Female Sexual Arousal During Rape: Implications on Seeking Treatment, Blame, and the Emotional Experience

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Abstract

Currently, survivors' experience during sexual assault is underrepresented in the literature especially regarding survivors who claim that they unwillingly became aroused during the assault. This lack of research may be due to the risk that it may seem accusatory or fear that it will harbor more self-blame and shame in an individual who is already experiencing immense blame and shame. It seems negligent to ignore this real experience that some sexual assault survivors experience and not allow them a platform to express their experience. The aim of this study was to compare females who experienced sexual arousal during their sexual assault to those who did not and assess their treatment seeking behaviors, different forms of blame, and their overall emotional experience. Female sexual assault survivors between the ages of 18 to 50 years old completed an online survey through Qualtrics and were placed into two separate groups (*N = 166;* 115 in the non-aroused group; 51 in the aroused group). There were no significant group differences in regards to help-seeking behaviors, satisfaction with one's therapist, self-blame, blame placed on the rapist, and control over the recovery process. There was statistical evidence that those who were sexually aroused told significantly fewer people about their sexual assault compared to those who did not endorse sexual arousal. These findings provide evidence that female sexual arousal is an actual experience and should no longer be spoken about anecdotally. Clinicians are encouraged to initiate the topic of arousal with their patients and emphasize that it is a natural, physical response in hopes to reduce any shame and blame that accompanies different rape myths.

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CHAPTER I

Literature Synthesis and Statement of the Problem

The terms rape, sexual assault, sexual abuse, and sexual misconduct have been widely used to cover an array of similar situations. These terms are not only vaguely defined but also differ among states. Currently, 25 states legally define rape using different terminology, descriptions and classifications. The other 25 states have no solid definition of such a complex trauma; instead these states have opted to classify all forms of nonconsensual sexual penetration as a crime (Rape, Abuse, and Incest National Network [RAINN], 2017). These states most commonly refer to rape as sexual assault, sexual abuse, or criminal sexual conduct. The majority of the country does have the words "consent" or "will" in the description of the crime. Florida, Michigan, Mississippi, New Mexico, and Rhode Island do not have "consent" or "will" in their definitions and focus on the forcible penetration aspect of rape (RAINN, 2017).

The U.S. Department of Justice-Federal Bureau of Investigation (FBI, 2017) defines rape as "penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim. This includes attempts or assaults to commit rape." This definition was created in 2013 after the FBI collected data on rape offenses to analyze what would make a better definition. Prior to the data collection, the definition of rape that the FBI used was "the carnal knowledge of a female forcibly and against her will" (FBI, 2017). This definition dates all the way back to 1876 when William Blackstone published the definition in his book Commentaries on the Laws of England.

Blackstone's definition was expanded during 1962 when the Model Penal Code (MPC) was created (Schulhofer, 2017). The MPC is an extremely influential resource for states to use in standardizing criminal laws. The MPC extended the definition to include nonviolent threats

such as blackmailing someone if they did not engage in sexual intercourse (Schulhofer, 2017). This expanded definition was not welcomed by all states and many continued to use Blackstone's definition. During the 1980s the feminist movement pushed to reform laws concerning sex crimes. During this time, people argued that rape was a violent act on women's autonomy, and they tried to enact laws that enforced the idea of "no means no" (Clay-Warner & Burt, 2005). Survivors expressed frustration about being blamed for their rape based on insignificant facts, such as what they were wearing that night, how much they drank, dancing, being on birth control, and other behaviors.

History and research have provided evidence that some men believe that these certain behaviors from women are signs of consent for future sexual experiences (Krause, DeRosa, & Roth, 2002; Muehlenhard & Linton, 1987). Professor Catharine MacKinnon's book, "Toward a Feminist Theory of the State" (1989, p. 177), addresses the fact that the term "will" is extremely subjective and the victim "may have or perceive no alternative but submit to survive." She argues that physical force is not necessary to constitute rape. When MacKinnon published this book, there were some states that were in agreement with her but the majority still believed there needed to be a component of violence inflicted on the victim (Schulhofer, 2017).

The MPC attempted to expand their definition but failed to mention that consent must be given prior to sexual contact, suggesting that saying "no" is insufficient proof that rape occurred. However, since 2001, 17 states have redefined rape so that an individual may withdraw his or her consent at any time and no longer requiring the stereotypical use of force to determine if a rape has occurred (Decker & Baroni, 2012; Lyon, 2004). In 2014, the state of California developed the "'yes means yes' law," requiring affirmative consent for sexual activity. Lack of protest, lack of resistance, and silence are unable to be interpreted as signs of consent under this new law

(Cook & Messman-Moore, 2017). Men often believe, and legal courts sometimes agree, that the woman has already "consented" with her prior behavior, so there is no need to consider voicing of non-consent later (Lonsway, 2010).

States are now not only changing their laws about consent but they are reexamining how consent is defined (RAINN, 2017). This may be in part because of advocacy and research regarding Tonic Immobility (TI). Tonic Immobility is a temporary motor inhibition or the freeze response that both humans and animals can experience when in the presence of danger (TeBockhorst, O'Halloran, & Nyline, 2015). Moller, Sondergaard and Helstrom (2017) conducted the first large sample size study of rape victims who experienced TI. They spoke to victims at a follow up appointment shortly after their initial hospital visit. They found that 70 percent of the women surveyed experienced moderate TI. Additionally, they discovered that there was a strong association between moderate TI and severe depression during the six-month follow up period. These findings are extremely important to how the definition of consent is worded. If courts demand that victims resisted for the assault to classify as rape, individuals who experience TI will not be able to make this claim. It is important that the court systems do not put further guilt and shame on the victim and recognize that this was not consent but the body's innate response to a serious attack.

With current research focusing on the victim's experience at the time of the rape it is crucial to include the variety of potential experiences. The limited research from Levin and Van Berlo (2004) that assessed female genital arousal during sexual assault suggests that 4-5 percent of female rape victims experienced orgasm during their trauma, though Levin and Van Berlo suspect these numbers are underreported due to fear of judgement. Despite this contribution to the field, limited research has directly assessed female genital arousal during sexual assault, and

the impacts it has on women and it is only spoken about anecdotally in clinical practice. Women who have experienced such arousal not only have to experience the shame and guilt that accompanies the rape but also confusion about why their body responded this way. To gain some clarity on their emotions, the victim may seek psychotherapy. Clinicians are trained to be nonjudgmental and comforting to the individuals they treat. However, there is no training on what approach to take with patients who come in expressing arousal during their sexual assault. The therapist may be perceived as confused or unaware how to respond, potentially causing additional distress to the patient. It would be wise for therapists to include arousal in their psychoeducation so that the survivor does not have to initiate the conversation. Researchers must look further into this topic to examine the evidence about sexual arousal during sexual assault. This will empower change and help redefine consent, just as research on tonic immobility. The courts will see that just like "freezing," arousal does not mean consent but instead is the body's innate response to sexual contact.

Statement of the Problem

One in six women will have reported an attempted or completed sexual assault in their lifetime (RAINN, 2017). However, their experience during these assaults is extremely under examined. It appears that only one study has explicitly examined the impacts that sexual arousal during sexual assault has on the victim (Levin & Van Berlo, 2004). This lack of examination in the research may be due to the risk that it seems accusatory, or fear that it will harbor more self-blame and shame in an individual who is already experiencing immense blame and shame. It is negligent to ignore this real experience that a portion of sexual assault victims experience and not give them a platform to express the challenges they faced after their assault. Due to this phenomenon being neglected in research, there is no formal education for therapists on how to

appropriately approach this delicate topic. If a victim discloses to the therapist that they are confused and ashamed because they were aroused during their rape, it is the job of the therapist to approach this with care and be cautious to not cause additional distress (Campbell & Raja, 1999). To advance research, clinicians and researchers should be aware of the exacerbating effects of arousal during sexual assault, as it will help them better recognize, understand, and treat clients' unique trauma reactions and symptom expression. Due to this, there is an immense need for research focused on female survivors' who experience sexual arousal during a sexual assault.

Literature Review

The present literature review examines the following topics: (1) physiological arousal (2) psychological arousal, (3) arousal non-concordance, (4) post trauma effects (5) secondary victimization, (6) psychological impact, (7) shame, (8) guilt and blame, (9) current rape trauma informed care. These topics lay the foundation for how experiencing arousal as a female, impacts seeking treatment and emotional expression.

Physiological Arousal. The majority of research on women's physiological genital arousal is conducted in a lab setting, making it appear difficult to generalize to real world experiences, but Paterson, Jin, Amsel, & Binik (2014) discovered that orgasmic pleasure and intensity were slightly higher in a laboratory setting compared to home. They believe this is because there is a greater sense of relief of tension in a laboratory environment. This low level of anxiety could be analogous to what is experienced during assault. Physiological sexual arousal was first documented by Masters and Johnson (1966), who characterized physiological arousal by an increase in genital blood flow, which leads to swelling of the vagina, vulva, and clitoris; increased genital sensation; and vaginal lubrication and lengthening. Research confirms

that the arousal process is a complex neurophysiological process involving the parasympathetic (PNS), sympathetic (SNS), and peripheral nervous systems (Stanton, Pulverman, & Meston, 2017; Traish, Kim, Min, Munarriz, & Goldstein, 2002) but when fear is added to the equation the process becomes even more complex (Suschinsky & Lalumière, 2011).

When humans are put in a fearful situation the amygdala alerts the hypothalamus and prefrontal cortex to identify relevant stimuli while activating the PNS. The amygdala is responsible for processing information regarding basic drives and emotions. When not functioning properly, these three structures impair the regulation of fear responses and hypervigilance to threat-related stimuli (Cuevas, Balbo, Duval & Beverly, 2017). Stimulated by the amygdala, the hypothalamic-pituitary-adrenal axis is activated, and the hypothalamus sends a signal to the pituitary gland, which activates the adrenal glands to release hormones that help the body respond to, cope with, and recover from trauma. Under stressful conditions, glucocorticoids such as cortisol provide the body with energy, and catecholamines, such as norepinephrine and epinephrine, prepare the body to respond (Southwick, Vythilingam, & Charney, 2005). It is important to note that norepinephrine is the dominant neurotransmitter through which the SNS exerts its effects, and norepinephrine agonists, such as ephedrine, increase arousal (Meston & Heiman, 1998). The release of cortisol and norepinephrine is critical for a flight or fight response, but overly high of levels can impair cognitive functioning in the prefrontal cortex by impacting working memory (Cuevas et al., 2017).

As stated above, the PNS is activated by the amygdala and incorporated with the increase and decrease in heart rate that occurs with respiration through the vagal nerve (Stanton et al., 2017). When one's heart rate increases from inhaling, the influence from the PNS decreases, and during exhaling the influence from the PNS increases. The influence from the PNS can change

quickly depending on the environment and need for arousal (Southwick, Rasmusson, Barron & Arnsten, 2005).

In times of stress the sympathetic nervous system (SNS) becomes dominant, allowing for increased physiological arousal to help the body with any immediate challenges (Appelhans & Luecken, 2006). If the body's innate response is to flee, the SNS facilitates blood flow to the lower extremities. If the body's innate response is to fight, the SNS facilitates blood flow to the upper extremities (Baldwin, 2013). Research demonstrates that when the SNS was sampled from women who were anticipating sex there was an increase in biochemical markers (Lorenz, Harte, Hamilton, & Meston, 2012). Many studies have suggested that the SNS activation during exercise significantly increased physiological sexual arousal in women, which may serve to replicate the fight or flight response (Meston, 2000; Meston, Gorzalka, 1995; Stanton et al., 2017). Palace and Gozalka (1990) reported an increase in the SNS when women were presented with anxiety evoking stimuli before viewing erotic stimuli compared to viewing neutral stimuli prior to viewing the erotic stimuli. This may be why some victims of sexual assault experience arousal.

When looking at the relationship between vagal activity and orgasm, much research has confirmed that the vagal nerves send genital sensory activity from the vagina to the brain (Frangos, Ellrich & Komisaruk, 2015; Komisaruk & Whipple, 2005). Vagal activity is at its peak when the body is at rest (Rottenberg, 2007). This is because the vagal pathway slows the heart rate so the body can conserve energy until conditions become more challenging (Stanton et al., 2017). Healthy individuals have a rapid withdrawal of vagal activity when placed in stressful situations (Berntson et al.,1997).

Lastly, the peripheral components involve the swelling and lubrication of the vagina from the increased blood flow. Little research has identified if there is an innate response for swelling and lubrication of the vagina regardless of psychological arousal. Suschinsky and Lalumière (2011) suggest that there is substantial ethnographic, historical, and comparative evidence suggesting that the threat of unwanted sexual activity has been used over human evolutionary history and that it is important that genital arousal leads to lubrication. This reduces the likelihood of injury occurring when unwanted sexual encounters take place. They discovered this theory by having 15 females listen to different scenarios read aloud that involved consensual sex and nonconsensual sex. To measure arousal, they used a vaginal photoplethysmograph (VPP). A VPP is a tampon-shaped device that works by using light to measure the amount of blood in the walls of the vagina. What they discovered is that women had an increased lubrication and vaginal contraction when listening to the nonconsensual sexual experiences. Levin (2003) suggests that it does not matter what type of sexual stimulus is present but instead that the female body prepares itself for vaginal penetration when cued by any sexual stimulus, producing lubrication in order to keep the body safe.

Handy and Meston (2016) used a VPP and an arousometer to conduct a study to identify the extent to which women could perceive their genital arousal. The arousometer is a device with a numbered lever to represent changes in sexual arousal. The participants were showed erotic images and asked to use the arousometer to rate their arousal. These ratings were then compared to the VPP measurements. They discovered a linear relationship between women's physiological and perceived genital arousal. This is evidence that women can perceive the degree of their genital arousal. A metanalysis of 132 articles related to women's arousal showed

that overall there seems to be a small positive relation $r = 0.26$ between physiological and subjective arousal (Chivers, Seto, Lalumière, Laan, & Grimbos, 2010).

Psychological Arousal. Female sexual arousal is considered a multidimensional and dynamic process that includes emotional, behavioral, and physiological components that are interrelated, but also partly independent (Laan & Everaerd, 1995). It is important to examine subjective arousal, which can be defined as an "affect-cognition blend in the conscious awareness of physiological sexual arousal and sexual affect such as interest, enjoyment, pleasure or anticipation" (Mosher, Barton-Henry, & Green, 1988, p. 414). This form of arousal is most commonly assessed retrospectively by asking the participant to think of their experience during a sexual encounter or when they were watching a film to induce arousal (Rellini, McCall, Randall, Meston, 2005). Research typically uses a Likert Scale to rate their arousal. This form of assessment has been questioned by some researchers because it is hypothesized that women's attitudes towards sex and sexual stimuli may skew their answer and not be a true estimate of their physiological arousal during the sexual experience (Handy & Meston, 2016). Because of this, the majority of current research incorporates a dual process approach by assessing both physiological arousal and subjective arousal (McDonagh-Coyle, McHugo, Friedman, Schnurr, Zayfert, & Descamps 2001; Meston, 2006; Relleni et al., 2005). Researchers agree that measuring subjective arousal is a vital part of the arousal picture, because there is scientific evidence that women are more inclined to pay attention to external stimuli than internal physiological states when assessing their level of sexual arousal (Pennebaker & Roberts, 1992; Rellini et al., 2005).

Research looking at fear and anxiety with sexual arousal has many mixed viewpoints. Dutton and Aron (1974) suggest an arousal misattribution theory that suggests that individuals

experiencing arousal when in danger may misinterpret their arousal and attribute it to the sexual stimuli. They discovered this by having one group of male participants cross a fear-arousing bridge that was suspended 230 feet above rapids and a second group of males cross a bridge that was 10 feet above a small river. Each group was then greeted by a female confederate who asked the men if they would like to participate in a project for her class that was on the "effects of exposure to scenic attractions on creative expression" (p. 511). The female would then have the men fill out a brief questionnaire as well as asking them to write a brief, dramatic story of what was happening in a picture that was presented. The picture presented was item 3GF from the Thematic Apperception Test (TAT) which is picture of a young woman covering her face with her other hand reaching out. Not only did Dutton and Aron (1974) measure perceived arousal through the sexual material in the stories written from the TAT but also by having the female confederate provide the males with her phone number to contact her if they had any questions regarding her project. The results indicated that those on the 230-foot bridge had more sexual content in their stories and were more likely to reach out to the confederate, which indicated that the authors confirmed their hypothesis. The greater one's fear, the more they would misattribute the arousal that was experienced from crossing the bridge as a sexual attraction to the female confederate. Unfortunately, they did not conduct this study on female participants.

Hoon, Wincze, and Hoon (1977) did provide evidence for the arousal misattribution theory with females by using a VPP to assess vaginal blood volume. They identified that females in their study became sexually aroused quicker by erotic stimulus, following exposure to anxiety provoking stimulus. The anxiety provoking stimulus were video clips involving tragic car accidents. Unfortunately, they did not measure the participant's subjective arousal. In

studies where the anxiety stimuli lead to increased physiological arousal, the primary effect is likely due to increases in SNS (Fleischman, Hamilton, Fessler, & Meston, 2015). However, some subjective sexual arousal research appears to differ. Palace and Gorzalka (1990) observed that women who were exposed to anxiety-inducing stimuli reported less arousal after the anxiety stimulus, while other studies showed activation of the sympathetic nervous system self-reported arousal did not change (Hamilton, Fogle, & Meston, 2008; Meston & Gorzalka, 1995). Additionally, Brauer, Le Kuile, and Janssen (2007) found that women who were told that they had a 60 percent chance of receiving a painful electric shock showed lower genital arousal than women who did not have any threats made against them which was assessed by a VPP. Once again, there was no subjective arousal measures administered. Even under circumstances that are not typical of arousal, individuals may become aroused. It is clear that sexual arousal is better understood as a primarily physiological reaction, not entirely a psychological one. Because of this, it is entirely possible for arousal to occur during sexual assault.

Arousal Non-Concordance. Levin and Van Berlo (2004) suggest that arousal stems from a sub-cortical level that increases vaginal blood flow and increases vaginal lubrication, meaning that at times women may not be perceiving themselves as aroused. This lack of accuracy in perception is slowly becoming known as "arousal non-concordance." Currently, research focuses on "sexual concordance" or the extent to which one's genital response and self-reported sexual arousal correspond with each other (Suschinsky & Lalumière, 2011; Suschinsky & Lalumière, 2012). The majority of the research compares men and women in a laboratory setting. Laboratory research suggests that men have significantly higher sexual concordance scores than women and that women's' concordance can vary depending on the day and circumstances presented (Chivers et al., 2010; Heiman, 1977; Suschinsky & Lalumière, 2011).

Attempting to identify why there is a difference in men and women's sexual concordance has proven to be difficult. Chivers et al., (2010) dismisses the idea that it is due to methodological factors such as stimulus length or content, statistical factors, sample characteristics such as age of participants or medication impacts, or the type of VPP used. Other hypotheses for lack of women's sexual concordance are that women are timid to report sexual responses in a laboratory setting and that participants may lack sexual experience, though these hypotheses have also been shown to be false (Suschinsky & Lalumière, 2012). At this current moment, there is no consensus or why women report lower sexual concordance.

What is agreed upon is that "low concordance between self-reported and genital sexual arousal may be the norm for many women" (Chivers et al., 2010). With this being said, this is even more evidence that arousal during rape could and does occur most likely at a percentage higher than the 4-5 percent that Levin and Van Berlo (2004) have suggested. Their suspicion that these numbers are underreported due to fear of judgement, shame, and embarrassment may be correct. Unfortunately, this would mean that these women are not getting the help or support they need.

Help-seeking. Though there is no consensus amongst researchers on how to define "help-seeking" it can generally be described as the process of obtaining support and assistance outside of one self during difficult times (Gourash, 1978). The majority of help-seeking is done informally, resulting in victims disclosing their rape to friends or family members as opposed to doctors or police (Ahrens, Cabral & Abeling, 2009; Starzynski, Ullman, Filipas, & Townsend, 2005; Ullman 1996). This form of disclosure may seem safer and provide less room for judgment by someone the victim does not know. Surprisingly, victim success outcomes are not based on who they tell but how the survivor was treated when they sought out help. When a

victim feels emotionally supported from a first responder, close friend, or confidant the survivor's traumatic stress is significantly reduced (Kaukinen, 2004). This, in turn, increases the survivors' desire to continue seeking additional support (Kilpatrick, Resnick, Ruggiero, Conoscenti & McCauley, 2007). Conversely, if the victim encounters a negative response they are likely to be discouraged to continue help-seeking behaviors (Ahrens, 2006, Campbell & Raja, 1999).

Help-seeking can be obtained through direct resources (family, friends, a doctor, therapists, support groups, rape advocates, or support hotlines) or indirect resources (search engine, magazines, or talking about the rape as though it happened to someone else). There are many factors that impact if the survivor seeks out help and in what specific form. Assaults that involve a stranger and exhibit greater violence are more likely to seek out help. This is thought to be due to violent rapes being a more "stereotypical" and "accepted" form of rape (Starzynski, Ullman, & Filipas, 2005). Another component that increases help-seeking is when one has a prior history of mental illness or has experienced traumatic events in the past (Starzynski, Ullman, Townsend, Long, & Long, 2007). This may be due to the survivor being comfortable in a mental health setting or being set up with a provider that they can confide in. No matter the reason, help-seeking behaviors after an assault are relatively infrequent.

It is estimated that only 30 percent of rape victims disclose their assault to informal sources (Wolitzky-Taylor, Resnick, & McCauley, 2011) and 19 percent seek formal help. When asked if this formal help was beneficial to those survivors who reported at least one incident to an agency, 29.6 percent said it was somewhat useful, 37.7 percent said it was very useful, and 33.1 percent said it was extremely useful. In contrast, 14.80 percent and 19.00 percent said it was not at all or a little useful (Groves & Peytcheya, 2008). Survivors might not seek help out of

shame, embarrassment, fear, judgment, and a lack of certainty about whether what happened constituted rape (Banyard, Moynihan, Walsh, Cohn, & Ward, 2010; Filipas & Ullman, 2001; Heath, Lynch, Fritch, McArthur, & Smith, 2011; Patterson, Greeson, & Campbell, 2009; Starzynski et al., 2005; Wolitzky-Taylor et al., 2011).

There are also demographic components impacting help-seeking. Starzynski et al. (2007) found that younger age or lesbian, gay, or bisexual sexual orientation were associated with decreased help-seeking in regards to formal resources. This research did not examine informal help-seeking. Ethnicity also plays a large role in help seeking behaviors. For every black woman that reports her rape there are 15 black women who do not report their rape (Institute for Gender and Cultural Competence, 2016). This pattern of underreporting is congruent across all minority groups, with Native American's being the highest group impacted and having some of the lowest help-seeking behaviors (RAINN, 2017). This discrepancy amongst ethnicities may be due to multiple factors such as fear of retaliation, revictimization, judgment, religious beliefs that reinforce the woman's victimization and legitimizes the abuser's behavior, distrust of law enforcement, fear that the intervention services are not culturally or linguistically competent, and, for immigrant and undocumented women, in particular, a fear or threat of deportation or separation from children (Patterson, Greeson, & Campbell, 2009). This discrepancy and fear of seeking help must be solved, as it is crucial that survivors access resources so that post-trauma effects are not strengthened.

Post trauma effects. Burgess and Holmstrom (1974) were the first to study the symptomatology of sexual assault victims. They coined the term "rape trauma syndrome," which is an acute phase of disorganization followed by a reorganization phase. This disorganization phase may include thoughts of suicide, denial, numbness, shame, or guilt. When

working through this difficult psychological phase the victim may experience setbacks such as secondary victimization and revictimization. Though normal, these experiences slow the process of healing and only confuse the victim (Steenkamp, Dickstein, Salters-Pedneault, Hofmann & Litz, 2012). In a five year follow up study done by Burgess and Holmstrom (1979), 35 percent of survivors believed they had recovered in a few months, 37 percent believed they recovered over a number of years and 26 percent stated they do not feel they have fully recovered. Since there was no definition of what "being recovered" entailed, the specific reason 26 percent felt they had not recovered was unknown. Some speculation can be made that they are still experiencing symptomology that was not present prior to their rape. This typically involves higher levels of anxiety, depression, sexual dysfunction health problems and social adjustment compared to nonvictims (Resick, 1983; Zoellner, Goodwin, & Foa, 2000).

Secondary victimization. Rape is a painful experience to talk about, especially to strangers. Women may avoid disclosing the rape due to feeling humiliated or embarrassed, fear of retaliation by the offender, fear of being subjected to hostile questioning, worry they will not be believed, or controllable or uncontrollable factors of their own behavior (Suarez & Gadalla, 2010). Police may ask questions which cause the victim to feel as if their experience is being doubted. It is a crime when the victim's responsibility is questioned, even though nothing could ever justify the behavior of a rapist (Crome & McCabe, 2001). Several studies have shown that because of this questioning, the survivor experiences negative social reactions such as doubt, ultimately increasing psychological symptoms because the victim feels they cannot express themselves without judgment from others (Campbell & Raja, 1999; Campbell, Wasco, Ahrens, Sefl & Barnes, 2001; Ullman, 1996).

Secondary victimization includes negative, prolonged, and compounded responses that are accompanied by judgmental attitudes and behaviors directed towards the victim, which results in the victim feeling alienation or a lack of support from different resources (Williams, 1984). This ultimately occurs when people blame the victim for being raped, due to their own sexist attitudes, the place the assault occurred, the victim's behavior, and more (Campbell & Raja, 1999). Commonly, people will state that the victim should not have worn suggestive clothing, been flirting with the perpetrator, or accepted drinks from him. In prior research, dressing in a "provocative" way, not showing active resistance, and inviting the perpetrator home have all been related to higher degrees of victim blaming (Cohn, Dupuis & Brown, 2009; Sims, Noel & Maisto, 2007).

These beliefs fall under the category of rape myth acceptance which is defined as the endorsement of "descriptive or prescriptive beliefs about rape (i.e., about what causes rape, its context, consequences, the perpetrators, victims and their interactions) that serve to deny, downplay or justify sexual violence that men commit against women" (Gerger, Kley, Bohner & Siebler, 2007, p. 423). Romero-Sanchez, Krahe, Moya and Megias (2018), wanted to clarify how the tendency to blame the victim was modulated by the victims' alcohol consumption and their acceptance or rejection of different types of drinks offered by the rapist. Through a sample of 137 participants, they found that when a woman accepted the perpetrator's offer to buy her a drink there were higher rates of attribution of blaming the victim. Lynch, Wasarhaley, Golding and Simcic (2013) used a mock juror to analyze judgments from 158 college students about the aggressor's actions, depending on the drink consumed (alcohol or non-alcohol) and who bought the drink (victim or perpetrator). They also found that when the victim consumed alcohol, the

participants attributed less blame to the perpetrator and found the victim less credible in her statement about the rape due to being intoxicated.

It is important to note a study conducted by Perilloux, Duntley and Buss (2014) that goes against what Lynch et al. (2013) and Romero-Sanchez et al. (2018) suggest. Perilloux, Duntley and Buss (2014) suggest that peers may be less likely to believe that the victim provoked the assault which differs from prior research. They believe their results differ because their sample consisted of college students who have most likely been exposed to some form of education on victim blaming and rape myths. They had 152 participants answer a 200 questionnaire regarding someone they knew who had been sexually assaulted. This questionnaire asked the participant to divide the blame (between 0% to 100%) to the victim, perpetrator, family, friends, the situation, and "other." On average, 82 percent of the blame was put on the perpetrator while only 8 percent was put on the victim. If the participants did receive prior education on the risks of rape myths then Perilloux, Duntley and Buss's study is good evidence that education is key to prevent secondary victimization from occurring.

These rape myths must be spoken about so that clinicians do not fall into these patterns, potentially causing secondary victimization. Campbell and Raja (1999) sought out to assess the impact that licensed mental health professionals have on secondary victimization through surveying licensed mental health professionals and asking what extent they believe professionals in their field engage in secondary victimization. They hypothesized that these attitudes are attributed to three sources. First, that court system personnel treat victims insensitively; second, there is a lack of resources and knowledge about how to gain assistance; and third, it is not known if when a rape victim seeks assistance whether the treatment will be helpful. Through surveying 286 professionals, 81 percent believed that contact with the legal system is

psychologically harmful to the victim and 58 percent felt that mental health professionals engaged in harmful counseling practices due to lack of training.

To provide further evidence that mental health workers continue to engage in rape myths and secondary victimization, Idisis, Ben-David and Ben-Nachum (2007) presented 72 participants (36 professional therapists and 36 non-therapists) with a rape scenario. Participants were asked to rate the severity of the crime using a scale of 0 to 10, with 10 representing the highest severity. Among both groups there was a slight tendency to blame the victim, especially women victims. When the patient enters therapy, they are coming in with the expectation they will not be blamed for their assault. This may be why on average, only 16.1 percent of individuals who disclose their rape do so to mental health professionals (Siegel, Sorenson, Golding, Burnam & Stein, 1989).

Campbell and Raja (1999) suggest that prevention of secondary victimization begins with early training in graduate school programs on how to appropriately discuss one's rape trauma so that victims feel more comfortable seeking professional help. More specifically, Ullman (2007) suggests the training be geared towards inquiring about the assault in a more sensitive manner and eventually processing the trauma as well as the symptoms. Once the trauma is processed, perhaps suicidal ideation, denial, numbness shame, guilt and revictimization will subside.

Revictimization. Women who have been raped are at an increased risk of being raped again (Filipas & Ullman, 2006; Littleton, Canales, & Backstrom, 2009). The theory behind this is that rape victims are more likely to engage in maladaptive coping strategies such as blaming themselves, excessive drinking, using drugs, or engaging in risky sexual behaviors (Filipas & Ullman, 2006; Messman-Moore, Ward, & Brown, 2009). These maladaptive coping strategies put the victim in high risk situations with men who are already involved in a lifestyle that is

conducive to risky behavior. Wilson, Calhoun, and Bernat (1999) had nonvictims, single incident victims, and revictimized women watch an audiotaped date rape scenario and asked each group to determine when the tape should be stopped to ensure an assault does not occur. They discovered that revictimized women who reported lower levels of posttraumatic stress disorder (PTSD) took longer to stop the audiotape than either single incident victims and nonvictims. This suggests that PTSD like arousal symptoms may serve as a protective factor to some extent due to increasing sensitivity to threatening cues in regards to sexual coercive interactions.

Littleton et al. (2009) believes that revictimization can occur because there is no acknowledgment that they were, indeed, raped. He discovered this by surveying 344 female college students who chose one label out of eight different possibilities to classify their assault experience. The participants who chose miscommunication, seduction, hook-up, bad sex, or "not sure" were placed in the unacknowledged group while those who chose rape, attempted rape, or another crime were placed in the acknowledged group. They then did a six month follow up survey and discovered that those in the unacknowledged group were twice as likely to have experienced an attempted rape during this time. The unacknowledged group also reported a greater degree of alcohol use and were more likely to have contact with the aggressor after the assault. Najdowski and Ullman (2011) did a similar study and found that 45 percent of their 555-person sample experienced revictimization during a one-year follow-up period. A survivor who thinks that their rape was caused by too much alcohol and socialization will have a heightened belief that they can control the likelihood of being revictimized and place themselves in risky situations unconsciously, ultimately causing an increased susceptibility to revictimization (Littleton, Grills, Layh, & Rudolph, 2017).

Physical impact. Researchers have suggested that the symptoms that come along with PTSD may result in an underlying biological susceptibility to diseases and physical symptoms (Koss & Heslet 1992; McFarlane, Atchison, Rafalowicz, & Papay 1994). It is thought that with the stress that follows a sexual assault, there is an increase in illnesses as the body's immune system is in a constant state of hyperarousal (Cohen, Evans, Stokols, & Krantz, 2013). This state of hyperarousal creates complications with consensual sexual intercourse. Sexual activity decreases immediately following an assault and overall satisfaction decreases with consensual partners due to orgasmic problems, discomfort, and pain during sexual intercourse (Letourneau, Resnick, Kilpatrick, Saunders & Best, 1996; Van Berlo & Ensink, 2000).

Additionally, women who have been raped report seeking more medical and mental health services (Kimerling & Calhoun, 1994; Koss, Koss & Woodruff, 1991). Zoellner, Goodwin and Foa (2000) discovered that both anger and depression were related to an increase in physical symptoms. They also discovered that the reexperiencing component of PTSD and not the hyperarousal component was what increased the self-reported physical symptoms with rape victims.

Psychological impact. Fear and anxiety appear to be the major areas of psychological distress for victims between 6 and 12 months after experiencing a sexual assault (Resick, 1993). Typically, this combination results in post-traumatic stress symptoms. Sexual assault results in the highest rates of PTSD relative to other traumas (Gilboa-Schechtman & Foa, 2001). Traumatized women are twice as likely as men to develop PTSD (10.4 % vs. 5.0%; Kessler, Sonnega, Bromet Hughes, & Nelson, 1995). The current edition of the Diagnostic and Statistical Manual (DSM-5) states one must have been exposed to a traumatic event to be diagnosed with PTSD, and rape definitely falls under this category. A rape survivor not only has to deal with the

high odds of being diagnosed with PTSD, but also depression and anxiety due to the guilt and shame that typically accompanies the trauma. Dickinson, deGruy, Dickinson, & Candib (1999) discovered that women who had been raped were three times more likely to meet criteria for lifetime major depression and 2.5 times more likely to report recent depression than nonraped women.

Research suggests that not all forms of guilt result in negative outcomes. If the guilt stems from self-blame and shame then the victim is more likely to experience PTSD, but if the guilt stems from recognizing behavioral mistakes, the victim may feel more empowered due to the perceived control and idea that they can make sure the event does not happen again (Arata & Burkhart, 1996; Breitenbecher, 2006; Koss, Figueredo & Prince, 2002). Perilloux, Duntley and Buss (2014), conducted a study that included 140 rape victims and looked at their self-blame. They discovered that victims who had a completed or attempted rape assigned 1/5 of the blame to themselves due to behaviors such as alcohol intoxication and not physically resisting enough, opposed to character flaws. The researchers do not think this amount of blame is a bad thing, but believe that it may serve as a way to cope and provide a sense of security that the victim will not be assaulted again. It is important to note that sexual assault is reported to have significantly greater amounts of guilt and shame compared to other traumas, as well as an increase in guilt, shame, fear and sadness post trauma (Amstadter & Vernon, 2008). Friends, family and those treating survivors of sexual assault must keep this in mind and do their best to decrease self-blame.

Shame. Many survivors know intellectually that arousal has nothing to do with consent, though they often struggle with guilt and shame after the attack. Universally, shame is looked at as a painful set of affective and cognitive states that result in self-judgment stemming from a

perceived transgression of social norms or expectations (Saraiya & Lopez-Castro, 2016). Shame in regard to sexual assault is defined as deep feelings of embarrassment for their exposure to sexual trauma that is associated with self-condemnation, powerlessness, failure and inadequacy (Hareli & Parkinson, 2008). This shame may be from the actual assault or from secondary victimization. They may also have shame regarding their reactions at the time of the assault or how the assault is currently impacting their daily lives and emotions (Roth & Newman, 1991). On average, 75 percent of women surveyed felt ashamed about themselves after being sexually assaulted (Vidal & Petrak, 2007).

Saraiya and Lopez-Castro (2016) conducted a metanalysis on shame and discovered that shame was associated with greater negative and self-critical thinking, hyperarousal, avoidance, PTSD-like symptoms, body shame, and biological stress due to increases in the sympathetic nervous system. While reviewing 47 articles on shame, their biggest conclusion was that experiencing shame after one traumatic event predicted immediate PTSD-like symptoms following a more recent traumatic event. Ultimately, shame acts as a mediator between the response of one traumatic event to the next. Due to this, shame is thought to be more detrimental than guilt because shame is so much more internalized (Vidal & Petrak, 2007). This fact alone makes shame difficult to address in treatment because the survivor typically avoids it due to its association with the traumatic event and emotions that get brought up while thinking about the event (Scragg & Turner, 2001; Wilson, Drozdek, & Turkovic, 2006). This suggests that clinicians may need to proactively initiate the conversation.

Many women may avoid the shame of rape all together by not identifying their experience as rape. Viewing the experience as rape could increase the likelihood that the woman will perceive herself as more vulnerable, less in control, and as having less power (Arata &

Burkhart, 1996). Another reason women do not label their experience as "rape" is to preserve their view of self-agency (Kahn, Jackson, Kully, Badger, & Halvorsen, 2003). They want to believe that if it was rape they would have had the capability to stop it from occurring. TeBockhorst, O'Halloran, and Nyline (2015) found that women who experienced TI during their rape were more vulnerable to shame. Some women also believe that it is worse to resist or to tell the perpetrator 'no' and have him continue than to refrain from saying no at all because then there would be no question that it was rape (Hipp, Bellis, Goodnight, Brennan, Swartout & Cook, 2017).

Guilt and Blame. Guilt and blame are used interchangeably throughout the literature but it is important to differentiate between the two. Blame encompasses the victim's hypothesis of why the assault happened (Ullman, Peter-Hagene & Relyea, 2014). Blame becomes guilt when the individual puts the blame on themselves rather than their actions. If an individual blames their rape on them drinking too much opposed to the perpetrator being a predator, they will typically have a greater sense of guilt. Guilt in sexual assault can be defined as the "survivors' feelings of culpability, or an emotional self-reproach for having any role in the trauma" (Tilghman-Osborne, Cole, & Felton, 2010, p. 544). Guilt can be experienced after enjoying the attention of the perpetrator before the assault, experiencing physiological pleasure during the attack, or having a history of exposure to violence (Koss, 2000). It may also be due to the process of disclosure or lack of disclosure and the impact it has on others (Roth & Newman, 1991).

Women are more likely to experience guilt and blame themselves for the rape if they knew the perpetrator (Culbertson & Dehle, 2001; Koss, 2000), if they experienced TI (Mezey & Taylor, 1988) or if the attack was nonviolent. This could be because these experiences during

rape do not fit society's vision that rape is typically done by an aggressive stranger and that the victim will always fight back (Fisher, Daigle, Cullen, & Turner, 2003). Amstadter and Vernon (2008) surveyed college students who had been involved in a traumatic event involving sexual assault, physical assault, transportation accident, or an illness/injury to compare emotional reactions during and after the trauma. The sexual trauma group reported the highest levels of trauma emotions, especially in regard to guilt during and after the traumatic event.

Ullman, Townsend, Filipas and Starzynski (2007) found that survivors engaging in greater self-blame may withdraw from their social network and seek less support, resulting in many negative effects. Their findings suggest that internal blame may impact the specific reactions the survivor receives from others upon disclosure of their rape, resulting in more internal guilt and shame. This heightened sense of guilt and shame is more likely to produce PTSD (Arata & Burkhart, 1996). The more the victim blamed themselves, the lower their self-esteem scores were in the months to follow (Burt and Katz, 1988). A longitudinal study from Frazier (2003) found similar results. Frazier discovered that the greater the victim's behavioral self-blame and the less the victim blames the rapist were associated with higher levels of distress. Frazier suggests this is due to the victim feeling overwhelmed by the fact that they cannot control others behaviors. Frazier also found that the belief that future assaults are less likely to occur was more strongly associated with lower distress levels than was future control over a second assault. The largest finding in this study was that the victim's perceived control over the recovery process was the biggest indicator of adaptability post assault.

Galliano, Noble, Travis, and Puechl (1993), support the idea that blame after rape significantly decreases one's well-being. They surveyed 35 rape survivors and found that those who experienced TI had significantly stronger guilt about not fighting back hard enough to

ultimately stop the rape. It is important that this guilt is processed as soon as possible to decrease current symptomology and prevent future setbacks. It is important that victims do not adapt a long-term victim mentality, which involves traits such as passiveness, ability to be controlled, and repression of anger which could result in revictimization (Idisis, Ben-David & Ben-Nachum, 2007). Instead, the victim must recognize that extreme feelings of shame and guilt will only prolong recovery.

Current Rape Trauma Informed Care. Only 16.1 percent of sexually assaulted respondents disclose their rape to a mental health professional and 1.9 percent to a rape advocate (Golding, Siegel, Sorenson, Burnam, & Stein, 1989). Ahrens, Cabral, and Abeling (2009) suggests that the low number of victims seeking mental health support is in part because women who initially received a negative reaction to their disclosure, such as blame or disbelief, are less likely to want to openly talk about their trauma again. They then keep their assault a secret in hopes to not experience the negative reaction again. This specific response makes it especially crucial to make the survivor feel as if they are understood and provided with hope for the future. Many of the treatment modalities used are focused on reducing general PTSD symptoms rather than a focusing on specific symptoms after experiencing a sexual assault (Kozlowska et al., 2015). This is problematic because research supports the notion that PTSD symptoms from sexual assault are exacerbated compared to other forms of trauma (Amstadter & Vernon, 2008). This issue aside, if the victim does seek mental health resources they can find support through rape advocates, individual therapy and group therapy.

A victim of sexual assault may seek support from a rape advocate at a rape crisis center after their assault. The rape advocates job is to support the victims while improving case processing, prevent secondary victimization, and provide the victim with information and

resources (Campbell, 2008). Because of this, survivors tend to rate advocates as supportive and informative (Campbell et al., 2011; Golding et al., 1989; Wasco et al., 2004). This support ultimately decreases PTSD symptomology and emotional distress (Ahrens, 1999). Unfortunately, not all communities have accessibility to rape advocates, so victims must find other means of support.

This other form of support could be in group therapy. Trauma-focused and present-focused group psychotherapy have both been found to reduce shame and PTSD symptomology despite the social aspect of shame (Cryer & Beutler, 1980). This form of group therapy can be beneficial to help victims hear others' experiences, normalizing their own while making connections with other people who have the traumatic experience in common (Mezey, 1997). Group treatment is also cost effective and can reach a greater audience (Hebert & Bergeron, 2007). Hebert and Bergeron (2007) sought out to determine the efficacy of group therapy with a sample of 41 women who experienced sexual assault. They investigated whether group therapy would decrease symptoms of self-blame, sexual anxiety, assertiveness and strategies used to cope with sexual abuse. They found that it did reduce symptoms after completion of the group as well as through a three month follow up period. Though there is a sense of community in group treatments, it is important that the victim be aware that hearing others stories may be triggering and provoke certain emotions. Because of this, group therapy poses a risk of revictimization and should not be used by those who are in the early stages of their recovery (Mezey, 1997). Ultimately, better research is needed to determine the exact pros and cons of group therapy in regard to victims of sexual assault (Russell & Davis, 2007).

Individual therapy is first structured on the importance of the therapeutic relationship. The survivor must feel that they can trust the therapist and be free of blame about their assault;

when this is established, deeper work can happen that addresses traumatic memories and symptomology. During the transition into trauma work the survivor must feel they are in control of their own recovery process and has some sense of authority over the pace that they are being exposed to their trauma (Orchowski, Untied & Gidycz, 2016). The most common clinical interventions to process the impact of rape include Cognitive Behavioral Therapy (CBT), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR) and Prolonged Exposure (PE). Once the trauma of the rape is successfully processed, the physiological symptoms should decrease (Kozlowska, Walker, McLean & Carrive, 2015).

CBT uses gradual exposure to the trauma while implementing cognitive restructuring techniques to help process, organize and make meaning of the rape. During the cognitive restructuring stage of CBT, the therapist must carefully challenge any faulty beliefs that the patient has about the rape (Feiring & Taska, 2005). The patient may believe she could have done something to prevent the rape, or blame herself, and the therapist must challenge these thoughts and provide a corrective experience. The survivor also needs a corrective experience from the therapist when the survivor was in a state of sexual arousal during the rape. This can be done during the psychoeducation phase of treatment. It would be helpful for the therapist to mention that arousal does occur during rape with some people. It is the therapist's job to show the patient that though they are experiencing these intense emotions they are still safe (Kozlowska et al., 2015). Therapists need to be aware that survivors who are flooded with highly arousing emotional states and physiologic sensations when they recall their rape will experience more distress and should process the rape at a slower pace (Koss et al., 2002). CBT typically ranges from six to twenty sessions depending on the targeted goal (Feiring & Taska, 2005).

Two forms of CBT that are often used in processing rape are CPT and PE. CPT focuses on identifying and targeting cognitive distortions through focusing on the relationships between experience, beliefs and emotions, and replacing distorted thoughts with more adaptive thoughts (Iverson, King, Cunningham & Resick 2015), while PE asks the survivor to develop a hierarchy of avoided situations to be reviewed through in vivo exposure. In PE, survivors will also be instructed to revisit the rape through their imagination as vividly as possible and describe it verbally in present tense (Rothbaum, Astin & Marsteller, 2005). CPT consists of 12 sessions while PE consists of 8-15 sessions. Much of the literature compares the two treatments, due to the extensive research on their use within the combat population. Nishith, Resick and Griffin (2002) examined 54 CPT patients and 54 PE patients who were seeking treatment for PTSD symptoms related to experiencing rape. They found that the reexperiencing symptoms of the participants in both CPT and PE became worse before getting better. Additionally, they claim that the total duration for both standardized modalities gives enough time to enter remission from PTSD symptoms caused by rape. CPT and PE were associated with significant changes in self-reported shame. In a study conducted by Foa and Meadows (1997), 46 percent of rape survivors who participated in PE treatment reported a 50 percent decrease in PTSD symptoms, while at a six month follow up 75 percent of PE participants no longer met the criteria for PTSD. While working in these modalities it is important that the therapist let the patient know that they may get worse before they get better. The therapist must also confront any shame that accompanies the trauma. Though the patient may be reluctant to express shame, the therapist must look for cues in their language, reluctance to disclose, and body language (Feiring & Taska, 2005).

EMDR is also used to process the trauma from rape. EMDR is designed to produce a rapid, stable desensitization effect on traumatic memories so that they can still be recalled but are

no longer associated with the increase in arousal through 6-12 sessions (Shapiro, 1995). This is done by bringing the traumatic memory and the somatic elements to mind in hopes to become substantially physiologically aroused during the stress-promoting memory. The victim then follows the therapist's finger in response to bilateral tones (Llinas, 2014). When comparing EMDR and PE between participants who had a PTSD diagnosis, both approaches have been shown to provide a significant reduction in symptoms that was maintained through a 3-6 month follow up period (Ironson, Freund, Strauss, and Williams, 2002; Rothbaum, Astin, & Marsteller, 2005). Ironson, Freund, Strauss, and Williams (2002), EMDR proved to have faster results, with a 70 percent reduction of symptoms within three sessions. According to Posmontier, Dovydaitis, and Lipman (2010), EMDR has been proven an effective, low cost, brief intervention for PTSD symptoms from sexual assault, though many researchers interpret the success of EMDR to the exposure aspect that has the victim engage in imaginal exposure, similar to PE, CBT and CPT (Russell & Davis, 2007, Rothbaum, Astin, & Marsteller, 2005).

Mezey (1997) suggests that the goal of the therapist should be to normalize the survivor's response to the rape, restore control, reduce rape-related psychopathology, reduce maladaptive coping behaviors, encourage restoration of healthy psycho-social functioning, facilitate contact with victim support services, and assist family in coming to terms with the rape. McLindon and Harms (2011) interviewed 15 therapists to find out how competent they felt with working with sexual assault survivors. Eleven participants claimed they had never received professional training in this domain, but twelve believed that professional experience was the most important tool in treating survivors of sexual assault. Though experience is important, therapists should not appear to be caught off guard or attribute shame and guilt to their patients if they disclose various responses to sexual assault that they have not heard of. To prepare the therapist for all types of

responses they may hear, there should be greater education on the different responses to rape, such as physiological and sexual arousal. Therapists can be prepared on how to approach the situation empathetically and with validation of different perceptions the survivor has about their assault.

Purpose of the Study

The present study aims to:

1. Enhance and add to the growing scientific literature on sexual assault while capturing the entire picture, which includes women who experience sexual arousal during their sexual assault.
2. Compare females who experienced sexual arousal during their sexual victimization to those who did not experience arousal during their sexual victimization to further understand the impacts that arousal has on the victim's desire to seek clinical treatment and what their therapeutic experience was like.
3. Compare the impact that arousal has in experiencing shame compared to rape victims who did not experience arousal.
4. These findings will allow clinicians a glimpse into what a portion of their patients may be dealing with, allowing the therapist to recognize that their patient may have experienced arousal and feel more comfortable talking with their patients about this experience.

Hypotheses

The hypotheses of the present study include the following:

Hypothesis 1. Survivors who did report sexual arousal will have significantly fewer direct and indirect help-seeking behaviors compared to survivors who did not report arousal during a sexual assault as measured by questions 12a-b on the demographic's questionnaire.

- Question 12a measures indirect resources used such as magazines, search engine, or talking about the event as if it happened to someone else. Question 12b measures direct resources used, such as talk therapy, emergency room services, informing the police, telling friends, family, support groups, a rape advocate, and calling a sexual assault hotline. Therapy will not be included in the analysis because all participants had to be in therapy in order to participate in the study. The direct and indirect scores will be added together for a total score and analyzed. The range of responses could be from 0-11. Starzynski, Ullman, and Filipas (2005) claim that victims who are considered more "stereotypical" (i.e., not experiencing arousal) are more likely to seek out help.

Hypothesis 2. Survivors who did report sexual arousal during their sexual assault will have told significantly fewer people about their assault compared to survivors who did not report sexual arousal during their sexual assault as measured by question 11 on the Demographic Screening Questionnaire: How many people have you told about your sexual assault?

Hypothesis 3. Survivors who did report sexual arousal will have significantly less satisfaction with their therapist compared to survivors who did not report sexual arousal during a sexual assault, as measured by the Client Satisfaction Questionnaire.

- The Client Satisfaction Questionnaire is a questionnaire given to patients to asses treatment satisfaction. There are eight items that are given on a Likert type scale of 1-4. The higher the score, the greater the satisfaction. The participants overall score will be calculated and compared.

Hypothesis 4. Survivors who did report sexual arousal during their sexual assault will have significantly greater behavioral self-blame compared to women who did not report sexual

arousal during their sexual assault measured through the Behavioral Blame scale on the Rape Attribution Questionnaire.

- The Behavioral Blame scale is comprised of five items on a Likert type scale of 1-5. The higher the overall score, the greater self-blame the survivor is experiencing with the highest score being 25. The participants overall score will be calculated and compared.

Hypothesis 5. Survivors who did report sexual arousal during their sexual assault will blame the rapist significantly less compared to survivors who did not report sexual arousal during their sexual assault measured through the Rapist Blame scale on the Rape Attribution Questionnaire.

- The Rapist Blame scale is comprised of five items on a scale of 1-5. The higher the overall score, the more blame the survivor puts on the rapist for their trauma with the highest score being 25. The participants overall score will be calculated and compared.

Hypothesis 6. Survivors who did report sexual arousal during their sexual assault will have significantly less feeling of control over their own recovery process compared to women who did not report sexual arousal during their sexual assault, measured through the Control Over Recovery Process scale on the Rape Attribution Questionnaire.

- The Control Over Recovery Process scale is comprised of five items on a scale of 1-5. For validity purposes there is a question that is reversed, meaning that reverse scoring was used. A score of 25 will indicate the highest score of feeling in control of one's own recovery process. The participants overall score will be calculated and compared.

Clinical and Theoretical Relevance

The purpose of this study is to achieve a better and clinical understanding of the long-term symptomology of survivors who experience sexual arousal during their sexual assault. More specifically, this study will aid in identifying the exacerbating impacts that the arousal had on the victim's desire to seek clinical treatment and what this experience was like. This study will also investigate the impact that arousal had in provoking guilt and self-blame compared to rape victims who did not experience arousal. These findings may remind clinicians to talk with their clients about arousal and help them recognize that it is a natural, physical response, instead of some desire or pleasure, with the hopes to ultimately decrease their shame. Additionally, the results of this study can assist future clinical research in recognizing that sexual arousal is under researched in the area of sexual assault.

CHAPTER II

Methodology

Research Design

This study aims to identify the effects of sexual arousal during sexual assault as compared to those who did not experience sexual arousal during a sexual assault. A quantitative, cross-sectional survey was utilized to analyze the differences and similarities between groups regarding help-seeking behaviors, therapeutic experience, shame, self-blame, and guilt associated with the rape. The term "help-seeking" is described as the process of seeking support and assistance during difficult times (Gourash, 1978) both indirectly (e.g., magazines, google search, talking about the trauma as though it did not happen to you but a friend) and directly (e.g. therapy, emergency room, police, friends, family, support group, rape advocate, sexual assault hotline). Survey research was used so that the sample would be generalizable to the general population in order to make inferences about certain characteristics, attitudes, or behaviors of the specific population (Creswell, 2014). Surveys were collected using the Internet due to its ability to reach more people in the target population, and because it has been extensively discussed in previous literature as a reliable method for targeting specific populations (Fowler, 2009; Sue & Ritter, 2012).

The survey is titled *Experiences During and After Sexual Assault* and it was designed in Qualtrics (www.Qualtrics.com) to be completed by females who have experienced sexual assault. Since the term sexual assault has not been concretely defined, the researcher provided a definition of sexual assault (see inclusion criteria below). The questions were given in multiple choice and Likert scale format. If the participant wished to end the survey without fully completing it they were directed to the debriefing page and thanked for their time.

The independent variable was female survivors of sexual assault under two conditions: those who experienced arousal during the assault and those who did not. To eliminate force choice, the question provided an option for the participant to choose "I do not remember" and a "maybe" option. The maybe option was grouped together in the yes category and the "I do not remember" group was not used. The dependent variables for hypothesis 1 included the Demographics Screening Questionnaire question 12a "Did you attempt to use any indirect resources" and 12b "Did you attempt to use any direct resources?" These two questions were then added together to create one total score of help-seeking behaviors. The dependent variable for hypothesis 2 was question 11 from the Demographics Screening Questionnaire which states "How many people have you told about your sexual assault?" Hypothesis 3's dependent variable consisted of the overall total score of the Client Satisfaction Questionnaire (Attkisson, 2008). Hypothesis 4's dependent variable was the total score of the Behavioral Blame scale on the Rape Attribution Questionnaire (Frazier, 2003). Hypothesis 5's dependent variable was the total score of the Rapist Blame scale on the Rape Attribution Questionnaire (Frazier, 2003). The final dependent variable for hypothesis 6 was the total score of the Control Over Recovery Process scale on the Rape Attribution Questionnaire (Frazier, 2003).

Participants

Data for this study were collected from women who have experienced a sexual assault, based upon the inclusion and exclusion criteria listed below. This information was received from the Demographic Screening Questionnaire (see Appendix A). The number of subjects needed based upon an a priori power analysis is 143 between both groups, with an effect size of .5.

Inclusion Criteria. Participants were chosen based on the following criteria: Participants were females 18 years or older who experienced rape after menarche. It was important to analyze females who experienced rape after menarche because hormonal activation is known to influence arousal directly due to the change in hormones such as progesterone and estrogen (Brooks-Gunn & Furstenberg, 1989). The term menarche was referenced to the participants as their first menstruation cycle as seen in question six of the Demographics Screening Questionnaire (i.e. Did the sexual assault occur before your first menstruation cycle). Additionally, participants must have engaged in at least one therapy session but do not need to currently be engaged in therapy. The term rape was defined, though the word "rape" was not included as some participants may not identify their experience as rape. The term that was used on the Informed Consent Form was "sexual assault" (see Appendix D).

Sexual assault will be defined as:

> "being a nonconsensual (unwilling) participant in sexual activity with another person. Engaging in sexual activity with another person without your consent, against your wishes or against your will. It can be committed by a wide range of people, including strangers, acquaintances, current or ex-romantic partners, dates, fellow employees, neighbors, fellow students, and others. Sexual activity may include but is not limited to, intercourse, anal sex, oral sex, or penetration" (Perilloux, Duntley, Buss, 2014).

Exclusion Criteria. Participants were not eligible to participate if they were under the age of 18, male, did not attend psychotherapy, or those who experienced their rape before menarche. The reason that those who did not attend psychotherapy were excluded was at the request of the Institutional Review Board. They declared that the participants must have seen a therapist to mitigate the risk involved in the study. They believed that it would be an extra safeguard. If a participant was triggered by the material in the survey they would have a guarantee resource to turn to (i.e.: their current or past therapist).

Protection of Human Participants.

This study was designed to adhere to the Ethics Code of the American Psychological Association (APA, 2002) as well as the Institutional Review Board of the Alliant International University (AIU) in San Diego, California. Individuals who participated in this study received a copy of the Informed Consent Form (see Appendix D) which met the APA and AIU standards and were able to print it through the online survey server. The Informed Consent Form detailed the purpose of this study and the participant rights as volunteers in the study. This study was conducted via an online survey. Participants were required to click "Yes" after reading the electronic Informed Consent if they chose to participate. The Informed Consent Form detailed the purpose of this study and the participants rights if they volunteered to participate.

Instrumentation and Measures.

Participants were recruited through a distribution of recruitment posts (Appendix E) on different online sites, with a brief description of the study and a link to the online survey. Specifically, this researcher posted the study on the following platforms: Reddit and Facebook. Participants were initially screened for study eligibility through the administration of a Demographic Screening Questionnaire (see Appendix A) that was presented at the beginning of the online survey. If the individual did not meet the inclusion criteria they were directed to the end of the survey, which debriefed and thanked them for their time and interest (Appendix F). Data were collected by utilizing the following: (1) Demographics Screening Questionnaire, (2) Physiological Arousal During Sexual Activity Survey, (3) Rape Attribution Questionnaire, and (4) Client Satisfaction Questionnaire. All four measures were conducted via Qualtrics (www.qualtrics.com), an online survey service, and took approximately 10-20 minutes to complete.

Demographics Screening Questionnaire. A Demographics Screening Questionnaire was created specifically for this study to determine whether the participant is eligible for the study, and to collect other information to use in the analyses (see Appendix A). The questionnaire collected the following information: sex at birth, ethnicity, current age, sexual orientation, gender of perpetrator, age the participant was sexually assaulted, if the assault occurred after menarche, if they participated in therapy, how they found their therapist, how many sessions of therapy they participated in, how many people they told about their assault, and if they sought help. The question regarding if they sought help, asked about indirect and direct help seeking behaviors. Direct help-seeking behaviors included therapy, emergency room, police, friends, family, support group, rape advocate, and sexual assault hotline. Therapy was not utilized in analysis due to all of the participants only qualifying for the survey if they had attended therapy. The indirect help-seeking behaviors included magazines, internet search, talking about the trauma as though it did not happen to the participant, and other. This indicates that the range of responses could be from 0-11. The Demographics Screening Questionnaire has a total of twelve questions.

Physiological Arousal During Sexual Activity Scale (PADAS). The Physiological Arousal During Sexual Activity Scale was created by Andrew Pari and Jennifer Freyd at the University of Oregon and adapted from Levin and Van Berlo's (2004) research. The purpose of Pari and Freyd's research was to look at betrayal trauma though the research never came to fruition so reliability of the measure was never established. After completing this current research, it was discovered through a split-half comparison that the measure had an internal consistency α reliability of .30 which is considered unacceptable. One of the reasons that this number could be so low is due to the low sample size. Due to no prior measure on sexual

arousal during sexual assault being available this measure was used, but it was revised to increase its reliability (see below). This questionnaire has a total of 10 questions that were utilized to gather information about arousal, specifically to determine which group the participant was placed in (see Appendix A). This was pulled from question two of the PADAS (Did you notice any pre-orgasmic sensations?). There was a choice of four responses, "yes," "no," "I do not remember" and a "maybe" option. The maybe option was grouped together in the yes category and the data from the "I do not remember" group was not used.

Rape Attribution Questionnaire (RAQ). The current study compared profiles of female survivors of sexual assault who experienced arousal with female survivors of sexual assault who did not experience arousal using the RAQ. The RAQ was developed by Frazier, Berman, and Steward (2003) to measure victims' beliefs about why the assault occurred through a temporal model of control. Frazier (2000) developed this model after noticing that trauma and stress involve components of the past, future, and present. The questionnaire includes five different attributions for the cause of the rape, which each include five questions; behavioral self-blame, characterological self-blame or shame, one's own control over the recovery process, blaming the rapist, future control, and future likelihood. blaming the rapist, future control, and future likelihood. For the purpose of this study's hypotheses, only self-blame, blaming the rapist, control over the recovery process were analyzed. The reason these scales were analyzed is because Frazier (2003) discovered that the greater the victim's behavioral self-blame is and the less the victim blames the rapist were associated with higher levels of distress. Frazier also identified that the victim's perceived control over the recovery process was the biggest indicator of adaptability post assault.

One-item criterion measures of each construct were also included on the questionnaire; making each scale consist with the original five items and the criterion item. The respondents used a five-point Likert scale to answer the 30 questions (see Appendix B). The questionnaire was normed from a sample of 171 females who experienced a sexual assault. The test showed good test-retest reliability. The internal consistency α reliabilities were .87 for behavioral self-blame, .87 for rapist blame, .81 for control over recovery, .70 for future control, and .83 for future likelihood. Test-retest reliabilities over two to six months post-sexual assault were as follows: .64 for behavioral self-blame, .79 for rapist blame, .69 for control over recovery, .70 for future control, and .83 for future likelihood.

Client Satisfaction Questionnaire-8 (CSQ-8). The Client Satisfaction Questionnaire-8 was designed in hopes to have a standardized measure to assess treatment satisfaction (Attkisson, 2008). Since the CSQ-8 is copyrighted the researcher obtained permission from the developer to implements its' use in this research. The CSQ-8 has been used extensively in comparison interventions, evaluation research and clinical trials. The CSQ-8 has eight items that measure clients' overall satisfaction and can be used starting with adolescents (See Appendix C). The 8 questions are on a Likert scale that ranges from 1 to 4 with 1 being very dissatisfied and 4 being very satisfied, meaning that a total score of 32 would indicate the highest level of satisfaction. The initial sample was conducted in a mental health setting with 248 diverse clients (Attkisson, 2012). The questionnaire showed good test-retest reliability with internal consistency having a coefficient alpha of .93. It has been showed in an array of published studies to hold an alpha ranging from .83 to .93 with an average alpha of .88.

Procedures

The data were collected via Qualtrics (www.qualtrics.com) and downloaded into SPSS Statistics software version 21 (SPSS Inc., IBM Corporation, Chicago, Illinois) upon completing sample size requirements. An initial screening was conducted to determine whether potential participants met the necessary inclusion criteria. Sampling occurred through social media platforms, public forums, and snowballing techniques. Specifically, this researcher began by convenience sampling through a post with a link to the survey on a Reddit thread that was already dedicated to bring social support to sexual assault survivors which was created by Andrew Pari called "Arousal/Orgasm in Sexual Assault: I Am A Psychotherapist, Founder/Director of Sexual Assault Awareness, (and local mod), Back to Talk Taboo, #MeToo & Answer Your Q's on SA!"

Upon completeing the survey, participants were given the opportunity to be entered into a drawing to win one of five $50 Amazon gift cards. Participants who wanted to take part in the drawing were sent to a different survey and asked to fill in their email address. When the data collection was complete a designated member of the research committee randomly selected, and notified the winners to maintain anonymity.

CHAPTER III

Results

This chapter includes the demographic data, hypotheses results with tables, and supplemental analysis results. The data analyses and results are described below.

Demographic Data

There was a total of 646 participants who attempted to take the survey although, only 166 qualified after specific exclusion criteria were applied. The exclusion criteria that disqualified the most people were if the participant had received therapy after their assault. Out of the remaining participants, 115 were placed in the non-aroused group and 51 were place in the aroused group. Sixteen of those placed in the yes group endorsed that they "maybe" experienced arousal. The ethnicity was predominately Caucasian (76.0 %). Only 10.87 percent identified as other, 7.07 percent identified as Asian, 4.35 percent of the sample was African American, 1.72 percent American Indian or Alaska Native, and none identified as Native Hawaiian or Pacific Islander. In regards to sexual orientation, 50.54 percent of the sample identified as heterosexual, 36.96 percent as bisexual, 7.61 as other, 3.26 percent as homosexual (lesbian/gay), and 1.63 percent preferred not to disclose their sexual orientation. Though the numbers for bisexual participants appears high, bisexual females are the highest population at risk for completed rape (RAINN, 2017). This is thought to be because bisexual females engage in greater substance use, are hypersexualized, and experience harassment from both the heterosexual and gay communities (Johnson, 2017). Participants' ranged in age from 18- 50 years old (M=26.11). The age that the participants were sexually assaulted ranged from 12- 49 years old (M=21.01). The vast majority of the participants were assaulted by males, with only four participants reporting a female raped them and one preferred not to answer.

Hypotheses Results

The present study proposed the utilization of a multivariate analysis of variance (MANOVA). A priori power analysis was run using G*Power software 3.1.9.2 to determine the minimum sample size needed to run a one-way MANOVA with an effect size of .5, power of .80, using a critical alpha of .05. The software determined a minimum sample size of 143 participants is needed to reach statistical significance. This test allowed us to determine if there was a significant difference in the amount of help-seeking behaviors sought out. Due to the MANOVA not meeting the assumptions, an Independent Samples, *t*-test was used.

Before the relevant procedure was applied, the validity of the two basic assumptions for the correct use of the Independent Samples *t*-test was checked. These include that there is normal distribution of the DV within each level of the IV and that there is equality of variances of the DV within each level of the IV. The assumption about the independence of the observations was satisfied by the way the data has been collected, so it was not checked formally. It is well known that the *t*-test procedures are robust against moderate deviations from the normal distribution of the DV thus an approximately normal distribution of the DV is required for the correct use of the *t*-test. The data did not deviate from the normal distribution as indicated by the results from the Levene's test F= 3.50 with p-value = 0.063 which showed that the assumption for Equality of Variances was satisfied. The independent *t*-test determined that there was no significant differences in the total number of direct and indirect help-seeking behaviors between the arousal group (M= 2.84, SD= 1.80) and non-aroused group (M= 3.19, SD= 2.20), t(166) = .991, p= 0.063. Cohens d (effect size) was 0.17. The range of responses for the arousal group was 1-7 while the non-arousal group endorsed a minimum of 1 help seeking

behavior and a maximum of 8. The most common endorsed form of help-seeking from both groups was searching the internet.

The conclusion represents that at alpha = 0.05 there was not statistically significant evidence to reject the null hypothesis in favor of the alternative hypothesis. In other words, there was not sufficient experimental evidence supporting the claim in Hypothesis 2 above, namely: "Survivors who report sexual arousal during their sexual assault have told significantly fewer people about their assault compared to survivors who do not report sexual arousal during their sexual assault."

Hypothesis 2. The remaining hypotheses were also tested using *t*-tests. A priori power analysis was run using G*Power software to determine the minimum sample size needed to run an independent *t*-test with a medium effect size of .5 (Cohens d), power of .80, using a critical alpha of .05. The software determined a minimum sample size of 51 per group or 102 between the two groups were needed for the remaining hypotheses. An independent 1 tailed *t*-test was used to determine if there was a significant difference between survivors who experienced arousal and those who did not in regard to the number of people that the survivor has told about the assault. This was done by looking at the means of the two independent variables from question 11 of the Demographic Screening Questionnaire: "how many people have you told about your sexual assault?"

Before the relevant procedure was applied to Hypothesis 2, the validity of the two basic assumptions for the correct use of the Independent Samples *t*-test was checked. The assumption about the independence of the observations was satisfied by the way the data has been collected, so it was not checked formally. It is well known that the *t*-test procedures are robust against moderate deviations from the normal distribution of the DV thus an approximately normal

distribution of the DV is required for the correct use of the *t*-test. The data significantly deviates from the normal distribution within both groups and therefore a Normalizing Log10 transformation was applied to the original DV. After completing this, the data no longer deviated from the normal distribution and the log data was normal Common log. The results from the Levene's test F= 0.003 with p-value = 0.959 showed that the assumption for Equality of Variances was satisfied. The independent *t*-test determined that there was significant difference in number of people told between the arousal group (M= 0.71, SD= 0.413) and the non-arousal groups (M= 0.87, SD= 0.392), t(164) = 2.41, p= .017. Cohens d (effect size) was .4. After converting the mean Log10 Transformation back, the mean for the arousal group was 7.89 and the mean for the non-arousal group was 11.58. The range of responses for the arousal group was 1-50 while the non-arousal group told a minimum of 2 and a maximum of 50.

The conclusion represents that at alpha = 0.05 there was sufficient, statistically significant evidence to reject the null hypothesis in favor of the alternative hypothesis. In other words, there was sufficient experimental evidence supporting the claim in Hypothesis 2 above, namely: "Survivors who report sexual arousal during their sexual assault have told significantly fewer people about their assault compared to survivors who do not report sexual arousal during their sexual assault."

Hypothesis 3. Hypothesis 3 was tested using an independent one tailed *t*-test. An independent one tailed *t*-test allowed us to determine if there was a significant difference of satisfaction with the therapist with those who experienced arousal compared to those who did not during their sexual assault by looking at the means of the Client Satisfaction Questionnaire (Attkisson, 2008) scores amongst the independent variable with two levels (aroused and non-aroused). The DV for that hypothesis was a composite scale named "Satisfaction with therapist."

It was calculated as a sum of scores given to the questions Q18 through Q25. Since the "Satisfaction with therapist" variable is a composite scale comprised from several individual items it was checked for its Internal Consistency. The results from the Levene's test F= 0.446 with p-value = 0.505 showed that the assumption for Equality of Variances has been satisfied. All other assumptions were satisfied. Table 1 shows the mean score of each question for each group to give a better understanding of the differences between both groups. The independent *t*-test determined that there was not a significant difference in the satisfaction of therapy between the arousal group (M= 21.01, SD= 6.92) and the non-arousal groups (M= 21.74, SD= 7.05), t(162) = 0.606, p= .545. Cohens d = .1. In other words, there was no sufficient experimental evidence supporting the claim in Hypothesis 3, "survivors who did not report sexual arousal will have significantly greater satisfaction with their therapist compared to survivors who report sexual arousal during a sexual assault, as measured by the Client Satisfaction Questionnaire."

Table 1.
Client Satisfaction Questionnaire Item Statistics Between Both Groups

Question	Arousal	N	Mean	Std. Deviation
How would you rate the kind of services you received?	Yes	51	2.59	.963
	No	113	2.73	.993
Did you get the kind of service you wanted?	Yes	51	2.63	.848
	No	113	2.69	.907
If a friend were in need of similar help, would you recommend your provider to him or her?	Yes	51	2.78	.986
	No	113	2.94	1.096
To what extent did the services meet your needs?	Yes	51	2.47	.902
	No	113	2.56	.944
How satisfied are you with the amount of help you received?	Yes	51	2.59	.963
	No	113	2.49	1.062
In an overall, general sense, how satisfied are you with the service you received?	Yes	51	2.69	.927
	No	113	2.72	.995
Have the services you received helped you to deal more effectively with your trauma?	Yes	51	2.71	.944
	No	113	2.88	.888
If you were to seek help again, would you come back to the same provider?	Yes	51	2.55	1.137
	No	113	2.73	1.112

Hypothesis 4. Hypothesis 4 stated that "survivors who reported sexual arousal during their sexual assault would have significantly greater behavioral self-blame compared to women who did not report sexual arousal during their sexual assault measured through the Behavioral Blame scale on the Rape Attribution Questionnaire. This hypothesis was tested using an independent one tailed *t*-test. An independent one tailed *t*-test allowed us to determine if there was significant difference in self-blame in women who experienced arousal compared to those who did not during their sexual assault by looking at the means of the independent variable with

two levels (aroused and non-aroused) of the Behavioral Blame scale on the Rape Attribution Questionnaire (Frazier, 2003). The DV for that hypothesis is a composite scale named Behavioral self-blame. It was calculated as a sum of scores comprised of five questions with the lowest possible score being 5 and the highest score being 25. Since the "Behavioral self-blame" variable is a composite scale comprised from several individual items it was checked for its Internal Consistency. The results from the relevant Reliability Analysis on that scale carried out by the use of SPSS obtained a value for Cronbach's Alpha of 0.866 which is evidence for a very high reliability. The results from the Levene's test $F= 0.306$ with a p-value = 0.581 showed that the assumption for Equality of Variances were satisfied as well as all other assumptions. Table 2 explores the mean score of each question within the independent variable to give a better understanding of the differences between both groups. Additionally, the independent *t*-test determined that there was no significant difference in the overall total of the Behavioral Self-Blame scale between the arousal group ($M= 18.71$, $SD= 4.80$) and the non-arousal groups ($M=18.02$, $SD= 5.31$), $t(162) = 0.780$, $p= .436$. Cohens d (effect size) was .1. In other words, there was no sufficient experimental evidence supporting the claim in Hypothesis 4.

Table 2.

Behavioral Self-Blame Item Statistics Between Both Groups

Question	Arousal	N	Mean	Std. Deviation
How often have you thought "I was assaulted because I used poor judgment."	Yes	51	3.76	1.031
	No	113	3.59	1.279
How often have you thought "I was assaulted because I should have resisted more."	Yes	51	3.39	1.201
	No	113	3.32	1.496
How often have you thought "I was assaulted because I just put myself in a vulnerable situation."	Yes	51	4.18	1.072
	No	113	3.96	1.202
How often have you thought "I was assaulted because I should have been more cautious."	Yes	51	3.73	1.266
	No	113	3.57	1.315
How often have you thought "I was assaulted because I didn't do enough to protect myself."	Yes	51	3.65	1.309
	No	113	3.58	1.301

Hypothesis 5. Hypothesis 5 stated that "survivors who did report sexual arousal during their sexual assault would blame the rapist significantly less compared to survivors who did not report sexual arousal during their sexual assault measured through the Rapist Blame scale on the Rape Attribution Questionnaire." This hypothesis was also tested using an independent one-tailed *t*-test. The DV for this hypothesis is a composite scale called Blame the rapist. It was calculated as a sum of scores comprised of five questions with the lowest possible score being 5 and the highest score being 25. Since there were multiple individual items, it was checked for its Internal Consistency. The results from the Levene's test F= 1.437 with p-value = 0.232 have showed that the assumption for Equality of Variances was satisfied along with all other assumptions. Table 3explores the mean scores of each question within the independent variable to give a better understanding of the differences between both groups. The independent *t*-test determined that there was no significant difference in the overall total of the Rapist Blame scale between the arousal group (M= 12.94, SD= 5.62) and the non-arousal group (M=14.31, SD=

5.08), t(162) = 0.780, p= .126. Cohens d was .3. In other words, there was no sufficient experimental evidence supporting the claim in Hypothesis 5. The arousal groups mean was 12.94 while the non-arousal group mean was 14.30. The highest score would be 25 which indicates that in all, this sample did not put much blame on their rapist especially in comparison to their self-blame scores (i.e., 18.72).

Table 3.
Blame the Rapist Scale Item Between Groups Statistics

	Any pre-orgasmic sensations?	N	Mean	Std. Deviation
I was assaulted because the rapist thought he could get away with it	Yes	51	3.47	1.554
	No	112	3.69	1.414
I was assaulted because the rapist wanted to feel power over someone.	Yes	51	2.80	1.442
	No	112	3.33	1.410
I was assaulted because the rapist was sick	Yes	51	2.59	1.564
	No	112	2.66	1.430
I was assaulted because the rapist was angry at women.	Yes	51	1.90	1.082
	No	112	2.13	1.260
I was assaulted because the rapist wanted to hurt someone	Yes	51	2.18	1.292
	No	112	2.50	1.433

Hypothesis 6. The final hypothesis, Hypothesis 6 was tested using an independent one-tailed *t*-test. This *t*-test allowed us to determine if there was a significant difference in feelings of control during the recovery process in women who experienced arousal compared to those who did not during their sexual assault by looking at the means of the independent variable on the Control Over Recovery Process scale of the Rape Attribution Questionnaire (Frazier, 2003). Before the *t*-test could be carried out specific assumptions needed to be met. The scale was checked for internal consistency and it was discovered from the relevant reliability analysis that Cronbach's Alpha= .312, which is evidence for very low reliability. For that reason, the scale

needed to be altered to ensure appropriate hypothesis testing. The results of this removal can be observed in Table 4. Through subsequent removal of negatively correlated items with the original individual items, reliability was increased. It was discovered that item #2 was negatively correlated with the original scale with a Correlation coefficient = - 0.682. Removal of that item from that scale lead to a new corrected scale with a high value for Cronbach's Alpha = 0.851. The results from the Levene's test F= 0.060 with a p-value = 0.808 have showed that the assumption for Equality of Variances was satisfied. After using the corrected scale, the rest of the assumptions were satisfied. Since the scale now has only four questions the range of possible scores changed to 4-20. Table 5 shows the mean score of each question within the independent variable to give a better understanding of the differences between both groups. Additionally, completing the independent *t*-test, it was determined that there was no significant difference in the overall total of the Feelings of Control Over the Recovery Process scale between the arousal group (M= 13.51, SD= 3.23) and the non-arousal groups (M= 13.14, SD= 3.34), t(162) = 0.606, p= .296. Cohens d was .2 which is considered to be a small effect size.

Table 4.
Removal of Items on Control Over Recovery Process Scale with Both Groups Combined

	Scale Mean if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
The assault is going to affect me for a long time but there are…	12.02	.385	.087
I don't feel there is much I can do to help myself feel better.	*13.32*	*-.682*	*.827*
I know what I must do to help myself recover from the assault.	12.85	.563	.185
I am confident that I can get over this if I work at it.	12.69	.621	.212
I feel like the recovery process is in my control.	12.99	.565	.236

Table 5.
Control Over Recovery Process Item Between Groups Statistics

	Did you notice any pre-orgasmic sensations?	N	Mean	Std. Deviation
The assault is going to affect me for a long time but there are things I can do to lessen its effects.	Yes	51	3.78	1.119
	No	111	4.00	.953
I know what I must do to help myself recover from the assault.	Yes	51	3.24	1.159
	No	111	3.04	1.300
I am confident that I can get over this if I work at it.	Yes	51	3.27	1.150
	No	111	3.25	1.187
I feel like the recovery process is in my control.	Yes	51	3.22	1.361
	No	111	2.85	1.343

Supplemental Analysis Results.

Supplemental analysis was conducted in order to see if the age that the participant was sexually assaulted was a moderator to the hypotheses. This was identified by subtracting the age that the participant was sexually assaulted from their current age. An Independent Samples *t*-test was conducted to determine if there was a significant difference between independent groups (participants (12-19) and (20-51)). All assumptions were met prior to analyzing the data with each hypothesis. After running the independent samples *t*-test, there was no significant difference between participants assaulted between ages 12-19 years and 20-51 years with any of the hypotheses. Looking at Table 6, it can be deduced that the adult survivors have higher mean scores than the teens, though this is expected to be because the majority of the respondents were assaulted as Adults (135), while the rest were assaulted as teens (31).

Table 6.
Participants by Age Sexual Assault Occurred

		Hy1			Hy2			Hy3		
		MEAN	SD	N	MEAN	SD	N	MEAN	SD	N
YES Arousal	12-19	2.83	1.84	10	7.00	2.33	10	24.10	5.00	10
	20-51	2.97	2.01	41	7.97	2.06	41	20.24	7.15	41
NO Arousal	12-19	2.99	2.02	21	7.34	2.55	21	22.29	7.40	21
	20-51	3.06	2.18	94	8.02	2.79	94	21.59	7.00	92
		Hy4			Hy5			Hy6		
		MEAN	SD	N	MEAN	SD	N	MEAN	SD	N
YES Arousal	12-19	20.40	4.06	10	9.40	4.48	10	14.90	1.37	10
	20-51	18.71	4.93	41	16.49	3.40	41	16.49	3.40	41
NO Arousal	12-19	19.65	5.03	21	15.62	4.87	21	16.60	2.70	20
	20-51	17.74	5.26	92	14.00	5.08	91	15.68	3.27	91

A second supplemental analysis was conducted to determine if the number of therapy sessions the participant endorsed was a moderator to the hypotheses. To determine this, a MANOVA was used with all hypotheses. The MANOVA indicated that there is no significant difference in the number of therapy sessions the participant engaged in their overall scores on all hypotheses between both groups. Table 7 indicates that the amount of therapy did not play a role in their recovery. The range of therapy for both groups were a minimum of one session and a maximum of 50. The non-arousal group had a mean number of therapy sessions endorsed at 11.58 while the arousal group endorsed a mean number of therapy sessions of 7.89.

Table 7.
Therapy Sessions as Moderator to Hypotheses

	Hy1			Hy2			Hy3		
	MEAN	SD	*p*	MEAN	SD	*p*	MEAN	SD	*p*
YES Arousal	2.83	1.84	.05	8.00	10.82	.06	21.22	7.17	0.29
NO Arousal	3.08	2.21		10.68	10.77		21.33	7.67	
	Hy4			Hy5			Hy6		
	MEAN	SD	*p*	MEAN	SD	*p*	MEAN	SD	*p*
YES Arousal	18.65	4.89	0.13	13.17	5.84	0.19	16.07	3.22	0.84
NO Arousal	17.68	5.86		14.02	5.57		15.22	4.39	

The third supplemental analysis conducted separated indirect and direct help seeking behaviors to assess if the groups endorsed using one over the other. The MANOVA test indicates that there was no significant difference in the amount of direct and indirect resources that each group endorsed, as evidenced by Table 8. The mean and standard deviation are the variables under investigation. Looking at the means, one can conclude that majority of the respondents endorsed the use of a search engine as a way of dealing with their trauma (M = 0.66), although survivors who didn't report arousal had a higher mean value (0.66) than survivors who report arousal during sexual assault (0.65). The lowest mean value (0.02, 0.09) was associated with those who employ the use of magazines.

In addition, survivors who did not report sexual arousal during sexual assault endorsed resources like magazine, internet search, emergency room, police, friends, family, and talking about the trauma as though it did not happen to you but a friend more than survivors who reported sexual arousal. Survivors who reported sexual assault preferred support group, rape advocate, and

other resources. Furthermore, both groups (aroused and not) equally endorsed the use of a sexual assault hotline. Furthermore, it can be concluded that those who report arousal during sexual assault felt more confident talking about their ordeal in public places like support group meeting, and advocacy centers. The results of the MANOVA indicate that survivors who do not endorse sexual arousal during their sexual assault reach out to their families for more support (M = .20) compared to women who report sexual arousal during their sexual assault (M = .39), which was supported by results from a MANOVA test, Wilks' $\lambda = 0.89$, F (1, 161) = 5.10, $p < 0.05$, which indicates a significant difference between the two groups (aroused and not).

Table 8.
Indirect and Directed Resources Analyzed Separately

	Any pre-orgasmic sensations?	Mean	Std. Deviation	*p*
Indirect resources: -Magazines	Yes	.02	.140	0.11
	No	.09	.283	
Indirect resources: -Internet search	Yes	.65	.483	0.86
	No	.66	.475	
Indirect resources: -Talking trauma as it did not happen to you	Yes	.22	.415	0.21
	No	.27	.446	
Indirect resources: -Selected Choice Other	Yes	.14	.348	0.10
	No	.06	.240	
Direct resources: - Emergency room	Yes	.10	.300	0.35
	No	.17	.381	
Direct resources: - Police	Yes	.24	.428	0.22
	No	.33	.472	
Direct resources: - Friends	Yes	.59	.497	0.17
	No	.63	.486	
Direct resources: - Family	Yes	.20	.401	0.02
	No	.39	.490	
Direct resources: - Support group	Yes	.18	.385	0.33
	No	.12	.328	
Direct resources: - Rape advocate	Yes	.29	.460	0.16
	No	.23	.420	
Direct resources: - Sexual assault hotline	Yes	.24	.428	0.14
	No	.24	.431	

The final supplemental analysis that was conducted assessed the psychometrics of the Physiological Arousal During Sexual Activity Scale (PADAS). The psychometrics were discovered through a split-half comparison of the data which can be observed through Table 9. The measure had an internal consistency α reliability of .30 which is considered unacceptable. One of the reasons that this number could be so low is due to the low sample size. It would be important for the psychometrics to be analyzed again with a larger sample through a possible pilot study.

Table 9.
Physiological Arousal During Sexual Activity Scale Psychometrics

	Mean	Std. Deviation	N	Cronbach's Alpha if Item Deleted
At any time during your sexual assault did you …. Increase in your pulse (heart rate)	0.91	0.30	51	0.34
Changes in your breathing, such as faster or slower	0.84	0.37	51	0.34
Increase in the sensitivity to your vagina and/or labia	0.72	0.46	51	0.70
Increase in the sensitivity to your clitoris	0.66	0.48	51	0.44
Lubrication ("wetness") of your vagina	0.78	0.42	51	0.26
Contractions of your pelvic muscles	0.75	0.44	51	0.47
Involuntary vocalizations or sounds	0.75	0.44	51	0.53
Did you notice any pre-orgasmic sensations?	1.28	0.63	51	0.02
Did you orgasm even if you did not want to?	1.16	0.37	32	0.41
Did you orgasm more than one time?	2.28	1.11	32	0.43

CHAPTER IV

Discussion

Given that many female survivors of sexual assault demonstrate mental health difficulties, it is surprising that no known research has examined the implications that physiological arousal during rape has on the survivor. The present study contained 164 participants and was designed to explore the experiences of female sexual assault survivors who were sexually aroused (*N*=51) and female sexual assault survivors who were not sexually aroused (*N*=115), in an attempt to see if those who claimed arousal had less help-seeking behaviors and greater symptomology. This study was done to enhance the growing scientific literature on sexual assault in attempt to capture the entire picture, which up until this point only anecdotally included women who experienced arousal during the assault. The results of this study have significant relevance for the field of sexual assault, since research on this subject matter has been marginal. Most importantly, this study demonstrates an estimated prevalence of arousal that has not been documented before. From this sample almost one-third of respondents endorsed arousal. This is significantly higher than Levin and Van Berlo's (2004) estimate of 4-5 percent of survivors' experience arousal. Though it is important to mention that the majority of respondents came from the Reddit page, "Arousal/Orgasm in Sexual Assault: I Am A Psychotherapist, Founder/Director of Sexual Assault Awareness, (and local mod), Back to Talk Taboo, #MeToo & Answer Your Q's on SA!" This chapter discusses the hypotheses, clinical implications of the findings, limitations of the present study, and suggestions for future research.

Hypotheses 1. Hypothesis 1: Survivors who did report sexual arousal will have significantly fewer direct and indirect help-seeking behaviors compared to survivors who did not report arousal during aexual assault as measured by questions 12a-b on the demographic's

questionnaire. It was discovered that there was no statistically significant evidence in support of this claim. Since literature on arousal during sexual assault is sparse, the basis for this hypothesis stemmed from the theory that the greater one's shame, the greater symptomology they would experience (Arata & Burkhart, 1996; Breitenbecher, 2006; Koss, Figueredo & Prince, 2002). This shame would then result in the survivor being less likely to seek help both through direct and indirect sources. Based upon the statistical analysis there is no evidence that arousal during rape influences indirect and direct help-seeking behaviors as measured by these questionnaires. The information that can be taken away based upon the data from this hypothesis is that both the arousal and non-arousal group reported using an internet-based search engine as the most indirect resource and talking to friends as the most frequent direct resource. This aligns with current research that states the majority of help-seeking after trauma is done by reaching out to friends and family (Ullman, 1996).

Hypotheses 2. Hypothesis 2: Survivors who did report sexual arousal during their sexual assault will have told significantly fewer people about their assault compared to survivors who did not report sexual arousal during their sexual assault. In the present study, survivors who reported sexual arousal during their sexual assault told significantly fewer people about their assault compared to peers in the non-aroused group, as suspected. Women may avoid telling others about their rape due to feeling embarrassed, having a fear of retaliation by the offender, fear of being subjected to hostile questioning, worry they will not be believed, or other uncontrollable factors (Suarez & Gadalla, 2010). Survivors who experience arousal are at risk for experiencing these feelings due to the lack of awareness about arousal during sexual assault. The arousal might also trigger greater self-blame or thoughts that the survivor could have done more to stop the assault. Ullman, Townsend, Filipas, and Starzynski (2007) found that survivors

engaging in greater self-blame may withdraw from their social network and seek less support. This is evident in the current sample and provides evidence that self-blame exacerbates feelings of isolation and perpetuates loneliness.

Hypotheses 3. Hypothesis 3: Survivors who did report sexual arousal will have significantly less satisfaction with their therapist compared to survivors who did not report sexual arousal during a sexual assault, as measured by the Client Satisfaction Questionnaire. It was discovered that there was no statistically significant evidence in support of this hypothesis. This hypothesis was based upon McLindon and Harms' (2011) research that the majority of therapists interviewed reported never receiving formal training on how to work with sexual assault survivors. It was suspected that if their patient disclosed arousal they would be thrown off guard and not respond in an appropriate way. This claim is substantiated by Campbell and Raja's (1999) work, where 58 % of professionals felt that mental health professionals engaged in harmful counseling practices due to lack of training. Despite these claims in the literature this does not appear to be the case in the present study. Both groups reported being moderately satisfied with their therapeutic experience.

Survivor success is based upon how a person responds when the survivor tells them their story (Kaukinen, 2004). This is good news for those in the arousal group who endorsed entrusting a therapist with their story first. If they value their therapist's services it seems very plausible that their therapist responded in an appropriate way, ultimately decreasing secondary victimization. The current study reports that the arousal group provided an overall mean score of 21.00 and the non-arousal group received a mean score of 21.72 on the CSQ-8. This places both groups in the moderately satisfied range. This is similar to Groves and Pevtcheva's research that examined survivors who received services after one traumatic incident at an agency. Amongst

their sample, 29.60 % said it was somewhat useful, 37.70 % said it was very useful, and 33.1 % said it was extremely useful. In contrast, 14.80 % and 19.00 % said it was not at all or a little useful. As for the current study, 37.00 % reported very satisfied, 65.00 % were mostly satisfied, 39.00 % indifferent, and 23.00 % quite dissatisfied as measured through question six on the CSQ-8. Though the hypothesis was not significant, these data are positive for clinicians as it means most clients were satisfied with therapy.

Hypothesis 4. Hypothesis 4: Survivors who did report sexual arousal during their sexual assault will have significantly greater behavioral self-blame compared to women who did not report sexual arousal during their sexual assault measured through the Behavioral Blame scale on the Rape Attribution Questionnaire. It was discovered that there was no statistically significant evidence in support of this hypothesis. The two groups were almost identical with their mean overall score on this scale. In fact, the arousal group only scored .68 points higher than the non-aroused group, meaning that it does not appear that arousal has much impact on the behavioral blame that survivors place on themselves. This can be explained by the theory that rape results in significantly greater amounts of guilt and shame compared to other traumas (Amstadter & Vernon, 2008). Since experiencing rape is so traumatic and violating, experiencing arousal may not cause much further distress. A score of 18.72 out of 25 on this scale is still high, meaning that the participants did place a decent amount of blame on their behaviors. Perilloux, Duntley, and Buss (2014) discovered that victims who experienced a completed or attempted rape put 1/5 of the blame on themselves due to behaviors such as drinking prior to the assault or not resisting enough. This falls in line with the current research and helps explain why the score was so high in both groups.

Blame encompasses the victim's hypothesis of why the assault happened (Ullman, Peter-Hagene & Relyea, 2014). If an individual blames their rape on them drinking too much as opposed to the perpetrator being a predator, they will typically have a greater sense of self-blame. In the current study, both groups reported having thoughts of self-blame "very often" opposed to not. The reason why is not entirely known. Some research suggests that women are more likely to experience guilt and blame themselves for the rape if they knew the perpetrator (Culbertson & Dehle, 2001; Koss, 2000), if they experienced TI (Mezey & Taylor, 1988), or if the attack was nonviolent. This could be because these experiences during rape do not fit society's vision of what constitutes rape, which is that rape is typically done by an aggressive stranger and that the victim will always fight back (Fisher, Daigle, Cullen, & Turner, 2003). It is important to consider these factors when talking to patients about the reasons why they are harboring such self-blame. The therapist should do their best to reassure the patient that these feelings are normal and valid but also stress that no one is prepared to handle a sexual assault nor do they think they would ever experience one. These two components alone make sexual assault more traumatic than other traumas. For instance, in a sample of college students surveyed who all experienced traumatic events, the sexual assault group reported the highest levels of trauma emotions (Amstadter & Vernon, 2008).

The investigator anticipated similar results of self-blame that came from studies on TI, though this turned out to not be the case. TeBockhorst, O'Hallorane, and Nyline (2015) claimed that rape survivors who experienced TI were more vulnerable to shame and self-blame because they no longer believed they had the capability to stop it from occurring again. Since the survivor had no control over experiencing arousal-like sensations one would suspect that self-

blame in the arousal group would be higher, but this did occur in the present study. Continued research needs to happen to tease out the results of this hypothesis.

Hypothesis 5. Hypothesis 5: Survivors who did report sexual arousal during their sexual assault will blame the rapist significantly less compared to survivors who did not report sexual arousal during their sexual assault measured through the Rapist Blame scale on the Rape Attribution Questionnaire. It was discovered that there was no statistically significant evidence in support of this hypothesis. The arousal groups mean was 12.94 while the non-arousal group mean was 14.30. The highest score would be 25 which indicates that in all, this sample did not put much blame on their rapist, especially in comparison to their self-blame scores (i.e., 18.72). Frazier (2003) discovered that the greater the victim's behavioral self-blame and how much the victim blames the rapist were associated with higher levels of distress. Based upon this assumption, the current sample would be anticipated to have high levels of distress.

This current sample goes against Perilloux, Duntley, and Buss's (2014) findings that asked peers to distribute blame to the victim and perpetrator of a sexual assault. On average, 82 % of the blame was put on the perpetrator while only 8 % was put on the victim. Though this question was not specifically asked to the victims, it would make sense if the numbers were comparable. In the current study, survivors had a higher score on the behavioral blame scale than they did on the rapist blame scale. This may be due to the participants not identifying with the questions asked in the rapist blame scale or perhaps they felt that their actions warrant self-blame. Either way, this does not suggest a good prognosis for the participants with these low scores.

Hypothesis 6. Hypothesis 6: Survivors who did report sexual arousal during their sexual assault will have significantly less feeling of control over their own recovery process compared

to women who did not report sexual arousal during their sexual assault, measured through the Control Over Recovery Process scale on the Rape Attribution Questionnaire. It was discovered that there was no statistically significant evidence in support of this hypothesis. In fact, the arousal and non-arousal group scored very similarly. They both scored a 9, meaning that they feel that they have little control over their recovery process. This is not promising for the sample's overall recovery, as victims perceived control over the recovery process is the biggest indicator of adaptability post assault (Frazier, 2003). These low scores could be indicators of why the self-blame scores are so high and rapist blame scores are so low.

In a study completed by Burgess and Holmstrom (1979), 26 % of rape survivors stated they did not feel they had fully recovered from their assault. This paired with the results from the current study demonstrate how difficult it is to fully recover from a sexual assault no matter if there was arousal. Not only is it difficult to recover but they are also at risk for perpetuating these thoughts of not being capable to recover. Rape survivors have been shown to blame themselves, engage in excessive drinking, use drugs, or engage in risky sexual behaviors (Filipas & Ullman, 2006; Messman-Moore, Ward, & Brown, 2009). Clinicians should address these behaviors if they notice them occurring with their patients who have experienced a sexual assault regardless if the patient endorses arousal. This will help victims not adapt a long-term victim mentality, which involves characteristics such as passiveness, ability to be controlled, and repression of anger which can also perpetuate revictimization (Idisis, Ben-David & Ben-Nachum, 2007).

It is important to note that the control over recovery process scale in particular was shown to have low reliability upon the first analysis due to the second question, "I don't feel there is much I can do to help myself feel better" being negatively correlated with the original

scale. A new reliability analysis with this item removed from the scale was carried out which lead to a corrected scale with a high value for Cronbach's Alpha= 0.827. This is evidence for a very high reliability. The investigator ended up taking out another question from this scale as well. This question stated, "The assault is going to affect me for a long time but there are things I can do to lessen its effects." After this was removed a high value for Cronbach's Alpha= 0.851 which is evidence for a very high reliability of the corrected scale. Despite this scale being corrected the hypothesis remained to have no statistical difference.

Supplemental Analysis. It is interesting to note that age did not play a role in the results of the hypotheses. According to RAINN, individuals ages 16-19 are four times more likely to be sexually assaulted though they are not the most at-risk age of getting assaulted (2017). The most at-risk group are individuals 18-34 which was congruent with the current sample. As previously stated, the fact that age was not a moderator to the hypotheses is most likely due to the low number of participants who endorsed being assaulted during their teenage years. The participants most likely endorsed experiencing their trauma later on in life due to the exclusion criteria that the participant must have experienced their rape after their first menstrual cycle.

Additionally, the number of therapy sessions the participant endorsed was also controlled for in all hypotheses. After completing the MANOVA, there were no significant difference in the number of therapy sessions the participant engaged in when comparing it to their overall scores on each hypothesis. Most interesting is that the participants endorsed being moderately satisfied with their therapeutic experience yet continued to endorse high levels of self-blame and low levels of blame towards the rapist. One would assume that if this was the case, perhaps they had not engaged in sufficient therapy sessions yet this was not the case for this sample. The mean of therapy for the arousal group was 7.89, and for the non-arousal group, the mean was

11.58. The evidence-based forms of therapy for sexual abuse traumas typically range from 16-22 sessions, indicating that the participants in this study were within that range.

The final supplementary analysis assessed indirect and direct help-seeking behaviors separately, unlike hypothesis 1 that looked at the total amount of help-seeking behaviors. Amongst the current sample, the non-arousal group endorsed using a search engine the most and magazines the least in regards to indirect help-seeking behaviors. For direct help seeking behaviors, the non-arousal group utilized talking to friends the most and emergency rooms the least. The arousal group also endorsed using a search engine the most and engaging in magazines the least for indirect help-seeking behaviors. The non-arousal group was the same as the arousal group for their most frequent direct help-seeking behavior (friends) but their least direct help-seeking behavior was support groups. Though it is great news that both groups are endorsing some form of help-seeking behaviors, it is congruent with current literature that help-seeking behaviors after an assault are lower than hoped (Starzynski, Ullman, Townsend, Long, & Long, 2007).

It is imperative that the respondents' sexual preference is taken into consideration when looking at help-seeking behaviors as non-heterosexual individuals have been shown to have significantly less help-seeking behaviors (Starzynski et al., 2007). Overall, the non-heterosexual participants from both groups of this sample showed significantly less help-seeking behaviors compared to their heterosexual peers. An initial question about help-seeking behaviors was asked to see if the participants would endorse help-seeking behaviors without being prompted. This question stated "After the sexual assault did you do anything to obtain help?" and occurred before the prompted questions about indirect and direct help-seeking behaviors. Amongst the non-heterosexual participants in the aroused group, half of the participants stated that they did

not do anything to obtain help after the assault. Amongst those that identified as non-heterosexual in the non-aroused group, 43 % answered they did not do anything to obtain help. This is startling when compared to the heterosexual arousal and non-arousal group. Only 12 % of the arousal group said that they did not do anything to obtain help while only 8 % of the non-arousal group claimed to not do anything after the assault. To encourage this diverse population to engage in help-seeking behaviors, hospitals, police agencies, and clinicians could promote help-seeking behaviors by being nonjudgmental and welcoming.

Conclusion

Though the majority of the hypotheses were not significant it is important to acknowledge that this is the first research that explicitly recognized arousal as a real experience of rape survivors. Most importantly, the investigator found that those who reported arousal told significantly fewer people compared to the non-arousal group. To the investigator's knowledge, arousal has not been mentioned often in the literature due to thoughts that it may cause the survivor to feel ashamed of their experience or appear to be victim blaming. This notion can now be laid to rest. These results have shown that arousal occurred in 31 percent of the current sample of sexual assault survivors who were recruited from a Reddit page specifically addressing arousal during sexual assault. Despite this large number it appears that those who experience arousal experience a similar experience to those who do not particularly, in regards to satisfaction with their therapist, self-blame, how much they blame the rapist, and feelings of control over the recovery process. This similar experience may be due to all of the participants needing to attend therapy. The sample would have been much more robust if this was not an inclusion criterion. In fact, 646 participants attempted to take the survey though only 166 qualified after saying they did not attend therapy after their assault.

Once again, the largest clinical finding is that arousal does in fact occur. This adds weight to the Suschinsky and Lalumière (2011) theory that genital arousal leads to lubrication to reduce the likelihood of injury occurring when unwanted sexual encounters take place. One in six women will have reported an attempted or completed sexual assault in their lifetime (RAINN, 2017). Based upon these numbers and the current study, two out of six women would report arousal. Currently the "lack of protest, lack of resistance, and silence are unable to be interpreted as signs of consent" in the state of California (Cook & Messman-Moore, 2017). After examining the results of this research, it is necessary to include a comment about arousal not indicating consent. This way, prosecutors will not be able to claim any forms of sexual arousal or lubrication as forms of consent, perpetuating further shame about being raped.

Clinical & Theoretical Implications

The findings from the present study provide the following implications for the population:

1. This is the first known research that has asked participants explicitly about sexual arousal during rape. Prior research has only spoken about the phenomenon anecdotally. This research gives evidence that it is a real experience and occurs more often than originally expected, ultimately sparking a dialogue of different experiences during rape.
2. Survivors who experienced arousal during their assault do not tell as many people as survivors who did not experience arousal. This may make it difficult for the survivor to open up to a therapist about their experience. The therapist may want to reference this research in attempts to normalize the experience even before the patient discloses arousal or not. The therapist should explicitly emphasize that arousal is a natural, physical response.

3. Despite arousal occurring, from this sample it appears that treatment does not need to differ. Rape is painful and traumatizing no matter the circumstance. It will be important that the therapist address the arousal in a nonjudgmental manner. A different treatment will not be needed as previously expected.
4. It is important to note that despite the participants being in therapy they are still experiencing significant levels of self-blame and low levels of blame towards the rapist regarding their trauma. This is not a good indicator for the sample's recovery as the greater the victim's behavioral self-blame and the less the victim blames the rapist are associated with higher levels of distress (Frazier, 2003).
5. Non-heterosexual participants from both aroused and non-aroused groups had significantly less help-seeking behaviors compared to heterosexual peers. This finding is congruent with the Starzynski et al. (2007) finding. With this in mind, it is extremely important that this population feels emotionally supported from the first person that they confide in as this support has been shown to reduce the stress that accompanies a sexual assault which in turn increases the survivors' desire to continue seeking additional support (Kaukinen, 2004; Kilpatrick, Resnick, Ruggiero, Conoscenti & McCauley, 2007).
6. The Institutional Review Board required that all participants needed to have engaged in therapy in order to participate due to concerns that the material in this research may be triggering to some participants. This concern does not appear to be valid as the primary investigator did not have any participants reach out to express that the survey was triggering or request greater resources than provided on the debrief form. This is congruent with current literature in that approximately only 1 % of the 31 % of dissertations submitted as severe risk were rated as "deserving" of a rating of severe risk

by graduate raters (Abu-Rus, Bussell, Olsen, Ardill, Davis-Ku, & Arzoumanian, 2018). This current research provides even more evidence that IRB committees limit possible research by claiming that studies are more psychologically risky than they may be in reality.

Limitations of the Present Study

1. The present study had an insufficient sample and would have likely benefited from a sample that did not come directly from a website directed towards women who have experienced arousal. A sample that stemmed from diverse outlets would aid in ensuring generalizability, allow more detailed analyses of the variables, and provide greater power to test hypotheses.
2. The present study did not reflect the ethnically diverse population of women who are sexually assaulted. Due to time constraints, the researcher was unable to keep the survey open to continue collecting data until a more generalizable sample was collected.
3. The present study did not include Hispanic as an option to choose from regarding ethnicity. Due to this, it is unknown if those in the "other" category were Hispanic or truly identified as "other."
4. Exclusion criteria cut out a large part of the sample specifically by targeting those who had previously attended therapy.
5. The reliability of the Rape Attribution Questionnaire was not sufficient with the current sample. After recognizing this, Cronbach's Alpha needed to be used and the researcher found that there was poor reliability, specifically in regards to Control Over Recovery Process Scale. The researcher then assessed the data with the corrected scale only having three questions which still yielded insignificant results.

6. The reliability of the Physiological Arousal During Sexual Activity Scale was not sufficient with the current sample. After identifying that there was poor reliability with this scale it would not be wise to use this measure in future studies. The scale needs to be modified in order to improve reliability and should not be used until a future pilot study is conducted on this scale.
7. The survey did not ask the participants specific questions that could impact the efficacy of their treatment, such as: How many therapists have you seen post assault; What type of therapy did you engage in post assault; Are you currently in therapy?
8. This study employed a cross-sectional design where participation was voluntary, so results may not be representative of all sexual assault survivors. Additionally, all data were collected in the summer and fall of 2019, so the results may not be representative of data collected at other times.
9. Many of the participants were recruited from the Reddit page specifically designed for survivors looking for information, help, or advice in an unconventional way where their identities were masked. It may be that this specific sample has reservations about seeking help in both direct and indirect ways which is why they reached out on the sub-Reddit page specifically targeted towards survivors who experienced arousal. This is a small proportion of the survivor population, and it is important to recognize the impact that retrieving the majority of the sample from Reddit has on the current study.
10. Collecting online data regarding retroactive sexual accounts is risky for multiple reasons. First, there is no guarantee if the participants are taking the time to actually read the survey thoroughly. To combat this the researcher did not accept any completed protocols that were completed before the projected expected time. Second, women's sexual

concordance has proven to be low due to timid reporting in the lab (Suschinsky & Lalumiere, 2012). Women may not have been honest regarding their arousal state at the time of their assault due to fear of how they would be perceived by the investigator.

Suggestions for Future Research

Suggestions for future research include:

1. Replicating the present study with a larger and more heterogenous sample to increase generalizability. Specifically, not using a convenience sample such as a Reddit page that is targeted towards survivors who endorse sexual arousal. It would be more appropriate to have participants from multiple different avenues such as Facebook, sexual assault advocacy groups, or Reddit pages that do not target arousal specifically.
2. Making the inclusion criteria broader while allowing for participants that have not participated in therapy. This will also researchers to identify the impacts that attending therapy verse not attending therapy has on those who experience arousal and those who do not.
3. Since the Physiological Arousal During Sexual Activity Scale had no prior research on its reliability, the present study found an alpha of .30. Thus the measure had to be revised in order to increase its reliability. Despite this it is important to note that the questions asked did not appear to produce a negative reaction among the participants as evidence by no participants reaching out to the primary investigator or supervisor, or complaining about it.
4. When the parasympathetic system is not functioning properly, an individual's ability to regulate fear responses is impaired. Due to this, it would be interesting to examine if there is a link between arousal during rape and significant trauma prior to the rape.

5. Two questions should be added to the demographics portion if this study is duplicated. Current literature claims that help-seeking increases when one has a prior mental health history (Starzynski, Ullman, Townsend, Long, & Long, 2007). It is suggested to ask the participants about their contact with mental health professionals prior to their assault. Additionally, it would also be wise to ask the participants what their relationship was with the rapist, as survivors whose assaults involve strangers are more likely to seek help due to it fitting the stereotypical idea of rape (Starzynski, Ullman, & Filipas, 2005).
6. Now that research has been conducted that confirms arousal during rape does occur, it would be wise to bring this research into the lab to rule out any hormonal factors that could impact arousal and to look at the physiological and subjective arousal at the same time. This could be done by replicating Hoon, Wincze, and Hoon's (1977) research that had participants watch an anxiety provoking video clip involving tragic car accidents while measuring their physiological arousal. It would be important to ask these participants how they are feeling in that moment. The participants would once again be placed into two groups: those who endorsed arousal during their rape and those who did not.

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Appendix A- Demographic Screening Questionnaire

1. Sex at birth: *Male, Female*
2. Ethnicity *(please select one): American Indian/ Alaska Native, Asian, Black/ African American, Hispanic or Latino, Native Hawaiian/ Pacific Islander, White, Other*
3. Current Age: _____
4. Do you consider yourself to be: *heterosexual, homosexual, bisexual, other, prefer not to say*
5. What was the age that you were sexually assaulted? _____
6. Did the sexual assault occur before your first menstruation cycle? *Yes, I do not remember, No*
7. What was the gender of the perpetrator? *Male, Female, Not sure, Prefer not to answer*
8. Any time after the assault, did you attend one session of individual psychotherapy? *Yes No*
9. If yes, who referred you to your therapist? *Self-referred, friend/family member, primary doctor, emergency room doctor, support group, rape advocate, other (please specify)*
10. How many sessions of psychotherapy did you engage in?
11. How many people have you told about your sexual assault?
12. After the sexual assault did you do something to obtain help (Y/N)

    12a. Did you attempt to use any indirect resources: *Magazines, google search, talking about the trauma as though it did not happen to you but a friend*

    12b. Did you attempt to use any direct resources: *therapy, emergency room, police, friends, family, support group, rape advocate, sexual assault hotline*

PHYSIOLOGICAL AROUSAL DURING SEXUAL ACTIVITY SCALE (PADAS)
Created by Andrew Pari LSW

At any time during this experience did you notice any of the following changes in your body? Experiencing arousal and/or orgasm is a known, though little researched aspect, of sexual assault and abuse. While it is typically emotionally painful for survivors to have experienced, it is a natural physical response and does not mean that the person experiencing this liked or enjoyed what happened to them.

1. <u>Females/Individuals who possess the below anatomy:</u>
   a. Increase in your pulse (heart rate)?
   b. Changes in your breathing, such as breathing faster or slower?
   c. Increase in the sensitivity to your vagina and/or labia?
   d. Increase in the sensitivity to your clitoris?
   e. Lubrication (or "wetness") of your vagina?
   f. Contractions of your pelvic muscles?
   g. Involuntary vocalizations or sounds (such as cries, grunt, groans, gasps and/or exclamations)?

2. Did you notice any pre-orgasmic sensations?
3. Did you orgasm? [Follow-up question to the ones above]
4. Did it happen more than one time during?

Appendix B- Rape Attribution Questionnaire

Rape Attribution Questionnaire
RAQ

Items

Below are statements describing thoughts women often have about why an assault occurred. Please indicate how often you have had each of the following thoughts in the past week.

Never	Rarely	Sometimes	Often	Very Often
1	2	3	4	5

How often have you thought: I was assaulted because . . . ?

Behavioral Self-Blame

1. I used poor judgment.
2. I should have resisted more.
3. I just put myself in a vulnerable situation.
4. I should have been more cautious.
5. I didn't do enough to protect myself.

Rapist Blame

1. The rapist thought he could get away with it.
2. The rapist wanted to feel power over someone.
3. The rapist was sick.
4. The rapist was angry at women.
5. The rapist wanted to hurt someone.

1	2	3	4	5
Strongly disagree	Disagree somewhat	Neither agree nor disagree	Agree somewhat	Strongly agree

Items

1	2	3	4	5
Strongly disagree	Disagree somewhat	Neither agree nor disagree	Agree somewhat	Strongly agree

Future Control

1. I have changed certain behaviors to try to avoid being assaulted again.
2. Since the assault, I try not to put myself in potentially dangerous situations.
3. I do not take any special precautions since the assault occurred. (reversed)
4. I have taken steps to protect myself since the assault.
5. I have made a change in my living situation since the assault.

Control Over the Recovery Process

1. The assault is going to affect me for a long time but there are things I can do to lessen its effects.
2. I don't feel there is much I can do to help myself feel better. (reversed)
3. I know what I must do to help myself recover from the assault.
4. I am confident that I can get over this if I work at it.
5. I feel like the recovery process is in my control.

Future Likelihood

1. I am afraid that I will be assaulted again. (reversed)
2. It is not very likely that I will be assaulted again.
3. Now that I have been assaulted, the odds are it won't happen again.
4. I feel pretty sure that I won't be assaulted again.
5. No matter what steps I take, I could be assaulted again. (reversed)

Appendix C- Client Satisfaction Questionnaire-8

CSQ-8 UK English

CLIENT SATISFACTION QUESTIONNAIRE

CSQ-8

Please help us improve our service by answering some questions about the help that you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions*. We also welcome your comments and suggestions. Thank you very much. We appreciate your help.

CIRCLE YOUR ANSWERS

1. How would you rate the quality of service you received?

4 *Excellent*	3 *Good*	2 *Fair*	1 *Poor*

2. Did you get the kind of service you wanted?

1 *No, definitely not*	2 *No, not really*	3 *Yes, generally*	4 *Yes, definitely*

3. To what extent has our service met your needs?

4 *Almost all of my needs have been met*	3 *Most of my needs have been met*	2 *Only a few of my needs have been met*	1 *None of my needs have been met*

4. If a friend were in need of similar help, would you recommend our service to him or her?

1 *No, definitely not*	2 *No, I don't think so*	3 *Yes, I think so*	4 *Yes, definitely*

5. How satisfied are you with the amount of help you received?

1 *Quite dissatisfied*	2 *Indifferent or mildly dissatisfied*	3 *Mostly satisfied*	4 *Very satisfied*

6. Have the services you received helped you to deal more effectively with your problems?

4 *Yes, they helped a great deal*	3 *Yes, they helped somewhat*	2 *No, they really didn't help*	1 *No, they seemed to make things worse*

7. In an overall, general sense, how satisfied are you with the service you received?

4 *Very satisfied*	3 *Mostly satisfied*	2 *Indifferent or mildly dissatisfied*	1 *Quite dissatisfied*

8. If you were to seek help again, would you come back to our service?

1 *No, definitely not*	2 *No, I don't think so*	3 *Yes, I think so*	4 *Yes, definitely*

WRITE ANY COMMENTS OVERLEAF

Appendix D- Informed Consent Form

This research is being conducted by Kayla Bunderson, MA, student at Alliant International University and supervised by Robert Geffner, Ph.D., ABPP, ABN, at the California School of Professional Psychology, San Diego Campus. You are invited to participate in a research project that will contribute important information to the field of sexual assault. This survey asks for your opinion and personal experience about different areas of sexual abuse.

All information you submit will be strictly confidential and anonymous. No names or personal information will be used in any reports or publication. All information collected will be stored on the Qualtrics website in a password protected account, while the data will be stored on a password protected computer. All information will be destroyed after 7 years.

In order to participate you must endorse the following:

- I can speak and read English
- I am 18 years old or above
- I am a survivor of sexual abuse that occurred after my first menstrual cycle. For the purpose of this study sexual abuse is defined as:
  "being a nonconsensual (unwilling) participant in sexual activity with another person. Engaging in sexual activity with another person without your consent, against your wishes or against your will. It can be committed by a wide range of people, including strangers, acquaintances, current or ex-romantic partners, dates, fellow employees, neighbors, fellow students, and others. Sexual activity may include but is not limited to, intercourse, anal sex, oral sex, or penetration" (Perilloux, Duntley, Buss, 2014).
- I have been informed about the purpose of the study.
- I understand that some of the questions may be triggering and upsetting to some individuals.
- I understant that the researchers invloved in this study are not responsible for the cost incurred for treatments or assistance sought by participating in this study.
- I am aware that I have the right to withdraw or discontinue my participation at any time without being penalized.

If you feel that you are in crisis at any time while completing the survey these resources are available 24/7:

Suicide Prevention Lifeline: 1-800-273-8255
National Sexual Assault Hotline: 1-800-656-4673
Free 24/7 crisis line through text: Text HOME to 741741
https://www.imalive.org
https://www.contact-usa.org/chat.html

In order to ensure that you have access to phone numbers and emails of contact persons responsible for the oversight, supervision or completion of this study, please either download or print this consent form before proceeding with this study.

For general questions about rights of research participants, please contact the Alliant International University Institutional Review Board at Alliant-irb@alliant.edu or 858-635-4741.
If you agree to participate in the study, please choose the "Yes" option. By electronically signing this consent form I recognize that I am not giving up any of my legal rights.

▭ Yes
▭ No

Approved by Alliant International University Institutional Review Board

Appendix E - Recruitment Advertisement

Dear Participant,

My name is Kayla Bunderson, M.A., and I am a doctoral student in the Clinical Psychology program at Alliant International University in San Diego, CA. I am conducting a study for my doctoral dissertation aimed to explore participants' experience of rape and the implications their experience has on seeking treatment. Currently, there is little research on survivor's experience during sexual assault especially those who experience arousal during their assault. It is my goal to bring light to this anecdotal experience so that survivors who have experienced this do not feel alone. Your answers will help expand the understanding of arousal in abuse and increase therapist's ability in treatment to help those dealing with it.

I am being supervised by Robert Geffner, Ph.D., ABPP, ABN, at the California School of Professional Psychology, San Diego Campus. To participate in this study, you must be able to speak and read English, engaged in at least one therapy session but do not need to currently be engaged in therapy, and have experienced a sexual assault after one's first menstrual cycle.

Each participant who voluntarily completes the survey will have the opportunity to have their name entered into a drawing to win one of five, $50 Amazon gift cards. Participants who would like to take part in the drawing will be sent to a different survey and asked to fill in their email address. Along with this survey you will be if you would like a summary of the aggregate results of the study once the study has been completed. Please answer the question and provide the email address you would like the results to be sent to. This survey takes approximately 10 - 15 minutes to complete online and is completely anonymous. If you are interested in taking this survey, please click on the link below or copy and paste the link into your Internet browser. If you have any questions or concerns about this study, please do not hesitate to contact me at kbunderson@alliant.edu or my faculty supervisor at bgeffner@alliant.edu.

Please feel free to pass along my contact information or this survey to other sexual abuse survivors who might be interested.

Thank you for your participation!

Kayla Bunderson, M.A.
Alliant International University, San Diego campus
California School of Professional Psychology

Robert Geffner, Ph.D., ABPP, ABN
Alliant International University, San Diego campus
California School of Professional Psychology

LINK TO STUDY WILL BE INSERTED HERE

Approved by Alliant International University Institutional Review Board
Appendix F – Debrief Form

Dear Participant,

Thank you for participating in this study! This form provides background about our research to help you learn more about why we are doing this study. Please feel free to ask any questions or to comment on any aspect of the study. To do so please contact the primary investigator, Kayla Bunderson at kbunderson@alliant.edu or my faculty supervisor Robert Geffner at bgeffner@alliant.edu

Currently, there is little research on survivor's experience during sexual assault especially those who experience arousal during their assault. It is my goal to bring light to this anecdotal experience so that survivors who have experienced this do not feel alone. Your answers will help expand the understanding of arousal in abuse and increase therapist's ability in treatment to help those dealing with it. Specifically, we are assessing aspects of shame and guilt that one may experience after sexual assault and satisfaction with one's treatment if they sought out treatment.

As you know, your participation in this study was voluntary. If you wish, you may withdraw after reading this debriefing form by clicking "do not submit," at which point all records of your participation will be destroyed. You will not be penalized if you withdraw. As some of the material in this study may have brought up distressing thoughts or emotions, it is important that you reach out for help if you are feeling that you are in crisis.

These resources are available 24/7:

Suicide Prevention Lifeline: 1-800-273-8255
National Sexual Assault Hotline: 1-800-656-4673
Free 24/7 crisis line through text: Text HOME to 741741
https://www.imalive.org
https://www.contact-usa.org/chat.html

You may keep a copy of this debriefing for your records by downloading it from this page. Once again, if you have any comments or questions please contact Kayla Bunderson at kbunderson@alliant.edu or Dr. Robert Geffner bgeffner@alliant.edu Please feel free to pass along my contact information or this survey to other sexual abuse survivors who might be interested.

Thank you for your participation!

Kayla Bunderson, M.A.
Alliant International University, San Diego campus
California School of Professional Psychology

Approved by Alliant International University Institutional Review Board