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Social Reactions to Sexual Assault Survivors Presenting with PTSD: The Impact of Survivor Gender and Psychotherapy Treatment-Seeking Status

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SOCIAL REACTIONS TO SEXUAL ASSAULT SURVIVORS PRESENTING WITH PTSD:
THE IMPACT OF SURVIVOR GENDER AND PSYCHOTHERAPY
TREATMENT-SEEKING STATUS

by

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In partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Grand Forks, North Dakota
August
2017

This dissertation, submitted by Shannon Marie Sommer in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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This dissertation is being submitted by the appointed advisory committee as having met all of the requirements of the School of Graduate Studies at the University of North Dakota and is hereby approved.

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Dr. Grant McGimpsey
Dean of the School of Graduate Studies

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Title   Social Reactions to Sexual Assault Survivors Presenting With PTSD: The Impact of Survivor Gender and Psychotherapy Treatment-Seeking Status

Department Psychology

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Shannon Marie Sommer
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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABSTRACT

The present study examined public perceptions of and willingness to provide social support to survivors of sexual assault presenting with posttraumatic stress disorder (PTSD) based on the survivor's gender (male vs. female), psychotherapy treatment-seeking status (no treatment vs. dropped out after four sessions vs. still in treatment), and participant gender (male vs. female). Participants ($n = 178$) read one of six vignettes based on a 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: no treatment vs. dropped out of treatment after four sessions vs. still in treatment) factorial design describing the life circumstances and PTSD symptoms of a survivor who had been sexually assaulted six months prior; they then completed manipulation check and perceptions, social support, and demographics questionnaires. Results indicated that male participants were significantly more likely than female participants to demonstrate negative social reactions (i.e., blaming the victim, treating the survivor differently, attempting to control the survivor's actions, encouraging distraction as a means of coping, and focusing on their own needs rather than the survivor's), and female participants were significantly more likely than male participants to demonstrate positive social reactions (i.e., providing emotional support/belief and practical support) after the survivor was sexually assaulted. Results also suggested that survivors who were described as "still in treatment" were perceived more positively, and participants were significantly less likely to attempt to control their actions and decisions compared to survivors described as not having sought treatment or having dropped out of therapy after four sessions. Implications are discussed.

CHAPTER I

INTRODUCTION

Rape is a serious act of violence that is present in various societies across the globe (MacFarlane, 1993). In the United States, approximately 1 in 5 women have been raped at some point in their lives (Black, Basile, Breiding, Smith, Walters, Merrick, Chen, & Stevens, 2011). Men are also the targets of sexual assault, with 1 in 71 men having been raped during his lifetime (Black et al., 2011). Rape is largely underreported, with only 19% of women and 13% of men who were raped after age 18 reporting those rapes to the police, which makes it difficult to accurately measure the total number of rapes that occur (Tjaden & Thoennes, 2006). The majority of both male and female survivors of sexual violence were assaulted by a male (Black et al., 2011; Tjaden &Thoennes, 2000). In fact, approximately 98% of perpetrators of sexual violence are male (Black et al., 2011). Stereotypically, rape is thought to be committed by a stranger (Anderson, 2007); however, it has been found that 51% of women were raped by an intimate partner, 41% by an acquaintance, and 14% by a stranger (Black et al., 2011). Research has also shown that 52% of men were raped by an acquaintance and 15% by a stranger (Black et al., 2011). The National Violence against Women Survey found that many survivors of rape are raped multiple times in his or her lifetime (Tjaden & Thoennes, 2000). Women in this survey who had been raped in the previous 12 months experienced an average of 2.9 rapes, and the revictimized men experienced an average of 1.2 rapes (Tjaden & Thoennes, 2000).Two in three individuals who had been raped also reported sexual revictimization (Sorenson, Siegel, Golding,

& Stein, 1991), which is consistent with findings that once an individual is sexually assaulted, he or she is at a higher risk for being assaulted again (Classen, Gronskaya Palesh, & Aggarwal, 2005; Gidycz, Coble, Latham, & Layman, 1993).

It is not uncommon for survivors to experience ridicule and blame for being sexually assaulted (Burt, 1980). Both men and women can experience negative social reactions at the hands of police or medical providers, as well as disbelief from family and friends with whom the survivor may share information regarding the sexual assault. In addition to the sexual assault itself, potential social supports' reactions may be affected by various symptom presentations that are common after an individual is raped (Ullman & Peter-Hagene, 2016). Some of the most common psychological consequences of being raped are posttraumatic stress disorder (PTSD), substance use, depression, anxiety, sexual dysfunction, and interpersonal difficulties (Resick & Schnicke, 1996). Two of the most common evidence-based psychotherapeutic interventions available to help survivors of sexual assault deal with the aftermath of their rape include cognitive processing therapy (CPT) and prolonged exposure (PE). Due to the exposure component, these treatments are very intense for the survivors who decide to undergo them, and many would benefit from a high level of social support during the course of treatment. However, research has also demonstrated a stigma surrounding the pursuit and receipt of mental health treatment (Corrigan, 2000; Wahl, 1999), which could lessen the degree of social support others are willing to provide. Given the traumatic experience, undeserved blame for having been assaulted, the intensity of the exposure-based treatment options, and the stigma surrounding seeking mental health treatment, the degree of social support provided to a survivor is especially important. In fact, it has been associated with more positive outcomes for survivors (Borja, Callahan, & Long, 2006). The current study investigated public perceptions of and willingness to

2

provide social support to survivors of sexual assault presenting with PTSD based on the survivor's gender, his or her psychotherapeutic treatment-seeking status, and the gender of the participant.

**Sexual Assault, Related Mental Disorders,
and Psychotherapeutic Interventions**

Burnam, Stein, Golding, Siegel, Sorenson, Forsythe, and Telles (1988) found that sexual assault was predictive of the later development of major depressive episodes, substance abuse or dependence disorders, and anxiety disorders (e.g., phobia, panic disorder, and obsessive-compulsive disorder). However, according to Resick and Schnicke (1996), the most commonly observed disorder that develops after a sexual assault is PTSD. According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), PTSD is classified under the "Trauma- and Stressor-Related Disorders," and this edition has been updated to recognize sexual assault as an event that can contribute to the development of the disorder. According to the *DSM-5* (APA, 2013), in order to be diagnosed with PTSD, the individual would have to meet seven criteria past the first criteria of having been exposed to the traumatic event: (1) the presence of intrusion symptoms (e.g., distressing memories, flashbacks, nightmares), (2) avoidance associated with the traumatic event (i.e., avoidance of thoughts, places, and/or people related to the trauma), (3) the presence of symptoms regarding negative changes in cognitions and mood regarding the traumatic event (e.g., self-blame, persistent negative emotions, anhedonia, distorted cognitions, social detachment), (4) the presence of symptoms that demonstrate marked changes in arousal and reactivity (e.g., hypervigilance, sleep disturbance, angry/aggressive outbursts, self-destructive behavior, exaggerated startle response), (5) disturbance duration of greater than one month, (6) clinically significant distress/impairment,

3

and (7) the disturbance is not due to a substance or other medical condition. In the first week

after the sexual assault, approximately 94% of rape victims meet the criteria for PTSD; however,

three months after the assault, that number drops to 47% due to the natural recovery process

(Resick & Schnicke, 1996).

Resick and Schnicke (1996) found that depression frequently co-occurs with PTSD in

sexual assault survivors. In fact, Burnam et al. (1988) found that sexual assault was predictive of

later onset of major depressive episodes. According to Au, Dickstein, Comer, Salters-Pedneault,

and Litz (2013), there is a relative absence of a distinct subset of sexual assault survivors with

only PTSD symptoms or only depression symptoms, which suggests that both PTSD and

depression could be manifestations of a general posttraumatic stress response instead of distinct

disorders after experiencing the trauma.

Ullman et al. (2006) found that survivors of sexual assault who had less education,

histories of other traumas, who blamed their character for the assault, believed drinking could

decrease distress, drank to cope with the effects of the assault, and were confronted with negative

social reactions were more likely to develop comorbid PTSD and drinking problems compared to

sexual assault survivors with only PTSD. This is also consistent with the results of the study

conducted by Peter-Hagene and Ullman (2014). They found that infantilizing social reactions

(e.g., patronizing the victim or treating them as if they were irresponsible) led the victim to feel

less in control, which was related to increased PTSD symptoms and problem drinking (Peter-

Hagene & Ullman, 2014). They also found that when people in the survivor's life provide

tangible social support, it can lead to increased perceived control over their recovery, which was

also related to fewer PTSD symptoms (Pater-Hagene & Ullman, 2014). This information could

be useful in a treatment setting because therapists could provide education to the social support

system of the survivors of sexual assault by suggesting they increase social support, as well as decrease infantalization due to the likelihood of increasing the survivor's perceived loss of control over their recovery (Peter-Hagene & Ullman, 2014).

Campbell, Dworkin, and Cabral (2009) focused on developing an ecological model of the impact of sexual assault on women's mental health. In doing so, they examined five different ecological levels: (1) individual level factors (i.e., survivor and assault characteristics), (2) microsystem factors (e.g., sources of support), (3) mesosystem (i.e., processes that contribute to links between systems and/or other individuals) or exosystem factors (i.e., formal systems with which the individuals may or may not have contact), (4) macrosystem factors (e.g., sociocultural perspectives related to race, ethnicity, and cultural identity), and (5) chronosystem factors (examines the cumulative effects of various sequences of developmental transitions throughout life) (Campbell et al., 2009). In terms of the individual level factors, they found mixed findings on the impact of sociodemographic variables, assault characteristics, and biological characteristics on the survivors' well-being after the assault (Campbell et al., 2009). They also found that: personality traits (e.g., neuroticism) were able to predict PTSD, poorer mental health before the assault led to multiple negative outcomes (e.g., depression, anxiety), avoidance as a means of coping can lead to various negative outcomes (e.g., longer recovery time, depression, PTSD), and perceived life threat and perceived dangerousness of the perpetrator can predict negative outcomes (e.g., depression, anxiety, PTSD symptoms) (Campbell et al., 2009). In terms of the microsystem factors, they found that positive social reactions and support from family, friends, and significant others can lead to less mental distress after the assault (Campbell et al., 2009). However, they found that negative social reactions from these same people can lead to various negative outcomes (e.g., depression, anxiety, and

5

posttraumatic stress) (Campbell et al., 2009). In terms of meso/exosystem factors, Campbell et al. (2009) found that secondary victimization (i.e., victim-blaming, minimal help) via the legal system can predict increased symptoms of disorders, such as depression and PTSD. However, they also found that community mental health programs can help counteract the negative effects of the other medical systems and thereby lead to less mental health distress after the assault (Campbell et al., 2009). In terms of macrosystem factors, Campbell et al. (2009) found that institutionalized racism, acceptance of rape myths, and cultural differences in responding to rape can lead to a sociocultural context in which it is more difficult for sexual assault survivors to recover from the traumatic event. In terms of the chronosystem factors, Campbell et al. (2009) found that repeated trauma and victimizations over the survivor's life can predict negative outcomes (e.g., depression, anxiety, and PTSD). Additionally, when looking at self-blame, the authors found that it can affect each ecological level: at the individual level, it is associated with PTSD and depression; at the micro and meso/exosystem levels, self-blame is increased when the victim is also blamed by others for the assault, which subsequently can lead to the survivor exhibiting symptoms of PTSD; at the macro level, the survivor's self-blame is affected by their internalized sociocultural beliefs; and at the chronosystem level, self-blame is higher among the survivors who have experienced multiple and higher levels of trauma throughout their lives (Campbell et al., 2009). Therapists can potentially use this ecological model to inform their approach to understanding the psychological experiences of survivors after the sexual assault, as well as aid in the formation of various policies and education programs for the different levels of the ecological system (Campbell et al., 2009).

Two common types of evidence-based psychotherapeutic interventions for survivors of sexual assault are cognitive processing therapy and prolonged exposure. Cognitive processing

therapy (CPT) aims to treat the symptoms of PTSD by utilizing psychoeducation, exposure, and cognitive techniques. It can occur in an individual or group treatment format, and it usually consists of 12 sessions that last approximately 60 minutes each when in an individual format and 90 minutes each when in a group format. After beginning the course of CPT with psychoeducation, the client is later asked to write about their rape using as much detail as possible and read it silently multiple times, which is part of the exposure component of the treatment. This exposure activates memories and affects, facilitates the extinction of strong negative emotions, and shows the therapist the "stuck points" to facilitate accommodation (Resick & Schnicke, 1996). A second common treatment for PTSD is Prolonged Exposure Therapy (PE). PE is an intervention that consists of 10 to 15 once- or twice-weekly treatment sessions that last for approximately 90 minutes and includes education about common reactions to trauma, breathing retraining, repeated in vivo exposure to objects or situations that the rape survivor may be avoiding due to trauma-related distress and anxiety, and repeated and prolonged imaginal exposure to the trauma memories (i.e., revisiting and describing the trauma memory in imagery) (Foa, Hembree, & Rothbaum, 2007). Both CPT and PE have been shown to be highly efficacious and effective in treating survivors struggling with PTSD and/or depression after the sexual assault (Resick, Nishith, Weaver, Astin, & Feuer, 2002). However, encouraging sexual assault survivor to expose themselves to memories and emotions related to the traumatic event through either treatment modality can be daunting given the fact that many survivors attempt to cope by avoiding the thoughts and feelings related to the assault. Due to the traumatic experience, severity of PTSD symptoms, and intensity of empirically-supported treatments for PTSD, it is especially important for survivors of sexual assault to receive a high degree of social support immediately after the assault, as well as throughout the course of treatment. However,

how others treat the survivor, as well as their perceptions of them, may be affected by the gender of the individual who was assaulted.

Perceptions of Sexual Assault Survivors Based on Survivor and Participant Gender

Various rape myths have been shown to be prevalent in the context of assigning blame to survivors of sexual assault. Burt (1980) examined the concept of rape myth acceptance and suggested that it tends to occur when a person holds attitudes that endorse sex role stereotyping, accepts interpersonal violence, and endorses adversarial sexual beliefs (e.g., rape is an "extreme" on the continuum of exploitation). Rape myth acceptance has been shown to lead to increased victim blame (Burt, 1980). Some of the rape myths associated with female survivors of male sexual assault include: the woman has a bad reputation, the woman could have resisted the sexual assault if she really wanted, the woman is known to be promiscuous, the woman should not have drank so much, and the woman was dressed provocatively (Burt, 1980). Some of the rape myths associated with male rape survivors include: a "real" man should be able to defend himself if someone is trying to rape him, a man is not affected by rape as much as a woman would be, a man cannot be raped, and a man implicitly provides consent if he experiences a physiological response to the sexual assault (e.g., getting an erection or ejaculating during the rape) (Coxell & King, 2010; Turchik & Edwards, 2012).

Past studies have shown that perceptions of blameworthiness vary by the gender of the survivor of sexual assault. Anderson and Lyons (2005) found that a perpetrator of female sexual assault received more blame for the rape compared to a perpetrator of male rape. Sommer, Reynolds, and Kehn (2015) found that a male survivor who was raped by a female perpetrator was blamed more for the sexual assault than a female survivor of a male perpetrator, which is also consistent with the findings of Smith, Pine, and Hawley (1988). Other studies have found

that when rapes are described as having been committed by a male perpetrator, participants perceived the assault as more severe for a heterosexual man than for a woman or a gay man (Doherty & Anderson, 2004; Ford, Liwag-McLamb, & Foley, 1998).

Previous studies have also found significant effects of participant gender regarding blame attribution in rape causes. Findings show that male participants compared to female participants tend to blame the victim more, hold more negative attitudes toward rape victims, have a greater belief in both male and female rape myths, view rape victims less sympathetically, and attribute more responsibility for the rape to the victim (Bell, Kuriloff, & Lottes, 1994; Grubb & Harrower, 2009; Mori, Bernat, Glenn, Selle, & Zarate, 1995; Nagel, Matsuo, McIntyre, & Morrison, 2005; Sommer et al., 2015; Whatley, 2005; Whatley & Riggio, 1993; White & Robinson Kurpius, 2002). There are varying explanations as to why this might occur. Lerner's Belief in a Just World theory (Learner, 1980) suggests that people tend to believe that good things happen to good people, and bad things happen to bad people. Whatley and Riggio (1993) found that men tend to believe in a just world more so than women, which may be why men tend to blame the victim more than women do. Another explanation for gender differences in victim blame and rape myth acceptance was suggested by Sommer et al. (2015), who examined the relationship between victim blame, rape myth acceptance, and one's life history strategy based on Life History Theory, which is an evolutionary theory that examines the allocation of various resources to fitness-relevant characteristics, such as first reproduction (Figueredo, Vásquez, Brumbach, & Schneider, 2004). Humans are said to have either a slow life history strategy or a fast life history strategy. Slow life history strategists focus on allocating resources to continued survival and are less likely to allocate many resources to reproductive efforts, whereas fast life history strategists focus much of their energy on reproductive efforts, which may include the utilization of coercive

9

strategies to obtain sex. Sommer et al. (2015) found that being a man was associated with having a fast life history strategy and endorsing more rape myths. They also found that fast life history strategists tended to blame the victim more and endorse more rape myths compared to slow life history strategists because it facilitates their strategy based on shorter-term mating, for example (Sommer et al., 2015). In addition to previous studies finding that men tend to blame victims of sexual assault in general compared to women, White AND Robinson Kurpius (2002) found that male participants tended to blame a male victim more than a female victim of sexual assault. The perceived severity or fault attributed to a male or female survivor in the context of a sexual assault may later have an effect on the degree of social support provided by the people in the survivor's life.

Social Support after Sexual Assault

Both the risk for the development of and recovery from PTSD have been found to be highly dependent on social phenomena (Charuvastra & Cloitre, 2008). Numerous studies have investigated the effects of social reactions on the coping and recovery of sexual assault survivors after the assault occurs. Filipas and Ullman (2001) found that sexual assault survivors typically experience both positive and negative social reactions when disclosing their assaults to informal and formal support providers. Further analysis suggested that the reactions of friends can be especially important in the recovery after sexual assault, with more positive reactions being more helpful and negative reactions more harmful in the recovery process (Filipas & Ullman, 2001). In fact, (Ullman, 1996a) found that emotional support from friends was related to a better recovery after the sexual assault compared to emotional support provided from other support sources.

Ahrens (2006) investigated various ways a survivor may be silenced from further sexual assault disclosures based on social reactions and found three routes to silence: (1) negative

10

reactions from legal, medical, mental health, rape crisis, and religious communities (i.e., professionals); (2) negative reactions from family and friends that reinforced the survivor's feelings of self-blame; and (3) negative reactions from formal and informal support providers that reinforced the survivor's uncertainty regarding whether the sexual assault qualified as a rape. It has also been found that being blamed by the first person to whom the survivor disclosed the trauma was associated with increased trauma-related distress and negative cognitions (Bonnan-White, Hetzel-Riggin, Diamond-Welch, & Tollini, 2015). Ullman (1996b) also found that sexual assault survivors who experienced negative social reactions, such as being treated differently and having someone try to take control, tended to have increased psychological symptoms, whereas survivors who encountered certain positive social reactions, such as being listened to by others, experienced better adjustment. Social reactions, such as victim blame, have been shown to be related to poorer recovery, and survivors who reported that others believed their story had a better self-rated recovery (Ullman, 1996). Ullman (1996b) found that this was the case only for female sexual assault survivors who disclosed the sexual assault several weeks to over a year after its occurrence, suggesting that the reactions of people in a survivor's support network can have a significant effect on a survivor's recovery months or even years after the trauma.

Ullman (2000) delineated the various subtypes of both positive and negative social reactions following a sexual assault. She found that positive social reactions could be broken down into two categories: emotional support (e.g., expressing love, caring, and esteem) and information/practical support (e.g., providing advice and information) (Ullman, 2000). Negative social reactions can be broken down into five categories: victim blame, taking control of the survivor's decisions (e.g., telling them they have to report the assault to the police), treating the survivor differently (e.g., stigmatizing responses), distraction (e.g., telling the survivor that they

11

need to get over it), and egocentric responses (e.g., responses in which the support provider focuses on their own needs rather than the survivor's) (Ullman, 2000). Orchowski, United, and Gidycz (2013) found that reactions in which people attempted to control the survivor's decisions led to increased symptoms of PTSD, depression, and anxiety, as well as decreased perceptions of others providing the survivor with reassurance of their worth. Social reactions in which the survivor was blamed were found to be related to decreased self-esteem and decreased engagement in adaptive, problem-focused coping (Orchowski et al., 2013). Ullman and Peter-Hagene (2014) found that negative social reactions to the disclosure of a sexual assault were related to PTSD both directly and indirectly via a lower perceived control over one's recovery and through maladaptive coping. Littleton and Breitkopf (2006) also found that rape survivors were more likely to engage in avoidance coping when receiving egocentric responses from someone in their social support network upon disclosure of the assault since the survivors typically found themselves then having to provide support to the individual from whom they were originally seeking support. Positive social reactions were associated with more adaptive coping (Ullman & Peter-Hagene, 2014), and reactions that provided emotional support to the survivor of sexual assault were related to increased coping by seeking additional emotional support (Orchowski et al., 2013). Positive social reactions to sexual assault disclosure were also related to a greater perceived control over one's recovery, which was also related to a decrease in PTSD symptoms (Ullman & Peter-Hagene, 2014).

Ullman and Filipas (2001a) found that survivors who were raped by a stranger were more likely to seek social support from formal providers. They also found that those survivors who did seek formal support tended to do so after having experienced more negative social reactions to the sexual assault disclosure compared to the survivors that only sought social support from

informal sources (Ullman & Filipas, 2001a). Ahrens, Campbell, Ternier-Thames, Wasco, and

Sefl (2007) found that survivors who disclosed the sexual assault to informal support providers

were more likely to receive positive reactions, whereas survivors who sought aid from formal

support providers were more likely to receive negative reactions, unless the formal support

providers were the ones to initiate the support themselves, at which time more positive reactions

would be provided. Ahrens, Cabral, and Abeling (2009) investigated the different social

reactions from support providers to the disclosures from sexual assault survivors and found that

friends and counselors tended to provide the most emotional support, relatively high levels of

tangible support, and relatively low levels of different types of negative reactions. However,

romantic partners tended to only provide a moderate level of support, the lowest amount of

tangible support, and the highest amount of negative reactions, such as blame, taking control, and

egocentric responses (Ahrens et al., 2009).

      Within the context of developing PTSD after a sexual assault, Schumm, Briggs-Phillips,

and Hobfoll (2006) found that a high degree of social support tended to predict a lower PTSD

symptom severity for women who experienced abuse as a child in addition to rape as an adult.

This finding is related to Ullman's, Filipas', Townsend's, and Starzynski's (2007) finding that

survivors who experienced negative social reactions from others in their lives tended to have a

more severe PTSD symptom presentation. King, King, Fouy, Keane, and Fairbank (1999) found

that the degree perceived emotional and practical support showed the largest associations with

the development of PTSD in both men and women after a trauma. Andrews, Brewin, and Rose

(2003) found that female survivors of violent crime were more likely than male survivors to

report having received negative responses from family friends, which could explain the increased

severity of PTSD symptoms in women compared to men six months after the violent crime.

Ullman and Filipas (2001b) found that a survivor with less education, greater perceived life threat during the sexual assault, and receipt of more negative social reactions when they disclosed the sexual assault were all associated with increased PTSD symptom severity. Also, they found that ethnic minority survivors of sexual assault were more likely to receive negative social reactions from others, as well as survivors of more severe sexual victimization, who also received fewer positive social reactions from others in addition to the increased negative social reactions they received (Ullman & Filipas, 2001b). Further, Ullman and Peter-Hagene (2016) found that not only did social reactions predict subsequent PTSD symptoms, but PTSD symptoms also predicted subsequent social reactions. Negative social reactions were, again, related to increased PTSD symptoms, and greater PTSD symptoms were related to increased negative social reactions (Ullman & Peter-Hegene, 2016). They also found that a survivor presenting with PTSD symptoms can lead to a greater likelihood of problematic responses from others at the time of disclosure (Ullman & Peter-Hagene, 2016), which could lead to the silencing of survivors and future disclosures, as discussed by Ahrens (2006). When investigating how types of negative social reactions can relate to post-assault outcomes, Relyea and Ullman (2015) found that 94% of the women in their sample had received reactions from people that acknowledged that the assault had occurred yet failed to provide support after the acknowledgment. This was associated with even worse coping than more hostile reactions (e.g., blaming or stigmatizing reactions; Relyea & Ullman, 2015).

When examining the utilization of various support sources following a sexual assault, Golding, Siegel, Sorenson, Burnam, and Stein (1989) found that of the two-thirds of sexual assault survivors who responded to survey, 59.3% had talked to a friend, 10.5% the police, 16.1% mental health professionals, 9.3% physicians, 3.9% clergy, 1.9% rape crisis centers, and

1.6% legal professionals. Women most often tended to confide in a female peer (Orchowski &
Gidycz, 2012). They also found that a survivor who was assaulted by a stranger, experienced a
greater degree of physical threat and sexual contact, and experienced increased emotional
distress related to the assault tended to talk about the assault more, especially to the police or to
physicians (Golding et al., 1989). The smaller percentage of sexual assault survivors who seek
mental health services as a form of social support could be due to the stigma surrounding mental
illness and treatment-seeking.

Perceptions of Mental Health Treatment-Seeking

Crisp, Gelder, Rix, Meltzer, and Owlands (2000) examined the opinions of a general
adult population regarding people with seven types of mental disorders: severe depression, panic
attacks, schizophrenia, dementia, eating disorders, alcoholism, and drug addiction. They found
that adults perceived people with schizophrenia, alcoholism, and drug addiction as unpredictable
and dangerous, with alcoholism and drug addiction being viewed as self-inflicted (Crisp et al.,
2000). Participants also reported viewing people described with each of the mental disorders as
"hard to talk with" (Crisp et al., 2000). Crisp et al. (2000) suggested that these negative views of
people with mental illness can place barriers in the mentally ill person's attempt to recover,
contributing to social isolation, employment difficulties, and distress. Fischer and Turner (1970)
described four factors that are likely to affect help-seeking behaviors: (1) recognition of one's
need for professional help, (2) ability to tolerate stigma associated with engaging in
psychotherapy, (3) interpersonal openness about one's problems, and (4) confidence in the
psychological professional's ability to be of assistance. Corrigan (2004) defined "public stigma"
as "the negative views society holds toward those who seek professional help," and described it
to be a barrier associated with seeking psychological help. The internalization of this public

stigma (i.e., internalizing the negative views society holds toward both mental illness and seeking help) has been termed "self-stigma" and is thought to lead to beliefs that oneself is inferior or weak due to the need to seek counseling (Vogel, Wade, & Hackler, 2007). Schaub and Williams (2007) suggested that due to societal gender roles in the United States dictating that men should be independent, emotionally-controlled, and able to solve his own problems, this self-stigma could be an important predictor regarding men's help-seeking behaviors; based on this self-stigma and internalized gender roles, counseling may be perceived as a threat to a man's masculinity. Mahalik, Good, and Englar-Carlson (2003) discussed various masculinity scripts, including the "strong-and-silent" script, "tough-guy" script, "give-'em-hell" script, "playboy" script, "homophobic" script, "winner" script, and "independent" script. They found that masculinity was associated with less help seeking and increased negative attitudes toward seeking psychological help, which comes with the irony that these traditional masculinity scripts often contribute to some of men's presenting problems and act as barriers to help seeking (Mahalik et al., 2003). Komiya, Good, and Sherrod (2000) found that identifying as male, perceiving stigma, being uncomfortable with emotions, and having lower psychological distress accounted for 25% of variance regarding attitudes toward seeking psychological help. Various studies have found that internalizing the male gender norms that men should be tough, competitive, stoic, controlled, self-sufficient and emotionally inexpressive can have negative effects on men's attitudes toward and perceptions of what it means to seek mental health services and that these characteristics are inconsistent with help-seeking (Courtenay, 2000; Mahalik et al., 2003; Moller-Leimkuhler, 2002). Behaviors, such as help seeking, are oftentimes viewed negatively by men and avoided because they have been associated with vulnerability and weakness (Pederson & Vogel, 2007). Messages such as "boys don't cry" have the possibility of

16

decreasing the likelihood of boys and men showing mental health symptoms to others since they have learned that others may not respond in a positive or helpful manner (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011).

When investigating the stigma and discrimination experienced by people currently seeking mental health services, Wahl (1999) found that they experienced stigma from family, coworkers, mental health caregivers, churches, and their community, which led them to report discouragement, hurt, anger, and a reduction in self-esteem due to public stigma. Further, the gender of the help-seeker can be a large factor in whether or not the individual seeks psychological help. Gender differences in help seeking behaviors have been found, with women being more likely to seek help compared to men (Morgan, Ness, & Robinson, 2003). Men's tendency to be emotionally restrictive causes them to hesitate when making decisions regarding help seeking, whereas women's openness characteristics tend to facilitate their more positive attitudes toward help seeking (Komiya et al., 2000). Mackenzie, Gekoski, and Knox (2006) found that identifying as female and older age were associated with increased positive attitudes toward seeking help, as well as intentions to engage in help seeking. They believed that women exhibited increased intentions to seek mental health treatment compared to men due to their positive attitudes regarding being psychologically open, whereas men's negative attitudes toward psychological openness may be contributing to their decreased tendency to seek mental health treatment (Mackenzie et al., 2006).

Jennings, Cheung, Britt, Goguen, Jeffirs, Peasley, and Lee (2015) focused on how perceived stigma toward seeking mental health treatment affects the willingness of college students to seek help. They found that higher perceived stigma was related to more negative attitudes toward seeking treatment, which may lead people to increase stigmatizing attitudes

17

toward themselves and lead them to attempt to solve their problems on their own (Jennings et al., 2015). This could be especially problematic for sexual assault survivors presenting with PTSD since many of the symptoms of PTSD can be so impairing in multiple areas of the survivor's life. It was also found that stigma can also be a factor in male students' fear regarding others' thoughts about them seeking therapy, as well as how they would think about themselves for asking for professional psychological help (Nam, Chu, Lee, Lee, Kim, & Lee, 2010).

Not only do men have to contend with internalized messages regarding help-seeking as a threat to masculinity (Vogel et al., 2011), but male sexual assault survivors also have to deal with the public perception that victimization is a feminine and/or feminizing experience, which is inconsistent with stereotypes of men (Howard, 1984), which is especially problematic for male survivors disclosing their sexual assault to a potential formal or informal support provider. Zinzow, Britt, Pury, Jennings, Cheung, and Raymond (2015) examined the treatment-seeking patterns associated with U.S. active duty soldiers with histories of being sexually assaulted. They found that most sexual assault survivors sought informal support (87.6%) and 59.3% sought formal treatment; however, stigma was found to be the largest barrier that kept people from seeking mental health treatment (Zinzow et al., 2015). Zinzow et al. (2015) found that one-third of treatment seekers had dropped out after beginning treatment. Other randomized clinical trials saw somewhat similar dropout rates for trauma-focused interventions, with 18.9% to 26.9% of sexual assault survivors discontinuing treatment after participating in one or more sessions (Hembree, Foa, Dorfan, Street, Kolwalski, & Tu, 2003). While studies have shown that the dropout rate for sexual assault survivors seeking treatment can be quite high, no studies have yet investigated how sexual assault survivors dropping out of treatment is perceived by the general public.

In one of the first studies to examine the stigma surrounding combat veterans seeking treatment for PTSD, a qualitative analysis of treatment-seeking combat veterans' focus groups showed that common perceived stereotypes of veterans seeking treatment for PTSD include labels of being dangerous, violent, or crazy, as well as the belief that the veteran is responsible for having PTSD (Mittal, Drummond, Blevins, Curran, Corrigan, & Sullivan, 2013). While some studies have examined factors associated with treatment-seeking behaviors for military persons presenting with PTSD, research on public perceptions of treatment-seeking behaviors of non-military sexual assault survivors is lacking.

Present Study

The present study investigated public perceptions of and willingness to provide social support to survivors of sexual assault presenting with PTSD as a function of the gender of the survivor (male vs. female), psychotherapy treatment-seeking status (no treatment vs. dropped out after four sessions vs. still in treatment), and participant gender (male vs. female). Given the extensive literature available on the relationship between sexual assault and PTSD, the well-established efficacy and effectiveness of exposure-based psychotherapeutic interventions for PTSD, and the benefit of positive social reactions and support on alleviating PTSD symptoms, this study is a valuable addition to the literature as it is the first to examine how public perceptions vary when an individual is described as having dropped out of treatment after a certain number of sessions and how this affects the amount of social support the participant is willing to provide to the distressed individual. While some studies have focused on the stigma surrounding sexual assault, some on the stigma surrounding mental illness, and others on the stigma surrounding mental health treatment-seeking, this study uniquely examined the interaction effects of all three stigmas on how sexual assault survivors are perceived and the

19

degree of social support participants reported being willing to provide. This study also examined differences based on the described gender of the survivor and participant gender. The following hypotheses were examined:

H1

It was predicted that survivors described as having dropped out of treatment after four sessions would be perceived more negatively, receive more negative social reactions, and less positive social reactions compared to survivors described as not seeking services or as still being in treatment. Participants may have viewed the individual that dropped out as having rejected a form of support, whereas they may have viewed the individual not seeking treatment as being self-reliant and the individual that was seeking treatment as already making an effort to improve their current situation.

H2

It was predicted that there would be a significant interaction between survivor gender and treatment-seeking status in that male survivors of sexual assault would be perceived more negatively than female survivors, receive less positive social reactions, and receive more negative social reactions than female survivors of sexual assault when described as "still in treatment" due to the societal norms that men should not openly express emotions or struggles (Courtenay, 2000; Mahalik et al., 2003; Moller-Leimkuhler, 2002), whereas this action is more acceptable for women (Komiya et al., 2000; Mackenzie et al., 2006).

H3

It was predicted that male participants would perceive sexual assault survivors more negatively, engage in more negative social reactions, and engage in less positive social reactions compared to female participants. Past research suggests that men tend to blame the victim more

20

and provide less emotional support compared to women (Bell, Kuriloff, & Lottes, 1994; Grubb & Harrower, 2009; Mori et al., 1995; Nagel et al., 2005; Sommer et al., 2015; Whatley, 2005; Whatley & Riggio, 1993; White & Robinson Kurpius, 2002).

H4

It was predicted that male survivors of sexual assault would be perceived more negatively and be blamed more for the sexual assault compared to female survivors of sexual assault. Rape myths present in society (Coxell & King, 2010; Turchik & Edwards, 2012) and previous studies describe social norms as a barrier to men seeking treatment since the norms dictate that men should be masculine and emotionally controlled (Moller-Leimkuhler, 2002).

H5

It was predicted that participants would be less willing to provide social support via positive social reactions to male survivors of sexual assault compared to female survivors of sexual assault.

CHAPTER II

METHODS

Participants

One hundred ninety participants completed the study. Participants incorrectly responding to either of the two manipulation check questions were eliminated ($n = 10$) and participants not identifying as either male or female ($n = 2$) were eliminated, resulting in a sample of 178 participants. The sample of participants consisted of 89 males and 89 females, ranging in ages from 22 to 74 ($M_{age} = 38.7$, $SD = 12.2$). The sample consisted of mostly European American/White (79.2%), heterosexual (92.1%) participants who completed at least some postsecondary education (89.9%). See Table 1 for sample characteristics.

Materials/Questionnaires

Vignettes

One of six hypothetical scenarios based on a 2 (gender of sexual assault survivor: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) factorial design describing the PTSD symptoms and treatment-seeking behaviors of a male or female survivor of sexual assault (see Appendix A for vignettes) was randomly assigned to participants via a computer software program.

Manipulation Check

  Participants were asked to identify the gender (male vs. female) of the survivor of sexual assault and the survivor's treatment-seeking status (none vs. dropped out after four sessions vs. still in treatment) described in the given scenario. See Appendix B for measure.

Perceptions

Participants were asked to complete a 30-item questionnaire measuring their positive (15 items) and negative (15 items) perceptions of the survivor of sexual assault described in the given vignette. They were asked to indicate their responses on a scale ranging from 0 (strongly disagree) to 6 (strongly agree). Items measuring negative perceptions were reverse-scored and added to the scores for the positive perceptions to obtain an overall perceptions score, with higher numbers indicating more positive perceptions of the survivor. Possible scores ranged from 0 to 180. The items on this scale have a reliability of alpha = 0.85. See Appendix C for measure.

Table 1. Participant Descriptive Characteristics.

n = 178	*n*
<u>Gender</u>	
Male	89
Female	89
<u>Age Range = 22 to 74</u>	
22-29	49
30-39	61
40-49	28
50-59	29
60-69	10
70-74	1
<u>Sexual Orientation</u>	
Heterosexual	164
Bisexual	11
Gay Man	1
Lesbian	1
Other	1

Table 1. cont.

	n
Race/Ethnicity	
European-American/White	141
Asian American	12
African-American/Black	9
Biracial	7
Hispanic	6
Native American/American Indian	1
Other	1
Multi-Racial	1
Completed Education	
Doctoral Degree	6
Master's Degree	11
Bachelor Degree	63
Associate Degree or Certificate Program	23
Vocational/Technical School	2
Current Undergraduate Student	8
Some College	47
High School	14
GED	3
Did not graduate high school	1
Vignette	
Female Survivor / No Treatment	32
Male Survivor / No Treatment	26
Female Survivor / Dropped Out of Treatment	32
Male Survivor / Dropped Out of Treatment	31
Female Survivor / Still in Treatment	26
Male Survivor / Still in Treatment	31

Social Support

Participants were asked to complete an 83-item questionnaire, partially adapted from

Ullman's (2000) Social Reactions Questionnaire, measuring the degree of social support they

were willing to provide the survivor of sexual assault described in the given scenario, as well as

their positive and negative reactions to the description provided in the vignette. They were asked

to indicate their responses on a scale ranging from 0 (strongly disagree) to 6 (strongly agree).

This questionnaire was comprised of both negative and positive social reactions organized into the seven subscales described below. See Appendix D for measure.

Negative Social Reactions. Based on the subscales of Ullman's (2000) Social Reactions Questionnaire, there were five types of negative social reactions included:

Blaming the Victim. This subscale examined the degree to which participants blamed the survivor of sexual assault described in the paragraph (e.g., "The person is to blame for the sexual assault"). This subscale included four items adapted from Ullman's (2000) Social Reactions Questionnaire and had Cronbach's Alpha = 0.82. Possible scores on this subscale ranged from 0 to 24 with higher scores indicating increased victim blame.

Treating the Survivor Differently. This subscale examined the degree to which participants indicated that they would treat the survivor of sexual assault differently due to the sexual assault (e.g., "I would begin to pull away from the person"). This subscale included eight items adapted from Ullman's (2000) Social Reactions Questionnaire and had a Cronbach's Alpha = 0.83. Possible scores on this subscale ranged from 0 to 48 with higher scores indicating a greater tendency to treat the survivor differently.

Attempting to Control the Survivor's Actions. This subscale examined the degree to which participants indicated that they would attempt to control the survivor's actions and decisions (e.g., "I would tell the person they have to report the sexual assault to police"). This subscale included five items adapted from Ullman's (2000) Social Reactions Questionnaire and had a Cronbach's Alpha = 0.74. Possible scores on this subscale ranged from 0 to 30 with higher scores indicating a greater tendency to attempt to control the survivor's actions and decisions.

Distraction. This subscale examined the degree to which participants indicated that they would encourage the survivor to utilize distraction as a means of coping with the sexual assault

25

(e.g., "I would tell the person to stop thinking about the sexual assault). This subscale included 12 items adapted from Ullman's (2000) Social Reactions Questionnaire and had a Cronbach's Alpha = 0.90. Possible scores on this subscale ranged from 0 to 72 with higher scores indicating a greater tendency to encourage distraction as a means of coping.

Egocentric Reactions. This subscale examined the degree to which participants indicated that they would have a tendency to focus on their own needs rather than the survivor's needs (e.g., "I would tell the person that it upsets me to talk about the sexual assault"). This subscale included 12 items adapted from Ullman's (2000) Social Reactions Questionnaire and had a Cronbach's Alpha = 0.92. Possible scores on this subscale ranged from 0 to 72 with higher scores indicating a greater tendency to be self-focused rather than focused on the survivor's needs.

Positive Social Reactions. Based on the subscales of Ullman's (2000) Social Reactions Questionnaire, there were two types of positive social reactions included:

Providing Emotional Support/Belief. This subscale examined the degree to which participants indicated that they would provide the survivor with emotional support and indicate belief of their account regarding the sexual assault (e.g., "I would listen to the person whenever they need to talk about the sexual assault"). This subscale included 30 items adapted from Ullman's (2000) Social Reactions Questionnaire and had a Cronbach's Alpha = 0.98. Possible scores on this subscale ranged from 0 to 180 with higher scores indicating a greater willingness to provide emotional support and belief to the survivor of sexual assault.

Practical Support. This subscale examined the degree to which participants indicated that they would provide the survivor with practical support and information after the sexual assault (e.g., "I would help the person find resources for dealing with their sexual assault"). This

subscale included 12 items adapted from Ullman's (2000) Social Reactions Questionnaire and had a Cronbach's Alpha = 0.94. Possible scores on this subscale ranged from 0 to 72 with higher scores indicating a greater willingness to provide practical support and information to the survivor of sexual assault.

Demographics

The demographic questionnaire asked participants to indicate their age, gender, sexual orientation, race/ethnicity, and level of education. See Appendix E for measure.

Procedure

All research was completed in accordance with prevailing ethical principles and was approved by the Institutional Review Board. Participants were recruited through Amazon's Mechanical Turk. Only Master workers (i.e., a performance-based distinction for workers who have been shown to consistently complete tasks with a high degree of accuracy across multiple task requestors) were allowed to complete this study because they have been shown to provide higher-quality data, correctly answer attention check and manipulation check questions, and have a high reputation with 95% approval ratings (Peer, Vosgerau, & Acquisti, 2014). Recruiting participants through Amazon Mechanical Turk allowed participants to click a link and receive an invitation to participate in the study, which then sent them to the online survey. After clicking on the link, participants were randomly given one of six hypothetical scenarios based on a 2 (gender of sexual assault survivor: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) factorial design describing the PTSD symptoms and treatment-seeking behaviors of a male or female survivor of sexual assault. Participants were then asked to complete various measures, including a manipulation check, a perceptions questionnaire, a social support questionnaire, and a demographics questionnaire. Upon

27

completion, participants were given the principal investigator's contact information and instructed to email if they had any questions or concerns. Participants were also provided with the number to a 24-hour hotline for sexual assault survivors and were instructed to contact them if experiencing any adverse reactions from participating in this study. Participants were paid $1.00 for their participation in the study.

CHAPTER III

RESULTS

Perceptions

A 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) X 2 (participant gender: male vs. female) analysis of variance (ANOVA) was conducted to analyze the overall public perceptions of sexual assault survivors. Results indicated a significant main effect for treatment-seeking status $F(2, 166) = 7.58$, $p = .001$, $\eta^2_p = 0.084$. Planned post hoc analyses using Tukey's honestly significant difference (HSD) indicated significance for the "still in treatment" condition and all other treatment-seeking statuses, which did not differ from one another. Participants perceived survivors who were still in treatment ($M = 137.04$, $SD = 3.25$) more positively than survivors who did not seek treatment ($M = 120.18$, $SD = 3.09$) or dropped out of treatment after four sessions ($M = 124.41$, $SD = 2.95$).

There was also a significant main effect for participant gender, $F(1, 166) = 7.34$, $p = .007$, $\eta^2_p = 0.042$ such that female participants ($M = 132.06$, $SD = 2.49$) viewed survivors of sexual assault more positively than male participants ($M = 122.36$, $SD = 2.57$). No significant main effect was found for gender of the survivor of sexual assault, $F(1, 166) = 0.078$, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and treatment-seeking status, $F(2, 166) = 0.05$, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and the gender of the participant, $F(1, 166) =$

0.016, ns. There was no significant two-way interaction between treatment-seeking status and participant gender, F (2, 166) = 0.083, ns. There was no significant three-way interaction between gender of the survivor of sexual assault, treatment-seeking status, or participant gender, F (2, 166) = 2.134, p > .05.

Negative Social Reactions: Blaming the Victim

A 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) X 2 (participant gender: male vs. female) ANOVA was conducted to analyze participants' tendency to blame the victim. Results indicated a significant main effect for participant gender, F (1, 166) = 11.582, p = .001, η^2_p = 0.065, such that male participants (M = 4.29, SD = 0.41) blamed the survivor of sexual assault more than female participants (M = 2.37, SD = 0.39). This main effect was qualified by a significant interaction between participant gender and treatment-seeking status, F (2, 166) = 3.12, p = .047, η^2_p = 0.036. Simple effects analyses of participant gender at each level of treatment-seeking status found a significant difference at the level of "no treatment" in that male participants (M = 5.90, SD = 0.67) blamed sexual assault survivors who do not seek treatment significantly more than female participants (M = 1.99, SD = 0.71). See Figure 1.

No significant main effect was found for gender of the survivor of sexual assault, F (1, 166) < 0.001, ns. There was no significant main effect for treatment-seeking status, F (2, 166) = 1.279, p > .05. There was no significant two-way interaction between gender of the survivor of sexual assault and treatment-seeking status, F (2, 166) = 0.415, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and the participant gender, F (1, 166) = 1.754, p > .05. There was no significant three-way interaction between gender of the survivor of sexual assault, treatment-seeking status, or participant gender, F (2, 166) = 0.028, ns.

30

Figure 1. Negative social reactions: Blaming the victim: Treatment-seeking status by participant gender interaction.

Negative Social Reactions: Treating the Survivor Differently

A 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) X 2 (participant gender: male vs. female) ANOVA was conducted to analyze participants' tendency to indicate they would treat the survivor differently after the sexual assault. Results indicated a significant main effect for participant gender, $F(1, 166) = 14.708$, $p < .001$, $\eta^2_p = 0.081$, such that male participants ($M = 17.98$, $SD = 0.96$) indicated they would treat the survivor differently significantly more compared to female participants ($M = 12.85$, $SD = 0.93$). No significant main effect was found for gender of the survivor of sexual assault, $F(1, 166) = 0.990$, ns. There was no significant main effect for treatment-seeking status, $F(2, 166) = 2.036$, $p > .05$. There was no significant two-way

31

interaction between gender of the survivor of sexual assault and treatment-seeking status, F (2, 166) = 0.501, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and participant gender, F (1, 166) = 0.027, ns. There was no significant two-way interaction between treatment-seeking status and participant gender, F (2, 166) = 0.367, ns. There was no significant three-way interaction between gender of the survivor of sexual assault, treatment-seeking status, or participant gender, F (2, 166) = 0.517, ns.
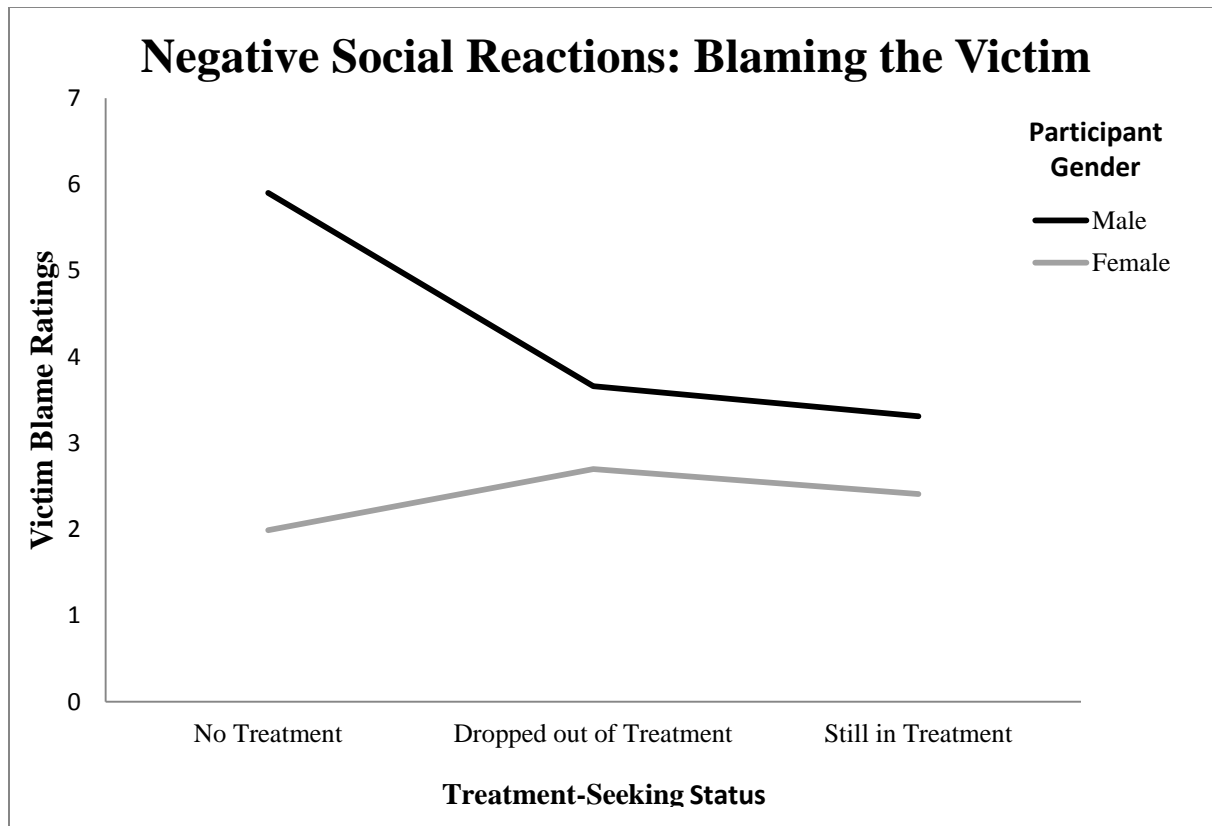
Negative Social Reactions: Attempting to Control the Survivor's Actions

A 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) X 2 (participant gender: male vs. female) ANOVA was conducted to analyze participants' indications that they would attempt to control the survivor's actions and decisions after the sexual assault. Results indicated a significant main effect for treatment-seeking status F (2, 166) = 3.224, p = .042, η^2_p = 0.037. Planned post hoc analyses using Tukey's HSD indicated significance for the "still in treatment" condition and all other treatment-seeking statuses, which did not differ from one another. Participants were significantly less likely to attempt to control the survivor's actions and decisions when the survivor was described as "still in treatment" (M = 12.35, SD = 0.86) compared to those described as not having sought treatment (M = 14.93, SD = 0.81) or having dropped out of treatment after four sessions (M = 14.97, SD = 0.78).

Results also indicated a significant main effect for participant gender, F (1, 166) = 4.241, p = .041, η^2_p = 0.025, such that male participants (M = 15.05, SD = 0.68) were more likely than female participants (M = 13.11, SD = 0.66) to indicate they would to attempt to control the survivor's actions and decisions after the sexual assault. No significant main effect was found for gender of the survivor of sexual assault, F (1, 166) = 0.86, ns. There was no significant two-way

interaction between gender of the survivor of sexual assault and treatment-seeking status, F (2, 166) = 0.636, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and participant gender, F (1, 166) = 0.25, ns. There was no significant two-way interaction between treatment-seeking status and participant gender, F (2, 166) = 0.114, ns. There was no significant three-way interaction between gender of the survivor of sexual assault, treatment-seeking status, or participant gender, F (2, 166) = 1.78, $p > .05$.

Negative Social Reactions: Distraction

A 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) X 2 (participant gender: male vs. female) ANOVA was conducted to analyze participants' indications that they would encourage the survivor to utilize distraction as a means of coping with the sexual assault. Results indicated a significant main effect for participant gender, F (1, 166) = 24.587, $p < .001$, $\eta^2_p = 0.129$, such that male participants ($M = 21.53$, $SD = 1.31$) indicated they would be more likely to encourage the survivor to utilize distraction as a means of coping after the sexual assault than female participants ($M = 12.49$, $SD = 1.27$). No significant main effect was found for gender of the survivor of sexual assault, F (1, 166) = 0.262, ns. There was no significant main effect for treatment-seeking status, F (2, 166) = 0.540, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and treatment-seeking status, F (2, 166) = 0.478, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and participant gender, F (1, 166) = 0.032, ns. There was no significant two-way interaction between treatment-seeking status and participant gender, F (2, 166) = 2.551, $p > .05$. There was no significant three-way interaction between gender of the survivor of sexual assault, treatment-seeking status, or participant gender, F (2, 166) = 0.036, ns.

Negative Social Reactions: Egocentric Reactions

A 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) X 2 (participant gender: male vs. female) ANOVA was conducted to analyze participants' indications that they would tend to focus on their own reactions and needs rather than the survivor's reactions and needs after the sexual assault. Results indicated a significant main effect for participant gender, F (1, 166) = 9.387, p = .003, η^2_p = 0.054, such that male participants' (M = 18.45, SD = 1.42) responses suggested they would be significantly more likely than female participants (M = 12.38, SD = 1.38) to focus on their own needs rather than the survivor's needs after the sexual assault. No significant main effect was found for gender of the survivor of sexual assault, F (1, 166) = 0.143, ns. There was no significant main effect for treatment-seeking status, F (2, 166) = 0.525, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and treatment-seeking status, F (2, 166) = 1.419, p > .05. There was no significant two-way interaction between gender of the survivor of sexual assault and participant gender, F (1, 166) = 0.370, ns. There was no significant two-way interaction between treatment-seeking status and participant gender, F (2, 166) = 2.365, p > .05. There was no significant three-way interaction between gender of the survivor of sexual assault, treatment-seeking status, or participant gender, F (2, 166) = 0.096, ns.

Positive Social Reactions: Providing Emotional Support/Belief

A 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) X 2 (participant gender: male vs. female) ANOVA was conducted to analyze participants' indications that they would provide the survivor with emotional support and indicate belief of the survivor's account after the sexual

assault. Results indicated a significant main effect for participant gender, $F(1, 166) = 18.251$, $p < .001$, $\eta^2_p = 0.099$, such that female participants ($M = 164.28$, $SD = 3.03$) indicated they were significantly more willing than male participants ($M = 145.71$, $SD = 3.12$) to provide survivors with emotional support and indicate belief of their account after the sexual assault. There was also a significant two-way interaction between gender of the survivor of sexual assault and treatment-seeking status $F(2, 166) = 3.910$, $p = .022$, $\eta^2_p = 0.045$. Simple effects analyses of gender of the survivor of sexual assault at each level of treatment-seeking status found a significant difference at the level of "still in treatment" in that participants were willing to provide significantly more emotional support and belief to female survivors of sexual assault ($M = 162.97$, $SD = 6.02$) who were still in treatment compared to male survivors of sexual assault ($M = 144.37$, $SD = 5.12$) who were still in treatment. See Figure 2.

No significant main effect was found for gender of the survivor of sexual assault, $F(1, 166) = 0.66$, ns. There was no significant main effect for treatment-seeking status, $F(2, 166) = 0.503$, ns. There was no significant two-way interaction between gender of the survivor of sexual assault and the participant gender, $F(1, 166) = 0.464$, ns. There was no significant two-way interaction between treatment-seeking status and participant gender, $F(2, 166) = 0.807$, ns. There was no significant three-way interaction between gender of the survivor of sexual assault, treatment-seeking status, or participant gender, $F(2, 166) = 1.855$, $p > .05$.

Positive Social Reactions: Emotional Support/Belief
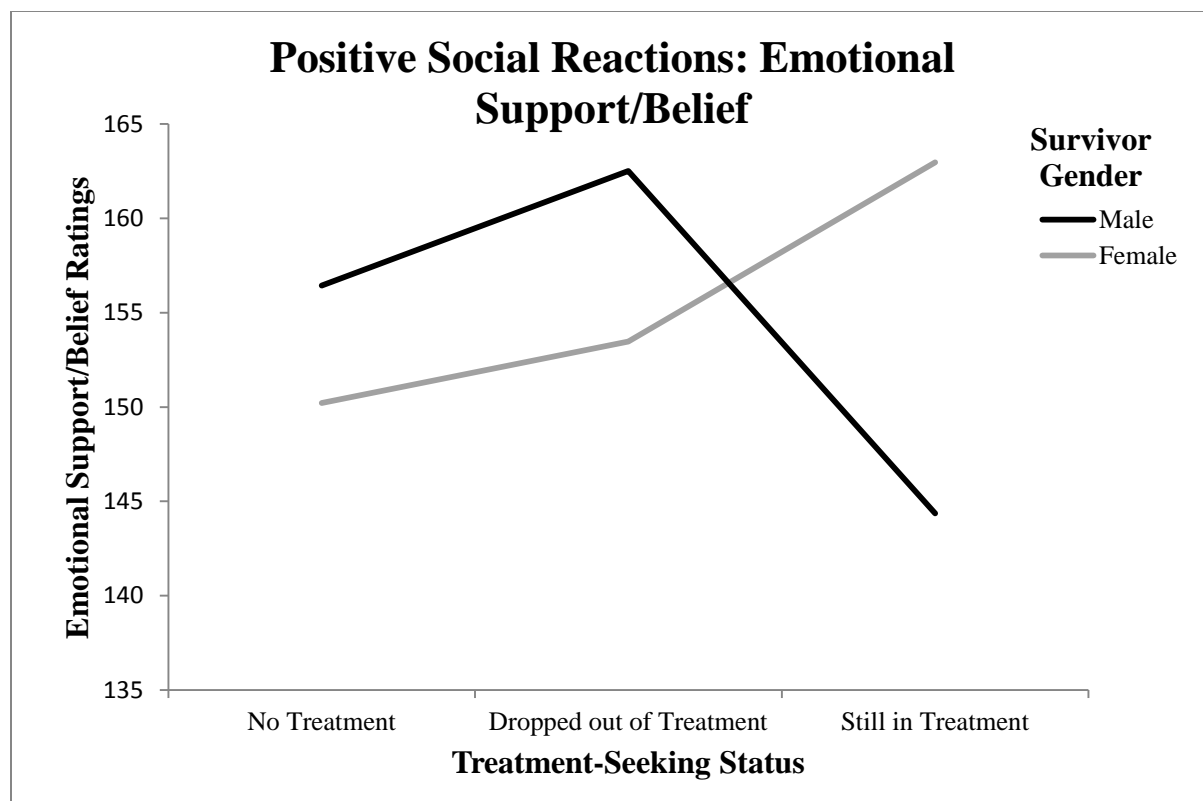
Figure 2. Positive social reactions: Providing emotional support/belief: Gender of survivor of sexual assault by treatment-seeking status interaction.

Positive Social Reactions: Practical Support

A 2 (gender of survivor of sexual assault: male vs. female) X 3 (treatment-seeking status: none vs. dropped out after four sessions vs. still in treatment) X 2 (participant gender: male vs. female) ANOVA was conducted to analyze participants' indications that they would provide survivors with practical support after the sexual assault. Results indicated a significant main effect for participant gender, $F(1, 166) = 13.821$, $p < .001$, $\eta^2_p = 0.077$, such that female participants ($M = 61.94$, $SD = 1.25$) were willing to provide significantly more practical support and information to sexual assault survivors compared to male participants ($M = 55.26$, $SD = 1.29$) after the sexual assault. No significant main effect was found for gender of the survivor of sexual assault, $F(1, 166) = 0.034$, ns. There was no significant main effect for treatment-seeking

status, $F(2, 166) = 1.638$, $p > .05$. There was no significant two-way interaction between gender of the survivor of sexual assault and treatment-seeking status, $F(2, 166) = 2.339$, $p > .05$. There was no significant two-way interaction between gender of the survivor of sexual assault and participant gender, $F(1, 166) = 0.998$, ns. There was no significant two-way interaction between treatment-seeking status and participant gender, $F(2, 166) = 1.251$, $p > .05$. There was no significant three-way interaction between gender of the survivor of sexual assault, treatment-seeking status, or participant gender, $F(2, 166) = 2.696$, $p > .05$.

CHAPTER IV

DISCUSSION

The present study examined public perceptions of and willingness to provide social support to survivors of sexual assault presenting with PTSD based on the survivor's gender (male vs. female), psychotherapy treatment-seeking status (no treatment vs. dropped out after four sessions vs. still in treatment), and participant gender (male vs. female). Results regarding participant gender differences in each negative social reaction (blaming the victim, treating the survivor differently, attempting to control the survivor's actions, distraction, and egocentric reactions) and each positive social reaction (providing emotional support/belief and practical support) were consistent with hypotheses in that male participants blamed the victim more, indicated they would treat the survivor differently, attempted to control their actions and decisions, encouraged distraction as a means of coping with the assault, focused more on their needs than the survivor's needs, provided less emotional support/belief, and provided less practical support to survivors of sexual assault compared to female participants. This is consistent with myriad previous studies indicating that male participants tend to blame the sexual assault survivor more, hold more rape-tolerant attitudes, and view sexual assault survivors less sympathetically when compared to female participants (Bell et al., 1994; Grubb & Harrower, 2009; Mori et al., 1995; Nagel et al., 2005; Sommer et al., 2015; Whatley, 2005; Whatley & Riggio, 1993; White & Robinson Kurpius, 2002). The findings in the current study replicate and extend these findings by suggesting that not only do men tend to engage in more negative social

38

reactions (e.g., blaming the victim) compared to women, but they also engage in less positive social reactions (i.e., providing emotional support/belief and practical support) than women. This could be due to the endorsement of traditional masculine gender norms denouncing emotionality and promoting self-reliance and a tough mindset when dealing with problems (Mahalik et al., 2003) like sexual assault. This could also lead to a man's tendency to provide less emotional support to others in need based on his understanding of societal rules regarding how to cope with issues that lead to emotional distress.

The prediction that participants would perceive survivors who were described as dropping out of treatment more negatively compared to survivors who were described as not having sought treatment or who were described as still in treatment was not supported. In fact participants perceived survivors who were described as still in treatment most positively, which is surprising given the many studies describing the stigma surrounding endorsement of mental health concerns and seeking mental health treatment and negative attitudes toward people diagnosed with mental disorders (Corrigan, 2004; Crisp et al., 2000; Schaub & Williams, 2007). Furthermore, the finding that survivors described as still in treatment received fewer negative social reactions in the form of controlling responses (e.g., participants endorsing that they would tell the survivor they need to report the assault to police) compared to survivors described as not having sought treatment or having dropped out of treatment suggests that participants may have viewed the survivor who was still in treatment as having control over his or her own recovery by continuing therapy, thereby "needing" less control from their informal social support provider. The finding that participants saw less of a need to control the survivor's actions when they were still in treatment to cope with the various symptoms of PTSD they were currently experiencing is a positive finding, especially given past studies that have found that people perceive those with

certain mental disorders as unpredictable and dangerous (Crisp et al., 2000) and people with

PTSD, specifically, as being dangerous, violent, or crazy (Mittal et al., 2013). One negative

aspect of this finding is that participants indicated they would be more likely to attempt to

control the survivor's actions when he or she was described as not seeking or having dropped out

of treatment. This is problematic because survivors with a decreased perception of control over

their own recovery have more negative outcomes, such as increased symptoms of PTSD,

depression, and anxiety, as well as decreased perceptions of reassurance of their worth

(Orchowski et al., 2013)

The predicted interaction between survivor gender and treatment-seeking status was

partially supported by the finding that at the level of "still in treatment," male survivors received

less positive social reactions in the form of emotional support and belief compared to female

survivors. This could be due to the endorsement of societal norms that men should be self-reliant

when solving problems (Courtenay, 2000; Mahalik et al., 2003; Moller-Leimkuhler, 2002),

which would be violated by a man seeking and continuing to attend therapy services, whereas

this action is more acceptable for women (Komiya et al., 2000; Mackenzie et al., 2006). The

prediction that male survivors described as still in treatment would be perceived more negatively

and receive more negative social reactions compared to female survivors described as still in

treatment was not supported. A significant interaction between treatment-seeking status and

participant gender was also found regarding the negative social reaction of blaming the victim in

that male participants tended to blame survivors who did not seek treatment significantly more

than female participants. Because men have been taught that society has the expectation that they

should be self-reliant, solve their own problems, and be able to protect themselves in various

situations (Courtenay, 2000; Mahalik et al., 2003; Moller-Leimkuhler, 2002; Schaub &

Williams, 2007), it is possible that male participants attributed these same rules to survivors of sexual assault who do not seek treatment. Because the survivor described in the paragraph had experienced the sexual assault and continued to experience a number of symptoms afterward that were affecting various areas of his or her life, it is possible that men viewed the continued symptoms as a failure to resolve one's own distress despite the decision to forgo treatment, in addition to "failing" to protect him- or herself during the assault. However, women may be in a better position to recognize the difficulty in pursuing mental health treatment since they are more likely to do so (Komiya et al., 2000; Mackenzie et al., 2006; Morgan et al., 2003), thereby recognizing that the decision regarding whether or not to seek treatment is not indicative of the level of victimization, nor the presence or absence of psychological symptoms related to the rape.

Surprisingly, hypotheses regarding main effects of survivor gender were not supported; no significant differences were found in the perceptions of male and female sexual assault survivors, nor were there differences in the positive and negative social reactions. One possible reason for this may be that, as intended, the vignette read by participants unambiguously indicated that the survivor, who was described as their friend, was indeed sexually assaulted, and it did not provide any information about the assailant. Previous studies have found that participant reactions, such as victim blame, to descriptions of sexual assault scenarios can change based on various factors, including survivor gender, gender pairings of the perpetrator and victim, and relationship to the offender. For example, Sommer et al. (2015) found that a male survivor who was raped by a female perpetrator was blamed more for the sexual assault than a female survivor of a male perpetrator, which was also consistent with the findings of Smith, Pine, and Hawley (1988). Additionally, because many people believe that sexual assaults are

mostly perpetrated by strangers (Anderson, 2007), the minimal information regarding the sexual assault scenario may have led participants to assume that their "friend" had been assaulted by a stranger as well, which has been shown to be associated with decreased victim blame relative to other perpetrator-victim relationships (Grubb & Harrower, 2009). The limited information regarding the sexual assault scenario and the matter-of-fact assertion that their "friend" was sexually assaulted potentially attenuated the frequent differences seen based on survivor gender.

Despite the differences between male and female participants on each social reactions measure, both male and female participants tended to rate potential negative social reactions low and potential positive social reactions high overall (see Table 2). One possible explanation for this is a social desirability bias, which suggests that participants may have responded in such a way to present themselves in a more positive light (Fisher, 1993) by indicating they would be less likely to react negatively and more likely to provide emotional and practical support to the survivor of sexual assault described in the paragraph. Paulhus (1984) suggested that people can provide socially desirable responses through two modes: being honest yet overly favorable in their self-presentation, or attempting to present oneself in a socially conventional way to avoid negative evaluations by others (Paulhus, 1991). Another possible explanation for the low endorsement of negative social reactions and high endorsement of positive social reactions is that participants were answering based on the expression of their values. Fisher and Katz (2000) assert that there are significant associations between measures of social desirability and self-reported values. They suggested that values that are most important to an individual have the greatest self-presentational implications, such as self-respect, a sense of accomplishment, warm relationships with others, being well respected, and self-fulfillment (Fisher & Katz, 2000). It is possible that participants, in general, valued having warm relationships with others, which could

Table 2. Participant Gender Main Effects: Means, Standard Deviations, and Score Ranges.

	Scale Range	Mean	SD
Overall Perceptions	0 to 180		
Male Participants		122.36	2.57
Female Participants		132.06	2.49
NSR: Blaming the Victim	0 to 24		
Male Participants		4.29	0.41
Female Participants		2.37	0.39
NSR: Treating the Survivor Differently	0 to 48		
Male Participants		17.98	0.96
Female Participants		12.85	0.93
NSR: Attempting to Control the Survivor's Actions	0 to 30		
Male Participants		15.05	0.68
Female Participants		13.11	0.66
NSR: Distraction	0 to 72		
Male Participants		21.53	1.31
Female Participants		12.49	1.27
NSR: Egocentric Reactions	0 to 72		
Male Participants		18.45	1.42
Female Participants		12.38	1.38
PSR: Providing Emotional Support/Belief	0 to 180		
Male Participants		145.71	3.12
Female Participants		164.28	3.03
PSR: Practical Support	0 to 72		
Male Participants		55.26	1.29
Female Participants		61.94	1.25

Note. NSR = Negative Social Reactions; PSR = Positive Social Reactions; SD = Standard Deviation

entail providing emotional and practical support to their "friend" while the survivor was dealing with the consequences of the sexual assault and PTSD symptoms. Hogg, Terry, and White (1995) also asserted that people have a need to see themselves positively in relation to relevant others, so participants in this study may have been attempting to fulfill that need by indicating that they would engage in positive social reactions rather than negative social reactions, which would likely be viewed as most helpful by the survivor in a real world situation.

Various studies have shown that negative social reactions are prevalent across many sexual assault disclosures, which is a large contributor to the subsequent development of PTSD and maladaptive coping. However, the results of this study suggest that people want to help and react to sexual assault disclosures and mental health concerns in positive ways that will facilitate recovery from the trauma, but they may just not know how to do so in real world situations. One potential solution to the dealing with the lack of know-how regarding how to engage in positive social reactions rather than negative social reactions is to offer classes or workshops related to reactions to sexual assault disclosures by close others (e.g., family and friends). Sexual assault disclosures can be unexpected, and when dealing with unexpected situations, people may resort to processing the information based on previously learned schemas, such as the belief in a just world. This could lead to increased negative reactions after the disclosure, such as asking questions or making statements that imply victim blame regarding the survivor's actions or decisions in the sexual assault scenario (e.g., "How much did you have to drink?" or "You should not have been walking around alone at night"). A common task for therapists aiding sexual assault survivors in their recovery is dealing with the hindsight bias (i.e., looking back on an event and believing one should have been able to predict what would happen or known how to best react in the given situation) and subsequent guilt-related cognitions. When attempting to

modify guilt-related cognitions due to hindsight bias, it is often discussed with clients that response options that they think of after the assault were not response options during the time of assault, which makes it unfair for them to blame themselves for not responding in the way that they deem most appropriate after the fact. The lack of knowledge on the part of potential social supports for how to best react socially upon disclosure of a sexual assault could be thought of using the same principle. Social supports react to sexual assault disclosure based on the beliefs, attitudes, and knowledge available to them at the time, which could be riddled with the endorsement of rape myths and filtered through the belief in a just world, thereby leading to increased negative social reactions. However, if classes or workshops address this lack of knowledge by having discussions about different potential positive social reactions that could be most helpful upon sexual assault disclosure by friends or family, then social supports would have these response options available to them at the time of a future disclosure. The availability of positive response options and education about unhelpful response options could lead to survivor perceptions of increased social support. Because increased social support has been shown to ameliorate PTSD symptoms and lead to better recovery after a sexual assault, these classes could be crucial and play an important role in reducing the frequency of development of PTSD after a sexual assault once the assault has been disclosed. Recently published studies have also discussed the need for educating informal social support providers, as well as formal support providers, about the helpful and unhelpful effects of different reactions to sexual assault disclosures to increase the support's ability to respond in supportive ways and aid in facilitating the survivor's recovery process (Relyea & Ullman, 2015; Ullman & Peter-Hagene, 2016). Future studies could examine how effective these classes or workshops are, if they are developed, in increasing social supports' ability to engage in positive social reactions and reduce their

45

engagement in negative social reactions, as well as how that affects the prevalence sexual assault survivors presenting with PTSD after disclosing.

One limitation of this study is the uncertainty surrounding what is driving participants' tendency to indicate they would provide relatively few negative social reactions and many positive social reactions when interacting with a friend who was sexually assaulted and experiencing PTSD. Many studies have documented the real-world negative reactions (e.g., blame) to sexual assault survivors and their subsequent psychological symptoms, including negative reactions by survivors' friends and family. However, the frequency of negative social reactions reported by survivors of sexual assault are not being reported to the same degree by participants, who were put in a position of being a social support for a "friend." This could be due to a variety of reasons, including social desirability bias, the participants' self-reported values, or the assumed relationship with the survivor (i.e., the fact that the survivor was described their friend). Future studies may benefit by including these measures in addition to the ones used in the current study to aid in deducing the cause of these response patterns.

Additionally this study lacks ecological validity in the sense that participants were asked how they would respond if their friend was sexually assaulted and presenting with PTSD, which makes the situation hypothetical. However, many studies have already examined how social supports actually respond to sexual assault disclosures by others (e.g., Ullman, 1996a; Ullman, 1996b; Ullman, 2000; Ullman & Filipas, 2001a; Ullman & Filipas, 2001b; Ullman & Peter-Hagene, 2014; Ullman & Peter-Hagene, 2016). Therefore, this study was useful in examining participants' desire and willingness to help sexual assault survivors in their social network and allowing those responses to be compared to previous studies about what is typically seen upon sexual assault disclosures.

Another potential limitation is the lack of ambiguity with which the sexual assault was described in the vignette. In the present study, participants were told that their "friend" was, indeed, sexually assaulted and was experiencing a number of PTSD symptoms. The vignette also did not provide much detail about the sexual assault itself or the perpetrator of the sexual assault, two factors that have been shown to have effects on public perceptions of sexual assault scenarios and survivors (Grubb & Harrower, 2009; Sommer et al., 2015). Both the lack of ambiguity and the lack of information regarding the sexual assault scenario and perpetrator could be the reason why this study has not replicated past studies demonstrating differences in public perceptions of male survivors versus female survivors. However, the lack of ambiguity was intentional in an effort to elicit participant reactions based on knowing that an assault occurred, that the survivor was experiencing psychological consequences (i.e., PTSD), and that the survivor had made a decision regarding seeking mental health services.

Limitations notwithstanding, the present study elicited participant perceptions and reactions to descriptions of treatment-seeking decisions of individuals after a sexual assault and suggested that societal norms regarding gender roles could be related to the increased emotional support provided to female survivors compared to male survivors who were actively engaged in mental health treatment. The current study also replicated past findings regarding men's tendency to blame the sexual assault survivors more, hold more rape-tolerant attitudes, and view sexual assault survivors less sympathetically when compared to female participants. However, this study also suggested that, overall, participants want to help friends by providing emotional and practical support after an assault rather than engaging in negative social reactions, such as blaming the victim or attempting to control the survivor's actions. It would be beneficial for classes to be developed to capitalize on this desire to help by teaching potential future social

supports for sexual assault survivors how to best react in helpful ways, rather than harmful ways, to someone in their social network upon disclosure of an assault. This could allow social supports to help facilitate the survivor's psychological recovery after the assault, as well as increase the survivor's perceived control over their own recovery, thereby reducing the severity of the survivor's PTSD symptoms.

APPENDICES

Appendix A
Vignettes

Female, No Treatment

Your female friend was sexually assaulted six months ago. Ever since the assault, she has been having trouble sleeping due to nightmares; frequent flashbacks where she feels as if she is re-experiencing the sexual assault; and frequent, distressing thoughts and memories related to her assault that come to her mind when she does not want to think about them. She has also begun avoiding different people and places that remind her of the assault, and she no longer feels safe in large crowds. If she does go out in public, she tends to sit in the corners of rooms so that she can scan the room for any possible threats to her safety. She reports feeling "on edge" for most of each day, and she tends to be more easily startled when unexpected events occur, such as a door making a loud noise when closing. Your friend has also been having difficulties connecting with family and friends, and she reports feeling detached from those in her life with whom she was close before the sexual assault. She reports feeling "numb" most of the time and that she has trouble feeling any emotions other than fear, guilt, and shame regarding what happened to her. She has decided not to seek mental health services (i.e., therapy) at this time.

Male, No Treatment

Your male friend was sexually assaulted six months ago. Ever since the assault, he has been having trouble sleeping due to nightmares; frequent flashbacks where he feels as if he is re-experiencing the sexual assault; and frequent, distressing thoughts and memories related to his assault that come to his mind when he does not want to think about them. He has also begun avoiding different people and places that remind him of the assault, and he no longer feels safe in large crowds. If he does go out in public, he tends to sit in the corners of rooms so that he can scan the room for any possible threats to his safety. He reports feeling "on edge" for most of each day, and he tends to be more easily startled when unexpected events occur, such as a door making a loud noise when closing. Your friend has also been having difficulties connecting with family and friends, and he reports feeling detached from those in his life with whom he was close before the sexual assault. He reports feeling "numb" most of the time and that he has trouble feeling any emotions other than fear, guilt, and shame regarding what happened to him. He has decided not to seek mental health services (i.e., therapy) at this time.

Female, Some Treatment (Dropped out after 4 sessions)

Your female friend was sexually assaulted six months ago. Ever since the assault, she has been having trouble sleeping due to nightmares; frequent flashbacks where she feels as if she is re-experiencing the sexual assault; and frequent, distressing thoughts and memories related to her assault that come to her mind when she does not want to think about them. She has also begun avoiding different people and places that remind her of the assault, and she no longer feels safe

in large crowds. If she does go out in public, she tends to sit in the corners of rooms so that she can scan the room for any possible threats to her safety. She reports feeling "on edge" for most of each day, and she tends to be more easily startled when unexpected events occur, such as a door making a loud noise when closing. Your friend has also been having difficulties connecting with family and friends, and she reports feeling detached from those in her life with whom she was close before the sexual assault. She reports feeling "numb" most of the time and that she has trouble feeling any emotions other than fear, guilt, and shame regarding what happened to her. She had decided to seek mental health services, but she discontinued therapy after four sessions.

Male, Some Treatment (Dropped out after 4 sessions)

Your male friend was sexually assaulted six months ago. Ever since the assault, he has been having trouble sleeping due to nightmares; frequent flashbacks where he feels as if he is re-experiencing the sexual assault; and frequent, distressing thoughts and memories related to his assault that come to his mind when he does not want to think about them. He has also begun avoiding different people and places that remind him of the assault, and he no longer feels safe in large crowds. If he does go out in public, he tends to sit in the corners of rooms so that he can scan the room for any possible threats to his safety. He reports feeling "on edge" for most of each day, and he tends to be more easily startled when unexpected events occur, such as a door making a loud noise when closing. Your friend has also been having difficulties connecting with family and friends, and he reports feeling detached from those in his life with whom he was close before the sexual assault. He reports feeling "numb" most of the time and that he has trouble feeling any emotions other than fear, guilt, and shame regarding what happened to him. He had decided to seek mental health services, but he discontinued therapy after four sessions.

Female, Still in Treatment

Your female friend was sexually assaulted six months ago. Ever since the assault, she has been having trouble sleeping due to nightmares; frequent flashbacks where she feels as if she is re-experiencing the sexual assault; and frequent, distressing thoughts and memories related to her assault that come to her mind when she does not want to think about them. She has also been avoiding different people and places that remind her of the assault, and she no longer feels safe in large crowds. If she does go out in public, she tends to sit in the corners of rooms so that she can scan the room for any possible threats to her safety. She reports feeling "on edge" for most of each day, and she tends to be more easily startled when unexpected events occur, such as a door making a loud noise when closing. Your friend has also been having difficulties connecting with family and friends, and she reports feeling detached from those in her life with whom she was close before the sexual assault. She reports feeling "numb" most of the time and that she has trouble feeling any emotions other than fear, guilt, and shame regarding what happened to her. She decided to seek mental health services. She is currently attending weekly therapy sessions, and she has attended eight sessions so far.

Male, Still in Treatment

Your male friend was sexually assaulted six months ago. Ever since the assault, he has been having trouble sleeping due to nightmares; frequent flashbacks where he feels as if he is re-experiencing the sexual assault; and frequent, distressing thoughts and memories related to his assault that come to his mind when he does not want to think about them. He has also begun avoiding different people and places that remind him of the assault, and he no longer feels safe in large crowds. If he does go out in public, he tends to sit in the corners of rooms so that he can scan the room for any possible threats to his safety. He reports feeling "on edge" for most of each day, and he tends to be more easily startled when unexpected events occur, such as a door making a loud noise when closing. Your friend has also been having difficulties connecting with family and friends, and he reports feeling detached from those in his life with whom he was close before the sexual assault. He reports feeling "numb" most of the time and that he has trouble feeling any emotions other than fear, guilt, and shame regarding what happened to him. He decided to seek mental health services. He is currently attending weekly therapy sessions, and he has attended eight sessions so far.

Appendix B
Manipulation Check

Did the profile you viewed belong to a male or female?

      MALE   FEMALE

Did the person described in the paragraph decide to seek mental health services (i.e., therapy)?

      NO, NOT AT THIS TIME

      YES, BUT THEY DISCONTINUED THERAPY AFTER FOUR SESSIONS

      YES, THEY ARE STILL IN THERAPY AND HAVE COMPLETED EIGHT
      SESSIONS SO FAR

Appendix C
Perceptions

Given the following rating scale, please indicate the extent to which you agree or disagree with the following statements regarding the person you read about in the paragraph.

Strongly Disagree			Neither Agree Nor Disagree			Strongly Agree
0	1	2	3	4	5	6

_____ 1. The person in the paragraph is friendly.

_____ 2. The person in the paragraph is thoughtful.

_____ 3. The person in the paragraph is caring.

_____ 4. The person in the paragraph is intelligent.

_____ 5. The person in the paragraph is independent.

_____ 6. The person in the paragraph is respectful.

_____ 7. The person in the paragraph is considerate.

_____ 8. The person in the paragraph is emotionally mature.

_____ 9. The person in the paragraph has a good sense of humor.

_____ 10. The person in the paragraph is healthy.

_____ 11. The person in the paragraph is responsible.

_____ 12. The person in the paragraph is resilient.

_____ 13. The person in the paragraph is strong.

_____ 14. The person in the paragraph deserves sympathy.

_____ 15. The person in the paragraph is safe to be around.

_____ 16. The person in the paragraph is to be feared.

_____ 17. The person in the paragraph is unstable.

_____ 18. The person in the paragraph is weak.

_____ 19. The person in the paragraph is an angry person.

_____ 20. The person in the paragraph is dangerous.

_____ 21. The person in the paragraph is irresponsible.

_____ 22. The person in the paragraph is cold-hearted.

_____ 23. The person in the paragraph is a bad friend.

_____ 24. The person in the paragraph is a liar.

_____ 25. The person in the paragraph is dishonest.

_____ 26. The person in the paragraph is crazy.

_____ 27. The person in the paragraph is strange.

_____ 28. The person in the paragraph is rude.

_____ 29. The person in the paragraph is unhealthy.

_____ 30. The person in the paragraph is selfish.

Appendix D
Social Reactions/Support Provided

Given the following rating scale, please indicate the extent to which you agree or disagree with the following statements regarding the person you read about in the paragraph.

Strongly Disagree			Neither Agree Nor Disagree			Strongly Agree
0	1	2	3	4	5	6

Negative Social Reactions

Blaming the Victim

1. The person is to blame for the sexual assault.
2. The person is to blame for their current state of being.
3. The person could have done more to prevent the sexual assault from occurring.
4. The person was not cautious enough.

Treating the Survivor Differently

1. The person is damaged.
2. The person's life will never go back to normal.
3. The person is tainted by the sexual assault.
4. I would begin to pull away from the person.
5. I would treat the person differently.
6. I would avoid talking to the person.
7. I would avoid spending time with the person.
8. I would put my needs ahead of the person's needs.

Attempting to Control the Survivor's Actions

1. I would tell the person they have to report the sexual assault to police.
2. I would tell the person they have to tell their family that they were sexually assaulted.
3. I would tell the person they have to go to therapy.
4. I would make decisions for the person.
5. The person does not know how to care for themselves.

Distraction

1. I would tell the person they need to change their behavior.
2. I would tell the person they need to change their thoughts.
3. I would tell the person they need to change their feelings.

4. I would tell the person to act as if the sexual assault never happened.
5. I would tell the person they need to get over it.
6. I would tell the person they need to move on with their life.
7. I would tell the person to stop talking about the sexual assault.
8. I would tell the person they need to stop talking about what they are going through.
9. I would tell the person to stop thinking about the sexual assault.
10. I would tell the person to keep the sexual assault a secret.
11. I would tell the person to keep what they are going through a secret.
12. I would tell the person to distract themselves with other things.

Egocentric Reactions

1. I would tell the person that it upsets me to talk about the sexual assault.
2. I would tell the person that it upsets me to talk about what they have been going through since the assault.
3. I would tell the person I am uncomfortable hearing about the sexual assault.
4. I would tell the person I am uncomfortable hearing about what they have been going through since the assault.
5. I would talk to the person about the sexual assault when it is convenient for me.
6. I would talk to the person about what they have been going through since the assault when it is convenient for me.
7. I would tell the person I am not ready to talk about their sexual assault.
8. I would tell the person I am not ready to talk about what they have been going through since the assault.
9. I would tell the person I do not want to talk about the sexual assault.
10. I would tell the person I do not want to talk about what they have been going through since the assault.
11. I would express so much anger toward the perpetrator that the person would have to calm me down.
12. I would want to seek revenge on the perpetrator.

Positive Social Reactions

Providing Emotional Support/Belief

1. I would listen to the person whenever they need to talk about the sexual assault.
2. I would listen to the person whenever they need to talk about what they have been going through since the assault.
3. I would answer the phone whenever the person calls me to talk about the sexual assault.
4. I would answer the phone whenever the person calls me to talk about what they have been going through since the assault.

5. I would answer emails, texts, and social media messages that the person sends to me related to the sexual assault.
6. I would answer emails, texts, and social media messages that the person sends to me related to what they have been going through since the assault.
7. I would meet the individual in person whenever they need to talk about the sexual assault.
8. I would meet the individual in person whenever they need to talk about what they have been going through since the assault.
9. I would comfort the person when they cry about the sexual assault.
10. I would comfort the person when they cry about what they have been going through since the assault.
11. I would tell the person it is not their fault that they were sexually assaulted.
12. I would tell the person it is not their fault that they are going through a hard time.
13. I would tell the person they are not to blame for what happened.
14. I would tell the person they are not to blame for what they have been going through since the assault.
15. I would tell the person they did not do anything wrong.
16. I would tell the individual that they are a good person.
17. I would tell the person that everything will be okay.
18. I would spend as much time with the person as they need.
19. I would not judge the person.
20. I would tell the person I believe them when they say they were sexually assaulted.
21. I would give this person advice when they ask for it.
22. I would support this person.
23. I would tell the person they are okay just the way they are.
24. I would listen to the person talk about their private feelings as often as they need to.
25. I would tell the person I will always be around if they need assistance.
26. I would try to cheer this person up.
27. I would tell the person they are loved.
28. I would tell the person I care for them.
29. I would show understanding of the person's experience.
30. I would see the person's side of things.

Practical Support

1. I would help the person find resources for dealing with their sexual assault.
2. I would help the person find resources for dealing with what they have been going through since the assault.
3. I would drive the person to medical appointments.
4. I would help the person financially.
5. I would encourage the person to seek therapy.

6. I would drive the person to psychotherapy appointments.
7. I would look after the person's pets or family members while they are away.
8. I would let the person stay with me as often as they needed to.
9. I would discuss different treatment options with the person.
10. I would provide the person with information.
11. I would help the person find information of any kind about coping with the sexual assault.
12. I would help the person find information of any kind about coping with what they have been going through since the assault.

Appendix E
Demographics

Please provide the following information:

Age: _____

Gender:
        _____Woman
        _____Man
        _____Transgender Woman
        _____Transgender Man
        _____Other
        _____Prefer not to say

Race/Ethnicity: (please check all that apply)
        _____African American / Black
        _____Asian American
        _____European American / White
        _____Hispanic
        _____Native American Indian
        _____Other:_____
        _____Prefer not to say

Sexual Orientation:
        _____Heterosexual
        _____Gay man
        _____Lesbian
        _____Bisexual
        _____Other
        _____Prefer not to say

Level of Education:
        ____ Did not graduate high school
        ____ Graduated high school
        ____ Earned a GED
        ____ Completed some college
        ____ Currently an undergraduate college student
        ____ Completed an associate degree or certificate program;
        ____ Currently a graduate student
        ____ Completed a bachelor degree
        ____ Completed a master's degree
        ____ Completed a doctoral degree
        ____ Other

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