EXAMINING SEXUAL ASSAULT DISCLOSURE AND NON-DISCLOSURE USING AN ATTACHMENT LENS

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ABSTRACT

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Research regarding non-disclosure among sexual assault victims remains limited with primary focus on non-disclosure to formal networks. The purpose of this study was to examine interpersonal factors related to disclosure and non-disclosure following sexual assault and potential outcomes associated with sexual assault disclosure to informal networks. Participants were recruited from social media sites and academic listservs. A total of 240 cisgender women completed an author-generated demographic questionnaire and six instruments online. Women with an insecure attachment orientation experienced higher rates of posttraumatic symptomology and overall wellness than women with a secure attachment orientation. Further, women who disclosed at higher rates experienced higher posttraumatic outcomes and higher wellness outcomes than non-disclosers. Analyses additionally revealed that positive social reactions and unsupportive social reactions to sexual assault disclosure are related to psychological wellness outcomes. Implications for theory, practice, policy, and research are provided.

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CHAPTER I

INTRODUCTION

Sexual assault refers to any intentional sexual act performed without explicit consent (Conley et al., 2017; Deitz et al., 2015; Klement et al., 2018; Marine & Nicolazzo, 2020) including a number of volatile acts such as threatened sexual assault, sexual coercion, unwanted touching, and attempted or completed rape (Deitz et al., 2015). In the United States, someone is sexually assaulted every 73 seconds (Rape, Abuse, and Incest National Network [RAINN], 2018), deeming sexual violence a pervasive national human rights and health concern (Basile & Smith, 2011; World Health Organization [WHO], 2018). Sexual assault occurrences often differ among gendered groups, with women being more likely to experience instances of sexual assault (Elliot et al., 2004). Current data suggest that between 13 and 43% of women experience sexual assault victimization in adulthood (Elliott et al., 2004; Smith et al., 2018). Thus, women are at highest risk for experiencing instances of sexual assault (Elliott et al., 2004).

Following sexual assault, victims often disclose to an informal support network, such as a person who is a family member, friend, or intimate partner (Ahrens et al., 2010; Dworkin et al., 2019; Nikulina et al., 2019). However, sexual assault remains the most underreported violent crime (Elliott et al., 2004; Jacques-Tiura et al., 2010; RAINN, 2018). In fact, while self-reports of sexual assault nearly doubled from the reported 1.4 victimizations per 1,000 people in 2017 to 2.7 victimization per 1,000 people in 2018,

formal reports (i.e., those made to law enforcement) decreased (Morgan & Truman, 2020). Discrepancies between self-reports and formal reports indicate a barrier to disclosure, which suggests that sexual assault crimes are occurring at a rate not well known nor fully understood (Conley et al., 2017).

Another important consideration for sexual assault victimization is the outcomes following an assault. Sexual assault is a profound trauma that has the ability to disrupt survivors' lives in meaningful ways (DeCou et al., 2019; Elliot et al., 2004). Research has indicated that sexual assault victimization has been consistently linked to a number of deleterious psychological health outcomes, including posttraumatic and depressive symptomology, feelings of shame and self-blame, substance use, and thoughts of suicide (Aakvaag et al., 2016; DeCou et al., 2019; Elliot et al., 2004; Hassija & Turchik, 2016; Jacques-Tiura et al., 2010; Miller et al., 2011; Ullman et al., 2007; Wilson et al., 2016). Additionally, the consequent symptomology associated with sexual assault is often reliant on the disclosure process (Ahrens et al., 2010; Dworkin & Allen, 2018; Jacques-Tiura et al., 2010; Ullman & Peter-Hagene, 2014).

The disclosure process salient to sexual assault refers to any act in which one person reveals information to a confidant about the discloser's sexual assault experience (Chaudoir & Fisher, 2010). While the details associated with disclosure vary, any act of disclosure is important to the recovery process (Dworkin et al., 2019; Orchowski & Gidycz, 2012; Therriault et al., 2020). Research has indicated that sexual assault survivors who are met with a negative response following disclosure experience additional or compounded psychological trauma (Jacques-Tiura et al., 2010; Ullman &

Peter-Hagene, 2014). This is, in part, because negative responses following disclosure perpetrate victim-based blame and in turn, exacerbate feelings of shame, which plays an integral role in the acquisition and development of posttraumatic and depressive symptomology (Badour et al., 2020; DeCou et al., 2019; Jordan, 2018; Ojserkis et al., 2014). In contrast, positive responses following disclosure may mitigate posttraumatic outcomes and thus are preferable for survivors (Orchowski & Gidycz, 2012; Therriault et al., 2020; Ullman & Peter-Hagene, 2014).

While responses to sexual assault disclosure impact trauma symptomology in meaningful ways, less is known about outcomes associated with sexual assault non-disclosure. A number of researchers have found that between nearly one-fourth and one-half of sexual assault victims never disclose their experiences of sexual assault to informal support networks (e.g., friends, family, or significant others; Ahrens et al., 2010; Carretta et al., 2016; Carson et al., 2020; Ullman et al., 2020). However, historically, researchers have found an association between traumatic-based disclosure and improved psychological well-being among survivors (Herman, 2015; Jacques-Tiura et al., 2010; Ullman & Filipas, 2001). Many mechanisms contribute to the advantageous effects of disclosure, though general findings implicate the helpfulness of social support following disclosure (Herman, 2015; Jacques-Tiura et al., 2010; Ullman & Peter-Hagene, 2014). Without disclosure, then, opportunities for social support are limited, and thus, understanding variables and outcomes associated with sexual assault non-disclosure remain important for study.

Given the interpersonal nature of disclosure, it is important to consider potential interpersonal barriers that may impact disclosure patterns among sexual assault survivors. Attachment theory may provide valuable insight to the disclosure process. Attachment orientations are conceptualized as secure and insecure, with insecure attachment orientations existing along two dimensions: anxious and avoidant (Bowlby, 1969, 1973, 1980; Mikulincer & Shaver, 2018). Attachment insecurities can impact emotional regulation and coping strategies (Garrison et al., 2014; Holmberg et al., 2011; Mikulincer & Shaver, 2018; Woodhouse et al., 2015). Given the importance of emotional regulation following traumatization and the impact of emotional regulation on disclosure (Garrison et al., 2014), it remains important to consider the ways that attachment may impact sexual assault recovery. Attachment theory suggests that people with anxious attachment orientations fear that others will not be available to provide support during times of need and thus, engage in disclosure less consistently (Garrison et al., 2014; Mikulincer & Shaver, 2018). Further, those with avoidant-presenting orientations fear that others' intentions are dubious and thus, attempt to minimize their emotional distress through avoidance (i.e., evade disclosure; Garrison et al., 2014; Mikulincer & Shaver, 2018). Therefore, given the compound knowledge that disclosure is perceived as beneficial for recovery (Herman, 2015) and that survivors' attachment orientations may impact emotional disclosure (Garrison et al., 2014), it remains important to consider the ways in which attachment may impact the process of disclosure post-assault, as it may provide meaningful insight to understanding the process of sexual assault recovery.

The research regarding sexual assault disclosure has been extensive; however, limited focus has been provided to areas of non-disclosure and the concomitant symptomology, which is problematic given the widespread belief that disclosure is more beneficial for survivors. In fact, recent findings have provided important contrary data, indicating that outcomes associated with sexual assault non-disclosure may be more beneficial than disclosure for survivors (Carson et al., 2020). Given that these findings contrast a number of maintained notions about sexual assault recovery, more research is needed regarding the variants of wellness outcomes for those who engage in disclosure versus non-disclosure following their assault. Additionally, further research is necessary regarding the potential impact of attachment on disclosure patterns among sexual assault survivors. While some research has sought out explanation for social barriers to disclosure (i.e., endorsement of rape myths, feelings of shame, etc.; Ahrens et al., 2010; Dworkin & Allen, 2018; Ullman et al., 2020), assessment of sexual assault survivors' attachment styles relative to disclosure has never been considered. Thus, the current study addressed relevant gaps regarding sexual assault and the process of sexual assault disclosure by assessing adult women with sexual assault experiences who have or have not disclosed post-assault. This study offered a novel perspective on sexual assault disclosure and non-disclosure through an attachment lens in an attempt to better understand disclosure choices and patterns among women survivors.

Research Questions

Question 1: What impact do survivors' attachment styles have on their likelihood of disclosing their experience of sexual assault to an informal support person (friends, family, or significant others)?

Question 2: What effect does sexual assault disclosure and non-disclosure have on psychological outcomes for sexual assault victims?

Question 3: How do others' reactions following post-assault disclosure impact psychological outcomes for sexual assault survivors with secure and insecure attachment orientations?

CHAPTER II

REVIEW OF THE LITERATURE

Sexual Assault

Sexual assault is a form of sexual violence that refers to any act consisting of intentional sexual contact or behavior without explicit consent (RAINN, 2018). As such, sexual assault encompasses a range of sexually violent acts including, but not limited to, unwanted touching, sexual coercion, and attempted or completed rape. Rape is defined as completed oral, anal, or vaginal penetration through the means of physical force (Smith et al., 2018). Sexual coercion refers to any form of unwanted penetration following non-physical pressure (Smith et al., 2018). Unwanted sexual touching includes sexual experiences such as fondling, groping, or grabbing that are unwanted (Smith et al., 2018). Non-contact sexual violence is additionally conceptualized as a form of sexual assault and may include threatened sexual attack (Morgan & Truman, 2020). In the United States, one in five women experiences sexual assault, with approximately one-half of these women experiencing such instances of victimization after age 18 (Deitz et al., 2015; Klement et al., 2018; Marine & Nicolazzo, 2020; Smith et al., 2018). This qualifies sexual assault as a pervasive human rights concern (Basile & Smith, 2011; WHO, 2018).

Sexual assault perpetrators can be either known (i.e., acquaintances, friends, family members) or unknown (i.e., strangers) to the victim; however, research consistently suggests that women are most often sexually assaulted by people they know

(i.e., acquaintance rape; Deitz et al., 2015; Fisher, 2000). Cleere and Lynn (2013) found that among a college-aged sample, 91% of women survivors knew their perpetrators. Similarly, Morgan and Ouderkerk (2019) indicated that 70% of sexual assault victims are assaulted by people known to them. Consideration for the prevalence of acquaintance-based sexual assault is important, especially when conceptualizing the process of disclosure. Specifically, experiencing acquaintance rape may amplify fear-based reactions to disclosure, as disclosure of a crime perpetrated by an acquaintance may be associated with a fear of retaliation or peer disbelief, if such acquaintance is well-known and liked by other peers (Cleere & Lynn, 2013; Gravelin et al., 2019). Similarly, various interpersonal characteristics may mitigate disclosure patterns in situations of acquaintance rape, as disclosure implicates the potential for relational loss or rejection. As such, this researcher explored victims' interpersonal orientations and the impact such orientations may have on patterns of disclosure in future sections.

Despite efforts to mitigate sexual assault victimization, the prevalence of sexual assault has perpetually remained steady throughout the last 4 decades (Klement et al., 2018; Marine & Nicolazzo, 2020). However, it remains important to note that many researchers have grappled with an accurate understanding of sexual assault prevalence rates, as sexual assault is commonly underreported by victims (American Psychological Association, 2018; Elliott et al., 2004). Thus, understanding concerning the implications associated with sexual assault is limited. Additionally, it is important to note that some women do not label their experiences as sexual assault, even when such experiences meet the legal definition of rape accordingly and thus, the researcher focused both on women

who self-identify their experiences as sexual assault and women whose experiences are consistent with that of the legal definition of rape. The researcher also solely focused on cisgender women within this thesis because, while men and transgender or gender non-conforming (TGNC) populations also experience sexual assault, focusing solely on women may permit more insight to psychological outcomes associated with non-disclosure rather than the compounding variables associated with gender socialization and marginalization salient to men and/or TGNC groups.

Rape Myths

Given its prevalence, it is important to assess complex attitudes associated with sexual assault. According to Link and Phelan (2001), "stigmatization is entirely contingent on access to social power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories, and the full execution of disapproval, rejection, exclusion, and discrimination" (p. 367). Sexual assault stigmatization, then, is conceptualized as the degree to which society adheres to erroneous assumptions or stereotypical thinking concerning sexual assault experiences (Ayala et al., 2018; Gerber et al., 2004). In particular, sexual assault victims are subject to various forms of culturally-informed stereotypical thinking, which is rooted in rape mythology (Ayala et al., 2018; Klement et al., 2018; Weiser, 2017). Rape myths include the assumption that women are responsible, in some capacity, for their sexual assault experiences, that men are never victims of sexual violence, that women enjoy being sexual assaulted, and that most perpetrators are unknown to the victim at the time of assault (Elliott et al., 2004; Klement et al., 2018; Weiser, 2017). Endorsement of these

myths serves to justify sexual assault and stigmatization by promoting victim blaming, minimizing perpetrator accountability, and overlooking instances of acquaintance rape (Elliott et al., 2004; Wilson et al., 2020). For example, Klement et al. (2018) noted that jurors who closely adhere to rape myth assumptions are more likely to find a sexual assault perpetrator not guilty. Consideration for the prevalence of rape myths is also especially important when attempting to conceptualize the process of disclosure and the social reaction salient to informal disclosures. Notably, Wilson et al. (2020) found that women who more strongly rejected rape myth ideology were more likely to demonstrate positive social reactions upon survivor disclosure. Taken together, sexual assault victims may experience feelings of distress in response to such publicly prevalent beliefs, as they portend the possibility for discrimination and exclusion (Deitz et al., 2015). In addition to societal stigma, the internalization or acceptance of rape myths perpetrates harmful ideology if survivors themselves endorse such assumptions (DeCou et al., 2019; Klement et al., 2018; Wilson et al., 2018). In particular, self-stigma may manifest as feelings of self-blame, shame, or embarrassment (Aakvaag et al., 2016; DeCou et al., 2019).

Despite the prevalence of rape myths and sexual assault stigma, there have been concerted efforts made that contribute to the eradication of such myths. Notably, feminist efforts such as the #MeToo and Time's Up movements have been instrumental in shifting the rate at which myth-based assumptions concerning sexual assault are overtly accepted (Alaggia & Wang, 2020). Particularly salient, the #MeToo movement, which gained social momentum in late 2017 following allegations towards public figure Harvey Weinstein, involves sexual assault survivors publicly disclosing their sexual assault

encounters in search of justice. The onset of such disclosure contributed to the normalization and vocalization of sexual assault experiences, which impacted the ways that individuals conceptualized their own encounters with sexual assault, thus demystifying deeply-rooted rape myths, which assert that sexual assault only applies to a certain type of victim (i.e., intoxicated, woman, wearing revealing clothing; Alaggia & Wang, 2020; Kunst et al., 2019). Similarly, third- and fourth-wave feminist movements have undoubtedly impacted the levels of societal sexism, which have additionally minimized acceptance of rape myths that place blatant blame on women for sexual assault (Ayala et al., 2018). However, despite the efforts of the proponents of the aforementioned movements, rape myths and sexual assault stigmatization remain pervasive and thus continue to shape the ways sexual assault victims and others conceptualize sexual assault experiences.

Sexual Assault as a CSI

A concealable stigma identity (CSI) is a marginalized, non-visible identity that requires self-disclosure for others to be aware of such an identity. Examples include sexual minority identity, marginalized religious or non-religious identity, HIV+ status, and having a mental illness (Abbott & Mollen, 2018; Quinn & Earnshaw, 2011). CSIs may serve as both protective and harmful, as the concealment of an identity central to one's being can be complex, especially in the face of stigmatization. Given the stigma and invisibility associated with sexual assault, it is reasonable to classify having a sexual assault victim identity as a CSI. Salient to CSI framework, the disclosure of a CSI requires intimate self-revelation and can potentially affect psychological, health, and

behavioral outcomes in a variety of ways (Chaudoir & Quinn, 2010). For example, Ahrens et al. (2007) suggested that disclosure of a history of having had an abortion may be detrimental to one's psychological health if such disclosure is met with a negative social reaction. Similarly, disclosure of sexual assault poses as a unique challenge, as both concealment and revelation can contribute to deleterious outcomes. As such, disclosure as a general construct was a variable of interest for the current investigation that the author explores in more detail later within the chapter.

Consequences Associated with Sexual Assault Victimization

Sexual assault is pervasive and often associated with maladaptive psychological adjustment (Deitz et al., 2015; Herman, 2015). In particular, among civilian traumas, sexual assault results in some of the highest rates of posttraumatic stress disorder (PTSD) and other adverse symptomology (Deitz et al., 2015; Peter-Hagene & Ullman, 2015). Researchers have found that sexual assault survivors are at heightened risk for the development of anxious, depressive, and posttraumatic symptomology, problematic substance use, sexual dysfunction, and revictimization (Aakvaag et al., 2016; DeCou et al., 2019; Miller et al., 2011; Ullman et al., 2007; Wilson et al., 2016). For example, Bryan et al. (2013) noted that, among survivors, sexual assault experiences are associated with increased rates of suicidal ideation. Further, in a nationally representative sample of 2,000 college women, Kilpatrick et al. (2007) found that one-half of rape victims met the criteria for a diagnosis of PTSD. The severity of maladaptive outcomes is associated with a number of factors including coping avoidance, severity of the violence of the act, feelings of self-blame, injury, and multiple sexual victimizations (Deitz et al., 2015;

Ullman et al., 2007; Ulman et al., 2020). However, though posttraumatic symptomology is a common consequence of sexual assault, not all sexual assault survivors experience posttraumatic symptom development similarly or at all. In some cases, trauma symptoms are exacerbated based on a number of factors associated with the assault and various other interpersonal factors, including social reactions following interpersonal disclosure (Therriault et al., 2020; Wilson et al., 2020). Thus, consideration for potential correlates of traumatic symptomology development is beneficial.

Sexual Assault Survivors and Shame

Traumatic symptomology is typically conceptualized in four distinct categories: 1) the re-living, or re-experiencing of trauma exposure through nightmares, flashbacks, or intrusive memories; 2) the avoidance of stimuli associated with traumatic exposure; 3) a negative alteration in thoughts or beliefs concerning oneself, others, and/or the world; and 4) experiences of hyperarousal (American Psychiatric Association [APA], 2013). Sexual trauma exposure is additionally associated with feelings of shame, disconnection, and/or guilt (Aakvaag et al., 2016; Badour et al., 2020; Jordan, 2018; Ojserkis et al., 2014). Shame is a negative evaluation of the self, which may be associated with feelings of interpersonal disconnection, distress, and powerlessness (Badour et al., 2020; Cândea & Szentagotai-Tătar, 2018; Jordan, 2018). Additionally, shame is commonly associated with the maintenance of posttraumatic symptomology and maladaptive outcomes following trauma exposure (Badour et al., 2020). Salient to the CSI framework, shame-presentations are evident among populations who experience stigmatization related to their identity or survivor status (Badour et al., 2020). This, then, contributes to the

process of interpersonal disclosure for sexual assault survivors. For example, Aakvaag et al. (2016) suggested that shame contributes to the ways individuals position themselves in social relationships by eliciting avoidance behaviors. Similarly, Thompson et al. (2007) identified shame as a social barrier that impacts formal disclosure decisions among sexual assault survivors, but not physical assault survivors. Thus, consideration for the implications associated with feelings of shame is especially important, as sexual assault survivors who maintain such feeling may not seek support for their distress and thus, will avoid opportunities for disclosure (Badour et al., 2020; Orchowski & Gidycz, 2012).

Association Between Sexual Assault Disclosure and Outcomes

Of note, research correlates of traumatic symptom development and sexual assault experiences are rooted in understanding those who disclose instances of sexual trauma to others, as little information is known regarding the wellness of survivors who never disclose their experiences. In fact, Ullman et al.'s recent findings (2020) suggested that sexual assault non-disclosure might serve as a protective factor for victims, as some research indicates that post-assault disclosure has the potential to make survivors susceptible to revictimization (Littleton et al., 2009; Mason et al., 2009). To measure disclosure rates, researchers often identify the number of people to whom a sexual assault victim has reported their sexual assault experience. For example, Carson et al. (2020) had participants answer, "whether they had disclosed or talked about the incident with anyone," using a yes or no answering option as part of the Sexual Experiences Survey (SES; p. 227). In situations of disclosure, researchers have suggested that disclosure most

frequently occurs with informal support confidants (Ahrens et al., 2007; Orchowski & Gidycz, 2012). This disclosure to informal supports poses as a challenge, however, as informal support providers might respond in varying ways that undoubtedly impacts the course of survivors' healing (Ahrens et al., 2007; Orchowski & Gidycz, 2012). Thus, the association between psychological wellness and sexual assault highlights the importance of assessing disclosure and non-disclosure patterns among sexual assault victims and the subsequent social reactions following disclosure.

Disclosure and Non-Disclosure

Disclosure refers to the act of opening up to or confiding in another person with the expectation that such disclosure will be well-received and understood (Archer & Burleson, 1980). Though self-disclosure encompasses various facets of personal information, this researcher explicitly examined forms of disclosure through the lens of sexual assault experiences. Interpersonal disclosure is complex and often salient to the lives of those with sexual assault history (Badour et al., 2020; Orchowski & Gidycz, 2012). Thus, for the purpose of this paper, sexual assault disclosure refers to the discussion between a survivor and informal source (i.e., friend, family member, roommate, etc.) in which the survivor shares their experience of sexual assault. Conversely, sexual assault non-disclosure refers to the withholding of one's sexual assault history in any context, or more specifically, the act of concealing one's sexual assault experience (Carson et al., 2020; Ullman et al., 2020). Though non-disclosure remains central to the development of this paper, implications and reasonings behind sexual assault disclosure are also identified in attempt to understand the construct of

sexual assault non-disclosure and the intentionality behind instances of victims' non-disclosure.

Sexual Assault Disclosure

While the factors contributing to a survivor's decision to disclose their sexual assault experience are not well understood, there are a few existing theories that offer some insight. The disclosure process model (Chaudoir & Quinn, 2010) states that disclosure and non-disclosure are conceptualized as goal-oriented, as researchers believe that people have motivational underpinnings salient to acts of disclosure. Other researchers have assessed a number of factors related to sexual assault disclosure including assault characteristics, the victim's experiences with past assaults, and the victim's conceptualization of their assault/experience (Ahrens et al., 2010; Starzynski et al., 2005). In this framework, the decision to disclose first requires acknowledgement of the nature of crime, which indeed requires victims to conceptualize their experience as an assault (Ahrens et al., 2010; Starzynski et al., 2005). For example, women who experience instances of sexual assault more consistent with classic rape scenarios are more likely to disclose post-assault (Ahrens et al., 2010; Wilson et al., 2016). Put another way, women who do not acknowledge an unwanted sexual encounter as sexual assault are less likely to disclose the experience interpersonally (Wilson & Miller, 2016; Wilson et al., 2020). Following acknowledgement, victims might consider the outcomes associated with disclosure and whether such outcomes are beneficial. Specifically, Ahrens et al. (2007) found that survivors who opted not to disclose often believed disclosure would be ineffective or detrimental, while those who readily disclosed

assumed that disclosure would mitigate feelings of distress. Thus, it is likely that general non-disclosure is positioned within perceived intrapersonal protectiveness salient to existing working schemas concerning support-seeking outcomes (i.e., attachment style).

Feminist-inspired movements such as the #MeToo movement founded by Tarana Burke have shifted disclosure patterns in the United States. In particular, following actor Alyssa Milano's call for public disclosure during the #MeToo movement, many people disclosed sexual assault experiences on mass social platforms in attempt to demonstrate the prevalence of sexual assault experiences for women, demystifying and drawing attention to their ubiquity in the process (Kunst et al., 2019; Wilson et al., 2020). However, it is important to acknowledge that these disclosures did not eradicate deeply-embedded rape myths (i.e., stigma) within our society, but rather, in some instances, further perpetrated them (Flood, 2019). Specifically, the mass rate with which individuals came forward regarding their own history of sexual victimization fostered disbelief in society concerning the truthfulness of disclosures (Flood, 2019; Kunst et al., 2019). Notably, a persistent and harmful rape myth is that falsified sexual assault reports are common, despite empirical evidence that indicates that false reports account for fewer than 10% of all reported sexual assault cases (Klement et al., 2018; Weiser, 2017). This disbelief, often analogous with dismissing women, is rooted in patriarchal values and sexist social norms that assume women are emotional, untrustworthy, malleable, and weak (Flood, 2019; Weiser, 2017; Wilson et al., 2016). Given that disclosure, when met with disbelief or victim-blaming behavior, has pervasive implications for wellness outcomes (Orchowski & Gidycz, 2012; Therriault et al., 2020; Ullman et al., 2010), this

systematic doubting of women may contribute to disclosure patterns, or more specifically, inhibit a woman's choice to disclose.

Accumulating research concerning the outcomes associated with sexual assault disclosure suggest that discussing information regarding one's sexual assault experience has psychological benefits (Herman, 2015; Jacques-Tiura et al., 2010; Pinciotti & Orcutt, 2020; Ullman & Filipas, 2001). However, researchers have cautioned that disclosure is only beneficial if such disclosure is met with a compassionate, supportive response (Ahrens, 2006; Chaudoir & Quinn, 2010; Jacques-Tiura et al., 2010; Lorenz et al., 2018; Therriault et al., 2020). Following disclosure, helpful responses are categorized as those that provide emotional or informational support such as a confidant who "told you that it was not your fault" (Ullman, 2000, p. 263). In contrast, unhelpful responses are categorized as a response that blames or stigmatizes the victim such as a confidant who "told you that you were irresponsible or not cautious enough" (Ullman, 2000, p. 264). Ullman (2000) further distinguished unhelpful responses along two dimensions: unsupportive acknowledgement and turning against reactions. In this framework, turning against reactions are conceptualized as overtly harmful and are most predictive of adverse outcomes including depressive and posttraumatic symptomology and self-blame (Pinciotti & Orcutt, 2020; Ullman, 2000; Ullman et al., 2017). Unsupportive acknowledgements, while also conceptualized as harmful, are more contingent on the survivor's perceived level of support paired with the response (Ullman et al., 2017). For example, turning against reactions include confidant anger directed at the aggressor,

which is a reaction that can be interpreted differently among survivors. Thus, turning against reactions are associated with mixed outcomes (Ullman et al., 2017).

Overall, researchers have overwhelmingly indicated that unhelpful social responses following post-assault disclosure have lasting detrimental effects on the psychological wellness of survivors, including increased posttraumatic symptomology and other deleterious outcomes (Ahrens et al., 2007; Therriault et al., 2020; Ullman & Peter-Hagene, 2014). For example, Dworkin and Allen (2018) posited that disclosure cessation is often salient to negatively-oriented confidant responses. In other works, Ahrens et al. (2007) noted that among a sample of 102 rape survivors, nearly one-third of the participants indicated that their disclosure was detrimental to their psychological well-being, especially in the face of a negative confidant reaction. Therriault et al. (2020) further posited that sexual assault survivors who are met with negative social reactions upon disclosure demonstrate more maladaptive responses such as increased psychological distress and lower rates of sexual adjustment compared to non-survivors or survivors who experience positive social reactions following disclosure. Thus, these findings suggest that initial disclosure experiences are especially impactful, considering the ambiguity and fragility associated with one's disclosure.

While survivors have the potential to receive a myriad of confidant responses upon disclosure, disclosures to informal support providers predict better outcomes for sexual assault survivors compared to disclosures to formal support providers. Notably, informal support confidants are more frequently perceived as more compassionate and supportive upon disclosure and reflecting this, nearly 75% of initial disclosures are

performed within such networks when given the opportunity (Ahrens et al., 2007; Dworkin & Allen, 2018; Kirkner et al., 2018; Lorenz et al., 2018). Thus, consideration for interpersonal disclosure specific to informal-support providers (vs. formal-support providers) may provide greater insight to interpersonal disclosure barriers.

Sexual Assault Disclosure and Title IX

Important for the development of this thesis, the recent passing of Texas Senate Bill 212 requires that:

> an employee of a post-secondary educational institution who witnesses or receives information regarding the occurrence of an incident of sexual harassment, sexual assault, dating violence, or stalking alleged to have been committed by or against a person who was a student enrolled at or an employee of the institution at the time of incident shall promptly report the incident to the institution's Title IX coordinator or deputy Title IX coordinator. (Sec. 51.252)

Thus, the disclosure of sexual assault in an academic setting, even through the means of research, will implicate survivors by involving them in a Title IX investigation. The intentionality behind the implementation of Title IX is to protect students from instances of sexual violence. However, there are underlying effects that undermine feminist values through involvement of the criminal justice system (Driessen, 2020). More specifically, Title IX requirements have the potential to mitigate a survivor's sense of empowerment within disclosure, as mandatory reporting leaves survivors with little control regarding their disclosure process (Driessen, 2020). This is important for consideration, as it directly impacts students in their process of informal disclosure. For example, disclosure

to an informal support (i.e., professor or colleague) will, as mandated by law, translate to formal disclosure without survivor intent. Additionally, the presence of Title IX reporting laws directly impacts research sampling, as the thesis writer and thesis reviewers fall within the realms of a post-secondary educational institution employee and thus, could not utilize the student body for data sampling without Title IX involvement. This has profound implications for future directions of research on Texas-based college campuses who have adopted these policies for use. Primarily, college populations are perceived to be at the highest-risk for sexual assault (Marine & Nicolazzo, 2020) and yet, disclosing their experiences that result in mandatory reporting statutes that survivors may experience their disclosure as distinctly disempowering and may stifle continued disclosure or support-seeking behaviors in a meaningful way (Driessen, 2020). Accordingly, for the current study, the researcher recruited participants from outside university channels, in spite the suitability of the campus' distinction as a public university primarily for women, to avoid undermining survivors' autonomy in making decisions about disclosure and subsequent reporting.

Sexual Assault Non-Disclosure

While many sexual assault victims choose to disclose their sexual assault experiences, some do not. Notably, between 19% and 48% of sexual assault survivors neglect to disclose instances of sexual assault, meaning they never disclose (Carretta et al., 2016; Carson et al., 2020; Ullman et al., 2020). Additionally, rape is the most underreported violent crime, as around 75% of sexual assault cases remain unreported to law enforcement (Morgan & Truman, 2020). Even with startlingly low reporting rates,

the prosecution gap within the criminal justice system remains pervasive. Of those who formally report their experience of rape, only 7% of perpetrators are prosecuted by law enforcement, which likely exacerbates survivor trauma (Campbell et al., 2015; Shaw et al., 2017). The underreporting of sexual assault victimization, then, remains prevalent, which poses a serious threat at both interpersonal and societal levels. Notably, researchers have largely assessed barriers to disclosure among formal support providers and thus, assessment of barriers salient to informal-support disclosure may be especially helpful, as there is scant literature assessing non-disclosure to such supports (Orchowski & Gidycz, 2012).

In conducting the literature review for this study, the researcher found only three investigations in which researchers directly examined the impact of informal-support non-disclosure. Primarily, Carretta et al. (2016) assessed non-disclosure rates among 242 college women and found that 24% had never disclosed their sexual assault experience. These findings additionally suggested that among the non-disclosing women, two-thirds blamed themselves for their sexual assault experience (Caretta et al., 2016). Relatedly, Carson et al. (2020) studied a sample of 221 sexual assault victims, of whom 25% had never disclosed their sexual assault experience prior to engaging in the study. Salient to these findings, non-disclosure was related to shame, fear, protection of privacy, and the experience of minimization (Carson et al., 2020). Similarly, Ullman et al. (2020) found several overarching themes salient to non-disclosure; such themes included fear of social stigmatization, desire for privacy, and a lack of perceived social support. These findings highlight potential internal and external barriers associated with non-disclosure patterns.

However, researchers have not yet considered the development of such barriers and thus, it may be helpful to assess from where such feelings of shame, fear, or privacy derive. For example, existing working models, such as attachment orientations, have the potential to impact and inform disclosure (or non-disclosure) patterns, as such orientations might inform perceptions of disclosure outcomes and thus, the researcher of the current investigation explored the implications associated with attachment orientation and disclosure.

Consideration for the protectiveness of non-disclosure is additionally important, as recent researchers have identified striking findings when considering the psychological outcomes associated with non-disclosure patterns (Therriault et al., 2020; Ullman et al., 2020). Importantly, Therriault et al. (2020) noted that in a sample of sexual assault survivors, those who received positive social reactions following disclosure (which had typically been conceptualized as more adaptive within previous literature) demonstrated more sexual difficulties in comparison to survivors who had never disclosed their sexual trauma. Relatedly, researchers have proposed that non-disclosure may be protective for psychological adjustment, as it may mitigate opportunities for re-traumatization (Ullman et al., 2020). Thus, psychological outcomes associated with non-disclosure are especially important for consideration, given that historically, researchers have found that interpersonal disclosure, when met with a positive social response, is most adaptive (Herman, 2015).

Attachment Theory

According to attachment theorists, infant-caregiver relationship dynamics produce meaningful implications for lifespan relationship functioning (Bowlby, 1969, 1973, 1980; Holmes, 2014). Adult attachment styles, then, are internal working models (i.e., mental representations of the self and others) acquired in response to childhood relational experiences (Ainsworth, 1982). Attachment theory further suggests that systems of attachment, called *attachment styles*, consist of two types: secure attachment and insecure attachment (Ainsworth, 1982; Holmes, 2014). The latter of such types is further distinguished along two dimensions: attachment-related avoidance and attachment-related anxiety (Mikulincer & Shaver, 2012). In instances of insecure attachment, Bowlby theorized that "a person's attachment system is up-regulated," and people alter their attachment-based behaviors in attempt to establish a sense of personal security (Mikulincer & Shaver, 2012, p. 259).

Those with anxious attachment orientations are thought to experience excessive worry concerning their relational supports' capacity to provide adequate support or assistance during times of need (Woodhouse et al., 2015). Also insecurely attached, those who maintain avoidant attachment orientations conceptualize their relational supports as distrustful and thus, exert avoidance-behaviors such as a self-reliance in attempt to emulate safety (Holmes, 2014). Further, in each instance of insecure attachment, fear of continued rejection is salient to the adoption of defensive or maladaptive coping strategies. Of particular importance for the current investigation, these coping strategies are coined as secondary attachment strategies, which consist of deactivation or

hyperactivation techniques (Woodhouse et al., 2015). Specifically, those with anxious attachments rely on the use of hyperactivating strategies (i.e., excessive attempts to engender relational proximity or support), while those with avoidant attachments utilize deactivating techniques (i.e., excessive self-reliance; Bruno et al., 2019; Holmes, 2014; Mikulincer & Shaver, 2007, 2012). Notably, each of these responses to insecure attachment orientations are adaptive and well-organized; however, they hold valuable implications for interpersonal communication and conflict resolution. Hence, individual differences in attachment orientations have the potential to impact stress or trauma-based responses, especially when such instances of stress are associated with the potential for interpersonal rejection or stigmatization.

Attachment-Based Stress Response

Attachment theorists posit that secure attachment is most adaptive and thus, those with secure attachment orientations are better positioned to adjust to stressful stimuli, including stressful stimuli of a traumatic nature (Holmes, 2014; Mikulincer & Shaver, 2012). In particular, secure individuals handle distress through acknowledgement and effective emotional regulation, meaning that they conceptualize problem-solving opportunities and engage in support-seeking behavior by turning to others for tangible forms of support (Mikulincer & Shaver, 2012, 2018). Notably, effective emotional regulation strategies are central to emotional expression and thus, securely attached individuals are often able to communicate their feelings without distortion techniques that are used in attempt to appease others (Woodhouse et al., 2015). In contrast, attachment theorists suggest that insecurely attached individuals cognitively appraise support

providers as unavailable or unresponsive and thus, are at risk for maladaptive emotional development in the face of distress (Holmberg et al., 2011). Those with anxious attachment orientations perceive others as capricious, and they may infer that support networks are not available during times of distress (Holmberg et al., 2011). Due to the fear that others will provide insufficient opportunities for support, people with anxious orientations utilize ineffective emotional regulation strategies such as exacerbation and exaggeration. In particular, exacerbating one's sense of distress might elicit a greater response from support networks, which affords individuals with greater attention and care (Mikulincer & Shaver, 2018). Also maladaptive, those with avoidant attachment orientations experience emotional dysregulation by inhibiting emotional expression. In particular, Mikulincer and Shaver (2018) posited that inhibitory efforts derive from internalized feelings of fear, shame, or anxiety, as such "emotional states are associated with threats and feelings of vulnerability" (p. 7). Notably, avoidant people frequently suppress emotionally contingent memories in attempt to mitigate feelings and expressions of distress (Holmberg et al., 2011). Thus, accumulating research posits that those with avoidant attachment styles may protect trauma survivors against elevated distress states through defensive strategies (i.e., social withdrawal, pushing others away; Fraley & Bonanno, 2004; Woodhouse et al., 2015).

Attachment-Based Disclosure

Primary to the purpose of this study, attachment orientations may affect personal comfort within interpersonal communication, such as disclosure. In particular, securely attached individuals maintain stable interpersonal working models that emphasize

relational intimacy and closeness through disclosure and emotional responsiveness (Holmberg et al., 2011; Mikulincer & Nachshon, 1991). However, those with avoidant attachment styles often isolate themselves socially in attempt to mitigate the need for emotional or relational dependence. Additionally, avoidantly-attached individuals seldom partake in self-disclosure, as disclosure is rooted within relational-closeness and thus, fosters susceptibility to disapproval (Mikulincer & Shaver, 2012). As such, these individuals are detached and avoidant in behavior, especially within interpersonal relationships. Conversely, those with anxious attachment models commonly demonstrate emotional openness and impulsivity (Mikulincer & Shaver, 2012). Hence, anxiously attached individuals readily disclose while simultaneously worrying whether others will demonstrate positive support. In instances of anxious attachment, disclosure has the potential to be exaggerated, sporadic, or partial, and such individuals may ruminate following initial disclosure, which then might inhibit future or additional interpersonal disclosure (Garrison et al., 2014). Additionally, anxious orientation may be especially susceptible to adverse outcomes when met with negative social reactions following disclosure. Taken together, these findings and theoretical implications suggest that one's attachment orientation may impact trauma-related disclosure patterns.

Rationale and Hypotheses

The purpose of this study was to assess hypothesized associations evident between female sexual assault survivors' non-disclosure and attachment orientations, as well as psychological outcomes associated with non-disclosure behavior. Given the paucity of literature concerning sexual assault non-disclosure as an isolated construct and

the mixed findings assessing wellness outcomes associated with non-disclosure, the researcher attempted to address evident gaps within sexual assault and non-disclosure literature. Although recently, some researchers (Caretta et al., 2016; Carson et al., 2020; Ullman et al., 2020) have assessed potential motivators for non-disclosure behavior in sexual assault survivors, it remains unclear how the development of certain intrapersonal variables that inform such motivators (e.g., a need for privacy or experiencing shame) are acquired and thus, consideration for such development remains necessary.

Primarily, internal working models, solidified in the formation of adult attachment orientations, may provide the foundation for the ways in which sexual assault survivors conceptualize the safety and/or importance of disclosing sexual assault experiences. Guided by the framework of attachment theory, a child-caregiver bond facilitates the development of a sense of self and trustworthiness of others (Trub, 2017). These working models, then, inform the development of self in adulthood and the use of defensive strategies employed as a measure of self-protection (Trub, 2017). As such, these working attachment models have meaningful implications concerning interpersonal communication and conflict resolution and thus, such orientations may impact the ways survivors cope with potential distress following sexual assault.

In particular, attachment orientations might influence the decision to disclose personal aspects of oneself to others, especially when such disclosure consists of traumatic-based and potential stigmatizing information. As such, via the current investigation, the researcher sought to understand barriers to disclosure, or rather non-disclosure, among survivors, through an attachment lens. Notably, understanding

working models that underlie non-disclosure behavior among sexual assault survivors will provide useful information to psychologists and other mental health practitioners, as they have the potential to inform future treatment orientations. Assessment for psychological outcomes associated with non-disclosure also remains important, as existing literature has yielded contradicting findings (Ahrens et al., 2010; Pennebaker, 1997; Ullman et al., 2010, 2020). Clarification and better understanding of non-disclosure is needed, as many current mental health providers conceptualize labeling and disclosure of sexual assault as overwhelmingly beneficial to survivor outcomes and accordingly, may advocate for disclosure among clients. For example, within cognitive-processing framework (CPT), a well-reputable and frequently utilized therapy, clients are expected to engage in excessive disclosure concerning their sexual trauma (Pinciotti & Orcutt, 2020). However, recent findings have identified non-disclosure as providing protective factors among some populations of survivors (Ahrens et al., 2010; Therriault et al., 2020; Ullman et al., 2020) and as such, in attempt to avoid exacerbation of posttraumatic symptomology, psychological outcomes, both positive and negative, associated with non-disclosure were assessed.

Hypothesis 1

Attachment orientation will be associated with disclosure of sexual assault victimization. In particular, it was predicted that attachment avoidance will be negatively associated with sexual assault disclosure and attachment security will be positively associated with sexual assault disclosure.

Hypothesis 2

Attachment avoidance and attachment anxiety will moderate the relationship between sexual assault disclosure and well-being. Given field evidence suggesting the importance of disclosure (Herman, 2015), it was predicted that non-disclosers of sexual assault who are high in attachment security will endorse more adverse psychological outcomes and posttraumatic symptomology than disclosers high in attachment security. However, given recent findings suggesting that non-disclosure may be protective for certain populations (Carson et al., 2020; Ullman et al., 2020), it is further predicted that disclosers high in attachment insecurity will endorse more adverse psychological outcomes and posttraumatic symptomology than non-disclosers high in attachment insecurity.

Hypothesis 3

Social responses to disclosure will be associated with psychological outcomes, such that individuals who receive positive responses upon disclosure will have less posttraumatic symptomology than disclosers with negative responses.

CHAPTER III

METHODOLOGY

Participants

The researcher assessed cisgender women who have experienced adulthood sexual assault (ASA). In total, 604 individuals of diverse ages engaged with the survey. Three hundred and forty-eight participants were excluded from further analysis due to the current study's inclusion criteria, which required that (a) participants are cisgender women; (b) participants experienced an unwanted sexual encounter in adulthood, as the experiences and outcomes salient to childhood sexual assault differ from ASA in meaningful ways (Campbell et al., 2008); (c) participants' sexual assault experiences occurred within the last 10 years; and (d) participants are 18 or older. Six additional participants were excluded due to study incompletion. Finally, 10 participants were further excluded due to reporting zero scale variance. Thus, the final analysis sample consisted of 240 sexually diverse cisgender women who had one or more sexual assault experiences in adulthood. There was no significant difference between those who stopped the study prematurely and those who completed it. The majority of participants who completed the study identified as straight (79.6%), while sexual minority participants made up 20.4% of the survey, with 12.6% identifying as bisexual. The remainder of participants identified as lesbian (2.1%), pansexual (2.9%), asexual (0.8%), and gay (0.8%). Sexual minority participants did not significantly differ in their reports of

psychological wellness, posttraumatic symptomology, or sexual assault disclosure from straight participants. The participants ranged in age from 18–59 years. The average participant age was 26 years old (M = 26.38, SD = 5.99). Additionally, the average amount of disclosure was 23% (M = 2.29, SD = 1.86), indicating relatively low rates of overall disclosure within the sample. However, only six participants reported never disclosing at all. A more detailed breakdown of overall disclosure can be seen in Table 1.

Table 1

Descriptive Data: Disclosure

Type of Disclosure	*M*	*SD*	Range
Immediate Family	3.57	3.60	0–10
Extended Family	2.10	2.64	0–10
Friends	3.10	2.62	0–10
Peers/Colleagues	1.59	2.35	0–10
Strangers	1.10	2.13	0–10

Note. N = 240. Disclosure amounts range from 0 to 10, with 0 representing non-disclosure and 10 representing maximum disclosure or rather disclosure to every person within the respective informal support category (i.e., disclosure rates to immediate family members, extended family members, friends, peer/colleagues, and strangers).

Procedure

A total of 240 cisgender women were recruited on a voluntary basis through various online sources, including social media platforms such as Facebook, Twitter,

Reddit, and various public listservs relevant to the topic. In particular, the researcher predominantly targeted social media sites utilized by sexual assault survivors in attempt to best reach the appropriate sample for the current investigation. Upon recruitment, each participant was informed of the purpose of the study, which was to investigate sexual assault survivors' experiences regarding the decision to disclose. Prior to taking part in the current study, participants indicated their informed consent (see Appendix A). When asked to indicate informed consent, participants were additionally provided with a list of mental health referrals including resources for counseling and other support services, such as crisis information (see Appendix B). Participants then completed a demographic questionnaire (see Appendix C) and the SES—Short Form Version (modified; SES-SFV; Koss et al., 2006; see Appendix D) to ensure compatibility with inclusion criteria. Participants who met inclusion criteria were directed to complete the remainder of the study, while participants who did not meet inclusion criteria were directed to the end of the survey and thanked for their interest. Participation included a series of online questionnaires and surveys including: the Revised Adult Attachment Scale (RAAS; Collins & Read, 1990; see Appendix E), WHO Well-Being Index (WHO-5; WHO, 1998; see Appendix F), the Posttraumatic Diagnostic Scale (PDS-5; Foa et al., 2016; see Appendix G), the Nebraska Outness Scale—Disclosure (modified; NOS-D; Meidlinger & Hope, 2014; see Appendix H), and the Shortened Social Reactions Questionnaire (SRQ-S; Ullman et al., 2017; see Appendix I). Participation occurred online using PsychData, a secure site that collects participant data through a numerical identification system. The numerical system allowed the researcher improved ability to ensure participant

confidentiality and anonymity. Upon completion of the survey, all participants were offered the opportunity to follow a separate link to input their email addresses to enter a drawing for a gift card as incentive for completing the study. The use of a separate link ensured that participants' email addresses were kept separate from their survey responses to better protect participant confidentiality and anonymity. Following data collection, all participant data were analyzed using Version 25 of SPSS software.

Instrumentation

Demographic Questionnaire

An author-generated demographic questionnaire was given to participants as a screener assessment to ensure qualification for the study. Questions assessed for age, gender, sexual orientation, and sexual assault experience.

Sexual Experiences Survey

The SES is a 10-scaled item survey developed in the late 1970s and later modified by Koss and Oros (1982). To ensure compatibility with the legal definition of sexual violence and modern language surrounding sexual violence, Koss et al. (2006) revised the survey and produced both a long-form (SES-LFV) and short-form scale (SES-SFV). The SES-SFV (Koss et al., 2006) measures the completed act of four non-consensual sexual behaviors including: 1) non-penetrative sexual behaviors, 2) oral sex, 3) vaginal penetration, and 4) anal penetration and the attempted act of three non-consensual sexual behaviors including: 1) oral sex, 2) vaginal penetration, and 3) anal penetration, totaling seven behavior-based questions (Koss et al., 2006). The remaining questions assess demographic information and the participants' identification with the label of a rape

victim. An example of a behavior-based question is, “Someone fondled, kissed, or rubbed up against the private areas of my body (*lips, breast/chest, crotch or butt*) or removed some of my clothes without my consent (*but did not attempt sexual penetration*) by…” representing a range of unwanted sexual behaviors (Koss et al., 2006, p. 1). Each of these items are followed by specific tactic inquisitions such as “using force, for example holding me down with their body weight, pinning my arms, or having a weapon” (Koss et al., 2006, p. 1). The scale additionally assesses for the age of occurrence for these experiences through two categories: within the last 2 months and since age 14 (Koss et al., 2006). In the current study, only the second category of these occurrences was assessed. However, given that the following study solely assessed sexual assault experiences in adulthood, the category of “since age 14” was modified to reflect "since age 18." The final question of the scale further assesses sexual assault occurrence by participants if they experienced an unwanted sexual assault experience more than one time.

The SES-SFV is the most commonly used scale to assess unwanted sexual experiences and demonstrates high internal consistency for women, with reported Cronbach’s alphas of 0.92–0.98 (Johnson et al., 2017). The Cronbach’s alpha score for the SES-SFV in the current study was 0.83. The measure has been validated for assessing a woman’s level of victimization ($r = 0.73$) by various studies over the years (Carson et al., 2020; Johnson et al., 2017; Koss & Gidycz, 1985). In past research, this instrument has also produced 93% agreement in test-retest reliability when measured 1-week apart (Carson et al., 2020). Given that some people whose experiences meet the legal definition

for sexual assault do not conceptualize their experiences as sexual assault, the SES-SFV was additionally used as a screener assessment to provide the researcher with an understanding of what types of sexual experiences the participant has endured to ensure eligibility for the study.

Adult Attachment Scale

The Adult Attachment Scale (AAS) was developed by Collins and Read (1990) from three studies (N = 406; 118; 142), largely built upon the earlier works of Hazan and Shaver (1987) and Levy and Davis (1988). Collins (1996) incorporated a fourth study to create a revised version of the AAS (RASS) that expanded the scales' assessment to include measurements of important close relationships beyond solely romantic ones. This allows the RAAS to evaluate attachment presentations in all relationships, including one's attachment to family members, friends, or partners (Collins, 1996). The RAAS demonstrates good test-retest reliability (70%) over a 4-year period, which is congruent with attachment stability recorded in other literature (Kirkpatrick & Hazan, 1994; Ravitz et al., 2010). Additionally, the RAAS has an average Cronbach's alpha of 0.72 (Collins, 1996), indicating good internal consistency. Notably, the average reported Cronbach's alpha using current sample data was 0.61, indicating relatively low to moderate scale reliability.

The RAAS is an 18-item, self-evaluation measurement that is distinguished into three categories (i.e., anxiety, dependence, and closeness) and each category consists of six-items. Anxiety items (α = 0.72) evaluate anxiousness in relationships, such as a fear of abandonment or a fear of being unloved; dependence items (α = 0.75) measure trust of

others and perceived support availability; and closeness items ($\alpha = 0.69$) evaluate a person's comfort with relational closeness and intimacy (Collins, 1996). An attachment orientation of secure, insecure anxious, or insecure avoidant is dependent on the interaction of these categorical scorings: a score high in closeness, low in anxiety and low in dependence yields a secure attachment; a score of low closeness, high anxiety, and high dependence belongs to an anxious attachment; and a score of low closeness, low dependence, and high anxiety yields a categorical scoring of avoidant attachment (Collins, 1996). An example of an item included in the RAAS is, "I am not sure that I can always depend on people to be there when I need them." Each question is followed by a 5-point Likert scale (1 = *not at all characteristic of me*; 5 = *very characteristic of me*; Collins, 1996).

Psychological Wellness Outcomes

Psychological wellness outcomes were assessed in part using the WHO-5 (WHO, 1998), which is one of the most commonly used measurements assessing subjective psychological well-being. The WHO-5 is a five-item questionnaire that measures a person's subjective state of psychological well-being and is used large-scale cross-cultural studies, indicating reliability across various demographic groups (Topp et al., 2015). Each scale item presents participants with a positively-worded self-statement, such as "I have felt cheerful and in good spirits" (WHO, 1998, p. 1). All items are followed by a 6-point Likert scale (0 = *none of the time* to 5 = *all of the time*) in which participant report their frequency of experiencing such emotions within the last 2-weeks (WHO-5, 1998). Item outcomes are summed and multiplied by four to create an index score

ranging from 0–100, with two important cut-off values (< 50 = poor well-being; < 28 = depression; WHO, 1998). Notably, the WHO-5 demonstrates adequate internal consistency (Topp et al., 2015). Additionally, the Cronbach's alpha score for the WHO-5 that was calculated by the researcher was 0.91, indicating strong scale reliability.

Posttraumatic Diagnostic Scale

To capture another dimension of psychological wellness, the PDS-5 (*DSM*-5; APA, 2013) was used. The PDS-5, created by Foa et al. (2016), is a 24-item, self-report scale that assesses posttraumatic symptomology experienced within the past month. This scale is preceded by the PTSD Symptom Scale—Self-Report (PSS-SR; Foa et al., 1993) and the Posttraumatic Diagnostic Scale (PDS; Foa et al., 1997). The original scaling items in the measures reflect the diagnostic criteria provided in the *DSM-III* (APA, 1980) and the *DSM-IV* (APA, 1994), respectively. However, to ensure congruence between current diagnostic measures, the PDS-5 is a modified scaling assessment that is in accordance with the *DSM-5* (APA, 2013; Foa et al., 2016). An example of a relevant modification is an adjustment of the timeframe in which symptoms are experienced (i.e., adjusted from 2-weeks to 1 month; APA, 2013; Foa et al., 2016).

The PDS-5 consists of 24 items, with two screening items that assess the participant's trauma history and isolate the participant's most impactful traumatic event (Foa et al., 2016). Twenty questions measure the symptom severity associated with the identified trauma using *DSM-5* cluster criteria (i.e., avoidance, changes in mood or cognition, and arousal/hyperactivity). Participants are presented with a descriptor (i.e., "Unwanted upsetting memories about the trauma") and asked to record the duration or

amount of distress congruent with such descriptor using a Likert-type scale ranging from 0 (*not at all*) to 4 (*six or more time per week/severe*; Foa et al., 2016). The remaining questions measure symptom onset and distress interference (Foa et al., 2016). Upon completion of the scale, a total PTSD severity score is calculated with higher scores indicating more severe symptomology. The PDS-5 has demonstrated validity among survivors of sexual trauma and sexual assault (Foa et al., 2016). Additionally, the PDS-5 is a reliable measure with a Cronbach's alpha of 0.95 and a full-scale test-retest reliability of 0.90 (Foa et al., 2016). For the current sample, the reported Cronbach's alpha score was 0.93.

Sexual Assault Disclosure Characteristics

To the best of the researcher's knowledge, an appropriate measure assessing the frequency of sexual assault disclosure does not exist. However, for the investigation, the author adapted a measure for assessment of identity disclosure among lesbian, gay, or bisexual populations. The NOS (Meidlinger & Hope, 2014) is a 10-item, self-report measure divided into two five-item subscales that assess for identity concealment (NOS-C) and identity disclosure (NOS-D). Given that the following study solely assessed disclosure patterns, only the NOS-D subscale was implemented. The NOS-D was then adapted to assess disclosure patterns among sexual assault victims by replacing "sexual orientation" with "non-consensual sexual experience." The NOS-D assesses disclosure by inquiring about a group of known persons awareness about the participant's concealed identity. For example, some of the groups of known persons include "Members of your immediate family (e.g., parents and siblings)" and "People you socialize with (e.g.,

friends and acquaintances)." Each item is following by an 11-point Likert scale, ranging from 0% to 100%, with higher scores indicating more disclosure. Overall disclosure scores are then determined by calculating the mean of all the individual items (Meidlinger & Hope, 2014). The NOS-D held acceptable internal consistency upon initial testing ($\alpha = 0.82$) and strong convergent validity, with high correlates among other outness measures (Meidlinger & Hope, 2014). The current study reported a Cronbach's alpha score of 0.72, thus indicating moderate scale reliability.

Social Reactions Questionnaire

The SRQ-S (Ullman et al., 2017) is a 16-item, self-report measurement adapted and shortened from the 48-item Social Reaction Questionnaire (SRQ; Ullman, 2000) that asks survivors what type of social reactions they received upon disclosing their sexual assault experience. The SRQ-S has acceptable internal consistency ($\alpha = 0.64–0.91$), especially when considering that each scale only consists of two-items and is well-validated for female sexual assault survivors (Ullman et al., 2017). Using the current sample, Cronbach's alpha scores for the SRQ-S indicated acceptable reliability ($\alpha =$ 0.70–0.81).

Items in the SRQ-S are divided into three primary subscales which categorize social reactions as (a) turning against, (b) unsupportive acknowledgement, and (c) positive reactions, as well as the eight specific scales (i.e., emotional support, tangible aid, blame, stigma, control, egocentric, distract, and infantilize), consisting of two-items each (Ullman et al., 2017). Turning against items are conceptualized as overtly hostile

and unhelpful for survivors (i.e., “Told you that you were irresponsible or not cautious enough”); unsupportive acknowledgement items are regarded as reactions that are not overtly hostile, but still unhelpful for survivors (i.e., “Expressed so much anger at the perpetrator that you had to calm them down”); and positive reactions are conceptualized as responses that provided survivors with tangible aide or emotional support (i.e., “Reassured you that you are a good person”; Ullman et al., 2017). Each social reaction item is followed by 5-point Likert scale ranging from 0 (*never*) to 4 (*always*).

CHAPTER IV

RESULTS

The goal of the current statistical analyses was to examine the effects of a person's attachment orientation on their process of sexual assault disclosure and the effects of sexual assault disclosure on an individual's self-evaluation of psychological wellness. The primary step was to ensure that all statistical assumptions were met. In line with assumptions, the data did not indicate any skewness and were normally distributed. Further, description and correlation statistics were examined. Once assumptions were checked, the researcher calculated appropriate output scores for each survey measure. Specifically, each participant's attachment orientation, total wellness score, posttraumatic outcome score, overall disclosure score, and average social reaction type was calculated. See Table 2 for a breakdown of obtained data.

Additionally, simple *t*-test analyses were run to assess for descriptive findings within the data. Findings revealed that of sexual assault experiences, 85% of women reported experiencing some type of completed rape (oral, anal, and/or vaginal), 58% reported experiencing attempted rape, and 86% reported experiencing unwanted touching and/or sexual coercion. Additionally, most participants described their sexual assault perpetrator(s) as male (82%), while 11.3% percent reported them to be female, and 6.7% reported their perpetrators to be both male and female. Further, using a one-way analysis of variance, results indicated that securely attached individuals reported a higher amount of sexual contact, attempted coercion, coercion, attempted rape, and/or rape experiences

(M = 10.27) than insecurely attached participants (M = 6.02), $p < 0.001$. The remaining statistical analyses utilized for each hypothesis will be discussed further below.

Table 2

Descriptive Data

Variable	*M*	*SD*	Possible Range	Actual Range
Attachment Anxiety	2.99	.70	0-5	1.17–4.83
Attachment Avoidance	3.21	.60	0-5	1.50–4.75
Disclosure	2.30	1.86	0-10	0–10
PTSD	32.39	16.23	0-80	0–78
WHO-5	12.09	5.81	0-25	0–24
SES	7.89	5.50	0-35	1–26

Note. N = 240. Disclosure amounts range from 0 to 10, with 0 representing non-disclosure and 10 representing maximum disclosure. PTSD scores are classified as follows: PTSD severity is determined by totaling the 20 PDS-5 symptom ratings (items 1–20). Scores range from 0-80. The following are clinical guidelines for PTSD symptom severity: 0–10 = minimal symptoms; 11–23 = mild symptoms; 24–42 = moderate symptoms; 43–59 = severe symptoms; 60–80 = very severe symptoms (Foa et al., 2016). WHO-5 scores are classified as follows: Item outcomes are summed and multiplied to create an index score ranging from 0–25, with two important cut-off values (< 12.5 = poor well-being; < 7 = depression; WHO, 1998). SES scoring is as follows: < 0 on all

items = non-victim; > 0 on any number of items = experience of sexual contact, attempted coercion, coercion, attempted rape, and/or rape (Koss et al., 2006).

Hypothesis 1

The researcher used a linear regression analysis to test Hypothesis 1, which predicted that attachment avoidance would be negatively associated with sexual assault disclosure, while attachment security would be positively associated with sexual assault disclosure. There were three independent variables, including attachment closeness, attachment anxiety, and attachment dependent, and the dependent variable was overall rate of disclosure. Results of the regression revealed that attachment was not a significant predictor of disclosure total scores, $F(3, 236) = 1.702$, $p = 0.167$, $R^2 = 0.021$. As such, Hypothesis 1 was not supported.

Hypothesis 2

Hypothesis 2, which predicted that attachment insecurity would moderate the relationship between sexual assault disclosure and well-being, was tested using a moderation analysis. The predictor variable was overall rate of disclosure; the moderation variable was attachment insecurity (e.g., anxiety and avoidance); and the outcome variable was well-being, which was calculated on the basis of both the participant's wellness and posttraumatic outcome scores. Thus, four moderation analyses were run, with attachment anxiety as the predictor variable and wellness as the outcome variable in analysis one, attachment anxiety as the predictor variable and posttraumatic outcomes as the outcome variable in analysis two, attachment avoidance as the predictor variable and

wellness as the outcome variable in analysis three, and attachment avoidance as the predictor variable and posttraumatic outcomes as the outcome variable in analysis four. Parallel analyses were run for each outcome using Aiken et al. (1991) multiple regression methodology.

The first hierarchical regression analysis examined whether anxious attachment symptoms moderated the relationship between disclosure rates and general psychological wellness. In the first step, two variables were included: total disclosure scores and anxiety subscale scores from the RAAS. Separately, the variables accounted for a significant amount of variance in total psychological wellness outcomes, $R^2 = 0.121$, $F(2, 237) = 16.382$, $p < 0.001$. Anxiety subscale scores and disclosure total scores were significant positive predictors of WHO-5 scores ($\beta = 0.309$, $t(239) = 5.074$, $p < 0.001$ and $\beta = 0.146$, $t(239) = 2.391$, $p = 0.018$, respectively). In the final step of the regression analysis, an interaction term between anxious subscale scores and total disclosure scores was created, which did not account for a significant proportion of the variance in WHO-5 total scores, $\Delta R^2 = 0.000$, $\Delta F(1, 236) = 0.005$, $p = 0.946$. Thus, the moderation effect was not significant.

The second hierarchical regression examined whether anxious attachment symptoms moderated the relationship between disclosure rates and posttraumatic symptomology. Similarly, in the first step, two variables were included: total disclosure scores and anxiety subscale scores from the RAAS. The variables accounted for a significant amount of variance in total posttraumatic symptomology scores, $R^2 = 0.223$, $F(2, 237) = 33.966$, $p < 0.001$. Anxiety subscale scores and disclosure total scores were

significant positive predictors of PDS-5 scores (β = .319, $t(239) = 5.567$, $p < 0.001$ and β = .332, $t(239) = 5.792$, $p < 0.001$, respectively). In the final step of the regression analysis, an interaction term between anxious subscale scores and total disclosure scores was created, which did not account for a significant proportion of the variance in PDS-5 total scores, $\Delta R^2 = 0.000$, $\Delta F(1, 236) = 0.002$, $p = 0.967$. Thus, the moderation effect was not significant.

The third hierarchical regression analysis examined whether avoidant attachment symptoms moderated the relationship between disclosure rates and general psychological wellness. As with the previous analyses, in the first step, two variables were included: total disclosure scores and avoidant subscale scores from the RAAS. The variables accounted for a significant amount of variance in total psychological wellness outcomes, $R^2 = 0.202$, $F(2, 237) = 30.071$, $p < 0.001$. Avoidant subscale scores and disclosure total scores were significant positive predictors of WHO-5 scores (β = 0.420, $t(239) = 7.240$, $p < 0.001$ and β = 0.147, $t(239) = 2.540$, $p = 0.012$, respectively). In the final step of the regression analysis, an interaction term between avoidant subscale scores and total disclosure scores was created, which did not account for a significant proportion of the variance in WHO-5 total scores, $\Delta R^2 = 0.011$, $\Delta F(1, 236) = 3.323$, $p = 0.070$. Thus, the moderation effect was not significant.

The fourth hierarchical regression examined whether avoidant attachment symptoms moderated the relationship between disclosure rates and posttraumatic symptomology. In the first step, two variables were included: total disclosure scores and anxiety subscale scores from the RAAS. The variables accounted for a significant amount

of variance in total posttraumatic symptomology scores, $R^2 = 0.262$, $F(2, 237) = 43.450$, $p < 0.001$. Avoidant subscale scores and disclosure total scores were significant positive predictors of PDS-5 scores ($\beta = 0.384$, $t(239) = 6.903$, $p < 0.001$ and $\beta = 0.335$, $t(239) = 6.034$, $p < 0.001$). In the final step of the regression analysis, an interaction term between avoidant subscale scores and total disclosure scores was created, which did not account for a significant proportion of the variance in PDS-5 total scores, $\Delta R^2 = 0.002$, $\Delta F(1, 236) = 0.720$, $p = 0.397$. Thus, the moderation effect was not significant.

Taken together, these series of hierarchical linear regression analyses indicate that one's attachment orientation does not moderate the relationship between disclosure and psychological wellness. As such, Hypothesis 2 was not supported although notably, analyses did support findings suggesting that attachment orientation and disclosure are significant predictors of psychological wellness outcomes.

Hypothesis 3

Hypothesis 3, which predicted that individuals who receive positive responses upon disclosure would have less posttraumatic symptomology than disclosers with negative responses, was investigated using a set of linear regression analyses. The independent variable for each of these analyses was social reactions upon disclosure, and the dependent variable was posttraumatic outcomes and wellness outcomes, respectively.

In the first regression analysis, the correlation between social reaction subscale scores (i.e., positive social reactions, turning against social reactions, and unsupportive acknowledgement) and posttraumatic outcomes was assessed. Results indicated that there was a collective significant effect between social reactions and posttraumatic outcomes,

$F(3, 236) = 44.34$, $p < 0.001$, $R^2 = 0.36$. Specifically, unsupportive acknowledgement ($\beta = 8.37$, $p < 0.001$) and positive reactions ($\beta = 2.69$, $p = 0.009$) were significant predictors of posttraumatic outcomes. Although unsupportive acknowledgement and positive reactions were both significant predictors of the model, when considering partial correlation findings, it is notable that unsupportive acknowledgement ($R_{partial} = 0.299$) explained the variance salient to positive reactions ($R_{partial} = 0.168$) in addition to variance unique to itself (see Table 3). Taken together, then, unsupportive acknowledgement is a better predictor of posttraumatic stress responses than positive reactions to disclosure of sexual assault.

Table 3

Regression Output: Social Reactions x Posttraumatic Outcomes

Variable	β	$R_{partial}$	*p*-value
Unsupportive Acknowledgement	8.370	0.299	0.000
Positive Reactions	2.685	0.168	0.009
Turning Against	2.911	0.123	0.059

Note: $R^2 = 0.36$; overall model $F(3, 236) = 44.341$, $p < 0.001$.

The second multiple linear regression analysis assessed the relationship between social reaction subscales and general wellness outcomes, using WHO-5 scores. The results indicated that there was a collective significant effect between social reactions and wellness outcomes, $F(3, 236) = 7.418$, $R^2 = 0.086$, $p < 0.001$. Only positive reactions ($\beta =$

1.13, $p = 0.006$) and unsupportive acknowledgement ($\beta = 1.57$, $p = 0.036$) were a significant predictor of wellness outcomes. Although unsupportive acknowledgement and positive reactions were both significant predictors of the model, when considering partial correlation findings, it is notable that positive reactions ($R_{partial} = 0.178$) explained the variance salient to unsupportive acknowledgement ($R_{partial} = 0.136$) in addition to variance unique to itself (see Table 4). As such, positive social reactions are a better predictor of posttraumatic stress responses than reactions that offer unsupportive acknowledgement to disclosure of sexual assault. Taken together, these two analyses indicate that positive social reactions and unsupportive social reactions are related to psychological wellness outcomes, and as such, Hypothesis 3 was supported.

Table 4

Regression Output: Social Reactions x Well-being Outcomes

Variable	*β*	$R_{partial}$	*p*-value
Unsupportive			
Acknowledgement	1.567	0.136	0.036
Positive Reactions	1.215	0.178	0.006
Turning Against	-0.702	-0.069	0.287

Note: $R^2 = 0.086$; overall model $F(3, 236) = 7.418$, $p < 0.001$.

Additional Hypothesis

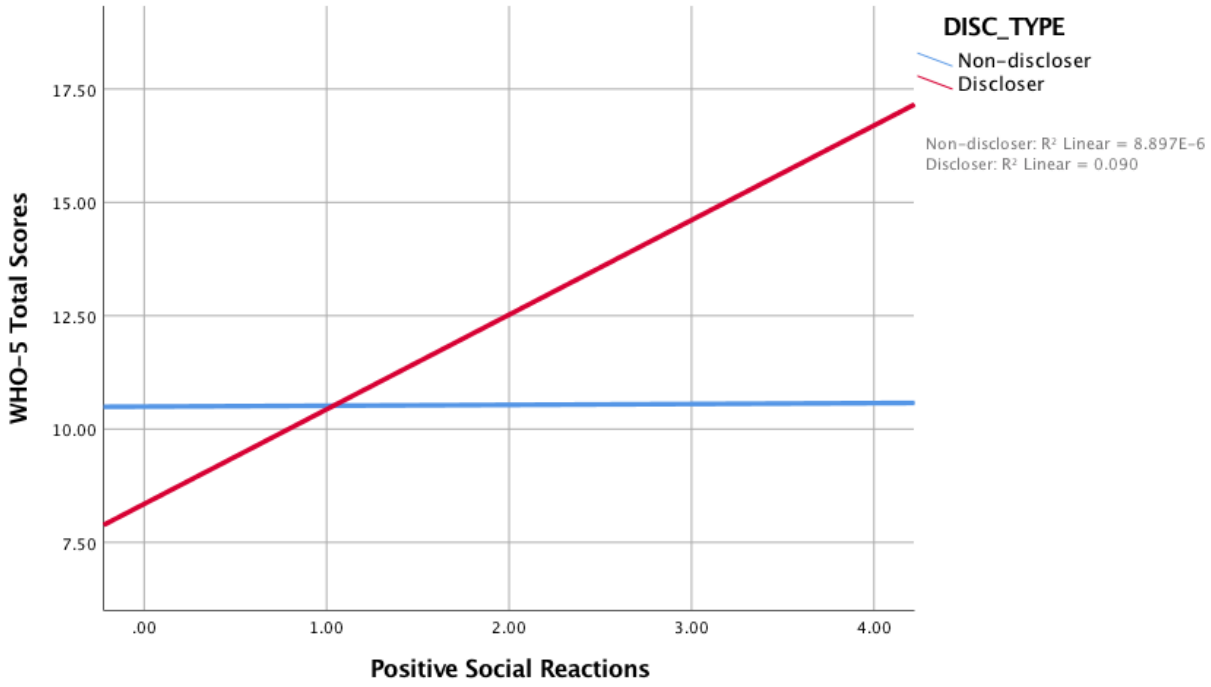
Based on findings from Hypothesis 3, an additional analysis assessing disclosure as a potential moderating variable was run. In particular, it was predicted that overall rate

of disclosure would moderate the relationship between social responses received upon disclosure and wellness outcomes. Thus, a moderation analysis was used, with social reactions upon disclosure as the predictor variable, overall rate of disclosure as the moderator variable, and wellness outcome as the outcome variable.

The overall model was significant, $R^2 = 0.126$, $F(3, 236) = 14.392$, $p < 0.001$. Specifically, an interaction term between positive reaction subscale scores and total disclosure scores was created, which accounted for a significant proportion of the variance in WHO-5 total scores, $\Delta R^2 = 0.053$, $\Delta F(3, 236) = 11.35$, $p < 0.001$, $\beta = 0.799$, $t(239) = 3.79$, $p < 0.001$ (See Figure 1). Notably, disclosure groups were created based on the amount of participant disclosure for the purpose of the figure. Participants who, on average, disclose their sexual assault experience less than 10% of the time were labeled as non-disclosers (34%), while participants who disclosure their sexual assault experience more than 10% of the time were categorized as disclosers (66%).

Figure 1

Changes in Well-being Outcomes as a Function of Social Reactions and Disclosure



Note. This figure demonstrates that there is a positive interaction effect between rates of disclosure and positive social reactions on well-being scores.

*$R^2 = 0.09$; overall model $R^2 = 0.126$, $F(3, 236) = 14.39$, $p < 0.001$.

CHAPTER V

DISCUSSION

Summary of Findings

While researchers have considered barriers to sexual assault disclosure to formal support networks, little is known about how those barriers differ among informal support disclosures. Further, scant research has focused on the interpersonal differences of disclosers and non-disclosers, as well as the impact of the kinds of reactions sexual assault receivers experience. Thus, the current study proposed that existing working schemas, such as attachment orientations, may be related to one's decision to engage in informal disclosure and as such, the author explored the influence of cisgender women's attachment orientation on her experiences with sexual assault disclosure and non-disclosure (H1). However, statistical analyses did not support a relationship between attachment orientation and overall rate of disclosure.

Further, existing research has overwhelmingly indicated that post-assault disclosure is associated with the psychological wellness of survivors. However, the outcomes of wellness remain mixed, as some findings indicate better outcomes for those who disclose (Ahrens et al., 2010), while other research has deemed non-disclosure as a potential protective factor (Carson et al., 2020; Ullman et al., 2020). Thus, in accordance with the proposition that attachment may influence disclosure in meaningful ways, the researcher further sought to expand upon previous research by examining the relationship

between sexual assault disclosure and psychological wellness, with attachment as a potential moderating factor (H2). Consistent with Hypothesis 1, statistical analyses did not support a moderating effect. However, statistical analyses did reveal the support of other important findings. Primarily, the results indicated a relationship between the overall rate of disclosure and psychological wellness. Specifically, disclosers reported higher overall wellness and higher posttraumatic outcomes compared to non-disclosers. Statistical analyses further suggested a relationship between attachment orientation and psychological wellness. In particular, securely attached individuals reported lower posttraumatic outcomes when compared to insecurely attached individuals. However, securely attached participants also reported lower scores on overall wellness compared to insecurely attached participants; notably, the researcher found that those with a secure attachment style also reported more sexual assault experiences than those with an insecure attachment style.

Lastly, existing research has posited that wellness outcomes following post-assault disclosure are often associated with the types of responses one receives upon disclosure. Thus, the researcher sought to replicate and extend existing work by considering the relationship between social responses to disclosure and psychological wellness outcomes (H3). Consistent with predictions, findings indicated participants who received higher rates of unsupportive social acknowledgements (negative or unhelpful reactions) also experienced higher posttraumatic outcomes. Further, in line with existing work, statistical analyses suggested that individuals who received higher rates of positive social reactions experienced better wellness outcomes. To expand upon this, further

analyses additionally revealed that the rates of one's disclosure strengthens the relationship between positive social reactions and psychological wellness. Otherwise stated, participants' overall wellness increased as they disclosed, but only when those disclosures were met with a positive social response.

Integration of Findings with Existing Literature

As previously noted, the researcher sought to address a number of gaps within sexual assault and disclosure literature by assessing potential associations between female sexual assault survivors' disclosure status and their attachment orientations. In particular, the researcher examined how one's decision to disclose is influenced by their attachment orientation. However, results did not reveal a relationship, which indicates that there are other potential interpersonal barriers, not reliant on attachment, that may be associated with sexual assault disclosure. Further, consideration for how these findings complement or contradict existing literature is nuanced, as the current study is the first known study to explicitly assess the relationship between attachment orientation and sexual assault disclosure.

However, Mikulincer and Nachshon (1991) found a relationship between broad self-disclosure and attachment. Specifically, Mikulincer and Nachshon (1991) described broad self-disclosure as any informational exchange that results in more awareness of the discloser's experiences. For example, the authors inquired about participants' level of self-disclosure regarding their "most horrifying fears" and events they feel guilty about to an informal support person (Mikulincer & Nachschon, 1991, p. 323). Further, Yukawa et al. (2007) posited insecurely attached individuals demonstrated higher forms of self-

concealment when compared to securely attached groups. Yukawa et al. (2007) defined self-concealment as the process of withholding or concealing distressing information about oneself from others. Therefore, the findings of the current study are seemingly inconsistent with broader disclosure literature and thus, it is likely that sexual assault disclosure differs from general self-disclosure in meaningful ways not yet captured. For example, the potentially stigmatizing nature of sexual assault may distinguish sexual assault disclosure from general self-disclosure, as individuals may find sexual assault disclosure to be fearful, perhaps in part due to concerns about the reactions they may face from those in their informal networks (Miller et al., 2011).

Due to the limited and incongruent findings salient to sexual assault non-disclosure and associated psychological wellness, the researcher additionally explored psychological outcomes related to disclosure and non-disclosure behavior. Specifically, she explored how disclosure behavior affected psychological wellness while additionally considering one's attachment orientation. Upon exploration, findings did not suggest a relationship between disclosure and psychological wellness when including attachment as a potential influencing factor. However, the results of the current study did yield support for a relationship between disclosure and psychological wellness and a relationship between attachment orientation and psychological wellness as independent constructs.

At first glance, the results of the current study were seemingly incongruent, as high disclosure indicated high posttraumatic outcomes *and* high wellness outcomes, while low rates of disclosure indicated low posttraumatic symptomology *and* low mental wellness. However, these findings may be conceptualized consistently with previous

literature, which has additionally revealed incongruent psychological wellness outcomes for disclosers of sexual assault. Specifically, Carson et al. (2020) posited that non-disclosers endorsed fewer posttraumatic outcomes when compared to disclosers, which is consistent with the findings of the current study. It is possible that the repeated occurrence of disclosing one's traumatic history further exacerbates survivor trauma symptoms and thus leads to re-traumatization and higher PTSD outcomes. Additionally, the potential for negative reactions upon disclosure is increased as survivors continue to disclose. Hence, consistent with findings that indicate the deleterious outcomes associated with negative responses upon disclosure (Lorenz et al., 2018; Therriault et al., 2020; Ullman & Peter-Hagene, 2014), it is also possible non-disclosure protects survivors against pejorative social responses (Carson et al., 2020; Ullman et al., 2020). Notably, the latter concept was further explored in Hypothesis 3 and is discussed later in this chapter.

The current study's findings indicating a relationship between attachment orientation and psychological wellness also revealed seemingly incongruent results, as an insecure attachment orientation predicted high posttraumatic outcomes *and* high wellness outcomes, while a secure attachment orientation predicted low posttraumatic outcomes *and* low wellness outcomes. Consistent with attachment research, individuals with an insecure attachment style experience higher rates of relational trauma, broadly construed (Scheidt et al., 2012; Woodhouse et al., 2015), which may be partially correlated to a higher occurrence of PTSD symptoms. Additionally, it is possible that attachment-related differences in emotional regulation are related to the maintenance and development of posttraumatic symptomology following a sexual assault experience (Mikulincer &

Shaver, 2018). Specifically, when compared to insecurely attached groups, securely attached individuals may be better equipped with more effective emotional regulation capabilities that enhance their ability to conceptualize problem-solving opportunities when experiencing stress (Mikulincer & Shaver, 2012, 2018). Thus, the findings of the current study supporting a relationship between attachment insecurity and higher rates of PTSD symptoms align with findings salient to attachment literature (Holmberg et al., 2011; Mikulincer & Shaver, 2012, 2018).

However, situating the current findings regarding attachment security and wellness outcomes within existing literature remains more difficult. In fact, the results of the current study contradict other research suggesting a positive relationship between attachment security and psychological well-being. For example, when looking at a sample of gay men, Trachtenberg-Ray and Modesto (2021) found the opposite, as the researchers' findings posited that a secure attachment orientation significantly predicted well-being. Similarly, Cheng et al. (2015) posited that attachment anxiety is related to mental health concerns, encompassing well-being. However, it is important to note that the findings promulgated by these researchers were yielded based on a sample of primarily men without a known sexual assault history, which may account for the discrepancies in the current findings. Further, individuals in the current study's sample who reported a secure attachment style additionally indicated a higher average occurrence of sexual assault experiences than participants with an insecure attachment style and thus, it is cogent that the number of sexual victimization experiences is related to lower rates of overall wellness.

Finally, given accumulating support regarding the relationship between social responses received upon disclosure and survivor wellness (Jacques-Tiura et al., 2010; Ullman & Peter-Hagene, 2014; Wilson et al., 2020), the researcher sought to replicate and extend existing work by considering such a relationship. The results yielded by the present study are consistent with findings of previous research (Jacques-Tiura et al., 2010; Therriault et al., 2020; Ullman & Peter-Hagene, 2014), which has suggested that sexual assault survivors are more susceptible to the development of posttraumatic outcomes when met with an unsupportive social response. Also consistent with sexual assault disclosure literature, the present study found support for a positive relationship between positive social responses and psychological wellness (Orchowski & Gidycz, 2012; Therriault et al., 2020; Ullman & Peter-Hagene, 2014).

The findings of the current study additionally identified a rather novel finding, which supports existing research and builds upon it. Specifically, the relationship between participants' overall wellness and disclosure increased as they were met with a positive response; participants experienced better psychological wellness upon higher rates of disclosure, but only when those disclosure were met with positive social reactions. In turn, non-disclosers' psychological wellness remained stable as they either discontinued disclosure behavior or never disclosed at all. This finding builds on disclosure literature (Therriault et al., 2020; Wilson et al., 2020) by indicating that providing emotional and informational support to survivors following disclosure ensures the most optimal outcomes concerning survivor psychological wellness.

Implications for Attachment Theory

Attachment theory is a longstanding approach that provides important understandings of relational functioning in adulthood. The findings of the current study have important implications and thus, may add to attachment-based understandings in meaningful ways. First, findings suggested that a secure attachment orientation is related to lower rates of posttraumatic symptomology for women who have experienced adult sexual assault. Attachment theorists may benefit from this knowledge, as it aligns with and adds to research concerning attachment-based stress responses by supporting the belief that securely attached-individuals are better equipped to handle traumatic experiences (Holmes, 2014; Mikulincer & Shaver, 2012).

Second, and contrary to the researcher's predictions, the findings indicated that female sexual assault survivors with insecure attachment orientations experience better overall psychological wellness when compared to those with a secure attachment orientation. Notably, this finding is inconsistent with other attachment-related work and therefore, attachment theorists may additionally benefit from this knowledge, as it highlights the potential psychological protectiveness salient to the development of an insecure attachment orientation. However, it is possible that experiences of psychological wellness are related to sexual victimization experiences, as securely attached participants reported a higher amount of sexual victimization than insecurely attached participants. Additionally, while the relationship between the survivor and their perpetrator was not explored, it is possible that such relationship plays an important role in the development of psychological wellness among survivors of varying attachment groups. For example,

given that one's attachment orientation influences their expectations and insecurities regarding themselves and intimate partners, it is possible that securely attached individuals may experience sexual assault perpetrated by an intimate partner more adversely than insecurely attached groups, as insecurely attached individuals may already hold negative or maladaptive schemas on relationship functioning (Fraley & Roisman, 2019).

Clinical and Policy Implications of Findings

The integration of research findings into clinical work remains especially important for the integrity of current and future research. Results of the current study have clinical relevance, as they reveal that the psychological outcomes associated with sexual assault disclosure are nuanced. Importantly, current findings suggest that disclosure of sexual assault experiences may not always nor consistently be associated with the alleviation of posttraumatic symptomatology. As such, psychologists and other mental health professionals (MHPs) who work with sexual assault survivors could benefit from the knowledge that frequent disclosers may be particularly susceptible to adverse posttraumatic outcomes and/or re-traumatization. Additionally, this study highlighted the importance of acknowledging the potential protectiveness of non-disclosure. With these findings in mind, clinicians should further consider their use of therapeutic treatment modalities, as some therapeutic approaches encourage repeated survivor disclosure. For example, CPT is a well-accredited therapeutic treatment approach used with sexual assault victims that encourages frequent and repeated disclosure. Notably, this therapeutic approach may not be inclusive, nor trauma-informed and thus, may exacerbate survivor

distress during and/or following treatment (American Psychological Association, 2018). Instead, psychologists and MHPs may benefit from a more inclusive, trauma-based treatment method when working with survivors of sexual assault (i.e., emotions-focused therapy, feminist trauma therapy; Richmond et al., 2013).

Additionally, sexual assault policymakers, such as those who have authored Title IX legislation, may also benefit from the acknowledgement of these findings. Specifically, the recent passing of Texas Senate Bill 212 requires that all academic employees of post-secondary education report any known occurrences of sexual assault among university students and/or employees (Sec. 51.252). Therefore, Title IX requirements mitigate survivor control regarding their disclosure process, which has profound implications when considering the findings of the current study, as results suggest that continued disclosure, or disclosure at higher rates, is associated with a greater experience of posttraumatic symptomatology. Similarly, the current findings also reveal that meeting survivors with an unsupportive social response (which includes controlling survivors' decisions upon disclosure) may additionally exacerbate posttraumatic symptomology. Thus, policymakers should consider that the standards implemented to protect sexual assault survivors may, in turn, exacerbate their psychological adjustment following assault.

Additionally, disclosure may also be associated with overall wellness for survivors. More specifically, the current findings suggest that disclosures met with a positive social response indicate better wellness outcomes, while disclosures met with reactions of unsupportive acknowledgement indicate higher posttraumatic outcomes.

These findings are additionally applicable to clinical work, as they reveal two important trends. Primarily, the findings of the current study could indicate the importance of meeting survivors with a positive social response if and when they disclose in therapeutic or clinical spaces. It is important that clinicians meet survivors with emotionally and informationally supportive reactions and resources upon disclosure. This approach may include offering unconditional positive regard, providing resources surrounding sexual assault recovery, and employing treatment modalities that encourage the reduction of survivor self-blame. Second, treatment of sexual assault survivors could further be benefited by the removal of unsupportive acknowledgement, such as egocentric and distraction-oriented responses. For example, egocentric responses include responses in which the support person expresses anger or distaste towards the assaulter, rather than providing support to the sexual assault victim. Therefore, the findings of the current study may suggest that responses that focus on anyone other than the sexual assault survivor might correlate with the victim's experiences of PTSD and as such, MHPs would benefit by placing attentional focus on the survivor, rather than themselves or the perpetrator in treatment. Other unhelpful responses include responses where the support person made decisions on behalf of the survivor, such as reporting the sexual assault experience (DePrince et al., 2021; Gueta et al., 2020; Orchowski et al., 2013). Therefore, for better treatment outcomes, MHPs should refrain from encouraging or telling their clients what to do following the disclosure of a sexual assault experience. Rather, clinicians should work to empower their clients to make their own decisions about reporting and support the decisions made by their clients.

Taken together, this study contributes to the growing body of sexual assault literature examining sexual victimization, disclosure, and outcomes through a feminist lens. Importantly, the researcher suggests that general endorsements of sexual assault disclosure should be cautioned, as the individual outcomes salient to disclosure vary. Additionally, the suggestions and recommendations outlined within this chapter are consistent with the *Guidelines for Psychological Practice with Girls and Women* (American Psychological Association, 2018). Predominantly, the guidelines assert the importance of empowering women in their decisions and utilizing treatment approaches that are trauma-informed and gender-relevant (American Psychological Association, 2018). The guidelines additionally address practitioners' self-awareness of biases as a critical component of psychological training (American Psychological Association, 2018). Regarding the current study, the researcher suggests that psychologists and other MHPs routinely evaluate their personal biases surrounding rape mythology in attempt to strengthen their ability to ethically treat sexual assault survivors (Wilson et al., 2020).

Study Limitations

There are several limitations concomitant to the current study that are noteworthy. First, the study sample was comprised of a convenience sample of adult cisgender women who self-reported an adult sexual assault experience within the last 10 years. This method of sampling limits the generalizability of study findings to participants reached through limited recruitment methods and thus, may not be generalized to include all sexual assault survivors. Moreover, the consent procedures of the current study required a history of sexual assault and thus, study engagement required participant acknowledgement of

sexual assault and an additional disclosure. Hence, it may be the case that individuals who do not perceive their nonconsensual sexual experience as an assault were less likely to participate in the study. Similarly, only six participants reported never disclosing their sexual assault to an informal support person, which may be related to the method of sampling, which required assault acknowledgement and further disclosure. Additionally, the inclusion of only cisgender women further limits the study's generatability, as current findings may not extend to include the outcomes salient to individuals from more diverse gender groups. Another important demographic limitation is the lack of data regarding the ethnic and racial background of the current sample, a limit imposed by the Institutional Review Board, likely due to concerns about the sensitivity of the measures and study's content and the resultant compromise to anonymity.

An additional limitation of the current study was the method of data collection, which was conducted online and solely included self-report measures, as this limits findings to each individual participant's subjective perceptions of their lived experiences. As such, participant responses may contain bias, be affected by recall issues, and may be subject to socially desirable responses and thus, it is not possible to ensure the accuracy of the data obtained. Further, the attachment measure utilized within the current study yielded low scale reliability ($\alpha = 0.61$), which may limit the validity of the current findings related to attachment. Notably, the low reliability yielded from the current study may be reflective of outdated language used within the measure and therefore, future research may explore more appropriate attachment measures that better capture more modern assessments for attachment style or implement attachment measures that

demonstrate greater psychometric properties, such as the Adult Attachment Interview (AAI; Ravitz et al., 2010). Moreover, the current study utilized a cross-sectional design and as such, no causal inferences can be made. Lastly, the majority of participants reported that a man sexually assaulted them (82%), which, while consistent with the gender compilation of most sexual assaults, may limit findings to outcomes analogous to sexual assault dynamics in which the genders of the perpetrator and survivor of assault differ. Importantly, sexual assault occurs across various dimensions and therefore, the current study findings are not generalizable to all contextual experiences of sexual assault.

Directions for Future Research

There are various routes for future research salient to the findings of the current study. Primarily, the finding indicating that securely attached individuals reported lower overall wellness indicates a need for further consideration. Thus, future research may seek to explore potential reasonings for these findings. For example, is it possible that insecurely attached groups have adopted better coping strategies that promote higher rates of overall well-being based on their predisposition to trauma in comparison to securely attached groups (Holmes, 2014; Mikulincer & Shaver, 2012). However, it is additionally possible that there is another influencing factor not yet captured in the literature that could better support these findings. Regardless, further consideration is important, as a better understanding of these findings may inform future clinical work in meaningful ways. Additionally, the current study does not permit conclusions based on

causality, as it cannot be determined whether participant wellness outcomes are a result of their attachment, sexual assault and/or disclosure experience.

Continued research on this topic should additionally explore a more ethnically, racially, and gender-diverse sample for better understanding of how sexual assault impacts survivor experiences broadly, as the current study solely assessed the experiences of cisgender women. Importantly, consideration for sexual assault among men and transgender or gender non-conforming groups should additionally be employed, as it is notable that while the majority of sexual assault literature considers the experiences of women, sexual assault occurs within all gendered groups. Moreover, the widespread use of technology as a medium for sexual assault disclosure reliant on feminist movements, such as #MeToo, indicates the importance of incorporating measures assessing for social media disclosure. For example, future research may benefit from examining how disclosure outcomes differ when disclosures are made in-person versus online.

Finally, continued research surrounding sexual assault disclosure should additionally consider the potential impact of COVID-19, as the societal shift following the widespread outbreak of coronavirus has the ability to impact all realms of research in meaningful ways. For example, given that sexual assault experiences most often occur by a person known to the victim (Deitz et al., 2015; Fisher, 2000; Morgan & Ouderkerk, 2019), it may additionally be the case that sexual assault has increased among partners due to COVID-19 induced isolation. Researchers have seen this trend occur with intimate partner violence (Boserup et al., 2020; Bradbury-Jones & Isham, 2020; Van Gelder et al., 2020; Wood et al., 2020) and thus, it is probable that such violence extends to sexual

violence. Taken together, continued research on sexual assault, disclosure, and wellness remains important for study and integral to the continued support of survivors.

Conclusion

The current study suggests that sexually assaulted cisgender women experience nuanced psychological outcomes following post-assault disclosure or non-disclosure. Specifically, findings revealed that women who have not disclosed their sexual assault experiences demonstrated better posttraumatic outcomes, though additionally experienced poorer general wellness outcomes. Moreover, this study further posits women who are met with positive social reactions upon disclosure experience better wellness outcomes generally. Additionally, inconsistent with the researcher's predictions, the current study did not find support for a relationship between a woman's attachment orientation and their experience(s) with sexual assault, as participant's rate of disclosure was not significantly related to their attachment orientation. However, attachment was related to overall psychological health outcomes in novel ways. Notably, the current study suggests that women who have a secure attachment style experience lower rates of posttraumatic symptomology and strikingly, lower rates of general mental wellness. Additionally, the findings of the current study underly the importance of critically assessing existing policy mandates and clinical approaches utilized for sexual assault survivors, as some policies and treatment modalities, through the encouragement and/or requirement of repeated disclosure, may enhance a survivors' experiences of distress following assault disclosure. Therefore, taken together, the present study expanded on existing sexual assault literature in meaningful ways and indicates a need for continued

understanding and integration of sexual assault disclosure research into clinical and legislative settings.

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Appendix A

Informed Consent Form

TEXAS WOMAN'S UNIVERSITY (TWU)
CONSENT TO PARTICIPATE IN RESEARCH

Examining Sexual Assault Disclosure and Non-Disclosure using an Attachment Lens

Principal Investigator: Darian Poe (she/her) ..... dpoe1@twu.edu
Faculty Advisor: Debra Mollen, PhD (she/her) ..... dmollen@twu.edu

Summary and Key Information about the Study

You are being asked to participate in a research study conducted by Darian Poe, a graduate student at Texas Woman's University, as a part of her thesis. The purpose of this research is to investigate sexual assault survivors' experiences regarding the decision to disclose. You have been invited to participate in this study because you are a woman and are a victim of sexual assault. As a participant, you will be asked to take part in an online study regarding your relationships with your family and friends, your experiences with sexual assault, and your experiences with post-assault disclosure. The total time commitment for this study will be about twenty-five minutes. Following the completion of the study you will receive the opportunity to enter a drawing to win one of six $25 gift cards for your participation. The greatest risks of this study include potential loss of confidentiality and emotional discomfort. We will discuss these risks and the rest of the study procedures in greater detail below.

Your participation in this study is completely voluntary and you may withdraw from the study at any time without penalty. If you are interested in learning more about this study, please review this consent form carefully and take your time deciding whether or not you want to participate. Please feel free to ask the researcher any questions you have about the study at any time.

Description of Procedures

As a participant in this study you will be asked to spend approximately twenty-five minutes completing an online study. The study will utilize several measures including the Sexual Experiences Survey (Koss et al., 2006), the Revised Adult Attachment Scale (RAAS; Collins & Read, 1990), the World Health Organization Well-Being Index (WHO-5; WHO, 1998), the Posttraumatic Diagnostic Scale (PDS-5; Foa et al., 2016), the Nebraska Outness Scale—Disclosure (modified; NOS-D; Meidlinger & Hope, 2014), and the Shortened Social Reactions Questionnaire (SRQ-S; Ullman et al., 2017). These measures will ask you questions about the status of your psychological wellbeing, your relationships with your family and friends, your experiences of sexual assault, and your experiences regarding disclosure post-assault. All questions will have you indicate on a scale you agree or disagree with a statement. Only the question inquiring about your age will be open ended. You will be automatically generated a code number so that identifying information will not be linked to your responses. In order to be a participant

in this study, you must be at least 18 years of age or older, be a woman, and have had at least one sexual assault experience in the last ten years, which must have occurred in adulthood.

Potential Risks

The online survey will ask you questions about your experiences with sexual assault. A possible risk in this study is discomfort with these questions you are asked. Some questions will require an answer before moving on. However, if you become tired or upset, you may take breaks as needed. You may also stop answering questions at any time and end the study study immediately by exiting the browser. If you feel you need to talk to a professional about your discomfort, the researcher has provided you with a list of resources below.

- National Sexual Assault Hotline: 800-656-HOPE (4673)
- National Sexual Assault Chat Hotline: https://hotline.rainn.org/online
- National Sexual Assault Chat Hotline (Spanish): https://hotline.rainn.org/es?_ga=2.157058171.1700195699.1618442619-715364447.1616110593
- Sexual Assault Providers in Your Area: https://centers.rainn.org/?_ga=2.180307428.1700195699.1618442619-715364447.1616110593
- Directory of Sexual Assault Organizations: https://www.nsvrc.org/organizations
- National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- More information about sexual assault resources: https://www.healthline.com/health/sexual-assault-resource-guide#if-you-want-legal-support

Another risk in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. The survey will not ask you any questions that will ask for identifying information. Data will be collected using a secure site, PsychData. Additionally, all downloaded data will be transmitted to a password protected computer that is only accessible by the primary investigator. Please note that there is a potential risk of loss of confidentiality in all email, downloading, electronic meetings and internet transactions.

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will try to help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary and you may withdraw from the study at any time. Following the completion of the study you will receive the opportunity to enter a drawing to win one of six $25 gift cards for your participation. Your email address will not be linked to your recorded responses. To ensure that your email address is kept separate from your response, a second survey link will be provided to you at the end of the study survey. You may click this link to enter your email address and the gift card drawing.

Questions Regarding the Study

You may print a copy of this online consent form to keep. If you have any questions about the research study, you should ask the researchers; their contact information is at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the TWU Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

By clicking on the "I Agree" button below, you are providing your consent to participate in this research study.

o I Agree
o I Do NOT Agree

Appendix B

Mental Health Resources

Mental Health Resources

- National Sexual Assault Hotline: 800-656-HOPE (4673)
- National Sexual Assault Chat Hotline: https://hotline.rainn.org/online
- National Sexual Assault Chat Hotline (Spanish): https://hotline.rainn.org/es?_ga=2.157058171.1700195699.1618442619-715364447.1616110593
- Sexual Assault Providers in Your Area: https://centers.rainn.org/?_ga=2.180307428.1700195699.1618442619-715364447.1616110593
- Directory of Sexual Assault Organizations: https://www.nsvrc.org/organizations
- National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- More information about sexual assault resources: https://www.healthline.com/health/sexual-assault-resource-guide#if-you-want-legal-support

Appendix C

Demographic Questionnaire

Age: _____

What is your gender?

a. Ciswoman (a woman whose assigned sex at birth is female)
b. Cisman (a man whose assigned sex at birth is male)
c. Transwoman
d. Transman
e. Gender non-conforming/non-binary
f. Other: _____
g. Prefer not to say

What is your sexual orientation?

a. Straight/heterosexual
b. Gay
c. Lesbian
d. Bisexual
e. Pansexual
f. Asexual
g. Other: _____

Have you been sexually assaulted in the last 10 years?

a. Yes
b. No

If yes, did your sexual assault occur in adulthood (after the age of 18)?

a. Yes
b. No

Appendix D

Sexual Experiences Survey-Short Form Version

The following questions concern sexual experiences that you may have had that were unwanted. We know that these are personal questions, so we do not ask your name or other identifying information. Your information is completely confidential. We hope that this helps you to feel comfortable answering each question honestly. Place a check mark in the box showing whether this experience has happened to you since age 18. Since age 18 refers to your life starting on your 18th birthday to today. If several experiences occurred on the same occasion--for example, if one night someone told you some lies and had sex with you when you were drunk, you would check both boxes a and c.

Sexual Experiences

1. **Someone fondled, kissed, or rubbed up against the private areas of my body (lips, breast/chest, crotch or butt) or removed some of my clothes without my consent *(but did not attempt sexual penetration)* by:**

a. Telling lies, threatening to end the relationship, threatening to spread rumours about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.

b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.

c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

d. Threatening to physically harm me or someone close to me.

e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

2. **Someone had oral sex with me or made me have oral sex with m without my consent by:**

a. Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.

b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.

c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

d. Threatening to physically harm me or someone close to me.

e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

3. **A man put his penis into my vagina, or someone inserted fingers or objects without my consent by:**

a. Telling lies, threatening to end the relationship, threatening to spread rumours about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.

b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.

c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

d. Threatening to physically harm me or someone close to me.

e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

4. **A man put his penis into my butt, or someone inserted fingers or objects without my consent by:**

a. Telling lies, threatening to end the relationship, threatening to spread rumours about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.

b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.

c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

d. Threatening to physically harm me or someone close to me.

e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

5. **Even though it didn't happen, someone TRIED to have oral sex with me, or make me have oral sex with them without my consent by:**

a. Telling lies, threatening to end the relationship, threatening to spread rumours about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.

b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.

c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

d. Threatening to physically harm me or someone close to me.

e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

6. Even though it didn't happen, a man TRIED to put his penis into my vagina, or someone tried to stick in fingers or objects without my consent by:

a. Telling lies, threatening to end the relationship, threatening to spread rumours about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.

b. Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.

c. Taking advantage of me when I was too drunk or out of it to stop what was happening.

d. Threatening to physically harm me or someone close to me.

e. Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

7. **Even though it didn't happen, a man TRIED to put his penis into my butt, or someone tried to stick in objects or fingers without my consent by:**

Telling lies, threatening to end the relationship, threatening to spread rumors about me, making promises I knew were untrue, or continually verbally pressuring me after I said I didn't want to.

Showing displeasure, criticizing my sexuality or attractiveness, getting angry but not using physical force, after I said I didn't want to.

Taking advantage of me when I was too drunk or out of it to stop what was happening.

Threatening to physically harm me or someone close to me.

Using force, for example holding me down with their body weight, pinning my arms, or having a weapon.

8. Did any of the experiences described in this survey happen to you 1 or more times?
   Yes No

9. What was the sex of the person or persons who did them to you?
   Female only
   Male only
   Both females and males
   I reported no experiences

Appendix E

Adult Attachment Scale

Please read each of the following statements and rate the extent to which it describes your feelings about romantic relationships. Please think about all your relationships (past and present) and respond in terms of how you generally feel in these relationships. If you have never been involved in a romantic relationship, answer in terms of how you think you would feel.

Please use the scale below by placing a number between 1 and 5 in the space provided to the right of each statement.

1----------2----------3----------4----------5
Not at all characteristic of me — **Very characteristic of me**

1) I find it relatively easy to get close to people. _____

2) I find it difficult to allow myself to depend on others. _____

3) I often worry that romantic partners don't really love me. _____

4) I find that others are reluctant to get as close as I would like. _____

5) I am comfortable depending on others. _____

6) I don't worry about people getting too close to me. _____

7) I find that people are never there when you need them. _____

8) I am somewhat uncomfortable being close to others. _____

9) I often worry that romantic partners won't want to stay with me. _____

10) When I show my feelings for others, I'm afraid they will not feel the same about me. _____

11) I often wonder whether romantic partners really care about me. _____

12) I am comfortable developing close relationships with others. _____

13) I am uncomfortable when anyone gets too emotionally close to me. _____

14) I know that people will be there when I need them. _____

15) I want to get close to people, but I worry about being hurt. _____

16) I find it difficult to trust others completely. _____

17) Romantic partners often want me to be emotionally closer than I feel comfortable being. _____

18) I am not sure that I can always depend on people to be there when I need them. _____

Appendix F

World Health Organization: Well-being Index (WHO-5)

WHO-5 Well-being Index

Please respond to each item by marking one box per row, regarding how you felt in the last two weeks.		All of the time	Most of the time	More than half the time	Less than half the time	Some of the time	At no time
WHO 1	I have felt cheerful in good spirits.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 2	I have felt calm and relaxed.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 3	I have felt active and vigorous.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 4	I woke up feeling fresh and rested.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 5	My daily life has been filled with things that interest me.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Appendix G

Posttraumatic Diagnostic Scale (PDS-5)

PTSD Diagnostic Scale for DSM-5

(PDS-5)

Instructions: Below is a list of problems that people sometimes have after experiencing a traumatic event. Write down the most distressing traumatic event that you checked on the last page:

Please read each statement carefully and circle the number that best describes how often that problem has been happening and how much it upset you over THE LAST MONTH. Rate each problem with respect to the traumatic event that you wrote above.

For example, if you've talked to a friend about the trauma one time in the past month, you would respond like this: (because one time in the past month is less than once a week)

Talking to other people about the trauma

0	(1)	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

1. Unwanted upsetting memories about the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

2. Bad dreams or nightmares related to the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

3. Reliving the traumatic event or feeling as if it were actually happening again

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

4. Feeling very EMOTIONALLY upset when reminded of the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

5. Having PHYSICAL reactions when reminded of the trauma (for example, sweating, heart racing)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

6. Trying to avoid thoughts or feelings related to the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

PTSD Diagnostic Scale for DSM-5

(PDS-5)

7. Trying to avoid activities, situations, or places that remind you of the trauma or that feel more dangerous since the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

8. Not being able to remember important parts of the trauma

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

9. Seeing yourself, others, or the world in a more negative way (for example "I can't trust people," "I'm a weak person")

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

10. Blaming yourself or others (besides the person who hurt you) for what happened

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

11. Having intense negative feelings like fear, horror, anger, guilt or shame

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

12. Losing interest or not participating in activities you used to do

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

13. Feeling distant or cut off from others

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

14. Having difficulty experiencing positive feelings

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

15. Acting more irritable or aggressive with others

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

PTSD Diagnostic Scale for DSM-5

(PDS-5)

16. Taking more risks or doing things that might cause you or others harm (for example, driving recklessly, taking drugs, having unprotected sex)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

17. Being overly alert or on-guard (for example, checking to see who is around you, being uncomfortable with your back to a door)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

18. Being jumpy or more easily startled (for example when someone walks up behind you)

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

19. Having trouble concentrating

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

20. Having trouble falling or staying asleep

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

DISTRESS AND INTERFERENCE

21. How much have these difficulties been bothering you?

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

22. How much have these difficulties been interfering with your everyday life (for example relationships, work, or other important activities)?

0	1	2	3	4
Not at all	Once a week or less/a little	2 to 3 times a week/somewhat	4 to 5 times a week/very much	6 or more times a week/severe

SYMPTOM ONSET AND DURATION

23. How long after the trauma did these difficulties begin? [circle one]
    a. Less than 6 months
    b. More than 6 months

24. How long have you had these trauma-related difficulties? [circle one]
    a. Less than 1 month
    b. More than 1 month

Appendix H

Nebraska Outness Scale-Disclosure (NOS-D) Modified

What percent of the people in this group do you think are aware of your sexual assault experience?

Members in your immediate family (e.g., parents and siblings):

□ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Members in your extended family (e.g., aunts, uncles, grandparents, cousins):

□ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

People you socialize with (e.g., friends):

□ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

People at your work/school (e.g., coworkers, supervisors, instructors, students):

□ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Strangers (e.g., someone you have a casual conversation with in line at the grocery store):

□ 0% □ 10% □ 20% □ 30% □ 40% □ 50% □ 60% □ 70% □ 80% □ 90% □ 100%

Appendix I

Shortened Social Reactions Questionnaire (SRQ-S)

SRQ-S Measure
How Other People Responded . . .

For this study, we are interested in people you know informally or socially, like parents, siblings, friends, romantic partners, and acquaintances (informal support networks), as opposed to professionals like doctors, lawyers, or therapists (formal support networks). The following is a list of reactions that other people sometimes have when responding to a person with a sexual assault experience. Please indicate how often you experienced each of the listed responses from **informal support networks**.

0	1	2	3	4
Never	Rarely	Sometimes	Frequently	Always

1. Told you that you were irresponsible or not cautious enough _____
2. Reassured you that you are a good person _____
3. Treated you differently in some way than before you told them that made you uncomfortable _____
4. Told you to go on with your life _____
5. Comforted you by telling you it would be all right or by holding you _____
6. Tried to take control of what you did/decisions you made _____
7. Has been so upset that they needed reassurance from you _____
8. Made decisions or did things for you _____
9. Told you that you could have done more to prevent this experience from occurring _____
10. Provided information and discussed options _____
11. Told you to stop thinking about it _____
12. Expressed so much anger at the perpetrator that you had to calm them down _____
13. Avoided talking to you or spending time with you _____
14. Treated you as if you were a child or somehow incompetent _____
15. Helped you get information of any kind about coping with the experience _____
16. Made you feel like you didn't know how to take care of yourself _____