The Report committee for Lindsey Arlene Langford

Certifies that this is the approved version of the following report:

Under the Radar: Posttraumatic Stress Disorder, Sexual Assault, and the College Woman

APPROVED BY

SUPERVISING COMMITTEE:

Supervisor: _____
Germine H. Awad

_____
Stephanie S. Rude

Under the Radar: Posttraumatic Stress Disorder, Sexual Assault, and the College Woman

by

Lindsey Arlene Langford, B.S.

Report

Presented to the Faculty of the Graduate School

of the University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Master of Education

The University of Texas at Austin

May 2011

Dedication

This document is written in loving memory of Lara Nan Langford.

Under the Radar: Posttraumatic Stress Disorder, Sexual Assault, and the College Woman

by

Lindsey Arlene Langford, MEd

The University of Texas at Austin, 2010

SUPERVISOR: Germine H. Awad

The current report reviews the recent literature on the relationship between Posttraumatic Stress Disorder (PTSD), sexual assault, and the resulting psychological impact on college women. This document is an overview of PTSD and sexual assault as defined in recent literature, and then reviews the significant impact both factors have on the college woman and her surrounding environment. Intervention and prevention strategies for the negative consequences of sexual assault and PTSD are included. Finally, this report provides suggestions for counselors on appropriate treatment and intervention plans for a college campus.

TABLE OF CONTENTS

Posttraumatic Stress Disorder (PTSD) is most commonly associated with male combat veterans (Smyth, Hockemeyer, Heron, Wonderlich, & Pennebaker, 2008). Although PTSD can develop as result of witnessing combat, there are other traumatic events known to cause symptoms related to PTSD. It has been well-documented the traumatic event most likely to cause the development of PTSD symptoms is sexual assault (Breslau, 2009; Frazier et al., 2009; Kessler et al., 1999; Smyth et al., 2008; Ullman & Filipas, 2001). Of women who have experienced sexual assault, one-third of victims will be diagnosed with PTSD at some point following the assault (Ullman, Filipas, Townsend, & Starzynski, 2007). Research has shown that college women experience sexual assault at higher rates than any other demographic group (Bondurant, 2010; 2009; Littleton & Henderson, 2009; Messman-Moore, Ward, & Brown, 2009; Smyth et al., 2008) and are therefore at a higher risk for developing PTSD.

According to the DSM-IV-TR (American Psychiatric Association [APA], 2000), in order to meet the diagnostic criteria for PTSD, a person must encounter a traumatic event. There are several criteria. A traumatic event (Criterion A1) has occurred when an individual "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 2000, p. 467). The symptoms caused by the traumatic event (Criterion B through D) must meet a specific level of severity within three distinct clusters: intrusion, avoidance, and hyperarousal (Lancaster, Melka, & Rodriguez, 2009). In addition, Criterion E and F require symptom severity to interfere with typical daily

functioning, e.g. socially, academically, occupationally, etc. for at least a span of one month (APA, 2000).

Out of the traumatic events a college student may potentially experience, studies have shown sexual assault to consistently be the most distressing event reported (Bernat, Ronfeldt, Calhoun, & Arias, 1998; Frazier et al., 2009). Women tend to represent a higher percentage of the population who report being victims of sexual assault. Specifically, one-fifth to one-quarter of college women reported experiencing rape during the course of their college career (Breslau, 2009; Frazier et al., 2009; Krebs, Lindquist, Warner, Fisher, & Martin, 2009a). During an academic year, approximately 2 to 3% of college women report experiencing forcible rape (Botta & Pingree, 1997; Krebs et al., 2009a). Due to the boundary violation and distress these encountered traumatic events evoke, women are often more likely to develop the criteria of PTSD.

The psychological distress of Rape-Related PTSD often can interfere with concentration, memory, motivation, persistence, and social functioning (Adkins, Weather, McDevitt-Murphy, & Daniels, 2008; Bernat et al., 1998). When this functioning is impaired it can interrupt the normal growth and development cycles (Sharkin, 2006). Stunted growth and impairment of functioning creates negative consequences for the victim. Students dealing with psychological distress might encounter effects such as academic failure, dropping out of college, and suicidality (Halligan, 2008; Smyth et al., 2008; Ullman & Najdowski, 2009).

Rape-related PTSD may also be associated with other negative consequences for the victim. Often these consequences, through rumination, can lead to increased risk of

panic, or negative thoughts or emotions, which in time can lead to development of other conditions such as depression, anxiety, substance abuse, social phobia, or hospitalization for supervision (Ehring & Ehlers, 2008; Frazier et al., 2009; Halligan, 2008; Smyth et al., 2008). Women in college with PTSD symptomology often resort to substance abuse to reduce their high levels of distress. Consequently, relying on substance abuse patterns, such as binge drinking, leads to an increased risk exposure to violence, rape or sexual assault re-victimization (Messman-Moore et al., 2009). Essentially, the effects of rape-related PTSD are disturbing to the victim and her surrounding environment.

Although college women typically report higher levels of distress as a result of unwanted sexual attention, this same population of women also tends to exemplify higher levels of growth and resiliency following trauma (Swickert & Hittner, 2009). Evidence states that women students are more likely to discuss severe or distressing traumatic events such as sexual assault with others, particularly close friends (Banyard, Moynihan, Walsh, Cohn, & Ward, 2010; Smyth et al., 2008). In telling or sharing the story of the traumatic event, some of the horror or helplessness is decreased; and the ability to cope and build resiliency is increased through sharing the burden of the distressing event (Halligan, 2008). Utilizing adaptive coping skills in response to sexual assault is an essential step in prevention of rape-related PTSD (Krause, Kaltman, Goodman, & Dutton, 2008). Therefore, research shows this is a recommended and significant component of treatment or response to sexual assault on a college campus.

Resiliency and coping skills, such as the sharing of the negative experience of sexual assault, should be incorporated within preventative outreach programs. These

programs, developed by college counselors, should focus on building awareness with college peers on: the severe disturbance and impact of sexual assault on a college campus, how to recognize warning signs of rape-related PTSD, and how to assist a friend in coping with an assault (Cukrowicz, Smith, Hohmeister, & Joiner, 2009; Smyth et al., 2008). Through coaching college students on how to share the burden of this unwanted experience with a friend, the student can assist the victim in building the necessary level of resiliency to overcome the distressing consequences of sexual assault (Cukrowicz et al., 2009; Smyth et al., 2008).

Rape-related PTSD has substantial implications upon college campuses. This paper has several objectives to help college counselors identify and best serve the college student population most affected by sexual assault and rape-related PTSD symptomology, the college woman. First, to review the definition of sexual assault and assault severity's significant relationship to PTSD and the factors that may further put a woman at risk of victimization; second, to analyze how PTSD symptomology presents in the effects of sexual assault, the impact of secondary victimization, and the specific consequences of rape-related PTSD on the victim; third, suggested treatment tips and implications for college counselors and limitations in the current research on rape-related PTSD; and lastly the implications of sexual assault on a college campus.

Sexual Assault

Adult Sexual Assault (ASA) is a salient issue in our culture. Approximately 18% of women have disclosed experiencing ASA (Najdowski & Ullman, 2009). Frazier et al. (2009) has found it to be consistently one of the most distressing events reported. Also, research has shown women are more likely to experience unwanted sexual attention than men. In one study, it was found that 27% of women and only 5% of men reported unwanted sexual attention (Frazier et al., 2009). As result, the following research discussion focuses on women. This chapter will provide definitions and effects of sexual assault to provide a thorough understanding of the concept.

Definition of Sexual Assault

Sexual assault can be broken into different levels of victimization. The different levels are unwanted sexual contact, sexual coercion, attempted rape, completed rape, and incapacitated sexual assault (Eadie, Runtz, & Spencer-Rodgers, 2008; Krebs et al., 2009a; Krebs, Lindquist, Warner, Fisher, & Martin, 2009b). The impact, level of stress, and extent of sexual force increases respectively through each stage or level, with completed rape being the most severe. In addition to the level of severity, an assault can be classified as incapacitated sexual assault. Incapacitated sexual assault is when alcohol or drugs were being used either before or during the victimization. This paper will focus on the sexual assault level completed rape.

Completed rape, the most severe level of sexual assault, occurs when intercourse and penetration do occur as a consequence of threat or force. Completed rape consists of multiple methods of intercourse: vaginal, oral, or anal (Ullman & Filipas, 2001).

Research has found completed rape is the level of sexual assault most likely to lead to severe PTSD symptoms (Eadie et al., 2008). As completed rape is the most severe level of sexual assault and the level most likely to cause PTSD symptomology, hereafter any use of the term sexual assault will refer to completed rape.

Incapacitated sexual assault occurs when victims are unable to consent to any level of sexual activity as result of voluntary or involuntary alcohol or drug intoxication. When women are unable to legally provide their consent as result of self-imposed intoxication this is referred to as alcohol and/or other drug (AOD)-enabled sexual assault (Krebs et al., 2009a). Drug-facilitated sexual assault (DFSA) occurs when the perpetrator provides a substance to the victim without her consent or knowledge. Examples of these substances, or more commonly referred to as date rape drugs, are Rohypnol (roofie), Ketamine, MDMA (ecstasy), and GHB (Krebs et al., 2009a). Any of the previously mentioned levels of sexual assault can additionally be classified as either AOD or DFSA as long as a substance (drug or alcohol) is involved in the force (Krebs et al., 2009a). The following section will delve further into specific effects of sexual assault that may cause PTSD symptomology.

Effects of Sexual Assault

The effects of sexual assault can be physically and psychologically damaging to the victim. There are many adverse effects a victim may endure, but the following will only focus on the effects that may cause PTSD. The effects as related to PTSD are risk of revictimization, low sexual self-esteem or sexual difficulties, and acting out sexually (DePrince, Combs, & Shanahan, 2009).

Research has shown once a woman has been victimized by sexual assault, her chances of experiencing revictimization increase. It is speculated this occurs as result of the victim developing a negative schema regarding intimate relationships with the expectation harm may be involved. In other words, the relationship-harm schema potentially impacts the victim's thoughts and behaviors in current relationships, including the unconscious expectation harm will occur in the relationship (DePrince et al., 2009).

Often the victim will have poorer sexual self-esteem and an increase in sexual difficulties (Eadie et al., 2008). Chapman (1989) found 60% of assaulted women reported either gynecological problems or long-standing sexual dysfunction. Sexual dysfunction may manifest in several ways: lack of control, increased sexual promiscuity, or complete inhibition to be sexually intimate. This in turn creates sexual complications thus rendering the victim incapable of participating in familiar, more comfortable, and intimate sexual relationship (Messman-Moore et al., 2009).

Another example of assault effects related to PTSD development is engaging in unsafe and risky sexual practices. Risky sexual behavior may occur as a negative method of self-medicating or coping. Engaging in such behavior is often associated with revictimization (Eadie et al., 2008; Messman-Moore et al., 2009). Finally, one of the most severe effects of sexual assault is the development of PTSD. A high correlation exists between sexual assault victims and resulting development of PTSD symptoms, specifically on a college campus.

Sexual Assault and Post Traumatic Stress Disorder

Recent prevalence estimates for rape amongst women ranges from 14 to 22% in various college and community recruited samples (Abbey, BeShears, Clinton-Sherod, & McAuslan, 2004; Brener, McMahon, Warren, & Douglas, 1999; Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). The experience of rape is often associated with development of severe and persistent psychological distress. This distress is often shown through PTSD symptoms. For example, it can be seen as reexperiencing the trauma through unwanted thoughts, avoiding certain reminders of the stressor such as people or places, and developing increased arousal such as a heightened startle response. When these symptoms persist, and interfere with everyday functioning for the duration of at least one month, PTSD may be the resulting diagnosis (APA, 2000; Littleton & Henderson, 2009). As result, between one half and nearly two thirds of rape victims eventually develop PTSD following the sexual assault trauma (Breslau et al., 1998; Eadie et al., 2008; Littleton & Henderson, 2009; Rothbaum, Foa, Riggs, Murdock, & Walsh, 1992).

Sexual assault is the Criterion A1 stressor to most likely cause PTSD symptoms. For example, Frazier et al. (2009) found the highest rates of PTSD occurred in individuals who encountered sexual assault. In other words, this study found that sexual assault victims reported more PTSD symptoms than any other traumatic Criterion A1 stressor (APA, 2000; Eadie et al., 2008). This can be explained by understanding the response (Criterion A2) the rape stressor (Criterion A1) can invoke in victims (APA, 2000). Sexual assault is the stressor most likely to cause Criterion A2 reactions: fear,

helplessness, and horror (Breslau & Kessler; 2001). Additionally, distress has been found to be more severe when the stressor is caused by another individual (APA, 2000; Breslau & Kessler, 2001; Frazier et al., 2009). Thus, sexual assault invokes a severe level of distress response as a result of the intrusiveness caused by another human being.

College women are a unique population facing sexual assault and PTSD symptoms. One in four women experience some form of sexual assault during their collegiate career; and during an academic year, 2 to 3% of college women report experiencing forcible rape (Botta & Pingree, 1997; Krebs et al., 2009a). Knowing this alarming statistic and the intrusive nature of sexual assault, college women are highly susceptible of developing PTSD. It is reported one half to nearly two thirds of rape victims develop PTSD as result of a traumatic sexual encounter (Breslau et al., 1998; Littleton & Henderson, 2009; Rothbaum et al., 1992). In consideration of the risk to college women of being victims of sexual assault, and the later manifestation of PTSD, the following discussion is centered on this demographic. The college woman referred to is considered to be the traditional college student, ages eighteen through twenty-two.

There are several factors to consider when exploring the relationship between sexual assault and PTSD. First, a review of risk factors for potential victimization and resulting development of PTSD symptomology. Next, a review of assault related factors that may predict the development of PTSD. Third, an overview of PTSD Criterion for diagnosis and how it may present in the college woman. Finally, research has shown sexual assault victims identify as one of two categories: acknowledged or

unacknowledged victim. How the victim defines her assault is explored as well as how the label predicts and impacts PTSD symptomology.

Risk Factors

With one-fifth to one-quarter of the college women population experiencing sexual assault, the most significant risk factor for being victimized by sexual assault is being a woman (Breslau, 2009; Frazier et al., 2009; Krebs et al., 2009a). The college environment involves experiences perceived as normal that inflict risk of sexual assault on the woman. Therefore, the normal college experience poses as a risk for a woman to experience sexual victimization. In addition to being a woman, research has found additional factors that may put her further at risk of being victimized. This section will provide an overview for college counselors to promote awareness of the factors that may put a woman at additional risk for sexual assault, and the potential development of PTSD symptomology.

The college woman who partakes in alcohol or other substances, with or without consent, increases her likelihood of exposure to violence or sexual assault (Krebs et al., 2009a). The college culture and lifestyle endorses frequent alcohol consumption. Therefore college women are at an increased risk of exposure just by participating in normal college extracurricular activities involving alcohol (Krebs et al., 2009a; Krebs et al., 2009b). The 2005 Core Alcohol and Drug Survey found 82% of students who were victimized by unwanted sexual encounters, specifically completed rape, were under the influence of either alcohol or drugs (Dowdall, 2007; Krebs et al., 2009a). Although this statistic is significant, it should be noted this study did not measure whether the victim

consented to consumption of the substance or not. Additional research has found 3.4% of college women who experienced completed rape were at an intoxication level that did not allow them to consent (Krebs et al., 2009a; Mohler-Kuo, Dowdall, Koss, & Wechsler, 2004). The inability to consent to sexual contact is a significant factor needing further research in order to implement the appropriate intervention for the college environment as a whole.

The age of a woman and the amount of formal education she has received are factors of increased risk for the college woman (Krause et al., 2008; Ullman et al., 2007). Highest frequency of trauma occurs between the ages of sixteen to twenty years old, which pertains to the traditional college freshman and sophomore (Breslau, 2009). Therefore, as a traditional college student, her first few years pose as a risk due to her age. As she progresses in her college tenure and increases in age, the additional risk of experiencing sexual assault will decrease (Eadie et al., 2008; Krebs et al., 2009a; Ullman et al., 2007). There is little to no research to date on the causal relationship between sexual assault, age, and education.

One significant risk factor to be aware of is previous exposure to trauma, in particular, sexual assault. Sexual assault trauma has been found to affect the victim's capability of recovering from subsequent traumatic events often leading to PTSD symptomology (Krause et al., 2008; Krupnick et al., 2004; Messman-Moore et al., 2009). College women who have experienced childhood sexual assault (CSA) or ASA are at a particularly higher risk of revictimization (Krause et al., 2008; Krebs et al., 2009b; Messman-Moore et al., 2009; Ullman et al., 2007). Revictimization, an effect of sexual

assault, can serve as a risk factor for PTSD symptomology as well as a side effect (Krause et al., 2008; Kessler et al., 1999; Messman-Moore et al., 2009). Additional risk factors are if a woman is single, if she is an ethnic or racial minority, and if her or her family has a history of mental health pathology (Krause et al., 2008; Ullman et al., 2007). The assault profile and related risk factors for PTSD symptomology play an important role in understanding the lasting impact of sexual assault on victims.

Assault Profile

Research has found specific factors of a sexual assault experience that may lead to PTSD symptomology (Eadie et al., 2008; Ullman et al., 2007). In order to understand specific factors potentially leading to PTSD, sexual assault will be broken into stages and reviewed. Ullman et al. (2007) has categorized the risk factors for PTSD into the following: assault-related factors and outcomes and postassault factors. The following sections will delve into each category to identify the specific risk and protective factors.

Assault-Related Factors are risk factors that occur during the actual assault. The assault factors related to PTSD development include relationship with the assailant, perceived life threat, degree of fear and of feeling helpless, violation of integrity, degree of violence involved, length of duration, and location of the assault (Bernat et al., 1998; Ullman & Filipas, 2001; Ullman, Filipas, Townsend, & Starzynski, 2006; Ullman et al., 2007). Ullman et al. (2006) found a victim who was attacked by a stranger assailant perceived a greater threat to life and experienced more violence, than a victim who knew or was acquainted with the perpetrator. Perceived threat of life, or intense fear and helplessness, is PTSD Criterion A2, and is the assault factor most related to PTSD

symptom severity. Additionally, there is a positive correlation between degree of violence and resulting likelihood of PTSD symptomology (APA, 2000; Ullman & Filipas, 2001; Ullman et al., 2006; Ullman et al., 2007). If the assault occurred in a location perceived as safe to the victim, this consequently threatens her security and perhaps triggers future avoidance of the location or stimuli, PTSD Criterion C (APA, 2000; Breslau, 2009; Ullman & Filipas, 2001).

Factors that may occur during assault and postassault are negative emotional reactions, panic symptoms and dissociation. Bernat et al. (1998) found these factors were significant in predicting PTSD symptomology. It is suggested if the victim is in a heightened state of physical hyperarousal during the assault she is likely to dissociate as an immediate mode of coping to manage psychological distress (Briere, Scott, & Weathers, 2005; Frazier et al., 2009). Postassault, if the victim experiences related or unrelated states of panic/anxiety, she may additionally experience dissociative flashbacks to the assault. This relationship needs further exploration, but it is speculated the intrusive thoughts during a flashback are significantly linked to PTSD symptom severity (Bernat et al., 1998).

Studies have shown the factors that occur in the aftermath of sexual assault are the causal factors to most likely lead to PTSD symptom severity (Ullman et al., 2007; Valentiner, Foa, Riggs, & Gershuny, 1996). Of the postassault factors, delayed disclosure, self-blame, and negative social reactions are the strongest correlates of PTSD symptom severity (Krause et al., 2008; Ullman et al., 2006; Ullman et al., 2007; Valentiner et al., 1996). These factors include the victim's social cognitive responses,

receiving minimal community services, utilizing maladaptive coping skills, and the victim's support system response to her disclosure, or in other words, secondary victimization (Ullman & Filipas, 2001; Ullman et al., 2007). The postassault effects will be further discussed in the following chapter. By understanding which correlates of sexual assault are most likely to lead to PTSD symptom severity, college counselors will be prepared to assist the victim appropriately. The next section provides an overview on how rape-related PTSD symptoms may present in the victim.

Presentation of PTSD Symptoms in a Sexual Assault Victim

PTSD symptom severity presents itself in several ways. This paper thus far has discussed the precipitating factors that may lead to the presentation of PTSD symptoms in a sexual assault victim. The goal in this section is to give college counselors an idea of how PTSD symptoms might present in a sexual assault victim.

PTSD is a process of developing distinctive symptoms as result of exposure to a traumatic event, or stressor. A stressor may be a number of things, but for the purpose of this paper, PTSD as related to the stressor sexual assault will be the focus. Research has found the most common PTSD Criterion responses that present in sexual assault victims are extreme fear and helplessness (Criterion A2), re-experiencing of the trauma (Criterion B), social withdrawal or numbing of general responsiveness and avoidance behaviors (Criterion C), and increased physiological arousal characteristics (Criterion D). Each of the above factors are particularly alarming when they continue to present for more than one month (Criterion E) and cause significant distress in normal functioning/routines

(Criterion F). If each of the Criterion factors is present in the victim, it is likely she has developed PTSD symptom severity (APA, 2000).

Criterion A2 requires a specific response following the traumatic stressor. This response must entail extreme fear, helplessness, and/or horror. Recent studies have found the emotional responses of Criterion A2 in sexual assault victims are strong predictors of PTSD development (APA, 2000; Breslau & Kessler, 2001; Brewin, Andrews, & Rose, 2000). Overall, the specific stressor itself has little effect on PTSD symptoms, the emotional reaction to the event, Criterion A2, is the strongest predictor of PTSD (Rubin, Bernsten, & Bohni, 2008).

Criterion B or re-experiencing of the trauma is when the victim experiences flashbacks to her assault at any point in time. This can be while she is in class, following her normal routine, or in persistent dreams. The intrusive reoccurrences may be in the form of thoughts, images, or perceptions. The victim at times may even feel as if the assault is recurring in the form of a hallucination, illusion, or dissociative flashback. Essentially, a victim is likely to experience severe distress and reactivity to any internal or external stimuli or cues that may symbolize or remind her of the assault. When this occurs, it is intrusive and potentially psychologically and physiologically debilitating (APA, 2000; Ehlers, Hackmann, & Michael, 2004).

Criterion C or social withdrawal and avoidance behaviors present as a general numbness not evident prior to the assault. The victim will likely go to extremes to avoid thoughts, feelings, conversations, activities, and/or people in order to avoid assault stimuli that may cause the victim to react. As a college woman, this may involve

withdrawing from friends or avoiding places she previously frequented. It is priority to the victim to avoid experiencing any stimuli that may remind her of the trauma. As a result of withdrawal, she may likely feel detached or estranged from others (Ullman et al., 2007). Other examples of Criterion C presentation may include inability to recall facts about the assault, a lack of interest in previously enjoyed activities and interests, a general feeling of numbness towards significant others, and a lack of expectation for the future (APA, 2000; Olff, Sijbrandij, Opmeer, Carlier, & Gersons, 2009).

Criterion D will present as significantly increased and persistent arousal or hypervigilance that was not considered normal prior to the assault. Victims often report struggling with sleep, frequent irritability or bursts of anger, increased difficulty in concentrating, and an exaggerated startle response (APA, 2000; Olff et al., 2009). The victim may appear jittery around stimuli associated with the trauma, for example close proximity to a male or someone who reminds her of the perpetrator.

If the victim has experienced any of the above symptoms for longer than a month, it is likely she is struggling with PTSD symptomology; particularly when these symptoms significantly interfere with her normal, daily functioning. This may be distress or impairment in her social, occupational, and/or academic domains (APA, 2000; Boals & Hathaway, 2010; McNally, 2003). Breslau (2009) found PTSD symptomology persisted longer in victims who experienced trauma directly and that involved violence or shock. Additionally, women with PTSD had longer duration of affect than males (Bernat et al., 1998; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Once the symptoms of

PTSD are present, the effects can be harmful to the victim as well as her community and college campus.

Victim Acknowledgment

Research has shown that specific characteristics of a sexual assault encounter can result in two different profiles of a victim. The first profile is the Acknowledged Victim. This is a woman who has acknowledged her experience as sexual assault and will define herself as a victim of the assault. The second profile is the Unacknowledged Victim. This woman will not call the sexual encounter an assault, and she will not label herself as a victim (Bondurant, 2001; Kahn, 2004; Littleton, & Henderson, 2009; Krebs et al., 2009b). By understanding the two profiles of victims, it will help college counselors in their treatment approach as well as increase their awareness of presenting PTSD symptoms.

The acknowledged victim discloses the assault to someone. This could be a friend, significant other, relative, parent, rape crisis center, police officer, and/or clergy. Littleton & Henderson (2009) found a majority of the victims disclosed to an informal source, in other words a friend, significant other, or family member. This victim typically experiences a more forceful attack despite her strong resistance and clear refusal. Also, greater assault violence, a factor associated with PTSD symptomology, is significantly associated to the victim disclosing her experience.

The Unacknowledged Victim is a woman who does not label her sexual assault encounter as rape or victimization (Littleton & Henderson, 2009). Studies of college rape victims found that between 47% and 73% of victims do not label their experience rape or

victimization and are therefore the unacknowledged victim (Bondurant, 2001; Fisher, Daigle, Cullen & Turner, 2003; Littleton & Henderson, 2009). Littleton & Henderson (2009) found 46% of unacknowledged victims were unsure how to label their experience.

Unlike the acknowledged assault, unacknowledged rapes are more likely to involve alcohol in the course of the encounter, either by the perpetrator, the victim, or both (Bondurant, 2001; Botta & Pingree, 1997: Littleton & Henderson, 2009). The assault is generally less violent, involves less force by the perpetrator, and the victim typically experiences less injury. Some researchers propose this occurs because the victim is either unable or chooses not to resist, possibly because they are incapacitated and unable to consent due to alcohol intake (Krebs et al., 2009b). More unacknowledged rapes involve alcohol use by the victim and perpetrator than acknowledged rapes (Littleton & Henderson, 2009). Often, the unacknowledged victim's assailant was someone they knew and the victim feels either the desire or responsibility to protect the assailant. It may be the victim's boyfriend, and the victim believes the act was as a result of love, desire, or miscommunication (Krebs et al., 2009b; Littleton & Henderson, 2009).

The unacknowledged victim is typically more poorly adjusted in the aftermath of the sexual assault than the victim who acknowledges the assault. Research predicts, because the victim has not disclosed her assault, she is likely not processing the assault and as result, is unable to define the experience (Botta & Pingree, 1997; Littleton & Henderson, 2009). It has been found 30% of unacknowledged rape victims will meet the criteria for PTSD (Littleton & Henderson, 2009). Yet, as result of her inability to disclose the assault, she is less likely to report PTSD symptomology. Therefore, the

acknowledged victim often receives more diagnosis and treatment, but this does not necessarily mean the prevalence of symptoms is any less in the unacknowledged victim. She has chosen not to disclose therefore symptoms go unreported. As a result of victims potentially not reporting their symptoms, it is imperative for college counselors to be aware of PTSD symptoms and their impact on the victim. Being able to recognize these symptoms will assist counselors in identifying the unacknowledged victims and are thus able to provide appropriate treatment for prevention of PTSD symptomology.

Effects of Rape-Related PTSD

The effects of Rape-Related PTSD are psychologically damaging and harmful to the victim and her surrounding community. Research suggests there are far-reaching, lasting consequences of Rape-Related PTSD. The effects impact the victim, her social support, and college community. Often the individual effects of rape-related PTSD manifest as a result of maladaptive coping mechanisms. A thorough, yet not inclusive, review of maladaptive coping mechanisms will be provided. The victim's support network is potentially victimized by the assault as well. Their reaction to the victim's disclosure can dually impact themself as well as cause further harm to the victim. A negative reaction from the victim's support system is called secondary victimization and will be further explored in this chapter (Ullman et al., 2007).

Individual Effects of Rape-Related PTSD

Effects of Rape-Related PTSD have the potential of being severe and debilitating. Examples of rape-related PTSD effects are development of comorbid disorders, general health issues and complaints, and suicide. Research has shown the development of PTSD may initiate additional diagnosis of Depression, Anxiety, Substance Use Disorder, Panic Disorder, and Social Phobia (APA, 2000; Breslau, 2009; Messman-Moore et al., 2009). Health related issues may present as severe somatic complaints, general sexual health concerns, or a lesser perception of health (DePrince et al., 2009; Eadie et al., 2008). More specific examples of health concerns are pelvic pain, excessive menstrual bleeding, STDs, urinary problems, pregnancy, and intimacy or sexual difficulties. As result of the

genuine concerns and a generally more poor perception of health is often associated with an increase in cost for university and community health services (Eadie et al., 2008).

Linehan (1999) found either negative life events or negative affective states pose as individual risk factors in prompting suicidal behavior. Sexual assault is a negative life event that may prompt suicidal behavior. Risk factors for suicidality in assault victims are similar to those of PTSD: experienced previous trauma, if the assault was completed rape, and if pathology such as depression is present (Ullman & Najdowski, 2009). Ullman and Brecklin (2002) found more severe depression symptoms lead to a stronger likelihood of lifetime suicidality. Also, if a victim presents with PTSD symptoms, she has an increased likelihood of having suicidal ideation. If a victim uses substances or self-blame as a coping mechanism, she is at a greater risk of serious suicidal ideation (Ullman & Brecklin, 2002; Ullman & Najdowski, 2009). Thus a counselor needs to be aware and alert of those victims who are struggling with Depression, PTSD, Substance Abuse Disorder, and/or place blame on themselves. Ullman and Najdowski (2009) found women who were younger, a minority, or bisexual were more likely to experience more severe suicidal ideation than women who are older, Caucasian, and heterosexual. Although this list is a great tool for college counselors to be aware of, it is not encompassing. The relationship between sexual assault, PTSD, and suicidal ideation needs to be further explored (Ullman & Najdowski, 2009).

Littleton and Henderson (2009) have found a significant relationship between victim identification and coping styles in prediction of PTSD symptomology. If the assault was more violent, the victim is likely to acknowledge her experience as rape; if in

response to the experience she utilizes maladaptive coping strategies, then she is at a higher risk of developing PTSD symptom severity (Littleton & Henderson, 2009). The victim profiles and coping strategies will be discussed in further detail as to how they mediate PTSD symptomology.

Coping

Coping is defined as the behaviors and thoughts used to respond to the traumatic stressor (Krause et al., 2008). Studies have shown it is not necessarily the level of trauma an individual may experience but how she responds to the trauma that predicts PTSD (Krause et al., 2008). Therefore, sexual assault victims who develop and maintain maladaptive coping strategies are more likely to experience PTSD symptom severity (Najdowski & Ullman, 2009). A review of maladaptive coping skills will be discussed in this section.

Maladaptive coping may present in multiple ways and is a strong causal factor in the development of PTSD symptomology (Krause et al., 2008; Littleton & Henderson, 2009). This style of coping is either identified as maladaptive or avoidance coping. Future references of negative styles of coping with sexual assault will be called maladaptive. Research has found, when the victim blames herself for the assault, she likely will be more poorly adjusted and as result develop maladaptive coping responses. This generally involves the assault's behavioral response as avoidant of the traumatic stressor (Najdowski & Ullman, 2009). Maladaptive coping responses typically present as self-criticism or self-blame, denial, problem and behavioral avoidance, social withdrawal, substance abuse disorder, and wishful thinking (Krause et al., 2008; Ullman & Filipas,

2001; Ullman et al., 2007; Valentiner et al., 1996). In other words, maladaptive coping often presents as PTSD Criterion C, persistent avoidance (APA, 2000).

Some maladaptive coping styles may occur as result of actively engaging in denial or disengagement in order to avoid persistent accusations of self-blame. Being in denial, or disengaging from symbolic stimuli, is an attempt to reduce distress without addressing the source of the distress, sexual assault. This problem behavior may lead to additional avoidance coping styles such as substance abuse and social withdrawal (Najdowski & Ullman, 2009).

Some studies have found the victim may develop substance abuse issues in order to self-medicate and avoid or relieve distressing symptoms (Breslau, 2009; Filipas & Ullman, 2006; Messman-Moore et al., 2009). Also, some women may partake in risky sexual behavior to cope with the assault (Filipas & Ullman, 2006; Messman-Moore et al., 2009). Both are considered maladaptive coping mechanisms and significant risk factors for revictimization (Filipas & Ullman, 2006; Messman-Moore et al., 2009). This leads into a negative cycle as both PTSD and revictimization are a risk factor and side effect for the other (Filipas & Ullman, 2006; Messman-Moore et al., 2009). Additional forms of maladaptive coping are choosing not to disclose the assault and unresolved attempts to attach personal meaning to the assault through rumination (Najdowski & Ullman, 2009; Ullman & Filipas, 2001).

Secondary Victimization

Secondary victimization has been found to be a predictor of PTSD symptomology as well as a negative side effect (Ullman et al., 2007). Secondary victimization is how the victim's social support networks respond to the victim's disclosure of sexual assault. Most often it is a negative response that involves stigmatizing, disbelieving, or blaming the victim for her assault. As a result of the negative social reaction and lack of support the woman experiences; further victimization ensues by internalizing the negative response. This form of maladaptive coping has been shown to be a significant predictor of PTSD symptomology (Banyard et al., 2009; Ullman et al., 2007).

Secondary victimization is often experienced by rape victims. Banyard et al. (2009) found 80% of the women who chose to disclose their assault did so to a friend or roommate, essentially a peer. Therefore it is necessary to understand the specifics of secondary victimization to create awareness for peers on how better to respond to a friend who is a victim. Negative social reactions may look like any variety of approaches, some may even seem helpful, but actually inflict additional psychological damage.

One approach that may seem helpful but is actually harmful is trying to or taking control of the victim's decisions for how she wishes to respond to the assault. The victim may be in a state of shock, experiencing strong emotions, or in denial, and a supportive party may wish to help the victim by taking charge of her response plan. By doing so, the victim's perception of control over the situation and her recovery is diminished (Banyard et al., 2009; Ullman & Filipas, 2001). Ultimately, part of the treatment plan should incorporate assisting the victim in regaining a sense of control. Research has shown

victims who reestablish a sense of control of their situation are more likely to cope with the assault at a much more effective rate (Ullman et al., 2007). The supportive party is recommended to listen and be present for the victim and allow her to take charge of her response plan. If she consults the supportive party for advice, that is fine, but always ensure she is the one making the final decision (Ullman, 2000; Ullman et al., 2007).

Blaming the victim for her sexual assault is also an example of a negative social reaction positively linked to symptomatic PTSD diagnosis. The social support responder may not realize their response is indicative of faulting the victim, but many responses may reinforce a victim's conclusion of self-blame. This may even appear in the form of questioning the victim about her experience. The victim may perceive questioning about her experience as evidence the responder disbelieves her recall of events (Ullman & Filipas, 2001).

Additional negative social reaction responses include treating the victim differently upon hearing her assault experience. Varying how you treat the victim, as a result of her experience further encourages sexual assault stigma and alienates her from social support. Often her perception of self-blame will increase as result of the change in treatment. Other reactions potentially leading to an increase in PTSD symptoms are distracting the victim from processing her experience or discouraging her from sharing. This does not indicate to the victim she has a supportive social network interested in hearing her version of the events (Banyard et al., 2009; Ullman & Filipas, 2001). This will potentially trigger PTSD Criterion C, avoidance of stimuli and social withdrawal

(APA, 2000). Finally, overly associating with the victim in egocentric responses is also discouraged (Ullman, 2000; Ullman et al., 2007).

If the victim is already displaying strong PTSD symptomology, she is more likely to elicit negative social reactions from others. Often this is as result of the stigmatization that surrounds sexual assault (Banyard et al., 2009; Ullman & Filipas, 2001). Sexual assault victims are therefore dealing with the consequences of secondary victimization not only for their disclosure but for simply being the victim as well. Ullman et al. (2006) found victims who did not know the perpetrator reported more negative social reactions from others than victims who knew or were acquainted with the perpetrator. In other words, an additional factor about the assault the victim cannot control often causes further blame or revictimization (Ullman et al., 2006).

The victim's social support is likely to be unsure of how to respond to victims of sexual assault. Therefore, when the victim is displaying PTSD symptoms during her maladaptive recovery, her support may be unsure how to respond, and thus choose not to. For the victim, this may give further incentive for socially withdrawing from her normal support groups and routines, Criterion C (APA, 2000; Ullman & Filipas, 2001). It is recommended, campus prevention plans incorporate preventative messaging that has zero tolerance for victim blaming (Krebs et al., 2009a). Examples of treatment and prevention plans incorporating such preventative messaging for a college campus will be discussed in the next section.

Treatment and Suggestions for Counselors

Treatment strategies and suggestions in response to traumatic stressors have been developed specifically for college or university campuses. Examples of treatment can either be a direct response treatment for the traumatized individual or a campus wide preventative outreach program. For example, Krause et al. (2008) supports utilizing formal support services such as a college counseling center to protect the victim from further psychological impairment. Based upon the high prevalence rates of traumatic stressors that occur on a college campus, it is necessary for faculty, staff and campus counselors to develop effective treatment plans (Bernat et al., 1998; Frazier et al., 2009; Smyth et al., 2008). This chapter will focus on treatment for the individual victim, suggestions for counselors in implementing select or universal population interventions, and limitations in research.

Victims will vary in how they interpret their sexual assault stressor. In order to develop an effective treatment response for college women who have experienced sexual assault, it is necessary to first understand their worldview or perspective of the encounter (Sue & Sue, 2003). Each experience is unique and each level of sexual assault has distinctive side effects, therefore the treatment and response should be exclusive to each victim (Krebs et al., 2009b). Examples of various treatment strategies, including examples of adaptive coping, will be discussed in this section.

Adaptive coping is a combination of approaches in managing the effects of the victim's sexual assault experience that generally facilitates greater recovery rates with substantially less risk of developing PTSD symptoms (Krause et al., 2008; Najdowski &

Ullman, 2009). The two more successful approaches of adaptive coping are encouraging the victim to disclose her experience to a trusted individual and if she has a perceived sense of control over her recovery (Krause et al., 2008).

Adaptive coping is essentially disclosing the sexual assault as well as maintaining a positive outlook on recovery. This can incorporate any of the following: seeking support from others, expressing the resulting emotion, disclosing the assault to an extent that allows the victim to externalize her experience, telling more people about the assault, facilitating acceptance coping responses, upholding a certain degree of optimism, focusing on life meaning as a buffer, and maintaining a positive, cognitive distance away from ruminating thoughts (Ullman & Najdowski, 2009). Research does not say these tasks are easy, but are possible with the inclusion of support networks in the victim's recovery (Swickert & Hittner, 2009). With assistance from the victim's support networks, she is able to focus on her recovery as an approach or problem to be solved.

Positive responses from the victim's support network are necessary in her recovery and should be an essential component of campus prevention and outreach campaigns. The following are examples of positive reactions a social support system may take in response to the victim's disclosure. First and foremost, the social support provider should offer validation and belief in the victim's assault experience. This indicates to the victim that her experience has been heard, thus allowing her to additionally externalize the experience from her psyche. Giving the victim an opportunity to process her story will likely prevent symptomatic development of PTSD symptoms (Ullman & Filipas, 2001). While listening to the victim's disclosure, offer

emotional and information support. Validate her story and offer support in the manner she needs. Assist her in finding control of her recovery and help her to focus on the strengths of her abilities thus enhancing her level of resiliency (Frazier et al., 2009). Once she is ready to seek help or treatment, offer aid or information about services she may seek to receive treatment. Information about campus treatment and/or mental health service providers should also be incorporated in campus prevention programs; thus allowing peer bystanders to have the tools to immediately help the victim in her time of need (Ullman, 2000; Ullman et al., 2007).

Finally, create a network of other assault victims by offering group therapy. By connecting with other survivors, it creates a bond of shared experience; as well as gives a victim an opportunity to assist a peer in need. This may provide meaning and purpose for the victim, further enhancing her perception of control over her recovery, thus reducing the likelihood or severity of PTSD symptoms (Halligan, 2008).

Suggestions for Counselors

As result of the high number of incidences and prevalence of sexual assault taking place on college campuses, it is necessary to formulate specific strategies and suggestions for college counselors. This section will review suggested prevention messaging and programs for a college campus.

In creation of campus wide prevention outreach programs, studies have suggested creating prevention messages, or social marketing strategies, addressing the campus view on sexual assault , methods of prevention, and how to support a victim of sexual assault (Banyard et al., 2009; Baugher, Elhai, Monroe, & Gray, 2010; Krebs et al., 2009b). In

social marketing messaging, a campus can reiterate the prevalence of and promote their stance on sexual assault, particularly in relation to substance abuse or incapacitated sexual assault (Krebs et al., 2009a). Despite many sexual assaults involving voluntary substance use by the victim, the assault is never her fault (Krebs et al., 2009a). Researchers are currently studying the possibility of a victim who voluntary uses substances, and is intoxicated, then she is considered an incapacitated person who cannot legally or otherwise consent to sexual contact (Krebs et al., 2009a). To supplement the messages, there are several programs recommended for use on the college campus.

Prevention and treatment programs/plans are necessary to maintain a safe environment for college women. Ullman et al. (2007) found women who did not feel another attack was imminent are less likely to develop PTSD symptoms. Therefore, it is important to establish a sense of safety and security immediately following the attack. Krebs et al. (2009a) suggest creating psychoeducational programs for both sexes to increase the safety and prevention of college women from experiencing sexual assault. Suggested program curriculums include how to intervene with a peer who is intoxicated and at risk, as well as instruction on self-defense techniques (Baugher et al., 2010; Krebs et al., 2009a). Additional strategies to implement postassault are: arrange friends to keep her company at night, call campus guard if on campus late, or suggest any other protective factors a campus has to offer. In accordance with the above recommendations, help the victim to formulate a plan as to how she will recover. This will restore her sense of control, identity, and integrity (Halligan, 2008; Najdowski & Ullman, 2009).

Sexual assault prevention programs have been recommended to incorporate student participation. Baugher et al. (2010) suggest conducting victim role-plays amongst student groups. This gives student participants the opportunity to empathize with the victims. The goal is to allow a student to internalize the experience through active participation and ultimately empathize with the victim. As a result, hopefully a decline of sexual victimization will occur (Baugher et al., 2010). In addition, create a coalition of campus-wide bystanders and allies of both women and men. The purpose of the coalition is to assist in the prevention of sexual assault and to offer support to the assault victim (Banyard et al., 2009; Krebs et al., 2009a). Finally, implementing a cognitive behavioral intervention that assists in changing how women and sexual assault victims are viewed and perceived on a college campus (Baugher et al., 2010). As research on sexual assault victims with PTSD symptomology continues to grow, information on suggestions and treatment plans will develop as well.

Limitations in Research

It is thought only 20% of rape victims actually report their assault. Therefore, 80% of sexual assault cases go undocumented and unreported. This is a staggering number and should be of noted importance to not just the college community, but the community at large as well. One study described this statistic in a different way, if 100 cases of sexual assault are reported (to the police), another 400 women, children, or men did not report the crime (Banyard et al., 2009)

If only a limited number of assault victims are choosing to disclose, this creates a drastic limitation in research as well. Studies currently available are based upon

information from women who have chosen to self-disclose. In the future, it is imperative individuals from the helping field, as well as those conducting studies on sexual assault, find methods or treatment solutions to assist those victims who are unwilling to disclose by coming forward and sharing their assault. Ullman et al. (2007) created a study on surveys sent across the community. This may be a useful strategy in identifying the women choosing not to disclose. In the study, Ullman et al. (2007) found over 1/3 of the women who reported having been sexually assault waited over a year to disclose their experience. The study did not further investigate why this length of time exists and/or what may have caused the victim to disclose.

Research predicts the women who choose not to disclose will likely not cope as successfully as those victims who choose to self-disclose. If the victim has chosen not to disclose, the opportunity to externalize the event has likely not occurred. Therefore, the possibility of PTSD Criterion B, C, and D are possible; all of which are examples of maladaptive coping (APA, 2000; Halligan, 2008). This may lead to academic drop-out, revictimization, substance abuse, and potentially suicide as worst-case scenarios (DePrince et al., 2009). If the undiagnosed women are silently suffering, the college campus and her support network is unable to assist or understand the resulting impact and change in the victim. In order to more appropriately assist this unique demographic of women, it is imperative to understand why disclosure does not occur and what, if any, intervention plans can change this phenomenon.

In addition to victims choosing not to disclose, some victims may present with a few of the PTSD Criterions, but not all, and are therefore described as subclinical. The

symptoms caused by the traumatic event (Criterion B through D) must meet a specific level of severity within three distinct clusters: intrusion, avoidance, and hyperarousal (Lancaster et al., 2009). Therefore, a person might have encountered a traumatic event, but not be diagnosed with PTSD, if they do not meet the minimum criteria on all three symptom clusters (Lancaster et al., 2009).

If a person does not meet the symptom cluster criteria, then diagnosis of PTSD is not possible (APA, 2000; Lancaster et al., 2009). If the individual met some, but not all of the required criterion symptoms, the victim is thus identified as subclinical PTSD. Studies have shown subclinical PTSD individuals often report more distress than those who met the required criterion levels of PTSD (Frazier et al., 2009). The distress caused by subclinical diagnosis of PTSD can negatively impact a college student's overall functioning.

It is necessary for college counselors, and university faculty and staff, to not only be able to identify PTSD symptoms in the "undiagnosed" distressed student, but to be aware of other diagnostic type symptoms in order to prevent further harm, stress or danger to the student (Krysinska & Lester, 2010). If a counselor is familiar and able to recognize PTSD symptomology in an "undiagnosed" student, they are able to implement a more tailored treatment approach in order to halt further distress in the form of conditions such as depression, anxiety or substance abuse (Eadie et al., 2008; Schäfer & Najavits, 2007).

Implications and Conclusion

With one in four women experiencing sexual assault and 46% of those women consequently experiencing assault-related PTSD (Botta & Pingree, 1997; Eadie et al., 2008; Kessler et al., 1995; Ullman et al., 2007); PTSD is a common effect of prevalent sexual assault victimization. Completed rape, with an unknown perpetrator, who caused negative emotional reactions in the victim is the assault profile most likely to lead to PTSD symptomology. Postassault, the more a victim tends to blame herself for the victimization, the more severe PTSD symptoms she is likely to experience. Additional risk factors of PTSD include secondary victimization and maladaptive coping.

Sexual assault, as do most traumatic stressors, does not singularly impact the victim. The assault is likely to impact her entire community, specifically her college campus, in a multitude of ways. The specific effects of sexual assault on a college campus are academic failure or dropout, substance abuse, revictimization, sexual health symptoms, social isolation, and suicide. This impact can impair the campus's general sense of wellness, productivity, and safety, increase medical expenses, trigger various pathological responses such as depression or anxiety, and hinder significant relationships in the victim's life (DePrince et al., 2009; Ullman & Filipas, 2001; Ullman & Najdowski, 2009). It is essential for college counselors to be aware of this significant impact and possibly incorporate this information in social marketing messaging campaigns.

Knowing the high prevalence of sexual assault on a college campus and the alarming numbers of victims who develop PTSD as a result; this is a significantly salient issue for college counselors and other university officials to be aware of. It is necessary

to be well versed in the various definitions of sexual assault to create a campus wide understanding that regardless of the circumstances, the victim is never at fault (Krebs et al., 2009a). By understanding how sexual assault may lead to PTSD symptom severity will assist college counselors in their response preparedness to hopefully prevent the severe side effects of PTSD: substance abuse, academic drop-out, and suicide (Eadie et al., 2008; Messman-Moore et al., 2009).

References

Abbey, A., BeShears, R., Clinton-Sherod, A.M., & McAuslan, P. (2004). Similarities and differences in women's sexual assault experiences based on tactics used by the perpetrator. *Psychology of Women Quarterly, 28,* 323-332.

Adkins, J., Weathers, F., McDevitt-Murphy, M., & Daniels, J. (2008). Psychometric properties of seven self-report measures of posttraumatic stress disorder in college students with mixed civilian trauma exposure. *Journal of Anxiety Disorders, 22*(8), 1393-1402.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

Banyard, V., Moynihan, M., Walsh, W., Cohn, E., & Ward, S. (2010). Friends of survivors: The community impact of unwanted sexual experiences. *Journal of Interpersonal Violence, 25*(2), 242-256.

Baugher, S. N., Elhai, J. D., Monroe, J. R., & Gray, M. J. (2010). Rape Myth Acceptance, Sexual Trauma History, and Posttraumatic Stress Disorder. Journal of Interpersonal Violence, 25(11), 2036-2053.

Bernat, J., Ronfeldt, H., Calhoun, K., & Arias, I. (1998). Prevalence of traumatic events and peritraumatic predictors of posttraumatic stress symptoms in a nonclinical sample of college students. *Journal of Traumatic Stress, 11(4),* 645.

Boals, A., & Hathaway, L. (2010). The importance of the DSM-IV E and F criteria in self-report assessments of PTSD. *Journal of Anxiety Disorders, 24*(1), 161-166.

Bondurant, B. (2001). University women's acknowledgment of rape. *Violence Against Women,7*(3), 294-314.

Botta, R. A., & Pingree, S. (1997). Interpersonal communication and rape: Women acknowledge their assaults. *Journal of Health Communication, 2*(3), 197-212.

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,* 252-259.

Breslau, N. (2009). The epidemiology of trauma, PTSD, and other posttrauma disorders. *Trauma, Violence, & Abuse, 10*(3), 198-210.

Breslau, N., & Kessler, R. (2001). The stressor criterion in DSM-IV posttraumatic stress disorder: An empirical investigation. *Biological Psychiatry, 50*(9), 699-704.

Breslau, N., Kessler, R.C., Chilcoat, H.D., Schultz, L.R., Davis, G.D., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: The 1996 Detroit area survey of trauma. *Archives of General Psychiatry, 55,* 626-632.

Brewin, C., Andrews, B., & Rose, S. (2000). Fear, helplessness, and horror in Posttraumatic stress disorder: Investigating DSM-IV criterion A2 in victims of violent crime. *Journal of Traumatic Stress, 13*(3), 499-509.

Briere, J., Scott, C., & Weathers, F. (2005). Peritraumatic and persistent dissociation in the presumed etiology of PTSD. *The American Journal of Psychiatry, 162*(12), 2295-2301.

Chapman, J.D. (1989). A longitudinal study of sexuality and gynecologic health in abused women. *Journal of the American Osteopathic Association, 89,* 619-624.

Cukrowicz, K. C., Smith, P. N., Hohmeister, H.C., & Joiner, T.E. (2009). "The moderation of an early intervention program for anxiety and depression by specific psychological symptoms." *Journal of Clinical Psychology 65*(4), 337-351.

DePrince, A. P., Combs, M. D., & Shanahan, M. (2009). Automatic relationship-harm associations and interpersonal trauma involving close others. *Psychology of Women Quarterly, 33*(2), 163-171.

Dowdall, G.W. (2007). The role of alcohol abuse in college student victimization. *Campus Crime, 2*, 167–187

Eadie, E., Runtz, M., & Spencer-Rodgers, J. (2008). Posttraumatic stress symptoms as a mediator between sexual assault and adverse health outcomes in undergraduate women. *Journal of Traumatic Stress, 21*(6), 540-547.

Ehlers, A., Hackmann, A., & Michael, T. (2004). Intrusive re-experiencing in post traumatic stress disorder: Phenomenology, theory, and therapy. *Memory*, *12*(4), 403-415.

Ehring, T., Frank, S., & Ehlers, A. (2008). The role of rumination and reduced concreteness in the maintenance of posttraumatic stress disorder and depression following trauma. *Cognitive Therapy and Research, 32*(4), 488-506.

Filipas, H.H. & Ullman, S.E. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence, 21,* 652-672.

Fisher, B.S., Daigle, L.E., Cullen, F.T., & Turner, M.G. (2003). Acknowledging sexual victimization as rape: Results from a national-level study. *Justice Quarterly, 20,* 535-574.

Frazier, P., Anders, S., Perera, S., Tennen, H., Tashiro, T., Park, C., et al. (2009). Traumatic events among undergraduate students: Prevalence and associated symptoms. *Journal of Counseling Psychology, 56*(3), 450-460.

Halligan, F. (2008). Youth and trauma: Terror, war, murder, incest, rape, and suicide. *Journal of Religion & Health, 48*(3), 342-352.

Kahn, A. (2004). 2003 Carolyn Sherif Award Address: What college women do and do not Experience as rape. *Psychology of Women Quarterly, 28*(1), 9-15.

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.

Kessler, R. C., Sonnega, A., Bromet, E., & Hughes, M. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, *52*, 1048–1060.

Kessler, R.C., Zhao, S., Katz, S.J., Kouzis, A.C., Frank, R.G., Edlund, M. et al. (1999). Past-year use of outpatient services for psychiatric problems in the National Comorbidity Survey. *American Journal of Psychiatry*, *156,* 115-123.

Krause, E., Kaltman, S., Goodman, L., & Dutton, M. (2008). *Avoidant coping and PTSD symptoms related to domestic violence exposure: A longitudinal study. Journal of Traumatic Stress, 21*(1), 83-90.

Krebs, C. P., Lindquist, C. H., Warner, T. D., Fisher, B. S., & Martin, S. L. (2009a). College women's experiences with physically forced, alcohol- or other drug enabled, and drug-facilitated sexual assault before and since entering college. *Journal of American College Health, 57*(6), 639-647.

Krebs, C. P., Lindquist, C. H., Warner, T. D., Fisher, B. S., & Martin, S. L. (2009b). The differential risk factors of physically forced and alcohol- or other drug-enabled sexual assault among university women. *Violence and Victims, 24*(3), 302-321.

Krupnick, J.L., Green, B.L., Stockton, P., Goodman, L., Corcoran, C., & Petty, R. (2004). Mental health effects of adolescent trauma exposure in a female college sample: Exploring differential outcomes based on experiences of unique trauma types and dimensions. *Psychiatry: Interpersonal & Biological Processes, 67,* 264-279.

Krysinska, K., & Lester, D. (2010). Post-traumatic stress disorder and suicide risk: A systematic review. *Archives of Suicide Research, 14*(1), 1-23.

Lancaster, S., Melka, S., & Rodriguez, B. (2009). A factor analytic comparison of five models of PTSD symptoms. *Journal of Anxiety Disorders, 23*(2), 269-274.

Linehan, M. (1999). Standard protocol for assessing and treating suicidal behaviors for patients in treatment. *The Harvard Medical School Guide to Suicide Assessment and Intervention,* 146–187.

Littleton, H., & Henderson, C. (2009). If she is not a victim, does that mean she was not traumatized?: Evaluation of predictors of PTSD symptomatology among college rape victims. *Violence Against Women, 15*(2), 148-167.

McNally, R. J. (2003). Progress and controversy in the study of posttraumatic stress disorder. *Annual Review of Psychology*, *54*, 229–252.

Messman-Moore, T., Ward, R., & Brown, A. (2009). Substance use and PTSD symptoms impact the likelihood of rape and revictimization in college women. *Journal of Interpersonal Violence, 24*(3), 499-521.

Mohler-Kuo M, Dowdall GW, Koss MP, & Wechsler H. (2004). Correlates of rape while intoxicated in a national sample of college women. *Journal of Studies on Alcohol and Drugs, 65*, 37–45.

Najdowski, C., & Ullman, S. (2009). PTSD symptoms and self-rated recovery among adult sexual assault survivors: The effects of traumatic life events and psychosocial variables. *Psychology of Women Quarterly*, *33*(1), 43-53.

Olff, M., Sijbrandij, M., Opmeer, B., Carlier, I., & Gersons, B. (2009). The structure of acute posttraumatic stress symptoms: 'Reexperiencing', 'active avoidance', 'dysphoria', and 'hyperarousal.'. *Journal of Anxiety Disorders*, *23*(5), 656-659.

Rothbaum, B.O., Foa, E.B., Riggs, D.S. Murdock, T., & Walsh, W. (1992). A prospective of post-traumatic stress disorder in rape victims. *Journal of Traumatic Stress, 5*, 455-475.

Rubin, D. C., Bernsten, D., & Bohni, M. K. (2008). A memory-based model of posttraumatic stress disorder: evaluating basic assumptions underlying the PTSD diagnosis. *Psychological Review*, *115*, 985–1011.

Schäfer, I., & Najavits, L. (2007). Clinical challenges in the treatment of patients with posttraumatic stress disorder and substance abuse. *Current Opinion in Psychiatry*, *20*(6), 614-618.

Sharkin, B.S. (2006). *College students in distress: A resource guide for faculty, staff, and campus community*. New York, NY: Haworth Press.

Smyth, J., Hockemeyer, J., Heron, K., Wonderlich, S., & Pennebaker, J. (2008). Prevalence, type, disclosure, and severity of adverse life events in college students. *Journal of American College Health, 57*(1), 69-76.

Swickert, R., & Hittner, J. (2009). Social support coping mediates the relationship between gender and posttraumatic growth. *Journal of Health Psychology*, *14*(3), 387-393.

Sue, D. W. & Sue, S. (2003). Dimensions of worldviews. In *Counseling the culturally diverse, theory and practice* (4th ed., pp. 265-289). New York: John Wiley & Sons.

Ullman, S. E. (2000). Psychometric characteristics of the Social Reactions Questionnaire: A measure of reactions to sexual assault victims. *Psychology of Women Quarterly*, *24*(3), 257-271.

Ullman, S.E. & Brecklin, L.R. (2002). Sexual assault history and suicidal behavior in a national sample of women. *Suicide and Life-Threatening Behavior, 32*, 117-130.

Ullman, S., & Filipas, H. (2001). Predictors of PTSD symptom severity and social reactions in sexual assault victims. *Journal of Traumatic Stress, 14*(2), 369-389.

Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (2006). The Role of victim-offender relationship in women's sexual assault experiences. *Journal of Interpersonal Violence, 21*(6), 798-819.

Ullman, S. E., Filipas, H. H., Townsend, S. M., & Starzynski, L. L. (2007). Psychosocial correlates of PTSD symptom severity in sexual assault survivors. *Journal of Traumatic Stress, 20*(5), 821-831.

Ullman, S. E., & Najdowski, C. J. (2009). Correlates of serious suicidal ideation and attempts in female adult sexual assault survivors. *Suicide and Life-Threatening Behavior, 39*(1), 47-57.

Valentiner, D.P., Foa, E.B., Riggs, D.S., & Gershuny, B.S. (1996). Coping strategies and posttraumatic stress disorder in female victims of sexual and nonsexual assault. *Journal of Abnormal Psychology, 105,* 455-458.