

Delaware State Plan for the Prevention of Sexual Violence 2009-2013



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**Delaware Health
And Social Services**

Office of the Secretary

1901 N DUPONT HIGHWAY NEWCASTLE DE 19720

TELEPHONE 302-255-9040 FAX 302-255-4429

January 29, 2010

Dear Community Members, Policy Makers, and Advocates:

Crimes of sexual violence (SV) have harmful and lasting consequences for victims, families and our communities. SV has a profound impact on physical and mental health. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences. Its impact on mental health can be as serious as its physical impact, and may be equally long lasting. Deaths following sexual violence may be as a result of suicide, HIV infection or murder – the latter occurring either during a sexual assault.

According to *One in Eight-Rape in Delaware: A Report to the State*, one in 8 women in Delaware have experienced rape at least once in their lives (Kilpatrick and Ruggiero, 2003). National data indicates that every six minutes, one rape is reported in the United States (compared with one murder every 27 minutes); 90% of child sexual abuse is committed by men and by persons known to the victim (70% to 90%); and 20% to 25% of women in college reported experiencing an attempted or a completed rape in college.

I support the Delaware State Plan for the Prevention of Sexual Violence as developed by ContactLifeline's Sexual Assault Network of Delaware (a multidisciplinary group) and it's subcommittee *Implementation and Action Committee* with technical and financial support provided by the Delaware Department of Public Health and the U. S. Centers for Disease Control and Prevention.

It is our collective responsibility to work to address the causes and impact of sexual violence through collaboration, prevention efforts and the distribution of resources.

Sincerely,

A handwritten signature in black ink that reads "Rita M. Landgraf".

Rita M. Landgraf
Secretary

Executive Summary

Delaware State Plan for the Prevention of Sexual Violence

2009-2013

Our hope is that the *Delaware State Plan for Prevention of Sexual Violence* will act as a prism – a reflective index that can refract energy and light into a spectrum through the phenomena of dispersion – that is to attract stakeholders, harness a common energy, and disperse that energy into action across the “Spectrum of Prevention”¹ in Delaware.

Our vision is for every child, man and woman to live in Delaware free of sexual violence. Free of fear – free of the aftermath. All of the lost and wasted resources, from the life-long impact on victims and from the cost of holding offenders accountable, will be invested in improving health care, community services, and education.

The Delaware Sexual Violence Prevention Plan has developed over time using input from key stakeholders - agencies and individuals that have been working towards ending sexual violence in Delaware. The plan reflects the combined efforts of ContactLifeline, Inc., the Delaware Department of Public Health and CONTACTLIFELINE SAND Delaware’s sexual violence coalition, the Sexual Assault Network of Delaware. ContactLifeline is the only rape crisis center in Delaware providing crisis intervention, education, and advocacy services and has served victim/survivors for over 35 years statewide. CONTACTLIFELINE SAND has members representing system and community-based victim services, law enforcement, the medical community, state agencies, state and private universities, advocacy groups and survivors.

CONTACTLIFELINE SAND will coordinate an Implementation and Action Committee charged with the development and oversight of primary prevention activities for sexual violence. CONTACTLIFELINE SAND’s Implementation and Action Committee will provide leadership and strategic planning for implementation of the goals and strategies outlined in the Delaware State Plan for the Prevention of Sexual Violence. Members of the committee will incorporate existing data and research to build upon the resources and current activities being done. The Implementation and Action Committee will assist in the measure of progress in prevention activities in order to evaluate the effectiveness of the prevention efforts and measure progress towards the plans goals. Outreach to communities and individuals who have not been represented and/or involved in the process thus far will be pursued on a statewide level.

¹ Cohen, Larry and Swift, Susan. “The Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention”. Injury Prevention . Volume 5,(1999).

According to the CDC, one in six women and one in 33 men noted in a national survey that they had experienced rape or attempted rape at some point in their lives.² In Delaware, one in eight women have experienced rape at least once in their lives. The ***“One in Eight – Rape in Delaware: A Report to the State”*** by Kilpatrick and Ruggiero, is a comprehensive report on sexual assault in Delaware in 2003.³ Using national data, the report estimates that:

- One in eight (38,000) or 12.2%, adult women living in Delaware have experienced rape during their lives.
- Of the 197,000 women living in New Castle County, over 24,000 have been raped.
- Of the 63,000 women living in Sussex County, over 7,700 have been raped.
- Of the 49,000 women living in Kent County, over 5,900 have been raped.
- 31% of Delaware women rape survivors have developed post-traumatic stress disorder (PTSD) as compared to 5% of women who were never victimized by violent crime.

This plan, the *Delaware State Plan for the Prevention of Sexual Violence*, outlines the “big picture” of preventing sexual violence in Delaware. By defining issues, setting goals, and establishing the infrastructure needed to achieve the goals, the plan lays forth a common vision of life in Delaware free of sexual violence.

Goals of the plan are listed below and are discussed in more detail in later sections:

- | | |
|---------|---|
| Goal 1: | To increase awareness and recognition that sexual violence is preventable. |
| Goal 2: | To strengthen social norms that encourages healthy and respectful relationships. |
| Goal 3: | To ensure that all voices are heard to promote primary prevention of sexual violence. |
| Goal 4: | To increase the capacity of individuals, groups and communities to prevent sexual violence. |

Preparation and writing of this plan included an investigation of sexual violence prevention efforts at the national level. Prevention materials and sexual violence data were surveyed and reviewed. The materials included both violence against women and sexual violence prevention plans. It is clear from the survey that the violence against women movement has historically engaged in an over-reliance on criminal justice systems, which has not effectively reduced or prevented sexual violence. We join other states in recommending that communities create and

² “Understanding Sexual Violence,” Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Atlanta, GA, 2007. Available at: <http://cdc.gov/ncipc/pub-res/images/SV%20Factsheet.pdf>.

³ Ruggiero, K.J., & Kilpatrick, D.G. (2003). ***“Rape in Delaware: A Report to the State.”*** Charleston, SC: National Violence Against Women Research Center, Medical University of South Carolina.

enhance alternatives to legal system intervention. Community accountability strategies can expand the focus of sexual violence prevention beyond the individual, interpersonal intervention to emphasize and nurture community and societal change.

During the five-year plan, the CONTACTLIFELINE SAND Implementation and Action Committee will facilitate and coordinate activities relating to the goals and strategies. As each strategy is implemented, the Committee will evaluate and document measures of progress toward the selected goals. Each year the Committee will issue a progress report and will include suggestions for retooling or refining the goals and strategies undertaken. Stakeholders will be invited to participate all throughout the implementation of the plan.

At the end of the five-year plan, a review of the implementation and planning process will be conducted. This will include an evaluation of its success and recommendations for continued efforts to prevent sexual violence in Delaware.

Overview – Planning and Action Process

This plan, the *Delaware State Plan for the Prevention of Sexual Violence*, outlines the “big picture” of preventing sexual violence in Delaware. By defining issues, setting goals, and establishing the infrastructure needed to achieve the goals, the plan lays forth a common vision of life in Delaware free of sexual violence.

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During the five-year plan, the CONTACTLIFELINE SAND (Sexual Assault network of Delaware) Implementation and Action Committee will facilitate and coordinate activities relating to the goals and strategies with the guidance of the rape prevention and education staff of the Delaware Department of Public Health. During 2010, one of the primary strategies will be to further assess and gather data by developing the use of an assessment tool/survey of not only prevention programming but to assist in building a more focused capacity.

As each strategy is implemented, the Committee will evaluate and document measures of progress toward the selected goals. Each year the Committee will issue a progress report and will include suggestions for retooling or refining the goals and strategies undertaken. Stakeholders will be invited to participate all throughout the implementation of the plan.

The Delaware Sexual Violence Prevention Plan has developed over time using input from key stakeholders—agencies and individuals that have been working towards ending sexual violence in Delaware. The plan reflects the combined efforts of ContactLifeline, Inc., the Delaware Department of Public Health and CONTACTLIFELINE SAND Delaware’s sexual violence coalition, the Sexual Assault Network of Delaware. ContactLifeline is the only rape crisis center in Delaware providing crisis intervention, education, and advocacy services and has served victim/survivors for over 35 years statewide. CONTACTLIFELINE SAND has members representing system and community-based victim services, law enforcement, the medical community, state agencies, state and private universities, advocacy groups and survivors.

CONTACTLIFELINE SAND’s purpose is to provide community awareness of the problem of sexual assault in all its forms, to assure adequate and effective treatment services for victims of sexual assault, to promote the coordination of services for victims and to encourage prevention efforts aimed at reducing the incidence of sexual violence. CONTACTLIFELINE SAND strives to bring education and prevention through the continued collaboration of both its community and state agency partners. CONTACTLIFELINE SAND promotes the growing belief that it is time to focus on prevention and time to allocate resources on decreasing and eliminating sexual violence.

CONTACTLIFELINE SAND will coordinate an Implementation and Action Committee charged with the development and oversight of primary prevention activities for sexual violence. CONTACTLIFELINE

SAND's Implementation and Action Committee will provide leadership and strategic planning for implementation of the goals and strategies outlined in the Delaware State Plan for the Prevention of Sexual Violence. Members of the committee will incorporate existing data and research to build upon the resources and current activities being done. The Implementation and Action Committee will assist in the measure of progress in prevention activities in order to evaluate the effectiveness of the prevention efforts and measure progress towards the plans goals. Outreach to communities and individuals who have not been represented and/or involved in the process thus far will be pursued on a statewide level.

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CONTACTLIFELINE Sexual Assault Network of Delaware Members
(SAND)

Cheri Will
Beebe Medical Center

Anita Symonds
Christiana Medical Center

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Dawn Culp
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Nancy McGee
ContactLifeline

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Part I. Vision and Plan

A. Vision for Delaware

Our vision is for every child, man and woman to live in Delaware free of sexual violence. Free of fear – free of the aftermath. All of the lost and wasted resources, from the life-long impact on victims and from the cost of holding offenders accountable, will be invested in improving health care, community services, and education.

Our hope is that the *Delaware State Plan for Prevention of Sexual Violence* will act as a prism – a reflective index that can refract energy and light into a spectrum through the phenomena of dispersion – that is to attract stakeholders, harness a common energy, and disperse that energy into action across the “Spectrum of Prevention”⁴ in Delaware.

It is our belief, that to prevent sexual violence, each and every Delawarean must be reached. In order to be effective, prevention strategies must address all persons who are potential victims/survivors as well as those who may become potential perpetrators **and** must support a community where sexual violence is not tolerated.

To turn this vision into reality, we begin with a plan. A plan calling us to redirect resources in our Delaware schools, businesses, religious institutions, civic groups and government, to better support primary prevention strategies. Our plan to implement community accountability strategies will help Delaware achieve a sexual violence free environment. Our call to action – **join us in our efforts**. Everyone can help create opportunities for primary prevention activities and apply best practices in strategies to prevent sexual violence in Delaware.

B. Introduction - Sexual Violence Prevention

What is sexual violence?

Sexual violence is the use of sexual actions or words that are unwanted by and harmful to another person. (For definitions of sexual violence and related terms, see Appendix 2 – Glossary of Terms.)

What is sexual exploitation?

Sexual exploitation is using children/youth/adults in a sexual manner for the individual or commercial gain of those more powerful, with no regard of the harm being caused to the person being used.

⁴ Cohen, Larry and Swift, Susan. “The Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention”. Injury Prevention . Volume 5,(1999).

What is violence prevention – the Public Health Approach

According to the Prevention Institute, violence prevention is “a systemic process that promotes healthy environments and behaviors that reduce the likelihood or frequency of violence against women.”⁵

The Centers for Disease Control and Prevention (CDC) recognize there are several ways to classify prevention and intervention activities. The most common and useful way, from a public health perspective, is the classification scheme presented by the Commission on Chronic Illness (1957). This scheme identifies activities according to when they occur in relation to the violence. While this plan calls for participation in primary prevention, it is crucial to continue successful secondary and tertiary interventions and to understand the interrelationships between the prevention approaches.

Primary Prevention:	Activities that take place before sexual violence has occurred to prevent initial perpetration or victimization.
Secondary Prevention:	An immediate response, after sexual violence has occurred, to deal with the short-term consequences of violence.
Tertiary prevention:	Long-term responses, after sexual violence has occurred, to deal with the lasting consequences of sexual violence for the victim/survivor, as well as sex offender treatment interventions.

Asking what norms, values, or belief systems contribute to sexual violence.

The main focus of this plan is to counteract existing social norms, values or belief systems that contribute to sexual violence.

Some of these norms include:

- objectification and oppression of women,
- social value placed on acquiring, claiming, and maintaining power,
- tolerance of aggression and attribution of blame to victims,
- unhealthy constructs of manhood, including domination and control,
- privacy attitudes individual, familial, and cultural, fostering secrecy and silence,
- tolerance surrounding the objectification of children and use of their sexuality as a commodity.

To counteract the prevailing social norms, strategies must address:

- changing the culture that encourages the objectification and exploitation of people of any age and gender,
- decreasing the demand and use of sexually explicit materials trending towards young children and violence,

⁵ *ibid.*

- supporting local and state policies ensuring safe and respectful workplaces,
- breaking the silence surrounding the social problem of sexual violence

Examining what public health has to do with sexual violence prevention.

The Delaware Department of Public Health is coordinating the strategic planning and development process of the *Delaware State Plan for Primary Prevention of Sexual Violence*, with close involvement from stakeholders (See Appendix 4 for a list of collaborators and interested stakeholders.) The Delaware Department of Public Health recognizes that sexual violence is more than a public safety concern or criminal justice issue. Sexual violence is a public health issue affecting the whole of the Delaware community.

Applying the public health model encompasses the following approach: defining the problem, identifying risk and protective factors, developing and testing prevention strategies, and assuring widespread adoption. Public health focuses on the broader picture – the big picture. It looks at the environment, defines the costs and causes associated with sexual violence, and sets goals and strategies for implementation with activities that are proven effective for changing social norms.

C. Defining the Problem

The Impact of Sexual Violence

The first step in the public health approach is to define the problem of sexual violence in terms of who is victimized and the impact on their lives and communities. However, defining and understanding the problem of sexual violence also requires we look at the costs, financial and emotional, the effects of technology, and the existing disparities in victimization.

According to the CDC, one in six women and one in 33 men noted in a national survey that they had experienced rape or attempted rape at some point in their lives.⁶ In Delaware, one in eight women have experienced rape at least once in their lives. The ***“One in Eight – Rape in Delaware: A Report to the State”*** by Kilpatrick and Ruggiero, is a comprehensive report on sexual assault in Delaware in 2003.⁷ Using national data, the report estimates that:

- One in eight (38,000) or 12.2%, adult women living in Delaware have experienced rape during their lives.
- Of the 197,000 women living in New Castle County, over 24,000 have been raped.
- Of the 63,000 women living in Sussex County, over 7,700 have been raped.
- Of the 49,000 women living in Kent County, over 5,900 have been raped.
- 31% of Delaware women rape survivors have developed post-traumatic stress disorder (PTSD) as compared to 5% of women who were never victimized by violent crime.

⁶ “Understanding Sexual Violence,” Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Atlanta, GA, 2007. Available at: <http://cdc.gov/ncipc/pub-res/images/SV%20Factsheet.pdf>.

⁷ Ruggiero, K.J., & Kilpatrick, D.G. (2003). ***“Rape in Delaware: A Report to the State.”*** Charleston, SC: National Violence Against Women Research Center, Medical University of South Carolina.

- 30% of rape survivors in Delaware experience major depression sometime in their lives; compared to 10% of women never victimized by violent crime.
- 13% of rape survivors, nearly 4,940 women in Delaware, will attempt suicide at some point after being victimized, compared to only 1% of women never victimized by violent crime.⁸

Additional data about sexual assault in Delaware is available from the Division of Public Health's 2005 Behavioral Risk Factor Survey, available on the Web at: <http://www.dhss.delaware.gov/dhss/dph/dpc/sexualassault.html>

These estimates are conservative because the study did not include women who experienced alcohol or drug-facilitated rape or attempted rape.

The Costs of Sexual Violence

Key findings tell us that women and children, both girls and boys, are most likely victimized by acts of sexual violence and that men and boys comprise the majority of perpetrators. In most cases a victim knows their perpetrator and that person is someone they trust. Beyond the suffering of victims, families and communities, sexual violence also has financial costs. These include medical, mental health, social and emergency services, insurance, legal costs, lost productivity, wages, and benefits.

While statistics can be helpful in studying and understanding a public health problem, numbers can also be impersonal. Regardless of the number assigned to victims, they each represent an individual in our community. Each represents a child, a spouse, a sibling, a friend, or a co-worker who is connected to us in many ways. The impact of sexual violence is so profound because it is shared by all of us through knowing someone who has experienced it. These facts and numbers are conservative measures because sexual violence crimes are known to be the most under-reported of all crimes.⁹

Sexual violence has widespread costs for everyone nationally and at the state level. With more than 38,000 survivors of sexual violence in Delaware, the financial and emotional impact on friends, family, neighbors and the community is devastating. Although it is difficult to measure directly the financial cost of health care tied to sexual violence, it is estimated by the National Institute of Justice that sexual violence costs a minimum annual loss of 127 billion dollars or about \$508 per U.S. resident. Tangible costs include initial police response, medical care, mental health services, property loss or damages and loss of productivity. Intangible losses include loss of quality of life, pain and suffering. These costs do not include the system costs for investigation, prosecution or incarceration of offenders. However, the referenced figure makes sexual assault the costliest crime in the country, ahead of homicide.¹⁰

⁸ Kilpatrick, D.G., C.N. Edmunds, and A.K. Seymour. 1992. *Rape in America: A Report to the Nation*. Arlington, VA: National Center for Victims of Crime; Charleston, SC: Medical University of South Carolina.)

⁹ *Ibid.*

¹⁰ US Department of Justice, *Victim Costs and Consequences: A New Look*, 1996; Summary by Virginians Aligned Against Sexual Assault.

The Children's Safety Network Economic and Insurance Resource Center reports the average cost of being a rape victim is estimated at \$110,000. This compares with victim costs of \$16,000 for robbery, and \$36,000 for drunk driving. Sexually violent acts against children (ages 0-14) cost \$71 billion every year, or 61% of the cost of all violent crime associated with this age group. Sexual violence against adolescents (ages 15-24) costs \$45 billion per year, or 29% of the cost of all violent crime associated with this age group.¹¹ The average cost of mental health care for a child sexual abuse victim is estimated to be \$5,800.¹²

The Role of Advancing Technology in Sexual Violence

Modern technology has increased availability of child pornography to potential perpetrators. Child pornography on the Internet has been found by the National Center for Missing and Exploited Children, to contain in 80% of images, children being abused and exploited by someone they knew and trusted. In 48% of the images a family member perpetrated the offenses. The Center also reported the age young males first saw pornographic images occurs at age 11 when a child's brain is still developing reasoning skills.¹³ Technology has been found to advance forms of exploitation, including images of child sexual assault (child pornography), child prostitution, sexual enticement of children through technological means (internet, social networking), recruitment or forcing of children into child sex tourism, and sex trafficking.¹⁴

Recognizing the Disparities in Sexual Violence Victimization

Recognizing that disparities for victims exist in sexual violence – that is specific groups of people are at increased risk of victimization and face additional barriers when trying to report the crime and access services for care – is an important aspect of defining sexual violence. Groups that are overlooked or oppressed are targeted by offenders because they are less likely as victims to report crimes of sexual violence or less likely to be believed even if they do report. Potential perpetrators in a position of power and control over potential victims increase the likelihood of assault.

Research reveals we are all at risk of becoming victims of sexual violence – male or female, young or old, urban or rural. Those at increased risk include children, females of all ages, people of color, people with disabilities, victims of intimate partner violence, people who are homeless, people with mental illness, adolescents, persons engaged in prostitution, and gay, lesbian, bisexual and transgender (LGBT) people. Prevention messages to populations at risk need to be clear and appropriate to their needs.¹⁵

¹¹ Children's Safety Network Economic and Insurance Resource Center

¹² Miller, Cohen and Wiersema (1996)

¹³ Nitin Gogtay, et al, "Dynamic mapping of human cortical development during childhood through early adult," Proceedings of the National Academy of Sciences of the United States of America, May 17, 2004, Vol. 101, pp. 8174-8179.

¹⁴ S.W. Cooper, R.E. Estes, A. Giardino, N. Kellogg, and V. Veith, Medical, Legal & Social Science Aspects of Child Sexual Exploitation: A Comprehensive Review of Pornography, Prostitution and Internet Crimes. GW Medical Publishing, Saint Louis, MO 2005.

¹⁵ Kilpatrick, D.G., C.N. Edmunds, and A.K. Seymour. 1992. ***Rape in America: A Report to the Nation.*** Arlington, VA: National Center for Victims of Crime; Charleston, SC: Medical University of South Carolina.)

Females are at special risk and that risk is compounded when they are also very young or very old, have disabilities or are members of non-traditional groups defined by race, income, ethnicity, or sexual orientation. In the United States, one in six women reported being raped or assaulted at some time in their lives.¹⁶ Relationship also matters, the National Violence Against Women Survey indicates that two thirds of adult women who reported being raped, physically assaulted, or stalked, were victimized by a current or former husband, boyfriend, or date.¹⁷

Children are also at increased risk. The estimated number of children under 18 in Delaware in 2007 is 228,097.¹⁸ It is estimated nationally that 20% of American women and 5-10% of American men have experienced child sexual abuse as children.¹⁹ Again relationship matters as family members constitute 30-50% of perpetrators against girls, and 10-20% against boys.²⁰ The highest assault rate was among girls aged 13-17. Girls are at even greater risk during their college years. In the United States 20-25% of college women experienced an attempted rape or completed rape during their college years.²¹

A person's advanced age increases vulnerability and risk of being victimized by sexual abuse and violence. Elder sexual abuse is defined as sexual activity that occurs when a person age 60 or older is forced, tricked, coerced, or manipulated into unwanted sexual contact.²² A Virginia study of elder sexual abuse in 2000, found that 18% of women raped each year are age 60 and older and victims are more likely to sustain physical injuries due to age and health conditions.²³ The National Elder Incidence Abuse Study estimates that a spouse, partner, other family member or caregiver perpetrated more than 85 percent of elder abuse cases.²⁴

A person with a disability is at increased risk of sexual violence. Among adults who are developmentally disabled, as many as 83% of the females and 32% of the males are the victims of sexual assault.²⁵ Persons with developmental disabilities are four to ten times more likely than others to be victimized by violence, abuse, and neglect.²⁶ Only 3% of sexual abuse cases

¹⁶ Tjaden, P. and Thoennes, N., *Extent, Nature, and Consequences of Intimate Partner Violence*, U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, Rockville, MD, 2000, publication NCJ 181867.)

¹⁷ *Preventing Violence Against Women Program Activities Guide*, Center for Disease Control and Prevention, National Center for Injury Prevention and Control, Atlanta, GA, undated. Available at <http://www.cdc.gov/ncipc/vaw.pdf>.

¹⁸ Kids Count in Delaware, Families Count in Delaware, Fact Book 2009. Center for Community Research and Service, College of Human Services, Education and Public Policy, University of Delaware.

¹⁹ Finkelhor, D. 1994 (Summer/Fall). Current information on the scope and nature of child sexual abuse. *The Future of Children: Sexual Abuse of Children* 4(2):31-53.

²⁰ *Ibid.*

²¹ Fisher, B., Cullen, F., Turner, M., *The Victimization of College Women*, U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, Washington, D.C., 2000, publication NCJ 182369.

²² Ramsey-Klawnsnik

²³ Teaster, P., & Roberto, K., (2004). Sexual abuse in older women living in nursing homes. *The Gerontologist*, 44, 788-796.

²⁴ *National Elder Incidence Abuse Study*, U.S. Department of Health and Human Services, Administration on Aging, 1998. Available at: http://www.aoa.gov/eldfam/Elder_Rights/Elder_Abuse/AbuseReport_Full.pdf.

²⁵ Johnson, I., Sigler, R. 2000. *Forced Sexual Intercourse Among Intimates*. *Journal of Interpersonal Violence*. 15 (1).

²⁶ Petersilia, P., Foote, J., and Crowell, N., eds., *Crime Victims with Disabilities*, National Academy Press, Washington, D.C., 2001. *Criminal Justice and Behavior*, 2001.

involving people with developmental disabilities are ever reported.²⁷ In a study of women with intellectual disabilities, 83 percent reported being sexually assaulted, and 50 percent of those reporting had been assaulted 10 or more times.²⁸ It is reported that 15% of children who are sexually abused have disabilities.²⁹

A victim of sexual violence is never at fault regardless of whether they identify or belong to a social or demographic group at increased risk. Individuals who perpetrate sexually violent acts are at fault **and** must be held accountable for their actions. Research and treatment programs for sex offenders will help communities develop effective strategies for prevention activities.

D. Identifying Risk and Protective Factors for Sexual Violence

Identifying risk and protective factors is the second step in the public health model. Specifically, the Center for Disease Control and Prevention has identified “risk and protective factors” as factors that either increase or decrease the likelihood of a person becoming a victim or perpetrator of sexual violence.³⁰

A list of risk and protective factors listed below is comprised from a variety of sources and represents the most commonly accepted in sexual violence prevention work.

Risk Factors to Identify

- Child neglect or maltreatment and poor attachment to parents or caregivers
- History of sexual abuse
- History of exposure and witnessing violence
- Physical or mental health concerns
- Having a disability or special need
- Oppression and discrimination
- Male superiority and right of domination belief structure
- History of an abusive relationship with intimate partner
- Homelessness and limited financial resource
- Overuse or misuse of alcohol or other drug substance
- Isolating or unsafe environment (school, community, and workplace)
- Violence tolerated and condoned by society such as
 - Attitudes and beliefs supporting sexual violence
 - Demand for and willingness to pay for child pornography depicting child sexual abuse
 - Consistent exposure to sexually violent media and content via the Internet or other media

²⁷ Valenti-Hein and Schwartz, 1995. *The Sexual Abuse Interview for Those with Developmental Disabilities*.

²⁸ Stimpson, L. and Best, M., *Courage Above All: Sexual Assault Against Women with Disabilities*, Toronto: Disabled Women’s Network, 1991.

²⁹ NCCAN. 1993. *A Report on the Maltreatment of Children with Disabilities*.

³⁰ The Public Health Approach to Violence Prevention, Centers for Disease control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, Atlanta, GA 2008. Available at: <http://www.cdc.gov/ncip/dvp/PublicHealthApproachtoViolencePrevention.htm>.)

Protective Factors to Identify

- Secure attachment and relationship with parent or caregiver
- Access to basic needs of food, services, housing and health care
- Life and coping skills
- Safe and inclusive environment (schools, community, and workplace)
- Existing and accessible community education and mentoring programs
- Messaging that supports gender equality, respect, and healthy sexual relationships

Identifying a person's risk and protective factors does not determine or predict that a person will or will not become a sexual violence victim or perpetrator.³¹ The risk and protective factors are indicators of potential concern and alert prevention specialists to take preventive action. A healthy community that practices and promotes respect and safety will not tolerate sexual violence and exploitation. This represents the community accountability approach and strategy of prevention.

E. Developing and Testing Prevention Strategies

Determinations on whether a particular prevention program is effective can be made through research and data collection. To be successful in reducing sexual violence, programs and their corresponding evaluations will need to be reviewed. Pilot interventions and prevention efforts will need to be proposed and funded after an assessment is done. And across the span of strategies and activities, best practices in primary prevention will need to be vetted and shared to ensure the best chances of success. Evaluating prevention programs or strategies is the responsibility of the Implementation and Action Committee of ContactLifeline SAND (Sexual Assault Network of Delaware.)

The Implementation and Action Committee is charged with facilitating and promoting the use of prevention strategies that span and reach all levels of our society, from individual and community strategies to organization and business practices and policies. Already awareness-building and education have been shown to make a difference – but more is needed. Education and awareness activities have been found to be most effective when coupled with policy change and community accountability approaches. Key factors in these approaches include: mobilizing men to be part of the solution, building coalitions of stakeholders and partners to promote primary prevention, and seeking companion legislative and policy changes to make Delaware communities safer.

F. Assuring Wide Spread Adoption of Sexual Violence Prevention

Through funding from the Centers for Disease Control and Prevention, the Delaware Department of Public Health has approved and directed a variety of prevention programs, activities, and events for preventing sexual violence. The Delaware Department of Public Health will coordinate efforts with ContactLifeline, CONTACTLIFELINE SAND, and key stakeholders to implement best practices and proven prevention strategies. Specific implementation of

³¹ *Ibid.*

strategies and related activities will be undertaken by many groups, organizations, and agencies throughout the state.

Part II. Goals and Strategies to Prevent Sexual Violence

A. The Spectrum of Sexual Violence Prevention

The foundation for this primary sexual violence prevention plan has been influenced by the **Spectrum of Prevention** as developed by The Prevention Institute.³² This approach develops strategies for primary prevention that go beyond efforts to solely educate the individual. It takes a more comprehensive, societal approach in changing societal norms and individual behaviors that contribute to sexual violence. When used in an organized, interactional way, the Spectrum of Prevention model can strengthen efforts on many levels and support strategies than can influence not only individual behavior, but the larger community and society as well. The African Proverb: *“It takes a village to raise a child.”* brings home the concept that it takes multiple efforts on behalf of a community and society to more effectively change violent behaviors in the individual. Preventing sexual violence in our state can only be accomplished by a commitment at many different levels to prevent sexual violence.

The Spectrum of Prevention is a model that can be used to establish a framework for primary prevention of sexual violence in Delaware. There are six levels of the spectrum as shown in the following chart:

Level of Spectrum	Definition of Level
Strengthening Individual Knowledge and Skills	Enhancing an individual’s capability of preventing violence and promoting safety
Promoting Community Education	Reaching groups of people with information and resources to prevent violence and promote safety
Educating Providers	Informing providers who will transmit skills and knowledge to others and model positive norms.
Fostering Coalitions and Networks	Bringing together groups and individuals for broader goals and greater impact.
Changing Organizational Practices	Adopting regulations and shaping norms to prevent violence and improve safety.
Influencing Policies and Legislation	Enacting laws and policies that support healthy community norms and a violence-free society.

The first level, *“Strengthening Individual Knowledge and Skills”*, takes into account an individual’s ability to prevent sexual violence with an increased capacity of knowledge and skills. This level applies to everyone including health care practitioners, human services professionals,

³² Cohen, Larry and Swift, Susan. “The Spectrum of Prevention: Developing a Comprehensive Approach to Injury Prevention”. *Injury Prevention* . Volume 5, 203-207 (1999).

teachers, day care providers, community leaders, parents, musicians, athletes and sports figures, etc.

The second level, *“Promoting Community Education”*, addresses the power and impact that community education can have in preventing sexual violence. Mass media campaigns, special events highlighting sexual violence prevention, and media coverage of the issue can be effective ways to raise awareness at the community level.

The third level, *“Educating Providers”*, focuses on the influence service providers may have on sexual violence prevention. By expanding the circle of influence to include a wider variety of professionals from a broad range of disciplines and vocations, an extensive network of sexual violence “preventers” can be mobilized. Examples of this broader circle are: radio/TV personalities, journalists, prison guards, bar and restaurant staff, youth club professionals, school counselors, etc.

Level four, *“Fostering Coalitions and Networks”*, brings together all participants across all sectors and fields that can have a greater impact on sexual violence prevention. In Delaware the Sexual Assault Network of Delaware (CONTACTLIFELINE SAND) has fostered a network of many individuals from a variety of disciplines (law enforcement, Delaware Department of Justice, victims services advocates, survivors of sexual assault, hospital SANE programs, rape crisis advocates, etc.) to work together on sexual violence prevention in Delaware.

Level five, *“Changing Organizational Practices”*, shows the power that institutional practices and policies can have on preventing sexual violence. By changing regulations, practices, policies and organizational culture, an organization can have a broader impact on changing community norms. Examples of institutions that can join in the community effort to prevent sexual violence are: business, government, faith-based organizations, schools, sports organizations, media, health care facilities, youth- serving organizations, etc.

Level Six, *“Influencing Policies and Legislation”*, represents the broadest level of influence that can have an impact on a greater number of individuals. Changes in formal policies and legislation can be effected on the local, state and Federal levels.

By developing strategies to address sexual violence prevention incorporating all levels of the ***Spectrum of Prevention***, a more comprehensive plan can be developed for Delaware action to prevent sexual violence.

B. Development of the Delaware Sexual Violence Prevention Plan

History of Development

The *Delaware Sexual Violence Prevention Plan* has developed over time using input from key stakeholders — agencies and individuals that have been working towards ending sexual violence in Delaware. The plan reflects the combined efforts of ContactLifeline, Inc., the Delaware Department of Public Health and CONTACTLIFELINE SAND Delaware’s sexual violence coalition, the Sexual Assault Network of Delaware. ContactLifeline is the only rape crisis center in Delaware providing crisis intervention, education, and advocacy services and has served victim/survivors for over 35 years statewide. CONTACTLIFELINE SAND has members representing system and community-based victim services, law enforcement, the medical community, state agencies, state and private universities, advocacy groups and survivors.

CONTACTLIFELINE SAND’s purpose is to provide community awareness of the problem of sexual assault in all its forms, to assure adequate and effective treatment services for victims of sexual assault, to promote the coordination of services for victims and to encourage prevention efforts aimed at reducing the incidence of sexual violence. CONTACTLIFELINE SAND strives to bring awareness and prevention through the continued collaboration of both its community and state agency partners. CONTACTLIFELINE SAND promotes the growing belief that it is time to focus on prevention and time to allocate resources on decreasing and eliminating sexual violence.

CONTACTLIFELINE SAND will coordinate an Implementation and Action Committee charged with the development and oversight of primary prevention activities for sexual violence. CONTACTLIFELINE SAND’s Implementation and Action Committee will provide leadership and strategic planning for implementation of the goals and strategies outlined in the *Delaware State Plan for the Prevention of Sexual Violence*. Members of the committee will incorporate existing data and research to build upon the resources and current activities being done and to focus on the development and utilization of an assessment to assist with a State profile. The Implementation and Action Committee will assist in the measure of progress in prevention activities in order to evaluate the effectiveness of the prevention efforts and measure progress towards the plans goals. Outreach to communities and individuals who have not been represented and/or involved in the process thus far will be pursued on a statewide level.

Delaware’s approaches to the problem of sexual violence have for the most part been secondary and tertiary prevention efforts. The secondary prevention approach has been implemented in the immediate aftermath of an incident of sexual violence to provide crisis intervention and to aid victim/survivors’ with the short-term consequences. And the tertiary prevention approach has been implemented as an intervention after sexual violence has occurred, providing long-term responses to deal with the lasting consequences of violence. As recommended by the CDC and following many other states, Delaware’s focus now shifts to the primary prevention approach. Primary prevention refers to approaches that seek to eliminate the root cause of sexual violence and to stop sexual violence from ever occurring.

Currently, there are only a small number of programs in Delaware that are providing primary prevention education programs and activities for the prevention of sexual violence. Primary prevention activities are provided through educational programs that challenge the beliefs and values behind rape myths and that teach young people to engage in responsible

sexual behavior. **ContactLifeline**, Delaware’s rape crisis center provides much of the known primary prevention for the prevention of sexual violence through school and community-based programs. **Prevent Child Abuse Delaware** provides additional educational programs for the primary prevention of child sexual abuse and the Delaware Coalition against Domestic Violence **Delta Project** promotes healthy relationship skills for adolescents in a primary prevention program for intimate partner violence. The Implementation and Action Committee will identify and support additional program activities that support primary prevention of sexual violence statewide.

Framework of the Plan

This plan, the *Delaware State Plan for the Prevention of Sexual Violence*, outlines the “big picture” of preventing sexual violence in Delaware. By defining issues, setting goals, and establishing the infrastructure needed to achieve the goals, the plan lays forth a common vision of life in Delaware free of sexual violence.

Preparation and writing of this plan included an investigation of sexual violence prevention efforts at the national level. Prevention materials and sexual violence data were surveyed and reviewed. The materials included both violence against women and sexual violence prevention plans. It is clear from the survey that the violence against women movement has historically engaged in an over-reliance on criminal justice systems, which has not effectively reduced or prevented sexual violence. We join other states in recommending that communities create and enhance alternatives to legal system intervention. Community accountability strategies can expand the focus of sexual violence prevention beyond the individual, interpersonal intervention to emphasize and nurture community and societal change.

During the five-year plan, the CONTACTLIFELINE SAND Implementation and Action Committee will facilitate and coordinate activities relating to the goals and strategies. As each strategy is implemented, the Committee will evaluate and document measures of progress toward the selected goals. Each year the Committee will issue a progress report and will include suggestions for retooling or refining the goals and strategies undertaken. Stakeholders will be invited to participate all throughout the implementation of the plan.

At the end of the five-year plan, a review of the implementation and planning process will be conducted. This will include an evaluation of its success and recommendations for continued efforts to prevent sexual violence in Delaware.

Goals of the plan are listed below and are discussed in more detail in later sections:

- Goal 1: To increase awareness and recognition that sexual violence is preventable.
- Goal 2: To strengthen social norms that encourages healthy and respectful relationships.
- Goal 3: To ensure that all voices are heard to promote primary prevention of sexual violence.
- Goal 4: To increase the capacity of individuals, groups and communities to prevent sexual violence.

- Goal 5: To seek action by local and state, public and private policy entities to prevent sexual violence.
- Goal 6: To evaluate data relevant to the Delaware State Plan for the Prevention of Sexual Violence and promote best practices for preventing sexual violence.

C. Goals and Strategies of the Delaware Sexual Violence Prevention Plan

1. Increase education that sexual violence is preventable.

Rationale: Sexual violence is viewed as a social norm of acceptable behavior in our society. This behavior is rarely challenged. Public concern about sexual violence often focuses on highly publicized cases of stranger rape and sexual assault thus perpetrating myths and stereotypes, which place blame and shame on victims of sexual assault. Treatment and services for victims and offenders is an important intervention, but treatment alone will never get at the root causes that can put an end to sexual violence.

Strategies:

- Plan primary prevention efforts for youth to impact their developing attitudes by utilizing best practice standards.
- Focus on key groups to change attitudes and behaviors thus promoting the value that sexual violence is preventable by developing and evaluating specialized curriculum.
- Support public health surveillance of sexual violence to increase the knowledge of protective factors.

2. Strengthen social norms that encourage healthy and respectful relationships.

Rationale: Changing social norms is critical to the prevention of sexual violence. By holding our culture accountable for the commonly accepted social norms of acceptance, encouragement and normalization of violent and sexually exploitative behavior, true change can happen.

Strategies:

- Form a committee within the CONTACTLIFELINE SAND network of local and statewide leaders and community groups to engage men in primary prevention of sexual violence.
- Create and deliver primary prevention presentations to the Delaware community to. Develop capacity building opportunities via the CONTACTLIFELINE SAND coalition network for communities, organizations and individuals to expand the primary prevention message.
- Teach and support programs that promote the value of sexual respect and healthy relationships.

3. Ensure that all voices are heard to promote primary prevention of sexual violence.

Rationale: Primary prevention of sexual violence can only occur when all community groups are represented and have a hand in the decision making of strategies and focus on community primary prevention efforts.

Strategies:

- Ensure that people from under-represented communities (including people with disabilities, GLBT persons, racial and ethnic groups) have a voice and an opportunity to share their unique perspectives, issues and solutions.
- Work with leaders of diverse cultural groups to develop capacity building approaches, programs, training curriculum and materials that are culturally appropriate and gender specific.
- Develop social marketing campaigns that focus on messages about healthy, respectful relationships and sexuality and are inclusive of all communities.

4. Increase the knowledge of individuals, groups and communities to prevent sexual violence.

Rationale: The social phenomenon of sexual violence is complex. Throughout society it is perpetuated and supported. Individuals, groups and communities often are aware of how serious sexual violence is and want to participate in prevention but lack the knowledge or resources to do so.

Strategies:

- Engage men and male leaders in activities that span the prevention spectrum.
- Develop and promote collaborative efforts with schools and colleges to educate youth about healthy sexuality, relationships, gender, and changing norms regarding sexual violence.
- Assess needs for sexual violence prevention and ways faith based communities can take effective significant action to elevate awareness.

5. Seek action by local and state, public and private policy entities to prevent sexual violence.

Rationale: The causes of sexual violence cannot be eliminated without investment by a broad spectrum of society. Collaborations can provide a foundation for developing better-coordinated interventions and prevention policies and programs.

Strategies:

- Establish relationships with other agencies that provide services to specific audiences.
- Identify traditional and non-traditional collaborations that may be effective in addressing sexual violence.
- Educate business and policy makers on the value and economy of prevention.

6. Evaluate data relevant to the *Delaware State Plan for the Prevention of Sexual Violence* and promote best practices for preventing sexual violence.

Rationale: Evaluation offers a way to assess strengths and weaknesses of prevention programs and allows for the tailoring of the efforts. Research is needed to define and promote evidenced based best practices strategies.

Strategies:

- Identify the best practices in sexual violence prevention, with a focus on preventing sexual violence before it starts.
- Improve data collection to better count sexual violence, its costs, and its prevalence and incidence, particularly high risk communities.
- Convene state, and local agencies to support ongoing research.

Part III. Implementation – Turning SV Prevention Plan into Action

A. Step 1 – Strengthen Sexual Assault Network of Delaware Capacity

Shared leadership by CONTACTLIFELINE SAND and the rape prevention and education staff of Delaware Public Health will aid in the communication of the goals and strategies outlined in the plan to key stakeholders and the implementation. The Implementation and Action Committee of CONTACTLIFELINE SAND will assume the following responsibilities:

- Develop and implement statewide assessment of needs
- Serving as “guardian of the plan” to ensure that it remains the focus of prevention work,
- Developing an overall framework for communicating about sexual violence prevention,
- Measuring the implementation progress of the plan,
- Ensuring open communication among key stakeholders,
- Acting on issues and needs identified by Implementation and Action Committee,
- Leading discussion on current developments/issues in the sexual violence field,
- Reviewing, sharing and incorporating legislative proposals relating to sexual violence prevention,
- Assessing funding issues, identifying funding opportunities, and seeking support,
- Identifying representation and leadership, particularly in at-risk communities, and promoting education and training opportunities, and
- Engaging other groups and supporting efforts to launch sexual violence prevention activities.

Three critical leadership and oversight responsibilities are the development and framing of sexual violence prevention messages, the development of policy and legislative recommendations to promote organizational policies and practices to effect change, and the compilation of research and data for the evaluation of prevention programs and activities.

Cultural competency in all primary prevention endeavors is paramount to success of the implementation of the sexual violence prevention plan. The Implementation and Action Committee is committed to engaging communities that are disproportionately affected by sexual violence in Delaware. This includes communities of color, immigrants and refugees, women who

have been trafficked or prostituted, adolescents, GLBT communities, disabilities communities, and men's groups.

B. Step 2 – Implement 5 Year Timeline

2009 - Engage Key Stakeholders and Additional Agencies and Community Members

Present the draft plan to stakeholders for review and feedback.
Incorporate suggestions and changes to finalize state plan.
Conduct key focus groups to obtain input (stakeholders).
Conduct key focus groups to obtain input (communities not heard from before).

Document and evaluate all prevention activities.
Collect research on evidence based best practices.
Formulate summary messages for prevention of sexual violence.
Post the plan, framed messages, resources and data on ContactLifeline/CONTACTLIFELINE SAND/DE Public Health websites.

2010 – Build Capacity of Sexual Assault Coalition CONTACTLIFELINE SAND

Conduct statewide needs assessment across communities and service providers.
Strengthen CONTACTLIFELINE SAND membership.
Educate partners on dynamics of sexual violence.
Develop social marketing campaign.
Conduct train-the-trainer activities.
Distribute sexual violence prevention policies.
Continue to frame and present sexual violence prevention messages.
Continue to document and evaluate all prevention activities.
Continue collecting research on evidence based best practices.
Update the sexual violence prevention plan and web site information.

2011 – Educate Communities and Elected Officials

Conduct a conference on sexual violence prevention (statewide).
Continue reviewing research on evidence based best practices.
Provide resources /presentations to community groups on sexual violence prevention.
Coordinate educational presentations to legislators and elected officials.
Continue to frame and present sexual violence prevention messages.
Continue to document and evaluate all prevention activities.
Continue collecting research on evidence based best practices.
Update the sexual violence prevention plan and web site information.

2012 – Share Best Practices

Present model policies and programs throughout community.
Continue training leaders and spokespersons.
Continue dissemination of media campaign.

Continue to frame and present sexual violence prevention messages.
Continue to document and evaluate all prevention activities.
Continue collecting research on evidence based best practices.
Update the sexual violence prevention plan and web site information.

2013 – Evaluate and Continue Prevention Strategies Towards Goals

Continue to frame and present sexual violence prevention messages.
Continue to document and evaluate all prevention activities.
Continue collecting research on evidence based best practices.
Update the sexual violence prevention plan and web site information.
Continue implementation of the plan.
Expand media campaign as new data emerges from evaluation.

Appendix 1: Glossary of Terms

- Primary Prevention:** Activities that take place before sexual violence has occurred to prevent initial perpetration or victimization.
- Secondary Prevention:** An immediate response, after sexual violence has occurred, to deal with the short-term consequences of violence.
- Tertiary prevention:** Long-term responses, after sexual violence has occurred, to deal with the lasting consequences of sexual violence for the victim/survivor, as well as sex offender treatment interventions.

³³ Chuck Derry, Gender Violence Institute. See <http://www.letswrap.com/GVI#sa>

Sexual Violence and Associated Terms

Sexual Violence — Overall Definition

Nonconsensual completed or attempted contact between the penis and the vulva or the penis and the anus involving penetration, however slight; nonconsensual contact between the mouth and the penis, vulva, or anus; nonconsensual penetration of the anal or genital opening of another person by a hand, finger, or other object; nonconsensual intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks; or nonconsensual non-contact acts of a sexual nature such as voyeurism and verbal or behavioral sexual harassment. All the above acts also qualify as sexual violence if they are committed against someone who is unable to consent or refuse.

Sexual violence is divided into four types and five classification categories:

- A completed sex act (as defined below) without the victim's consent, or involving a victim who is unable to consent or refuse (as defined below).
- An attempted (non-completed) sex act without the victim's consent, or involving a victim who is unable to consent or refuse (as defined below).
 - Abusive sexual contact (as defined below).
 - Non-contact sexual abuse (as defined below).
 - Sexual violence, *type unspecified*.

Consent - Words or overt actions by a person who is legally or functionally competent to give informed approval, indicating a freely given agreement to have sexual intercourse or sexual contact.

Inability to Consent - A freely given agreement to have sexual intercourse or sexual contact could not occur because of age, illness, disability, being asleep, or the influence of alcohol or other drugs.

Inability to Refuse - Disagreement to have sexual intercourse or sexual contact was precluded because of the use or possession of guns or other non-bodily weapons, or due to physical violence, threats of physical violence, real or perceived coercion, intimidation or pressure, or misuse of authority.

Sex Act (or Sexual Act) - Contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object.

Abusive Sexual Contact - *Intentional* touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse.

Appendix 2: Sexual Violence Surveillance, Uniform Definitions and Recommended Data Elements-CDC

Non-Contact Sexual Abuse- Sexual abuse that does not include physical contact of a sexual nature between the perpetrator and the victim. It includes acts such as voyeurism; unwanted exposure of an individual to exhibitionism; unwanted exposure to pornography; verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; or taking nude photographs of a sexual nature of another person without his or her consent or knowledge, or of a person who is unable to consent or refuse.

Incident - A single act or series of acts of sexual violence that are perceived to be connected to one another and that may persist over a period of minutes, hours, or days. One perpetrator or multiple perpetrators may commit an incident. Examples of an incident include a husband forcing his wife to have unwanted sexual acts but only one time, a stranger attacking and sexually assaulting a woman after breaking into her apartment, a man kidnapping a female acquaintance and repeatedly assaulting her over a weekend before she is freed, a college student forced to have sex by several men at a fraternity party, or a man forcing his boyfriend to have unwanted sex.

Involved Parties

Victim - Person on whom the sexual violence is inflicted. *Survivor* is often used as a synonym for *victim*.

Perpetrator- Person who inflicts the sexual violence.

Intimate Partner- Current legal spouses, current common-law spouses, current boyfriends/girlfriends (opposite or same sex), former legal spouses, former common-law spouses, separated spouses, or former boyfriends/girlfriends (opposite or same sex). Intimate partners may or may not be cohabiting. Intimate partners may or may not have an existing sexual relationship. If the victim and the perpetrator have a child in common but no current relationship, then by definition they fit into the category of former legal spouse, former common-law spouse, or former boyfriend/girlfriend. States differ as to what constitutes a common-law marriage. Users of the Recommended Data Elements will need to know what qualifies as a common-law marriage in their state.

Current or Former Legal Spouse - Someone to whom the victim is or was legally married, as well as a separated legal spouse.

Another Current or Former Intimate Partner- Someone, besides a legal current, former, or separated spouse, with whom the victim has or had an ongoing intimate relationship, such as a common-law spouse, former common-law spouse, separated common-law spouse, cohabiting intimate partner, former cohabiting intimate partner, boyfriend/girlfriend, former boyfriend/girlfriend (opposite or same sex).

Appendix 3: CONTACTLIFELINE SAND Membership – Key Stakeholders

Cheri Will

Beebe Medical Center

Anita Symonds

Christiana Medical Center

Kathy Keating

Nanticoke Memorial Hospital

Dawn Culp

Kent General Hospital

Laurie Pezick

Department of Corrections

Angela Sequin

University of Delaware

Sherri Gigliotti

Department of Justice

Maureen Monagle

Criminal Justice Council

Debbie Reed

Delaware Victim Center

Bridget Poulle

Domestic Violence Coordinating Council

Loretta Cannatelli

Delaware Girls Initiative

Patricia Tedford

ContactLifeline, Inc

Tiffany Whitehurst

Planned Parenthood of DE

Gail Riblett

Department of Health and Human Services

Debbie Sharp

Survivor

Valerie Tickle

Criminal Justice Council

Pat Maichle

Developmental Disabilities Council

Nancy McGee

ContactLifeline

Marcy Refac

People's Place

Susan Schmidhauser

Department of Justice

Valerie Marek

Survivors of Abuse in Recovery (SOAR)

Stephanie Hamilton

Wilmington Police Department

Fred Breukelman

Division of Public Health

Veronica Colombo

Delaware State Police

Polli Funk

Staff: ContactLifeline/SAND
Policy/Prevention Director

Elizabeth McCourt

ContactLifeline

Implementation and Action Committee

Patricia Tedford Polli Funk Cheri Will
Elizabeth McCourt Gail Riblett
Fred Breukelman

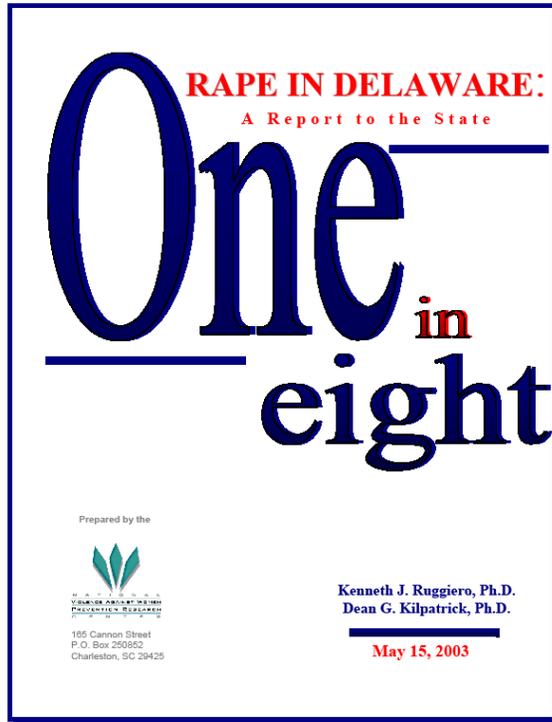
Appendix 4: Logic Model for Sexual Assault Prevention in Delaware

Logic Model for Sexual Violence Prevention in Delaware

Inputs	Strategies or Activities		Outputs		Impacts and Outcomes		
					Medium	Medium	Long-Term
Limited funding and staffing	Establishment of the State Plan for Prevention of Sexual Violence	Expand contacts with community groups to implement plan objectives			Increased understanding by partners of primary prevention of sexual assault	Improvement in community attitudes and	Decrease in underlying conditions which lead to sexual violence
CDC staff for technical assistance	Community-based primary prevention / education	Trainings for volunteers and staff			Increased number of active partners	Increased resources for prevention of sexual assault	Increase in community support for positive relationships and respectful behavior
Sexual Assault Network of Delaware (SAND)	Media campaigns to promote healthier relationships	Track # of organizations using State Plan and implementing activities	⇨		Increased knowledge of effective, evidence-based programs	Increase in # of policies and environmental changes which lead to reduced sexual assault	Increase in community support for positive relationships and respectful behavior
Contact-Lifeline	Outreach to underserved communities	Monitoring of sexual assault prevalence and of knowledge and social values change			Increased knowledge of underlying causes of sexual violence		Decrease in sexual violence
Division of Public Health resources for data, evaluation and technical assistance	Evaluation of activities and their implementation.				Increase use of social ecological model		
	Fund raising						

Appendix 5: "One in Eight"

"One in Eight – Rape in Delaware: A Report to the State" by Kilpatrick and Ruggiero, 2003



RAPE IN DELAWARE:

A Report to the State

One in eight

Prepared by the



165 Cannon Street
P.O. Box 250852
Charleston, SC 29425

Kenneth J. Ruggiero, Ph.D.
Dean G. Kilpatrick, Ph.D.

May 15, 2003

What is Forcible Rape?

Attempts to discuss the topic of rape and other forms of sexual assault are often hampered by the fact that people define terms differently. In this report and in the National Women's Study and the National Violence Against Women Survey, rape is defined as "an event that occurred without the girl or woman's consent that involved the use of force or threat of force, and that involved sexual penetration of the victim's vagina, mouth, or rectum." This is a very conservative definition of rape that meets the legal definition of forcible rape in all jurisdictions within the United States and in the federal criminal code. Although most jurisdictions also include unsuccessful attempts as forcible rapes, this report does not do so. The estimates of forcible rape provided are based on cases that occurred at any time during a woman's life, including when she was a child. Cases of forcible rape were included whether or not they were reported to police and irrespective of whether the perpetrator was a stranger, family member, or acquaintance.

Clearly, many other types of sexual assault exist that do not constitute forcible rape. They occur frequently and often have impacts on the women and children who experience them. However, this report addresses only the forcible rape of women and female children. Other types of sexual assaults, including assaults against men and boys, will not be addressed.

Other Types of Rape

Unfortunately, forcible rape is not the only type of rape that women and children in America experience.

- Attempted forcible rape is legally defined in most jurisdictions as attempts to commit forcible rape that are not successful. Generally, penalties for attempted forcible rape are equal to those as if the attempt was successful.
- Legal statutes in many states as well as at the federal level also prohibit rapes which occur when a perpetrator engages in a sex act with an unwilling victim who is unconscious or who is intoxicated with alcohol or drugs to the point that their ability to appraise or control their conduct is substantially impaired. The Federal Criminal Code defines this type of rape as aggravated sexual abuse by other means. Sometimes it is referred to as drug or alcohol facilitated rape.
- The term incapacitated rape is sometimes used to describe drug or alcohol facilitated rape as well as when the victim is either unconscious or too impaired for any reason to know what she is doing or give consent.
- Another type of rape is statutory rape. This occurs when a perpetrator commits any type of nonforcible sex act with an under aged child. In the Federal Code, sex act is defined as any type of sexual penetration (i.e. vaginal, anal, or oral) including any penetration of the vagina or anus by hands, fingers, or objects.

Rape in Delaware: A Report to the State

Kenneth J. Ruggiero, Ph.D.
Dean G. Kilpatrick, Ph.D.
May 15, 2003

Citation:

Ruggiero, K. J., & Kilpatrick, D.G. (2003). *Rape in Delaware: A Report to the State*.
Charleston, SC: National Violence Against Women Prevention Research Center,
Medical University of South Carolina.

Prepared by the



Executive Summary

“...nearly one out of every eight adult women, or nearly 38,000 adult women in Delaware, has been the victim of forcible rape sometime in her lifetime.”

Having accurate information about the magnitude and nature of the rape problem at the state level is extremely important for policymakers as well as for those who attempt to prevent rape or to provide services to rape victims and survivors. Without such information, it is difficult to know how big the rape problem is or to design effective rape prevention and intervention services. Data on rape from national samples are useful because they provide some indication of the magnitude of the problem in the nation as a whole. However, having state-level data is more useful for those charged with addressing the problem of rape within a state.

This report provides information addressing four goals:

- To identify national sources of information about rape and how we used information from the best sources to estimate rape in Delaware
- To produce an estimate of the number and percentage of adult women in Delaware who have ever been raped
- To compare the magnitude of the rape problem in Delaware with that in the nation at large
- To provide guidance as to how better estimates of Delaware's rape problem can be obtained

After reviewing several national sources of information about rape, we determined that the most methodologically sound information comes from the National Women’s Study (NWS) and the National Violence Against Women Survey (NVAWS). Data from these studies indicate that approximately 13.4% of adult women in the United States have been victims of completed forcible rape sometime during their lifetime. These studies also found that risk of having ever been raped was related to a woman’s current age, her race/ethnicity, and the region of the nation she currently lives in. Both studies also found that the majority of rapes these adult women had experienced occurred when they were under the age of 18.

We then developed a method for estimating the prevalence of rape in Delaware using this national information about the prevalence of rape and risk factors for having been raped. Briefly described, we determined demographic and geographic risk factors for rape among the approximately 11,000 women who participated in the NWS and the NVAWS. Next, we obtained a breakdown of the Delaware population of women on these risk factors using Census data. Finally, we used this demographic and geographic risk factor information to produce estimates of the percentage of Delaware women who had ever been raped by statistically adjusting the

national estimate of rape based on the age and racial/ethnic breakdown of adult women in Delaware as well as the geographic region in which Delaware is located.

Using this procedure, we estimated that approximately 12.2% of adult women in Delaware have been victims of one or more completed forcible rapes during their lifetime. According to the 2000 Census, there are over 308,000 women age 18 or older living in Delaware. This means that the estimated number of adult women in Delaware who have ever been raped is nearly 38,000. This estimate of the magnitude of Delaware's rape problem is conservative because it does not include women who have never been forcibly raped but who have experienced attempted rapes, alcohol or drug facilitated rapes, incapacitation rapes, or statutory rapes (i.e., rapes in which no force or threat of force was used but the perpetrator had sex with an underage child or young adolescent). Nor does this estimate include any types of rape that have been experienced by female residents of Delaware who are currently under the age of 18. Nor does the estimate include male rape victims of any age. This estimate also does not address possible changes in rape prevalence or in disclosures of rape cases to interviewers that may have occurred over time.

Our estimate of the lifetime prevalence of rape among adult women (i.e., the percentage of adult women who had ever been forcibly raped) in Delaware was slightly lower than the estimate for the nation as a whole. This slight difference between the 12.2% prevalence in Delaware and the 13.4% prevalence nationally is partly due to the fact that Delaware is in a region of the nation that has a lower-than-average rape prevalence according to the NWS and NVAWS data. Notwithstanding its apparent slightly lower prevalence of rape, Delaware has a substantial rape problem as reflected by our conservative estimate that nearly one out of every eight adult women, or nearly 38,000 adult women in Delaware, has been the victim of forcible rape sometime in her lifetime. To the extent that adult women in Delaware are similar to their national counterparts, it is likely that many of their rape experiences happened when they were children or adolescents.

It is important to note that the methodology we used to estimate the prevalence of rape in Delaware is no substitute for conducting a well-designed victimization survey within the state. This point is highlighted by a comparison we did of rape prevalence estimates obtained in a recently completed victimization survey and estimates obtained using the methodology we used for this report. This survey of Washington State women included questions about rape that were similar to victimization questions in the NWS and NVAW. The use of similar questions for each survey enabled us to compare the results of the Washington State survey against our estimate for Washington of the prevalence of rape among women (our estimate for Washington was made using the same methodology described in this Report). We found that our estimate was substantially lower than the estimate obtained from the Washington State survey. This confirms the importance of conducting state level victimization surveys using good methodology.

Introduction

How much rape occurs each year at the national and state level? How many women in the United States have ever been raped? How many women in Delaware have ever been raped? How does the problem of rape in Delaware compare to the problem of rape in America? Without the answers to these questions, it is impossible to know the magnitude of Delaware's rape problem or to put it in perspective. Public policymakers, the public health system, the criminal justice system, and rape crisis centers cannot determine the effectiveness of their efforts to prevent rape, apprehend and punish rapists, and provide effective services to rape victims without such information.

At the state and local level, most of the information about rape comes either from police reports or from agencies such as rape crisis centers that provide services to sexual assault victims. By their very nature, police reports only include information about recent cases of sexual assault that have been reported to law enforcement. Yet, research suggests that only 1 in 6 rapes are reported to law enforcement (Kilpatrick, Edmonds & Seymour, 1992). Likewise, a significant percentage of sexual assault victims do not seek services from rape crisis or other sexual violence agencies. Therefore, data from police reports or sexual violence agencies clearly cannot provide a comprehensive picture of the new cases of sexual assault that occur each year within a state. In addition, the effects of rape upon its victims are often profound and persistent. These effects of rape on women's physical and mental health can last for years, for decades, or even for a lifetime. Thus, any attempt to measure the magnitude of a state's rape problem should not be limited to an estimate of how many recent rape cases have occurred or how many women have been recently raped. Instead, it is important to determine how many women within a state have ever been raped because many of these women may still be having problems that require services.

At the national level, there are two U.S. Department of Justice-sponsored sources of information about rape that provide data on recent rape cases that occur each year. The FBI Uniform Crime Reports includes information about a subset of new rapes that occur each year that are reported to police. The National Crime Victimization Survey also provides information about new cases of rape that occur each year and includes unreported as well as reported cases. However, both the FBI Uniform Crime Reports and the National Crime Victimization Survey have methodological problems that result in their producing substantial underestimates of the number of new rape cases each year. Unfortunately, neither of these two sources is designed to measure whether a woman has ever been a victim of rape. For these reasons, the FBI Uniform Crime Reports and the National Crime Victimization Survey data are not particularly useful for determining the magnitude of the rape problem within a state.

Most experts agree that the best way to obtain estimates of rape prevalence (i.e., the percentage of women in the population who have ever been raped) is to conduct a well-designed victimization survey. Briefly described, such surveys involve obtaining a representative sample of the groups of people you wish to study and asking them a series of questions that inquire about rape experiences that they may have had within specific time frames. Research indicates that rape is more difficult to measure than many other types of crime in victimization surveys because women are more reluctant to disclose rapes than other crimes. For this reason, there are a number of technical challenges to measuring rape properly in a victimization survey. Among

the many challenges victimization surveys must address are obtaining a representative sample of women to survey, using proper screening questions that measure the types of rape experiences you wish to detect, and establishing a private and confidential environment for the interview that encourages women to disclose their rape experiences to the interviewer.

At the national level, there have been two major victimization surveys that are widely viewed as being the best studies yet conducted with respect to providing information about rape prevalence among adult women. The first study is the National Women's Study (NWS). The NWS generated the information that was used in the *Rape in America* report (Kilpatrick, et al., 1992), and has resulted in numerous scientific and professional publications (see following website for a list of NWS publications: <http://www.musc.edu/cvc/NIDApubs.htm>). The NWS was a peer reviewed research project that was funded by the National Institute of Drug Abuse. The second study was the National Violence Against Women Survey (NVAWS, Tjaden & Thoennes, 2000), another peer reviewed research project that was funded by the National Institute of Justice and Centers for Disease Control and Prevention. Both of these studies used large, nationally representative samples of adult women. Both studies used well-designed, virtually identical screening questions that measured forcible rapes women had experienced throughout their lives. Both studies used only female interviewers and other procedures to insure that women could complete the interviews in private, confidential settings. Both studies have yielded numerous high quality publications to the scientific literature. In short, the NWS and NVAWS provide the best national information we have about the prevalence of forcible rape among adult women in America.

The remainder of this Report provides the following information: 1) What the NWS and NVAWS tell us about the prevalence of rape and about demographic and geographic factors that increase the risk that a woman will have been forcibly raped sometime during her life; 2) A method we developed to use the national data on rape prevalence and risk factors for rape to estimate the prevalence of women in Delaware who have ever been raped; 3) The estimates of rape prevalence in Delaware that we obtained by using this method; 4) Limitations of the methods we used and the estimates we obtained; 5) The importance of obtaining better estimates of rape in Delaware by conducting a good victimization survey within the State.

Rape in America: Findings from the NWS and NVAWS

The NWS, conducted in 1989, and NVAWS, conducted in 1995, both were telephone victimization surveys of adult (ages 18 and older) women in the United States. Together, these studies surveyed national household probability samples of 12,008 women who were asked whether they had been forcibly raped at any time in their lives. Of these women, 11,007 completed one set of questions about rape, whereas approximately 1,000 of the women in the NVAWS were asked a different set of experimental questions about rape. To ensure that we based our estimates upon information obtained with reliable and consistent methods of measuring rape, we used only information obtained from the 10,680 of the 11,007 women who were asked virtually identical questions and who had little if any missing data. A more thorough description of the methodology of these two studies is provided in Appendix I. The actual screening questions used to measure forcible rape are presented in Appendix II.

For both the NWS and NVAWS, several steps were taken to increase the likelihood that women would report their rape experiences accurately, including:

- Ensuring that the interviews were conducted in a private setting
- Introducing questions about rape in a way that clearly communicated the types of rape experiences being measured
- Asking highly specific questions about different kinds of rape
- Using female interviewers only

In the NWS, 12.7% of surveyed women reported that they had been victims of at least one forcible rape in their lifetime. In the NVAWS, 14.8% of women indicated that they had been raped at least once. Together, these studies suggested that about 1 in 7 (14.0%) adult women in America--or 15.1 million women--have been forcibly raped at least once in their lifetime. Findings from the NWS and NVAWS also indicate that 0.43% of all women surveyed had experienced rape *within the past year*. This equates to an estimated 465,000 adult American women in the U.S. who were raped during a 12-month period.

The numbers above represent the estimated *total number of women* who have ever been raped. But it is important to note that many American women have been raped on more than one occasion. In fact, of the women who reported rape in the NWS and NVAWS, nearly one-half stated that they had been raped on two or more occasions. Findings from the NWS and NVAWS also have taught us that rape in America is a tragedy of youth. Nearly 60% of the women who had been raped at some time in their lives were first raped in childhood. Nearly 30% experienced their first or only rape when they were younger than 11 years of age.

Who is at Greatest Risk for Having Been Raped?

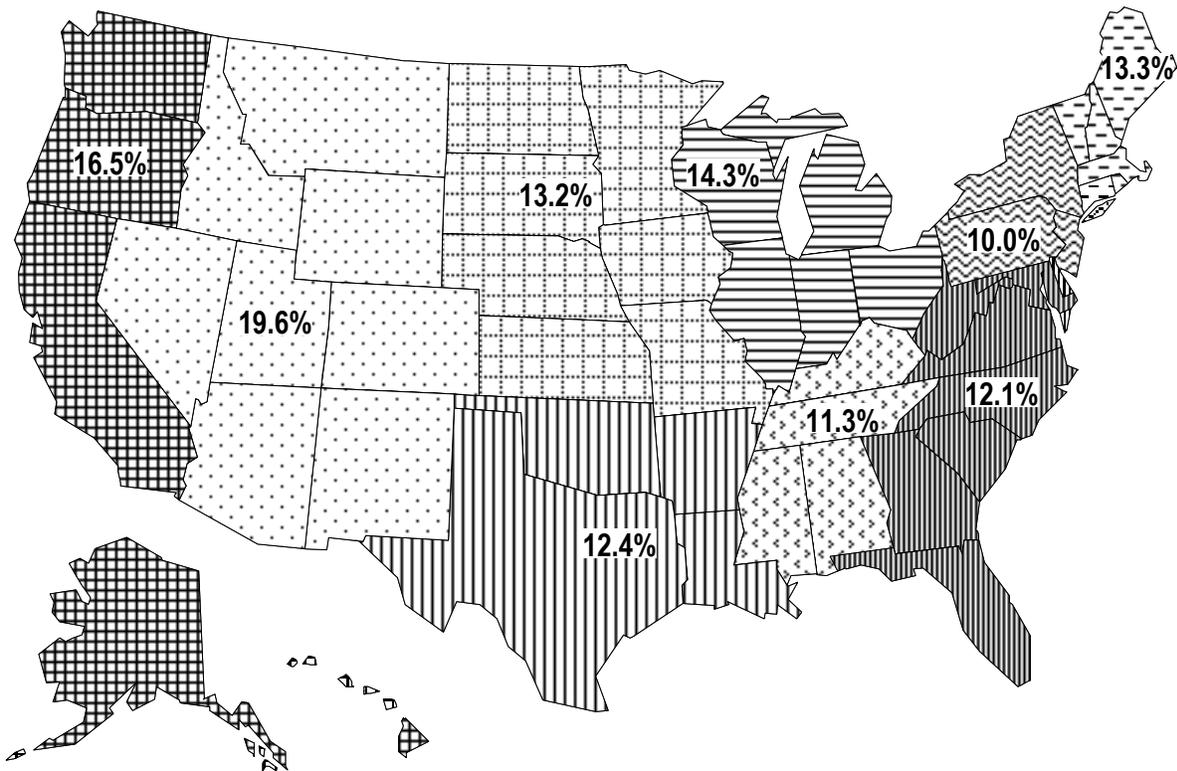
Rapists--not the women and children they rape--are wholly responsible for America's rape problem. However, there is evidence that several factors increase women and children's risk of being attacked by a rapist. Our strategy for obtaining an estimate of forcible rape in Delaware was to examine the extent to which various demographic characteristics of women and geographical areas in which they currently live were related to risk of forcible rape at the national level. We used information from the NWS/NVAWS to conduct this examination. Of particular interest were characteristics that were measured in both the NWS and NVAWS and that are available at the state level in the 2000 Census. Any such characteristics related to risk of forcible rape at the national level in the NWS/NVAWS can be used to produce an estimate of rape in Delaware. We examined several characteristics, including:

- Rural vs. urban vs. suburban areas
- Size of metropolitan area
- Race/ethnicity
- Current household income
- Age at the time of the survey
- Region of the country

Risk for a woman having ever been raped was not related to the size of the metropolitan area in which she lived at the time of the survey. Additionally, although findings from the NWS indicated that women currently living in urban and suburban areas were more likely to have ever been raped than women currently living in rural areas, this information was not available in the NVAWS. Thus, it was necessary to drop these two geographic characteristics from further consideration.

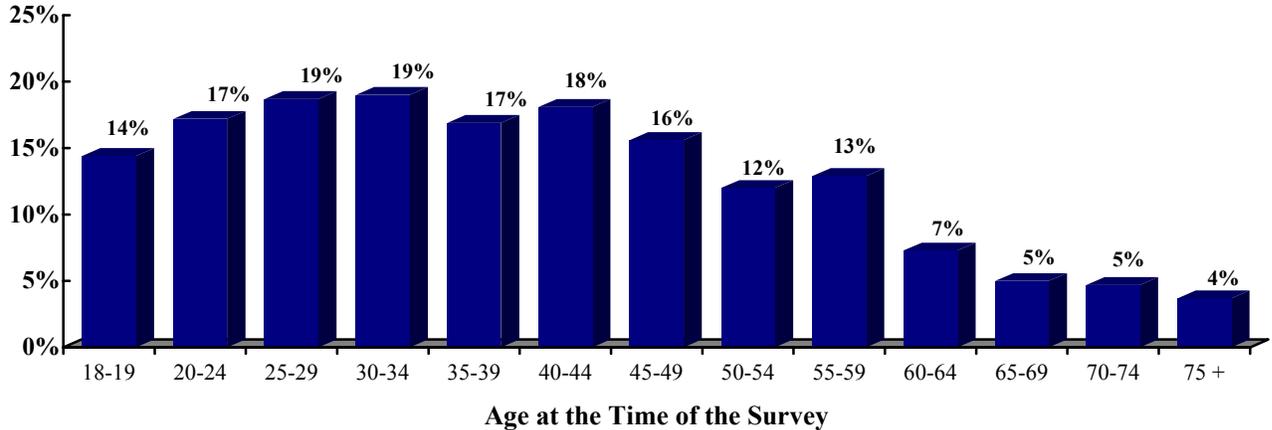
Region of the country was related to a woman's likelihood of having been raped at sometime during her life (See Appendix III for a description of the states that are within each census region division). For example, rape was much more likely to be disclosed by women currently living in the Mountain and Pacific region divisions of the U.S. than in the mid-Atlantic and East South Central region divisions. For the remaining five regions of the country, percentages of women who had ever been raped ranged from approximately 12%-14% (see Figure 1). One important clarification is that the NWS and NVAWS did not measure the state or geographic region of the country in which women had been raped; they measured where women, including rape victims, were living at the time they participated in the surveys. Thus, it is inappropriate to infer that more rapes occur in some census region divisions of the country than others. This may be true, but it cannot be demonstrated using information from these two studies because women may have been raped in one location and now reside in another.

Figure 1: Census Region Division Differences in the Lifetime Prevalence of Rape



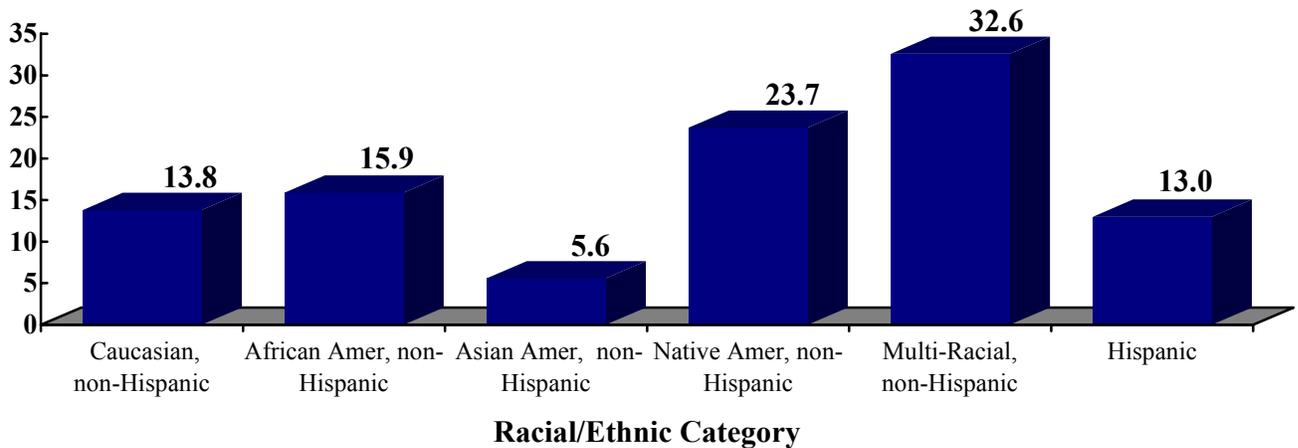
A woman's age at the time of the survey was also related to how likely she was to have ever been raped. Younger women were more likely to have been forcibly raped at some time in their lives than were older women (see Figure 2). Women between the ages of 20-44 had the highest levels of risk for having ever been raped (over 15%), whereas women ages 65 and older had the lowest levels of risk (less than 5%).

Figure 2: Rape Prevalence As a Function of Current Age



Racial/ethnic background also was related to whether a woman reported having ever been raped. For example, less than 6% of Asian American women were raped at least once during their life, whereas nearly 24% of Native American women have been raped (see Figure 3). Relatively similar percentages of women ever having been raped were found among the three most populous racial/ethnic groups in the nation: Caucasians, Hispanics, and African Americans.

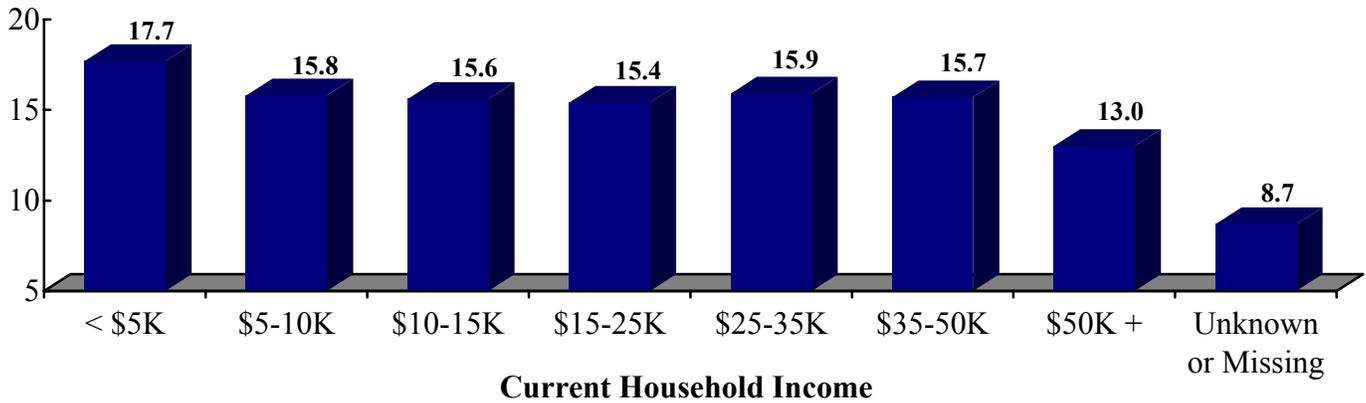
Figure 3: Rape Prevalence As a Function of Race/Ethnicity



Household income was related to risk that a woman was ever raped but not in a straightforward way. As is shown in Figure 4, women with extremely low household incomes of less than \$5,000 a year had the highest risk of rape (i.e., 17.7%), and women with incomes of \$50,000 or more per year had the lowest risk (13.0%). Women in the middle income groups, those who made between \$5,000-\$50,000 had a similar risk of rape that was lower than that of the poorest women and greater than that of the most affluent women. Income information was missing for a relatively

high number of cases (approximately 1900). Interestingly, women who either didn't know or didn't answer the income question were least likely to report having ever been raped.

Figure 4: Rape Prevalence As a Function of Current Household Income



Census information includes age, racial/ethnic, and household income distributions on the state level. Thus, our next step was to adjust the NWS and NVAWS samples to match the distribution of age, race, and income in Delaware. After adjusting for these demographics, we then made further adjustments based on the knowledge that Delaware is located in the South Atlantic region of the country. The next section provides additional details about how national data from the NWS and NVAWS were used to estimate rape in Delaware.

Method for Using National Data to Produce State-Level Estimates

The best way to estimate the extent of the rape problem in Delaware is to conduct a properly designed victimization survey. However, we can get some sense of how big the rape problem is in Delaware by using information about rape that is available from the NWS and NVAWS. It is important to not simply apply the national estimate at the state level. As shown in Figure 1, the region of the country that a woman lives in is related to her likelihood of having ever been raped. Further, the percentage of women who have ever been raped clearly differs across age groups, racial/ethnic backgrounds, and, to a lesser extent, household income. Because state populations vary widely in their demographic distributions, it is important to take these characteristics into account when estimating the prevalence of rape at the state level.

It was necessary to remove household income from consideration for three reasons. First, 17% of surveyed women were uncertain about or declined to disclose their household income, which limited our ability to make adjustments for this variable. Second, Census information on household income is not broken down by age and race within each state in a way that matched the levels of income used to estimate rape in Delaware. Third, it was not possible to take into account inflation since the time of the NWS and NVAWS surveys. For these reasons, our estimates of rape in Delaware did not take into account household income. However, to the extent that Delaware has a higher percentage of extremely poor women than the nation at large, the estimated percentage of women who have ever been raped would also be higher.

Three factors were used to adjust national data in order to estimate rape in Delaware: age, racial/ethnic background, and geographic region. Our estimates for rape in Delaware were influenced by adjustments for these variables because Delaware's population differs demographically from that of the nation as a whole. To illustrate with the example of racial/ethnic background, according to the 2000 Census:

- 10.3% of adult women in the U.S. are of Hispanic ethnicity, whereas 4.8% of adults in Delaware are of Hispanic ethnicity
- 72.1% of adult women in the U.S. are of European descent (non-Hispanic), whereas 72.5% of adults in Delaware are of European descent (non-Hispanic)
- 11.7% of adult women in the U.S. are of African descent (non-Hispanic), whereas 18.9% of adults in Delaware are of African descent (non-Hispanic)

Although the actual statistical procedures used to produce the estimates of rape prevalence in Delaware were complex, the basic approach we used was simple and involved four steps. First, we determined the geographic and demographic risk factors for having ever been raped using the NWS and NVAWS data as described above. Second, we used NWS and NVAWS data to obtain statistical estimates for the prevalence of rape according to the age and race/ethnic groups for the geographical region of the country where Delaware is located. Third, we used data from the 2000 Census to provide a breakdown of the adult female population of Delaware with respect to age and race/ethnicity. Fourth, we statistically adjusted the rape prevalence estimates we obtained from the NWS and NVAWS to account for the age and race/ethnicity breakdown of adult women living in Delaware according to estimates from the 2000 Census.

Refer to Appendix III for more technical details describing the statistical methods we used for estimating rape in Delaware.

Estimating Rape in Delaware

Based upon the method described above, we estimate that approximately 12.2% of women in Delaware have been raped at some time in their lifetime. Converting this percentage into real numbers yields the following:

- Of the over 308,000 adult women living in Delaware, nearly 38,000 have been raped at least once during their lives
- Of the 197,000 women living in New Castle County, over 24,000 have ever been raped
- Of the 63,000 women living in Sussex County, about 7,700 have ever been raped
- Of the 49,000 women living in Kent County, over 5,900 have been raped

These estimates are conservative because they do not include women who were never forcibly raped but who *have* experienced alcohol- or drug-facilitated rape, incapacitated rape, statutory rape (i.e., rapes in which the perpetrator had sex with an underage child or adolescent without using force or threat of force), or attempted rape. Statutory rape, as well as alcohol- and drug-facilitated rape, and incapacitated rape, were not measured in the NWS and NVAWS. Findings from the NVAWS indicate that 2.8% of surveyed women reported an attempted rape but denied

having experienced a completed forcible rape. Particularly in cases where attempted rape includes perceived threat of harm and/or death, such experiences can affect victims in a way that is similar to how victims of completed rape are affected. Note that the rape estimates listed for counties above simply used state level estimates of rape and applied them at the county level, without adjusting for differences in the demographic makeup of each county. Thus, to the extent that a particular county differs demographically from the state as a whole (e.g., higher percentage of minority women, lower percentage of young adults), estimates for that county may be biased.

Our findings clearly demonstrate the fact that Delaware has a substantial rape problem, as reflected by our conservative estimate that nearly one out of every eight adult women, or nearly 38,000 women in Delaware, has been the victim of one or more forcible rapes in her lifetime. Knowing the percentage of women who have been raped and the number of rape victims in Delaware is important, but it provides only partial information about Delaware's rape problem. Data from the *Rape in America* report compiled using NWS information found that women with a history of rape were at a greater risk for several mental health problems (Kilpatrick, et al., 1992). For example, victims of rape were found to be 6.2 times more likely than nonvictims (31% vs. 5%) to experience posttraumatic stress disorder (PTSD), a debilitating mental health disorder that occurs in response to a traumatic event, such as military combat or violent crime. Similarly, victims of rape were found to be 5.5 times more likely to have PTSD at the time of the survey than women who had never been victims of crime (11% vs. 2%).

If we assume that rape victims in Delaware are similar to rape victims nationally and experience the same risk of developing mental health problems, we would estimate that of the 38,000 adult women in Delaware who have been forcibly raped, nearly 12,000 have developed PTSD at some time in their lives, and over 4,000 currently meet full criteria for PTSD. Several other mental health problems often affect rape victims, including:

- Major depression at some time in their lives, experienced by 30% of rape victims (over 11,000 victims in Delaware) and 10% of women never victimized by violent crime.
- Current major depression, which is experienced by 21% of rape victims (about 7,900 victims in Delaware) and 6% of women who were never victimized by violent crime.
- Serious suicidal thoughts at some time in their lives, experienced by 33% of rape victims (over 12,000 victims in Delaware) and 8% of nonvictims of crime.
- Suicide attempt at some time in their lives, reported by 13% of rape victims (about 4,900 victims in Delaware) and only 1% of nonvictims of crime.
- Marijuana use at some time in their lives, reported by 52% of rape victims (nearly 20,000 victims in Delaware) and 15.5% of nonvictims.
- Cocaine use at some time in their lives, reported by 15.5% of rape victims (over 5,800 victims in Delaware) and 2.6% of nonvictims.
- Use of hard drugs other than cocaine at some time in their lives, reported by 12.1% of rape victims (nearly 4,600 victims in Delaware) and only 1.2% of nonvictims.

These and other estimates derived from NWS findings provide compelling evidence about the extent to which rape is associated with increased risk of mental health and substance use

problems of women in Delaware. Rape poses a threat even to women's continued survival, as indicated by the increased risk of attempting suicide reported by rape victims compared to nonvictims.

Limitations of Our Estimation Methodology

The estimate in this Report of the number of women in Delaware who have ever been raped is almost certainly an underestimate of Delaware's rape problem for the following reasons:

- It includes only estimates of adult women who have been victims of forcible rape. Thus, Delaware's female children and adolescents who have been forcibly raped are not included in our estimate.
- Alcohol or drug facilitated rapes and other types of incapacitated rapes are not included in our estimates because these types of rape were not measured in either the National Women Study or the National Violence Against Women survey.
- Our estimate does not include statutory rapes (i.e., rapes in which no force or threat of force was involved but the perpetrator had sex with an underage child or adolescent).
- Our estimate does not include attempted rapes.
- Rapes of boys or men are not included.

For reasons that will be described subsequently, it is reasonable to assume that a well-designed victimization survey conducted in Delaware using appropriate screening questions would produce a higher estimate of rape than the methodology that was used in this Report.

It is important to remember that our estimate of rape, like all estimates, is subject to a host of potential measurement problems. To the extent that the NWS and the NVAWS excluded some women from their sampling frames (e.g., women who did not reside in households with telephones or who did not speak English or Spanish), rapes experienced by such excluded women could not be measured. To the extent that some participants in the NWS and NVAWS were unwilling to disclose their rape experiences to the interviewers, rape estimates from these two studies would be lower than they should be. Consequently, any measurement problems in the NWS or NVAWS would be reflected in the estimates of rape in Delaware we produced. To the extent there are other important aspects of Delaware's people or Delaware's culture related to risk of rape that we did not include in our methodology, our rape estimates for Delaware will be less precise than we would like.

It should also be noted that our estimate that 12.2% of adult women in Delaware have been forcibly raped does not mean that all the rapes experienced by these women occurred within the State of Delaware. Clearly, America is a mobile society, and many women change residences often throughout their lives. The methodology we used in this Report was based on rape prevalence within the geographical regions where women were residing at the time they were interviewed in the two surveys - not where they were living when they were raped. As with all national surveys, the number of individuals representing the population within each state is limited, and this can lead to limitations in estimating state prevalences. Only a limited number of risk factors for rape were examined in this study. Prevalence of rape could have varied within different states in the same region, and this variability could affect the accuracy of the estimates.

Also, differences in how the surveys and the Census coded race and ethnicity along with differences in how individuals self-identify with a particular race or ethnic group could affect these estimates. Additionally, the NVAWS was conducted in 1995; the NWS Wave 1 was conducted in 1989, and 2000 Census estimates were used. The amounts that rape prevalence and population may have changed during this time period were not addressed in this study. Notwithstanding these limitations, we believe that the estimates we produced for this Report are the best that can be obtained without actually conducting a well-designed victimization survey. For reasons just described, the estimates in this Report are likely to be conservative underestimates of the problem of rape in Delaware.

Comparing Our Method to Victimization Survey Results

The method we used to estimate the prevalence of forcible rape in Delaware is the best way we could devise to use national information to produce an estimate of rape in Delaware. However, it is no substitute for conducting a well-designed victimization survey within the state. To illustrate this point, we will describe the results of a very important study that was recently conducted in the State of Washington. Full details about the study and its findings are contained in a recent report prepared by Lucy Berliner and colleagues (Berliner, Fine, & Moore, 2001).

The Washington State victimization survey was conducted with a household probability sample of adult women who were current residents of the state. In order to permit comparisons with the rest of the nation, the designers of this victimization survey decided to use the same forcible rape screening questions that were used in the NWS and NVAWS. The results of the survey indicated that 23.1% of the adult women in the survey had been forcibly raped. This estimate of 23.1% for the State of Washington was substantially higher than the 13.4% estimate for the nation as a whole obtained from the NWS and NVAWS.

We decided to use the findings from the Washington State victimization survey as a “gold standard” to evaluate how well our estimation procedure worked compared to an actual victimization survey. Using the same procedures we used to estimate rape in Delaware, we estimated that 17.7% of adult women in Washington had been victims of at least one forcible rape. This estimate was 4.3 percentage points higher than the national average of 13.4%. However, our estimate was 5.4 percentage points lower than the estimate obtained by the victimization survey.

Although there are several technical reasons that may account for the differences in these two estimates, we believe that the major reason is that well-designed victimization surveys provide better estimates within a state than the type of statistical estimation procedure we used. This suggests that the best way Delaware can improve its information about rape is to conduct a victimization survey.

Obtaining Better Estimates of Rape in Delaware

In the last part of this report, we offer suggestions about some key elements of a well-designed victimization survey. Elsewhere, we have discussed methodological issues involved in conducting good victimization surveys to measure sexual assault (Kilpatrick, 2002; Kilpatrick & Acierno, 2003). However, here we would like to stress three points:

- Who is included and who is excluded from a victimization survey will affect the estimate of rape you obtain
- The types of rape you are attempting to measure and the screening questions you use to measure them will have a profound effect on the estimates of rape you obtain
- It is essential to provide a private confidential setting in which to conduct the victimization survey. Likewise, it is important to use interviewers who are sensitive and well-trained to conduct the survey.

With respect to the first point, it is obvious that rape experiences of groups of people who are excluded from a victimization survey will not be measured and included in an estimate of rape. Thus, to the extent that the methodology of a survey excludes groups of people (e.g., men, non-English speaking people, children and teenagers, the homeless), rapes that they experienced will not be included in state estimates. It is generally impossible to include all groups of interest, but it is important to recognize that excluding them may create an underestimate.

The issue of what types of rape are included and how rape experiences are measured via screening questions is critical. Forcible rape is important, but so are other types of rape and attempted rape. Victimization surveys that measure attempted rape, alcohol and drug-facilitated rape, incapacitated rape, and statutory rape will yield higher estimates of rape than those that only measure forcible rape. Likewise, the screening questions used in a victimization survey are extremely important.

A recently completed victimization survey of rape on college campuses documents the importance of screening questions (Fisher, Cullen, & Turner, 2000). The authors of this study conducted two large victimization surveys with nationally representative samples of female higher education students. Students were asked about forcible rape experiences occurring since the start of the current school year. The screening questions for one survey were those used in the U.S. Justice Department National Crime Victimization Survey. In the second survey, screening questions quite similar to those used the NWS and NVAWS were used. All other methods used in the two surveys were identical. **When the results of the two surveys were compared, the prevalence of forcible rape was 11 times greater when the NWS/NVAWS screening questions were used than when the NCVS screening questions were used.** We believe that this finding has two important implications. First, it documents that the NWS/NVAWS screening questions for forcible rape are much more sensitive than those used in the NCVS. Second, because the NCVS screening questions are so insensitive, the data on past year rapes from the NCVS are likely to substantially underestimate the true extent of past year rape in America.

With respect to the need for privacy and confidentiality for victimization survey respondents, it is obvious that most people are more likely to disclose unpleasant and potentially stigmatizing experiences if they are in a private setting and if they believe that what they tell you will be kept confidential. Therefore, it is extremely important to design victimization surveys to maximize privacy and confidentiality. Careful selection and training of interviewers is also important. Most experts believe that use of female interviewers is preferable. Likewise, careful training is needed to insure that interviewers are comfortable asking sensitive questions, that they follow the survey interview protocol, and that they know how to deal with interview participants who become distressed.

Although many people are concerned that conducting victimization surveys might cause extreme trauma for some victims, experience suggests otherwise. Over 16,000 women were interviewed in the NWS, NVAWS, and the campus rape study, and only a small handful of participants were sufficiently upset to require their needing to talk with a mental health professional. In no cases did distressed participants require actual mental health intervention. However, we think it is a good idea to build in access to a mental health professional with violence against women experience to manage the rare instances in which women become unduly upset.

Final Suggestions

If you decide to conduct a victimization survey, here are a few suggestions:

Suggestion 1. Start with a survey of adult women. If you have sufficient resources, expand the survey to adult men. If you have even more resources or have a particular focus on youth, conduct a victimization survey of teenagers. Start out with household samples because most people live in houses. Surveys of particularly underserved groups who do not live in houses or apartments are more difficult to conduct and require more complicated sampling methods.

Suggestion 2. Use the NWS/NVAWS forcible rape screening questions. They have been demonstrated to be feasible to use and are much more sensitive than the National Crime Victimization Survey questions. If you use them, you will be able to compare rape prevalence in your state with the prevalence in the nation as a whole. If you use different questions, it will be impossible for you to compare your findings about forcible rape in your state with national estimates or with those in other states such as Washington.

Suggestion 3. If possible, expand your victimization survey to include attempted rape, drug or alcohol-facilitated rape, incapacitated rape, and statutory rape. The National Violence Against Women Prevention Research Center is currently conducting a national study of young adults that is measuring drug or alcohol-facilitated rape. We would be pleased to consult with you regarding appropriate screening questions.

Appendix I: Overview of NWS and NVAW Methodology

National Women's Study

The National Women's Study (NWS) was a 3-wave longitudinal survey of a large national probability sample of adult women in the United States. Telephone interviews for the NWS were conducted first in 1989 (follow-up surveys were conducted in 1990 and 1991, but are not included in this Report). Of the 4,008 women surveyed, 2,008 represented a cross-section of all adult women in America, and 2,000 comprised an oversample of younger women ages 18-34 years. In addition to accumulating information about forcible rapes that occurred at any time during women's lifetimes, the NWS also examined major mental health problems such as posttraumatic stress disorder, suicide attempts, alcohol abuse and dependence, and drug abuse and dependence.

Potential respondents for the NWS included all women at least 18 years of age in the residential population of the United States. Respondents were identified using a two-staged area probability sampling procedure. In the first stage, the U.S. was divided into four geographic regions and three census size-of-place strata, which yielded a total of 12 mutually exclusive and exhaustive groupings of the U.S. population. In the second stage of sample selection, random-digit dialing was used to select households located within each geographic area. The number of households selected within each of the 12 strata was proportional to the percentage of the entire U.S. population that resided in each stratum. These sampling procedures yielded a population-based random-digit-dialing sample of households. Within households, the number of adult women residing in the household was determined, and one adult woman was randomly selected for interviewing.

Eighty-five percent of eligible respondents agreed to participate in the study and completed the NWS interview. Because the survey included an oversample of younger women, the sample data were weighted to U.S. Census projections of the demographic distribution of the adult female population. That is, adjustments were made to the sample of 4,008 women on the basis of age and race to bring the sample demographically in line with 1989 Census estimates of the distribution of these demographic characteristics in the United States. All sample selection and survey interviewing were done by female interviewers from Schulman, Ronca, and Bucuvalas, Inc. (SRBI), a national survey research organization in New York City. Dr. John Boyle directed the survey for SRBI.

National Violence Against Women Survey

The National Violence Against Women survey (NVAWS) also was a victimization survey of adult women. Specifically, telephone interviews were conducted in 1995-1996 with a national household probability sample of 8,000 women in the United States. Rape screening questions used in the NVAWS were virtually identical to the questions used in the NWS, which enabled us to combine these samples to examine the magnitude of the rape problem at the national and state level with greater precision than is possible with only one sample. As with the NWS, NVAWS questions assessed victimization experiences that were not reported to authorities in addition to those that were reported. Unlike the NWS, major mental health problems were not examined in the NVAWS.

Potential respondents for the NVAWS included all women at least 18 years of age in the residential population of the United States. The sample was managed at the level of U.S. Census region, which provided mutually exclusive, comprehensive groupings of the U.S. population. Within each region, a simple random-digit dialing procedure was used to draw participants from households with a telephone, with nonworking and nonresidential numbers being screened out. In households that had more than one eligible adult, the adult woman with the most recent birthday was selected for interviewing.

Seventy-two percent of eligible respondents agreed to participate in the study and completed the NVAWS interview. As with the NWS, all sample selection and survey interviewing were done by female interviewers from SRBI, a national survey research organization in New York City. Dr. John Boyle directed the survey for SRBI.

Appendix II: NWS and NVAWS Screening Questions

It was important to use screening questions that clarified the types of rape experiences being measured (i.e., those that occurred at any time during a woman's life, that included any type of perpetrator, and that may or may not have been reported to police). The screening questions also measured the key elements of forcible rape as defined by law:

- Use of force or threat of force
- Lack of consent; and
- Sexual penetration

The NWS pioneered the use of clear, explicit screening questions in victimization surveys. Part of the procedure used was the following introduction that set the context for the actual screening questions:

"Another type of stressful event that many women have experienced is unwanted sexual advances. Women do not always report such experiences to police or other authorities or discuss them with family or friends. The person making the advances isn't always a stranger but can be a friend, boyfriend, or even a family member. Such experiences can occur at any time during a woman's life--even as a child. Regardless of how long ago it happened or who made the advances..."

After this introduction, the NWS screening questions were as follows:

- Has a man or boy ever made you have sex by using force or threatening to harm you or someone close to you? Just so there is no mistake, by sex we mean putting a penis in your vagina.
- Has anyone, male or female, ever made you have oral sex by using force or threat of harm? Just so there is no mistake, by oral sex we mean that a man or a boy put his penis in your mouth or someone, male or female, penetrated your vagina or anus with their mouth or tongue.
- Has anyone ever made you have anal sex by using force or threat of harm? Just so there is no mistake, by anal sex we mean that a man or boy put his penis in your anus.
- Has anyone, male or female, ever put fingers or objects in your vagina or anus against your will by using force or threats?

The introduction used in the NVAWS differed somewhat from the one used in the NWS, but covered many of the same general points. Here is the NVAWS introduction:

"We are particularly interested in learning about violence women experience, either by strangers, friends, relatives or even by husbands and partners. I'm going to ask you some questions about unwanted sexual experiences you may have had either as an adult or as a child.

You may find the questions disturbing, but it is important we ask them this way so that everyone is clear about what we mean. Remember the information you are providing is confidential. Regardless of how long ago it happened..."

The NVAWS used the following four screening questions to measure forcible rape:

- Has a man or boy ever made you have sex by using force or threatening to harm you or someone close to you? Just so there is no mistake, by sex we mean putting a penis in your vagina.
- Has anyone, male or female, ever made you have oral sex by using force or threat of harm? Just so there is no mistake, by oral sex we mean that a man or boy put his penis in your mouth or someone, male or female, penetrated your vagina or anus with their mouth or tongue.
- Has anyone ever made you have anal sex by using force or threat of harm? Just so there is no mistake, by anal sex we mean that a man or boy put his penis in your anus.
- Has anyone, male or female, ever put fingers or objects in your vagina or anus against your will by using force or threats?

As is apparent, the approach used to measure forcible rape in the NWS and NVAWS was quite similar, and the screening questions were virtually identical. The fact that the two studies used such similar methods to measure forcible rape and that the screening questions tapped all of the key elements of forcible rape provided considerable justification for combining the data on rape from the NWS and NVAWS.

Appendix III: Methods for Estimating Rape in Delaware (Technical Details)

Initially, Census 2000 population estimates for Delaware were obtained for each of the 13 age groups (i.e., 18-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, and 75 and over) and 6 racial/ethnic groups (i.e., African-American, Asian-American, Caucasian, Native American, multi-racial, and Hispanic). However, due to sparse data for these 78 age-by-race subgroups, the 13 age groups subsequently were collapsed into 6 groups (i.e., ages 18-24, 25-34, 35-44, 45-54, 55-64, and 65 and over).

SUDAAN (2002), a software product designed to analyze clustered data in epidemiological studies and complex sample surveys, was used to generate beta coefficients (via multiple logistic regression) taking the sampling design and weighting into account for each of the age-by-race/ethnicity- by -region subgroups entered into the analysis. These coefficients were converted to rape-prevalence point estimates for each region-specific age-by-race/ethnicity subgroup and weighted by corresponding age-by-race/ethnicity Census 2000 population estimates for Delaware. Statistical programming written in SAS (2002) specifically for this project then used standard errors generated with the regression analysis to obtain estimates of the corresponding standard errors for rape prevalence estimates.

This method used region-specific estimates of the odds of rape (i.e., risk of ever having been raped for women living in one region relative to women living in the lowest risk region) to calculate state-specific prevalence proportions. In this case where the prevalence of completed rape is not rare, the transformation of the region-specific race/ethnicity-by-age log odds to the corresponding prevalence proportions produces an unbiased estimate of the prevalence compared to the method of multiplying a prevalence estimate by the odds ratio. Also, this methodology took the original sampling design into account before adjusting to the Census 2000 numbers by using weighted data in the multiple logistic regressions. Had sampling design not been taken into account, this method would have produced biased standard errors and confidence intervals.

Census Region Divisions of the United States

New England: New Hampshire, Vermont, Massachusetts, Connecticut, Maine, Rhode Island

Middle Atlantic: New York, Pennsylvania, New Jersey

East North Central: Illinois, Indiana, Ohio, Wisconsin, Michigan

West North Central: Missouri, Nebraska, Minnesota, Kansas, North Dakota, South Dakota, Iowa

South Atlantic: Florida, Georgia, South Carolina, North Carolina, Virginia, District of Columbia, Maryland, West Virginia, Delaware

East South Central: Alabama, Tennessee, Kentucky, Mississippi

West South Central: Texas, Oklahoma, Louisiana, Arkansas

Mountain: Arizona, New Mexico, Utah, Colorado, Montana, Nevada, Idaho, Wyoming

Pacific: California, Washington, Oregon, Alaska, Hawaii

Limitations

Note that, to the extent that states within regions vary in rape prevalence (i.e., extent to which, within the South Atlantic region, rape prevalence in Delaware differs from that in Florida, Georgia, South Carolina, North Carolina, Virginia, District of Columbia, Maryland, and West Virginia), the estimates produced by these procedures may be biased. Additionally, with the differences in time between the years in which the surveys were conducted (i.e., 1989 and 1995) and Census 2000 estimates, secular and cohort trends may be possible but could not be examined. Further, only a limited number of covariates were included in the logistic regression models due to sparse data and limited information. Of particular note are the complications associated with estimating prevalence for persons of Hispanic/Latino ethnicity as well as interpretation of the racial category “two or more races.”

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Place information about state sexual assault coalition here.

Place information about state Rape Prevention Education program here

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THE NATIONAL VIOLENCE AGAINST WOMEN PREVENTION RESEARCH CENTER

“To help prevent violence against women by advancing knowledge about prevention research and fostering collaboration among advocates, practitioners, policy makers, and researchers.”

Mission Statement

The National Violence Against Women Prevention Research Center (NVAWPRC) was established in 1998 by the Centers for Disease Control and Prevention. The NVAWPRC is a consortium of researchers and practitioners concerned with violence against women from the Medical University of South Carolina, National Crime Victims Research and Treatment Center, Charleston, SC; Wellesley College, Wellesley Centers for Women, Wellesley, MA; and University of Missouri-St. Louis, Center for Trauma Recovery, St. Louis, MO. The Co-Directors of the Center are Drs. Dean G. Kilpatrick, Patricia A. Resick, Nan Stein, and Linda M. Williams.

The Center's goals are to improve prevention research and foster partnerships among researchers, advocates, practitioners, and public policy makers by identifying and overcoming the barriers to these collaborations. NVAWPRC also serves as a clearinghouse for prevention strategies by keeping researchers and practitioners aware of training opportunities, policy decisions, and recent research findings. The NVAWPRC website contains the latest research on violence against women and serves as a resource to everyone involved in the field of violence prevention. The NVAWPRC has also developed several special reports and training materials that may be obtained by contacting the Center at (843)-792-2945 or at our web address: <http://www.vawprevention.org>.



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