

Attitudes Towards Unwanted Sexual Situations

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## Abstract

Undergraduate, female students are at a higher risk for unwanted sexual experiences. In 2014 White House Task Force to Protect Students from Sexual Assault estimated that 1 in 5 women on college campuses have experienced sexual assault while in college (Muehlenhard et al., 2017). Prior research on stigma has focused on other identities such as members of the LGBTQ+ community, those living with HIV/AIDS and those with mental health challenges. While the adverse health outcomes associated with sexual assault are similar to those other stigmatized, concealable identities there has not been any research specifically focused on how stigma impacts sexual assault survivors. Minimal research has been conducted regarding their willingness to seek help after their experience. The present study aims to examine how self-stigma, perceived stigma, and attitudes towards unwanted sexual experiences impacts help-seeking behaviors in hypothetical scenarios. It also examines whether help-seeking behavior in hypothetical scenarios of sexual assault vary based on the source and gender of support. To answer these questions, 131 self-identified females enrolled in Principles of Psychology at SUNY Brockport completed an online survey via Qualtrics. Existing measures of perceived stigma and self-stigma of individuals with concealable identities were adapted for sexual assault.

**Definition of sexual assault**

Defining and distinguishing what is sexual assault, rape, sexual battery, sexual harassment, etc. has been subjective. It is difficult to define sexual assault. A narrow definition could omit and invalidate people's experiences. However, a broad definition could include incidents that would generally be considered trivial and could overinflate prevalence rates (Muehlenhard et al., 2017). Muehlenhard et al (2017) used the term sexual assault to refer to sexual penetration and sexual touching obtained by threats of force, usage of force, or incapacitation. Sexual touching was further defined as nonpenetrative sexual contacts. For the purpose of their review, rape referred to sexual penetration by force or incapacitation. Sexual battery refers to sexual touching obtained by force or incapacitation (Muehlenhard et al., 2017). It has been suggested that definitions should be based on the legal definitions. However, laws differ from state to state (Muehlenhard et al., 2017). The New York State penal law lists various crimes in Article 130 under the umbrella term "sexual offenses." Sex offenses occur when a sexual act is committed without the victim's consent ("Sex offenses"., 2020).

**Prevalence of sexual assault experience among college students**

Undergraduate students and female students are at higher risk for unwanted sexual experiences. In a systemic review by Muehlenhard et al. (2017) of four studies, they concluded that approximately one-in-five women will experience sexual assault or rape while in college, and that the statistic for seniors are closer to one-in-four. However, this statistic does not account for women who experience sexual assault or rape more than once (Muehlenhard et al., 2017). Due to the subjective nature of sexual assault definitions, some people experience sexual assault but are not aware that is what

occurred. Due to mass media, often the word “rape” or “sexual assault” elicits thoughts of a violent sexual encounter with one or more strangers. Individuals may not classify their experience as sexual assault, especially if the perpetrator was someone they knew.

Women are less likely to classify an encounter as sexual assault or rape if the perpetrator was a romantic partner, if the incident involved incapacitation, if there was not excessive force used, or if the person believes they did not resist as much as they should have (Muehlenhard et al., 2017).

### **Percentage of help-seeking**

It was reported in 1987 by Mary Koss and her colleagues that in a national sample of 6,159 college students from 32 institutions, 42% of participants did not disclose their experiences to anyone (Koss et al., 1987). The National College Women Sexual Victimization study stated that fewer than 5% of those who were raped or had experienced attempted rape did not report to law enforcement (Miller et al., 2011). The NCWSV also found that approximately one-third of females injured during a rape and female physical assault victims receive medical treatment (Tjaden & Thoennes., 2000). The study conducted by Miller et al. (2011) found that out of their 144 participants, only 1 reported her experience to law enforcement. The sample consisted mostly of women who were assaulted by acquaintances, were intoxicated, or were verbally coerced. Research of college students have found that approximately 12.5% of rapes and 4.3% of sexual battery were reported to formal sources such as crisis centers, school officials, health centers, helplines, hospitals, and police regardless of whether the sources were at the school or not (DeLoveh & Cattaneo., 2017).

### **Barriers to help-seeking**

In 2010, Gulliver, Griffiths, and Christensen looked at barriers and facilitators that adolescents and young adults identified in regard to seeking mental health treatment. Participants identified perceived stigma and embarrassment, and self-reliance as some of the largest barriers to seeking mental health treatment. These individuals also held similar negative beliefs which consisted of concerns regarding confidentiality, fear of others finding out, believing that the treatment would not be useful or beneficial, and a feeling that the individual could handle the situation on their own (Gulliver et al., 2010). The individual's fear of what others would think of them extended to the individual providing the help as well. These concepts predominant among adolescents may correlate to treatment for sexual assaults as well. People may not seek help out of fear of under-reactions, which feel like a secondary victimization (DeLoveh & Cattaneo., 2017). Secondary victimization, also referred to as revictimization, is a term used to refer to the blame, stigma, alienation, trauma, and distress that victims experience by the criminal justice and medical systems (Maier., 2008). Secondary victimization, also sometimes referred to as revictimization, is a term used to refer to the blame, stigma, alienation, trauma, and distress that victims experience as a response by the criminal justice and medical systems (Maier., 2008). Recently, literature had begun to look at how disclosure to informal sources also can act as a barrier to help-seeking. People may not seek help after a sexual assault because they are worried that the source they disclose to will force them to disclose to another source, often formal such as law enforcement (DeLoveh & Cattaneo., 2017).

### **Sources of Disclosure**

After experiencing an unwanted sexual experience, victims may choose to disclose to a formal or informal support source. Informal sources of support consist of friends and family (Sabina & Ho., 2014; DeLoveh & Cattaneo., 2017). Sabina & Ho reviewed 45 articles and reports with sample sizes ranging from five to 5,446 and found that in general victims of sexual assault do not disclose to formal sources and instead disclose to informal sources. Overall, rates of informal disclosure were considerably higher than rates of formal disclosure. Informal disclosure rates ranged from 41% in a study of 1,230 college students who are victims of unwanted sexual intercourse to 100% of a convenience sample of 12 women about sexual assault. Three studies found that disclosure to the police ranged from 0% for sexual coercion and date rape to 12.9% in a study of 5,446 undergraduate students for forced sexual assault. Studies also found that usage of campus services were 0% in 114 college students, and victims' crisis and health care centers were 15.8% in a study of 5,446 undergraduate students (Sabina & Ho, 2014). DeLoveh & Cattaneo conducted interviews with 14 college students, both undergraduate and graduate, who had self-identified as having an unwanted sexual experience. Of the 14 participants, 13 reported disclosing to at least one informal source and ten of these participants the informal source was their first disclosure (DeLoveh & Cattaneo., 2017)

Previous research has determined that sexual assault victims are more likely to disclose to informal sources such as friends or family over formal sources like the police or medical professionals. Most commonly, female friends are the main source of disclosure (Sabina & Ho, 2014). There is a gap in existing research when looking at both formal and informal sources, and the gender of the sources. The relationship between

female victimization and the gender of the support source utilized has not been investigated. Would a woman be more likely to disclose to a female regardless of what whether she is a formal or informal support source?

### **Support sources can be unhelpful**

Research has found that law enforcement engages in disbelieving and victim-blaming reactions that discourage women from reporting their experience. Greenson et al (2016) interviewed women about their experiences disclosing their assault to law enforcement. They concluded that experiences with law enforcement were mixed. Women frequently experienced a positive interaction with one officer and a negative interaction with another. Positive interactions are characterized by the police believing them, validating their experience and the decision to report. Negative experiences consisted of blaming the victim, focusing on behaviors other than those that occurred at the time of assault such as their school attendance or friends, and questioning the validity of the story. Additionally, victims were often lectured about their decisions, such as drinking or their clothing (Greenson et al., 2016). The fear of these negative experiences with law enforcement may discourage other women from reporting. There are also issues within the medical system that discourage women from seeking medical attention. A study found that medical students are more likely to blame a hypothetical rape victim that does not fit the stereotype of a “real” rape victim (i.e., raped by a stranger, appears emotionally distressed upon arriving at the emergency room; Maier., 2008). Health concerns as a result of a rape, such as unwanted pregnancies, STDs, HIV and AIDS are not usually addressed or adequately explained to victims in the emergency room. Victims may have to wait for a long time, unable to change, eat, use the bathroom, or anything

else that may dispose of evidence while waiting to be seen. Once seen, the examination is invasive and may be done by a male or someone without proper training on how to interact with a rape victim (Maier., 2008). Emergency room professions may not view rape victims as a legitimate patient in need of an emergency service because rape kits are not conducted for medical purposes. Their intent is to collect forensic evidence (Maier., 2008).

### **Victim blaming**

In a study conducted by Paul, Gray, Elhai, and Davis (2009) researchers examined rape myth acceptance. They reported that someone with a strong belief in rape myths, such as women wearing revealing clothes are asking to be sexually assaulted, are more likely to have stereotypical and negative beliefs regarding sexual assault and those who experience it. Individuals who have experienced sexual assault and believe that their peers hold negative stereotypes and beliefs associated with rape myth acceptance may experience more distress (Paul et al., 2009). This distress stems from a fear of being blamed for their victimization or stigmatized by others. Individuals that feel others hold victim blaming beliefs are less likely to disclose or seek treatment after an unwanted sexual experience (Paul et al., 2009). PTSD is commonly found in sexual assault victims and may play a role in a victim's development of maladaptive behaviors like avoidance behaviors such as failure to disclose and seek support (Ullman & Filipas., 2001). College students that are sexually assaulted may receive more negative responses because they're expected to know better and not put themselves at risk. Women who are sexually assaulted while in college may be more susceptible to rape myths and blame, especially if

the assault took place at a party. This study has also shown that younger women are held more responsible for their sexual assaults than older women (Ullman & Filipas., 2001).

### **Other negative attitudes**

Some individuals do not seek help because they are fearful that disclosing and engaging in help-seeking behaviors will not be helpful and may result in feeling revictimized (Sabina & Ho., 2014). Those who have had unwanted sexual experiences may believe that disclosure will lead to revictimization, victim blaming, “slut shaming”, and more pain than concealing the incident. The fear that disclosing will result in stigma is called anticipatory stigma. Due to other’s stories, media depictions, and the way peers discuss sexual assault, those who experience it may not disclose to anyone to avoid negative social reactions. Rape myth acceptance has been associated with negative psychological outcomes in college students who have experienced sexual assault (Dworkin et al., 2017). Survivors may internalize stigma regarding their victimization, which results in self-blame, shame and guilt. Rape myth acceptance could affect self-blame and how personal rape experiences are perceived, as well as beliefs about others, themselves, and the world (Dworkin et al., 2017).

### **How stigma relates to psychological well-being**

There is evidence that stigma can influence recovery for survivors of sexual victimization (Dworkin et al., 2017). Public stigma is a phenomenon of a majority of society endorsing stereotypes about and acting negatively against a stigmatized group (Wong et al., 2018). Public stigma may also be referred to as enacted stigma, perceived stigma, or social stigma (Wong et al., 2018). Anticipatory stigma is a person’s belief that others will act in a discriminatory or hostile way if their stigmatized identity is discovered

(Andresen & Blias., 2017). Self-stigma occurs when people believe and internalize negative stereotypes and as a result believe themselves to be less competent or unworthy of better conditions than the general public because of their stigmatized identity (Mak & Cheung., 2010). Self-stigma can be broken into three components: self-stigmatizing cognitions, self-stigmatizing affect, and self-stigmatizing behaviors. Self-stigmatizing cognitions are self-depreciatory thoughts, a feeling of inferiority and incompetence, and a negative sense of self. Self-stigmatizing affect is made up of feelings of sadness, embarrassment, shame, and anger. Self-stigmatizing behaviors are self-degradation, self-isolation, concealment of their stigmatized status, social withdrawal and social avoidance (Mak & Cheung., 2010). Self-stigma may also be referred to as internalized stigma or felt stigma (Wong et al., 2018). It's been asserted that a majority of individuals who have been sexually assaulted and/or raped do not seek help services of any kind. These individuals do not seek services from mental health professionals, victim programs, or crisis centers for post-assault aid (Kimberling and Calhoun, 1994). The direct relationship between stigma regarding sexual assault and negative outcomes has not been studied so far. Self-stigma among individuals with experiences of sexual assault may present similar negative outcomes as other concealable, stigmatized identities. Sexual assault survivors display adverse health outcomes. Some psychological consequences experienced by survivors are shock, denial, anxiety, depression, PTSD, and higher rates of suicide (Paul et al., 2009). There are also physical health outcomes as well. Aside from injuries sustained during the assault, survivors go to a physician for allergies, back pain, pounding heartbeats, tension headaches, menstrual symptoms, nausea, skin disorders, and

sudden weight changes more frequently after an unwanted sexual experience (Kimberling and Calhoun, 1994).

### **How stigma relates to help-seeking**

Like those with mental health issues, some individuals who experience sexual assault and/or rape may have a high level of self-stigma and perceived (public) stigma may be less likely to seek help (Nam et al., 2013). Previous research supports this result, showing that people with higher self-stigma were less likely to seek help to maintain a positive image of themselves (Nam et al., 2013). When survivors internalize stigma regarding their sexual victimization it may manifest as self-blame, shame, and guilt. These feelings have been associated with negative psychological outcomes among college students (Dworkin et al., 2017). In a study of 209 female veterans, it was found that those with high self-stigma regarding their sexual assault within the military were less likely to report their assault (Andresen & Blais., 2017). A study of 144 female college undergraduates found that participants fearful of others learning about their assault were less likely to disclose. These women were also more likely to be sexually revictimized again in the future (Miller et al., 2011).

### **Aims of this study**

There are three aims of the present study. The first is to develop measures of perceived stigma and self-stigma against individuals who have experienced sexual assault by adapting existing measures used for people with concealable stigmatized identities. The second is to examine how self-stigma, public stigma, and individuals' attitudes regarding sexual assault impact help-seeking behavior in hypothetical scenarios. Finally,

to examine whether help-seeking behavior in hypothetical scenarios of sexual assault vary based on the source and gender of support (e.g., police, mental health professionals, friends, etc).

## **Method**

### **Participants**

The sample consisted of 131 students at SUNY Brockport enrolled in Principles of Psychology during the Fall 2020 semester who self-identified as female. The participants' ages ranged from 18 to 40, with the mean age being 18.86 (SD=2.5). 112 (86.8%) of the participants self-identified as white, 13 (10.1%) self-identified as black or African American, and 2 (1.6%) self-identified as multiracial. The majority of participants, 110 (85.3%) participants self-identified as heterosexual, only 2 (1.6%) participants self-identified as homosexual, and 13 (10.1%) identified participants as bisexual. 90 (69.8%) participants were first year students, 20 (15.5%) participants were second year, 11 (8.5%) participants were third years, and 8 (6.2%) participants were in college for four years or longer. 54 (41.9%) of the participants had a previous unwanted sexual experience, and 75 (58.1%) did not.

### **Design and Procedure**

The design was a correlational, survey study. Research approval was sought and obtained from the Institutional Review Board at SUNY Brockport after a full board review. Participants were recruited through the SONA system, a departmental human subject pool system. . The survey was administered via Qualtric. As compensation for participation participants were granted 1 research credit for their class. In order to maintain anonymity in the process of credit granting, after participants completed the

Qualtrics survey, they were directed to an independent Google Form to provide personal information. In the Qualtrics survey, participants were asked in the demographics section if they had a previous unwanted sexual experience. If the participant answered “yes”, they were presented with an additional measure - the self-stigma measure. A link to resources was included on every page of the survey in case the participant felt emotionally distressed by the survey. The website is provided by SUNY sexual assault and violence response (SUNY SAVR). It has a search engine that allows individuals to find resources based on their locations. Individuals may search resources by entering a zip code, searching for a college campus, or looking through resources offered by New York State and nationally. Additional details about the resources are provided on the website, such as whether they’re available 24/7, the confidentiality, if it’s an LGBT+ organization, and if the resource offers forensic exams.

### **Development and Adaption of Measures**

**Help-seeking intention.** Nine hypothetical scenarios depicting various unwanted sexual situations were created. These scenarios included various relationships to the participant such as a partner, a friend, a co-worker, a classmate, and a potential romantic partner, and different methods of perpetrating the experience like threats, the use of violence, coercion, and alcohol identified in the Sexual Experiences Survey (Koss & Gidycz., 1985). In some scenarios the act was completed and in others it was merely attempted. Eight common support sources for sexual assault were identified (i.e., police, doctor, advocate, support group, mental health professional, family members, friends, and anonymous call-center representatives). Using a 5-point Likert scale ranging from (1) extremely likely to (5) extremely unlikely, participants answered how likely they would

be disclosing an unwanted sexual experience and seeking help from a man and woman in the support sources for each scenario.

Participants who answered “yes” to the demographic question of having a prior unwanted sexual experience were prompted with an additional question prior to the scenarios. This question stated that there were hypothetical scenarios that potentially would be emotionally distressing or triggering and offered these participants the ability to skip this section of the survey, if preferred.

### **Stigma experience.**

The Public (Societal) Stigma Scale (PSS) was adapted using the Minority Stress Scale (Norichi Pala et al., 2017) and the HIV Felt Stigma Scale (Herek, Saha, & Burack, 2013). These scales were chosen because they assess stigma experiences among individuals with concealable identities, and that having unwanted sexual experiences could be regarded as an concealable stigmatized identity. The scale consists of 7 items using a 5-point Likert Scale ranging from (1) strongly disagree to (5) strongly agree.

**The Self-Stigma and Concealable Identity Scale .** The Self-Stigma and Concealable Identity Scale (SSCIS) was adapted and shortened to apply to sexual assault. The measure originally measures a person’s self-stigma based on their concealable identity, which is left blank to be applied to various concealable identities. For sexual assault, items were altered to be grammatically accurate or removed due to not being applicable for sexual assault. An example of a removed item was “I cannot measure up to others no matter how hard working I am due to my identity as someone who experienced sexual assault.” This measure was only presented to participants who answered “yes” to experiencing a sexual assault. The measure contains 9 items scored on a 5-point Likert

Scale ranging from (1) completely disagree to (5) completely agree. Higher scores represent higher levels of self-stigma.

### **Measures**

**Illinois Rape Myth Acceptance Scale.** The Illinois Rape Myth Acceptance Scale (IRMA) measures individual levels of endorsement of rape myths, or stereotypes regarding unwanted sexual experiences. These generally are a cluster of cultural beliefs and attitudes related to accepting gender stereotypes and roles, interpersonal violence, and adverse sexual beliefs. The IRMA short version consists of 21 items broken down into 8 subscales on a 7-point Likert Scale ranging from (1) not at all agree to (7) very much agree. These subscales are she asked for it, it wasn't really rape, he didn't mean to, she wanted it, she lied, rape is a trivial, rape is a deviant event, and some filler items. Higher scores indicate a higher degree of rape myth acceptance.

**Alcohol and Sexual Consent Survey.** The Alcohol and Sexual Consent Survey (ASCS) measures the participant's beliefs regarding a person's ability to consent to sexual contact when under the influence of alcohol. The ASCS is broken down into two subscales: campus beliefs and myths and sexual assault programming messages. The ASCS scale consists of 12 items in which participants are asked to choose the degree to which they agree with the statements on a 7-point Likert scale ranging from (1) not at all agree to (7) very much agree. A higher score indicates more acceptance of sexual consent experiences in which at least one participant is under the influence of alcohol.

**Sexual Experiences Survey.** The Sexual Experiences Survey (SES) measures various unwanted sexual experiences under different conditions since age 14 and within the last 12 months. The short version of the measure consists of seven unwanted sexual

experiences with five ways the perpetrator engaged in the experience. These included telling lies, using threats, or verbally pressure, getting angry and criticizing the attractiveness of the victim, taking advantage of a person who was not sober, threatening physical harm to the victim or someone close to them, or using force.

## Results

### **Hypothesis One: Potential Differences in Help-Seeking Intention across Support**

#### **Sources**

A repeated measures ANOVA with a Greenhouse-Geisser correction was used to determine if the likelihood to seek help after a sexual assault may differ across various support sources. Results indicated that there were significant differences in the likelihood to seek help after a sexual assault across various support sources,  $F(4.44, 541.38) = 29.30, p < 0.001$ ). Post Hoc tests using Bonferroni correction were then conducted. Results indicated that participants were more likely to seek help from police than doctors, advocates, and support groups ( $p < 0.001, p = .003, p < 0.001$  respectively). Participants were more likely to seek help from mental health professions than doctors ( $p < 0.001$ ), advocates ( $p = 0.001$ ), support groups ( $p < 0.001$ ), and anonymous call-center representatives ( $p < 0.001$ ). Participants were more likely to seek help from friends than any other support source ( $p < 0.001$ ). Please see Table 1 for the mean and *SDs* of each support source.

### **Hypothesis Two: Potential Gender Preference in Help-Seeking Intention**

Dependent-samples t-tests were conducted to compare the preference of male support sources to female support sources. For this hypothesis, higher scores indicated lower help-seeking intention from the support source. There was a significant difference

between likelihood to disclose to male police ( $M = 2.78$ ,  $SD = 0.99$ ) and female police ( $M = 2.19$ ,  $SD = 0.89$ );  $t(122) = -0.45$ ,  $p < 0.01$ . A significant difference was also found between male doctors ( $M = 3.06$ ,  $SD = 1.12$ ) and female doctors ( $M = 2.37$ ,  $SD = 1.03$ );  $t(122) = -0.55$ ,  $p < 0.0001$ . There was a significant difference between disclosing to male advocates ( $M = 3.06$ ,  $SD = 1.04$ ) and female advocates ( $M = 2.39$ ,  $SD = 1.12$ );  $t(122) = -8.89$ ,  $p < 0.0001$ . A significant difference was determined between male-led support groups ( $M = 3.27$ ,  $SD = 1.10$ ) and female-led support groups ( $M = 2.48$ ,  $SD = 1.15$ );  $t(122) = -9.39$ ,  $p < 0.001$ . There was a significant difference between male mental health professionals ( $M = 2.88$ ,  $SD = 1.45$ ) and female mental health professionals ( $M = 2.10$ ,  $SD = 0.91$ );  $t(122) = -9.08$ ,  $p < 0.001$ . A significant difference also was found between male family members ( $M = 3.16$ ,  $SD = 1.22$ ) and female family members ( $M = 2.19$ ,  $SD = 1.12$ );  $t(122) = -10.67$ ,  $p < 0.001$ . There was a significant difference male friends ( $M = 2.49$ ,  $SD = 1.20$ ) and female friends ( $M = 1.55$ ,  $SD = .58$ );  $t(122) = -9.29$ ,  $p < 0.001$ . A significant difference between male anonymous call-center representatives ( $M = 3.15$ ,  $SD = 1.26$ ) and female anonymous call-center representatives ( $M = 2.71$ ,  $SD = 1.34$ );  $t(122) = -6.08$ ,  $p < 0.001$ .

### **Hypothesis Three: Potential Correlates of Help-Seeking Intention**

A Pearson correlation coefficient was computed to assess the relationship between self-stigma and support source, see Table 2. There was a significant, positive, weak correlation between self-stigma and disclosing to friends,  $r = .29$ ,  $p = 0.05$ . A Pearson correlation coefficient was also computed to assess the relationship between perceived-stigma and support source. Significant, positive correlations were found between perceived-stigma and disclosing to police ( $r = .23$ ,  $p < 0.01$ ), doctors ( $r = .19$ ,  $p < 0.05$ ),

family member ( $r = .31, p < 0.001$ ), and friend ( $r = .18, p < 0.05$ ). Finally, a Pearson correlation coefficient was computed for Rape Myth Acceptance and reluctance to disclose a sexual assault. This was also calculated for the Alcohol and Sexual Consent Scale. For both measures, there was no statistically significant difference in disclosure of a sexual assault to any of the eight support sources.

### **Discussion**

The present study was conducted to examine help-seeking behaviors of self-identified college women after hypothetical scenarios of sexual assault. It also looked at a gender preference in the support source help is sought from. Lastly, it investigated whether self-stigma, perceived stigma, and/or attitudes towards sexual assault impacted the willingness to seek help from each support source.

The first hypothesis aimed to look at how likely self-identified college women were to seek help from various support sources in hypothetical scenarios of sexual assault. The second hypothesis examined whether there was a gender difference between the support sources preferred in hypothetical scenarios of sexual assault. The present findings support previous literature (Sabina & Ho., 2014) that after a sexual assault people are most likely to disclose their experience to a female friend. In the present study, participants reported that they were more likely to seek help from friends than other support sources in hypothetical scenarios of sexual assault. Participants also reported that they were more likely to seek help from female support sources than male support sources, and this pattern was shown consistently across support sources. Participants were most likely to seek help from female friends compared to all other support sources. Results also indicated that participants were less likely to seek help from doctors,

advocates, support groups, and anonymous call center representatives compared with police officers and mental health professionals.

The third hypothesis sought to look at whether self-stigma, perceived stigma, and attitudes towards sexual assault may correlate with individuals' willingness to seek help in hypothetical scenarios of sexual assault. Self-stigma was found to be significantly associated with disclosure to friends. Perceived stigma was found to be significantly associated with police officers, doctors, family members, and friends.

In the present study, individuals' attitudes toward sexual assault were indicated by their scores in the Rape Myth Acceptance Scale, as well as their scores in the Alcohol and Sexual Consent Scale. Results showed that attitudes toward sexual assault were not significantly associated with willingness to disclose a sexual assault, regardless of the support source. A possible reason for the null association found in the present study is the presentation order of the measures. In the present study, the hypothetical scenarios of sexual assault were presented prior to the Alcohol and Sexual Consent Scale and the Rape Myth Acceptance Scale. Given that the hypothetical scenarios required participants to imagine themselves being the victims in those scenarios, it may have primed the participant to feel more sympathetic towards the situation, and therefore altered their responses to the measures of attitudes toward sexual assault. Future studies may counter-balance the presentation orders of help-seeking intention (i.e., hypothetical scenarios of sexual assault) and attitude toward sexual assault and re-examine the association between the two variables.

### **Limitations and Future Directions**

One of the limitations in this study was the use of convenience sampling. This resulted in a sample that was relatively homogeneous in regard to age (~19), race (86.8% white), and sexuality (85.3% heterosexual). An additional limitation was the absence of a demographic question regarding sex. The study was open to self-identified women however a question was not included to ask if the participant was transgender or cisgender. Including this question in the demographic section would allow for comparison between transgender women and cisgender women in their experience of sexual assault or preferences in support source. In the present study, 54 participants (out of 131 participants) indicated past unwanted sexual experience and completed the self-stigma measure. However, the sample size was too small for conducting confirmatory factor analysis.

Future research should aim to recreate the present study with a more demographically diverse sample. Differences in race, age, gender, and sex may be identified in more diverse samples. There is a possibility that individuals' willingness to seek help from various support sources and/or different gender preferences may vary across demographics. Additionally, future research may use a larger sample to further examine the impact of self-stigma on the disclosure of an unwanted sexual experience. Future research may also examine why self-identified women prefer to disclose to some sources but not others, and why they prefer to disclose to other women than men. Also, it may be important to examine the consequence of getting preferred support (vs. not so preferred support), how that may impact the victim's well-being and recovery. Is it common for there to be women in positions to support sexual assault survivors? Finally,

future research may look to answer this question by inspecting implementation of women in support sources for sexual assault.

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Table 1. Mean and Standard Deviations of Help-Seeking Intention Across Support Sources

Support Sources	Mean	<i>SD</i>
Male Police Officer	2.78	0.99
Female Police Officer	2.19	0.89
Male Doctor	3.06	1.08
Female Doctor	2.37	1.03
Male Advocate	3.06	1.04
Female Advocate	2.39	1.12
Male-led Support Group	3.27	1.10
Female-led Support Group	2.48	1.15
Male Mental Health Professional	2.88	1.15
Female Mental Health Professional	2.10	0.91
Male Family Member	3.16	1.22
Female Family Member	2.19	1.12
Male Friend	2.49	1.20
Female Friend	1.55	0.58
Male Anonymous Call Center Representative	3.15	1.26
Female Anonymous Call Center Representative	2.71	1.34

Table 2. Correlation Between Stigma Measures and Support Sources

Variable	ASCS	RMA	SSCIS	PSS	Police	Doctor	Advocate	Support Group	MHP	Family	Friend	Representative
ASCS	-	0.33**	-0.02	-0.18*	-0.06	-0.02	-0.01	-0.02	-0.05	-0.09	0.06	0.01
RMA	-	-	0.09	0.02	0.06	0.05	0.09	0.12	0.02	0.08	0.1	0.12
SSCIS	-	-	-	0.51**	0.22	0.17	0.08	0.13	0.05	0.18	0.29*	0.03
PSS	-	-	-	-	0.23*	0.19*	0.05	0.04	0.14	0.31**	0.18	0.05

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

**Appendix A**

## Hypothetical Scenarios of Sexual Assault

1. You were watching a movie with a friend in his dorm. As the movie wore on, he kissed you and you felt uncomfortable. He tried to remove your clothes and you say “no, please stop.” He assured you that “you’ll like it.” You push him off you. His attempt was unsuccessful.
2. You’re in a relationship. Your boyfriend wants to have sex, but you do not. You say that you’re not in the mood. Your boyfriend says “Well, if you really loved me you would.” After repeating this for a while, you give in.
3. Your friend offers to walk you home late one night. When you arrive at your home, he asks to come inside to use the bathroom. You let him inside. He kisses you and puts his hands under your shirt. You push them away and say stop. He puts his hands around your throat and says if you scream, he will choke you.
4. Your classmate comes over to study. While studying, he asks if you want to make it more fun. You ask what he means. He asks if you want to have sex. You say no. He kisses you; you freeze. He removes your clothes and has sex with you. You don’t fight him or say anything else.
5. You started texting a guy a few weeks ago. You think he might like you, and you feel excited. He asks if you want to hang out and watch a movie. You agree. While watching the movie, he kisses you. You kiss him back. When he tries to remove your clothing, you tell him to stop. You don’t want to. He calls you a tease and says if you didn’t want to hook up, you shouldn’t have invited him over.

6. Your manager offers to drive you home from work. She pulls off on the side of the road and begins to kiss you. You tell her to stop. She says if you do not engage in sexual activities with her, she will get you fired from your job. You cannot afford to lose your job.
7. Your manager calls you into his office. He tells you to sleep with him. You refuse. He says that he will tell everyone you slept with him and you will lose your job. If you sleep with him, he will give you a raise and not have you fired.
8. You get drunk and decide to spend the night at a friend's house. You fall asleep and wake up to your friend kissing you and putting her hand down your pants. You try to tell her to stop, but you lose consciousness.
9. After drinking with friends one night, a few walk home with you and are planning to spend the night. You are drunk and decide to go to sleep in your bed. You wake up to someone on top of you. He covers your mouth and tells you to be quiet. You try to fight him off but you can't.

## **Appendix B**

### Alcohol and Sexual Consent Scale

1. A woman who is drinking heavily can still give legal consent to sexual activity.
2. A person who is sexually assaulted after drinking alcohol should only blame him- or herself.
3. Consensual drunk sex is a normal and harmless part of college life.
4. Alcohol is the most common date rape drug (or substance).
5. When a person is drinking alcohol, he or she is implying interest in engaging in sexual activity.
6. If both partners are drunk and have sex, there is no way the man can be accused of sexual assault or rape.
7. The more alcohol a person has consumed, the less able he/she is to consent to sexual activity.
8. For men, intoxication is not a defense against the charge of rape or sexual assault.
9. If a person who has been drinking becomes sleepy or unconscious, he/she cannot give consent to any sexual activity.
10. When alcohol is involved in a sexual situation, communication signals are easily misinterpreted.
11. As a general rule, alcohol makes sexual situations easier and more enjoyable for both men and women.
12. Alcohol use makes a person more vulnerable to sexual assault.

Ward, R. M., Matthews, M. R., Weiner, J., Hogan, K. M., & Popson, H. C. (2012).

Alcohol and sexual consent scale: Development and validation. *American Journal of*

*Health Behavior*, 36(6), 746–756. <https://doi->

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## Appendix C

### Rape Myth Acceptance Scale Short Version

1. If a woman is raped while she is drunk, she is at least somewhat responsible for letting things get out of control.
2. Although most women wouldn't admit it, they generally find being physically forced into sex a real "turn-on."
3. If a woman is willing to "make out" with a guy, then it's no big deal if he goes a little further and has sex.
4. Many women secretly desire to be raped.
5. Most rapists are not caught by the police.
6. If a woman doesn't physically fight back, you can't really say that it was rape.
7. Men from nice middle-class homes almost never rape.
8. Rape accusations are often used as a way of getting back at men.
9. All women should have access to self-defense classes.
10. It is usually only women who dress suggestively that are raped.
11. If the rapist doesn't have a weapon, you really can't call it a rape.
12. Rape is unlikely to happen in the woman's own familiar neighborhood.
13. Women tend to exaggerate how much rape affects them.
14. A lot of women lead a man on and then they cry rape.
15. It is preferable that a female police officer conduct the questioning when a woman reports a rape.
16. A woman who "teases" men deserves anything that might happen.
17. When women are raped, it's often because the way they said "no" was ambiguous.

18. Men don't usually intend to force sex on a woman, but sometimes they get too sexually carried away.
19. A woman who dresses in skimpy clothes should not be surprised if a man tries to force her to have sex.
20. Rape happens when a man's sex drive gets out of control.

Payne, D. L., Lonsway, K. A., & Fitzgerald, L. F. (1999). Rape myth acceptance: Exploration of its structure and its measurement using the Illinois Rape Myth Acceptance Scale. *Journal of Research in Personality*, 33(1), 27–68. <https://doi-org.brockport.idm.oclc.org/10.1006/jrpe.1998.2238>

## Appendix D

### Self-Stigma and Concealable Identity Scale, Adapted for Sexual Assault

1. My identity as someone who experienced sexual assault is a burden to me.
2. My identity as someone who experienced sexual assault incurs inconvenience in my daily life.
3. The identity of being someone who experienced sexual assault taints my life.
4. I feel uncomfortable because I am someone who experienced sexual assault.
5. I fear that others would know that I am someone who experienced sexual assault.
6. I feel like I cannot do anything about my status as someone who experienced sexual assault.
7. I estrange myself from others because I am someone who experienced sexual assault.
8. I avoid interacting with others because I am someone who experienced sexual assault.
9. I dare not to make new friends lest they find out that I am someone who experienced sexual assault.

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## Appendix E

### Public (Societal) Stigma Scale Adapted from the Minority Stress Scale and HIV Felt Stigma Scale

1. Most people think a person who experienced sexual assault is disgusting.
2. Most people would welcome a person who experienced sexual assault.
3. Most people are afraid to be around a person who experienced sexual assault.
4. Most people think a person who experienced sexual assault should feel guilty about it.
5. Most people would not want to date a person who experienced sexual assault.
6. Most people would not want to marry a person who experienced sexual assault.
7. Most people think if you are a person who experienced sexual assault you are not as good as everyone else.

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