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The Role of Social Support in the Disclosure and Recovery Process of Rape Victims

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by

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Dedication

This dissertation is dedicated to my grandmother, Umeko Sugimura Glass, who instilled the importance of education in me. She taught me that perseverance could make anything possible. Grandma, you have always been the voice in my head telling me to keep going and I know you will be smiling down on me as I walk across that stage.

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Abstract

Women disproportionately account for a majority of all completed and attempted rape victimizations each year in the U.S. relative to men. Female college students, in particular, have been noted as a group with the highest risk for rape. Rape among women not only has a substantial public health impact, but has been linked to a number of individual mental health and substance use problems. Despite the fact that service utilization (formal help-seeking with a counselor, mental health professional, rape crisis center, and police reporting) has been shown to deter negative sequelae of rape, few victims of rape receive assistance from a victim service agency or report the incident to police; and among college student victims, this rate is even lower. Instead, rape victims are more likely to disclose the event and seek help from an informal source, such as a family member, spouse/romantic partner, friend, or acquaintance. Traditionally seen to have a positive impact on victim's mental health, informal social support may play a different role in rape victims with high levels of alcohol involvement or among those who have experienced an alcohol-involved rape.

Current measures of social support fail to examine the factors that prompt victims to utilize their social support system and the role that alcohol use may play in victim's disclosure and recovery process. The current study explored the idea that social support may act as a barrier to help-seeking behavior, particularly formal treatment, among victims with alcohol involvement. This study had three primary aims: (a) to identify constructs related to the decision-making process to disclose a rape to an informal social

support, (b) to understand victim and victim supporters' perceptions of social support and the impact of these perceptions on rape victims' post-rape mental health, and (c) to determine the role that alcohol plays in the disclosure process. To achieve these aims, the study used a mixed method approach (utilizing data from in-depth, semi-structured (face-to-face) qualitative interviews correlated with quantitative survey data) with a sample of college students (N=46) who were categorized into two groups: female college students who had experienced a rape in their lifetime (Victims; N=16) and college students who had had a rape disclosed to them (Supporters; N=30). The use of thick description provided Victims and Supporters a voice that could not be heard through existing quantitative measures. Qualitative data unveiled the fact that the perceptions surrounding social support during disclosure of a rape are often very different between Supporters and Victims. Victims themselves more often report feeling uncomfortable or guilty because of their own acceptance of rape myths, which appears to hinder them from further help-seeking. However, Victims appear to be prompted to disclose to an informal social support when they feel they are ready to talk and are provided a comfortable environment, but both Victims and Supporters feel that Supporters are unprepared to provide sufficient aid and the support provided during the disclosure may be inadequate. Despite the feelings that professional help would be beneficial, Victims are often stalled by complicating factors during the assault or their individual characteristics, such as alcohol involvement. Recent efforts on educating the general public on rape myths were evident during the interviews, but these beliefs still remain in students' feelings surrounding rape and utilizing mental health services.

Chapter 1

Introduction

Rape is defined as forced sexual intercourse (meaning vaginal, anal, or oral penetration by the offender), which may include psychological coercion as well as physical force (BJS, 2012; Tjaden & Thoennes, 1998). Women disproportionately account for an estimated 94% of all completed rapes and 91% of all attempted rapes each year in the U.S. relative to men (Rennison, 2002). In fact, nearly 1 in 6 American women have been the victim of attempted or completed rape in their lifetime; and an estimated 302,100 women are raped each year, totaling over 17 million women experiencing rape in their lifetime (Tjaden & Thoennes, 1998). Female college students, in particular, have been noted as a group with the highest risk for rape, with a victimization rate of about 1 in 4 (26%) and 29.4% of women victims' aged 18-24 years at time of first rape (BJS, 2012; Fisher, Cullen, & Turner, 2000; Koss, 1985). Additionally, rape among women has a substantial public health impact, resulting in $26 billion of economic burden each year (Post, Mezey, Maxwell, & Wibert, 2002).

Public health professionals have emphasized the importance of offering treatment and victim services for rape victims due to the documented prevalence and incidence of mental health problems in this population (Ullman, Townsend, Filipas, & Starzynski, 2007). Major depression, anxiety, and post-traumatic stress disorder (PTSD) are the most

common mental health disorders experienced by rape victims (R. Campbell, Dworkin, & Cabral, 2009; Miller, Amacker, & King, 2011). Rape victims report experiencing an average of five or more poor mental health days than those who have not been victimized (Vandemark & Mueller, 2008). In a nationally representative sample, 31% of female rape victims reported lifetime PTSD compared to only 5% of females who had never been victims of crime (Kilpatrick, Edmunds, & Seymour, 1992; Ullman et al., 2007). If left untreated or unaddressed, psychiatric comorbidities can become chronic and lead to other impairments in physical and psychosocial functioning. This may be especially relevant to college-aged women because research shows that the earlier problems develop and the longer they go untreated (as most do with this particular age group (Thompson, Sitterle, Clay, & Kingree, 2007)) the more deeply entrenched these problems become and may impact the student's education, economic, and social well-being (Zivin, Eisenberg, Gollust, & Golberstein, 2009).

Problem drinking and drug use have also been found to be highly correlated with rape and mental health problems among female rape victims (Cohn, Zinzow, Resnick, & Kilpatrick, 2013; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Klein, 2004; Ullman, Starzynski, Long, Mason, & Long, 2008). Victims of sexual assaults are 13 times more likely to abuse alcohol and 26 times more likely to abuse drugs compared to non-victims (Jewkes, Sen, & Garcia-Moreno, 2002). In a recent study of female college rape victims, those who had an alcohol-related rape reported significantly higher rates of past year binge drinking and drug use compared to non-impaired victims, both prior to and after the assault (Littleton, Grills-Taquechel, & Axsom, 2009). Furthermore, problem drinking is correlated with a greater incidence of mental health problems among

rape victims in cross-sectional studies, and predicts worse post-rape depression and PTSD symptoms in longitudinal studies (Ullman, Filipas, Townsend, & Starzynski, 2006).

Despite the fact that service utilization (defined herein as any formal help-seeking with a counselor, mental health professional, rape crisis center and police reporting) has been shown to deter negative sequelae of rape (Thompson et al., 2007), a mere 1 in 5 victims of rape or sexual assault receive assistance from a victim service agency or report the incident to police; and among college student victims, this rate is even lower (2-5%) (Koss, Gidycz, & Wisniewski, 1987; Langton, 2011; Thompson et al., 2007). According to the National Crime Victimization Survey (NCVS), about 74% of all sexual assaults are not reported to the police and only about 20% of victims seek assistance from a victim service agency (i.e., counseling, rape crisis, or victim advocacy center) after an assault (Langton, 2011).

Lack of contact with formal support services can carry serious consequences because of research showing that victims of sexual assault are already vulnerable to high rates of mental health and substance use problems relative to non-victims, which may persist, and even worsen, over the course of the individual's lifetime (R. Campbell et al., 2009). This is especially relevant given that most rapes experienced by college women go unreported or undisclosed to judicial or criminal authorities (Langton, 2011; Thompson et al., 2007). Thus, many college student rape victims may not be accessing treatment or crisis-intervention services that are available to them and at no cost (see Violence Against Women Act (VAWA) Reauthorization, 2013). Reporting to police is thought to act as a "gateway" for women to learn about and gain better access to services

to which they are entitled as crime victims. But without making this connection, many women are not even aware of the services they could be using to ameliorate rape-related physical and emotional consequences (Fisher, Daigle, Cullen, & Turner, 2003; Skogan, 1984). This point is emphasized by empirical data showing that, while about 59% of the victims who report their rape to police are treated for their injuries, only 17% of rape victims with unreported victimizations receive treatment (Rennison, 2002).

Even though most rape victims do not seek formal treatment services or report the incident to police, they are instead more likely to disclose the event to an informal source, such as a family member, spouse/romantic partner, acquaintance, or friend. In fact, in a recent qualitative study of 102 female rape survivors, almost 75% of first disclosures of a rape or sexual assault were to informal members in the woman's support network, with almost 40% of first disclosures to friends (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007). Examinations of community-residing (non-college) victims have shown rates of disclosure to informal sources to be almost 61%; and even higher rates of disclosure to informal social supports have been found among female college student rape victims relative to adult populations (Ahrens et al., 2007; Fisher et al., 2003; Orchowski & Gidycz, 2012; Thompson et al., 2007). Further, studies have documented that in both community and college-aged samples, women who have experienced a rape are most likely to disclose to a friend or peer, as opposed to a partner, family member, co-worker, neighbor, or stranger (Ahrens et al., 2007; Orchowski & Gidycz, 2012).

It is important to note that, even though disclosure is more prevalent than formal help-seeking, rates of informal disclosure to certain types of sources are still very low. In general, rape disclosure rates to family members, counselors, or campus authorities are

less than 10% (Fisher et al., 2003). There remains a gap in the literature to understand why victims choose to disclose to certain individuals over others. Research in this area is needed to better understand how informal sources can not only make themselves more "accessible" to victims, but more importantly, how professionals and public policy makers in this area can educate informal sources of support about how to respond to a friend who has been raped. This is especially important for college student females since they are the least likely group to report the incident to authorities, instead disclosing to peers, but have the greatest number of easily accessible services and programs on campus specifically designed for college students (Fisher et al., 2003).

While disclosure to informal sources may be one reason why college student rape victims do not seek out more formal types of interventions, low rates of service utilization have also been linked to victim's negative experiences with or perceptions of the criminal justice system (Kaukinen & DeMaris, 2009). One reason may be because women recognize that rapes are rarely prosecuted and often do not result in a conviction. Each year only 2% of reported rapes end with a conviction/imprisonment (*U.S. Senate Judiciary Committee: Conviction and Imprisonment Statistics*, 1993). According to the FBI, out of every 100 rape cases, 12 lead to an arrest, 9 are prosecuted, and only 5 lead to a felony conviction (FBI; Justice, 2010; Reynolds, 1999). Victims may not want to endure the stress of reporting to police or try to pursue conviction, particularly if they do not believe the criminal justice system will work in their favor. Female victims who do report the incident to formal sources often indicate that their interactions with others invoke feelings of re-victimization. For example, in a study of college women, Greene

and Navarro (1998) found that women who reported their sexual assault to authorities[1] (crisis center/emergency personnel or campus counselor) often described their experience with the system as a "second rape" or emotional "re-victimization", because they have to re-experience the event in telling it to others in great detail. Rape victims often report feelings of shame, embarrassment, guilt, and other negative emotions from disclosing a rape to a formal source (Thompson et al., 2007; Zinzow & Thompson, 2011).

College student victims may have a particularly unique experience when reporting a rape to campus police or any "formal" entity on a campus (victim advocacy center, the counseling center, etc.) because of the nature of the college setting. One reason is the high prevalence of acquaintance or date rape among college students, with about 90% of college women reporting victimization by someone known to them, including a classmate, a dorm-mate, or a friend of a friend (Abbey, 2002). That is, perpetrators of female college student rape victims are likely to be a peer or part of the victim's peer group, perhaps someone who lives down the hall or maybe someone the victim has to see every day in class. This familiarity between the victim and the perpetrator may impact the victim's decision to report because the perpetrator may be a part of a victim's social network and the victim may not want to look "uncool," "like a cry baby," or be blamed for reporting the incident to campus administrators or police. Further, the victim may not want to get the perpetrator "in trouble."

Another reason why victim's experiences with the criminal justice system may inhibit the desire to report a rape may be due to victim's lack of knowledge or awareness of what constitutes a rape, what could be reported as an illegal behavior, and not knowing

[1] The sample did not report to local or campus police at any of the three time points in data collection.

how or where to report a rape. Many victims do not perceive or acknowledge unwanted sexual experiences without consent as a rape, and therefore may not believe it is serious enough to report to authorities (Amstadter, McCauley, Ruggiero, Resnick, & Kilpatrick, 2008; Cohn et al., 2013; Wolitzsky-Taylor et al., 2011; Zinzow & Thompson, 2011). For example, Thompson and associates (2007) found that the majority of female college student victims did not report a sexual assault because they thought the incident was not serious enough to risk having people find out or to involve the police. Furthermore, these victims felt ashamed, embarrassed, and at fault for the incident, exacerbating their perception that the incident may not be serious enough to report or hindering them from acknowledging the incident as a rape.

Beyond rape acknowledgment, victims may not know how to report a rape – to police, campus authorities, or hospital. After a rape, victims may feel very overwhelmed, both physically and emotionally, and not know how or where to begin the process of seeking help. Victims, particularly those who may not view the incident as serious, who blame themselves for the incident (such as when alcohol or drugs are involved), or who do not acknowledge the incident as a rape, may feel hesitant about contacting formal entities if uninformed about the process of reporting.

Problem drinking among victims can further complicate disclosure of a rape incident and the stigmatization of being a rape victim (Ullman et al., 2008). Previous literature suggests that victim's alcohol involvement (particularly at the time of the incident and/or as a general pattern of behavior) and negative peer reactions about alcohol-involved rapes may increase a victim's apprehension to report (Ruback, Menard, Outlaw, & Shaffer, 1999). These findings highlight that for a female college student

victim of an alcohol-involved rape, negative reactions to her disclosure may be one of the biggest barriers to reporting (Thompson et al., 2007). Women who have experienced an alcohol-involved sexual assault or who have history of alcohol and/or substance abuse may perceive negative reactions from others when the incident is disclosed, especially to formal community supports (i.e., police, hospitals, etc.). Theory would suggest that women who have experienced alcohol-involved rapes may perceive negative social reactions from others when they disclose the incident because of myths or stereotypes people hold about women who drink as being "easy" or "loose" (Blume, 1991). It is because as a society, it is socially unacceptable and viewed as "irresponsible" behavior for women to be drunk, compared to men, who are given a "break" for being intoxicated, labeled as a "good old boy", or seen as just "acting out" (Blume, 1991).

Research has found that rape victims who experience negative social reactions from others following disclosure of their rape are more likely to have a history of problem drinking, as well as use alcohol to cope with stress, and have greater rates of post-rape problem drinking than those who do not experience negative social reactions from others (Ullman et al., 2006; Ullman & Najdowski, 2009). College women, in particular, are at greater risk for experiencing a drug and/or alcohol-facilitated or incapacitated (e.g. losing consciousness due to alcohol use) rape than non-college aged women because of the frequency with which they engage in heavy or binge drinking behavior (Abbey, 2002; Ullman et al., 2008). For example, a recent population-based study of college students showed that 41.1% of the women in the sample met weekly binge drinking criteria (4+ drinks in a two hour period), and binge drinking among college women is associated with a 7.8 times increased risk of being raped while

intoxicated (Beseler, Taylor, & Leeman, 2010; Mohler-Kuo, Dowdall, Koss, & Wechsler, 2004). Further, between one-half to two-thirds of college rape victims report drinking alcohol prior to the assault (Abbey, 2002; Littleton et al., 2009).

Although there are few studies that have examined the difference between post-assault experiences between drug/alcohol incapacitated/intoxicated victims and non-impaired victims, there is evidence that victims who have experienced a drug or alcohol-involved incapacitated or intoxicated rape[2] are more likely to experience feelings of self-blame, distress, and exhibit maladaptive coping such as substance use than those who were not incapacitated/intoxicated during the rape. These feelings could also discourage victims to disclose the incident to others (Littleton et al., 2009). Additionally, women who have experienced alcohol-involved rapes are more likely to blame themselves for the incident, or less likely to acknowledge the event as a rape (R. Campbell et al., 2009). Women who are intoxicated during an assault indicate little to no physical force used during the incident, which is associated with non-acknowledgment and self-blame (A. S. Kahn, Mathie, & Torgler, 1994). One reason for this link is that victims who do not experience what is considered a "stereotypical" rape (rape perpetrated with force and /or use of a weapon by a stranger) may not label their experience as a rape (A. S. Kahn et al., 1994; Peterson & Muehlenhard, 2011). For example, in a study (Peterson & Muehlenhard, 2011) that examined factors associated with labeling an unwanted sexual incident as a rape, those who did not acknowledge the incident as rape were more likely to say that the incident was "a mistake on [their] part," while those that called their

[2] Intoxicated rapes are rapes that involve drinking during the incident, where incapacitated rapes refer to the victim passing out or losing control over her behavior by voluntarily consuming alcohol or taking drugs. The term alcohol-involved rape is used throughout as a general term referring to a rape that involved alcohol consumption at any level. The victim has not consented in all three situations.

experience rape reported less self-blame. Therefore, blame and non-acknowledgment may lead to low rates of reporting if the victim does not believe the experience to be a rape or crime.

Review of the literature suggests that alcohol is also a key factor when investigating a victim's perceptions of her social support network, desire to disclose a rape to someone in her network, help-seeking behavior, and post-rape psychosocial functioning. Social support – typically defined as interactions between individuals or an individual's environment that are perceived as positive or helpful to a person's well-being – is central to treatment seeking behavior because it can promote or hinder a victim from reaching out and is emphasized as an effective intervention component of many mental health and substance abuse treatment models (Ullman et al., 2007). Social support is believed to play a positive role in an individual's physical and psychological well-being (Cohen & Wills, 1985; Komproe, Rijken, Ros, Winnubst, & t'Hart, 1997). Specifically, any type of social support (formal or informal) is thought to be a protective factor during stressful experiences and will promote help-seeking if an individual perceives that s/he will receive positive responses from others when dealing with a stressful event (Cohen & Wills, 1985; Fleet & Hiebert-Murphy, 2013). In turn, help-seeking provides more resources for someone to cope with the negative consequences of victimization (Cohen & Wills, 1985; Fleet & Hiebert-Murphy, 2013; Komproe et al., 1997).

Traditionally seen to have a positive impact on victim's mental health, social support may play a different role in rape victims with high levels of alcohol involvement or among those who have experienced an alcohol-involved rape[3]. According to *Labeling*

[3] This study focuses primarily on alcohol not only because of the increased prevalence rates of drinking in college environments and in sexual assaults, but the stigma attached to drinking behaviors, especially on

Theory (Lemert, 1951; Taylor, Wood, & Lichtman, 1983; Wortman & Lehman, 1983), social support has the potential to *negatively* impact a victim's post-rape mental health by stigmatizing the woman through internalization of the responses and perceptions of those in her social network. That is, victims may experience and perceive negative responses from others when disclosing or seeking help from someone in their social support network, if the rape involved alcohol or if the victims has a history of engaging in risky behavior, such as heavy alcohol use. These adverse responses may negatively impact the victim's well-being and self-esteem (Taylor et al., 1983). As both heavy alcohol use and rape are significantly higher in female college student samples than the general (adult) population, the intersection of these two problems is salient. One reason for potential stigmatization and labeling by others may be that female college student rape victims are perceived as behaving against traditional societal expectations of how women should act compared to men when pertaining to alcohol – that women who drink are seen as neglecting their stereotypical role as a nurturer and caretaker, and instead are characterized by the loss of sexual inhibitions (Huselid & Cooper, 1992; Ricciardelli, Connor, Williams, & Young, 2001).

Negative reactions aside, the extant literature also suggests that informal social support may create a barrier to services if the victim receives positive support (i.e., has someone willing to listen, receives sympathy, is able to talk to about thoughts and feelings with others, has someone to tell them words of comfort or encouragement, etc.), but the supporter is unable to provide sufficient assistance. The assistance may be

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the Victim's part. Further, drug use was examined in this study, but there were no cases of only drug use reported. Importantly, most studies that examined substance use/abuse focused on alcohol, not other types of drugs.

insufficient if the victim develops major depression, PTSD, or whose alcohol use escalates to something more severe after the rape. Informal supporters may be attentive and able to listen empathetically, but do not possess the professional skills to appropriately treat such problems. Further, even if he or she was a professional, it would be outside the boundaries of ethics to treat a friend for a medical or psychological problem. Individuals who have supported a rape victim indicate a range of feelings in response to the disclosure, from anger to helplessness, but there is limited research on how supporters may provide a false sense of helpfulness to the victim and the victim's perception of helpfulness (Ahrens & Campbell, 2000). For example, even though a victim may disclose an incident to a close and supportive friend or loved one, how prepared or how effective is that informal source of support at providing information and advice on recovering from the psychological consequences of a sexual assault? Part of the difficulty in understanding these varying aspects of social support and how it impacts post-rape outcomes are the broad definitions and numerous measures utilized in current social support literature (Cohen & Wills, 1985).

Current questionnaire assessments that have been used to measure social support and help-seeking and service utilization behavior in sexual assault survivors have focused on classifying different types of social support (perceived and/or received or formal vs. informal). These measures, however, do not examine the factors that prompt victims to utilize their social support system and the role that alcohol use may play in victim's perceptions and receipt of both positive and negative formal and informal support. There are still many questions that remain unanswered about the factors related to the decision-making process of disclosing a rape to social supports. For example, *what prompts*

victims to disclose or reach out to informal social support? *What do women hope to attain by disclosing a rape to people in their social network*? *What is the sequence by which alcohol use (at the time of the rape, before the rape, after the rape, or a combination thereof) may impact a victim's decision to disclose the incident to one or more social supports*? *What factors, in conjunction with alcohol, impact how much time has elapsed between a rape and the decision to disclose the rape to informal social supports*? Perhaps more insight into the answers to these and many other questions about how and when victims choose to utilize their informal social support network following a rape, and how these support networks facilitate or deter future help-seeking, may better inform screening and intervention efforts, leverage treatment planning, and assist in treatment-matching. This might be done by exploring the help-seeking experiences of both rape victims who have disclosed the incident to someone in their support network and individuals who have had a rape disclosed to them. Such information could provide a foundation to understand how different types of social support may be helpful, particularly for rape victims with prior or current alcohol involvement. Therefore, it is essential to examine the ***process*** of disclosure and impact of disclosure to forms of informal social support on rape victims' mental health in order to develop new ways to identify, prevent, and better treat this high-risk population.

Given that service utilization and rape reporting are especially low in college students, it has been suggested that it is more likely that college students may disclose a rape to people in their social network (Ahrens et al., 2007; Fisher et al., 2003; Orchowski & Gidycz, 2012; Thompson et al., 2007). However, alcohol use by the victim, at the time of the rape, or at some point in her lifetime, may be a factor that impedes reporting and

disclosure, and may also negatively influence the outcomes of disclosure (Littleton et al., 2009; Thompson et al., 2007; Ullman, 2003). Labeling Theory (Lemert, 1951) would suggest that college student female rape victims with alcohol involvement may be negatively labeled by their social supports because more blame and responsibility of the rape may be placed on the victim since she was drinking at the time of the incident. However, we know very little about the decision-making process leading up to disclosure for college student rape victims with alcohol involvement (at the time of the rape or at some point in their life). This is very important to know given the high rates of rape and alcohol use on college campuses, despite education efforts designed to combat these deleterious behaviors (Abbey, 2002; Littleton et al., 2009; Ullman & Najdowski, 2009; Ullman et al., 2008). Furthermore, victims in general (regardless of college-status) may blame themselves more, may be further stigmatized, or may not acknowledge a rape if alcohol is involved and they receive these negative reactions (Abbey, 2002; R. Campbell et al., 2009; A. S. Kahn et al., 1994).

The current study seeks to explore the idea that social support may act as a barrier to help-seeking behavior, particularly seeking formal treatment, among victims with alcohol involvement. This study has three primary aims (a) to understand and articulate the varying facets of social support, (b) to identify the decision-making process that influences college women's choice to disclose a rape to informal support systems, and (c) to develop more nuanced constructs to understand the impact of alcohol involvement on women's decision-making process to disclose a rape and their perceptions of the reactions of those to whom they disclose (as well as the perceptions of the supporter in regards to their reaction to alcohol involvement). To achieve these aims, the proposed

study will use a mixed method approach (utilizing data from in-depth, semi-structured (face-to-face) qualitative interviews correlated with quantitative survey data) to meet two main goals. The short-term goal of this dissertation is to identify concepts and develop a nuanced understanding of the perceptions of social support, the role of alcohol, and the impact of these factors on college student rape victims' decisions to disclose a rape to someone in their support network and on post-rape health outcomes. The long-term goal of this dissertation is to transfer the concepts that are identified in this proposal to the development of a measure that captures the multidimensionality of social support in the lives of female rape victims – the precursors leading to the use of social support, and the consequences thereof (both positive and negative), to identify women at risk of developing mental health problems or triage women to treatment based on alcohol use, decision-making, and social support composition.

Chapter 2

Literature Review

Alcohol Involvement among Sexual Assault Victims and College Students

Research demonstrates a strong link between alcohol use and sexual assault, particularly among college students (Ullman & Najdowski, 2009; Ullman et al., 2008). The role of alcohol in cases of sexual assault can be quite complicated and differs depending on who was consuming alcohol at the time of the incident (offender, victim, or both), a victim's history of alcohol or substance use prior to the assault, and victim's alcohol consumption post-assault. At the incident level, alcohol has been referred to as the most common "rape drug," as about two-thirds victims of sexual assault report consuming alcohol prior to the assault and nearly 50% of all rapes involve alcohol (on the part of the victim or perpetrator) (Abbey, 2002; Littleton et al., 2009; Mohler-Kuo et al., 2004). Cross-sectional research indicates that 49% to 75% of women with alcohol or drug use problems have histories of sexual victimization, while longitudinal studies show that about 35% to 40% of women will go on to develop an alcohol problem (or increase their alcohol consumption) following a rape (Kilpatrick et al., 1997; Wekerle & Hall, 2002). Of all age groups, young adults aged 18 to 24 have the highest prevalence of heavy and high-risk drinking, as well as alcohol use disorders (AUDs) (R. W. Hingson, Heeren, & Winter, 2006; NIAAA, 2008). With this in mind, it is no surprise that in a

study of 340 female college student rape victims, 62% indicated that they were either impaired or incapacitated during a rape incident (Littleton et al., 2009).

College student women report higher levels of binge drinking (4+ drinks within 2 hours) and heavy drinking (3+ drinks in a single day/7+ drinks per week) compared to any other age group, which place them at greater risk for experiencing sexual assault (R. Hingson, Heeren, Zakocs, Kopstein, & Wechsler, 2002; R. W. Hingson, Assailly, & Williams, 2004; R. W. Hingson & Zha, 2009; Neal & Carey, 2007; NIAAA, 2008, 2013; Wechsler, Davenport, Dowdall, Moeykens, & Castillo, 1994). Peer environments that are prevalent in college student social settings (i.e., fraternities, sororities, parties, bars, nightclubs), encourage heavy drinking which increases one's risk for sexual assault and puts women at risk by placing them in situations of increased contact with motivated offenders and decreased contact with capable guardians (Abbey, 2002; Knight et al., 2002; Ullman, 2003). For example, college women drinking at a bar or fraternity may be at greater risk of sexual assault where sexually aggressive men may target them, especially if they are alone inside or outside the party (Ullman, 2003). Even if capable guardians are present (for example, non-intoxicated peers or bystanders), they may be unwilling to intervene in these situations (Banyard, Plante, & Moynihan, 2005). With the marked increased risk of female college students being raped and the high rates of co-occurring alcohol use among this age group, it is timely to examine the impact of these behaviors on the mental health of rape victims.

The Impact of Rape on Victims: Alcohol Use, Disclosure, and Mental Health

Female college students have been found to have the highest rates of rape compared to adult women in the general population (Fisher et al., 2000). In national

sample of college women, over 50% of the women reported being sexually assaulted, with 15% of the women meeting the legal definition of rape and another 12% experiencing an attempted rape (Abbey, 2002). Rape has been described as one of the most severe types of traumatic experiences, leaving both physical and mental "scars" on victims (R. Campbell et al., 2009). Victims may suffer a multitude of long-term mental health problems, including depression, anxiety, and most commonly, post-traumatic stress disorder (PTSD) (Ullman et al., 2006). As noted previously, problem drinking is also prevalent among rape victims, and has been identified as both a pre-cursor and consequence of rape, and has also been linked to mental health problems (Abbey, 2002; Ullman et al., 2006; Ullman et al., 2008). It is particularly important to examine how women's alcohol use is linked to the rape disclosure process and post-rape mental health outcomes, given prior research showing that incident alcohol use, or a pattern of alcohol misuse among victims, is linked to low rates of reporting and post-rape help seeking (Amstadter et al., 2008; Kilpatrick et al., 1997; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley, 2007).

Mental health. Rape can have substantial short-term and long-term impacts on the mental health and well-being of victims, including major depressive disorder (MDD), generalized anxiety, panic attacks, substance and alcohol abuse, and PTSD (Miller et al., 2011). Depression is characterized by feeling down/irritable or having loss of interest/pleasure for most of the day, nearly every day, for at least two weeks (APA, 1994). PTSD is characterized by re-experiencing the original trauma, avoiding situations that remind an individual of the original trauma, and being aroused to the point that individuals have difficulty sleeping and are hypervigilant (APA, 1994). Studies have

found that 13% to 51% of women who have been sexually assaulted meet diagnostic criteria for MDD and between 17% to 65% of sexually assaulted women develop PTSD (R. Campbell et al., 2009). Furthermore, most women (73% to 82%) who have been sexually assaulted in their lifetime have been found to develop fear and/or generalized anxiety, with approximately 12% to 40% experiencing generalized anxiety (R. Campbell et al., 2009). These mental health problems have been found to be significantly stronger among victims of sexual violence compared to non-sexual violence victims.

In addition to the above mentioned clinical diagnoses, alcohol abuse is also highly prevalent among women who have been raped and has a high degree of co-occurrence with both MDD and PTSD (Najavits, Weiss, & Shaw, 1997). Previous literature shows that sexual assault victims are more likely to report comorbid PTSD and alcohol problems than non-victims (Kilpatrick et al., 1997; Najavits et al., 1997). Further, victims with drinking problems are more likely to have co-morbid psychological symptoms, particularly PTSD, compared to victims without drinking problems (Ullman et al., 2008). Najavits and associates have found comorbidity rates of PTSD and substance abuse among women to be between 30% to 59% (1997). Studies have shown that people with both PTSD and substance abuse, compared to people with only substance abuse, also have more associated life problems. These problems range from mood and anxiety disorders to medical problems. For women with PTSD and substance use problems, a number of other life problems have been reported, such as, homelessness, custody loss of children, and battered women syndrome (Najavits et al., 1997). These findings further illustrate rape victims' susceptibility to mental health problems post-

assault, particularly among victims who experienced an alcohol-involved rape or have a history of problem drinking.

Consequences of alcohol on post-rape outcomes. Alcohol use not only increases one's risk of rape, but also impacts post-rape mental health and subsequent alcohol use (Ullman, 2003). Research indicates that rape victim substance use at the time of the assault most often predicts self-blame after the incident (Littleton et al., 2009). Further, compared to victims with PTSD only, those with comorbid PTSD and alcohol use, are more likely to report high levels of self-blame for the assault, believe drinking could reduce distress, drink to cope with the emotional aftermath of the rape, and reportedly receive negative social reactions from others (Ullman et al., 2006). Likewise, research that has examined the impact of alcohol involvement during the assault on recovery by comparing rape victims who were impaired, incapacitated, and non-impaired, indicate that impaired/incapacitated victims reported significantly higher levels of hazardous drinking and self-blaming cognitions compared to non-impaired victims post-assault (Littleton et al., 2009). In fact, victims who have experienced an alcohol or substance-involved rape report feelings of blame not only from themselves, but receive blame from others as well. Scenario research shows that people believe that women who drink are more aggressive, less socially skilled, and more sexually disinhibited than non-drinking women (George, Cue, Lopez, Crowe, & Norris, 1995). These negative perceptions and rape myths held by society further negative consequences and post-rape outcomes.

There are several reasons purported in the literature to explain why women may consume alcohol after a rape. Given the fact that incapacitated/intoxicated victims

experience more self-blame and negative reactions (stigma) from others, it has been suggested that they may use maladaptive coping strategies post-assault to avoid or ruminate on such negative emotions (Littleton et al., 2009). The types of coping strategies practiced by rape victims can have a substantial impact on their recovery (Littleton & Breitkopf, 2006). Research indicates that rape victims are more likely to use maladaptive strategies, as opposed to adaptive strategies, when they experience negative sequelae (i.e., self-blaming cognitions, embarrassment, negative reactions from others, etc.) (Littleton & Breitkopf, 2006). One maladaptive coping strategy of rape victims, particularly ones with a history of problem drinking, may increase alcohol use post-assault to mask the negative emotions and mental health problems from the rape itself, as well as the negative reactions and feelings of self-blame of an alcohol-involved rape. Some research has shown that college women use drinking as a coping style more often than college men and that college students who drink to cope report higher avoidance coping strategies (to deal with recent stressful events), positive alcohol expectancies, and lower coping abilities (Park & Levenson, 2002). A study of college women found that victims who were using alcohol or drugs during the assault reported significantly higher levels of binge drinking, self-blaming cognitions, and feelings of stigma, compared to non-impaired victims (Littleton et al., 2009). Littleton and associates explained that engagement in these maladaptive coping strategies may be easier for impaired or incapacitated victims, compared to non-impaired victims, because they are able to think about how the assault could have been avoided over and over (i.e., ruminative counterfactual thinking).

Reporting and disclosure. Statistics indicate that between 2% and 20% of rapes are reported to formal agencies such as police, hospitals, or rape crisis centers (Ahrens & Campbell, 2000). Among college student victims, these rates are even lower (Koss et al., 1987; Langton, 2011; Thompson et al., 2007). Typical barriers to reporting include incident characteristics at the time of the assault (i.e., use of a weapon, relationship between victim and offender, etc.), emotions post-assault (i.e., self-blame, guilt, shame, embarrassment), whether or not the incident is acknowledged as a rape, concerns about confidentiality, and fear of not being believed (Sable, Danis, Mauzy, & Gallagher, 2006; Thompson et al., 2007). Those who do not report rapes are more likely to be assaulted by an acquaintance or intimate (as opposed to a stranger), assaulted with a weapon present, or to have experienced an alcohol-involved rape (Thompson et al., 2007).

Victims who report a rape to police or mental health professionals have been found to have better physical and psychological recovery than victims who do not report the incident to police or mental health professionals[4] (Thompson et al., 2007). This association may be due to the fact that victims who report are made aware of the victim services available, and thus may have improved access to mental health care, medical care, and other rape crisis services. Evidence suggests that victims who receive assistance from a service agency (publically or privately funded agencies that provide support and protection from sexual assault, services for physical or mental recovery, and guidance through the criminal justice system in obtaining restitution) are more likely to experience a follow-up criminal justice system action, such as an offender arrest or

[4] It is important to note that police and mental health professionals may respond to the reporting of a rape differently. Specifically, research has shown that police are more likely to perceive a victim's appearance or behavior as the cause of the rape, compared to mental health professionals who are less likely to hold rape myths (Feild, 1978).

contact from a court official, compared to victims who did not receive assistance from a service agency (Langton, 2011). Thus, there is a need to close the gap between victims' needs and services received.

Despite the noted benefits of formal reporting, it is more often the case, however, that victims of sexual assault disclose the incident to friends and family (Ullman, 1999). In fact, two-thirds of women eventually disclose the sexual assault to an informal social support, such as a family member, friend, or a romantic partner (Ullman et al., 2008). However, studies have found that rape victims with psychological vulnerabilities, such as those who have experienced childhood sexual assault, are found to delay disclosure even to informal forms of support compared to those who have less severe vulnerabilities (Ullman, 1996). In other words, victims who have experienced child sexual assault are less likely to disclose (or are likely to delay disclosure and/or reporting) future victimizations as an adult, perhaps because victims who have experienced this previous trauma are desensitized. Therefore, it is essential to understand the compounding effect of psychological vulnerabilities and previous trauma on victim's disclosure and recovery, as it may prevent acknowledgment of future rape (due to desensitization), serve as a barrier to disclosure/reporting, and hinder recovery.

Alcohol can further complicate and impact a victim's decision of whether or not to report or disclose the incident, especially if the victim was intoxicated during the assault, for a number of reasons (Thompson et al., 2007). First, a victim may be too intoxicated to resist, thus leaving little to no injury or physical proof (as in the case of most rapes). Women who are injured during a rape incident are more likely to report an incident to police than women who have no injuries because the incident is more

believable (Thompson et al., 2007). Second, intoxicated victims may have limited memory if the victim was too intoxicated to remember important details of the event. As with proof of injury, the key factor of believability is clouded when a victim cannot recall details of the event. Third, alcohol-involved rapes do not fit the stereotypical vision of a rape and therefore victims may not acknowledge the incident as a rape (Mohler-Kuo et al., 2004; Thompson et al., 2007). Studies have shown that the most common reasons for not reporting a rape was because the incident was not perceived as serious enough or the incident was not viewed as a crime (Thompson et al., 2007). In fact, until recently, the FBI's Uniform Crime Report (UCR) definition of rape did not include non-forcible rapes (i.e., rapes with victims incapacitated by alcohol/drugs and unable to consent). Therefore, victims of alcohol(or drug)-involved rapes often do not label their rape experience as actual rape because it does not fit the traditional script of being characterized by physical force, violence, resistance, blitz rape, and stranger perpetrator (A. S. Kahn et al., 1994). Hence, alcohol-involved rapes have been linked to higher levels of self-blame and guilt because they do not fit the traditional rape script (Littleton et al., 2009). In turn, it has been shown that victims who report feelings of self-blame, shame, or guilt in response to a rape are more likely to drink at hazardous levels post-assault and less likely to disclose (Thompson et al., 2007).

Research shows that victim's perceptions of stigma and negative social reactions from others are also common barriers to reporting and disclosure for sexual assault victims (Ullman & Filipas, 2001). This is especially true for women who have experienced an alcohol-involved rape, or who may have a history of alcohol use (Stormo, Lang, & Stritzke, 1997). For example, female problem drinkers perceive greater stigma

from society in response to physical and sexual victimization compared to women with little to no alcohol involvement (Blume, 1991; Gomberg, 1988). This may contribute to the decreased rates of disclosure. Moreover, stigma has also been related to the relationship of the victim and offender. Research indicates that the time from the incident to disclosure is much longer when offenders are known to victims, whereas victims are more likely to report and disclose the incident more quickly if the rape was perpetrated by a stranger (Thompson et al., 2007; Wolitzsky-Taylor et al., 2011). Alcohol-involved rapes are more likely perpetrated by someone known to the victim, and research indicates that victims take longer to report or disclose a rape perpetrated by a known person (Abbey, 1991; Mohler-Kuo et al., 2004; Wolitzsky-Taylor et al., 2011). Rapes in which the offender is known and alcohol is involved are highly prevalent among college students (Abbey, 1991, 2002). Consequently, 42% of female college student rape victims never tell anyone about the incident (Koss et al., 1987).

Unique experiences of college student rape victims. College student victims may have a particularly unique experience in terms of reporting to formal entities and disclosure to informal supports because of the nature of the college environment. About 90% of college women who were raped indicate that they were victimized by someone known to them, including a classmate, a dorm-mate, or a friend of a friend (Abbey, 2002). That is, perpetrators of female college student rape victims are likely to be a peer or part of the victim's peer group, perhaps someone who lives down the hall or maybe someone the victims has to see every day in class. This familiarity between the victim and the perpetrator may impact the victim's decision to report because the perpetrator may be part of a victim's social network and the victim may not want to look "uncool,"

"like a cry baby," or be blamed for reporting the incident to campus administrators or police. Therefore, the close-knit social network of college students may present a distinct process of disclosure compared to the general population.

Social Support and Rape Victims

Social support can provide sexual assault victims important resources to cope with the experience and feelings post-assault and may offer varying pathways to recover (Kaukinen & DeMaris, 2009). It is important to note that there are two main types of social support: formal and informal. Formal social supports are typically defined as law enforcement, rape crisis centers, hospitals, and mental health professionals, while friends or relatives are considered informal social supports (Ullman & Filipas, 2001). As part of a larger body of literature, the Stress-Buffer Model (Cohen & Wills, 1985; Wheaton, 1985) makes the assumption that any type of social support, formal or informal, will buffer the negative consequences experienced by victimizations. This is because social support can act as a protective factor and may intervene between a stressful event and one's reaction to the event.

Social support may provide the victim with the necessary (emotional and cognitive) resources to increase the ability to cope with the aftermath of a traumatic event. Social supports may do this by helping to minimize the negative effects of the event or redefine the incident as manageable, decreasing the victim's stress response. There are three ways in which social support can buffer against negative post-assault outcomes. First, there is support that is available to victims. Available support is defined as support that is perceived to be accessible in a time of need. Second, there is support that is received. Support that is received describes the actual support that someone has

accepted from others. Third, quality support is defined as support that is considered helpful, satisfactory, or valued.

Research testing the Stress-Buffer Model suggests that perceptions of available and quality support from one's social network lessens the impact of stressful life events (Cohen & Wills, 1985). It has been found that when victims anticipate positive responses from others when dealing with a stressful event, they are more likely to seek help. This increased likelihood of help-seeking behavior in turn provides the victim with resources to cope with the negative consequences of victimization (Cohen & Wills, 1985). Specifically, available support has been shown to directly benefit depression and received support has also been shown to benefit depression, but indirectly via appraisal and coping (Komproe et al., 1997). And although little research has applied the Stress-Buffer Model to sexual assault victims, in a review of empirical evidence on general social support and its impact on sexual assault victims, some studies have found that victims with various forms of social support reported better post-assault outcomes (self-rated recovery, psychological symptoms/adjustment, and depression) than victims without support (Ullman, 1999).

Labeling theory. While the concept of social support is traditionally seen to have a positive impact on victim health outcomes, social support may play a different role among women who have experienced a sexual assault, particularly those with alcohol problems or women who experienced an alcohol-involved rape. In contrast to the Stress-Buffer Model, Labeling Theory (Lemert, 1951) suggests that social support may actually negatively impact victims and their recovery. Labeling theory[5] takes the stance that

[5] The labeling theory is a perspective rooted in the idea that labeling and reacting to people as criminals is a major factor in chronic involvement in illegal activity. However, Taylor and associates (1983) argue that

victims may experience or perceive negative reactions from others as a result of the primary victimization and that the victim status (being labeled a victim) can be compared to a secondary victimization. Secondary victimization may occur when, after disclosing an event to someone or a service entity, the victim has a negative experience, such as feeling doubted or blamed for the incident (R. Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). Even the perceived emotional reaction of pity from a women's social support network may highlight the victim's loss of power and be construed as "condescending" or patronizing. Victims may then internalize the negative responses and perceptions by others. This internalization can lead to isolation and depression (Kenney, 2002).

Labeling theory implies that social support of rape victims can unintentionally exacerbate post-rape physical and mental health (Kaukinen & DeMaris, 2009). A central concept behind labeling theory is stigmatization. That is, disclosing an incident to someone may evoke certain stereotypes and myths about what it means to be a rape victim or negative reactions regarding incident-specific details (Krahe, 1992). Disclosure of an incident can force a victim into "re-living" the event, evoking negative emotions and feelings from the event. Therefore even simply disclosing victimization to someone may be detrimental to one's mental health (Kenney, 2002). Research has often described the act of rape disclosure as a "second victimization or second rape," particularly if a victim reports or discloses the event to a formal social support (i.e., police, hospital, or campus counselor) (R. Campbell et al., 2001). Reporting to formal social support entities or disclosure to informal social supports may involve a battery of questions and most

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the labeling process is experienced not only by offenders, but by victims as well. Specifically, the negative social reactions and interactions with others can negatively impact victims even when the non-victim has the best intentions.

likely will require the victim to explain the incident in detail; recalling the events with such detail may negatively impact her mental health by essentially have her re-live the traumatic event.

The term "victim"[6] can also carry negative connotations and has been debated among scholars and health professionals as stigmatizing (Herbert & Dunkel-Schetter, 1992). Simply labeling someone as a rape victim, as opposed to a more positive term like survivor, can be detrimental to the recovery process. This label can be detrimental because it may impact how others respond to victims (i.e., emotional reactions such as pity or helplessness) and victims may then internalize the reactions and perceptions from others, seeing themselves as others do. Labeling one's self as a "victim" has been associated with perpetuating victims' feelings of helplessness, low self-esteem, and loss of power/status. The manifestations of these negative emotions can then lead one to "play the role" she has been assigned and may then contribute to feelings of vulnerability, worthlessness, and blame for the incident (Herbert & Dunkel-Schetter, 1992; Krahe, 1992). For example, in a longitudinal study of adult sexual assault victims, Ullman and Najdowski (2011) found that negative reactions by anyone to whom the rape victims disclosed led to increased self-blame (e.g., it happened because I am a bad person) over time.

Taking alcohol involvement into consideration, labeling theory suggests that alcohol use by the victim in the past, or at the time of the incident, can exacerbate the stigma of being a rape victim because others may attribute the victim's so-called "risky"

[6] Some researchers believe that the utilization of the term survivor has a more positive connotation and can provide women with a sense of identity (not as a victim) and empower them to feel like they have control of their life (Herbert & Dunkel-Schetter, 1992). The term victim is used throughout this dissertation, as opposed to survivor, not to be derogatory, but to be clear about the uncontrollable nature of the negative life event of the individuals being referenced.

behavior as the reason she was victimized. Society holds myths about women who drink: they are: "loose," "irresponsible," or "immoral" (Blume, 1991). College student studies showing videotapes and vignettes of young women drinking alcohol versus young women drinking coke have found that the young women drinking alcohol are described as more promiscuous, weak, aggressive, and immoral. Furthermore, when undergraduates were given vignettes that involved varying versions of rape scenarios with alcohol, more responsibility for the rape was placed on female victims who drank alcohol, regardless of the perpetrators alcohol intake (Bieneck & Krahé, 2011; Blume, 1991; Deming, 2013). Therefore, women with a history of excessive or problem drinking, or who experienced an alcohol-involved rape, may be more likely to experience negative social reactions from others upon disclosure, thus leading to feelings of self-blame, embarrassment, or shame (Littleton & Breitkopf, 2006; Ullman & Filipas, 2001; Ullman & Najdowski, 2011). These feelings of self-blame may then intensify the risk of the victim experiencing mental health problems, such as depression, anxiety, or PTSD (Littleton & Breitkopf, 2006; Ullman & Filipas, 2001). Furthermore, it has been found that lifetime substance abuse diagnosis among women who have been raped is linked to PTSD. Emotionally distressed victims may not be able to protect themselves because of numbing or avoidance symptoms that decrease their ability to detect risk and they may therefore be more likely to experience revictimization. Another explanation for this finding is that emotionally distressed victims who turn to risky behavior, such as substance abuse, are more likely to be targeted by perpetrators because they are seen as vulnerable (Ullman & Najdowski, 2011). However, most of the previous literature has

failed to test labeling theory and the relationship between social support, mental health, and problem drinking.

Kaukinen and Demaris (2009), however, conducted a secondary analysis of the Violence and Threats of Violence against Women and Men in the United States Survey, 1994-1996 (NVAWS), to examine the extent to which help-seeking from both formal and informal social supports may buffer (Stress-Buffer Model) or aggravate (Labeling Theory) the impact of sexual assault on female victim's mental health. Findings from this study show support for both perspectives, but find stronger evidence of the negative impact of social support as implied in Labeling Theory. Specifically, women who sought help did not differ from those who did seek help on problem drinking or mental health indices after the rape. In fact, post-rape symptoms of depression were greater in those who sought help from friends and family. The authors argue that community and social support can be both sources of protection and hurt and they highlight the importance of examining the type of support provided. For instance, some people in a victim's support network may be helpful at alleviating negative post-rape outcomes, but others may provide advice or information that exacerbates victim's negative consequences of rape (Kaukinen & DeMaris, 2009). Although this study began to broach some of the limitations of previous social support research, the motivations and needs of sexual assault victims leading one to seek help are still untouched.

Supporters of rape victims. A central tenant to labeling theory is societal reaction. It is essential to examine the role of supporters when investigating the process of disclosure, the reaction/response of the supporter, and the impact of social support on rape victim's recovery, as some theorists believe that the reaction (negative or positive)

of supporters (formal or informal) is the determining factor in victims post-rape mental health. Cross-sectional studies show that negative reactions to rape disclosures, such as victim-blame, disbelief, stigmatizing responses (treating the victim differently), resulted in victim's feeling increased self-blame, maladaptive coping strategies, PTSD, and sexual revictimization (Littleton & Breitkopf, 2006; Ullman et al., 2007). Similarly, a prospective longitudinal study showed that negative reactions from others led to increased self-blame, although positive reactions did not reduce self-blame in a sexual assault victims (Ullman & Najdowski, 2011). Furthermore, negative reactions predicted future PTSD and more severe PTSD symptoms at Time 1 was related to increased rates of revictimization (Ullman & Najdowski, 2011).

Research that includes supporters of rape victims has focused on victim's perceptions, supporter's reactions during disclosure, and the impact of these reactions on rape victims. The current extant literature has neglected to focus on the thoughts, feelings, perceptions, and beliefs of supporters themselves. It is important to study supporters given the fact that they may have emotional reactions to rape disclosure that impact their ability to support the victim. In an exploratory study of 60 friends of rape victims, evidence was shown that friends were often uncertain about what victims needed and how to help, scored high on emotional distress, felt ineffective, and perceived change in the relationship with the victim (Ahrens & Campbell, 2000).

Current assessments of social support. Review of the current measures of social support highlight four main limitations: 1) current measures vary considerably in regards to content (no standardization or clear definition of social support); 2) most current measures were not developed and tested specifically with samples of rape

victims, particularly college student victims; 3) current measures ignore factors that prompt victims to use their social support system (or hinder them, such as alcohol involvement of the victim); and 4) current measures overlook the quality of support provided to victims (which may be affected due to victim or rape characteristics, such as alcohol involvement). Studies of social support among rape victims have found mixed results in regards to its impact on victim's mental health (Ullman, 1999). For example, some studies find no significant effect of social support on rape victim's psychological well-being; whereas others have found positive effects of social support on rape victims' recovery (Ullman, 1999). Furthermore, a few studies that included negative reactions from social supports consistently found that it negatively affected sexual assault victim's mental health outcomes (i.e., depression, PTSD, anxiety, and self-esteem) (Orchowski, Untied, & Gidycz, 2013).

Some possible reasons for these inconsistent findings are that studies have not used the same measures of social support, such that the content of the current measures of social support vary considerably. Certain measures contain a single variable, examining the number of people a victim disclosed (or could disclose to) and their responses, while others look at living arrangements, perceived types of support available (i.e., tangible, informational, emotional), quality of relationships, or family closeness. Further, most social support measures have been developed to assess general concepts of social support, but are not specific to the components of social support experienced by sexual assault survivors. Some studies simply use quantity of network supports as a proxy for positive social support by assessing the number of people in his/her network, the number

of persons told about the incident, or the number of social relationships available (Atkeson, Calhoun, Resick, & Ellis, 1982; Burgess & Holmstrom, 1978).

In contrast, other studies have used social support measures (See Table 1) that focus on assessing positive/negative support perceived available and received or the supporters' reaction to the victim's (of any tragic event) disclosure (i.e., by asking the victim how they felt others responded to them). For example, the *Social Support Survey Instrument (SSSI)* (Sherbourne & Stewart, 1991) consists of 19 items that measure how often an individual has the presence (availability) of emotional/informational (i.e., someone to confide in, share worries with, understand your problems, give you advice, etc.), tangible (i.e., someone to help if confined to a bed , prepare meals, help with chores, etc.), and affectionate support (i.e., someone to show love and affection, hug you, love you), as well as positive social interaction and active support . Likewise, the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988) is a 12-item measure that yields scores for victims' (of any tragic event) perceived support from family, friends, and a significant other as well as overall social support. The MSPSS has demonstrated strong internal consistency in previous studies (Dahlem, Zimet, & Walker, 1991). However, this measure focuses solely on victim's perceptions of support, which may not be congruent with the intentions of supporters. That is, while some supporters may intend to be compassionate and sympathetic toward a victim upon disclosure, a victim may misguidedly perceive these behaviors as "pity" and "shame," thereby further exacerbating the victim's perceived sense of stigma, guilt, and self-blame (Kenney, 2002).

Table 1. Current Measures of Social Support and Use in Previous Studies

Measure	Number of Items	Dimension and/or Type of Support Assessed						Validation Sample
		Available/ Perceived	Received	Emotional	Tangible	Informational	Other	
Social Support Survey Instrument (SSSI)	19	X		X	X	X		Patients from Medical Outcomes Study (MOS)
Multidimensional Scale of Perceived Social Support (MSPSS)	12	X						Undergraduate Students
Interpersonal Support Evaluation List (ISEL)	48	X						College Students w/ Various Problems
Crisis Support Scale (CSS)	7 (2x)		X					Various w/ General Trauma
Social Reactions Questionnaire (SRQ)	48		X	X	X		X	Rape Victims via: Community Volunteers College Students Victims Contacting Mental Health Agencies
Crime Impact Social Support Inventory (CISSI)	42	X		X	X		X	Victim Service Agency
Inventory of Socially Supportive Behaviors (ISSB)	40		X	X	X		X	Community

Perceived social support has also been measured using the Interpersonal Support Evaluation List assessment (ISEL; Cohen & Hoberman, 1983). The ISEL is a 48-item questionnaire used to measure college student victims' (of any stressful life experience) perceived availability of social support. Respondents are asked to rate each social support statement (e.g., "I know someone who I see or talk to often with whom I would feel perfectly comfortable talking about any problem I might have adjusting to college life") as either probably true or probably false. The ISEL yields four subscales: belonging, tangible, self-esteem, and appraisal, as well as a total score of perceived social support availability.

Another common shortcoming of existing assessments of social support is that some measure social support more generally, with little regard to support in response to specific needs, such as rape and sexual assault. Further, examinations of the relationship between social support in response to rape disclosure and PTSD, as well as other indices of post-rape functioning, would benefit from considering the quality of support at different points in time since the incident. The *Crisis Support Scale* (CSS; Elklit, Pedersen, & Jind, 2001) is one such measure that enables temporal differentiation in victim's perceptions of trauma support before and after a traumatic event (natural disaster or death of loved one). By temporal differentiation, the CSS is able to measure changes in victim's perceptions of social support in response to the incident. However, while the CSS does measure trauma-specific support, as opposed to questionnaires that measure social support more generally, it still lacks a specific focus on rape-related trauma, which has its own unique correlates and consequences relative to other types of traumatic events (Joseph, Andrews, Williams, & Yule, 1992; Kilpatrick et al., 1997).

Lastly, there are only a few measures in the published literature designed to assess social support in persons who have experienced sexual assault and/or rape. However, these measures fail to specifically address how social support may differ when examining its impact on sexual assault disclosure and mental health outcomes and do not capture the factors that motivate/prompt a victim to seek out informal social support. Moreover, most measures do not differentiate social support providers in terms of informal and formal forms of support.

The only measure that looks at how social support may have a negative impact on victim's mental health and recovery is the *Social Reactions Questionnaire* (SRQ; Ullman, 2000), while all others assume that social support is positive or illicit a positive reaction. The SRQ is a 48-item self-report measure used to assess both positive and negative reactions from others following the disclosure of rape. The SRQ does make the distinction between informal and formal support, but ignores the need to measure the factors that encourage victims to actually use their support system, like the other social support measures.

It is essential to understand the quality of social support and the process of sexual assault victim's disclosure, particularly when alcohol is involved (pre or post incident), in order to positively inform future interventions and public health initiatives to improve mental health outcomes. However, at this time, there are no current measures that are able to quantify the decision-making process leading up to disclosure of rape to informal forms of social support, or the role of alcohol use and mental health in this process – as either the catalysts or inhibitors to disclosure; or following the disclosure process. These major limitations speak to the need of exploring the factors that prompt victims to use

their support system (among those who do), the quality of that social support, and the impact of that social support on post-rape outcomes among alcohol and non-alcohol involved rape victims. Identifying these nuanced constructs may help answer many questions that remain about how women who have been raped make decisions to disclose the incident to informal sources – the most frequently used method of post-rape disclosure. For instance, *how do victims feel about disclosing such an incident to their support system? What prompts victims to utilize their support system? How prepared are victims' social supports to provide support that will promote recovery? What types of positive and negative assistance are supporters providing (from both the victim's and supporter's perspectives)? What victim or incident characteristics (alcohol involvement or college student environment) influence supporters' reactions and responses during disclosure? Is it possible that a "strong" social support system (i.e., lots of friends or one close friend) create a barrier for victims to seek formal treatment?*

Using Qualitative Methods to Address Limitations

Using more in-depth, qualitative methods of assessment may assist in uncovering more nuanced, detailed factors related to disclosure and social support of rape victims. Current quantitative assessments are limited; certain aspects of how social support operates in the decision-making process of rape disclosure and its impact on mental health of the supported have yet to be conceptualized. Qualitative methods are a better approach to understand both victim's and supporter's perceptions of the rape disclosure process, the impact of social support and mental health problems on victim's recovery, and how victim's alcohol/drug involvement (prior to, during, or after the incident) plays a role in the process of disclosure, as well as the type and quality of social support received

by victims because this approach allows responses to these questions without the constraints of forced-choice responses typically found in standard paper-and-pencil questionnaires. Qualitative research is a broad approach to studying social phenomena and assumes that researchers learn from participants to understand their lives (Marshall & Rossman, 2006).

There are a number of advantages to using qualitative methods. First, they provide depth and detail, create openness, provide flexibility, attempt to avoid pre-judgments, and are useful in developing and constructing theories or concepts (Sofaer, 1999). Quantitative measurements can only provide results of pre-set answers based on existing knowledge. Second, qualitative data may help generate themes and concepts without the constraints of existing quantitative measures or a researcher's pre-conceived notions of what to query (Maxwell, 2005). In this way, qualitative research allows for a natural unfolding of themes and content related to the impact of varying dimensions of social support that correlate with perceptions of mental health problems among rape victims with and without an alcohol use disorder (Marshall & Rossman, 2006). These themes may then serve as the foundation to develop a more comprehensive measure of social support that may assist in treatment-matching and improve health promotion campaigns on college campuses in an effort to target female rape victims less likely to seek help. Finally, the use of qualitative data collection in conjunction with quantitative measures (mixed methods), will provide triangulation of concepts that emerge using qualitative data, as the dominant method, with quantitative data about rape victims and their individual and incident characteristics (Bloomberg & Volpe, 2012). *Triangulation* (D. T. Campbell & Fiske, 1959; Denzin, 1978; Webb, Campbell, Schwartz, & Sechrest,

1966) is the utilizing of multiple methodologies to study one phenomenon, providing "a more complete, holistic, and contextual portrayal of the units of study" (Jick, 1979, p. 603). Further, the use of quantitative data with qualitative data will assist in the interpretation of the data and allow new and deeper dimensions of the social support process to emerge, while taking certain victim, supporter, or assault characteristics into consideration.

The Current Study

Review of the literature indicates a need to clarify *the role of social support in the disclosure and recovery process of rape victims*, particularly among those not seeking treatment and who have alcohol use problems, specifically, female college students. Most research has utilized a theoretical framework that is built on the assumption that social support has a positive impact on sexual assault victims' mental health outcomes. However, there is also a smaller body of research acknowledging that social support can have a negative impact on rape victim's mental health outcomes. Discussions regarding the conceptualization of social support define it as not only the actual and/or expressive necessities supplied by the community, social networks, and confiding partners, but also the perceived social support (Cullen, 1994). Current research fails to capture the elements of social support that impact one's usage of her network or take into consideration the specific nature of the situation (sexual assault), as well as the victim's alcohol involvement.

To this point, measurement development has focused mostly on social reactions after disclosure, ignoring the motivating factors that victims may experience prior to disclosing the event and to whom. Reactions from others, if they are positive, are a

primary determinant in the recovery process, but if negative, can be linked to subsequent post-rape problems (Heise & Garcia-Moreno, 2002). Further, thus far, research has used generalized assessments of perceived or received social support in an individual's life to examine its role in the recovery of trauma survivors more generally, and sexual assault victims more specifically. These measures have focused on victim's perceptions of the reporting process in response to formal social supports, as opposed to victim's perceptions of the disclosure process to informal forms of social support. This is noteworthy given that many more victims will informally disclose a rape to a member in his/her support network than to formal entities, such as a physician, police officer, or mental health professional. None of the validated questionnaires that exist in the current literature assess constructs or dimensions related to the decision-making process that may inhibit or promote rape victims from disclosing the incident to their peer network, the role alcohol may play in the disclosure process, or the impact of disclosure on future outcomes. Moreover, research in this area is typically based on the assumption and theoretical perspective that any social support will buffer against negative consequences victims may experience post-assault. Studies have mostly sampled from treatment-seeking populations and rape crisis centers, with a few studies focusing on community samples.

Since most rape victims disclose the incident to informal forms of support, there is a need to examine non-treatment-seeking victims. *Studies have rarely examined the decision-making process leading up to disclosure specifically with college students*. Given the fact that college students are at greater risk of being sexually assaulted relative to adult women, it is important to examine their decision-making process to disclose to

informal social supports, the quality of support they receive from informal social supports, and the role that alcohol plays in both of these processes. Furthermore, social support measures used in these same studies are not comprehensive in that they either focus on perceived available or received support, but rarely both. More importantly, the measures are general and ignore the sensitive nature of the type of support that would be sought after a rape, the motivations that underlie a victim's desire to utilize available social support, and the impact that alcohol involvement (both at the time of the incident and/or as a pattern of behavior prior to the incident) has on the utilization of social support, the quality of support received, and post-rape mental health outcomes.

Given this information, the focus of this dissertation is to take a mixed methods approach to identify concepts and develop nuanced constructs of the perceptions of social support, the role of alcohol, and the impact of these factors on college student rape victims' decisions to disclose a rape and post-rape outcomes. To obtain this information, in-depth (face-to-face), semi-structured interviews will be conducted with victims who have disclosed a rape to someone in their social network and individuals who have had a rape disclosed to them (hereinafter referred to as the Supporters). Specifically, in a sample of 46 college students (16 rape victims and 30 supporters), the current study will address the following aims:

Aim 1: To identify constructs related to the decision-making process to disclose a rape to an informal social support. To meet this aim, the following research questions are of proposed:

a. What prompts victims to utilize their informal support system vs. formal support?
b. How do victims feel about disclosing such a rape to their support system?

c. What factors influence female rape victims to utilize and impede the use of their social network?

Aim 2: To understand victim and victim supporters perceptions of social support and the impact of these perceptions on rape victims' post-rape mental health. With this aim, the following research questions are hoped to be answered:

a. How prepared are victims' social supports to provide support that will promote recovery?
b. What types of positive and negative assistance are supporters providing (from both the victim's and supporter's perspective)?
c. Does a "strong" (available, consistent, unbiased, non-judgmental) social support system create a barrier for victims to seek formal treatment?

Aim 3: To determine the role that alcohol plays in the disclosure process. With this aim, the following research questions are proposed:

a. How do assault characteristics of female rape victims with a history of alcohol involvement affect their use of informal social support and their mental health outcomes?
b. How does alcohol abuse history of the victim impact whether and when social support will be used, the type of social support received by the victim, and the influence of social support on the post-rape mental health of the victim?

Figure 1 below outlines the theoretical model and hypothesized relationships between the factors of interest. In the middle of the figure, previous literature indicates that alcohol-involved rape can impact a victim's ability to acknowledge the incident as a rape or can be linked to drinking history (or a history of illicit drug use). Next, victim

characteristics, drinking history, and rape acknowledgment may then impact the rape disclosure process in terms of the supporter's perceptions and reactions to the victim. On the left hand side of the figure, the supporter's perceptions and reactions to the victim can lead to a number of outcomes: whether or not the victim chooses to disclose the incident with formal entities or informal social supports and how the interaction with the supporter affects the victim's mental health and post-rape drinking (or illicit drug use). Further, in the top right hand corner of the figure are characteristics of the victim that have been demonstrated in the literature to impact reporting and disclosure rates.

As a long-term goal of the project, the depth and understanding gleaned from this dissertation will assist in the future development of a social support measure that captures the multidimensionality of sexual-assault-related social support that impacts the disclosure process. The measure can then be used to inform intervention efforts to increase help-seeking behavior and to improve the mental health status of female rape victims in college.

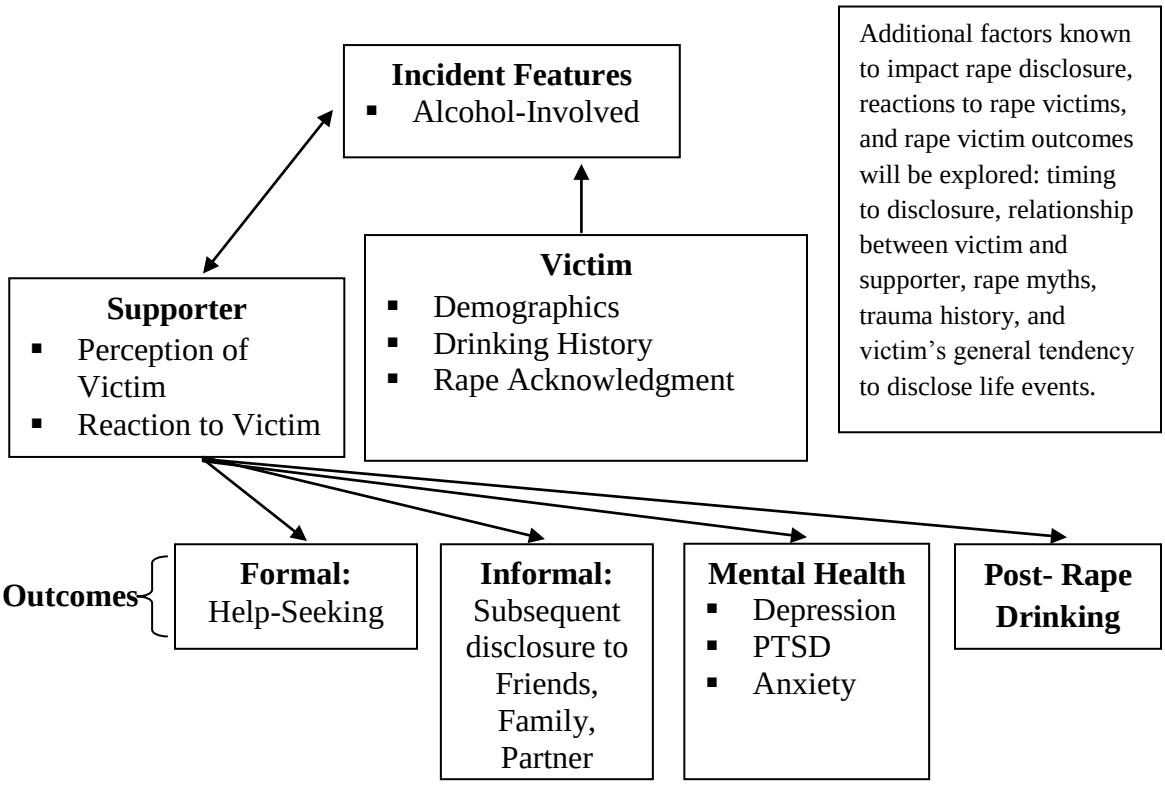

Figure 1. *Proposed Theoretical Model Measuring the Impact of Alcohol on Female College Student Rape Victims' Disclosure Process and Post-Rape Outcomes*

Chapter 3

Method

Research Design

Given the exploratory nature of the aims and research questions, qualitative and quantitative data collected using a *thematic analysis* approach, for the purposes of triangulation, were used to conduct the current study. Qualitative methods and thematic analysis are particularly conducive to the discovery of concepts for theory development. Thematic analysis, a common form used to encode qualitative information, examines themes and patterns within the data collected to answer research questions that seek to describe a specific phenomenon (Guest, 2012). Moreover, this approach is most appropriate when the aims of a study are focused on the process of social interactions, as opposed to theory testing, and provide a deeper understanding of social phenomena grounded in systematic analysis of data (Lingard, Albert, & Levinson, 2008).

Specifically, data collected from study participants will serve as the basis for discovering theoretical concepts that clarify the role of social support in the disclosure and recovery process of rape victims, particularly among those not seeking treatment and who have alcohol use problems, such as female college students. This approach is a methodology that allows the participant to play a role in the development of concepts about the phenomena that are not being measured, which can then be used to develop a measure that captures the complex relationship between social support and the disclosure

process of female rape victims[7]. With the purpose of this study in mind, both qualitative and quantitative data are needed to answer the research questions (See Table 2).

Table 2. *Overview of Information Needed for the Research Study*

Study Aims	Research Questions	Information Needed	Method(s)
1. To identify constructs related to the decision-making process to disclose a rape to an informal social support.	a. What prompts victims to utilize their informal support system vs. formal support? b. How do victims feel about disclosing such a rape to their support system? c. What factors influence female rape victims to utilize and impede the use of their social network?	Participants' perceptions and feelings of relevant factors in deciding to disclose a rape to an informal social support. Rape victims' tendency to disclose, assault characteristics, rape history, rape acknowledgment, rape myth acceptance, and life events.	Interview Surveys
2. To understand victim and victim supporters perceptions of social support and the impact of these perceptions on rape victims' post-rape mental health.	a. How prepared are victims' social supports to provide support that will promote recovery? b. What types of positive and negative assistance are supporters providing (from the victim's and supporter's perspective)? c. Does a "strong" social support system create a barrier for victims to seek formal treatment?	Participants' perceptions and feelings of social support and how social support aids victim recovery. Rape victims' mental health history, social support.	Interview Surveys
3. To determine the role that alcohol plays in the disclosure process.	a. How do assault characteristics of female rape victims with a history of alcohol involvement	Participants' perceptions about the role of alcohol in the disclosure process.	Interview

[7] Participatory Research (PR) or Participatory Action Research (PAR) was considered for this study, but was deemed inappropriate given the nature of the dissertation. PR and PAR emphasize the idea that research and action must be performed *with* participants, not *on* or *for* people. This particular approach encourages participant involvement throughout the planning and implementation of the research study and is often used in community-based initiatives that promote change within the people involved.

	affect their use of informal social support and their mental health outcomes? b. How does alcohol abuse history of the victim impact whether social support will be used, the type of social support received by the victim, and the influence of social support on the mental health of the victim?	Rape victims' assault characteristics, mental health, and alcohol/drug use history.	Surveys

Qualitative research design and rationale. Qualitative methods, used in this study as the dominant method, allowed for the emergence of concepts missing in current literature on social support without being constrained by the limitations of current quantitative assessments and preconceived notions of what these constructs might be. Quantitative measures were used in conjunction with the qualitative data to provide comparison and reference points for examination of group differences in the information gleaned via qualitative methods.

Qualitative data were collected through in-depth (face-to-face), semi-structured interviews with participants, heretofore referred to as the Victims and Supporters. There are a number of strengths to using interviews as a data collection method. They allow for 1) fostering face-to-face interactions with participants, 2) uncovering participants' perspectives, 3) describing complex interactions and processes, 4) formulating hypotheses in a flexible manner, 5) measuring the context in which information is remembered with greater precision, and 6) facilitation of analysis, validity checks, and triangulation (Marshall & Rossman, 2006). In-depth, semi-structured interviews allow for "a conversation with a purpose" (R. L. Kahn & Cannell, 1957, p. 149). This

technique provided the opportunity for the interviewer to explore any pertinent information that comes up as the interview takes place to obtain rich information that may be missed if quantitative assessment techniques were used.

Quantitative assessment techniques limit and restrict the information that is gathered by the interviewer, as they lack the interactivity between the interviewer and interviewee that is fostered in qualitative methods. Semi-structured interviews especially promote this interactivity between the interviewer and interviewee; questions are predetermined in semi-structured interviews, but allow for the interviewer to ask additional questions and divert from the predetermined questions when a new idea or concept is brought up by the interviewee. Moreover, quantitative measures force numerical values or scales on interviewee's responses to questions, where qualitative measures allow for the interviewee to respond freely without pre-set answers.

When using qualitative methods, it is important to attend to issues of trustworthiness – efforts made to address the more traditionally-known, quantitative concept of validity (the extent to which a concept or measure accurately reflects what it claims to measure) and reliability (the consistency of a measure over time) (Bloomberg & Volpe, 2012). Guba and Lincoln (1998) contend that trustworthiness of qualitative research should differ from quantitative terminology, using the terms *credibility*, *dependability*, *confirmability*, and *transferability* to assess reliability and validity. Credibility (or validity) criterion focus on whether the study findings are accurate and reached in an objective manner. It is important to note that this key component in research design is not aimed to verify the conclusions reached, but to test the methodological and interpretative validity or *how* the conclusions were reached.

Methodological validity for this study was met by explaining how the research design matches the research questions and aims of the study. Further, data were collected from multiple sources (Victims and Supporters), which provided varying perspectives on the process of disclosure and how it impacts victims. Additionally, interpretive validity was met by detailing how the data have been interpreted and analyzed.

On the other hand, dependability (or reliability) examines if the findings are consistent and dependable with the data collected. This criterion was met by documenting the procedures and showing that coding schemes and categories have been used consistently (see Chapter 4). Further, all coders were asked to code several of the same interviews at multiple times during data collection to establish inter-rater reliability by determining the percent agreement among the raters (Miles & Huberman, 1994). Specifically, 11 interviews total (5 Victim and 5 Supporter interviews), approximately 24% of the sample, were used to calculate percent agreement. The final percent agreement was 93.2% for this sub-sample. The first five interviews in the beginning of data collection were coded by two raters, with an additional person being included to discuss coding disagreements. These coding disagreements were handled by using a majority vote to determine the final code for each interview question. The same process was used at the early midpoint of data collection (3 interviews) and towards the end of data collection (3 interviews).

Next, confirmability, the component that focuses on ensuring objectivity, was addressed by clearly demonstrating the decisions made in the research process in field notes and transcripts. Finally, transferability (generalizability) refers to the ability of a specific phenomenon in a specific context to transfer to another context. Although this

study is specific to female college student rape victims, the participants and context explored may be applicable to similar situations and similar samples. To that end, sufficient detail of the context and participants is provided, which may then be found relevant in some broader context.

Quantitative research design and rationale. Quantitative methods were used to obtain specific information about the victim, supporter, and rape incident in a quick, efficient manner. The quantitative portion of this study was used to help parse out individual/group differences in nuanced characteristics, to answer exploratory questions such as "for whom" and "under what circumstances" do rape victims disclose or find informal social support disclosure beneficial or detrimental.

Quantitative data were collected through self-report surveys. Self-report questionnaire information was linked to the interviews to further categorize, as well as organize concepts and compare different characteristics among those interviewed. All of the questionnaires used in this study have strong psychometric properties, showing good reliability and validity in a variety of samples, including college students.

Sampling and Participants

Purposive (theoretical) sampling techniques were used in the recruitment of participants for this study. Purposive (theoretical) sampling allows for researchers to use information-rich cases that are able to provide insight and understanding to the phenomenon of interest (Draucker, 2007). Given the use of in-depth, qualitative methodology, it is commonly acceptable to have a sample size of 15 to 30 (Creswell, 1998; Guest, Bunce, & Johnson, 2006). According to previous literature, it is at this point that saturation, a guiding principle to sample size in qualitative studies, is typically

met (Creswell, 1998; Guest et al., 2006). Saturation is met when most or all of the concepts of interest are revealed and the collection of new data will no longer provide additional information. These guidelines and previous literature were used in considering the optimal sample size to obtain saturation. Specifically, data collection ended after determining there were no new concepts or codes emerging from the most recent interview data collected.

A total of 46 participants were interviewed: 16 female victims of rape in college who disclosed the incident to an informal source (Victims) and 30 college students (33.3% male) who have had someone disclose a sexual assault to him/her (Supporters). Female college students were recruited for the study by means of advertisements in the form of announcements in classes, web advertisements, and flyers posted on the USF Tampa campus[8]. A majority of the participants heard about the study via class announcements (52.2%) or flyers (26.1%). Advertisements asked for women who have ever disclosed an unwanted sexual experience in their lifetime to participate in a 2 hour confidential research study. Eligible participants for the Victim group had to meet the following criteria: 1) female, 2) 18+ years old, 3) college student, 4) victim of a rape in her lifetime (determined at the screen through a series of behaviorally specific questions that query about oral, anal, or vaginal penetration since victims may not label the event a rape themselves), 4) disclosed the incident to a friend, relative, or acquaintance, and 5) history of any alcohol use (use of AUDIT screening tool – see Measures). College students (both male and female) were recruited for the Supporters group via similar

[8] For this study, the recruitment parameters were set to the USF Tampa campus only since the interview location was at this campus, making travel easier for participants. Additionally, USF Tampa campus offers a diverse population.

advertisements asking for research participants who have had someone disclose details of an unwanted sexual experience to them. Eligible participants for the Supporters group had to meet the following criteria: 1) 18+ years old, 2) college student, and 3) had a rape disclosed to him/her in his/her lifetime. See Figure 3 below for a visual guide to the screening process. If at any point the criterion was not met, then the person was considered ineligible. A total of 41 of the 87 screened were deemed ineligible for the study. Specifically, 3 potential participants were screened out because they were not college students and another 38 had not had a rape disclosed to them in their lifetime.

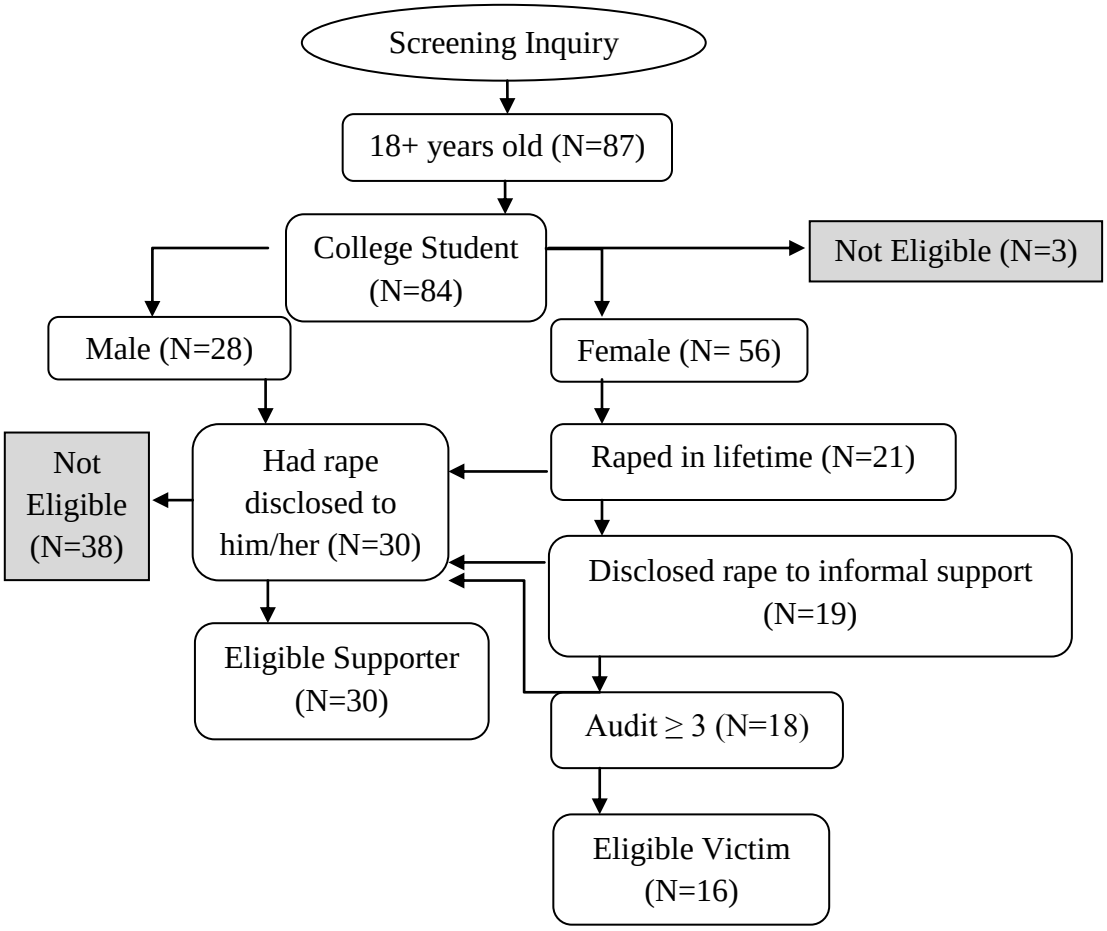

Figure 2. Study Participant Eligibility Flowchart

All participants were compensated for their time. Compensation was in the form of $20 cash or extra credit, if the student is in an extra credit eligible class. Additionally, an alternative, non-research extra credit assignment was made available to those who did not wish to participate in a research study for extra credit. See Appendix A for screening form.

Participants ranged in age from18-61 (M=25.91, SD=8.95) and had an average income of $10,000 to $19,999 (SD=.96); the majority were either juniors (32.6%) or considered in the other category (i.e. graduate student or non-degree seeking) (32.6%), not involved in Greek life (84.8%) or student athletics (95.7%), employed part-time (54.3%), single (76.1%), and lived off-campus (95.7%). Over half of the sample (63.0%) was White, 19.6% Black (9), 8.7% Asian (4), and 8.7% Multiracial (4) and most of the sample was Non-Hispanic (78.3%). See Table 3 below for demographics by group membership.

Table 3. Sample Demographics by Group Membership

Measure	Supporters (N=30)	Victims (N=16)	Total Sample (N=46)
	Mean (SD)/Percent	Mean (SD)/Percent	Mean (SD)/Percent
Gender			
Male	33.3%	0%	21.7%
Female	66.6%	100%	78.3%
Age	26.63 yrs. (9.05)		25.91 yrs. (8.95)
Race			
White	63.3%	62.5%	63.0%
Black	23.3%	12.5%	19.6%
Asian	0.0%	25.0%	8.7%
Multiracial	13.3%	0.0%	8.7%
Ethnicity			
Hispanic	20.0%	25.0%	21.7%
Non-Hispanic	80.0%	75.0%	78.3%
Income	$20K - $29K (2.14)	$10K - $20K (.96)	$10K - $20K (.96)

Educational Status			
Freshman	0.0%	6.3%	2.2%
Sophomore	6.7%	18.8%	10.9%
Junior	33.3%	31.3%	32.6%
Senior	20.0%	25.0%	21.7%
Other	40.0%	18.8%	32.6%
Employment Status			
Unemployed or Disabled	20.0%	18.8%	19.6%
Part-Time	50.0%	62.5%	54.3%
Full-Time	30.0%	18.8%	26.1%
Marital Status			
Single	80.0%	68.8%	76.1%
Living w/ Partner	13.3%	12.5%	13.0%
Married	3.3%	12.5%	6.5%
Divorced	3.3%	6.3%	4.3%
Residence			
On-Campus	3.3%	6.3%	4.3%
Off-Campus	96.7%	93.8%	95.7%
Greek Membership			
No	86.7%	81.3%	84.8%
Yes	13.3%	18.8%	15.2%
Student Athlete			
No	93.3%	100.0%	95.7%
Yes	6.7%	0.0%	4.3%

Measures

This study consists of two sets of measures: open-ended questions to prompt discussion in a face-to-face interview (See Appendix B) and paper-pencil self-report questionnaires to obtain demographics, mental health problems (depression, anxiety PTSD), alcohol (and other drug) use consumption and history, lifetime rape and trauma experiences, and social support (See Figure 1 for hypothesized relationships between measures). Table 4, below, illustrates a snapshot of the specific measures used with each group (Victims and Supporters).

Table 4. *Specific Measures Utilized for Victims and Supporters Groups*

Measure	**Victims**	**Supporters**
Alcohol Use Disorders Identification Test (AUDIT)	X (at screening)	X
Demographics	X	X
Depression	X	X
Anxiety	X	X
PTSD	X	X
Michigan Alcoholism Screening Test (MAST)	X	X
Drug Abuse Screen Test (DAST)	X	X
Social Support Survey Instrument (SSSI)	X	X
Sexual Experiences Survey – Short Form (SES-SF)	X	X
Additional Assault-Related Characteristics Questions	X	X
Illinois Rape Myth Acceptance – Short Form (IRMA-SF)	X	X
Distress Disclosure Index (DDI)	X	X
Life Events Checklist (LEC)	X	X
Qualitative Interview Questions	X	X

Demographics and victim/supporter status. Basic demographic information was collected from all participants including: gender, age, race/ethnicity, education, income, marital status, and employment. Information was also collected regarding group membership, either victim or supporter. See Appendix C.

Mental health. The following measures were used to assess the three most commonly reported mental health problems experienced by rape victims. The information has been correlated with the other quantitative measures and qualitative data to examine differences in the disclosure experience across sub-groups of rape victims (e.g., those with higher depression, more traumatic life events, etc.). Current or past mental health symptoms experienced by Victims and Supporters may impact their feelings about social support and the disclosure process. For example, if a Victim reports symptoms of depression, then she may feel that her social support network is not helpful or that disclosing the incident failed to alleviate or exacerbated her negative feelings post-

assault. Likewise, Supporters with mental health problems may react differently (more or less helpful/empathetic) to Victims than those without mental health symptoms.

Depression. The *Patient Health Questionnaire (PHQ-9; (Kroenke, Spitzer, & Williams, 2001)* is a 9-item depression module, taken from the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ), that measures depressive symptoms and closely aligns with DSM-IV criteria for diagnosis of a Major Depressive Disorder (MDD). Each of the 9 items is scored from 0 (*not at all*) to 3 (*nearly every day*). Major depression is diagnosed if 5 or more of the 9 depressive symptoms criteria have been present at least "more than half of the days" in the past 2 weeks, and 1 of the symptoms is depressed mood or anhedonia. Other depression is diagnosed if 2-4 of the depressive symptoms have been present at least "more than half of the days" in the past 2 weeks, and 1 of the symptoms is depressed mood or anhedonia. The PHQ-9 also determines severity by summing responses to the 9 criteria. Total scores of 1-4 indicate minimal depression, 5-9 indicate mild depression, 10-14 indicate moderate depression, 15-19 indicate moderately severe depression and 20-27 indicate severe depression.

An additional item that assesses impairment of social, occupational, or other important areas of everyday functioning is at the end of the questionnaire and should be asked if any criteria is endorsed. Furthermore, it is advised that the interviewer inquire about bereavement or physical causes of depression prior to final diagnosis. This assessment tool is one of the most common tools used to identify depression and is parallel to the DSM-IV criteria, allowing for a quick diagnosis and severity rating.

This measure was included in analyses because of the high correlation between rape and major depressive disorder (R. Campbell et al., 2009; Resick, 1983, 1993) and because of the high correlation between alcohol involvement and depression (Petrakis, Gonzalez, Rosenheck, & Krystal, 2002). Some theory and literature on social support would suggest that victims who disclose the incident and seek social support will report less mental health problems, but labeling theory suggests the impact of social support and the disclosure process may be different when alcohol is involved. It is this relationship that is of interest to the study aims and has been examined.

Anxiety. The *Generalized Anxiety Disorder (GAD-7; (Spitzer, Kroenke, Williams, & Lowe, 2006)* is a 7-item scale that measures anxiety symptoms, with responses ranging from 0 (*Not at all sure*) to 3 (*Nearly every day*), providing a 0 to 21 severity score. A score of 0 - 4 indicates minimal anxiety, 5 – 9 indicates mild anxiety, 10-14 indicates moderate anxiety, and 15-21 indicates severe anxiety. The GAD-7 is linked to DSM-IV criteria and a total score of 10 or greater is the cutoff point for identifying GAD. Additionally, there is a qualifying question at the end of the scale to further evaluate if the anxiety is impacting everyday functioning.

This scale has been validated in both general and clinical populations and was found to be more sensitive than other anxiety questionnaires (Dear et al., 2011). This measure was included in the study because of the high correlation between rape and anxiety disorders and between anxiety disorders and alcohol involvement, which may impact Victims and Supporters perceptions of the disclosure process (R. Campbell et al., 2009; Kushner, Sher, Wood, & Wood, 1994).

Post-traumatic stress disorder (PTSD). The *PTSD Checklist – Civilian Version (PCL-C)* is a 17-item scale that measures PTSD severity, with responses range from 1 (*Not at Al)l* to 5 **(***Extremely)*, with a total score ranging from 17-85; Or responses can be treated as categories 3–5 (*Moderately* or above) as symptomatic and responses and 1–2 (below *Moderately*) as non-symptomatic, then use the following DSM criteria for a diagnosis: Symptomatic response to at least 1 "B" item (Questions 1–5), Symptomatic response to at least 3 "C" items (Questions 6–12), and Symptomatic response to at least 2 "D" items (Questions 13–17). This measure was included in the study because of the high correlation of rape and PTSD (Kilpatrick et al., 1992; Ullman et al., 2007) and PTSD with other mental health problems commonly experienced by rape victims (Najavits et al., 1997), as well as PTSD with drinking problems and substance abuse (Kilpatrick et al., 1997).

Alcohol and drug involvement.

Screening for alcohol use. The *Alcohol Use Disorders Identification Test (AUDIT;(Saunders, Aasland, Babor, de la Fuente, & Grant, 1993)* has been used in the initial screen to identify alcohol use and hazardous drinking behavior in the past year. This screening tool consists of 10 items and has been found to be especially sensitive when applied to women and minorities. Responses for each question range from 0 to 4, measuring quantity, frequency, and drinking problems. A score of 3 or greater (AUDIT C criteria) was required at screening for Victims to be eligible for the study. This criterion is necessary to find participants with a history of hazardous alcohol use in the past year, in an effort to meet the aims of the study. Two individuals did not meet this

criterion and were deemed ineligible[9]. The AUDIT was also administered to Supporters during the interview to determine quantity, frequency, and risky drinking behavior, as it may impact their perceptions of alcohol use among rape victims. Supporters were not required to meet any alcohol use criteria.

Alcohol use problems. The *Michigan Alcoholism Screening Test (MAST;(Selzer, 1971)* is a 25-item instrument that assesses lifetime drinking problems. This measure has been used in addition to the AUDIT since it assesses a variety of consequences from drinking; whereas the AUDIT assesses quantity and frequency of use. Supporters are also assessed with this measure since their experiences with alcohol may impact how they feel about victim's alcohol use and perceive alcohol's role in rape. Responses are dichotomous (*yes* or *no*) and then summed to get a total number of endorsed alcohol-related problems. The measure can then be used as a continuous measure or given a cut-off point (5) to differentiate those with and without a drinking problem.

Drug use and problems. The *Drug Abuse Screen Test (DAST-10; Skinner, 1982)* is a brief 10-item instrument, adapted from the 28-item version, used to screen and assess past year drug-related problems. Responses are dichotomous (*yes* or *no*) and then summed to get a total number, which can be interpreted into a drug problem severity level (0 = no problems reported, 1-2 = low level, 3-5 = moderate level, 6-8 = substantial level, and 9-10 = severe level). Although drug use is not a primary focus of the study, this measure was included because of the documented links between drug use, alcohol use, and rape in college student victims (McCauley, Ruggiero, Resnick, Conoscenti, &

[9] Although criteria were set to find participants who have drunk at a hazardous level at some time, this criterion did not screen out participants who did not have an alcohol-involved rape. In fact, about 56.2% of all Victims did not report any alcohol use at the time of the incident, allowing instances of rape with and without alcohol involvement to be examined.

Kilpatrick, 2009). Further, alcohol and drug use are highly co-morbid with each other, so it may be likely that a small sub-set of rape victims who report drug use consequences may have a different experience with the disclosure process than those who do not report drug use problems. This has not been tested before; however, theory would suggest that the process of disclosure may be different from alcohol use because drugs are illegal.

Social support. The *Social Support Survey Instrument (SSSI)* (Sherbourne & Stewart, 1991) consists of 19 items that measure the presence of emotional/informational, tangible, and affectionate support, as well as positive social interaction and other types of support by using a Likert scale (1 = none of the time, 2 = a little of the time, 3 = some of the time, 4 = most of the time, 5 = all of the time). The survey has four subscales, but can also be calculated as an overall support index. This particular measure of social support has been used because it is the most comprehensive measure that assesses perceived and available support. Although the SRQ is another valid and reliable measure for rape victims and was considered for use in the quantitative measurement portion of this study, it only assesses reactions to disclosure, which has been assessed in the qualitative portion of the interview.

Sexual history and assault-related characteristics. The *Sexual Experiences Survey – Short Form (SES-SF)* (Koss et al., 1987) 10-item questionnaire has been used to determine lifetime sexual assault history. This measure briefly gathers information about participants' sexual experiences since age 14 and past year. It also measures the quantity of experiences and how the incidences were performed (e.g. by force or by threats). Particularly, Supporters may be more empathetic to Victims if he/she has experienced a similar incident. For example, if a Supporter has been raped or sexually assaulted in the

past, s/he may have had a positive or negative experience with the disclosure process, which could influence his/her recommendations to the Victim to report (or not) the rape or seek mental health counseling. Additionally, specific assault-related characteristics about the most recent disclosed incident have been assessed in an additional seven questions: stranger vs. non-stranger, force/injury, substance/alcohol use during event, disclosure/reporting, acknowledgment, number of victimizations, and the time elapsed since the most recent assault.

Rape myth acceptance. The *Illinois Rape Myth Acceptance – Short Form (IRMA-SF)* (Payne, Lonsway, & Fitzgerald, 1999), is a 20-item instrument that measures general rape myth acceptance. This short-form takes items from each subscale from the full 45-item scale and has been found to be a valid and reliable measure when examining rape myth acceptance, particularly in college student samples. Participants rate their level of agreement to items using a 7-point scale, ranging from 1 (not at all agree) to 7 (very much agree). Higher scores indicate stronger belief in rape myths. Rape myths held by either Victims or Supporters may significantly impact his/her perception of the rape incident and his/her reactions during the disclosure process, particularly the use of alcohol during the incident or other assault-related characteristics. For example, if a victim was drinking during the incident and a Supporter holds rape myths about victim blaming (believing the victim put herself at risk by drinking), then s/he may react differently during a disclosure.

Tendency to disclose. Tendency to discuss problematic experiences with others has been assessed using the 12-item *Distress Disclosure Index* (Kahn & Hessling, 2001). This measure is a brief measurement tool to gauge how the participant feels about

disclosing experiences with others, in general. Participants respond to items such as, "When something unpleasant happens to me, I often look for someone to talk to", along a 5-point scale, ranging from "strongly disagree" to "strongly agree". Higher scores reflect higher tendency to disclose stressful experiences to others. Kahn and Hessling (2001) reported that the scale demonstrates good reliability and validity.

Traumatic life events. Potentially traumatic events have been measured with the Life Events Checklist (LEC) (Blake, Weather, Nagy, Kaloupek, Charney, & Keane, 1995). The LEC assesses the exposure of 16 potentially traumatic events and 1 additional other stressful event or experience. For each item, the respondent checks whether the event happened to them personally; they witnessed the event; they learned about the event; they are not sure if the item applies to them; or if the item does not apply to them. Items that the respondent endorses as happened to them personally receive a score of 1, while all other responses receive a score of 0. Item scores are then summed for a total score. This instrument has demonstrated good reliability and validity in previous research (Gray, Litz, Hsu, & Lombardo, 2004). Traumatic life events may greatly impact how he/she perceives a rape incident. For example, previous research indicates that those who have a history of trauma may be "desensitized" and less likely to perceive the need to disclose such incidences (Ullman, 1996).

Procedure

To start, participants were screened by telephone to determine initial eligibility (See Appendix A). Eligible individuals were then scheduled for a 2 hour face-to-face assessment and interview. Interviews with all participants were conducted in a private office located at the University of South Florida. At the assessment, after providing

informed consent and checking their college student ID, self-report data were collected on demographics, alcohol use, depression, anxiety, and PTSD symptomatology, lifetime sexual assault and traumatic experiences, and informal social support. Finally, participants were interviewed for approximately 1 hour using open-ended questions to guide the discussion in a semi-structured interview method, which were audio digitally-recorded. Participants were then thanked and given $20 for their time or provided a proof of participation receipt to receive extra credit. Additionally, referrals for treatment were provided as necessary or if requested[10].

Analytic Plan

Qualitative data collected for this study have been analyzed with a commonly used qualitative method called thematic analysis. Thematic analysis was performed in three main steps (See Figure 3). This approach begins with data collection, as opposed to formulating a priori hypotheses, as in traditional quantitative data analysis. An important part of thematic analysis, familiarization of the data is critical and this analysis process starts with data collection. Therefore, the PI of the study conducted all interviews of both Victims and Supporters to become familiar with the patterns of the data. A preliminary codebook was developed during the beginning of data collection, which assigned anticipated possible responses for each pre-determined question of the semi-structured interview based on previous knowledge. In-depth interviews of both groups were then: 1) transcribed verbatim by trained undergraduate study assistants and entered into ATLAS.ti©, a qualitative data management software program; 2) examined by the PI to

[10] All screening and interviews of participants were conducted by the principle investigator (PI) of the study.

generate categories and themes within the data; and 3) coded and tagged for patterns and themes that emerged through examining the data (Strauss & Corbin, 1998).

Thematic analysis coding allowed for the identification of disclosure and social support-related themes that emerged in the interviews of both groups. It also allowed for the identification of themes not initially proposed in the study, but that which may have emerged during the course of data collection (interviews). Next, the codebook went through an iterative process as specific recurrent themes were found among the codes and categorized. At this point, similarities and differences between the categories were examined to reduce the number of overlapping constructs and to distinguish among unique constructs to be included in the future development of a new social support measure. Then specific themes/constructs were organized to meet the aims and to respond to the research questions of the study. Finally, the characteristics of the sample (rape incident characteristics, mental health symptoms, alcohol use history, etc.) were examined using descriptive statistics, provided by the quantitative measures. These sample characteristics were also used to examine group similarities and differences for the purpose of triangulation of concepts and ideas that emerged from the qualitative data.

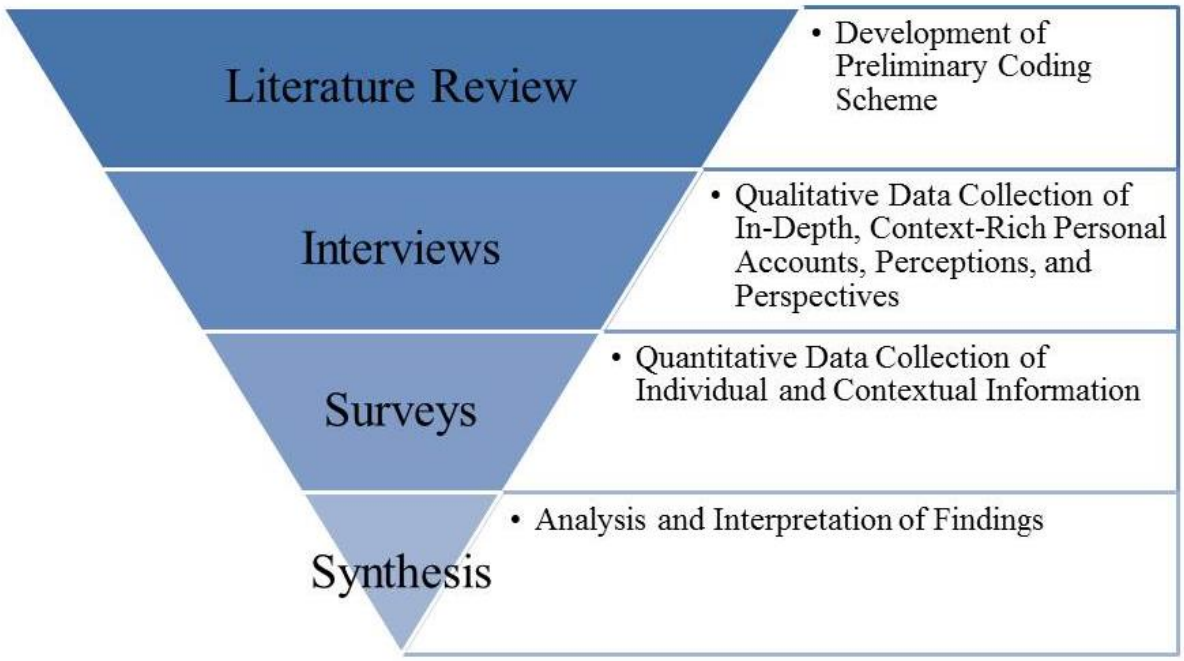

Figure 3. *Flowchart of Synchrony between Research Design and Analytic Plan*

Ethical Considerations

All research studies must consider ethical issues and ensure the safety of its participants (Marshall & Rossman, 2006). The written, informed consent obtained provided participants with information about how their data and identity would be secured, that the interview is sensitive in nature, and the study is voluntary. Specifically, for the purposes of this study, there was no linking information to the data collected. Consent forms with names are kept in a separate locked cabinet from the research data, which has no identifying mark on them. Also, given the topic of this study, participants were told that some questions would be upsetting and that they may withdraw from the study at any time without penalty and that they did not have to answer any questions that made them feel uncomfortable. Treatment referral forms were made available to any participants who requested the information. Lastly, procedures were put into place such that, if a participant reported suicidal or homicidal ideation with intent and plan,

emergency services (local campus police and/or 911) would be called. No emergency services were utilized during data collection, as they were not needed. The study was approved by the USF Institutional Review Board (IRB) (See Appendix D.)

Alternative Design Considerations

A possible limitation to the study is the sampling of Victims and Supporters as two separate groups, rather than dyads. Sampling dyads would have been beneficial for triangulation of the information received from each perspective on the one incident. However, this limitation is not a major concern given that the exploratory nature of this study seeks to uncover general concepts about the rape disclosure process between victims and their informal social supports and the impact of disclosure on post-rape outcomes. A future study would examine similar outcomes using dyads of victims and their supporters. We anticipated that these dyads would be difficult to recruit and thus chose to examine victims and supporters separately.

We had considered changing the eligibility criteria to allow victims who had experienced a recent rape (past year). However, research indicates that victims with previous trauma or psychological vulnerabilities delay disclosure (Ullman, 1996). Thus, by the nature of what we know so far about the disclosure process, we did not expect to recruit many recently raped victims or if we did, these individuals might not be representative of the population of rape victims. Finally, the inclusion of female rape victims with an alcohol use disorder (AUD) diagnosis as eligibility criteria was considered while designing this study. A more inclusive, continuous measure of alcohol use and variability of drinking patterns were sought for this study though.

Chapter 4

Results

A three-part analysis was used to examine the data and the results of the study are presented in this manner. First, quantitative data from the surveys are presented to provide an overview of the sample and individual characteristics and to provide a framework for the qualitative data. Next, qualitative data gleaned from the semi-structured interview portion of the study session are presented. The qualitative data provide in-depth, context-rich personal accounts, perceptions, and perspectives about the process of rape disclosure. Lastly, the quantitative and qualitative data were analyzed and presented together to provide context for the themes that emerged from the qualitative data and to assist in the interpretation of findings.

Quantitative Results

Survey data collected on participants (both Supporters and Victims) may serve as a way to provide an overview of the characteristics of the sample and give context to the perceptions and views illustrated in the transcripts of their qualitative interviews. The following section provides descriptive statistics on participants' mental health, substance use, alcohol use, trauma history, social support, and feelings about disclosure in general, as well as feelings about rape. Results are organized by concept and aim.

Sexual history and assault-related characteristics (Aim 1 and Aim3). Data were collected from both Supporters and Victims on their lifetime and past year sexual

experiences. It is important to note that both Supporters also experienced unwanted sexual experiences. Specifically, about 52.2% of the total sample (both Supporters and Victims) reported having an unwanted sexual experience in their lifetime (i.e. unwanted touching, attempted unwanted penetration, or unwanted penetration), 30.0% of Supporters and 93.8% of Victims[11]. Further, all of these participants reported having two or more incidents in their lifetime. Over half of the total sample (65.2%) reported having had someone penetrate them either orally, vaginally, or anally without their consent in their lifetime (since age 14), with 37.0% of participants reporting penetration without their consent in the past year. However, only 21.7% of participants acknowledged being raped (oral, vaginal, or anal penetration without consent) in their lifetime. See Table 5 below.

Table 5. *Sexual Experiences History for Total Sample and by Group Membership*

Sexual Experience	Supporters (N=30)	Victims (N==16)	Total Sample (N=46)
	Frequency (%)	Frequency (%)	Frequency (%)
Past Year Sexual Assault - Touching	10.0%	62.5%	28.3%
Past Year Sexual Assault - Attempted Penetration	33.3%	18.8%	28.3%
Past Year Rape - Penetration[a]	36.7%	37.5%	37.0%
Lifetime Sexual Assault – Touching	26.7%	93.8%	50.0%
Lifetime Sexual Assault – Attempted Penetration	46.7%	56.3%	50.0%

[11] All Victims were confirmed to have experienced an unwanted sexual experience in their lifetime when asked during the screening process; however a discrepancy was found among the self-report survey data and the qualitative description of their experiences. One Victim did not report an unwanted sexual incident in the self-report data, but did confirm an incident during the screening and the qualitative interview portion of the study. Future studies should review and confirm quantitative data with participants, as participants may need clarification of the survey questions.

Lifetime Rape - Penetration[a]	53.3%	87.5%	65.2%
2 or More Unwanted Sexual Experiences	30.0%	93.8%	52.2%
Reported Lifetime Rape[b]	0.0%*	62.5%	21.7%

[a] Responded "yes" to description of rape in SES survey.
[b] Responded "yes" to "have you ever been raped?" on SES survey.
* One Supporter (3.3%) refused to answer.

The characteristics of the most recent unwanted sexual assault that was disclosed to an informal social support are illustrated in Table 6 below by group membership (Supporter or Victim). Although Supporters also experienced unwanted sexual experiences (illustrated in Table 5 above), the table below refers to the incident that was disclosed to them, not their own experiences (for which further information was not collected). In general, victims were on average about 18 years old at the time of the incident. Victims (25%) reported that the perpetrator was a current partner, while Supporters (20%) described the relationship between the perpetrator and the victim as "friends." Overall, about 37% of all incidents involved alcohol and/or drugs on the part of the victim, with a majority (82.4%) of these incidents involving alcohol only. Likewise, 34.8% of all incidents involved alcohol (or drugs) on the part of the perpetrator, with a majority (93.8%) of the perpetrators reportedly consuming alcohol during the incident. Further, about 23.9% of participants reported the victim being physically injured during or as a result of the incident, with 10.9% describing the injury as serious and 13.0% describing the injury as minor.

According to Supporters, victims were almost 22 years old at the time of disclosure and Supporters were almost 23 years old at the time of disclosure; with an average time between incident of report and the disclosure of that incident being several

days. Unlike the discrepancy found among the victim perpetrator relationship, both Supporters and Victims reported that the victim-supporter relationship during the disclosure was "friends." Regarding feelings about the disclosure, participants were also asked to describe or label the incident. According to Victim's, a little over a third (37.0%) described the incident as "unpleasant, but not a crime", with 31.3% saying "it was a rape", 25% calling it "a crime, but not a rape", and 6.3% feeling unsure about how to describe the incident. On the other hand, more than half of Supporters (63.3%) described the incident as a rape, 16.7% labeled the incident "a crime, but not a rape", 13.3% were unsure of what to call the incident, and 6.7% said it was "unpleasant, but not a crime." Finally, a majority of Supporters (70.0%) explained that the incident was not reported to police and an even larger number of Victims (93.8%) did not report their incident to police.

Table 6. *Assault-Related Characteristics of Most Recent Incident Disclosure*

Characteristic	Supporters (N=30)	Victims (N=16)	Total Sample (N=46)[12]
	Mean (SD) / Percent	Mean (SD) / Percent	Mean (SD) / Percent
Victim Age - Incident	17.93 yrs. (6.42)	17.81 yrs. (3.85)	17.89 yrs. (5.61)
Victim Age - Disclosure	21.83 yrs. (9.26)	---	---
Supporter Age - Disclosure	22.73 yrs. (9.31)	---	---
Relationship between Perpetrator and Victim	Partner 16.7% Family 13.3% Friend 20.0% Colleague 16.7% Stranger 13.3% Acquaintance 10.0% Other 10.0%	Partner 25.0% Family 6.3% Friend 18.8% Colleague 18.8% Ex-Partner 18.8% Stranger 6.3% Acquaintance 6.3%	Partner 19.6% Family 10.9% Friend 19.6% Colleague 17.4% Ex-Partner 6.5% Stranger 10.9% Acquaintance 8.7% Other 6.5%

[12] Total characteristics were included to provide overall data about the rape incidents examined in the study, while the Victim and Supporter columns illustrate any differences found among the incidents reported by the two groups.

Relationship between Supporter and Victim	Partner 10.0% Family 3.3% Friend 63.3% Colleague 10.0% Ex-Partner 3.3% Acquaintance 6.7% Other 3.3%	Partner 12.5% Family 25.0% Friend 62.5%	Partner 10.9% Family 10.9% Friend 63.0% Colleague 6.5% Ex-Partner 2.2% Acquaintance 4.3% Other 2.2%
Victim Alcohol/Drug Use During Incident	33.3% Alcohol 70.0% Drugs 0.0% Both 30.0%	43.8% Alcohol 100.0% Drugs 0.0% Both 0.0%	37.0% Alcohol 82.4% Drugs 0.0% Both 17.6%
Perpetrator Alcohol/Drug Use During Incident	30.0% Alcohol 88.9% Drugs 0.0% Both 11.1%	43.8% Alcohol 100.0% Drugs 0.0% Both 0.0%	34.8% Alcohol 93.8% Drugs 0.0% Both 6.3%
Physical Injury	26.6% Serious 13.3% Minor 13.3%	18.8% Serious 6.3% Minor 12.5%	23.9% Serious 10.9% Minor 13.0%
Description of Incident	Unpleasant, but not Crime 6.7% Crime, but not Rape 16.7% It was Rape 63.3% Unsure 13.3%	Unpleasant, but not Crime 37.5% Crime, but not Rape 25.0% It was Rape 31.3% Unsure 6.3%	Unpleasant, but not Crime 17.4% Crime, but not Rape 19.6% It was a Rape 52.2% Unsure 10.9%
Reported to Police	Reported 10.0% Someone Else Reported 13.3% Not Reported 70.0% Unsure 6.7%	Reported 6.3% Someone Else Reported 0.0% Not Reported 93.8% Unsure 0.0%	Reported 8.7% Someone Else Reported 8.7% Not Reported 78.3% Unsure 4.3%

Rape myth acceptance (Aim 1). General rape myth acceptance scores among participants shows that on average people score a 2.13 in agreeing with rape myths on a scale from 1 (not at all /disagree) to 7 (very much/agree) . Additionally, no statistical difference was found between the mean scores of Supporters and Victims, although Victims scored slightly higher on general rape myth acceptance (Total score range from 20 to 140).

Table 7. *Rape Myth Acceptance by Group Membership*

Sample	Mean (SD)	Avg. Response
Supporter (N=30)	40.67 (6.68)	2.03
Victim (N=16)	46.06 (10.91)	2.30
Total Sample (N=46)	42.54 (8.67)	2.13

Tendency to disclose (Aim 1). Participants scored an average of 3.18 on a scale of 1 to 5, with 5 higher scores indicating a higher tendency to disclose stressful experiences to others. There was no significant difference in means between Supporters and Victims (Total score range from 12 to 60).

Table 8. *Tendency to Disclose by Group Membership*

Sample	Mean (SD)	Avg. Response
Supporter (N=30)	39.23 (10.98)	3.27
Victim (N=16)	36.13 (11.59)	3.01
Total Sample (N=46)	38.12 (11.17)	3.18

Traumatic life events (Aim 1). On average, Victims experienced a little over 6 types of traumatic events in her lifetime, as did Supporters (Possible score range from 0 to 17). Further, there are no significant differences in the number of non-assault traumatic events experienced by Supporters and Victims. The difference between the two groups occurred when the types of trauma each group has been exposed to were examined: assault versus non-assault. Victims experienced significantly more traumatic assault-related events than Supporters (see below). Specifically, Victims averaged almost three types of assault events, while Supporters averaged a little over one type of assault event in their lifetime.

Table 9. *Comparison of Number of Traumatic Life Events by Group Membership*

Lifetime Exposure to Trauma[1]	Supporters (N=30)	Victims (N=16)	Total Sample (N=46)	F (df)	P value
	Mean (SD)	Mean (SD)	Mean (SD)		
Any Event	6.10 (3.71)	6.31 (2.47)	6.17 (3.30)	.042 (1,44)	.838
Assault Event	1.47 (1.33)	2.63 (1.02)	1.87 (1.34)	9.165** (1,44)	.004
Non-Assault Event	4.63 (2.93)	3.69 (2.06)	4.30 (2.67)	1.315 (1,44)	.258

[1] Lifetime exposure was positive if the event "happened to me" or "witnessed it."

*p < .05 **p<.01

Mental health (Aim 2 and Aim 3). Depression total scores indicated that Victims (7.63 with a range of 5-9; maximum total score of 27), on average, report mild depression. Likewise, Victims also report mild anxiety (score of 5.41 with a range of 5-9; maximum total score of 21). Further, with a total score ranging from 17-85, Victims (35.06) indicated significantly more PTSD symptoms than Supporters (25.70).

Table 10. *Mean Differences of Mental Health by Group Membership*

Measure	Supporters (N=30)	Victims (N=16)	Total Sample (N=46)	F (df)	P value
	Mean (SD)	Mean (SD)	Mean (SD)		
Depression	5.00 (4.38)	7.63 (5.71)	5.91 (4.98)	3.025 (1,44)	.089
Anxiety	4.73 (5.00)	6.69 (5.58)	5.41 (5.23)	1.472 (1,44)	.232
PTSD	25.70 (9.19)	35.06 (16.52)	28.96 (12.87)	6.151* (1,44)	.017

*p < .05 **p<.01

Social support (Aim 2). In general, perceived and available social support mean scores show that, on average, Supporters and Victims feel that they have all types of support "most of the time" (Subscale score ranges from 1 to 5; Total mean scores range from 19 to 95). Further, when looking at means by group membership, there is no

significant difference in the support perceived to be available between Supporters and Victims.

Table 11. *Mean Differences for Social Support by Group Membership*

Measure	Supporters (N=30)	Victims (N=16)	F (df)	P value
	Mean (SD)	Mean (SD)		
Emotional Support	4.00 (.95)	3.69 (1.03)	1.100 (1,44)	.300
Tangible Support	3.87 (1.27)	3.75 (1.35)	.084 (1,44)	.773
Affectionate Support	3.96 (1.29)	4.00 (1.05)	.014 (1,44)	.907
Positive Social Interaction	4.14 (.93)	3.98 (1.09)	.292 (1,44)	.592
SSSI Total Score	20.04 (4.20)	19.04 (4.72)	.538 (1,44)	.467

*p < .05 **p<.01

Alcohol and drug involvement (Aim 3). Examining the total sample, 19.6% drank at least two or more days a week and 19.6% consumed six or more drinks per episode at least once a month. Of notable interest, 39.1% of participants reported guilt over drinking and not being able to remember what happened the night before as a result of drinking. With this in mind, using MAST criteria, about 30.4% of the sample had a lifetime drinking problem. See Table 12 below for additional drinking characteristics. When looking at group differences and drinking, Victims had significantly higher AUDIT scores than Supporters (Total score range from 0 to 40). However there was no difference in MAST (Total score range from 0 to 25) or DAST (Total score range from 0 to 10) scores (See Table 13).

Table 12. *Drinking Characteristics of Total Sample (N=46)*

Characteristic	Supporters (N=30)	Victims (N=16)	Total Sample (N=46)
	Frequency (%)	Frequency (%)	Frequency (%)
Drinks 2+ days/week	23.3%	12.5%	19.6%
Consumed 6+ drinks/episode one/month	16.7%	25.0%	19.6%
Failure to fulfill role obligations	13.3%	25.1%	17.3%
Concerned significant others	6.7%	37.6%	17.4%

Guilt over drinking	20.0%	75.0%	39.1%
Unable to remember because of drinking	29.9%	56.2%	39.1%
Injury because of drinking	13.3%	18.8%	15.2%
Drinking Problem	20.0%	50.0%	30.4%

Table 13. *Mean Differences of Alcohol and Drug Use by Group Membership*

Measure	Supporters (N=30)	Victims (N=16)	Total Sample (N=46)	F (df)	P value
	Mean (SD)	Mean (SD)	Mean (SD)		
AUDIT Total	4.17 (3.85)	8.50 (6.00)	5.67 (5.09)	8.887 **(1,44)	.005
MAST	4.03 (2.98)	4.94 (3.04)	4.35 (3.00)	.948 (1,44)	.336
DAST	1.50 (1.38)	2.25 (1.73)	1.76 (1.54)	2.570 (1,44)	.116

*p < .05 **p<.01

Overall, quantitative results reveal a variety of information about the sample. In general, participants reported low levels of rape myth acceptance, higher tendencies to disclose stressful events to others, and high levels of perceived available social support (no statistical difference between Supporters and Victims). On average, participants experienced a little over 6 types of traumatic events in their lifetime. When examining group differences, Victims had significantly more assault related events than Supporters. Likewise, Victims reported mild depression, mild anxiety, and significantly more PTSD symptoms and alcohol use than Supporters. Results also indicate that although all Victims experienced rape in their lifetime and almost all of the Victims in the study (15 out of 16) had been revictimized (experienced 2 or more unwanted sexual assault incidents), only a little over half actually labeled their experience as rape. Over half of Supporters also experienced rape in their lifetime, but none of them actually state that they have ever been raped. When examining the characteristics of the most recent rape incident that was disclosed to the Victim or Supporter, Victims more often described the

incident as "unpleasant, but not a crime", while Supporters more often described the incident disclosed to them as a rape (even though they themselves do not recognize similar incidences that happened to themselves). Further, a majority of these incidents were not reported to the police. Instead, most of the incidents were disclosed to friends, as opposed to formal forms of social support. Moreover, a little over a third of the incidents involved alcohol or drugs. Of these incidents, almost all of them involved alcohol, as opposed to drugs. In fact, none of the incidents involved strictly drugs. Finally, about a quarter of incidents resulted in physical injury. While these data provide information on the sample and incident characteristics, there remains the question about the process of disclosure that cannot be captured by current quantitative measures. Qualitative results from the semi-structured interview portion of the study session fill this gap and are presented in the next section.

Qualitative Results

Iterative process of coding and qualitative coding scheme. A preliminary coding scheme was developed during the beginning of data collection using *etic* codes, codes derived on an a priori basis from theory or previous research (Bloomberg & Volpe, 2012). These initial codes were predicted responses assigned to each of the pre-determined qualitative questions asked during the semi-structured interviews by the PI and study team (See Appendix E for the final coding scheme and frequencies of each code by question). The first coding scheme consisted of 208 total codes used to code the possible responses of both the Supporters and Victims responses to the interview questions (122 codes for Supporters and 160 codes for Victims). After conducting several interviews, the coding scheme was reevaluated to see if all of the responses thus

far could be coded with the initial coding scheme. As expected, *emic* codes, codes derived from the words of participants, emerged in the data and were added to the coding scheme. For example, when Supporters were asked how they felt about being approached to discuss an unwanted sexual incident, an unanticipated theme that emerged in the interviews was the idea that some Supporters felt good about the disclosure because it validated their friendship. The study team met weekly to review the current coding scheme and discuss possible new codes as new data were collected. This iterative process continued through data collection until no more codes emerged from the data. Specifically, the coding scheme went through six iterations, with the final code count at 277. Next, low-frequency codes[13] were eliminated and remaining codes were organized into sub-categories and 29 larger categories/themes. These larger themes or categories were then organized by aim and research question to examine the dynamics of the disclosure process among college student rape victims and their informal social supports.

Identification of disclosure and social support themes. The following section identifies themes related to the disclosure process and social support of rape victims found in the interviews of Supporters and Victims by aim and research question. See Table 14 below for an overview of the 29 themes found during qualitative data analysis. The process of the specific codes collapsed into themes is visually documented under each theme described in the following text. Codes beginning with a "B" are codes from both Supporters and Victims, codes starting with an "S" are Supporter only codes, and codes with a "V" are codes from Victims only. The findings are then presented by way of "thick description" using the participant's quotations from interview transcripts to

[13] Codes with less than a 20% frequency were considered low frequency and eliminated, with the exception of low frequency codes relevant to the primary aims of the study.

illustrate the various themes (Denzin, 2001). Specifically, the qualitative findings are presented in order by aim, research question, and theme. Within each theme related to that research question the following is presented: a description of the theme, frequency rates of responses related to the theme, a visual mapping of the responses collapsed into the theme, and quotations illustrating the theme.

Table 14. *Overview of Qualitative Themes by Aim and Research Question*

Aim	Research Question	Themes
Aim 1: To identify constructs related to the decision-making process to disclose a rape to an informal social support.	RQa: What prompts victims to utilize their informal support system vs. formal support?	Comfortable Environment Openness with Family Relatable/Problems in Common with Friends Limited – Non-Personal Issues with Acquaintances No Community Outreach Community Resource Awareness Presence of Close Relationships Quality of Relationships
	RQb: How do victims feel about disclosing a rape to their support system?	Unmatched Feelings and Perceptions Unlimited Topics Among Informal Supports Health Topics Among Unknown Persons No Topics Off-Limits
	RQc: What factors influence female rape victims to utilize and impede the use of their social network?	Timeliness Immediate Needs Belief in Rape Myths

Aim 2: To understand victim and victim supporters perceptions of social support and the impact of these perceptions on rape victims' post-rape mental health.	RQa: How prepared are victims' social supports to provide support that will promote recovery?	Inadequate (Negative) Approachable (Positive)
	RQb: What types of positive and negative assistance are supporters providing (from the victim's and supporter's perspective)?	Available Support Essential Support Situational support
	RQc: Does a "strong" social support system create a barrier for victims to seek formal treatment?	Promotion of Formal Support Unmatched Feelings and Perceptions of Informal Support Barriers
Aim 3: To determine the role that alcohol plays in the disclosure process.	RQa: How do assault characteristics of female rape victims with a history of alcohol involvement affect their use of informal social support and their mental health outcomes?	Limited Impact of Alcohol (or Drugs) on Disclosure, Response, and Perceptions Victim Guilt Judgment Uncertainty on the Impact of Alcohol (or Drugs)
	RQb: How does alcohol abuse history of the victim impact whether social support will be used, the type of social support received by the victim, and the influence of social support on the mental health of the victim?	Victim Credibility Limited Impact of Alcohol (or Drugs) on Response, Disclosure, or Type of Support Sought

Aim 1: To identify constructs related to the decision-making process to disclose a rape to an informal social support.

RQa: What prompts victims[14] to utilize their informal support system vs. formal support? Victims were prompted to utilize informal versus formal supports due to the following considerations: comfortable environment, openness with family, relatable/problems in common with friends, limited-non-personal issues with acquaintances, no community outreach, community resource awareness, presence of close relationships, and quality of relationships.

Comfortable environment. The disclosure process was often described by Supporters in the study as one that happened in a comfortable environment. Three codes were collapsed into this reoccurring theme (See figure below).

(S1CASUAL)Disclosure was Casual/Came up in Conversation
(S1PERSON)Disclosure was In-Person
(S1ONE)Disclosure was One-on-One
} Comfortable Environment

Figure 4. *Mapping of "Comfortable Environment" Theme*

Specifically, Supporters frequently described the disclosure process as occurring in-person (56.7%) and one-on-one (63.3%), as opposed to disclosing the incident via the telephone/electronic communication (i.e. text message, e-mail, or web-based forum) or in a group setting. Further, the disclosure occurred casually and simply came up in conversation (40.0%) more often than the victims approaching their social supports to have a specific conversation about the incident. According to Supporters, the in-person and one-on-one setting provided victims with a comfortable environment to divulge the incident and relevant details to the Supporter. Participants described these casual disclosures in the following ways:

[14] A number of themes include both Victim and Supporter responses given that the aims of this study are focused on the disclosure process, in general, and how people feel or would feel about disclosing a rape to someone. Further, over half (53.3%) of Supporters reported a rape in their lifetime and can provide valuable information and perspective related to the research questions.

"Umm, we were actually hanging out at a friend's house…and umm, it was it was just kinda [sic] a topic that came up later in the night after we were all drinking and hanging out {I: mhm}and I don't even know how it came up-but it came up."

-Supporter

"It kinda come up [sic] when we were just having a general conversation and then she, like, brought it up."

-Supporter

"Um, it was definitely, uh, after a while of knowing me and really, really liking spending time with me, liking the fact that I was always there {I: Right} you know, um, we were sitting in my car and we were just at, like, the river. Like, where I'm from there's, like, this river and everybody goes to it cause [sic] it's really nice and it's quaint, whatever {I: Right}. And we were sitting in my car talking and she just says "listen, I wanna [sic] talk to you about something" and I'm like "Okay shoot" you know?"

-Supporter

Openness with family. An overwhelming majority of both Victims and Supporters described a wide range of topics to which they approached their families, so these responses were collapsed into one main theme of openness with family (See figure below).

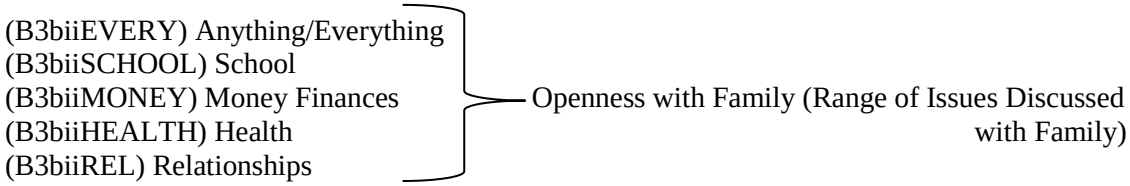

Figure 5. *Mapping of "Openness with Family" Theme*

One third (34.8%) of all participants reported that they would approach their family for help about a variety of matters including, school (32.6%), relationships (26.1%), money/finances (21.7%), and health (21.7%). Only a small number (6.5%) of participants explained that they were not close with their family and felt there was nothing they could tell them. This openness with family can be characterized by the following participant responses when asked about the types of topics they approach their family with:

> "Um, pretty much anything, like health, finances, school, work, planning my future."
>
> -Victim

> "I mean I talk to them about most topics, probably everything but just more on a like general level…"
>
> -Supporter

> "Yeah, we'll pretty much talk about everything."
>
> -Supporter

"My family, they are very supportive and I could talk to them about anything."

-Supporter

Relatable/problems in common with friends. As with family, participants felt that they could approach their friends with a variety of topics: school, relationships, and work, which were collapsed into one theme described as relatable or problems in common with friends.

Figure 6. *Mapping of "Problems in Common with Friends" Theme*

However, most of the topics they described were ones that they felt their friends could relate to or share in common, such as relationships (54.3%), school (52.2%), and work (28.3%). Stated differently, these topics seemed to be characterized by student-relevant issues. Specifically, participants stated the following:

"Um, to friends I usually go for, um, if I'm having a problem with, uh, other classmates, you know, other friends, um, sometimes if I'm having a problem with my boyfriend I'll go to some of my female friends."

-Victim

"Mostly like about school stresses and stuff like that cause we're all students so that's something that they can relate to with."

-Victim

"Usually school-related issues, or issues we can relate to each other about, sometimes family or relationship issues."

-Victim

Limited – non-personal issues with acquaintances. Although an informal form of social support, participants did not report approaching acquaintances with many topics or issues. Acquaintances were defined for the participant as any person whom they knew, but did not consider a friend or family member.

Figure 7. *Mapping of "Non-Personal Issues with Acquaintances" Theme*

If participants did report approaching acquaintances with problems, 43.5% reported reaching out about problems about which the acquaintances could relate or had in common with the acquaintance. A third of participants (32.6%) reported not confiding in acquaintances for any types of problems. As one participant stated:

"Um, just very minor things, nothing too important to me."

-Victim

Another participant explicitly stated:

> "Nothing personal {I: mhm} I mean nothing um--unless I think it is something that, that someone whooo needs some sort of help or has come to me for some sort of advice, um, I wouldn't get too personal with it, but if it's something that I have experienced or something I have gone through, um, you know I might let them know that it is something that I could speak to a little bit, but I wouldn't open up and you know reveal any type of personal information with an acquaintance."
>
> -Supporter

No community outreach. When participants were asked about if they utilize any community resources, over half (60.9%) responded that they had not. As a more formal form of social support, half of participants (50.0%) explained that they simply felt that they had never needed this type of support. Further, a majority of participants (69.6%) reported not being comfortable approaching or utilizing community resources for help with any of their problems. One of the main reasons cited for not utilizing resources in the community was that they didn't need this type of help or they didn't feel their problems were serious enough to seek formal community services. Both Victims' and Supporters' perspectives were important to obtain since Supporters may function as a gatekeeper to services. In other words, if a Supporter does not utilize community resources, they may not promote the use of these resources to Victims during disclosure.

(B3bivNOTHING) Nothing
(B5NO) No Resource Utilization
(B5NONEED) No Need for Community Resources
} No Community Outreach

Figure 8. *Mapping of "No Community Outreach" Theme*

Participants most often stated the following when asked about topics they approached the community with:

> "I don't generally seek out community support [I: mhm] Umm, I am more of a private person."
>
> -Supporter

> "Um, I don't know that I have. Uh, I can't say that I have ever sought out assistance or resources in that - in any of those kind of, um, [inaudible] I haven't ever had the need for money or food or a crisis scenario that required I seek out social services [sic]."
>
> -Supporter

> "No, I haven't really needed to use any of these resources."
>
> -Victim

> "No reason - just I feel like I don't really go through enough for me go to like community's programs."
>
> -Supporter

"I don't feel as if I need them. I know people that do, they need it, like I don't feel as if I'm in the position where I need to use it and for church I utilize it because like I know the people there, I can trust them."

-Supporter

"Um, I don't know that with my personal life I talk, uh, or seek out community assistance. At least not, um, I don't know [inaudible] anything that's been - that's transpired that I would seek out community assistance for. I mean, {I: mhm} I [inaudible] I have also familiarized myself with the nature of the [inaudible] community that I don't know if I look for additional - things that might disclose or places to disclose them."

-Victim

Community resource awareness. With the lack of formal resources being utilized in the community, particularly among rape victims, what types of resources are college students aware of in the community that could help with their physical or mental well-being? Again, the inclusion of Victims' and Supporters' knowledge and perspective of the community resources available and why or why not they use them is important to understand the use of informal versus formal forms of social support during times of need. For those who are aware of community resources, what makes them appealing?

Both Supporters and Victims frequently (58.7%) stated that they knew about student services available on the USF campus. Often participants would specifically describe the fact that they knew about "10 free counseling sessions" offered to students

and the victims at the Victim Advocacy Center. In fact, for the smaller number of participants (39.1%) that said they did utilize community resources, the two main reasons for using them was because they were convenient (28.3%) and free or affordable (17.4%). Participants were also aware of local hospitals (37.0%), crisis centers/hotlines/911 (32.6%), and private counseling (28.3%). It is almost important to note that resources were not listed for participants; participants recalled the resources when asked where they would go if they needed help with physical or mental problems.

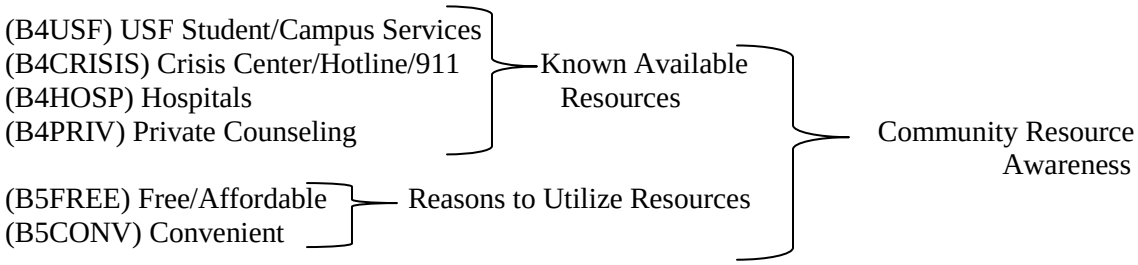

Figure 9. *Mapping of "Community Resource Awareness" Theme*

Participants most often described their awareness of community resources in the following ways:

> "Victim advocacy office, um, the counseling center, the wellness center {I: all part of USF?} Yeah, all the USF stuff and then Crisis Center of ____ (city), I go there and their helpful [inaudible] hotline, um, what else? All the organizations - the student organizations [sic]."
>
> -Victim

"Um, well I know there's a lot of things here at USF. Um, I haven't personally been to any one of the meetings or- but I know that they're there."

-Victim

"Umm, there is the 211 hotline, umm… any of the local E.R's can assist with any mental health problems, there are umm... crisis hotlines and abuse hotlines. There are a lot of resources in our community, actually."

-Supporter

"Yeah, It's convenient cause it's on campus, um it's affordable for me at least cause like mm the student health services fee is like covered in my tuition stuff so (I: Right) it's nothing that's coming directly out of my pocket."

-Supporter

"I think it was just convenience sake, {I: Okay.} P: because I was living on campus so it was right there, I mean it worked you know within whatever school schedule I had {I: Right} P: so it's not like I had to, you know, go off campus {I: Yeah} P: go somewhere else, so."

-Victim

"Like counseling center because it was, honestly it was free."

-Victim

Presence of close relationships. Another main element found in both Victim's and Supporter's dialogues regarding the disclosure process was the presence of close relationships. In fact, just over half (52.2%) of the participants explained that they sought out certain people when experiencing problems because they had a "close relationship" with the individual. Participants also specified that they most often sought out family (69.6%) and friends (43.5%) who were close to them for support when they were experiencing problems, as opposed to peers or professionals in the community. A smaller number of people explained that they sought support via close relationships with their significant other (26.1%). A common reason for seeking out these particular people for support was that participants (21.7%) had known the designated supporter for a long time. When Victims were asked specifically why they chose their supporter in the most recent disclose rape incident, 31.3% reported it was also because they had known the person for a long time. The biggest factor influencing Victims to disclose the incident was that the supporter was labeled as a best friend or confidant (56.3%) and the Victim simply told that person everything.

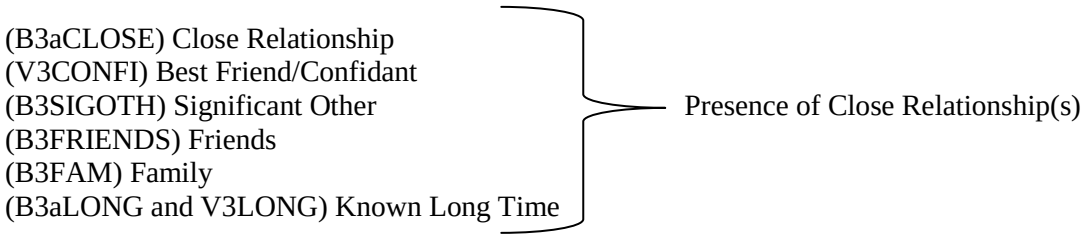

Figure 10. *Mapping of "Presence of Close Relationship(s)" Theme*

This theme of close relationships was described by most participants in the following ways when asked why they chose certain people to share their problems with:

"They understand me better and I'm closer to them than I am to a lot of people that are - at least a lot of friends that I have here."

-Supporter

"I would say they're the closest to me. I mean, uh, we just share a bond, I guess, that most individuals don't share."

-Supporter

"Because I've known them forever, I feel like I can tell them anything that they are the most comfortable people I could be around."

-Victim

Quality of relationships. Going beyond just the types of support participants sought when experiencing problems, when asked about why they chose those particular people or groups of people, they often characterized these relationships by specific qualities.

(B3aGET) They "Get" Me
(B3aTRUST and V3TRUST) Trust
(B3aRESP) Respect Advice/Opinion
} Relationship Qualities

Figure 11. *Mapping of "Quality of Relationships" Theme*

Specifically, both Supporters and Victims said that their support system said "they get me" (39.1%). This idea is best illustrated by the comment of one participant who said:

"Um, cause [sic] I feel they - they understand me best. They've grown up with me, they've known - they know what I've been through and where I'm coming from {I: mhm} so understand my views [sic] on things."

-Supporter

Participants also sought out people whom they respected their advice or opinion (32.6%) on the specific topic that was bothering them:

"Because I trust her, and I believe that whatever recommendations or suggestions she have [sic] will be something valuable."

-Supporter

Another main quality expressed by participants was the idea of trust (26.1% both Supporters and Victims; 43.8% Victims only). One Supporter said:

"Uh, because I trust that they have my best interest in mind and they wouldn't give me any ill advice."

-Supporter

Similarly, a victim simply stated the following about their confidant:

"I don't trust anyone as much as him."

-Victim

RQb: How do victims feel about disclosing a rape to their support system (and victim supporters feel about having a rape disclosed to them)? Feelings surrounding the disclosure of a rape were described by: unmatched feelings and perceptions, unlimited topics among informal supports, health topics among unknown persons, and no topics off-limit.

Unmatched feelings and perceptions. An undeniable theme found throughout the interviews with both Supporters and Victims was the idea of their unmatched feelings and perceptions about the disclosure process. On one hand, Supporters reactions about the disclosure process were described as feeling comfortable when the information was disclosed to them (43.3%), feeling sympathetic without it impacting their response (36.7%), feeling bad (26.7%), and even feeling like the disclosure validated their friendship and showed that the person trusted them (23.3%):

> "…shocking at first but, uh, I didn't have a problem with it {I: right}. I never felt uncomfortable."
>
> -Supporter

"I felt honored. I felt privileged that [Victim's name] would confide in me like that - that she saw me, you know, my relationship with her or, you know, she trusted me with it. So {I: mhm} I - I was honored, um, I was horrified by, you know, what happened but I was honored that she chose me {I: okay} and I felt responsibility."

-Supporter

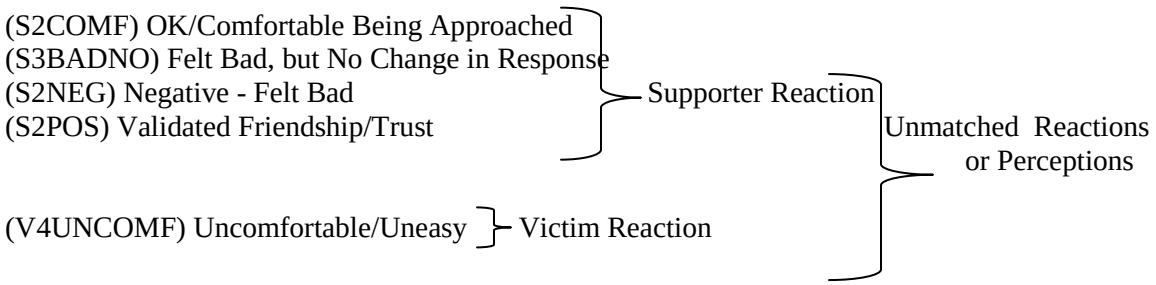

Figure 12. *Mapping of "Unmatched Reactions or Perceptions" Theme Among Supporters and Victims*

On the other hand, a majority of Victims (75.0%) stated that they felt uncomfortable or uneasy during the disclosure process. One participant stated the following when asked how they felt disclosing the incident:

"Really uncomfortable and just embarrassed."

-Victim

Another Victim described the following:

"Um, I felt vulnerable, I wasn't sure how she was going to react, like I knew that she wouldn't judge me but I wasn't sure, you know, how she would react to it, what she would say."

-Victim

Unlimited topics among informal supports. Not surprisingly, Victims (50%) emphasized that they could discuss practically anything and everything with their informal forms of social support:

"Just my friends and family, I can talk to them about anything."

-Victim

(V4aEVERY) Anything/Everything ⎫ Unlimited Topics Among Informal Supports

Figure 13. *Mapping of "Unlimited Topics Among Informal Supports" Theme*

Health topics among unknown persons. When Victims were asked what types of topics they would feel more comfortable disclosing to people they did not know, they most frequently said health (37.5%) or sex (31.3%). Participants described the comfort surrounding these topics when telling a stranger, as opposed to a friend or family member, in the following ways:

"Um, probably more mental health type stuff. My family doesn't really talk about emotions that much."

-Victim

"Yeah, really self-help I think as long as you're identified by a number not a name, I'm open to discussing rape, I'm open to discussing sexual disease, {I: Right} sexual activity. Those things I'm open to {I: Right} discussing {I: Mhm}, if it's an anonymity."

-Victim

(V4bHEALTH)
(V4bSEX) } Health Topics Among Unknown Persons

Figure 14. *Mapping of "Health Topics Among Unknown Persons" Theme*

No topics off-limits. The majority of Victims (75.0%) stated that there were no topics that they did not feel comfortable talking about to anyone. In fact, as one participant stated, talking to someone was necessary to feel better:

"Now a days, I don't think so… You know if you talk to people you know it's not going to hurt as much or it's not…you just have to move on. [laughs]"

-Victim

(V4cNOTHING } No Topics Off-Limits

Figure 15. *Mapping of "No Topics Off-Limits" Theme*

RQc: What factors influence female rape victims to utilize and impede the use of their social network (using victim and victim supporter perspective)? Factors influencing the utilization or impedance of the use of one's social network related to the following: timeliness, immediate needs, and belief in rape myths.

Timeliness. Timeliness is a main theme related to what prompts victims to disclose and utilize their social support system. The timing between the incident and the

disclosure, as reported by the Supporters, can be broken in to two sub-categories: early disclosure and delayed disclosure. Early disclosure, disclosure hours, days, or a month after the incident, was most often described by Supporters (56.7%). However, there was a smaller portion of victims who had delayed disclosure, which was typically around five to six years after the incident (16.7%).

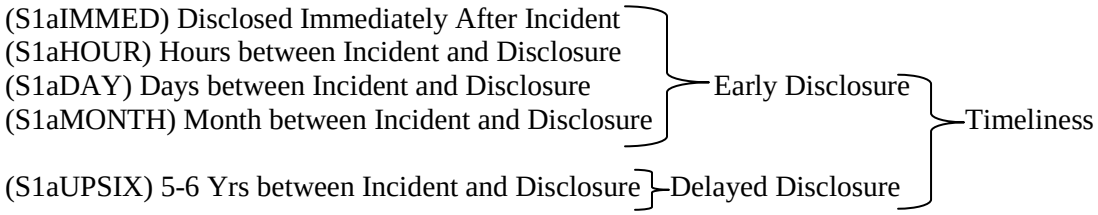

Figure 16. *Mapping of "Timeliness" Theme*

This idea of timeliness, particularly early disclosure, may be surprising considering the low rates reporting found in the literature, but these findings may account for the subsequent theme that influenced Victims to disclose the incident. Although the concept of timing is straightforward, the following participant statements illustrate this theme further:

> "It was actually like for [pause] let's say about ten hours because (I: 10, ok.) It happened in the morning and she told me in the evening."
>
> -Supporter

> "Uh, I would only say a matter of days…at the most."
>
> -Supporter

"From the time the incident happened to her to the time she told me about it, it had been about 5 years."

-Supporter

Immediate needs. Of particular interest was the main reason Victims were prompted to disclose the incident. The figure below illustrated the three main reasons (by code) influencing disclosure.

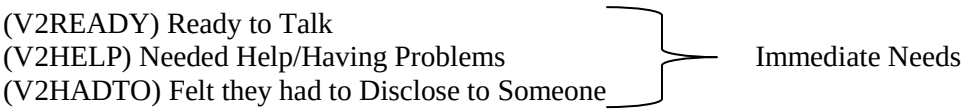

Figure 17. *Mapping of "Immediate Needs" Theme*

Over half (56.3%) of the Victims felt that they needed help at the time or were experiencing problems due to the incident. Others said they were "ready to talk" (31.3%) or felt they had to disclose (37.5%). Explicitly stated:

"At that point in time I was just ready to say, "this happened" and it's over and I can move on."

-Victim

"Um, (pause) it's hard to say. I guess I was like one big secret and I was like "I don't know what to do about this" and finally my friend was there one day and I just couldn't hold it in anymore, I just had to talk to someone. {I: You just had to tell somebody} Yeah."

-Victim

"Well, my roommate was actually kinda there when it happened, so she knew that you know something bad had happened. So, I told her, then I was kinda feeling that like I still needed to get it off my chest to people that were close to me. I thought it was something that they needed to know. {I: Okay} So, I started reaching out to more people about it."

-Victim

Belief in rape myths. While most of the themes that emerged from the interviews expressed why Victims disclosed the incident, the single, largest theme found regarding an impeding factor for disclosure was their belief in rape myths.

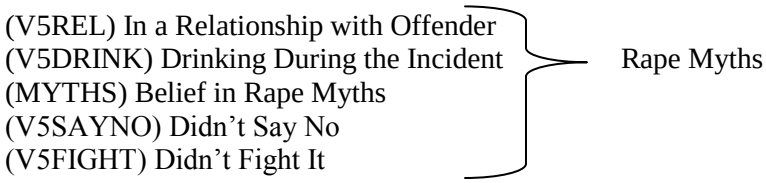

Figure 18. *Mapping of "Belief in Rape Myths" Theme*

Out of all of the interviews, there were 39 examples of rape myths. The following are several examples of the rape myth expressed by participants:

"Yeah I was under age so I would have never told anybody formally that I, you know, even if I know your allowed to tell the pol… and this is… this is what I'm trying to say, people have like one idea of rape that is only one kind and then I never would have called the police and reported this because I knew him, we had been sleeping together before…"

-Victim

"It's - it's the same, but just because of - she was a stripper. {I: Mhm} She presented herself as tight, skimpy, and that's not a reason but {I: right} if you're walking out late at night {I: right} three o'clock in the morning, you're half naked {I: right}, you know, something's bound to happen {I: right} if that person crosses you, so…"

-Supporter

"This particular girl is very naïve... lived a very sheltered life and I kinda [sic] think this was sort of a buyer's remorse in that she made a decision that she couldn't live with. [I: okay] and it doesn't change my opinion of her, um, but I also think she needed to realize that, that is a serious accusation."

-Supporter

Most often Victims (43.8%) reported that drinking during the incident affected their disclosure or feelings about the disclosure:

"I was underage at the time {I: Right} and I'm like what's more serious, me underage drinking or me being raped?"

-Victim

"I consumed alcohol and so I didn't- I wasn't sure if my roommate was gonna come back with "oh well you know you were drunk, well you kind of had it

coming." {I: Right} you know, like, I didn't want her to also, kind of, play out the stereotypes."

-Victim

"I was really, really, really, really, really drunk and he was sort of drunk, I don't know. I don't really know how drunk he was {I: right}. I feel like he wasn't that drunk cause he was sober enough to drive and, like, all of that stuff so, I mean, just honestly at first I didn't want to tell people cause I didn't even realize, like, - cause I don't remember most of it {I: right} so it was, like, was it really rape? Because, like, I was really drunk and I remember saying "No" but, like, I really drunk {I: right} and, like, I was, like, I didn't want to tell people that, like, {I: right} cause it would be like "why didn't – couldn't you get away, why didn't you try – like, why didn't you do this and this and this" and just, like, "well, I was drunk" {I: right} and a lot of people say, like, "oh, if it's – if you were drunk it's your fault" {I: right}. But it's really not [laughter]"

-Victim

A smaller number of victims (25.0%; N=4) were hindered in terms of the disclosure because they were in a relationship with the offender. Often these same Victims didn't say "No" during the incident (18.8%; N=3) or didn't fight it (18.8%; N=3). Victims characterized this assault characteristic and its impact in the following ways:

"That, you know, how could your boyfriend rape you if you're in a relationship together?"

-Victim

"Partially because I think that, you know, the blame might have been put on me because it was my fault, because I couldn't say no."

-Victim

Aim 2: To understand victim and victim supporters perceptions of social support and the impact of these perceptions on rape victims' post-rape mental health.

RQa: How prepared are victims' social supports to provide support that will promote recovery? Supporters reported the following two main themes in regards to preparedness: inadequate (negative) or approachable (positive).

Inadequate (negative). Supporters most often (93.3%) reported at least one negative feeling about being approached to discuss an unwanted sexual incident (see Figure 18 below for specific coded feelings).

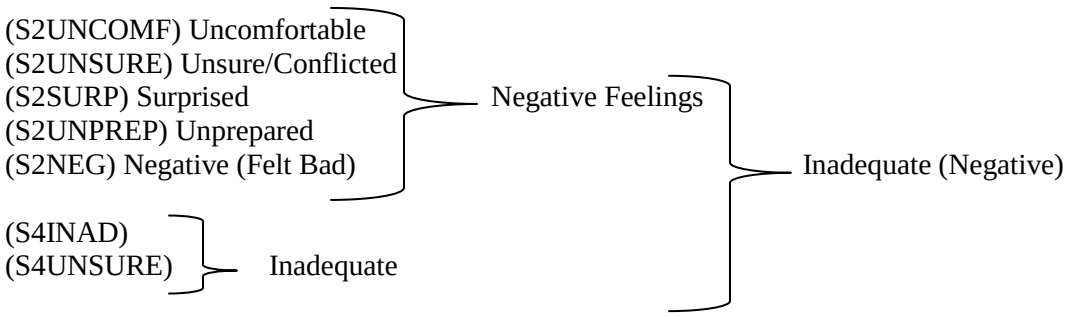

Figure 19. *Mapping of "Inadequate (Negative) Theme*

Further, when asked how he/she felt about the amount of support, information, or resources he/she was able to provide the victims, 40% of Supporters said they felt inadequate or unsure. Moreover, much of these feelings of inadequacy appeared to be complicated by the fact that the victim did not want to seek further support:

> "Well, I mean, the best thing I coulda [sic] done at the time was tell her to go, you know, you know, file a police report, go get checked, make sure everything's okay {I: right} you know, the way you're supposed to do it but, I mean, at the - she wasn't willing to. At all. She just wanted to forget about the whole thing and that - that bothered me."
>
> -Supporter

> "[Pause] Less than I would have liked to. Uh… [inaudible] you know, she didn't want to talk about it much. {I: mhm} uh, after that, so, I think I did as much as I could and I don't know how much - how much I could have… I'm not a trained therapist, I think that's what she - that's what she needed so…"
>
> -Supporter

Another participant described these feelings of inadequacy stemmed from not being knowledgeable about this sensitive topic:

> "Well I felt a little bit bad, but maybe that was part of just, you know, [inaudible] the victim but, uh, at the time, I mean, I was eighteen so I, you know, I wasn't

extremely knowledgeable about anything in the sexual abuse, you know, category I: right} or anything like that. So I felt bad that I couldn't provide more, but I was pretty happy with, you know the fact that she was willing to come and talk to me and - and that she trusted and respected me enough to open up to me."

-Supporter

Approachable (positive). Although a vast majority of the Supporters reported some types of negative or inadequate feelings about the disclosure process, about 43.3% of them said they were still comfortable being approached to discuss an unwanted sexual incident. Similarly, 36.7% of Supporters overtly stated that they felt good about the amount of support they were able to provide the victim during the disclosure process. A smaller 22.3% stated that they felt OK or neutral about the aid they provided.

Figure 20. *Mapping of "Approachable (Positive)" Theme*

Overall these various codes seem to indicate a positive or approachable tone regarding the disclosure process from Supporters:

"I was open to the whole thing as far as her talking to me about it {I: mhm} because I've never - it's never happened to me before but I can just imagine, like, {I: right} how - how I would feel, so I was, I mean, I was just accepting anything that she wanted to just - cause it's always better just to say something than keep it in."

-Supporter

"Pretty-felt pretty good um, we got her help, we got her out of the situation, we got her removed, we actually got her into counseling and um, last I know she was doing actually really good."

-Supporter

"Oh, support. Definitely 100%. I'm glad I was able to listen. I'm glad that I listened the way I did {I: Right} and I'm glad we were where we were {I: Right} because she felt comfortable and, like, safe and stuff {I: Right}. Um, resources, none. Because I knew she didn't want to tell anybody."

-Supporter

RQb: What types of positive and negative assistance are supporters providing (from the victim's and supporter's perspective)? The types of support or assistance provided can be categorized into three main types: available support, essential support, and situational support.

Available support. More generally participants defined social support as "having people that are there for me" and "having someone to talk to."

(B1THERE) Having People That Are There For You
(B1TALK) Having Someone To Talk To } Available Support

Figure 21. *Mapping of "Available Support" Theme*

Specifically, a majority of participants (80.4%) defined social support as having people available for them during times of need:

> "Um, just being there, being able to listen, and, like, maybe give advice but more so just to listen"
>
> -Supporter

> "Uh people who are there for me when I need to - when I need support when I'm going through a hard time or even, like to celebrate good things with too. And I'll be there for them it's like a mutual, a mutual reciprocal situation so it's not just for me, like I give support to them too."
>
> -Victim

More than half of participants (56.5%) also defined social support as having someone available to talk to:

"Having friends and family that you can talk to when you need support for either an event or certain things that are happening in your life."

-Supporter

Essential support. Participants also described their feelings about social support as being something that was essential to their well-being. All 46 participants (100%) said that social support from family and friends was the most important to their well-being. Further, more often participants stated that friends (28.3%) or a group of people/network of friends (34.8%) were how they defined this essential type of social support:

"Having a good group of friends, um, and a community that kind of accepts that what you went through was real and just [pause] acceptance."

-Victim

"Um, person or a group of friends, um, not just friends but, um, people who are older than you and who can give you accountability [I: Ok] who know what you're going through and can give you advice and support [I: Ok] for what you've been through."

-Victim

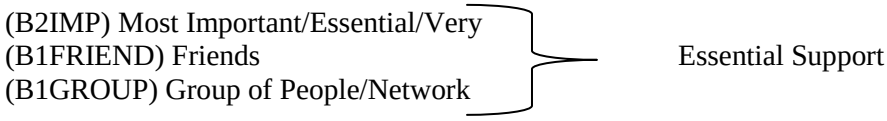

Figure 22. *Mapping of "Essential Support" Theme*

Situational support. The theme of situational support emerged when asking participants about their feelings towards support from acquaintances and the community (see Figure below).

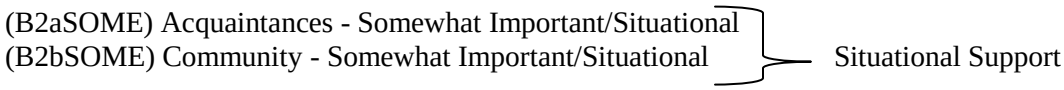

Figure 23. *Mapping of "Situational Support" Theme*

Most participants[15] (60.9%) explained that acquaintances were only somewhat important to their well-being or only important in certain situations:

> "I think that a certain amount of social support from acquaintances is important because we all have a need for other people to sorta [sic] validate us in a way, but I think it's not as important as social support from a family or a friend."
>
> -Supporter

> "Um, not as important I guess, maybe it depends on the situation."
>
> -Supporter

Likewise, half of participants (50.0%) also said that the community or community resources were somewhat important or important only in select situations:

> "I think it's good to know that there are resources in the community for you, so again, if needed, again, me just my personality and kinda the way I handle my

[15] Quotes from only Supporters were provided in this section because these quotes illustrated the theme best. However, Victims also described situational support, but in more succinct manners.

personal business, I'm not very likely to utilize them, but I do take comfort in knowing that there are resources there if I need them."

-Supporter

"I think it depends on the situation, but uh, like if it was a natural disaster or something {I: mhm} it would probably be important. But, I don't think the community cares if like a boyfriend breaks up with you or something that your friends don't care about. {I: something more personal} right."

-Supporter

RQc: Does a "strong" social support system create a barrier for victims to seek formal treatment? Assistance or support provided by Supporters to Victims that impacted seeking formal treatment were due to the following considerations: promotion of formal support, unmatched feelings and perceptions of informal support, and barriers.

Promotion of formal support. A prominent theme found throughout the interviews, particularly among Supporters, was how they encouraged the utilization of formal forms of support during or after the disclosure.

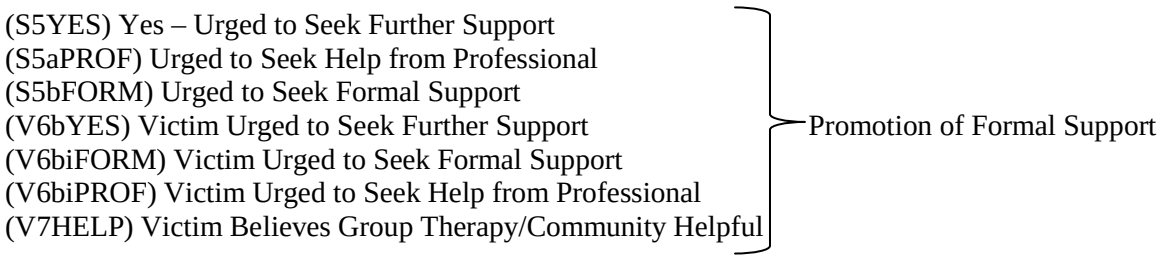

Figure 24. *Mapping of "Promotion of Formal Support" Theme*

A little over half of all Supporters (56.7%) actually referred the victim to seek further support. Of those who referred the victim to seek further support, 52.9% promoted the use of formal support alone (35.3% both informal and formal). These Supporters (58.8%) mostly referred victims to a professional (i.e. therapist, counselor, or psychiatrist) for further support:

> "I did encourage the person to seek psychiatric help but kind of from a broader stand point not just specifically "do this."
>
> -Supporter

> "I referred her to um, I gave her the name to actually 3 local, um, domestic violence agencies, I also put her in contact with the state attorneys, um, victim witness coordinator, and um, provided her with information um, she was a student for both a university um, counseling center, and as well as um, a referral to a friend of mine who I know was a mental health counselor that works particularly with women who have been victims as well."
>
> -Supporter

> "Yeah, the counselor at school but not an outside resource."
>
> -Supporter

Among Victims, exactly half (50%) were urged by their confidant to speak to someone else. Similar to the Supporters' disclosures, Victims were suggested to seek formal

support (25.0%) or, more specifically, support from a professional (25.0%). As one Victim stated:

> "Um, he suggested that I talk to someone in the crisis center about it and I did go."
>
> -Victim

Victims (75%) also reported feeling that group therapies or other forms of social support in the community were "helpful." Example statements from participants show this positive perception of group therapy and community social support, yet many have not considered going themselves:

> "I think they're good when the timing is right. Like I wouldn't-like I said I wouldn't think about doing it now because it's all too soon after the fact, but I can see eventually after you start to accept it more and move on from it, maybe forgive what happened than I would see talking about it {I: Right} with other people."
>
> -Victim

> "Um, I don't have a problem with it; I just never participated in any of it."
>
> -Victim

"I think they could be helpful, I'm just not aware of a lot of the ones that are available. I know that I would prefer anonymous types of groups though."

-Victim

Unmatched feelings and perceptions of informal support. Victims appeared to have inconsistencies in their feelings and perceptions of informal social support and the disclosure process. In general, most Victims (87.5%) felt "good" about their social support system. Likewise, a majority of Victims (68.8%) felt that disclosing the incident alleviated negative feelings. However, when asked how they felt about the social support they received after the disclosure, a little over half of Victims (56.3%) said that they felt that is was good, but not completely helpful.

"…it was good because they were able to listen and stuff but it, I didn't necessarily- I felt better but I didn't um. I feel like I kind of, it was just kind of this bomb that they were just like, "oh". They didn't - I feel like they felt like they didn't know how to respond."

-Victim

"P: [pause] um, I only told about two friends at the time {I: mhm} and um, I mean, they helped me out a lot-I kinda [sic] ignored the problem and they-I, I feel like they were just trying to be there for me, so I ignored the problem for a while, but they still tried to get me in the right spot. So, so they did a lot for me. I: Okay. And-and what did they do for you? P: Um, just there to talk to me, kinda [sic]

getting me out of the relationship. Trying to push me forward and stop letting me just sit there and take whatever."

-Victim

In fact, 25% of Victims said that speaking to a professional would have been more helpful than disclosing to an informal social support, while another 31.3% of Victims stated nothing else would have been helpful:

"I think um now honestly maybe going to some counseling sessions and stuff. You know or maybe like a group you know with people who have been through the same things you know I think that would have definitely helped a lot."

-Victim

"I don't really know, maybe if I would've talked to a professional that had explained to me at the time of being drunk doesn't matter- doesn't make me feel guilty, at the time I didn't know any better."

-Victim

"They could have, honestly, I would say, like, if they suggested, like, "Oh, I'll go to, like, the support group with you" or something like "Oh, we need to go talk to, like, one of the counselors at – like, {I: mhm} on campus" or something. That would have definitely helped other than just saying, like, "Oh, I'm sorry" and giving me a hug."

-Victim

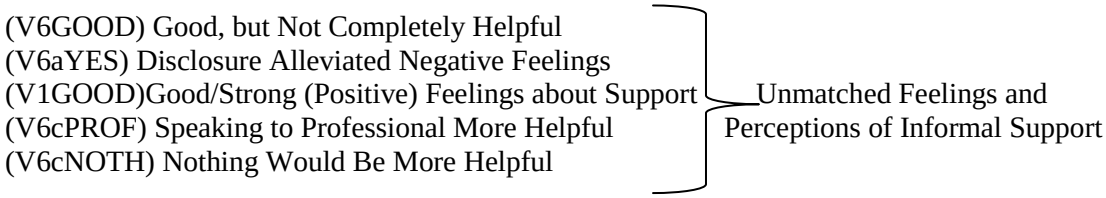

Figure 25. *Mapping of "Unmatched Feelings and Perceptions of Informal Support" Theme*

Barriers. Although a number of Victims reported positive feelings about community support and thought speaking to a professional would have been more helpful, a minority of Victims (N=4) actually sought formal support. Victims often (68.8%) stated that a barrier to seeking support was because of feelings of shame or guilt:

"Just when I feel like things are my fault or that I could of done something to change the situation. I don't want to look weak, or also I might think that I'm going to be judged or something like that."

-Victim

"Um, kind of my pride. Definitely my pride. I just don't want to, like, put it out there, I guess {I: mhm}. Also, I just – I'm really good at avoiding things so

definitely that but I think mainly it's just – like, from – people don't really help, like, for the families and friends and stuff and then formal, it's just, like, it's expensive and stuff like that {I:right} so just a bunch of different things and – but mostly my pride. Just, like, I don't want to put it out there. I don't want to be seen as, like, broken or anything."

-Victim

Supporters (20.0%) also stated that victims' risky behavior influenced their response to the victim:

"Like in the past she has been somewhat- she has been sexually active (I: Mhm.) so like one of my concern is [sic] um "what do you mean by you got raped?"

-Supporter

I: Right. And so you thought maybe because she was sexual active that it wasn't a rape or? P: No I didn't think it was a rape."

-Supporter

"…she happened to be quite the party girl {I: mhm} and she used to, um, deal Molly so - and she used to be totally borderline alcoholic {I: Right} so that - those were all things that, like, I knew about her but it didn't really affect it I: Right, so it didn't impact how you responded? P: Not at all. Even in a way, and I know this isn't very accurate, very PC or anything like that but, like, those sort of experiences, I think, let her be, like ,the loose cannon that she was when she got

older and was able to have some freedom {I: Right} because, like, she was so confined, so emotionally, like, tormented {I: Right} too and physically, um, that, like, now suddenly she's getting pleasure in taking a drug, getting pleasure in drinking {I: Right} alcohol, getting messed up and that's the way she likes it now {I: Right} so I felt bad for her really."

-Supporter

At the same time, more Supporters (33.3%) said that victims' past behavior didn't impact how they responded to the victim:

"I know she was a cocaine user {I: Mhm} P: I don't know, I don't think that had anything to do with it {I: Right} P: You know, we all lived through the sixties and we all did those things, and um, I don't think that had anything to do with why she was raped."

-Supporter

In fact, a large number of Supporters (40.0%) said they felt the incident couldn't or shouldn't have happened to the victim because she was "a good person" and felt that this idea impacted their response:

"Um, it - it was definitely - I was shocked because she is such a nice girl and you wouldn't never have [sic] guessed that would happen to her but she's very quiet so, um, it was just - it was - it was good that she coulda came [sic] - she came out

to me and told me about it {I: right} because, you know, I just felt like I was her support system in a way {I: mhm} so…"

-Supporter

"P: She was just a good girl at the time, she was sweet, you know it's - she wasn't letting her environment, um, dictate who she was, her personality. She was still a - a very sweet young girl. I: Right, and so that just kinda - the aspects of that, you just thought that wouldn't happen to her or, you know, you felt worse about it because she was…P: I felt worse about it."

-Supporter

"Mmm, I guess because she's always been a good person {I: Mhm} I mean, her attitude was always good and nothing, she didn't, never seen anything negative come from her, {I: Right} so it made me want to help her even more."

-Supporter

Victims (43.8%) also explained that they were hindered by the fact that they felt awkward about seeking support because of how uncomfortable the disclosure felt:

"Kinda just having to tell it all over again to people, 'cause you know if you go to counseling they're going to make you, you know say it all over again and then in terms of group therapy, you have to deal with other people's reactions, not

necessarily saying they would be negative because they have been through it too {I: Right} But still, I just worry about the judgment from people."

-Victim

"It's mostly- it's to the point where I'm so tired of repeating myself over and over again and hearing the same cliché responses. [I: Right] So, and just cause when you talk about it you kind of relive it."

-Victim

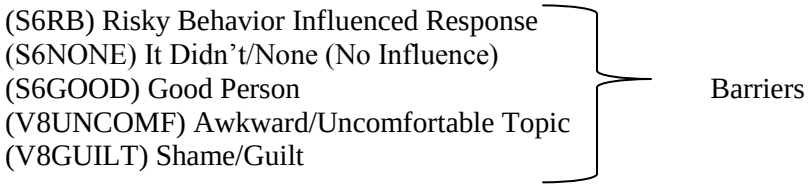

Figure 26. *Mapping of "Barriers" Theme*

Aim 3: To determine the role that alcohol plays in the disclosure process.

RQa: How do assault characteristics of female rape victims with a history of alcohol involvement affect their use of informal social support and their mental health outcomes? Assault characteristics affected the use of further support and mental health outcomes in the following ways: limited impact of alcohol (or drugs) on disclosure, response, and perceptions, victim guilt, judgment, and uncertainty on the impact of alcohol (or drugs).

Limited impact of alcohol (or drugs) on disclosure, response, and perceptions. A majority of Supporters (80.0%) did not feel the victim's alcohol or drug use during the incident impacted their response to the Victim or perception of the incident:

"I don't think I would have responded any differently regardless."

-Supporter

Most Victims (62.5%) also did not feel like their use of alcohol (or drugs) impacted the disclosure process to their informal social support:

"Not on my part, but on the offender's part."

-Victim

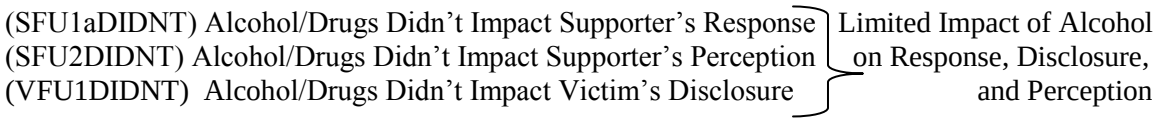

Figure 27. *Mapping of "Limited Impact" Theme*

Victim guilt. A minority of Supporters responded differently (3.3%) or perceived the incident a certain way (6.7%) because they felt like the victim was guilty or responsible for the incident because of their alcohol (or drug) use at the time of the incident:

"It might be - I think it makes - it plays a big role and I know her. She wasn't ever able to hold her liquor {I: mhm} ever. So for her, it was something that the most minimal amount of either of the substances will affect her greatly in her own behavior. Not in the behavior of others, but her own behavior. {I:Right} So I think it does."

-Supporter

> "yeah and I think that…that... that kind of-I mean that my response was that she had lower inhibitions and did something that she wouldn't have normally done and while you wouldn't normally do it if you're agreeable in the moment, you can't go back and say it's not what I wanted.."
>
> -Supporter

Victims themselves (18.8%; N=3) felt their use of alcohol (or drugs) during the incident impacting how they felt about deciding to disclose the incident to someone:

> "I mean I probably wouldn't have even thought this study pertained to me because I was drunk. Like oh I was drunk and I didn't say no so. Like, or it's that idea when you're drunk and you're coming on to someone so in your head your like oh, I wanted to. Like that's yes cause [sic] I started it does that make sense? So I probably never would have disclosed to anyone that this sort of thing happened because I was blaming myself for being a part of it."
>
> -Victim

> "[Sigh] Um, in that case it was, you know, I was at a party, I was consuming alcohol, and I just…"
>
> -Victim

(SFU1aGUILT)Felt Victim Guilty/Responsible – Use During Incident
(SFU2GUILT) Felt Victim Guilty/Responsible – Perception of Incident } Victim Guilt
(VFU1GUILT)Victim Felt Guilt/Responsible During Disclosure

Figure 28. *Mapping of "Victim Guilt" Theme*

Judgment. Another theme found among Victims (18.8%; N=3) regarding their use of alcohol (or drugs) and its impact on their decision to disclose was being worried about judgment:

> "I didn't tell anyone else at first, the first disclosure because I knew that people would say it was my fault, plus I didn't get any relief from disclosing."
>
> -Victim

> "Well, [inaudible] when it comes to disclosing [inaudible] to disclosing it to other people, it was just more, like, she's gonna - they're gonna ask me, like, how I got in that situation {I: right} how I, like, did this, like, why did I go back and, like, questions that I can answer but {I: right} they're going to be really judgmental about it {I: mhm} and I don't like that judgment."
>
> -Victim

(VFU1JUD) Worried about Judgment During Disclosure } Judgment

Figure 29. *Mapping of "Judgment" Theme*

Uncertainty on the impact of alcohol (or drugs). Supporters sometimes (16.7%) felt confused or unsure about the victim's use of alcohol (or drugs) on their response to the disclosure:

"Um… I don't know that it did. I mean, I - because of the - I - I don't know that it would have changed my opinion, I mean I had a - I had an opinion about the prior alcohol and drug use but I don't know that this scenario changed that opinion."

-Supporter

Supporters (13.3%) also felt confused or unsure about how the victim's use of alcohol or drugs during the incident changed their perceptions about the incident:

"My perceptions? I: Mhm. Yeah, did the fact that she was drinking or [inaudible] she may drink in the past, did it influence your perception of the incident? No? P: But she said that it, uh, but she said it - it reduced her abilities to resist {I: right} to a point where she didn't really offer much resistance."

-Supporter

"Um… no, I mean, I felt - I don't want to say she put herself in that situation, but it was just - she wasn't doing her best to avoid it [by drinking]."

-Supporter

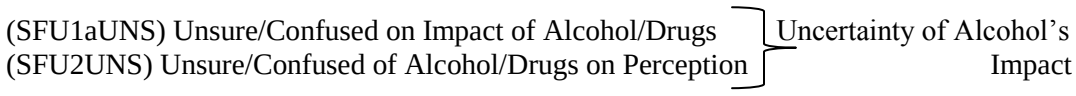

Figure 30. *Mapping of "Uncertainty" Theme*

RQb: How does alcohol abuse history of the victim impact whether social support will be used, the type of social support received by the victim, and the

influence of social support on the mental health of the victim? Alcohol abuse history impacted victim credibility in some cases, but in others, the impact of alcohol (or drugs) on response, disclosure, or type of support sought was limited.

Victim credibility. The idea of "victim credibility" appeared to play a role when discussing the victim's use of alcohol (or drugs) in the past and the victim's feelings about seeking support. Past use impacted 6.7% of Supporter's response to the disclosure because they felt the victim was guilty. Likewise, 18.8% (N=3) of Victims reported their feelings of guilt about past use impacted their decision to disclose or seek further help, as well as their credibility.

> "Yeah I was under age so I would have never told anybody formally that I, you know, even if I know your allowed to tell the pol… and this is… this is what I'm trying to say, people have like one idea of rape that is only one kind and then I never would have called the police and reported this because I knew him, we had been sleeping together before…"
>
> -Victim

> "Partially because I think that, you know, the blame might have been put on me because it was my fault, because I couldn't say no."
>
> -Victim

> "Well, uh, their reaction. {I: Okay} you know, they would of, you know, I mean, I mean, more than likely they would have okay, well you know you kinda put

yourself in that situation, so {I: so they would have said that it was your fault} Right."

-Victim

(SFU1bGUILT) Felt Victim Guilty/Responsible – Past Use
(VFU1bGUILT) Victim Felt Guilty/Responsible – Past Use on Disclosure
(VFU3CRED) Afraid Victim Lose Credibility – Use and Seeking Support
(VFU3GUILT) Victim Felt Guilty/Responsible – Use and Seeking Support
(VFU3JUD) Worried About Judgment – Use and Seeking Support
} Victim Credibility

Figure 31. *Mapping of "Victim Credibility" Theme*

Limited impact of alcohol (or drugs) on response, disclosure, or type of support sought. A majority of Supporters (90.0%) stated that victim past use did not impact their response to the disclosure or guidance to seek additional support (93.3%). Only one Supporter (3.3%) was unsure if past use impacted their response.

"I don't think so, again, um, because the-the victim um, the heavy alcohol user, um, appeared heavy drug use as well {I: right} um, again because of that I know that she is particularly vulnerable as well because of the individuals she associates with makes her um, particularly vulnerable as well."

-Supporter

Similarly, only 6.7% of Supporters felt unsure or confused about victims alcohol or drug use on seeking further support:

"It didn't affect it, it was just like-like I was just indifferent about it because I knew they liked each other anyway {I: Right, so you don't think the victim should

seek any further support?} Yeah, I didn't see it as something as serious like that so."

-Supporter

Over half (62.5%) of Victims did not feel like alcohol or drugs impacted their decision to disclose or seek formal support (56.3%). Moreover, only one Victim (6.3%) didn't seek further support because she was unaware of where to go, which was complicated by their perception of alcohol involvement:

"Um, I didn't feel like I needed any more help or know where to go, I didn't want people to judge me {I: Right} Um, but I didn't want them to think my drinking was getting out of control either. I feel like more people would say I put myself in that situation."

-Victim

(SFU1bDIDNT) Past Use Didn't Impact Response
(SFU1bUNS) Unsure/Confused About Impact
(SFU3DIDNT) Use Didn't Impact Guidance
(SFU3UNS) Unsure/Confused Re: Guidance
(VFU1bDIDNT) Past Use Didn't Impact Disclosure
(VFU3DIDNT) Use Didn't Impact Seeking Support
(VFU3WHERE) Didn't Know Where to Go
} Limited Impact of Alcohol (or Drugs) on Response, Disclosure, or Type of Support Sought

Figure 32. *Mapping of "Limited Impact on Disclosure and Support Sought" Theme*

Synthesis of Themes in Context

The qualitative themes found in the interview transcripts provide an abundance of information about Victim's and Supporters' experiences during the disclosure process. However, it is important to organize these themes to examine similarities and differences

for the triangulation of concepts and ideas. For example, what is the context in which Victims are more likely to disclose in a timely manner (i.e. timeliness theme) as opposed to delaying disclosure? In other words, what sample characteristics found in the quantitative data (e.g. acknowledgment of the rape, victim/perpetrator relationship, etc.) are correlated with this theme of timeliness? In an effort to put these findings in context, the qualitative themes found were examined within the quantitative data. Specifically, each qualitative theme was coded as a "yes" or "no" and added to the SPSS quantitative database. Then, bivariate correlations between each of the themes and quantitative variables of interest were analyzed for each research question. The results are presented by aim and research question.

Aim 1: To identify constructs related to the decision-making process to disclose a rape to an informal social support.

RQa: What prompts victims to utilize their informal support system versus formal support? A total of eight themes were identified during qualitative data analysis that describe participant's perceptions of what prompts individuals to utilize their informal social support system: comfortable environment, openness with family, relatable/problems in common with friends, non-personal issues with acquaintances, no community outreach, community resource awareness, presence of close relationships[16], and quality of relationships. These themes were examined in relation to the recent assault characteristics, one's tendency to disclose issues in general, rape acknowledgment, general rape myth acceptance, rape history, and life event history. See Table 15.

[16] Correlation of "Presence of Close Relationships" could not be computed because the variable is constant. All participants expressed that they had a close relationship with at least one person and valued the closeness they shared.

Table 15. *Correlations Among Qualitative Themes Related to Prompting Disclosure, Assault Characteristics, Rape Myths, and Lifetime Trauma History (N=46)*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1. DDI	-	.03	-.09	.08	**-.35***	.09	-.16	.04	-.02	.08	-.05	-.01	-.16	.00	.11	-.02	-.05	-.08	-.08	-.10
2. IRMA		-	.18	.17	-.29	-.05	-.04	.01	.01	.02	**-.39****	.26	.10	-.24	.02	-.26	-.05	**-.41****	.28	.22
3. LEC - Assault			-	.27	-.11	-.17	.22	-.13	.04	.11	-.10	**.59****	**.48****	**-.39****	-.09	-.01	-.07	-.14	-.20	-.13
4. LEC-Non-Assault				-	-.20	.01	.19	-.06	-.07	-.08	.03	.08	.10	.20	-.08	-.18	.20	-.00	-.02	**-.29***
5. Perpetrator/ Victim Relationship[1]					-	-.04	.08	-.20	-.01	-.15	.00	-.19	-.19	.01	-.24	.10	.14	.17	-.15	.07
6. Victim/ Supporter Relationship[1]						-	-.02	-.15	-.00	.10	-.01	-.17	-.16	**.39****	-.17	-.20	.07	-.03	-.02	.15
7. Physical Injury							-	-.27	-.20	-.18	.25	.04	.18	-.07	-.19	-.12	-.22	.01	.04	-.19
8. Incident Not Reported to Police								-	**.32***	.10	**-.30***	.21	.18	.07	.17	**.31***	.07	-.13	-.05	-.07
9. Victim Consumed Alcohol									-	**.67****	-.05	.10	.09	-.05	**.30***	-.14	.21	-.11	.07	.11
10. Perpetrator Consumed Alcohol										-	-.00	.15	**.44****	-.18	.28	-.06	.29	-.12	.18	.22
11. Rape Ack.[2]											-	-.13	-.04	.00	-.01	-.09	-.10	**.29***	-.18	-.22
12. 2 or More Unwanted Sexual Experiences												-	**.58****	**-.44****	.11	.13	-.07	-.24	-.04	-10
13. Lifetime Rape													-	**-.37***	-.15	.17	-.09	-.15	.07	-.09

14. Comfortable Environment														-	-.13	-10	.09	.13	-.06	-.12
15. Openness with Family															-	-.05	**.31***	.04	.20	-.01
16. Relatable Problems w/ Friends																-	-.01	-.20	-.22	-.10
17. Non-Personal Issues w/ Acquaintances																	-	.17	.11	.07
18. No Community Outreach																		-	-.16	-.18
19. Community Resource Awareness																			-	.13
20. Quality of Relationships																				-

Note. DDI = Distress Disclosure Index, IRMA = Illinois Rape Myth Acceptance scale, LEC = Life Events Checklist. Bolded items indicate significant correlations that are discussed in the text.

[1] Higher scores indicates that the offender was a stranger or unfamiliar

[2] Rape acknowledgment was positive if the event was recognized as a rape

*$p < .05$ **$p < .01$

Correlations analyses among qualitative themes related to prompting disclosure, assault characteristics (most recent disclosure), rape myths, and lifetime trauma history provide the following contextual information. The disclosure of the most recent rape incident occurred in a more intimate and comfortable environment (one-on-one and in-person) that was disclosed casually in conversation significantly more often when the Supporter was less familiar and participants reported decreased number of assault-related traumatic events. Participants who also reported that they felt they could discuss anything with their family disclosed or had a rape disclosed to them that involved alcohol use on the victim's part. Likewise, those who have openness with family are significantly less likely to discuss issues or problems with acquaintances. Moreover, participants who value the quality of their relationships report less traumatic life events (non-assault). Those who typically discuss relatable problems with friends are significantly less likely to report the incident to police. Rape acknowledgment is significantly related to lower levels of rape myth acceptance and increased reporting to police. The incident was less likely to be reported when alcohol was involved by the victim. There was also a significant positive relationship between victim alcohol use and perpetrator use. Finally, participants who do not utilize community resources report decreased levels of rape myth acceptance. All significant correlations found were moderate to strong correlations (see Table 15 for specific coefficients).

RQb: How do victims (and supporters) feel about disclosing rape to their social support system? When examining the feelings surrounding the disclosure process, a main theme discovered during qualitative data analysis was unmatched feelings and perceptions among Victims and Supporters. Supporters reported positive feelings or

sympathetic feelings, while Victims reported feeling uncomfortable during the disclosure. Participants also report being able to talk about anything among informal supports and health-focused topics among unknown persons or formal supports. Further, most participants reported that there were no topics off-limits. These themes were examined in relation to the recent assault characteristics, one's tendency to disclose issues in general, rape acknowledgment, general rape myth acceptance, rape history, and life event history. See Table 16.

During the incident disclosure, Supporters reported feeling bad for the victim or sympathetic significantly more when the Supporter was less familiar with or a stranger to the victim or when they had an increased tendency to disclose stressful events in general. There was no significant relationship between Supporters' positive feelings (i.e. felt it validated friendship or felt good that the victim would come to them) with assault or individual characteristics. On the other hand, a strong relationship was found between Victims who felt uncomfortable disclosing the incident significantly more when they had been sexually victimized two or more times. There was also a significant, negative relationship between Victims' feeling uncomfortable during the disclosure and Supporters' feelings of sympathy and positivity during the disclosure. Participants who reported experiencing two or more unwanted sexual experiences indicated they were significantly more likely to discuss unlimited topics with informal social supports, only health topics among persons unknown, and that no topics were off-limits (they could talk to someone about any issue).

Table 16. *Correlations Among Qualitative Themes Related to Feelings About Disclosure, Assault Characteristics, Rape Myths, and Lifetime Trauma History (N=46)*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1. DDI	-	.03	-.09	.08	-.35*	.09	-.16	.04	-.02	.08	-.05	-.01	-.16	.00	**.33***	-.22	-.00	**-.38****	-.01
2. IRMA		-	.18	.17	-.29	-.05	-.04	.01	.01	.02	-.39**	.26	.10	-.08	-.19	.21	.25	.10	.17
3. LEC-Assault			-	.27	-.11	-.17	.22	-.13	.04	.11	-.10	.59**	.48**	-.06	-.13	.28	.22	.28	**.32***
4. LEC-Non-Assault				-	-.20	.01	.19	-.06	-.07	-.08	.03	.08	.10	.03	.16	-.26	-.16	-.02	-.14
5. Perpetrator/ Victim Relationship[1]					-	-.04	.08	-.20	-.01	-.15	.00	-.19	-.19	.26	-.02	-.04	-.01	-.14	-.11
6. Victim/ Supporter Relationship[1]						-	-.02	-.15	-.00	.10	-.01	-.17	-.16	.16	**.36***	-.28	-.19	-.20	-.24
7. Physical Injury							-	-.27	-.20	-.18	.25	.04	.18	.18	.03	-.01	-.15	.09	-.09
8. Incident Not Reported to Police								-	.32*	.10	-.30*	.21	.18	-.28	-.18	.05	.15	.13	.05
9. Victim Consumed Alcohol									-	.67**	-.05	.10	.09	-.06	.10	.16	.12	-.03	.06
10. Perpetrator Consumed Alcohol										-	-.00	.15	.44**	-.02	.04	.19	.03	-.12	.09
11. Rape Ack.[2]											-	-.13	-.04	.11	.26	-.07	-.27	-.05	-.07
12. 2 or More Unwanted Sexual Experiences												-	.58**	-.21	-.22	**.57****	**.44****	**.37***	**.47****
13. Lifetime Rape													-	-.07	-.23	**.33***	.22	.28	.23
14. Positive Feeling (Supporter)														-	.26	**-.48****	**-.37***	**-.31***	**-.48****
15. Supporter															-	**-.43****	**-.34***	-.28	**-.43****

Sympathy																			
16. Uncomfortable Feeling (Victim)																-	**.51***	**.65****	**.55****
17. Unlimited Topics Among Informal Supports																	-	**.33***	**.51****
18. Health Topics Among Unknown Persons																		-	.21
19. No Topics Off-Limits (In general)																			-

Note. DDI = Distress Disclosure Index, IRMA = Illinois Rape Myth Acceptance scale, LEC = Life Events Checklist. Bolded items indicate significant correlations that are discussed in the text. Significant items not bolded have been discussed in a previous section.

[1] Higher scores indicates that the offender was a stranger or unfamiliar

[2] Rape acknowledgment was positive if the event was recognized as a rape

*p < .05 **p < .01

There was also a strong correlation between the types of topics discussed with different groups, indicating that most participants could talk about anything with informal social supports, mostly health-related topics with formal social supports, and that they could find someone to talk to about any given issue. There was a moderately significant, negative relationship between discussing health related topics only and a general tendency to disclose. Finally, participants who reported increased assault life events were significantly, positively related to feeling like there were no topics off-limits in a moderate correlation.

RQc: What factors influence female rape victims to utilize and impede the use of their social network? Three main themes emerged when examining what factors influenced the utilization of victims' social network or hindered the utilization of victims' social network: timeliness (time between event and disclosure), immediate needs, and belief in rape myths. These themes were examined in relation to the recent assault characteristics, one's tendency to disclose issues in general, rape acknowledgment, general rape myth acceptance, rape history, and life event history. See Table 17.

Correlation analyses between the qualitative themes and quantitative factors that may influence one's choice to utilize their social support system provided the following information. Victims were significantly more likely to report the incident quickly (month or less time elapsed) when the perpetrator was less familiar or a stranger. Participants who reported an increased number of assault-related trauma events were significantly more likely to believe in rape myths and to disclose the incident as a result of having problems or immediate needs.

Table 17. *Correlations Among Qualitative Themes Related to Factors that Promote or Hinder the Disclosure Process, Assault Characteristics, Rape Myths, and Lifetime Trauma History (N=46)*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. DDI	-	.03	-.09	.08	-.35*	.09	-.16	.04	-.02	.08	-.05	-.01	-.16	-.06	-.18	.01
2. IRMA		-	.18	.17	-.29	-.05	-.04	.01	.01	.02	-.39**	.26	.10	-.06	.06	**.29***
3. LEC-Assault			-	.27	-.11	-.17	.22	-.13	.04	.11	-.10	.59**	.48**	-.03	**.38****	**.36***
4. LEC-Non-Assault				-	-.20	.01	.19	-.06	-.07	-.08	.03	.08	.10	.27	-.17	-.13
5. Perpetrator/ Victim Relationship[1]					-	-.04	.08	-.20	-.01	-.15	.00	-.19	-.19	**.34***	-.09	-.01
6. Victim/Supporter Relationship[1]						-	-.02	-.15	-.00	.10	-.01	-.17	-.16	.09	-.20	-.27
7. Physical Injury							-	-.27	-.20	-.18	.25	.04	.18	.07	-.06	-.20
8. Incident Not Reported to Police								-	.32*	.10	-.30*	.21	.18	-.23	.08	.00
9. Victim Consumed Alcohol									-	.67**	-.05	.10	.09	.16	.08	.23
10. Perpetrator Consumed Alcohol										-	-.00	.15	.44**	.10	.21	.18
11. Rape Acknowledgment[2]											-	-.13	-.04	-.10	-.13	**-.37***
12. 2 or More Unwanted Sexual Experiences												-	.58**	-.26	**.54****	**.44****
13. Lifetime Rape													-	-.10	**.38****	.18
14. Timeliness														-	**-.51****	.05
15. Immediate Needs															-	**.47****
16. Belief in Rape Myths																-

Note. DDI = Distress Disclosure Index, IRMA = Illinois Rape Myth Acceptance scale, LEC = Life Events Checklist. Bolded items indicate significant correlations that are discussed in the text. Significant items not bolded have been discussed in a previous section.

[1] Higher scores indicates that the offender was a stranger or unfamiliar

[2] Rape acknowledgment was positive if the event was recognized as a rape

*p < .05 **p < .01

The quantitative measure of rape myth acceptance also showed a positive, moderately significant relationship with one's belief in rape myths found in the qualitative data. Participants who reported belief in rape myths were also significantly more likely to not acknowledge the incident as a rape, reported having two or more lifetime victimizations, and disclosed as a result of experiencing problems or having immediate needs because of the incident. Finally, those who reported being prompted to disclose because of needing immediate help or experiencing problems as a result of the incident had a strong, positive relationship with experiencing two or more unwanted sexual assaults and were more likely to have delayed disclosing the incident (waited more than a month after the incident).

Aim 2: To understand victim and victim supporters perceptions of social support and the impact of these perceptions on rape victims' post-rape mental health.

RQa: How prepared are victims' social supports to provide support that promotes recovery? Qualitative data indicated that the support provided was perceived to be either inadequate (negative) or the supporter was approachable or felt good about the support provided (positive). These themes were examined in relation to mental health problems, general available support (total index), and varying types of available social support (i.e., emotional, tangible, affectionate, and positive support). See Table 18.

Correlation analyses indicated that there was no significant relationship between how prepared the social supports felt during the disclosure and mental health or perceived available social support. However, there was a strong positive correlation between depression, anxiety, and PTSD symptoms. In other words, those that experienced symptoms of depression were significantly more likely to also have experienced

symptoms of anxiety and PTSD. Further, participants who experienced mental health problems reported significantly lower levels of social support available to them.

Table 18. *Correlations Among Qualitative Themes Related to Social Support Preparedness, Mental Health History, and Perceived Available Social Support (N=46)*

	1	2	3	4	5	6	7	8	9	10
1. Depression	-	**.77****	**.84****	**-.44****	-.24	**-.44****	**-.31***	**-.33***	-.11	-.20
2. Anxiety		-	**.78****	**-.54****	**-.34***	**-.48****	**-.41****	**-.42****	-.17	-.09
3. PTSD			-	**-.54****	**-.35***	**-.47****	**-.43****	**-.41****	-.23	-.22
4. Social Support Total				-	**.79****	**.71****	**.80****	**.82****	-.10	.11
5. Emotional Support					-	**.44****	**.50****	**.59****	-.04	.18
6. Tangible Support						-	**.70****	**.32***	-.18	.08
7. Affectionate Support							-	**.50****	-.21	.04
8. Positive Support								-	-.01	.08
9. Inadequate Preparation (Negative)									-	.21
10. Approachable (Positive)										-

Note. PTSD = Post-Traumatic Stress Disorder. Bolded items indicate significant correlations that are discussed in the text.
*p < .05 **p < .01

RQb: What types of positive and negative assistance are supporters providing (from the Victim's and Supporter's perspective)? Themes that emerged when discussing the types of support participants felt were important to their well-being were essential support (need for friends or a group of people to provide support), available support (having people to talk to or just having people there), and situational support (limited support from people less familiar or support needed only in certain situations). These themes were examined in relation to mental health problems, general available support (total index), and varying types of available social support (i.e., emotional, tangible, affectionate, and positive support). See Table 19.

Correlation analyses indicated that available support was significantly related to decreased PTSD symptoms (moderate relationship), but was not significantly related to depression, anxiety, or feelings about their social support. Situational support was also not significantly related to mental health or perceptions of social support.

Table 19. *Correlations Among Qualitative Themes Related to Perceptions on Support Provided, Mental Health History, and Perceived Available Social Support (N=46)*

	1	2	3	4	5	6	7	8	9	10	11
1. Depression	-	.77**	.84**	-.44**	-.24	-.44**	-.31*	-.33*	-.26	-	.11
2. Anxiety		-	.78**	-.54**	-.34*	-.48**	-.41**	-.42**	-.22	-	.15
3. PTSD			-	-.54**	-.35*	-.47**	-.43**	-.41**	**-.31***	-	.15
4. Social Support Total				-	.79**	.71**	.80**	.82**	.09	-	.05
5. Emotional Support					-	.44**	.50**	.59**	.13	-	-.06
6. Tangible Support						-	.70**	.32*	.22	-	.06
7. Affectionate Support							-	.50**	.09	-	.13
8. Positive Support								-	-.01	-	.04
9. Available Support (Qual)									-	-	.23
10. Essential Support (Qual)[17]										-	-
11. Situational Support (Qual)											-

Note. PTSD = Post-Traumatic Stress Disorder. Bolded items indicate significant correlations that are discussed in the text. Significant items not bolded have been discussed in a previous section.
*p < .05 **p < .01

RQc: Does a "strong" social support system create a barrier for victims to seek formal treatment? When examining how the disclosure to a social support impacted the victims in seeking formal treatment, qualitative data, in fact, indicated that there was a promotion of formal support. Further there was a theme of unmatched feelings and perceptions of informal support. Specifically, Victims often said that they felt good about the help they received from their Supporter, but Victims also said that speaking to a professional would have been more helpful or that the support was not completely helpful. There was also a theme of barriers that hindered the promotion or use of formal support. These themes were examined in relation to mental health problems, general available support (total index), and varying types of available social support (i.e., emotional, tangible, affectionate, and positive support). See Table 20.

[17] Correlation of "Essential Support" could not be computed because the variable is constant. All participants expressed that they had friends or a group of people that they deemed essential to their well-being.

Table 20. *Correlations Among Qualitative Themes Related to Support Provided and Barriers to Seeking Further Support, Mental Health History, and Perceived Available Social Support (N=46)*

	1	2	3	4	5	6	7	8	9	10	11	12
1. Depression	-	.77**	.84**	-.44**	-.24	-.44**	-.31*	-.33*	-.01	.22	.24	.15
2. Anxiety		-	.78**	-.54**	-.34*	-.48**	-.41**	-.42**	-.08	.14	.16	-.09
3. PTSD			-	-.54**	-.35*	-.47**	-.43**	-.41**	.06	**.32***	.23	.13
4. Social Support Total				-	.79**	.71**	.80**	.82**	-.20	-.05	-.21	.15
5. Emotional Support					-	.44**	.50**	.59**	-.24	-.10	-.26	.12
6. Tangible Support						-	.70**	.32*	.07	-.00	-.13	-.00
7. Affectionate Support							-	.50**	-.08	.06	-.03	.03
8. Positive Support								-	-.23	-.04	-.17	.22
9. Promotion of Formal Support									-	**.41****	**.37***	.01
10. Felt Good about Support (Victim)										-	**.73****	.28
11. Professional Help Would Be Helpful (Victim)											-	.20
12. Barriers												-

Note. PTSD = Post-Traumatic Stress Disorder. Bolded items indicate significant correlations that are discussed in the text. Significant items not bolded have been discussed in a previous section.
*p < .05 **p < .01

Correlation analyses examined whether feelings about the helpfulness of the disclosure, the promotion of formal support, or barriers to seeking further support were related to mental health problems and perceived available support. Victims who reported feeling "good" about the disclosure reported that they were urged to seek further support or urged to formal support from a professional. Feeling good about the support received during the disclosure was also significantly related to higher levels of reported PTSD

symptoms. Feeling good about the support received during the disclosure was also significantly positively related to feeling that speaking to a professional would have been even more helpful (strong relationship). Likewise, promotion of formal support during the disclosure was significantly positively related to feelings that seeking professional help after the informal disclosure would have been even more helpful. Mental health problems were not significantly related to feelings about the support provided during the disclosure. Further, quantitative measures of social support were not significantly related to feelings about their support during the disclosure or barriers to seeking further support.

Aim 3: To determine the role that alcohol plays in the disclosure process.

RQa: How do assault characteristics of female rape victims with a history of alcohol involvement affect their use of informal social support and their mental health? Several themes emerged when examining the role of alcohol in its relation to the incident characteristics of the rape, mental health, and the reported disclosure process: limited impact of alcohol (or drugs), victim guilt, judgment, and uncertainty of the impact of alcohol or drugs on the disclosure, response, and perceptions of the incident. See Table 21.

Table 21. *Correlations Among Qualitative Themes Related to the Impact of Alcohol Use on Disclosure, Assault Characteristics, Mental Health History, and Alcohol/Drug Use History (N=46)*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Victim Age	-	.09	-.13	.17	.08	.56**	.30*	-.10	-.05	.07	-.04	.05	-.05	.05	.01	.06	.10	.08
2. Perpetrator/ Victim Relationship[1]		-	-.04	.08	-.20	-.01	-.15	.00	-.14	-.01	-.16	-.11	.01	-.24	.21	-.07	.02	.12
3. Victim/Supporter Relationship[1]			-	-.02	-.15	-.00	.01	-.01	-.25	-.18	-.14	-.23	-.28	-.13	-.08	-.02	-.14	-.15
4. Physical Injury				-	-.27	-.20	-.18	.25	.11	.01	.07	-.09	.07	-.03	.06	-.18	-.14	.11
5. Incident Not Reported to Police					-	.32*	.10	-.30*	.01	.14	-.02	.08	-.16	.14	-.19	.12	.09	-.11
6. Victim Consumed Alcohol						-	.67**	-.05	-.26	-.17	-.26	.15	.00	.18	-.20	**.46****	**.35***	.01
7. Perpetrator Consumed Alcohol							-	-.00	-.10	-.03	-.12	.27	.04	.18	-.23	**.33****	.18	.03
8. Rape Acknowledgment[2]								-	-.07	-.11	-.24	-.01	.08	.07	.02	-.11	-.12	.11
9. Depression									-	.77**	.84**	**.60****	**.65****	.19	.00	-.25	-.16	-.03
10. Anxiety										-	.78**	**.53****	**.53****	.15	.03	-.16	-.14	.05
11. PTSD											-	**.50****	**.51****	.05	.06	-.18	-.17	-.06
12. AUDIT Total												-	**.70****	**.39****	-.27	.19	.07	-.03
13. Drinking Problems													-	**.40****	-.09	-.04	-.15	.06
14. Drug Problems														-	-.22	.10	.10	-.12
15. Limited/No Impact of Sub. Use on Perceptions															-	**-.46****	-.27	.12
16. Victim Guilt																-	.19	-.16
17. Judgment																	-	-.12
18. Uncertainty on Impact of Alcohol																		-

Note. Bolded items indicate significant correlations that are discussed in the text. Significant items not bolded have been discussed in a previous section.
*p < .05 **p < .01

Correlation analyses indicated that participants who reported increased levels of alcohol use (AUDIT total) and drinking problems showed higher levels of depression, anxiety, and PTSD. There was also a significant relationship between increased alcohol use and problems with drug problems. In disclosures where the victim reportedly consumed alcohol there was a significant positive relationship with victim blaming and feelings of judgment (as captured by interview). There was also a significant positive relationship between perpetrator drinking and victim guilt. Participants who did not perceive that alcohol or drugs impacted the disclosure or support provided were significantly less likely to blame the victim for the incident. No significant relationships were found among the theme of uncertainty surrounding alcohol's role on the incident or mental health.

RQb: How does alcohol abuse history of the victim impact whether social support will be used, the type of social support received by the victim, and the influence of social support on the mental health of the victim? Two main themes emerged during the interviews regarding the impact of victim's alcohol abuse history: victim credibility and a limited impact of alcohol on response, disclosure, or type of support sought. These themes were examined in relation to incident characteristics of the rape, mental health, alcohol use history, and the reported disclosure process. See Table 22.

Although a number of participants reported a limited impact of alcohol (or drug) use on supporters' responses, victims' disclosure, and the type of support sought, it did not have a significant relationship with substance use during the incident, how they described the incident (rape acknowledgment), drinking history, or mental health history. However, perceptions of victim credibility, as a result of past substance use, did impact

some participants' responses during the disclosure. Specifically, questions of victim credibility had a moderate to strong, significant positive relationship to disclosures that involved the victim's alcohol consumption, perpetrator's alcohol consumption, and alcohol use history of the victim. These findings indicate that any alcohol use during the incident (by the victim or perpetrator) and victim's history of alcohol use, play a role in both victim and supporter responses to a rape disclosure.

Table 22. *Correlations Among Qualitative Themes Related to the Impact of Prior Alcohol Use on Disclosure, Assault Characteristics, Mental Health History, and Alcohol/Drug Use History (N=46)*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1. Victim Age	-	.09	-.13	.17	.08	.56**	.30*	-.10	-.05	.07	-.04	.05	-.05	.05	.14	.27
2. Perpetrator/ Victim Relationship[1]		-	-.04	.08	-.20	-.01	-.15	.00	-.14	-.01	-.16	-.11	.01	-.24	-.14	.10
3. Victim/Supporter Relationship[1]			-	-.02	-.15	-.00	.01	-.01	-.25	-.18	-.14	-.23	-.28	-.13	-.06	-.01
4. Physical Injury				-	-.27	-.20	-.18	.25	.11	.01	.07	-.09	.07	-.03	-.15	.20
5. Incident Not Reported to Police					-	.32*	.10	-.30*	.01	.14	-.02	.08	-.16	.14	.24	-.01
6. Victim Consumed Alcohol						-	.67**	-.05	-.26	-.17	-.26	.15	.00	.18	**.36***	.08
7. Perpetrator Consumed Alcohol							-	-.00	-.10	-.03	-.12	.27	.04	.18	**.39****	-.06
8. Rape Acknowledgment[2]								-	-.07	-.11	-.24	-.01	.08	.07	-.22	-.14
9. Depression									-	.77**	.84**	.60**	.65**	.19	.16	.01
10. Anxiety										-	.78**	.53**	.53**	.15	.25	.09
11. PTSD											-	.50**	.51**	.05	.13	.06
12. AUDIT Total												-	.70**	.39**	**.55****	-.12
13. Drinking Problems													-	.40**	.26	-.15
14. Drug Problems														-	.19	-.12
15. Victim Credibility															-	-.18
16. Limited Impact of Alcohol on Response, Disclosure, or Type of Support Sought																-

Note. Bolded items indicate significant correlations that are discussed in the text. Significant items not bolded have been discussed in a previous section.
*p < .05 **p < .01

Chapter 5

Discussion and Conclusion

The role of social support on the disclosure and recovery process of rape victims is unclear, particularly among college student females not seeking treatment and who have alcohol use problems. To this point, research has utilized a theoretical framework built on the assumption that social support has a positive impact on sexual assault victims' mental health outcomes. However, a smaller body of research acknowledges that social support can have a negative impact on rape victims' mental health in some instances. Such discrepancies in the research suggest more work is needed to understand why this gap exists. One reason could be that current quantitative assessments of the link between social support and rape disclosure are limited; certain aspects of how social support operates in the decision-making process of rape disclosure and its impact on mental health have yet to be conceptualized.

This study used a mixed methods approach to identify concepts and develop nuanced constructs of the perceptions of social support, the role of alcohol, and the impact of these factors on college student rape victims' decision to disclose a rape and post-rape outcomes. A total of 46 participants were interviewed: 16 female victims of rape in college who disclosed the incident to an informal source (Victims) and 30 college students (33.3% male) who have had someone disclose a sexual assault to him/her

(Supporters). Participants ranged in age from 18-61 (M=25.91, SD=8.95), with the average Victim age being around 18 years old.

All rape victims reported revictimization (having two or more rape incidents in their lifetime). Although the rate of revictimization may be high in this sample, it is not surprising since prior research has shown increased revictimization rates among those who report higher levels of self-blame, maladaptive coping strategies (e.g., use of alcohol or drugs to cope), and PTSD (Ullman & Najdowski, 2011). Therefore, this sample appears to be representative of rape victims given the criteria for inclusion in the study (i.e., alcohol use and disclosure to informal social support).

The following sections discuss the major findings for each study aim: constructs surrounding the decision-making process to disclose a rape (Aim 1), the perceptions of social support and its impact on post-rape mental health (Aim 2), and the role of alcohol during the disclosure process (Aim 3).

Constructs Surrounding the Decision-Making Process to Disclose a Rape

At this time, there are no current measures that are able to quantify the decision-making process leading up to disclosure of rape to informal forms of social support, or the role of alcohol use and mental health in this process – as either the catalysts or inhibitors to disclosure; or following the disclosure process. These major limitations speak to the need of exploring the factors that prompt victims to use their support system. Examination of the themes that emerged related to prompting disclosure indicated that disclosure most often occurred one-on-one, in-person, and during general conversation. Given the fact that most disclosures came up in conversation, perhaps the environment felt relaxed and secure enough to prompt the victim to bring up the incident with the

individual during their conversation. Also, there was a significant relationship between disclosing in this type of intimate, but casual environment and the relationship between the supporter and victim. Interestingly, casual (unplanned) disclosures were more likely to occur when the relationship between the victim and supporter was less familiar (not a partner or family member). Most often victims disclosed the incident to friends to whom they felt they could relate and trust. And although few participants explicitly brought up going to certain self-help groups with sexual-related problems, the ones that do this stated they would be more likely to discuss them with people they did not know, such as health professionals or individuals in anonymous groups. These findings illustrate the limitation of using existing quantitative measures since current social support measures focus on one's perception of *available* support. This finding elucidates the fact that although one may report a strong and available social support system, one may not actually utilize it after a traumatic incident such as rape. The disconnect between Victims' perceptions of whom they trusted and whom they would report a rape emerged as a central theme from the interviews. When discussing the disclosure process with victims, victims tended to not focus on the person to whom they disclosed, but rather their own sense of readiness to disclose or having an opportune moment.

Consistent with previous literature, more often victims disclosed the rape more shortly after the event happened only when the perpetrator was either a stranger or less familiar to them (Thompson et al., 2007). Victims who delayed disclosure (more than a month time elapsed) were prompted because they had immediate needs, such as revictimization. Even when victims experienced problems or felt they needed to talk to someone about the incident, they did not report to police or seek formal treatment (100%

of cases). In fact, those who reported that they were more likely to talk to friends about problems were significantly less likely to report the incident to police. Thus, as hypothesized, having a social network, in some instances, may hinder access to rape-related healthcare, as police reporting is one avenue in which victims can receive information about free services available to her. Furthermore, victims who did not view the incident as a rape or crime were less likely to report it to police and were more likely to believe in rape myths. These latter findings are consistent with prior research (A. S. Kahn et al., 1994; Peterson & Muehlenhard, 2011), and further validates that the sample chosen from the present investigation is representative of samples used in previous research studies.

Belief in rape myths appeared to be another hindrance to the use of one's social support network. Common rape myths described during interviews revolved around the use of alcohol during the incident as the victim's fault for the incident, having a relationship with the offender as justification for penetration, being involved in risky behavior, and not saying "no" or fighting back during the incident as potential consent. Most of these rape myths were endorsed by Victims as opposed to Supporters and were significantly related to lower rates of rape acknowledgment, higher rates of revictimization, and higher rates of problems or immediate needs related to the incident (immediate mental health, physical, and social needs as described qualitatively by Victims). These findings show that individuals that report immediate needs and are at risk for revictimization may benefit the most from seeking formal support, but are the least likely to be connected with formal support services since they do not recognize the incident as a rape or self-blame for the incident. Further, memos taken after interviews

reveal that Supporters would often report rape myths that they held about the incident once the audio-recorder was turned off, even though they responded negatively to acceptance or belief in rape myths during the interview. Participants often said that they knew they should not judge or blame the victim, but then they would describe aspects of rape myths. Qualitative data gathered from these memos may indicate that public health campaign efforts have brought awareness of rape myths to college students, but student's beliefs about them have not been changed. Political correctness appears to be the underlying factor in this discrepancy. In other words, participants knew what the "correct" or "right" thing to say.

Perceptions and feelings surrounding the disclosure may have also influenced future help-seeking, which may explain the high rates of revictimization. Specifically, Victims mostly described the disclosure as uncomfortable, while Supporters said they felt good about the victim coming to them and sympathetic to the Victim's situation. There was a significant correlation between Supporter sympathy and the Supporter's level of familiarity with the victim. That is, Supporters were more sympathetic upon disclosure when they were less familiar with the victim. This relationship may seem unexpected, but may be explained considering that alcohol-involved rapes were more likely to be disclosed to people that are closer to them in the Victim/Supporter relationship, as opposed to strangers. Therefore, the stigmatizing factor of alcohol is often not present during these disclosures between Supporters and Victims who are not close. Perhaps, it is also easier for Supporters to not judge or let the Victim's history influence their feelings about the rape if they do not know them as well. Moreover, Victims who felt uncomfortable during the disclosure process were strongly related to revictimization.

Multiple victimizations may further hinder Victims to seek help if they feel others will say they are putting themselves in that situation.

It is also important to note that although participants were aware of community resources, particularly on campus, most students had not ever utilized any of these free and convenient services. This observation is consistent with prior quantitative work (Thompson et al., 2007; Zinzow & Thompson, 2011). The most frequent reason stated for not using community resources was that participants felt they did not need them. This finding shows the need to reinforce with students that mental health and other types of support can be useful even when they do not think that they need them. It is also telling that there remains a stigma surrounding mental health services and other help-seeking behaviors among college students despite the vast array of public education programs targeted toward this age group and demographic.

Perceptions of Support during Disclosure and its Impact on Mental Health

It was anticipated that the perceptions of both the Victim and Supporter would impact post-rape mental health outcomes of the Victim. Study results indicated that Victims who described feeling positively about the support provided during the disclosure were urged to seek further support or urged to seek formal support from a professional. Feeling good about the support was positively related to PTSD symptoms and the perception that speaking to a professional would have been even more helpful. This latter finding was inferred from reports during the interviews that Victims experiencing more problems appeared to be the most positive about the disclosure process and open to seeking further support. Conceivably, Victims with the most problems experienced a greater release after disclosing. Likewise, promotion of formal

support during the disclosure process helped victims feel that seeking further professional help would have been even more helpful. This finding is important in that it illuminates how the mere suggestion of seeking formal support from a friend or family member can make the victim feel more open to seeking further help. Supporters encouraged the victims to seek formal help during the disclosure process about half of the time. In the cases where this suggestion was made, then seeking social support would be good, as it would be a mediator that links victims to other sources of help. However, in the absence of this suggestion, then seeking informal support may be a sort of "dead end" to recovery.

Conversely, Supporters' feelings about the disclosure were not significantly related to mental health symptoms of the Victim. That is, Victims had high or low levels of mental health symptoms, regardless of how Supporters perceived the disclosure process. Further, participants who reported higher levels of quantitatively measured social support experienced significantly fewer mental health problems (R. Campbell et al., 2009; Miller et al., 2011; Ullman, 1999). These findings lead one to believe that regardless of the feelings during disclosure, support in any form may be beneficial to one's well-being. This also suggests that, to some degree, Victim's post-rape mental health is largely internal and not due to external sources.

Interestingly, when support was assessed through qualitative data, there was no significant relationship between available support (as described via interviews) and depression or anxiety. PTSD symptoms were lower though in those reporting available support. This disconnect highlights the differences in findings when using quantitative and qualitative approaches. Qualitative and quantitative methods illustrate different aspects of the whole process, lending one to believe that both are needed to fully

conceptualize the process of rape disclosure. The large difference between the quantitative and qualitative data is that the qualitative data takes into account that the participant values this type of support, whereas the quantitative measure simply records if they have this type of support available. If one does not value the type of support available to them, then he/she is not going to utilize it or benefit from it.

The Role of Alcohol during the Disclosure Process

As expected, alcohol plays an important role in shaping the disclosure process and subsequently impacts mental health. Specifically, alcohol involvement predicted disclosure in that alcohol-involved incidents were less likely to be reported to the police and was instead disclosed to an informal support. Disclosure was then found to impact the presence and severity of mental health problems. However, participants reported limited impact of alcohol on perceptions, response, disclosure, and type of support sought. This unexpected finding may be attributed to the fact that over a third of incidents occurred when the victim was a child and alcohol was not involved. In cases where alcohol was involved during the incident, as anticipated, both Supporters and Victims reported feeling that the victim was at fault or responsible for the incident. Even when it was only the perpetrator drinking, Victims still report a high level of guilt and self-blame, showing how strong the perceptions of victim blame are in any type of rape, alcohol or non-alcohol involved. These feelings were often accompanied by the Victim reporting being worried about judgment during the disclosure. Likewise, Victim credibility was questioned when the victim had a history of alcohol or drug use. Supporters and Victims did report that Victim credibility influenced seeking further support, particularly formal support. That is Supporters or Victims reported that Victims'

past substance use or alcohol involvement made Victims appear to be responsible for the incident and, therefore, worried that formal supports may judge the situation as way less favorable for the Victim. This barrier to services is of particular interest, especially in regards to interventions targeted towards college students to reduce sexual risk behaviors and victimization. Although college students are aware of "rape myths" and when asked directly about their belief in them they typically say "no", but qualitative descriptions of feelings and perceptions surrounding alcohol involved rapes say otherwise. Victims are often hesitant to disclose or seek further help because of the negative feelings during the initial disclosure and Supporters are often hesitant to promote additional help-seeking or report to the police for the same reasons.

Consistent with current bystander literature, sexual assault that happens in college party environments or with a partner (dating violence) is often not viewed as sexual assault or rape, especially when alcohol is involved (Koelsch, Brown, and Boisen, 2012). Typically seen as a risk factor, college party environments may actually provide an opportunity for bystanders to intervene, if college students are provided bystander education. Recently, university sexual assault prevention programs have started including bystander education, which informs students on risky situations and how they can take responsibility to prevent and intervene in these situations. In fact, a new provision to the VAWA (2013) is the Campus Sexual Violence Act (SaVE Act). The SaVE Act requires pertinent personnel at colleges and universities to report domestic violence, dating violence, and stalking, beyond crime categories the Cleary Act already mandates, as well as adopting certain institutional policies to address and prevent campus sexual violence. New training related to the SaVE Act provides colleges an opportunity

to change how rapes are perceived by potential supporters and to prepare potential supporters on assisting victims when a rape is disclosed to them.

Further, even though the impact of alcohol on mental health was not quantitatively found to be significantly correlated, the personal accounts provided by participants during the qualitative interviews tell another story. The comorbidity of alcohol use and mental health problems were evident. The use of qualitative methods allowed for participants to describe, in greater depth, how they truly felt about a sensitive topic without having to label their thoughts or beliefs that they have been told were unacceptable. However, these beliefs still influence how they react and respond during the disclosure process and therefore may impact the victim's mental health, as made evident in the qualitative results.

Limitations and Future Research

Although the current study has utilized a novel approach to uncover more nuanced, detailed factors related to the disclosure process of rape victims and its impact on feelings and perceptions surrounding the disclosure, it is important to note the limitations of this study that may lead to opportunities for future research in this area. As indicated previously in the methodology, this study used a sample of Victims and Supporters as two separate, unrelated groups, rather than dyads. Sampling dyads would have been beneficial for triangulation of the information received from each perspective on the one incident. Building on the themes found in this study, the next step will be to sample dyads to confirm and fine-tune specific themes or constructs found.

The sample also consisted of only female victims. To date, very little information is known about male rape victims; however, previous research indicates that a majority of

college student rapes involve a female victim. Further, the study used a college student sample. As research shows that college student and older community samples have different risk factors and consequences of rape, generalizability is limited. Small sample size is another limitation; nevertheless, this smaller sample size allowed for in-depth qualitative analysis and was believed to be a representative sample given the common findings with previous research. Although a number of findings were consistent with existing quantitative literature, qualitative studies using a larger sample would be beneficial in confirming the qualitative themes that emerged in this study. Additionally, self-report measures were collected at one time-point and future research would benefit from understanding how the associations among rape disclosure, assault characteristics, alcohol use, and mental health outcomes change over time. Finally, because a cross-sectional sample was used in the current study, caution should be provided when interpreting causality between the disclosure process and mental health/substance use outcomes. Based on the nature of the data, it is not certain whether interactions during the disclosure process influence future use of formal support, or whether assault characteristics (including alcohol involvement) impact the type of support provided, which may result in mental health or alcohol problems. Future longitudinal studies would be ideal to illustrate the predictor variable occurring prior to the outcome.

A number of clinical and policy implications can be gleaned from this study. To start, public health efforts that target college students should focus on alleviating the label of mental health services and instead take a proactive approach in providing these types of services to all students before problems arise. If students are exposed to these services, their thoughts about not needing services described in this study may change.

Another possible clinical implication is the use of anonymous interventions. Specifically, a web-based intervention that allows individuals to get immediate, anonymous feedback about a sexual assault situation in a comfortable environment could be beneficial. A different approach that could improve a victim's reporting environment is more training to educate police officers to be more sympathetic and to understand the impact of their response. Further, some states require the use of rape kits to confirm the incident for prosecution, but again, this formal process can be a burden on the victim. Perhaps these services could be offered in the comfort of their own home via a mobile rape unit. This change in the reporting process could vastly improve reporting rates, as well as conviction rates. Lastly, as an initial long-term goal of this study, a more comprehensive quantitative measure of social support should be developed to include a utilization aspect.

Conclusion

The use of qualitative methods through thematic analysis in conjunction with quantitative measures provided a better understanding of the decision-making process in disclosing a rape and the context to which disclosure occurs among female college student rape victims and their supporters, as well as their mental health and substance use history as it relates to their perception of the disclosure. Specifically, the use of thick description provided Victims and Supporters a voice that could not be heard through existing quantitative measures. The concepts that emerged through the in-depth (face-to-face), semi-structured interviews unveiled the fact that the perceptions surrounding social support during disclosure of a rape are often very different between Supporters and Victims. Victims themselves more often report feeling uncomfortable or guilty because of their own acceptance of rape myths, which appears to hinder them from further help-

seeking. However, Victims appear to be prompted to disclose to an informal social support when they feel they are ready to talk and are provided a comfortable environment, but both Victims and Supporters feel that Supporters are unprepared to provide sufficient aid and the support provided during the disclosure may be inadequate. Despite the feelings that professional help would be beneficial, Victims are often stalled by complicating factors during the assault or their individual characteristics, such as alcohol involvement. Recent efforts on educating the general public on rape myths was evident during the interviews, but these beliefs still remain in students and their feelings surrounding rape and utilizing mental health services.

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Appendices

Appendix A. Screening Questions

How did you hear about the study?

Victim Group Eligibility

Gender? (Female Only)

What is your age? (18+)

Are you currently enrolled in college?

In your lifetime, have you had an unwanted sexual experience that involved oral, vaginal, or anal penetration to which you did not consent?

If yes, did you disclose the event to someone?

Have you consumed ever consumed alcohol? (AUDIT, with AUDIT C criteria)

AUDIT

Question	0	1	2	3	4
1. How often do you have a drink containing alcohol?*	Never	Monthly or Less	2-4x Month	2-3x Week	4 or More xWeek
2. How many drinks containing alcohol do you have on a typical day when you are drinking?*	1 or 2	3 or 4	5 or 6	7, 8, or 9	10 or more
3. How often do you have six or more drinks on one occasion?*	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
5. How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
6. How often during the last year have you been unable	Never	Less than Monthly	Monthly	Weekly	Daily or Almost

to remember what happened the night before because you had been drinking?					Daily
7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night or heavy drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
8. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or Almost Daily
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
AUDIT Total					
*AUDIT C Total					

Supporter Group Eligibility

What is your age? (18+)

Are you currently enrolled in college?

In your lifetime, have you had an unwanted sexual experience that involved oral, vaginal, or anal penetration disclosed to you?

Appendix B. Qualitative Interview Questions

Both Supporters and Victims

1) What is your definition of social support?
2) How important do you feel social support from friends and family is to your well-being?
    a. Acquaintances?
    b. Community?
3) When you are experiencing problems, to whom do you seek help or support?
    a. Why do you seek out those people?
    b. What types of topics do you approach with the different groups in your support system?
        i. Friends?
        ii. Family?
        iii. Acquaintances?
        iv. Community?
4) What types of resources are you aware of in the community that could provide help with your mental and/or physical well-being?
5) Do you utilize these resources? Why or why not?

Supporters

1) How did the victim(s) of sexual assault approach you to disclose the incident?
    a. How much time had elapsed since the incident before being approached?
2) How did you feel about being approached to discuss an unwanted sexual experience?
3) How did the nature of the topic impact your response/discussion with the victim?
4) How did you feel about the amount of support, information, and resources you were able to provide to the victim?
5) Did you refer the victim to seek further support?
        i. Where?
        ii. Formal or informal support?
6) What aspects of the victim's past behavior may have influenced the way you responded?

Victims

1) How do you feel about your social support system?
2) What influenced your choice to disclose the incident?
3) What factors influenced whom you chose to disclose the incident?
4) How did you feel about discussing an unwanted sexual experience with someone?
    a. What topics, if any, would you only feel comfortable disclosing to your informal social support system (i.e., friends, family, or acquaintances)?

b. What topics, if any, would you feel more comfortable disclosing to people you did not know (i.e., counselor or self-help group)?
c. What topics, if any, would you not feel comfortable disclosing to anyone?

5) What were the things that that happened before or during the incident that affected your disclosure or feelings about disclosing the incident?
6) How do you feel about the social support you received after disclosing the incident?
    a. Do you feel that it alleviated negative feelings about the incident?
    b. Did the confidant suggest you speak to someone else?
        i. If so, who?
    c. What do you feel would have been more helpful?
7) What are your feelings about group therapies or other forms of social support in the community?
8) What types of things do you feel hinder you from seeking forms of social support (either formal or informal)?

*Follow-up Questions regarding alcohol (if not mentioned): How did your use of alcohol (or drugs) during the incident or in the past affect your decision to disclose? Seek informal or formal support?

Appendix C. Demographics Form

Demographic Information

1. Group: ____ Victim ____ Supporter

2. Gender: ____ Male ____ Female

3. Age: _____ yrs.

4. Race: (please check one)
   ____ White
   ____ Black
   ____ Asian
   ____ Native American
   ____ Multiracial

5. Ethnicity:
   ____ Hispanic
   ____ Non-Hispanic

6. Current Educational Status:
   ____ Freshman
   ____ Sophomore
   ____ Junior
   ____ Senior
   ____ Other

7. Employment:
   ____ Unemployed or Disabled
   ____ Employed Part-Time (working 1-30 hrs a week)
   ____ Employed Full-Time (working more than 30 hrs a week)
   ____ Retired

8. Estimated Annual Income:
   ____ Under $10,000
   ____ $10,000 - $19,999
   ____ $20,000 - $29,999
   ____ $30,000 - $39,999
   ____ $40,000 - $49,999
   ____ $50,000 - $59,999
   ____ $60,000 - $69,999
   ____ $70,000+

9. Marital Status:
   ____ Single
   ____ Living w/ Partner
   ____ Married
   ____ Separated
   ____ Divorced

____ Widowed

10. Current Residence:
    On-Campus
    Off-Campus

11. Sorority or Fraternity Membership?
    Yes
    No

12. University-Affiliated Athletic Team?
    Yes
    No

Appendix D. IRB Approval Letters

USF
UNIVERSITY OF
SOUTH FLORIDA

RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
(813) 974-5638 • FAX (813) 974-7091

10/9/2013

Ms. Jessica Mitchel
University of South Florida
Department of Criminology
13301 Bruce B. Downs Blvd., MHC 2722C
Tampa, FL 33620

RE: **Expedited Approval for Initial Review**
IRB#: Pro00014884
Title: The Role of Social Support in the Disclosure and Recovery Process of Rape Victims
Study Approval Period: 10/9/2013 to 10/9/2014

Dear Dr. Mitchell:

On 10/9/2013, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
Dissertation Prospectus Defense.doc

Consent/Assent Document(s)*:
Consent Form Revised.pdf
Waiver of Consent Script for Screening .pdf

*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent document(s) are only valid during the approval period indicated at the top of the form(s).

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR

56.110. The research proposed in this study is categorized under the following expedited review category:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your study qualifies for a waiver of the requirements for the documentation of informed consent for screening purposes as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

Kristen Salomon, Ph.D., Vice Chairperson
USF Institutional Review Board

USF
UNIVERSITY OF
SOUTH FLORIDA

RESEARCH INTEGRITY AND COMPLIANCE
Institutional Review Boards, FWA No. 00001669
12901 Bruce B. Downs Blvd., MDC035 • Tampa, FL 33612-4799
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9/16/2014

Jessica Mitchell, M.A.
USF Department of Criminology
4202 E. Fowler Ave.
Tampa, FL 33620

RE: **Expedited Approval for Continuing Review**
IRB#: CR1_Pro00014884
Title: The Role of Social Support in the Disclosure and Recovery Process of Rape Victims

Study Approval Period: 10/9/2014 to 10/9/2015

Dear Ms. Mitchell:

On 9/15/2014, the Institutional Review Board (IRB) reviewed and **APPROVED** the above application and all documents outlined below.

Approved Item(s):
Protocol Document(s):
Dissertation Prospectus Version 4_4-2-14_Clean

The IRB determined that your study qualified for expedited review based on federal expedited category number(s):

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Please submit an amendment to the IRB within 30 days to remove individuals from the application who are no longer on study staff.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval by an amendment.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.

Sincerely,

John A Schinka, Ph.D.

John Schinka, Ph.D., Chairperson
USF Institutional Review Board

Appendix E. Coding Scheme and Frequency for Responses to Qualitative Interview Questions: Final Iteration

Both Supporters and Supported (N=46)

1) What is your definition of social support? (Aim 2-RQA)

Friends	B1FRIEND	13 (28.3%)
Family	B1FAM	9 (19.6%)
Group of People/Network	B1GROUP	16 (34.8%)
Having people that are there for you	B1THERE	37 (80.4%)
Having someone to talk to	B1TALK	26 (56.5%)
Financial/Tangible	B1MONEY	1 (2.2%)
Having places to go/get information	B1INFORM	2 (4.3%)
Different/All Forms	B1ALL	5 (10.9%)
Unsure	B1UNSURE	0 (0%)

2) How important do you feel social support from friends and family is to your well-being? (Aim2-RQA)

Most Important/Essential/Very	B2IMP	46 (100%)
Somewhat Important/Situational	B2SOME	0 (0%)
Not Important	B2NOT	0 (0%)

a. Acquaintances?

Most Important/Essential/Very	B2aIMP	6 (13.0%)
Somewhat Important/Situational	B2aSOME	28 (60.9%)
Not Important	B2aNOT	13 (28.3%)

b. Community?

Most Important/Essential/Very	B2bIMP	9 (19.6%)
Somewhat Important/Situational	B2bSOME	23 (50.0%)
Not Important	B2bNOT	13 (28.3%)

3) When you are experiencing problems, to whom do you seek help or support? (AIM1-RQA)

No One	B3NONE	3 (6.5%)
Best Male Friend	B3MALE	4 (8.7%)
Best Female Friend	B3FEMALE	3 (6.5%)
Significant Other	B3SIGOTH	12 (26.1%)
Friends (group)	B3FRIENDS	20 (43.5%)
Peer/Colleague	B3PEER	3 (6.5%)
Family	B3FAM	32 (69.6%)
Professional	B3PROF	1 (2.2%)

a. Why do you seek out those people? (AIM1-RQA)

Trust	B3aTRUST	12 (26.1%)
Known Long Time	B3aLONG	10 (21.7%)
Comfortable	B3aCOMF	7 (15.2%)
No Judgment	B3aJUD	8 (17.4%)
Respect Advice/Opinion	B3aRESP	15 (32.6%)
Close Relationship	B3aCLOSE	24 (52.2%)
They "Get" Me	B3aGET	18 (39.1%)
Similar Problems/Interests/Relate	B3aSIM	4 (8.7%)

b. What types of topics do you approach with the different groups in your support system? (AIM1-RQB and AIM2-RQA)

i. Friends?

Anything/Everything	B3biEVERY	9 (19.6%)
Nothing	B3biNOTHING	1 (2.2%)
School	B3biSCHOOL	24 (52.2%)
Money/Finances	B3biMONEY	3 (6.5%)
Health	B3biHEALTH	4 (8.7%)
Relationships	B3biREL	25 (54.3%)
Sex	B3biSEX	0 (0%)
Work	B3biWORK	13 (28.3%)
Similar Problems/Relate	B3biSIM	8 (17.4%)
General Guidance	B3biGUIDE	5 (10.9%)
Leisure (i.e. drinking)	B3biDRINK	3 (6.5%)
Future Plans	B3biPLAN	2 (4.3%)

ii. Family?

Anything/Everything	B3biiEVERY	16 (34.8%)
Nothing	B3biiNOTHING	3 (6.5%)
School	B3biiSCHOOL	15 (32.6%)
Money/Finances	B3biiMONEY	10 (21.7%)
Health	B3biiHEALTH	10 (21.7%)
Relationships	B3biiREL	12 (26.1%)
Sex	B3biiSEX	0 (0%)
Work	B3biiWORK	9 (19.6%)
Similar Problems/Relate	B3biiSIM	5 (10.9%)
General Guidance	B3biiGUIDE	5 (10.9%)
Leisure (i.e. drinking)	B3biiDRINK	1 (2.2%)
Future Plans	B3biiPLAN	6 (13.0%)

iii. Acquaintances?

Anything/Everything	B3biiiEVERY	1 (2.2%)
Nothing	B3biiiNOTHING	15 (32.6%)
School	B3biiiSCHOOL	8 (17.4%)
Money/Finances	B3biiiMONEY	0 (0%)
Health	B3biiiHEALTH	1 (2.2%)
Relationships	B3biiiREL	1 (2.2%)
Sex	B3biiiSEX	1 (2.2%)
Work	B3biiiWORK	6 (13.0%)
Similar Problems/Relate	B3biiiSIM	20 (43.5%)
General Guidance	B3biiiGUIDE	5 (10.9%)
Leisure (i.e. drinking)	B3biiiDRINK	1 (2.2%)
Future Plans	B3biiiPLAN	0 (0%)

iv. Community?

Anything/Everything	B3bivEVERY	2 (4.3%)
Nothing	B3bivNOTHING	32 (69.6%)
School	B3bivSCHOOL	1 (2.2%)
Money/Finances	B3bivMONEY	0 (0%)
Health	B3bivHEALTH	1 (2.2%)
Relationships	B3bivREL	0 (0%)
Sex	B3bivSEX	1 (2.2%)
Work	B3bivWORK	3 (6.5%)
Similar Problems/Relate	B3bivSIM	5 (10.9%)
General Guidance	B3bivGUIDE	8 (17.4%)
Leisure (i.e. drinking)	B3bivDRINK	0 (0%)
Future Plans	B3bivPLAN	1 (2.2%)

4) What types of resources are you aware of in the community that could provide help with your mental and/or physical well-being? (AIM1-RQB)

None	B4NONE	4 (8.7%)
USF Student/Campus Services	B4USF	27 (58.7%)
Shelters	B4SHEL	1 (2.2%)
Food Pantry	B4FOOD	2 (4.3%)
Crisis Center/Hotline/911	B4CRISIS	15 (32.6%)
Anonymous Self-Help Groups	B4ANON	8 (17.4%)
Police	B4POLICE	1 (2.2%)
Hospitals	B4HOSP	17 (37.0%)
Private Counseling	B4PRIV	13 (28.3%)
Church	B4CHURCH	2 (4.3%)

5) Do you utilize these resources? Why or why not? (AIM2-RQD)

Yes	B5YES	18 (39.1%)
No	B5NO	28 (60.9%)
Reasons:		
Never Needed	B5NONEED	23 (50.0%)
"Not for me" – Others	B5NOTME	3 (6.5%)
Don't know where to go	B5DKNOW	5 (10.9%)
Scared/Apprehensive of Judgment	B5JUD	1 (2.2%)
Free/Affordable	B5FREE	8 (17.4%)
Convenient	B5CONV	13 (28.3%)

Supporters (N=30)

1) How did the victim(s) of sexual assault approach you to disclose the incident? (AIM1-RQA)

Casual/Came up in Conversation	S1CASUAL	12 (40.0%)
Specific Conversation	S1SPEC	9 (30.0%)
I Approached Them/Kept Asking	S1APP	6 (20.0%)
On Telephone/Other Electronic	S1TELE	6 (20.0%)
In Person	S1PERSON	17 (56.7%)
One-on-One	S1ONE	19 (63.3%)
In a Group	S1GROUP	2 (6.7%)

   a. How much time had elapsed since the incident before being approached? (AIM1-RQA)

Immediately After	S1aIMMED	2 (6.7%)
Hours	S1aHOUR	4 (13.3%)
Days	S1aDAY	6 (20.0%)
Months	S1aMONTH	5 (16.7%)
A Year	S1aYEAR	1 (3.3%)
1-2 Years	S1aUPTWO	2 (6.7%)
3-4 Years	S1aUPFOUR	2 (6.7%)
5-6 Years	S1aUPSIX	5 (16.7%)
6-10 Years	S1aSIXTEN	0 (0%)
Over 10 Years	S1aOVERTEN	3 (10.0%)

2) How did you feel about being approached to discuss an unwanted sexual assault? (AIM1-RQB and AIM2-RQB)

Uncomfortable	S2UNCOMF	6 (20.0%)
Unsure/Conflicted	S2UNSURE	4 (13.3%)

OK/Comfortable	S2COMF	13 (43.3%)
Surprised	S2SURP	6 (20.0%)
Unprepared	S2UNPREP	4 (13.3%)
Positive (Validated friendship/trust)	S2POS	7 (23.3%)
Negative (Felt bad)	S2NEG	8 (26.7%)

3) How did the nature of the topic impact your response/discussion with the victim? (AIM1-RQB)

It Didn't/Same as Other Topics	S3SAME	7 (23.3%)
Felt Uncomfortable	S3UNCOMF	4 (13.3%)
Don't know/Unsure	S3UNSURE	6 (20.0%)
Couldn't Relate/Sympathize	S3NREL	3 (10.0%)
Felt Bad, but No Change Response	S3BADNO	11 (36.7%)
Took it more seriously	S3SERIOUS	3 (10.0%)

4) How did you feel about the amount of support, information, and resources you were able to provide to the victim? (AIM2-RQB)

Felt Good (Positive)	S4GOOD	11 (36.7%)
OK (Neutral)	S4OK	7 (22.3%)
Inadequate (Negative)	S4INAD	10 (33.3%)
Unsure	S4UNSURE	2 (6.7%)

5) Did you refer the victim to seek further support? (AIM2-RQC and AIM2-RQD)

Yes	S5YES	17 (56.7%)
No	S5NO	13 (43.3%)

a. Where?

Friends	S5aFRIEND	2 (6.7%)
Family	S5aFAM	6 (20.0%)
Professional (i.e. Therapist, Counselor, or Psychiatrist)	S5aPROF	10 (33.3%)
USF Student Services	S5aUSF	3 (10.0%)
Hospital	S5aHOSP	2 (6.7%)
Police	S5aPOLICE	5 (16.7%)

b. Formal or informal support?

Informal	S5bINFORM	2 (6.7%)
Formal	S5bFORM	9 (30.0%)
Neither	S5bNEITH	2 (6.7%)
Both	S5bBOTH	6 (20.0%)

6) What aspects of the victim's past behavior may have influenced the way you responded? (AIM2-RQC)

It Didn't/None	S6NONE	10 (33.3%)
Risky Behavior	S6RB	6 (20.0%)
Heavy Drinker	S6HD	2 (6.7%)
Substance User	S6SUB	1 (3.3%)
Naïve/Inexperienced	S6INEXP	2 (6.7%)
Good Person (Couldn't/Shouldn't happen to that person)	S6GOOD	12 (40.0%)
Previous Trauma	S6TRAUMA	2 (6.7%)
Romantic Feelings	S6FEEL	1 (3.3%)

*Follow-up Questions regarding alcohol (if not mentioned): How did the victim's use of alcohol (or drugs) during the incident affect your response to the disclosure? (AIM3-RQA)

It Didn't	SFU1aDIDNT	24 (80.0%)
Felt Victim Guilty/Responsible	SFU1aGUILT	1 (3.3%)
Unsure/Confused	SFU1aUNS	5 (16.7%)

…or in the past affect your response to the disclosure? (AIM3-RQB)

It Didn't	SFU1bDIDNT	27 (90.0%)
Felt Victim Guilty/Responsible	SFU1bGUILT	2 (6.7%)
Unsure/Confused	SFU1bUNS	1 (3.3%)

Perceptions of the incident? (AIM3-RQA)

It Didn't	SFU2DIDNT	24 (80.0%)
Felt Victim Guilty/Responsible	SFU2GUILT	2 (6.7%)
Unsure/Confused	SFU2UNS	4 (13.3%)

Guidance to seek additional (maybe formal) support? (AIM3-RQB)

It Didn't	SFU3DIDNT	28 (93.3%)
Afraid Victim Lose Credibility	SFU3CRED	0 (0.0%)
Judgment	SFU3JUD	0 (0.0%)
Trouble w/ Law (underage)	SFU3LAW	0 (0.0%)
Additional Support for Drinking	SFU3DRINK	0 (0.0%)
Unsure	SFU3UNS	2 (6.7%)

Victims (N=16)

1) How do you feel about your social support system? (AIM2-RQA)

Good/Strong (Positive)	V1GOOD	14 (87.5%)
OK (Neutral)	V1OK	3 (18.8%)
I don't have one	V1DONT	0 (0.0%)

Bad/Weak (Negative)	V1BAD	0 (0.0%)

2) What influenced your choice to disclose the incident? (AIM1-RQA)

Ready to Talk	V2READY	5 (31.3%)
Needed Help/Having Problems	V2HELP	9 (56.3%)
Felt I Had to Disclose	V2HADTO	6 (37.5%)
Came Up in Conversation	V2CAMEUP	3 (18.8%)
Someone Asked Me	V2ASK	1 (6.3%)
Tell Everything to Person/Confidant	V2CONFI	1 (6.3%)

3) What factors influenced whom you chose to disclose the incident? (AIM1-RQA and AIM1-RQC)

Trust	V3TRUST	7 (43.8%)
Known Long Time	V3LONG	5 (31.3%)
Comfortable	V3COMF	4 (25.0%)
No Judgment	V3JUD	1 (6.3%)
Respect Advice/Opinion	V3RESP	1 (6.3%)
Best Friend/Confidant	V3CONFI	9 (56.3%)

4) How did you feel about discussing an unwanted sexual assault with someone? (AIM1-RQB)

Uncomfortable/Uneasy	V4UNCOMF	12 (75.0%)
Ready to Discuss	V4READY	2 (12.5%)
Comfortable	V4COMF	3 (18.8%)
Bad	V4BAD	1 (6.3%)
OK (Neutral)	V4OK	2 (12.5%)

   a. What topics, if any, would you only feel comfortable disclosing to your informal social support system (i.e. friends, family, or acquaintances)? (AIM1-RQB)

Anything/Everything	V4aEVERY	8 (50.0%)
Nothing	V4aNOTHING	2 (12.5%)
School	V4aSCHOOL	1 (6.3%)
Money/Finances	V4aMONEY	1 (6.3%)
Health	V4aHEALTH	1 (6.3%)
Relationships	V4aREL	1 (6.3%)
Sex	V4aSEX	4 (25.0%)
Work	V4aWORK	0 (0.0%)
Similar Problems/Relate	V4aSIM	1 (6.3%)
General Guidance	V4aGUIDE	2 (12.5%)

Leisure (i.e. drinking)	V4aDRINK	1 (6.3%)
Future Plans	V4aPLAN	0 (0.0%)

b. What topics, if any, would you feel more comfortable disclosing to people you did not know (i.e. counselor or self-help group)? (AIM1-RQB)

Anything/Everything	V4bEVERY	4 (25.0%)
Nothing	V4bNOTHING	2 (12.5%)
School	V4bSCHOOL	0 (0.0%)
Money/Finances	V4bMONEY	0 (0.0%)
Health	V4bHEALTH	6 (37.5%)
Relationships	V4bREL	1 (6.3%)
Sex	V4bSEX	5 (31.3%)
Work	V4bWORK	0 (0.0%)
Similar Problems/Relate	V4bSIM	2 (12.5%)
General Guidance	V4bGUIDE	0 (0.0%)
Leisure (i.e. drinking)	V4bDRINK	2 (12.5%)
Future Plans	V4bPLAN	0 (0.0%)

c. What topics, if any, would you not feel comfortable disclosing to anyone? (AIM1-RQB)

Anything/Everything	V4cEVERY	0 (0.0%)
Nothing	V4cNOTHING	12 (75.0%)
School	V4cSCHOOL	0 (0.0%)
Money/Finances	V4cMONEY	0 (0.0%)
Health	V4cHEALTH	1 (6.3%)
Relationships	V4cREL	0 (0.0%)
Sex	V4cSEX	2 (12.5%)
Work	V4cWORK	0 (0.0%)
Similar Problems/Relate	V4cSIM	0 (0.0%)
General Guidance	V4cGUIDE	0 (0.0%)
Leisure (i.e. drinking)	V4cDRINK	1 (6.3%)
Future Plans	V4cPLAN	0 (0.0%)

5) What were the things that that happened before or during the assault that affected your disclosure or feelings about disclosing the incident? (AIM1-RQA)

In a Relationship with Offender	V5REL	4 (25.0%)
Don't Remember Details	V5MEM	1 (6.3%)
Didn't Say No	V5SAYNO	3 (18.8%)
Didn't Fight It	V5FIGHT	3 (18.8%)
Drinking During the Incident	V5DRINK	7 (43.8%)

History of Heavy Drinking	V5PASTD	0 (0.0%)
Substance Use During the Incident	V5SUBUSE	0 (0.0%)
History of Substance Use	V5PASTUSE	0 (0.0%)

6) How do you feel about the social support you received after disclosing the incident? (AIM2-RQC)

Completely Satisfied	V6COMP	3 (18.8%)
Good, but Not Completely Helpful	V6GOOD	9 (56.3%)
Inadequate	V6INAD	5 (31.3%)

a. Do you feel that it alleviated negative feelings about the incident? (AIM2-RQC)

Yes	V6aYES	11 (68.8%)
No	V6aNO	3 (18.8%)
Unsure	V6aUNSURE	1 (6.3%)

b. Did the confidant suggest you speak to someone else? (AIM2-RQC)

Yes	V6bYES	8 (50.0%)
No	V6bNO	8 (50.0%)
Don't Remember	V6bMEM	0 (0.0%)

i. If so, who?

Informal	V6biINFORM	3 (18.8%)
Formal	V6biFORM	4 (25.0%)
Friends	V6biFRIEND	1 (6.3%)
Family	V6biFAM	3 (18.8%)
Professional (i.e. Therapist, Counselor, or Psychiatrist)	V6biPROF	4 (25.0%)
USF Student Services	V6biUSF	0 (0.0%)
Hospital	V6biHOSP	1 (6.3%)
Police	V6biPOLICE	1 (6.3%)

c. What do you feel would have been more helpful? (AIM2-RQC)

Speaking to a Professional	V6cPROF	4 (25.0%)
Reporting to Police	V6cREP	1 (6.3%)
Keeping it to Myself	V6cKEEP	1 (6.3%)
Nothing	V6cNOTH	5 (31.3%)
Disclosing in Person	V6cINPER	2 (12.5%)
Being believed	V6cBELIEVE	1 (6.3%)

7) What are your feelings about group therapies or other forms of social support in the community? (AIM2-RQA and AIM2-RQD)

Helpful	V7HELP	12 (75.0%)
"Not for Me"	V7NOTME	4 (25.0%)
Awkward/Uncomfortable	V7UNCOMF	1 (6.3%)
Unsure	V7UNSURE	1 (6.3%)

8) What types of things do you feel hinder you from seeking forms of social support (either formal or informal)? (AIM2-RQD)

Not Ready to Talk	V8NREADY	2 (12.5%)
No One to Go to	V8NONE	2 (12.5%)
Unsure Where to Go	V8WHERE	2 (12.5%)
Awkward/Uncomfortable Topic	V8UNCOMF	7 (43.8%)
Shame/Guilt	V8GUILT	11 (68.8%)

*Follow-up Questions regarding alcohol (if not mentioned): How did your use of alcohol (or drugs) during the incident? (AIM3-RQA)

It Didn't	VFU1DIDNT	10 (62.5%)
I Felt Guilty/Responsible	VFU1GUILT	3 (18.8%)
Worried about Judgment	VFU1JUD	3 (18.8%)

…or in the past affect your decision to disclose? (AIM3-RQB)

It Didn't	VFU1bDIDNT	13 (81.3%)
Felt Victim Guilty/Responsible	VFU1bGUILT	3 (18.8%)

Seek informal or formal support? (AIM3-RQB)

N/A/It Didn't	VFU3DIDNT	9 (56.3%)
Afraid Victim Lose Credibility	VFU3CRED	3 (18.8%)
I Felt Guilty/Responsible	VFU3GUILT	2 (12.5%)
Worried about Judgment	VFU3JUD	3 (18.8%)
Didn't Know Where to Go	VFU3WHERE	1 (6.3%)

Other Codes (Anywhere in Document):

Victim Blaming/Rape Myths	MYTHS	39 counts