An Exploratory Case Study of a Sexual Assault Telephone Hotline: Training and Practice Implications

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Abstract

Using archival data, this case study systematically examines telephone calls received by a regional sexual assault hotline in the Southeastern United States over a 5-year period. A stratified random sample (*n* = 383) reveals that hotline staff require diversity and depth in knowledge and skills, demonstrated by the hotline's primary use as a crisis service, combined with notable use by long-term survivors. Findings include the utility of the hotline by survivors and community stakeholders, categories of assault, the time gap between incidents occurring and contacting the hotline, call severity and urgency, and services and referrals provided. Implications for training, practice, and future research are discussed.

According to the National Intimate Partner and Sexual Violence Survey (2011), 18.3% of U.S. women (almost one in five) and 1.4% of men (one in 71) have experienced rape at some time in their lives. In the 12 months prior to that survey, 5.6% of women and 5.3% of men reported experiencing sexual violence other than rape, such as sexual coercion, unwanted sexual contact, or non-contact unwanted sexual experiences. Although substantial, researchers estimate that these reports underrepresent the actual number of

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sexual assaults occurring in the population due to barriers such as a victim's sense of shame, social stigma, and reluctance to use services (Tjaden & Thoennes, 2006).

Young people are disproportionately affected by sexual violence. In a national survey of adults, 42.2% of female rape victims were first raped before the age of 18 (Black et al., 2011). More than 12% of female rape victims and 27.8% of male rape victims were first raped when they were aged 10 years or younger (Black et al., 2011). Thirty percent of female rape victims were first raped between the ages of 11 and 17 years (Black et al., 2011). According to the High School Youth Behavior Survey conducted by the Centers for Disease Control and Prevention (CDC; 2011), 11.8% of girls and 4.5% of boys from grade school reported that they were forced to have sexual intercourse.

Rape and sexual assault may cause serious and long-lasting consequences for survivors, particularly when untreated (Finn, Garner, & Wilson, 2011). In addition to the immediate physical and emotional harm caused by rape, symptoms suffered by those who experience sexual assault include low self-esteem, depression, anti-social behavior, substance abuse, and self-mutilation (Finn & Hughes, 2008; Krebs, Linquist, Wanrner, Fisher, & Martin, 2009). Survivors of rape are also 13 times more likely to attempt suicide than the general population and 6 times more likely than victims of other crimes (Tjaden & Thoennes, 2006). As such, the trauma of sexual assault should be met with the adequate provision of timely services that address short- and long-term emotional and physical needs of survivors.

Sexual Assault Hotlines

Since the 1970s, sexual-assault hotlines have grown in popularity in North America as convenient conduits, whereby survivors, their loved ones, and professionals coalesce to provide immediate support. The Rape, Abuse, and Incest National Network (RAINN; 2011) identified 1,095 crisis hotline affiliates in the United States alone. However, despite their wide use, empirical research about them is limited and much remains unknown or unclear about their service efficacy as appropriate counseling modalities (Resnick, Acierno, Kilpatrick, & Holmes, 2005; Wasco et al., 2004). These gaps in knowledge pose a troubling challenge in our current political and economic environment, where evidence-based practices are highly desirable to direct and inform professional fields of practice (Finn & Hughes, 2008; Resnick et al., 2005; Wasco et al., 2004). In addition, research is needed to illuminate and capitalize on the unique potential of hotlines in terms of their expansive community reach, immediate accessibility, and autonomous nature.

For traumatic events in general, it is well known that telephone hotlines play an important role in providing immediate support for survivors. However, service providers in other sectors (i.e., health care, human services, and legal services) either lack training, or do not offer trauma-informed services to address problems associated with sexual violence (Elliott, Bjelajac, Fallot, Markoff, & Reed, 2005). Thus, sexual assault hotlines provide a critical community service niche; yet scholarly literature offering evidence-based practices and training guidance for hotline workers is lacking (Finn et al., 2011; Resnick et al., 2005; Wasco et al., 2004).

A meta-analysis of training manuals from all Sexual Assault Coalitions in the United States by Macy, Giattina, Sangster, Crosby, and Montijo (2009) provided service-delivery recommendations for sexual assault service providers. These authors reported that the primary objectives of sexual assault hotline services should minimally include reducing the immediate impact of assault, enhancing survivors' capacity to cope effectively with the crisis, and increasing survivors' understanding of sexual assault and the likely long-term impact of the assault, safety resources, and survivors' legal and medical options. Telephone hotline services should provide responsive and timely crisis intervention to all primary and secondary victims (i.e., family and friends of the primary victim) of sexual violence within their community or region (Macy et al., 2009). However, they also serve the needs of those who grapple with issues of suicide, mental illness, sexual orientation, and homelessness (Gould et al., 2004). In the process of providing callers with information about medical and legal issues related to sexual assault and the traumatic consequences of sexual violence, it is recommended that providers should be non-judgmental, use active listening skills, help survivors clarify and identify their feelings and thoughts, help survivors explore their options and problem solve, emphasize survivors' intrapersonal and interpersonal strengths and resources, and offer genuine empathetic responses (Macy et al., 2009). Providers should also ensure survivors' safety, including safety from self-harm by addressing suicidal thoughts (Macy et al., 2009).

Some literature recommends that crisis hotlines be available without interruption (i.e., 24 hr a day, 7 days a week, and 365 days a year), and that callers have immediate contact with service providers (Macy et al., 2009). Research also suggests that both professional staff and volunteers who have received training can provide effective crisis services (Finn et al., 2011; Macy et al., 2009). Thus, hotlines are not only considered an essential resource for crisis services but they can also be an inexpensive and convenient intervention tool, as the anonymity of communication reduces barriers for help-seeking behavior (Macy et al., 2009).

Although extant findings are promising, other research has shown that much remains unknown about their efficacy (Finn et al., 2011; Macy et al., 2009; Resnick et al., 2005). For example, a critical knowledge gap exists regarding the structure, components, and content of telephone hotlines and it is unclear how services are specifically delivered to survivors (Resnick et al., 2005; Wasco et al., 2004). Despite the wide popularity of such hotlines, practically no research examines if, and how, they meet stated goals. Thus, currently, community programs have limited evidence-based guidance for developing or implementing training curricula, or so-called "best-practice models." Furthermore, sexual assault services may vary considerably both within and across communities, agencies, and service providers, because of diverse philosophical and theoretical foundations (Macy et al., 2009). One cause of such differences is whether the sexual assault service is a stand-alone center or affiliated with a larger agency, such as a domestic violence shelter, hospital, or community mental health organization (Patterson, 2010). Although stand-alone agencies are afforded more autonomy developing agency policy, agencies attached to larger organizations may have different goals and service philosophies (Patterson, 2010). As funders

progressively demand agencies to deliver standardized services based on "the best available" research, sexual assault providers are in need of evidence-based guidelines to help inform their important community work (Finn & Hughes, 2008; Resnick et al., 2005; Wasco et al., 2004).

The purpose of this study is to offset this acknowledged literature gap by examining data over a 5-year period in a single not-for-profit regional sexual assault telephone hotline located in the Southeastern United States. Using a case analysis design, this study explores how victims and the public use the hotline service by identifying the frequency and types of callers, the time gap between an incident occurring and contacting the hotline, categories of assault, and what services and referrals are provided. These data are then compared for congruence with the stated agency's program goals and volunteer training curricula to assess whether content adequately prepares volunteers for the reality of hotline usage. In addition, implications for hotline training and practice recommendations are provided based on the nature and content of the calls from this data set.

Method

In this study, the terms *victim* and *survivor* are used interchangeably. Based on extant literature, the term *survivor* conveys the strength of persons who have been assaulted, whereas the term *victim* reflects the actual criminal nature of the act. The use of the labels, *primary, secondary*, and *non-victim* reflect how information was originally documented by the agency where data were collected.

Design and Sample

A retrospective analysis of archival data was performed using the documentation of hotline calls from a rural sexual assault center (SAC) in a Southeastern state. Referred to herein as "call sheets," documentation per hotline calls from January 2008-December 2012 comprised the sampling frame ($n = 1,970$). For manageability in coding each call sheet and its narrative component, 20% of the sampling frame was selected for analysis using stratified random methods ($n = 383$). This sample size balanced feasibility with the desire to have a robust representation. The sample was proportionate to the number of calls received per month, to account for potential seasonal spikes. Figure 1 displays the average number of calls monthly across the 5-year sampling period to account for seasonal fluctuations. All sampled call sheets were included, except those designated as "prank calls," when agreed upon by two researchers of the team, resulting in a final sample of $n = 357$.

The agency in this analysis serves a rural, multi-county region, including a university town, with an estimated population in 2010 of about 117,000, and a concentrated student population (U.S. Census Bureau, 2014). One explanation for the elevated hotline activity evident in September may be the sizable influx of students into a college community. This hotline has been operating for nearly 40 years, and the agency additionally offers a multitude of services for survivors, friends and family members, and
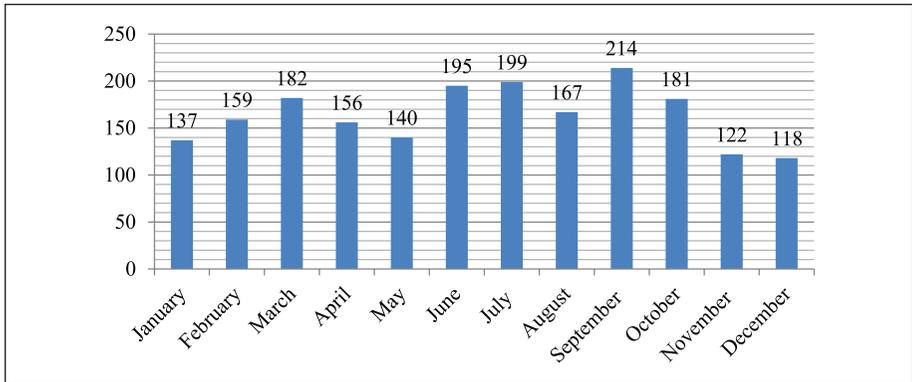
Figure 1. Total number of calls over a 5-year period, divided by month (*n* = 1,970).

professionals. These include free and confidential medical and legal advocacy, an adult survivor support group, counseling referrals for survivors, and support for secondary survivors. In addition, the agency provides on-site forensic interviewing and evaluations for children, medical accompaniment, teen and children's support groups, a non-offending caregiver support group, counseling referrals, medical and legal advocacy, and other referrals as needed, free of charge.

Agency employees staff the hotline during business hours, and approximately 20 volunteers participate in answering calls during evenings, nights, and weekends. Hotline volunteers receive training on topics including terms and basic information regarding sexual assault, information on the roles of collaborative agencies (including law enforcement, sexual assault nurse examiners [SANEs], and the district attorney's office), crisis intervention models and techniques, types of assault, child sexual abuse, medical and forensic concerns, the life-long effects of abuse, investigative processes, mandated reporting, boundaries, and ethics. Volunteers participate in a 3-day training course, totaling 12 hr.

Procedures

On the call sheets, the majority of variables were directly transposed from information routinely collected by the agency. In addition, a written summary description of each call allowed the authors to measure call severity, urgency, and the designated primary presenting problem. When possible, details of the relationship of callers to an identified primary victim were also noted from summary information, as well as what was provided to each caller in terms of information, referrals, and empathy.

The research team consisted of a faculty member and three graduate students. The faculty member's expertise is in program evaluation, and the first and second authors have extensive experience in hotline services, with the second author drawing from a career in crisis hotline intervention, frontline service delivery, training, and administration. During coding, a process of interrater reliability was conducted by the researchers

using a random sample of 30 call sheets (84%+ agreement) for establishing confidence in the reliability of data interpretation. When discrepancies occurred, researchers convened to clarify and reach congruence on all study variables. In all, the following variables were included in analyses.

Variables of Study

1. The date of call was recorded and used to identify annual trends, as well as the time lapse between date of assault and date of hotline usage.
2. The start and end time of each call was used to measure *duration* in minutes. Designation of a.m./p.m. was included on the call sheets, but not routinely filled out, and therefore the time of day could not be examined.
3. *Caller type* was categorized as primary victim, secondary victim, or non-victim. Secondary victims were defined as callers with a familial or friendship relationship to a primary victim. This variable was re-coded for analysis, placing secondary victims into the non-victim category, except where secondary victims are uniquely specified.
4. The *sex of victim* was dichotomous, male or female, as was the *sex of non-victim* callers (as applicable).
5. Of non-victim callers, the caller's *relationship to the victim* was designated as professional, family, or friend. Professional and family relationships were further defined in detail by the authors during a review of summary descriptions on each call sheet (e.g., law enforcement or mother).
6. The *age of victim* was recorded as a scale-level variable, in years. Age was re-coded into a categorical variable for analysis as follows, age 0-17, age 18-24, and age 25 and above. These choices were made to identify the prevalence of minor victims, as well as victims in the young adult age range per the local university population. Age was also analyzed around the median (described below).
7. Choices for the caller's *reason for calling* included an interest in internal agency services or interest in external community services. These categories were not mutually exclusive.
8. The *date of sexual assault* was used for coding the time frame between sexual assault and the date of the hotline call as follows: within 72 hr, 72 hr-1 week, 1 week-1 month, 1 month-1 year, 1-3 years, or more than 3 years.
9. As the definition of the term *sexual assault* may vary among organizations, the current study relied on the definition provided in the training materials specific to the research site. This definition distinguished sexual assault as "an overall term used when a person is forced into unwanted sexual contact. This term covers everything from harassment and indecent exposure to rape." The agency receives calls related to sexual assault across the spectrum of physical and non-physical contact, and training materials are inclusive of the various occurrences.

To better understand the nature of hotline calls received and inform training accordingly, the authors used the descriptive summary written on each call sheet to designate

calls as pertaining either to a *report of sexual assault with physical contact, other psychological distress, information only with no report of sexual assault*, or *not applicable to agency services*. These categories were mutually exclusive. If an occurrence of sexual assault with physical contact was described in the call, regardless of when it occurred, *report of sexual assault with physical contact* was chosen. The category of *other psychological distress* was designated when descriptions of psychological distress were present, but not in combination with a report of a sexual assault with physical contact. The category of *other psychological distress* captured experiences of psychological distress such as trauma due to sexual assault from other unwanted contact and callers who expressed emotions such as uncertainty, fear, and anxiety, but did not report a specific incident of sexual assault.

10. Also from the description section, each call was ranked for severity on a 5-point Likert-type scale with 1 = *low severity* and 5 = *high severity*. This variable was re-coded for analysis into "low," "moderate," and "high" categories. Scores of 1 and 2 were combined to represent "low severity," score of 3 represented "moderate severity," and scores of 4 and 5 represented "high severity."

For example, a caller reporting a recent sexual assault with physical contact was rated as highly severe. Callers describing suicidal ideation and other forms of self-harm, immediate safety concerns, and/or extreme life interference were also labeled as highly severe. The authors did not assume that a sexual assault with physical contact created severe psychological distress or suicidal ideations, or that sexual assault without physical contact did not cause severe psychological distress. Therefore, these factors, both together and separate, could contribute to a designation of "high severity." Examples of moderately severe calls included someone reporting that they were in services, but still experiencing some discomfort or distress due to a past assault or someone reporting some, but not extreme discomfort due to ongoing sexual harassment. Finally, examples of low severity calls included informational calls about sexual assault without any report of sexual assault, or calls not pertaining to sexual assault at all. In some instances, discussion was needed to arrive at a consensual use of the rating system.

11. Each call was also rated as either *urgent* or *not urgent*. Urgent calls were defined as requiring a form of immediate action on the part of the hotline staff or volunteer, such as referral to an advocate or law enforcement.
12. What was provided to each caller was also identified. The following categories were designated by the authors: *information, empathy, advocate, referral*, or *law enforcement*. More than one category could apply. The term *advocate* refers to an employee of the agency, available to victims 24/7, whose purpose is to provide support during a medical exam and/or law enforcement interview and to serve as the point of contact for victims to discuss options. In addition, the details of referrals were recorded when available (i.e., counseling, other SAC).

Table 1. Callers With a Relationship to the Primary Victim, by Type (*n* = 159).

	n	%	% per category
A. Professionals	78	49.1	
1. Health professionals			39.5
2. Law enforcement			25.0
3. Counselors			11.8
4. Social workers			6.6
5. Department of family and children			5.3
6. Other			11.7
B. Family members	60	37.7	
1. Mother			61.7
2. Aunt			10.0
3. Grandmother			6.7
4. Father			5.0
5. Other			16.8
C. Friends	21	13.2	

Note. Subcategories of professionals and family members representing less than 5% were combined as "Other." For professionals, this included advocates, attorneys, church staff, Department of Juvenile Justice, and professors. For family members, the other category included boyfriends, brothers, cousins, grandfathers, husbands, sisters, and step mothers. The label "health professional" includes nurses, SANE nurses, and doctors (ER physicians, ob/gyns, etc.). The label "law enforcement" includes police officers, detectives, captains, and the sheriff's office. SANE = sexual assault nurse examiner; ER = emergency room; ob/gyns = obstetrician/gynecologists.

This project was approved by the Institutional Review Board at the University of Georgia in 2013. All identifying information was redacted from all call sheets to further safeguard anonymity. Two research assistants not associated with the project completed this safeguarding process under the supervision of one of the main researchers. Call sheets were then stored in a locked office and were only accessible to the research team.

Results

Caller Types

The data revealed diversity in hotline usage. Primary victims called the hotline directly in 40.7% of cases, whereas the remaining 59.3% of calls were made by non-victims (re-coded to combine the original categories of *non-victim* and *secondary victim* callers). Callers were female in more than 80% of both victim and non-victim categories. The majority of non-victim callers identified having a relationship to a primary victim (44.5%). Of these, professionals comprised the largest category (49.1%), followed by family members (37.7%) and friends (13.2%). Table 1 displays details of professional

and family callers by type. Health personnel, law enforcement, and mothers of victims called with notable frequency.

Of the 120 calls that documented the age of the reported victim, the type of caller varied in relation to the victim's age. The majority of calls regarding children (aged 0-17 years) were made by family members (64.6%) compared with friends or professionals. The most common relationship of callers to victims aged 18-24 years was friends (40%), whereas the most common relationship of callers to adult victims aged 25 years and above was professional (55.6%).

Demographic Characteristics of Victims

Victims were 86.5% female and 13.5% male. A small number of calls (3.1%) reported multiple victims, both male and female. Of calls identifying the victim's age, 46.7% were minors, 30.8% were between 18 and 24, and 22.5% were 25 or older. The median age of the sample was 18, with a range from 2-56 ($M = 19.9$, $SD = 12.3$). Information regarding race, socioeconomic status, or other demographic descriptors was not available.

Primary Reason for Calling

The largest portion of calls reported a *sexual assault with physical contact* (42.9%), whereas 24.9% of calls involved *other psychological distress*. Calls requesting *information only with no report of sexual assault* represented 26% of the sample, and less than 7% of calls were deemed *not applicable to agency services*.

Call Duration

The median call duration was 5 min, with an expansive range between less than 1 min and 125 min ($M = 9.5$, $SD = 12.08$). The upper boundary for an extreme outlier in the data set was calculated to be 31 min, and 13 calls lasted longer than 31 min. No apparent trends were identified among the 13 calls that exceeded the outlier boundary.

Severity and Urgency

Severity of calls was distributed as follows: 45.3% were "highly severe," 24.8% were "moderately severe," and 29.9% were deemed "low in severity." Despite the predominance of high severity, the majority of calls were not urgent in nature (73.7%). The remaining 26.3% were rated as urgent and required immediate action by hotline staff. When statistically tested, calls made by professionals were more likely to be urgent, compared with calls made by family or friends of survivors ($\chi^2 = 9.05$, $df = 1$, $n = 159$, $p < .001$). For this analysis, family and friends were re-coded into one category for comparison with professionals.
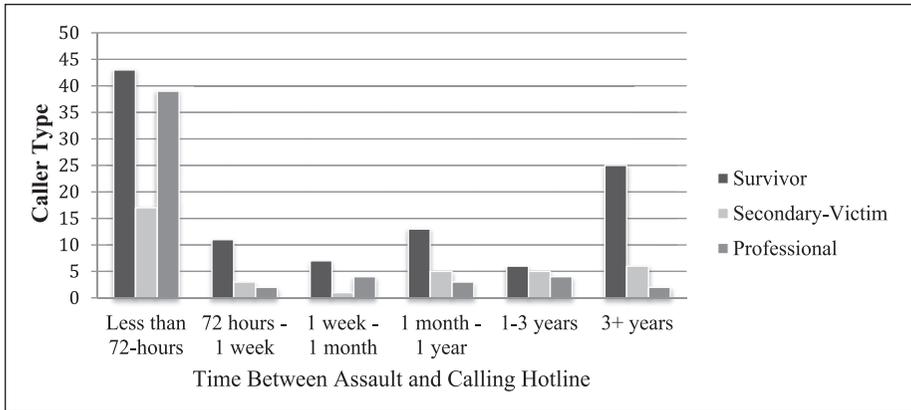
Figure 2. Time between assault and calling the hotline, by caller type (*n* = 196).

Date of Assault and Hotline Usage

A date of the actual assault was recorded for over half the sample (55%). By examining the time frame of assault in relation to the time of the hotline call, it is evident that the hotline is primarily accessed as a "crisis service." The majority of calls (50.5%) were made within 72 hr of assault. However, surprisingly the data reveal that the next most frequent use of the hotline involved calls made 3 or more years after assault (16.8%), demonstrating the necessity for hotline staff to be prepared to respond to both immediate and long-term effects of assault.

Figure 2 displays the time lapse between assault and contacting the hotline in relation to the type of caller, and shows that professionals appear to call largely within a 72-hr period. This assumes that when a caller reports a date of assault and is not a survivor themselves or a friend or family member, their relationship is likely professional. A follow-up comparison was made between the type of caller, re-coded into *primary victim* and all *non-victim* callers and the time frame of assault, re-coded into calls *within 72 hr* and *more than 72 hr* of assault. Chi-square analyses supported a significant relationship ($\chi^2 = 8.27$, $df = 1$, $n = 196$, $p < .01$), with a small effect size (phi $= -.205$, $p < .05$; no cells had an expected count less than 5). Non-victims were more likely to contact the hotline within a 72-hr window of assault (65.5%) rather than after 72 hr (38.5%). Notably, non-victims (56.6%) outnumbered primary victims (43.4%) as callers within 72 hr of assault, likely due to the number of professional callers.

Differences Between Victim and Non-Victim Callers

To understand more about differences between victim and non-victim callers, chi-square tests of independence were conducted regarding duration of call, age of the victim, primary reason for calling, severity, and urgency (see Table 2). Except severity, each variable was re-coded into dichotomous categories. The duration of call was

Table 2. Selected Chi-Square Analyses of Victim Callers Compared With Non-Victim Callers.

		Victims	Non-victims	
	Available *ns*	%	%	χ^2
1. Call duration	339			28.75***
5 min or less		34.1	65.9	
More than 5 min		73.1	36.4	
2. Time between assault and hotline call	196			8.27*
Less than 72 hr		43.4	56.6	
More than 72 hr		63.9	36.1	
3. Age of victim	120			30.60***
Age 17 and younger		14.3	85.7	
Age 18 and older		64.1	35.9	
4. Primary reason for calling hotline	237			7.18*
Sexual assault with physical contact		45.4	54.6	
Other psychological distress		63.5	36.5	
5. Severity	335			40.89***
Low		15.2	84.8	
Moderate		61.2	38.8	
High		45.6	54.4	
6. Urgency	338			0.542
Not urgent		42.0	58.0	
Urgent		37.6	62.4	

*$p < .05$. ***$p < .001$.

re-coded at the median point ($M_e = 5$), representing calls lasting *5 min or less* and *more than 5 min*. Age of victim was also re-coded around the median (18), labeled as *age 17 or younger* and *age 18 or older*. For severity, the categories of low, moderate, and high applied as described above. Regarding the primary reason for calling, analyses were performed to compare the categories of *other psychological distress* with reported *sexual assault with physical contact*. The categories of *information only* and *not applicable to agency services* were excluded.

Results revealed that calls with primary victims were more likely to last longer than the median ($M_e = 5$ min) compared with non-victim callers ($\chi^2 = 28.75$, $df = 1$, $n = 339$, $p < .001$). Non-victim callers were more likely to call regarding a sexual assault with physical contact compared with psychological distress ($\chi^2 = 7.18$, $df = 1$, $n = 237$, $p < .01$) and were also more likely to call in reference to minor victims ($\chi^2 = 30.63$, $df = 1$, $n = 120$, $p < .001$). Low severity calls were more likely to be made by

Table 3. What Was Provided to Callers (*n* = 357).

	n	(%) Yesª
Information	259	72.5
Empathy	142	39.8
Referrals	137	38.4
Advocate	54	15.1
Law enforcement	15	4.2

ªNot mutually exclusive.

non-victims ($\chi^2 = 40.89$, *df* = 2, *n* = 335, *p* < .001); however, analysis did not support a significant relationship between caller type and call urgency between these categories ($\chi^2 = .54$, *df* = 1, *n* = 338, *p* > .05).

Differences in Duration

As expected, but important to confirm for evaluation purposes, a significant relationship was supported between severity and call duration. In addition to calls with survivors lasting longer, hotline staff spent more time on calls of higher severity ($\chi^2 = 52.39$, *df* = 2, *n* = 351, *p* < .001). Calls with family were also more likely to be longer than 5 min compared with professionals and friends ($\chi^2 = 18.30$, *df* = 2, *n* = 159, *p* < .001).

Services Provided

Agency-related services were the primary reason for calling (82.9%), whereas 31% of callers sought external community resources (not mutually exclusive). Information (72.5%) and empathy (39.8%) were provided most frequently and 38.4% of callers received referrals (see Table 3).

The majority of referrals made by hotline staff and volunteers were to internal agency personnel (45.2%), followed by other SACs (11.9%) and counseling (10%). Referrals to law enforcement and/or health services were provided in less than 5% of referred cases. In addition, despite the frequency of minor victims, child advocacy or child protective service referrals were also made in less than 5% of referred cases (see Table 4). There was no significant difference between reports of sexual assault with physical contact or other psychological distress in terms of referrals made, coded *yes* or *no* ($\chi^2 = .16$, *df* = 1, *n* = 240, *p* > .05).

Discussion

As expected, the hotline was used by primary victims as a community crisis resource for information, empathy, and support. The anonymous nature of hotlines may empower victims to seek out help despite feelings often experienced post assault, such as self-blame, shame, or guilt. Researchers concur the actual number of reported

Table 4. The Frequency of Referrals, by Type (*n* = 137).

Referrals by type	Percentage[a]
1. Internal agency personnel	45.2
2. Other sexual assault centers	11.9
3. Counseling	10.0
4. Domestic violence	5.9
5. Child protection	5.0
6. Child advocacy	5.0
7. Sexual assault nurse examiner	5.0
8. Health departments	3.0
9. Housing	3.0
10. Rape, Abuse, and Incest National Network (RAINN)	2.2
11. Victim assistance programs	1.5

[a]Not mutually exclusive per client.

assaults likely significantly underestimates its actual occurrence (Tjaden & Thoennes, 2006), and the anonymous nature of the hotline provides a valuable linkage for victims who may not otherwise access community resources, or chose to navigate the legal system on their own, that is, to report. Interestingly, approximately half (50.5%) of calls were within 72 hr of the sexual assault, with the second highest percentage being more than 3 years after the sexual assault (16.8%). Therefore, our findings support the idea of hotlines being primarily used as a crisis resource (often by nonvictims), but that long-lasting effects of sexual assault also prompt individuals to seek support. Coupled with the time lapse between assault and call time, a clear picture emerged of non-primary victim callers, who were professionals or secondary victims assisting with the immediate impacts of sexual assault or primary victims struggling with continued consequences. These findings have important implications for training and help to fill the sizable knowledge gap of evidence-based practice within sexual assault hotlines.

Hotlines Utilized by Service Providers

In addition to serving as a crisis resource for survivors, the hotline also served as a valuable linkage between service providers. The diversity of callers illustrated that the hotline is used not only by primary victims but also by the broader community affected by sexual assault, including medical personnel, law enforcement officials, and secondary victims. In addition, stakeholders in the sexual assault community utilized this resource in a number of ways. When professionals called (mostly medical and law enforcement personnel), these calls were likely to pertain to a recent sexual assault with physical contact and were triaged to the appropriate resource, including agency response services such as an advocate who would attend to immediate needs or

community resources such as a specially trained SANE, to perform a forensic exam. These calls were immediate in nature and the hotline performed a decided linkage function for community resources. Although some may simply perceive of a hotline in relation to crisis calls, these data indicated that hotlines expeditiously bring stakeholders together and connect survivors with resources beyond those offered by the agency. Furthermore, as research indicates that victim survivors report a significant amount of re-victimization by the legal and medical system that can at times be assuaged by the presence of an advocate or SANE nurse (Campbell, 2008; Maier, 2008), sexual assault hotlines serve a primary function in preventing further victimization and reducing the severity of long-term psychological effects of a sexual assault. This study's findings support that the hotline effectively attenuated the impact of sexual assault not only through counseling but also due to their referrals to other valuable resources.

Hotlines Serve Unique Populations

Male victims. Males may be more likely to use the hotline than other resources, as indicated by a disproportionate number of male callers. Hotline usage for male victims was slightly higher (13.5%) than national reports of the incidents of male victims of sexual assault (Black et al., 2011). These findings may indicate that male victims are more likely to take advantage of hotlines due to their anonymous nature, particularly those males who experience long-term psychological distress from sexual assault. Furthermore, men may attach greater stigma to sexual assault and abuse and thus may be less likely to reach out for help. Important to note, men are less likely than women to disclose and seek help for sexual assault, and more likely to deny long-term effects (Holmes, Offen, & Waller, 1997). The hotline appears to serve an often hidden population that has normally been underserved. The majority of the non-victim callers (mostly friends and family [50.9%]) were women (83.9%). Although many factors may influence the high numbers of female non-victim callers, the propensity of primary victims to disclose to women seems a logical assumption. In turn, women may be more likely to act as helpers or caregivers.

Victims who are minors. This hotline served a surprising number of minor victims: 46.7% of calls reporting age concerned a victim under the age of 18, and the majority of those calls came from family or friends rather than professionals. This incidence could be the result of callers being more likely to report age when referencing a child victim; nevertheless, the hotline is a clear point of access for caregivers of child victims to receive support. Given the negative effects often associated with childhood sexual abuse, the availability of the hotline to assist such callers provides a vital function for this vulnerable population. Training that pertains to the specific needs of children and their caregivers may prove helpful.

College-aged victims. In addition to child victims, a substantial amount of assault occurs for college-aged victims. It has been reported that 37.4% of female rape victims were first raped between the ages of 18-24 (Black et al., 2011), and in a study of

undergraduate women, 19% experienced attempted or completed sexual assault since entering college (Krebs et al., 2009). In the current study, the second largest age group of victims represented, that of 18-to 24-year-olds, could be influenced by the fact that the service area for the hotline includes a large university that, at the time of data collection, did not have rape crisis services or a women's resource center available on campus. Hotlines may be particularly valuable for communities with a high percentage of young adults, as it appears they function as an integral part of the university's rape-crisis response.

Practice Implications

Secondary and Tertiary Prevention

The large proportion of calls regarding minors can have practice implications for training and policy. Childhood victimization is a strong predictor for later victimization (Kimerling, Alvarez, Pavao, Kaminski, & Baumrind, 2007; Stwartout, Stwartout, & White, 2011). Re-victimization is substantially linked to more anxiety, depression, and post-traumatic stress disorder (PTSD) than a singular episode of victimization and future health problems (Arias, 2004; Kimerling et al., 2007). Given the propensity for childhood victims to experience subsequent victimization, and the likely negative effects associated with that, services are needed that acknowledge and address this particularly vulnerable population. From a public health perspective of primary, secondary, and tertiary preventions, the sexual assault community could benefit from a crafted secondary prevention approach with these callers to mitigate the risk associated with childhood victimization and prevent further victimization. For hotline staff, sharing this knowledge and responsibly with callers could prompt further action and service-seeking behaviors for child victims. The knowledge that support is also linked to more positive long-term outcomes (Walsh, Fortier, & DiLillo, 2010) could also benefit these callers, as they struggle with their next steps in this process.

Training Should Reinforce Both Short- and Long-Term Needs of Callers

The severity of calls, coupled with the lapse in time between assault and call, reinforced the primary purpose of the hotline is a crisis service, but additional analysis also revealed its substantial use by victims more than 3 years after the initial sexual assault. Therefore, hotline workers must be trained and prepared to handle the immediate emotional impacts of sexual assault, as well as the long-term emotional impact of sexual assault. As most of those calling immediately were professionals or secondary victims assisting with the immediate impacts of sexual assault, a thorough knowledge of community resources and linkages is crucial. Hotline workers can also (in tandem) help the callers address the emotional needs of the primary victims. Volunteer training materials for the agency in this case study included information on crisis counseling skills; however, our data indicated that more information may be needed regarding the long-term effects on survivors. Providing such information to secondary victims, when

appropriate, may also help mitigate some of the immediate emotional and physical impacts of assault.

Of the callers reporting other psychological distress, more than 40% were prompted by an assault that happened more than 3 years in the past, and even decades in the past. As expected, these calls lasted longer, leading us to believe that actual counseling and empathic responses were provided. Our findings suggested that, in addition to resources about crisis counseling, hotline volunteers need knowledge on the long-term effects of assault and the most effective ways to serve as a helper. In addition to psychological distress, sexual assault can have a devastating impact on one's physical health. An assessed 105,187 females and 6,526 males aged 10-24 years received medical attention in U.S. emergency departments during 2004-2006 as a result of non-fatal injuries sustained from a sexual assault (CDC, 2009). Based on data from 2005 from the Behavioral Risk Factor Surveillance System (BRFSS), links were found for both men and women between history of non-consensual sex and high cholesterol, stroke, and heart disease: female victims of non-consensual sex were more likely to report heart attack and heart disease compared with non-victims (Smith & Breiding, 2011). Additional knowledge of these long-term physical impacts of sexual assault could empower survivors in understanding their own situations, and to seek support despite a possible significant time lapse.

In addition, hotline workers should receive training on the complex reactions survivors may experience after a sexual assault. In Weiss (2009) examination of 944 victim narratives from the National Crime Victimization Survey (NCVS), she found that one in five women who experienced sexual assault excuses or justifies her experiences using language that indicates male sexual aggression is natural, normal within dating and relationships, or the victim's fault. When victims downplay sexual assault as unintentional or not-so-bad, they create a non-crime narrative that requires no formal action to be taken (e.g., reporting the incident to police, seeking support services). This minimization permits survivors of assault to evade uncomfortable situations, such as reporting their loved ones, peers, or colleagues. Furthermore, by not acknowledging the crime, victims are able to deny their victimhood and preserve their sense of power and control (Weiss, 2009).

Crafting such narratives may help victims handle the immediate emotional fallout of experiencing trauma, but the long-term effects of these accounts may not be as beneficial (Weiss, 2009). These accounts concurrently excuse offenders while inadvertently transmitting blame back to the victims. If survivors of sexual assault assume accountability, their sense of shame and self-blame may decrease the likelihood that they seek support for their medical and emotional needs, which may explain our findings of more non-victim than victim callers within 72 hr. Likewise, for persons in abusive relationships, these narratives may be immobilizing victims to stay in violent relationships that they have rationalized as typical or acceptable. Moreover, these accounts increase the likelihood of re-victimization, including further emotional and physical trauma (Weiss, 2009). Training should include appropriate ways of challenging callers' narratives that blame themselves or that inoculate an offender's actions by using language that normalizes sexual aggression.

In addition to this recommended training, hotline workers must be aware that the climate in which sexual violence is occurring and being reported, investigated, and experienced has changed with the recent proliferation of social media outlets. An increasing number of cases involving such public shaming may indicate a growing trend, with future training implications for service providers, including hotline volunteers. Despite evidence suggesting that social media may pose a threat to vulnerable populations (Luxton, June, & Fairall, 2012), little research has been conducted on this particular population of survivors, their needs, and the best ways to provide support and treatment. This related information was not in the scope of the current study, but is recommended for future research.

Limitations

Results of the current study pertain to only one agency hotline and are limited in their generalizability, as sexual assault hotlines are not isomorphic with respect to their service delivery. In addition, the collected data were also somewhat limited. For instance, not all items were completed on all call sheets (e.g., sex of caller, existing caller, caller's first language, type of call). In future evaluation efforts, care should be taken to have hotline staff and volunteers document items completely when possible. For example, we were unable to provide time of day patterns as they pertain to calls due to the a.m./p.m. designation often being left blank.

Concluding Remarks

Sexual assault is a pervasive problem with significant negative impacts on survivors and their communities. A vital component of service provision, anonymous 24-hr telephone hotlines are well-situated to provide crisis counseling, linkages to services, information, and referrals. Given the lack of available standardized training materials, and/or best-practice guidelines for hotline service provision, the current study contributes to filling a void in the literature by providing a picture of hotline callers and services provided, and specifically relating this knowledge to practice implications.

Continued research is needed to further explore the findings in this analysis. Evaluation should be extended to additional research sites with efforts to incorporate service quality into the research designs. Based on this study, it is recommended that hotline providers minimally collect information on the following variables (in addition to those already identified in this study), and carefully monitor staff and volunteer documentation to facilitate evaluation efforts: (a) services requested by callers and details of support and services provided by hotline workers, (b) time (a.m./p.m. designation) and day of call, (c) type of assault reported (e.g., drug-assisted assault, sexual harassment, or acquaintance rape), (d) age and sex of victim (if possible), (e) whether the caller is currently receiving services or has had treatment in the past, and (f) safety of the caller.

Finally, future research could focus on specific types of callers and specialized needs—such as male callers, or family and friends. Also, as social media changes the

nature of our daily communication, research focusing on ameliorating specific negative effects associated with this phenomenon could prove helpful.

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