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Posttraumatic Stress and Posttraumatic Growth Among Female Victim/Survivors of Adult Sexual Assault: The Importance of Social Reactions

A dissertation submitted in partial satisfaction of the requirements for the degree of Doctor of Philosophy in Counseling, Clinical, and School Psychology

by

Lauren Michele Koch

Committee in charge:

Professor Merith Cosden, Chair

Professor Steve Smith

Professor Tania Israel

September 2018

The dissertation of Lauren Michele Koch is approved.

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Professor Tania Israel

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Professor Steve Smith

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Professor Merith Cosden, Committee Chair

September 2018

Posttraumatic Stress and Posttraumatic Growth Among

Female Victim/Survivors of Adult Sexual Assault:

The Importance of Social Reactions

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by

Lauren Michele Koch

ACKNOWLEDGEMENTS

My graduate school journey was successful in large part due to the support of my mentors, friends, and family. To my research advisor and mentor, Dr. Merith Cosden – thank you for supporting me, pushing me to grow as a researcher, and sticking with me as I fought against the ever present dissertation avoidance monster. Dr. Steve Smith, you've been (and will remain) an invaluable mentor to me. Thank you for believing in me when I didn't believe in myself. Dr. Tania Israel, thank you for showing me what it means to be a strong and committed educator and for inspiring me to maintain my feminist perspective in my work as a researcher and clinician.

Thank you to the friends who were working on their degrees alongside me. Beatriz Bello and Lindsey Liles – your support kept me pushing myself in those moments when I questioned my abilities. The relationships we've built are important and meaningful and I am so glad to call you my friends.

Without my family, I would not be where I am today. Thank you to my parents, Byron and Kristi, for your unwavering love, support, and belief in me. To my brother, Christofer – thank you for reaching out to me in the times I needed it the most. To my sister-in-law, Cassie, and my chosen family, Derek and Jolean – thank you for your love and acceptance. Finally, to my niece and nephews, Masie, Paxon, and Weston – thank you for bringing me joy and laughter.

Lastly, I want to thank the women who participated in this study, as well as the millions of other victim/survivors of sexual violence. Your voices and your experiences matter and they can help drive change. Thank you to the victim/survivors who feel able to speak out and are demanding to be heard for those of us who are not able or not ready. To

the victim/survivors who have chosen not to talk about your experiences – you do not have to speak out for your experiences to matter. As I worked on this study, I felt a kinship with you. So thank you, and me too.

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Lauren Michele Koch, M.A.

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June 2018

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EDUCATION

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2014 **Master of Arts in Counseling Psychology**
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HONORS AND AWARDS

2017 **Susan A. Neufeldt Award for Excellence in Clinical Supervision**
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2015 **Graduate Student Travel Award**
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2015 **Ray E. Hosford Award for Excellent Research**
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2014 **Graduate Student Travel Award**
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CLINICAL EXPERIENCE

2017-2018 **Psychology Resident**
STRONG STAR/CAP PTSD Research Consortium
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Experience: Deliver Prolonged Exposure Therapy in an intensive outpatient setting to Active Duty military service members and Veterans with PTSD. Participate in weekly consultation call with experts in Prolonged Exposure. Deliver CBT to Veterans with posttraumatic headache. Provide individual psychotherapy in randomized clinical trials. Conduct independent evaluations for randomized clinical trials utilizing assessments including the CAPS-5, C-SSRS, SITBI, and MINI. Conduct risk assessments as needed for independent evaluators.
Time Commitment: 32 hours/week
Supervisors: Alan Peterson, Ph.D.; Dhiya Shah, Psy.D.; Lindsay Bira, Ph.D.; Casey Straud, Ph.D.

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ADVANCE Clinic
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Experience: Individual psychotherapy with case conceptualization and intervention informed by CBT and ACT orientations. Maintain caseload of 2 long-term patients.
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Transitional Care Clinic
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2016-2017 **Student Clinician**
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Experience: Administered semi-structured clinical interviews and standardized assessments with Veteran and civilian with substance use disorders entering drug treatment courts and/or county funded substance use treatment programs.
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2015-2016 **Student Clinician**
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Experience: Completed comprehensive adult and child psychological assessments using neuropsychological, cognitive, achievement, and personality measures. Responsible for 3 cases, including intake, assessment, report writing, and feedback sessions.
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Experience: Provided on-site supervision to advanced practicum students conducting individual, couple, and family psychotherapy utilizing live video feed. Aided in skill development and case conceptualization. Maintained assessment and research databases for tracking patient progress via weekly assessments. Participated in weekly case assignment meetings to assign

patients to clinicians and track patient concerns.
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CLINICAL AND ASSESSMENT TRAININGS

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Oct 2017 Certified in the Clinician-Administered PTSD Scale for DSM-5, University of Texas Health Science Center at San Antonio, STRONG STAR/CAP PTSD Research Consortium, Certified by Candice Presseau, Ph.D.

Sept 2017 Prolonged Exposure Workshop, San Antonio Military Medical Center, Department of Behavioral Medicine, Trained by Gerry Grace, Ph.D. and CAPT Rick Schobitz, Ph.D.

Sept 2017 Self-Injurious Thoughts and Behaviors Interview, University of Texas Health Science Center at San Antonio, STRONG STAR/CAP PTSD Research Consortium, Trained by Brooke Fina, LCSW.

Aug 2017 Dialectical Behavior Therapy Skills Training, University of Texas Health Science Center at San Antonio, Department of Psychiatry, Trained by Kelly Guynes, LCSW from DBTWise.

Aug 2017 Mini International Neuropsychiatric Interview, University of Texas Health Science Center at San Antonio, Department of Psychiatry, Trained by Jeslina Raj, Ph.D.

Jan 2016 Gottman Method Couples Therapy Level 1 Training, University of California, Santa Barbara, Department of Counseling, Clinical, and School Psychology, The Gottman Institute.

RESEARCH EXPERIENCE

2012-2017 **Graduate Student Researcher**
University of California, Santa Barbara
Experience: In collaboration with the Substance Abuse and Mental Health Services Agency (SAMHSA), was involved in grant management, data collection, entry, and analysis, database creation and maintenance, report writing, and training and consultation on administration of symptom and outcome assessments. Collaboration with multidisciplinary teams, including judges, public defenders, probation officers, program managers, and

community mental health and substance use treatment providers.
Major Projects:
Substance Abuse Treatment Court: Assisted Santa Barbara County in the program evaluation of drug treatment court.
Re-Entry Drug Court: Assisted Santa Barbara County in the program evaluation of a community reintegration drug court program for repeat felony adult offenders with a substance related crime.
Veterans' Treatment Court: Assisted Santa Barbara County in the program evaluation of a veterans' treatment court to meet the needs of substance-using justice-involved veterans.
FRESH (Families in Recovery Embracing Sobriety and Healing) Start: Assisted Santa Barbara County in the program evaluation of a trauma informed residential substance use treatment for pregnant and postpartum women and their children.
Family Treatment Drug Court for Children Affected by Methamphetamine: Assisted Santa Barbara County in the program evaluation of a family treatment drug court designed to increase early reunification of parents and children involved in the child welfare system by providing trauma-informed substance use treatment.
Bridges to Recovery: Assisted Santa Barbara County in the program evaluation of a culturally sensitive community re-entry program for incarcerated adolescent males.
Advisor: Merith Cosden, Ph.D.

PEER-REVIEWED PUBLICATIONS

Koch, L. M., & Cosden, M. (2018). Substance abuse. In E. Braaten (Ed.), *The SAGE encyclopedia of intellectual and developmental disorders*. Thousand Oaks, CA: SAGE Publications.

Cosden, M., Sanford, A., **Koch, L. M.**, & Lepore, C. E. (2016). Vicarious trauma and vicarious posttraumatic growth among substance abuse treatment providers. *Substance Abuse, 37*(4), 619-624. doi:10.1080/08897077.2016.1181695

Cosden, M., & **Koch, L. M.** (2015). Changes in adult, child, and family functioning among participants in a family treatment drug court. *Child Welfare, 94*, 89-106.

PROFESSIONAL REPORTS

Cosden, M., & **Koch, L.** (2016). *Santa Barbara Veterans Treatment Court: Evaluation report.* Final Evaluation Report to Substance Abuse and Mental Health Services Administration (SAMHSA). Santa Barbara, CA.

Cosden, M., **Koch, L.**, & Bello, B. (2016). *Evaluation of Fresh Start: A residential treatment*

program for pregnant and perinatal women and their children. Final Evaluation Report to Substance Abuse and Mental Health Services Administration (SAMHSA). Santa Barbara, CA.

Cosden, M., & **Koch, L.** (2015). *Evaluation of family treatment drug court for Children Affected by Methamphetamine.* Final Evaluation Report to Substance Abuse and Mental Health Services Administration (SAMHSA). Santa Barbara, CA.

Cosden, M., Sharkey, J., Thomat, A., **Koch, L.**, & Rodriguez, R. (2013). *Bridges to Recovery (B2R): Helping incarcerated adolescent males re-enter the community.* Final Evaluation Report to Substance Abuse and Mental Health Services Administration (SAMHSA). Santa Barbara, CA.

PROFESSIONAL PRESENTATIONS

Koch, L. M. (2018, May). *PTSD, posttraumatic growth, and social reactions following Sexual assault.* Poster presented at the UT Health Department of Psychiatry Annual Research and Quality Improvement Day, San Antonio, TX.

Lopez, A., Cosden, M., & **Koch, L. M.** (2016, June). *When client trauma traumatizes the helper: Understanding and working with vicarious trauma and vicarious posttraumatic growth.* Symposium conducted at the annual National Association of Drug Court Professionals Training Conference, Anaheim, CA.

Koch, L. M., & Cosden, M. (2015, August). *Changes in adult, child, and family functioning among participants in a family treatment drug court.* Poster presented at the American Psychological Association Annual Convention, Toronto, ON, Canada.

Cosden, M., **Koch, L. M.**, Gauthier, J. R., & Lopez, A. (2015, July). *Vicarious trauma and vicarious posttraumatic growth among service providers in problem-solving courts.* Symposium conducted at the annual National Association of Drug Court Professionals Training Conference, Washington, D.C.

Koch, L. M. (2014, November). *Changes in adult, child, and family functioning among participants in a family treatment drug court*. Presented to the Department of Counseling, Clinical, and School Psychology at the annual Research Festival in fulfillment of Master of Arts degree requirements. University of California, Santa Barbara.

Cosden, M. A., **Koch, L. M.**, & Groce, D. (2014, May). *Secondary trauma is not secondary in importance: Supporting staff doing trauma informed treatment.* Symposium conducted at the annual National Association of Drug Court Professionals Training Conference, Anaheim, CA.

Koch, L. M., Sanford, A. E., Lepore, C. E., & Cosden, M. A. (2014, May). *Effects of*

providing trauma-informed substance abuse treatment: Secondary trauma or posttraumatic growth? Poster presented at the Annual Convention of the Association of Psychological Sciences, San Francisco, CA.

Cosden, M., & **Koch, L. M.** (2014, April). *Children Affected by Methamphetamine: Family treatment drug court*. Presentation provided to SAMHSA representatives at annual site visit, Santa Maria, CA.

Koch, L. M. (2013, August). Family treatment drug court: Children Affected by Methamphetamine (CAM). In M. A. Cosden (Chair), *Three models of drug courts: Trauma-informed, family, and veteran.* Symposium conducted at the American Psychological Association Annual Convention, Honolulu, HI.

Thomat, A., **Koch, L.**, Cosden, M. A., & Sharkey, J. D. (2013, August). *Strengths as predictors of antisocial and prosocial outcomes in delinquent youth.* Poster presented at the American Psychological Association Annual Convention, Honolulu, HI.

TRAININGS CONDUCTED

Koch, L. M., Liles, L., Vasquez, E., & Bello, B. (2015, November). *Addiction Severity Index administration and scoring training.* Presentation and training hosted by Santa Barbara County Alcohol and Drug Program, for treatment providers, Santa Maria, CA.

Koch, L. M., Liles, L., Bello, B., & Vasquez, E. (2015, October). *Addiction Severity Index administration and scoring training.* Presentation and training hosted by Santa Barbara County Alcohol and Drug Program, for treatment providers, Santa Barbara, CA.

Gauthier, J. R., & **Koch, L. M.** (2014, September). *Addiction Severity Index administration and scoring training.* Presentation and training hosted by Santa Barbara County Alcohol and Drug Program, for treatment providers, Solvang, CA.

TEACHING EXPERIENCE

Teaching Associate (Instructor of Record), University of California, Santa Barbara
Spring 2016 CNCSP 101: Introduction to Applied Psychology
Supervisor: Shane Jimerson, Ph.D.

Teaching Assistant, University of California, Santa Barbara
Summer 2015 CNCSP 115: College Student Peer-Helping and Leadership
Supervisor: Tania Israel, Ph.D.

Spring 2015 CNCSP 114: Psychology of Gender

Supervisor: Erika Felix, Ph.D.

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Supervisor: Tania Israel, Ph.D.

Summer 2014 CNCSP 115: College Student Peer-Helping and Leadership
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Summer 2013 CNCSP 115: College Student Peer-Helping and Leadership
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COMMUNITY OUTREACH

Koch, L. M., & Choi, A. (2014, May). *Hooking up on college campuses.* Presentation at a University of California, Santa Barbara undergraduate resident hall, Santa Barbara, CA.

Koch, L. M., & Choi, A. (2014, April). *Hooking up on college campuses.* Presentation at a University of California, Santa Barbara Active Minds meeting, Santa Barbara, CA.

Koch, L. M., & Choi, A. (2014, April). *Hooking up on college campuses.* Presentation at a University of California, Santa Barbara Resident Advisor training, Santa Barbara, CA.

EDITORIAL ACTIVITIES

2017 **Reviewer**
Translational Issues in Psychological Science

DEPARTMENTAL/UNIVERSITY SERVICE

2014-2015 Student Representative to Department Faculty
2014-2015 Department Information & Technology Group, Student Representative
2013-2014 Department Admissions Committee, Member
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PROFESSIONAL AFFILIATIONS

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ABSTRACT

Posttraumatic Stress and Posttraumatic Growth Among

Female Victim/Survivors of Adult Sexual Assault:

The Importance of Social Reactions

by

Lauren Michele Koch

In the United States, millions of women have experienced some form of sexual violence. The relationship between sexual assault and posttraumatic stress disorder (PTSD) has been well documented. However, more recent research is focusing on positive outcomes of trauma, including posttraumatic growth (PTG). The current study examined the relationships between childhood trauma, PTSD symptoms, PTG, and social reactions to disclosure among female victim/survivors of adult sexual assault (ASA). Additionally, victim/survivors' reasons for disclosure or non-disclosure and the ways in which disclosure was helpful or unhelpful were explored.

Participants were 196 women who reported experiencing unwanted sexual contact since the age of 14 in an online survey. The survey included the following scales: the *Sexual Experiences Survey – Short Form Victimization* (Koss et al., 2006) identified unwanted sexual contact; the *Adverse Childhood Experiences* (Felitti et al., 1998) scale assessed childhood trauma; the *PTSD Checklist for DSM-5* (Weathers et al., 2013) assessed PTSD symptoms; the *Posttraumatic Growth Inventory* (Tedeschi & Calhoun, 1996) assessed experience of PTG; and the *Social Reactions Questionnaire* (Ullman, 2000) assessed frequency of positive and negative social reactions to disclosures of ASA. Open questions were asked to obtain information about non-disclosure and disclosure experiences.

Analyses found that more frequent negative social reactions were predictive of more PTSD symptoms. Unexpectedly, both more frequent negative social reactions and more frequent positive social reactions were predictive of more PTG. The relationship between PTSD and PTG was positive and linear. Neither delay of disclosure nor childhood trauma were predictive of PTSD or PTG. A relationship between delay of disclosure and negative social reactions was not found.

The most common reasons for non-disclosure were feelings of shame and self-blame. Participants who disclosed did experience blame and judgment, though nearly half reported there were no unhelpful parts to disclosure. The most common reasons for disclosure were seeking emotional support or to process the trauma, which were also the most common responses when asked what parts of disclosure were helpful.

The findings in the current study have important implications for shaping how people respond to victim/survivors' disclosures. Providing psychoeducation to communities and the people serving them could help increase the frequency of supportive reactions and reduce the frequency of negative social reactions. Additionally, an understanding of the realities of social reactions to victim/survivors' disclosures and their relationship with both PTSD and PTG can inform psychologists' work with victim/survivors.

While this study was in progress, millions of women disclosed their sexual assault experiences on the Internet in the #NotOkay and #MeToo movements. Future research should examine the function of positive and negative social reactions victim/survivors experience online. Research should also examine women's reasons for disclosing online versus in person.

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CHAPTER 1 Introduction

Background and Rationale for Study

Sexual violence is a particularly pervasive and devastating crime. Sexual violence takes place in a "rape supportive culture" in which primarily male perpetrators are protected and primarily female victim/survivors[1] are blamed (Warshaw, 1994). Filipovic (2008) explains, "At the heart of the sexual assault issue is how mainstream American culture constructs sex and sexualities along gendered lines. Female sexuality is portrayed as passive, while male sexuality is aggressive" (p. 18).

Rape myths perpetuate this culture, with societal messages that there must be physical force or injury for an assault to count as rape, only sexually pure women can be raped, or that victim/survivors ruin men's lives (Harding, 2015). Rape culture can be seen in the movies that treat rape as just "bad sex" or even desirable and in the justice system in which police can use "feeling" to determine if a victim/survivor is telling the truth and perpetrators can sue for custody of children conceived by rape (Harding, 2015).

Rape culture facilitates the high rates of sexual violence seen today (Filipovic, 2008; Harding, 2015; Warshaw, 1994). Estimates of the lifetime prevalence of adult sexual assault (ASA) for women vary, with studies reporting rates as low as 16% and as high as 42% (Basile & Smith, 2011; Kilpatrick et al., 2013). Often cited in the literature is the rate of 20% reported by the Centers for Disease Control and Prevention (CDC; 2014).

While a cultural shift is clearly needed to reduce the prevalence of sexual violence, it

[1] Literature on sexual assault varies in terms of the use of "victim" versus "survivor" when discussing women who have been sexually assaulted. It has been argued that the term "victim" implies weakness and refers to the sexual assault, while "survivor" implies complete strength and refers to the end of the healing process – both of which may feel constricting (Thompson, 2000). Guerette and Caron (2007) use the term "victim/survivor" to avoid disempowering women who have been sexually assaulted by labeling them. As such, I've chosen to use the term victim/survivor.

is important to understand both the positive and negative sequelae of ASA to aid treatment efforts and add to the growing body of research regarding the trajectories of healing following sexual assault. This study will examine the relationships between childhood trauma, posttraumatic stress, posttraumatic growth, and social reactions to disclosure among female victim/survivors of ASA.

Posttraumatic Stress Disorder. Posttraumatic Stress Disorder (PTSD) is often diagnosed in victim/survivors of sexual assault. Numerous studies have found that victim/survivors of sexual assault report higher rates of PTSD than do victim/survivors of most other traumas (Basile & Smith, 2011; Norris, 1992; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). These high rates of PTSD are of particular concern given that many individuals diagnosed with PTSD are not in remission several years after diagnosis (Elliott, Mok, & Briere, 2004; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Ullman, Filipas, Townsend, & Starzynski, 2007).

Posttraumatic Growth. While much of the research on trauma focuses on negative psychological health outcomes, researchers are beginning to examine positive outcomes, including posttraumatic growth (PTG). PTG is defined as "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p. 1). Research indicates that a majority of individuals who have experienced trauma also experience some amount of growth (Cobb, Tedeschi, Calhoun, & Cann, 2006; Dekel, Mandl, & Solomon, 2011; Grubaugh & Resick, 2007).

While PTG requires that a traumatic event occur, the relationship between PTSD and PTG is unclear. Some studies have found a positive linear relationship (Barton, Boals, & Knowles, 2013; Dekel, Ein-Dor, & Solomon, 2012), while others have not found a

significant relationship between the two (Groleau, Calhoun, Cann, & Tedeschi, 2013; Grubaugh & Resick, 2007; Schuettler & Boals, 2011; Stockton, Hunt, & Joseph, 2011). It is also possible that the relationship between PTSD and PTG is curvilinear, in which those with moderate levels of distress experience the most growth (Dekel et al., 2011; Kleim & Ehlers, 2009; Kunst, 2010; Shakespeare-Finch & Lurie-Beck, 2014).

Sexual Assault Disclosure. Disclosing and discussing traumatic experiences is an adaptive form of coping (Janoff-Bulman, 1992; Ullman, 2010; Van der Kolk, 2014). Given the stigmatization of sexual violence, victim/survivors of sexual assault may be reluctant to disclose their experience (Miller, Canales, & Amacker, 2011). This is particularly important, given that delayed disclosure is associated with more PTSD symptoms and less PTG (Miller et al., 2011; Ullman, Filipas, et al., 2007).

Disclosure of sexual assault experiences can help victim/survivors obtain support and services, though it also puts them at risk for receiving unwanted social reactions. Social reactions to sexual assault disclosure can be conceptualized as positive or negative (Ullman, 2000). Negative social reactions to sexual assault disclosure have consistently been found to have a negative impact on victim/survivors of sexual assault. These reactions may discourage victim/survivors from disclosing in the future (Ahrens, 2006). They are also associated with increased PTSD symptoms (Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010; Ullman & Filipas, 2001; Ullman & Peter-Hagene, 2014) and mental health problems in general (Orchowski & Gidycz, 2015; Orchowski, Untied, & Gidycz, 2013). Research has found that more negative social reactions are associated with less PTG (Ullman, 2014).

Positive social reactions have a less clear relationship with sexual assault outcomes. Studies have found that more positive social reactions are associated with more PTSD

symptoms (Ullman & Peter-Hagene, 2014). However, others have not found this relationship (Ullman & Peter-Hagene, 2016). Positive social reactions may also be related to PTG, with more positive social reactions associated with more PTG (Ullman, 2014).

Purpose of Current Study

The purpose of the current study is to clarify the relationships between childhood trauma, PTSD symptoms, PTG, and social reactions to disclosure among female victim/survivors of ASA. Thus far, research findings have been inconsistent in regard to the relationship between PTSD and PTG. More research is needed to clarify this relationship. While the relationship between delayed disclosure and PTSD has been researched, there do not appear to be any published studies examining the relationship between delayed disclosure and PTG. Further, little research has been done clarify the relationship between social reactions and PTG. While some researchers have examined the disclosure experiences of victim/survivors of sexual assault, more research is needed to better understand the many factors related to disclosure, including reasons for disclosing or not disclosing and the ways in which disclosing is helpful and unhelpful. This study aims to provide a better understanding of this process.

Research Questions and Hypotheses

Five hypotheses will be tested in an attempt to answer these questions. Additionally, a small qualitative analysis will be conducted to gain a richer understanding of victim/survivors' disclosure experiences.

First, it is hypothesized that longer delay of disclosure will be associated with more negative social reactions. Research on the relationship between delayed disclosure and subsequent social reactions is limited. However, Ullman (1996) found that delayed

disclosure was associated with methods of coping common among women who have experienced negative social reactions. Thus, it is expected that longer delay of disclosure will be associated with more negative social reactions.

Second, it is hypothesized that more types of childhood trauma, longer delay of disclosure, and more negative social reactions will be associated with more PTSD symptoms. Some research suggests that PTSD symptoms are more severe for victim/survivors of ASA (Ullman & Peter-Hagene, 2016). It is likely that some women in this study will have childhood trauma histories (Basile & Smith, 2011), including prior sexual victimization. Thus, it is hypothesized that more types of childhood trauma will be associated with more PTSD. Research suggests that delayed disclosure is associated with more PTSD symptoms (Ullman, Filipas, et al., 2007), as are negative social reactions (Jacques-Tiura et al., 2010; Ullman & Filipas, 2001; Ullman & Peter-Hagene, 2014). It is anticipated that this study will confirm these findings.

Third, it is hypothesized that fewer types of childhood trauma, shorter delay of disclosure, and fewer negative social reactions will be associated with more PTG. Research has suggested that prior sexual victimization is associated with lower PTG (Elderton, Berry, & Chan, 2017; Ulloa, Guzman, Salazar, & Cala, 2016). Thus, it is hypothesized that fewer types of childhood trauma will be associated with more PTG. Previous research has found delayed disclosure to be associated with less PTG among victim/survivors of sexual assault (Miller et al., 2011), so it is expected that shorter delay of disclosure will be associated with more PTG. Research suggests that negative social reactions are associated with less PTG (Ullman, 2014), so it is hypothesized that fewer negative social reactions will be associated with more PTG.

Fourth, it is hypothesized that more positive social reactions will be associated with more PTG. Ullman (2014) found that positive social reactions are associated with more PTG and it is hypothesized that this study will confirm these findings.

Lastly, it is hypothesized that PTSD symptoms will be associated with PTG. While previous findings regarding this relationship have been inconsistent, there is some indication that PTSD and PTG have a positive linear relationship (Barton et al., 2013; Dekel et al., 2012), which is consistent with the theory explaining PTG (Tedeschi & Calhoun, 1996; 2004). Shakespeare-Finch and Lurie-Beck (2014) recommend that all researchers assess for both linear and curvilinear relationships between PTSD and PTG, in part to help clarify what have thus far been inconsistent findings in the current literature. Therefore, a curvilinear relationship between PTSD and PTG will also be considered.

CHAPTER 2 Literature Review

The definition of ASA varies in the literature, as do prevalence estimates. Several risk factors for ASA have been identified and it is associated with both physical and mental health outcomes, including PTSD. While much of the research on sexual assault has focused on negative mental health outcomes, more recently research has focused on PTG.

Many researchers hypothesize that disclosing trauma experiences helps to promote healing and theories of disclosure have been proposed to explain this process. Disclosure puts victim/survivors of sexual assault in a position to receive both positive and negative social reactions. Research has helped to clarify victim/survivors' experiences of these social reactions and identify associated physical and mental health outcomes.

Adult Sexual Assault

Definition. Multiple definitions of ASA are utilized in the literature and rape tends to have a narrower definition than sexual assault, such that rape is one form of sexual assault. Koss (1993) defined rape as "nonconsensual oral, anal, or vaginal penetration, obtained by force, by threat of bodily harm, or when the victim is incapable of giving consent" (p. 1062). Sexual assault is frequently defined as "unwanted sexual contact, verbally coerced intercourse, attempted rape, and rape resulting from force or incapacitation (e.g., from alcohol or drugs)" (Ullman & Peter-Hagene, 2014, p. 500). In this paper, the term sexual assault will be used unless an article reviewed specifically uses the term rape. Unless otherwise noted, literature reviewed conceptualizes ASA as occurring since age 14 and child sexual abuse (CSA) as occurring before age 14.

Prevalence. Estimates of the prevalence of the sexual assault of women vary, ranging from 16% to 42% (Basile & Smith, 2011; Centers for Disease Control and

Prevention (CDC), 2014; Elliott et al., 2004; Kilpatrick et al., 2013; Littleton, Breitkopf, & Berenson, 2008). Basile and Smith (2011) report that approximately 1 in 6 women are victim/survivors of lifetime attempted or completed rape, while the CDC (2014) reports that 1 in 5 women are victim/survivors of completed rape in their lifetime. Elliott and colleagues (2004) used a sample of 941 individuals demographically comparable to the population reported in the 1990 United States census to investigate the prevalence of sexual assault at age 18 or older. In this sample, 22% of women reported experiencing sexual assault, though only sexual assaults involving force or threats of force were considered in this study (Elliott et al., 2004). More recently, Kilpatrick and colleagues (2013) found that 42% of women in a nationally representative sample of over 3,000 people reported experiencing some form of sexual assault. The variation across estimates may in part be due to the difficulty in obtaining a representative sample or a result of the multiple and conflicting definitions of what sexual assault actually is. Further, accurate prevalence rates require that women disclose their experiences of sexual assault. Given the stigma, women may be less willing to disclose sexual assault experiences than other traumas.

Risk Factors. Women experience higher rates of ASA in their lifetime than do men (CDC, 2010; Norris, 1992). Additionally, racial and ethnic minority women, particularly American Indian/Alaskan Native (AIAN) and African American women, experience higher rates of sexual violence than do White women (Basile & Smith, 2011; CDC, 2012). AIAN women experience the highest rates of rape, with rates ranging from 29.9% (CDC, 2010) to 48.2% (Evans-Campbell, Lindhorst, Huang, & Walters, 2006). African American women experience higher than average rates of rape than do White women (CDC, 2010). West (2004) argues that African American women experience higher rates of rape due to the

legacy of slavery, the sexual victimization women experienced in slavery, racial stereotypes that suggest African American women sexually promiscuous, and economic inequality. These arguments could be extended to AIAN women, as they live with the legacy of AIAN genocide as well as economic inequality.

Women who identify as bisexual experience higher rates of sexual assault than those with other sexual orientations. The CDC (2010) reports that 46.1% of bisexual women have been raped in their lifetime and 79.9% have experienced some other form of sexual assault. It is unclear why bisexual women experience higher rates of sexual assault (CDC, 2010; Rothman, Exner, & Baughman, 2011). Rothman and colleagues (2011) suggest sexual minorities may be targeted due to their sexual orientation, though there has been little research on this.

Youth also presents a risk, and the CDC (2012) reports that nearly half of female rape victim/survivors are assaulted prior to the age of 18 and 79.6% before the age of 25. Adolescent girls experience the highest rates of sexual assault, with rates ranging from 39.9% to 52.5% (Humphrey & White, 2000; Young, Grey, and Boyd, 2009).

Having limited economic resources is another risk factor for sexual assault (Byrne, Resnick, Kilpatrick, Best, & Saunders, 1999; Elliott et al., 2004). One longitudinal study found that women falling below the poverty line were significantly more likely to report a new physical or sexual assault two years later than were women living above the poverty line (Byrne et al., 1999).

Lastly, women who are victim/survivors of CSA are more likely to experience ASA (Basile & Smith, 2011; CDC, 2012; 2014; Elliott et al., 2004). Longitudinal studies have found that CSA is a significant predictor of sexual assault in both adolescence (Humphrey &

White, 2000) and adulthood (Barnes, Noll, Putnam, & Trickett, 2009; Relyea & Ullman, 2017). These studies have also found that adolescent sexual assault predicts ASA (Humphrey & White, 2000) and ASA predicts future sexual assaults in adulthood (Relyea & Ullman, 2017). The reasons for this relationship are unclear. Some researchers posit that victim/survivors are more likely to use substances to cope, which in turn makes them more vulnerable to future assaults (Basile & Smith, 2011). Environmental factors may also be responsible for this relationship. Women who have limited economic resources may not have access to safe living spaces (Byrnes et al., 1999). Relyea and Ullman (2017) found that revictimization was associated with social environments that were unsupportive or hostile toward victim/survivors.

Physical and Mental Health Outcomes. Sexual assault is associated with numerous physical and mental health outcomes. Physical health outcomes include chronic pain and headaches, gastrointestinal disorders, and heart disease (Basile & Smith, 2011; CDC, 2012; 2014). Mental health outcomes of sexual assault include PTSD, depression, suicidality, problems with interpersonal relationships, and problems with sexual functioning (Basile & Smith, 2011).

Posttraumatic Stress Disorder. Research has consistently found that sexual assault is associated with higher levels of PTSD than are other traumatic events, with the exception of combat (Basile & Smith, 2011; Norris, 1992). In a nationally representative sample of over 4,000 women, 32% of those who reported experiencing rape also had a lifetime history of PTSD (Resnick et al., 1993). Further, women who report being victim/survivors of crime

(including rape) are more likely to have a lifetime history of PTSD than women who report non-crime related traumas (Breslau, 2009; Resnick et al., 1993).

In a nationally representative sample of over 5,000 men and women, women were approximately twice as likely to have a lifetime diagnosis of PTSD compared to men (Kessler et al., 1995). Nearly half of the women who reported that the most significant trauma they had experienced was rape also had a lifetime diagnosis of PTSD (Kessler et al., 1995). These rates of PTSD are significant, as over a third of those diagnosed with PTSD in this sample had symptoms for years without remission (Kessler et al., 1995).

More recent research has confirmed this relationship between sexual assault and PTSD, in addition to the other long-term symptoms victim/survivors experience (Elliott et al., 2004; Ullman, Filipas, et al., 2007). Ullman, Filipas, and colleagues (2007) found that in a sample of 600 women with histories of sexual assault, approximately 70% qualified for a PTSD diagnosis despite the assaults occurring an average of 13 years prior.

Posttraumatic Growth

Definition. PTG is "positive psychological change experienced as a result of the struggle with highly challenging life circumstances" (Tedeschi & Calhoun, 2004, p. 1). PTG requires a significant crisis and involves actual growth beyond pre-trauma levels of functioning (Tedeschi & Calhoun, 2004). Tedeschi and Calhoun (2004) conceptualize PTG as both an outcome of trauma and as an ongoing process. They conceptualize and measure this growth as occurring in five areas: Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life (Tedeschi & Calhoun, 1996). For this study, Tedeschi & Calhoun's (1996; 2004) conceptualization of PTG will be used.

Relating to Others involves developing more meaningful relationships, with a greater

sense of closeness and intimacy (Tedeschi & Calhoun, 2004). New Possibilities refers to the realization of different life paths available (Tedeschi & Calhoun, 2004). For example, experiencing a sexual assault might lead someone to work at a rape crisis center, something she had never before considered. Personal Strength involves the realization that one has made it through a traumatic experience, and the knowledge that one can withstand future challenges and traumas (Tedeschi & Calhoun, 2004). Spiritual Change involves deeper existential reflection and Appreciation of Life refers to deeper engagement in daily living, appreciating "the little things," and more clarity on what is important in life (Tedeschi & Calhoun, 2004).

Thriving. Thriving is "the ability to go beyond the original level of psychosocial functioning" following profound challenge or adversity (O'Leary, 1998, p. 429). It involves behavioral, cognitive, and emotional change and developing new values or added meaning to life (O'Leary, 1998). Thriving can involve the development of new skills, higher confidence and mastery to handle future events, and strengthened sense of security in relationships (Carver, 1998). While thriving and PTG are sometimes referred to as nearly similar constructs (Carver, 1998; Joseph, Murphy, & Regel, 2012), they do appear to have some differences. For example, changes in relationships in the midst of thriving are security and attachment based (Carver, 1998), versus the increased meaning and intimacy with PTG (Tedeschi & Calhoun, 2004). Additionally, spiritual changes are not specifically accounted for in thriving. PTG and thriving appear to be distinct, yet overlapping, constructs.

Prevalence. Recent studies have found moderate to high rates of PTG among victim/survivors of trauma, including sexual assault, ranging from 25% to 99% (Elderton et al., 2015; Grubaugh & Resick, 2007; Ulloa et al., 2016; Valdez & Lilly, 2015). However,

some researchers caution against comparing findings on rates of PTG, given that there does not appear to be a consistent threshold used to define PTG (Elderton et al., 2015; Ulloa et al., 2016). Valdez and Lilly (2015) used the average item score on the *Posttraumatic Growth Inventory* (PTGI; Tedeschi & Calhoun, 1996), requiring an average item score of at least 1 on a Likert scale from 0 to 5 for growth to be considered present. Alternatively, Grubaugh and Resick (2007) only required that participants endorse some aspect of growth on the PTGI (Tedeschi & Calhoun, 1996) in order for growth to be considered present. Currently, there is not a clear and agreed upon standard for a threshold for measuring growth on the PTGI (Tedeschi & Calhoun, 1996).

Theory. It is generally agreed upon that PTG results from cognitive processing (Janoff-Bulman, 2004; Joseph et al., 2012; Tedeschi & Calhoun, 2004). Trauma challenges the victim/survivor's understanding and assumptions about the world, resulting in what Janoff-Bulman (1992) called "shattered assumptions" (Tedeschi & Calhoun, 2004). The trauma pushes the victim/survivor to re-examine her previous assumptions about herself, other people, and the world. Cognitive processing can involve rumination over the details of the trauma or the differences between pre- and post-trauma worlds (Tedeschi, Calhoun, & Cann, 2007). However, PTG requires more than just cognitive processing (Tedeschi et al., 2007). Emotional distress resulting from the trauma is necessary for PTG to occur (Calhoun & Tedeschi, 2004; Joseph et al., 2012; Tedeschi et al., 2007). Tedeschi and Calhoun (2004) highlight the paradox that PTG requires a significant trauma, stating that "out of loss there is gain" (p. 6). PTSD and PTG are conceptualized as independent of one another; PTSD and PTG are not two ends of a spectrum but rather experiences that victim/survivors of trauma

can have simultaneously (Tedeschi & Calhoun, 2004). Research findings on the relationship between PTSD and PTG have been inconsistent.

Support for Theory. There is some research to support Tedeschi & Calhoun's (2004) PTG theory, particularly regarding rumination (Kleim & Ehlers, 2009; Lindstrom, Cann, & Calhoun, 2013; Stockton et al., 2011). One study found that deliberate rumination was associated with more PTG, but only if the rumination centered on meaning making and learning from the traumatic experience (Stockton et al., 2011). When the rumination was intrusive, there was significantly less PTG (Stockton et al., 2011). In contrast, another study found that challenge to core beliefs, intrusive rumination, and deliberate rumination predicted more PTG (Lindstrom et al., 2013). Lindstrom and colleagues (2013) suggest these findings support the belief that "shattered assumptions" may play an important role in the development of PTG. Additionally, it is possible that the rumination associated with PTG may be suggestive of underlying cognitive processing. Importantly, in a 17-year longitudinal design, Dekel and colleagues (2012) found that PTSD symptoms predicted future PTG, but that PTG did not predict future PTSD symptoms.

Relationship between PTSD and PTG. Research findings on the relationship between PTSD and PTG have been inconsistent. Several studies have found support for a positive and linear relationship between PTG and PTSD in both undergraduate and clinical samples (Barton et al., 2013; Dekel et al., 2012; Shakespeare-Finch & Armstrong, 2010; Tiamiyu et al., 2016), while others have failed to find a relationship (Groleau et al., 2013; Schuettler & Boals, 2011; Stockton et al., 2011).

It is possible that the relationship between PTSD and PTG is curvilinear (Dekel et al., 2011; Kleim & Ehlers, 2009; Kunst, 2010; Shakespeare-Finch & Lurie-Beck, 2014). Dekel

and colleagues (2011) found that while PTSD and PTG were positively correlated, a curvilinear relationship in which moderate PTSD led to the most PTG better represented their data. In a meta-analysis of 42 studies, Shakespeare-Finch and Lurie-Beck (2014) found that the relationship between PTSD and PTG was significantly better explained by a curvilinear rather than linear analysis, noting the effect sizes for both analyses were very similar. They suggest that while PTSD is associated with an increase in PTG, as symptoms become too severe, growth is hindered (Shakespeare-Finch & Lurie-Beck, 2014).

Some researchers argue that their findings suggest PTSD and PTG are independent constructs. In a sample of treatment seeking victim/survivors of physical and sexual assault, Grubaugh and Resick (2007) argued that the lack of a significant relationship between PTSD and PTG supported the theory that they are independent constructs. Borja, Callahan, and Long (2006) found that victim/survivors of sexual assault reported both growth and distress, which they suggest provides support for the theory that PTSD and PTG are independent constructs. In contrast, Stermac, Cabral, and Clarke (2014) argued that the constructs are independent due to their findings that more PTSD was associated with less PTG.

Posttraumatic Growth and Sexual Assault

There is a growing body of literature exploring PTG among victim/survivors of sexual assault and interpersonal violence. Some researchers suggest that the relationship between PTG and sexual trauma is unique compared to its relationship with other traumas, at least in part due to social stigma attached to sexual violence. Ulloa and colleagues (2016) argue that "it is precisely this potential shame, embarrassment, and perceived societal implications associated with sexual trauma that could either make psychological growth more possible or could shape the type of growth that might occur" (p. 288).

In a longitudinal study, Hansen, Hansen, and Nielen (2017) did not find significant growth or positive change among female victim/survivors of sexual assault. They suggest this may indicate a difference in experience between interpersonal traumas, particularly sexual trauma, and non-interpersonal traumas (Hansen et al., 2017). Another study found that while victim/survivors of sexual assault experienced more PTSD and less PTG than victim/survivors of other traumas, they still experienced moderate levels of PTG (Shakespeare-Finch & Armstrong, 2010).

Longitudinal research has suggested that positive changes after sexual assault can be present as early as two weeks post-trauma (Frazier, Conlon, & Glaser, 2001), and that higher levels of social support are associated with more positive changes (Frazier, Tashiro, Berman, & Steger, 2004). Frazier and colleagues (2004) reported these positive changes included growth that could be conceptualized as PTG, suggesting that more social support leads to more PTG. Additionally, positive changes appear to increase over time, while negative changes decrease (Frazier et al., 2001), which seems to contradict Tedeschi and Calhoun's (2004) theory that with more distress comes more growth.

Prolonged trauma and revictimization may hinder PTG following sexual assault and intimate partner violence (Cobb et al., 2006; Elderton et al., 2015; Ulloa et al., 2016; Valdez & Lilly, 2015). Cobb and colleagues (2006) assessed PTG in victim/survivors of intimate partner violence, including sexual assault. Most of the women reported experiencing moderate levels of PTG, but women who remained in the abusive relationships experienced significantly less PTG than those who didn't (Cobb et al., 2006). Valdez and Lilly (2015) found that an increase in positive world assumptions over the course of a year was associated with an increase in PTG over the same time period. Overall, they found that world

assumptions were more positive at the end of the year, but this was not true for women who were revictimized over the course of the year (Valdez & Lilly, 2015). Revictimization may reinforce negative world assumptions (Ulloa et al., 2016; Valdez & Lilly, 2015), thus preventing the cognitive processing necessary for PTG (Valdez & Lilly, 2015).

Disclosure of Trauma

Disclosing and discussing traumatic experiences is an adaptive form of coping (Janoff-Bulman, 1992; Ullman, 2010; Van der Kolk, 2014) and the author is unaware of any literature that suggests disclosure is not adaptive. Disclosure of trauma allows victim/survivors to cognitively process the trauma, experience healthy changes in trauma cognitions (Pennebaker, 1997; Pennebaker & Beall, 1986), and ultimately make sense of and integrate the traumatic experience into their understanding of the world post-trauma (Janoff-Bulman, 1992). Tedeschi and Calhoun (1996) posit that self-disclosure may encourage PTG through increasing the cognitive processing of the trauma, and they note that disclosure to supportive others can encourage this type of cognitive processing.

Disclosing sexual assault experiences to another person can help victim/survivors access emotional or legal help and support (Ullman, 2010). If disclosing results in access to social support, this can aid the process of healing and learning to trust people again (Janoff-Bulman, 1992). However, disclosure can be unhelpful or even harmful when victim/survivors experience social judgment (Herman, 1997), victim-blaming (Janoff-Bulman, 1992; Ullman, 2010), and rejection (Ullman, 2010).

It does appear that the majority of victim/survivors of sexual assault disclose their experience to at least one person, with disclosure rates ranging from 58% to 92% (Ahrens, Cabral, & Abeling, 2009; Warshaw, 1994). However, it is difficult to accurately estimate

disclosure rates, given that this necessitates disclosure to the researcher.

Non-Disclosure of Sexual Assault.[2] Some researchers view non-disclosure or the refusal to talk about a trauma as potentially harmful (Ullman, 1996; 2010; Van der Kolk, 2014). One study found that delayed disclosure (months or years after the trauma) of sexual assault experiences was associated with higher use of avoidance coping, which can be an indicator of PTSD (Ullman, 1996). Littleton and colleagues (2008) found that delayed disclosure was associated with more severe PTSD symptoms.

Ullman (2010) notes that much of the research on disclosure of sexual assault has relied on reports of sexual assault to law enforcement. Estimates suggest that as few as 10-23% of sexual assaults are reported to the police (Herman, 1997; Morgen & Kena, 2017). There are many reasons victim/survivors do not disclose to the police, including fear of being blamed or accused of lying and fearing their assault is not serious enough to warrant a police report (Ullman, 2010). Some argue that reporting to the police risks exposure to hostile reactions, discouragement from filing an official report, blaming statements, and re-traumatization (Brownmiller, 1975; Campbell, 2005; Herman, 1997; Shaw, Campbell, Cain, & Feeney, 2017).

Social Reactions to Sexual Assault Disclosure

Trauma recovery takes place in the context of relationships. Janoff-Bulman (1992) explains that through "ongoing interactions with others, survivors learn directly about their world postvictimization" (p. 146). This can be a difficult process to engage in when the current culture tends to at least partially blame victim/survivors for their assaults (Koss,

[2] To my knowledge, no empirical studies have been conducted to demonstrate that non-disclosure of sexual assault can have a neutral or positive impact on victim/survivors. It is possible that non-disclosure is not harmful for some people, though this is difficult to verify given the necessity of disclosure when responding to surveys for research.

1993). Thus, social reactions to disclosures of sexual assault are likely important in recovery following the assault. Researchers have focused on gaining a better understanding of how positive and negative social reactions affect victim/survivor recovery and coping.

Defining and Researching Social Reactions. The *Social Reactions Questionnaire* (SRQ; Ullman, 2000) is a self-report measure of the frequency of perceived positive and negative social reactions to disclosures of ASA. Positive social reactions to the victim/survivor include providing emotional support, believing her, spending time with her, and helping her access medical care or contact the police (Ullman, 2000). Negative social reactions to the victim/survivor include making unwanted decisions for her, pulling away from her, encouraging her not to talk about the assault, and overtly blaming her for the assault (Ullman, 2000). Most of the reviewed literature used the SRQ to measure social reactions to sexual assault disclosures.

Victim/Survivors' Experiences of Disclosure and Social Reactions. Some of the literature on social reactions to disclosure of sexual assault has attempted to provide a deeper understanding of the disclosure experience from the perspective of victim/survivors. Ahrens (2006) conducted qualitative interviews with eight adult women with histories of rape who disclosed their experiences of rape within days of the assault, but then chose to discontinue disclosing for prolonged periods of time (months to years). These women were "silenced" by negative social reactions resulting in questioning whether future disclosures would be helpful, doubt about the experience counting as rape, and increased self-blame (Ahrens, 2006). Relatedly, Ullman (1996) found that delayed-disclosure (months or years after the assault) was associated negative social reactions.

Victim/survivors more commonly disclose to friends and family versus formal

support providers, such as law enforcement (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007; Jacques-Tiura et al., 2010). Ahrens and colleagues (2007) found that disclosures to formal supports were more likely to result in negative social reactions, but only when the disclosure was initiated by the victim/survivor, and disclosures to informal supports were more likely to result in positive social reactions.

Women who are racial or ethnic minorities may receive different social reactions than White women. Ullman & Filipas (2001) found that being a member of a racial or ethnic minority was associated with more frequent negative social reactions, with Latina women reporting the highest levels of negative social reactions. Jacques-Tiura and colleagues (2010) found that African American women received significantly more disregard than White women when disclosing to a formal support.

Mental Health Outcomes. There are many possible mental health outcomes from social reactions to disclosures of sexual assault. Orchowski and colleagues (2013) found that controlling social reactions were associated with increased levels of posttraumatic stress, depression, and anxiety, and that victim-blaming reactions were associated with lower self-esteem. A longitudinal study found that reports of negative social reactions predicted higher levels of interpersonal sensitivity, hostility, paranoia, and phobic anxiety three months later (Orchowski & Gidycz, 2015). Though not conclusive, this may suggest that negative social reactions impact psychological functioning. Additionally, victim/survivors' belief that their sexual assaults occurred because of their behavior, their character, or by chance was positively correlated with negative social reactions and negatively correlated with positive social reactions (Orchowski & Gidycz, 2015). While it is possible that victim/survivors

assign blame for the assault based on experienced social reactions, it is also possible that self-blaming victim/survivors influence people's reactions to their disclosures.

Social Reactions and Posttraumatic Stress Disorder. There is significant evidence to suggest a relationship between negative social reactions and PTSD, in which more negative social reactions predict more severe PTSD symptoms. One study found that experiencing being treated differently or attempts at distraction were predictive of more severe PTSD symptoms (Ullman & Filipas, 2001). Another found that controlling reactions, particularly those that felt infantilizing to the victim/survivor, predicted more severe PTSD symptoms (Peter-Hagene & Ullman, 2014). Using a path model analysis, Ullman and Peter-Hagene (2014) found that negative social reactions had a significant direct effect on PTSD symptoms, and an indirect effect in which maladaptive coping served as a mediator. Avoidance coping has also been found to partially mediate the effect of negative social reactions on PTSD symptoms (Ullman, Townsend, Filipas, & Starzynski, 2007). In a three-year longitudinal study, Ullman and Peter-Hagene (2016) found that negative social reactions were predictive of future PTSD symptoms, and that PTSD symptoms predicted future negative social reactions. This could indicate that more severe PTSD symptoms bring about negative social reactions from others (Ullman & Peter-Hagene, 2016)

Interestingly, positive social reactions may also be associated with more severe PTSD symptoms (Ullman, Filipas, et al., 2007; Ullman & Peter-Hagene, 2014). Ullman, Filipas, and colleagues (2007) state that this may indicate that victim/survivors in higher distress seek more help. Ullman and Peter-Hagene (2014) noted that the relationship between positive social reactions and PTSD was much weaker than the relationship between negative social reactions and PTSD. However, in a year-long longitudinal study Hansen and colleagues

(2017) found that positive social support was associated with less severe PTSD.

Social Reactions and Posttraumatic Growth. Research on the relationship between social reactions and PTG is limited, though there is preliminary support for Ulloa and colleagues' (2016) assertion that social support and reactions may influence whether PTG occurs. Ullman (2014) found that negative social reactions that made victim/survivors feel turned against were associated with less PTG. Less PTG was also significantly associated with more PTSD symptoms, maladaptive coping, and self-blame, though these variables were not analyzed to determine their relationship with negative social reactions (Ullman, 2014). Research has also found that positive social reactions are related to more PTG (Borja et al., 2006; Ullman 2014). Hassija and Turchik (2016) found that disclosure of sexual assault to a supportive other and obtaining mental health care significantly predicted the experience of PTG. While social reactions were not measured, it is possible that disclosing to someone supportive resulted in receipt of positive social reactions.

Conclusion

Sexual assault affects a significant portion of the female population and undoubtedly is a significant public health concern. In particular, there is substantial research indicating a high rate of PTSD among victim/survivors of sexual assault. There is also a growing body of research suggesting that PTG is another outcome of trauma. Some studies have found that victim/survivors of sexual assault do indeed experience PTG in addition to PTSD. However, the relationship between PTSD and PTG is not entirely clear. Some studies have found both positive and curvilinear relationships between PTSD and PTG, while others have not found a significant relationship at all. Additionally, while victim/survivors of sexual assault still experience PTG, they may experience less PTG than victim/survivors of other traumas.

Research indicates that disclosure of sexual assault is important for the trauma recovery process, as long as the reactions to the disclosure to not cause additional harm. Disclosing sexual assault experiences necessitates opening oneself up to social reactions, which can be both helpful and harmful to the victim/survivor. Studies have found an important relationship between negative social reactions and psychological functioning, and in particular PTSD. Unfortunately, most of the research has been cross-sectional, precluding an understanding of the impact social reactions have on psychological outcomes for victim/survivors and the impact victim/survivors' psychological functioning has on social reactions. What little longitudinal research has been done indicates that negative social reactions might play a causal role in reduced psychological functioning, self-blame, maladaptive coping, and revictimization. Negative social reactions might also hinder the experience of PTG.

Evidence for a relationship between positive social reactions and psychological outcomes is more limited and includes the theoretically unexpected findings that positive social reactions are positively correlated with PTSD symptoms. While research on positive social reactions and PTG is relatively new, the initial findings are promising and may indicate that positive social reactions provide benefit to victim/survivors of sexual assault.

While some studies indicate the importance of childhood trauma, delay of disclosure, and social reactions to the development of PTSD and PTG, not all of these relationships have been clarified or confirmed. The current study seeks to add to the understanding of these relationships. The first study hypothesis, that delayed disclosure will be associated with more negative social reactions, is driven from the relative lack of literature on this relationship. The second study hypothesis (more types of childhood trauma, longer delay of

disclosure, and more negative social reactions will be associated with more PTSD symptoms) assesses relationships that have some research confirmation, though the relationship between delay of disclosure and PTSD symptoms needs confirmation. The third hypothesis (fewer types of childhood trauma, shorter delay of disclosure, and fewer negative social reactions will be associated with more PTG) seeks to confirm previous findings and to assess the relationship between delay of disclosure and PTG, which to the author's knowledge has not yet been confirmed. The fourth hypothesis seeks to confirm the finding that more positive social reactions are associated with more PTG. Lastly, given the inconsistent findings on the relationship between PTSD and PTG, this study seeks to determine whether the relationship is linear or curvilinear, as well as the direction of this relationship.

CHAPTER 3 Method

Participants and Setting

Participants were recruited from Amazon's Mechanical Turk (MTurk), an online resource that allows participants to complete surveys anonymously. MTurk is a good alternative to university student samples, as it provides a more demographically diverse sample with a similar quality of data (Buhrmester, Kwang, & Gosling, 2011). Some researchers have found that people on MTurk will misrepresent their demographics or experiences in order to participate in a survey (Kan & Drummey, 2018), though this is a risk in all survey research. Importantly, some research has suggested that web-based surveys may be particularly useful for obtaining accurate information from victim/survivors of sexual assault (Stermac et al., 2014).

English-speaking individuals residing in the United States were able to select this survey on MTurk. In total, 443 individuals accessed the survey. They were asked to participate in the survey if they identified as female, were 18 years of age or older, and answered "yes" to the question: *Since your 14th birthday, have you ever experienced unwanted sexual contact?*

Cohen's (1992) recommendations were used to determine minimum sample size. Assuming a medium effect size, running a multiple regression with four independent variables, and $\alpha = .05$ requires a minimum of 84 participants to establish adequate power of .80. Of the 443 people who accessed the survey, 2 did not provide consent and 209 reported they were men, under 18 years of age, or had not experienced unwanted sexual contact. The remaining 232 met participation criteria and responded to the survey. After reviewing responses to validity checks, the final sample included 196 participants.

Table 1

Participant Demographics

	Total % (N = 196)	Disclosed % (N = 109)	Not Disclosed % (N = 87)
Age			
18-24	11.73	9.17	14.94
25-34	42.86	41.28	44.83
35-44	26.02	31.19	19.54
45-54	13.78	11.93	16.09
55-64	4.08	4.59	3.45
65+	1.53	1.84	1.15
Race/Ethnicity			
White	75.51	72.48	79.31
Black or African American	9.18	10.10	8.04
Hispanic or Latina/o	5.61	6.42	4.60
Asian or Asian American	3.06	2.75	3.45
Biracial or Multiracial	4.59	5.50	3.45
American Indian or Alaska Native	2.04	2.75	1.15
Sexual Orientation			
Heterosexual	76.02	73.39	79.31
Bisexual or Pansexual	15.82	19.27	11.49
Asexual	4.08	3.67	4.60
Gay or Lesbian	3.06	3.67	2.30
Other	.51	-	1.15
No Response	.51	-	1.15
Highest Level of Education			
High School Diploma or GED	7.14	9.17	4.60
Some College*	30.61	24.77	37.93
Associate Degree	12.24	4.59	21.84
Bachelor's Degree	39.80	51.38	25.29
Master's Degree	8.67	9.17	8.04
Doctorate Degree	1.53	.92	2.30

Participants ranged in age from 18 to older than 64, with most aged 25 to 44 (68.88%). Most identified as White (75.51%), with the remaining participants identifying as Black/African American, Hispanic/Latina/o, Asian/Asian American, American Indian/Alaska Native, or Biracial/Multiracial. Most reported their sexual orientation as heterosexual (76.02%) or bisexual/pansexual (14.80%). All reported they had graduated from high school or had a GED; 12.24% held an Associate Degree, 39.80% a Bachelor's Degree, 8.67% a Master's Degree, and 1.53% a Doctorate Degree. Detailed demographics can be seen in Table 1.

Of note, there were educational differences between disclosing and non-disclosing participants. More disclosing participants reported their highest level of education was a Bachelor's Degree, $\chi^2 = 13.75$, $p < .001$. More non-disclosing participants reported their highest level of education was Some College, $\chi^2 = 3.95$, $p = .047$, or an Associate Degree, $\chi^2 = 13.40$, $p < .001$.

Instrumentation

Sexual Experiences Survey – Short Form Victimization (SES-SFV; Koss et al., 2006). The 10-item self-report SES-SFV was used to assess participants' sexual victimization experiences. For the current study, two of these items were removed: one asking about participant demographics and one asking about perpetrator demographics. The SES-SFV includes seven items assessing for attempted or completed sexual assaults ranging from unwanted sexual touch to rape, each with five sub-items assessing whether the perpetrator used coercion, alcohol or drugs, threats of violence, or physical force (Koss et al., 2007). Frequency of experiences are assessed for both the last 12 months and since the age of 14, allowing for frequencies of 0, 1, 2, or 3+ (Koss et al., 2007). The SES-SFV can be scored to

determine the most severe form of sexual assault experienced: no assault, sexual contact, sexual coercion, attempted rape, or rape (Koss et al., 2007). The SES-SFV has adequate test-retest reliability and strong internal consistency for both unwanted sexual experiences since age 14, $\alpha = .92$, and in the last 12 months, $\alpha = .92$ (Johnson, Murphy, & Gidycz, 2017). The current study also found strong internal consistency for unwanted sexual experiences since age 14, $\alpha = .96$, and in the last 12 months, $\alpha = .99$.

Adverse Childhood Experiences scale (ACE; Felitti et al., 1998). The ACE scale was used to assess participants' self-reported potentially traumatic experiences in childhood. The scale provides a count of up to ten types of potential traumas: psychological abuse, physical abuse, sexual abuse, physical neglect, emotional neglect, divorced parents, substance abuse in the household, mental illness in the household, domestic violence, and having a household member go to prison (Felitti et al., 1998). The ACE scale provides a count from zero to ten of types of childhood traumas experienced (Felitti et al., 1998). The number of items endorsed on the ACE scale is associated with both physical and mental health outcomes, with the endorsement of four or more items being associated with significantly more physical and mental health problems (Felitti et al., 1998; Whitfield, Anda, Dube, & Felitti, 2003).

PTSD Checklist for DSM-5 (PCL-5; Weather et al., 2013). The self-report PCL-5 was used to assess how bothered participants were by self-reported posttraumatic stress symptoms in the last month. Instructions were modified to ask only about symptoms related to participants' most recent experience of unwanted sexual contact. The PCL-5 contains 20 items loading onto four factors: Re-experiencing, Avoidance, Hyperarousal, and Negative Alterations in Cognitions and Mood. For the purposes of the current study, only the score for the total scale was used in analysis. The PCL-5 total score has strong internal consistency, α

= .94 (Blevins, Weathers, Davis, Witte, & Domino, 2015). The current study found similarly strong internal consistency, $\alpha = .97$. The PCL-5 has also demonstrated good test-retest reliability, convergent validity, and discriminant validity (Blevins et al., 2015).

Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). The self-report PTGI was used to measure psychological growth following trauma. Instructions were modified to ask only about growth related to participants' most recent experience of unwanted sexual contact. The PTGI contains 21 items loading onto five factors: Relating to Others, New Possibilities, Personal Strength, Spiritual Change, and Appreciation of Life. For the purposes of the current study, only the score for the total scale was used in analysis. The PTGI has demonstrated strong internal consistency, $\alpha = .90$ (Tedeschi & Calhoun, 1996) and good construct validity (Hooper, Marotta, & Depuy, 2009; Shakespeare-Finch, Martinek, Tedeschi, & Calhoun, 2013; Taku, Cann, & Calhoun, 2008). Internal consistency for the current study was strong, $\alpha = .98$.

Social Reactions Questionnaire (SRQ; Ullman, 2000). The 46-item self-report SRQ was used to measure of the frequency of positive and negative social reactions participants experienced following their disclosures of ASA. Instructions were modified to ask only about social reactions to disclosures of participants' most recent experience of unwanted sexual contact. Two subscales factor onto Positive Reactions: Tangible Aid/Information Support and Emotional Support. Relyea and Ullman (2015) have suggested that negative social reactions are best represented by two factors. Three subscales factor onto Turning Against (Victim Blame, Treat Differently, and Taking Control-Infantilizing) and three subscales factor onto Unsupportive Acknowledgement (Egocentric, Distraction, and Taking Control). The SRQ has demonstrated good internal consistency, with the following

Cronbach's alphas: Positive Reactions, $\alpha = .92$; Turning Against $\alpha = .92$; Unsupportive Acknowledgment $\alpha = .85$ (Relyea & Ullman, 2015). Internal consistency for the current study was strong: Positive Reactions, $\alpha = .91$; Turning Against $\alpha = .95$; Unsupportive Acknowledgment $\alpha = .86$. It also has demonstrated good test-retest reliability and convergent validity (Relyea & Ullman, 2015; Ullman, 2000).

Disclosure. Participants were asked: *How much time has passed since your most recent experience of unwanted sexual contact (in months)?* To assess for disclosure, they were asked: *Some people talk to other people about their experiences of unwanted sexual contact, while other people do not. Have you told anyone about your most recent experience of unwanted sexual contact?* If they answered "no," they were asked the following open-ended question: *What were your reasons for not telling anyone about your most recent experience of unwanted sexual contact?* Participants who responded "yes" were asked: *After your most recent experience of unwanted sexual contact, how long did you wait to share your experience with someone (in days, months, or years)?* Participants who responded "yes" were also asked three open ended questions: 1) *What were your reasons for telling someone about your most recent experience of unwanted sexual contact?* 2) *In what ways (if any) did telling someone about your most recent experience of unwanted sexual contact help you?* 3) *In what ways (if any) was telling someone about your most recent experience of unwanted sexual contact unhelpful?* These questions were specifically developed for this study.

Validity Checks. Five questions were imbedded into the measures to assess for validity by asking participants to select specific answers: 1) *Please select yes* (in the ACE; Felitti et al., 1998); 2) *Please select a little bit* (in the PCL-5; Weathers et al., 2013); 3) *Please select the answer 4* (in the PTGI; Tedeschi & Calhoun, 1996); 4) *Please select always*

(in the SRQ; Ullman, 2000); and 5) *Please select rarely* (in the SRQ; Ullman, 2000).

Procedures

Once participants consented to the study, they were asked to provide information about their age, race/ethnicity, sexual orientation, and education. They then responded to the SES-SFV (Koss et al., 2007), the ACE scale (Felitti et al., 1998), the PCL-5 (Weathers et al., 2013), and the PTGI (Tedeschi & Calhoun, 1996). They were then asked how much time had passed since their most recent experience of unwanted sexual contact and whether they had disclosed this. Participants who did not disclose were directed to the appropriate open-ended question. Participants who did disclose were asked how much time passed between their most recent experience of unwanted sexual contact and their first disclosure and were then directed to complete the appropriate open-ended questions and the SRQ (Ullman, 2000). Upon completion of the survey, a debriefing page appeared with information on national resources for victim/survivors of sexual assault, including rape crisis hotlines. Participants were paid $1 through the automated service provided by MTurk regardless of whether they completed the entire survey or passed validity checks. In order to be included in the analysis, all validity questions were required to be answered correctly.

CHAPTER 4 Results

Preliminary Analysis

Some participants did not respond to all questions on the PCL-5 ($N = 9$), the PTGI ($N = 9$), and the SRQ ($N = 10$). Upon review, the data appeared to be missing at random. Parent (2013) found that with low levels of missing data, multiple imputation and mean substitution produced similar results. Thus, using Parent's (2013) suggestion, missing responses were replaced using the mean of the participant's remaining responses from the subscale that included the missing item. Descriptive statistics for the ACE, PCL-5, PTGI, and SRQ can be found in Table 2.

Of the 196 participants, 97% reported at least one potentially traumatic childhood experience on the ACE scale and 58% reported four or more. Number of experiences endorsed ranged from 0 to 10, with $M = 4.81$ ($SD = 3.08$). Notably, just over half of participants reported experiencing sexual abuse in their childhood ($N = 99$). The frequency of endorsement for each item on the ACE can be seen on Table 3.

Most participants reported experiencing at least one symptom of PTSD on the PCL-5, with 11% reporting no symptoms. PCL-5 scores ranged from 0 to 70, with $M = 22.37$ ($SD = 19.76$). Weathers and colleagues (2013) suggest that a score of 33 or higher indicates a possible PTSD diagnosis. Nearly a third (30%) of participants scored at or above this threshold.

Most participants also reported experiencing at least some PTG on the PTGI, with only 8% reporting no growth. PTGI scores ranged from 0 to 105, with $M = 37.14$ ($SD = 30.33$), indicating on average a 'very small' to 'small' degree of growth.

Table 2

Descriptive Statistics for Measures

Measure	*N*	*M*	*SD*	Observed Range	Scale Range
Adverse Childhood Experiences	196	4.81	3.08	0-10	0-10
PTSD Checklist for DSM-5	196	22.37	19.76	0-79	0-80
Posttraumatic Growth Inventory	196	37.14	30.33	0-105	0-105
SRQ Positive	108	2.15	.82	.20-3.80	0-4
SRQ Turning Against	108	.53	.80	0-3.38	0-4
SRQ Unsupportive Acknowledgment	108	.86	.69	0-3.08	0-4

Note. SRQ is the Social Reactions Questionnaire.

Table 3

Endorsement of Items on the Adverse Childhood Experiences Scale (N = 196)

	%
Emotional neglect	84.69
Verbal abuse	56.10
Sexual abuse	50.50
Parents separated or divorced	50.50
Physical abuse	46.40
Household member with substance use problems	45.40
Household member with mental illness	42.90
Physical neglect	39.80
Domestic violence	36.70
Household member went to prison	27.55

Out of the total sample, 109 participants reported that they had disclosed their most recent experience of unwanted sexual contact to someone and 87 did not. One participant did not respond to the SRQ, leaving 108 participants who responded to the measure. All participants reported at least some Positive social reactions, with scores ranging from .20 to

3.80, *M* = 2.15 (*SD* = .82). This indicates participants on average experienced positive reactions 'sometimes' to 'frequently.' Fewer participants reported negative social reactions, with 38% reporting no Turning Against negative reactions and 8% reporting no Unsupportive Acknowledgment negative reactions. Turning Against scores ranged from 0 to 3.38, *M* = .53 (*SD* = .80). Unsupportive Acknowledgment scores ranged from 0 to 3.08, *M* = .86 (*SD* = .69). This indicated that participants on average experienced negative reactions at a frequency between 'never' and 'rarely.' In all, 94% of participants reported experiencing both positive and negative social reactions, with the rest reporting only positive social reactions.

All but four participants responded to questions regarding their experiences of unwanted sexual contact on the SES-SFV. Table 4 provides a count of the different types of unwanted sexual contact participants reported. Each experience was endorsed by over half of participants, with unwanted sexual contact being the most frequently endorsed (92%). Table 5 provides a count of the most severe form of unwanted sexual contact participants experienced, with the majority of participants reporting that rape was their most severe experience (76%).

Participants were asked how many months had passed since their most recent experience of unwanted sexual contact. Additionally, participants who reported having disclosed their most recent experience of unwanted sexual contact were asked how long they waited to disclose. Due to the wide dispersion of responses, median splits (see Tables 6 and 7) and histograms (Figures 1 and 2) were used to display the data.

Table 4

Participants' Report of Types of Unwanted Sexual Contact in Adulthood on the Sexual Experiences Survey – Short Form Victimization (N = 196)

	%
Unwanted Sexual Contact	91.84
Attempted Coercion	61.73
Coercion	62.24
Attempted Rape	62.76
Rape	76.02

Table 5

Participants' Most Severe Experience of Unwanted Sexual Contact on the Sexual Experiences Survey – Short Form Victimization (N = 196)

	%
Unwanted Sexual Contact	3.57
Attempted Coercion	3.06
Coercion	7.14
Attempted Rape	8.17
Rape	76.02
No Response	2.04

Table 6

Time Passed Since Most Recent Unwanted Sexual Contact (N = 196)

	%
0-14 months	24.49
14 months to 5.5 years	25.00
5.5-12.5 years	25.00
12.5-71.5 years	24.49
No Response	1.02

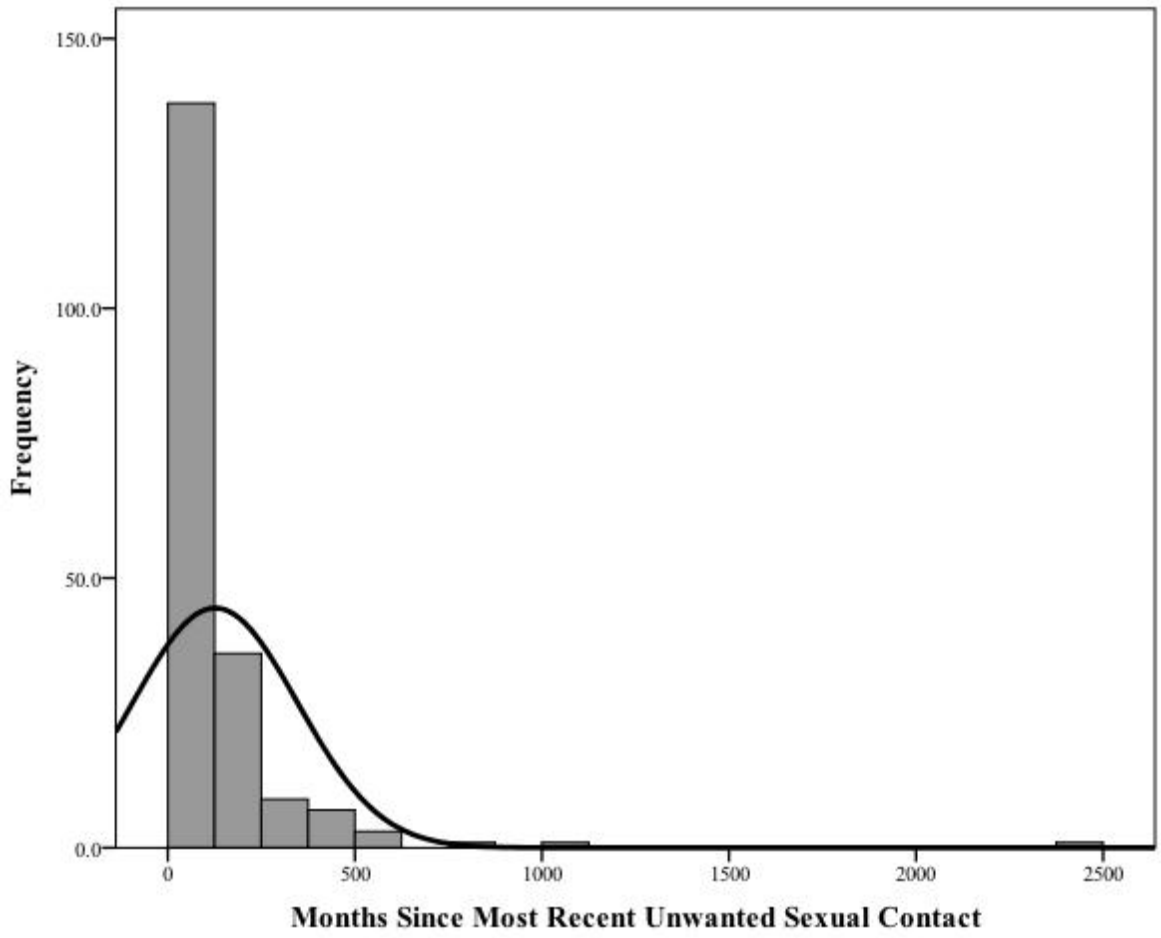

Figure 1. Histogram of Months Passed Since Most Recent Unwanted Sexual Contact with Normal Distribution Curve.

Table 7

Time Waited Before Disclosure (N = 108)

	%
0-1 days	32.41
1 day to 1 week	16.67
1 week to 2 years	29.63
2-32 years	18.52
No Response	2.77

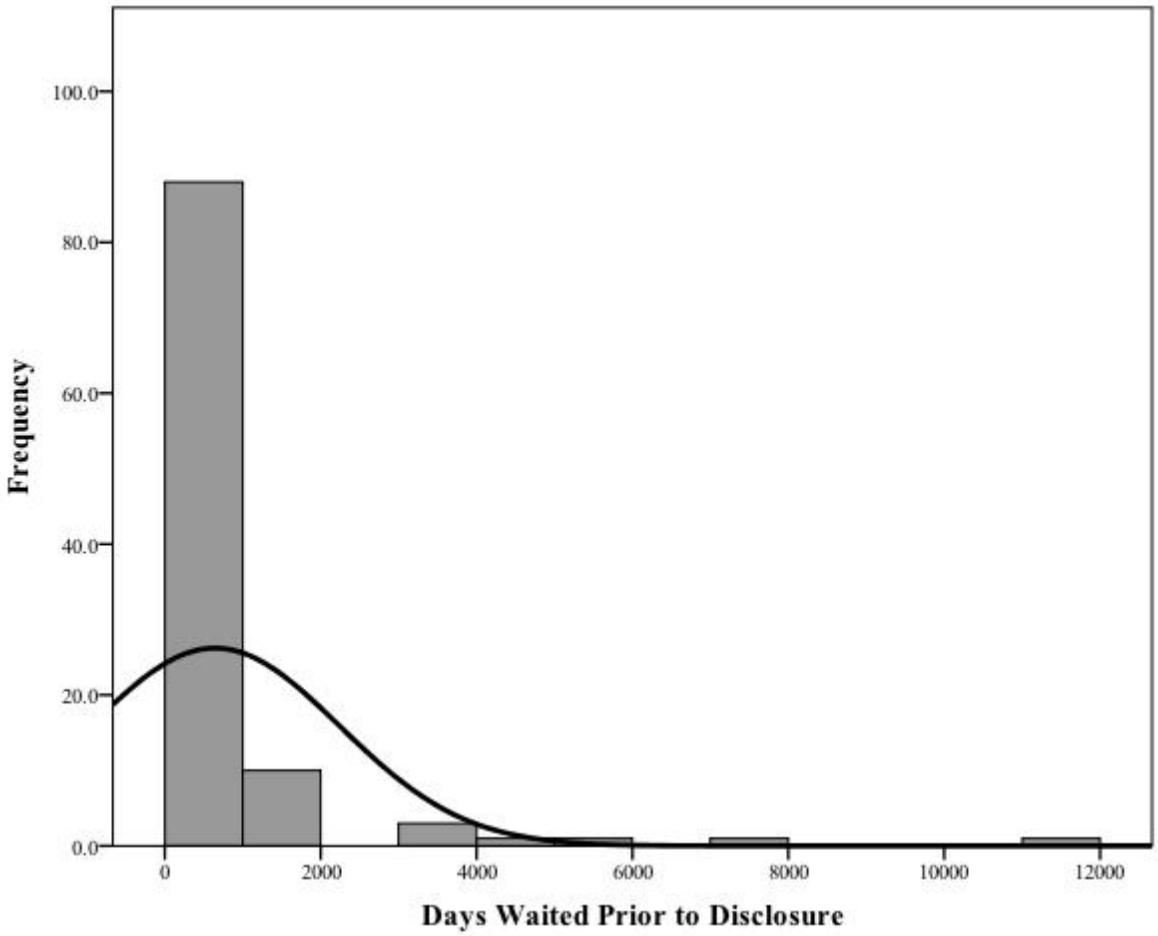

Figure 2. Histogram of Days Waited Before Disclosure with Normal Distribution Curve.

The distributions for each measure were assessed for normality utilizing Kim's (2013) methods. Based on the current study's sample size, values above $z = \pm 3.29$ indicate a non-normal distribution. The first four hypotheses pertained only to participants who reported that they had disclosed their most recent experience of unwanted sexual contact. Normality for the measures used in these hypotheses was assessed for only that portion of the sample ($N = 108$). Distributions for the ACE, PCL-5, PTGI, and SRQ Positive all fell within acceptable ranges of normality.

The distribution for delay of disclosure was positively skewed (skew = 5.78, *SE* = .27, $z = 21.26$). Due to values of zero, a constant of one was added to each value and then a logarithmic transformation was performed. Following the transformation, the data fell within an acceptable range of normality (skew = .31, *SE* = .24, $z = 1.33$).

The distributions for both SRQ subscales, Unsupportive Acknowledgment (skew = .94, *SE* = .23, $z = 4.08$) and Turning Against (skew = 1.88, *SE* = .23, $z = 8.07$), were moderately positively skewed. Due to values of zero, a constant of one was added to each value and then a square root transformation was performed for both scales. Following the transformation, the distribution for Unsupportive Acknowledgment was within an acceptable range (skew = -.19, *SE* = .81, $z = -.94$). However, Turning Against remained out of range (skew = .81, *SE* = .23, $z = 3.56$). Other transformation attempts for Turning Against were less successful. Given the scale's close proximity to normality, the square root transformation was used for analyses and findings should be interpreted with caution.

The fifth hypothesis pertained to all participants ($N = 196$), so normality for the PCL-5 and PTGI were assessed again, this time with the entire sample. The PTGI fell within the acceptable range of normality. The PCL-5 was moderately positively skewed (skew = .79,

SE = .17, *z* = 4.51). Due to data values of zero, a constant of one was added to each value and then a square root transformation was performed. After transformation, the distribution was within the normal range (skew = -.11, *SE* = .17, *z* = -.63).

Hypothesis 1

The first hypothesis predicted that longer delay of disclosure would be associated with more negative social reactions. Pearson correlations were run between delay of disclosure and the SRQ Unsupportive Acknowledgment, as well as between delay of disclosure and the SRQ Turning Against. Neither the SRQ Unsupportive Acknowledgment, $r(103) = -.11$, *ns* (*M* = .83, *SD* = .41), nor the SRQ Turning Against, $r(103) = .05$, *ns* (*M* = .50, *SD* = .53), were significantly correlated with delay of disclosure. These findings do not support the hypothesis.

Hypothesis 2

A multiple regression analysis was conducted to test the hypothesis that more types of childhood trauma, longer delay of disclosure, and more negative social reactions would be associated with more symptoms of PTSD. The ACE, delay of disclosure, SRQ Turning Against, and SRQ Unsupportive Acknowledgment explained 36.36% of the variance of PTSD, $F(4, 100) = 14.28$, $p < .001$. As seen in Table 8, only the SRQ Turning Against and the SRQ Unsupportive Acknowledgment were significant predictors of PTSD. These findings provide partial support for the hypothesis, specifically that negative social reactions would be associated with PTSD.

Table 8

Multiple Regression Analysis Predicting PTSD on the PCL-5 (N = 105)

Variables	B	SE	β	*t*
SRQ Turning Against	10.83	4.31	.27	2.51*
SRQ Unsupportive Acknowledgment	19.66	5.40	.39	3.64***
Delay of Disclosure	1.97	1.34	.12	1.47
Adverse Childhood Experiences	.03	.57	.004	.05

*$p < .05$, ***$p < .001$

Note. PCL-5 is the PTSD Checklist for DSM-5; SRQ is the Social Reactions Questionnaire.

Table 9

Multiple Regression Analysis Predicting Posttraumatic Growth on the PTGI (N = 105)

Variables	B	SE	β	*t*
SRQ Turning Against	-3.95	7.35	-.06	-.54
SRQ Unsupportive Acknowledgment	37.91	9.21	.49	4.12***
Delay of Disclosure	4.04	2.29	.16	1.77
Adverse Childhood Experiences	-.53	.97	-.05	-.55

***$p < .001$

Note. PTGI is the Posttraumatic Growth Inventory; SRQ is the Social Reactions Questionnaire.

Hypothesis 3

A multiple regression analysis was conducted to test the hypothesis that fewer types of childhood trauma, shorter delay of disclosure, and fewer negative social reactions would be associated with more PTG. The ACE, delay of disclosure, SRQ Turning Against, and SRQ Unsupportive Acknowledgment explained 20.62% of the variance of PTG, $F(4, 100) = 6.50$, $p < .001$. As seen in Table 9, only the SRQ Unsupportive Acknowledgment was a significant predictor of PTG. However, the relationship between the SRQ Unsupportive Acknowledgment and PTG was positive, such that more unsupportive negative social reactions were associated with more PTG. Thus, the findings do not support the hypothesis.

Table 10

Multiple Regression Analysis Predicting Posttraumatic Growth on the PTGI (N = 107)

Variables	B	SE	β	*t*
SRQ Positive	15.28	3.48	.39	4.39***

***$p < .001$

Note. PTGI is the Posttraumatic Growth Inventory; SRQ is the Social Reactions Questionnaire.

Hypothesis 4

A regression analysis was conducted to test the hypothesis that more positive social reactions would be associated with more PTG. The SRQ Positive explained 15.37% of the variance of PTG, $F(1, 106) = 19.26$, $p < .001$ (see Table 10). These findings support the hypothesis and suggest that more positive social reactions are associated with more PTG.

Hypothesis 5

The fifth hypothesis predicted that PTSD and PTG would have a positive and linear relationship. A hierarchical regression analysis was conducted to test both a linear and a curvilinear relationship between PTSD and PTG. First, a linear relationship between PTSD and PTG was tested. The PCL-5 explained 14.73% of the variance of PTG, $F(1, 194) = 33.52$, $p < .001$. In the second step, a curvilinear relationship between PTSD and PTG was tested using Shakespeare-Finch and Lurie-Beck's (2013) suggested method. While this model remained significant, $F(2, 193) = 16.75$, $p < .001$, and explained 14.80% of the variance of PTG, the added quadratic variable did not significantly contribute to the variance of PTG, $\beta = -.08$, $t(193) = -.37$, *ns* (see Table 11). Thus, the relationship between PTSD and PTG is best described as linear for this dataset, which supports the hypothesis.

Table 11

Hierarchical Regression Analysis Predicting Posttraumatic Growth on the PTGI (N = 196)

Variables	B	SE	β	*t*
Step 1				
PCL-5 (linear)	4.88	.84	.38	5.79***
Step 2				
PCL-5 (1inear)	5.90	2.86	.46	2.06*
PCL-5 (quadratic)	-.13	.35	-.08	-.37

*$p < .05$, ***$p < .001$

Note. PTGI is the Posttraumatic Growth Inventory; PCL-5 is the PTSD Checklist for DSM-5.

Qualitative Findings

The author organized the responses thematically into categories that were descriptive of the responses in each category. This process was informed by Braun and Clarke's (2006) guidelines for thematic analysis, though a full thematic analysis was not conducted. Results should be reviewed with this in mind. The author first read through all participant responses to become familiar with the data. Following this, the author generated preliminary codes for every participant response, with the responses determining the codes that were generated. Participant responses could contain multiple codes. Once preliminary codes were developed, the author reviewed these and sorted them into themes and subthemes. The author then reviewed and coded participant data again using the developed codes for themes and subthemes. After additional review and refinement of themes, the themes were named and defined.

Reasons for Non-Disclosure. Of the 87 participants who did not disclose, 85 (98%) responded to the question: *What were your reasons for not telling anyone about your most recent experience of unwanted sexual contact?* The remaining participants did not respond

($N = 2$). A summary of the thematic responses along with select participant responses can be found in Table 12. The primary themes in the answers to this question were: Shame and Self-Blame, Prevent Negative Outcomes, Personal Matter, Moving On, Not Needed, Concern for Others, and Perpetrator Identity.

The most frequent theme in participant responses were experiences of shame or self-blame (Shame and Self-Blame). Participants wrote about feeling ashamed or embarrassed that they had been sexual assaulted. Some participants wrote that they blamed themselves for the assault. One participant referenced both of these, writing, "Because I was ashamed that I had put myself in the position. I take almost full responsibility for it." Another referenced self-blame in part of her response, saying, "Besides it was pretty much my fault for getting drunk around those kinds of guys."

Participants also wrote about wanting to avoid undesirable outcomes from disclosure (Prevent Negative Outcomes). Some participants described wanting to avoid certain reactions, including reactions of pity, sadness, or compassion. Participants also reported fearing judgment or disbelief. One participant wrote, "People may also judge me in a certain way if I open up." Some participants described wanting to avoid emotional discomfort ("…it makes me sad and upset to think about it") and not trusting others ("…I don't want someone to tell someone else"). By choosing not to disclose, participants could protect themselves from these experiences.

Some participants wrote that they did not disclose because the sexual assault was a personal or private experience (Personal Matter). They described their assaults as something to keep private ("It's not anyone's business. I am an adult"). Others described not wanting to talk about the assault with other people or wanting to deal with the assault on their own.

Some participants described a desire to move on from the sexual assault (Moving On). Some responses described having already moved on or wanting to move on and forget. One participant wrote, "It was something I didn't WANT to remember, something I tried to deny happened, something I just wanted to forget, pretend it NEVER happened." Other participants wrote that they did not want to talk about the sexual assault.

Another theme in participant responses was that they had no need to disclose (Not Needed). They wrote that the assault was not a big deal or not serious enough to warrant disclosure ("It did not seem significant or worth telling"). Others wrote that they did not need to disclose the experience or that they could deal with the experience on their own.

Some participants wrote that they were concerned about the effect that disclosure would have on others (Concern for Others). They wrote that they did not want to burden or upset other people ("I dont want to bother anyone"). Two participants described feeling concern for the perpetrator of the assault. One participant wrote, "I don't think he intentionally did it. I just don't think he was very smart."

Lastly, some participants wrote that they did not disclose due to the identity of the person who assault them (Perpetrator Identity). Some participants wrote that the perpetrator was a family member or friend ("I would NEVER tell a member of my family as it was a family member that was involved") and others wrote that the perpetrator was someone they shouldn't have been spending time with ("It was a guy who had never acted like this before, but I was supposed to have been staying away from him").

Reasons for Disclosure. Of the 109 participants who disclosed, 105 (96%) responded to the question: *What were your reasons for telling someone about your most recent experience of unwanted sexual contact?* The remaining participants provided answers

not relevant to the question ($N = 2$) or did not respond ($N = 2$). A summary of the thematic responses along with select participant responses can be found in Table 13. The primary themes in responses to this question were: Personal Need, Relational, Proximity to Assault, and Responsibility to Others.

The most frequent theme in responses was that participants disclosed in order to obtain needed support or help (Personal Need). Some participants reported disclosing because they were feeling emotionally upset. In part of her response, a participant said, "I told her about it right away because I was shaken up, angry, horrified and deeply upset." Participants also described needing to talk about or process the assault ("Because I felt like I needed to talk about it") or needing comfort and emotional support ("I wanted to get it off my chest and hear someone else validate my feelings"). Some participants described needing to unburden themselves ("I needed to let it out"). Others described simply wanting or needing to tell someone about the assault. Some participants described wanting to feel better, obtain advice, or access formal supports including law enforcement and medical care.

Participants also described their disclosures as occurring due to their relationship with the person to whom they disclosed (Relational). Some participants explained the importance of the type of relationship they had with the person they disclosed to, describing relationships with friends, romantic partners, and family members. One participant wrote, "I knew when we met that I would marry him, and that I could trust him. He was finally someone I could open up to about the experiences with my ex-husband." Other participants wrote about shared disclosures, in which the person they disclosed to also shared their own sexual assault story ("I was having a relatable conversation with someone else who also experience something similar"). Some participants wrote that they needed to explain their symptoms,

behaviors, or sexual preferences to someone. Others reported they simply wanted to share their experience with the person or that the experience just camp up in conversation.

Another theme was disclosure to a person due to their presence during or after the assault (Proximity to the Assault). Some participants wrote that the person they disclosed to was physically near the location of the assault and others reported that the assault occurred in front of other people. One participant wrote, "My partner and friends were present when it happened and I went up to them to tell them about it right away." Other participants wrote that their disclosure was blurted out due to their distress following the assault.

Lastly, participants described disclosing for the benefit of other people (Responsibility to Others). They wrote about the desire to protect other people from the perpetrator, either by telling them or making a formal report to law enforcement. One participant wrote, "I had to report it and I would never let someone like that in danger another woman again." Two participants wrote about disclosing because someone deserved to know, with the implication that the person may not want to remain in a relationship upon knowing she had been assaulted. In part of her response, a participant wrote, "I felt shameful, and thought he should know before we were married, in the event he no longer wanted to."

Ways Disclosure was Helpful. Of the 109 participants who disclosed, 97 (89%) responded to the question: *In what ways (if any) did telling someone about your most recent experience of unwanted sexual contact help you?* The remaining participants provided answers not relevant to the question ($N = 7$), did not respond ($N = 3$), or responded with what they found unhelpful about the experience ($N = 2$). A summary of the thematic responses along with select participant responses can be found in Table 14. The primary themes in

participant responses were: Emotional Support, Felt Good, Tangible Aid, and Relational Benefit. Of note, some participants ($N = 8$) reported that there were no helpful parts of their disclosure experience.

The most frequent theme in participant responses was that people responded to disclosures in an emotionally supportive way (Emotional Support). Participants described feeling comforted and supported by the people they told. One participant wrote,

> It helped me being that I had someone there to care for me and my being raped. My mom has always cared about me no matter what, so i figured I would be able to get extra support from my mom. She totally knew how to handle the situation with me. I am glad she is around.

Participants wrote that talking about and processing the assault was helpful. They also described feeling less alone ("It eased my mind that I was not alone") and being told or realizing that the assault was not their fault ("They helped me understand that it was not my fault"). Some participants described receiving support in ending their relationship with the perpetrator, and others wrote about receiving needed advice.

Participants also reported feeling better after disclosing their experiences (Felt Good). They described feeling unburdened, referencing feelings of relief, freedom, and liberation ("I felt kind of free"). Others described feeling better, either due to a reduction of negative emotions such as stress or shame, or due to an increase in positive emotions. Some participants wrote that disclosing allowed them to begin healing or to move on from the trauma of the assault. One participant wrote, "It helped me not hide the incident and I could move on from it."

Assistance obtaining needed help was another theme in participant responses

(Tangible Aid). Specifically, participants described receiving help to obtain psychological and medical resources and care. One participant wrote, "I did not have to go to the doctor alone. She encouraged me to go in the first place." Participants also described feeling protected from the perpetrator by the person they disclosed to.

Lastly, participants wrote that disclosure was helpful to their relationship with the person to whom they disclosed (Relational Benefit). Participants wrote about experiencing a shared understanding with the person they disclosed to ("it did make me feel much better because they had the same thing happen to them") and discovering that people wanted to help them ("…people were there for me in bad times"). Others described the strengthening of the relationship and feeling able to open up to others.

Ways Disclosure was Unhelpful. Of the 109 participants who disclosed, 93 (85%) responded to the question: *In what ways (if any) was telling someone about your most recent experience of unwanted sexual contact unhelpful?* The remaining participants responded with what they found helpful about the experience ($N = 10$), did not respond ($N = 5$), or provided answers not relevant to the question ($N = 2$). A summary of the thematic responses along with select participant responses can be found in Table 15. The primary themes in participant responses were: Negative Reactions, Emotional Discomfort, and Didn't Get Better. Notably, nearly half of the responses ($N = 39$) stated that there were no unhelpful parts of their disclosure experiences.

The most frequent theme in participant responses was the experience of unwanted or unhelpful reactions (Negative Reactions). Some participants reported feeling blamed or judged ("My family acted as though I deserved it"), or generally feeling unsupported by the people they disclosed to ("I might have told the wrong person, and they didn't seem to be too

comforting either"). A few participants wrote that the person to whom they disclosed became emotionally distressed or uncomfortable. Other participants described social fallout, including the perpetrator becoming angry or the ending of social relationships. Some participants described being pushed to report the assault or resolve conflict that resulted from the assault. Lastly, a few participants reported that their assault experiences were dismissed or downplayed.

Another frequent theme was the experience of unwanted emotions during or after the disclosure (Emotional Discomfort). Many participants referenced experiencing emotions they did not want to experience, including awkwardness, insecurity, and fear. One participant said, "It made me feel really small and incompetent." Participants also described feeling ashamed or embarrassed about either having been assaulted or their response to the assault. Some participants described feeling emotionally vulnerable or worrying that the person they disclosed to might tell someone else about the assault ("they knew something personal about me"). Lastly, some participants noted that they felt as if they were reliving the assault while disclosing.

Lastly, some participants wrote that disclosing didn't improve their feelings or experiences (Didn't Get Better). They wrote that they didn't feel better after disclosing and that disclosing couldn't change what had already happened to them. One participant described both of these thoughts in her response, writing, "It just didn't help overall. What can anyone do about it? Nothing. I still suffer."

Table 12

Themes, Subthemes, and Participant Quotes for Reasons for Not Disclosing (N = 85)

Theme	*N*
Shame and Self-Blame	30
Shame or Embarrassment: *I think I would feel very shamed if someone were to find out*	27
Self-Blame: *I felt I put myself in the situation and felt I was to blame to a degree.*	8
Prevent Negative Outcome	23
Unwanted Reactions: *I didn't want the pity that they would have given me.*	9
Disbelief or Judgment: *I am afraid they will blame me. That would really hurt me.*	8
Emotional Discomfort: *not comfortable disclosing*	6
Distrust Others: *I didn't want to tell anyone in fear that they might tell someone else*	5
Worsen Situation: *I felt like telling someone would just make it worse.*	1
Personal Matter	15
Don't Want To: *I do not want to talk about it with anyone.*	7
Private or Personal: *I keep such experiences private.*	5
Want to Deal on Own: *I chose to deal with it on my own.*	3
Moving On	13
Move on or Forget: *It is best forgotten*	8
Don't Want to Talk: *I don't feel like discussing it.*	5
Not Needed	10
Not a Big Deal: *I didn't think it was a big enough deal to talk about*	7
No Need To: *No need to tell anyone. It's over with and done!*	3
Can Deal on Own: *I knew I could handle it on my own.*	2
Concern for Others	8
Burden Others: *I didn't want to upset anyone.*	6
Concern for Perpetrator: *I knew that if I said anything the boy who was involved would get in trouble, and I felt very conflicted about that, since he was my friend at the time.*	2
Perpetrator Identity: *It was a guy who had never acted like this before, but I was supposed to have been staying away from him.*	6
Other	11
Happened Long Ago (*N* = 4); Nobody to Tell (*N* = 3); Nothing can be Done (*N* = 2); I Don't Know (*N* = 2)	

Table 13

Themes, Subthemes, and Participant Quotes for Reasons for Disclosing (N = 105)

Theme	*N*
Personal Need	60
Emotionally Upset: *I was going thought a break down when it came out as I was crying.*	16
Talk and Process: *Just needed to tell someone and talk about it*	14
Emotional Support: *I felt abused and I needed some support from someone I could trust.*	14
Unburden: *to get things off my chest. its [sic] bad to bottle things up*	12
Wanted or Needed To: *I'm not sure. Maybe I just needed someone to know.*	7
Feel Better: *I wanted to tell someone so that I would feel better and to get if off my chest.*	6
Advice: *To ask what I should do*	6
Get Help or Care: *I needed someone to go to the clinic with me.*	6
Other Personal Need	4
To Survive; Knew I Couldn't Bottle it Up From Past Experience; It Had Happened to Me Before; Worried Something Bad Might Happen to Me	
Relational	29
Type of Relationship: *I just wanted to tell her; she's my best friend and we tell each other everything.*	8
Shared Disclosure: *I wanted to share with them my own experiences when they told me of theirs.*	8
Explain Something: *To let them know how I react to sex*	7
Share: *I told someone just to share my experience with them.*	4
It Came Up: *I think we were just talking about unwanted sexual experiences and I brought it up.*	3
Proximity to the Assault	12
They Were There: *Because she was in the same house, just not the same room.*	9
Blurted it Out: *I was still in shock and just blurted it out.*	3
Responsibility to Others	11
Protect Others: *I wanted to warn others about this person*	7
Formal Report: *I needed to tell my father because we had to call the police. I needed to file a report and look at mug shots.*	3
Deserved to Know: *He deserved to know*	2
Other	5
It was Time; I Thought I was Pregnant; To Know if It was Unusual; I Figured He'd be Telling Others; Perpetrator Died	

Table 14

Themes, Subthemes, and Participant Quotes for Ways Disclosing Was Helpful (N = 97)

Theme	*N*
Emotional Support	44
Comfort and Support: *It helped me because i knew the friend would listen and believe me what happened*	16
Talking and Processing: *It helped me to process what happened.*	10
Not Alone: *It made me feel less alone.*	10
Not My Fault: *I felt like I wasn't alone and it wasn't my fault for being too intoxicated*	9
Leave Perpetrator: *...it gave me strength to escape my abusive situation.*	5
Advice: *It helped me receive comfort and advice.*	2
Felt Good	37
Unburdened: *it was a relief to not have to hold it inside*	21
Felt Better: *I felt a large amount of stress to fall by the wayside and like I was going to be ok.*	12
Can Move On/Heal/Cope: *I starting healing and letting it go*	9
Not a Secret: *It made me feel like i had a secret that i finally let go of*	5
Tangible Aid	9
Resources and Care: *my friend helped me gather resources for therapy.*	5
Felt Protected: *This helped by knowing people have my back and were protective over me.*	4
Relational Benefit	9
Shared Understanding: *I felt better after telling my friend/coworker about it because she had experience a similar situation*	4
People Want to Help: *I knew that I wouldn't be left to rot, people want to help.*	3
Strengthened Relationship: *Possibly made our relationship stronger.*	1
Opened Up: *It allowed me to open up like I hadn't in the past*	1
Other	13
Alerted Others; Someone Would Know if I Went Missing; Comfort with Sex; Express Why I Have Issues; They Were Outraged; Made the Problem Smaller; Brainstormed How to Stop Him; Understand I Deserve Better; Helped Momentarily; Don’t Feel Dirty; Learned People are Evil; Made Me Less Gullible; Don’t Know	
No Helpful Parts	8

Table 15

Themes, Subthemes, and Participant Quotes for Ways Disclosing Was Unhelpful (N = 93)

Theme	*N*
No Unhelpful Parts	39
Negative Reactions	25
Blamed or Judged: *felt like they may judge me or blame me*	7
Unsupported: *It was unhelpful because my partner did not react in a helpful or supportive way*	6
Responses of Distress or Discomfort: *I upset my mother when she found out, she felt she was a bad mom*	4
Social Fallout: *Rumors were started about the event and the person in question became very angry.*	4
Pushed to Report or Resolve: *She thought I should report it but I did not want to.*	3
Dismissed or Downplayed: *I found out the dude is known for this behavior (drunk groping) and most people just put up with it and don't care.*	3
Emotional Discomfort	20
Unpleasant Emotions: *It brought up a lot of unpleasant emotions and fear*	11
Shame and Embarrassment: *I felt ashamed I did not speak up sooner.*	6
Vulnerable: *I was afraid that my friend would tell other people.*	5
Remembering and Reliving: *When I talk about it, I feel like I'm reliving it.*	4
Didn't Get Better	11
Don't Feel Better: *It didn't make the memories or feelings go away*	6
Nothing Could Change: *It didn't change what happened and didn't get me justice*	6
Other	10
Told Wrong Person; Unintended Disclosure; Couldn’t Identify Perpetrator; No Justice; Encouraged to Stay in Relationship; Labeled a Victim; Feel Like a Victim; Self-Blame When Disclosing; I No Longer Needed the Help; Person Joked About Hurting Perpetrator	

CHAPTER 5 Discussion

The current study examined the relationships between childhood trauma, posttraumatic stress, posttraumatic growth, and social reactions to disclosure among female victim/survivors of ASA. Additionally, the current study examined victim/survivors' reasons for disclosing or not disclosing, and ways in which disclosing can be helpful or unhelpful.

Most participants reported experiencing at least some posttraumatic growth. However, the average amount of growth fell between a 'very small' to 'small' degree of growth. This exceeds the threshold used by Grubaugh and Resick (2007), though it is lower than the average amount of growth reported by a previous sample of victim/survivors of interpersonal violence (Valdez and Lilly, 2015).

For participants who disclosed, negative social reactions were significantly related to both PTSD and PTG. Both unsupportive and turning against negative social reactions were significant predictors of PTSD, with higher frequency of negative reactions predicting more severe PTSD symptoms. This confirms previous findings on this relationship (Jacques-Tiura et al., 2010; Ullman & Filipas, 2001; Ullman & Peter-Hagene, 2014). It is notable that this relationship was found, given that the average reported frequency of negative social reactions fell between 'never' and 'rarely.'

More PTG was predicted by more frequent positive social reactions for disclosing participants. This confirms Ullman's (2014) finding and could suggest that positive social reactions facilitate the PTG process. Unexpectedly, more frequent unsupportive negative social reactions were also predictive of more PTG. This contradicts previous findings regarding the relationship between negative social reactions and PTG (Ullman, 2014) and suggests that social reactions in general are predictive of PTG. It is possible that social

reactions in general, including unsupportive reactions, encourage victim/survivors to re-examine their pre-trauma beliefs and assumptions, facilitating more PTG. This relationship may also be explained by victim/survivors' responses to these reactions; they may change their social contacts or seek alternative help. Negative reactions in which the victim/survivor felt turned against was not found to be a significant predictor of PTG.

Delay of disclosure was not found to have a significant relationship with either type of negative social reaction. Additionally, it did not significantly predict PTSD or PTG among disclosing participants, which contradicts previous research (Miller et al., 2011; Ullman, Filipas, et al., 2007). The previous research on delay of disclosure is limited and it is possible that delay of disclosure does not have a relationship with PTSD or PTG. It is also possible that the sample size of the current study was not large enough to identify the relationship.

Childhood trauma was not found to be a significant predictor of PTSD or PTG among participants who disclosed, which contradicts findings in previous studies (Elderton et al., 2017; Ulloa et al., 2016). This could be due to the way childhood trauma was assessed. Rather than assessing for the frequency or intensity of childhood trauma, the ACE (Felitti et al., 1998) was used to assess the total number of types of childhood trauma.

The finding that PTSD and PTG have a positive and linear relationship among disclosing and non-disclosing participants is consistent with Tedeschi and Calhoun's (1996; 2004) theory of PTG and confirms previous findings (Barton et al., 2013; Dekel et al., 2012). It is notable that PTSD symptoms accounted for less than 15% of PTG, which is in line with Tedeschi and colleagues' (2007) explanation of the many possible factors that can influence PTG.

The author is not aware of any previous qualitative research with participants who have not disclosed their sexual assault experience. The current study examined the reasons victim/survivors choose not to disclose, as well as reasons other victim/survivors chose to disclose and their experiences with disclosure. One striking theme was non-disclosure due to feelings of shame, embarrassment, or self-blame, which seems to speak to the pervasiveness of rape culture. The societal messages women receive about why sexual assault occurs, who is to blame, and what it means to be a victim/survivor can facilitate these feelings of shame and self-blame.

Also notable were reports of trying to prevent unwanted outcomes, including negative social reactions. Indeed, the participants who did report disclosing shared experiencing reactions of blame, judgment, and lack of support, as well as feeling ashamed or embarrassed. However, nearly half of the participants who reported disclosing stated that there were no unhelpful parts of their disclosure experiences.

Participants who reported having disclosed their most recent sexual assault experience wrote about a range of reasons for their disclosures. Many wrote about seeking emotional support, needing to unburden themselves, seeking advice, and needing support accessing help or care. These types of supports are akin to positive social reactions. Importantly, the most frequent themes in responses regarding helpful parts of disclosure were receiving emotional support, feeling better, and obtaining help or care, suggesting that participants were able to access the support they were seeking.

In this study, participants who had disclosed their most recent experience of unwanted sexual contact reported higher levels of education compared to participants who had not disclosed. Additional research is needed to determine if there is a consistent difference in

educational attainment between disclosers and non-disclosers and how education might influence decisions to disclose.

Limitations

There are some limitations to the current study concerning the sample demographics, measurements utilized, analysis, and the range of data collected. While the participants in this sample were racially diverse, the sample was still primarily White. Results should be interpreted with this in mind. Additionally, all participants reported having a high school diploma or GED. It is possible that responses from women with less education (and likely fewer economic resources) would be different than those obtained in the current study. Different recruitment strategies (i.e., in-person surveys; targeting diverse communities) may be needed to obtain more racially and economically diverse samples.

Additionally, measurements selected to assess for unwanted sexual experiences and childhood trauma did not provide possibly important information. The SES-SFV (Koss et al., 2006) only allows respondents to report having experienced a specific assault up to 3+ times and participants could endorse specific types of unwanted sexual contacts that may have occurred at the same time. Thus, it was not possible to determine any estimate of the lifetime number of sexual assaults participants had experienced. This would have allowed for controlling prior victimization in adulthood while running the analyses. Additionally, the ACE (Felitti et al., 1998) does not assess for the frequency or intensity of childhood trauma and may not have provided the information necessary to determine the role childhood trauma played in participants' experiences of ASA.

A qualitative analysis was not completed to review participants' answers to open ended questions and no auditor was used to confirm the determined themes. While the

author organized the responses with Braun and Clarke's (2006) guidelines in mind, the results for this portion of the study should be confirmed in the future in a qualitative analysis.

Of note, the current study did not assess for disclosure or non-disclosure of any assaults other than the most recent sexual assault. Findings from the open-ended questions should be interpreted cautiously, with the understanding that the non-disclosing women may have disclosed other sexual assaults and the disclosing women may have sexual assault experiences they had not disclosed.

Lastly, while nearly a third of participants' responses suggested a possible PTSD diagnosis, on average participants endorsed low rates of PTSD symptoms. They also reported experiencing only a 'very small' to 'small' degree of PTG. The relationships between childhood trauma, social reactions, PTSD, and PTG may be different for more symptomatic populations. Additionally, participants endorsed very low frequencies of negative social reactions. This could mean that victim/survivors are not experiencing these reactions at high frequencies, or it could be that these participants in particular are experiencing low frequencies for an unknown reason. Additionally, the low frequencies reported may have impeded the ability to see significant relationships between negative social reactions and other variables in the study.

Implications

In the midst of the proposal and completion of this study, a cultural shift around disclosure of sexual assault began. Near the end of the 2016 U.S. presidential election it was reported that Republican candidate Donald Trump had been recorded in 2005 stating he could grope women without their consent (Fahrenthold, 2016). Women took to Twitter to share their stories using the hashtag #NotOkay (Wang, 2016), borrowed from Canada's

Young Women's Christian Association (YWCA, 2014). In less than one day, more than 1 million women tweeted about their sexual assault experiences (Wang, 2016).

Most recently, the hashtag #MeToo was used following the report that a high-powered Hollywood producer had been sexually harassing women for decades without consequence and paying them to stay silent (Kantor & Twohey, 2017). Tarana Burke began the "Me Too" campaign in 2006 to address sexual assault experienced by girls and women of color (Ohlheiser, 2017). On Twitter, women tweeted #MeToo with or without their stories of sexual harassment and violence nearly 1 million times in just two days (CBS News, 2017). On Facebook, the hashtag was used over 12 million times (CBS News, 2017).

Sexual assault disclosure may be facilitated by these online movements. Disclosing sexual assault experiences on the Internet allows women to reach millions, if not billions, of people worldwide. The current study found that women choose to disclose for a variety of reasons, including to meet personal needs (i.e., emotional support, unburden), in response to another person's disclosure, and to protect others from the perpetrator. While some of these reasons could be satisfied by disclosing on the Internet, it is possible that there are additional reasons for online disclosure.

Disclosing sexual assault experiences on the Internet can expose victim/survivors to significantly more social reactions, both positive and negative. Given the significant relationship found in the current study between negative social reactions and PTSD, it is important to understand the function of negative social reactions that occur online, rather than face to face with the victim/survivor. Given the significant relationship found in the current study between positive social reactions and PTG, it will also be important to study the function of positive social reactions occurring online

Research should also be done to better understand women's reasons for disclosing online versus in person. At least two studies have been published examining themes in tweets using the hashtag #NotOkay. Jenkins and Mazer (2017) found that many of the women using this hashtag tweeted that this was their first disclosure. Another study described the use of this hashtag as a form of resistance and primary themes found in non-disclosing tweets were comments about the problem of rape culture and the need for social change (Maas, McCauley, Bonomi, & Leija, 2018). Future research could examine women's first disclosure experiences, either in person or online. Researchers should also consider developing a survey to assess reasons for disclosure.

The findings in the current study also have important implications for shaping how people respond to victim/survivors' disclosures in their communities. A growing body of research indicates that negative social reactions are harmful to victim/survivors of sexual assault. Further, it is likely that positive social reactions are beneficial to victim/survivors. These social reactions come from friends, family, police, and medical providers. Efforts to provide psychoeducation to communities and the people serving them could help reduce the frequency of negative reactions and help people learn how to be supportive of the victim/survivors in their lives.

These findings can also inform practicing psychologists in their work with victim/survivors. Richmond, Geiger, and Reed (2013) write about the benefits of feminist trauma-informed therapy for victim/survivors of sexual assault. This therapy includes acknowledging the victim/survivor's social context, including acknowledging external factors that cause or contribute to mental health symptoms (Richmond et al., 2013).

Understanding the realities of social reactions to victim/survivors' disclosures and their relationship with both PTSD and PTG can inform these therapeutic conversations.

Conclusion

The current study confirmed previous findings that more frequent negative social reactions are associated with more severe PTSD symptoms. Unexpectedly, more frequent unsupportive negative social reactions were associated with more PTG. Confirming the limited available research, the current study found that more frequent positive social reactions were associated with more PTG. A positive and linear relationship between PTSD and PTG was found, consistent with previous findings and current theory. Participant responses to open questions highlighted reasons for non-disclosure, with some of the non-disclosing women's feared outcomes being reported by women who did disclose. Encouragingly, a significant minority of women who disclosed reported there was nothing unhelpful about their disclosure experiences and most reported at least some helpful parts of their disclosure experiences. Future research is needed, particularly to understand the changing culture of disclosure.

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