An Intervention Model for Recruiting Rape Victims into Treatment

by

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Abstract

The percentage of rape victims who do not seek social support after rape is alarming, particularly given the potential consequences of not seeking help. The present study attempts to address the dilemma of rape and attempted rape victims' lack of support seeking through a two-phase online intervention designed to encourage them to seek treatment. The study manipulates factors involved in characterizing oneself as a rape victim and in seeking help for problems resulting from rape. It was hypothesized that victims who received the intervention would seek counseling more than victims in a wait-list control group. Participants were 1322 women ranging in age from 17 to 39 from a large, southeastern university. Of these women, 344, or 26% of the sample, reported an experience consistent with a legal definition of rape or attempted rape. Unfortunately, it was not possible to fully examine the proposed model in this study, as hypothesized differences between intervention and control subjects did not exist. However, interesting trends developed collapsing across treatment groups. While few participants sought formal help, almost three-fourths sought informal help and almost half sought information about counseling. These findings are made even more salient by the large number of non-recent victims who sought help for the first time. Taking part in the study itself appeared to encourage victims who had gone without help for some time to actually seek help. In addition, higher levels of distress were associated with seeking help, as were higher levels of negative social reactions, stigma, and self-blame. Perceived need for help was found to mediate the relationship between distress and intent to seek help. Limitations and suggestions for future research are discussed.

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Aims

Rape victims, while often suffering problems with depression, anxiety, lowered self-esteem, sexual dysfunction, and continued victimization, are often reluctant to seek counseling. With a focus on college women, a group at high risk for rape, this study attempts to address the dilemma of rape victims not initiating counseling by constructing an intervention designed to encourage them to seek treatment. The study itself will manipulate factors involved in characterizing oneself as a rape victim (stigma and self-blame) to affect the willingness to seek help from problems resulting from rape. Specifically, it is hypothesized that victims of rape and attempted rape will be more likely to seek counseling if they receive an intervention that reduces self-blame and the stigma associated with rape.

Background and Significance

Overview of Rape

Rape is a more common occurrence on college campuses than many realize and has been found to affect approximately 18.5% of college women (Koss & Burkhart, 1989). If one includes attempted rapes, the percentages range from 28% (Koss, 1988) to 38% (Koss, 1985) of college women who find themselves victimized.

The issue becomes more complex because of differences in how people subjectively define experiences as "rape." Many women have experiences that meet a legal definition of rape but indicate on questionnaires that they do not conceptualize their experiences as rape (Kahn, Mathie, & Torgler, 1994; Koss, 1988; Murnen, Perot, & Byrne, 1989; Patton & Mannison, 1995; Reilly, Lott, Caldwell, & DeLuca, 1992). The term "unacknowledged rape victims" has been applied to these women (Levine-MacCombie & Koss, 1986). Percentages of unacknowledged victims are alarming, and range from 42% up to 73% of all rape victims (Botta & Pingree, 1997; Frazier & Seales, 1997; Kahn, Mathie, & Torgler, 1994; Koss, 1988; Layman, Gidycz, & Lynn, 1996; Murnen et al., 1997).

Potential Problems Resulting from Rape

Rape victims often find themselves emotionally affected as a result of their rape

experiences (Schwartz & Leggett, 1999) and can suffer problems such as depression, anxiety, posttraumatic stress disorder, and sexual dysfunction (Becker, Skinner, Abel, & Cichon, 1986; Burgess & Holmstrom, 1979; Frank, Turner & Duffy, 1979; Kilpatrick, Resick, & Veronen, 1981; Kilpatrick, Veronen, & Best, 1985; Kilpatrick, Veronen, & Resick, 1979; Koss, Dinero, Seibel, & Cox, 1988; Layman et al., 1996; Nadelson, Notman, Jackson, & Gornick, 1982; Veronen, Kilpatrick, & Resick, 1979). Victims of attempted rape also report an intense emotional reaction after their experience (Koss, 1985).

Victims of rape and attempted rape are at increased risk for revictimization (Kilpatrick & People Against Rape, 1983; Koss & Burkhart, 1989; Layman et al., 1996). Multiple-incident rape victims have also been found to be more frequent victims of other violent crimes and to have histories of physical abuse as children and/or adults (Ellis, Atkeson, & Calhoun, 1982). Layman et al. found that over two-thirds of the women in their sample had been victimized as children, and therefore had experienced revictimization. Almost one-third of the victims maintained a relationship with the man who raped them, and one-fourth continued to have sexual relations with him after the rape. However, victims were not asked if continued sexual relations were voluntary or forced. It is of note that 90% of victims who had sex with their perpetrators after the rape were unacknowledged, suggesting that not acknowledging rape leads to continued victimization. Koss (1985) found that 76% of unacknowledged rape victims in her sample were romantically involved with the man who raped them, placing them at greatly increased risk due to proximity. Revictimization is a threat with acknowledged victims, as well. Lees (cited in Kilpatrick and People Against Rape, 1983) found that their sample of acknowledged victims were more likely to have been sexually molested as children and to have a history of physical abuse as children and adults. Multiple-incident rape victims, even more than single-incident victims, demonstrate problems with adjustment, suspiciousness and hostility, fewer and less satisfying social and sexual relationships, and more depression and suicide attempts (Ellis et al., 1982). Unacknowledged victims have sometimes been found to have symptomatology similar to that of acknowledged victims (Botta & Pingree, 1997). Accurate estimates of their symptom levels are difficult, however, as they may underestimate due to not conceptualizing their experiences as rape (Layman

et al., 1996).

The Benefits of Social Support

Social support has consistently been shown to be a prominent factor that can help victims improve their functioning after traumatic events (Gore, 1985; Sarason, Sarason, & Pierce, 1995; Thoits, 1986). In fact, talking about a crime experience with others has been cited as the single most therapeutic factor reported by victims (Davis & Friedman, 1985).

Victim self-characterization influences the social support processes chosen and used to overcome psychological distress, as well as the support that is available to victims (Groth & Burgess, 1980; Kilpatrick & People Against Rape, 1983; Koss, 1992, 1993). Support seeking, the process of seeking support for oneself, is a form of social support that will be chosen by victims in varying degrees depending on the amount of stigma and self-blame they feel as a result of their experience. Support seeking can include seeking support from informal sources such as family and acquaintances (Dakof & Taylor, 1990) or from formal sources such as counselors or crisis centers (Koss & Burkhart, 1989). Trauma victims generally prefer informal sources of help to formal sources such as mental health practitioners and the criminal justice system (Wills, 1987), but informal supports are not always willing or able to provide the degree of assistance required.

After experiencing a traumatic event such as rape, discussing the experience with supportive others helps people discover the meaning of the experience for themselves, gain control over their emotions, and rebuild positive assumptions about the world (Janoff-Bulman, 1992; Pennebaker, 1990). Being able to discuss one's feelings about trauma with supportive others has been found highly important for successful coping in a number of studies (Greenberg & Stone, 1992; Pennebaker & Beall, 1986). The need for an outlet for emotions after trauma may continue for months or even years (Frieze & Bookwala, 1996). After sharing their emotions, receiving supportive social responses to disclosures helps victims blunt the distress associated with negative cognitions and counteract their tendencies to avoid confronting trauma-related thoughts (Lepore, Silver, Wortman, & Wayment, 1996). Cognitive processing involving contemplation, reappraisal, and acceptance of the event can then proceed. Not confiding in others about rape is associated with both cognitive and symptomatic problems (Koss, 1988). Counseling

in particular is important in helping victims reinterpret their experiences and avoid assimilating the "degradation and helplessness" they feel into their beliefs and behavior (Koss & Burkhart, 1989, p. 35). Without treatment and learning new coping responses, victims turn to former maladaptive coping styles. Resulting low self-esteem and powerlessness could lead to continued involvement in abusive relationships (Koss & Burkhart). In addition, if victims receive unsupportive and negative social responses to disclosures, inhibition and avoidance of trauma-related thoughts and memories can result, leading to increases in psychological distress (Lepore et al., 1996).

Factors Involved in Seeking Support

Fear of societal reactions to rape is evidenced by the number of victims who do not disclose their experiences to others. Koss (1988) reports that 42% of victimized women told no one about their assault. In another study (1985), she found that 48% of acknowledged victims and over half of unacknowledged victims did not report the rape to anyone. Koss, Dinero, Seibel, and Cox (1988) found that 26.8% of stranger rape victims discussed the rape with no one, compared to 46% of acquaintance rape victims. The percentage of victims who do not seek social support after rape is alarming, particularly given the potential consequences of not seeking help.

Despite the benefits of therapy, few victims seek counseling as a means of social support after rape (Botta & Pingree, 1997; Ellis et al., 1982; Kilpatrick & People Against Rape, 1983). Koss and Burkhart (1989) report that less than one-half of adult victims judged to need therapy three months post-rape agree to accept it. Frank and Stewart (1983) found that even fewer victims complete a course of therapy. Just one-quarter of victims who entered a rape treatment program immediately post-rape completed a 14-hour course of therapy. Beginning therapy after rape and terminating it prematurely could prove harmful as victims likely uncover painful issues that do not get resolved, potentially leaving them with untreated symptoms, cognitive distortions, and a negative view of professional mental health services as a result.

When victims do attend therapy, victimization issues are not always central to treatment. Kilpatrick and People Against Rape (1983) found twice as many victims in therapy in their sample than had sought therapy for problems they felt to be victimization-related. This finding

demonstrates that many victims have problems related to rape and do not associate the two. In fact, unacknowledged victims may underestimate their symptoms or experiences because they may not have strong reactions to the experience due to not viewing it as rape, or because they are reluctant to report the experience (Layman et al., 1996). The stigma of being a "rape victim" can keep individuals from seeking help from others (Koss, 1992, 1993). Unacknowledged victims are particularly unlikely to turn to others for help after rape, often because they feel partially at blame for the assault and do not wish to invoke the negative reactions of others (Botta & Pingree, 1997; Frazier, 1990; Frazier & Seales, 1997; Pitts & Schwartz, 1997). In addition, unacknowledged victims may still be in a relationship with the perpetrator, and acknowledging the rape could present a threat to the continuation of the relationship. The role of stigma and self-blame in characterizing as a victim and in help-seeking will be discussed further below, with stigma being addressed first.

Stigma involves at least two components: (1) the recognition of difference in a person based on some distinguishing characteristic or "mark," and (2) a consequent devaluation of the person (Dovidio, Major, & Crocker, 2000). Goffman (1963) describes stigma as a sign or mark that designates its bearer as "spoiled" and valued less than a "normal" person. A mark has been defined as "perceived or inferred conditions of deviation from a prototype or norm that might initiate the stigmatizing process" (Jones et al., 1984, p. 8). A marked person may or may not be stigmatized. Stigmatizing implies that the mark has been attributed to dispositions that discredit the bearer of the mark and "spoil" his identity (Jones et al.).

A number of rape studies identified fear of stigma as a causal factor in the reluctance of individuals who have experienced rape to self-characterize as rape victims (Groth & Burgess, 1980; Kilpatrick & People Against Rape, 1983; Koss, 1992, 1993). Crocker, Major, and Steele (1998) discuss core features of the experience of stigma that are likely to tax the coping resources of those who self-identify as victims. The first is the possibility that the individual will be the target of prejudicial views, thereby increasing the frequency and/or intensity of threats to the self. The second feature of stigma is awareness of the devalued nature of one's social identity, which provides a threat to self-esteem (Baumeister & Leary, 1995). A third core aspect of stigma

is the awareness that others likely hold negative stereotypes about one's status. These stereotypes are a constant threat even if victims do not give credence to the stereotypes (Steele, 1997). A fourth defining feature is uncertainty about whether one is being treated in a prejudicial manner based on one's status. This uncertainty develops because nonstigmatized people often try to disguise their true attitudes toward stigmatized others out of sympathy or concern over not appearing prejudiced (Carver, Glass, & Katz, 1977). The ambiguity that this creates for victims is likely to be a source of stress (Crocker & Major, 1989).

Social rejection of stigmatized individuals can lead to social isolation and lack of social support (Miller & Major, 2000). The fact that stigma threatens social identity as well as personal identity creates the possibility of more severe implications (Miller & Major, 2000). Trauma victims are likely to choose support according to the degree to which it threatens self-esteem and activates stigma. Some sources of support, such as seeing a mental health professional, may have stigma associated with them and decrease the likelihood of their use (Yates, 1992). Some individuals are unlikely to seek help and claim victim status due to embarrassment associated with the traumatizing event itself (Crocker & Major; 1989; Wells, Robins, Bushnell, Jarosz, & Oakley-Brown, 1994). This phenomenon is likely with rape victims.

Another factor that has been found to significantly contribute to the unwillingness of rape victims to characterize as "victims" and feel justified in help-seeking is self-blame. The role of self-blame in help-seeking after trauma has been debated in the literature. Among rape victims, the development of self-blame has been linked to enhanced feelings of control among some victims (Janoff-Bulman, 1979). According to this hypothesis, victims who blame themselves may cope more successfully as long as the blame is directed at specific, controllable behaviors. This behavioral self-blame is believed to be related to better adjustment because victims feel they can avoid being raped in the future by changing those behaviors (Frazier, 1990). Characterological self-blame, involving attributions to stable and uncontrollable aspects of the self, is seen as maladaptive because it does not provide a heightened sense of control (Frazier, 1990).

However, several studies have shown that the long-range consequences of self-esteem problems offset any immediate gains in sense of control (Koss & Burkhart, 1989). Frazier (1990)

found that both behavioral and characterological self-blame were significantly associated with post-rape depression. She suggests that victims may not make the distinction between blaming their behavior and blaming their character that Janoff-Bullman's theory implies. She also found that perceptions of future control are associated with better adjustment (Anderson & Arnoult, 1985). Control over the future rather than the past appeared to be associated with decreased depression. Meyer and Taylor (1986) found that coping strategies for rape based on self-blaming attributions were linked to negative adjustment. The more a woman attributed blame to her own modifiable behaviors, the more likely she was to experience sexual dissatisfaction and depressive symptoms. The more she felt her attack was part of a pattern of victimization and bad luck, the more likely she was to experience fear and symptoms of depression. Meyer and Taylor found that societal blame (external) appeared preferable to self-blame for individuals in search of a cause for their trauma. Katz and Burt (1988) also found that self-blame was associated with worse functioning in a rape victim sample.

Victims of rape also have to contend with the possibility that those to whom they disclose will view the experience as somehow deserved or justified by the victim's behavior. In the worst case scenario, secondary victimization results (Ryan, 1971). Victims are blamed for their situation by non-victims, who attribute the misfortune to internal qualities of the victims. Victims are unlikely to seek help if secondary victimization occurs.

Several studies suggest that the opinions of others affect willingness to acknowledge that one was raped. Pitts and Schwartz (1997) found that blame by others contributed to victims not viewing their experiences as rape. However, each victim in their sample who was told by others that she was not responsible for the rape defined the experience as rape. With the exception of one study (Layman et al., 1996), researchers have found that unacknowledged rape victims are more likely than acknowledged victims to blame themselves for their rape experiences (Botta & Pingree, 1997; Frazier & Seales, 1997). Overall, the primary course of action for victims is to separate from responsibility for their trauma. Koss and Burkhart (1989) suggest that until victims can accept their victimization by denying self-blame for their rape, they will be unable to progress toward trauma resolution.

Several other factors contribute to support-seeking by victims, one of these being self-efficacy, the perception that one will be able to initiate and carry out a coping strategy (Bandura, 1997). The belief that one has control over reducing distress will increase the likelihood that available coping options will be used after trauma (Ross & Mirwosky, 1989). Help-seeking behaviors have been found to increase under conditions of high perceived control (Norris, Kaniasty, & Scheer, 1990). The potential benefits of help-seeking behaviors have to be evaluated as worth the threat to self-esteem engendered by their use (Fisher, Nadler, & Whitcher-Alagna, 1982).

Alternatively, Thoits (1985) states that emotional support from significant others may buffer or reduce distress by bolstering aspects of the self that have been threatened by trauma. If past coping attempts have proven fruitful, they are likely to be repeated (Yates, Axsom, & Tiedeman, 1999). However, when victims feel that help is not readily available from either formal sources (due to inconvenience, cost, or lack of insurance; McKinlay, 1975; Mechanic, 1982) or from informal sources, they may turn to self-reliant coping options (Yates et al., 1999). These options often include avoidance as a means of coping, and thus prove problematic in the long-term.

Consensus, the degree to which a person's experience is considered similar or dissimilar to others' experiences (Kelley, 1973), influences victim characterization and help-seeking. Botta and Pingree (1997) found that having a friend who was sexually assaulted by an acquaintance predicted women acknowledging their own rape experiences. They conclude that knowing someone who characterizes as a victim seems to help other victims self-characterize.

Consensus also influences victims' choice of coping strategies. Outreach efforts aimed at educating others about available support can be helpful in demonstrating that seeking help is a viable coping mechanism (Freedy & Kilpatrick, 1994), particularly if community members are willing to provide testimonials about their use of these services (Gist & Stolz, 1982). These efforts provide comparison others while reducing stigma about seeking treatment. They also influence attributions for problem-solving by legitimizing the use of outside aid when needed (Yates et al., 1999). Knowing others who have sought help strongly influences both formal and

informal help-seeking (Rickwood & Braithwaite, 1994).

Recruitment Issues

Given the importance of seeking help after rape and the knowledge that many victims do not choose to seek help, the question remains of how to narrow this gap. More specifically, the issue of how rape victims get recruited into counseling, or into seeking any type of support, bears examination. The research addressing this question is sparse at best, and focuses on issues of victim comfort with disclosing assault histories. Koss (1993) suggests that interviewer effects and the chance of others overhearing answers to questions, as with phone interviews, decreases the willingness of victims to report rape. Gosling, Vazire, Srivastava, and John (2004) go one step further and suggest the format of web-based questionnaires to increase participant comfort with disclosing personal information, and note that this format could increase reporting of issues such as sexual behavior. The issue of online surveying will be revisited later.

As research does not sufficiently address the recruitment of rape victims into counseling, recruitment of other groups of people into interventions was examined. The field of motivational interviewing offers some useful recommendations on strategies counselors can use to motivate people to change (i.e., seek help). Miller and Rollnick (1991) suggest that identifying and removing barriers to treatment increases motivation to change. Such barriers might include cost, transportation, and location of treatment. Barriers can also be attitudinal, such as fearing that change will result in negative consequences. Providing choices is also recommended, as this decreases resistance and dropout. Examining the perceived desirability of present behavior can also lead to change if the potential benefits of changing are greater than those of maintaining the status quo. Providing feedback helps with this process, as people often fail to view their present situations objectively. Miller and Rollnick propose that these motivational strategies for change are particularly useful in providing brief interventions. The parallels between these recommendations and the present study will be elucidated below.

The Proposed Model

The proposed model suggested a mediational process between the effects of the intervention message and help-seeking, as depicted in Figure 1. It was proposed that the

intervention would affect perceived need for help, which would affect intent to seek help, which would affect seeking counseling. Each of these components will be examined individually.

First of all, the intervention message was designed to increase perceived need for help, as it was hypothesized that perceiving a need for help is the first step in the process of seeking help. The intervention provided feedback (as recommended in motivational interviewing) to victims that, according to their survey responses, they had experienced unwanted sexual activity and could benefit from counseling. This feedback alerted victims that they had an issue to address. The intervention message listed potential problems that could occur as a result of this victimization, such as emotional problems, sexual dysfunction, and self-esteem problems, again affecting victims' need for help. It mentioned these problems being prevalent within victims from the Virginia Tech student population (based on pilot data) in an effort to personalize the risks. In an attempt to reach victims who were not currently having problems or who were denying problems, the intervention suggested that problems could appear even after time had passed, thereby addressing the potential complications of not seeking help and the benefits of seeking help. Tapping into the same issue, in an effort to increase perceived need, the intervention message pointed out the increased risk of revictimization if these experiences were not addressed.

The model suggests that perceived need for counseling leads to intent to seek counseling. Alerting participants to the issue of their victimization and informing them of reasons to seek counseling were hypothesized to lead them to plan to seek counseling to address the issue. The intervention message incorporated several recommendations from motivational interviewing regarding intent to seek treatment. It provided choices for treatment that attempted to decrease barriers to treatment seeking. Free services were listed, with two of the three located directly on the Virginia Tech campus, and the third having a 24 hour hotline. The message also addressed attitudinal barriers by targeting the efficacy of counseling provided by experienced counselors in helping many others with similar problems. Attempts were made to decrease the stigma victims might feel about having experienced a rape or attempted rape by providing normative statistics for victimization. The stigma of seeking counseling was also addressed by stressing the confidential, nonjudgmental nature of the treatment victims could receive. Attempts were made to decrease

self-blame by mentioning the prevalence of feeling partially responsible for the assault even when that was not the case. Targeting the efficacy of treatment and attempting to lower stigma and self-blame were efforts to increase intent to seek counseling among victims.

A web-based format for this study was chosen partially due to its fit with the proposed model. Due to the nature of the questions being asked, assuring participant comfort and confidentiality was key. Participants could take part in the study in the privacy of their own homes, without invoking the potential stigma of reporting in person for a study on sexual assault. And they could disclose their histories to a computer without having to consider the immediate social reaction they might receive from an unknown experimenter. Therefore, experimenter effects and stigma were greatly reduced due to the study design.

The last step in the proposed model is intent to seek counseling leading to actually seeking counseling. It was hypothesized that some planning and forethought (intent) occurs before making a change such as seeking counseling. To help increase the power of this final step in the model, victims were encouraged to print a copy of the intervention message to keep. They were also sent more detailed information about counseling options two days after completing the first phase of the study. These reminders about the intervention message were planned to increase the chance that intent to seek counseling would lead to actual follow through by increasing the power of the message.

The Present Study

This study attempted to address the dilemma of rape victims not initiating counseling by constructing a theory-based intervention designed to encourage them to seek treatment. The study itself manipulated factors involved in characterizing as a rape victim and in seeking help for problems resulting from the rape, as delineated above, with an emphasis on stigma and self-blame. The efficacy of treatment and consensus were addressed in the intervention in efforts to customize the intervention for this population. .

Hypotheses

The working model suggests a series of relationships that are articulated in the following hypotheses (see Figure 2):

Hypothesis 1:

Victims of rape and attempted rape who receive the intervention will seek counseling more than victims in the wait-list control group.

Hypothesis 2:

Victims of rape and attempted rape who receive the intervention will report more perceived need for counseling than victims in the wait-list control group.

Hypothesis 3:

Victims of rape and attempted rape who receive the intervention will report more intent to seek counseling than victims in the wait-list control group.

Hypothesis 4:

The relationship between the intervention and seeking counseling will be mediated by perceived need for counseling.

Hypothesis 5:

The relationship between the intervention and seeking counseling will be mediated by intent to seek counseling.

Hypothesis 6:

The relationship between the intervention and intent to seek counseling will be mediated by perceived need for counseling.

Hypothesis 7:

The relationship between perceived need for counseling and seeking counseling will be mediated by intent to seek counseling.

Experimental Design and Methods

Design

A web-based format was chosen for this study to increase participants' comfort with the task and to obtain the necessary number of participants to make meaningful comparisons. The psychology participant pool at a large, southeastern university was used to recruit female undergraduate participants for the study through the use of fliers that advertised the study as an

opportunity for extra credit by completing measures related to experiences, beliefs, and psychological state (Appendix A) and the psychology department web page that offered extra credit opportunities. Interested students were directed to a website to complete the study. The website was designed so that women who endorsed having an experience that met a legal definition of rape or attempted rape (victims) would be randomly assigned to an intervention or wait-list control group. They would complete several measures about their victimization experience that those who did not endorse such an experience would not complete. Some measures were completed by all participants in the study. Victims viewed either an intervention or matched wait-list control message that encouraged them to seek counseling. They were invited to complete a second web-based phase of the study a month later for purposes of assessing whether they sought counseling or other forms of help.

Participants

A total of 1322 women from the psychology participant pool at Virginia Tech participated in Time 1 for one hour of extra course credit, with 127 of these women participating in Time 2 for one additional hour of additional credit. Data were collected during the Fall 2002, Spring 2003, and Fall 2003 semesters. A university undergraduate population fit well with the goals of the study as college students are in the high-risk age and occupation group for reported rapes (Koss & Gidycz, 1985).

Procedures

The study was conducted in two phases. At Time 1, participants viewed a screen describing the study as an effort to understand the relationships between individuals' sexual experiences, attitudes, help-seeking, and psychological state. This screen also served as informed consent (Appendix B). Participants then completed a few demographic questions (Appendix C). Next they completed the Sexual Experiences Survey to assess their experiences with coercive sexual activity (SES; Koss & Gidycz, 1985; Appendix D). Participants who answered affirmatively to one or more rape or attempted rape items (hereafter referred to as victims) on the SES were asked several questions, based on those used by Layman et al. (1996), about their most serious experience in order to gain information about their acknowledgment status, the

circumstances of the assault, and any revictimization the women had experienced (Appendix E).

Participants who were victims were then asked if they had disclosed the assault. If they had, any negative stigmatizing reactions they received were assessed using the Social Reactions Questionnaire (SRQ; Ullman, 2000; Appendix F). Next the degree of stigma victims felt as a result of the assault was assessed with Gibson and Leitenberg's Stigma Scale (SS; 2001; Appendix G). To assess victims' internal attributions for the assault, they completed a self-blame scale developed by Meyer and Taylor (SBS; 1986; Appendix H). Victims then completed a questionnaire assessing their experiences with help-seeking (Appendix I). This questionnaire was partially based on questions used by Botta and Pingree (1997).

The next set of measures was completed by all participants rather than by victims only. Participants completed the Veronen-Kilpatrick Modified Fear Survey (MFS; Veronen & Kilpatrick, 1980; Appendix J) to assess their fears in a variety of situations. Participants then completed the Personal Disturbance Scale (PDS; Bedford & Deary, 1997; Bedford et al., 1999; Appendix K), a measure of state anxiety and depression, and the Posttraumatic Stress Diagnostic Scale (PSS; Foa, Riggs, Dancu, & Rothbaum, 1993; Ullman, 2000; Appendix L) a measure of PTSD symptomatology.

Based on their responses to the SES, victims who were neither presently in counseling nor had satisfactorily completed counseling that addressed their assault history since the rape or attempted rape (as assessed by a series of computer programmed skip-out questions) were randomly assigned by computer to one of two groups: intervention or wait-list control group. A screen provided an intervention or a matched message depending on a participant's group assignment.

The intervention (Appendix M) suggested to victims that their survey responses indicated they had experienced unwanted sexual activity. The wording "unwanted sexual activity" was chosen to reach both acknowledged and unacknowledged victims as the words "rape" or "assault" could turn unacknowledged victims away. The intervention de-emphasized stigma and self-blame for the rape or attempted rape by providing normative data and suggesting that victims were not to blame even though they may feel partially responsible for the unwanted sexual activity. It listed

potential problems victims might face, such as emotional problems, sexual dysfunction, and self-esteem problems. The message mentioned that these problems may not present immediately and the risk of revictimization was greater for those who did not seek treatment. The message suggested that participants would likely benefit from counseling and attempted to reduce the stigma of seeking counseling with a focus on consensus and confidentiality. It addressed the efficacy of treatment with mention of experienced counselors. Three local treatment options were given.

The wait-list control group was given a matched message (Appendix N) with information about online surveying. The message was matched as closely as possible to the intervention message in presentation format and length. It presented the study as a comparison of online responses to traditional pencil and paper measures and stressed the importance of confidential, convenient methods of survey administration. It stated that some people may find taking online measures unpleasant, and mentioned the availability of experienced counselors for helping with distress that might arise from taking surveys online. It provided the same local treatment options as the intervention message.

Both messages stayed on the screen for a minimum of two minutes before victims were allowed to continue. A print option was given for both screens as well. In addition, an option was given to e-mail the experimenter if a printed copy was desired but could not be printed at the time of survey completion. Victims then completed questions about how much they felt they needed counseling and their likelihood of seeking services (Appendix O).

At the end of the survey, all victims who met a legal definition of rape or attempted rape were notified that they were eligible to complete Time 2 of the study, which would occur a month after Time 1. They were asked to provide their e-mail addresses so they could be sent further directions in one month. The intervention group was notified that they would be receiving more information by e-mail within the next few days about the specific counseling options that had been listed. Two days after completing Time 1, they received an e-mail attachment with this information (Appendix P).

One month after completing Time 1, victims were contacted by e-mail notifying them that

they could now complete Time 2 of the study for an additional point of extra credit, again online. If they did not complete Time 2 measures within one week, they were sent another e-mail telling them that they had one week to complete Time 2 if they desired, otherwise they would not have the opportunity again. The computer system did not allow victims to complete Time 2 measures after this second week had passed in order to retain the integrity of the design.

At Time 2, victims completed a questionnaire about their experiences with help-seeking since Time 1 to assess whether the intervention had worked (Appendix Q). This questionnaire included items examining reasons victims did or did not seek help, depending on their help-seeking status. It also assessed the future plans to seek help and counseling of victims who had not sought any type of help.

The following Time 1 measures were readministered at Time 2: Social Reactions Questionnaire, Stigma Scale, Self-Blame Scale, Modified Fear Survey, Personal Disturbance Scale, and Posttraumatic Stress Diagnostic Scale. In a final questionnaire (Appendix R), victims were asked to characterize the unwanted sexual experience they reported at Time 1 as "rape, attempted rape, some other type of crime, miscommunication, seduction, or not sure" to see if their characterization had changed since Time 1. They then answered brief questions about any life experiences they had encountered since Time 1 in order to see if any other experiences may have affected their functioning at Time 2. Finally, victims answered questions assessing how well they remembered the message they were given at the end of Time 1. Wait-list control subjects were given the intervention at this time, encouraging them to seek treatment as well. All subjects saw a final screen reminding them of local counseling options (Appendix S).

Victims who affirmed that they sought help from one of the recommended counseling locations received a release of information form online for the center where they claimed they sought counseling. If victims were willing, they were encouraged to print the form, sign it, and return it to the experimenter by mail or by leaving it in a secure drop box in the psychology department (Appendix T). If victims did not respond to the first request for a release of information within one week, they were sent a second request. After receiving releases of information, the experimenter planned to verify that victims who claimed they sought counseling

services actually sought those services.

Measures

Sexual Experiences Survey (SES; Koss & Gidycz, 1985; Appendix D).

The SES has been used to assess sexual victimization in several thousand women since its development (many being college students) with no ill effects reported (Botta & Pingree, 1997; Kahn et al., 1994; Koss, 1985; Koss & Gidycz, 1985; Koss & Oros, 1982; Layman et al., 1996; Merrill et. al., 1998). For the present study, 6 items were selected from the original 10-item yes/no SES, a self-report measure. The 6 items chosen reflect behavioral descriptions of experiences that meet a legal definition of rape or attempted rape in Virginia. Internal consistency of the original scale using Cronbach's alpha was .74 (Koss & Gidycz). Test-retest reliability was .93 (Koss & Gidycz). The correlation between a woman's level of victimization based on self-report and responses relayed to an interviewer was .73, $p < .001$ (Koss & Gidycz). In the present study, the alpha of the six SES items was .63.

Social Reactions Questionnaire (SRQ; Ullman, 2000; Appendix F).

The SRQ is a self-report measure designed to assess common reactions rape victims receive from others (Ullman, 2000). The present study used the five scales measuring negative social reactions as victims' reports of negative reactions received from others were key to the study. These five scales are as follows: taking control of the victim's decisions, victim blame, treating the victim differently, distraction, and egocentric behavior. The 26 items are ranked on a 5-point Likert scale ranging from 0 (never) to 4 (always) to describe how often the victim received each reaction from others. Good reliability and validity have been demonstrated on the SRQ for several samples of sexual assault victims, including community volunteers, college students, and victims who contacted mental health agencies (Ullman, 2000). Internal consistency reliability using Cronbach's alpha of the negative social reactions subscales was .83 for taking control, .80 for victim blame, .86 for treating differently, .80 for distraction, and .77 for egocentric behavior (Ullman). Test-retest reliability using Pearson's correlation was .78 for taking control, .64 for victim blame, .81 for treating differently, .74 for distraction, and .80 for egocentric behavior (Ullman). Concurrent validity between the SRQ and open-ended questions on

responses from others told about the assault averaged across all negative reactions was found to be r (257) = .21, p = .006 (Ullman, 2000). The alphas of the negative social reactions subscales for the present study were .81 for taking control, .83 for victim blame, .86 for treating differently, .79 for distraction, and .72 for egocentric behavior.

Stigma Scale (SS; Gibson & Leitenberg, 2001; Appendix G).

The SS is a self-report measure that assesses degree of stigma victims feel as a result of sexual assault. It is an expanded version of the stigma scale developed by Coffey, Leitenberg, Henning, Turner, and Bennett (1996) to examine stigma in adult victims of child sexual abuse. For each of nine items, victims are to rank their degree of stigma on a 5-point Likert scale ranging from 1 (not at all) to 5 (very much). The SS had an internal consistency alpha of .93 in Gibson and Leitenberg's sample of young adult sexual assault victims. In the present study, the alpha level was .92.

Self-Blame Scale (SBS; Meyer & Taylor, 1986; Appendix H).

The SBS is a self-report measure that assesses victims' attributions for their assault (Meyer & Taylor, 1986). The original scale has three factors assessing behavioral self-blame, characterological self-blame, and societal blame. This study addresses only the first two factors as it focused on victims' internal attributions for the assault. For each item listed, victims indicated how much they felt it was responsible for the assault on a 5-point Likert-type scale ranging from 1 (not at all) to 5 (completely). Meyer and Taylor found the scale measuring behavioral self-blame to have a reliability coefficient as analyzed with Cronbach's alpha of .79. The characterological self-blame scale had a reliability coefficient of .64 (Meyer & Taylor). Alphas in the present study were .81 for behavioral self-blame and .69 for characterological self-blame.

Veronen-Kilpatrick Modified Fear Survey (MFS; Veronen & Kilpatrick, 1980; Appendix J).

The MFS is a self-report measure of fear responses in sexual assault victims. It was developed by expanding the Fear Survey Schedule III (Wolpe & Lange, 1964) to include fears generated by rape victims. Six of the 8 factors of the MFS were found to differentiate victims from non-victims (Resick, Veronen, Kilpatrick, Calhoun, & Atkeson, 1986), and these factors are

included in the present study. For each of 41 items, victims are to rank their degree of disturbance on a 5-point Likert scale ranging from 1 (not at all) to 5 (very much). Alpha coefficients for subscales as found by Resick et al. were .93 for vulnerability, .85 for sexual fears, .92 for social evaluation, .87 for agoraphobia, .65 for loud noises, and .90 for weapons. In the present study, alphas were .89 for vulnerability, .81 for sexual fears, .89 for social evaluation, .71 for agoraphobia, .34 for loud noises, and .90 for weapons. The loud noises subscale was not used for analyses due to its low alpha coefficient.

Personal Disturbance Scale (PDS; Bedford & Deary, 1997; Bedford et al., 1999; Appendix K).

The PDS is a self-report scale consisting of seven state of anxiety items and seven state of depression items; it assesses for the presence of symptoms within the past month (Bedford & Deary, 1997; Bedford et al., 1999). It is empirically derived from the Delusions-Symptoms-States Inventory (DSSI, Bedford & Foulds, 1977) and has been widely used with various psychiatric populations and in general medicine (Bedford & Deary). Positively endorsed items on the PDS are ranked on a 4-point Likert-type scale ranking degree of distress from 0 (not at all) to 3 (unbearably). The PDS has high internal consistency with a total Cronbach's alpha of .88, an alpha for depression of .86, and an alpha for anxiety of .73 (Bedford et al.). The present study had a total alpha of .90, a depression alpha of .87, and an anxiety alpha of .83.

Posttraumatic Stress Diagnostic Scale (PSS; Foa, 1995; Foa et al., 1993; Ullman, 2000; Appendix L).

The PSS is a self-report scale comprised of Part 3 of the Posttraumatic Stress Diagnostic Scale (Foa, 1995; Ullman, 2000). It consists of 17 items corresponding to one of the 17 DSM-IV diagnostic criteria for PTSD and is used to assess PTSD symptom severity. Participants rate how often they have experienced each symptom during the past week using a 4-point Likert-type scale ranging from 0 (not at all or only one time) to 3 (5 or more times per week/almost always). The PSS was chosen for this study as it has been validated with sexual assault victims (Ullman). Test-retest reliability is good (r = .74) with an 87.3% agreement between diagnoses over a two-week period, and a Pearson correlation of .83 for symptom severity scores (Foa; Ullman). The PSS has good internal consistency (alpha = .92) and validity when compared with the SCID-PTSD module

($\kappa = .59$) with 79.4% agreement between the measures (Foa; Ullman). Foa et al. found a total Cronbach's alpha of .91, a reexperiencing alpha of .78, an avoidance alpha of .80, and an arousal alpha of .82. In the present study, total alpha was .92, reexperiencing alpha was .80, avoidance alpha was .83, and arousal alpha was .83.

Intent Questionnaire (Appendix O)

The Intent Questionnaire is a self-report questionnaire developed by the author to assess the perceived need and intent of victims of rape or attempted rape to seek formal counseling or help as a result of the victimization. It also includes items assessing the degree of risk victims perceive for revictimization and the degree victims feel they have been affected by emotional problems or problems in functioning as a result of the victimization. For each of 6 items, victims rate their degree of endorsement on a 7-point Likert scale ranging from 1 (not at all) to 7 (a lot). Items load on two factors: perceived need for help and intent to seek help. The perceived need for help factor had a Cronbach alpha of .88, and the intent to seek help factor had an alpha of .91. The scale had a total internal consistency alpha of .86.

Help-Seeking Questionnaire (Appendix Q)

The Help-Seeking Questionnaire is a self-report questionnaire developed by the author to assess help-seeking experiences endorsed by victims after having participated in Time 1 of the present study. Victims are presented with dichotomous "yes/no" items to answer regarding whether they sought formal counseling or information about formal counseling at one of the three recommended treatment locations or at another location. Victims are also asked to check each source of informal help they used since Time 1 of the study out of a list of options. In another set of questions, items are included listing potential theory-based reasons victims either sought help or did not seek help, depending on their status. For each of 15 items, victims rate their degree of endorsement on a 7-point Likert scale ranging from 1 (not at all) to 7 (a lot). The Cronbach alpha of items assessing reasons for seeking help was .89, and the alpha for reasons for not seeking help was .95. The last two items assess plans to seek help or counseling in the future, using the same Likert scale. These items had an alpha level of .87.

Pilot Testing

Many of the online measures and topics of this survey were initially piloted by Littleton (2003) with a sample of 14 Abnormal Psychology and 4 Introductory Psychology undergraduate women who took the survey for extra course credit. Participants reported feeling comfortable with the online nature of the study, and preferred completing the measures online to a traditional paper and pencil format. In addition, they reported feeling the measures were clear and easy to complete. In the present study, pilot information was collected from 7 participants, 4 receiving the intervention message and 3 receiving the wait-list control message. Pilot subjects were sent an e-mail message by the experimenter requesting that they send a response e-mail with their phone number and the best time to reach them if they were willing to answer a few brief questions by phone about their experience completing the survey. These 7 women were not included in either Time 1 or Time 2 data sets. They were assigned an extra credit point for participating in piloting of the study. Participants reported feeling no undue distress as a result of the topic of the study and that measures were clear and easy to complete. One intervention participant told the experimenter that she had known she needed to seek counseling as a result of her victimization for a long time and was now planning to do so. She then thanked the experimenter for helping her address this issue.

Results

Participant Characteristics

A total of 1322 women completed Time 1 of the survey. Table 1 depicts the following demographic information regarding these women. Women ranged in age from 17 to 39 (M = 19.01, SD = 1.35), with no significant differences between women assigned to intervention (M = 19.0, SD = 1.45) and wait-list control groups (M = 19.0, SD = 1.34), t (1142) = -.738, $p > .05$. Regarding ethnicity, 82.9% of women in the sample were Caucasian, 6.3% were African American, 6.4% were Asian, and 4.4% endorsed "other." There were not significant differences in ethnicity between women assigned to intervention and wait-list control groups, χ^2 (3) = 2.67, $p >$ .05. Regarding education level, 47.8% of women were in their first year of college, 30.7% in their second year, 13.2% in their third year, 6.7% in their fourth year, and 1.6% had been in college

more than four years. Again, significant differences did not exist between women assigned to intervention and wait-list control groups, χ^2 (4) = 6.39, $p > .05$.

Victim Characteristics

Of the women completing the survey, 344, or 26% of the sample, reported an experience consistent with a legal definition of rape or attempted rape on the SES (see Table 2). This percentage is similar to 28% of the sample found by Koss (1988) to be victims of rape or attempted rape. Actually, in the present study, 13% of women reported having had more than one experience that met a legal definition of rape or attempted rape. Women who had experienced rape (n = 123) comprised 9.3% of the total sample and 35.8% of victims, women who had experienced attempted rape (n = 99) 7.5% of the total sample and 28.7% of victims, and women who had experienced both rape and attempted rape (n = 122) 9.2% of the total sample and 35.5% of victims, with no significant differences between treatment groups. It is apparent that including victims of attempted rape in this study captured the experience of a clinically significant proportion of the university undergraduate population.

When asked how they characterized their experience or most serious experience at Time 1, only 16% of the victim sample meeting a legal definition of rape acknowledged the rape and 10% of the victim sample meeting a legal definition of attempted rape acknowledged the attempted rape (see Table 3). Therefore, consistent with previous research, 74% of victims in this study were unacknowledged victims. Acknowledgement status did not differ by treatment group.

Comparisons were made between acknowledgement status at Time 1 and Time 2 for victims who participated in Time 2 of the study (see Figure 3). The relationship between acknowledgement status and time was significant, χ^2 (1) = 24.85, $p < .01$. Fifteen percent of unacknowledged victims had changed to acknowledged victims at Time 2. However, 33% of acknowledged victims had changed to *unacknowledged* victims at Time 2, which was not at all expected.

The length of time since the rape or attempted rape varied within the sample of victims. Twenty one percent of victims were victimized less than 6 months ago, and 22% between 6 months to 1 year ago. Forty four percent of victimizations occurred from 1 to 3 years ago, and

12% more than 3 years ago. The percent of victims in each time category did not differ by treatment group.

Examining the acknowledgement status of victims as a function of time since the assault proved informative. Within victims who were assaulted less than 6 months ago, 88.9% were unacknowledged. The percentage of unacknowledged victims dropped to 67.5% for victims assaulted 1 to 2 years ago, and 40% for victims assaulted more than 3 years ago. The percentage of unacknowledged victims decreased dramatically over time.

Time 2 Sample

The attrition rate was higher than anticipated from Time 1 to Time 2, with only 36.9% (n = 127) of eligible victims from Time 1 participating in the Time 2 survey. The number of participants with data available for Time 2 analysis was further reduced by another factor. As a result of programming problems, the treatment group (intervention versus wait-list control) did not record for 14 participants, requiring their data be deleted from any analyses examining treatment group differences. After all problematic data were removed from the data set, data from 106 victim participants was available for most analyses performed. The number of participants assigned to each condition (intervention versus wait-list control) was identical (53 intervention, 53 control) in this group. Also, the demographic characteristics (e.g., age, race, education level) for the 106 victims participating in Time 2 were similar to those of the 217 victims who did not participate. The two groups were compared on a host of other variables central to the proposed model, including rape versus attempted rape, acknowledgement status, recency of victimization, perceived need for help, intent to seek help, distress, social reactions, stigma, and self-blame. There were not significant differences between victims who participated in Time 2 and those who did not on any of these variables.

Intervention Effects

Hypothesis 1 stated that victims of rape and attempted rape who received the intervention message would seek counseling more than victims in the wait-list control group. Unfortunately, very few participants overall sought counseling (7, or 6.5% of the total victim sample), and they were fairly evenly divided across conditions (4 intervention, 3 wait-list control; see Table 4).

Thus, hypothesis 1 was not supported. All of these victims sought help at the Virginia Tech Cook Counseling Center on campus. None of the victims returned release of information forms to the experimenter in order to validate that they sought counseling. It is of note that 5 out of the 7 victims who sought formal counseling had been victimized more than 1 year ago, with 4 out of these 5 having been victimized more than 2 years ago. Of the 7 participants who did seek counseling, 5 were unacknowledged victims and 2 were acknowledged, a breakdown similar to the overall rate of acknowledged and unacknowledged victims in the sample. Two of these women were victims of rape, 3 were victims of attempted rape, and 2 were victims of both rape and attempted rape. Women who did seek counseling had higher scores on measures of distress, social reactions, stigma and self-blame than women who did not seek counseling, although not significantly so (see Table 5).

Although differences did not exist between intervention and control victims in actually seeking counseling, it was possible the intervention had an effect on seeking information about counseling (e.g., calling a center to inquire about counseling, looking at a center's website, picking up a brochure about counseling). To test this, a chi-square was conducted to examine patterns of seeking information about counseling between intervention and control victims. Differences were not significant between groups regarding how much they sought information about formal counseling, $\chi^2(1) = 1.59$, $p > .05$ (intervention: $n = 25$; control: $n = 19$; see Table 4). However, 41.1% of victims across groups reported at least one instance of seeking information about counseling since completing Time 1 of the survey, a notable increase over the 6.5% of victims who actually sought counseling. In other words, far more victims sought information about counseling than actually sought counseling. A chi-square analysis was conducted to test if acknowledgement status moderated the effect of the intervention (intervention versus wait-list control group) on seeking information about formal counseling, and results were not significant, $\chi^2(1) = .03$, $p > .05$.

Further exploratory analyses were conducted to test if victims of rape and attempted rape who received the intervention message would seek informal help (talking to someone for the first time about the unwanted sexual experience) more than victims in the wait-list control group.

Although differences were not significant between intervention and control groups, χ^2 (1) = .68, p > .05 (see Table 4), an impressive 73.8% of victims across groups sought informal help after taking part in the study. Of these victims, 48% were in the intervention group and 52% were in the control group. Frequencies were obtained to examine which sources of informal support were preferred, and friends were the preferred support for most victims (40.4%), followed by significant others (11%) and family (6.4%). A chi-square analysis was conducted to test if acknowledgement status moderated the effect of the intervention on informal help-seeking, and results were not significant, χ^2 (1) = 1.85, p > .05.

Hypothesis 2 stated that victims of rape and attempted rape who received the intervention message would report more perceived need for counseling than victims in the wait-list control group. An independent *t*-test found no significant difference between groups, t (342) = .33, p > .05, d = .06 (intervention: M = 1.83, SD = 1.22; control: M = 1.76, SD = 1.30; see Table 6). The Likert scale for perceived need ran from "1 = not at all" to "7 = a lot" regarding perceived need for counseling, so both groups reported low need for counseling. A treatment group x acknowledgement status factorial ANOVA revealed no significant differences on perceived need for counseling.

Slightly modifying hypothesis 2, an exploratory analysis was conducted to examine if victims of rape and attempted rape who received the intervention message would report more perceived need for help (rather than counseling) than victims in the wait-list control group. An independent *t*-test revealed no significant difference between groups, t (342) = .82, p > .05, d = .13 (intervention: M = 1.94, SD = 1.36; control: M = 1.77, SD = 1.31; see Table 6), with both groups reporting low need for help. A treatment group x acknowledgement status factorial ANOVA found acknowledgement status to be a moderator of intervention on perceived need for help, F (1, 340) = 4.11, p < .05, f = .16 (small/medium effect size). Acknowledged victims who received the intervention perceived a greater need for help (M = 2.54, SD = 1.65) than unacknowledged victims who received the intervention (M = 1.68, SD = 1.13). Acknowledged victims who received the control message perceived a lower need for help (M = 1.74, SD = 1.21) than unacknowledged victims who received the control message (M = 1.79, SD = 1.36).

Hypothesis 3 stated that victims of rape and attempted rape who received the intervention message would report more intent to seek counseling than victims in the wait-list control group. An independent *t*-test found no significant differences between groups, t (342) = -.628, $p > .05$, d = .17 (intervention: M = 1.52, SD = .95; control: M = 1.62, SD = 1.06; see Table 6). Using the same Likert scale mentioned above, both groups reported low intent to seek counseling. It was suspected that acknowledgement status might serve as a moderator for the effect of treatment on intent to seek counseling, so a treatment group x acknowledgement status factorial ANOVA was run. This analysis revealed only a main effect of acknowledgement status on intent to seek counseling, F (1, 340) = 5.59, $p < .05$, f = .17, with acknowledged victims planning to seek counseling (M = 1.86, SD = 1.22) significantly more than unacknowledged victims (M = 1.45, SD = .89), again with both groups reporting low intent. The effect size comparing acknowledged to unacknowledged victims was small/medium.

Slightly modifying hypothesis 3, an exploratory analysis was conducted to examine if victims of rape and attempted rape who received the intervention message would report more intent to seek help (rather than counseling) than victims in the wait-list control group. An independent *t*-test found no significant differences between groups, t (342) = -.71, $p > .05$, d = .11 (intervention: M = 1.59, SD = 1.07; control: M = 1.71, SD = 1.16; see Table 6), with both groups reporting low intent with the same Likert scale mentioned above. A treatment group x acknowledgement status factorial ANOVA indicated only a main effect of acknowledgement status on intent to seek help, F (1, 340) = 3.26, p = .07, f = .14, with acknowledged victims planning to seek help (M = 1.90, SD = 1.12) more than unacknowledged victims (M = 1.55, SD = 1.10). Again, there was low intent to seek help with both groups.

Two other items were included in the Time 1 survey to assess the effects of the intervention. The first of these assessed perceived risk to victims of further unwanted sexual experiences. Independent *t*-tests revealed no significant differences between intervention and wait-list control groups, t (342) = .10, $p > .05$, d = .02 (intervention: M = 2.14, SD = 1.23; control: M = 2.12, SD = 1.57; see Table 6). Both groups reported feeling at low risk of further assaults, using the previously mentioned Likert scale. A treatment group x acknowledgement status factorial

ANOVA found only that acknowledgement status was a moderator of treatment on perceived risk of further unwanted sexual experiences, F (1, 340) = 4.78, $p < .05$, $f = .17$ (small/medium effect size). Acknowledged victims who received the intervention perceived a greater risk ($M = 2.54$, $SD = 1.24$) than unacknowledged victims who received the intervention ($M = 1.97$, $SD = 1.19$). Acknowledged victims who received the control message perceived a lower risk for revictimization ($M = 1.78$, $SD = 1.35$) than unacknowledged victims who received the control message ($M = 2.25$, $SD = 1.64$).

The second item assessed the degree to which victims felt they had been affected by emotional problems or problems in functioning as a result of unwanted sexual activity. No significant differences between groups were found via independent t-tests, t (342) = -1.28, $p > .05$, $d = .21$ (intervention: $M = 2.37$, $SD = 1.63$; control: $M = 2.71$, $SD = 1.86$; see Table 6). Both groups reported feeling they had been affected at low levels by the assault, using the same Likert scale previously discussed. Only a main effect of acknowledgement status on feeling affected by problems as a result of victimization was discovered with a treatment group x acknowledgement status factorial ANOVA, F (1, 340) = 14.26, $p < .01$, $f = .29$, with acknowledged victims feeling affected significantly more ($M = 3.31$, $SD = 2.07$) than unacknowledged victims ($M = 2.23$, $SD = 1.50$). The effect size comparing acknowledged to unacknowledged victims was medium/large.

The proposed model suggests a relationship between perceived need for help and intent to seek help. This relationship was tested with Pearson's correlations between individual need and intent items and factor scores. Correlations were significant between all individual need and intent items ($p < .01$), with correlations ranging from .30 to .92. Correlations were also significant between indices of need and intent, $r = .43$, $p < .01$.

People choose to seek help for a variety of reasons. It was desirable to examine if the reasons chosen by victims in this study were related to the proposed model. To assess this, frequencies were obtained for reasons victims endorsed for seeking help, based on key components of the intervention message. The top reasons victims who did seek help endorsed for seeking help based on Likert item means were as follows (in descending order): (a) feeling they were not the only one who had experienced unwanted sexual activity, (b) fearing having unwanted

sexual activity again in the future, (c) feeling they would not be looked down upon because they had unwanted sexual activity, (d) feeling they would not be blamed for having unwanted sexual activity, and (e) feeling a counselor had helped others with similar problems (see Table 7). These items address issues of stigma, fear of revictimization, self-blame, and the efficacy of treatment. There were no significant differences between intervention and control participants in reasons for seeking help on any item.

Frequencies were also obtained for reasons subjects endorsed for not seeking help. This information could be obtained on only a subsample of Time 2 victims (n = 26, or 25%) due to a computer programming error that transformed the Likert scale for reasons endorsed for not seeking help into a dichotomous "yes/no" scale for a portion of the participants. Victims who did have Likert data for these items did not differ on key variables (completed versus attempted rapes, acknowledgement status, recency of victimization, distress, social reactions, stigma, self-blame) from victims who did not have Likert data for these items. The top reasons victims who did not seek help endorsed for not seeking help based on Likert item means were as follows (in descending order): (a) not fearing having emotional problems in the future, (b) not experiencing emotional problems, (c) not having difficulty with sexual dysfunction, (d) not experiencing problems with low self esteem, and (e) not fearing having unwanted sexual activity again in the future (see Table 8). These items address issues of distress, problems in functioning, and fear of revictimization. There were significant differences between intervention and control participants in feeling like they were the only one who had experienced unwanted sexual activity, t (24) = 2.14, p < .05, d = .71. Interestingly, intervention participants reported significantly higher means (M = 2.50, SD = 1.88) than control subjects (M = 1.36, SD = .63) on this item. This result was opposite what would have been predicted, providing further evidence that the intervention message did not have the desired effect.

Independent t-tests were conducted to test the potential effects of the intervention on plans to seek counseling or informal help in the future for subjects who had not sought any form of help at Time 2. There were not significant differences between groups on either plans to seek counseling, t (80) = .159, p > .05, d = .04 (intervention: M = 2.10, SD = 1.53; control: M = 2.05,

SD = 1.22) or plans to seek informal help, t (80) = .165, $p > .05$, d = .04 (intervention: M = 2.20, *SD* = 1.44; control: M = 2.15, *SD* = 1.24), with both groups reporting little plans on a 1 to 7 Likert scale. A treatment group x acknowledgement status factorial ANOVA was conducted to examine if acknowledgement status moderated the effect of the intervention on plans to seek counseling and informal help in the future. Acknowledgement status did not moderate the effect of the intervention on plans to seek counseling, F (1, 77) = 2.20, $p > .05$, f = .17, or informal help, F (1, 77) = .75, $p > .05$, f = .10, in the future.

It was not appropriate to test mediational hypotheses 4 to 7 as significant differences were not found between intervention and wait-list control participants on hypotheses 1 to 3, on which hypotheses 4 to 7 were contingent.

Manipulation Check

A manipulation check item helps provide insight into the overall limited intervention effects. Manipulation check analyses were run on a portion of victims (n = 37, or 35%) rather than on all victims due to a programming error that presented the manipulation check in an improper screen sequence (immediately after a treatment group screen) with some victims, rendering the check invalid. Victims who did have usable manipulation check data did not differ on key variables (completed versus attempted rapes, acknowledgement status, recency of victimization, distress, stigma, self-blame, help-seeking) from victims who did not. For participants with valid data, the manipulation check conducted at Time 2 revealed that both intervention (91%) and control victims (100%) remembered the message they received at the end of Time 1 as focusing on "help for problems resulting from unwanted sexual activity." Another response option (intended for control victims) was "help for problems resulting from completing survey questions online," and 9% of intervention victims chose this option, with none of the control sample choosing it. This suggests that the impact of taking many victimization measures may have been greater than that of the content of the intervention messages victims received.

Distress

Distress can play a role in choosing to seek help, therefore relationships among distress and components of the proposed model were examined in this study. Littleton (2003) found that

victims had significantly higher distress scores than non-victims in a study based on the same sample. It follows that the participants in the present study were more distressed overall than those who had not been victimized. Paired *t*-tests were conducted to compare Time 1 to Time 2 changes on measures of distress, with interesting results (see Table 9). Total scores on the Modified Fear Survey (MFS) lowered significantly from Time 1 to Time 2, t (112) = 3.85, p < .01, d = .30, as did factor scores of vulnerability fears, t (112) = 3.54, p < .01, d = .24, sexual fears, t (112) = 3.12, p < .01, d = .29, social evaluation fears, t (112) = 2.69, p < .01, d = .23, agoraphobia fears, t (112) = 2.93, p < .01, d = .25, and fear of weapons, t (112) = 3.12, p < .01, d = .24. All effect sizes were small comparing Time 1 to Time 2 scores. The Personal Disturbance Scale (PDS) also revealed significantly lowered scores from Time 1 to Time 2 on total scores, t (112) = 2.02, p < .05, d = .15, and the anxiety scale, t (112) = 2.46, p < .05, d = .19, again with small effect sizes. The percent of victims meeting clinical elevation in anxiety was 50.47% (n = 54) at Time 1 and 46.73% (n = 50) at Time 2. Scores on the depression scale lowered from Time 1 to Time 2, but did not reach significance. Clinical elevation on the depression scale was 35.51% (n = 38) for victims at Time 1 and 33.64% (n = 36) for victims at Time 2. Total and factor scores on the PTSD Symptom Scale (PSS) did not change significantly from Time 1 to Time 2 although all lowered.

Given the lowered scores on distress measures from Time 1 to Time 2, a series of time x help-seeking factorial ANOVAs were conducted to assess if differences in distress were moderated by help-seeking. In each case, time is one variable of interest and seeking a particular form of help is another. Regarding MFS scores, a main effect of seeking information about formal counseling was present, F (1, 105) = 5.05, p < .05, f = .22. Victims who sought information about formal counseling had higher levels of fear (M = 101.06, SD = 25.10) than victims who did not seek information about formal counseling (M = 90.44, SD = 26.44), with a medium effect size. Time 1 and Time 2 differences in fears were not moderated by seeking information about formal counseling, however, F (1, 105) = .570, p > .05, f = .07, nor by seeking informal help, F (1, 105) = 1.95, p > .05, f = .14.

A similar pattern was found for PDS, with a main effect of seeking information about

formal counseling, F (1, 105) = 13.69, $p < .01$, $f = .35$. Victims who sought information about formal counseling had higher levels of emotional distress ($M = 11.73$, $SD = 9.08$) than victims who did not seek information about formal counseling ($M = 6.2$, $SD = 7.57$). The effect size comparing victims who sought information about counseling with those who did not was large. A main effect of seeking informal help was also present, F (1, 105) = 4.42, $p < .05$, $f = .20$, with victims who sought informal help exhibiting higher levels of emotional distress ($M = 9.43$, $SD = 9.06$) than victims who did not seek informal help ($M = 5.77$, $SD = 6.92$), with a medium effect size. Again, neither seeking information about formal counseling, F (1, 105) = 2.96, $p > .05$, $f = .17$, nor seeking informal help, F (1, 105) = .268, $p > .05$, $f = .003$, were moderators for differences in emotional distress from Time 1 to Time 2.

Regarding PSS scores, a main effect of seeking information about formal counseling was present, F (1, 105) = 9.05, $p < .01$, $f = 27$. Victims who sought information about formal counseling had higher levels of PTSD symptoms ($M = 13.77$, $SD = 11.07$) than victims who did not seek information about formal counseling ($M = 8.26$, $SD = 9.78$); the effect size was medium. A main effect of seeking informal help was present as well, F (1, 105) = 7.38, $p < .01$, $f = .27$, with victims who sought informal help reporting higher levels of PTSD symptoms ($M = 12.0$, $SD = 10.98$) than victims who did not seek informal help ($M = 6.38$, $SD = 8.47$); the effect size was again medium. Time 1 and Time 2 differences in PTSD symptoms were not moderated by seeking information about formal counseling, F (1, 105) = .047, $p > .05$, $f = .004$, nor by seeking informal help, F (1, 105) = .270, $p > .05$, $f = .05$.

Overall, the pattern for distress was as expected, with participants with higher levels of distress seeking support. These findings provide validity data for the measures developed by the experimenter to assess help seeking.

Additionally, time x acknowledgement status mixed factorial ANOVAs were conducted to assess if differences in distress scores were moderated by acknowledgement status. Differences in fears were not moderated by acknowledgement status, F (1, 104) = 1.52, $p > .05$, $f = .14$. In a separate study based on the same data, acknowledged victims were found to report more emotional distress than unacknowledged victims (Littleton, 2003). In the present study,

acknowledgement status moderated differences in emotional distress from Time 1 to Time 2, F (1, 104) = 11.07, $p < .01$, $f = .45$, with a large effect size. Emotional distress scores lowered more with acknowledged victims (Time 1: $M = 10.55$, $SD = 9.45$; Time 2: $M = 8.39$, $SD = 7.93$), with significant differences between Time 1 and Time 2 in this group, t (30) = 1.96, $p = .05$, $d = .27$, than with unacknowledged victims (Time 1: $M = 8.25$, $SD = 8.52$; Time 2: $M = 7.69$, $SD = 8.57$), with non-significant differences between Time 1 and Time 2 in this group, t (74) = .82, $p > .05$, $d = .07$. In a separate study based on the same data, acknowledged victims reported more PTSD symptoms than unacknowledged victims (Littleton, 2003). In the present study, acknowledgement status moderated differences in level of PTSD symptoms from Time 1 to Time 2, F (1, 104) = 7.69, $p < .01$ $f = .38$, with a large effect size. Level of PTSD symptoms lowered more with acknowledged victims (Time 1: $M = 12.90$, $SD = 11.69$; Time 2: $M = 10.23$, $SD = 10.79$), with significant differences between Time 1 and Time 2 in this group, t (30) = 2.27, $p < .05$, $d = .25$, than with unacknowledged victims (Time 1: $M = 10.25$, $SD = 10.03$; Time 2: $M = 9.73$, $SD = 10.54$), with non-significant differences between Time 1 and Time 2 in this group, t (74) = .51, $p > .05$, $d = .05$.

Modified Mediational Analyses

A portion of the proposed mediational model remained intact upon evaluation, with modifications. It was suspected that perceived need for help would mediate the relationship between distress and intent to seek help. This relationship was examined with MFS, PDS, and PSS scores (see Figure 4).

For step one of a mediational hypothesis, a relationship must exist between the mediator and the predictor variable. A linear regression conducted using MFS to predict perceived need for help was significant, $\beta = .408$, $p < .01$. Step two requires that a significant relationship emerge when the criterion variable is regressed on the predictor variable. To test this, a simple linear regression was conducted using MFS to predict intent to seek help. The result of this regression was significant, $\beta = .242$, $p < .01$. Finally, in step 3 the criterion variable is regressed on both the mediator and the predictor variable. If there is mediation, the mediator should have a significant impact, but the impact of the predictor variable should be significantly decreased. Baron and

Kenny (1986) recommend simultaneous entry of the mediator and the predictor variable as the effect of the mediator on the dependent variable is examined after the predictor variable is controlled, and the effect of the predictor variable on the criterion variable is examined after the mediator is controlled. Therefore, MFS and perceived need for help were entered simultaneously in the prediction of intent to seek help. The results of this multiple linear regression supported the mediational role of perceived need for help. Perceived need for help significantly predicted intent to seek help, $\beta = .381$, $p < .01$, but MFS no longer significantly predicted intent to seek help, $\beta = .087$, $p > .05$.

These procedures were repeated with PDS and PSS scores, supporting the mediational role of perceived need for help in both cases, as seen in Figure 4.

Social Reactions, Stigma, and Self-Blame

Social reactions, stigma, and self-blame were theoretically relevant to the proposed model as it was suspected that these variables would impact perceived need for counseling and intent to seek counseling. Lowering negative social reactions, stigma, and self-blame would likely encourage victims to seek counseling. Paired *t*-tests were conducted to compare Time 1 to Time 2 changes on measures of social reactions, stigma, and self-blame (see Table 10). On the Social Reactions Questionnaire (SRQ), a comparison of Time 1 and Time 2 scores revealed significant lowering on factor scores of taking control of the victim's decisions, $t(79) = 2.09$, $p < .05$, $d = .18$, and egocentric behavior, $t(79) = 2.04$, $p < .05$, $d = .22$. Total scores on the SRQ lowered from Time 1 to Time 2 as well, although not significantly, $t(79) = 1.48$, $p > .05$, $d = .13$. Total scores on the Stigma Scale (SS) lowered significantly from Time 1 to Time 2, $t(105) = 3.09$, $p < .01$, $d = .24$. And scores on both factors of the Self Blame Scale (SBS) lowered significantly from Time 1 to Time 2 (behavioral self-blame, $t(105) = 2.52$, $p < .05$, $d = .21$; characterological self-blame, $t(105) = 2.60$, $p < .05$, $d = .21$). All of the effect sizes comparing Time 1 to Time 2 scores were small.

Given the lowered scores on measures from Time 1 to Time 2, a series of time x help seeking mixed factorial ANOVAs were conducted to assess if differences in negative social reactions, stigma, and self-blame were moderated by various forms of help seeking. In each case,

time is one variable of interest and seeking a particular form of help is another. Regarding SRQ scores, there was a main effect for seeking information about formal counseling, F (1, 78) = 15.85, $p < .01$, $f = .45$, with a large effect size. Victims who sought information about counseling received higher levels of negative social reactions ($M = 25.83$, $SD = 15.7$) than those who did not seek information about counseling ($M = 14.16$, $SD = 12.8$). A main effect also existed for seeking informal help, F (1, 78) = 5.49, $p < .05$, $f = .27$, with a medium effect size. Victims who sought informal help had higher levels of negative social reactions ($M = 21.16$, $SD = 15.96$) than victims who did not seek informal help ($M = 13.38$, $SD = 11.38$). Both of these findings were opposite than expected. Time 1 and Time 2 decreases in negative social reactions were not moderated by seeking information about counseling, F (1, 78) = 1.53, $p > .05$, nor by seeking informal help, F (1, 78) = .24, $p > .05$.

Regarding SS scores, a main effect of seeking information about formal counseling was present, F (1, 104) = 5.10, $p < .05$, $f = .22$, with a medium effect size. Victims who sought information about formal counseling had higher levels of stigma ($M = 27.94$, $SD = 10.27$) than victims who did not seek information about formal counseling ($M = 23.82$, $SD = 9.84$), again opposite than expected. Differences in stigma from Time 1 to Time 2 were not moderated by seeking information about formal counseling, F (1, 104) = .27, $p > .05$. However, these decreases were moderated by seeking informal help, F (1, 104) = 8.30, $p < .01$, $f = .28$, with a medium effect size. Results were consistent with previously mentioned findings, as victims who sought informal help had a moderate decrease in stigma from Time 1 to Time 2 (Time 1: $M = 27.17$, $SD = 10.74$; Time 2: $M = 26.08$, $SD = 10.10$), with non-significant differences between Time 1 and Time 2 in this group, t (77) = 1.37, $p > .05$, $d = .11$, while victims who did not seek informal help had a greater decrease in stigma from Time 1 to Time 2 (Time 1: $M = 25.29$, $SD = 9.66$; Time 2: $M = 19.36$, $SD = 7.43$), with significant differences between Time 1 and Time 2 in this group, t (27) = 3.44, $p < .01$, $d = .80$, with a large effect size.

Lastly, SBS scores approached only a main effect of seeking information about formal counseling, F (1, 104) = 3.53, $p = .06$, $f = .18$. Victims who sought information about counseling had higher levels of self-blame ($M = 23.42$, $SD = 6.93$) than victims who did not seek information

about counseling (M = 21.13, SD = 6.64). Differences in self-blame from Time 1 to Time 2 were not moderated by seeking information about counseling, F (1, 104) = .00, $p > .05$, nor by seeking informal help, F (1, 104) = 3.03, $p > .05$.

Overall, the decrease in scores from Time 1 to Time 2 for negative social reactions, stigma, and self-blame was as expected. However, the finding that victims with higher levels of these variables sought more help was opposite than expected.

In addition, time x acknowledgement status mixed factorial ANOVAs were conducted to assess if decreases from Time 1 to Time 2 in social reactions, stigma, and self-blame were moderated by acknowledgement status. Decreases were not moderated by acknowledgement status for social reactions, F (1, 78) = .046, $p > .05$, f = .03; stigma, F (1, 104) = 2.30, $p > .05$, f = .15; or self-blame, F (1, 104) = .96, $p > .05$, f = .10.

Coinciding Events

The preceding results would be sufficient if circumstances of victims' lives could be controlled from Time 1 to Time 2 of the study. As this obviously was not possible, it was appropriate to examine the effects of life events that would be pertinent to the proposed model. Two such events were experiencing another sexual assault or another significant life event (e.g., death in the family, end of a relationship, new job). Time x revictimization and time x life event mixed factorial ANOVAs were conducted to examine the moderating effects of having another sexual assault (n = 20; 18.69% of the sample), as assessed by the SES, or some other significant life event (n = 25; 23.58% of the sample), as assessed by the follow-up questionnaire, on changes in distress scores between Time 1 and Time 2 of the study. Regarding fears reported on the MFS, Time 1 and Time 2 differences in fears were moderated both by having another SES event since Time 1 of the study, F (1, 105) = 13.02, $p < .01$, f = .35, and by having some other significant life event since Time 1 of the study, F (1, 104) = 4.32, $p < .05$, f = .27. As depicted in Figure 5, victims who experienced another SES event had an increase in fears from Time 1 to Time 2 (Time 1: M = 101.05, SD = 28.77; Time 2: M = 106.85, SD = 28.58), while victims who did not experience another SES event had a decrease in fears from Time 1 to Time 2 (Time 1: M = 98.0, SD = 24.03; Time 2: M = 87.40, SD = 26.42), with a large effect size. Victims who had not

experienced some other significant life event since Time 1 of the study had a greater decrease in fears from Time 1 to Time 2 (Time 1: $M = 99.15$, $SD = 23.88$; Time 2: $M = 88.98$, $SD = 27.17$) than participants who did experience such an event (Time 1: $M = 97.68$, $SD = 28.36$; Time 2: $M = 97.32$, $SD = 29.70$); effect size was medium.

Regarding emotional distress reported on the PDS, PDS scores decreased over time, but that pattern was not moderated by whether victims experienced another SES event since Time 1 of the study, $F(1, 105) = 1.87$, $p > .05$, $f = .13$. In addition, a main effect was revealed for whether victims had experienced another SES event since Time 1 of the study, $F(1, 105) = 6.48$, $p < .05$, $f = .23$. Victims who had experienced another SES event had higher PDS scores ($M = 12.5$, $SD = 11.58$) than those who had not experienced another SES event ($M = 7.55$, $SD = 7.62$), with a medium effect size. Changes in distress scores were moderated by having some other significant life event since Time 1 of the study, $F(1, 104) = 3.25$, $p < .05$, $f = .25$. Victims who had experienced a significant life event had increased PDS scores from Time 1 to Time 2 (Time 1: $M = 11.76$, $SD = 10.76$; Time 2: $M = 12.80$, $SD = 10.16$). Victims who had not experienced a significant life event had decreased PDS scores from Time 1 to Time 2 (Time 1: $M = 8.07$, $SD = 7.98$; Time 2: $M = 6.59$, $SD = 7.51$). The effect size for this comparison was medium.

On the PSS measure of PTSD symptoms, a main effect was revealed for having some other significant life event since Time 1 of the study, $F(1, 104) = 4.76$, $p < .05$, $f = .29$. Victims who had a significant event had higher PSS scores ($M = 15.32$, $SD = 12.69$) than those who did not have a significant life event ($M = 9.18$, $SD = 9.54$), with a medium effect size. Time 1 and Time 2 differences in PSS scores were not moderated by having some other SES event since Time 1 of the study, $F(1, 105) = 2.81$, $p > .05$, $f = .14$, nor by having another significant life event since Time 1 of the study, $F(1, 104) = .703$, $p > .05$, $f = .12$.

Victims who had experienced another sexual assault since Time 1 were of particular interest regarding the potential relationship of this revictimization to other key variables. Change in acknowledgement status over time was one of the variables whose relationship to revictimization was worthy of further examination. This relationship was significant for participants who were not revictimized, $\chi^2(1) = 21.65$, $p < .01$. At Time 2, 16% of these victims

had changed from unacknowledged to acknowledged. Again the problem arises of victims changing from acknowledged to *unacknowledged* at Time 2, with 34% of victims changing status in this manner. These percentages closely match the acknowledgement status changes from Time 1 to Time 2 across all victims in the sample. There were too few data points per cell to test significance for participants who were victimized. Two of 18 victims changed from unacknowledged to acknowledged, and the 1 victim who was acknowledged at Time 1 remained acknowledged at Time 2.

The relationship between revictimization and help seeking was also worth examining, as it was suspected that having another sexual assault from Time 1 to Time 2 would lead to increased help-seeking. This was not the case with seeking information about formal counseling, as the relationship between being revictimized and seeking information about counseling was not significant, χ^2 (1) = .381, $p > .05$. Among participants who were not revictimized, 43% sought information about counseling, and 57% did not. Among participants who were revictimized, 35% sought information about counseling, and 65% did not. However, the relationship between revictimization and seeking informal help was significant, χ^2 (1) = 5.71, $p < .05$. Among participants who were not revictimized, 69% sought informal help and 31% did not. And among participants who were revictimized, an impressive 95% sought informal help.

Discussion

Victim Characteristics

Similar to Koss' 1988 national sample, 26% of the sample studied met a legal definition of rape or attempted rape. Also similar to Koss' sample, 74% of victims in the present study were unacknowledged, denying that they had ever been victimized. These percentages grow even more disconcerting when one considers that 13% of the sample had been revictimized, reporting more than one SES event. Particularly disturbing is the degree to which this happened within the one month between Time 1 and Time 2 of the study, occurring with 18.69% of victims. These women were shown to have significantly more emotional distress and fears than women who had not been victimized during this time period. A large portion of the university female population is attempting to cope with the results of multiple victimizations in addition to the "normal" stressors

of college life. Furthermore, 47.8% of victimized women were in their first year of college, with almost half of the sample having experienced the sexual assault within the past year, making the transition to college even more difficult. Results of this study certainly elucidate the need for further counseling and education about sexual assault within the university population.

Help-Seeking

The present study also offers some insight into the direction help-seeking might take to be most appealing to victims. Very few participants sought formal counseling. It is possible that being asked about personal experience with some of the key variables of the study may have discouraged victims from seeking formal counseling. Specifically, being asked many questions about stigma, self-blame, and distress could have made victims uncomfortable and reluctant to enter into a counseling relationship where they would be exposed even further to these unpleasant topics. The process of counseling often involves an increase in distress before symptoms are alleviated, and victims may have been reluctant to face that process.

It is also possible that the intervention message was not credible, or that victims did not "buy into it." The message itself may not have been strong enough to encourage victims to seek counseling, despite efforts to increase its impact. Additionally, victims may not have believed that the message applied to them personally. Although many victims endorsed distress, self-blame, stigma, and other key variables of the intervention message, they may have ignored the message if perceiving that a portion of the message did not apply to their situation.

It may be worthwhile to reflect on the potential normative qualities of rape in undergraduate women when considering why victims did not seek counseling. Acquaintance rape in particular is a common phenomenon, and may occur to such a degree as to be considered "normal," or at least not worth a big reaction. Consensus may work in a manner opposite from desired if women know many others who were raped and consider this experience a part of college life. In this case consensus may have minimized the seriousness of the assault or led to victims not feeling entitled to treatment.

While not many participants actually sought formal counseling, a strong effect is seen when examining patterns of seeking information about formal counseling, a task likely less

threatening to victims. Forty-one percent of victims sought information about counseling in some manner within the month between Time 1 and Time 2 of the study. Taking part in the study appeared to help victims at least consider the benefits of counseling. However, the potential for social desirability bias must be considered. Participants may have deduced that the purpose of the study was to assess help-seeking, and tried to comply with imagined experimenter desires.

It is possible that more victims would have followed through on seeking information about counseling and actually sought counseling if the Time 2 assessment were conducted greater than one month after Time 1. The perceived constraints of their college schedules may not have allowed time for counseling at the time of assessment. On the other hand, the effects of the intervention could fade over an increased time interval, leading to even fewer victims seeking counseling.

The most dramatic results are seen in the victims who sought informal help by talking to someone for the first time about their victimizing event after Time 1 of the study. Almost three-fourths of victims sought informal help, preferring to talk to friends, significant others, and family, in that order. Among participants who were revictimized during the interval from Time 1 to Time 2, 95% sought informal help, suggesting that this means of help seeking was particularly attractive to them in attempting to alleviate the significant distress they endorsed. The preference for informal help is not surprising, and replicates other research (Wills, 1987). Given that friends were the overwhelming preferred source of support for these undergraduate women, the college environment is an excellent pool of support with its daily contact with peers through living quarters, classes, dining halls, and social outlets.

Based on the large number of participants who sought some form of help, and even more so the finding that many of them were not recent victims, it does appear that taking part in the study itself may have led to these help-seeking patterns. Of course, this conclusion is premature without the addition of a control group who did not take part in the study for comparison. A study that incorporates this suggestion is worthy of consideration for the future.

Lack of Intervention Effects

The overall lack of intervention effects on help-seeking bears further discussion. The

manipulation check helps explain this pattern and revealed that both intervention and control participants remembered the message they received at the end of Time 1 to be help for problems resulting from unwanted sexual activity. In fact, even more control that intervention victims reported that this was the topic of the message they saw. One potential explanation for this finding is participant fatigue by the end of the study. The impact of filling out other measures for an hour before receiving the treatment message may have left participants less receptive to paying attention to and remembering the topic of the message. In other words, the pre-measures may have compromised the effect of the intervention. This possibility becomes even more salient when one considers the degree of exposure to victimization-related measures during the study. Victims filled out measures of stigma, self-blame and negative social reactions regarding sexual assault, in addition to answering direct questions about characteristics of the assault. It is not surprising that the nature of these questionnaires would have an impact on the memory of victimization-related concepts, leading victims to report these concepts as the nature of the treatment message.

Furthermore, exposure to victimization-related questions and the potential problems resulting from victimization were much greater collapsed across intervention and wait-list control groups (over one hour of exposure to these measures for all victims) than exposure to the intervention or wait-list control messages (two minutes). Efforts were made to increase the impact of the treatment message, such as encouraging participants to print the message and sending further information about counseling options to the intervention group two days after Time 1. However, baseline exposure still differs greatly between the victimization measures taken by all victims for at least an hour and the two-minutes spent viewing the treatment group message.

Acknowledgement Status and Help-Seeking

At the end of Time 1, acknowledged victims expressed plans to seek counseling and help more than unacknowledged victims. This trend makes logical sense, as acknowledged victims, having recognized they had experienced sexual assault, were more ready to address these issues than unacknowledged victims who had not conceptualized their experiences as assault. In addition, acknowledged victims who received the intervention message expressed more need for counseling and help than unacknowledged victims who received the intervention. One can

speculate that acknowledged victims were more amenable to hearing the message and believing it as they felt it applied to them as victims. In addition, unacknowledged victims may have had more to lose by seeking help. Some of them were still in relationships with the perpetrator of the assault, and seeking help would threaten that relationship. Also, given that acknowledgement status was related to time since the assault, with more victims endorsing acknowledged status with longer increments since the assault, these unacknowledged victims may have simply not been ready to hear the intervention message and respond to it as many of them were recent victims.

In a similar vein, acknowledged victims perceived a greater risk of further assaults than unacknowledged victims, which seems logical as unacknowledged victims did not believe they were assaulted in the first place. And acknowledged victims felt more affected by emotional problems or problems in functioning as a result of the assault, again making sense as unacknowledged victims may attribute any problems they experienced to factors other than the assault.

Despite these distinctions, acknowledgement status did not prove to be a moderator of seeking information about formal counseling or seeking informal help. This issue will be revisited in the discussion that follows of the role of acknowledgement status in distress.

One further finding regarding acknowledgement status requires discussion. The relationship between acknowledgement status and time was significant, with 15% of unacknowledged victims becoming newly acknowledged at Time 2 of the study, However, 33% of acknowledged victims changed status to *unacknowledged* at Time 2. It is hypothesized that this change in status may be due to discomfort with the topic of measures taken during the study, as discussed earlier, and a desire to disassociate from connection with these issues. If a victim is no longer acknowledged, she is no longer a victim in her mind, and the negative associations with distress, stigma, and self-blame do not apply to her anymore. It is of note that no pilot participants reported discomfort with taking measures in the study, and no participants in the study contacted the examiner with problems. Another possible explanation relates to the high levels of informal support seeking in this study. If supports chosen reacted in a negative manner to the disclosure, this could have contributed to a change in acknowledgement status. However, negative social

reactions among victims were not common.

Distress

Levels of participants' distress decreased overall from Time 1 to Time 2. Specifically, scores lowered significantly for total fears and all fear subscales (vulnerability, sexual fears, social evaluation, agoraphobia, and fear of weapons). There were significant differences from Time 1 to Time 2 on total emotional distress and the anxiety subscale, with the depression subscale decreasing as well. And total scores of PTSD symptoms and all PTSD subscales (reexperiencing, avoidance, and arousal) decreased from Time 1 to Time 2. These findings are more salient given that distress scores for victims in the sample were higher in the first place than scores for non-victims, based on a separate study by Littleton (2003). Lowering of distress scores at Time 2 in the present study could relate to the finding of one-third of victims changing from acknowledged status at Time 1 to unacknowledged at Time 2. Changing acknowledgement status to unacknowledged could have served to alleviate distress, as victims were taking away the distress associated with being an assault victim.

Main effects existed for seeking information about formal counseling on all three distress measures, with victims who sought information about counseling reporting higher levels of fear, emotional distress, and PTSD symptoms than victims who did not seek information about counseling. This trend is logical as victims with higher levels of distress were considering alleviating that distress, although they did not follow through with actually seeking counseling.

Main effects also existed for seeking informal help on emotional distress and PTSD symptoms, with victims who sought informal help reporting more emotional distress and PTSD symptoms than victims who did not seek informal help. This finding is explained with similar reasoning as above; victims with higher levels of distress chose informal support to alleviate that distress. Victims with lower levels of distress may not have felt they needed help from others as they did not feel much distress.

Interestingly, neither seeking information about formal counseling nor seeking informal help moderated changes in distress from Time 1 to Time 2. In other words, neither of these interventions led to the noted distress reduction. As a result, hypotheses will be offered to explain

the resulting changes in distress. It is possible that taking the survey itself contributed to lower scores. Victims may have felt they shared their assault history with an unseen third party, thereby reducing some of their distress. Another option is that distress arose at exposure to victimization questions during Time 1. At exposure to these same questions at Time 2, victims may have habituated to the distress they experienced at Time 1, with the questions being familiar and the thoughts they brought up no longer being new or as alarming. Adding a control group who did not take part in the study would assist in testing these hypotheses.

Lastly, differences in emotional distress and PTSD symptoms from Time 1 to Time 2 were moderated by acknowledgement status. Emotional distress and PTSD symptoms lowered more for acknowledged victims than for unacknowledged victims from Time 1 to Time 2. This finding is particularly interesting given that in a separate study based on the same data, Littleton (2003) found that acknowledged victims reported more emotional distress and PTSD symptoms than unacknowledged victims at Time 1; acknowledged victims had higher scores in the first place. The moderation in the present study could be explained by acknowledged victims being able to conceptualize the distressing symptoms they experienced as being due to the fact they were victimized. The ability to explain their distress in a satisfactory manner could have led to alleviated concern over symptoms, and reduced symptoms in turn. On the other hand, unacknowledged victims had no schema for why they were experiencing distress. They may have been more concerned about these symptoms as a result, and this uneasy feeling may have continued through to Time 2, particularly with taking multiple measures again.

The lowering of distress scores at Time 2 for acknowledged victims could also explain the previously discussed finding that acknowledgement status did not moderate seeking information about formal counseling or informal help seeking, even though at the end of Time 1 acknowledged victims had plans to do so more than unacknowledged victims. Despite having plans to seek counseling and help, acknowledged victims may not have found following through with these plans necessary as their distress lowered over the month interval between Time 1 and Time 2.

Modified Mediational Model

Although the initially proposed mediational model could not be fully examined, a portion of the model remained intact with modifications. The originally hypothesized relationship between perceived need for help and intent to seek help did exist. However, distress fit into the model in lieu of the intervention as significant differences were not found between intervention and wait-list control participants. Perceived need for help was found to mediate the relationship between distress, as measured by fears, emotional distress, and PTSD symptoms, and intent to seek help.

Social Reactions, Stigma, and Self-Blame

Participants' overall negative social reactions, stigma, and self-blame decreased from Time 1 to Time 2. Specifically, there were significant decreases in total stigma and in both behavioral and characterological self-blame. Total negative social reactions also decreased from Time 1 to Time 2.

Findings were unexpected regarding scores in negative social reactions, stigma, and self-blame revealing main effects for seeking information about formal counseling. For negative social reactions, a main effect also existed for seeking informal help. The unexpected twist was that victims who sought help had higher scores on these variables than those who did not seek help. This finding could be explained by these victims feeling uncomfortable with the degree of negative social reactions, stigma, and self-blame they were experiencing, and therefore seeking help to alleviate that discomfort. Another possibility is that informal supports were affiliated with the perpetrator of the assault, and suggested that the victim not characterize as having been raped to prevent social rifts. Thereby, seeking informal help could lead to an increase in negative social reactions, stigma, and self-blame.

Decreases in stigma scores were moderated by seeking informal help, with victims who did not seek informal help having a greater decrease from Time 1 to Time 2 than victims who did seek informal help. This finding could be consistent with the hypotheses offered if the informal help sought was not efficient at helping to reduce stigma, as mentioned above. Victims who did not seek help may have felt more stigma at exposure to the concept of stigma at Time 1, and this level may have dissipated by Time 2 of the study, explaining the greater decrease in scores with

this group. This issue warrants further study.

Surprisingly, decreases in negative social reactions, stigma, and self-blame were not moderated by acknowledgement status. This finding could be construed as an encouraging sign due to the high number of victims overall who sought informal help and the positive reactions of supports. Seeking this support could help move unacknowledged victims toward being able to acknowledge the victimization and decrease their level of distress over time as well.

Reasons for Seeking Help and Not Seeking Help

Response sets for seeking help and not seeking help varied between help-seekers and non-help-seekers. Lack of distress, not having problems in functioning, and not having a fear of revictimization were key in non-help-seeking victims' decisions not to seek help. It is possible that victims who did not seek help avoided thinking too deeply about their victimization. It would be easy to conclude, "I'm doing fine, it won't happen again," and to avoid thinking about the issue further. However, there were many repeat assaults in this sample, and the risk of being revictimized has been well documented in the literature (Kilpatrick & People Against Rape, 1983; Koss & Burkhart, 1989; Layman et al., 1996). Furthermore, repeat assaults are associated with increased problems with distress and functioning (Ellis et al., 1982). Victims who did not seek help are not necessarily as secure as they might like to think.

Feeling like they would not be stigmatized or blamed and fear of revictimization were the key factors reported in help-seeking victims' decisions to seek help. Interestingly, fear of revictimization showed up among the top reasons chosen in both lists, with very different results. Based on responses chosen, victims who sought help processed factors key to their recovery in considering stigma (Koss, 1992, 1993) and self-blame (Frazier, 1990; Katz & Burt, 1988; Meyer & Taylor, 1986). It is unclear whether this processing was done before or after taking part in the present study, but the end result will be a chance for resolution of assault issues in these victims.

Web-Based Survey Administration

Participants seemed to appreciate the relative anonymity of the web-based study. Pilot participants verbalized this to the experimenter, and the amount of disclosure in text-box responses suggests that participants felt comfortable confiding intimate details of their lives and

sexual histories to an unseen experimenter. Indeed, results from several studies have suggested that web-based surveys are the preferred method of dispersion for topics such as sexual assault (Koss, 1993; Turner et al., 1998). It is of note that no victims who sought formal counseling submitted a release of information form to the experimenter in order for this self-report to be checked. This may be a result of victims wanting to keep their anonymity rather than revealing their identities at the end of the study. A more likely explanation is that participants did not need to complete this task to receive extra credit for the study, so they chose not to do it.

Gosling, Vazire, Srivastava, and John (2004) address the concern that anonymity provided by web-based questionnaires compromises data integrity. They conclude that the anonymity afforded by web surveys is beneficial in addressing sensitive issues, and suggest measures to reduce repeat responding. Repeat responding was not an issue in the present study due to the need for participants to provide student identification numbers to receive extra credit. The study was programmed to block any repeat student identification numbers from being allowed to complete the study a second time.

Limitations

While the web-based format of the present study provided many benefits (subject anonymity, ease of data collection) conducting data online also imposed some limitations. The lack of human contact in presenting issues of sexual assault to participants could have decreased the persuasiveness of the intervention message. The presence of an empathic experimenter, while taking away anonymity, could have increased the impact of the intervention message. Steps such as encouraging participants to print the message and sending them a follow-up e-mail message with further information about counseling options were put in place to counterbalance this potential limitation.

In a similar vein, the web-based data collection and its reliance on self-report measures eliminated the potential for an experimenter trained in clinical interviewing to interpret the subtleties in participants' behavior. This ability could help in cases of underreporting when nonverbal behaviors indicate discomfort while verbalizations deny any problems. Also lost in online data collection is the potential to question ambiguous responses and ensure that

participants understand directions and interpret key concepts of the study correctly.

Gosling et al. (2004) cite the benefits of automatic data entry in web-based surveys. However, this was a problem on several measures in the present study. Due to the encrypting of data by the computer programmer to retain subjects' confidentiality, the experimenter could not view data until it was sent at the end of each semester in a viewable format. So data points that were lost during a semester of data collection due to programming errors were not retrievable or available for analysis.

Attrition from Time 1 to Time 2 was another potential limitation of the present study. Based on other online studies addressing victimized samples (Layman et al., 1996), it was estimated that at least 74% of participants in the Time 1 sample would take Time 2 of the study as well. However, this did not occur, and only 36.9% of eligible victims from Time 1 participated in Time 2 of the study. The attrition was not systematic, so results were not affected in this sample.

Future Directions

The present study led to several suggestions for future research encouraging victims of rape and attempted rape to seek treatment. First of all, a comparison between the effects of an in-person delivery of the intervention message and an online delivery appears appropriate. Examining the impact on help seeking of empathic responding and the ability to tailor the intervention message to individual circumstances would be informative. An in-person delivery of the intervention message also provides an opportunity for an experimenter to ensure that participants understand key concepts correctly. It is suggested that participants be given materials to take with them to read later even if met by an experimenter in person. Equally important would be an assessment of victims' comfort with the trade off of anonymity for human contact, as pilot victims in the present study reported feeling comfortable with the web-based nature of the study.

One potential barrier to treatment seeking in the present study could be the quality of the treatment options provided to participants. Some of the treatment options provided have a negative reputation among the student population, and this could have decreased the desire to seek formal counseling. The benefits of proximity and free treatment kept these options in consideration for this study, but other factors equally deserving of consideration may outweigh

the importance of addressing these particular barriers to treatment. For example, a future study could examine the effects of providing known quality treatment options, such as popular private practice psychologists, on seeking counseling

Another worthwhile direction for future study is the further examination of negative social reactions, stigma, and self-blame, and their relationship to help seeking. An exploration of reasons why higher levels of these variables relate to help seeking would be particularly interesting, as the answer to that question is unclear at the present time. These factors are usually perceived as barriers to help-seeking, and they had the opposite effect in the present study.

Increasing the amount of time between Time 1 and Time 2 assessments would also provide further information. The one-month interval used in the present study may not have allowed sufficient time for victims to seek formal counseling, particularly if they took Time 1 during a particularly hectic time such as midterms. Increasing the one-month interval would be particularly helpful in assessing whether or not victims who sought information about formal counseling had sought counseling. However, an increased time interval could reduce intervention effects. It would also create the potential for even more attrition, and in cases where extra credit points for research participation are used, participants may drop out of the study if they earn their maximum level of points before Time 2. An extra incentive for taking Time 2, such as being given more money for taking Time 2 than Time 1, could help with the issue of attrition.

Several sets of results suggested the need to add a control group of victims who did not take the study. This would allow more valid conclusions regarding the apparent effects of taking the study on seeking informal support and on seeking information about formal counseling, given that the intervention message did not lead to those effects. A control group would also satisfy questions regarding the impact of taking the study on lowered distress levels from Time 1 to Time 2. A present competing hypothesis includes habituation to initial distress that arose at exposure to victimization questions.

Lastly, further study of factors leading to a change in acknowledgement status is warranted. It is of concern that one-third of victims in the present study had a change in acknowledgement status from acknowledged to unacknowledged. Over a period of years, a trend

existed as measured in this study for acknowledgement status to shift from unacknowledged to acknowledged. It is unlikely that time alone accounts for this change. One possible explanation for a change in status from unacknowledged to acknowledged is that persisting psychological distress or problems in functioning contribute to a change in acknowledgement status. As victims notice that they continue to have problems, they may look for explanations and fall upon the victimizing event as a solution, thereafter acknowledging they were raped. In addition, the reactions of those to whom they disclose the assault may lead to a change in acknowledgement status. If support people chosen display strong reactions at the disclosure, it may lead victims to believe they were assaulted.

Conclusion

It was not possible to fully examine the proposed model in this study as hypothesized differences between intervention and control subjects did not exist. However, interesting trends developed across groups, including seeking informal help by almost three-fourths of victims in the sample and seeking information about formal counseling by almost half of the sample. These findings are made even more salient by the large number of non-recent victims who sought help. Taking part in the study itself appeared to encourage victims who had chosen to go without help for some time to seek help across groups. Distress reported by victims decreased significantly from Time 1 to Time 2, although not as a result of seeking help. Whether this decrease is because of exposure to that help is unclear because a no-contact control group was not included in the study design. This suggests avenues for further research. Significant decreases in negative social reactions, stigma, and self-blame were noted from Time 1 to Time 2, although high levels of these variables were associated with help-seeking. This issue also provides suggestions for further study.

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Table 1

Demographics

	Intervention	Control	Total
Age			
18	21.2%	17.4%	38.6%
19	17.7%	15.5%	33.2%
20	7.9%	7.2%	15.1%
21	4.3%	2.8%	7.1%
Other	3.2%	2.8%	6%
Ethnicity			
Caucasian	44.5%	38.4%	82.9%
African American	3.9%	2.4%	6.3%
Asian	3.4%	3%	6.4%
Other	2.3%	2.1%	4.4%
Year in College			
First	26.4%	21.4%	47.8%
Second	15.9%	14.8%	30.7%
Third	6.7%	6.5%	13.2%
Fourth	4.3%	2.4%	6.7%
More than Four	.91%	.69%	1.6%

Table 2

Responses to Sexual Experiences Survey items

	Intervention	Control	Total
Attempted intercourse by threat or force	4.7%	4.9%	9.6%
Attempted intercourse due to intoxication	4.8%	5.6%	10.4%
Intercourse due to intoxication	5.6%	5.6%	11.2%
Intercourse by threat or force	2%	1.9%	3.9%
Sexual acts by threat or force	2%	1.5%	3.5%
Sexual acts due to intoxication	3.2%	3.4%	6.6%

Percent given is percent of total sample of victims and nonvictims.

Table 3

Characterization of SES experience

	Intervention	Control	Total
Rape	8.2%	7.6%	15.8%
Attempted rape	5.7%	4.7%	10.4%
Some other type of crime	3.1%	3.4%	6.5%
Miscommunication	15.9%	18.6%	34.5%
Seduction	5.1%	4.4%	9.5%
Not sure	12.2%	11.1%	23.3%

Table 4

Forms of help-seeking chosen by victims

	Intervention	Control	Total
Formal counseling	3.7%	2.8%	6.5%
Information about counseling	23.4%	17.7%	41.1%
Informal support	38.3%	35.5%	73.8%

Table 5

Distress, SRQ, SS, and SBS scores for women who sought counseling

Measure Total Score	Sought Counseling Mean (*SD)*	Didn't Seek Counseling Mean (*SD*)
MFS	104.14 (32.60)	98.18 (24.40)
PDS	12.28 (8.67)	8.62 (8.80)
PSS	15.42 (7.91)	10.64 (10.65)
SRQ	31.80 (5.93)	20.35 (15.66)
SS	28.66 (15.81)	26.55 (10.14)
SBS	23.83 (10.98)	22.77 (6.34)

MFS = Modified Fear Survey, PDS = Personal Disturbance Scale, PSS = PTSD Symptom Scale

SRQ = Social Reactions Questionnaire, SS = Stigma Scale, SBS = Self Blame Scale

Table 6

Means for perceived need for help and intent to seek help

Item	Intervention Mean (*SD)*	Control Mean (*SD*)
Feel need help as result of unwanted sexual activity	1.94 (1.36)	1.77 (1.31)
Feel need counseling as result of unwanted sexual activity	1.83 (1.22)	1.76 (1.30)
Feel at risk revictimization as result of unwanted sexual activity	2.14 (1.23)	2.12 (1.57)
Feel affected by problems as result of unwanted sexual activity	2.37 (1.63)	2.71 (1.86)
Total for Need factor	8.27 (4.63)	8.36 (5.28)
Likely to seek help as result of unwanted sexual activity	1.59 (1.07)	1.71 (1.16)
Likely to seek counseling as result of unwanted sexual activity	1.52 (.95)	1.62 (1.06)
Total for Intent factor	3.11 (1.94)	3.33 (2.11)
Scale Total	11.39 (5.97)	11.70 (6.27)

Table 7
Reasons victims did seek help

Item	Intervention Mean (*SD*)	Control Mean (*SD*)	Total Mean (*SD*)
I had experienced unwanted sexual activity.	2.92 (1.88)	3.69 (2.49)	3.30 (2.19)
I felt I would not be blamed for having experienced unwanted sexual activity	3.75 (1.60)	3.15 (1.77)	3.45 (1.69)
I felt I would not be looked down upon because I had experienced unwanted sexual activity.	3.58 (1.97)	3.38 (1.80)	3.48 (1.85)
I felt that I was not the only one who had experienced unwanted sexual activity.	3.83 (1.99)	3.62 (2.02)	3.72 (1.97)
I was experiencing emotional problems.	2.83 (1.85)	3.23 (2.55)	3.07 (2.20)
I was experiencing problems with low self-esteem.	2.75 (1.81)	3.46 (2.43)	3.10 (2.12)
I was having difficulty with sexual dysfunction.	2.50 (1.73)	2.00 (1.52)	2.25 (1.62)
I feared having emotional problems in the future.	3.42 (2.19)	3.23 (2.08)	3.32 (2.10)
I feared having unwanted sexual activity again in the future.	3.67 (2.06)	3.38 (1.89)	3.52 (1.94)
I felt what I discussed with a counselor would be kept confidential.	3.08 (2.19)	3.08 (2.66)	3.08 (2.42)
I felt a counselor would not judge me.	3.08 (2.02)	3.15 (2.64)	3.11 (2.33)
I felt a counselor would have enough experience to help me with this problem.	3.08 (2.02)	3.31 (2.68)	3.20 (2.35)
I felt a counselor had helped others with similar problems.	3.33 (2.27)	3.38 (2.75)	3.36 (2.48)
Other	1.50 (1.16)	2.15 (2.30)	1.82 (1.73)

Likert scale 1 (not at all) to 7 (a lot)

Table 8
Reasons victims did not seek help

Item	Intervention Mean (*SD*)	Control Mean (*SD*)	Total Mean (*SD*)
I had not experienced unwanted sexual activity.	2.11 (1.67)	3.12 (2.16)	2.62 (1.92)
I felt I would be blamed for having experienced unwanted sexual activity	2.17 (1.40)	1.92 (1.14)	2.04 (1.27)
I felt I would be looked down upon because I had experienced unwanted sexual activity.	2.75 (1.42)	2.42 (1.82)	2.58 (1.62)
I felt that I was the only one who had experienced unwanted sexual activity.	2.44 (1.88)	1.33 (.63)	1.88 (1.25)
I was not experiencing emotional problems.	5.06 (2.27)	4.19 (2.63)	4.62 (2.45)
I was not experiencing problems with low self-esteem.	4.48 (2.54)	3.91 (2.61)	4.19 (2.57)
I was not having difficulty with sexual dysfunction.	4.90 (2.31)	4.19 (2.22)	4.54 (2.26)
I did not fear having emotional problems in the future.	4.67 (2.10)	4.71 (2.36)	4.69 (2.23)
I did not fear having unwanted sexual activity again in the future.	3.69 (2.06)	4.31 (2.23)	4.00 (2.14)
I felt what I discussed with a counselor would not be kept confidential.	2.07 (1.37)	1.78 (1.71)	1.92 (1.54)
I felt a counselor would judge me.	2.57 (1.88)	2.36 (2.13)	2.46 (2.00)
I felt a counselor would not have enough experience to help me with this problem.	2.49 (2.06)	2.14 (1.83)	2.31 (1.94)
I felt a counselor had not helped others with similar problems.	1.75 (.96)	1.71 (1.26)	1.73 (1.11)
Other	1.71 (1.36)	1.53 (1.52)	1.62 (1.44)

Table 9

Changes in distress scores from Time 1 to Time 2

Measure	Time 1 M (*SD*)	Time 2 M (*SD*)
MFS vulnerability	33.46 (10.47)	30.95 (10.99)**
MFS sexual fears	13.92 (5.09)	12.58 (4.59)**
MFS social evaluation	27.52 (8.10)	25.62 (9.09)**
MFS agoraphobia	9.98 (3.64)	9.08 (3.42)**
MFS weapons	10.26 (3.87)	9.35 (3.72)**
MFS total	99.08 (25.54)	91.43 (27.87)**
PDS anxiety	5.32 (4.64)	4.51 (4.35)*
PDS depression	3.94 (4.61)	3.47 (4.48)
PDS total	9.27 (8.76)	7.99 (8.37)*
PSS reexperiencing	2.64 (2.62)	2.37 (2.70)
PSS avoidance	4.44 (4.59)	4.05 (4.61)
PSS arousal	4.06 (4.20)	3.56 (4.23)
PSS total	11.15 (10.37)	9.99 (10.63)

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

MFS = Modified Fear Survey, PDS = Personal Disturbance Scale, PSS = PTSD Symptom Scale

Table 10

Changes in SRQ, SS, and SBS scores from Time 1 to Time 2

Measure	Time 1 M (*SD*)	Time 2 M (*SD*)
SRQ taking control	4.98 (4.81)	4.11 (4.94)*
SRQ victim blame	2.28 (2.54)	2.48 (2.98)
SRQ treating differently	2.25 (3.52)	2.27 (3.16)
SRQ distraction	5.67 (4.47)	5.20 (4.79)
SRQ egocentric	4.56 (3.41)	3.8 (3.45)*
SRQ total	19.76 (14.75)	17.88 (15.43)
SBS behavioral	15.08 (4.32)	14.18 (4.42)*
SBS characterological	7.74 (3.15)	7.09 (3.39)*
SBS total	22.83 (6.61)	21.28 (7.02)*
SS total	26.66 (10.45)	24.30 (9.89)**

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

SRQ = Social Reactions Questionnaire, SS = Stigma Scale, SBS = Self Blame Scale

Figure 1. Model depicting the proposed interrelationships of the constructs in this study.

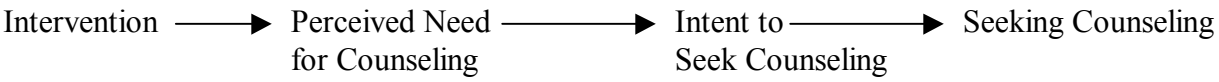


Figure 2. Hypotheses and components of the model.

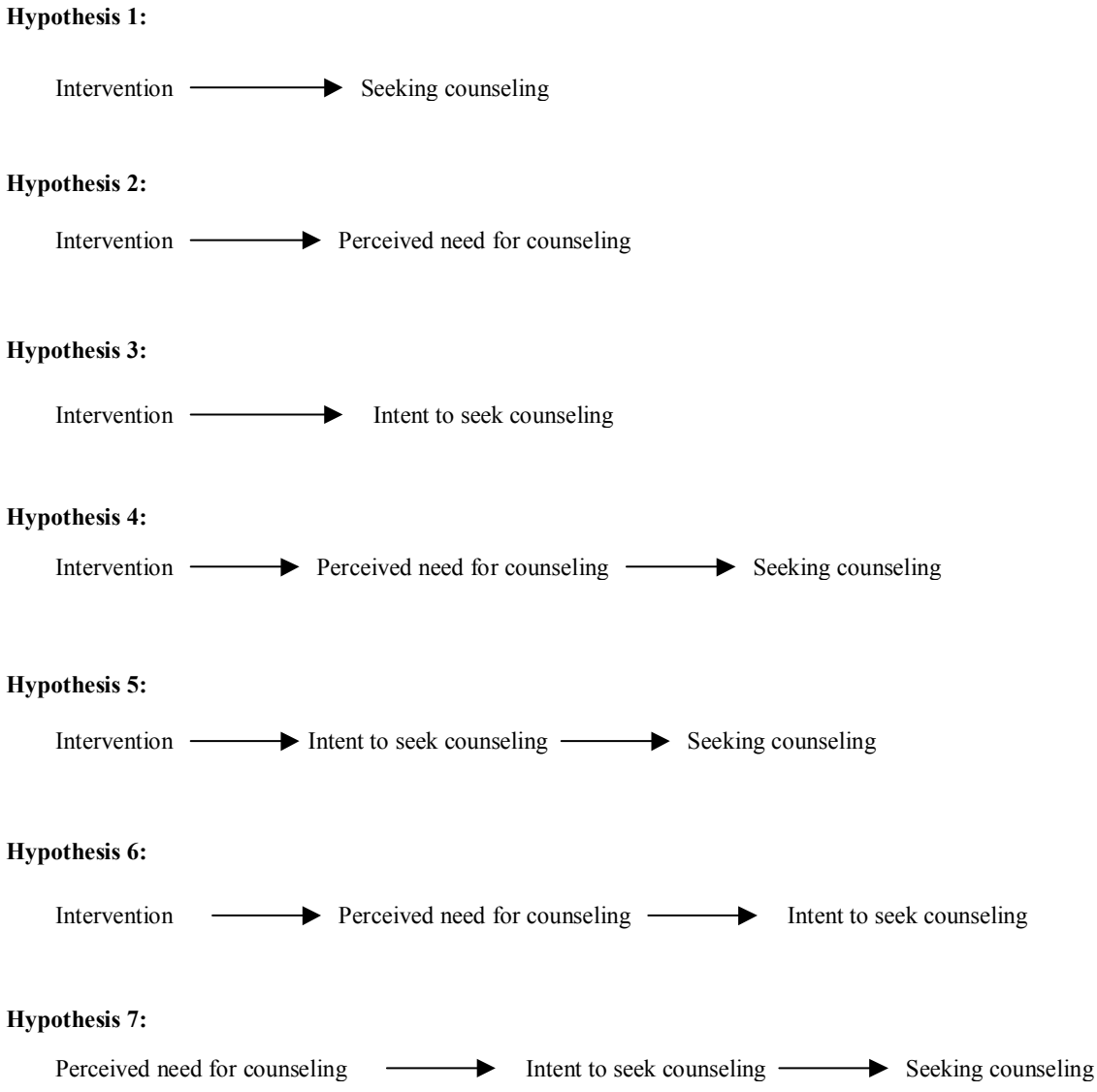


Figure 3. Acknowledgement status comparisons between Time 1 and Time 2.

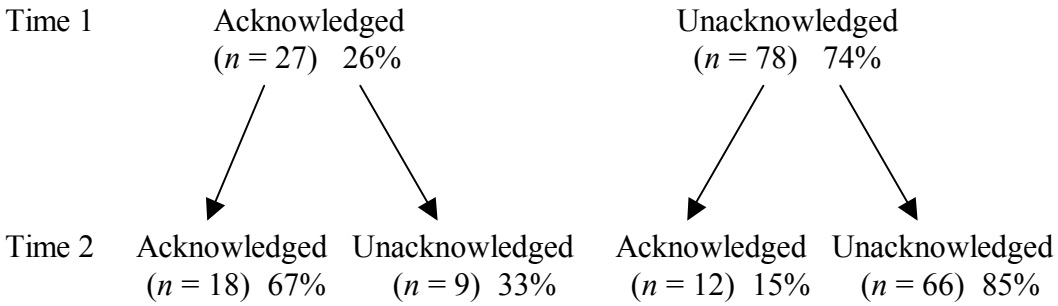
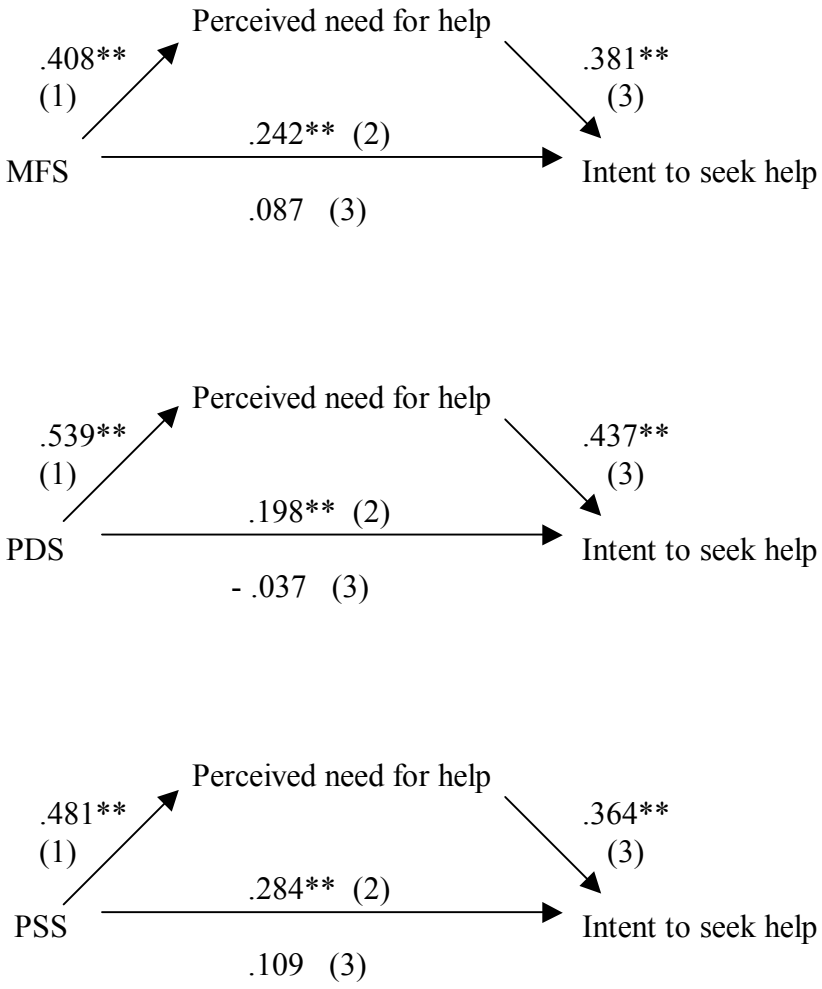
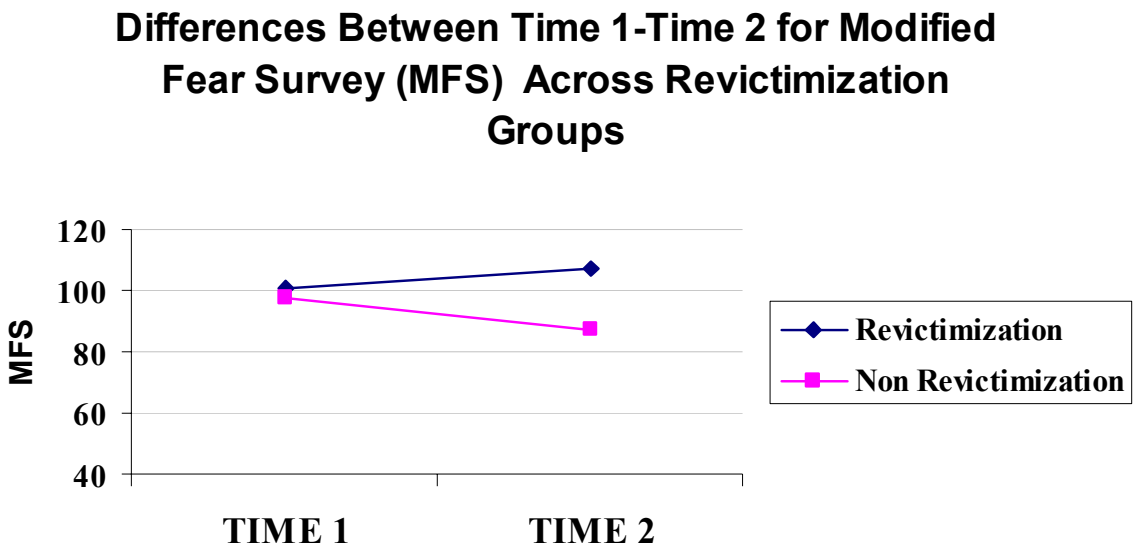


Figure 4. Modified mediational model.



** $p < .01$

Figure 5.


Differences Between Time 1-Time 2 for Modified Fear Survey (MFS) Across Revictimization Groups
120
100
80
60
40
MFS
TIME 1
TIME 2
Revictimization
Non Revictimization

Appendix A

Study 9

Open to all females
Complete several measures online related to your experiences, beliefs, and psychological state

1 point Extra Credit!
Plus you can qualify to earn one more
Completely confidential

Appendix B

SEXUAL EXPERIENCES, ATTITUDES, AND HELP-SEEKING

Principal Investigator: Melisa Chelf, M.A.
Faculty Sponsor: Danny Axsom, Associate Professor of Psychology, Virginia Polytechnic Institute and State University, 231-6495, or e-mail at axsom@vt.edu

INFORMATION

Purpose: You are invited to participate in a research study. The purpose of this study is to understand the relationships between individuals' sexual experiences, attitudes, and help-seeking.

Procedure and Duration of Participation: You will be asked to complete several self-report questionnaires online. You will be answering questions about your sexual experiences, including negative sexual experiences, attitudes about yourself and others, your current psychological state, and your history of seeking help from others. Filling out these questionnaires should take no more than 30 minutes.

Risks and Safeguards: Due to the nature of the questionnaires used in this research study, there is a chance of some emotional upset. This includes questions about negative sexual experiences, things that make you upset or fearful, and feelings of sadness and anxiety. Should this occur, please let the experimenter know immediately or contact Dr. Danny Axsom at 231-6495. If you would like to get more information about the issues covered in the questionnaires you can contact the Women's Resource Center hotline at 639-1123. If you would like to speak to a counselor or would like to speak to someone about any concerns you may have regarding your responses, you can contact Cook Counseling Center at 231-6557.

Benefits: While you will accrue no personal benefits from your participation, the information gathered in this study will aid in understanding the relationships between sexual experiences, attitudes, psychological functioning, and help-seeking.

Confidentiality: All the information that you provide will be kept confidential and access to your data will be restricted to the primary investigator. You may be asked to provide your email address to allow us to contact you about the study and about participating in a follow-up session. You will also be asked to provide some basic demographic information. This is the only identifying information that will be collected. Information about your email address will be destroyed after all the data have been collected. Your data will be kept in a secure location. Your student ID number will be collected to assign your extra credit. This information will be encrypted and will not be part of your data file.

Compensation: For your participation in this study, you will receive the equivalent of one hour of extra credit in any one course which offers extra credit for participation in psychological experiments. Contact your course instructor regarding alternative means of obtaining extra credit. You may also qualify to participate in a follow-up session for an additional one point of

extra credit.

Freedom to Withdraw: You are free to withdraw from the study any time you choose by closing the web window. If you choose to withdraw you will not be penalized by losing extra credit hours. Contact Melisa Chelf at 961-2290 should this occur.

Approval of Research: This research project has been approved, as required, by the Institutional Review Board for Research Involving Human Subjects at Virginia Polytechnic Institute and State University as well as the Human Subjects Committee of the Department of Psychology.

Participant's Responsibilities: I voluntarily agree to participate in this study. I have the following responsibility: To fill out all questionnaires honestly and to the best of my ability.

Participant's Permission:
By participating in the following study, I acknowledge that I understand the information provided about this project and the conditions of this project. I understand that if I participate, I may withdraw at any time without penalty. I agree to abide by the rules of this project.

Should I have any questions abut this research or its conduct, I may contact:

Melisa Chelf	231-9627
Danny Axsom	231-6495
David Harrison Chair, Human Subjects Committee	231-4422
David Moore Chair, IRB Research Division	231-4991

Appendix C

Age _____

Year in School
____ First
____ Second
____ Third
____ Fourth
____ Fifth
____ Sixth
____ Other (Please specify) _____

Ethnicity
____ Caucasian
____ African-American
____ Asian
____ Other (Please specify) _____

Appendix D

For each of the following questions, answer whether you have had this experience since age 14.

Have you had a man attempt sexual intercourse (get on top, attempt to insert his penis) when you didn't want to by threatening or using some degree of force (twisting your arm, holding you down, etc.) but intercourse did not occur? ___ Yes ___ No

Have you had a man attempt sexual intercourse (get on top, attempt to insert his penis) when you didn't want to when you were incapacitated or unconscious (for example, due to alcohol or drugs), but intercourse did not occur? ___ Yes ___ No

Have you had sexual intercourse when you didn't want to because you were incapacitated or unconscious (for example, due to alcohol or drugs)? ___ Yes ___ No

Have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down etc.) to make you?
___ Yes ___ No

Have you had sexual acts (anal or oral intercourse or penetration by objects other than the penis) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you? ___ Yes ___ No

Have you had sexual acts (anal or oral intercourse or penetration by objects other than the penis) when you didn't want to because you were incapacitated or unconscious (for example, due to alcohol or drugs)? ___ Yes ___ No

Appendix E

Please take a few minutes to think about your experience with unwanted sexual contact. If you have had more than one experience, think about the most serious experience and please answer the following questions about your experience to the best of your ability.

What term do you think best describes your experience?
___ Rape
___ Attempted rape
___ Some other type of crime
___ Miscommunication
___ Seduction
___ Not sure

What was your relationship with the man at the time of this experience?
____ Stranger
____ Just met
____ Acquaintance (classmate, member of brother fraternity, etc.)
____ Friend
____ Dating casually
____ Steady date
____ Romantic partner
____ Relative

What consensual physical activities had you engaged in with this man before this experience?
____ None
____ Kissing only
____ Petting above the waist
____ Petting below the waist
____ Sexual intercourse

How much alcohol had you consumed at the time of the experience (1 drink = 1 pint of beer, 1 shot or 1 small mixed drink)?
____ None
____ 1-3 alcoholic drinks
____ 4-6 alcoholic drinks
____ >6 alcoholic drinks

Were you using illegal substances at the time of the experience?
___ None
___ Marijuana only

___ Other illegal drugs

How much alcohol do you think the man had consumed at the time of the experience (1 drink = 1 pint of beer, 1 shot or 1 small mixed drink)?
____ None or don't know
____ 1-3 alcoholic drinks
____ 4-6 alcoholic drinks
____ >6 alcoholic drinks

What illegal substances do you think he was using at the time of the experience?
___ None or don't know
___ Marijuana only
___ Other illegal drugs

What methods of force did he use during the incident (mark all that apply)?
___ Verbal threats to harm you or others
___ Using his superior body weight
___ Twisting your arm or holding you down
___ Hitting or slapping you
___ Choking or beating you
___ Showing or using a weapon

What did you do during the incident to show that you did not want to engage in that activity (mark all that apply)?
___ Turned cold
___ Reasoned with him or pleaded with him
___ Cried
___ Screamed for help
___ Ran away
___ Physically struggled

How many times did you have this type of experience with this man?
___ 1 time
___ 2 times
___ 3 times
___ more (please write how many times)

After this incident, did you continue to have a relationship with the man? Yes No

How many times have you had this type of experience with other men?
___ none

___ 1 time
___ 2 times
___ 3 times
___ more (please write how many times)

How long ago did this incident occur?
___ less than 6 months ago
___ 6 months to 1 year ago
___ 1 to 2 years ago
___ 2 to 3 years ago
___ more (please type how many years)

Appendix F

Have you disclosed the event you described to anyone else? Yes No
Approximately how many people have you told about this event? _____

Please indicate how often you have received the following reactions from others regarding this event.

0 = never 1 = rarely 2 = sometimes 3 = frequently 4 = always

___ 1. Acted as if you were damaged goods or somehow different now.

___ 2. Told you to stop talking about it.

___ 3. Made decisions or did things for you.

___ 4. Told you that you could have done more to prevent this experience from occurring.

___ 5. Expressed so much anger at the other person involved that you had to calm him/her down.

___ 6. Pulled away from you.

___ 7.Tried to take control of what you did/ decisions you made.

___ 8.Told you that you were irresponsible or not cautious enough.

___ 9. Said he/she feels personally wronged by your experience.

___ 10.Treated you differently in some way than before you told him/her that made you feel uncomfortable.

___ 11. Told you to stop thinking about it.

___ 12. Tried to discourage you from talking about the experience.

___ 13. Said he/she knew how you felt when he/she really did not.

___ 14. Told you that you were to blame or shameful because of this experience.

___ 15. Has been so upset that he/she needs reassurance from you.

___ 16. Avoided talking to you or spending time with you.

___ 17. Told you to go on with your life.

___ 18. Told others your experience without your permission.

___ 19. Wanted to seek revenge on the other person involved.

___ 20. Focused on his/her own needs and neglected yours.

___ 21. Encouraged you to keep the experience a secret.

___ 22. Treated you as if you were a child or somehow incompetent.

___ 23. Said he/she feels you're tainted by this experience.

___ 24. Distracted you with other things.

___ 25. Minimized the importance or seriousness of your experience.

___ 26. Made you feel like you didn't know how to take care of yourself.

Appendix G

The questions below refer to your experience with unwanted sexual activity. If you have had more than one experience, think about the most serious experience when answering the following questions.

1 = not at all 2 3 4 5 = very much

____ 1. How ashamed do you feel about this experience?

____ 2. How much do you think others would blame you for what happened?

____ 3. How much do you think you are different from other women because of this experience?

____ 4. How much do you feel tainted ("dirtied") by this experience?

____ 5. How concerned are you that other people will think something negative about your sexuality if they found out?

____ 6. How concerned are you about what other people would think of you if they found out what happened?

____ 7. How embarrassed are you about telling people what happened?

____ 8. How concerned are you about people not respecting you much if they were to find out what happened?

____ 9. How concerned are you about how other people would react if they were to find out what happened?

Appendix H

For each of the factors, please indicate how much you feel it is to blame for the event you have described.

1 = not at all 2 = a little 3 somewhat 4 = a great deal 5 = completely

___ 1. I am too trusting.

___ 2. I got what I deserved.

___ 3. I made a rash decision.

___ 4. I can't take care of myself.

___ 5. I should have been more cautious.

___ 6. I am a poor judge of character.

___ 7. I am a victim type.

___ 8. I am too impulsive.

___ 9. I have bad luck.

Appendix I

If you have told anyone about this unwanted sexual experience, who did you tell? (Check all that apply).

___ I told no one about this experience.
___ Counselor
___ Support Group
___ Rape crisis center
___ Crisis hotline
___ Leader at place of worship
___ Doctor
___ Police
___ Family
___ Friend
___ Significant other
___ Trusted authority figure (i.e., employer)
_____ Other (please list)

Appendix J

Listed below are a number of things that people find fear-provoking or disturbing. For each item, please indicate how disturbing you find it to be.

1 = not at all 2 = a little 3 somewhat 4 = greatly 5 = very much

___ 1. Parking lots
___ 2. Being in a car alone
___ 3. Being on an elevator alone
___ 4. Noise of vacuum cleaners
___ 5. Guns
___ 6. Darkness
___ 7. Closed spaces
___ 8. Being teased
___ 9. Answering phones
___ 10. Being criticized
___ 11. Failure
___ 12. Feeling disapproved of
___ 13. Being in a strange place
___ 14. Weapons
___ 15. Knives
___ 16. Watching sex on TV or movies
___ 17. Walking on a dimly lit street
___ 18. Being alone
___ 19. Not being believed
___ 20. Sudden noises
___ 21. A man's penis
___ 22. Sexual intercourse
___ 23. Dreams
___ 24. Looking foolish
___ 25. Strangers
___ 26. People talking about you
___ 27. People behind you
___ 28. Shadows
___ 29. Sexual fantasies
___ 30. Making mistakes
___ 31. Testifying in court
___ 32. Journeys by train
___ 33. Journeys by car

___ 34. Losing control
___ 35. Medical odors
___ 36. People in authority
___ 37. Dull weather
___ 38. Large open spaces
___ 39. Ugly people
___ 40. One person bullying another
___ 41. Nude men

Appendix K

For each item, please indicate how much you have been bothered by that problem in the past month.

0 = not at all 1 = a little 2 = a lot 3 = unbearably

____ 1. Recently I have been worried about every little thing.

____ 2. Recently I have been so miserable I have had difficulty with my sleep.

____ 3. Recently I have been breathless or had a pounding of my heart.

____ 4. Recently I have been so worked up that I couldn't sit still.

____ 5. Recently I have been depressed without knowing why.

____ 6. Recently I have gone to bed not caring if I never woke up.

____ 7. Recently, for no good reason, I have had feelings of panic.

____ 8. Recently I have been so low in spirits that I have sat for ages doing absolutely nothing.

____ 9. Recently I have had a pain or tense feeling in my neck or head.

____10. Recently the future has seemed hopeless.

____11. Recently worrying has kept me awake at night.

____12. Recently I have lost interest in just about everything.

____13. Recently I have been so anxious that I couldn't make up my mind about the simplest thing.

____14. Recently I have been so depressed that I have thought of doing away with myself.

Appendix L

Below is a list of problems that people sometimes have after experiencing a negative event. Negative events include being in a major accident, having unwanted sexual activity, observing the death or injury of another, or learning that you or a loved one had a serious illness. For each item indicate how often that problem has bothered you in the LAST week (not the week after the event happened). Rate each problem with respect to the most serious negative event you have ever experienced.

0	1	2	3
Not at all or only 1 time	Once a week or less/once in awhile	2-4 times per week/ half the time	5 or more times per week/ almost always

___ 1. Having upsetting thoughts or images about the event that came into your head when you didn't want them to.

___ 2. Having bad dreams or nightmares about the event.

___ 3. Reliving the event, acting or feeling as if it was happening again.

___ 4. Feeling very emotionally upset when you were reminded of the event (for example, feeling scared, angry, sad, guilty, etc.)

___ 5. Experiencing physical reactions when you were reminded of the event (for example, breaking out in a sweat, heart beating fast).

___ 6. Trying not to think about, talk about, or have feelings about the event.

___ 7. Trying to avoid activities, people, or places that remind you of the event.

___ 8. Not being able to remember an important part of the event.

___ 9. Having much less interest or participating much less often in important activities.

___ 10. Feeling distant or cut off from people around you.

___ 11. Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings).

___ 12. Feeling as if future plans or hopes will not come true (for example, will have no career,

marriage, children, or long life).

___ 13. Having trouble falling or staying asleep.

___ 14. Feeling irritable or having fits of anger.

___ 15. Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read).

___ 16. Being overalert (for example, checking to see who is around you, being uncomfortable with your back to a door, etc.).

___ 17. Being jumpy or easily startled (for example, when someone walks up behind you).

What was the negative event you were thinking of when answering the above questions?

_____

Appendix M

Counseling may help you!

- According to your survey responses, you are like **one-third of women on college campuses** who have experienced unwanted sexual activity.

- It is common for women to feel at least somewhat responsible for these experiences, even when they are **not to blame**.

- Surveys at Virginia Tech suggest that students who have experienced unwanted sexual activity have significantly more **emotional problems** like anxiety and depression and fears. Sexual dysfunction and self-esteem problems are also common.

- These problems don't always show up immediately, and can appear after some time has passed. Even if you haven't had emotional problems, the **risk of having unwanted sexual experiences happen again** is greater if these experiences are not addressed.

- Counseling has helped **many** others who have had unwanted sexual activity, and **you** may benefit from **confidential**, **nonjudgmental** help that is available from experienced counselors.

Counseling options in Blacksburg include:

Virginia Tech Cook Counseling Center at 231-6557.
Hours of operation 8 to 5, Monday through Friday.
Free to registered students.

Virginia Tech Women's Center at 231-7806.
Hours of operation 8 to 5, Monday through Friday.
Free services.

Women's Resource Center at 639-1123.
Hotline available 24 hours a day, 7 days a week.
Free services.

You are encouraged to print a copy of this page to keep. Click here for a printer-friendly version of this page. _____

If you aren't able to print a copy at this time, send an e-mail to cchelf@vt.edu and a copy will be sent to you.

Appendix N

Innovative Online Surveying!

- This study compares **online survey responses** to responses given in person with paper and pencil measures, the method used to ask questions in many previous studies.

- Online surveys are preferred by some researchers because **measures can be completed confidentially** without having to share answers with an experimenter.

- With online surveying, people are also free to take the surveys in whichever setting they choose, **whenever it is convenient** for them.

- Most people do not find completing surveys online upsetting, but it is **possible** that some people may find answering online questions unpleasant.

- **Confidential** counseling is available from **experienced** counselors if you feel uncomfortable as a result of completing this survey online.

Counseling options in Blacksburg include:

Cook Counseling Center at 231-6557.
Hours of operation 8 to 5, Monday through Friday.
Free to registered students.

Women's Center at 231-7806.
Hours of operation 8 to 5, Monday through Friday.
Free services.

Women's Resource Center at 639-1123.
Hotline available 24 hours a day, 7 days a week.
Free services.

You are encouraged to print a copy of this page to keep. Click here for a printer-friendly version of this page. _____

If you aren't able to print a copy at this time, send an e-mail to cchelf@vt.edu and a copy will be sent to you.

Appendix O

Please answer each of the following questions using the scale below.

1	2	3	4	5	6	7
not at all			some			a lot

____ How much do you feel you need help as a result of having experienced unwanted sexual activity?

____ How much do you feel you need *counseling* as a result of having experienced unwanted sexual activity?

____ How much do you feel you are at risk of having further unwanted sexual experiences?

____ How much do you feel you have been affected by emotional problems or problems in functioning as a result of having experienced unwanted sexual activity?

____ How likely are you to seek help as a result of having experienced unwanted sexual activity?

____ How likely are you to seek *counseling* as a result of having experienced unwanted sexual activity?

If you could choose ideal help of any kind, what would this be? (Please describe briefly).

Appendix P

Thank you for your participation in Part 1 of the study Attitudes, Beliefs, and Experiences. Attached you will find more detailed information about the specific counseling options in Blacksburg that were listed in Part 1. If you have any questions about these counseling options or the study in general, please contact Melisa Chelf at 961-2290 or reply to this e-mail.

Virginia Tech Cook Counseling Center

Phone: 231-6557
Hours of operation: 8 to 5, Monday through Friday.
Location: 240 McComas Hall
Website: www.ucc.vt.edu
Free to registered students.

The Cook Counseling Center at Virginia Tech offers individual and group counseling for women who have experienced unwanted sexual activity. Additionally, knowledgeable counselors can assist with information about sexual assault and referrals for long-term counseling if needed. Advocacy services are available in the event that students need academic assistance. All services are confidential.

Virginia Tech Women's Center

Phone: 231-7806
Hours of operation: 8 to 5, Monday through Friday.
Location: Price House, Stanger Street
E-mail: womctr@vt.edu
Websites: www.womenscenter.vt.edu
Free services.

The Women's Center at Virginia Tech offers a variety of services to women who have had unwanted sexual experiences. Assistance can also be provided to women's friends and families if desired. Trained professionals are available to provide crisis intervention, counseling, and advocacy for on- and off-campus health care, law enforcement, and judicial proceedings. In addition, the Center offers support groups, information, and referrals for long-term counseling. Counselors can assist students by advocating for them in cases of academic difficulty resulting from assault. All services are confidential.

Women's Resource Center

Phone: 639-1123
Hotline available 24 hours a day, 7 days a week.
E-mail: info@wrcnrv.org
Website: www.wrcnrv.org
Free services.

The Women's Resource Center offers individual counseling and support groups for women who have experienced unwanted sexual activity and for those in their lives who are also affected by this experience. Information on the medical, legal, and psychological aspects of unwanted sexual contact is provided. Clients may be seen in locations convenient to them (at Virginia Tech, local churches, etc.) or in the Radford office. The Women's Resource Center has a 24-hour crisis hotline and 24-hour information and referral system. Counselors are available to accompany women to the hospital for assault exams and can also provide advocacy services for court. All services are confidential.

Appendix Q

Since completing Time 1 of this study a month ago, have you done any of the following regarding the Virginia Tech Cook Counseling Center (located on campus at McComas Hall)? Please check all that apply.

___ Attended a counseling appointment.
___ Attended a counseling support group.
___ Called to set up a counseling appointment.
___ Called to sign up for a counseling support group.
___ Called to ask about counseling.
___ Called to ask about a counseling support group.
___ E-mailed them.
___ Gone to their website.
___ Picked up a brochure about counseling.

Since completing Time 1 of this study a month ago, have you done any of the following regarding the Virginia Tech Women's Center (located on campus at Price House on Stanger Street)? Please check all that apply.

___ Attended a counseling appointment.
___ Attended a counseling support group.
___ Called to set up a counseling appointment.
___ Called to sign up for a counseling support group.
___ Called to ask about counseling.
___ Called to ask about a counseling support group.
___ E-mailed them.
___ Gone to their website.
___ Picked up a brochure about counseling.

Since completing Time 1 of this study a month ago, have you done any of the following regarding the Women's Resource Center (located in Radford but with options to be seen closer to Blacksburg)? Please check all that apply.

___ Attended a counseling appointment.
___ Attended a counseling support group.
___ Called to set up a counseling appointment.
___ Called to sign up for a counseling support group.
___ Called the crisis hotline for assistance.
___ Called to ask about counseling.
___ Called to ask about a counseling support group.
___ E-mailed them.
___ Gone to their website.
___ Picked up a brochure about counseling.

Since completing Time 1 of this study a month ago, have you done any of the following regarding anywhere OTHER THAN the Virginia Tech Cook Counseling Center, Virginia Tech Women's Center, or the Women's Resource Center? Please check all that apply.

___ Attended a counseling appointment.
Where?_____
___ Attended a counseling support group.
Where?_____
___ Called to set up a counseling appointment.
Where?_____
___ Called to sign up for a counseling support group.
Where?_____
___ Called a rape crisis center. Which one?
_____
___ Called a crisis hotline. Which one?
_____
___ Called to ask about counseling.
Where?_____
___ Called to ask about a counseling support group.
Where?_____
___ E-mailed them.
___ Gone to their website.
___ Picked up a brochure about counseling.

Since completing Time 1 of this study a month ago, have you talked to any of the following FOR THE FIRST TIME about your unwanted sexual experience? (Please check all that apply).

___ I told no one about this experience.
___ Family
___ Friend
___ Significant other
___ Leader at place of worship
___ Medical Personnel (i.e., doctor, nurse, nurse practitioner)
___ Police
___ Trusted authority figure (i.e., instructor, resident assistant, employer)
___ Other (please specify) _____

Since completing Time 1 of this study a month ago, did you seek help or information, such as from one of the places listed above, or talk to any of the people above about your unwanted sexual experience?

___ Yes
___ No

Please answer each of the following questions using the scale below.

1	2	3	4	5	6	7
not at all			some			a lot

Since completing Time 1 of this study a month ago, how much did each of the following reasons influence your decision to seek help or information, such as from one of the places listed above, or to talk to any of the people above about your unwanted sexual experience?

___ I had experienced unwanted sexual activity.
___ I felt I would not be blamed for having experienced unwanted sexual activity.
___ I felt I would not be looked down upon because I had experienced unwanted sexual activity.
___ I felt that I was not the only one who had experienced unwanted sexual activity.
___ I was experiencing emotional problems.
___ I was experiencing problems with low self-esteem.
___ I was having difficulty with sexual dysfunction.
___ I feared having emotional problems in the future.
___ I feared having unwanted sexual activity again in the future.
___ I felt what I discussed with a counselor would be kept confidential.
___ I felt a counselor would not judge me.
___ I felt a counselor would have enough experience to help me with this problem.
___ I felt a counselor had helped others with similar problems.
___ Other (please specify)

_____
_____
_____

Since completing Time 1 of this study a month ago, how much did each of the following reasons influence your decision NOT to seek help or information, such as from any of the places listed above or NOT to talk to any of the people above about your unwanted sexual experience?

___ I had not experienced unwanted sexual activity.
___ I felt I would be blamed for having experienced unwanted sexual activity.
___ I felt I would be looked down upon because I had experienced unwanted sexual activity.
___ I felt that I was the only one who had experienced unwanted sexual activity.
___ I was not experiencing emotional problems.
___ I was not experiencing problems with low self-esteem.
___ I was not having difficulty with sexual dysfunction.
___ I did not fear having emotional problems in the future.
___ I did not fear having unwanted sexual activity again in the future.
___ I felt that what I discussed with a counselor would not be kept confidential.
___ I felt that a counselor would judge me.
___ I felt that a counselor would not have enough experience to help me with this problem.

___ I felt that a counselor had not helped others with similar problems.
___ Other (please specify)
_____
_____
_____

___ How likely are you to seek help in the future as a result of having experienced unwanted sexual activity?
___ How likely are you to seek *counseling* in the future as a result of having experienced unwanted sexual activity?

Appendix R

Your answers to Time 1 of this study a month ago suggest that you had experienced unwanted sexual activity. When you think of that experience, what term do you feel best describes it?
___ Rape
___ Attempted rape
___ Some other type of crime
___ Miscommunication
___ Seduction
___ Not sure

Have you experienced any other significant life events (positive or negative) since completing Time 1 of this study a month ago? ___ Yes ___ No
If so, please specify.

_____
_____
_____

What do you remember about the message you received at the end of Time 1 of this study? Please describe briefly.

_____
_____
_____
_____
_____

Which one of the following was the focus of the message you got at the end of Time 1 of this study?
___ Help for problems resulting from unwanted sexual activity
___ Help for problems resulting from physical violence
___ Help for problems resulting from completing survey questions online
___ Help for problems resulting from participating in psychology experiments

Appendix S

You have reached the end of the survey. Thank you for your help and conscientiousness.

You may print this page as proof of your participation in Time 2 of the study Attitudes, Beliefs, and Experiences for 1 point of extra credit.

Student ID:

Date:

Session ID:

If you have any questions or concerns about this research, you can contact Melisa Chelf at 231-9627 or Danny Axsom at 231-6495. Once again, local counseling options are listed below:

Virginia Tech Cook Counseling Center at 231-6557
Hours of operation 8 to 5, Monday through Friday
Free to registered students

Virginia Tech Women's Center at 231-7806
Hours of operation 8 to 5, Monday through Friday
Free services

Women's Resource Center at 639-1123
Hotline available 24 hours a day, 7 days a week
Free services

Appendix T

- In order to further assess which counseling options are most helpful to study participants, I am interested in looking at how quickly centers were able to give appointments to those who asked for them.

- To get this information, I will need a signed release of information form to show the center where you sought counseling that you agreed for me to contact them.

- If you are willing to assist me in collecting this information, please print the release of information form appearing on the next screen, sign it, and return it to me by one of the following methods within 1 week:

    - Drop it off in the secure drop box outside my office, Derring 4082 (next door to the Introductory Psychology Office)

    - Mail it to me at the following address:
      Melisa Chelf
      Psychology Department
      Derring Hall
      Virginia Tech
      Blacksburg, VA 24061

- Please note that **I will NOT be obtaining any information covered in your counseling sessions**. I am interested in how long it took the center to get your appointment scheduled. Sending me this release of information form is completely voluntary and does not affect your participation in this study or assignment of extra credit points in any way.

CURRICULUM VITA
CAROLE MELISA CHELF

WORK ADDRESS
WVU School of Medicine, Charleston Division
Dept. of Behavioral Medicine
501 Morris St., P.O. Box 1547
Charleston, WV 25326
304-341-1504

HOME ADDRESS
1424 Kanawha Blvd. E. #21
Charleston, WV 25301
304-344-1424
cchelf@charter.net

PERSONAL

Date of Birth: 12-10-68

EDUCATION

Ph.D. Virginia Polytechnic Institute and State University, expected May 2004
Major: Clinical Psychology
Dissertation: An Intervention Model for Recruiting Rape Victims into Treatment

M.A. Western Carolina University, 1993
Major: Clinical Psychology
Thesis: Strategic Self-Presentation of Socially Anxious and Nonanxious Individuals

B.A. Clemson University, 1991
Major: Psychology

AWARDS AND HONORS

Research Assistantship, Western Carolina University, Criminal Justice Department. September 1991-December 1992.

Passed thesis prospectus with Honors at Western Carolina University, April 1992.

Psi Chi National Honor Society in Psychology

Golden Key Honor Society

Sigma Tau Epsilon Liberal Arts and Sciences Honorary

Psychology Club, Clemson University, Treasurer 1989-1990.

Kappa Alpha Theta Fraternity for Women, Clemson University, Vice President Efficiency 1990-1991, Corresponding Secretary 1989-1990.

PUBLICATIONS
Refereed

Chelf, M., & Ellis, J. (2002). Young adults who were sexually abused: Demographics as predictors of their coping behaviors. Child Abuse and Neglect: The International Journal, 26, 313-316.

PUBLICATIONS
In Preparation

Chelf, M., & Kowalski, R. (2004). Self-presentational facilitators and inhibitors. Manuscript in preparation.

Jones, R., Langley, A., & Chelf, M. (2004). Post-traumatic symptomatology in children following wildfires. Manuscript in preparation.

PRESENTATIONS AND PAPERS

Chelf, M., & Axsom, D. (2003, November). An intervention model for recruiting rape victims into treatment. Poster presentation at the annual meeting of the Association for Advancement of Behavior Therapy, Boston, MA.

Ellis, J., & Chelf, M. (2001, April). Sexual abuse: Later adaptive behaviors and suicide. Poster presentation at the annual meeting of the American Association of Suicidology, Atlanta, GA.

Chelf, M., & Kowalski, R. (1995, March). Strategic self-presentation of socially anxious and nonanxious individuals. Poster presentation at the annual meeting of the Southeastern Psychological Association, Savannah, GA.

Chelf, M., & Kowalski, R. (1994, May). Strategic self-presentation of socially anxious and nonanxious individuals. Poster presentation at the meeting of the North Carolina Psychological Association, Atlantic Beach, NC.

JOURNAL REVIEWS

June**,** 2000. Reviewed article submitted for publication to Aggression and Violent Behavior: A Review Journal.

October, 1999. Reviewed article submitted for publication to Journal of Clinical Child Psychology

RESEARCH GRANTS AND FUNDING ACTIVITY

Interviewer for NIMH-sponsored grant "One-Session Treatment of Specific Phobias in Children," funded to Thomas H. Ollendick, Ph.D., of Virginia Polytechnic Institute and State University, and Lars-Goran Ost, Ph.D., of Stockholm University. August 2002-May 2003. Conducted diagnostic interviews for children and parents with specific phobias, assisted in collection of physiological measures.

Chelf, M. (2002). Contributing variables for treatment initiation of unacknowledged rape victims. Funded by Graduate Student Assembly, Virginia Polytechnic Institute and State University, $500.

Graduate research assistant for FEMA-sponsored grant "The Psychological Impact of Residential Fires on Children and Their Parents," funded to Russell T. Jones, Ph.D., of Virginia Polytechnic Institute and State University. August 2000-May 2001. Served as primary research assistant; assisted in protocol selection and development, grant administration, and subject interviewing.

Interviewer for NIMH-sponsored Residential Fire research grant, funded to Russell T. Jones, Ph.D. and Thomas H. Ollendick, Ph.D., of Virginia Polytechnic Institute and State University. August 1999-December 2000. Interviewed victims of residential fires to determine the impact on children and their parents.

Subject recruiter and scheduling coordinator for NIMH-sponsored Residential Fire research grant, funded to Russell T. Jones, Ph.D. and Thomas H. Ollendick, Ph.D, of Virginia Polytechnic Institute and State University. May 2000-August 2000. Contacted victims of residential fires and coordinated interview scheduling.

Chelf, M. (1993). Strategic self-presentation of socially anxious and nonanxious individuals. Funded by Sigma Xi, Western Carolina University, $200.

Assistant for research grant from Buncombe County Drug Commission, Asheville, NC, funded to Laura Moriarty, Ph.D., of Western Carolina University. January 1992-May 1993. Assisted in administering substance abuse surveys and compiling results.

OTHER RESEARCH ACTIVITY

Assist in data collection, scoring, and recording for Cardiopulmonary Questionnaire with Matthew Herridge, Ph.D., of WVU School of Medicine, Charleston Division. October 2003-present.

Assisted in data collection for Freedom from Tobacco Program with Norman Montalto, M.D., and Scott Fields, Ph.D., of West Virginia University Physicians of Charleston. October-December 2003.

Research Assistant supervised by Patricia Connor-Greene, Ph.D. Clemson University, 1990. Study of the relationship between gender, ethnic group, and eating disorders.

CURRENT RESEARCH INTERESTS

The impact of trauma on children and adults; methods of encouraging victims of trauma to seek treatment. The assessment and treatment of phobic and anxiety disorders of children.

TEACHING EXPERIENCE

Teaching Assistantship, Virginia Polytechnic Institute and State University, Psychology Department. August 2002-May 2003. Taught two sections of Psychological Disorders of Children with 52 students in each section. Responsibilities included class organization, lecture preparation, lecturing, test construction and administration, grading student exams.
Received overall student evaluation ratings as follow out of possible 4.0:

Fall 2002 3.8 mean score
Spring 2003 3.7 mean score

Teaching Assistantship, Virginia Polytechnic Institute and State University, Psychology Department. July 2002-August 2002. Taught Developmental Psychology to12 students during intensive six-week summer session. Responsibilities included class organization, lecture preparation, lecturing, test construction and administration, grading student papers and exams.
Received overall student evaluation ratings as follow out of possible 4.0:

Summer Session 2 2002 3.9 mean score

Teaching Assistantship, Virginia Polytechnic Institute and State University, Psychology Department. August 2001-May 2002. Taught two sections of Abnormal Psychology with 75 students in each section. Responsibilities included class organization, lecture preparation, lecturing, test construction and administration, grading student papers, presentations, and exams.
Received overall student evaluation ratings as follow out of possible 4.0:

Fall 2001 3.5 mean score
Spring 2002 3.5 mean score

Teaching Assistantship, Virginia Polytechnic Institute and State University, Psychology Department. August 1999-May 2000. Taught four Introductory Psychology Recitation sections with approximately 32 students in each section. Responsibilities included lecture preparation, lecturing, quiz construction, grading student papers and quizzes.
Received overall student evaluation ratings as follow out of possible 4.0:

Fall 1999 3.8 and 3.8 mean scores for two sections
Spring 2000 3.8 and 3.7 mean scores for two sections

Teaching Assistantship, Western Carolina University, Psychology Department. January 1993-May 1993. Graded student papers, tutored, taught Introductory Psychology classes as needed.

SEMINARS PRESENTED

Chelf, M. (2003, December). Child abuse. Presentation to the Family Medicine physicians and residents of West Virginia University Physicians of Charleston.

Chelf, M. (2003, October). Moral development. Presentation to the Behavioral Medicine and Psychiatry faculty and residents of WVU School of Medicine, Charleston Division.

Chelf, M. (1997, October). School-based services: T.I.E.S. (Together In Educating Students). Presentation to the Children and Youth staff of Frontier Health, Kingsport,TN.

Chelf, M., Lysette, L., Bowman, K., Cook, B., & Haile, S. (1996, August). Beyond our beliefs: Sensory based treatment of child sexual abuse. Presentation to the clinical staff of Frontier Health, Johnson City, TN. Based on teachings from Beyond our beliefs: Sensory based treatment of child sexual abuse workshop by Jan Hindman (1996, May) in Asheville, NC.

Chelf, M., Poe, S., & Hogan, S. (1996, March). Ecosystemic play therapy: Assessment, treatment planning, and interventions. Presentation to the clinical staff of Frontier Health, Johnson City, TN. Based on teachings from Ecosystemic play therapy: Assessment, treatment planning, and interventions workshop by Kevin O'Connor (1995, November) in Dayton, OH.

EMPLOYMENT AND EXPERIENCE IN PROFESSIONAL PSYCHOLOGY

Predoctoral Intern, WVU School of Medicine, Charleston Division. July 2003-present. Participate in a variety of rotations in an academic medical center setting. Provide **outpatient** services including individual psychotherapy, intake interviews, assessment, and crisis management to adults, adolescents, and children. Co-led outpatient group for women with Dissociative Disorders. Provided **inpatient** services including individual and group psychotherapy and psychological assessment to adults. Assisted in **Emergency Room** call for patients with psychiatric conditions. Assisted clinical psychologist in **Family Medicine** setting: conducted individual co-therapy with adults and children, diagnostic assessments, and physician precepting in both an urban and rural clinic. Assisted clinical psychologist in **Cardiac Rehabilitation** unit: led and co-led psychoeducational groups for cardiac patients, completed intake screenings and diagnostic assessments, provided psychological consultations and tobacco cessation consultations and interventions to patients throughout the hospital system. Provide **Consultation and Liaison** services to patients with psychiatric conditions throughout the hospital system: conduct full assessments, present patients to attending psychiatrists on rounds, and provide follow-up services. Receive supervision from multiple licensed clinical psychologists and psychiatrists. Training director John C. Linton, Ph.D., Chief Psychologist.

Practicum Student, Virginia Polytechnic Institute and State University, Blacksburg, VA. August 1999-May 2003. Provided outpatient services including intake interviews; individual therapy to adults, adolescents, and children; family and couple's therapy. Administered psychological assessments to children and adults. Services are provided through the Psychological Services Center, the training program for clinical psychology doctoral students at Virginia Tech. Assisted in clinical supervision to students in their first year in the clinical psychology graduate program. Received supervision from multiple licensed clinical psychologists.

Externship Student, Southwestern Virginia Mental Health Institute, Marion, VA. May 2001-August 2001. Provided individual, family, and group psychotherapy to adolescents in an inpatient state psychiatric hospital. Conducted intake interviews and psychological assessments. Supervision with licensed clinical psychologist.

Licensed Psychological Examiner, Frontier Health (formerly Watauga Mental Health Services, Incorporated), Johnson City, TN. August 1994-August 1999. Provided outpatient services including intake interviews; individual, group, and family psychotherapy with children, adolescents, and adults. Assisted in providing contractual services to community agencies with emphasis on school-based intervention programs and delinquent youth. Served as coordinator of school-based intervention programs and conducted analyses of programs' therapeutic effectiveness. Administered psychological assessments to children and adults. Supervision with licensed clinical psychologist.

Licensed Psychological Associate, Developmental Evaluation Center, Cullowhee, NC. September 1993-June 1994. Assessed preschool children for developmental delay and atypical behavior. Worked closely with parents, teachers, and other professionals in intervention planning and coordinating children's services. Supervision with licensed psychologist.

Intern, Counseling and Psychological Services Center, Cullowhee, NC. January 1993-June 1993. Provided individual and group psychotherapy and crisis intervention services to university students. Conducted intake interviews and psychological assessments. Supervision with licensed counseling psychologist.

Practicum Student, Developmental Evaluation Center, Cullowhee, NC. January 1992-May 1992. Assessed preschool children for developmental delay and atypical behavior. Worked closely with parents and teachers in intervention planning. Supervision with licensed psychologist.

Practicum Student, Clemson University, Clemson, SC. January 1991-May 1991. Assisted Spurgeon Cole, Ph.D., with clinical interviews for court-involved clients and administration of disability evaluations for adults and children. Supervision with licensed clinical psychologist.

PROFESSIONAL AFFILIATIONS

American Psychological Association, Associate Member
Association for Advancement of Behavior Therapy, Student Member
Southeastern Psychological Association, Member

PROFESSIONAL LICENSES

Licensed Psychological Examiner, State of Tennessee (#PE0000011416). License held April 1995 to August 1999 when retired license due to move out of state.

Licensed Psychological Associate, State of North Carolina (#1666). License held November 1993 to September 1994 when retired license due to move out of state.

PROFESSIONAL MEETINGS ATTENDED

November 2003	Assoc. for Adv. of Behavior Therapy	Boston, MA
November 2002	Assoc. for Adv. of Behavior Therapy	Reno, NV
November 2001	Assoc. for Adv. of Behavior Therapy	Philadelphia, PA
April 2001	American Association of Suicidology	Atlanta, GA
March 1996	Southeastern Psychological Association	Norfolk, VA
November 1995	Midwest Children's Conference	Dayton, OH
March 1995	Southeastern Psychological Association	Savannah, GA
May 1994	North Carolina Psychological Association	Atlantic Beach, NC
April 1994	Southeastern Psychological Association	New Orleans, LA
March 1993	Southeastern Psychological Association	Atlanta, GA
March 1992	Southeastern Psychological Association	Knoxville, TN