WHERE DO I TURN? A QUALITATIVE INVESTIGATION OF COLLEGE STUDENTS' HELPSEEKING DECISIONS AFTER SEXUAL ASSAULT VICTIMIZATON

by

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Dedication

This dissertation is dedicated to survivors of sexual assault/unwanted sexual experiences and those who help them.

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Abstract

WHERE DO I TURN? A QUALITATIVE INVESTIGATION OF COLLEGE STUDENTS' HELPSEEKING DECISIONS AFTER SEXUAL ASSAULT

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Sexual Assault (SA) is a widespread problem in the United States (U. S.) and research suggests that college women are at even higher risk for this type of victimization than women in the general population (e.g. Fisher, Cullen, & Turner, 2000; Tjaden & Thoennes, 2006). Resources designed to address these negative consequences exist both on and off college campuses, but there is evidence that they are underutilized by survivors in general and by college student survivors in particular. The current study used grounded theory to explore how SA survivors make decisions about helpseeking. In-depth interviews were conducted with 14 college survivors of SA to develop a theoretical model for the decision-making process. The resulting model, "Deciding Where to Turn," suggests that survivors engage in three key decision points: determining if there is a problem related to the SA ("Do I Need Help"), considering options ("What Can I Do"), and weighing the consequences of these options ("What Will I Do"). This process results

in one of four behavioral choices: cope on one's own without support from others, seek support from friends/family, seek support from formal resources, or covert helpseeking, where needs are met without disclosure. "Deciding Where to Turn" contributes to the literature by providing a broader framework for understanding helpseeking decisions after SA, and covert helpseeking in particular adds to the way researchers and practitioners think about helpseeking. The implications of the results for research and practice are discussed.

Introduction

Sexual assault (SA) is a pervasive problem in the U.S. Each year, researchers estimate that more than 300,000 women (0.3 percent of the U.S. female population) are victims of rape or attempted rape (Tjaden & Thoennes, 2006). Prevalence estimates are even more staggering for college women. Recent studies have found that at least 2.8 percent of college women reported being victims of rape or attempted rape in a given academic year of approximately seven months (Fisher, Sloan, Cullen, & Lu, 2000; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007). Fisher and her colleagues (2000) note that projecting these statistics across the college experience is problematic because rates of SA may not remain consistent across summer months or throughout the college experience. However, if these rates were to remain consistent, as many as 20 to 25 percent of college women may experience rape or attempted rape while they are attending college (Fisher et., 2000).

Such high prevalence rates are particularly distressing because SA victimization has been consistently associated with numerous immediate and long-term negative outcomes including both physical and psychological problems. A variety of resources that might alleviate these problems do exist, but relatively few SA survivors access them (Campbell, Wasco, Ahrens, Self, & Barnes, 2001). Research estimates that 14 to 43

percent of SA survivors seek help from formal resources (Campbell, 2008). When SA survivors do not receive the services they need, their physical and mental health concerns may remain untreated and may subsequently lead to long-term complications.

The purpose of this review is to examine the literature relevant to formal helpseeking for SA victimization. First, I will summarize the literature on the prevalence and impact of SA in both general population and among college women specifically. Second, I will review research on the availability and utilization of the main types of resources available to SA survivors, with a focus on college SA survivors. Third, I will review factors that influence SA survivors' use of formal services, highlighting the gaps in the field's current understanding. The final section proposes a study aimed at addressing some of these gaps using in-depth interviews with college SA survivors. I assert that an increased understanding of when and why college SA survivors choose to use particular formal services would help to inform strategies for outreach and intervention.

Before moving on to the literature review, I would like to add a few notes about the terminology I have chosen. First, although the terms "sexual assault" and "rape" are gender neutral, research has consistently found that most SA survivors are female and most SA offenders are male (Tjaden & Thoennes, 2000, 2006). This finding has resulted in most research on SA focusing on female SA survivors with male offenders. Therefore, the following review also focuses on female SA survivors with male offenders.

Second, I have chosen to use the term "survivor" rather than "victim" in this literature review. Although the overall literature is inconsistent regarding the use of these

terms, my own experience as an advocate and therapist for SA survivors has led me to strongly prefer the term "survivor." Feminist theory and research suggest that the term "victim" suggests weakness and powerlessness while the term "survivor" suggests empowerment (Jacobs, 1998). I have chosen the term "survivor" with the intent of remaining consistent with feminist theory and a focus on empowerment for those working to heal from SA.

Third, I have used the term "formal" to describe organizational-based resources for SA in a way that is consistent with the literature. The literature on helpseeking for SA has consistently differentiated between organizational-based/formal resources (e.g. police, medical professionals, mental health professionals, and advocacy services such as rape crisis centers) and other informal sources that SA survivors may turn to for help (e.g. friends and family; e.g. Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007; Ullman, 2007). I have also used the term "advocacy services" to refer to resources such as rape crisis centers or sexual assault service organizations whose focus is to provide crisis intervention and to advocate for SA survivors with other formal resources such as police (Campbell, 2008; Campbell & Patterson, 2011).

Finally, I have used the term "underutilize" to refer to the relatively low percent of SA survivors who seek help from formal resources. Although this term contains an embedded assumption that services are beneficial, it is the most common term used in the research on SA and helpseeking so I have chosen to use it to be consistent with this literature (e.g. Campbell, 2008; Campbell, Ahrens, Sefl, Wasco, & Barnes, 2001; Campbell & Patterson, 2011; Ullman, 2007). Information about the benefits and

drawbacks of various formal resources will be discussed in the section on experiences with formal service providers.

The Problem of SA

Prevalence of SA in the General Population and Among College Women

Research has consistently found that SA is a widespread problem in the U.S., and college women appear to be particularly likely to experience this form of victimization (e.g. Fisher et al., 2000; Kilpatrick et al., 2007). In the 1980s, Koss, Gidycz, and Wisniewski (1987) conducted one of the early studies that demonstrated the high risk for SA among a national sample of college women. Arguing that previous research on SA used measures that were not sensitive enough to capture all women's experiences, the researchers administered a behaviorally-focused self-report questionnaire (the Sexual Experiences Survey) to 3,187 women at 32 colleges in the U.S. They found that a surprising 53.7 percent of the women studied reported some form of sexual victimization since the age of 14. Using mutually exclusive categories based on the most severe form of SA experienced, this number included 14.4 percent who experienced unwanted sexual contact, 11.9 percent who experienced sexual coercion, 12.1 percent who experienced an attempted rape, and 15.4 percent who experienced a completed rape. Koss and her colleagues (1987) concluded that their study supported other published assertions of high rates of rape and other forms of SA among large samples, while noting that their results were only truly generalizable to college students. They attributed the much higher rates

found in their study compared to studies such as the National Crime Survey (NCS) from the same years to differences in their methodology, most notably the use of behaviorally-focused questions. However, more recent research has suggested that these methodological differences were not the sole explanation for the differences in their findings.

Recent studies of SA have allowed for better comparisons between college women and women in the general population due to increased similarities in methodologies. For example, one of the most widely cited recent studies regarding the overall prevalence and incidence of SA in the general population is the National Violence Against Women (NVAW) study (Tjaden & Thoennes, 2000, 2006), which used behaviorally-focused questions similar to those used by Koss and her colleagues (1987). As a part of this nationally representative study, researchers conducted telephone interviews with 8,000 women regarding their experiences as victims of rape and attempted rape. They found that 17.6 percent of the women surveyed were raped in their lifetime and 0.3 percent had been raped in the 12 months immediately preceding the survey alone. In comparison, the National College Women Sexual Victimization (NCWSV) study used questions similar to those used in the NVAW study to screen for SA experiences in a national sample of 4,446 women who were attending 2-year or 4-year colleges (Fisher et al., 2000). They found that 2.8 percent of participants reported rape (1.7 percent) or attempted rape (1.1 percent) during the previous seven months of the academic year. The differences in these rates of comparable forms of SA suggest that SA is more common among college women than among women in the general population

and that the findings by Koss and her colleagues (1987) were due to actual differences in prevalence rates rather than methodological differences alone. This is especially so considering that the NCWSV measured SAs that occurred over approximately seven months compared to 12 months measured by the NVAW.

A literature search found only one study that directly compared women in the general population to college women. In this study, Kilpatrick and his colleagues (2007) conducted telephone interviews with 3,001 nationally representative women in the general population and 2,000 nationally representative college women using the same methodology. They found that 0.6 percent of women in the general population and 2.95 percent of college women reported that they were raped during the seven month period measured by the survey. In other words, these findings indicated a rate of rape among college women that was nearly five times that of women in the general population.

In addition to studies suggesting higher prevalence rates for SA among college women than women in the general population, research has suggested that these rates have not diminished since they were first reported[1]. In a recent study, 935 undergraduate women from a state university completed extensive questionnaires regarding unwanted sexual experiences since entering college (Gross, Winslett, Roberts, & Gohm, 2006). The researchers found that 18.8 percent of these women reported experiencing a completed rape compared to 15.4 percent in the study by Koss and colleagues (1987). They found

[1] Psychology and sociology both recognize that social constructionism can play a role in the identification of a social problem and, therefore, in prevalence rates. According to this concept, whether and how society/researchers define a social problem affects how they study that problem (Brown, 1995). Thus, prevalence rates of sexual assault may be affected over time by changes in how society recognizes and defines it.

this higher percentage of rape victimization despite limiting the timeframe of the more recent study to sexual experiences since enrolling in college rather than since the age of 14. The study also found that 27 percent of the women surveyed reported some form of unwanted sexual contact ranging from kissing and petting to oral, anal, or vaginal intercourse since enrolling in college. Gross and his colleagues (2006) concluded that their findings, viewed collectively with other research, suggest that the rates of rape among college women have remained relatively stable since the study by Koss and her colleagues (1987).

Collectively, the data on SA prevalence clearly suggests that SA is a widespread problem in the U.S. and that college women are at an even greater risk for SA than women in the general population. Recent research even suggests that college women may be as much as five times more likely than women in the general population to experience SA in a given academic year (Kilpatrick et al., 2007). In order to guide prevention and intervention efforts, researchers have explored possible risk factors for SA and reasons for this higher level of risk among college students.

Who are SA Survivors?

The literature on SA has identified a number of factors that increase the risk for SA (for a full review see Ullman & Najdowski, 2011). For example, regional differences in unemployment, economic inequality, and differences in cultural attitudes such as holding traditional beliefs about sex roles and rape myth acceptance are all societal factors that have been associated with an increased risk for SA. Situational factors are

environments that allow SA to occur (Adams-Curtis & Forbes, 2004) and include being on a date, attending a party, going to a bar, and being in an isolated or private location (Ullman & Najdowski, 2011). However, much more research has focused on who SA survivors are.

Research has consistently found that a number of individual-level factors are associated with an increased risk for SA. Demographic factors such as being younger, an ethnic minority, unmarried, unemployed, and of lower socioeconomic status are all associated with increased risk for SA, though the reasons for these associations are still unclear. Failure to perceive risk in a situation and/or reduced ability and willingness to act when a threat is perceived are also associated with an increased risk for experiencing SA. Risk-taking behaviors such as a tendency to engage in risky or impulsive sex, including having many sexual partners, have been consistently associated with an increased risk for SA (Ullman & Najdowski, 2011). However, some researchers have asserted that the findings on dating and sexual behaviors may primary reflect probabilities; that is, an increase in dating/sexual partners is likely to increase her exposure to potential perpetrators and sexual coercion (Adams-Curtis & Forbes, 2004).

Alcohol use/abuse is a robust risk factor for SA, but the direction of this relationship is still unclear (Ullman, 2003; Ullman & Najdowski, 2011). Alcohol use may increase the risk for SA by decreasing a woman's perception of risk and resistance to sexual aggression/coercion and increasing her likelihood of being targeted by sexually aggressive men (Adams-Curtis & Forbes, 2004; Ullman, 2003; Ullman & Najdowski, 2011). However, experiencing SA may also contribute to subsequent alcohol use

(McCauley, Ruggiero, Resnick, & Kilpatrick, 2010; Ullman, 2003). According to Ullman (2003), the relationship between alcohol use and SA is likely bidirectional, with earlier SA leading to alcohol use and other risky behaviors as coping mechanisms. This assertion is consistent with research that suggests that many individual risk factors are potentially mediators of the effect of prior victimization (Ullman & Najdowski, 2011). Researchers have studied associations between drug use/abuse less frequently than alcohol use and the results of these studies are mixed.

Prior victimization includes sexual, physical, and emotional assault/abuse in childhood, adolescence, and/or adulthood and is actually the single greatest risk factor for SA (Ullman & Najdowski, 2011). The risk for further victimization also increases if the previous abuse was more substantial or consisted of multiple incidents, especially if it occurred during childhood or adolescence. Research has also found that experiencing SA is associated with numerous negative psychological effects and behaviors, including alcohol use, engaging in risky behaviors, and failure to perceive or act on perceived risk (Campbell, Dworkin, & Cabral, 2009; Ullman & Najdowski, 2011). Because of such findings, some researchers assert that the associations between prior victimization and the risk for future SA are mediated by other individual/behavioral risk factors (Ullman & Najdowski, 2011).

Overall, a number of societal, situational, and individual factors have been associated with an increased risk for experiencing SA. Although some factors such as prior victimization and alcohol use/abuse have shown a consistent relationship, the mechanisms for how these factors increase risk are still largely unclear.

Why are Prevalence Rates Higher among College Women?

Researchers have used routine activities theory to explore differential risk for victimization from various crimes, including the higher prevalence for SA among college women (Mustaine & Tewksbury, 2002; Schwartz & Pitts, 1995). This theory suggests that understanding the social context of a crime is essential for understanding why some people are at higher risk for becoming victims of that crime. To this end, the theory proposes that the interaction of three factors affect the likelihood that a crime will occur: the absence of capable guardianship, the availability of suitable targets or victims, and the presence of likely offenders. Routine activities theory further proposes that the lifestyle of individuals guides them to various interactions with people and situations that may increase and/or decrease their risk of victimization (i.e. present them as available targets). The following sections will use the framework of routine activities theory to explore factors that may increase the risk for SA among college women.

Guardianship. The issue of capable guardianship has received the least attention in the literature on SA and routine activities theory. In the broader literature on routine activities theory, capable guardianship is often discussed in terms of property (i.e. property is easier to steal if no one is guarding it; Schwartz & Pitts, 1995). However, the absence of capable guardianship also describes a lack of supervision. Schwartz and Pitts (1995) acknowledged that previous researchers attributed date rape on college campuses to a movement away from colleges acting as guardians. There may be some support for this argument when considering that the most common location for the SA of college women is either the woman or the offender's residence (Fisher et al., 2000), where they

are less likely to be supervised. However, this explanation does not necessarily differentiate college women from women in the general population since women who do not attend college also frequently live and attend functions without supervision. A study by Mustaine and Tewksbury (2002) approached the issue of guardianship from the perspective of self-guardianship rather than supervision from another person. In this study, the researchers used self-report questionnaires to collect data from 674 college women from 12 colleges across eight states. Students answered questions about alcohol and drug use, unwanted sexual experiences in the six months preceding the study, and their daily activities. When asking about daily activities, the authors included questions about self-protective behaviors such as carrying mace, a weapon, or a cell phone for the purpose of protection. They found that these self-protective behaviors were not significantly correlated with experiences of SA.

Overall, the concept of capable guardianship is problematic for the crime of SA regardless of the type of guardianship considered because SA is most often committed by someone the victim knows. National statistics estimate that nearly 84 percent of female SA survivors knew the offender (Tjaden & Thoennes, 2006). The statistics for college women are even higher with nearly 90 percent knowing the offender before the SA (Fisher et al., 2000). For college women, the person committing the SA is most often a classmate, friend, boyfriend, ex-boyfriend, or an acquaintance (Fisher et al., 2000). Logically, all forms of guardianship are less likely to be active during familiar situations and with familiar people because they seem safe. Therefore, guardianship behaviors do not appear to influence college women's vulnerability for SA.

Target/victim vulnerability. According to routine activities theory, some women are more "suitable" targets (i.e. victims) for SA due to individual-level variables. These variables include demographic factors as well as lifestyle and activity choices.

Demographics.

Age. As indicated previously, studies on the prevalence of SA have consistently found that younger women are at higher risk for experiencing SA (Ullman & Najdowski, 2011). The risk of SA is highest for adolescent women (approximately ages 15 to 19), closely followed young adult women in their early 20s (approximately ages 20 to 24; Fisher, Sloan, Cullen, & Lu, 1998; Humphrey & White, 2000). Therefore, the age of college women may partially explain the higher prevalence rates of SA among this population. While women may attend college at any age, the overall college population tends to be youthful, with the majority of the undergraduate population falling between the ages of 18 and 24 (Fisher et al., 1998). However, several studies have suggested that the prevalence of SA among college women is even higher than that of comparable age groups.

For example, Fisher and her colleagues (1998) conducted telephone interviews using methodology similar to that of the National Crime Victimization survey (NCVS), allowing them to make reasonable comparisons between their findings and national prevalence rates. The NCVS is an annual, nationally representative study on criminal victimization in the U.S. and is considered the primary source of information for national statistics (Bureau of Justice Statistics, n.d.). Fisher and her colleagues (1998) found that 3.73 percent of the women surveyed reported rape or attempted rape during the measured

academic year of approximately six to nine months. Comparing their results to the NCVS, the authors reported that the women in this study experienced rape or attempted rape at 3.3 and 3.1 times that of the NCVS for 20 to 24-year-olds in 1993 and 1994 respectively. The researchers did not find similar differences in rates of victimization when comparing other forms of violent crime (Fisher et al., 1998).

Another example is the study by Kilpatrick and his colleagues (2007; described previously) which compared SA survivors in the general population with those in the college population. While this study did not report direct comparisons by age group, they did report that they purposely oversampled younger women in the population to facilitate comparisons with the college women. This resulted in the majority of women in the general population sample being between the ages of 18 and 34. They found that the rate of rape for college women was nearly five times that of women in the general population (2.95 percent and 0.6 percent respectively). These studies suggest that other factors beyond age play a role in the increased rates of SA among college women.

Other demographic variables. Research has identified several other demographic variables that have frequently been associated with an increased risk for SA. These variables include marital status, ethnicity, employment status, and socioeconomic status (e.g. Tjaden & Thoennes, 2000). However, these variables have been less consistently correlated with the risk of SA among college women. For example, some studies found that rape is more prevalent among white and Native American women on college campuses (e.g. Koss et al., 1987; Kalof, 2000) while other studies found higher prevalence rates among African American women (e.g. Gross et al., 2006) or no

significant correlations based on ethnicity (e.g. Mustaine & Tewksbury, 2002). When considering demographic variables, Mustaine and Tewksbury (2002) found that age and marital status were the only variables correlated with SA, but these correlations disappeared when entered into linear regression models along with lifestyle variables. According to the authors, the finding that demographic variables are no longer statistically relevant when other lifestyle variables are included is actually consistent with routine activities theory. They argue that researchers often use demographic variables as proxies for lifestyle, therefore, these demographic variables are not statistically relevant when more specific behaviors are also examined.

Lifestyle / Activity choice.

Alcohol and drug use. Research has found that the use of alcohol/drugs is among the strongest predictors of SA, especially among college students (Mustaine & Tewksbury, 2002; Ullman & Najdowski, 2011). However, the frequent use of alcohol/drugs by college students requires a more complex measure than dichotomizing students into substance users and non-users. For example, one study found that 44 percent of students report instances of binge drinking (Weschler, Lee, Kuo, & Lee, 2000). Studies that consider the relationship between SA and alcohol/drug use therefore often use measures that include the frequency and amount of substance use. Many of these studies have found a positive correlation between a woman's use of alcohol/drugs and SA (e.g. Kilpatrick et al., 2007; Krebs, Lindquist, Warner, Fisher, & Martin, 2007; McCauley et al., 2010; Schwartz & Pitts, 1995). One prominent explanation for this increased risk of SA is that intoxicated women are more vulnerable to sexual advances than non-

intoxicated women (Mustaine & Tewksbury, 2002; Schwartz & Pitts, 1995). Research supports this explanation, suggesting that college men may view intoxicated women as more sexually available. For example, one study that found one in four undergraduate men admitted to actively seeking to get a woman intoxicated explicitly to have sex with her (Tyler, Hoyt, & Whitbeck, 1998). Another study surveyed college men about acts of SA that they may have committed (Lisak & Miller, 2002). The authors found that 6.4 percent of the 1882 men surveyed reported that they had committed acts that met the criteria for rape or attempted rape and 80 percent of these reported raping a woman who was incapacitated due to alcohol/drugs. As described previously, however, the relationship between alcohol use and SA is complex and may be bidirectional in nature such that experiencing SA leads to increased drinking and increased subsequent risk (McCauley et al., 2010; Ullman, 2003).

Leisure activities. In addition to alcohol and drug use, certain types of leisure activities have been associated with an increased risk for SA. For example, consistent with research on the general population, SA is more prevalent among college women who frequently engage in public activities at night, including bars and night clubs (Fisher et al., 2000). Mustaine and Tewksbury (2002) attempted to further differentiate the types of leisure activities associated with SA by inquiring about time spent "hanging out" and "going out at night for leisure" versus going to movies. They found that frequently "going to movies" was negatively correlated with SA while "hanging out" and "going out at night for leisure" were positively correlated with SA. While the extent to which these activities overlap with alcohol/drug use remains unclear, it may be that more structured

activities provide less opportunity for SA to occur (Mustaine & Tewksbury, 2002; Ullman & Najdowski, 2011).

School related activities. Involvement with a variety of school-related organizations including clubs, fraternities/sororities, and athletic teams are frequently a part of the college experience. Unfortunately, numerous studies have found that women who are involved in such group activities experience even higher rates of SA than their peers do. For example, Mustaine and Tewksbury (2002) found that women who were members of a high number of college groups, clubs, and organizations had 1.19 higher odds of SA than women involved in few to no groups, clubs, and organizations. They also found that female college athletes had 1.83 higher odds of SA than college women who were not on athletic teams. Numerous studies have also found that women who are members of sororities and fraternities experience higher rates of SA than their peers do (e.g. Boeringer, 1996; Copenhaver & Grauerholz, 1991; Kalof, 1993). Interestingly, Mustaine and Tewksbury (2002) did not find an association between sorority/fraternity membership and rates of SA. The authors propose that it is exposure to fraternity men, who have been associated with higher rates of SA perpetration, rather than sorority/fraternity membership, that increases the risk of SA. In reality, increased exposure to potential offenders may better explain the higher prevalence of SA among college women than a number of the risk factors proposed as "target attractiveness."

Exposure to potential offenders. Routine activities theory has often taken the presence of potential offenders for granted and focused on the attractiveness of a target in explaining differential risk for victimization. While studies such as those described above

are careful not to blame the victim for her SA, the focus is on aspects of the student's lifestyle or behavior that places her at greater risk for SA victimization. This approach is justified to some extent based on evidence that participation in various activities such as those described previously is associated with an increased risk for SA. However, these activities may increase the risk of SA precisely because they expose college women to more potential offenders. For example, numerous studies have found that male fraternity members and college athletes are disproportionately associated with risk for SA perpetration (e.g. Benedict & Klein, 1997; Copenhaver & Grauerholz, 1991; Humphrey & Khan, 2000). Research has also indicated that simply attending college may increase one's exposure to potential SA offenders. In a review of literature from the 1980s and early 1990s, Belknap and Erez (2007) found that approximately one-third of college men said that they would rape a woman under some circumstances if they knew they could get away with it. Other research suggests that more than 6 percent of college men report committing acts that meet the legal definitions of rape or attempted rape and more than 60 percent of these report multiple committing multiple acts (Lisak & Miller, 2002).

Overall, this section used routine activities theory (capable guardianship, target/victim vulnerability, and exposure to potential offenders) to explore potential factors associated with increased risk for SA among college women compared to women in the general population. The concept of capable guardianship is a problematic component for explaining the increased risk for college women, regardless of how it is measured, because of the high probability that a SA will be committed by someone the SA survivor already knows (Mustaine & Tewksbury, 2002). Although research has

identified several individual and situational risk factors (i.e. target/victim vulnerability) associated with an increased risk for SA among college women (Adams-Curtis & Forbes, 2004; Mustaine & Tewksbury, 2002), the overall magnitude of the differences between college SA survivors and other college women is relatively small (Adams-Curtis & Forbes, 2004). While there is some evidence that attending college exposes college women to more potential offenders (Belknap & Erez, 2007; Benedict & Klein, 1997; Humphrey & Khan, 2000)), it is still unclear how these statistics compare with men in the general population. In general, the risk factors associated with SA by someone known to the SA survivor are usually among the most common components of daily college life (Adams-Curtis & Forbes, 2004). Researchers' understanding of the high rates of college SA continues to evolve, and many colleges have implemented prevention efforts based on the findings to date (Daigle, Fisher, & Stewart, 2009; Karjane, Fisher, & Cullen, 2002; McMahon & Banyard, 2012). However, while such efforts at prevention may have some influence and will hopefully prove to be more effective over time, the factors described above are likely to persist to some degree. The stubbornness of this pattern is disturbing, not least because of clear evidence that SA victimization is associated with numerous immediate and long-term negative impacts, including both physical and psychological problems.

Impact of SA

The literature on the impact of SA has not clearly differentiated between women in the general population and college women. Therefore, I have provided a general

review the research on the physical and psychological consequences of SA and have indicated information specific to college students when it was available.

Physical Impact. SA can result in a wide range of physical consequences including immediate physical injuries, sexually transmitted infections (STIs), pregnancy, and long-term physical problems. The following sections will review the literature on these physical impacts of SA.

Immediate Injuries. Estimates of physical injury from SA have primarily focused on immediate injuries such as bruises, lacerations, and fractures. The reported rates of these types of injuries vary significantly based on the methods of assessment used, such as self-reports collected through surveys and interviews or medical assessments by medical personnel (e.g. Fisher et al., 2000; Kilpatrick et al., 2007; Sommers & Buschur, 2004).

Sommers and Buschur (2004) recently reviewed common physical injuries that accompany SA for the purpose of better informing nurses who may encounter SA survivors, including those who may not have initially disclosed the assault. According to this review, non-genital injuries are particularly common with SA with estimates of injuries ranging from 20 to 76 percent. Researchers classified approximately 81 percent of these injuries as mild including bruises, scratches, and abrasions. They classified about 17 percent of non-genital injuries as moderate including lacerations, large bruises, and fractures. While severe injuries are relatively rare (about 0.6 percent), these include major skeletal fractures and trauma that may require hospitalization and/or surgical interventions.

Estimates of genital injuries have ranged from five to 87 percent (Sommers & Buschur, 2004). These injuries usually include abrasions, bruising, and tearing of the external genitals and are often accompanied by pain and/or bleeding. While injuries to the internal genitals are less common, one study reported that 11 percent of women experienced vaginal injuries and 13 percent experienced cervical injuries. In severe cases, these injuries have also required hospitalization or even surgical intervention (Sommers & Buschur, 2004).

Sommers and Buschur (2004) stressed the importance of considering the location and possible causes of injuries in addition to the severity of the injuries. They asserted that most experts agree that injuries to the center of the body, such as the trunk, face, or head are usually intentional while injuries to extremities, such as arms or legs, are more likely to occur accidentally in the course of SA. Examples of common injuries that medical professionals may look for include signs of forcible restraint, mouth injuries from gagging or forced oral sex, and patterns of muscle soreness or stiffness consistent with SA (Sommers & Buschur, 2004).

Sexually transmitted infections and pregnancy. In addition to the immediate physical injuries described above, survivors of SA are at risk of becoming pregnant and of acquiring STIs from the assault. Research on the number of SA-related pregnancies has consistently reported rates between one and five percent (e.g. Holmes, Resnick, Kilpatrick, & Best, 1996; Riggs, Houry, Long, Markovchick, & Feldhaus, 2000). Researchers concluded that pregnancy occurs with significant frequency and medical

guidelines routinely recommend pregnancy testing and/or emergency contraception after a SA (Campbell, Patterson, & Lichty, 2005; Holmes et al., 1996).

In a review of the literature on SA and STIs, Reynolds, Peipert, and Collins (2000) found that the rates for common STIs after SA ranged from zero to 26 percent. The authors found only two studies that focused on the risk for HIV/AIDS after SA but concluded that the rates are very low. They also noted that it is difficult to determine with certainty whether the STIs in these studies were newly acquired from the SA itself. Nonetheless, the risk for acquiring an STI is widely acknowledged and medical guidelines routinely recommend screening and treatment for STIs for survivors of SA (Campbell, Townsend, Long, Kinnison, Pulley, & Adames, 2006; Reynolds et al., 2000).

Long-term physical impact. Although the long-term physical impact of SA is not well understood, several studies have found that SA survivors report more health complaints than those without a history of SA (e.g. Conoscenti & McNally, 2005; Golding, 1994, Golding, Cooper, & George, 1997). For example, Golding (1994) examined associations between SA history and various self-reported measures of physical health using data from the 1,610 women who participated in the Los Angeles Epidemiologic Catchment Project. She found that women with a history of SA were significantly more likely to report poor overall perceptions of their health, several chronic diseases, and various physical complaints. More specifically, she found that women with a history of SA reported significantly higher rates of diabetes, arthritis, and physical disabilities. They also reported significantly more gastrointestinal problems, various types of pain, cardiopulmonary symptoms, neurological symptoms, and symptoms

associated with sexual activity and reproductive organs. Women with a history of SA were also more likely to report higher numbers of symptoms. Golding (1994) found that 29.3 of the women with a history of SA reported six or more symptoms of health problems compared to 15.8 percent of women without a history of SA.

Golding (1994) is careful to note, however, that women with a history of SA are more likely to report both medically explained symptoms and symptoms that do not appear to have a clear medical explanation. She reported that 11.0 percent of the women with a history of SA reported six or more symptoms that did not have a medical explanation, compared to 4.6 percent of women who did not report a history of SA. This is consistent with other research on SA and physical health, which suggests that long-term physical and psychological effects of SA may be interconnected (e.g. Arnold, Rogers, & Cook, 1990; Koss, Koss, & Woodruff, 1991). The interconnection may be due to somatization, which is the physical manifestation of a psychological problem, or less directly through changes in behaviors and/or resources. For example, Koss and her colleagues (1991) proposed that SA survivors might interpret the SA as a bodily threat and, in turn, increase their attention to subtle physical symptoms or even interpret emotional reactions as physical illness.

A focus on somatization has been particularly prominent in research on sexual problems. In a review of the literature, Van Berlo and Ensink (2000) found that 25 to 59 percent of SA survivors reported sexual problems, which sometimes persisted for years after the assault. They found that the most frequently reported problems were fears of sex, a loss of interest in sex, a lack of pleasure, and physical symptoms such as a feeling

of genital burning and pain during intercourse. The authors asserted that these symptoms often do not have an identifiable medical explanation and may be associated with depression or post-traumatic stress disorder (PTSD).

Research clearly indicates that physical ramifications are common from SA ranging from immediate and long-term physical injuries to the risk of STIs and pregnancy. Medical services may be important in reducing the overall physical impact of SA. However, research on these physical ramifications has also suggested that the physical and psychological sequelae are intertwined.

Psychological Impact. The psychological impact of SA has been well established and has been the subject of numerous reviews (e.g. Briere & Jordan, 2004; Campbell et al., 2009; Koss, 1993). Overall, these studies have concluded that SA can be a severe psychological trauma that may lead to a variety of psychological problems. Between 73 and 82 percent of women with a lifetime history of SA experience fear and/or anxiety, 12 to 40 percent develop generalized anxiety, and 17 to 65 percent develop post-traumatic stress disorder (PTSD; Campbell et al., 2009). Many SA survivors meet the diagnostic criteria for depression (13 to 51 percent) and may experience suicidal ideation (23 to 44 percent) and even attempt suicide (2 to 19 percent; Campbell et al., 2009). SA survivors may also become dependent on alcohol (13 to 49 percent) and other illicit substances (28 to 61 percent), which some researchers suggest may be an attempt to self-medicate for symptoms such as depression and anxiety (Campbell et al., 2009; Sturza & Campbell, 2005).

When considering college students specifically, one study found that about half of SA survivors met the criteria for PTSD in their lifetime and over one-third met the criteria at the time of the study (Kilpatrick et al., 2007). About two out of five SA survivors met diagnostic criteria for depression in their lifetime and over one-third met criteria at the time of the study. This study also found that SA survivors in college reported significantly higher rates of binge drinking and substance abuse than their peers who had not reported a history of SA.

In a recent review, Campbell and her colleagues (2009) noted that the detrimental psychological impact of sexual assault has been widely accepted. However, they argue that the field needs a framework for conceptualizing this harm in a way that recognizes the socio-cultural context in which both SA and recovery occur. The following is a brief summary of the ecological model of the psychological impact of SA proposed by the authors.

Individual-level factors. Research has considered various aspects of SA survivors themselves that may be associated with the severity of the psychological impact of SA. Factors studied have included sociodemographic variables, pre-existing psychological conditions, and coping strategies. Many of these studies found a lack of differences or inconsistent results, leaving the association between individual-level factors and the psychological impact of SA unclear. For example, most studies on the association between sociodemographic variables and the psychological impact of SA found no differences based on ethnicity/race, income level, marital status, or employment status. However, studies considering the association with education level and age have yielded

inconsistent results (Campbell et al., 2009). Studies also found inconsistent results concerning pre-existing psychological conditions. Specifically, several studies found that pre-existing mental health conditions were positively associated with psychological difficulties after SA while other studies found no relationship (Campbell et al., 2009).

Studies also report inconsistent results regarding the role of coping strategies in the psychological impact of SA. In these studies, researchers have generally grouped the methods that SA survivors use to cope with their emotional reactions into approach and avoidance strategies (Campbell et al., 2009). Approach strategies usually involve confronting negative emotions, such as expressing emotions, finding ways to reduce stress, and seeking social support or help. Avoidance strategies, on the other hand, are usually those in which the survivor finds ways to avoid negative emotions, such as staying home, withdrawing, and using/abusing substances. Approach strategies have often been associated with faster recovery from SA and lower rates of depression, anxiety, and PTSD when compared to avoidance strategies (Campbell et al., 2009). However, some studies found conflicting results, which suggest that more complex relationships exist between coping strategies and the psychological impact of SA. For example, researchers sometimes found that seeking social support is not associated with symptom severity, approach strategies are related to higher levels of distress, and avoidance strategies are related to lower levels of distress (Campbell et al., 2009). Campbell and her colleagues (2009) note that coping strategies may change over time and across situations and argue that these conflicting findings suggest the importance of examining the context in which various coping strategies are used.

Assault characteristics. Much like individual-level factors, the relationship between characteristics of the assault and the post-assault sequelae has been inconsistent (Campbell et al., 2009). For example, some studies have found that the level of injury sustained is positively correlated with PTSD, depression, and anxiety. However, other studies have found no relationship between injury and psychological distress. The impact of the relationship between the victim and the offender has also yielded inconsistent results. While some studies have found that SA by a stranger is associated with increased rates of PTSD and depression, other studies have found that SA by an intimate partner is just as likely to predict PTSD as SA by a stranger. Researchers suggest that this is because women assaulted by acquaintances or intimate partners are more likely to be blamed for the assault by others and by themselves (Campbell et al., 2009).

Interpersonal/microsystem factors. The microsystem includes informal support structures or interpersonal relationships that surround survivors of SA, such as family and friends. Numerous studies have found that positive reactions to SA disclosure have small or non-significant effects on psychological symptoms while negative reactions have strong and consistent negative effects on survivors and their recovery, both immediately and more than a year after the negative reaction was received (Campbell et al., 2001; Ullman, 1999, 2007; Ullman, Starzynski, Long, Mason, & Long, 2008). Negative reactions to SA disclosure can invalidate the survivor's experience and produce an unsupportive environment and feelings of rejection during the recovery process, often referred to as secondary victimization or a second rape (Campbell, 2008; Ullman, 1999). However, the division of positive and negative responses to SA disclosure may be less

clear than was once believed due to the way SA survivors interpret reactions. One study specifically found that SA survivors disagreed about whether reactions such as wanting to seek revenge, telling the survivor to get on with her life, and taking control of the survivor's decisions were positive or negative (Campbell et al., 2001). SA survivors' interpretations of these reactions were based on their perceptions of the intent of the support provider. The researchers also found that SA survivor exhibited higher levels of psychological and physical symptoms when they interpreted these reactions as negative and lower levels of psychological and physical symptoms when they interpreted them as positive.

Formal resources/mesosystem factors. The mesosystem for SA recovery includes formal resources for help such as legal, medical, and mental health agencies as well as advocacy services such as rape crisis centers. Although research has consistently shown that these resources are underutilized, they can help to facilitate recovery when provided with empathy and support. Unfortunately, SA survivors may not receive services in this manner and insensitivity within these systems can exacerbate survivors' feelings of powerlessness, shame, and guilt (Campbell et al., 2009). Recent research by Campbell (2005, 2008) highlighted this experience, particularly within the legal and medical systems. This study found that more than 80 percent of survivors reported feeling badly about themselves because of encounters with legal and/or medical systems, nearly 90 percent felt violated, and 80 percent said they were reluctant to seek further help. Reported experiences with mental health systems have been more positive with most survivors reporting the services were helpful and supportive, however some studies have

reported that access to quality services may be limited. Survivors have also usually reported positive experiences with advocacy services, which may provide mental health counseling as well as help survivors to navigate legal and medical systems (Campbell, 2008; Campbell et al., 2009).

Cultural/macrosystem factors. The macrosystem for SA recovery includes larger cultural messages about SA that provide context for both SA and recovery. According to Campbell and her colleagues (2009), most research at this level of the ecological model has considered the acceptance of rape myths among participants who have not experienced SA. However, one study found that survivors of SA by an intimate partner or date blamed themselves because their experiences did not fit the stereotype of a violent stranger rape (Harned, 2005). Several other studies also found that women did not report SA because they were unsure that their experience was a crime (e.g. Fisher et al., 2000; Kilpatrick et al., 2007). These types of findings provide further evidence of the broad acceptance of rape myths and such beliefs may encourage both SA survivors and those around them to blame the survivor for the SA, which may impede psychological recovery (Ahrens, 2006; Harned, 2005).

In general, the research demonstrates that SA survivors are at significant risk for experiencing numerous immediate and long-term physical and psychological consequences from SA. The immediate physical consequences from SA victimization may include bruises, lacerations, fractures, STIs, and pregnancy (sommers & Buschur, 2004) and long-term consequences may range from poor overall perceptions of health to increased risk for chronic diseases such as diabetes, arthritis, and physical disabilities

(Conoscenti & McNally, 2005; Golding, 1994). The psychological impact of SA includes anxiety, PTSD, depression, alcohol/substance use and abuse, and attempts of suicide (Campbell et al., 2009).

Overall, the SA literature demonstrates that SA is a significant problem in the U.S. and that college women are even more likely to experience SA than women in the general population (Fisher et al., 2000; Tjaden & Thoennes, 2006). Although a number of risk factors have been identified in both the general population and among college women, it is unclear whether these factors provide useful levels of distinction between SA survivors and those who do not experience SA, especially due to the overall high prevalence rates (Adams-Curtis & Forbes, 2004; Mustaine & Tewksbury, 2002; Ullman & Najdowski, 2011). The research also demonstrates that the experience of SA may have numerous negative immediate and long-term physical and psychological impacts on the survivor. It is clear that there is a need to minimize such impacts and to help SA survivors cope effectively with the aftermath of SA. In the following sections, I will discuss the types of services generally available to college students, the extent to which survivors tend to use them, and factors that may influence utilization.

Resource Availability and Utilization

The problem of SA has received significant attention from researchers, service providers, and the public since the 1970s (Campbell et al., 2001; Tjaden & Thoennes, 2000). Since then, numerous formal resources have become available and/or more attuned to the needs of SA survivors (Campbell et al., 2001; Ullman & Filipas, 2001a). These include legal, medical, and mental health services as well as advocacy services such as rape crisis centers. The problem of SA on college campuses has also received increased scrutiny since the late 1980s from the U.S. Congress, college officials, and the public (Fisher et al., 1998; Sloan, Fisher, & Cullen, 1997). As a result, many colleges provide student-focused resources that parallel those available in the broader community. Despite the availability of these numerous resources, research on service utilization has consistently found that formal resources for SA are underutilized (e.g. Campbell, 2008, Campbell et al., 2001; Ullman, 2007).

Limited research has focused on helpseeking rates and patterns specifically among college students, therefore most of what is reviewed in this section is based on research in the general population. The one study that compared rates of helpseeking among college SA survivors with those in the general population found somewhat lower rates among college student survivors, despite the likelihood of additional resources

available to them through their college (Kilpatrick et al., 2007). Research in the general population has found that approximately 14 to 43 percent of SA survivors seek some type of formal help, with some variation among the four main categories of formal services: legal, medical, mental health, and advocacy services (Campbell, 2008; Patterson, Greeson, & Campbell, 2009; Ullman, 2007). The following sections will summarize the literature on the utilization of formal resources for SA.

Legal Resources

The SA helpseeking literature generally defines legal resources as reporting to law enforcement (e.g. Campbell, 2008; Campbell et al., 2001, Golding, Siegel, Sorenson, Burnam, & Stein, 1989). Police tend to be the initial contact for SA survivors who do seek legal help and act as a gateway to prosecution (Campbell, 2008). Police may also address SA survivors' immediate safety concerns, inform them of their legal rights, and provide referrals to other formal services (Campbell et al., 2001). However, evidence suggests that SA is one of the most under-reported crimes, with estimates ranging from less than five percent to nearly 40 percent being reported (Campbell, 2008; Fisher et al., 2000).

Among college students, research suggests that rates of reporting SA to law enforcement may be on the low end of this spectrum. For example, the National College Women Sexual Victimization study (NCWSV; described previously) found that approximately than 4.8 percent of college SA survivors reported the SA to law enforcement (Fisher et al., 2000). A study comparing college women to women in the

general population found that approximately 16 percent of female SA survivors in the general population reported their SA to law enforcement compared to approximately 12 percent of female SA survivors in the college sample (Kilpatrick et al., 2007). Additional research comparing rates of reporting SA or reasons for possible differences in reporting between these two populations could not be found.

Medical Resources

Medical services for SA victimization may provide forensic evidence collection, medical examinations, information on pregnancy and STIs, and referrals to counseling and other formal resources (Patterson et al., 2009; Resnick et al., 2000). Overall, the literature on medical resources has not differentiated between types of medical facilities. Estimates of helpseeking from medical resources range from 26 to 40 percent of all SA survivors (Campbell, 2008; Resnick et al., 2000; Tjaden & Thoennes, 2000), and remain low even when studies have only considered women who reported that they were injured during the SA. For example, one study found that only 36 percent of women who reported being injured during the SA received subsequent medical treatment (Tjaden & Thoennes, 2000). Studies suggest that trends among college students are consistent with those of the general population (e.g. Kilpatrick et al., 2007; Krebs et al., 2007).

Mental Health Resources

Mental health resources for SA generally provide individual and/or group counseling to help SA survivors cope with the psychological sequelae stemming from the assault. Mental health resources may include community clinics, campus counseling

centers, private practices, and advocacy services when individual and/or group counseling is provided (Campbell, 2008). Studies indicate that while SA survivors may seek such resources, they often delay until months or years after the assault, and that even then they may not raise the issue of SA victimization specifically (e.g. Symes, 2000; see Ullman, 2007 for a review). Because of these issues, estimates of mental health service seeking vary widely (from approximately 16 to 60 percent; Campbell, 2008; Ullman, 2007). Studies that have focused on college students have reported rates of mental health service seeking among SA survivors that are consistent with those found in the general population (Kilpatrick et al., 2007; Krebs et al., 2007).

Advocacy Services

Advocacy services such as rape crisis centers provide a variety of services for SA survivors including immediate crisis intervention, individual counseling, support groups, and advocacy for working with medical and legal resources (Patterson et al., 2009). Like other formal resources for SA, a minority of survivors (between 4 and 22 percent; Kilpatrick et al., 2007; Ullman, 2007; Zweig & Burt, 2003) use these services. Studies of college SA survivors report rates consistent with those found in the general population (Kilpatrick et al., 2007).

Overall, the broader body of research on formal helpseeking clearly demonstrates that these resources are underutilized by SA survivors in the general population. While research across various types of formal resources has found that approximately 14-43 percent of SA survivors seek some type of formal help, it is also clear that the utilization

of individual types of resources may be substantially lower (Campbell, 2008; Kilpatrick et al., 2007; Ullman, 2007). The small amount of research on helpseeking among college SA survivors suggests that rates of helpseeking are similar to or lower than those in the general population. In order to maximize the likelihood that SA survivors needing help get it, the field needs a better understanding of why SA survivors do and do not seek help from the various resources available to them. The following sections will review the literature on determinants of helpseeking, highlighting gaps in the existing research.

Determinants of Helpseeking

The literature on helpseeking for SA has tended to dichotomize SA survivors into helpseekers and non-helpseekers and to examine correlates that differentiate between these two groups, the experiences of helpseekers, or barriers to helpseeking among non-helpseekers. Findings from this literature suggest that some SA survivors consider risks and rewards when deciding whether to seek help (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007). However, other SA survivors disclose the assault because of situational factors, such as others being present at the scene of the SA, rather than a conscious decision-making process. (Ahrens et al., 2007). Nonetheless, these situational factors may also result in receiving formal help (Ahrens et al., 2007). SA survivors may also seek help at multiple times and from multiple resources (Symes, 2000; Zweig & Burt, 2003; Kennedy, Adams, Bybee, Campbell, Kubiak, & Sullivan, 2013). These factors suggest that helpseeking decisions are more complex than researchers have conceptualized them in the literature thus far, a suggestion also made by Kennedy and her colleagues (2012) in their recently proposed heuristic model which focuses on placing helpseeking within cultural contexts. It is unclear from the research thus far how the college context may affect decisions about seeking help for SA.

The violence against women literature has used ecological models to explore interconnections between individuals and their communities with regard to prevention, treatment, and the impact of SA (Campbell et al., 2009). In this section, I will examine the SA helpseeking literature using an ecological model to consider how various ecological levels influence the helpseeking decisions of SA survivors. More specifically, I will consider how cultural context, formal resources, interpersonal relationships, and individual factors may affect helpseeking decisions (Figure 1).

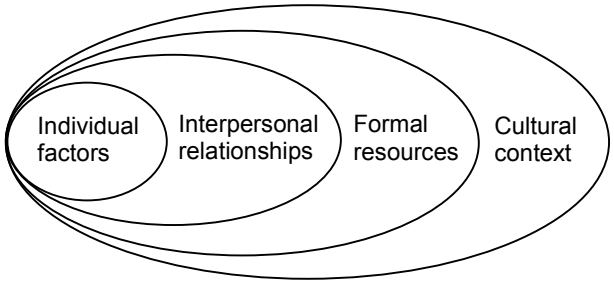

Figure 1: *An ecological model of helpseeking*

Cultural Context

Cultural beliefs and attitudes regarding SA provide the context in which people at all other levels of the ecological model think about and respond to SA. Since both SA and helpseeking for SA occur within this context, cultural beliefs affect the helpseeking decisions of SA survivors (Kennedy et al., 2012). Confusingly, U.S. culture simultaneously acknowledges and denies SA (Ullman, 2010). American society publicly

acknowledges that SA is wrong, however, the actual response to SA and SA survivors effectively condones it by treating survivors whose experiences are inconsistent with stereotypes of rape as "illegitimate" (Ullman, 2010). Most research on the larger cultural messages about SA has focused on the acceptance of rape myths (Campbell et al., 2009; Harned, 2005; Lonsway & Fitzgerald, 1994). This section defines rape myths, summarizes the research on rape myth acceptance, describes cultural factors specific to college communities, and summarizes what is known about how ethnicity may influence helpseeking. Later sections will clarify how the acceptance of rape myths affects helpseeking for SA at other levels of the ecological model and will identify areas where more research is needed.

Rape myths and rape myth acceptance as a component of culture. Researchers have defined rape myths as "attitudes and beliefs that are generally false but are widely and persistently held, and that serve to deny and justify male sexual aggression against women" (Lonsway & Fitzgerald, 1994, p. 134). Examples of rape myths include what has been called the "classic" or stereotypical rape (i.e. by a stranger, in an unfamiliar place, and using a weapon and/or resulting in significant physical harm), the belief that women routinely lie about SA, and the belief that only "bad" women are raped (Fisher, Daigle, Cullen, & Turner, 2003; Harned, 2005, Lonsway & Fitzgerald, 1994). Researchers have argued that such myths about SA function as a way for individuals and society to avoid confronting reality about the effects and extent of SA (Lonsway & Fitzgerald, 1994). They also allow people to believe that the world is a just place where bad things only happen to bad people (the "just world phenomenon;"

Lonsway & Fitzgerald, 1994). Rape myths achieve this function by minimizing and/or denying the SA and shifting the blame from the offender to the victim. For example, people might tell a SA survivor that what she experienced was not really rape (i.e. because it does not fit the stereotype) or that she should have expected the SA because she put herself in certain circumstances (i.e. that she behaved like a "bad" woman; Cook, 1995; Lonsway & Fitzgerald, 1994; Ullman, 2000).

Numerous studies on rape myth acceptance demonstrate that these myths are prevalent in the American culture and that they influence the ways that people think about and respond to SA and SA survivors (Campbell et al., 2009; Franiuk, Seefelt, Ceptess, & Vandello, 2008; Lonsway & Fitzgerald, 1994; Ryan, 2011). The prominence of rape myths produces a negative cultural context for those who experience SA and therefore acts as a barrier to helpseeking by discouraging SA survivors from identifying their experiences as SA or victimization. I will discuss more specific ways that rape myth acceptance may affect helpseeking at each level of the ecological model in the relevant sections. However, it is also important to recognize that SA and helpseeking may occur in the context of multiple, overlapping communities or sub-cultures within the larger cultural context. For example, college SA survivors from an ethnic minority may be influenced by the broader American culture, the cultural context of college, and their own ethnic community.

The cultural context of college.

Attitudes and beliefs of college students. In a recent review on college women's SA experiences, Adams-Curtis and Forbes (2004) eloquently described the college context:

> The college experience juxtaposes the powerful motives of sex and aggression in a population that is still forming a stable identity within an environment that includes strong peer pressures for sexual activity, the ritualistic abuse of alcohol, a culture that objectifies women, and a culture that frequently views sexual intercourse as an act of masculine conquest" (p. 91-92).

Recognizing this, many colleges provide education and prevention programs that target SA (Daigle et al., 2009; Karjane et al., 2002; McMahon & Banyard, 2012). Unfortunately, a recent review article found that while most of these programs achieve their goals of increasing knowledge and improving attitudes about SA, they do not produce long or lasting reductions in SA rates (Daigle et al., 2009). One study that may help to shed light on these findings considered college students' perceptions of both the acceptability and the expectation of male sexual aggression against women (Cook, 1995).

Cook (1995) argued that the acceptance of sexual aggression and the expectation of sexual aggression are separate but related concepts that may both result in blaming the victim for SA. In this study, 546 college participants completed measures that asked them to indicate the extent to which sexual aggression was acceptable or should be expected in common situations. The author found that participants generally did not find sexual aggression to be acceptable except in the following three situations: when the woman

says yes to sex and then changes her mind, when the woman has "led him on," and when the couple has had sex previously. Cook (1995) also found that participants expected sexual aggression to occur in a variety of dating situations. These included situations that have been identified in other research as risk factors for SA (e.g. when there is heavy alcohol/drug use) and when participants perceived "miscommunications" about sex to occur (e.g. when the woman asks the man out or agrees to go to his apartment). Overall, the study found that 25 percent or more of the participants expected sexual aggression to occur in more than 70 percent of the situations presented to them. Nearly 36 percent of participants expected the use of force when a woman consents to intercourse then changes her mind. Based on these findings, the author argues that students make separate judgments about whether SA is acceptable or expected in various situations and both judgments may have significant implications for SA helpseeking. For example, if someone "should expect" SA to occur in a particular situation and it does, it may not seem worth reporting, even if the survivor does not find it acceptable. This type of nuance is one example of how the college context may affect helpseeking for SA, but more research is needed to understand various contextual influences on helpseeking decisions. Another important aspect of the college context is the frequent use of alcohol/drugs and how the use of these substances may affect helpseeking decisions.

Alcohol/drugs. Alcohol and drug use are common on college campuses and are associated with both increased rates of SA and decreased rates of helpseeking for SA (Fisher et al., 2003; Kilpatrick et al., 2007; Krebs et al., 2007; Tjaden & Thoennes, 2006; Weschler et al., 2000). One study found that alcohol/drugs were used in 70 percent of the

SA incidents described by SA survivors (Fisher et al., 2003). More specifically, the authors found that SA offenders used alcohol/drugs in 68.6% of the incidents, SA survivors in 43.2 percent of the incidents, and both the offender and the survivor used alcohol/drugs in 41.7 percent of the SA incidents. However, researchers have focused primarily on the intoxication of SA survivors themselves when considering the role that alcohol/drugs play in helpseeking (e.g. Kilpatrick et al., 2007; Krebs et al., 2007). Within this literature, researchers have distinguished between SAs that occur when an offender deliberately gives the survivor drugs without her permission or purposely gets the survivor drunk to obtain nonconsensual sex (Alcohol or Drug Facilitated SA) and SA that occurs after the SA survivor voluntarily becomes intoxicated (Alcohol or Drug Enabled SA; Krebs et al., 2007). The distinction between these reasons for intoxication may have important implications for helpseeking. Unfortunately, despite the distinctions made when gathering data, both of the large-scale studies that focused on helpseeking implications of the SA survivor's intoxication combined these two categories for their statistical analysis (Kilpatrick et al., 2007; Krebs et al., 2007). Nonetheless, both studies found that SA survivors were significantly less likely to seek help from law enforcement if alcohol/drugs were involved in the SA.

Researchers have proposed several reasons why survivors of SA that involved alcohol/drugs may be less likely to seek formal help. First, some authors have argued that alcohol/drug use are a prominent part of college life for many college students, even if they are under the legal drinking age or their colleges have policies prohibiting alcohol/drugs (Fisher et al., 2003; Karjane et al., 2002). SA survivors may therefore fear

getting themselves or their friends in trouble for the use of these substances. Supporting this assertion, one study noted that 21.4 percent of the SA survivors in their study reported using alcohol at the time of the SA incident while being younger than the legal drinking age (Fisher et al., 2003). A second reason that survivors of SA involving alcohol/drugs may be less likely to seek formal help is that they may be even less clear about whether a crime was committed or whether the incident was serious enough to report compared to survivors of forced SA (Kilpatrick et al., 2007; Krebs et al., 2007). Finally, some authors have suggested that SA survivors are even more concerned that support providers will not believe them or will blame the survivor for the assault if they were intoxicated when it occurred (Fisher et al., 2003). While researchers have proposed these explanations, no studies were found that actually asked college SA survivors how their intoxication affected their decisions about whether and where to seek formal help for the assault.

The cultural context of ethnicity. Being a member of an ethnic minority adds an additional cultural context for SA helpseeking. Numerous studies have found that women from ethnic minorities are less likely to seek help for SA than White women are, particularly from formal service providers (Alvidrez, Shumway, Morazes, & Boccellari, 2011; Amtadter, McCauley, Ruggiero, Resnick, & Kilpatrick, 2008; Lonsway & Fitzgerald, 1994; Ullman, 2007). These findings are consistent with the broader literature on ethnicity and helpseeking, especially for mental health problems (for reviews see Cauce et al., 2002; Leong, Wagner, & Tate, 1995). This broader literature suggests that cultures may vary in how problems are perceived and conceptions of what should be

done to cope, including whether help should be sought (e.g. Cauce et al., 2002; Holcomb-McCoy, 2000; Leong et al., 1995).

For example, in different ethnic groups, a mental health problem such as depression may be more likely to be identified primarily as a practical problem (e.g. reduced academic performance), an emotional problem (e.g. feeling "sad"), or even a physical problem (e.g. somatization such as stomach aches; Cauce et al., 2002; Holcomb et al., 2000; Leong et al., 1995). How the problem is perceived then subsequently affects conceptions of what to do about the problem. For SA survivors, such differences may therefore significantly affect how they view and cope with post-assault sequelae.

In addition to differences in how they initially perceive problems, the general helpseeking literature has found that ethnic groups differ in beliefs about the best way to handle problems (Cauce et al., 2002). For example, researchers have found that some Asian American groups believe that it is best to avoid thinking about upsetting thoughts or events (Cauce et al., 2002). Similarly, researchers have found that African Americans are more likely to believe the best coping method is to use self reliance and will power to overcome the problem (Cauce et al., 2002; Matthews, Corrigan, Smith, & Aranda, 2006). Stigma about a particular type of problem within an ethnic community can also negatively affect helpseeking (Leong et al., 1995; Matthews et al., 2006). For example, studies have found that Latino communities may view mental illness as a problem caused by a weak character and helpseeking for mental illness as a disgrace (Leong et al., 1995).

There are consistent findings throughout the helpseeking literature that individuals from ethnic minority groups are more likely to seek help from informal,

rather than formal, resources, though the reasons for this preference vary (Cauce et al., 2002; Holcomb-McCoy, 2000; Leong et al., 1995; Matthews et al., 2006). Numerous studies have found that African Americans tend to be distrustful of mainstream social institutions such as mental health clinics and hospitals and suggest that this is due to a significant history of institutional and societal racism (Leong et al., 1995; Matthews et al., 2006). Many Asian American communities view seeking help from formal resources as a source of shame or "loss of face", which researchers suggest stems from a cultural emphasis on collectivism rather than individualism (Cauce et al., 2002; Leong et al., 1995). Numerous other cultural factors such as language barriers and fears about the cultural competency of the help provider can also reduce the likelihood that an individual from an ethnic minority will seek help (Cauce et al., 2002; Leong et al., 1995).

In the case of SA, it is important to consider possible ethnic differences in the perception of both post-assault sequelae and the SA itself. Much like cultural examinations regarding SA in the broader American culture, a significant amount of research has focused on attitudes toward SA survivors and the acceptance of rape myths within various ethnic communities as they attempt to understand this trend (Lefley, Scott, Llabre, & Hicks, 1993; Lonsway & Fitzgerald, 1994l Ullman 2007). Overall, this research has yielded mixed results (Campbell et al., 2001; Lonsway & Fitzgerald, 1994; Ullman, 2007). While some studies have found that SA survivors from ethnic minorities were more likely to report negative reactions from their communities and/or formal services than white SA survivors were, other studies have found no effects based on ethnicity (e.g. Campbell et al., 2001; Ullman 2007; Ullman & Filipas, 2001b). However,

numerous studies have found that rape myth acceptance is correlated with an increased acceptance of traditional sex roles and negative attitudes toward women (e.g. Lefley et al., 1993; Lonsway & Fitzgerald, 1994). This finding suggests that ethnic groups with stronger beliefs in traditional sex roles are more likely to adhere to rape myths that blame many SA survivors for their own victimization, and this stigma is likely to reduce helpseeking. Thus far, however, research has not directly investigated how these cultural attitudes toward women and sexual assault influence decisions about seeking help for SA, particularly within a college context.

Formal Resources

Formal resources for SA exist within the cultural context but at a broader level in the ecological model than interpersonal relationships or individual factors. Formal service providers may accept rape myths to varying degrees, which likely affect how these service providers respond to SA survivors who seek help. SA survivors who expect formal service providers to treat them poorly are unlikely to seek services related to the assault. Furthermore, if SA survivors do seek help from formal resources and actually experience rejection, disbelief, or poor treatment, they may be less likely to seek help from other formal resources in the future. Since the research on formal helpseeking has generally divided SA survivors according to whether they sought help (i.e. helpseekers and non-helpseekers), I will examine this literature in three parts. The first section focuses on SA survivors who have not sought help and how their expectations about formal service providers act as a barrier to seeking help. The second section focuses on

SA survivors who have sought help and how their experiences with formal service providers may influence future decisions about seeking help. The third section examines expectations and experiences of college students in particular with regard to helpseeking for SA.

Expectations about formal service providers. In their study of SA survivors who did not seek help, Patterson and her colleagues (2009) found that many SA survivors were afraid that formal service providers would not believe them, not help them, or directly mistreat them, particularly if their experiences of SA did not adhere to the classic rape scenario. In other words, SA survivors are afraid that formal service providers adhere to rape myths in a way that is consistent with the larger culture. SA survivors also reported that they feared formal service providers would only assist them if they sought help immediately after the SA occurred and were clearly in crisis (Patterson et al., 2009). Again, this fear is consistent with the minimizing effect of rape myths and suggests that if the SA survivor is not in crisis then the SA was not severe enough to warrant help.

Some of the SA survivors in this study reported that they did not seek help from formal service providers because they were afraid that interactions with these providers would prolong painful feelings about the SA and hinder their recovery (Patterson et al., 2009). These SA survivors were often concerned that service providers would "grill" them about the SA, meaning that the service provider would require the survivor to discuss the rape in detail and answer numerous, invasive questions (Patterson et al., 2009). Some SA survivors were also afraid that medical or social services would automatically contact or force them to contact additional agencies such as law

enforcement. These SA survivors therefore perceived seeking help through any formal resource as overly risky (Patterson et al., 2009). These types of concerns allude to the complex nature of seeking help after SA, but the literature on barriers to helpseeking has tended to view helpseeking as a single yes/no decision rather than a series of multiple decisions not to seek help from a variety of resources. This literature also stops short of asking SA survivors how they assess their own needs and whether or how formal resources could address these needs.

Experiences with formal service providers. Many SA survivors do not seek help due to fear that formal service providers will mistreat them (Patterson et al., 2009). SA survivors may have obtained these fears from their own previous experiences with various social services or from hearing about the experiences of others (Patterson et al., 2009). In fact, research clearly indicates that many SA survivors experience secondary victimization from their interactions with various service providers and these experiences may hinder future helpseeking (e.g. Ranjbar & Speer, 2013). A recent review article reported that 80 percent of SA survivors were reluctant to seek further help because of their experiences with legal or medical resources (Campbell, 2008). Campbell (2008) argued that formal service providers often do not treat all SA survivors or all SAs equally and stated that myths about what constitutes "real" rape persist among formal service providers. She illustrated this point by describing how police design investigations to weed out SA cases by actively discouraging SA survivors from pursuing prosecution and graphically portraying the personal costs for the survivor (e.g. repeated questioning, multiple trips to court, humiliating cross-examination). Thus, SA survivors' fears that

they will be "grilled" about the assault are justified. Campbell (2008) asserts that successful prosecution is not random and is significantly more likely when the SA survivor is from a privileged background and the SA adheres to the stereotypical rape scenario.

While research has shown that SA survivors may have negative experiences with some service providers, the literature also indicates that such experiences are likely to vary by the type of resource utilized. In one study, Campbell and her colleagues (2001) asked SA survivors whether they felt their experiences with various formal service providers were overall healing, hurtful, or neither. They found that advocacy services were described as the most healing (75 percent of those who used this type of service) followed by mental health resources (70 percent), medical resources (47 percent), and legal resources (35 percent). On the other hand, some of the women found that these same resources were hurtful. Their findings were consistent with other research that has found legal resources to be the most hurtful (52 percent) followed by medical (29 percent). SA survivors indicated that mental health and advocacy services were the least hurtful (25 percent and 12 percent respectively).

Understanding SA survivors' experiences with formal service providers is an important aspect of understanding future helpseeking decisions. Nonetheless, it is still unclear from this research whether the SA survivors who were mistreated by formal service providers actually avoided further help from formal resources. For instance, it is unclear whether a SA survivor who was treated badly by police would also avoid

counseling services in the future. It is also unclear from this literature how the college context might affect such decisions.

Formal services and the college context. Research specifically focused on college SA survivors' expectations and experiences with formal services has been limited. In accordance with the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act (the Clery Act), colleges that receive federal aid from the Department of Education are required to publish information about SA resources both on-campus and in the surrounding community (Fisher et al., 1998; Karjane, et al., 2002; Sokolow, 2000). They are required to publish information about students' options for notifying proper law enforcement and the availability of other formal resources for SA. Following the enactment of the Clery Act, Congress also mandated a study of colleges' response to SA and their compliance with the Clery Act (Karjane et al., 2002). The study found that colleges vary widely in their compliance in that only 60 percent of the colleges studied provided a written SA policy at all and, among those, only 45 percent included statements regarding the legal and disciplinary options available to student SA survivors. The study also found that only 58 percent of the colleges surveyed provided students with written information about the availability of other resources for student SA survivors on-campus and in the surrounding community (Karjane et al., 2002).

Some researchers have argued that this lack of information from colleges may not only fail to encourage students to seek help from formal resources, but it may also provide students with a subtle message that the college is unsupportive of SA survivors (Fisher et al., 2003; Karjane et al., 2002). In this way, student SA survivors who have not

yet sought help may expect negative reactions from service providers that are similar to the expectations described from research within the general population. However, recent research also suggests that student SA survivors who do seek help from their colleges often encounter active mistreatment from college officials (Jones, 2009). A recent study conducted by the Center for Public Integrity reported that students who attempt to seek help for SA from college officials often encountered a process that they found intimidating, unsympathetic, and unlikely to result in punishment of the offender (Jones, 2009; Ravitz, 2009). Thus, student SA survivors who seek help from college officials appear to report experiences that are most consistent with those of SA survivors who seek help from law enforcement. It is important to note that this particular study was conducted through an organization focused on investigative journalism and may therefore be more biased than a peer-reviewed research publication. Unfortunately, a peer-reviewed study on student SA survivors' experiences with college officials was not available. Furthermore, the extent to which student SA survivors seek help from college officials or from on-campus resources versus community resources remains unclear. It is also unclear from literature why student SA survivors may choose on- or off-campus resources.

Interpersonal Relationships

Interpersonal relationships such as those with family and friends provide another important context for decisions about seeking help for SA within the ecological model. The tendency of SA survivors to turn to informal resources such as family and friends for

support suggests that the reactions of these support providers may play an important role in SA survivors' decisions about seeking help from formal resources. While SA survivors may expect positive support from these relationships, the effect of disclosing to family and friends may be somewhat more complex than it first appears. For instance, these support providers may feel hurt by the knowledge that a loved one experienced SA (Ahrens, Cabral, & Abeling, 2009). When this happens, the SA survivor may feel guilty for causing the support provider pain by disclosing the SA (Ahrens et al., 2009). Family and friends may also react in a number of negative ways such as treating the survivor differently after learning about the SA, trying to make decisions for the survivor, or even blaming the survivor for the SA. Furthermore, since most SAs are committed by someone the survivor already knows, family and friends may also know the offender and have difficulty believing that this person could or would commit SA (Ahrens et al., 2007). Overall, the research on informal support providers suggests that negative reactions from family/friends can have a profound negative impact on the SA survivor and, having received negative reactions from those closest to them, the survivor may be less likely to seek help from other resources (Campbell, 2008; Ullman, 1999, Ullman et al., 2008). However, it is unclear from this research whether SA survivors consciously incorporate the negative reactions of family and friends into their decisions about seeking help from formal resources. Research has also suggested that positive reactions may have limited effect on SA survivors and that negative reactions may trump positive ones (Ahrens et al., 2009; Ullman & Filipas 2001a; Ullman & Filipas 2001b). One recent study on adolescent SA survivors does suggest that positive reactions from peer and family systems can

positively impact survivors' willingness to see formal help, though it is unclear to what extent these findings apply to college and other adult SA survivors (Fehler-Cabral & Campbell, 2013).

The SA offender. Another important interpersonal relationship with regard to formal helpseeking for SA is the relationship between the SA survivor and the offender. The SA survivor-offender relationship is one of the most widely researched aspects of SA helpseeking, particularly with regard to reporting to law enforcement (Fisher et al., 2003). This relationship can range from strangers to intimate partners, with other types of acquaintances such as classmates, friends, and coworkers falling in between (Fisher et al., 2003; Kilpatrick et al., 2007; Koss, Dinero, Seibel, & Cox, 1988; Tjaden & Thoennes, 2006). However, research has found that more than 83 percent of SAs are committed by someone the SA survivor already knows, and this trend is particularly apparent in college samples (Fisher et al., 2003; Kilpatrick et al., 2007; Koss et al., 1988; Tjaden & Thoennes, 2006). In their study of college women, Fisher and her colleagues (2000) found that approximately nine out of 10 SA survivors knew the offender and these offenders were most often a boyfriend, ex-boyfriend, classmate, friend, or other acquaintance.

In general, SA survivors are less likely to seek formal help for the assault as their relationship to the offender becomes more intimate (Fisher et al., 2003). Ullman and Filipas (2001a) found that 78 percent of women who were assaulted by strangers disclosed the SA to formal help resources compared to 58 percent of women who were assaulted by men they knew. Other studies have similarly found that women who are

assaulted by acquaintances are less likely to receive medical care (Resnick et al., 2000), crisis intervention (Koss et al., 1988), or to report the incident to police (Fisher et al., 2003; Kilpatrick et al., 2007; Koss et al., 1988).

The negative correlation between formal helpseeking and the SA survivor-offender relationship is connected to other interpersonal relationships and to other levels within the ecological model. Numerous studies have found that SA survivors often indicate fear that the perpetrator will seek retaliation as a primary reason for not seeking help, particularly from law enforcement (e.g. Bachman, 1998; Krebs et al., 2007; Patterson et al., 2009; Tjaden & Thoennes, 2006). More specifically, SA survivors report that they are afraid the SA offender or his family/friends will kill or hurt them or their family/friends if they seek formal help and that formal resources such as law enforcement will not be able to protect them from this retaliation (Patterson et al., 2009). Even when retaliation is not a primary fear, however, the SA survivor-offender relationship may significantly affect helpseeking decisions due to the larger cultural context of rape myths. Being assaulted by an acquaintance diverts from the classic rape scenario and is likely to increase the likelihood of negative reactions from other interpersonal relationships and from formal resource providers. What is not clear in the literature is how the survivor-offender relationship affects helpseeking decisions among college SA survivors compared to those in the general population and whether the relationship influences decisions about turning to on-campus or community resources.

Individual factors

SA survivors, like those around them, may have positive or negative feelings about themselves after experiencing SA. Rape myths also provide overarching themes for the types of negative reactions that SA survivors have; after all, SA survivors live in the same social climate in which the SA occurred (Harned, 2005). Three overarching concepts have emerged from the SA literature regarding SA survivors' reactions to SA that are consistent with the functions of rape myths: perceptions of severity, labeling the SA as victimization and self-blame.

Perceptions of severity. Correlational research has found that SA survivors with more physical injuries and higher levels of psychological distress are more likely to seek help (Fisher et al., 2003; Ullman et al., 2008; Ullman & Filipas., 2001a). SA survivors are also more likely to seek help if the offender used weapons, threats of force, or actual force during the assault (Fisher et al., 2003; Kilpatrick et al., 2007; Resnick et al., 2000). Conversely, SA survivors are significantly less likely to report the SA to police or to seek other forms of formal help if they do not perceive the assault to be "serious enough" (Fisher et al., 2003; Kilpatrick et al., 2007; Tjaden & Thoennes, 2006). For example, one study found that SA survivors endorsed the reason that the incident was "not serious enough" to report to police in eight out of ten incidents of SA (Fisher et al., 2003). Another study found that SA survivors said they would have sought help if their SA had been more violent and resulted in more visible injuries (Patterson et al., 2009).

SA survivors may also believe that their psychological distress is not serious enough to warrant help from formal resources. In interviews with 29 SA survivors who

did not seek formal help, Patterson and her colleagues (2009) found that participants perceived that "serious" SA results in having a "nervous breakdown" or being "emotionally scarred" from the experience. What is clear from this research is that SA survivors may endure soreness, internal pain, and psychological distress while falsely believing that these injuries are not "serious enough" to receive help from formal resources (Patterson et al., 2009). It is unclear whether college SA survivors hold similar perceptions about the severity of the assault and how this might affect their decisions about using on-campus or community resources.

Labeling the SA as victimization. One of the major goals of the women's movement has been to empower women to label their unwanted sexual experiences as sexual abuse or assault, thereby challenging rape myths and recognizing the seriousness of their victimization (Harned, 2005). Despite decades of this movement, research continues to indicate that more than 60 percent of the women whose experiences meet legal definitions of sexual abuse or assault do not label their experiences as victimization (Bondurant, 2001; Harned, 2005; Littleton & Henderson, 2009). Most studies on SA labeling have found that women are less likely to label their SA experiences as victimization (e.g. rape, attempted rape, some other type of crime) as their experiences differ from the classic rape scenario, particularly when the SA is less violent (Bondurant, 2001; Littleton & Henderson, 2009). Studies on labeling SA as victimization have also noted that the responses of many participants who do not label are indicative of their attempts to minimize their experience. For example, participants may indicate that their experiences were miscommunications, were not a big deal, that they did not seriously

harm the participant, or that their experiences were typical of dating behavior (Harned, 2005; Littleton & Henderson, 2009). In this way, SA survivors demonstrate their own acceptance of rape myths.

There is limited research that specifically examines the relationship between labeling unwanted sexual experiences as victimization and helpseeking. One study reported a correlation between participants who labeled their experiences as victimization and an increased likelihood of seeking help from formal resources compared to participants who did not label their experiences as victimization (Littleton & Henderson, 2009). Specifically, the study found that 36.3 percent of participants who labeled their experiences as victimization sought help from formal resources compared to 9.6 percent of those who did not label as victimization. Based on this research, it appears that labeling SA experiences as victimization and helpseeking may occur simultaneously and influence one another as SA survivors work towards recovery. Regrettably, the literature on labeling SA experiences and the literature on helpseeking for SA are not yet integrated. It would seem that not labeling SA as victimization would act as a barrier to seeking help from those formal resources that depend on identification as a victim. In particular, not labeling SA as a crime would seem to prohibit helpseeking from law enforcement and to hinder helpseeking from organizations specifically focused on providing services for SA (e.g. rape crisis center). Additional research might also investigate how changes in the way a SA survivor labels her experience may subsequently affect helpseeking behaviors.

Self-blame. Numerous studies have found that SA survivors often blame themselves for their own victimization and higher levels of self-blame are associated with decreased rates of helpseeking (Campbell et al., 2009). In a recent review article, Campbell and her colleagues (2009) argue that self-blame is actually a meta-construct that is influenced by both internal and external forces and is generally associated with increased symptoms of PTSD and depression. While some studies have differentiated between types of self-blame (e.g. blaming one's character versus blaming one's behavior), research on these distinctions has produced inconsistent results. Nonetheless, it is clear that self-blame can be generated or intensified by negative reactions from others including both informal and formal support providers (Campbell et al., 2009).

Self-blame can also be generated by internal interpretations of the SA. For example, one study found that SA survivors often consider their own level of responsibility when deciding how to label their experiences (Harned, 2005). Harned (2005) found that SA survivors who did not label their experiences as victimization often blamed themselves for not resisting enough, not adequately expressing non-consent, or eventually giving in to sex due to pressure from the offender. On one hand, when alcohol was involved, those who did not label their experiences as victimization viewed their own intoxication as evidence that they were to blame for their experience. On the other hand, those who labeled their experiences as victimization viewed being excessively intoxicated as diminishing their capacity to give knowing consent. These types of studies help researchers to understand how self-blame can be generated or intensified through internal or external reactions to SA and suggest subsequent increases in the negative

psychological effects of SA. This research has also found negative correlations between self-blame and helpseeking. What is not clear is how self-blame might fit into actual decision-making regarding formal helpseeking.

Summary of the Helpseeking Literature

The literature on SA and helpseeking suggests that while some SA survivors may consciously consider risks and rewards when deciding whether to seek help, other SA survivors may not use such conscious, rationale-focused, goal oriented methods to make helpseeking decisions (Ahrens et al., 2007). The literature also indicates that SA survivors may seek help from multiple resources at various points in time after the SA (Zweig & Burt, 2003; Symes, 2000). These findings suggest that SA helpseeking decisions are more complex than they have been portrayed thus far in the literature. A social-ecological view of helpseeking also helps to demonstrate this complexity.

Cultural attitudes toward SA provide a context in which helpseeking decisions occur, and these attitudes permeate all other levels of the social-ecological system. Research on dominant cultural beliefs about SA have found that rape myths continue to be commonly accepted in American culture and these myths produce a negative context for SA survivors and helpseeking (Campbell et al., 2009; Franiuk et al., 2008; Lonsway & Fitzgerald, 1994; Ullman, 2010). Differences among ethnic groups in rape myth acceptance, perceptions of SA sequelae, and the best way to cope with these problems can further complicate helpseeking decisions for SA survivors and influence the likelihood that they will seek formal help (Campbell et al., 2001; Cauce et al., 2002;

Lonsway & Fitzgerald, 1994; Ullman, 2007). Rape myth acceptance also appears to be common on college campuses (Adams-Curtis & Forbes, 2004; Cook, 1995). The role of alcohol and helpseeking for SA requires further investigation, especially among the college population for whom alcohol use/abuse is a common cultural component and likely a frequent factor in SA (Fisher et al., 2003; Kilpatrick et al., 2007; McCauley et al., 2010; Ullman, 2003).

The pervasiveness of rape myths can significantly affect SA survivors' interactions with both formal and informal resources as well as how the survivor views herself. Rape myth acceptance among some service providers negatively affects how they treat SA survivors and can result in secondary victimization (Campbell, 2008). For SA survivors, expectations that they will be treated poorly acts as a significant barrier to seeking help. These expectations may be based on broader cultural perceptions about how people will respond to SA disclosure, information gleaned from hearing of others' experiences, or direct negative experiences with service providers in the past (Patterson et al., 2009). Although there is some indication that negative experiences with formal resources result in SA survivors expressing reluctance to seek further help (Campbell, 2008), it remains unclear in the literature thus far how positive or negative experiences with one type of service provider actually affect expectations of and interactions with other types of resources.

After experiencing SA, many survivors initially turn to family and friends for support (Ahrens et al., 2009). The reactions of these informal support providers can have profound effects on recovery and may affect the likelihood that the survivor will seek

help from formal resources (Ahrens et al., 2009; Ullman et al., 2008). Reactions from informal support providers may be complicated due to factors such as rape myth acceptance, the support providers own emotional reaction (e.g. feeling upset that a loved one experienced SA; Ahrens et al., 2007), and whether a prior relationship existed between the survivor and the offender. Studies have consistently found the majority of SAs are committed by someone the survivor already knows, which increases the likelihood that both she and others will blame her for her own SA (Fisher et al., 2003; Harned, 2005).

It is also clear from the literature that the acceptance of rape myths can significantly affect SA survivors' own perceptions. Studies have consistently found that SA survivors are less likely to label their experience as SA/victimization, less likely to seek help, and more likely to blame themselves for their SA as their experience moves away from the classic rape scenario (Campbell et al., 2009; Fisher et al., 2003; Harned, 2005; Littleton & Henderson, 2009).

In summary, the research on formal helpseeking for SA thus far has helped to clarify some factors that affect the likelihood of seeking help and a number of barriers to helpseeking. This review also suggests that the primary barrier to helpseeking is the extent of rape myth acceptance at various social-ecological levels. However, significantly less research currently exists regarding why SA survivors actually do seek help and how they arrive at these decisions, particularly in the context of multiple available resources. This research has also left significant gaps in the understanding of how college students

make sense of the variety of on- and off-campus resources and how they make decisions about where to turn.

The Current Study

The literature has clearly established that SA is highly prevalent among the college population and that experiencing SA victimization can result in numerous immediate and long-term consequences for the survivor's physical and psychological health. While researchers have identified various risk factors for SA victimization in both the general population and among college students, it is unclear to what extent these risk factors truly differentiate between those who experience SA and those who do not. The high prevalence of this form of violence suggests that victim profiles are of limited use. Furthermore, most SAs are committed by someone the survivor knew prior to the assault and in the context of common aspects of college life.

The literature also demonstrates that numerous formal services are available to SA survivors but that a relatively low percentage of those who experience SA actually use these services. While the literature has considered possible barriers and correlates for helpseeking after SA, it has predominantly addressed helpseeking as a dichotomous variable (i.e. whether or not a survivor has sought help). Researchers have used this dichotomy to consider both overall helpseeking and whether or not survivors sought help from a particular type of resource (e.g. law enforcement). What has been missing is a broader consideration of SA survivors' decision making across multiple avenues of

formal help. In the case of college students, this may include factors in deciding whether to use campus or community resources as well as which type of resources to use. For example, why did a SA survivor decide to contact a counselor but not a rape crisis center? Why did a SA survivor decide to contact the rape crisis center on campus but a counselor in the community? This study used in-depth interviews with college survivors of SA and a grounded theory approach to develop a broader theory of helpseeking for SA among college students.

The inductive nature of grounded theory allowed the researcher to develop a better understanding of SA helpseeking decisions from the perspective of SA survivors themselves by considering factors that the survivors believed were most relevant to their process of making decisions about formal helpseeking. This included their perceptions of the SA itself, how the SA affected them, their needs after the SA, and how they went about considering and/or accessing formal resources. This approach also allowed the researcher to begin examining a fundamental assumption in the literature: that formal resources are underutilized. This assumption in the literature appears to be based on perceptions by researchers and service providers that (1) all SA survivors need services and (2) that the services available address their needs. There is certainly support for these perceptions in the literature. Once again, research has consistently found that high percentages of survivors experience significant physical and psychological consequences of the SA. It also appears that services can be beneficial, particularly mental health and advocacy services. However, the research thus far did not appear to have considered how survivors' own perceptions of their experiences, the consequences, and their needs may

drive their own helpseeking decisions. The current study aimed to gain insight into such factors.

Since a theory of SA helpseeking among college students was developed inductively from the data, no hypotheses were made for this study. However, based on the literature to date, the researcher expected that a number of themes were likely to emerge. These themes included the following: variation in the survivor's perceptions of blame for the SA based on the context of the SA and the survivor-offender relationship, variation in the survivor's perceptions of post-assault sequelae, variations in how the survivor labeled the SA, and variation in perceptions of and experiences with formal service providers. The researcher expected that how the survivors described these themes and other factors that the researcher did not anticipate would provide insight into the helpseeking process for college SA survivors.

Methods

Qualitative Research and Grounded Theory

One of the most important reasons for conducting qualitative research is the desire to see a phenomenon from the viewpoint of participants and to use this understanding to contribute to empirical knowledge (Corbin & Strauss, 2008). At their core, qualitative methodologies focus on learning about the meanings that people make of their experiences within the contexts that they are lived (Morrow, 2007; Yeh & Inman, 2007). Qualitative methods, such as grounded theory, are also particularly well suited for increasing empirical understanding about processes, such as decision-making (Morrow, 2007). A grounded theory approach was chosen for this study because the primary purpose was to develop a broader theory of college SA survivors' helpseeking decisions across multiple avenues of formal help.

Grounded theory is a qualitative research design where the researcher develops theory about actions, interactions, or processes based on or "grounded" in the data obtained from participants about their lived experiences (Creswell, Hansen, Plano, & Morales, 2007; Fassinger, 2005). The process of grounded theory is therefore inductive or working from the "ground" up as the researcher develops categories, themes, and eventually theory from this data. However, the process of grounded theory also involves

deductive testing of themes and categories as they emerge by comparing them to both new and existing data (i.e. within and between cases); a process called "constant comparison" (Corbin & Strauss, 2008; Fassinger, 2005, Morrow, 2007). Thus, grounded theory involves a concurrent process of data collection, coding, conceptualizing, and theorizing (Fassinger, 2005).

Procedures

Recruitment. Participants were initially recruited for this study through advertisements placed on bulletin boards at various locations on the GMU campus and distributed through email listservs for the GMU community. The advertisements stated that the researcher was looking for participants who have had "unwanted sexual experiences" since entering college to help improve researchers' understanding of the process students go through as they decide whether to talk to a professional for help. The term "unwanted sexual experiences" was chosen instead of terms like "rape" or "sexual assault experiences" because research indicates that more than 60 percent of women whose experiences meet legal definitions of SA do not label their experiences with these or similar terms (Bondurant, 2001; Harned, 2005; Littleton & Henderson, 2009). Nonetheless, research suggests that individuals can still experience the negative effects of SA whether or not they identify their experience as SA/victimization (Littleton & Henderson, 2009). A copy of the advertisements are included in Appendix A.

Screening measures. A website was created for the purposes of providing potential participants with additional information about the study and screening

participants to determine if they met selection criteria before they were asked to participate in a full interview. The website included a link to information about the primary investigator, a link to information about the primary investigator's advisor, and a link to a resource page for victims of SA. Interested participants completed an online questionnaire that assessed demographic information, their "unwanted sexual experiences," their emotional reactions, and whether they contacted professional services about these experiences. Questions about demographic information and whether participants contacted professional services about their "unwanted sexual experiences" were created specifically for this study (see Appendix B). Participants' "unwanted sexual experiences" were assessed by questions derived from commonly used research definitions of SA. Emotional reactions to these unwanted sexual experiences were assessed by the PTSD Symptom Scale Self Report (PSS-SR; Foa, Riggs, Dancu, & Rothbaum, 1993), which has been used to measure PTSD symptoms in numerous studies of SA (e.g. Littleton et al., 2009). A full copy of the proposed website content is included in Appendix B. After participants completed this online screening questionnaire, the researcher attempted to contact each participant to follow-up with her/him and/or to invite them to participate in a full interview.

Interviews. A semi-structured interview was developed based on a review of the literature and therefore included open-ended questions/probes related to various factors that have been correlated with helpseeking for SA, such as information about the SA itself and social support. However, interview questions focused primarily on participants' decisions about seeking formal help after experiencing SA. The interview consisted of

open-ended questions and probes with the purpose of identifying various formal resources from which participants considered seeking help and how they came to their decisions about whether or not to use these services. Open-ended questions are essential for qualitative research for the purposes of building rapport with participants and gaining rich information necessary to increase understanding of the unique aspects of the problem being studied (Corbin & Strauss, 2008). Participants received $20 for their participation in the interview. A copy of the interview is included in Appendix C.

Data Analysis

Data analysis was based on the grounded theory methods described by Corbin and Strauss (2008). The goal of this approach was to provide a thorough analysis of how college SA survivors came to decisions regarding formal helpseeking. A research team was trained to transcribe, code, and analyze data in accordance with these methods.

Research assistants transcribed interviews and checked each other's transcriptions for accuracy. The interviewer also reviewed the transcripts and settled any uncertainties. Transcripts were entered into Microsoft Word and Microsoft Excel (Microsoft Corporation, 2007) to be filed, organized, and analyzed. Word processing programs such as Microsoft Word have been found capable of coding, sorting, and retrieval functions that are typically found in qualitative data analysis software (La Pelle, 2004; Ryan, 2004).

Three types of coding occurred in the analytic process. First, the research team used open coding to identify concepts, themes, and possible alternative meanings within the data (Corbin & Strauss, 2008). As open coding progressed, the research team further

described concepts according to properties (i.e. characteristics that make it distinct) and dimensions (i.e. the position of the property along a continuum; Corbin & Strauss, 2008). The entire research team discussed discrepancies and settled them through consensus. In accordance with the methods proposed by Corbin and Strauss (2008), the research team compared incidences of a concept to new and existing data throughout analysis and continuously revised concepts to enhance understanding of the data, a process called "constant comparison" (Corbin & Strauss, 2008; Fassinger, 2005). The research team determined that saturation had been reached when additional concepts cease to emerge and at least 75 percent of the participants were represented by each of the main concepts.

As open coding proceeded, the research team identified broader relationships between concepts (key categories) in a process called axial coding (Corbin & Strauss, 2008). Saturation for this level of analysis was reached when no additional key categories emerged and all participants were represented in each key category.

In the final stage of analysis, the research team used selective coding to integrate the key categories into an overarching explanatory summation of the data (Corbin & Strauss, 2008). A single core concept of "Deciding Whether and Where to Seek Help" was used to describe participants' helpseeking decision process in accordance with the data and a model diagram was developed to describe the relationships between key categories and the core concept.

Participants

Grounded theory typically uses in-depth interviews with a small number of participants in order to gain a deeper understanding of a particular phenomenon or process. Seventeen potential participants initiated the online screening. Of these, one did not complete any of the screening questions after providing contact information and one completed the information but was ineligible for the interview due to reporting no unwanted sexual experiences. Neither of these participants responded to attempts to contact them. The 15 remaining participants were invited to participate in the interview portion of the study. Of these, 14 responded to contact attempts and completed the in-person interviews. One participant did not respond to contact attempts or schedule an interview.

Of the 14 participants who completed the in-person interviews, there were 13 women and one man. Participants ranged in age from 19 to 25 with a mean age of 21.29 and a median age of 21.50. They included one freshman, two sophomores, four juniors, four seniors, and three graduate students. When asked to self-identify their ethnic background, 11 identified as white/Caucasian, one as Hispanic, and two as multi-racial.

Trustworthiness

Recent literature suggests that, despite its increasing acceptance, there is subtle but ongoing concern in the research community that qualitative research is simply a collection of anecdotes and that it does not have a firm "scientific grounding" (Williams & Morrow, 2009, p. 576). Williams and Morrow (2009) argue that the validity, or

"trustworthiness," of the study is what differentiates qualitative research from anecdotes or even journalism. One factor that may contribute to the perception that qualitative research lacks a firm scientific grounding is the lack of consistent language for discussing standards of trustworthiness such as those used in quantitative research (e.g. validity, reliability, and generalizability). Using the same terms and standards as quantitative research generally does not make sense due to the vastly different processes, procedures, and epistemological underpinnings between these research traditions (Morrow, 2005; Ponterotto, 2005; Williams & Morrow, 2009). While standards of trustworthiness have been established for judging the rigor of qualitative research, these standards have often been discussed via numerous terms including validity, quality, rigor, credibility, as well as trustworthiness (Fassinger, 2005; Morrow, 2005; Williams & Morrow, 2009; Yeh & Inman, 2007). For the purposes of this study, I have chosen to address the methodological concerns of trustworthiness using the three major categories defined by Williams and Morrow (2009): integrity of the data, balance between participant meaning and researcher interpretation, and clear communication and application of the findings.

Integrity of the Data. Assuring the integrity of the data requires evidence that the data are of sufficient quality and quantity (Williams & Morrow, 2009). This is achieved by using multiple methods or "triangulation," reaching a point of redundancy or saturation in data collection, and adequate searches for disconfirming evidence.

Triangulation. According to Denzin and Lincoln (2000), triangulation is best understood as a strategy for adding rigor, breadth, and depth to a study. This term is often used to describe the use of multiple methods, data sources, investigators, and theories in

qualitative research (Denzin & Lincoln, 2000; Morrow, 2005). It reflects an attempt to secure an in-depth understanding of the phenomena being studied and the context of participants' experiences while reducing the risk of making chance associations in data analysis (Denzin & Lincoln, 2000; Yeh & Inman, 2007). In general, triangulation is using multiple methods to "check" the interpretation of the data and to add additional sources to the data corpus (Williams & Morrow, 2009). A variety of methods have been recognized as components of triangulation including those that were used in this study: a research team, memos, a self-reflective/analytic journal by the primary investigator, and follow-up contact with participants (Denzin & Lincoln, 2000; Fassinger, 2005; Morrow, 2005).

Research team. As Corbin and Strauss (2008) point out, different analysts may focus on different aspects of the data and/or arrive at different interpretations. Therefore, conducting analysis with a research team uses these differences to enhance the overall analysis by encouraging discussions about the data, exploring possible interpretations, and providing "checks" on the emerging codes and theory. A research team was used throughout the analytic process, as described in the procedures section.

Memos. All members of the research team used memos throughout the analytic process as they developed and organized codes, categories, properties, and dimensions of the data. Memos are notes of ideas, insights, feelings, and questions that arise while analyzing data and are an integral aspect of qualitative data analysis (Corbin & Strauss, 2008; Yeh & Inman, 2007). By using memos, the research team was able to monitor for researcher bias and track the analytic process. These memos became a part of the data

corpus, providing additional data in the analytic process (Fassinger, 2005, Morrow, 2005).

Self-reflective/analytic journal. In addition to memos written during analysis, the primary investigator maintained an ongoing self-reflective/analytic journal throughout data collection and analysis. Journals have been used in qualitative research to provide an "analytic space" for the researcher to take a step back from the data, to track the overall analytic process, to continue to identify biases and assumptions, and to help separate the researcher's perspectives from the participants' stories (Fassinger, 2005; Morrow, 2005; Morrow, 2007; Williams & Morrow, 2009). Similar to memos, this journal provided a record of ideas, insights, feelings, and questions that arose from the primary investigator throughout data collection and analysis. However, journal writing was not necessarily tied to specific data.

Follow-up contact with participants. Follow-up contact with participants has become a common method for "checking" on researcher interpretations of data (Fassinger, 2005; Morrow, 2005; Williams & Morrow, 2009; Yeh & Inman, 2007). This may include contact shortly after the interview as well as later in the analytic process to clarify information from the interview, ask follow-up questions, allow participants to provide additional information, and obtain participant feedback on the developing theory. Follow-up contact with participants also provides additional data for the data corpus. Follow-up contact was initiated with participants shortly after the interviews and again at the end of data analysis. No participants provided additional data at the first follow-up.

Four participants chose to review the model after data analysis was complete. These participants concurred with the proposed model.

Redundancy/saturation. The most widely accepted indicator that adequate data have been collected is the redundancy of data and theoretical saturation (Corbin & Strauss, 2008; Morrow, 2005; Williams & Morrow, 2009; Yeh & Inman, 2007). Redundancy refers to the point when new cases no longer provide additional information (Williams & Morrow, 2009). Saturation refers to the point when themes or categories are fully "flushed out" so that they reflect the complexity of the phenomenon under investigation (Williams & Morrow, 2009). Both redundancy and saturation were reached in this data.

Disconfirming evidence. When analyzing data, there is a natural tendency for researchers to seek confirmation of their initial and emerging findings (Morrow, 2005). Therefore, the research team deliberately sought disconfirming evidence throughout the analytic process via repeated comparisons within and between cases and between new and existing data (i.e. constant comparison; Corbin & Strauss, 2008; Morrow, 2005; Yeh & Inman, 2007). Concepts and themes were revised according to findings from this deliberate process.

Balance Between Participant Meaning and Researcher Interpretation. All research is subjective to some degree whether it is qualitative or quantitative because all investigators are products of their own cultures, times, experiences, and training (Corbin & Strauss, 2008; Miles & Huberman, 1994; Morrow, 2005; Williams & Morrow, 2009; Yeh & Inman, 2007). Bias affects research as soon as a research question is asked and

can enter the research in numerous ways, from the reason the question is asked, to how the question is asked, to how the data are interpreted (Williams & Morrow, 2009). An important aspect of establishing trustworthiness in qualitative research is explicitly acknowledging subjectivity on the part of both participants and researchers and establishing a balance between these subjectivities (i.e. the participants' meaning and the researchers' interpretation; Williams & Morrow, 2009). Ultimately, this balance requires explicit disclosure of known biases and assumptions held by the researchers as well as an ongoing awareness of self throughout the research (Morrow, 2005; Williams & Morrow, 2009). These ideas are often referred as "bracketing" and "reflexivity" respectively (Morrow, 2005; Williams & Morrow, 2009, Yeh & Inman, 2007). The methods described for ensuring the integrity of the data through triangulation already provide numerous ways of "checking" researcher bias and engaging in ongoing reflexivity. In the following paragraphs, I "bracketed" my known biases by describing my background and assumptions about helpseeking for SA. All members of the research team also discussed their own biases and expectations for the study when they joined the team. Discussing these biases in the beginning, as well as utilizing the memo process, encouraged constant evaluation of whether and how biases may be affecting analysis. These were discussed throughout the analytic process.

Bracketing. My interest in working with survivors of SA began when I was a college undergraduate in Women's Studies. During this time, I also began volunteering as an advocate for survivors of SA and intimate partner violence (IPV) with a hotline and in the emergency departments of two hospitals. I continued this work after graduating by

working as a legal advocate for survivors of IPV; splitting my time between a shelter for survivors of IPV and the city prosecutor's office. As a graduate student in clinical psychology, my research has continued to focus primarily on SA and IPV. My clinical interests continue to include the treatment of anxiety and depression with a specialized interest of working with survivors of physical, sexual, and psychological abuse and neglect.

Through my educational training and work experience, I have developed a feminist frame for viewing violence against women. This frame affects my initial approach to the current study in a number of ways. First, I suspect that the choice to seek help from anyone, especially formal resources, is a complex process that is affected by factors within the individual SA survivor and the context(s) of her/his life and the SA. This view has led me to develop a semi-structured interview with open-ended questions about these various factors. Second, I believe that helpseeking is not a single, dichotomous choice, even when the decision is to seek formal help. Therefore, I have chosen to ask participants about various formal resources that they considered and how they made decisions about whether or not to contact these resources for help. I recognize that this process may be different for different types of resources, particularly in recognition of previous research that has indicated some resources are consistently more likely to result in secondary victimization than others are (Campbell, 2008; Ullman, 1999). Finally, I believe that the survivor's perceptions of the SA and its impact are more influential in survivors' helpseeking decisions than objective measures of their symptoms. In other words, I believe that the subjectivity of the SA survivor matters and I

hoped to gain insight into how survivors' perceptions affect their helpseeking decisions through this research. Nonetheless, I must reveal my own bias that formal resources, particularly psychological resources, are beneficial in coping with the aftermath of SA. My bias is based on my experiences working with SA survivors and the research thus far about formal resources (Campbell, 2008; Taylor & Harvey, 2009).

Clear Communication and Application of the Findings. Demonstrating trustworthiness in qualitative research requires that the researcher clearly communicate the results and identify why the results matter (Williams & Morrow, 2009). In the next sections, this dissertation will present findings and discuss their importance. An audit trail (i.e. a record of the analytic process) is also included in Appendix D (Bowen, 2009;Rodgers & Cowles, 1993).

Results

Participants' reports of unwanted sexual experiences (USE) and service utilization were obtained initially through the online pre-screening and clarified during the in-person interview. These results provided context for understanding participants' decision-making process regarding helpseeking. The concepts that follow this initial section focus on the development of a theoretical model of helpseeking. Although the primary focus of this study was to examine how participants made decisions about utilizing formal resources, it became increasingly clear that decisions about formal resources were part of an overall decision-making process about needs for support and disclosure. Therefore, the model that emerged from this study incorporates participants' decisions to cope with their USE independently or with the help of friends/family as well as with the utilization of formal resources. Participants were invited to review the model and to provide feedback at the end of data analysis. Four participants chose to provide feedback and these participants concurred with the model.

A note about the language used in the results: during the interview process, participants were asked about how they refer to their experiences. Consistent with previous research, many participants did not label their experiences as SA or rape. Nonetheless, all participants responded to advertisements for this study which used the

language of "unwanted sexual experiences." The acronym USE will be used throughout the results section.

USEs and Service Utilization

USEs. Participants reported a range of USEs since entering college (see Table 1). Of the ten participants who reported that the USE included vaginal, oral, or anal intercourse, all but one reported knowing the offender. Four of these participants reported multiple incidents with the same offender and two participants reported multiple incidents with different offenders. None of these participants reported physical violence such as being punched or kicked during the USE, but some participants did report being held down by the offender, fear of what would happen if they resisted, and fear of physical violence specifically (see Table 2). Five participants indicated alcohol/legal or illegal drugs played a role in their USEs.

Four participants reported that the USE included an attempt at vaginal, oral, or anal intercourse. These four participants do not include those described previously who reported multiple experiences with the same offender. Once again, participants generally knew their offender. Each of these four participants also reported unwanted touching in the course of the attempted intercourse. All 14 participants reported unwanted intercourse or attempted intercourse, but two participants reported separate incidents of unwanted touching. When unwanted touching occurred, either separately or in the course of attempted intercourse, most participants reported that it occurred unexpectedly.

Table 1

Types of USEs and Relationship to Offenders

Relationship to offender	Unwanted intercourse	Attempted intercourse	Unwanted touching **
Stranger	1	0	1
Acquaintance	2	1	1
Date	0	1	0
Friend	4	1	1
Boyfriend	3	1	0
Ex-boyfriend	2	1	0
Total number of participants *	10	4	2

* These categories are not mutually exclusive as some participants reported multiple USEs. Totals therefore reflect the number of participants who reported within each category rather than the sum of the categories.

** This column only includes unwanted touching that occurred separately from attempted intercourse

Table 2

Types of USEs and Facilitating Factors

Facilitating Factor	Intercourse	Attempted Intercourse/Unwanted touching
Alcohol/drug use	5	1
Physical violence	0	0
Held down/Prevented from leaving	5	0
Fear of physical violence	2	0
Threatened to end the relationship	1	0
Fear of what would happen if refused	4	0
Happened unexpectedly	N/A	6
Total number of participants *	10	6

* These categories are not mutually exclusive as some participants reported multiple USEs. Totals therefore reflect the number of participants who reported within each category rather than the sum of the categories.

Participants reported that their USEs had occurred anywhere from 3 months to more than 4 years before their interview. They reported a wide range of symptoms between the incidents and their interview. Qualitative descriptions of symptoms will be discussed further in the section on perceived impact. Participants were also asked in the online pre-screening to report the frequency of common emotional responses to USEs that they have had in the past week (the PSS-SR). Participant scores on the PSS-SR ranged from zero to 35 (possible range zero to 51) with a mean score of 13.57 and a median score of 11.50. Unfortunately, five participants revealed in the interview that they had answered these questions based on how they remembered feeling shortly after their USEs rather than during the past week. The other nine participants indicated that they did respond based on the past week. Prior studies have reported mean PSS-SR

scores ranging from 8.7 to 42.0 (e.g. Fairbrother & Rachman, 2004; Littleton et al., 2009). It is unknown whether other studies encountered similar discrepancies in the reporting timeframe (see Table 3).

Table 3

PSS-SR Scores with Reference Time for Symptoms Reported

Reference time for symptoms	Number of participants	Range of scores	Mean	Median
All participants	14	0-35	13.57	11.5
Symptoms from week before interview	9	0-35	11.11	8
Symptoms from shortly after USE	3	3-34	18	14

Service Utilization. Most participants in this study reported using at least one type of formal resource (see Table 4). Most also reported considering at least one formal resource that they ultimately did not use. Seven participants described using some resources while only considering others. Participants consistently reported that whether they used on- or off-campus resources was based primarily on cost and convenience. Much of the use of formal resources was done without disclosure, as will be detailed later. Only one participant used more than two resources and this participant reported using all available resources (medical, mental health, advocacy, legal, and school officials).

Table 4

Types of resources used, considered but not used, and number of resources used

Resource	Used	Considered only	1 Resource used	2+ Resources used
Medical	8	0	3	5
Mental health	5	5	2	3
Advocacy	3	4	0	3
Legal	1	4	0	1
School officials	1	0	0	1
Total participants *	10	9	5	5
No formal resource used/considered	4	5	N/A	N/A

* These categories are not mutually exclusive

The Theoretical Model – Deciding Where to Turn

This model, Deciding Where to Turn, reflects the complicated nature of deciding whether and where to seek help after a USE that emerged from this study (see Figure 2). As depicted in this model, the survivor generally engages in three key decision points: determining whether there is a problem that she/he needs to cope with related to the USE (Do I Need Help), considering her/his options (What Can I Do), then weighing the consequences of using these options (What Will I Do). Although numerous life factors may influence these concepts, a key modifier that emerged from the data is past experiences with abuse and helpseeking. The cognitive and emotional process represented by the decision points results in a behavioral choice: cope on one's own without support from others, seek support from friends/family, seek support from formal resources, or find a covert way to meet one's needs.

For the survivors in this study, the goal of helpseeking was feeling "OK" or generally unaffected on a regular basis due to the USE. Survivors who reported feeling OK reported that they no longer needed help while others described needing help because they still felt affected.

> I'm like okay now. So, I don't need to talk about it with anyone.
>
> * * *
>
> I'm perfectly fine now <pause> I mean, I'm happy, I can trust my boyfriend now, but he's great and <pause> I'm not scared of that happening anymore.
>
> * * *
>
> I'm back to my old, normal self.
>
> * * *
>
> I feel like it's still negatively affecting me after [all this time] <laugh>. It's just still kinda trucking along with me and it's annoying.

The process of moving to feeling OK can be long for some survivors. Thus, survivors may move through the model multiple times en route to this goal, influenced by shifting perceptions including those created by the helpseeking process itself.

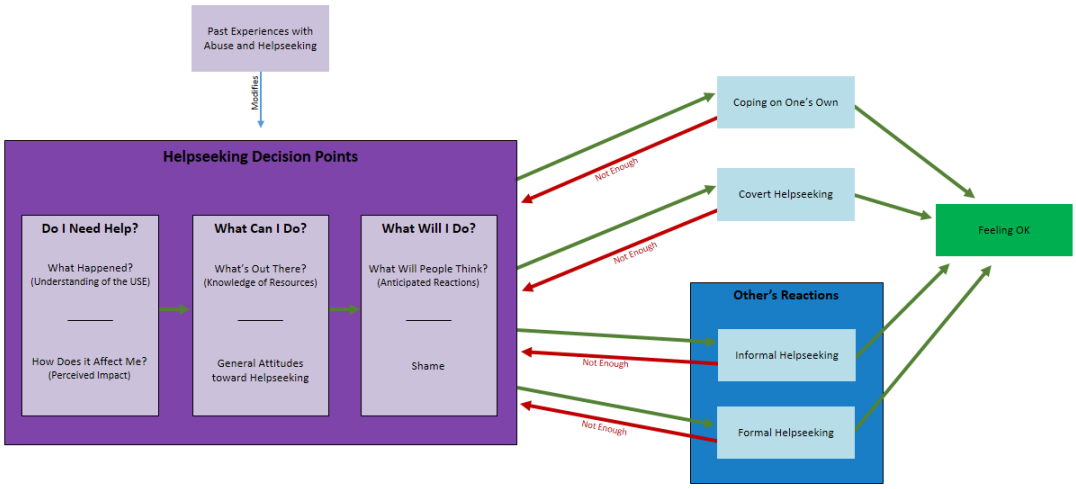

Figure 2: *Deciding Where to Turn*

Do I Need Help?

In order for survivors of USEs to consider seeking help, they must first determine that there is a problem that they need help for by interpreting the USE itself (What Happened) and the extent and way that they perceive being impacted (How Does it Affect Me). Survivors then use this information to consider the type of help that they may need and what resources might best fit those needs. These two concepts are discussed in the sections below.

What Happened? The concept of What Happened was the participant's interpretation of the USE itself. This concept was primarily defined by the extent that

participants blamed themselves versus the offender for the USE (Attributions of Blame) and the extent that they understood it as SA (Labeling).

Attributions of Blame. Participants seemed to quickly and automatically attribute blame based on their own reactions at the time of the USE, which each of them naturally described while describing the USE itself. All 14 participants described attempts to resist the USE or inability to do so (see Table 5). Most participants described various forms of verbal resistance ranging from saying "no" or "stop" to telling the offender to leave. Some participants also used physical resistance ranging from attempting to push the offender away to kicking the offender and spraying him with pepper spray. Nearly half of the participants described being unable to resist the USE due to various forms of incapacitation including intoxication, situational factors such as weakness from medical procedures, or feeling "locked up" by fear and disbelief about what was happening.

Table 5

Number of participants who used these forms of resistance

Type of Resistance	Participants
Incapacitated - blacked out (alcohol use)	3
Incapacitated – other	1
Froze/"locked up"	2
Verbal resistance	8
Physical resistance	4
Total number of participants who reported these reactions	14

Participants tended to blame themselves at least partly for the incident, and in about half of the cases they blamed the offender as well (see Table 6). Very few participants blamed the offender exclusively for the USE.

Table 6
Attributions of Blame

Attributions of Blame	Participants
Blame self only	6
Blame both self and offender	6
Blame offender only	2
Total	14

All 12 of the participants who blamed themselves described some variation of one or more of three themes: saying they "let it happen," saying they didn't resist enough, or questioning what they should have done differently.

> I guess, I thought that I should have you know punched the guy in the face and you know ran away or something, I don't know <pause> or at- at least not let it happen multiple times.
>
> * * *
>
> Why would I not like, you know, like yell or like push or anything? I just kind was like passive about it. I didn't even like want to do it, I just like--I didn't--I don't know why I didn't--I went along with it
>
> * * *

> It's kind of like me telling myself that I was stupid to even be there. I shouldn't have stopped by the tree. I should've just <pause> kept walking. Like it was my fault for being there, and so, my fault for it happening.

When participants blamed the offender as well as themselves, they often described feeling manipulated or coerced. A few participants described the offender as responsible for the USE overall while still blaming themselves for not resisting further.

> Umm, I mean, I don't think it's my fault because he, like, made me do it, but, umm, I blame myself for not being able to res--resist it…

Both of the participants who described blaming the offender and not themselves for the USE reported being incapacitated at the time.

Labeling. The way that participants attributed blame for the USE influenced their labeling of the incident, which in turn influenced their helpseeking decisions. Most notably, participants who labeled their experience as SA were the only participants who reported using advocacy and legal services.

Participants generally did not label their USE automatically during the interview, but they were asked in the course of the interview what they usually called their experience and how they felt about labels such as SA and rape. Their responses to these questions helped to clarify the way they interpreted the USE, but also revealed the complex nature of labeling due to perceived societal interpretations of words such as SA and rape.

> I had a couple friends say, "it sounded – that sounds like it could be rape" and I was like "I don't really like that word." I don't want to be a rape victim. Um, and I know that in some people's definition, yeah that's included. Um, but I would just rather not think of myself that way.
>
> * * *
>
> I don't technically use rape because it's unwanted, but I feel like rape is such a heavy word that I almost associate with being beaten almost, you know you die from it or there's some… I think it's much worse than what I experienced.

Four of the 14 participants labeled their experience as SA by the time of the interview. Although they varied in how quickly they came to this label from a few days after the USE to at least a few months, each of these participants was clear about how this label fit the experience.

> I really wouldn't know how to label it. But that's how I guess in my mind before I came here, that's how I guess I would map it out in stages. You know the first time, the first couple times it was date rape, then the times where I was, I had physical injury it was assault, and then after the first year of me letting him do it that was just a severe lapse of judgment on my part.

Two additional participants were hesitant to label the USE as SA, but did use related labels of "domestic abuse" and "violence against women."

> Violence against women to me is kinda like the umbrella for all of those things that have happened. Um domestic violence, things like that. I really do feel like

> just the word violence against women is just all-encompassing of all of it... I feel like I'm a victim of it. I feel like I don't know how to deal with it at times and I'm just trying to like… work through it but I don't have any other language for it really.

The remaining participants labeled their experience in terms such as "a bad party" or being "taken advantage of," or they described referring to it in general terms such as "the incident" or "what happened to me." Some of these participants described questioning whether the experience was SA while others were much clearer about not wanting to use those labels. Participants who debated whether it was SA were also more likely to report that they considered but did not use advocacy or legal services.

> I felt violated but I didn't know like if I really was. I didn't know like -- I don't know… I just I guess if it was sexual assault then I would feel like less like it was my fault or something. But I don't think it is, so.

* * *

> Like I never really wanted to face it, I never wanted it to be real. And then once that label and like kind of real term comes- comes to light and it essentially labeled to my experience, it's- makes it real.

Some participants explicitly linked their thoughts about labeling to their helpseeking choices. Their concerns included the idea that seeking help would mean labeling the experience as SA and feeling uncertain whether advocacy services would apply to their specific experiences.

> In my mind seeking help for it would have labeled it. And I think it's more important the label that you put on it and not the label that your clinician puts on it.
>
> * * *
>
> I don't necessarily want to go in and you know say hey, I was a victim of rape like that's scary to me.

In sum, the first component of participants' helpseeking decisions was made up of their interpretation of What Happened to them, including their attributions of blame and labeling of the incident. As participants considered whether and where to seek help, they also evaluated how the incident impacted them in the short and long term.

How Does it Affect Me? When discussing their helpseeking decisions, all participants described the way that the USE impacted them. Impact translated into a perceived level of need; the question then became whether this need was severe enough to consider seeking help. Participants described three types of impact: physical, psychological, and social.

Physical impact. Eleven of the 14 participants described perceiving a physical impact or concern about a possible physical impact resulting from their USEs. All participants reported a range of perceived physical impact from no concerns to minor concerns or injuries with one diagnosed case of an STI resulting from the USE (Table 7).

Table 7

Perceived Physical Impact or Concern about Physical Impact

Type of physical impact	Participants
STI	7
Pregnancy	4
Minor physical injury (bruises, soreness)	3
General concern about injury	2
Other (physical symptoms of depression)	1
Reported no physical concerns	3

When participants perceived a physical impact or were concerned about a possible physical impact from the USE, they considered seeking help.

> And it was pushed down so hard that it hurt the back of my throat and then my throat hurt for like two or three weeks afterwards. So bad that I thought I might have an STD but I went and got checked and they went, "no nothing." Um it was just injured.
>
> * * *
>
> I just felt like I needed to do--like I was like--could I be like, could something have happened? Like, could I have gotten a STD or gotten pregnant or like things like that. I was worried about that kind of thing.

Participants also described changes in their perceptions of the physical impact of the USE after seeking help or from receiving information later via regular medical checkups.

> And the feeling of not knowing bothered me. So I went to a gynecologist and had them do, you know, a pap smear, regular checkup, and waited for the results and everything turned out to be ok. And that aspect, like physical issues that I might be dealing with completely went out the window; 'cause I got the a ok "there's nothing wrong" so.
>
> * * *
>
> No I didn't have any signs or symptoms of anything, which is why it was kind of shocking when I got the phone call that I had [an STI] that… I had no idea that came completely off- out of nowhere.

Psychological impact. All 14 participants reported perceiving some type of psychological impact from their USEs. These impacts ranged from mild distress to one suicide attempt. While participants described their experiences in a wide range of terms, most of their descriptions were consistent with symptoms of depression and PTSD. These symptoms included but were not limited to anhedonia, withdrawing from others, struggling with coursework, becoming upset when reminded of the incident, avoidance of physical and emotional reminders, difficult sleeping and anger.

> I mean now I can talk about it, but I didn't wanna think about it for like, I don't know, like six months or something. Like if that--if that like something that reminded me of it ever came up, I'd just be like oh my god, like that wasn't me, I'm not thinking about it. Like, it doesn't count or something and it never

happened. I tried to conv--I mean, I knew that it happened, but at the same time, I was like, that was like not me. So, you know, I'm not gonna think about it.

* * *

Um I… I was just really easy to feel defeatist. Um… because… just everything just kept, connecting back to that. Well if that could happen to me then who knows what's gonna happen to me in the future and I might as well not even, try. Um… and it just--it gave me a general upset feeling for a very, very long time. It took me… until – actually it's not still completely gone. Um… it just doesn't feel like things are gonna work out the way I planned 'cause I never planned for anything like this to happen.

* * *

It's like, well, I mean, in hindsight, how could I have not realized that that was why. But yeah like, I stopped going to class, I was a really good student before that and I just kind of—like if friends would call I wouldn't answer the phone, I didn't' see anyone, I like gained like 20, 30 pounds. I was just sleeping all day. I didn't- wouldn't leave my house for like weeks at a time. It was like – it was bad.

* * *

I was afraid to be home; I was afraid to be out at night; I was afraid to be alone; I was afraid of him.

Social impact. The perceived social impacts that participants described in this study were often related to psychological impacts but focused specifically on their relationships with others. For example, when participants described withdrawing from

social connections, this concept fit with symptoms of depression as well as changes in their relationships with friends. Twelve of the 14 participants described some type of perceived social impact or concern about future social impact. Participants primarily described impacts on dating/sexual relationships and friendships.

Of the 12 participants who reported concerns about social impact, nine discussed impacts on their dating/sexual relationships. These concerns focused on both current relationships and worries about how their USEs would impact future romantic relationships.

> Yeah I definitely um, pull my emotions out of a situation once it's reached that intimacy period. Like the guy that I was – he was really nice and then we got there and I was like, "I don't want to talk to you anymore." <laugh> "Like it's… not working out."
>
> * * *
>
> Oh I went on a celibacy streak. Not because I was, you know, angry or against the world or against men but because I couldn't – just cannot be intimate to save my life. Like it bothered me, I didn't feel… that anything was there. I felt like my arousal with my body reaction but definitely not my mind.
>
> * * *
>
> It's something that happened – something bad that happened. It's something that probably changed how I'm gonna go about my love life for the rest of my life. Um <pause> but I don't know what I want to do about it.

Of the 12 participants who reported concerns about social impact, six discussed impacts on their friendships. These perceived social impacts ranged from temporarily withdrawing from friends, to ceasing associations with certain friends, to ongoing hesitancy to trust friends.

> Umm, and all these different kind of like negative emotions and what essentially happened is that I really didn't talk to anybody for two weeks. Like I didn't get on any social network, I didn't talk to anybody on the phone um. You know at that time I was living at home umm, and so of course I had like the interaction with my parents or something but never really giving them an inkling that something had happened.
>
> * * *
>
> Um, I met him through one of my best friends in high school. And although him and- they don't necessarily hang out anymore, she's still hangs out with that crowd of people, and it makes me uncomfortable being around them now.
>
> * * *
>
> And we like were clear, like "Don't let me go home with anyone," don't let—and then like those friends just disappeared and so I was really – I think that was what I struggled with the most after—like thinking that no one really like has your back except yourself. Like, you're really the only one who can take care of yourself and I had those kind of like, I can't trust anyone except myself, so I can't drink, I

can't do any of these things that might put me in danger. And that was, yeah that was like the worst part, I guess.

In sum, participants perceived a wide range of physical, psychological, and social impacts from USE (How Does it Affect Me). These perceptions interacted with participants' interpretation of the USE (What Happened) to determine whether there was a problem that they needed to seek help for and what type of help they needed (Do I Need Help). For example, participants generally considered seeking help from medical resources when they perceived physical impact and from mental health resources when they perceived psychological or social impact. Interpretation of the USE also influenced how participants defined their needs, particularly by defining their experience as SA, other forms of victimization, or other "bad" experiences. These interpretations played a particularly strong role when considering advocacy and legal resources, but also influenced helpseeking more generally, such as when participants thought about what they might be asking for help for and how asking for help might define their experience.

What Can I Do?

Once survivors of USEs determine that there is a problem that they might need help for, their decisions are quickly mediated by what they know about available resources (What's Out There) and their general attitudes about helpseeking (General Attitudes Toward Helpseeking). These mediators interact with one another and allow survivors to consider the potential options available to them as they cope with the aftermath of the USE.

What's Out There? Once participants determined that they needed help, they implicitly considered the options available to them. Participants often did not consciously go through a list of resources. Instead, they seemed to draw on this knowledge intuitively, suggesting that knowledge of resources is a mediator between identifying need and deciding what to do. Their awareness of resources was apparent as they described utilizing resources as well as when they explained their rationale for not utilizing resources. The distinction between considering a resource and awareness of a resource was also clarified by the explanations of their decisions, indicating that considering a resource meant thinking about using it as opposed to simply knowing that it was there. Participants were generally aware of medical, mental health, and legal resources, but varied in their level of awareness of advocacy resources.

> Yeah, I do know my other options and just, with my mom I didn't really think it was possible nor do I think I would want to do anything legal like tell the police because I didn't- I did want it to happen and I didn't try to force him off me or anything like that so I feel like I wouldn't be taken completely serious.

Participants also seemed to be generally aware of the existence of advocacy resources (e.g. SA services, rape crisis center) but were often less certain about the function of this resource.

> Um, I didn't know what they could do… Like, whether it was the same thing as talking to a counselor, or if they were more like the police and they would want me to contact somebody, I didn't know like how they would help me, so…

* * *

> I didn't feel bad about the experiences of going to sexual assault services. I just didn't know what to expect from them. And then what I got from them was not what I felt I needed at the time, but I don't want to blame them for that because I don't know what their job is.

In sum, the first component of What Can I Do was participants' knowledge of the resources that may be available to them (What's Out There). The second component is participants' General Attitudes Toward Helpseeking, which affected their perceptions of the viability of these resources.

General Attitudes Toward Helpseeking. In order to use a formal resource, survivors need to both know that the resource is available and feel that it is acceptable for them to use it. Participants' General Attitudes Toward Helpseeking naturally emerged as they described their helpseeking decisions and ranged from positive to negative, with most participants (ten of 14) revealing mixed attitudes, two revealing positive attitudes, and two revealing negative attitudes. Again, these attitudes interacted with their knowledge of the resources (What's Out There) and acted as a mediator between Do I Need Help and What Will I Do. Typically, the more negative their attitudes, the less likely they were to seek help and the more easily they were dissuaded by concepts describe in What Will I Do (i.e. What Will People Think and Shame).

The majority of participants described mixed attitudes toward helpseeking to varying degrees. Six of these ten participants suggested that seeking help may be acceptable in a general sense, but felt that they wanted to handle the effects of the USE

their "own way." Some of these participants also suggested that they not only wanted to handle it themselves, but that they felt like they should handle it alone.

> I guess I wanted to handle it <pause> my way not anyone else's way…
>
> * * *
>
> I think part of the problem um as to why I probably didn't go back to counseling or try out the uh, sexual assault services or anything else like that. Um I'm very, very independent and I think that's probably one of the reasons like, like I said I felt like I could do it on my own.
>
> * * *
>
> Like, 'cause some people probably feel like "oh I *have* to like talk about it with someone," and that's okay. But I think there's like -- it gets to a point where like, you know, like you have to like think by yours—like you have try to help yourself .
>
> * * *
>
> I think I know that therapy is beneficial, but I think most people, again, would probably assess you know the problem and decide, "oh well it's probably not worth it… So being able to kind of come to terms with something without necessarily like bothering somebody else or wasting, you know, just um, – it kinda is unfair to the people that genuinely deserve or need the counseling...

The other four of the ten participants who described mixed attitudes toward helpseeking described attitudes that varied by resource. For example, one of these

participants described a positive perspective on advocacy resources but also stated "I don't trust doctors for anything."

In sum, what survivors of USEs know about the resources available to them is clearly an important factor in their ability to consider seeking help, but equally important are their general beliefs about the acceptability of seeking formal help. As their attitudes toward formal helpseeking became more negative, participants' seemed to require a greater perceived need (Do I Need Help) to consider formal help and were more easily dissuaded by concepts described in the following section: What Will I Do?

What Will I Do?

Once participants determined that there was a need for help and considered what resources they could utilize, they evaluated whether they were willing to utilize these resources by assessing possible consequences. Two related concepts emerged in their evaluation: What Will People Think and Shame.

What Will People Think? All participants described the reactions they anticipated from help sources, ranging from negative (e.g. fear of negative judgment) to positive (anticipating support), as they described their decision making. These anticipations came from prior experience or general knowledge about the resources. When participants anticipated negative reactions, these anticipations acted as barriers to helpseeking, reducing but not necessarily eliminating the likelihood of seeking help. In some cases, this led to utilizing resources without disclosure, which will be discussed

further in the section on Covert Helpseeking. When participants anticipated positive reactions, they tended to disclose and seek some type of support.

Nearly all participants (13 of 14) described anticipating negative reactions from at least one formal or informal resource that they considered, while only four participants anticipated positive reactions. Four themes emerged from these data: fear of negative judgment, fear that others would react disproportionately, fear of getting oneself or the offender in trouble, and anticipating support.

Fear of negative judgment. Fear of negative judgment or stigma was the most common of negative anticipation themes among participants (ten of 14 participants).

> I know there's stigma around this so it's given me a much more guarded approach.
>
> * * *
>
> Um I feel like people would challenge my story if I told them that I was raped.
>
> * * *
>
> I guess that I was, you know, was a slut, or, you know didn't care about, well, I mean he didn't know before I told him. I guess that he would think that.. Also, that he would think that I just let myself get walked ov- walked on and, which was true, but… I was afraid of him knowing that, I guess.

Fear that others will react disproportionately. Five participants reported fear that others would under- or over-react to disclosure of their USE which increased their hesitancy to disclose or to seek services.

I knew that the local police couldn't do anything because it was--I know that the--<pause> I don't know…. it was like these kind of college sexual assaults never go anywhere.

* * *

I don't know. They probably would have been way more concerned about it then I was.

* * *

I always feel like if I tell someone that I was raped or something along those terms there's that feeling of, you know, alarm and "We need to do this, this, this, this, this, this, and this" and I didn't want to be anymore, at the time I didn't want to feel anymore, anxious than I already was so if saw- came with a very calm attitude about it and I didn't use any, I want to say trigger words in that aspect to really click in that doctor's mind, what's going on.

* * *

I thought about going to my professor once, she was so sweet and you know definitely a feminist in her views, but they always like- like to remind you that there's anything, you know, "that we find about that need help – that needs attention or something, you know, like we have to pass that information along to someone." And I'm like I don't want to pass this information along to someone.

Fear of getting in trouble. (Four participants.)

Well, I think after it first happened I thought about talking to the police and then I was like, oh, I was drunk, I don't wanna get in trouble myself and I don't want them to think it happened because I was drunk.

* * *

What was our employer gonna think? What legal issues am I gonna get in if I actually, you know, cause if you call the cops… it's expected you're gonna press charges.

Expecting support. (Four participants.)

I don't tell every single person, I tell those who I think 1) can handle it and 2) who will just lend a hand for support, not feel bad but just kind of offer like if you ever need anything let me know.

* * *

So I kinda went in there thinking okay I'm gonna get, I guess, names and things that I can do.

* * *

Mhm working with them I really feel like they care. Like they – they're passionate about making sure that the stuff doesn't help – happen and kinda like helping women through it.

When participants described their anticipated reactions, they rarely specified who they anticipated these reactions from. Rather, this concept emerged as participants

explained more broadly why they made the helpseeking and disclosure decisions that they made. Ultimately most participants (13 of 14) eventually disclosed their USE to informal resources such as friends and family, despite frequently anticipating negative reactions. The frequency of informal helpseeking, the tendency for it to occur before formal helpseeking, and the broad nature of concerns about what others would think led to the inclusion of informal resources into the proposed model.

In sum, what participants anticipated others would think about their USE disclosure was the first potential consequence that participants weighed in deciding what to do. These anticipations also reacted with a second consequence: participants' own levels of shame.

Shame. The concept of shame emerged from the data as a consequence that was closely related to but separate from What Will People Think. It appeared most frequently with fears of negative judgment. Although it was clearly connected with social implications, shame was not necessarily based on others' reactions but emerged as participants described their own sense of being embarrassed and not wanting others to know about their USE. Participants were most likely to describe feelings of shame when explaining their reasons for not seeking help, suggesting that experiencing increased shame was a consequence that they wanted to avoid. Ten of the 14 participants discussed this concept ranging from a mild to a strong sense of embarrassment about the USE.

> I didn't wanna mention it because I- I initially thought in my head maybe it's because it's not something I want to be associated with me.

* * *

I know I didn't want to talk to a friend because then they would have had that knowledge of me and, you know they would keep on knowing me into the future and, I guess I didn't want that to be in anyone's head at all.

* * *

I mean, maybe I should have told somebody but that would have like been embarrassing for me also. <pause> I don't know, just, having my mom and my dad know about it, it's like embarrassing/awkward, and also the fact I was drunk, I feel stupid.

A few participants clearly described how feelings of shame negatively influenced their helpseeking decisions.

Well, I think after it first happened I thought about talking to the police and then I was like, oh, I was drunk, I don't wanna get in trouble myself and I don't want them to think it happened because I was drunk. And then it'd just be like embarrassing that now people know.

* * *

I really think I would have had to wait until the suicide point before I would have asked for help just because I did feel so embarrassed. Because everybody did know me as a strong person. So, to turn around and admit to the fact that I let somebody do this to me...

As these quotes illustrate, participants described fears not only of what others would think of them because of their USE, but also a sense of shame about others knowing, regardless of how they might react. Thus, anticipated reactions and shame emerged together in this model as the primary consequences that participants' weighed in their helpseeking decisions.

Helpseeking Decisions

Once survivors of USEs have determined that there is a problem that they need help for (Do I Need Help), considered the options available to them (What Can I Do), and weighed the consequences of those options (What Will I Do), they then engage in a behavioral choice: to cope on one's own, to seek help from informal resources like family and friends, to seek help from formal resources, or to find a covert way to meet one's needs. If this choice does not lead to the survivor feeling generally unaffected from the USE on a regular basis, she/he returns to an earlier component of the model and makes a new decision.

Coping on One's Own. The choice to cope on one's own is a decision to use internal strategies to manage the impact of the USE. While all participants described some attempts to cope on their own, all 14 of the participants in this study eventually sought some type of help either directly or covertly. Participants ranged in the amount of time between the USE and initially seeking additional resources from a few hours to a few months. The data also revealed that participants sometimes reverted to coping on their own after experiencing negative consequences from other helpseeking decisions.

The most common strategy for coping alone was avoidance, which was reported by 12 of the 14 participants. This included generally avoiding thoughts of the USE but was often facilitated by avoiding the offender, reminders of the USE, people in general, or via substance use.

> Like sometimes I would rather just like push it aside, and you know, maybe believe that it never happened or you know kind of push it out of my mind and essentially forget about it and learn from it but forget about it.
>
> * * *
>
> I wanted to talk about that with someone, but… I just at the same time like I just didn't want to think about it. It's like I didn't want to tell anyone.
>
> * * *
>
> Just cutting myself off from people except, you know, going to parties and drinking. And <pause> just <pause> getting through each day and <pause> hoping the next would be better somehow even though I wasn't changing at all.

Other coping strategies described by participants included becoming more guarded in their interactions with others, normalizing or minimizing the experience, and generally trying to make sense of the offender's actions, all of which overlapped significantly in the concepts described in determining the problem (i.e. interpreting the USE and perceived impact). These data therefore provided additional support for the pattern proposed by this model, where participants return to the decision-making process when their needs have not been met by their initial helpseeking decisions.

Covert Helpseeking. The concept of covert helpseeking emerged from the data as a variety of strategies that participants used when they decided to seek help but did so without disclosing their USE. These strategies included direct service use without disclosure as well as alternative ways of connecting with resources. Half of the participants in this study reported at least one form of covert helpseeking (see Table 8).

Table 8
Participants' overt and covert helpseeking

Resource Type	Overt Use	Covert Use	Total
Medical	4	4	8
Mental health	5	0	5
Advocacy	3	1	4
Legal	1	1	2
Other resources	N/A	2	2
Total participants *	7	7	12

* These categories are not mutually exclusive. Two additional participants sought help overtly from informal resources only.

Direct use of formal services without disclosure. The notion of direct service use refers to using services as they were designed to be used. Participants in this study reported the direct use of formal services without disclosure predominantly within medical resources. Fully half of the participants who used medical resources reported that they did so without disclosing their USE. Only one of these participants also used another form of formal resources, and the participant did disclose to that resource. Importantly, three of the four who did not disclose to medical resources also did not initially report medical resources as one of the services used in the online pre-screening measure for this

study, though they did discuss it during the interview. These participants described perceiving a need for medical services, but not wanting the provider to know or anticipating negative reactions.

> I just wanted relief but I guess, I don't know. I have no problems not disclosing information to my doctor and, it was <pause> I guess it was just kinda like just give me the antibiotics. And, you know, of course they have to do a thorough exam and everything and make sure. I guess the fact they never questioned it and the fact that I just wanted the antibiotics…
>
> * * *
>
> I mean I obviously went to the doctor and I didn't say why I just wanted to get checked but… nothing in terms of a long term, like a physical… indication of what I experienced was there.

One participant described accessing self-help information online. This method of accessing resources was also direct and without disclosure.

> I think after afterward I really tried my best to research online and see what people usually go through and I think it helped me cope with it because, you know one, one you don't realize you're alone and, two, the fact that I'm not the only one.

Covert Connections with Formal Resources. Two of the participants in this study described ways that they accessed formal services indirectly and without disclosure. One of these participants described volunteering for an advocacy resource while the other

described helping police in an ongoing investigation of the perpetrator for another matter. Both participants described feeling helped by connecting with these resources.

> So earlier on I didn't feel like I could handle going to the police. Um but then later on I realized that he was already in more trouble than I realized, and I just kind of helped the police as much as I could in that sense. They – I think everyone in the police department knew that I was for him going to jail by the end of my interview.

* * *

> I've never told my friends, I never told my parents, never really told anyone and so I feel like my way of rectifying it without having to use my voice is trying to volunteer my time to prevent, you know like the same thing from happening to somebody else so I, its <laugh> it's like a way of lifting that weight in a way that I'm kind of helping, um, but, never really talked about it before, so.

The participant who described volunteering with an advocacy resource also described participating in outreach programs for the organization, such as The Clothesline Project (The Clothesline Project, n.d.). Her comments suggest that outreach programs may provide another source of covert help for survivors of USEs.

> I think probably one of the most therapeutic moments was, at a table um for like the shirts that they hang on the clothes lines. We were sitting over at a table kinda by like the <campus location name> and none of us said anything to each other but it's like we could all sense that we had been through something <pause> Um

> and we just sat at the table together in pure silence just working on our shirts, putting down our deepest thoughts, our deepest feelings about what happened to us on shirts. And we didn't say anything. We just looked at each other's shirts and put them all up together and we were just kinda of looking at them together. And I can't explain it but it was kinda like a shared experience.

Covert Use of Informal Resources. One participant described receiving support from friends who knew that she had broken up with her boyfriend, but were not aware of the USEs within the relationship.

> Also, my close girlfriends, even though they didn't really know what was going on, mu-- <sniffle> Just, you know, being with them and, knowing that they, you know, are there for me. That helped too.

In sum, the data suggest that survivors of USEs may find a wide range of ways to meet their needs following USEs even without disclosing the experience to others. Most of these means involve connecting with formal resources, but some survivors may also obtain help from informal resources in covert ways. Since covert helpseeking did not involve disclosure, these participants avoided the potential impact of other's reactions.

Others' Reactions to USE Disclosure. When participants did disclose their USE as they reached out to others for help, how those people actually reacted appeared to impact future helpseeking as well as the course of recovery. This was sometimes due to impacting the various factors that influence helpseeking, such as altering their

anticipations of how others would react in the future. Other times this initial support was enough to help facilitate feeling OK.

Informal Resources. All but one participant (13 of 14) disclosed their USE to at least one informal resource prior to participating in this study. For ten participants, informal resources such as friends, family, or new boyfriends were also their first attempts to seek help. The remaining four participants initially sought help through covert means.

Of the 13 participants who disclosed to informal resources, seven reported only positive reactions, one reported only negative reactions, and five reported mixed reactions depending on the specific person they disclosed to. Six of these 13 participants reported that the support they received from informal resources and/or covert means were helpful enough to meet their current needs. The other seven participants who disclosed to informal resources also disclosed later to formal resources.

Formal Resources. Seven participants disclosed their USE to at least one formal resource. Each of these participants had disclosed their USE to informal resources and reported receiving positive reactions from those prior to disclosing to a formal resource. Five of these participants reported receiving positive reactions from the first formal resource that they used, which helped them to feel better and sometimes facilitated additional resource use (two participants).

> And she was really nice and she gave me… she just let me tell her what had happened and she… reassured me that it wasn't my fault. That, yeah it was sexual

> assault um and that these are the options you have and um then she really recommended that I go down to student health and, get checked out in case there were – something had happened.

One participant reported mixed reactions from her first contact with counseling services because she felt like they listened, but they immediately referred her to off-campus resources.

> Just ‘cause it - it took a lot, just <pause> go to someone and ta- talk about this and then they put- passed me out the door.

One other participant reported negative experiences with both legal and medical services. She described generally feeling as though she was “a nuisance” to them. This participant eventually did seek additional services from other formal resources, but she took some time and reported increased impact in the form of symptoms of depression before doing so.

In sum, nearly all of the participants in this study disclosed to informal resources and half disclosed to formal resources when they sought help. All of those who disclosed to formal resources did so after receiving positive reactions from informal resources. Other participants relied exclusively on informal resources or sought help covertly. By the time they participated in this study, most participants described positive reactions from at least one resource when they chose to disclose their USE.

Modifier – Past Experiences with Abuse and Helpseeking

Although the concepts within the model could be modified by any number of life experiences, past experiences with abuse, including USEs, and helpseeking emerged as a common modifier. This seems to be due primarily to prior movement through the helpseeking model. However, some past USEs and/or abuse may have occurred during childhood, leading to additional limits on participant's own abilities to choose whether and where to seek help that were not examined as part of this study.

Nine participants reported a variety of USEs, harassment, and other abusive relationships prior to the USEs that occurred in college. These experiences included sexual abuse by a parent or step-parent (two participants), forced oral sex by an acquaintance (one participant), unwanted touching and verbal abuse by peers (one participant), sexual harassment by a teacher (one participant), being filmed by a friend without knowledge while changing (one participant), being stalked by an acquaintance (one participant), physical abuse by a partner (one participant), physical abuse from a parent (one participant), and emotional abuse by a partner (one participant). One of these participants reported more than one prior type of experience.

Although these participants described varying forms of abuse, a few themes emerged that suggested these experiences affected the concepts described in the model relevant to helpseeking for their more recent USEs. The clearest concepts affected were What Will People Think and What Happened. For example, some participants described reporting their earlier experiences to authority figures but feeling as though nothing was

done to the offenders. These experiences therefore appeared to impact how participants anticipated others, including formal help providers, would respond to new disclosures.

> … so I went to my mom and I told her and they went through the appropriate channels and went to the police and, um. Unfortunately, they couldn't do anything 'cause there was no physical proof.

In some cases participants also felt as though they were not believed, their trust was violated, or they generally felt as though the helpseeking experience was negative.

> Um my name got out when I made a complaint… Which I probably should have expected 'cause of a lot of times when they say things are confidential they're not.
>
> * * *
>
> I told my mom when I was 15 and she didn't believe me, so that's uh, that's it really… she believes me now, but she thinks that I'm exaggerating how much it affected me. So, she says "Oh, well, I'm sure it was like not a big deal or whatever"
>
> * * *
>
> I mean just because of my past experience … and having to go to the police with that. It's just not an experience that I would want to do again. It wasn't completely comfortable.

Other participants suggested that their prior experiences impacted their understanding of the USE(s) reported for this study (What Happened). This included affecting the way

they reacted at the time of more recent USEs and an awareness of repeated patterns of not seeking help, despite identifying the experience as similar to those in the past.

> My passiveness I think is very similar in those situations. I think I was far more feisty than [during earlier experience] though – and maybe it was like a kind of, unfortunately, maybe like tame that feistiness or me seeing that fighting back isn't a good idea, he's gonna burn you.
>
> * * *
>
> Mhm; and I feel like I kind of had the same reaction as like, um- In high school ... I didn't tell anybody about it, until like, two years later, I talked to like a counselor. But, I feel like I went through the same thing like, being like invaded, my, my personal self and like not really telling anybody, until like after it's happened and after it's already like, passed through.

These themes suggest that prior USEs, other forms of sexual victimization, and abuse from family or partners can moderate survivors' helpseeking decisions by moderating the main factors for helpseeking.

Summary

This study provides a broader theory of how college students make helpseeking decisions after SA using the inductive methods of grounded theory. By including both those who had and who had not utilized formal resources in one study, it was possible to consider factors that go into the decision-making process more fully than looking at barriers or facilitators separately. Although the study aimed to focus primarily on factors

that determine helpseeking from formal resources, what emerged was a comprehensive picture of helpseeking decisions. This model suggests that whether and where college SA survivors seek help is an iterative process rather than a single, dichotomous choice. This process involves numerous assessments of the need for help, considerations of what can be done, and evaluations of the consequences of reaching out. Changes in the factors that make up these assessments (i.e. the concepts in the model) may result in multiple forms of helpseeking over time. The model also suggests that formal helpseeking needs to be seen within the context of helpseeking more generally, which includes informal resources and covert ways of obtaining help.

Discussion

Research has linked SA to numerous immediate and long-term negative impacts including both physical and mental health problems (Campbell, Dworkin, & Cabral, 2009) and has provided evidence that formal resources are utilized by small percentages of survivors (Campbell, 2008; Patterson, Greeson, & Campbell, 2009; Ullman, 2007). Such results have led to the conclusion that formal services are underutilized, based on implicit assumptions that (1) all survivors need services and (2) the services available would address their needs. Research has also tended to consider barriers and correlates of helpseeking by dichotomizing participants into helpseekers and non-helpseekers. Through qualitative methodology, this study was able to set aside that categorization, and to gain insight into how survivors' own perceptions of their experiences influenced their decisions about whether and where to seek help.

The Model – Deciding Where to Turn

Although this study was initially focused on formal helpseeking, what emerged was a more comprehensive model of the helpseeking process: Deciding Where to Turn. The results suggest that decisions about formal helpseeking do not occur independently from other helpseeking decisions, but emerge along with decisions about and experiences with informal resources, covert ways of seeking help, and coping independently.

"Deciding Where to Turn" shows that these decisions involve repeated assessments of the need for help, considerations of what can be done, and evaluations of the consequences of reaching out, and emphasizes the importance of survivors' own perspectives at each of these decision points. If, as the model suggests, these related decisions emerge within an iterative process rather than as a single dichotomous choice, research that dichotomizes participants into helpseekers and non-helpseekers may be missing important facets of the helpseeking process.

The results from this study provide evidence both in support of and contrary to the conclusion in the literature that formal services are underutilized. On the one hand, these results provide support for the roles of established barriers and correlates of helpseeking and suggest a framework for how these factors fit together. On the other hand, these results emphasize the importance of the survivors' perceptions of their own needs and provide a framework for understanding ways survivors reach out when they do not believe their needs require the direct use of formal resources. In fact, several participants in this study reported that informal resources and/or covert resources met their needs. Some survivors in this study also described feeling OK by coping on their own for at least a period of time, though all eventually accessed additional resources, which emphasizes the cyclical nature of helpseeking. The concept of covert helpseeking, which emerged from these data, also suggests that greater numbers of survivors may be accessing resources than previously thought.

Do I Need Help?

”Deciding Where to Turn” incorporates most of the correlates to helpseeking commonly cited in prior research including perceptions of severity (e.g. Fisher et al., 2003), labeling (e.g. Littleton and Henderson, 2009), and self-blame (e.g. Campbell et al., 2009). The results show that these correlates are salient to survivors and that they come together in the key decision point “Do I Need Help,” which includes both perceptions of what happened and how it affected them. Although this study did not articulate specific hypotheses, this decision point also incorporates the three anticipated themes related to the correlates found in prior research: that survivors would vary in their perceptions of post-assault sequelae, in how they label the experience, and in their perceptions of blame based on the context of the SA and the survivor-offender relationship.

The results show that how the survivor defines “What Happened” incorporates two commonly cited correlates with helpseeking: self-blame and labeling. More specifically, the data suggests that it is the balance of how the survivor attributes blame between her/himself and the offender that is connected with labeling and, in turn, with defining “What Happened.” This connection between attributions of blame and labeling in assessing what happened adds support to prior research (Harned,2005). For example, Harned (2005) found that survivors often consider their own level of responsibility when deciding how to label the experience and that these variables were negatively correlated. Interestingly, the survivor-offender relationship did not emerge in this study as one of the concepts that participants used in their helpseeking decisions, despite being one of the

most commonly found correlates (e.g. Fisher et al., 2003) and this researcher anticipating a connection between the relationship and attributions of blame.

Research has found a positive correlation between perceptions of severity in the post-assault sequelae and formal helpseeking (Fisher et al., 2003; Ullman et al., 208; Ullman & Filipas, 2001a). The results from this study add support to prior findings while also suggesting the importance of how the survivor defines "What Happened" in their determination of "How Does it Affect Me." When formal resources are utilized, the type of resource chosen is dictated primarily by survivors' assessments of their own needs, such as using medical resources for physical concerns and mental health resources for psychological and social concerns. However, a trend in the findings suggests that survivors who describe their experiences as SA or other victimizations early on also tend to seek formal help more quickly and to disclose to these resources. Although legal and advocacy resources tend to encounter more barriers across all three decision points, these resources specifically require the survivor at least be contemplating that "What Happened" might be SA in order to be considered. When survivors do not conceptualize the experience as a possible SA, they believe that legal and advocacy resources do not apply based on what they understand about the functions of such resources ("What's Out There").

What Can I Do?

The results of this study suggest that survivors' knowledge of resources ("What's Out There") and their "General Attitudes Toward Helpseeking" largely exist prior to the

USE and that they interact to form the mediating variable of "What Can I Do." The data from this study also suggest that USE survivors are generally aware of the existence of the four primary types of formal help (medical, mental health, legal, and advocacy), though they are often less certain of the function of advocacy resources. This finding about advocacy resources is consistent with a recent quantitative study which found that only about half (54%) of the students in the study remembered receiving information about sexual assault resources on campus (Hayes-Smith & Levett, 2010). Taken together, these findings suggest that current approaches for educating students about advocacy resources are not effective enough for them to remember the information presented and new strategies are needed.

Research has considered general attitudes toward helpseeking primarily in terms of how they create barriers for particular populations such as ethnic minorities and men (e.g. Lonsway & Fitzgerald, 1994; Masho & Alvanzo, 2010; Ullman, 2007). The data from this study adds support for the assertion that negative attitudes about helpseeking decrease the likelihood of seeking help, particularly from formal resources. This study contributes to the literature by suggesting that the specific role for these attitudes is as a mediating factor in the helpseeking decision process. This study also contributes by suggesting that survivors may not be aware of the source of these attitudes, as described further in the section on limitations.

What Will I Do?

In addition to the correlates cited above, research has suggested that negative anticipations of how both formal and informal resources may respond act as significant barriers to helpseeking (e.g. Campbell, 2008; Patterson et al., 2009; Ullman et al., 2008) and this study supports that conclusion. Participants in this study specifically described fears of being judged negatively, getting in trouble, or receiving disproportionate reactions from help providers than they wanted. Participants' concerns about disproportionate reactions from help providers were particularly interesting since they included both under- and over-reactions. While most research has focused on under-reactions and shaming responses as forms of secondary victimization (e.g. Campbell, 2008), concern about over-reactions has begun to appear in the literature. For example, Patterson and her colleagues (2009) noted that some survivors feared that seeking help from medical or social services would automatically force them to contact additional agencies, such as law enforcement. Taken together, these findings suggest that gauging survivors' perceptions of their own needs and their desires about what happens next are important components of help provision.

Participants' concerns about how others would respond to disclosure was not separated by resource type in this study, but nearly all of the participants described fears of negative reactions from at least one potential resource including both formal and informal resources. Consistent with previous research (e.g. Ahrens et al., 2009), most participants did disclose to at least one resource prior to participating in this research, and they were most likely to initially disclose to informal resources. Most participants

reported that they primarily received supportive responses from these resources, again consistent with previous research on disclosure to informal resources (e.g. Ahrens et al. 2009). However, most participants in this study also described anticipating negative reactions from at least one resource prior to their actual disclosures. Research has found that negative reactions from family/friends can have a profound negative impact on the SA survivor while positive reactions have limited effects (Ullman, 1999). The results of the current study may help to shed light on this finding. One explanation may be best described through the analogy of a scale. Since survivors anticipate negative reactions, they have pre-weighted the scale. Therefore, even small negative reactions from others can tip the scale to produce negative impacts. However, positive reactions must first overcome the initial weight of negative anticipations before the scale can tip towards positive impacts.

The concept of shame is discussed surprisingly little in research on helpseeking for SA. It is discussed much more in connection with the impacts or symptoms of SA and sexual abuse (e.g. Campbell et al., 2009; Rahm, Renck, & Ringsburg, 2006). In this study, however, shame emerged within the decision point of "What Will I Do," when participants weighed the consequences of seeking help. Shame emerged as a separate concept from concerns about what others would think and focused primarily on survivors' own feelings of embarrassment or not wanting others to know. Thus, in the current study, shame emerged as a barrier to helpseeking. This finding is consistent with other research on shame more generally. Tangney and Dearing (2003), leading experts on

shame, proposed that one way shame can be destructive is as a lack of motivation to seek care.

Research has often differentiated between shame and guilt by defining shame as being directed toward the self and guilt as directed towards an action (Tangney & Dearing, 2003). This distinction is similar to that made between characterological self-blame and behavioral self-blame, though research on these distinctions in self-blame have produced inconsistent results (Campbell et al., 2009). The current study suggests that shame and self-blame are distinct concepts and that they affect helpseeking at different stages. The results specifically suggest that self-blame is part of defining "What Happened" and assessing "Do I Need Help" while "Shame" is a barrier to helpseeking that is weighed in determining "What Will I Do." The distinction between shame and self-blame found in this study may provide an area for future research, as discussed in the section on research implications.

Outcomes –Helpseeking Decisions

The concept of covert helpseeking is an emerging concept that was reported by half of the participants in this study. Generally, covert helpseeking appeared when participants perceived a need for help related to the USE but determined that the potential consequences of seeking help directly were greater than acceptable and/or they believed they could have their needs met without disclosing to the resource used. While the idea that helpseeking without disclosure occurs may not be surprising to practitioners, research has not identified it as a meaningful category of behavior. In prior work, such

behavior would fall into one or the other dichotomous categories of helpseeking (yes or no), depending on definitions. Considering covert helpseeking as a set of strategies that may or may not meet the needs of survivors opens up important new research questions and ways of understanding survivors' choices. Further considerations of this concept are discussed in the sections on research and practice implications.

One of the main questions this study explored was how survivors make decisions about where to seek formal help once they've decided to do so, including the type of formal resources and whether they were on- or off-campus. Results showed that survivors generally make choices about on- versus off-campus resources due to convenience and financial considerations. Regarding the specific type of formal resources chosen, the results emphasize that survivors choose the type of resource based on their own perception of need and the choice is mediated by their knowledge of resources and general attitudes about helpseeking (i.e. "What Can I Do?"). This distinction is important since survivors may identify their own needs differently from service providers and survivors are often concerned with disproportionate reactions from service providers, as discussed previously.

Limitations

There are several limitations to the current study. First, USE survivors who agree to participate in research may be different from other survivors and this may be particularly so for participation via in-person interviews. Thus, their process of deciding whether and where to seek help may be different than those who did not participate.

Second, due to the qualitative nature of the study and the small number of participants the findings may not be generalizable to larger populations of USE survivors in college or in the general population. Nonetheless, qualitative approaches are helpful for gaining insight into processes salient to participants, such as decision-making, and the number of findings consistent with prior research suggest the proposed model may be a viable framework for how components of helpseeking fit together.

Other factors that may limit generalizability were the relatively homogeneous nature of participants including socioeconomic status, the intentional focus on traditionally aged college students, the limited numbers of male participants (n=1), and the small number of ethnic minority participants (n=3). People from more impoverished neighborhoods than college students tend to come from may have more experiences with various types of trauma and other experiences that may influence how they think about helpseeking (Bennett Cattaneo & DeLoveh, 2008; Lowe, Galea, Uddin, & Koenen, 2014). The applicability of the model to other age groups is an area for future research. In order to encourage discussions of diversity without leading participants, the interviewer asked the following question as a probe (see Appendix C for complete interview questions): "What, if anything, do you think might have made you cope with this experience differently than others with a similar experience?" Although some participants mentioned individual differences (e.g. that they prefer to handle things on their own) or differences in their experiences (e.g. prior USEs), none of the participants mentioned ethnicity or other commonly researched aspects of diversity as influencing their coping strategies. Since only one male participated in the current study, his interview was

analyzed later in the analytic process and constant comparison was used to consider similarities and differences in the data. The research team concluded that data from this interview was consistent with the emerging concepts. Research on helpseeking suggests that it is unlikely that factors like ethnicity and gender are not a factor (e.g. Lonsway & Fitzgerald, 1994; Masho & Alvanzo, 2010; Ullman, 2007). However, it is possible that (1) survivors are not aware of how ethnicity/gender affects their decisions and (2) cultural differences may already be reflected in the subjective nature of the concept "General Attitudes Toward Helpseeking." For example, prior research on helpseeking has suggested that cultures may vary in how problems are perceived and what should be done to cope (e.g. Cauce et al., 2002; Holcomb-McCoy, 2000; Leong et al., 1995), considerations that are explicitly part of the proposed model.

Finally, the retrospective nature of the current study relied on participants' recollections. Some factors relevant to helpseeking may not have been recalled. However, since this study focused on their own understanding of their helpseeking decisions, it seems reasonable to assume that participants remembered factors most salient to them.

Research Implications

"Deciding Where to Turn" provides a useful framework for a comprehensive understanding of decision making about helpseeking. Future research should test whether this model remains a useful framework outside of the college setting and over longer periods of time. Participants in this study reported their most recent USEs from 3 months to 4 years prior to the study, though research has shown that survivors may seek formal

help many years after a USE (Ullman, 2007). Future research should also consider whether the types of formal resources available to survivors change over longer periods of time and how that may affect the model. For example, reporting a USE to police may not be possible after a period of time while counseling resources remain availale. It is anticipated that the model will remain useful across both longer periods of time and outside of the college setting, though the availability of some specific resources may change.

Future research should also explore how particular concepts within the model may affect the balance between decision points to better predict the specific helpseeking method(s) chosen by survivors. One such consideration is whether the concept of "What Happened" is a stronger predictor for some helpseeking choices than others. Another question is how knowledge of resources ("What's Out There") interacts with "General Attitudes Toward Helpseeking." Future research might specifically explore differences in college students' broad awareness of resources verses specific knowledge of campus policies and procedures and whether "General Attitudes Toward Helpseeking" impacts their memories of such knowledge. This connection may be important for a deeper understanding of the mediating effect of "What Can I Do" in the decision-making process, especially given that these concepts exist within survivors prior to the USE.

Research has shown that more than 83 percent of SAs are committed by someone the survivor already knows and that this trend is particularly apparent in college samples (Fischer et al., 2000; Fischer et al., 2003; Kilpatrick et al., 2007; Tjaden & Thoennes, 2006). This study was consistent with these finding. In fact, only one incident of

unwanted intercourse or attempted intercourse was committed by a stranger in this data. Research has also consistently found that the survivor-offender relationship is negatively correlated with helpseeking (Fischer et al., 2003; Ullman & Filipas, 2001a). However, the survivor-offender relationship did not emerge in this study as one of the concepts participants used in their helpseeking decisions. Given the consistency of this correlation in previous research, it is likely that the survivor's relationship to the offender influences one of the other concepts that emerged in this study. Research suggests that the survivor-offender relationship influences how survivors label their USEs (Bonderant, 2001; Harned, 2005). Therefore, future research should consider whether and how the survivor-offender relationship influences the survivor's understanding of "What Happened" and how that may affect the overall model.

This study proposes that self-blame and shame are each important components of helpseeking decisions but that they arise at different points in the helpseeking process. Future research may consider whether the proposed model helps to clarify the conflicting findings on the predictive abilities of behavioral versus characterological self-blame found in prior research and how characterological self-blame relates to shame. It is anticipated that such research would add support to the assertion in this model that (behavioral) self-blame is part of defining "What Happened" and "Do I Need Help" while shame acts as a potential consequence/barrier to helpseeking.

Another significant area for research concerns the development of measures that accurately account for survivors' subjectivity. For example, the PSS-SR relies on survivors' reports of the frequency of their symptoms but does not account for the extent

that survivors feel negatively affected by these symptoms. An accurate measure of perceived impact across physical, psychological, and social symptoms is essential given the importance of survivors' perceptions of their own needs proposed in the model. Similar concerns exist across the proposed concepts. For example, the results suggest that it is not only how a survivor attributes blame but how this attribution affects her/his conception of "What Happened" that contributes to her/his perception of need.

Covert helpseeking may be the most intriguing concept to emerge from this study and it has numerous implications for both research and practice. Of the 14 participants in the current study, fully half of them sought some form of support without disclosure and six of these did so by connecting in some way with formal resources. Even after setting aside online resource use and seeking informal support without disclosure, six participants reported a total of six instances of covert connections with formal resources. For five of these cases, the formal resource that was used covertly was not reported as a resource used by the participant in the online questionnaire. This finding suggests that survivors often do not report covert helpseeking as helpseeking, which may mean that current estimates for service utilization are low. This finding, in turn, suggests two important research questions: (1) how often and under what circumstances does covert helping occur; and (2) is disclosure necessary for effective service use? With respect to the first question, further qualitative research might explore whether and when additional sources of covert helpseeking occur beyond those identified in this study while quantitative research might consider accurate means for measuring the frequency and circumstances of its occurrence. With respect to the second question, research might

explore whether covert helpseeking is an effective strategy for particular circumstances, such as when the perceived risk of disclosing is equal or greater than perceived need and when survivors feel strongly that they should cope on their own but still need some additional information/resources to do so. Covert helpseeking may also provide an opportunity for "Testing the Waters" of helpseeking, a concept proposed by Symes (2000).

Practice Implications

"Deciding Where to Turn" provides a framework for understanding helpseeking choices that is useful for existing practitioners as well as for training new practitioners. The model specifically aids in considering formal helpseeking as only one viable component in the quest to feel OK and emphasizes the importance of survivors' own assessment at each decision point. Using this framework can help providers to meet survivors where they are by listening carefully to survivors' descriptions of their own needs. Practitioners should also monitor survivors' responses as they are providing help or information on other resources to reduce survivors' perceptions of either under- or over-reactions on the part of the practitioner. Practitioners might assume that what is most needed is to take the survivor seriously and to let her/him know that what happened is not her/his fault, but studies now suggest that over-reactions are just as concerning for survivors as under-reactions (this study; Patterson et al., 2009). It may be more important to reflect survivors' own sense of the situation without pushing her/him to feel differently about it that she/he does.

The current study suggests that survivors are often uncertain about the role of advocacy resources and that they may be particularly hesitant to use these resources when they do not want to think of their experiences as SA. Outreach initiatives by advocacy resources would therefore benefit from clarifying their roles in the community and discussing their services through the language of USEs in addition to SA. Indeed, while concerns about labeling may be especially true for advocacy resources, the consistent hesitancy to label by most participants suggests that language is important to consider across all resource types. Since participants were concerned about over-reactions as well as under-reactions from help providers, it seems reasonable to assume that perceived pressure to label as SA is one form of perceived over-reaction. Once again, this study suggests throughout the proposed model that it is important to meet survivors where they are in determining their own needs.

Practitioners should also consider the potential role of covert helpseeking in their practice, since survivors may choose not to disclose or to only vaguely disclose a USE. On one hand, this emphasizes the importance of maintaining a sensitivity about USEs even when a client has not reported such experiences. Such sensitivity might include regularly explaining procedures, such as each step in a gynecological exam, as well as continuous awareness of language choices and perceived judgments throughout service provision. On the other hand, an awareness of the potential benefits of covert helpseeking may help practitioners to generate additional recommendations for resource utilization when survivors are concerned about consequences. Examples might include attending an

outreach presentation, volunteering for an organization, or simply obtaining a medical checkup without disclosing the USE if needed.

The findings regarding covert helpseeking along with the finding that survivors may choose on-campus resources primarily due to convenience has important practice implications for on-campus resources, particularly when off-campus resources are readily available. Specifically, on-campus resources may be able to assist survivors more broadly through education and prevention efforts, including bystander intervention efforts. A review of college education and prevention programs that target SA found that most achieved their goals of increasing knowledge and improving attitudes about SA, though they do not appear to have produced long or lasting reductions in SA rates (Daigle et al., 2009). Although survivors did not specifically point to such programs, this study found how survivors define their own experiences and how they anticipate others will react are key factors in their decision-making process. It stands to reason that education and prevention programs may therefore help those who have already experienced USEs by helping them to recognize symptoms that they may need help for, to improve the support they may anticipate from informal resources such as their peers, and by providing definitions of SA that they can weigh against their own experiences without pressure to use such labels. The current study also suggests an important additional role for outreach and prevention programs: to provide a variety of opportunities for covert helpseeking.

A final implication for both research and practice among college USE survivors is the issue of confidentiality. Once again, it is important to consider how survivors may perceive actions by resource providers as over-reactions. Outreach initiatives and

education programs can help by clearly describing the roles and limits of confidentiality across possible resource providers. This includes whether, when, and how survivors will be required to report their experiences to other authorities if they disclose to specific campus resources, including resources that may be considered less formal such as professors. Such considerations have become more complex for universities since the data for this study were originally collected due to increased scrutiny of the role of Title IX regarding cases of SA. On April 4, 2011, the United States Department of Education issued a "Dear Colleague" letter that emphasized universities' responsibilities for handling allegations of SA under Title IX (Ali, 2000). Although data were initially collected shortly after that date, changes in how universities have chosen to respond to this call have continued to evolve, including who is required to report allegations to the Title IX office (Grasgreen, 2012). Depending on the procedures enacted by a university, various personnel including faculty, staff, and even some offices that focus on SA such as women's centers may be required to report allegations to the Title IX office for further investigation. While counseling centers and health centers continue to generally be exempt, students may be increasingly uncertain about where they can turn if they do not want to report their experiences to school officials. Policy makers should evaluate the impact of these changes.

Conclusion

The current study uses grounded theory to explore how USE survivors make decisions about helpseeking. The resulting model, "Deciding Where to Turn," suggests

that survivors engage in three key decision points in their process: determining if there is a problem related to the USE ("Do I Need Help"), considering options ("What Can I Do"), and weighing the consequences of these options ("What Will I Do"). This process results in one of four behavioral choices: cope on one's own without support from others, seek support from friends/family, seek support from formal resources, or find a covert way to meet one's needs. For survivors of this study, the goal of these choices was to feel "OK." The model demonstrates that feeling OK is an iterative process rather than a single, dichotomous choice. The results suggest numerous implications for research and practice, including the need for increased understanding of survivors' subjective assessments of their own needs and the potential benefits of covert helpseeking.

Appendix A: Recruitment Advertisement

Appendix B: Website Content

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

About This Study

Hello, my name is Heidi DeLoveh. I am a doctoral student at George Mason University and I am conducting this study for my dissertation under the supervision of Dr. Lauren Cattaneo. Thank you for your interest in my research.

The purpose of this study is to learn more about the process that students go through after an unwanted sexual experience as they decide whether to talk to a professional for help. Previous research has shown that many students have sexual experiences during their college years that they did not want to happen. These experiences may occur with an intimate partner, a classmate, a new acquaintance, or a stranger. Students who have had unwanted sexual experiences have described a wide range of physical and emotional effects afterwards. There are no right or wrong reactions to an unwanted sexual experience and there are no right or wrong ways to ask for help. Nonetheless, professionals such as counselors, medical practitioners, sexual assault advocates, and police do want to help. By participating in this study, you can help such professionals to better understand why students do or do not seek their services.

You are eligible to participate in this study if you have had an unwanted experience since entering college at George Mason University, are currently enrolled as a student, and are between the ages of 18 and 25. If you are interested in participating in this study, please click below.

Yes, I am interested in participating

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Volunteer Informed Consent

George Mason University Department of Psychology
Contact Heidi DeLoveh with any questions (link provided in the menu on the left side of the screen).

Study Title
Seeking Help for Unwanted Sexual Experiences

Research Procedures
This research is being conducted to learn more about the process that students go through after an unwanted sexual experience as they decide whether to talk to a professional for help. If you agree to participate, you will be asked to complete a series of online questions about unwanted sexual experiences you have had since entering George Mason University (GMU), your emotional reaction, and whether you contacted any professional services about these experiences after they happened. These online questions will take about 10 minutes to complete. You will also be asked to provide contact information so Ms. DeLoveh can contact you either to check-in about how you are feeling after completing these questions or to request a longer interview.

If you are asked to participate in a longer interview, the interview will be conducted in person and will take approximately 90 minutes to complete. In the interview, you may be asked more in-depth questions regarding the unwanted sexual experiences you described in the online questions, but the primary focus will be on understanding the decisions you made after these experiences regarding any professional services. There are no right or wrong ways to respond to unwanted sexual experiences and no right or wrong ways to ask for help. Once again, the purpose of this study is to improve professionals' understanding of your decisions. At the end of the interview, you will be provided with a form on which you will be able to indicate whether Ms. DeLoveh has your permission to contact you again. She will not contact you without your explicit permission. If you give her permission, Ms. DeLoveh may contact you again by telephone to ask follow-up questions to clarify information discussed in the interview or to offer you the opportunity to review the results and provide additional input.

Risks
You will be asked questions of a personal nature about unwanted sexual experiences and your decisions about professional services related to these experiences. You are free to decline to answer any questions that you do not wish to answer, or you may stop participating at any time without penalty. It is possible that you might become upset after completing the online questions or the interview. Please note that if you do feel upset and would like to speak with someone, you can contact the GMU Counseling and Psychological Services (CAPS) at (703)993-2380 or the GMU Center for Psychological Services at (703)993-1370 during regular business hours. You can also contact Sexual Assault Services 24-hours/day at (703)380-1434. Additionally, Ms. DeLoveh will contact all participants to check-in and to inquire if they are in need of additional support or services.

Benefits
There are no direct benefits to you as a participant. It is anticipated that your participation will help to increase understanding of how students make decisions about seeking professional services after having unwanted sexual experiences.

Confidentiality
The data in this study will be confidential. However, the law requires certain limits to confidentiality: If you tell us about a child who is being abused, or about your intent to hurt someone else or yourself, it may be necessary to report that information to authorities. The first part of this study is online and, while no computer transmission can be perfectly secure, reasonable efforts will be made to protect the confidentiality of your online transmission. The following procedures will be followed in order to keep your personal information confidential in this study:

1) Your name will not be included on the online questions. Contact information will be stored separately from other data.
2) A randomly generated code will be placed on the collected data.
3) Through the use of an identification key, the researcher will be able to link your data to your contact information. However, only the researcher will have access to the identification key, which will be stored in a password protected file.

To insure that your responses to online questions are not viewed by another person, please do the following:

1) Do not leave the computer terminal or your browser (e.g. Internet Explorer, Mozilla Firefox, Google Chrome, etc.) before finishing the online questions (e.g. answer the phone, leave the computer unattended, etc.). It is possible for a third party to inadvertently access your responses if you leave the terminal before completing the questions and closing the browser.
2) Exit/Close your internet browser as soon as you finish responding to the questionnaire. Your responses might be visible if you (or someone else) clicks the "back" button on the browser. You can eliminate this possibility by exiting or closing the browser as soon as you finish responding and have submitted your responses.

If you are asked to participate in the interview portion of this study, the interview will be audio-taped. The following procedures will be followed in order to maintain your confidentiality:

1) Immediately after the interview, the tape will be labeled with a code rather than your name or other identifying information and the tape will be stored in a locked file. The identification key will be kept in a password protected computer file that will be accessible only to the researcher.
2) When the audio-tapes are transcribed, any identifying information such as names or places will be substituted with generic terms (e.g. "friend" or "class"). Audio-tapes will be erased or taped over after transcription is completed.
3) When reporting findings in written reports, direct phrases from interviews might be used. These phrases will not include any identifying information. You also have the right to request that we not use direct phrases from your interview.

Participation
You must be 18 years or older to participate in this study. Your participation is voluntary, and you may withdraw from the study at any time and for any reason. If you decide not to participate or if you withdraw from the study, there is no penalty or loss of benefits to which you are otherwise entitled. There are no costs to you or any other party. You will receive $20 for your participation after completing the interview.

Contact
This research is being conducted by Heidi DeLoveh under the supervision of Dr. Lauren Cattaneo in the George Mason University Department of Psychology. Ms. DeLoveh may be reached at hdeloveh@gmu.edu or (571)969-5162 for questions or to report a research-related problem. You may reach Dr. Cattaneo at lcattane@gmu.edu or (703)993-4728.

You may contact the George Mason University Office of Research Subject Protections at (703)993-4121 if you have any questions or comments regarding your rights as a participant in this research.

This research has been reviewed according to George Mason University Procedures governing your participation in this research

Consent
By pressing the "I Agree" button, you agree that you have read this form and agree to participate in this study.

I Agree

Version Date: March 2011

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Contact Information

Thank you for participating in this study. Ms. DeLoveh would like to contact you either to check-in with you about your participation or to request your further participation in a longer interview. By completing the following information, you are granting Ms. DeLoveh permission to contact you. Please note that email is not considered a confidential means of communication therefore any email contact will be used only to arrange other contact by phone or in-person.

- First Name:
- Last Name:
- Phone number:
- Email:
- Preferred form of initial contact:
  - ☐ Telephone
  - ☐ Email

Submit

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

General Questions

First, I would like to ask you a few questions about yourself in general. Please enter your information into the space provided.

- How old are you? ☐
- What year are you at George Mason?
  - ☐ Freshman
  - ☐ Sophomore
  - ☐ Junior
  - ☐ Senior
- What is your gender?
  - ☐ Female
  - ☐ Male
  - ☐ Other, please describe ☐
- What is your ethnic background? ☐
- What is your current living situation (e.g. living on/off campus, living with/without roommates, living at home with parents, etc.)?

☐

Submit

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Unwanted Sexual Experiences

You responded to a flyer that asked about unwanted sexual experiences. The following will ask you about these experiences.

- Since entering GMU, have you ever had sexual intercourse including vaginal, oral, or anal intercourse when you did not want to?

Yes **No**

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Unwanted Sexual Experiences

- What was your relationship to the person you had sexual intercourse with when you did not want to?

- Which of the following reasons most closely resembles why you had sexual intercourse when you did not want to? Please check all reasons that apply to you. If this occurred more than once, include all of your reasons.

  - ☐ You had been drinking or using drugs and were unaware of what was happening or were unable to stop it.
  - ☐ The other person used physical violence such as slapping or hitting you.
  - ☐ The other person held you down or otherwise prevented you from leaving.
  - ☐ You were afraid the other person would use physical violence such as slapping or hitting you.
  - ☐ The other person threatened to end the relationship.
  - ☐ You were afraid of what would happen if you did not have sex with the person.
  - ☐ Other. Please describe:

Submit

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Unwanted Sexual Experiences

- Since entering GMU, has anyone attempted, but not succeeded in making you have sexual intercourse including vaginal, oral, or anal intercourse when you did not want to?

Yes **No**

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Unwanted Sexual Experiences

- What was your relationship to the person who attempted to have sexual intercourse with when you did not want to?

Submit

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Unwanted Sexual Experiences

- Since entering GMU, has anyone touched you in a sexual way when you did not want or invite him/her to? This may include forced kissing, touching of private parts, grabbing, fondling, and rubbing up against you in a sexual way, even it was over your clothing

Yes No

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Unwanted Sexual Experiences

- What was your relationship to the person you who touched you in a sexual way when you did not want or invite it?

- Which of the following reasons most closely resembles why the person was able to touch you in a sexual way when you did not want it? Please check all reasons that apply to you. If this occurred than once, include all of your reasons.

  - ☐ The other person touched you unexpectedly and without warning, so you did not have the opportunity to stop it before it happened.
  - ☐ You had been drinking or using drugs and were unaware of what was happening or were unable to stop it.
  - ☐ The other person used physical violence such as slapping or hitting you.
  - ☐ The other person held you down or otherwise prevented you from leaving.
  - ☐ You were afraid the other person would use physical violence such as slapping or hitting you.
  - ☐ The other person threatened to end the relationship.
  - ☐ You were afraid of what would happen if you did not have sex with them.
  - ☐ Other. Please describe:

Submit

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Unwanted Sexual Experiences

- Since entering GMU, have you experienced another type of unwanted sexual experience that the previous questions have not adequately described? If so, please describe our experience here.

Submit

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Use of Professional Services

I want to ask you a few questions about any professional services that you used or considered using after the unwanted sexual experiences just described.

- Did you ever use any of the following professional services because of your unwanted sexual experience? Please check all services that you used.

  - ☐ Medical provider
  - ☐ Counselor or other psychological service
  - ☐ Rape crisis center or sexual assault services
  - ☐ Police (on- or off-campus)
  - ☐ GMU official other than police (e.g. dean, course instructor)
  - ☐ Other. Please describe:

- Other than the services you actually used, did you ever consider using any of the following professional services because of your unwanted sexual experiences? Please check all services that you considered.

  - ☐ Medical provider
  - ☐ Counselor or other psychological service
  - ☐ Rape crisis center or sexual assault services
  - ☐ Police (on- or off-campus)
  - ☐ GMU official other than police (e.g. dean, course instructor)
  - ☐ Other. Please describe:

Submit

Additional Information:

Heidi L.M. DeLoveh, MPhil

Lauren Bennett Cattaneo, Ph.D.

Resources for unwanted sexual experiences

Emotional Response

Below is a list of problems that people sometimes have after unwanted sexual experiences. Please read each one carefully and select the number that best describes how often that problem has bothered you in the past week. Rate each problem with respect to the unwanted sexual experience(s) you indicated earlier.

0 = Not at all or only one time
1= once per week or less / once in a while
2= 2 to 4 times per week / half the time
3 = 5 or more times per week / almost all the time

0	**1**	**2**	**3**	
○	○	○	○	Having upsetting thoughts or images about the experience that came into your head when you didn't want them to.
○	○	○	○	Having bad dreams or nightmares about the experience.
○	○	○	○	Reliving the experience, acting or feeling as if it was happening again.
○	○	○	○	Feeling very emotionally upset when you were reminded of the experience (for example, feeling scared, angry, sad, guilty, etc.).
○	○	○	○	Having physical reactions when you were reminded of the experience (for example, breaking out in a sweat, heart beating fast).
○	○	○	○	Trying not to think about, talk about, or having feelings about the experience.
○	○	○	○	Trying to avoid activities, people, or places that remind you of the experience.
○	○	○	○	Not being able to remember an important part of the experience.
○	○	○	○	Having much less interest or participating much less often in important activities.

○	○	○	○	Feeling distant or cut off from people around you.
○	○	○	○	Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings).
○	○	○	○	Feeling as if future plans or hopes will not come true (for example, will have no career, marriage, children, or long life).
○	○	○	○	Having trouble falling asleep or staying asleep.
○	○	○	○	Feeling irritable or having fits of anger.
○	○	○	○	Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read).
○	○	○	○	Being overalert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.).
○	○	○	○	Being jumpy or easily startled (for example, when someone walks up behind you).

Submit

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Thank You

Thank you for your participation in this study. Your responses have been submitted and Ms. DeLoveh will attempt to contact you within the next 24 hours.

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Appendix C: Semi-structured Interview

1) Hi. My name is Heidi DeLoveh. Thank you for agreeing to participate in this interview. Let's begin by reviewing the purpose of this study and informed consent with you. (See informed consent form).

2) I am interested in knowing how you became interested in this project. How did you find out about it?

    a. *Probe:* What appealed to you about this study?

3) Before we begin to talk about the focus of this interview, it would be helpful to learn a little more about you and your life. Could you tell me a little about your everyday life? For example, in the online questions you said that you are (*refer to participant's living arrangements*), what is that like for you?

    a. *Probe:* Tell me about your social supports.

    b. *Probe:* What do you like to do for fun?

    c. *Probe:* Are you involved in any clubs or other organizations?

    d. *Probe:* Do you work? What do you do?

4) Although the main focus of this interview will be about the decisions you made after an unwanted sexual experience, it would be helpful if we could briefly discuss the unwanted sexual experience itself. Is that OK? You checked yes to the question that asked if you ___(*indicate type of unwanted sexual experience*). Could you tell me more about your experience?

    a. *Probe:* When did this happen?

    b. *Probe:* Where did this happen?

        i. For example, was it on campus?

    c. *Probe:* What was your relationship with this person before this experience?

i. For example, were you friends?

d. *Probe:* In the online questions, you indicated that you (*refer to indicated reactions from the PSS-SR measure*). Tell me more about how this experience affected you. How did you feel after this happened?

e. *Probe:* Did your feelings change over time?

i. When/why did they change?

f. *Probe:* What, if anything, do you think might have made you cope with this experience differently than others with a similar experience?

g. *Probe:* How do you usually refer to what happened to you? What do you call it?

h. *Probe:* In the online questionnaire, you indicated that you (*refer to reason the unwanted sexual experience occurred indicated on questionnaire*). Could you tell me more?

i. How do you feel this experience was different from a wanted/consensual sexual experience?

5) **[Use question 5 only if participant indicated that she/he did not use any professional services in the online survey. Otherwise, use question 6].** Now that I have a better sense of what happened to you (*use the label that the participant used for the experience*), let's talk about how you coped with this experience. When you completed the online questions, you said that you did not use any of the professional services listed. Is that correct? Did you tell anyone about what happened to you?

a. *Probe*: Why / Why not?

b. *Probes for if participant told someone:*

i. Whom did you tell? (*Clarify participant's relationship to that person.*)

ii. Why did you choose to tell (*use participant's label for the person told*)?

iii. What was (*use her/his label for the person told*)'s reaction?

iv. Did (*use participant's label for the person told*)'s reaction affect your decision not to use any professional services?

v. Did you tell anyone else? Who? (*Clarify participant's relationship to that person.*Repeat questions ii through iv.)

vi. *If participant describes telling only friends or only family members, ask about the other. (E.g. if only describes telling friends, ask if they told family and why/why not).*

c. *Probes for if participant did not tell anyone:*

i. What made you decide to tell me?

d. **[Go to question 9].**

6) **[Use question 6 only if professional services were used]**. Now that I have a better sense of what happened to you (*use the label that the participant used for the experience*), let's talk about how you coped with this experience. When you completed the online questions, you said that you talked to (*insert the type of service or services they reported talking to after the* SA). Did you tell anyone about what happened to you before you talked to (*insert name of service or services again*)?

a. *Probe*: Why / Why not?

b. *Probe*: Whom did you tell?

i. Why did you choose to tell (*use participant's label for the person told*)?

c. What was (*use her/his label for the person told*)'s reaction?

d. Did (*use participant's label for the person told*)'s reaction affect you decision to use professional services?

7) Once again, you said that you used (*insert type of professional service or services used*). Can you tell me about your decision to talk to them? (*Ask this question and question 8 for each resource used*).

a. *If more than one resources was used:* Which resource did you talk to first?

b. *Probe:* When did you talk to them?

c. *Probe:* Why did you choose this type of professional?

d. *Probe:* Was this on- or off-campus?

i. Why did you choose there?

e. *Probe*: Did you tell them you were there because of (*use participant's label for their SA experience*)?

8) What was it like to ask for help from this resource (*return to question 7 if more than one service was used*)?

    a. *Probe:* How did they respond?

    b. *Probe:* Did you feel like you got what you were looking for from them?

        i. How so? (Or – Why / Why not?)

        ii. Did you feel like you needed additional help that they did not provide? What was that?

            1. *If additional help was needed:* Did you seek help for this from another resource?

9) **[Use question 9 only if participant indicated that they considered professional resources that they did NOT use].** When you completed the online questions, you said that you considered using (*insert types of resources considered*) but did not seek services from them. Why not?

    a. *Probe:* Did your experience with (*insert name of resource where participant did seek help*) impact this decision?

        i. How?

10) **[Ask question 10 only if there were types of services that were neither considered nor used].** You said that you did not consider using (*insert types of services neither considered nor used*). Why not?

11) We have covered all of the main questions I have for you today. Is there anything that I haven't asked about that is relevant to your decisions about seeking professional help regarding (*use the label they provided for their unwanted sexual experience*)?

12) Is there anything you think people trying to provide help or reach out to students should know?

13) I appreciate your willingness to share your thoughts and experiences on such a personal topic. What was it like for you to participate in this interview?

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Appendix D: Audit Trail

Data collection	Participants initiated their participation by completing the online questionnaire (see Appendix B) and were assigned a participant number. Responses were reviewed and those who met criteria were invited for in person interviews. All interviews were completed and audio recorded by the primary researcher. Interviews followed a semi-structured format (see Appendix C).
Analytic journal	A self-reflective/analytic journal was initiated shortly before data collection began and was maintained by the primary researcher throughout data collection and analysis.
Transcription	Audio recordings of the interviews were transcribed by a research assistant and reviewed by a second research assistant. Each interview was then reviewed again by the primary researcher. Once transcriptions were finalized, they were coded with sequence numbers. Sequence numbers provided a unique line number each time the speaker changed in the interview and allowed for later sorting of the interview data across participants. Sequence numbers facilitated constant comparison by allowing interviews to be both sorted by analytic codes and to be re-assembled into their original interview sequence. All data was stored on encrypted drives and transcripts were kept separate from identifying data.
Open coding and memos	Each interview was initially read by at least two members of the research team. As team members read the interview, they wrote memos for each section that they felt related to the research question. Each memo was given a title, which served as the initial codes in the open coding process. Each section that was coded by any team member was then reviewed by the research team. Codes were compared and contrasted. Disagreements in code names or substance were noted and resolutions were incorporated into new memos.

Subsequent coding	As coding proceeded, the research team engaged in constant comparison within and between transcripts. Changes to concept titles and definitions were tracked throughout the process. Emerging concepts were tested against older data as well as transcripts being newly analyzed. Confirming and disconfirming evidence were sought. Coding ended when theoretical saturation was reached.
Trustworthiness techniques	A research team was used to analyze the data and each transcript was coded and reviewed by multiple team members. Memos were utilized throughout the analytic process. A self-reflective/analytic journal was maintained by the primary researcher. Participants were invited to provide feedback on the results of analysis.

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Curriculum Vitae

Heidi L. M. DeLoveh received her Bachelor of Fine Arts (BFA) in Photography and Bachelor of Arts (BA) in Women's Studies from The Ohio State University in Columbus, OH where she graduated Magna Cum Laude. She received a Master of Philosophy (M.Phil) from the University of Glasgow in Glasgow, Scotland. Heidi's research interests include sexual assault, intimate partner violence, the psychology of gender, and community outreach and consultation. Her clinical interests include depression, anxiety, relationship issues, women's issues, and identity formation/exploration including sexual orientation and gender identity. She also has a special interest and experience in helping clients recover from physical, sexual, and psychological abuse and neglect.