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BARRIERS TO SEEKING CAMPUS THERAPEUTIC
SERVICES FOR SEXUAL ASSAULT

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ABSTRACT

Previous research has found that the majority of sexual assault survivors do not receive therapeutic treatment for their traumatic experience(s), despite the detrimental psychological effects sexual assault can produce (e.g. Kimerling & Calhoun, 1994; Koss & Harvey, 1991; New & Berliner, 2000). The present study examines potential barriers to seeking campus therapeutic services in college women who have experienced sexual assault (or hypothetical sexual assault among those with no history of sexual assault).

Overall, knowledge about sexual assault services on campus was quite limited.

Knowledge of the location of the campus counseling center was related to an increased likelihood of intending to use campus counseling services if any unwanted sexual experiences occur. The primary reasons students felt they did not or would not use campus therapeutic services after unwanted sexual experiences were examined.

Unwanted sexual experiences were found to be significantly predictive of having sought therapy. Respondents who had unwanted sexual experiences had higher levels of PTSD, depression, and alcohol abuse symptom severity than respondents who had not had these experiences.

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CHAPTER I

REVIEW OF RELEVANT LITERATURE

1.1 Definitions of Sexual Assault

The language used in research concerning sexual assault and rape experiences can vary from study to study and it is important to be consistent (Muelenhard, Powch, Phelps, & Guisti, 1992). Throughout this document, sexual assault, rape, sexual coercion, and unwanted sexual experiences will be used specific. Sexual coercion refers to sexual activity that is pressured or threatened, but not to the point where the law is violated (i.e. threatening to leave the relationship or spreading rumors). Rape is most often considered an act of unwanted penetration due to force or when the individual is not able to consent (i.e. intoxicated or under the age of consent). Sexual assault refers to rape, attempted rape, and unwanted sexual contact (i.e. forced petting, fondling, or kissing). Finally, unwanted sexual experiences will be used as an umbrella term to include all sexual assault, sexual coercion, and rape experiences.

1.2 Prevalence of Sexual Assault on College Campuses

Previous research has consistently shown that approximately 25% of college women experience sexual assault while in college (Abbey, Ross, McDuffie, & McAuslan, 1996; Brener, McMahon, Warren, & Douglas, 1999; Gross, Winslett, & Gohm, 2006;

Koss & Dinero, 1989; Koss, Gidycz, & Wisniewski, 1987). In addition, depending on the methodology used in each study, at least 25% of college women report sexual coercion, that is not necessarily considered sexual assault, during college (Abbey, Ross, McDuffie, & McAuslan, 1996; Chan, Straus, Brownridge, Tiwari, & Leung, 2008; Gross, Winslett, & Gohm, 2006; Koss, Gidycz, & Wisniewski, 1987; Walsh, Banyard, Moynihan, Ward, & Cohn, 2010). It is clear that during women's time enrolled in college, unwanted sexual experiences, ranging from sexual coercion (i.e. continual verbal pressure and threatening to end the relationship) to forcible rape (i.e. holding down victim while penetrating), are abundant. Because college is a time to foster education and growth in young women, and because this is a high-risk time for trauma in women's lives, it is important that survivors of unwanted sexual contact have available treatment resources and know how and where they can receive those resources. Further, it is vital to have a clear understanding of the barriers that may exist to seeking therapeutic support in the aftermath of an assault in order to best facilitate sound mental health in college women.

1.3 Psychological Outcome of Sexual Assault

Sexual assault has been related to several adverse psychological outcomes, including posttraumatic stress disorder (PTSD), depression, and substance abuse. In fact, depression and fear elevations were sustained throughout the year following women's sexual assault in a sample of rape crisis center clients (Kimerling & Calhoun, 1994). These reactions are common in the immediate aftermath of an assault, but dissipate with time for most people (Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992). The majority of sexual assault victims will have diagnosable PTSD, if the duration criterion is excluded, for the first few weeks after the incident (Rothbaum, Foa, Riggs, Murdock, & Walsh,

1992). Even after three or four months, forty-seven percent of the survivors still met the criteria for PTSD. Further, continued, chronic elevations in psychological symptoms have been shown in a small but significant proportion of sexual assault victims (Burnam et al., 1988; Kilpatrick, Saunders, Veronen, Best, & Von, 1987; Kimerling & Calhoun, 1994). In women who have experienced sexual assault during their lives, between 17% and 65% develop PTSD, and sexual assault survivors are among the most likely population to develop PTSD (Clum, Calhoun, & Kimerling, 2000; Kilpatrick, Saunders, Veronen, Best, & Von, 1987; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992).

In addition, survivors of sexual assault are more likely to have comorbidity between PTSD and other psychiatric disorders than non-survivors (Zinzow et al., 2010). For example, among women who have experienced some type of sexual trauma in their lives, there is a link to substance abuse, which may help survivors cope with their traumatic event and reduce tension (Harned, 2004; Ullman, Filipas, Townsend, & Starzynski, 2005). Unwanted sexual encounters were significantly associated with screening positive for depression in college students seeking primary care services (Mackenzie et al., 2011). In fact, 49.2% of the college women who reported unwanted sexual encounters screened positive for depression. Furthermore, women who have experienced childhood or adult sexual assault have a greater history of suicide attempts (Davidson, Hughes, George, & Blazer, 1996). For college women who report having had a severe level of sexual coercion, there is an association with higher suicidal ideation and depression (Chan, Straus, Brownridge, Tiwari, & Leung, 2008). Community rates of seeking mental health services, particularly for shortly after the assault, have been found to be less than 30 percent (Burnam, et. al., 1988; George, Winfield, & Blazer, 1992). Although some survivors cope quite well after a sexual assault, nearly half of sexual

assault survivors eventually seek treatment once their symptoms become unbearable (Koss & Harvey, 1991), yet this may be years or decades after their assault(s). The availability of campus counseling during students' college years allow for ample opportunity to provide immediate therapeutic treatment to alleviate many of these symptoms and give students their best chance to succeed and experience good mental health. Early treatment has better outcomes in decreasing distress and negative psychological symptoms, yet sexual assault victims often do not receive early treatment (Russell & Davis, 2007).

1.4 Utilization of Therapeutic Services on Campus

Research on the use of campus counseling services shows that, regardless of sexual assault history, few students seek services. Eisenberg, Golberstein, & Gollust (2007) found that fifteen percent of college students used either psychotherapy or psychotropic medications in the past year. In their sample, nine percent used psychotropic medication and ten percent had at least one counseling visit. This rate of psychotherapy use is less than in the general population, where 17.9% had at least one counseling visit in the last year (Wang, Lane, Olfson, Pincus, Wells, & Kessler, 2005). Of students who had received counseling services in the last year, only 38% of those received the services from their university counseling center (Eisenberg, Golberstein, & Gollust, 2007). Even among students with difficult problems, such as PTSD, most only used services due to problems related to stress, rather than for their PTSD symptoms (Benton, Robertson, Tseng, Newton, & Benton, 2003). While many students will seek therapeutic services for a broad problem, such as stress, specific disorders may be ignored or avoided. Importantly, it was found that students receiving counseling services

were more likely to stay in school and not drop out than students who had not received counseling services (Lee, Olson, Locke, & Michelson, 2009). In fact, unwanted sexual experiences are associated with school withdrawal (Harned, 2004). Since students are often attending college to increase their life opportunities, and sexual assault is at the least a major life set-back, receiving timely treatment for any psychological consequences of the assault is essential.

Although it is clear sexual assault happens frequently on college campuses, little is known about treatment seeking behaviors in college victims. In general, most women who experience sexual assault and are in college do not seek treatment or use available campus resources. Although the prevalence of college survivors who seek mental health treatment remains unclear, when looking at utilization of mental health services on campus, only between 0.17 percent and 3.45 percent of the students indicated they were seeking services due to sexual assault (Benton, Robertson, Tseng, Newton, & Benton, 2003). In another study of a college that has a rape crisis center on campus, only three percent of students who experienced unwanted sexual contact and six percent who experienced unwanted sexual intercourse while enrolled in the school sought services (Walsh, Benyard, Moynihan, Ward, & Cohn, 2010). Of the students who sought services, not all services were therapeutic (i.e. services include legal, support, education, and therapy) and it is unclear what proportion of the students seeking crisis center services used therapeutic services. It is notable that even on a college campus that has an established rape crisis center, services are still rarely utilized.

1.5 Barriers to Utilizing Therapeutic Services

Knowing both that sexual assault can have devastating effects on victims and that

few psychological treatment resources are used highlights the importance of understanding what barriers, if any, preclude use of therapeutic services post-sexual assault. One potential barrier is the lack of knowledge of campus resources for sexual assault. Through an analysis of sixty universities' available sexual assault resources on campus, Hayes-Smith and Hayes-Smith (2009) found that only 33% have a women's resource facility, and not all have sufficient information available via the internet, even though students indicated that this is the primary way they seek information. In addition, in the same study, a website content analysis was conducted. Six schools displayed no literature on their websites and 35% of the schools were considered to have a poor quality of sexual assault literature, while many others used language that reinforced rape myths. About half the schools reported federally-mandated crime statistics on their websites. Further, when examining students' perception of receiving the federally-mandated sexual assault materials, the majority (54%) of the students indicated they had received resource information, yet 13% indicated they did not receive the information, and 33% were unsure if they had received the information (Hayes-Smith & Levett, 2010). Despite receiving information, only 39% of those students knew where to get information about sexual assault on campus if they needed it. All resources were available on campus, yet not all students realized this. Even within a campus with a rape crisis center, the majority of students did not use services available, although knowledge of where the center was located was a predictor of perceived use of services (Walsh, Banyard, Moynihan, Ward, & Cohn, 2010). Clearly, the process of disseminating sexual assault resources and materials is not uniform or does not make a strong enough impression on students.

It seems it is not enough to have sexual assault resources available somewhere, in some capacity on campus, and further, the type of materials and resources and

dissemination process may play a role in predicting utilization. When examining a prevention education program on college campuses that focused on teaching students about consent for sex, the longer treatment group, which included a presentation and an activity, had the most knowledge-based gain concerning consent (Borges, Banyard, & Moynihan, 2008). Even in brief educational programs examining increased knowledge and understanding of consent are effective, although longer interventions seem to be more effective in promoting positive change in college students, with the duration of the programs examined ranging from 7 minutes to 2,520 minutes (Anderson & Whiston, 2005). Perhaps simply investing more time and energy into educating students about sexual assault can result in increased awareness of available sexual assault resources. For students who participated in various sexual assault education programs across the country, a medium effect was found for an increased knowledge about rape compared to students who did not participate in a program (Anderson & Whiston, 2005). A small effect size was found for these programs having a positive influence on rape attitudes, yet there was not sufficient evidence that these programs impact behavioral intentions, rape-related attitudes, and sexual assault incidence. According to students, having resources easily available online and having a sexual assault educational course, much like the alcohol awareness course many first-year students take, may help with utilization of sexual assault resources (Hayes-Smith & Levett, 2010). Another suggestion is to emphasize privacy in the use of campus resources since many students are concerned about their perpetrator or friends finding out about their assault and experiencing negative consequences as a result of others knowing (Walsh, Banyard, Moynihan, Ward, & Cohn, 2010). Although these suggestions are useful and further investigation can expand on these ideas, still little is known about barriers for utilization of specifically therapeutic

resources on campuses that can target the important psychological consequences that arise from sexual assault.

Another potential barrier for sexual assault treatment is whether victims identify their unwanted sexual experience as rape or sexual assault. In a college sample, only 36% of students called their experience rape despite endorsing behavioral sexual assault items (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). In another college sample, only 11.8% of rape victims labeled their experience as rape (Schwartz & Leggett, 1999). Often, individuals will acknowledge they have experienced certain sexual assault behaviors, yet will not label those behaviors as rape, despite the endorsed behaviors meeting the legal definition of rape. Women who identify their experience(s) as rape are often less familiar with their perpetrator and have extremely negative reactions to their trauma (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). When their perpetrator was a boyfriend or their perpetrator was under the influence of drugs or alcohol, the women were less likely to identify/label their experience as rape. In fact, sexual assault victims on campus are more likely to disclose their sexual assault if the sexual assault was more stereotypical in nature (i.e. perpetrated by a stranger, weapons involved, and identified what happened as rape), yet most sexual assaults are perpetrated by acquaintances without weapons (Fisher, Daigle, Cullen, & Turner, 2003). Seeing as the overwhelming majority of college women's rapes are perpetrated by someone they know (Abbey, Ross, McDuffie, McAuslan, 1996), labeling their experience as rape is unlikely. Only five percent of the survivors in this study reported their campus sexual assault to campus authorities. Interestingly, survivors of childhood sexual assault are more likely to identify their sexual assaults as rape (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). Overall, it seems many women do not identify their unwanted sexual experiences as rape, despite

the experiences fitting legal definitions of rape.

It is important to know whether labeling an event as rape effects women's psychological well-being after unwanted sexual experiences. To examine this, Harned (2004) examined three path analysis models to best determine whether women labeling their unwanted sexual experiences was related to psychological outcome. The best fitting model suggests that labeling is not relevant to the likelihood of negative outcomes and that it is simply the unwanted sexual experience itself that is associated with psychological and school distress. In this sample, 34.3% of the students indicated some sort of unwanted sexual contact by a dating partner while in college and of the women who endorsed a sexual assault experience, only 15.1% labeled their experience as sexual assault. The labeling was irrelevant to the severity of psychological distress, and the unwanted sexual experience itself was related to the subsequent psychological distress. When women do not label their rape as rape, the absence of the rape label is not protective from experiencing psychological distress. Women raped while intoxicated are also no less emotionally affected by their experience nor are they more or less likely to blame themselves for the sexual assault (Schwartz & Leggett, 1999). Whether women experience their sexual assault while heavily intoxicated or physically forced, they are still deeply affected in general. These findings that suggest labeling does not influence psychological outcome illuminate the importance of understanding if labeling influences treatment seeking behavior after a sexual assault. If not labeling a rape as rape makes a woman less likely to seek therapeutic support, work can be done in college campuses to encourage proper identification of unwanted sexual experiences.

1.6 Current Study

For this current study, students' knowledge about campus sexual assault resources and potential barriers to seeking these services will be examined. Among student who have experienced unwanted sexual contact, therapy use and rates of PTSD, depression, and alcohol abuse symptoms will be compared. The ultimate goal of this study is to see what barriers exist for students who have experienced unwanted sexual contact and what barriers students without a sexual assault history perceive to exist. To begin with, we suspect that our results will match previous research which has found that few sexual assault survivors will have sought therapeutic treatment, despite symptomology. This finding would reinforce the importance of universities making support services well-known to students. In addition, we hypothesize the following:

1.6.1. In the context of a real or hypothetical sexual assault, those who know about available therapeutic resources will indicate they would be more likely to seek services than those students who do not know about available therapeutic resources.

1.6.2. In general, the majority of rape survivors will not label their rape experiences as rape. Sexual assault survivors who label their sexual assault as rape will be significantly more likely to seek therapeutic support after a sexual assault experience than the survivors who do not label their sexual assault as rape. It seems likely that the mere identification of what happened will encourage seeking support. The likelihood of seeking therapeutic support after unwanted sexual experiences will be influenced by labeling the experience as rape, rather than severity of symptoms.

1.6.3. Survivors who label their rape experiences as rape will have more depressive and posttraumatic stress symptoms and more alcohol use than survivors who do not label their rape experiences as rape. Unwanted sexual experiences will be associated with seeking therapy and experiencing more PTSD, depression, and alcohol

abuse symptoms.

1.6.4. Survivors who do not utilize therapeutic services will be significantly more likely to indicate that they feel the unwanted sexual experience they endured did not impact them enough to warrant seeking services than survivors who did utilize therapeutic support.

CHAPTER II

METHODS

2.1 Recruitment of Respondents

Female students who were currently enrolled in college at a Midwestern university, were recruited through advertisements and campus outreach. They were directed to a link to survey monkey to complete the survey. Women who participated had a chance to win one of four modest (\$25) gift certificates from a random drawing.

Utilizing a snowball recruitment strategy, participants were asked to nominate other potential participants who may be interested in completing the survey. Participants were informed they were able to decline nominating another participant and there would be no penalty for doing so. The survey took approximately thirty minutes to complete, with the option of discontinuing at any point. Referrals for campus counseling, local mental health agencies, and the local rape crisis center were provided before and after the survey.

2.2 Procedure

After completing informed consent, participants completed the battery of questionnaires at their own pace. Symptom severities of depression, alcohol use, and PTSD were used instead of categories of diagnosable participants and no diagnosis participants because the goal of this study was to examine negative psychological

outcomes, rather than diagnoses. Participants were categorized by their behaviorally described unwanted sexual experiences ranging from non-victim status to rape victim. Rape survivors were grouped based on whether or not they labeled their rape experience as rape. Finally, these groups were compared concerning their knowledge of campus resources, therapeutic experience, and perceived barriers for therapeutic services.

2.3 Measures

Demographics and background. Basic demographic information, including current year in college, was collected from the participants. In addition, participants indicated their therapeutic treatment history, both on and off campus.

Sexual Experiences Survey (SES; Koss et. al., 2007). First, participants completed Koss and colleagues revised Sexual Experiences Survey, a well validated and reliable questionnaire assessing various behavioral sexual coercion and sexual assault experiences (SES; Koss et. al., 2007; Koss & Gidycz, 1985; Koss, Gidycz, & Wisniewski, 1987; Koss & Oros, 1982). Internal consistency (Cronbach's alpha) of the SES items has been found to be 0.74 in college women and test-retest reliability was found to be stable with a 93% agreement between the two times the survey was completed (Koss & Gidycz, 1985). Next, participants were asked if they had ever experienced rape. This method provides for the most accurate assessment of sexual assault experiences and accounts for hidden victims who have not labeled their experience as rape. The SES utilizes behaviorally-oriented items to assess rape, attempted rape, sexual coercion, unwanted sexual contact, and non-victim status. Endorsing any of the items from each category indicates having experienced an unwanted sexual experience.

Assessment of Perceived Barriers. Participants who indicated experiencing unwanted sexual contact indicated whether various barriers prevented them from seeking any therapeutic support after the sexual assault. In addition, participants who did not report any unwanted sexual experiences were asked to indicate which barriers might exist to seeking therapy if they were to experience a sexual assault. Questions included “I did/do not feel the incident warranted therapy” and “I did/do not know about available services”. In addition, questions assessing respondents’ knowledge of available counseling services on campus and the student women's center were assessed.

Posttraumatic Diagnostic Scale (PDS; Foa, Cashman, Jaycox, & Perry, 1997). The Posttraumatic Diagnostic Scale (PDS) was used to assess symptoms of PTSD that are congruent with Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) guidelines. The PDS demonstrates high internal consistency at 0.92 for Total Symptom Severity, high test-retest reliability at 0.83 for Total Symptom Severity, and validity (Foa, Cashman, Jaycox, & Perry, 1997). The PDS assesses for PTSD symptoms over the past month based on a four point Likert scale (0 = Not at all or only one time, 1 = Once a week or less/once in a while, 2 = Two to four times a week/half of the time, and 3 = Five or more times a week/almost always) with 17 symptom items. These items are used to examine the severity of symptoms, with scores ranging from 0-51, with higher scores indicating more symptoms. The PDS also includes an assessment of all traumatic events experienced and the event that is most bothersome according to the participant.

The Center for Epidemiologic Studies Depression Scale Revised (CESD-R; Eaton, Muntaner, Smith, Tien, & Ybarra, 2004). The CESD-R was used to assess depressive symptoms consistent with DSM-IV-TR criteria (Eaton, Muntaner, Smith, Tien, & Ybarra, 2004; Radloff, 1977). The CESD-R has shown high internal consistency, with

a Chronbach's alpha of 0.92 (Van Dam & Earleywine, 2011). The CESD-R uses 20 questions with a four point Likert scale (0=rarely or none of the time/less than 1 day, 1=some or a little of the time/1-2 days, 2=occasionally or a moderate amount of the time/3-4 days, and 3=most or all of the time/5-7days) to assess depression symptoms over the past week. Scores can range from 0-60, with higher scores being indicative of more symptoms.

Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, De La Fuente, & Grant, 1993) to assess risky alcohol use and dependence, the brief Alcohol Use Disorders Identification Test (AUDIT) was utilized. The AUDIT (and abbreviated form) has high internal consistency, with a Chronbach's alpha of 0.80 and good test-retest reliability, with correlation ranging from 0.60 to 0.80 overall (Meneses-Gaya, Zuardi, Loureiro, & Crippa, 2009). The AUDIT is comprised of 10 questions assessing alcohol consumption, alcohol dependence, and alcohol-related problems. Severity of hazardous alcohol use and dependence is based on a score of 0-40, with higher scores indicating more hazardous alcohol use.

2.4 Analyses To begin, respondents' knowledge of campus sexual assault resources and rates of unwanted sexual experiences was examined. Chi-square statistics were calculated to assess the relationship of knowledge of therapeutic services and perceived likelihood of using them. Chi-square statistics were also calculated to assess the relationship of having unwanted sexual experiences and seeking therapy. In addition, multiple bivariate correlations were conducted to compare levels of PTSD, depression, and alcohol abuse symptoms between respondents with and without unwanted sexual experiences.

Overall use of therapy was combined because only 9 participants had therapy on campus and 37 participants had therapy outside of campus. Some participants had both campus and community therapy and combining the two therapy categories also made sure participants were not double counted for a total of N=40 participants with therapy experience. Chi-square statistics were then conducted to compare those who have had therapy in their pasts with those who felt their unwanted sexual experience did not warrant therapy in regards to their knowledge of campus services and likelihood of using services if sexually assaulted in the future.

CHAPTER III

RESULTS

A total of 79 female participants (69 undergraduate students and 10 graduate students) finished the survey and were included in the results. Participants had a mean age of 25.06 (SD=6.57) and a range of 18-47. The majority of participants were Caucasian (82.3%), followed by African American (6.3%) and Hispanic (6.3%), and finally Asian (2.5%) and more than one race (2.5%). In addition, 38% of the participants were single, 26% dating and living separately, 16.5% married, 13.9% dating and cohabiting, and 5.5% engaged. A general descriptive overview of the results will be presented, followed by the results of each of the four hypotheses. A category of any unwanted sexual experiences was created that combined rape (N=11), attempted rape (N=7), sexual coercion (N=16), and unwanted sexual contact (N=26) for a total of N=30 with some women experiencing more than one type of unwanted sexual experience. Participants reported an average of 2.37 unwanted sexual experiences, with a SD of 6.57. Depression symptom scores averaged 16.5, with a SD of 10.27. PTSD symptom scores averaged at 7.83, with a SD of 8.29. Alcohol use scores averaged 5.04, with a SD of 5.35.

Frequencies were computed to compare rates of sexual assault when using dichotomous questions (i.e. Have you ever been raped?) to behavioral descriptions of

unwanted sexual experiences (see Table 1). According to the dichotomous question, 8 participants indicated being raped, while 11 participants had behavioral experiences that met the criteria for the legal definition of forceful rape. In addition, 19 other participants had some type of sexual assault or sexual coercion experience, and many women fit more than one category. According to the PDS sexual assault questions (which are more behavioral), 28 participants indicated having experienced at least one type of sexual assault. These findings highlight the importance of using behavioral descriptions of sexual assault to uncover all victims, rather than just victims who label their sexual assaults as rape.

Table 1. *Unwanted sexual experiences based on behavioral and dichotomous indications*

	%	N
Sexual Assault History	38%	30
Unwanted Sexual Contact	32.9%	26
Sexual Coercion	20.3%	16
Attempted Rape	8.9%	7
Rape	13.9%	11
SES endorsed sexual assault item(s)	36.7%	29
Have you been raped?	Yes=7.6% No=92.4%	Yes=6 No=73
PDS endorsed sexual assault item(s)	Yes=35.4%	Yes=28
Raped and labeled rape	54.5%	6
Raped and did not label rape	45.5%	5

Note. Overall behavioral and dichotomous items indicating rape experience are in bold. Percentages of the SES categories may exceed 100%, as some participants may have experienced more than one category of unwanted sexual experience.

To test Hypothesis 1.6.1, which predicted that respondents who know about available sexual assault resources on campus will indicate they would be more likely to seek services than those students who do not know about available therapeutic resources, a Pearson's chi-square test for independence was conducted. The results indicated a significant association between knowing where the counseling center is located on campus and the perceived likelihood of using campus therapeutic services if a sexual assault were to be experienced, $\chi^2(1, n=78) = 10.33, p < .01, \phi = .37$. Results show that students who were aware of where the counseling center is located on campus were more likely to indicate they think they would seek campus counseling services if they were to suffer an unwanted sexual experience. There was no significant relationship found for knowing that there are free counseling services on campus and perceived likelihood of using campus therapeutic services if a sexual assault was experienced, $\chi^2(1, n=78) = 1.28, p = .527, \phi = .13$. Results suggest a higher level of knowledge about counseling services on campus (i.e. location) is what contributes to a higher likelihood of using campus counseling services for an unwanted sexual experience.

Hypotheses 1.6.2. and 1.6.3. could not be fully examined because too few participants labeled their sexual assaults as rape. However, part of Hypothesis 1.6.2. was found to be unsupported. For participants who have experienced rape, six labeled their experience as rape, while five did not label their experience as rape. Due to our small sub sample size, these results should be interpreted with caution. For Hypothesis 1.6.3, we did find significant correlations between having had unwanted sexual experiences and seeking therapy and PTSD, depression, and alcohol use symptoms. The strength of the relationships between having had unwanted sexual experiences, symptoms of PTSD,

depression, and alcohol abuse, and previous therapy use were examined (N=79) (see Table 2). Unwanted sexual experiences and depression symptom severity were significantly correlated, $r = .253$, $p < .05$. Experiencing at least one unwanted sexual experience was also significantly correlated with both PTSD symptom severity, $r = .251$, $p < .05$ and alcohol abuse symptoms, $r = .426$, $p < .01$. These results are consistent with previous literature. In addition, unwanted sexual experiences and past therapy use were significantly correlated, $r = .354$, $p < .01$. Since unwanted sexual experiences and past therapy use were found to be correlated, a chi-square analysis was conducted to examine this relationship further. Results of the chi-square analysis of independence (using Yates Continuity Correction) found that experiencing unwanted sexual experiences is related to seeking therapy, $\chi^2 (1, N=79) = 6.06$, $p < .05$, $\phi = .303$. These results were significant, despite only 4 of 30 of the therapy seeking participants indicating they had therapy for an unwanted sexual experience. Interestingly, only depression symptom severity was significantly correlated with past therapy use ($r = .342$, $p < .01$), while PTSD severity and alcohol abuse severity were not significantly related.

Table 2. *Bivariate correlations of victimization status, symptomology, and past therapy use.*

	Therapy Use	Unwanted Sexual Experiences	Depression Symptom Severity	PTSD Symptom Severity
Therapy Use	-	-	-	-
Unwanted Sexual Experiences	.354**	-	-	-
Depression Symptom Severity	.342**	.253*	-	-
PTSD Symptom Severity	.196	.251*	.490**	-
Alcohol Abuse Severity	.112	.426**	.021	.085

* *Correlation is significant at the 0.05 level (two-tailed).*

***Correlation is significant at the 0.01 level (two-tailed).*

Note: The amount of therapy sessions was used when correlated with unwanted sexual experiences.

Next, we examined how aware students are about the resources available on campus for survivors of sexual assault (see Table 3). While 71.8% of the student were aware there is free counseling available on campus, only 30.8% knew where the counseling center is located, and only 11.5% of students indicated they have used the campus counseling services. Further, only one individual indicated that she had used campus counseling for her sexual assault. Around half (51.3%) of the students were aware there is a women's center on campus, only 35.9% know where it is located, and 15.4% are aware of what services are offered through the women's center.

Table 3. *Awareness of resources on campus for victims of unwanted sexual experiences and general use of counseling by students. (N=78)*

	Yes/No	Frequency	Percentage
Aware of free campus counseling	Yes	56	71.8%
	No	22	28.2%
Aware of campus counseling center location	Yes	24	30.8%
	No	54	69.2%
Aware of women's center on campus	Yes	40	51.3%
	No	38	48.7%
Aware of location of women's center	Yes	28	35.9%
	No	50	64.1%
Aware of what services women's center offers	Yes	12	15.4%
	No	66	84.6%
Used campus counseling services	Yes	9	11.5%
	No	69	88.5%
Used community therapy	Yes	37	47.4%
	No	41	52.6%

For Hypothesis 1.6.4., another Chi-square test for independence (with Yates Continuity Correction) found there was no significant relationship between utilizing counseling services and feeling the unwanted sexual experience(s) did/does not warrant seeking therapy, $\chi^2 (1, n=78) = .000, p = .926, \phi = -.010$. However, feeling the unwanted sexual experience(s) did/does not warrant seeking therapy (40.5%) was the most frequently indicated reason participants felt they did not or will not seek therapy (see Table 4). The other most popular reasons cited were feeling therapy was/is not needed (29.1%), not having time (24.1%), not knowing about available services (22.8%), and fearing others would find out (20.3%).

Table 4. *Frequency of perceived barriers to seeking therapeutic services after an unwanted sexual experience.*

	Frequency	Percentage
I did not feel the incident warranted needing therapy	32	40.5%
I feared others finding out	16	20.3%
I feared the perpetrator would find out and hurt me or get into trouble	8	10.1%
I felt it would not be helpful	14	17.7%
I felt I did not need counseling or therapy	23	29.1%
I had not considered seeking therapeutic services	6	7.6%
I did not know about available services	18	22.8%
I did not have time	19	24.1%
This is a private matter	11	13.9%
Other	17	21.5%

Note. These results combine survivors and non-victims. Percentages will exceed 100% as participants were able to choose more than one reason they may not have or may not seek therapeutic services on campus.

CHAPTER IV

DISCUSSION

The purpose of the current study was to assess student's knowledge of campus-based services, such as counseling and the women's center, and to identify barriers to seeking treatment after experiencing unwanted sexual contact. Overall, support was found for some of our hypotheses. For our first hypothesis, we hypothesized that students would know very little about what services are available on campus for survivors of sexual assault and that knowing more about services would be predictive of a greater likelihood for indicating they would seek services if they were to experience a sexual assault in the future. The data supported this hypothesis. Although almost three-fourths of the students indicated they were aware there is free counseling on campus, knowledge beyond that, such as knowing the location of the counseling center, only one-third of respondents had. These results are consistent with previous finding by Hayes-Smith & Levett (2010), who reported that only 39% of their student sample knew where to find sexual assault resources if needed. In addition, in this current study, knowing where the counseling center is located was found to be significantly predictive of an increased likelihood of intention to seek campus services if a sexual assault were to occur. This was also true at a university with a rape crisis center on campus (Walsh, Banyard, Moynihan, Ward, & Cohn, 2010). These results suggest that a higher level of knowledge of what services exist to help survivors of sexual assault, may contribute to a

higher usage of these important services. Since only 9 participants indicated using campus counseling, and only 1 indicated her counseling was related to the sexual assault, this proportion was too small to be meaningful to use to examine whether perceived likelihood of seeking services is related to actually having sought services in the past.

Because only 11 participants met the criteria for having experienced rape, the second and third hypotheses could not be fully tested. Five of these women did not label their rape experience as rape, while six of these women did label their rape experience as rape. This study examined labeling in regards to rape (rather than sexual assault experiences), making these results difficult to compare to other studies. Although it was suspected that rape survivors who label or identify their experience as rape are more likely to seek therapeutic support, results were almost identical for both survivors who label and survivors who do not label. A larger overall sample size would be needed to ensure that the subsample of rape survivors is large enough to conduct a meaningful analysis comparing rape survivors who label to rape survivors who do not label on symptomology and therapy seeking behaviors.

Finally, our last hypothesis had mixed support. Survivors of any type of unwanted sexual contact, that have had therapy, did not significantly differ in feeling the incident(s) they experienced did not warrant needing therapy from the survivors who have no had therapy. There was significant support, however, found for feeling an incident of unwanted sexual contact did/does warrant seeking therapy being predictive of indicating perceived likelihood of seeking therapeutic support after experiencing a sexual assault. The top reasons respondents indicated they would not seek therapeutic support after a sexual assault were feeling the incident did/does not warrant therapy, feeling therapy was/is not needed, not having time, not knowing about available services, and

fearing others would find out.

Our results did find that only 4 of the 40 participants who had any past therapy went to therapy regarding their sexual assault. Further, over half (N=21) of the participants who indicated they have used therapy reported some sort of unwanted sexual contact in their past. These findings lend support to the idea that women often seek therapy for problems that may have resulted from their unwanted sexual experiences, yet not actually identify they sought therapy due to unwanted sexual experiences. Through a chi-square analysis, having at least one unwanted sexual experience was predictive of having sought therapy. Even if women are not identifying their unwanted sexual experiences as their reason for therapy, it is clear that the psychological consequences from these experiences does have a significant influence on women's treatment-seeking behavior.

Limitations

The largest limitation of this study is the relatively low sample size. In particular, a large sample of a general population is needed to yield a sufficient number of rape survivors. Many of our hypotheses were still able to be examined efficiently, yet, due to low numbers, we were unable to compare rape survivors who label their experience as rape to rape survivors who did not label their experience as rape with regard to symptomology and treatment seeking behaviors. Having a larger sample and more substantially sized subgroups for comparison can make results more significant and increase power. While other studies examined identifying the broader category of sexual assault experiences as sexual assault experiences, rather than being limited to rape, this study did not include sexual assault identification. Future research may benefit from

using questions assessing rape labeling and sexual assault labeling to get a more full picture of women's overall labeling behaviors.

Because this sample was comprised entirely of college students, it is not possible to generalize these results to non-college populations in regards to treatment seeking behaviors after sexual assault. Further, because students self-selected into the study, it cannot be confirmed that these students are representative of the larger student population on the campus used. The questions were geared specifically to campus-based resources for sexual assault and general community-based resource knowledge is not comparable.

Directions for Future Research

An important strength of this current study is that the results indicate the many college survivors of sexual assault do not know where to seek mental health treatment, and very few students used campus counseling in general, despite the free and easy accessible services. More work should be done examining what type of symptom profiles lead women to seek therapeutic support more readily. In this study, we found that depression symptom severity was indicative of seeking treatment, rather than the sexual assault itself, according to respondents reasoning for seeking treatment. More education by colleges about the psychological responses that may happen for many women after unwanted sexual experiences and where women can go for support may increase treatment seeking behaviors. In addition, colleges can provide a short course discussing unwanted sexual experiences for new students to increase awareness, and hopefully, in turn increase labeling behaviors. This is especially important since Harned (2004) found that labelers and non-labelers did not significantly differ in symptom severity.

While this study examined knowledge about and barriers to seeking counseling services for college women, it would be helpful to examine the primary barriers to seeking treatment and knowledge of resources for community women after unwanted sexual experiences. In addition, further research should seek to increase the sample size used and include more than one university to ensure results are both accurate and generalizable to college women. Exploring the relationship between labeling/not labeling rape experiences as rape and therapy experience and symptomology would be an important direction to move towards. If non-labeling survivors are less likely to seek treatment than survivors who label their rape as rape, yet are comparable in rates of symptomology, the importance of rape-related education is highlighted. Correctly identifying sexual assault experiences may be an important piece in getting survivors therapy more quickly and efficiently.

REFERENCES

- Abbey, A., Ross, L. T., McDuffie, D., & McAuslan, P. (1996). Alcohol and dating risk factors for sexual assault among college women. *Psychology of Women Quarterly, 20*, 147-169.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- Anderson, L. A., & Whiston, S. C. (2005). Sexual assault education programs: a meta-analytic examination of their effectiveness. *Psychology of Women Quarterly, 29*, 374-388.
- Benton, S. A., Robertson, J. M., Tseng, W., Newton, F. B., & Benton, S. L. (2003). Changes in counseling center client problems across 13 years. *Professional Psychology: Research and Practice, 34*, 66-72.
- Borges, A. M., Banyard, V. L., & Moynihan, M. M. (2008). Clarifying consent: primary prevention of sexual assault on a college campus. *Journal of Prevention & Intervention in the Community, 36*(1/2), 75-88.
- Brener, N. D., McMahon, P. M., Warren, C. W., & Douglas, K. A. (1999). Forced sexual intercourse and associated health-risk behaviors among female college students in the United States. *Journal of Consulting and Clinical Psychology, 67*(2), 252-259.
- Burnam, M. A., Stein, J. A., Golding, J. M., Seigel, J. M., Sorenson, S. B., Forsythe, A. B., & Telles, C. A. (1988). Sexual assault and mental disorders in a community population. *Journal of Consulting and Clinical Psychology, 56*(6), 843-850.
- Chan, K. L., Straus, M. A., Brownridge, D. A., Tiwari, A., & Leung, W. C. (2008). Prevalence of dating partner violence and suicidal ideation among male and

- female university students worldwide. *Journal of Midwifery & Women's Health*, 53(6), 529-537.
- Clum, G. A., Calhoun, K. S., Kimerling, R. (2000). Associations among symptoms of depression and posttraumatic stress disorder and self-reported health in sexually assaulted women. *Journal of Nervous & Mental Disease*, 188(10), 671-678.
- Davidson, J. R. T., Hughes, D. C., George, L. K., & Blazer, D. G. (1996). The association of sexual assault and attempted suicide within the community. *Archives of General Psychiatry*, 53(6), 550-555.
- Eaton, W.W., Muntaner, C., Smith, C., Tien, A., & Ybarra, M. (2004). Center for Epidemiologic Studies Depression Scale: review and revision (CESD and CESD-R). In: Maruish ME, ed. *The Use of Psychological Testing for Treatment Planning and Outcomes Assessment*. 3rd ed. Mahwah, NJ, 363-377.
- Eisenberg, D., Golberstein, E., & Gollust, S. E. (2007). Help-seeking and access to mental health care in a university student population. *Medical Care*, 45(7), 594-601.
- Fisher, B. S., Daigle, L. E., Cullen, F. T., & Turner, M. G. (2003). Reporting sexual victimization to the police and others. Results from a national-level study of college women. *Criminal Justice and Behavior*, 30(1), 6-38.
- Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of Posttraumatic Stress Disorder: the Posttraumatic Diagnostic Scale. *Psychological Assessment*, 9(4), 445-451.
- George, L. K., Winfield, I., & Blazer, D. G. (1992). Sociocultural factors in sexual assault: Comparison of two representative samples of women. *Journal of Social Issues*, 48(1), 105-125.

- Gross, A. M., Winslett, A., Roberts, M., & Gohm, C. L. (2006). An examination of sexual violence against women. *Violence Against Women, 12*(3), 288-300.
- Harned, M. S. (2004). Does it matter what you call it? The relationship between labeling unwanted sexual experiences and distress. *Journal of Consulting and Clinical Psychology, 72*(6), 1090-1099.
- Hayes-Smith, R., & Hayes-Smith, J. (2009). A website content analysis of women's resources and sexual assault literature on college campuses. *Critical Criminology, 17*, 109-123.
- Hayes-Smith, R. M., & Levett, L. M. (2010). Student perceptions of sexual assault resources and prevalence of rape myth attitudes. *Feminist Criminology, 5*(4), 335-354.
- Kahn, A. S., Jackson, J., Kully, C., Badger, K., & Halvorsen, J. (2003). Calling it rape: differences in experiences of women who do or do not label their sexual assault as rape. *Psychology of Women Quarterly, 27*, 233-242.
- Kilpatrick, D. G., Saunders, B. E., Veronen, L. J., Best, C. L., & Von, J. M. (1987). Criminal victimization: lifetime prevalence, reporting to police, and psychological impact. *Crime & Delinquency, 33*(4), 479-489.
- Kimerling, R., & Calhoun, K. S. (1994). Somatic symptoms, social support, and treatment seeking among sexual assault victims. *Journal of Consulting and Clinical Psychology, 62*(2), 333-340.
- Koss, M. P., Abbey, A., Campbell, R., Cook, S., Norris, J., Testa, M....White, J. (2007). Revising the SES: a collaborative process to improve assessment of sexual aggression and victimization. *Psychology of Women Quarterly, 31*, 357-370.

- Koss, M. P., & Dinero, T. (1989). Discriminant analysis of risk factors for sexual victimization among a national sample of college women. *Journal of Consulting and Clinical Psychology, 57*(2), 242-250.
- Koss, M. P., & Harvey, M. R. (1991). *The rape victims: clinical and community interventions*. Newbury Park, CA: Sage.
- Koss, M. P., & Gidycz, C. A. (1985). Sexual Experiences Survey: reliability and validity. *Journal of Consulting and Clinical Psychology, 53*(3), 422-423.
- Koss, M. P., Gidycz, C. A., & Wisniewski, N. (1987). The scope of rape: incidence and prevalence of sexual aggression and victimization in a national sample of higher education students. *Journal of Consulting and Clinical Psychology, 55*(2), 162-170.
- Koss, M. P., & Oros, C. J. (1982). Sexual Experiences Survey: a research instrument investigating sexual aggression and victimization. *Journal of Consulting and Clinical Psychology, 50*(3), 455-457.
- Lee, D., Olson, E. A., Locke, B., & Michelson, S. T. (2009). The effects of college counseling services on academic performance and retention. *Journal of College Student Development, 50*(3), 305-319.
- Mackenzie, S., Wiegel, J. R., Mundt, M., Brown, D., Saewyc, E., Heiligenstein, E.,...Fleming, M. (2011). Depression and suicidal ideation among students accessing campus health care. *American Journal of Orthopsychiatry, 81*(1), 101-107.
- Meneses-Gaya, C. D., Zuardi, A. W., Loureiro, S. R., & Crippa, J. A. S. (2009) Alcohol Use Disorders Identification Test (AUDIT): an updated systematic review of psychometric properties. *Psychology & Neuroscience, 2*(1), 83-97.

- Muehlenhard, C. L., Powch, I. G., Phelps, J. L., & Giusti, L. M. (1992). Definitions of rape: Scientific and political implications. *Journal of Social Issues, 48*(1), 23-44.
- New, M., & Berliner, L. (2000). Mental health services utilization by victims of crime. *Journal of Traumatic Stress, 13*(4), 693-707.
- Radloff, L. S. (1977). The CES-D scale: a self-report depression scale for research in the general population. *Applied Psychological Measurement, 1*, 385-401.
- Rothbaum, B. O., Foa, E. B., Riggs, D. S., Murdock, T., & Walsh, W. (1992). A prospective examination of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5*(3), 455-475.
- Russell, P. L., & Davis, C. (2007). Twenty-five years of empirical research on treatment following sexual assault. *Best Practices in Mental Health, 3*(2), 21-37.
- Saunders, J. B., Aasland, O. G., Babor, T. F., De La Fuente, J. R. & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on early detection of persons with harmful alcohol consumption-II. *Addiction, 88*, 791–804.
- Schwartz, M. D., & Leggett, M. S. (1999). Bad dates or emotional trauma? The aftermath of campus sexual assault. *Violence Against Women, 5*(3), 251-271.
- Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (2005). Trauma exposure, posttraumatic stress disorder and problem drinking in sexual assault survivors. *Journal of Studies on Alcohol and Drugs, 66*(5), 610.
- Van Dam, N. T., & Earleywine, M. (2011). Validation of the Center for Epidemiologic Studies Depression Scale—Revised (CESD-R): pragmatic depression assessment in the general population. *Psychiatry research, 186*(1), 128-132.
- Walsh, W. A., Banyard, V. L., Moynihan, M. M., Ward, S., & Cohn, E. S. (2010).

Disclosure and service use on a college campus after an unwanted sexual experience. *Journal of Trauma & Dissociation*, *11*, 134-151.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 629.

Zinzow, H. M., Resnick, H. S., Amstadter, A. B., McCauley, J. L., Ruggiero, K. J., & Kilpatrick, D. G. (2010). Drug-and alcohol-facilitated, incapacitated, and forcible rape in relation to mental health among a national sample of women. *Journal of Interpersonal Violence*, *25*(12), 2217-2236.

APPENDICES

APPENDIX A

IRB Approval Notification

From:

_____@csuohio.edu

To:

Caitlin Martin, Lisa Stines Doane, Ph.D.

Date:

Tue, Mar 19, 2013 4:55 pm

Subject: Proposal #29813

Dear Investigators Doane and Martin:

Thank you for your prompt response to the IRB suggested revisions. Your Proposal #29813 is now complete and you are authorized to commence with your study. After the Office receives your revised proposal, you should be receiving a written authorization from the IRB Office, but this notice suffices for the launching of your survey.

My good wishes and the best of luck retrieving this very important set of data.

XXXX, Primary Reviewer, IRB
IRB Submission # 29813-DOA-HS

APPENDIX B

Informed Consent

Campus Therapeutic Services

Informed Consent

Introduction:

You are invited to participate in a research project being conducted by Student Investigator, Caitlin Martin under the supervision of Dr. Lisa Stines Doane, a faculty member in the Department of Psychology at Cleveland State University and licensed clinical psychologist. It is up to you to decide whether or not to take part in this study. Please read this entire consent form and take your time to make your decision.

Purpose:

During college, the likelihood of experiencing an unwanted sexual experience is quite high for women. Often, there can be negative psychological outcomes of these experiences, yet the utilization of therapeutic services is low. This study is being conducted to determine potential barriers in place that decrease the likelihood of female students using campus counseling services after experiencing an unwanted sexual experience. For students who have not had any unwanted sexual experiences, we are interested in how likely it is that they would use campus counseling services in the future. In addition, it is important to know how much students know about available resources on campus for students who have experienced an unwanted sexual experience. Approximately 400 women will participate in this study.

Procedures:

In this study you will be asked to complete a series of questions about your history of trauma and current psychological symptoms. You will also be asked a series of questions relating to your past history, use of psychological services, and knowledge of campus resources. This survey will take approximately a half hour to complete.

Risks and Discomforts:

Risks from participating in this study are minimal, and include psychological distress at the content of the questions. It is possible that you may find that some of the more personal items on the questionnaires may cause you to feel distressed, upset, or uncomfortable. There may also be risks in your taking part of this study that we do not know about. You have the right to withdraw from the study at any time if you find the questions too distressing or personal. Cleveland State University students may call the Cleveland State University Counseling Center at 216-687-2277. Referrals for other area mental health services are available by contacting Mobile Crisis at 216-623-6888 24

hours a day, 7 days a week. The Cleveland Rape Crisis Center 24-hour crisis hotline number is 216-619-6192.

Benefits:

If you agree to take part in this study, there may or may not be direct benefit to you. We hope the information learned from this study will benefit students who are victims of trauma.

Payments to Participants:

Four (4) participants in this study will each receive a \$25 gift card to amazon.com. At the end of each survey, you will be prompted to click on a link to a different webpage, where you must enter your email address if you want to be entered into the drawing to win the gift card. Please note that, although entering your email address is optional, you must do so if you would like to be entered into the drawing. All winners will be contacted via email after the study is completed. Your email address will not be connected to your survey.

Confidentiality of records:

The results of this research may be presented at scientific meetings or published in professional journals. These reports will not contain any specific or individual responses, only the total as a group.

Confidential Data Collection:

The information you provide to us as part of this study will be stored in an electronic file on a password-protected desktop computer. Your electronic signature, provided below should you choose to participate in the study, will be kept separate from your data, and nobody will be able to link your responses to your name. Email addresses entered for the drawing will be kept separate from your data, and nobody will be able to link your responses to your email address.

Right to refuse or withdraw:

Participation in this research is voluntary and you have the right to withdraw at any time. If you withdraw from the survey without completing it, any responses given will be discarded and your data will not be used.

Who to contact with questions:

If you have questions about this study, you may contact:
Lisa Stines Doane, Ph.D.: l.doane@csuohio.edu, 216-687-3759
Caitlin Martin: c.a.martin46@csuohio.edu, 216-687-3540

Institutional Review Board

This project has been reviewed and approved by the Cleveland State University Institutional Review Board (IRB). If you have any questions about your rights as a research participant, you may call the IRB at 216-687-3630.

Acceptance and Electronic Signature:

I have read the information provided above, I understand this consent form, and all of my

questions have been answered. I am 18 years or older and I voluntarily agree to participate in this study.

By moving forward to complete this survey, you are voluntarily agreeing to participate in the survey and you agree to the following statement: I understand that if I have questions about my rights as a research subject I can contact the CSU Institutional Review Board at (216) 687-3630.

Electronic Signature and Date