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Predictors of Decision-Making and Well-Being among Victims of Sexual Assault

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Predictors of Decision-Making and Well-Being among Victims of Sexual Assault

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Sociology

by

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Abstract

After sexual assaults, victims face many decisions regarding disclosure and reporting. Most research identifying risk factors for poor health among sexual assault victims, including assault typology, prior victimization, and substance use, does little to contextualize decision-making and reflective framing among sexual assault victims. Yet the real or perceived reactions of friends, family, and law enforcement can have a lot to do with how victims come to view their decisions in hindsight. The concordance between their decisions immediately following the assault and the decisions they wish they had made in retrospect can have substantial implications for mental health and well-being. Using a national sample of women (n=962), the current study examines the situational influences on victim reporting and sexual assault disclosure. I then explore how these factors affect the concordance between victims' post-assault actions and retrospective approval of those decisions, and assess the potential link between victim retrospective approval and mental health. Finally, I discuss the results and the implications of these findings for broader conversations about victims' services, post-traumatic growth and closure.

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Introduction:

Studies have shown that between 13% and 18% of women report having experienced an attempted or completed rape (Kilpatrick, Edmunds, and Seymour, 1992; Tjaden and Thoennes, 2006; Kilpatrick et al., 2007; Black et al., 2011). Moreover, as these studies only focus on rape and do not include other forms of sexual victimization, the number of women sexually assaulted in their lifetime may be even greater. Research has also identified numerous consequences of sexual victimization including, but not limited to, depression and posttraumatic stress disorder (Atkeson et al., 1982; Kilpatrick et al., 1992; Rothbaum et al., 1992; Kilpatrick et al., 2007). There is also increasing evidence that various assault and post-assault characteristics influence the likelihood and severity of depression and PTSD (Ullman et al., 2006; Ullman et al., 2007a; Zinzow et al., 2010a; Zinzow et al., 2010b; Walsh and Bruce, 2011). One post-assault characteristic that is heavily focused on in the literature is the victim's decision to disclose and/or report. Researchers have found that a victim's decision to talk about their assault can have a serious effect on their mental health. For example, Jacques-Tiura et al. (2010) found that victims who report their assault are more likely to experience PTSD, compared to those victims who did not report. Unfortunately, studies of other post-assault outcomes and their influence on victims' mental health are lacking.

In particular, we know little about how victims' feel about their post-assault decisions, and whether assessments regarding their decisions to disclose or not affect their mental health. Based on my review, only one published study has tested the relationship between regretting one's decision to disclose/report and mental health. Jacques-Tiura et al. (2010) found that victims who regret their post-assault disclosure/reporting are more likely to experience PTSD than those victims who did not regret their decision. While Jacques-Tiura et al.'s (2010) study

associated regretting disclosure/reporting with PTSD, there are no known studies to corroborate these findings. Additionally, research has yet to identify how regretting decisions to not report/disclose can influence PTSD and other measures of victim mental health and well-being, including depression.

Research has yet to identify which characteristics and situations correlate with a victim's likelihood of regretting, and many questions remain unanswered. Does knowing the assailant or being injured increase victims' likelihood of regretting their decision? Do victims who report their assault face increased likelihood of regretting their decision compared to those that do not report? Does regretting non-reporting place victims at substantially higher risk for negative mental health consequences than regretting reporting?

This paper attempts to answer these questions and fill the gap in this area of research. Using a sample of 962 female sexual assault victims, I assess the correlates of reporting and regret. I then use logistic regression to test the potential relationship between regretting reporting, PTSD, and depression, as well as the potential relationship between regretting non-reporting, PTSD, and depression. Finally, I test the difference between regretting reporting and non-reporting with regard to the impact on PTSD and depression.

Understanding the factors that increase a victim's likelihood of regret and, subsequently, understanding how regret can influence a victim's mental health is crucial to victimization research. The period after victimization can be a confusing and discombobulating time, when victims are forced to make difficult and consequential decisions. They may be particularly vulnerable to the assessments and recommendations of others. While those who were sexually assaulted perhaps face the toughest challenges, all victims face some choice, and thus are at risk

for negative appraisal of their own decision-making. It is critical that law enforcement officers, medical personnel, other practitioners, and supporters understand the causes and consequences of victims' decisions and better assist victims so that they can make the best choices for their long-term well-being.

Literature Review:

There is a great deal of literature on sexual victimization, covering numerous subtopics and research questions, making a comprehensive review of all the research beyond the scope of the current project. Rather, I will focus on the literature related to my research questions. Specifically, to effectively provide context to this study, I focus on three topics within the sexual victimization research: (1) prevalence and typologies of adult sexual assault, (2) the relationship between adult sexual assault, PTSD and depression, and (3) the impact of disclosure and/or reporting on PTSD and depression. Reviewing the research on these topics, I highlight how my project contributes to the existing knowledge on sexual assault victim decision-making and well-being.

Prevalence of Sexual Victimization:

Throughout the paper, I use the term "sexual assault" to refer to any type of sexual victimization (unless otherwise specified). Although this approach may over-generalize and not acknowledge the many unique characteristics among various types of victimization, using one overall term produces a degree of cohesiveness and consistency within the paper. Studies have long documented the pervasiveness of sexual victimization in the U.S. An early study of college women found that over half of the respondents (53.7%) indicated that they had been victim of some form of sexual assault (Koss, Gidycz, Wisniewski, 1987). Among them, 27.5% of the

women indicated they had been victims of attempted or completed rape (Koss et al., 1987). Later, the National Women's Study, a longitudinal project conducted between 1990 and 1992, revealed that 13% of the respondents had been the victim of at least one completed rape; using Census information, this translates into 1 in 8 women (Kilpatrick et al., 1992). Similarly, the National Violence Against Women Survey (NVAWS), conducted in 1995-1996, revealed that nearly 18 percent (17.6%) of the surveyed women were the victims of attempted or completed rape; these results indicate that 1 out of 6 women in the United States has been raped at some point during her lifetime (Tjaden and Thoennes, 2006).

More recent data continues to find that sexual victimization is a common occurrence. A two-sample survey of women, conducted in 2006, found that the lifetime prevalence of rape in the general population was 18% while the prevalence for college women was 11.5% (Kilpatrick et al., 2007). Using these results and the 2005 Census data, Kilpatrick et al. (2007) estimate that 20 million women in the United States have been raped at some point in their lives.

Victim Typology:

Research on sexual victimization finds that most adult sexual victimizations share some common characteristics. First, most sexual victimization involves female victims and male perpetrators. Tjaden and Thoennes (2006) found that 85.8% of the assault victims identified in the NVAWS were female. Furthermore, 99.6% of the victimized women and 85.2% of the victimized men were assaulted by a male perpetrator (Tjaden and Thoennes, 2006). Analyses from the NCVS produced similar results (Sinozich and Langton, 2014).

In addition, most female victims of sexual assault are between the ages of 18 and 24. Findings from at least four national studies support this conclusion. Dividing the adult lifespan

into three timeframes (18-24, 25-29 and 29+), the National Women's Study found that more assaults occurred during the youngest age category than the other two categories combined (Kilpatrick et al., 1992). Analyses of the NCVS indicated that 16-19 year olds have the highest prevalence rates; however, most adult sexual victimizations occurred between the ages of 20-24 (Rennison, 1999). Data from the NVAWS indicated that 29.4% of the rapes occurred when the victims were between the ages of 18 and 24, compared to 16.6% occurring when the victims were 25 years or older (Tjaden and Thoennes, 2006). A longitudinal review of the NCVS from 1995 to 2013 provided similar findings (Sinozich and Langton, 2014).

Furthermore, victims typically know or are acquainted with their assailant; studies find that women are less likely to be victimized by strangers. For example, analysis of the National Women's Study found that only 22% of victimizations were completed by a stranger or someone that the victim did not know well (Kilpatrick et al., 1992). Similarly, Ullman et al. (2006) found that only 20% of victimizations were completed by strangers while nearly half (45%) were completed by acquaintances. Almost a quarter of assaults (22.4%) were completed by intimate partners or husbands, and 12% were completed by relatives. Tjaden and Thoennes (2006) reveal similar findings.

While the age and gender combination suggest that higher rates of sexual victimization among college women is simply a product of population concentration, scholars argue that the unique characteristics of the college environment place young women at an even higher risk. That is, many believe that college women are "at greater risk for rape and other forms of sexual assault than women in the general population or in a comparable age group" (Fisher, Cullen and Turner, 2000, p.1). However, research on victimization rates among college students has been inconsistent in this regard. In the Campus Sexual Assault (CSA) study, the authors identified

college victims, between the ages of 18 and 25, and compared the number of attempted or completed sexual assaults before the victims entered college as well as the number of assaults since entering college. These researchers found that more women were victimized since entering college (19%) than were victimized before (15.9%) (Krebs et al., 2007).

However, some studies suggest otherwise. For example, Sinozich and Langton's (2014) analysis of NCVS data indicates that from 1995 to 2013, nonstudents were 1.2 times more likely to be victimized than college students in the same age category. Similarly, when Kilpatrick et al. (2007) compared the prevalence rates of sexual victimization between the general population and college women, they found that the general population had a higher victimization rate (18%) than did women in college (11.5%).

Assault Typology:

Researchers tend to classify sexual victimization by mode of assault. Specifically, they rely on three assault tactic typologies: forcible, incapacitated, drug and alcohol facilitated. While incapacitated or drug and alcohol facilitated assaults can also be classified as forcible, it is important to note that the researcher defines these categories as mutually exclusive (Kilpatrick et al., 2007, p.10). Whilst the definitions may vary faintly by researcher, Kilpatrick et al. (2007) clearly defines and identifies the differences between the three assault tactics. Forcible assault is defined as any "unwanted sexual act" in which the victim "experiences force, threat of force, or sustains an injury during the assault" (Kilpatrick et al., 2007, p.10). Forcible assaults do not involve substance use by the victim. Incapacitated assault is any "unwanted sexual act... that occurs after the victim voluntarily uses drugs or alcohol. The victim is passed out or awake but too drunk or high to know what she is doing or to control her behavior" (p.10). Drug and alcohol

facilitated assault refers to the instances in which the “perpetrator deliberately gives the victim drugs without her permission or tries to get her drunk, then commits an unwanted sexual act against her” (p.10). Similar to incapacitated assault, the victim is too intoxicated to know what is happening or to control her or her perpetrator’s behavior. There is reason to believe that the prevalence of specific typologies varies between college assaults and assaults in the general population.

Comparing the prevalence rates of each assault tactic to victim type (college or non-college female), Kilpatrick et al. (2007) found that women in the general population are more likely to experience forcible assault, while college women are more likely to experience incapacitated or drug and alcohol facilitated assault. Specifically, incapacitated/ drug and alcohol facilitated assault was nine times more common among victims in college compared to victims in the general population (Kilpatrick et al., 2007, p.23).

There is also reason to believe that assault tactics are linked to the type of victim-offender relationship. Kilpatrick et al. (2007) found that incapacitated and drug and alcohol facilitated assaults are more likely to be committed by strangers, classmates and peers while forcible assaults are more likely to be completed by relatives, intimate partners and husbands.

Consequences of Sexual Victimization:

Research has identified the many mental health consequences related to sexual assault victimization. In particular, researchers have found that sexual victimization is related to depression and posttraumatic stress disorder (PTSD). For example, Atkeson et al. (1982) conducted a longitudinal study of the relationship between sexual victimization and depression. Using the Beck Depression Inventory (BDI), they found that victims had more depressive

symptoms than non-victims at 2 weeks, 1 month and 2 months post-assault (Atkeson et al., 1982). Initial assessments also revealed that “75% of the victims reported mild to severe levels of depressive symptoms” with assessments 1 year post-assault indicating that “26% were still reporting mild to severe levels compared to 17% of the controls” (Atkeson et al., 1982, p. 99). When the researchers used the Hamilton Psychiatric Rating Scale for Depression (HPRS), they found similar results. Specifically, victims indicated more depressive symptoms at 2 weeks, 1 month, 2 months and 4 months post-assault. Furthermore, 57% of victims revealed mild to severe levels of depression early on while only 14% revealed the same levels 1 year after the assault (Atkeson et al., 1982).

The National Women’s Study also found that victims were more likely to experience depression than non-victims (Kilpatrick et al., 1992). Specifically, 30% of victims have experienced one major depressive episode compared to 10% of non-victims. Furthermore, 21% of victims were experiencing a depressive episode during the time of the study compared to 6% of non-victims (Kilpatrick et al., 1992). Finally, Kilpatrick et al. (2007) found that depression was common among both student (about 40% lifetime, about 33% current) and nonstudent victims (about 33% lifetime, about 25% current). Research has also identified the prevalence rates of PTSD among sexual assault victims.

In a study of recently assaulted women, Rothbaum et al. (1992) found that nearly all of the victims (94%) met the criteria for PTSD about 2 weeks after the incident. Three months after the incident, nearly half of the victims (47%) still met the criteria (Rothbaum et al., 1992). Similarly, the National Women’s Study found that 31% of the victims experienced PTSD at some point after the assault (Kilpatrick et al., 1992). This study also indicated that victims were

“6.2 times more likely to develop PTSD than women who had never been victims of crime (31% vs. 5%)” (Kilpatrick et al., 1992, p.7).

Recent research continues to illustrate the prevalence of PTSD among sexual assault victims. Kilpatrick et al. (2007) evaluated the lifetime and current prevalence of PTSD among the general population and college women. They found that about 40% of the general population and about 50% of the college population experienced PTSD at some point in their lives. Furthermore, 25% of the general population and 33% of the college population met the criteria for PTSD at the time of the study (Kilpatrick et al., 2007). However, the researchers state that the increased PTSD prevalence for college students could be attributed to a potential “recency effect whereby younger (college) women have fewer years elapsed between the rape and interview, on average” (Kilpatrick et al., 2007, p. 50).

Finally, Kessler et al. (1995) found that sexual victimization was more likely to be associated with PTSD than other types of trauma, including combat (p.1053). Similarly, Frazier et al. (1997) stated that sexual victimization seems more likely than other types of trauma to result in PTSD (Ullman and Filipas, 2001b, p.370). In addition to overall higher rates of mental health problems for victims, studies have also examined how the mental health consequences of sexual assault may vary across demographic factors.

Predictors of Negative Consequences:

Researchers have found that characteristics of the assault are associated with the likelihood of experiencing depression and PTSD. Zinzow et al. (2010b) found that all three types of assault (forcible, incapacitated and drug and alcohol facilitated) were correlated with depression, with drug and alcohol facilitated assaults having the greatest increase in likelihood of

depression. Furthermore, Zinzow et al. (2010b) found that knowing the assailant slightly decreased the likelihood of depression. Finally, the researchers found that injury was a predictor of depression. Zinzow et al. (2010a) also found this relationship. Ellis, Atkeson and Calhoun (1981) found that unknown perpetrators increased the likelihood of depression. However, DeMaris and Kaukinen (2005) found that knowing the perpetrator increased the likelihood of depression. They also find that assault severity increases depression. Finally, Boudreaux et al. (1998) found that life threat was associated with depression.

Other assault characteristics have also been linked to PTSD. Zinzow et al. (2010b) found that all three types of victimization increased the likelihood of PTSD with forcible assault having the greatest increase in likelihood. However, Zinzow et al. (2010a) found that only forcible and drug and alcohol facilitated assaults were associated with an increased likelihood of PTSD. Zinzow et al. (2010b) also found that knowing the assailant slightly decreased the likelihood of PTSD. Ullman et al. (2006) found that being related to the assailant was most likely to be associated with PTSD and not knowing the assailant being the second most likely, with acquaintance and romantic partner assailants being the least likely. They also found that assault characteristics mattered depending on the victim-offender relationship. Specifically, “more severe sexual assaults were related to greater PTSD symptoms for women assaulted by acquaintances and romantic partners or husbands. Perceived life threat was related to more PTSD symptoms for women assaulted by acquaintances and relatives” (Ullman et al., 2006, p. 811). Boudreaux et al. (1998) found that life threat and injury increased the likelihood of PTSD, as did Ullman and Filipas (2001b). Similarly, Ullman et al. (2007a) found that life threat was associated with increased PTSD severity. However, they found that the victim-offender relationship, assault severity and offender violence were not predictive of PTSD symptomology.

While characteristics of the assault are predictive of mental health outcomes, characteristics of victims may or may not be influential. Studies of depression across race and other characteristics have yielded mixed results. Boudreaux et al. (1998) found that race was a predictor of depression. Specifically, non-White victims had a higher likelihood of depression than White victims. However, Kaukinen and DeMaris (2005) found that controlling for victimization eliminated this association. The researchers did note, however, that age at time of assault influenced the likelihood of depression differently depending on race; adult sexual assault increased depression among African American women while child sexual assault increased depression amongst Latina women (Kaukinen and DeMaris, 2005). Child sexual assault, adolescent sexual assault and adult sexual assault all increased depression among White women. (Kaukinen and DeMaris, 2005). Finally, Zinzow et al. (2010a) found that for victims, age, income and marital status were all predictive of major depressive episodes.

Studies of PTSD have also yielded mixed results in this regard. Ullman and Filipas (2001b) found that higher education levels were associated with decreases in PTSD symptoms. However, Ullman et al. (2007a) found that race, education and marital status were not associated with PTSD severity; although they did find that older age corresponded with a decrease in PTSD severity. Ullman et al. (2006) also found that race and education were unrelated. However, they found that age mattered depending on the victim-offender relationship. Specifically, “older women had fewer PTSD symptoms when assaulted by relatives” (Ullman et al., 2006, p.811). Finally, Zinzow et al. (2010a) found that lower income was associated with a higher likelihood of PTSD.

How women think about their victimization can also have serious consequences for their mental health, both with regards to depression and PTSD. Zinzow et al. (2010b) found that

labeling the incident a crime or assault was slightly related to an increase in the likelihood of having a major depressive episode. Walsh and Bruce (2011) found that self blame and perceived likelihood of future victimization was associated with an increase in depression while levels of present control were negatively related.

Boudreaux et al. (1998) found that victims who suffered from depression were more likely to experience PTSD. Zinzow et al. (2010b) found that remembering the incident decreased the risk of PTSD while labeling it a crime or assault increased the risk. Ullman et al. (2007a) found that the number of traumatic events and experiencing child sexual abuse increased the risk of PTSD. Walsh and Bruce (2011) found that offender blame was associated with an increase in PTSD, as was the perceived likelihood of future assault. However, levels of present control were negatively associated. Ullman et al. (2006) found that “greater attributions of characterological self-blame were related to greater PTSD symptom severity for stranger, acquaintance, and partner or husband victims” (p.811). Finally, the researchers found that control over the recovery process was only negatively associated with PTSD when assaults were completed by significant others or husbands (Ullman et al., 2006).

While most of the research has focused exclusively on the negative consequences of sexual assault, more recent research has suggested that sexual victimization can lead to posttraumatic growth. Posttraumatic growth refers to the psychosocial positive changes that occur after a traumatic event. As Frazier, Conlon and Glaser (2001) indicate, these positive changes typically “reflect three general life domains: changes in one’s sense of self (e.g., increased strength and maturity), changes in relationships (e.g., increased closeness to others), and changes in spirituality or life philosophy (e.g., changes in life priorities)” (p.1048). Using a sample of adult rape victims, Burt and Katz (1987) found that at least 50% of the respondents

indicated some level of positive change with half of them indicating “somewhat” or a “great deal” of change (p.67). In a similar study, victims indicated posttraumatic growth as early as 2 weeks post-assault (Frazier et al., 2001). Grubaugh and Resick (2007) also found that posttraumatic growth is common among treatment-seeking victims of physical and sexual assault. In their study only 1% of the victims indicated they had not experienced any growth while 22% indicated very small, 32% indicated small, 24% indicated moderate, 11% indicated great and 10% indicated a very great deal of growth (Grubaugh and Resick, 2007).

Unfortunately, the literature on posttraumatic growth is rather limited, and we know little about the correlates of posttraumatic growth. For example, assessments of one’s decision-making can be an important influence on positive growth. While I have no measure and am not focusing on posttraumatic growth in this project, it is an important avenue of research that I believe can be associated with victim’s retrospective approval of their decisions. One possibility is that if victims do not regret their decisions, they may be more likely to achieve posttraumatic growth; while regretting decisions may impede or hinder victim’s ability to positively change following their victimization.

Prevalence of Informal Disclosure:

After an assault, victims face numerous decisions. One of the earliest decisions is disclosure. They must decide to whom, if anyone, they will reveal their victimization. Much of the research on disclosure distinguishes between disclosure to informal agents (such as friends and family members) and formal agents (such as law enforcement). Research has consistently found that victims are more likely to tell informal support providers than police and other formal agencies. Using three subsamples, Ullman and Filipas (2001a) found that 87% of those who had been sexually victimized told someone. Of those, 38.1% disclosed to only an informal support

provider (Ullman and Filipas, 2001a). Furthermore, of those who disclosed, 94.2% told friends or family (Ullman and Filipas, 2001a). Similarly, Starzynski et al. (2005) found that 80% of the victims in their sample told someone of their assault. Furthermore, of those that did, 97.6% of them disclosed to an informal support. Ahrens et al. (2007) found that 74.6% of the victims in their community sample reported to an informal source with most reporting to a friend (38.2%) or family member (22.5%). Similarly, using a sample of college women, Littleton (2010) found that most victims disclose to friends (83.3%), family (31.9%), and/or a romantic partner (55.5%). Finally, Krebs et al. (2007) found that 70% of victims of forcible rape and 64% of incapacitated rape victims disclosed their assault to an informal support provider. Disclosure rates are important because the reactions from these informal sources will influence the victim's decision to formally report the assault to police.

Prevalence of Reporting/ Formal Disclosure:

The prevalence rates of disclosure to formal sources, especially reporting to law enforcement, are considerably lower than disclosure to informal sources. Rates vary significantly across studies, with rates of formal reporting (to the police) ranging from about 5% to 30%. Littleton (2010) found that only 5.7% of the college victims reported the assault to the police. In their sample of non-college women, Ahrens et al. (2007) found that 5.9% of victims told police. Ullman and Filipas (2001a) found that 26.4% of the victims in their sample told the police. Starzynski et al. (2005) found that although most victims report to both informal and formal sources (59%), those who disclose to one source are more likely to tell informal sources (38.5%); rarely do victims only disclose to formal sources (3%). Furthermore, NCVS data from 1995 to 2013 indicates that prevalence rates of formal reporting to law enforcement is lower for college students than for non-college women in the same age category (20% versus 32%) (Sinozich and

Langton, 2014). When Wolitzky-Taylor et al. (2011a) asked about the most recent or only rape experienced, 15.8% of the victims indicated that the incident was reported by them or someone else. Kilpatrick et al. (2007) found that in the general population, about 16% of assaults were reported to police while in the college population the reporting rates were only 11.5%. Finally, whether an assault is formally disclosed (reported to law enforcement) varies across tactic typology.

Wolitzky-Taylor et al. (2011a) found that forcible assaults were more likely to be reported than incapacitated or drug and alcohol facilitated (17% versus 11.9%). When using a college sample, Wolitzky-Taylor et al. (2011b) found that only 11.5% of assaults were reported. Akin to the general population, forcible assaults among college women were more likely to be reported than incapacitated or drug and alcohol facilitated assaults (16% versus 2.7%) (Wolitzky-Taylor et al., 2011b). Kilpatrick et al. (2007) produced similar findings.

Timing of Disclosing/Reporting:

Ullman (1996c) and her colleagues (Ullman et al., 2006; Ullman and Filipas, 2001a) have repeatedly found that for victims who do disclose/report, about a third of victims who disclose/report do so immediately, while a third do so days after an assault and the last third disclose/report a year or more post-assault. When looking specifically at the formal reporting rates for victims, Walsh and Bruce (2014) found that of those victims who reported to police, 83.8% did so within a week. But why do victims disclose or report their assault?

Correlates of Disclosure/Reporting:

Ullman and Filipas (2001a) found that assaults by strangers are more likely to be formally reported while assaults by non-strangers are more likely to be informally disclosed.

Women with children are more likely to formally report while women without children are more likely to informally disclose. Physical injury and life threat is associated with formal reporting while not sustaining an injury or experiencing life threat is related to informal disclosure. Furthermore, Ullman and Filipas (2001a) found that ethnic minorities, women with children, receiving tangible aid, and receiving controlling responses were predictive of disclosing to both formal and informal sources. Finally, incurring an injury, experiencing life threat, receiving aid, receiving blaming and controlling responses were all predictive of formal reporting (Ullman and Filipas, 2001a). Jacques-Tiura et al. (2010) found that there were some differences with regards to disclosure and race. Specifically, White women (67%) were more likely to disclose than African American women (52%). Furthermore, there was a small difference in disclosing rates to informal sources with White women (99%) disclosing more than African American women (92%) (Jacques-Tiura et al., 2010). However, there were no ethnic differences regarding formal rates of reporting.

In a study of college students, Fisher et al. (2003) found that formal reporting was more likely if the assailant was a stranger, if the assaults were more serious, if the victim and offender's ethnicity were different, if the victim was African American, and if the assault occurred on campus property. Conversely, younger and lower socioeconomic class victims were less likely to report. Finally, assaults were less likely to be reported when both the victim and offender used drugs or alcohol (Fisher et al., 2003).

On the other hand, Starzynski et al. (2005) found that race, education, income and sexual orientation were not predictive of reporting to informal or both informal and formal sources. However, stranger assaults, having a weapon used during the assault, having PTSD, and having

greater self blame were predictive of formal and informal reporting. Walsh and Bruce (2014) also found that having PTSD was associated with a higher likelihood of reporting to police.

Kilpatrick et al. (2007) found that among the general population, verbal threat, injury, perceived fear, stranger assailants, concerns about STDs/HIV/AIDs, and having someone outside the family know about the assault were all predictive of formal reporting. Furthermore, the victim labeling the assault as rape was indicative of reporting. However, victims in the general population were less likely to report if the assailant had been a friend and if they had used alcohol. For the college population, Kilpatrick et al. (2007) found that physical force, verbal threat, injury, perceived fear, and concern about family knowing about the incident were all associated with formal reporting. Victims who remembered the incident “extremely well” were more than three times as likely to report as those who remembered “very well.” And, similar to the general population, alcohol use was predictive of not reporting while labeling the incident as rape was predictive of reporting.

Reasons for Disclosing/Reporting

Ahrens et al. (2007) found that victims were more likely to disclose and/or report because they were actively help seeking (63.8%) with about a third (36.2%) doing so because it was initiated by others. Most of those who disclosed/reported for help seeking reasons were doing it for emotional support (38.3%) or to just talk about it (12.8%), not to catch the assailant (5.3%). Of those who disclosed because it was initiated by others, the majority did so because they were explaining their behavior (12.8%) or there was a discussion about rape (8.5%) (Ahrens et al., 2007). Jacques-Tiura et al. (2010) also looked at the most common reasons to disclose and/or report. The researchers found that the most common reasons were because the victim was close

to the person they told, the victim needed to talk to someone, the victim talked about everything with the person they told, the victim wanted the person to be aware of the situation, the victim needed support or comfort, and the victim needed advice. The least common reasons indicated by the victims were that the man needed to be prosecuted and that the person disclosed/reported to witnessed the event (Jacques-Tiura et al., 2010). Finally, Cohn et al. (2013) looked at the barriers of victim reporting. Overall, the most common reasons for not reporting were fear of reprisal, not wanting family or others to know, lack of proof, and not being sure it was a crime or that harm was intended. The least common reasons were the victims did not know how to report, the victims were afraid of being treated badly by those in the criminal justice system, and they did not think the assault was serious enough to report.

Consequences of Disclosure and Reporting:

Assault disclosure and reporting can have both positive and negative consequences for victims, depending on the type of reaction. Research has indicated that informal and formal sources differ in their reactions and that respondents influence victims in different ways. Ahrens et al. (2007) found that overall, positive reactions (61.3%) are more common than negative reactions (38.7%). Ullman (1996a) found that formal reporting to police was associated with negative social reactions. Similarly, Ahrens et al. (2007) found that victims who report to formal sources, as a way of help seeking, experience more negative reactions than they do positive reactions. Also, if the formal reporting was initiated by someone else, victims experience more positive than negative reactions (Ahrens et al., 2007). This distinction was not found with regard to informal disclosure; among informal sources, positive reactions are more common than negative reactions in both victim-initiated and other-initiated reporting. Furthermore, Ullman (1996b) found that support from different providers affect the victim's recovery. For example,

emotional support, positive reactions, and neutral reactions from friends are all more related to better recovery than support or the same reactions from others. Notably, research also finds that those with high rates of depression are more likely to engage in family and friend help-seeking (Kaukinen and DeMaris, 2009).

Research has indicated that positive reactions are beneficial to victim well-being and mental health. For example, Ahrens et al. (2007) found that victims “who received negative reactions were more likely to report detrimental outcomes (n=29) than nondetrimental outcomes (n=7), whereas survivors who received positive reactions were more likely to report nondetrimental outcomes (n=55) than detrimental outcomes (n=2)” (p. 45). Relyea and Ullman (2015) found that positive reactions were related to more contact and support. While the researchers did not find a relationship between positive reactions and PTSD, they did find that positive reactions slightly lowered depression and lowered characterological self-blame. Similarly, Ullman (1996c) found that the specific reaction of “being listened to” was related to better self-rated recovery and fewer psychological symptoms. However, there was no relationship between being believed, having emotional support and psychological symptoms. Furthermore, instrumental aid was actually associated with more psychological symptoms. Ullman (1996a) found that positive reactions were associated with decreases in characterological and behavioral self blame. Campbell et al. (2001) found that two specific reactions, being believed and having someone to talk to, were associated with victim well-being. Specifically, being believed was negatively associated with PTSD while having someone to talk to was negatively associated with PTSD, depression, and other health symptoms. Finally, Jacques-Tiura et al. (2010) found that support was unrelated to PTSD. However, supportive reactions were inversely related to unsupportive reactions therefore indicating that positive reactions and the

benefits of those reactions are inversely related to negative reactions and the aforementioned consequences.

Researchers have consistently identified various detrimental consequences of negative social reactions. Ullman et al. (2007b) found that increases in negative social reactions were related to increases in self blame, avoidance coping and PTSD symptomology. Ullman and Filipas (2001b) also found that negative social reactions are associated with greater PTSD symptom severity. The researchers identified the two reactions with the strongest correlations as being treated differently and receiving stigmatizing responses. Relyea and Ullman (2015) specifically focused on two different negative reactions: being turned against and unsupportive acknowledgement. The researchers found that being turned against was related to less social contact and social withdrawal and was marginally predictive of depression and predictive of PTSD. Moreover, unsupportive acknowledgement was not related to social contact but was predicative of depression and PTSD. It's important to note that although both negative reactions were related to PTSD, unsupportive acknowledgement was more strongly related to both depression and PTSD.

Orchowski, Untied, and Gidycz (2013) found that controlling reactions increase PTSD and depression symptomology. Peter-Hagene and Ullman (2014) also found that infantilizing and controlling reactions were associated with PTSD. Furthermore, tangible support was positively associated with perceived control while controlling reactions were negatively associated with perceived control. These relationships are important because Peter-Hagene and Ullman (2014) also found that perceived control was associated with a decrease in PTSD symptoms. Finally, the researchers found that tangible support was not a “protective factor” against PTSD. Ullman (1996c) found that various negative social reactions (except victim

blame) were associated with poor self-rated health and more psychological symptoms. Jacques-Tiura et al. (2010) found that formal reporting, disregard from others and regretting one's decision to disclose all were predictive of PTSD symptomology. Campbell et al. (2007) did not find a significant relationship between negative social reactions and mental health. However, they found a trend relationship in which increases in the number of negative reactions were associated with PTSD, depression, and other health problems. Furthermore, two specific negative reactions, being called irresponsible and patronizing, were also related to PTSD, depression, and health problems. Overall, Campbell et al. (2007) found evidence that suggests "negative social reactions are 'worse' than no social reactions at all" (p. 295).

While most of the evidence indicates that positive reactions are beneficial to the victim while negative social reactions are detrimental, there are some exceptions. Ullman and Peter-Hagene (2014) found that both positive and negative social reactions are related to PTSD. However, it is important to note that the relationship was stronger for negative reactions. Moreover, positive reactions were associated with adaptive coping strategies and perceived control while negative reactions were associated with maladaptive coping and less perceived control. Similarly, Ullman et al. (2007a) also found that both positive and negative reactions were associated with more severe PTSD symptomology.

Only recently has published research begun to look at the correlates and impact of regretting disclosure and/or reporting and only one known study has assessed the consequences. Using a sample of 272 African American and Caucasian women, Jacques-Tiura et al. (2010) examined the characteristics and implications of disclosing and reporting. One of the hypotheses they tested focused on analyzing the potential relationship between regretting disclosure and/or reporting and PTSD. Jacques-Tiura et al. (2010) found that "almost 1 in 5 participants wished

they had not told someone because of the negative responses they received, which made them feel ashamed and at fault” (p.81). Furthermore, the researchers found that regretting one’s decision to disclose and/or report was positively associated with PTSD symptomology. Finally, Jacques-Tiura et al. (2010) found that victims who regretted their decision also received less support and more disregard.

However, previous research has yet to fully examine the relationship between retrospective approval of decision making, with regard to disclosure and reporting, and mental health status. Specifically, while Jacques-Tiura et al. (2010) looked at the effects disclosing/reporting had on PTSD, they did not examine the effect of disclosing/reporting on depression or the effects of non-reporting. Since previous research has consistently identified depression as a consequence as sexual assault and negative social reactions, it’s possible that regret is also associated with depression.

The impact depression can have on a victim’s life is tremendous. Depression can negatively influence a victim’s physical health, work/school and home life. Social withdrawal is also a symptom of depression. For sexual assault victims in particular, withdrawal has the potential to increase anxiety, drug and alcohol abuse, and could possibly lead to the victim experiencing PTSD. Furthermore, depression influences self-esteem, which could cause the victim to doubt their pre and post assault decisions and further the victim’s anxiety and mental health issues. Finally, depression has been associated suicide. With depression having such detrimental consequences, it is imperative that the potential relationship between regret and depression be assessed in order to fully understand the impact that regretting reporting can have on a victim.

Moreover, sexual victimization research has yet to examine the consequences of victims regretting their decision not to report. As the research indicates, the great majority of victims do not report their assault to police. In order to understand the consequences typically encountered, we need to study the situations most sexual assault victims face. Currently, there are no published empirical investigations of the causes and correlates of regret among non-reporters. Consequently, we do not know if regretting reporting affects victims the same way as regretting non-reporting.

However, previous research illustrates how regretting reporting could differ from regretting non-reporting. Ahrens et al. (2007) and Jacques-Tiura et al. (2010) found that victims disclose/report because they want to talk to someone about the assault, not necessarily to catch the assailant. Therefore, not reporting prevents the victim from being able to talk about it and could lead to less perceived control. Because Peter-Hagene and Ullman (2014) found that perceived control was associated with less PTSD and depression, it is possible that not reporting is associated with both increased PTSD and depression among sexual assault victims. Moreover, non-reporting victims could potentially be more likely to internalize fears, doubts and/or feelings of shame. This internalization could also lead to social withdrawal and possible mental health consequences such as PTSD and depression. Finally, victims who do not report could be continually questioning what would have happened if they had reported their victimization. Doing so could cause them to relive or revisit their experience, thus postponing healing, preventing closure, and causing the majority of victims to experience PTSD and/or depression. These possibilities and potential mental health consequences makes the study of regret among non-reporters particularly important. Furthermore, by assessing the effects of regretting reporting and non-reporting, support providers can be more informed when advising victims and provide

victims with a better understanding of their options and the potential consequences. In essence, understanding how victims have been impacted by their decision and the potential consequences of these choices can help other victims to make informed decisions based on what is best for their mental health and well-being.

Recap:

Research suggests sexual victimization is a considerable problem in the United States, with young women, between the ages of 18 and 24, and college women having heightened risk. Assailants are typically men who are familiar with the victim. Forcible assaults are the most often reported assaults within the general population, while for college women, incapacitated and drug/alcohol facilitated are the most common.

Evidence also finds that although depression and PTSD are common among victims, various demographic, assault, and post-assault characteristics affect the likelihood and severity of symptoms. Research indicates that victims overwhelmingly disclose to informal support providers, while far fewer formally report to police. Furthermore, the effect of disclosing/reporting on PTSD and depression can vary considerably, depending on the responses of others. Recent research has also indicated that regretting one's decision to disclose and/or report increases a victim's likelihood of experiencing PTSD.

Current Study:

Using a combined sample of general and college female sexual assault victims, this study assesses the correlates and impact of regret. Furthermore, I evaluate the potential relationships between regretting reporting/non-reporting, depression, and PTSD. First, I examine the predictors of reporting, and then I examine the predictors of regret, all of which is consistent with

previous research. However, this project extends the literature and expands on the work done by Jacques-Tiura et al. (2010) by examining the importance of regretting reporting and non-reporting on both lifetime and current depression and PTSD.

Hypotheses:

-TABLE 1 HERE-

I hypothesize that, when controlling for other factors, (H1) victims who did not report are more likely to regret than those who did report. Those who do not report will never know what would have happened if they had reported. They won't know if reporting would have made them feel better. They don't know how the police would have reacted or if reporting would have helped them with regard to victim assistance programs. Furthermore, those who do not report will never know if their assailant would have been held accountable or if their reporting could have prevented others from being victimized. Although victims who report may encounter negative social reactions from police and may not feel they got the justice they deserve, they will always know they did what they could and will never wonder "what if..." I believe these differences, specifically regarding uncertainties, are the reason that those who do not report are more likely to regret than those who do report.

Furthermore, I hypothesize that (H2 and H3) reporting will be positively associated with PTSD while being negatively associated with depression. I predict reporting and PTSD will be positively related because reporting forces the victim to tell and relive their experiences multiple times, therefore increasing the likelihood of experiencing PTSD. However, when the victim reports, it may decrease their likelihood of regretting and, therefore, decrease their likelihood of experiencing depression.

I also predict that, when controlling for other factors, (H4, H5, H6 and H7) regretting (among reporters and non-reporters) will be positively associated with PTSD and depression. These hypotheses are based partially in the findings of Jacques-Tiura et al. (2010), which suggested that regretting disclosure/reporting was associated with PTSD. Previous research has consistently identified depression as a consequence of sexual victimization and negative social reactions indicating the plausibility of an association with regret.

While I predict that regret will be associated with both PTSD and depression, I believe the association will differ based on whether the victim decided to report or not. I predict that (H8) for reporting, the association between regretting and the mental health variables will be stronger for PTSD; while (H9) for non-reporting, the association will be stronger for depression. I believe that the association between regret, PTSD, and depression will be stronger for regretting reporting and PTSD because victims who report must relive or re-experience their assault during the reporting process. Moreover, if there is a trial, the victim may have to see her assailant, which could act as a trigger and cause the victim to relive the assault. Finally, there is also the possibility that the victim will experience negative social reactions that could intensify the anxiety and distressing nature of reporting. While victims who report have to encounter situations that are indicative of PTSD, those victims who do not report must face other challenges.

I believe the association between regret, PTSD, and depression may be stronger for regretting non-reporting and depression because without reporting victims will probably not talk about the assault with any formal support provider and probably won't receive any information regarding victim assistance programs. Furthermore, victims who do not report will wonder what would have happened if they had. For example, victims may wonder whether they could have

prevented someone else from being assaulted. These questions, and the doubt associated with them, can create inner-conflict and worsen internalized issues. These are some of the challenges that victims who do not report must face and could explain the potential increased association between regretting non-reporting and depression.

Methods:

Data Description:

This study uses data from the National Women's Study-Replication. This is a two sample study with a general sample and a college sample of females. The college sample list was purchased from the American Student List (ASL), which contains about 6 million students from approximately 1,000 universities. The list sample consisted of 17,000 students from 253 universities in 47 states. Both samples were classified by region and randomly selected using the random digit dial methodology. The interviews were completed between January 23 and June 26, 2006, by the national surveying firm SRBI (Schulman, Ronca, Bucuvalas, Incorporated). English and Spanish versions of the interviews were used. The general population had a sample size of 3,001, while the college population had a sample size of 2,000. However, this project combined the two samples and was then limited to a final sample of 962, which only included sexual assault victims (710 victims from the general sample and 252 from the college sample). In order to distinguish between the two samples, I coded the data into a dichotomous variable in which 0 indicated the victim came from the general sample and 1 indicated the victim came from the college sample.

Dependent Variables:

Mental Health: The four mental health variables (lifetime depression, current depression, lifetime PTSD and current PTSD) were assessed using the National Women’s Study PTSD and major depressive episode (MDE) modules, along with structured interviews that were based off of the *Diagnostic and Statistical Manual of Mental Disorders-IV* (DSM-IV) criteria. These measures were used by previous researchers including researchers that have also used this data (Zinzow et al., 2010b; Zinzow et al., 2011; McCauley et al., 2011). Furthermore, research indicates support for the validity and reliability of these measures (Resnick et al., 1993; Kilpatrick et al., 2003).

All four mental health measures are dichotomized. For lifetime depression, 0 equals no depression and 1 equals the presence of depression at some point in the victim’s life. Similarly, 0 equals no current depression and 1 equals the victim currently experiencing depression. For lifetime PTSD, 0 equals no PTSD and 1 equals the presence of PTSD at some point in the victim’s life. Finally, 0 equals no current PTSD and 1 equals the victim currently experiencing PTSD.

Lifetime depression is identified using the responses to 18 questions, which are listed in appendix A. All questions could be answered with a yes/ no response. If the victims answered yes to five or more questions, I coded it as 1, indicating that they had experienced depression at some point in their life. If they answered yes to four or less, I coded it as 0, indicating that they had not.

Current depression was measured using similar questions; the only difference is questions 1-16 included a qualifying time frame of the last six months. For example, has this trouble

concentrating happened during the past 6 months? If the victims indicated yes on 5 or more questions, I coded it as 1, indicating that they were currently experiencing depression; for victims who indicated yes on four or less of the questions, I coded it as 0, indicating that they were not currently experiencing depression.

Lifetime PTSD is identified using the responses of 23 different questions, which are listed in appendix B. There were three groups of questions. If the victims answered yes to one or more questions in the first section, three or more questions in the second section, and two or more in the third section, I coded it as 1, indicating that they had experienced PTSD at some point in their life. If the victims did not answer yes to the required number of questions in each section, I coded it as 0, indicating that they had not experienced PTSD. All questions could be answered with a yes/ no response.

Current PTSD was measured using a similar method and similar questions; the only difference is the questions included a qualifying time frame of the last six months. For example, have these bad dreams occurred during the past 6 months? If the victims answered yes to one or more questions in the first section, three or more questions in the second section, and two or more in the third section, I coded it as 1, indicating that the victims were currently experiencing PTSD.

Regret: Regretting reporting/ non-reporting was assessed by the single item: “Do you think you made the right or wrong decision at that time when you decided (to report/ not report) the incident to police?” The respondents could then answer “right decision,” “wrong decision,” or “not sure.” I coded regret as a dichotomous variable where 1 equaled the presence of regret. Regret is also used as an independent variable in some analyses.

Control Variables:

Demographics: As previously stated, a dichotomous variable was created to distinguish victims from the general and college sample. For this victim demographic variable, 0 equals the general sample and 1 equals the college sample. Race is assessed by one item asking: “In which of the following categories do you belong?” Respondents could answer “Pacific Islander, Native American or Alaskan Native,” “Asian,” “African American,” “White” or “don’t know.” Due to low variability, I collapsed race into two categories. That is, models include a race dichotomous variable of white and nonwhite, where 1 equals white. Time since the assault is a continuous variable that was calculated by subtracting the victim’s current age and the victim’s age at time of assault.

Assault Characteristics: Various assault characteristics are included using dichotomous variables. The victim-offender relationship variable was based off of whether or not the respondent had seen the assailant prior to the assault. I coded nonstranger assailants as 0 and stranger assailants as 1. I coded injury so that 0 indicated that the victim was not injured and 1 indicated that the victim experienced some form of injury during the assault. Similarly, I coded perceived life threat was coded so that 0 equals no life threat while 1 equals perceived life threat during the assault. Finally, the type of incident is assessed by an item asking: “Was this a single incident or a series of incidents where the same person did the same things over a period of days, weeks or months?” I coded single incidents as 0 and a series of incidents as 1.

Post-Assault Characteristics: How well the victim remembered the event, or the victim’s recall, is assessed using a nominal variable with four categories: extremely well, very well, not so well and not so well at all.

Reporting: If the assault was never reported, I coded it as 0. If it was reported by someone other than the victim, I coded it as 1. If the assault was reported by the victim, I coded it as 2.

Analytical Strategy:

Logistic regression is an extension of regression that uses a categorical, dichotomous dependent variable. Unlike OLS, which fits a model through a system of estimates, logistic regression uses maximum likelihood estimation which increases the probability of a better fit. In logistic regression in SPSS, b's represent log of odds and Exp(B)s represent odds ratios. All three of the dependent variables in this project are dichotomous, so I use multivariate logistic regression for my analyses. Previous research using this data has also used logistic regression, further supporting use of this methodology (Amstadter et al., 2010; McCauley et al., 2010; McCauley et al., 2011; Wolitzky-Taylor et al., 2011a; Wolitzky-Taylor et al., 2011b; Zinzow et al., 2011; Zinzow et al., 2010a; Zinzow et al., 2010b).

To test hypotheses one through three, I combine the general and college sample, then separately regress reporting and regret on the other predictors. To test hypotheses 4 and 5, I select a subsample of victims who reported, and run analyses in which I separately regress PTSD and depression on regret and on the other predictors. To assess hypotheses 6 and 7, I select a subsample of victims who did not report, then run separate analyses regressing PTSD and depression on regret and on the other predictors. Finally, for hypotheses 8 and 9, I use the Paternoster test to compare the prior regressions and assess the strength of the relationships.

Findings:

-TABLE 2 HERE-

Table 2 presents the descriptive statistics of the sample. Overall, a majority of the sample was white and the average time since an assault was 14.9 years. In general, the victims experienced a single incident, rather than a series of incidents, and they knew their attacker, which is consistent with the previous literature. Most victims did not incur an injury or experience a perceived life threat. About a third of the victims remembered the details of the assault extremely well, a third remembered very well, and a third remembered not so well or not well at all. Consistent with previous research, a majority of the victims did not report (83.1%). Of the victims who did not report, nearly half (44.1%) regretted their decision; less than 5% of the victims who reported regretted their decision. Finally, 67% of victims reported experiencing depression in their lifetime, and 56.9% reported currently experiencing depression; 39.6% of victims reported experiencing PTSD in their lifetime, and 38.1% reported currently experiencing PTSD.

-TABLE 3 HERE-

Before testing the hypotheses, I ran a correlation matrix in order to identify any potential problems with multicollinearity. As expected, there is a modest but significant correlation amongst a majority of the variables; there are a few moderate correlations. Specifically, perceived life threat and injury have a moderate correlation of .413, significant at the .01 level. Similarly, perceived life threat and remembering has a moderate correlation of -.311 that is also significant at the .01 level. It makes sense that increases in severity of the assault and injury would correspond with increases in victim's perceived life threat and that life threat would affect

victim's recall. Finally, time since the assault and the victim's demographic group have a moderate correlation of $-.446$, significant at the $.01$ level.

The highest correlations are amongst the mental health variables-- lifetime depression, current depression, lifetime PTSD, and current PTSD. These relationships are expected due to the nature of their classification, but are worth mentioning. Depression and current depression have a correlation of $.609$. Depression and PTSD have a correlation of $.518$. Finally, depression and current PTSD have a correlation of $.434$. Current depression and PTSD have a correlation of $.347$. Current depression and current PTSD have a correlation of $.622$. Finally, PTSD and current PTSD have a correlation of $.485$. These correlations are significant at the $.01$ level.

-TABLE 4 HERE-

Crosstabulations, presented in table 4, support my first hypothesis that non-reporters are more likely to regret than reporters. Only 4.6% of reporters indicated regret, compared to 44.6% of non-reporters. These results indicate little variation with regard to regretting among reporters. Regressing regret on all predictors, including reporting, shows that reporting does decrease the likelihood of regretting. The low variation among regretting reporters does not allow for further examination of regretting reporters and how their regret influences lifetime depression, current depression, lifetime PTSD, or current PTSD. Therefore, hypotheses 4 and 5 are not tested.

-TABLE 5 HERE-

Only the victim demographic group, the victim-offender relationship, time since the assault, injury and perceived life threat are significant when predicting reporting. The victim demographic group was negatively associated with reporting, which indicates that college victims are less likely to report, compared to victims in the general population. The victim-

offender relationship is negatively related with reporting, which indicates that victims assaulted by strangers are less likely to report than those victims assaulted by an acquaintance. Time since is also negatively associated with reporting; increases in the time since the assault corresponds with decreases in the likelihood of the victim reporting. The $\text{Exp}(B)$ is 0.964, indicating a 3.6% decrease in the odds per year since the event. Injury and perceived life threat are both positively associated with reporting. The $\text{Exp}(B)$'s for both variables are over 2, indicating that victim's who sustain an injury or experience perceived life threat have more than twice the odds of reporting. Race, type of event, and victim recall were not significantly associated with reporting.

-TABLE 6 HERE-

Regressing regret on the other predictors indicates that reporting is negatively associated with regret; victims who report have .139 lower odds of regretting. Injury and perceived life threat are positively associated with regret. The $\text{Exp}(B)$'s for both variables are over 2, indicating that victims who sustain an injury or experience perceived life threat have twice the odds of regretting their decision than those who are uninjured or have no perceived life threat. The victim-offender relationship is negatively associated with regret, indicating that victims who are assaulted by a stranger have .509 lower odds of regretting. Finally, time since the event is positively associated, so that increases in the time since the assault correspond with increases in odds of a victim's likelihood of regretting. The $\text{Exp}(B)$ is 1.019, which suggest the increase in odds is about 2% per year. Victim demographic group, type of event, victim recall, and race were not significantly associated with regret.

In order to minimize problems and identify any changes in regret, I ran individual, three step models for lifetime and current depression, and for lifetime and current PTSD. The first

model, model A, included regret, race, the victim-offender relationship, the type of event, the victim's recall, and time since the assault. Injury was introduced in model B and perceived life threat was introduced in model C. Models A, B and C only included non-reporters, due to the low variation in regretting reporters. Model D included all predictors except for regret and included both reporters and non-reporters.

-TABLE 7 HERE-

In order to test hypothesis 3, reporting's affect on lifetime depression, I regressed all predictors, except for regret, on depression. Model D presents the results. I find that only type of event, victim recall, and injury are significantly associated with depression. The type of event is positively associated with lifetime depression; victims who experience multiple victimizations have higher odds of experiencing depression during their lifetime than victims who experience one assault. Victim recall is negatively associated with depression, so victim's who have poor recall are .826 times less likely to experience depression than those victims who recall the events well. Injury is positively associated, which indicates that being injured increases a victim's likelihood of experiencing lifetime depression by nearly 53%. The victim demographic group, race, the victim-offender relationship, the time since the assault, perceived life threat and reporting were not significantly associated with lifetime depression; therefore, these results do not indicate support for hypothesis 3.

To test hypothesis 7, all predictors, except for reporting, were regressed on lifetime depression. Models A-C illustrate the results. When looking specifically at non-reporters, I find that regret is positively associated with lifetime depression. It is important to note that regret was

significant in model A, but not models B or C, which indicates that regretting is an important predictor of depression until all other factors are added, thus indicating support for hypothesis 7.

Type of event, victim recall, and injury are also associated with lifetime depression. Type of event is positively related which indicates that victims who experience multiple victimizations have a higher odds of experiencing depression in their lifetime than victims who experience one victimization. Victim recall is negatively associated with lifetime depression and is significant in models A and B, but not C. This indicates that better recall decreases a victim's odds of experiencing depression. Finally, injury was positively and significantly associated with lifetime depression in model B, but not C.

-TABLE 8 HERE-

Similar to the previous table, Model D in table 8 presents the logistic regression of current depression on all predictors except for regret, therefore testing hypothesis 3. I find that only race and time since the assault are significantly related. Race is negatively associated, which indicates that victims who are white have a decreased odds of currently experiencing depression compared to those victims who are nonwhite. Time since the assault is also negatively associated with current depression, which indicates that increases in time decrease a victim's odds of experiencing current depression. The $\text{Exp}(B)$ is 0.973, which suggests that the decrease in odds is about 3% per year. None of the other predictors, including reporting, were predictive of current depression. These results, and those from table 6, do not support hypothesis 3.

The results in Models A-C illustrate the logistic regression of all predictors, except for reporting, on current depression. When looking at non-reporters, I find that regret is positively

associated with current depression but is only significant in the first model. Similar to the results in table 6, these results indicate support for hypothesis 7.

The only other significant relationships are race and time since the assault. Race is negatively associated with current depression in models A and B, but not in model C. Time since the assault is also negatively associated with current depression, indicating that increases in time since the assault decrease a victim's odds of currently experiencing depression. The Exp(B) is 0.975, which suggests that the decrease in odds is about 2.5% per year.

-TABLE 9 HERE-

Model D presents findings from the logistic regression of lifetime PTSD on all predictors except for regret, therefore testing hypothesis 2. Only type of event, time since the assault, injury, and perceived life threat are significantly associated. Type of event is positively associated with lifetime PTSD indicating that victims who experience multiple victimizations have higher odds of experiencing PTSD at some point in their lives than those victims who experience one assault. Time since the assault is negatively associated with PTSD. Therefore, increases in time since the assault decrease the victim's odds of experiencing lifetime PTSD. Both injury and perceived life threat are positively associated with PTSD; victim's who sustain an injury or experience a perceived life threat have increased odds of experiencing PTSD compared to those victims who do not. The victim demographic group, race, victim-offender relationship, victim recall, and reporting are not associated with lifetime PTSD, and do not support hypothesis 2, which states that reporting will be positively associated with lifetime PTSD.

The results in Models A-C illustrate the logistic regression of all predictors, except for reporting, on PTSD. When using the subsample of non-reporters, regretting is positively associated with lifetime PTSD. Although the significance drops to the .05 level in the second and third model, it is apparent that regretting is an important predictor of PTSD, even when taking the other seven variables into account. These results show support for hypothesis 6.

The type of event, time since the assault, injury and perceived life threat are also significantly associated with lifetime PTSD. The type of event is positively associated with lifetime PTSD which indicates that victims who experience multiple victimizations have higher odds of experiencing PTSD than victims who experience a single victimization. Time since the assault is negatively associated so that increases in time since the assault correspond with decreases in the odds of a victim experiencing PTSD in their lifetime. Injury is positively associated with lifetime PTSD. The $\text{Exp}(B)$ is 2.341 which suggest a victims odds of experiencing PTSD in their lifetime more than double if they are injured during their assault. Perceived life threat is also positively associated with PTSD. The victim demographic group, race, the victim-offender relationship and victim recall are not significantly associated with lifetime PTSD.

-TABLE 10 HERE-

Model D presents the logistic regression of current PTSD on all predictors except for regret, therefore testing hypothesis 2. I find that only race, time since, injury, and perceived life threat are significantly associated. Both race and time since the assault are negatively associated with current PTSD. This suggests that increases in time since the assault and being white decreases a victim's odds of currently experiencing PTSD, compared to victim's who are more

recently assaulted and/or are nonwhite. Injury and perceived life threat are both positively associated with current PTSD. The victim demographic group, victim-offender relationship, type of event, victim recall, and reporting were not significantly associated with current PTSD. These results, and those from table 8, do not support hypothesis 2, which stated that reporting would be positively associated with PTSD.

Finally, the results in Models A-C illustrate the logistic regression of all predictors, except for reporting, on current PTSD. When singling out non-reporters, I find regret to be significantly and positively associated. However, regret is only significant in Model A. These results, and results from table 8, indicate support for hypothesis 6.

The type of event is also significantly and positively associated to current PTSD in Model A, but not Model B or C. Race is negatively associated, which indicates that victims who are white have decreased odds of currently experiencing PTSD compared to those victims who are nonwhite. Time since the assault is also negatively associated. The $\text{Exp}(B)$ is 0.968 which suggests the decrease in odds of reported PTSD is about 4% per year. Injury is positively associated with current PTSD but only in Model B. Perceived life threat is also positively associated with PTSD. The victim demographic group, victim-offender relationship, and victim recall were not significantly associated with current PTSD.

The results from these four tables do not indicate support for hypotheses 2 and 3, but they do indicate support for hypotheses 6 and 7; regretting non-reporting is positively associated with lifetime and current depression and PTSD. However, because of the low variation in reporters, hypotheses 8 and 9 cannot be tested. Instead, as a supplemental analysis, a Paternoster test (Paternoster et al., 1998) was run to compare predictor coefficients across models to identify any

differences in predictors amongst reporters and non-reporters. The formula used was $(b_1 - b_2) / \sqrt{se_1 + se_2}$. Regret is not compared as there are almost no reporters who regret.

-TABLE 11 HERE-

The only significant Z-score differences between reporters (group 1) and non-reporters (group 2) are in regard to lifetime depression and lifetime PTSD. There are significant differences between the two groups with regard to how the type of event influences depression. Reporters and non-reporters also differ in how type of event and time since influences lifetime PTSD. These results indicate that there are some differences between how predictors influence mental health variables among different subgroups of victims; future studies should examine the differences between reporters and non-reporters.

Summary of Findings:

The goal of this study was to assess the impact of reporting/ not-reporting and the potential impact of regretting that decision on the victims' mental health and well-being. In order to do this, I set out to test 9 hypotheses. I suggested that non-reporters would be more likely to regret than reporters and that reporting would be positively associated with PTSD, while being negatively associated with depression. Moreover, I predicted that regretting (both reporting and not reporting) would be positively associated with PTSD and depression. Finally, I hypothesized that regretting reporting would have a stronger association with PTSD than with depression, while regretting not reporting would have a stronger associated with depression rather than PTSD.

The results of my analyses support my first hypothesis and indicate that non-reporters have a higher likelihood of regretting than reporters. The results did not illustrate a significant

relationship between reporting and depression or PTSD; therefore hypotheses 2 and 3 were not supported. Hypotheses 4 and 5 could not be tested due to the low number of regretting reporters. The results of the logistic regression of predictors on the mental health variables, among non-reporters, indicated support for hypotheses 6 and 7.

Importantly, the results from the logistic regressions indicate that individual and situational factors, including regret, influence PTSD and depression differently. Regret is significantly associated with lifetime PTSD in all three models. These results indicate that regret is a major predictive factor of PTSD but other factors, besides regret, influence a victim's likelihood of experiencing depression. Among the logistic regressions of lifetime and current depression, regret is only significant in the first models, yet the coefficients changed little. Moreover, the p-values of depression, especially lifetime depression, changed drastically. In model A of lifetime depression, the p-value of regret is .035. In model B, it increases to .105. Finally, for model C, the p-value is .149. For model A of current depression, the p-value of regret is .041. In model B, it is .085. Finally, for model C, the p-value is .114. These differences may be the result of minor multicollinearity and/or overfitting of the models (although it seems the sample size is adequate to handle the number of included predictors), future research should continue to address the different predictive factors that influence PTSD and depression.

Due to the minimal variation in regretting reporters, I did not test hypotheses 8 and 9. However, I did make some additional comparisons to identify any differences in predictors among the subsample of victims. There were only three significant differences. Reporters and non-reporters differ with regard to how the type of event influences lifetime depression and how the type of event and time since the assault influences lifetime PTSD.

These findings are important with regard to the previous work done by Jacques-Tiura et al. (2010), who found that regretting among victims who disclose/ report is positively associated with PTSD. Jacques-Tiura et al. (2010) were able to identify the influence of regret on disclosers/reporters because their sample was limited to victims who disclosed to at least one person (which could include reporting). However, the sample used in this project was not restricted in that way. My sample included reporting (but not disclosure) and included reporting and non-reporting victims, allowing me to assess the correlates of regret in ways that the previous research did not. Collectively, my work and the findings of Jacques-Tiura et al. (2010), suggest that regret is not an exclusive phenomenon; it is not experienced only among victims who disclose/report or victims who do not. Although the specific contexts in which regret emerges and the focus of regret can vary, regret is a potential consequence facing all victims. Moreover, it is not the choice to disclose or report but how the victims feel about their decision that truly matters and influences their mental health and well-being.

Limitations:

This study has some interesting findings, but is not without limitations. The sample size of the data is a substantial drawback. As indicated before, the small sample size and lack of variability among reporters impeded my ability to test for the potential impact regretting has on reporters' mental health. Additionally, I was unable to test the differences between reporters and non-reporters with regard to predictors and mental health consequences. Finally, the small sample size limited the number of predictors I could incorporate into the models. Various predictors scattered throughout the literature that I was unable to account for, including type of assault tactic, reasons for disclosing/reporting or not disclosing/reporting, and reasons for regretting that decision should be incorporated into future studies.

Another limitation of this study is type of data used. Using a secondary data source, I was limited to the variables that were already included in the National Women's Study-Replication. Although this provided me with several testable hypotheses, I was limited in what information and potential relationships I could investigate and the comparability of my findings with prior work. For example, the National Women's Study-Replication evaluated regret with regard to reporting, it did not measure regret relevant to disclosure. Few variables were the same or proxies for those in Jacques-Tiura et al. (2010), and their dataset is not yet available for public use. Thus I was precluded from replications or making direct comparisons with this work.

Additional data collection efforts could allow for a more comprehensive look at the post-assault process, including other factors and events that could influence a victim's mental health and well-being. Although beyond the scope of the current study, using a primary data source would allow researchers to evaluate the complete sequence of events and decisions that influence victims' health and well-being. Larger sample sizes, possibly oversampling target groups to increase the number of victims included, and using variables that are similar to previous studies, would allow future researchers to test and/or control for more variables and unpack these complex relationships.

Thus, although these findings answer some questions, they raise some as well. First, I cannot explain why there is variability with regard to regret among non-reporters, but not among reporters. Perhaps it is because some victims who do not report have little to no control over what happens to them, or their assailant, after the assault, while other non-reporters do have agency. It is possible that the affirming consequences of reporting nearly always outweigh feelings of powerlessness, therefore explaining the discrepancy in regret between reporters and non-reporters. Second, while I find regret is significantly associated with PTSD, I cannot fully

explain what causes or influences this relationship. One potential influence could be the feeling of discontent, which could cause the victim to consistently think about the assault and any post-assault decisions. This fixation could then lead to changes in behavior, including avoidance, nightmares and/or flashbacks, and leading to increased risk of PTSD. Additionally, victims who regret not reporting could have heightened risk of PTSD due to the responses of family, friends and/or law enforcement, which is consistent with previous research on reactions to disclosure/reporting. If a victim does not report and their informal or formal support providers question their decision, or react negatively, the victim's self-doubt could increase. This increasing self-doubt could then cause the victim to pull away from their support systems and internalize any negative thoughts or feelings. Moreover, this increased focus on the assault, seclusion and internalization could lead to changes in behavior, interests, and other things that are associated with PTSD. Finally, this study has provided evidence of the mental health consequences of decision-making among victims, and thus raises questions as to the other health consequences regret may have. In addition to PTSD, regretting their decision could increase victims' likelihood of experiencing a substance abuse disorder or other physical and/or mental health disorders.

Conclusion:

Acknowledging the limitations and the questions that arise, my findings have important implications for academics and practitioners. This project extends the current literature in important ways. First, it examines the role and impact of regretting non-reporting on victims' mental health. This is something that has yet to be fully explored. Previous research by Jacques-Tiura et al. (2010) only evaluated regret amongst victims who disclosed and/or reported. By assessing a different subsample of victims, we are able to better understand how regret impacts

and influences victims. These results, in conjunction with Jacques-Tiura et al. (2010)'s findings, illustrate that regret is a potential factor for all victims. However, based on the number of victims who do not report, these results focus on one of the most common subgroups of victims, making the results increasingly relevant in the field.

These findings, and previous work done by Jacques-Tiura et al. (2010), illustrate that regretting increases a victim's likelihood of experiencing PTSD. The devastating effects of depression and PTSD make it imperative that we understand the correlates of mental health difficulties among victims of crime. However, research has yet to examine the other health consequences of regretting. Regretting could potentially influence a victim's likelihood to experience a substance abuse disorder, like alcoholism. PTSD also has a high rate of comorbidity with other anxiety, affective and substance abuse disorders (Kessler et al., 1995); therefore making it possible that regretting indirectly increases the likelihood of these disorders as well. Furthermore, regretting also could manifest physically, therefore impacting a victim's physical and mental health.

While previous work tends to focus on the characteristics of a singular event, few studies look at the complete sequence of events and decisions that can influence the outcome and consequences of a person's victimization. This project extends the literature by looking at sexual victimization in this way, by looking at various events and how different decisions can affect future events and future consequences. In essence, this project attempts to provide a more complete assessment of how victims are influenced by their assault, rather than just a snapshot of how certain characteristics influence one aspect of their life. By conducting studies in this way, we are better able to understand how changes in assault characteristics, disclosing/reporting, reactions to disclosing/reporting, and victim's retrospective approval of their decision making

can influence their lives and the potential consequences they may endure. Moreover, if future researchers continue this trend and examine the complete sequence of events following an assault, they can not only answer the questions that arise from these findings but they can also identify how regret, among other factors, influences the next step in the sequence of events: posttraumatic growth.

The current study offers significant insight with regard to posttraumatic growth research. The presence of regret and/ or PTSD can potentially hinder or postpone posttraumatic growth in victims. By minimizing a victim's likelihood of regretting, we can decrease their likelihood of experiencing PTSD (and possibly other mental health/ substance abuse disorders), and potentially increase their likelihood of experiencing posttraumatic growth. If these relationships exist, law enforcement and mental health professionals might be able to minimize the negative consequences associated with being victimized and, subsequently, increase the number of people who "grow" because of their victimization. Although the current research typically assesses these phenomena independently, future research should evaluate them together in order to identify any potential relationships and in order to fully understand how being victimized influences a person's health and well-being. One possibility is that reducing regret and fostering victims' satisfaction with their decision making can provide substantial health benefits, such as reducing the likelihood and severity of depression and PTSD and allowing for posttraumatic growth.

While these findings, and their implications, specifically relate to sexual assault victims, they also shed light onto how the retrospective approval of decision-making can influence victims of other crimes. One potential influence on these outcomes is how victims feel about their decision to disclose and/or report. For some, post-victimization recovery is an extremely

difficult challenge. Victims can understandably experience a lack of agency and self-trust. Victimization, whether it be domestic violence, assault, etc., can affect a person's mental health and well-being. By understanding how regret works and influences sexual assault victims, we are better able to help prevent all victims from experiencing the negative physical and mental health consequences, while increasing their potential for positive post-assault experiences.

While many things, including being victimized, may be beyond their or our control, some choices are not. Complete crime prevention or control over the conditions under which it occurs is a lofty and likely unattainable goal. Nor can we entirely control whether victims report crime or how well victims recall their assaults. However, we have a great deal of control over how we respond to victims of crime, including the policies and practices used in law enforcement, mental health facilities, medical centers, and victims' support agencies. Moreover, using this information, friends, family, psychologists, religious personnel, and others can better advise victims of their post-assault options, regarding reporting, and the potential consequences of their decisions.

Appendices:**A:**

- 1) Has there ever been a period of two weeks or more when you had trouble concentrating or keeping your mind on what you were doing, even when you tried to concentrate?
- 2) Has there ever been a period of two weeks or more when you lost interest in activities which usually meant a lot to you?
- 3) Has there ever been a period of two weeks or more when you stopped caring about activities in your life that used to be important to you?
- 4) Has there ever been a period of two weeks or more when you had difficulty falling asleep or staying asleep?
- 5) Has there ever been a period of two weeks or more when little things bothered you a lot or could make you very angry?
- 6) Has there ever been a period of two weeks or more when you were feeling depressed, sad, down or irritable most of the day, nearly every day?
- 7) Has there ever been a period of two weeks or more when you were uninterested in most things or unable to enjoy thing you used to do nearly every day?
- 8) Has there ever been a period of two weeks or more when you lost weight without dieting?
- 9) Has there ever been a period of two weeks or more when you gained more weight than you should have naturally?
- 10) Has there ever been a period of two weeks or more when you had significant increase or decrease in appetite?
- 11) Has there ever been a period of two weeks or more when you slept much more or a lot less than is normal for you?

12) Has there ever been a period of two weeks or more when you felt tired and low in energy all the time?

13) Has there ever been a period of two weeks or more when you felt guilty about things in the past, when you felt very bad about yourself, or when you felt worthless?

14) Has there ever been a period of two weeks or more when you had a hard time thinking, concentrating or making decisions about everyday things?

15) Has there ever been a period of two weeks or more when you felt things were so bad that you thought about hurting yourself or you would be better off dead?

16) Has there been a time of two weeks or longer during the past six months when you thought about death a lot?

17) Have you felt so low you thought about killing yourself?

18) Did you ever actually try to kill yourself?

B:

Section 1:

1) Has there been a period of two weeks or more when you had repeated bad dreams or nightmares that were related to the unwanted sexual experience previously discussed?

2) Has there been a period of two weeks or more when you kept having unpleasant memories about the unwanted sexual experience previously discussed or seeing them in your mind?

3) Has there ever been a period of two weeks or more when disturbing memories, about the unwanted sexual assault that was previously discussed, kept coming into your mind, whether you wanted to think of them or not?

4) Has there ever been a period of two weeks or more when you felt a lot worse when you were in a situation that reminded you about the unwanted sexual experience previously discussed?

5) Have you ever had a flashback that was related to the unwanted sexual experience that was previously discussed?

Section 2:

6) Has there ever been a period of two weeks or more when you lost interest in activities which usually meant a lot to you?

7) Has there ever been a period of two weeks or more when you stopped caring about activities in your life that used to be important to you?

8) Has there ever been a period of two weeks or more when you deliberately tried very hard not to think about the unwanted sexual experience that was previously discussed?

9) Has there ever been a period of two weeks or more when you deliberately tried to avoid any feelings about the unwanted sexual experience discussed earlier?

10) Has there even been a period of two weeks or more when you went out of your way to avoid certain people, places, or activities that might remind you of the unwanted sexual experience discussed earlier?

11) Has there ever been a period of two weeks or more when you felt cut off from other people or found it difficult to feel close to people?

12) Has there ever been a period of two weeks or more when it seemed you could not feel things anymore or that you had much less emotion that you used to?

13) Has there been a period of two weeks or more when you felt that your future has been cut short because something bad had happened to you?

14) Throughout this interview we have talked about bad experiences that you may have had. Have you ever felt that there were parts of the unwanted sexual experience that you couldn't remember?

15) Has there been a time of two weeks or longer when you were uninterested in most things or unable to enjoy things you used to do nearly every day?

16) Has there been a time of two weeks or longer when you lost weight without dieting?

Section 3:

17) Has there ever been a period of two weeks or more when you had trouble concentrating or keeping your mind on what you were doing, even when you tried to concentrate?

18) Has there ever been a period of two weeks or more when you felt you had to stay on guard much of the time?

19) Has there ever been a period of two weeks or more when you had difficulty falling or staying asleep?

20) Has there ever been a period of two weeks or more when unexpected noises startled you more than usual?

21) Has there ever been a period of two weeks or more when little things bothered you a lot or could make you very angry?

22) Has there ever been a period of two weeks or more when you found yourself reacting physically to things that reminded you of the unwanted sexual experience previously discussed?

23) Has there been a time of two weeks or longer when you had a hard time thinking, concentrating or making decisions about everyday things?

Tables:

Table 1: Hypotheses

H1:	Victims who don't report are more likely to regret
H2:	Reporting will be positively associated with PTSD
H3:	Reporting will be negatively associated with depression
H4:	Among reporters, regretting will be positively associated with PTSD
H5:	Among reporters, regretting will be positively associated with depression
H6:	Among non-reporters, regretting will be positively associated with PTSD
H7:	Among non-reporters, regretting will be positively associated with depression
H8:	For reporting, the association between regret and PTSD will be stronger than for depression
H9:	For non-reporting, the association between regret and depression will be stronger for PTSD

Table 2: Description of Sample (N=962)

	Percent/ Mean (S.D.)
Demographics:	
White	81% (n=746)
Nonwhite	19% (n=175)
Time Since Assault	14.9 yrs (11.09)
Characteristics of the Assault:	
Knew Assailant	87.7% (n=831)
Single Incident	69.5% (657)
Incurred Injury	34.2% (324)
Perceived Life Threat	39.1% (n=364)
Victim Recall:	
Extremely Well	32.1% (n=202)
Very Well	32.3% (n=305)
Not So Well	23.5% (n=222)
Not Well At All	12.2% (n=115)
Reporting:	
Reported	11.8% (n=112)
Did Not Report	83.1% (n=786)
Someone Else Reported	5.1% (n=48)
Dependent Variables:	
Regret	33.6% (n=323)
<i>Symptomology:</i>	
Lifetime Depression	67% (n=645)
Current Depression	56.9% (n=470)
Lifetime PTSD	39.6% (n=381)
Current PTSD	38.1% (n=328)

Table 3: Correlation Matrix

	Race	Demographic Group	Regret	Injury	Perceived Life Threat	Reported	Victim-Offender Relationship	Type of Event	Victim Recall	Time Since the Assault	Lifetime Depression	Current Depression	Lifetime PTSD	Current PTSD
Race	1	.025	-.049	-.064	-.139**	-.020	.000	-.056	.103**	-.037	-.018	-.122**	-.027	-.110**
Demographic Group	.025	1	-.081*	-.086**	-.209**	-.095**	-.017	-.092**	.088**	-.446**	-.055	.014	.035	.044
Regret	-.049	-.081*	1	.144**	.193**	-.277**	-.038	.128**	-.079*	.141**	.062	.052	.120**	.054
Injury	-.064	-.086**	.144**	1	.413**	.230**	-.040	.144**	-.184**	.048	.145**	.089*	.248**	.125**
Perceived Life Threat	-.139**	-.209**	.193**	.413**	1	.243**	-.037	.158**	-.311**	.154**	.111**	.086*	.218**	.134**
Reported	-.020	-.095**	-.277**	.230**	.243**	1	-.100**	.054	-.102**	-.031	.057	.054	.119**	.047
Victim-Offender Relationship	.000	-.017	-.038	-.040	-.037	-.100**	1	.138**	-.051	.052	-.010	-.062	-.010	-.011
Type of Event	-.056	-.092**	.128**	.144**	.185**	.054	.138**	1	-.115**	.186**	.107**	.149	.163**	.063
Victim Recall	.103**	.088**	-.079*	-.184**	-.311**	-.102**	-.051	-.155**	1	-.161**	-.091**	-.051	-.080*	-.074*
Time Since the Assault	-.037	-.446**	.141**	.048	.154**	-.031	.052	.186**	-.161**	1	-.006	-.097**	-.083*	-.145**
Lifetime Depression	-.018	-.055	.062	.145**	.111**	.057	-.010	.107**	-.019**	-.006	1	.609**	.518**	.434**
Current Depression	-.122**	.014	.052	.089*	.086*	.054	-.062	.049	-.051	-.097**	.609**	1	.347**	.622**
Lifetime PTSD	-.027	.035	.120**	.248**	.218**	.119**	-.010	.163**	-.080*	-.083*	.518**	.347**	1	.485**
Current PTSD	-.110**	.044	.054	.125**	.134**	.047	-.011	.063	-.074*	-.145**	.434**	.622**	.485**	1

*p<.05 **p<.01

Table 4: Crosstabulation of Official Reporting and Victims Regretting their Decision

Regret

	n (%)	n (%)
Reported	5 (4.6%)	103 (95.4%)
Not Reported	318 (44.6%)	395 (55.4%)

Table 5: Logistic Regression of Reporting on Predictors

Variables:	B	Sig.	S.E.	Exp(B)
College Population	-0.947	**	0.331	0.388
White	0.175	-	0.287	1.191
Stranger Assailant	-0.796	**	0.290	0.451
Multiple Victimizations	0.158	-	0.249	1.171
Poor Recall	-0.153	-	0.123	0.858
Time Since Event	-0.036	**	0.012	0.965
Injured	0.806	**	0.242	2.239
Perceived Life Threat	0.793	**	0.258	2.210
Constant	-1.293	*	0.513	0.257
<i>Pseudo R²:</i>	0.4011			

*p<.05 **p<.01

Table 6: Logistic Regression of Regret on all Predictors except Depression and PTSD

Variables:	B	Sig.	S.E.	Exp(B)
Reported	-1.971	**	0.304	0.139
Injured	0.736	**	0.195	2.087
Perceived Life Threat	0.845	**	0.199	2.329
Stranger Assailant	-0.675	**	0.260	0.509
Multiple Victimizations	0.377	-	0.194	1.458
Poor Recall	-0.040	-	0.091	0.961
Time Since Event	0.020	*	0.009	1.020
College Population	0.000	-	0.219	1.000
White	-0.038	-	0.223	0.963
Constant	-0.430	-	0.411	0.651
<i>Pseudo R²:</i>	0.5245			

*p<.05 **p<.01

Table 7: Logistic Regression of Lifetime Depression on Predictors

Variables:	Model A				Model B				Model C				Model D			
	B	Sig.	S.E.	Exp(B)												
College Population	-0.226	-	0.211	0.798	-0.177	-	0.213	0.838	-0.178	-	0.215	0.837	-0.346	-	0.189	0.708
White	0.209	-	0.219	1.232	0.236	-	0.220	1.267	0.256	-	0.223	1.292	0.055	-	0.196	1.056
Regretted	0.368	*	0.175	1.446	0.292	-	0.180	1.339	0.267	-	0.185	1.307	-	-	-	-
Stranger Assailant	-0.038	-	0.265	0.963	-0.031	-	0.265	0.970	-0.004	-	0.267	0.996	-0.068	-	0.224	0.934
Multiple Victimizations	0.569	**	0.204	1.767	0.551	**	0.207	1.735	0.494	*	0.210	1.639	0.464	**	0.179	1.590
Poor Recall	-0.217	*	0.086	0.805	-0.193	*	0.087	0.824	-0.175	-	0.091	0.840	-0.156	*	0.079	0.855
Time Since Assault	-0.015	-	0.009	0.985	-0.015	-	0.009	0.985	-0.016	-	0.009	0.984	-0.015	-	0.008	0.985
Injured	-	-	-	-	0.458	*	0.201	1.580	0.371	-	0.213	1.449	0.516	**	0.180	1.676
Perceived Life Threat	-	-	-	-	-	-	-	-	0.216	-	0.218	1.241	0.182	-	0.182	1.200
Reported	-	-	-	-	-	-	-	-	-	-	-	-	0.04	-	0.124	1.041
Constant	0.963	*	0.402	2.619	0.784	-	0.409	2.189	0.679	-	0.423	1.971	1.003	**	0.366	2.727
<i>Pseudo R²:</i>	0.5537				0.5518				0.5524				0.5482			

*p<.05 **p<.01

(Model D includes both reporters and non-reporters)

Table 8: Logistic Regression of Current Depression on Predictors

Variables:	Model A				Model B				Model C				Model D			
	B	Sig.	S.E.	Exp(B)												
College Population	0.115	-	0.219	1.122	0.156	-	0.221	1.169	0.143	-	0.224	1.153	-0.052	-	0.195	0.949
White	-0.481	*	0.233	0.618	-0.472	*	0.234	0.624	-0.464	-	0.237	0.629	-0.620	**	0.207	0.538
Regretted	0.369	*	0.180	1.446	0.318	-	0.185	1.374	0.301	-	0.191	1.352	-	-	-	-
Stranger Assailant	-0.173	-	0.280	0.841	-0.174	-	0.281	0.840	-0.164	-	0.282	0.848	-0.421	-	0.238	0.657
Multiple Victimizations	0.247	-	0.200	1.280	0.235	-	0.202	1.265	0.190	-	0.206	1.210	0.205	-	0.174	1.227
Poor Recall	-0.149	-	0.091	0.862	-0.134	-	0.092	0.875	-0.128	-	0.096	0.880	-0.100	-	0.082	0.905
Time Since Assault	-0.024	**	0.009	0.977	-0.024	**	0.009	0.976	-0.025	**	0.009	0.975	-0.027	**	0.008	0.973
Injured	-	-	-	-	0.287	-	0.198	1.333	0.245	-	0.213	1.277	0.291	-	0.178	1.338
Perceived Life Threat	-	-	-	-	-	-	-	-	0.097	-	0.220	1.102	0.227	-	0.184	1.255
Reported	-	-	-	-	-	-	-	-	-	-	-	-	0.047	-	0.118	1.049
Constant	1.087	*	0.428	2.967	0.979	*	0.434	2.661	0.947	*	0.447	2.577	1.430	**	0.385	4.180
<i>Pseudo R²:</i>	0.5720				0.5710				0.5714				0.5682			

*p<.05 **p<.01

(Model D includes both reporters and non-reporters)

Table 9: Logistic Regression of Lifetime PTSD on Predictors

Variables:	Model A				Model B				Model C				Model D			
	B	Sig.	S.E.	Exp(B)												
College Population	0.129	-	0.209	1.138	0.241	-	0.215	1.272	0.319	-	0.220	1.376	0.238	-	0.189	1.269
White	-0.086	-	0.216	0.918	-0.047	-	0.221	0.954	-0.035	-	0.227	0.966	0.005	-	0.191	1.005
Regretted	0.778	**	0.172	2.178	0.614	**	0.179	1.848	0.471	*	0.185	1.602	-	-	-	-
Stranger Assailant	-0.204	-	0.260	0.815	-0.201	-	0.267	0.818	-0.183	-	0.271	0.833	0.002	-	0.223	1.002
Multiple Victimizations	0.750	**	0.188	2.117	0.679	**	0.194	1.973	0.580	**	0.199	1.786	0.623	**	0.168	1.865
Poor Recall	-0.074	-	0.087	0.928	-0.022	-	0.089	0.978	0.050	-	0.095	1.051	0.002	-	0.080	1.002
Time Since Assault	-0.019	*	0.009	0.981	-0.019	*	0.009	0.981	-0.019	*	0.009	0.982	-0.024	**	0.008	0.977
Injured	-	-	-	-	0.968	**	0.187	2.632	0.851	**	0.199	2.341	0.850	**	0.166	2.339
Perceived Life Threat	-	-	-	-	-	-	-	-	0.588	**	0.210	1.800	0.630	**	0.174	1.878
Reported	-	-	-	-	-	-	-	-	-	-	-	-	0.186	-	0.113	1.204
Constant	-0.517	-	0.394	0.596	-0.914	*	0.414	0.401	-1.242	**	0.437	0.289	-1.048	**	0.366	0.351
<i>Pseudo R²:</i>	0.5554				0.5467				0.5430				0.5495			

*p<.05 **p<.01

(Model D includes both reporters and non-reporters)

Table 10: Logistic Regression of Current PTSD on Predictors

Variables:	Model A				Model B				Model C				Model D			
	B	Sig.	S.E.	Exp(B)												
College Population	0.043	-	0.215	1.044	0.095	-	0.217	1.099	0.166	-	0.224	1.181	0.011	-	0.192	1.011
White	-0.735	**	0.226	0.480	-0.727	**	0.227	0.484	-0.726	**	0.232	0.484	-0.616	**	0.198	0.540
Regretted	0.369	*	0.182	1.446	0.283	-	0.187	1.327	0.171	-	0.194	1.187	-	-	-	-
Stranger Assailant	0.067	-	0.281	1.069	0.076	-	0.283	1.079	0.129	-	0.289	1.138	-0.016	-	0.230	0.985
Multiple Victimizations	0.410	*	0.199	1.506	0.379	-	0.202	1.461	0.287	-	0.208	1.333	0.218	-	0.174	1.243
Poor Recall	-0.166	-	0.093	0.847	-0.147	-	0.094	0.863	-0.081	-	0.099	0.922	-0.100	-	0.083	0.905
Time Since Assault	-0.031	**	0.010	0.970	-0.032	**	0.010	0.969	-0.033	**	0.010	0.968	-0.039	**	0.009	0.962
Injured	-	-	-	-	0.434	*	0.196	1.543	0.301	-	0.211	1.352	0.355	*	0.174	1.426
Perceived Life Threat	-	-	-	-	-	-	-	-	0.598	**	0.220	1.818	0.485	**	0.183	1.624
Reported	-	-	-	-	-	-	-	-	-	-	-	-	0.023	-	0.115	1.023
Constant	0.382	-	0.425	1.465	0.218	-	0.435	1.244	-0.107	-	0.457	0.899	0.270	-	0.378	1.310
<i>Pseudo R²:</i>	0.5560				0.5539				0.5502				0.5571			

*p<.05 **p<.01

(Model D includes both reporters and non-reporters)

Table 11: Z-Score Comparison of Logistic Regression Coefficients of Predictors of Mental Health Outcomes (Paternoster et al., 1998)

	Injury	Perceived Life Threat	Victim-Offender Relationship	Type of Event	Victim Recall	Time Since	Race	Victim Demographic Group
Lifetime Depression	0.668	0.804	0.422	-1.926*	1.277	-0.426	-0.266	-1.322
Current Depression	0.693	1.592	-0.617	-0.373	0.337	-0.722	-1.043	-1.213
Lifetime PTSD	0.050	0.419	1.721	-2.393**	-0.349	-1.735*	0.762	-0.247
Current PTSD	0.487	0.015	0.118	-0.550	-1.193	-1.073	-0.246	0.998

*p<.05 **p<.01

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September 23, 2015

Office of Research Compliance
Institutional Review Board

MEMORANDUM

TO: Alishia Walton
Mindy Bradley

FROM: Ro Windwalker
IRB Coordinator

RE: New Protocol Approval

IRB Protocol#: 15-09-102

Protocol Title: *Predictors of Decision-Making and Well-Being among Victims of Sexual Assault*

Review Type: EXEMPT EXPEDITED FULL IRB

Approved Project Period: Start Date: 09/23/2015 Expiration Date: 09/22/2016

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (<https://vpred.uark.edu/units/rscp/index.php>). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 5,001 participants. If you wish to make *any* modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 109 MLKG Building, 5-2208, or irb@uark.edu.