginia. No demographics.
Sudderth, 2006 [b]	First round of qual interviews included 33 SA, DV, and CSA responders in Connecticut; second round focused on leaders (exact *n* not provided). Also examined documents from the developing stage of the collaboration. Demographics: Type of organization.
Ullman & Townsend, 2007 [a]	Qual interviews with 25 current/former advocates from a RCC in a large Midwestern city. Demographics: Gender, race, age, income, experience working with survivors, types of training, education, feminist orientation.
Ullman & Townsend, 2008 [a]	Qual interviews with 25 current/former advocates from a RCC in a large Midwestern city. Demographics: Gender, race, age, income, work experience, training, education, feminist orientation.
Wasco & Campbell, 2002 [a]	Qual interviews with 8 advocates with 1+ year of experience who had worked with a survivor in the past 6 months. Demographics: Race, age, number of years of experience, number of survivors served.
Macy et al., 2011 [b]	Quant survey with 97 directors of North Carolina SA and DV agencies. Demographics: Role, length of employment in current position, education.
Macy et al., 2013 [b]	Quant surveys with 103 directors of North Carolina SA & DV agencies. Demographics: Position, years' experience, education, agency characteristics, focus, location.
Gmelin et al., 2018 [b]	Qual interviews with 27 training site leads from hospitals and SA and DV agencies across six unspecified states. Demographics: Type of agency.
Carlyle & Roberto, 2007 [a]	Quant surveys from 63 volunteers from two RCCs in one large Midwestern city and one medium Southeastern city. Demographics: Race, gender.
Herz et al., 2007 [b]	Quant surveys with 415 professionals, (62 victim advocates), from Nebraska SA and DV agencies. Demographics: Gender, race/ethnicity, age, years' experience.
Kolb, 2011a [b]	Ethnographic study of one DV/SA agency. Observation of staff meetings and client sessions and 14 qual interviews with staff members. Survivor demographics: Ethnicity, gender, SES.

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Study	Method, sample, and demographics
Kolb, 2011b [b]	Ethnographic study of one DV/SA agency. Observation of staff meetings/client sessions, 14 qualitative interviews with staff. Survivor demographics: Ethnicity, gender, SES.
Kolb, 2011c [b]	Ethnographic study of one DV/SA agency. Observation of staff meetings/client sessions and 14 qualitative interviews with staff. Survivor demographics: Ethnicity, gender, SES.
Cole, 2011 [a]	Quant surveys with 78 professionals in 3 Kentucky SARTs. Demographics: Professional role, gender, education, number of years in work.
Cole & Logan, 2008b [a]	Open-ended qual surveys with 79 medical, criminal justice, victim advocacy professionals involved with each of three active SARTs in one state. Demographics: Gender, education, number of years working in the field.
Greeson & Campbell, 2015 [a]	Quant interviews with 172 SART leaders across the U.S. Demographics: Professional role.
Cole & Logan, 2008a [a]	Qual surveys with 231 SANE program coordinators across the U.S. Demographics: Job title, location of services, characteristics of agencies.
Cole & Logan, 2010 [a]	Mixed-method surveys completed with 78 participants from 3 Kentucky SARTs. Demographics: Gender, education, years in current profession.
Downing & Mackin, 2012 [a]	Qual interviews with 14 female SANEs from Iowa and one unspecified state who had completed 5+ exams total and 1+ exam in the past 12 months. Demographics: Gender, years of experience, number of cases.
Maier, 2012a [a]	Qual interviews with 39 SANEs from four East Coast states. Demographics: Age, gender, race/ethnicity, type of nursing degree, education.
Lewis et al., 2003 [a]	Mixed methods study: Quant surveys with 123 nurse managers, site visits/qual interviews with 20 nurse managers from 20 Ohio hospitals. Demographics: SANE/ SARTmembership.
Rich & Seffrin, 2013 [a]	Quant surveys with 429 police officers from police departments in the Northeastern U.S. Demographics: Gender, age range, education, type of agency, position.
Rich & Seffrin, 2014 [a]	Quant surveys with 429 police officers from Northeastern police departments. Demographics: Gender, age range, education, type of agency, position.

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Study	Method, sample, and demographics
Patterson, 2014 [a]	Qual interviews with 10 nurses and 13 advocates from Midwestern RCCs. Demographics: Participant role as nurse or advocate, years of experience, average number of survivors served.
Patterson & Pennefather, 2015 [a]	Qual interviews with 10 nurses and 13 advocates from a Midwestern RCC. Demographics: Whether participants were nurses or advocates, years of experience, average number of cases.
Patterson & Tringali, 2015 [a]	Qual interviews with 10 nurses, 13 advocates from a Midwestern SANE program operated through a focal RCC. Demographics: years of experience, number of cases.
Perry et al., 2015 [a]	Qual interviews with 9 patients, 13 professionals (rape advocates, abortion providers, social workers, clinical administrator) from Chicago reproductive health clinics and RCCs. Demographics: Professionals: Career; patients: Gender
DiNotto et al., 1989 [a]	Mixed methods interviews with 25 rape service programs, 42 law enforcement agencies, 32 hospitals, 21 states attorney offices, 11 interviews with other service providers, and 11 rape survivors, all within Florida. Demographics: Agency affiliation.
Harrison et al., 2010 [a]	Mixed methods study: Qual interviews with three RCC directors, a representative from the Department of Health and Environmental Control, and 5 emergency department administrators; quant surveys with 16 hospital ED staff. All participants were from four cities in South Carolina. Demographics: Professional role.
Murray, Crowe, & Akers, 2016 [b]	Delphi method using quant and qual questionnaires with SA and DV agencies across the U.S. 6 participants completed 1st open-ended questionnaire, 10 completed the 2nd, 10 completed 3rd, and 3 participants completed all three. Demographics: Region, job title, gender, race/ethnicity, years of experience, aim of organization.
Gaines & Wells, 2017 [a]	Qual surveys with 35 prosecutors; qual interviews with 44 SA investigators (31 juvenile case investigators, 13 adult). Participants came from Houston, TX and Harris County Police Department and District Attorney's Office. Demographics: Assignment to adult or juvenile cases.

[a] Examines SA advocacy only
[b] Examines SA and DV advocacy; "Qual" denotes qualitative methodology; "Quant" denotes quantitative methodology.

Author Biographies

Annie Wegrzyn, MA, is a Community Psychology doctoral candidate at DePaul University. Her research explores the experiences of survivors and the work of responders within community-based responses to gender-based violence. More specifically, her research interests focus on multidisciplinary collaboration; trauma-informed care; and vicarious traumatization among victim advocacy providers.

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Megan R. Greeson, PhD, is an Associate Professor of Community Psychology at DePaul University. She conducts collaborative community-based research and evaluation to understand and improve how individuals, organizations, and communities address gender-based violence. Her current projects focus on interdisciplinary collaboration in responding to sexual assault.

Catherine Pierre-Louis, MA, is a doctoral candidate in Clinical Psychology (Community Psychology track) at DePaul University in Chicago, IL. Prior, she graduated from Boston University in 2015 (BA. Psychology, public health minor) and worked for 2 years in Massachusetts General Hospital's Behavioral Medicine program. Her academic interests include work with historically underrepresented/disenfranchised groups in community mental health around various psychosocial problems.

Emily Patton, BA, is a recent graduate from DePaul University where she studied psychology and public health. She actively engaged in research during her undergraduate years that focused on topics related to sexual and relationship violence in which she participated in multiple community presentations. Her current research interests involve disclosure experiences, institutional betrayal, and program evaluation.

Jessica Shaw, PhD, is an Assistant Professor in the Psychology Department at the University of Illinois at Chicago. Her research focuses on understanding and improving system responses to sexual assault through collaborative, multidisciplinary efforts. She is committed to developing responsive and relevant research and evaluation projects so findings can be used to inform policy and practice.