

A Constructivist Grounded Theory  
Exploration of Wellbeing in Female  
Adult Sexual Assault Victims/Survivors

by

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## ABSTRACT

The purpose of this constructivist grounded theory study was to explore the perceptions of adult female sexual assault victims/survivors about their wellbeing: their definitions and descriptions of wellbeing; the impact of the assault on wellbeing; and barriers and facilitators to achieving wellbeing following assault. Feminist theory provided the sensitizing concepts for this research. Data were collected via semistructured interviews with 22 adult women who had experienced at least one episode of sexual assault at or above the age of 18. Data analysis included first, second, and third level coding techniques, memo writing, and data displays. Participants experienced negative effects to their overall wellbeing as well as to the wellbeing domains of physical, mental, career/economic/financial, relational, and spiritual. The findings of this study support wellbeing as a core category encompassing the five domains listed above, also described in the literature. The participants also confirmed and expounded in depth on the dynamic, interactive, and overlapping nature of each of the domains of wellbeing and their ability to enhance, maintain, or worsen health status and overall wellbeing. In addition, a new construct emerged that cut across all domains, that of safety, and the overarching significance of culture was recognized. Additional research should continue to explore wellbeing in diverse populations of sexual assault victims/survivors. Additional research should also explore the significance and function of safety in sexual assault victims/survivors. Formal and informal supporters of sexual assault victims/survivors should be aware of the complex ways that sexual assault affects

women. In addition, they should be aware of helpful resources for sexual assault victims/survivors.

## DEDICATION

I dedicate this dissertation work to my loving and patient husband, Rosario Curcuru. I could not have done this without your words of encouragement and all of the extra duties you have taken on during the last four years. I also dedicate this work to my three rock star daughters, Wen, Alice, and Téa. You offered inspiration to me every day.

I dedicate this dissertation to my friends, who struck a perfect balance between compassion and tough love. Finally, I dedicate this dissertation to the amazing, resilient women who took the time to share the most intimate details of your lives, receiving only my gratitude and chocolate as a thanks.

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## DEFINITIONS

*Adult sexual assault (ASA)*: “an act of forcing another person into sexual activity against his or her will” at or above the age of 18 (The National Center for Victims of Crime, 2012, para 1).

*Childhood sexual abuse (CSA)*: “an act of forcing another person into sexual activity against his or her will” below the age of 18 (The National Center for Victims of Crime, 2012, para 1).

*Child abuse*: “child abuse and neglect as any recent act, or failure to act, on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act that presents an imminent risk of serious harm to a child” (National Institute of Justice, 2011, para 1). For this study, the term *childhood sexual abuse* will be used when it is possible to be specific; the term *child abuse* will be used in cases of child abuse, when childhood sexual abuse is not specified.

*Victim/Survivor*: Any woman who has experienced adult sexual assault. As some women refer to themselves as victims while others refer to themselves as survivor or as victim/survivors after sexual assault (Guerette & Caron, 2007), the combination term victim/survivor will be used throughout this proposal in an attempt to be inclusive.

*Wellbeing*: A state of existence characterized by subjective positive ratings in multiple domains of life. It includes the domains of physical, social, spiritual, financial, and psychological health.

*IPV*: The physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy (Centers for Disease Control and Prevention, 2015, para 1).

# CHAPTER 1

## INTRODUCTION

With this study, I sought to explore wellbeing in women who have experienced adult sexual assault. Included in this exploration of wellbeing are the definition, description, and barriers and facilitators that arise in seeking wellbeing. I expected that the knowledge generated from this study would create new insights about wellbeing in sexual assault victims/survivors. In addition, I hoped that this study would inform the practice of professionals, such as healthcare professionals, mental health therapists, clergy, and law enforcement professionals who work with women who have experienced sexual assault. I utilized a constructivist grounded theory methodology to conduct this study. I conducted semistructured interviews with 22 participants, who were at least 18 years of age and had experienced sexual assault at or above the age of 18, to gather data.

I begin the chapter with a background and context of sexual assault of adult women in the United States. I also briefly discuss the construct of wellbeing. I follow this section with the problem statement, the statement of purpose, and the research questions. After these sections, I discuss my approach and assumptions as a researcher. I conclude this chapter with a discussion of the rationale and significance of this study and definitions of key terms used.

### **Background and Context**

Sexual assault is widespread in the United States, affecting up to 20% of women over their lifetime in the United States, or about 300,000 women a year (Centers for Disease Control, 2010; Tjaden & Thoennes, 2006). Sexual assault is defined by The

National Center for Victims of Crime (2012, para 1) as “an act of forcing another person into sexual activity against his or her will.” Women who have experienced sexual assault demonstrate health disparities in many areas, including mental, physical, and behavioral.

The impacts of sexual assault are tremendous. For example, women who have experienced sexual assault face significantly increased risks of sexually transmitted infections, pelvic inflammatory disorder, and unplanned pregnancies (McFarlane et al., 2005; Champion, Piper, Shain, Perdue, & Newton, 2001). Women who have suffered sexual assault also have a significantly increased risk of chronic diseases such as diabetes or hypertension (Street, Stafford, Mahan, & Hendricks, 2008). Perhaps less obvious is the connection between sexual assault and women’s education, career, and achievement years after the event (Adams, Greeson, Kennedy, & Tolman, 2013; Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012; Jozkowski & Sanders, 2012). The current research highlights some of the health disparities that victims and survivors of sexual assault experience; however, many questions remain unanswered. The current state of research about sexual assault is fragmented, focusing on specific physical, mental, behavioral, or relationship aspects rather than a holistic view of the issues. In addition, most of the research on sexual assault uses a cross-sectional design, which limits knowledge regarding how victims and survivors respond to sexual assault over time. It is nearly impossible to suffer health disparities in one domain (physical, for example) without also suffering health disparities in other domains.

Also lacking in much of the research about sexual assault is the voice of women who have experienced it. Most of this quantitative research is done on women and about women, but not with women. Examining the effects of sexual assault and other forms of

violence against women in a wider context allows participants and researchers to move away from a simplistic focus on pathology and focus on strengths and agency as well (Campbell & Bunting, 1991; Sokoloff, 2008).

**Wellbeing.** Wellbeing is a construct that includes the following intersecting domains: physical health, mental health, social connectedness, financial health, and spirituality (Centers for Disease Control and Prevention, 2013; Keifer, 2008). Figure 1 represents the intersecting domains of wellbeing. Wellbeing may be defined differently between different cultural groups, level of ability and disability, gender, country of origin, age, and trauma experience. Positive wellbeing is associated with positive physical and mental health outcomes, family and community relations, and economic benefits (Centers for Disease Control and Prevention, 2013). Individuals with higher levels of wellbeing have a decreased risk of disease, illness, and injury, enhanced immune functioning, speedier recovery, and increased longevity (Centers for Disease Control & Prevention, 2013). Without knowledge about wellbeing from the perspective of the sexual assault victim or survivor, the ability to create programs to improve their wellbeing is impaired. In this study, wellbeing is defined as a state of existence characterized by subjective positive ratings in multiple domains of life. It includes the domains of physical, relational, spiritual, financial, and mental health. As Figure 1 demonstrates, the various domains overlap and interact with other domains. For example, an individual's relational or spiritual health may facilitate improved psychological and or physical health. The converse is also true. An individual's poor relational health may serve as a barrier to positive mental, economic wellbeing if he or

she has a difficult time getting along and interacting with others in the workplace, making advancement impossible.



*Figure 1.* Lack of perspective from victims and survivors.

Wellbeing cannot be defined or described by clinicians or researchers. When clinicians and researchers define wellbeing for groups or individuals, they frequently miss fundamental concepts (Keifer, 2008; Laffrey, 1986). According to Keifer (2008, p. 249), improving health and wellbeing is dependent upon encouraging individuals and groups to define wellbeing for themselves:

If this concept is not well understood and incongruence exists, then the wellbeing may be an elusive goal of clinical practice. Healthcare professionals need to be clear about what wellbeing is, before they can effectively enable their clients to work toward it.



## **Problem Statement**

Sexual assault is prevalent in the United States and is associated with many adverse health conditions. Although researchers have uncovered many of the harms that victims/survivors of sexual assault experience, most of the research has been fragmented, focused on only mental or physical health while neglecting the complex nature of wellbeing. In addition, feedback from sexual assault victims/survivors on how they describe wellbeing and the factors that improve or worsen it is scarce. To improve the wellbeing of women who have experienced sexual assault, we need to learn what this means to them—how they describe it, what factors facilitate it, and what factors detract from it. We can use this information to work toward improving the wellbeing of sexual assault victims/survivors.

## **Statement of Purpose and Research Question**

The purpose of this constructivist grounded theory study is to explore the perceptions of adult female sexual assault victims/survivors on their wellbeing, such as how they define and describe it, the impact of sexual assault upon it, and barriers and facilitators that arise in attempts to achieve it. To fulfill this purpose, I attempted to answer the following questions: a) How do participants describe and define wellbeing in their lives? b) How do participants perceive their wellbeing after experiencing adult sexual assault? c) What factors function as facilitators or barriers to participant achievement of overall wellbeing or certain aspects of wellbeing?

## **Research Approach**

With the approval of the Arizona State University and Western Michigan University Institutional review boards, I explored the various ways that female sexual

assault victims/survivors described, defined, and obtained various states of wellbeing in their lives. I explored the participants' perceptions of the influence of sexual assault on their overall wellbeing and its impact on various domains of wellbeing. I explored factors that functioned as facilitators or barriers to finding wellbeing.

To explore the description, definition, and process of obtaining wellbeing, I conducted semistructured interviews with 22 adult women (women over the age of 18) in various confidential settings in Kalamazoo and Calhoun counties, Michigan. All of the participants had experienced adult sexual assault (at or above the age of 18 years old), though several participants experienced more than one adult sexual assault. Multiple participants had also experienced childhood sexual abuse before experiencing sexual assault as an adult. Each interview was digitally recorded and transcribed verbatim. Participants also completed a basic demographic form.

Before I began the research, I conducted a literature review of relevant literature on sexual assault, feminist theory and research methodology, and constructivist grounded theory methods. I created a domain analysis on which I based my code book before I began interviews. I revised the domain analysis and code book throughout the data collection and coding process, as guided by emerging data and categories. Dr. Eve Krahe was my coding mentor. Dr. Krahe worked with me throughout the coding process by coding all of the interviews with me. We conducted frequent meetings at which we discussed the interviews, emerging data and categories, coding process, and personal experiences with the data and coding process. Our inter-rater reliability was 91% to 96% on three interviews. In addition to working with Dr. Krahe during the coding process, I

frequently discussed my findings and ideas with academic and clinical peers throughout the data collection and analytic process.

I initially conducted purposive sampling of a diverse population of participants, based on age, income, education, relationship to assailant, sexual orientation, and race, to explore and reflect on various perspectives. After I had achieved saturation in all of the wellbeing domains except spirituality, I conducted purposive sampling to saturate this category.

### **Assumptions**

Based on my experience as a women's health nurse practitioner, sexual assault nurse examiner, and Ph.D. candidate, I made several assumptions regarding this study. First, I assumed that most women would perceive sexual assault as a negative factor in many domains of wellbeing. Second, I assumed that many factors, such as peer support, experience with the legal and healthcare system, and relationship to the assailant, would be significant influencers on wellbeing. Third, I assumed that certain demographic factors would influence the ways in which women described, defined, and obtained wellbeing. For example, I predicted that women with lower educational achievement and lower incomes would experience more barriers in achieving wellbeing. Fourth, I assumed that wellbeing would improve as time since the sexual assault(s) passed.

### **The Researcher**

Many aspects of my life potentially had an impact on this study. For example, I am the daughter of a woman who experienced severe intimate partner violence at the hands of her husband and my father. I witnessed this violence for years as a child. I am the mother of three young girls, and I am conscious of their vulnerability as girls.

Besides these very personal family influences, I have been involved in the overlapping issues of feminism, violence against women, and women's health for all of my adult life.

I have considered myself as a feminist for all of my adult life. Although there are many complex and academic definitions of a feminist and feminism, I identify with the basic definition by Merriam-Webster (n.d.), which states that feminism is "the belief that men and women should have equal rights and opportunities." Because sexual assault disproportionately affects women and the majority of assailants are men, I believe that sexual assault is an important feminist issue. Since the age of 18, I have volunteered or worked for many different organizations that embrace a feminist purpose and identity, such as family planning organizations and women's crises shelters. I have been politically active in feminist causes throughout this time. I was fortunate to have academic experience in feminism, participating in a seminar in feminist theory and another seminar called "Advanced Victimology."

While conducting this research, I was working as a women's health nurse practitioner and as a sexual assault nurse examiner. I have been a women's health nurse practitioner for 9 years and a sexual assault nurse examiner for 7 years. This experience helped me to gain some insight into the lives of women who experienced sexual assault. For example, several women revealed to me how vulnerable they felt when they obtained health care, especially breast and pelvic exams. Many times, women would reveal a sexual assault or childhood molestation that they had never disclosed to anyone else. I felt incredibly honored in these situations. I also felt that I had a responsibility to learn more about the ways in which sexual assault influenced various parts of women's lives, as well as about the ways in which they coped with assault(s). I never cease to be

amazed, inspired, and saddened by the ways in which women cope with sexual assault. I attempted to dive deep into this territory and come up with new understanding and knowledge. My ultimate goal is that this knowledge will be used to improve the wellbeing of victims/survivors of sexual assault.

Although my personal, political, academic, and professional experiences have helped me develop insight into the experience and impact of sexual assault on women's lives, these experiences are also a liability. These experiences may have also served to bias my judgment in all areas of this study, from my research questions, to methodology, to interpretation. To minimize these biases, I have made my theoretical orientation and background explicit. I have engaged in critical self-reflection activities such as journaling and having discussions with professional and academic peers and with my mentors.

### **Rationale and Significance**

The rationale for this study emerges from my desire to explore the impact of sexual assault on the lives of women from a more holistic vantage point. I want to explore the strength and skills women have used to cope with sexual assault, as well as the pathology that has resulted from these attacks. I want to also explore with these women the strengths and deficits of various areas of culture that have a significant influence on the wellbeing of sexual assault victims/survivors.

Exploring the wellbeing of women who have experienced adult sexual assault is critical so that we can learn ways in which, as a society and professionals, we can work to improve wellbeing and the process of obtaining it. The current state of the science demonstrates the various negative impacts of sexual assaults on women, but this

knowledge is fragmented and incomplete, frequently focusing on certain areas of wellbeing while ignoring other domains. In addition, the current research focuses on the pathological processing of women who have experienced sexual assault while ignoring their strength, resilience, and creativity.

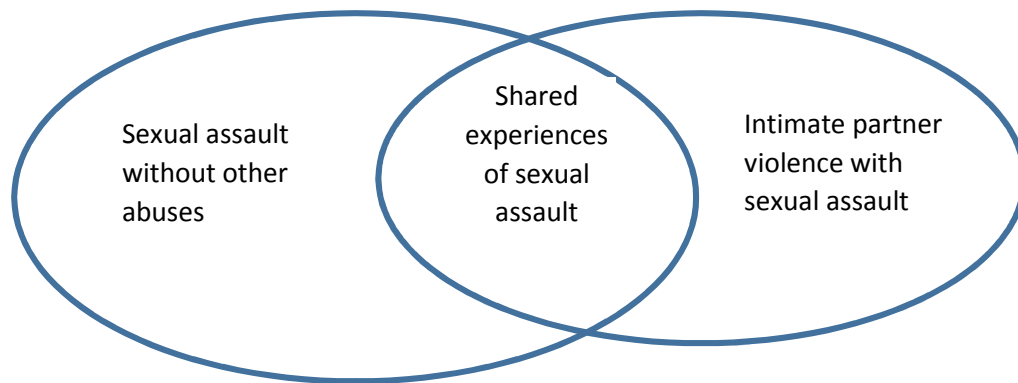
## CHAPTER 2

### PROBLEM

It is estimated that sexual assault affects up to one out of every five women in their lifetime in the United States (Centers for Disease Control, 2010; Tjaden & Thoennes, 2006). According to the U.S. Department of Justice (DoJ), sexual assault is

any type of sexual contact or behavior that occurs without the explicit consent of the recipient. Falling under the definition of sexual assault are sexual activities such as forced sexual intercourse, forcible sodomy, child molestation, incest, fondling, and attempted rape. (U.S. DoJ, 2012, para. 2)

The sexual assaults of most women are perpetrated by someone they know, and the assault frequently occurs within the context of a violent relationship (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Temple, Weston, Rodriguez, & Marshall, 2007; Tjaden & Thoennes, 2006). As I review the literature, I will attempt to specify when sexual assault is measured separately, or within intimate partner violence. Sometimes, the researcher makes this relationship clear; on other occasions, the researcher does not clarify the context of sexual assault. For the purposes of this literature review, the reader would do well to bear in mind Figure 2, which demonstrates how sexual violence occurs both within the context of a violent intimate partner relationship and as isolated incidents of violence.



*Figure 2.* Sexual assault within intimate partner violence and without intimate partner violence

Victims/survivors of sexual assault experience severe and negative physical, psychological, behavioral, and social outcomes that linger long after they are assaulted. Although researchers have described many of these health disparities, their focus is frequently narrow, focusing on specific body systems (like reproductive health outcomes) or on physical or mental health outcomes. However, poor physical, psychological, or social health outcomes rarely occur in isolation; rather, they are intertwined in a complex manner. The wellbeing construct may help illuminate how various health constructs (physical, psychological, relational, etc.) interact with and influence one another.

Although there is no consensus about the definition of wellbeing, the Centers for Disease Control and Prevention (2013, para 4) define it as “the presence of positive emotions and moods (e.g. contentment and happiness), [and] the absence of negative emotions (e.g. depression and anxiety), satisfaction with life, fulfilment and positive functioning.” Wellbeing is a construct that includes physical, psychological, spiritual, social, and financial aspects of a person (Centers for Disease Control and Prevention, 2013; Keifer, 2008). Wellbeing concepts can vary significantly among different cultural



groups, level of ability and disability, gender, country of origin, age, and trauma experience (Keifer, 2008).

We must focus on wellbeing because it has an important impact on individuals and society. Positive wellbeing is associated with positive physical and mental health outcomes, family and community relations, and economic benefits (Centers for Disease Control and Prevention, 2013). Individuals with higher levels of wellbeing have a decreased risk of disease, illness, and injury, enhanced immune functioning, speedier recovery, and increased longevity (Centers for Disease Control & Prevention, 2013).

Learning the perspective of sexual assault victims/survivors on wellbeing is critical to assisting victims/survivors to achieve or improve it. When health care providers and researchers define health and wellbeing, these definitions frequently differ from those of patient populations (Keifer, 2008; Laffrey, 1986). According to Keifer (2008, p. 249), improving health and wellbeing is dependent upon encouraging individuals and groups to define wellbeing for themselves:

If this concept is not well understood and incongruence exists, then the wellbeing may be an elusive goal of clinical practice. Healthcare professionals need to be clear about what wellbeing is, before they can effectively enable their clients to work toward it.

Subjective and objective research is necessary to measure and describe wellbeing (Centers for Disease Control and Prevention, 2013). Although quantitative instruments measure wellbeing, they may not capture the complexity of the concept (Keifer, 2008). Voices and stories can deepen understanding about the context of certain phenomena. It is imperative, then, to examine wellbeing from an individual viewpoint while also considering the impacts of race, class, and ethnicity (Williams & Elliot, 2010). A

grounded theory study will assist in the identification of the basic social processes in attaining and maintaining wellbeing, and possibly result in the development of a theory of wellbeing (Keifer, 2008). Specifically, this study will assist in identifying how women who have experienced sexual assault define and describe wellbeing. In addition, this study will assist in identifying factors that increase or decrease sexual assault victims' and survivors' wellbeing.

### **Background and Significance**

**General physical health.** Women who have experienced sexual assault demonstrate significantly increased risks of physical health problems compared to women who have not been sexually assaulted. Women who have experienced sexual assault are significantly more likely to have chronic health conditions like diabetes, hypertension, obesity, and disability (Campbell et al., 2008; Jozkowski & Sanders, 2012; Plichta & Falik, 2001; Street, Stafford, Mahan, & Hendricks, 2008). Plichta and Falik (2001) assessed several self-reported health characteristics of women who had experienced sexual assault and women who had not (N=1,821). They reported that women who had experienced sexual assault were more than twice as likely to be diagnosed with a chronic health condition that requires ongoing treatment (AOR 2.1, 99% CI [1.41, 3.15],  $p < 0.01$ ). Street et al. (2008) also reported (N=3,946) that women who had experienced sexual assault and sexual harassment were nearly three times more likely to be diagnosed with chronic health conditions like diabetes, hypertension, arthritis, or cancer (AOR 2.83, 95% CI [2.14, 3.72]). Jozkowski and Sanders (2012) reported, based on an online survey of women (N=2,915), that sexual assault victims/survivors

were significantly more likely to self-report a high overall negative healthcare score (AOR 1.56, 95% CI [1.35, 1.82]).

These findings are important because they demonstrate a link between sexual assault and negative physical health outcomes that are not immediately intuitive, like the links between sexual assault and sexually transmitted infections or unintended pregnancy. Although these large quantitative studies contribute to our knowledge about the correlation between adult sexual assault and negative physical health conditions, we still have several gaps in our knowledge about this connection. For example, the cross-sectional nature of the studies limit our knowledge about the nature of time. Is there a relationship between time that has passed since sexual assault and negative health conditions? We also lack information on contextual factors of sexual assault and negative physical health. For example, we do not have research that explores factors that may moderate or mediate poor health outcomes, such as mental health symptoms or diagnoses, presence and quality of social networks, financial security, and presence and quality of spirituality.

Studies on other populations have shown that these factors do have a significant effect on some of the health outcomes discussed above, such as cardiac disease and hypertension, obesity, and diabetes, but have not focused specifically on women who have experienced sexual assault. For example, in a study of 155 Black college students, with a mean age of 19.4 researchers reported that perceived racism significantly predicted negative subjective health symptoms (assessed by the psychometric properties of the Symptom Checklist) ( $p < 0.01$ ) and the objective measure of cardiovascular reactivity ( $p = 0.002$ ) (Bowen-Reid & Harrell, 2002). Interestingly, spirituality moderated both the

subjective symptoms as well as the cardiac reactivity, such that groups with self-reported high levels of spirituality did not demonstrate negative health symptoms even in the presence of perceived racism (Bowen-Reid & Harrell, 2002). Researchers who assessed 148 adult women for the correlation of various childhood traumas and stressors reported that childhood sexual assault was associated with more than three times risk for adult obesity OR=3.6, 95% [1.8, 7.1], and that PTSD had a significant indirect effect on BMI ( $p<0.05$ ) but depression did not (Dedert et al., 2010). In a longitudinal prospective study, researchers followed 11,615 non-diabetic adults between the ages of 48-67 for six years to determine factors associated with diabetes. At baseline, individuals with depressive symptoms were significantly more likely to: have a higher BMI, fasting insulin, systolic blood pressure, caloric intake, more physical inactivity, and to be currently smoking ( $p<0.05$ ) (Golden, Williams, Ford, Yeh, Sanford, Nieto, et al., 2004). Six years later, the individuals in the highest quartile of depressive symptom were significantly more likely to have developed Type II Diabetes Mellitus, even after adjusting for smoking, physical activity, caloric intake, RR =1.28, [1.02–1.60] (Golden et al., 2004). It is possible that women who had experienced sexual assault were among these groups studied, but this was not assessed or analyzed. We do not know if sexual assault victims/survivors have unique stresses and differences in factors like spirituality that may mediate risks like hypertension, diabetes, and obesity.

**Chronic pain.** Sexual assault victims/survivors are significantly more likely than non-victimized women to report chronic pain. When assessing women (N=612) who had been recently diagnosed with a non-viral sexually transmitted infection (chlamydia, gonorrhea, syphilis, or trichomonis) (N=612) for various pain conditions, Champion and

colleagues (Champion, Piper, Shain, Perdue, & Newton, 2001) noted that sexual assault victims/survivors were significantly more likely to report abdominal pain ( $p < 0.05$ ), dyspareunia ( $p < 0.01$ ), and dysmenorrhea ( $p < 0.01$ ). In a cross-sectional study (N=268), Campbell and colleagues (2008) reported that women who had experienced sexual assault experienced significantly more pain clusters as ( $\chi^2 = 0.07 - 0.29$ , depending on low- high clusters of violence,  $p < 0.05$ ], and that this pain was mediated by PTSD symptoms. These researchers added the total of the severity of childhood sexual assault, adult sexual assault, intimate partner violence, of sexual harassment to determine the cluster levels of violence. Women who experienced severe forms of each type of abuse would demonstrate a high cluster of violence (Campbell et al., 2008). Jozkowski and Sanders (2012) found that sexual assault victims/survivors significantly more likely to say that pain interfered with their work both outside and inside the home a good amount to most of the time (AOR 1.37, 95% CI [1.18–1.59],  $p < .001$ ).

This research is important, as it demonstrates a significant relationship between sexual assault and the negative physical health indicator of pain. Two of the research teams even demonstrated a link between different domains in wellbeing. Campbell and colleagues (2008) reported that PTSD, within the mental health domain of wellbeing, significantly mediated chronic pain. Jozkowski and Sanders (2012) reported a link between the physical health domain and economic domain of wellbeing, reporting a significant relationship between pain and its interference with work outside and inside the home in women who have experienced sexual violence.

**Sleep disturbance.** Sexually assaulted women are significantly more likely to experience sleep disturbance. Astbury and colleagues (2011) examined data the from the

Australian Longitudinal Study of Women's Health of women aged 24-30 years (n=9,061) and reported that sexual assault victims/survivors experienced significantly more sleep difficulties like recurrent sleeping difficulties ( $p<0.001$ ), severe tiredness ( $p<0.001$ ), difficulty falling asleep ( $p<0.001$ ), restless sleep ( $p<0.001$ ), and use of prescription sleep medication ( $p<0.001$ ). In a smaller study and older study, researchers reported that up to 26% of sexual assault victims/survivors experience "a lot" of nightmares, based on self-reports of 598 women, and that these nightmares were significantly correlated with changes in sleep habits (Krakow, Tandberg, Barey, & Scriggins, 1995). Researchers reported that a group of 125 sexual assault victims/survivors who had been diagnosed with PTSD experienced nightmares frequently: an average of every other night (Krakow et al., 2002)

Despite the strength of the present research, several gaps remain in our knowledge about the experience of pain in women who have experienced sexual assault. The cross-sectional nature of the research (Champion et al., 2001; Jozkowski & Sanders, 2012) limits our knowledge about the impact of time since assault(s) and pain conditions. Besides the two studies that address the mental health and economic domains (Campbell et al., 2008; Jozkowski & Sanders, 2012) of wellbeing, there is no research that addresses other domains of wellbeing and how they relate to the experience of pain in women who have experienced sexual assault. Finally, the research does not address the ways in which sexual assault victims/survivors perceive the impact of sexual assault on their pain experience, and the barriers and facilitators to improving their pain experience. Although nightmares and sleep disturbance can be significant problems, we lack the knowledge

about how long these symptoms persist, what helps, and how they interact with other wellbeing domains.

**Reproductive health.** Negative reproductive health complications that are significantly associated with sexual assault are un-intended pregnancies, sexually transmitted infections, pelvic inflammatory disorder, and cervical dysplasia. Unplanned pregnancies as a result of sexual assault range from 5% (Holmes, Resnick, Kilpatrick, Best, 1996) to 23% (McFarlane et al., 2005). Sexually transmitted infections and pelvic inflammatory disease are also significant risks of sexual assault (Allsworth, Anand, Redding, & Peipert, 2009; Champion et al., 2001; McFarlane et al., 2005). Champion et al. (2001) also found a significant relationship between a history of sexual assault and sexually transmitted infections compared to non-assaulted women ( $p < 0.001$ ). These researchers also reported a significant relationship between a history of sexual assault and pelvic inflammatory disorder (PID), ( $p < 0.01$ ) (Champion et al., 2001). A study of 4,732 participants demonstrated that a history of sexual assault was associated with a 2.6 times higher risk (AOR 3.6 95% CI [1.7, 4.0]) of being diagnosed with invasive cervical cancer after adjusting for demographic characteristics, smoking, and illegal substance use (Coker, Hopenhayn, DeSimone, Bush, & Crofford, 2009).

These large and well-organized studies highlight the negative association between sexual assault and negative reproductive health outcomes. However, several gaps in our knowledge remain. The studies by Holmes and colleagues (1996) and McFarlane and colleagues (2005) directly tie sexual assault to un-planned pregnancies. The other adverse reproductive health outcomes, however, are more difficult to connect directly to sexual assault. For example, are the significantly higher rates of sexually transmitted

infections and pelvic inflammatory disease (Champion et al., 2001) the direct result from sexual assaults or are they the result of other more complex factors? For example, Teitleman et al. (2011) found that young women who had experienced sexual assault had more difficulty negotiating condom use with later partners. Miner and colleagues (2006) also found that women who had experienced both childhood sexual abuse and adult sexual assault were significantly less likely to consistently use condoms than women who had not experienced sexual assault. We also lack information about the persistence of sexually transmitted infections and pelvic inflammatory infections over time. Do women who have experienced sexual assault continue to experience these diagnoses? And, are there moderating or mediating factors, like participation in mental health therapy or access to and satisfaction with health care, or support received from family and or friends after the assault.

**Intersection of reproductive health, health seeking behaviors, and relational health.** Although it would seem that seeking gynecological care from a health care provider would help mitigate many risks to reproductive health, the reality is much more complicated. Only 22% to 45% of sexual assault victims /survivors seek health care (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Rennison, 2002). The reasons women don't seek assistance are not fully understood. However in a study of twenty nine self-identified adult sexual assault survivors who were mostly racial or ethnic minorities, the following reasons were identified for not seeking formal assistance after sexual assault: 1) feeling unworthy of help, 2) belief that they didn't qualify for help, 3) idea that formal assistance would not improve wellbeing, 4) worries about increased danger or retaliation



from assailant, and 5) worries that formal help would harm their wellbeing (Patterson, Greeson, & Campbell, 2009).

When women do seek health care, the quality varies widely. The health care sexual assault survivors receive in emergency rooms is often inadequate. For example, only 34% to 69% of victims/survivors are offered prophylaxis against sexually transmitted infections in the emergency department (Amey & Bishaie, 2002; Campbell, 2005). In addition, a survey of 400 emergency room physicians found that the majority (53%) would not prescribe emergency contraception to sexual assault victims/survivors if more than 48 hours after the assault, even though it can be effective up to 120 hours after sexual intercourse (Bakhru, Mallinger, and Fox, 2010). Compared with the health care in a traditional emergency room, victims/survivors treated by a Sexual Assault Nurse Examiner (SANE) are more likely to receive prophylaxis against sexually transmitted infections and pregnancy. Victims/survivors who are treated by SANEs are offered prophylaxis against sexually transmitted infections 90% of the time (Ciancone, Wilson, Collette, and Gerson, 2000; vs. 34% to 69% in the emergency department (Amey & Bishaie, 2002; Campbell, 2005). In a study of 91 hospitals in North Carolina, authors reported that the presence of SANEs was associated with a significantly higher rate of pregnancy prophylaxis (77% vs. 46%,  $p < 0.05$ ) than hospitals without SANEs (Woodell, Bowling, Moracco, & Reed, 2007). This research both fills in gaps in our knowledge about health seeking attitudes and behaviors and creates more questions. Part of the reason that women have negative reproductive health diagnoses is that the majority do not seek care, as demonstrated by Ahrens et al. (2001) and Rennison (2002). The small but significant study by Patterson and colleagues (2009) helps to explain why women

may not seek care that can reduce their chances of negative reproductive health outcomes. However, larger studies with larger and more diverse sample sizes need to confirm these results. In addition, we need to know what does motivate women to seek healthcare after sexual assault and how they differ from women who do not seek care. Does race and ethnicity influence this care seeking? Do financial resources and proximity to a healthcare facility make an impact?

The research about the differences in care received from SANEs and traditional providers is interesting and may provide explanations about which sexual assault victims/survivors are more likely to be at risk for adverse reproductive health outcomes. However, we lack information about long term impacts of the different types of care. For example, we do not know if the perception of care received immediately after sexual assault has an impact on future health seeking behaviors. If a woman is refused prophylaxis against un-intended pregnancy, is she more likely to distrust future health care providers?

### **Mental Health**

Sexual assault is associated with significantly increased risk of both psychological health and risky behavior. Significant mental health effects associated with sexual assault are: depression (Kaukinen & DeMaris, 2009; Kaukinen & DeMaris, 2005; Kimerling et al., Lacey et al., 2013; Mendelson et al., 2010; Ramos et al., 2004; Street et al., 2010), post-traumatic stress disorder (PTSD) (Campbell et al., 2008; Jacques-Tiura et al., 2010; Kimerling et al., 2010; Street et al., 2008; Temple et al., 2007), suicidal ideation (Ackard et al., 2002), somatization (Street et al., 2010), and disassociation (Temple et al., 2007).

**Depression.** The link between a history of adult sexual assault and depression is strong. In a secondary analysis of a national dataset (N=15,366), Kaukinen and DeMaris (2005) reported that sexual assault significantly predicted depression ( $\beta = 1.37, p < 0.05$ ), explaining 13% of variance of depression. Women who experienced sexual assault while serving in the military were nearly three times (OR 2.96, 95% CI [2.72, 3.22]) as likely to be diagnosed with depression compared to women who had not experienced sexual assault based on a review of medical records (Kimerling et al., 2010). Plichta and Falik (2001) reported that sexual assault victims/survivors were more than five times more likely (OR 5.32, 95% CI [3.41, 8.31]) to meet the diagnosis of depression or anxiety based on the CES-D than non-victims/survivors. Two separate research groups reported that sexual assault victims/survivors experienced depression at more than four times the rate of non-victims ( $\chi^2 = 4.47, p < 0.05$ ) (Ramos et al., 2004) (AOR 4.51, 95% CI [3.30, 6.16]) (Street et al., 2008).

One group of researchers reported significant increases in depression as women were exposed to multiple levels of violence. For example, in a cross-sectional study of 677 participants, female sexual assault victims/survivors demonstrated more than twice as likely chance as meeting criteria for depression (OR 2.52, 95% CI [1.50, 4.22]) than non-victims and survivors (Mendelson et al., 2010). When researchers included neighborhood violence and partner violence with sexual assault, women who experienced all of these types of violence had more than eight times the rate of depression as women who did not experience sexual assault, intimate partner, and neighborhood violence (OR 8.12, 95% CI [2.98, 22.14]) (Mendelson et al., 2010).

**Suicidal ideation and attempts.** Ullman and Najdowski (2009) assessed the relationship between demographic variables, presence of previous traumatic events in adulthood and childhood, type of sexual assault, substance use, presence and severity of PTSD and depression, satisfaction with social support, disclosure to formal sources, and perceived role over recovery of 969 adult sexual assault victims/survivors. They reported that younger age ( $p<0.01$ ), non-white ( $p<0.05$ ), self-blame ( $p<0.05$ ), substance use ( $p<0.05$ ) and lack of information or aid given by others ( $p<0.05$ ) as significant predictors of suicidal ideation. The only significant predictors of suicide attempts were a history of childhood sexual assault ( $p<0.05$ ), and disclosure to formal sources (physician or psychologist) ( $p<0.05$ ) (Ullman & Najdowski, 2009).

**PTSD.** Experiencing adult sexual assault places women at significantly increased risk of PTSD. In a cross-sectional survey (N=3,946), Street et al. (2008) found that sexual assault victims/survivors experienced current or lifetime PTSD symptoms at more than seven times the rate as non- sexual assault victims /survivors (Current PTSD, AOR 7.15, 95% CI [4.03, 12.69], lifetime PTSD, AOR 7.03, 95% CI [5.05, 9.79]). Kimerling et al. (2010) found a lower, but still significant association between a history of sexual assault and PTSD in women who had been sexually assaulted in the military (OR 3.82, 95% CI [3.51, 4.16]) in addition to depression (discussed earlier). In a cross-sectional study of 835 women, Temple et al. (2007) found that a history of sexual assault explained 16% of the variance of PTSD symptoms ( $R = 0.40$ ,  $R^2 = 0.16$ ,  $p<0.001$ ).

There are several important contextual factors when discussing PTSD and sexual assault. Two research teams found a significant correlation between more sexual assault incidences and higher levels of sexual violence (based on five questions from the

Severity Against Women Sexual Abuse Subscale) (Campbell et al., 2008; McFarlane et al., 2005). While Bryant-Davis et al. (2011) found that more social support was significantly associated with fewer PTSD symptoms ( $\beta = 0.17$ ,  $p < 0.05$ ), they also reported that religious coping was significantly associated with increased PTSD symptomology ( $\beta = 0.24$ ,  $p < 0.05$ ) in a cross-sectional study of 413 African American women. On the other hand, Borja and colleagues (2006) reported that negative social support significantly predicted post-traumatic stress syndrome symptoms ( $p < 0.01$ ) in racially diverse female sexual assault victims/survivors ( $N=115$ ). The interaction between race and ethnicity and PTSD of sexual assault victims/survivors has been investigated, but the results raise even more questions. For example, black women who had experienced sexual assault were significantly more at risk of PTSD if they were assaulted by a current romantic partner or non-partner, but not if they were assaulted by a former romantic partner. However, the risk remained significant for PTSD symptomology regardless of the perpetrator-victim relationship for white women (Temple et al., 2007).

This research indicates that sexual assault presents significant mental health risks for women. In addition, these researchers have demonstrated links between different wellbeing domains. Bryant-Davis (2011) and colleagues demonstrated the intersection of both social support and spirituality on PTSD, which fits within the mental health domain. This research is an important start to a more holistic investigation into the context of sexual assault and wellbeing. However, this study was limited, all the participants were Black. The sample in the study (Borja et al., 2006) did display more racial diversity, but the researchers did not analyze race as a predictor. Temple (2007) and colleagues

demonstrate that race and perpetrator-victim relationship may be significant factors in the development of PTSD symptoms. The finding that women of different races, who experience sexual assault within different contexts, experience significantly different mental health outcomes. We know little about what these factors are, such as what barriers and facilitators to positive mental health may be present to white or black women? In addition, the analysis of the victim perpetrator relationship and its resultant PTSD symptomology is a good beginning into looking at the interaction between the relationship and mental health domains of wellbeing.

**Connections between mental health and formal health care system.** The context of health care in the immediate period after sexual assault appears to have a significant effect on victims/survivors. Some studies have demonstrated that this health care is associated with increased feelings of trauma and victimization (Campbell, 2008; Campbell, Wasco, Ahrens, Self, & Barnes, 2001; Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010). Out of 81 adult female sexual assault victims/survivors who sought emergency health care in the immediate period after sexual assault, 80% reported that they would be reluctant to seek help in the future, 91% felt violated, and 94% felt disappointed (Campbell et al., 2005). Researchers found a significant relationship between secondary victimized emotions (defined as how sexual assault victims /survivors felt as a result of contact with health care professionals after sexual assault, such as self-blame, depression, anxiety, etc.) and PTSD symptoms ( $p < 0.05$ ) when they sought health care immediately after assault (Campbell & Raja, 2005). Significantly higher rates of PTSD in were reported by African American women when they felt disregarded by health care providers (Jacques-Tiura et al., 2010). Ullman and Najdowski (2009),

discussed earlier, reported that disclosure to a physician or psychologist was a significant predictor ( $p < 0.05$ ) of suicide attempts. The authors explain that this significant relationship may be due to suicidal women being more likely to have contact with a physician or psychologist, not because of quality of care given. However, the cross-sectional nature of this study limits our ability to determine the direction of this relationship.

**Mental health and time interaction.** Some researchers have reported the relationship to time and mental health. Specifically, Koss & Figueredo (2004), assessed sexual assault victims/survivors for mental health symptomology in the immediate period after sexual assault and different time points for two years. The participants' initial PTSD scores were 2.5 standard deviations above community health norms, however, time was associated with significant reductions in symptoms. After two years, the PTSD scores of the sexual assault victims and survivors were not significantly different than the un-victimised community sample (Koss & Figueredo, 2004). Other negative health symptoms, assessed by the Brief Symptoms Inventory Global Survey (BDSI) did not abate as significantly with time. Although the BDSI score of sexual assault victims/survivors declined significantly over two years, the means score remained an entire standard deviation above the non-victimised group (Koss & Figueredo, 2004).

Initial PTSD scores 2.5 standard deviations above community health norms, after 2 years, over 2 standard deviations lower than at time 1, similar to non-PTSD norm groups. Psychopathology (assessed by The Brief Symptoms Inventory Global Survey) - declined by 0.70 standard deviations from time 0 to 2 years, but still 1 standard deviation

elevated from non-patient norms. Curvilinear relationship – improved health outcomes and time – flattened out at about 5 months.

**Behavioral health.** Unhealthy behaviors like substance abuse, risky sexual practices, and disordered eating are significantly higher for victims/survivors of sexual assault (Ackard et al., 2002; Kaukinen & DeMaris, 2009; Kaukinen & DeMaris, 2005; Lacey, McPherson, Samuel, Sears, & Head, 2013; Miner et al., 2006; Molina, 2007).

**Disordered eating.** Women who have experienced sexual assault are at significantly higher risks of displaying disordered eating. In a study of adolescents (N=81,247), researchers reported that female adolescents who had experienced sexual assault were significantly more likely to disclose binge eating (OR 1.9, 95% CI [1.69, 2.05],  $p < 0.001$ ), fasting (OR 2.2, 95% CI [2.10-2.34]  $p < 0.001$ ), use of diet pills OR 2.7, 95% CI [2.48-2.92],  $p < 0.001$ ), self-inflicted vomiting (OR 2.8, 95% CI [2.53-2.99],  $p < 0.00001$ ), or over-use of laxatives in an attempt to lose weight (OR 3.4, 95% CI [2.97-3.79],  $p < 0.00001$ ) (Ackard & Neumark-Sztainer, 2002). When comparing women (n=32) who had experienced a major life threatening event such as a physical assault, or robbery to women who had experienced sexual assault (n=40), researchers reported that the sexual assault victims/survivors had significantly higher risks of disordered eating such as binge eating ( $\chi^2=17.52$ ,  $p < 0.001$ ) and purge eating ( $\chi^2=16.33$ ,  $p < 0.001$ ) (Carlo, Alice, Stefano, & Valdo, 2004).

The research linking sexual assault to disordered eating is significant. However, we have several gaps in this area. For example, we lack research that explores the facilitators and barriers to healthy eating behaviors, positive body image, and how these behaviors interact with other domains of wellbeing. For example, does a strong sense of



spirituality help to prevent un-healthy eating behaviors or help to make them less severe, for less time. Do women with strong relationship networks have fewer problems with disordered eating? Does the age when a woman is sexually assaulted play a role in eating disorders? Do women practice more or less disordered eating as time passes? Is cumulative violence over a lifetime associated with more disordered eating patterns? And, how do sexual assault victims/survivors view this disordered eating? Does it help them to feel more control for a short time? Is disordered eating actually a way for women to practice some agency after experiencing trauma? In addition, do victims/survivors from different racial groups and ethnicities have different rates or severity of disordered eating?

***Substance abuse.*** Researchers report that women who have experienced sexual assault are significantly more likely to disclose substance abuse. In a retrospective study of women in the military (N=164,603), researchers reported that sexual assault victims/survivors were nearly three times as likely (OR 2.9,95%, CI[2.53, 3.29]) to meet the criteria for a substance abuse disorder as women who had not experienced sexual assault (Kimerling et al., 2010). The context in which victims /survivors become substance abusers appears to be important. For example, Kaukinen and DeMaris (2009) reported that sexual assault victims/survivors are significantly less likely to be substance abusers if their accused assailant has been arrested compared to sexual assault victims/survivors whose accused assailant has not been arrested. In addition, victims and survivors are more than two times (OR 2.1, 95% [1.10, 3.87],  $p<0.05$ ) as likely to exhibit problem drinking within 2 years after sexual assault compared to women who have

experienced sexual assault more than 2 years prior to the study (Kaukinen & DeMaris, 2009).

The research that demonstrates a strong link between sexual assault and substance abuse is important. In addition, these researchers reported the importance of context of substance abuse. Kaukinen and DeMaris (2009) addressed the time factor, reporting that time does have a relationship to problem drinking, reporting that women do report less problem drinking as time passes since the sexual assault. However, we still lack information about what facilitates healthier alcohol consumption behavior. Do women abuse alcohol less because they no longer have the need to self-medicate? Do other domains of wellbeing, such as spirituality, relationships, and financial health have an influence on this drinking? In the large study by Kimerling and colleagues (2010), we lack the knowledge about the sequence of sexual assault and substance abuse. For example, did women who had a substance abuse disorder have this habit before they were assaulted, putting them more at risk for assault? If so, how did substance use patterns change after the assault, and were there moderating or mediating factors of this abuse?

**Risky sex.** Five separate focus groups composed of women and female adolescents who had experienced sexual assault mentioned increased difficulty negotiating condom use with their partners after experiencing sexual assault (Teitleman et al., 2011). Another group of researchers reported no significant difference in condom use in women who had experienced sexual assault as adults (odds ratio and significance level not reported) (Miner et al., 2006). However, adult women who had experienced sexual assault as a child and again as an adult were four times less likely (AOR 4.0,  $p < 0.05$ , CI not reported) to use condoms than women who had not experienced sexual

assault (Miner et al., 2006). Sexual assault victims/survivors are nearly three times more likely to participate in prostitution than women who had not experienced sexual assault (Miner et al., 2006).

### **Connections Between Health and Social Support**

Wellbeing is dependent upon supportive relationships with others. According to Kitayama and Markus (2000, p. 115), “Wellbeing then is very much a collaborative project, one can’t experience wellbeing by one’s self; it requires engaging in system of consensual understandings.” This can be problematic for women who have experienced sexual assault, as sexual assault occurs within a culture that frequently blames the victim instead of the perpetrator or society (Campbell & Raja, 2005; Rozee & Koss, 2001; Suarez & Gadalla, 2010; Washington, 2001). Jozkowski and Sanders (2012) found that women (n=1,394) who have experienced sexual assault are significantly more likely to say that their physical and mental health interferes with their social activities all or most of the time (AOR 1.40, 95% [1.21–1.62],  $p < .001$ ).

**Intimacy/sexual health.** Sexual assault victims/survivors are significantly more likely to rate themselves as un-attractive (Jozkowski & Sanders, 2012). Jozkowski and Sanders (2012) also reported that sexual assault victims/survivors are significantly more likely to state that their physical health limited their sexual activity (AOR 1.50, 95% [1.26–1.80],  $p < .001$ ). In addition, Champion and colleagues (2001) reported that a history of sexual assault was associated with a significantly increased risk of dyspareunia ( $p < 0.01$ ).

This research highlights an important area of women’s health, their ability to have satisfying intimate and or sexual relationships. These researchers demonstrate a

significant relationship between sexual assault and difficulty obtaining and maintaining healthy intimate relationships. However, several gaps in this area remain. For example, how long do sexual assault victims/survivors rate themselves as un-attractive? Are there other factors that ensure that these women continue to feel this way? Does it matter if they have a healthy, romantic relationship before or at the time of the assault? Do other wellbeing domains have an influence in this feeling of attractiveness? For example, if a woman has a network of supportive friends, does this make a difference in the perception of un-attractiveness or the time that this perception lasts? How long does dyspareunia last? Are women who have experienced sexual assault more or less likely to disclose this painful sex with their healthcare providers than women who have not experienced assault? If they do disclose this pain and are referred to physical therapy, are they more or less likely than non-victimized women to pursue this treatment?

**Spiritual coping and health.** There appears to be a strong relationship between spirituality and religious practices and health outcomes. After experiencing sexual assault, many women significantly change their view of the importance of spirituality, resulting in higher or lower ratings of spirituality (Kennedy, Davis, & Taylor, 2009; Ben-Ezra et al., 2010). The impact of spirituality on health is conflicting. Bryant-Davis et al. (2011) found that religious coping did not have an effect on depression but actually increased PTSD symptoms. Ahrens et al. (2010) found that religious coping has a significant effect on depression symptoms, and that the type of coping can either significantly increase or decrease depression symptoms. When women engage in negative religious coping behaviors, like avoidance coping or express anger and disconnect from God, they experience significantly increased depression symptoms ( $\beta$

0.46,  $p < 0.05$ ) (Ahrens et al., 2010). However, when the sexual assault victims/survivors engaged in positive religious coping such as “allowing God to help them deal with the sexual assault (Ahrens et al., 2010, p. 1249), helping others, or being more active in church, they experienced significantly less depression ( $\beta = -0.36$ ,  $p = 0.05$ ). The limited research that has examined spirituality and sexual assault has found that race may be a significant factor in coping, with Black women more likely to engage in spirituality based coping and good deeds than white women (Ahrens et al., 2010).

These researchers have made important contributions to our knowledge about the spirituality domain of wellbeing. In addition, Bryant-Davis (2011) and colleagues demonstrated the connection between the spirituality domain and the mental health domain. In addition, this research creates new questions, such as why do religious coping behaviors decrease depressive symptoms while increasing PTSD symptoms? In addition, while spiritual coping was assessed by Bryant-Davis et al. (2011), the religion itself was not assessed. Because of this, we do not know if these effects are the same with diverse religious and spiritual beliefs and practices. Ahrens and colleagues (2010) did investigate the differences in religious coping between black and white women, which does point to differences in coping strategies. While this study is important in highlighting different coping strategies and their associations with mental health, two important domains of wellbeing, it is limited in that it only investigates the religious coping strategies of Christians.

### **Sexual Assault and Socioeconomic Status and Achievement**

Researchers who assessed the relationship between intimate partner violence including sexual assault and job performance, academic achievement, and income found

that they are inversely related. Two studies (Adams, Greeson, Kennedy, & Tolman, 2013); (Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012) did not specifically assess for the effect of sexual assault on the dependent variables, educational attainment, income, job stability, and material hardship, but included sexual assault as part of the independent variable, intimate partner violence (IPV). In a longitudinal study of (N=498) women, the experience of IPV in adolescence significantly predicted lower educational achievement ( $b = -0.52, p < .05$ ). With education as a significant mediator, women who experienced IPV as an adolescent also earned significantly less income than women who had not experienced IPV ( $b = -342.81, p < .01$ ) after controlling for other variables within the study (Adams et al., 2013). In a different analysis of this group, researchers (Adams et al. 2012) reported that current IPV ( $B = -3.061, p < .05$ ) and IPV within the last three years ( $B = -2.936, p < .05$ ) was significantly associated with job instability. In addition, these researchers reported that women who were currently experiencing IPV ( $B = 1.330, p < .001$ ) or had experienced IPV within the last three years ( $B = .697, p < .001$ ) faced significantly increased objective economic hardship compared with women who had experienced IPV more than five years ago or not at all. Recent IPV was significantly related to anticipated hardship ( $B = .552, p < .001$ ), but IPV that ended within the last three years ( $B = .085, p = .614$ ) and IPV that ended three to five years ago were not significantly related to anticipated hardship ( $B = -.163, p = .332$ ). In an analysis that compared women who had experienced sexual assault to women who had not experienced sexual assault, Jozkowski and Sanders (2012) reported that sexual assault victims/survivors were significantly more likely to do work or other activities less

carefully than usual in past week because of emotional problems, defined as feeling anxious or depressed (AOR 1.37, 95% [1.18–1.59]),  $p < .001$ ).

Research about IPV and sexual assault and its influence on academic, work, and financial difficulties is important, as it connects a history of sexual assault with future educational and income disparities. In addition, Adams and colleagues (2012, 2013) followed the participants over time, highlighting the relationship to time since experienced violence and adverse outcomes. While these researchers have increased our knowledge of the connection between sexual assault and adverse economic, educational, and income measures, we still have many gaps in our knowledge. For example, we do not know whether these economic hardships apply to women who experienced sexual assault outside of the context of IPV, or if sexual assault within the context of IPV had different outcomes, as the researchers included sexual assault under the IPV category.

**Lack of information of health outcomes in diverse socio-cultural contexts.**

We know even less about the context of wellbeing in marginalized populations of women, such as racial, ethnic and sexual minority women because these women are under-represented in studies (Bryant-Davis, Chung, & Tillman, 2009; Wadsworth & Records, 2013). This is important, as these victims/survivors may experience unique strengths and/or barriers in their reactions to sexual assault (Bryant-Davis et al., 2009). In addition, racial minority women, especially Latinas and African Americans, suffer a disproportionate burden of negative reproductive health outcomes like significantly higher rates of cervical cancer (Centers for Disease Control & Prevention, 2012). Racial minority women are also at significantly higher risk of un-intended pregnancy (Finer & Zolna, 2011). Sexual minority women, including lesbian, bi-sexual, or transgender,

experience sexual assault at the same rate or higher than heterosexual women (Balsam, Beauchaine, & Rothblu, 2005; Stoddard, Dibble, & Fineman, 2009). However, they have historically faced burdens in help-seeking, as many programs have prohibited serving this population (National Coalition of Anti-Violence Coalition, 2010). There is a lack of research about the unique context that facilitates or hinders resilience in lesbian, bisexual, and transgender female sexual assault victims/survivors. However, the research that does exist has found that lesbian and bisexual women have significantly higher levels of PTSD and depression than heterosexual women who experienced sexual assault (Long, Ullman, Long, Mason, & Starzynski, 2009). While the causes of these negative reproductive health outcomes are complex, a significant portion is due to a lack of access to culturally sensitive care (National Cancer Institute, 2008).

**Lack of knowledge about long term health outcomes.** It is not known if the victims/survivors' perception of care received immediately after a sexual assault continues to influence their health care perceptions and care seeking behaviors. However, researchers have found that victims/survivors are significantly less likely to seek regular and preventive health care, to perceive barriers to obtaining health care, and have difficulty talking to their providers (Ackerson, 2010; Champion et al., 2001; Plichta & Falik, 2001). Although many women consider pelvic and breast exams uncomfortable and invasive, these exams can cause extreme distress in victims/survivors of sexual violence (Ackerson, 2010; Robohm & Bottenheim, 1996; Weitlauf et al., 2010). Indeed, the following words have been used to describe their experiences with such exams: “panic, terror, helplessness, shame, disgust, humiliation, grief, rage and fear” (Robohm &



Buttenheim, 1996, p. 68). It is not known how long this aversion to healthcare lasts, or what facilitates victims and survivors to obtain satisfactory health care.

**Physical, psychological, and social health interconnected.** There is an intimate connection between our neurophysiological states and our physical, social, and psychological wellbeing. These connections have been demonstrated by several physiological research studies that have demonstrated significant connections between negative affect style, increased stress, and cortisol levels and decreased immune response (Rosenkranz et al., 2003), increased blood pressure and perceived racism (Din-Dzietham, Nembhard, Collins, & Davis, 2004), increased cortisol, stress, and hypertension (Barksdale, Woods-Giscombe, & Logan, 2013). There is limited research on the wellbeing of sexual assault victims/survivors that supports these connections as well. PTSD is a significant mediator in non-pain physical clusters like fatigue, nausea, and shortness of breath in women who have experienced sexual assault (Campbell et al., 2008). In addition, PTSD may mediate both perceptions of health care and health care seeking patterns (Weitlauf et al., 2010). Women who met criteria for PTSD associated with sexual assault were significantly more likely to perceive pelvic exams as unnecessary and potentially harmful than women who had never been sexually assaulted or women who had been sexually assaulted but did not meet PTSD criteria (Weitlauf et al., 2010).

**Lack of information on wellbeing.** While the research that demonstrates connections between psychological, behavioral, physical, and social responses has contributed to our understanding of wellbeing after sexual assault, it is still limited and fragmented. Researchers have traditionally focused on narrow health outcomes, but a

wider view of wellness or wellbeing is necessary. Wellbeing is a construct that includes the physical, psychological, spiritual, social, financial, and creative domains of an individual (Centers for Disease Control and Prevention, 2013; Keifer, 2008). Currently, we lack research that assesses the wellbeing from the perspective of victims/survivors following a sexual assault. The concept of wellbeing can differ significantly between different cultural groups, gender, levels of ability or disability, and those affected by trauma (Keifer, 2008). The current dearth of information about wellbeing after sexual assault is significant for several reasons. First, examining the effects of sexual assault and other forms of violence against women in a wider context allows participants and researchers to move away from a simplistic focus on pathology and focus on strengths and agency as well (Campbell & Bunting, 1991; Sokoloff, 2008). Second, a lack of knowledge about wellbeing prevents us from developing interventions that improve the wellbeing of victims and survivors of sexual assault.

### **Subjective Wellbeing Congruent with Objective Health Measures**

Wellbeing has been examined in many different contexts, including mental illness, care-takers, survivors of cerebral vascular accidents, adolescent African American females, and persons with disabilities (Plach & Heidrach, 2002; Powell-Young, 2012; Putnam, Geenan, Saxton, Finney, & Dautel, 2003; Ried, Tueth, Handberg, & Nyanteh, 2006; Schennach-Wolff et al., 2010). Individual perception of wellbeing is a significant predictor equal to or better than objectively measured physical and psychological illness, of future morbidity and mortality (Naber, Kollack-Walker, Stauffer, Case, Kapur, et al., 2013; Plach & Heidrach, 2002; Ried, Tueth, Handberg, & Nyanteh, 2006; Schennach-Wolff et al., 2010; Wong et al., 2010).

**Wellbeing is excellent predictor of outcomes.** When researchers compare various objective and subjective measures of wellbeing, they are both significant predictors of morbidity and mortality outcomes in diverse populations. In a population of N=3,124 German adults aged 40-85, authors reported that in adults aged 65 and older, positive affect (one of the domains in their operationalization of wellbeing) was a more significant predictor of mortality than subjective physical health ratings and physical activity ( $p < 0.05$ ), although positive affect did not significantly predict mortality in middle age adults (Wiest, Schüz, Webster, & Wurm, 2011). In two studies with individuals who have been diagnosed with schizophrenia, subjective wellbeing was a significant predictor of remission (Naber, Kollack-Walker et al., 2013; Schennach-Wolf et al., 2010). In a study of participants with documented coronary arterial disease and hypertension, subjective wellbeing was a significant predictor of adverse clinical outcomes after adjusting for demographics and baseline medical conditions (Ried et al., 2006). In a study of predictors of hospital re-admissions (N=320), authors found that subjective wellbeing was the only significant predictor of re-admission. In addition, wellbeing had a significant mediating effect on re-admissions via age, income, and satisfaction with care (Wong et al., 2010).

### **Necessity of Wellbeing Research with Sexual Assault Victims and Survivors**

Throughout this chapter, I have illustrated the many health disparities that sexual assault victims/survivors experience compared with women who have not experienced sexual assault. In order to effectively improve the health of these women, we need to explore how these constructs of health and wellbeing and health relate to each other. Identifying the theoretical basis and components of a concept such as wellbeing are the

first steps in developing a complex and effective intervention program to improve subjective and objective health and wellbeing outcomes (Campbell et al., 2000; Keifer, 2008). Wellbeing cannot be defined or described by clinicians or researchers solely by objective data. When clinicians and researchers define wellbeing for groups or individuals, they frequently miss fundamental concepts (Keifer, 2008; Laffrey, 1986; Powell-Young, 2012). According to Keifer (2008, p. 249), improving health and wellbeing is dependent upon encouraging individuals and groups to define wellbeing for themselves:

If this concept is not well understood and incongruence exists, then the wellbeing may be an elusive goal of clinical practice. Healthcare professionals need to be clear about what wellbeing is, before they can effectively enable their clients to work toward it.

Researchers have begun using the construct of wellbeing, as identified by patient populations and cultural groups (Wong et al., 2010) in order to build effective interventions. It is time to do the same for women who have experienced sexual assault. In the next chapter, chapter 3, I will discuss my plan to contribute to this research.

## **CHAPTER 3**

### **METHODOLOGY**

#### **Introduction**

This chapter begins with a description of the sensitizing concepts that provide the epistemological and ontological background for this study. Following this description is a discussion of traditional and constructivist grounded theory methodology. I will then discuss the research design, including sample and setting, recruitment, informed consent, confidentiality, avoidance of harm, and data collection. The chapter concludes with a discussion on the proposed analytic strategies, time-line, and validation and verification of conclusions.

As demonstrated in chapter 2, most of the research about the wellbeing of sexual assault victims/survivors is fragmented, focusing on various domains of wellbeing, but none focuses on a more holistic construct of wellbeing that includes all of these domains. Furthermore, the majority of this research is quantitative. We lack input from the point of view of sexual assault victims/survivors about their perspective on wellbeing: its definition, facilitators, and barriers. As Keifer (2008) explained, learning the perspective of groups and individuals is the first step toward being able to improve it. Therefore, we turn to a research methodology that elicits the viewpoints of sexual assault victims/survivors as a means of understanding the issues they face, with the goal of constructing a theory that can be used as a basis for targeted, effective intervention.

## **Sensitizing Concepts**

Sensitizing concepts are the researchers' "background assumptions and disciplinary perspectives" that signal them to look for certain situations and processes in the data (Charmaz, 2006, p. 16). Sensitizing concepts are useful in the beginning to help form interview questions, conduct and listen to interviews, and to examine and analyze the data. While sensitizing concepts provide a starting point, the researcher must not allow them to force data to fit the theory (Charmaz, 2009; Charmaz, 2006; Lather, 1991). If the sensitizing concepts do not fit with the emerging data, the researcher must not continue to use them. If the sensitizing concepts do fit with the emerging data, the researcher can build upon them to construct new theory from within the emerging data (Charmaz, 2006).

Feminist theory provided the sensitizing concepts for this research. The topic of wellbeing after sexual assault fits well with sensitizing concepts from feminist theory for several reasons. The majority of sexual assault victims/survivors are women, and the majority of sexual assault assailants are men (Tjaden & Thoennes, 2006). Sexual assault, as described in the first chapter, is forcing another person to participate in sexual activity (National Center for Victims of Crime, 2012). Sexual assault is a sexualized form of aggression that can only exist in an environment with male domination (Brownmiller, 1975; Helliwell, 2000; Lorde, 1984). Sensitizing concepts from feminism are useful to "...address issues of gendered epistemic subjectivity and agency, and to expose the politics of knowledge..." (Code, 2000, p. 173). Feminist research (1) makes knowledge that is useful and accessible to those who are best able to use it, including study participants, academics, practitioners, and policy influencers (2) employs non-oppressive

and reflexive methods (3) cultivates collaboration (4) rejects dichotomies between the personal and political and (5) recognizes participants as the experts in their own lives (Campbell & Bunting, 1991; Hesse-Biber & Piatelli, 2007; Wuest, 1995).

To be clear, feminism is not a research method; rather, it is a philosophic assumption that can be used to meet both the demands of the discipline and feminist scholarship (Wuest, 1995). Feminist research seeks to uncover the invisible, such as the voices of marginalized populations, issues like violence against women, and power and authority (Hesse-Biber & Piatelli, 2007). The goal of feminist research is transformation (DeVault & Gross, 2007). While all feminist research presumably espouses the aforementioned goals and principles, there is no monolithic form of feminist research (Harding, 2006). Instead there are three main strands of feminist epistemology include feminist empiricism, standpoint theory, and postmodernism (Code, 2000).

Sensitizing concepts from feminist standpoint theory that are used to inform this study include: the situatedness of knowledge, production of research for women, overt political engagement on forces that oppress women, examination of patriarchal structures, examination from the point of view of women's lives, presentation of outcomes as a collective position, and identification of the values and interests of researchers who conducted the research (Harding, 2006). The first concept, that all knowledge is situated, is a rejects the possibility of researcher objectivity. This concept highlights the social and historical influences on research and knowledge creation and contrasts sharply with the positivist position that science can and should be a-political (Code, 2000). The second sensitizing concept from feminist standpoint theory is that researchers should produce research that is useful for women. Research that is simply about women or done

by women is not feminist, instead, it must produce a tangible benefit for women. The third sensitizing concept is that research should be overtly politically engaged in a “...conscious, intentional critical focus on the power relations that oppress women...” (Harding, 2006, p. 83). This third concept encompasses a wide range of topics, ranging from physical to financial, emotional, and financial oppression. The fourth sensitizing concept drawn from standpoint theory is that researchers should “study up” (Harding, 2006, p. 84). This means that researchers must examine the ways that dominant institutions, including research institutions, are complicit with maintaining a patriarchy. The fifth sensitizing concept influenced by standpoint theory, is that research should start from women’s lives, not from disciplinary or social policy frameworks that justify “...by treating as natural, women’s oppression, domination, and exploitation” (Harding, 2006, p. 84). This means that researchers must make the familiar strange. In research about sexual assault, for example, we may question why we, as a society, accept sexual assault as inevitable. The sixth sensitizing concept influenced by standpoint theory is that researchers must present the results as a collective position, as opposed to an individual’s work or opinion. The final sensitizing concept from standpoint theory is that researchers must strive to produce more critical accounts of social relations than conventional research attempts to produce while claiming value neutrality. In other words, according to Harding (2006, p. 85), researchers must identify “...which values and interests have which effects on the production of knowledge.”

Constructivist grounded theorists view grounded theory methodology and theoretical sensitizing concepts as compatible (Charmaz, 2009; Lather, 1991; Suddaby, 2006). According to Lather (1991),



Building empirically grounded theory requires a reciprocal relationship between data and theory. Data must be allowed to generate propositions in a dialectical manner that permits use of a priori theoretical frameworks, but that keeps a theoretical framework from becoming the container into which the data must be poured (p. 62).

## **Methodology**

**Classical grounded theory.** A constructivist grounded theory methodological approach guided this study. Grounded theory as a qualitative methodology was introduced by two sociologists, Barney B. Glaser and Anselm L. Strauss, in 1967 with the publication of the book *The Discovery of Grounded Theory*. The key characteristics of their “classic” grounded theory are: theoretical sensitivity, theoretical sampling, constant comparative analysis, coding and categorizing the data, theoretical memos and diagrams/visual displays, and integration of the theory (McCann & Clark, 2003).

Theoretical sensitivity is the ability of the researcher to conceptualize and articulate theory as it “emerges from the data” (Glaser & Strauss, 1967, p. 46). Once a researcher has become theoretically sensitive, through theoretical insight and the personal experience of the research, it continues to grow and deepen with time (Glaser & Strauss, 1967).

Grounded theorists believe in two sequential types of sampling, purposive sampling and theoretical sampling. Researchers utilizing a grounded theory methodology initially utilize purposive samples based on predetermined criteria. As data from this sample are collected and analyzed, researchers decide how to sample more selectively to assist in conceptualizing an evolving theory (McCann & Clark, 2003). Theoretical

sampling continues until theoretical saturation is met, meaning that no new data emerges (McCann & Clark, 2003; Glaser & Strauss, 1967).

Researchers using grounded theory methodology conduct constant comparative analysis. This means that data collection and analysis occur simultaneously (McCann & Clark, 2000; Glaser & Strauss, 1967). According to Glaser and Strauss (1967), there are four stages in constant comparative analysis: comparing incidents applicable to each category, integrating theories and their properties, delimiting the theory, and writing the theory. The researcher continues the process of constant comparative analysis until a she or he generates a theory with enough detail and abstraction (McCann & Clark, 2000).

Grounded theorists utilize three levels of coding: open, axial, and selective (McCann & Clark, 2000a). Open coding, also known as Level 1 or substantive coding, consists of breaking down data into discrete parts. The researcher then gives codes or conceptual labels to these data (McCann & Clark, 2000a). According to McCann and Clark (2000a), there are two types of open coding – in vivo codes and sociological constructs. In vivo codes are direct quotes used by participants. They help to give meaning to the data and prevent the researcher from imposing her or his ideas on the codes (McCann & Clark, 2000a). Sociological constructs are formed from a combination of the researcher's thoughts and experience with the field data. Axial coding, introduced by Strauss and Corbin, involves putting the data back together through categorizing and linking it (McCann & Clark, 2000a). In addition, the researcher uses selective coding to establish links between different categories.

Grounded theorists use theoretical memos and diagrams or visual displays as a part of their analytical process. Memos are notes made by the researcher throughout the

research to record ideas and events and to develop theory (Glaser & Strauss, 1967; McCann & Clark, 2000a). Diagrams represent the conceptual relationships between categories in a visual format (McCann & Clark, 2000a; Miles, Huberman, & Saldaña, 2014).

**Constructivist grounded theory.** Researchers have adapted grounded theory to fit with various ontological and epistemological positions. Kathy Charmaz, a former graduate student of both Glaser and Strauss, describes grounded theory as “an umbrella covering several different variants, emphases, and directions...” (2009, p. 128). Charmaz created a different variant of grounded theory, called constructivist grounded theory based on a constructivist epistemology, which differs from a positivist epistemology (Charmaz, 2006). In addition, there are three main features of constructivist grounded theory that differentiate it from classic grounded theory, as described by Glaser and Strauss (Charmaz, 2006). The three main areas where objectivist and constructivist grounded theory differ are: foundational assumptions, theoretical sensitivity, focus, and implications for data analysis.

Charmaz defines and describes constructivist grounded theory as

...a contemporary revision of Glaser and Strauss’s classic grounded theory. It assumes a relativist epistemology, sees knowledge as socially produced, acknowledges multiple standpoints of both the research participants and the grounded theorist, and takes a reflexive stance toward our actions, situations, and participants in the field setting – and our analytic constructions of them (2009, p. 129).

Researchers utilize a reflexive stance to analyze their research, experience, decisions, and interpretations and how those interests, positions, and assumptions influenced their research. This reflexive stance helps to inform readers how the researcher has conducted

research, related to and represented participants in the results and analysis (Charmaz, 2006).

A foundational difference between constructivist grounded theory and classic grounded theory is the view of reality. Constructivist grounded theory fits within the pragmatist tradition, in which reality is perceived as fluid and uncertain. This contrasts with the more objectivist position of classic grounded theory, which fits within a more positivist or objectivist position, where it is possible to observe and describe reality from an un-biased viewpoint (Charmaz, 2009; Charmaz, 2006). Researchers who adhere to objectivist grounded theory, like Glaser and Strauss, believe that there is an external reality that can be incompletely discovered and described (Charmaz, 2011; McCann & Clark, 2000a).

While objectivist grounded theorists assume the role of data discovery, constructivist grounded theorists opine that data is mutually created via interaction (Charmaz, 2009, McCann & Clark, 2000a). Objectivist grounded theorists view their role as one of a neutral observer who witness the emergence of data. Constructivist grounded theorists assume that knowledge is in-separable from social constructions. According to a constructivist grounded theorist, the creation and dissemination of knowledge is not neutral; instead it is created under the influence of pre-existing structural conditions, and surfaces in emergent situations (Charmaz, 2009). The creation of knowledge is dependent upon "... the perspectives, privileges, positions, interactions, and geographic locations" of the researcher (Charmaz, 2009, p. 130).

The ideal constructivist grounded theorist embraces the "messiness" inherent in the research process (Charmaz, 2009, p. 142). Constructivist grounded theorists claim

that it is impossible to create knowledge from a neutral stance. In addition, they take it a step further, by encouraging an explicit discussion about the researcher's position. In addition, they encourage an open and continuous effort to maintain reflexivity during the entire research process (Charmaz, 2009). According to Charmaz, digging deep into the research process, with an attempt to understand both the diverse perspectives of the participants and our own perspectives is necessary in order to provide a deeper, more complex, and reflexive analysis (Charmaz, 2009).

Constructivist grounded theorists attempt to enter, understand, and describe both the stated and the silent meanings and actions of the participants. To do this, researchers must "break open" the assumptions of the participants and themselves and examine them (Charmaz, 2009, p. 142). In addition, a constructivist grounded theorist also attempts to uncover and describe participants' meaning and actions within larger social structures or ideologies. The researchers attempt to interpret the connections between personal thoughts and actions and the micro and macro levels of society (Charmaz 2009). This constructivist view differs from the classic grounded theory viewpoint that describes only the observable words and actions of the participants (Charmaz, 2009).

Constructivist grounded theorists differ from objectivist grounded theorists in their focus. Objectivist grounded theorists emphasize creating context free generalizations that can generate theory and maintain a micro focus, or focus on the observed world of the participants (McCann & Clark, 2000a; Charmaz, 2009).

Constructivist grounded theorists focus on both the micro and macro (cultural scene) influences on participants (McCann & Clark, 2000a).

Traditional grounded theorists seek to create abstract generalizations that are context-free. However, constructivist grounded theorists strive to create a theoretical explanation of a phenomenon that is credible and useful, within the historical and socio-political context. Constructivist grounded theorists acknowledge that their theories and explanations are partial and context dependent (Charmaz, 2009).

Traditional grounded theorists and constructivist grounded theorists also differ on their view of the role of literature reviews and theoretical sensitivity. Traditional or objectivist grounded theorists adhere to a strict idea of theoretical sensitivity. Objectivist grounded theorists conduct a literature review strictly to support an emerging theory (McCann & Clark, 2000a). In addition, they avoid becoming preoccupied with any preconceived theories, as "...theoretical sensitivity is lost...for then it becomes doctrinaire..." (Glaser & Strauss, 1967). Constructivist grounded theorists take a more nuanced stance toward literature reviews and use of theoretical frameworks.

Constructivist grounded theorists utilize literature reviews to enhance their theoretical sensitivity and to support emerging theory (McCann & Clark, 2000a; Charmaz, 2009).

In summary, sensitizing concepts from feminist theory are congruent with a constructivist grounded theory methodological approach because both view human experience as the central role to knowledge production, acknowledge that knowledge is contextual and relational, reject dualism, question the influence of social structures on behavior, and are capable of promoting social change (Charmaz, 2006; Plummer & Young, 2010; Weust, 1995).

## **Research Design**

**Sample and sampling.** There were two stages of sampling in this study. In the initial purposeful sampling, I sampled to achieve maximum variation based on age, race and ethnicity, geographic location within Battle Creek and Kalamazoo, socio-economic status, and relationship to the sexual assault perpetrator. The purpose of maximum variation sampling is to examine and reflect diverse perspectives (Creswell, 2013; Miles & Huberman, 1994). Because women of every age, race, sexual orientation, and socio-economic background are affected by sexual assault (Centers for Disease Control, 2010; Tjaden & Thoennes, 2006), I made every attempt to ensure a diverse sample. Then, with the initial analysis and emergence of more focused conceptual questions on the domains, processes, barriers and facilitators of wellbeing, I began theoretical sampling in order to focus and deepen my exploration and analysis. Please see the recruitment section for more details.

**Inclusion and exclusion criteria.** Criteria for participation were willingness to participate, female, at least 18 years of age, self-identified history of being sexually assaulted (as defined in the fourth paragraph of this chapter by The National Center for Victims of Crime) after the age of 18, and ability to speak and understand English. Because there is a lack of research on the impact of time and wellbeing after sexual assault, there were no time limits on the interval since sexual assault and inclusion in the study. Women who have experienced both childhood and adult sexual assault were included, because women who have experienced sexual assault are significantly more likely than non-sexually assaulted women to have been sexually abused as children (Campbell et al., 2008; Miner et al., 2006; Plichta & Falik, 2001; Ramos et al., 2004).

Women younger than 18 at the time of the study, or women who have experienced only sexual assault below the age of 18, were excluded because researchers have demonstrated that the context and outcomes of sexual assault at these younger ages is different than sexual assault in adult women (Kaukinen & DeMaris, 2005; Livingston, Hequeembourge, Testa, & VanZile-Tamsen, 2007; Miner, Flitter, & Robinson, 2006; Ramos, Carlson, & McNutt, 2004). Specifically, this study did not include adolescents below the age of 18 or women who have only experienced sexual assault as a child or adolescent because when researchers compared childhood and adolescent sexual assault to adult sexual assault (N=319), they found that the assault characteristics differed significantly in the relationship of victims/survivors to perpetrators, type of aggression, preceding activities, and location of assault (Livingston et al., 2007). For example, adult women who experienced sexual assault were more likely to experience verbal sexual coercion, be assaulted by a former or current intimate partner, and to have had consensual intercourse before the assault. In contrast, adolescent women were more likely to have been assaulted by an acquaintance, friend, or a stranger, or authority figure, and to be assaulted at social gatherings or parties, than adult women (Livingston et al., 2007).

Outcomes may also differ when comparing sexual assault that occurs only in childhood versus sexual assault that occurs in adulthood. For example, Ramos and colleagues (2004) reported in a cross-sectional study of 491 participants that women who had experienced sexual assault as children demonstrated significantly more anxiety symptoms than women who had not been victimized or were sexually assaulted as an adult (Ramos, Carlson, & McNutt, 2004). These researchers also reported that women who had experienced childhood sexual abuse were significantly more likely than non-



assaulted women to disclose suicidal ideation OR 2.2, (Confidence Interval not reported)  $\beta = .84, p = .03$ , while there was no significant difference between women who had been assaulted only as adults and women who had never been assaulted (Miner, Flitter, & Robinson, 2006). Kaukinen and DeMaris (2005), who conducted a secondary analysis of 15,366 women, reported that while adolescents who had experienced sexual assault were significantly more likely to use illicit drugs than non-victimized adolescents AOR 2.7, 95% CI [1.70, 4.19],  $p < 0.01$ , there was no significant difference in illicit drug use by women who reported being sexually assaulted as an adult.

Currently, there is scant research that addresses the changes of various wellbeing domains over time. Therefore, there were no time limits imposed on study participants since the sexual assault. Because there is very little research that highlights the differences and similarities in the various domains of wellbeing of women with diverse scenarios of sexual assault, for example, sexual assault by acquaintances, partner or ex-partner, stranger, etc., all types of relationships between victim/survivor and assailant were included. I hoped that exploring the relationship of the women to her assailant would enhance our understanding of wellbeing, its barriers and facilitators.

Men were excluded from this study. While studying the effects of sexual assault on men is an important topic, there are many differences in this experience. For example women are significantly more likely to be injured during the assault (31.5%) versus men (16.1) (Tjaden & Thoennes, 2006). In addition, the majority of sexual assault victims/survivors are females (Tjaden & Thoennes, 2006).

**Theoretical sampling.** After collecting and coding seventeen interviews, I found that all of my categories except spirituality were saturated. A category is an aggregation

of similar themes, reducing a large amount of material into significant and parsimonious units of analysis (Miles & Huberman, 1994). This led me to construct propositions for further exploration and using theoretical sampling to deepen and “...elaborate the categories, discover variation within them, and define *gaps among categories* (Charmaz, 2006, p. 108, emphasis original). I consulted with my coding mentor and my qualitative methods mentor and, while I initially thought that I would attempt to recruit more heavily from religious institutions to fulfill this category, my mentor suggested that I think more deeply and inclusively about the concept of spirituality. She e-mailed me the following thought provoking comment

...It may be simply that you hope to live another day to care for your children, or that you may be able to stand between them and harm during the next onslaught, or that you can summon up the courage to go on or leave... (B. Evans, personal communication, February 27, 2015).

The author Roland Merullo offers a similar definition of religion

I think everybody has a religion that they live by, if you define religion as a philosophy about life – why we’re here, what we should do, what happens to us.... (Merullo, 2015).

With this new perspective of spirituality in mind, I continued recruiting in the same way that I had been doing. I revised questions for the remaining five participants to focus more on their definitions of spirituality, what they felt was meaningful in life, factors that had an impact on their spirituality, and how their spirituality informed other domains of wellbeing. I also went back to my data to re-examine spirituality from this point of view.

## **Setting**

Calhoun and Kalamazoo counties are adjacent counties in southwest Michigan. Calhoun County has a population of 135,009, and Kalamazoo County has a population of 254,580 (United States Census Bureau, 2013). Both counties are relatively economically disadvantaged, as their percentage of persons living below the poverty level are 17% for Calhoun County and 18.6% for Kalamazoo County, compared with 14.3% at the national level (United States Census Bureau, 2013). The proportion of African American/Black and White racial composition of these counties is similar to the racial and ethnic composition of the United States, with 82.6% to 83.4% White alone, 11.1-11.2% African Americans, compared to the national level of 77% White alone and 13.1% African American/Black (United States Census Bureau, 2013). While American Indians or Alaska Natives, Native Hawaiians, other Pacific Islanders, and Hispanic/Latinos are also live in Calhoun and Kalamazoo Counties, their proportion is less than that of the U.S. population as a whole (United States Census Bureau, 2013). These counties are diverse settings in terms of race, ethnicity, and economic status.

Because most victims/survivors of sexual assault do not seek legal or health care assistance (Alvidrez, Shumway, Morazes, & Boccellari, 2011; Campbell et al., 2001), an accurate account of women who experience sexual assault in Kalamazoo and Battle Creek was not possible. According to the Michigan State Police, there were 181 sexual assaults reported to police in Kalamazoo County during the year of 2012 and 129 in Battle Creek (Michigan State Police, 2013). There were a total of 19 arrests for these sexual assaults in Kalamazoo and 18 in Battle Creek (Michigan State Police, 2013). The majority of sexual assailants in Michigan were acquaintances, friends, and romantic

partners of the victims and survivors (State of Michigan, 2012). The majority of victims and survivors were females (97%), Caucasian (71%) and between the ages of 15 and 19 years old (State of Michigan, 2012). These statistics demonstrate that Calhoun and Kalamazoo Counties offer an appropriate location to conduct this study. The setting is racially, ethnically, and economically diverse. Sexual assault characteristics in these counties reflect sexual assault characteristics nationwide: the majority of the victims are female, and most are committed by a known assailant (Centers for Disease Control, 2010; Ellsberg, Jansen, Heise, Watts, Garcia-Moreno, 2008; Temple, Weston, Rodriguez, & Marshall, 2007). However, adequate numbers of participants should be available to achieve data saturation.

Interviews were conducted in a private office space agreed upon by the participant and myself. We utilized private office spaces at the Sexual Assault Services of Bronson Battle Creek, the Sociology Department at Western Michigan University, the YWCA of Kalamazoo, a participant's own office, the woman's co-op of Battle Creek, and a church. I encouraged the participants to choose the confidential interviewing space most convenient and comfortable for them to maximize feelings of safety.

### **Recruitment**

Because women of all races, ethnicities, socio-economic status, educational background, and sexual and gender orientation are affected by sexual assault (Centers for Disease Control, 2010; Tjaden & Thoennes, 2006), I attempted to capture a diverse sample. After receiving approval by the Institutional Review Board at Arizona State University and Western Michigan University, I intentionally recruited participants by

three methods which I adapted to meet the needs of individuals and supporting organizations.

**Fliers, brochures, and internet.** In the first method, I planned to distribute fliers and brochures to organizations in Battle Creek and Kalamazoo who agreed to display study recruitment materials in. To increase my chances of obtaining a diverse sample of participants, I distributed recruitment posters to many different types of organizations, such as health care facilities, restaurants, churches, synagogues, coffee shops, salons, and laundromats across many different zip codes in the Kalamazoo and Battle Creek areas. Several health care provider offices agreed to assist in the recruitment efforts for this study, as well. These providers agreed to display the recruitment posters in the exam rooms and or bathrooms of their facilities.

The recruitment materials included posters, brochures, and a website devoted to the study. These materials all contained the purpose and procedures of the study and contact information. In addition, the website contained frequently asked questions and links to local, state, and national resources for victims/survivors of sexual assault. Please see Appendix D for content of website; Appendix C for poster and brochure samples). Western Michigan University provided me with a confidential phone and answering system where potential participants could call and ask questions and leave contact information for me to call or e-mail them. I had hoped to be able to display recruitment materials in counseling offices, but the therapists and organizations preferred that I give them the recruitment materials, allowing the counselors to decide to whom the recruitment information be given, described further below.

**Referrals.** Initially, I requested counseling offices and individual therapists to allow me to display recruitment materials in their offices. They preferred, instead, to discuss the study with their clients who met the criteria themselves. Several therapists told me that they felt this offered potentially more safeguards to more vulnerable women. One therapist, who had experienced adult sexual assault, expressed her desire to participate in the study, in part, so that she could more clearly communicate the process to her counseling clients.

**Partnering with local organizations.** Third I made efforts to partner with advocacy organizations that serve racial and sexual minorities, and persons with low incomes and housing insecurity like the Kalamazoo Gay and Lesbian Resource Center, and the Hispanic American Council, the NAACP of Kalamazoo, and the Douglass Community Center, the Women's Co-Op, the Kalamazoo YWCA, Sexual Assault Services of Calhoun County, Ministry with Community, Western Michigan University, and the Northside Ministerial Alliance. These organizations allowed me to discuss my study at meetings, display recruitment materials, and use confidential office space to conduct interviews.

**Informational sessions.** When health care and mental health organizations agreed to participate in the recruitment process, either by posting my recruitment materials or giving study brochures to the participants, I hosted an informational session about my study. In this informational session, I discussed the purpose of my study, inclusion criteria and the data collection process. I also provided informational resources for women who had experienced intimate or sexual violence.

**Local newspaper article.** Unexpected assistance in my recruiting efforts came from a reporter with the *Battle Creek Enquirer*. Upon seeing the recruitment material displayed around Battle Creek, the reporter called and requested an interview with me. He published an article about the study with contact information. Several women contacted me as a result of this article. Three of these women became participants in the study.

**Diversity of sample.** In an attempt to achieve maximum variation sampling, I monitored the diversity of my sample throughout my analysis by comparing the demographic characteristics to the demographics of Battle Creek and Kalamazoo. When I initially had recruited a non-diverse sample (composed almost exclusively of white women who had completed a university education), I sought more assistance from community cultural brokers, such as the agencies discussed above as well as friends and acquaintances who belonged to these communities. Through these cultural brokers, I was finally able to recruit two Black women. Please see table one for demographic details of this sample.

Table 1

*Demographic Characteristics of Sample*

<b>Characteristic</b>	<b>n</b>	<b>Range</b>	<b>Mean</b>
<b>Race</b>			
White/Caucasian	20		
Black /African American	2		
<b>Age</b>		25-77	44
<b>Marital status</b>			
Married	6		

<b>Characteristic</b>	<b>n</b>	<b>Range</b>	<b>Mean</b>
In committed relationship	4		
Single	7		
Divorced	5		
<b>Children</b>	13	0-4	1.4
<b>Highest Education</b>			
Graduate school	4		
College graduate	9		
Some college	8		
High school	1		
<b>Yearly income</b>	18	0-96 K	22K

In an attempt to recruit more economically diverse women, I spent two days at a day shelter in downtown Kalamazoo. Unfortunately, I did not successfully recruit any participants from this shelter for the study. One of the shelter workers told me that this was not a surprise, as clients needed to compartmentalize their lives and histories to survive. She went on to tell me that only after working five days a week for five months did some clients open up to her a little bit. Although I was not able to recruit women from the day shelter, I was eventually able to recruit women from diverse educational and income backgrounds through my regular recruitment activities.

**Saturation.** Study recruitment and data collection continued until data were sufficiently rich to develop a theory and definition of wellbeing after sexual assault. Charmaz (2006) suggests that data collection is complete when the researcher has gained sufficient background information about the persons, settings and processes to reflect the range of the contexts of the study, detailed descriptions of participants' actions and views. For example, the data showed how participants changed over time as they related



their stories, and were rich and deep enough to facilitate the development of analytic categories and generate ideas.

In grounded theory, it is not possible to know how many participants are needed to achieve theoretical saturation. Some researchers suggest that this usually occurs between twenty and sixty interviews (Laverty, 2003; Polkinghorne, 2005, Creswell, 2013). I found this to be the case for me, as well. By the time I had conducted 17 interviews and had completed some data analysis, I had theoretical saturation for every category except spiritual health. At this point, I began theoretical sampling to saturate the spirituality category, interviewing five more participants for a total of twenty two.

### **Informed Consent**

After a participant expressed interest in the study, I contacted her via her preferred method of communication to set up a time to discuss the study in more detail via a telephone conversation. During the telephone conversation, I conducted a screening interview and distress protocol, as developed by Draucker, Martsof, & Poole (2009). See Table 2 for details on this protocol. Draucker and colleagues developed the following interview questions for researchers to use in research that involves potentially vulnerable participants or sensitive topics. When I called the potential participant at the requested number (or answered the phone from a potential participant), I stated the following: “This is Pam Wadsworth from Western Michigan University and Arizona State University. Thank you for your interest in this study. Do you have any questions? (The questions were answered). Could you please verify that you are at least 18 years old? Could you please tell me/verify your name and contact number? Because the topic of sexual assault can be sensitive and might bring up difficult feelings, I am asking women who might be

experiencing high levels of stress or emotional difficulties to not participate at this time. Is it okay for me to ask you some questions to find out if there is any reason you should not participate?" (No participant answered no. If they had answered "no," I would thank them for their time and interest). When participant answered "yes," I conducted the following protocol:

Table 2

*Screening Interview and Distress Protocol (Draucker, Martsof, & Poole, 2009)*

<b>Screening Questions</b>	<b>No</b>	<b>Yes</b>	<b>Follow Up Questions</b>	<b>Caller Responses</b>	<b>Acute Emotional Distress? (Y or N)</b>	<b>Imminent Danger? (Y or N)</b>
1. Are you feeling a high level of stress or emotional distress?			1. Please tell me what you are experiencing. 2. Are these feelings getting in the way of things that you need to do (like school, work, etc.) 3. Are these feelings preventing you from taking care of yourself? 4. Have you recently been in the hospital for these feelings?			
2. Do you have any current thoughts of hurting yourself?			1. Please, tell me what thoughts you are having? 2. Do you intend to harm yourself? 3. How do you intend to harm yourself? 4. When do you intend to harm yourself? 5. Do you have the means to hurt yourself?			

None of the potential participants answered “yes” to any of these questions. After I conducted this screening, we agreed to schedule an interview. If the participant's answers had indicated acute distress or safety concerns, but not imminent danger, I was prepared to : 1.) Decline to schedule the interview, 2.) Recommend the caller contact her mental health provider, and give contact information for local mental health providers if

participant did not have one and 3.) Report this finding to Dr. Moe within 12 hours. If the participant responses did reflect imminent danger, I had plans to 1.) Encourage the caller to have someone (including emergency services, if necessary) transport them to the emergency department at a local facility that with emergency psychological services and 2.) Notify Dr. Moe immediately.

The potential participants were given more detailed information about the study, such as the purpose, procedures, and methods to help ensure confidentiality, and potential risks and benefits of the research. They were encouraged to ask questions and voice concerns. If the participant still expressed interest, I screened her to ensure that she met all of the eligibility requirements of the study. Nine participants did not meet the adult sexual assault eligibility requirement as set by this study, sexual assault at or before the age of 18. Three women changed their mind about participating in the study. One woman told me that while she was dealing with the trauma well, she did not feel ready to discuss it with a stranger. The second woman did not come to the agreed upon interview. When I called her, she told me that changed her mind. The third woman had scheduled an interview, later told me that she needed to re-schedule, but never called again. I did not collect any information on these potential participants who declined to participate. As a result, I do not know if these women differed in any way from the women who did participate.

If the participant agreed to participation and met all of the eligibility requirements, we agreed on a meeting place and time for the consent process and the semistructured interview. The participant had the choice of the interview location, provided it was in a private office within a safe location (safety determined by myself and

the participant). When the participant arrived, I gave her a packet with information on local and national resources, such as shelters, support groups, counseling services, healthcare, and advocacy groups. At this time, I reiterated the purpose and procedures of the research. The potential participant was informed that the study was completely voluntary, and that she had the right to decline participation any time in the study, for any reason, without penalty. After participants had been informed of the purpose, procedures, and their right to decline participation at any time, I summarized each point of the consent form to the participants. I also gave the participants a chance to read this consent form themselves.

In order to increase confidentiality of the participants, I asked each participant to choose a pseudonym to be used during the interview process and data analysis. The participant was also instructed not to use the real names of others in her interview, and to avoid using nicknames or street names that could be used to identify her. I informed the participant that I would be the only one who would know her name, and that I would not disclose this to anyone. In the case that the participant used her real name or identifying information about herself or others inadvertently during the interview, I redacted this from the transcripts.

When participants agreed to participation in the study, I asked them to give verbal consent. Participants who agreed to participate in the study read the following statement, which was digitally recorded before the semistructured interview began “I discussed the study with Pam Wadsworth. I have also read or been read the consent for this research. I understand that I have the right to end the interview at any time, for any reason. I understand that I can refuse to answer any of the questions for any reason, without

penalty. I will be using the name \_\_\_\_\_ throughout this interview, which is not my real name or my nickname.”

The topic of sexual assault is a sensitive topic, and a compromise of confidentiality may be harmful to participants. The IRB at Arizona State University specifically requested that participants be given the short consent form, without a signature line, for this reason. This decision was based on the recommendation by the United States Health and Human Services Code 45 CFR 46.117c that investigators may waive the written consent of participants if “The only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality” (Health and Human Services, para 82). This code also waives the requirement for a signature on the consent if the research “presents no more than minimal risk of harm to subjects” (Health and Human Services, para. 82).

### **Confidentiality**

I informed all of the participants of their rights to confidentiality and the procedures I used to safeguard it, including their choice of a pseudonym to be used during the interview process and data analysis. I informed the participant that I would be the only one who knew her name, and that I would not disclose this to anyone. I informed the participant that I would try to avoid compromising her confidentiality via deductive disclosure. Deductive disclosure happens when a researcher describes enough identifying details about a person or situation to enable other individuals in the community to identify the participant (Kaiser, 2009). I informed the participant that she had the right to retract any of her statements from being included in the transcript. The transcripts were be locked in a file cabinet in a locked, secured room in my personal

home office and I was the only person with access to this information. The digital files of the transcripts were stored on the hard drive of my personal laptop. I shared each of these transcripts via e-mail, or the U.S. Postal service with my coding mentor, as well as other members of my committee, as needed. This computer and these files were protected with a password that was changed every thirty days.

### **Avoidance of Harm**

This study presented a small risk of psychological distress and discomfort. Researchers have reported that research participants who participate in research about traumatic events, such as sexual assault, experience some level of distress (Carlson, Newman, Daniels, Armstrong, Roth, & Loewenstein, 2003; Decker, Naugle, Cater-Visscher, Bell, & Seifert, 2014; Ferrier-Auerbach, Erbes, & Polusney, 2009; Griffin, Resnick, Waldrop, & Mechanic, 2003; Newman, Walker, & Gefland, 1999). This upset or distress occurs in various methods of data collection, such as interviews and written surveys (Carlson et al., 2003; Decker et al. 2014; Ferrier-Auerbach et al., 2009; Newman et al., 1999). Participants with a higher baseline of distress, indicated by higher PTSD symptomology, depression, or other symptoms experienced a higher level of distress after the studies (Carlson et al., 2003; Ferrier-Auerbach et al., 2009; Newman et al., 1999). Participants found the interviews upsetting for the following reasons: remembering or reliving the past, upset by detailed nature of the questions, emergence of painful insights, upset about talk about trauma, evoking negative emotions, dissociation, embarrassing or shameful, and other (Carlson et al., 2003).

While there is a risk of social or psychological discomfort, previous research with victims/survivors of sexual assault has demonstrated that many participants do not

experience this discomfort. In fact, some researchers have even reported that some sexual assault victims/survivors benefit from the research. Researchers who conducted interviews with adolescents aged 13-17 (N=65) reported that the majority of the participants: felt somewhat to very comfortable (92%), somewhat to very comfortable answering questions about sexual activities (88%), did not feel sad or depressed during the study (92.5%), and willing to very willing to complete a similar interview in the future (95%) (Jones, Gruber, & Freeman, 1983). There were no significant differences in the responses between participants who had experienced sexual abuse or assault and non-victimized participants (Jones et al., 1983). Carlson and colleagues (2003) reported that while some participants experienced distress during research about trauma, many participants found the research personally useful. Researchers who assessed the response to an interview about childhood trauma (N=265) reported that none of the women who participated in the interviews expressed regret (Newman et al., 1999). In addition, none of the participants wanted to stop the interview (Newman et al, 1999).

Some participants report that they benefit from research that assesses their traumatic experiences. For example, Campbell and colleagues (Campbell, Adams, Wasco, Ahrens, & Sefl, 2010), who interviewed adult women about their sexual assault experiences, reported that many voiced the idea that participation in the research gave them the opportunity to discuss their experiences and possibly contribute to the improvement in the lives of other victims/survivors. Carlson and colleagues (2003) reported that participants found the following useful about their trauma experience interviews: new insights, helped to talk to someone, helped remember the past better, idea that research would be helpful to others, catharsis, helpful in own therapy, and



remembering positive aspects of life (Carlson et al., 2003). Other researchers reported that in a study of 108 rape survivors who participated in a series of assessments over 2 days for 3-5 hours each day, the participants rated the research as generally positive and interesting, and would be willing to participate in a similar study in the future even though they did experience a short period of moderately high distress while discussing the sexual assault, which was generally short lived (Griffin, Resnick, Waldrop, & Mechanic, 2003). While undergraduate university students with an abuse experienced significantly more bother than students without a history of abuse, by an interview and questionnaire assessing abuse ( $p=0.001$ ), they also were significantly more likely than non- victimized students find the research useful ( $p=0.0006$ ) (Decker et al., 2014). The participants named insight into themselves and ability to help others as benefits to participation in the research (Decker et al., 2014).

I attempted to mitigate the possibility of psychological harm and distress during each phase of the study. In my recruitment materials, I stated the purpose and the criteria of the study, allowing women to self-select themselves into participation. As I discussed earlier, I screened each interested participant for psychological distress. I had a triage plan in case women did express psychological distress, outlined in the recruitment section. When women cried during the interview, I paused and assessed whether they were distressed and if they wanted to continue. Several women did cry, but each of them denied distress and wanted to continue the interview. I gave each participant an extensive list of resources to assist with physical and mental health care needs.

As a women's health nurse practitioner for nine years, I have worked with many women who have experienced sexual assault as an adult and/or as children. As a sexual

assault nurse examiner for over seven years, I have also had the opportunity to work with women who have experienced sexual assault. This experience has helped to improve my skills in communication and supportive interaction with such women.

In addition to the psychological risks, some participants may have been be inconvenienced by the time it took to participate in the interview (the interviews ranged in time from 35 to 146 minutes,  $M = 73$  minutes). In addition, while every attempt was to protect confidentiality, it is possible that a participant's identity may be deduced from written publications or presentations. Because participants were not reimbursed for their travel time or childcare, they may have experienced economic risks to participate. Participation in this study presented no physical or legal risks.

### **Data Collection**

Feminist intensive semistructured interviews were chosen as the method of data collection for this study. These interviews are a directed conversation that “fosters eliciting each participant's interpretation of his or her experience” (Charmaz, 2006, p. 25). In a grounded theory study, the researcher devises a small number of broad and open ended questions. The researcher then focuses the interview questions to encourage a detailed discussion of the topic (Charmaz, 2006). Accordingly, “[b]y creating open-ended, non-judgmental questions, you encourage unanticipated statements and stories to emerge... [it] goes between the surface of ordinary conversation and examines earlier events, views, and feelings afresh...” (Charmaz, 2006, p. 26). Such interviews use active listening, defined as a

...fully engaged practice that involves not only taking in information via speech, written words, or signs, but also actively processing it – allowing that information

to affect you, haunt you, make you uncomfortable, and take you on unexpected detours... (DeVault & Gross, 2007, p. 182).

Researchers engaging in feminist intensive interviewing make a concerted effort to reduce the hierarchy between the researcher and participants (Campbell, Adams, Wasco, Ahrens, & Sefl, 2010). Some of the ways that this hierarchy can be reduced is by engaging in mutual dialog and disclosure, normalizing experiences, and remaining attuned to emotionality of the participant's experiences (Campbell et al., 2010; Lather, 1991). In mutual dialog and disclosure, both the researcher and the participant are allowed to ask questions (Campbell et al., 2010; Lather, 1991). The ability to ask questions of the researcher gives power back to the participants, which is particularly important to trauma survivors, as regaining control is vital in the recovery process (Frazier, Tashiro, Berman, Steger & Long, 2004). Normalizing women's experiences helps them feel less isolated, and "may be particularly helpful for trauma survivors who may be bogged down in self-doubt or self-blame" (Campbell et al., 2010, p. 62). Charmaz (2006) also encourages the researcher to validate the meaning and intensity of the participant's experience. Remaining attuned to the emotionality of participants' experiences means that when participants demonstrate emotions such as sadness, anger, frustration and grief, researchers "should not move on to the next question, but instead should talk about those feelings while providing tissues, touch (if appropriate), or affirming gestures" (Campbell et al., 2010, p. 63). Charmaz further asserts that the participant's comfort level has a higher priority than "obtaining juicy data" (p. 30). As suggested by Charmaz, I avoided ending interviews abruptly or when the participant appeared distressed. I attempted to slant ending questions toward positive responses to

end the interview at a more positive level. These types of closing questions were included in my interview guide (Appendix F).

If the participant exhibited signs of distress, such as uncontrolled crying, incoherent speech, or indications of flashbacks, I stopped the interview and assessed for acute emotional distress, and safety concerns of imminent danger. As suggested by Draucker, Martsof, and Poole (2009), I gave the participant time to regroup and assess her mental status by asking the following questions: a) Please tell me what you are thinking and feeling now; b) Do you feel like you can go on about your day?; c) Do you feel safe?; and d) Would you like to continue with the interview? If the participant was not experiencing acute distress or safety concerns and wished to continue the interview, we did so. If the participant were experiencing acute distress, I would have encouraged her to contact her mental health provider or provide her with local mental health resources, including therapists, the Griffin Help Line, and Borgess Emergency Department. I also planned to contact Dr. Moe within 2 hours of the occurrence.

One participant, Arrica, cried throughout the interview. Before we started the digital recording, she warned me that she had been crying a lot in the last few weeks, and had begun therapy to figure this out. She also told me that the tears were not necessarily out of distress, depression, or sadness, but because “ I – I think the reason I’m crying a lot is those walls are coming down....And, as I said, for the first time in my life I feel safe” (p. 30, lines 23-26). About midway through the interview, we took a short break so that I could get her more tissues, turned off the recorder, and asked her if she wanted to continue, reiterating that we could stop at any time, for any reason, and she assured me that she was “ok” and would like to continue the interview.

The focus of the interview was the participants' perception of how sexual assault has influenced their life and wellbeing. All interviews were be digitally recorded. These questions (Appendix F) were formulated based on various domains of wellbeing, such as perceptions of physical, mental, social, and behavioral health, spirituality, life satisfaction, financial stability, career and educational achievement. I discuss the wellbeing construct and domains more extensively in chapter 2. In grounded theory, the interviewer must remain both flexible, allowing ideas and issues to emerge, while also structured, to focus the data and fill in analytic gaps (Charmaz, 2006). The participants were also asked about their perceptions about the barriers and facilitators of wellbeing.

In addition, participants were asked to provide basic demographic data including age, race and ethnicity, highest educational achievement, sexual orientation, and relationship status (single, living together, living apart, but in committed relationship, married, divorced, separated, widowed). Please see appendix E for this form. Because a critical aspect of constructivist grounded theory is to examine the contextual influence and situatedness of time, place, culture, and situation (Charmaz, 2006), these demographic variables assisted in the analysis. In addition, a participant sample that mirrors the population affected by a phenomenon increases the quality and trustworthiness of the conclusions of the researcher (Miles and Huberman, 1994). Extant literature also demonstrates that women with different demographic characteristics may experience and interpret sexual assault differently (Jacques-Tiura et al., 2010; Temple et al., 2007), so inclusion of the demographic variables helped me to interpret the interview data in context.

## **Field Notes**

I took field notes before and after the interviews. Depending on the interview, I wrote about processes occurring in the setting, the participant's verbal and nonverbal expressions, as well as the physical environment. The field notes helped me to remember what was going on during the interview- actions, impressions, feelings, etc. Reviewing the field notes with the transcripts helped inspire insights about the congruence or incongruence between words and body language and emotion (Charmaz, 2006).

## **Data Management and Analysis**

I subscribed to the constructivist grounded theory data analysis procedures of immediate and constant data analysis. I transcribed verbatim the initial 10 interviews in order to facilitate increased interaction with the data. This increased interaction assisted me to learn the nuances of the participants' language and meanings (Charmaz, 2006; Hesse-Biber & Leavy, 2011) and sparked additional research ideas and questions (Charmaz, 2006; Sandelowski, 1995). I used these ideas to refine and direct my questions to gain a deeper understanding of wellbeing after sexual assault. The transcribed texts were compared to the audio records for accuracy and identifying information. I redacted any identifying information (such as names or identifying situations).

Data collection and analysis occurred concurrently, as this iterative process inspired deeper questions and analysis (Charmaz, 2006). Domain analysis, memo-writing, coding, displaying data, and participating in intensive discussions with my coding and members of my committee each informed each other. However, in order to make this audit trail transparent and understandable; I have described each of these analytical techniques below.

## **Getting a Sense of the Whole**

Sandelowski (1995) advises researchers to take the initial time to get a sense of each interview before moving on to data analysis. Following Sandelowski's suggestion, I read each interview as many times as necessary in order to understand the key elements. Simply reading these interviews inspired new thoughts, inspiration, and reflexivity (Sandelowski, 1995). Reflexivity is the process during which the researcher ponders research experiences, feelings, and assumptions (Charmaz, 2006).

As I read through each transcript, I highlighted quotes or passages that seemed worthy of attention, as advised by Saldaña (2013), Miles and Huberman (1994) and Sandelowski (1995). In addition, I jotted notes and thoughts in the margins. These notes were used later to create different types of codes (Miles & Huberman, 1994). They also functioned to encourage creativity and imaginative thinking (Sandelowski, 1995).

As I read through and highlighted transcripts, I underlined meaning units. Meaning units are defined as a collection or chunk of words or statements that convey the same meaning (Miles & Huberman, 1994). Meaning units can be words, sentences, or paragraphs (Graneheim & Lundham, 2004). These meaning units were sifted and refined into themes, which were labeled with codes. Codes are "shorthand labels" used to identify themes, which are topics recurring with some regularity in the data (Miles and Huberman, 1994, p. 57). More theoretical and subtle than a code, a theme is an outcome of coding and analytic reflection (Saldaña, 2013).

Prior to fieldwork, I created a provisional "start list" of codes, derived from literature and my sensitizing concepts, that was used to begin looking at my data (Miles and Huberman, 1994; Sandelowski, 1995). According to Saldaña (2013, p. 3), a code is

“...most often a word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data.” These codes were based on some of the domains of wellbeing, such as physical, mental, relational, spiritual and financial health (CDC, 2013). Charmaz (2006) argues that while initial codes can be used to provide starting points to look “...*at* your data but they do not offer automatic theoretical concepts *for* analyzing these data...” and must be examined for preconceptions (p. 68, italics original). I used the reflective questions Charmaz (2006) offered to help avoid the imposition of pre-existing assumptions, such as asking myself if and how the concepts help me to understand the data.

To create a codebook for the study, I began by using an ethnographic technique to organize start codes into a coding scheme. This technique, called a domain analysis, is simply a way to look at categories of meaning in interview data. I reviewed transcripts for conceptually similar themes/codes, organizing them into clusters or groups called domains, or categories of meaning, adding to or collapsing those domains as the data demanded (Spradley, 1980). Then the relationship of each theme to the overall topic of the domain was examined to determine “fit” of the theme within the category. This relationship is called “semantic” (related to meaning). There are several types of semantic relationships, for example: strict inclusion (x is a kind of y), spatial (x is a place in y), cause-effect (x is a result of y), rational (x is a reason for doing y), location for action (x is a place for doing y), function (x is used for y), means-end (x is a way to do y), sequence (x is a step/stage in y), and attribution (x is an attribution or characteristic of y). After the semantic relationship within the domain was determined, then each theme was tested against the relationship and the category. For example, reading from the bottom up,



you can see that “forced vaginal intercourse” is a type of “sexual assault”; “forced oral intercourse” “is a type of” “sexual assault,” and so forth. In this way, themes could be easily be considered in relation to one another and to the larger category of meaning as the codebook is developed.

Table 3

*Domain Analysis: Relationship of Themes to Domains*

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<b>Domain (Category of Meaning): Sexual Assault</b>
Semantic Relationship: ↑ is a type of ↑
Theme: forced vaginal intercourse
Theme: forced oral intercourse
Theme: Drug facilitated involuntary vaginal intercourse

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A codebook was used to facilitate transparency on my thought process and judgment. A codebook is a written and organized collection of codes, content descriptions, with an illustrative data example (Saldaña, 2013). A codebook allows the researcher to organize and re-organize codes into major categories and subcategories. The inclusion of the codebook in a dissertation acknowledges long and rigorous effort, and analytic growth (Saldaña, 2013). The codebook includes the name of the code, a detailed description of the code's qualities, inclusion and exclusion criteria, typical exemplars, atypical exemplars, and "close, but no" data exemplars that should not be assigned to this code (Saldaña, 2013, p. 25).

**Initial Coding**

I conducted various levels of coding throughout the entire project. Coding is the method of describing what the data are about (Charmaz, 2006; Miles & Huberman, 1994) and often involves categorizing and summarizing meaningful segments of data (Charmaz, 2006; Miles & Huberman, 1994). I followed the guidance Charmaz gave (2006) of asking the following questions in each transcript: "What is this data a study of? What does the data suggest? Pronounce? From whose point of view? What theoretical

category does this specific data dictate?” (p. 47). I also attempted to initially move quickly through the data during initial coding, as doing so can “spark your thinking and spawn a fresh view of the data” (Charmaz, 2006, p. 48).

The initial coding techniques I utilized were, incident to incident and in vivo coding (Charmaz, 2006). The second phase of coding consisted of focused coding (Charmaz, 2006). The third level of coding consisted of axial coding and theoretical coding. These levels of coding, along with various techniques used by constructivist grounded theorists are discussed below.

**Incident to incident coding.** For incident to incident coding, I explored the varied ways that participants describe events, both mundane, and exciting (Charmaz, 2006). According to Charmaz (2006), incident to incident coding is most useful with observational data. As I reviewed field notes of my observational data, I found this coding useful.

**Use of in vivo codes.** In vivo codes are words or phrases used by the participants that serve as “symbolic markers of participants’ speech and meaning” (Charmaz, 2006, p. 55). As a sexual assault nurse examiner, I have heard some examples of phrases I would use as in vivo codes. For example, many women report feeling “dirty.” According to Charmaz (2006, p. 55), there are three kinds of in vivo codes that may be useful in a constructivist grounded theory study:

...terms that everyone ‘knows’ that convey a condensed and significant meaning, a participant’s innovative term that communicates meanings or experience, or an insider shorthand term that is unique to a specific group

Every effort was made to include in vivo data in study reports as a means of accurately reflecting and staying close to the data. Despite working for several years with women who have experienced sexual assault, I was constantly surprised, touched, and intrigued with the language that they used to describe the experience of sexual assault as well as their lives afterward.

### **Second Level Coding**

**Focused coding.** The second phase of coding in constructivist grounded theory is called focused coding (Charmaz, 2006). During focused coding, I sorted through the codes I had established in initial coding to determine their adequacy in capturing the domains and processes of wellbeing. I agreed with Charmaz, who emphasized the iterative process of coding and analysis, finding that this process did prompt additional insights and questions that led me to both re-examine my earlier data and to return to the field with more questions.

### **Third Level Coding**

**Axial coding.** Axial coding is a type of coding where the researcher treats a category as an axis around which the analyst defines relationships, specifying dimensions of the category (Charmaz, 2006). Some grounded theorists use axial coding to transform distinct codes into coherent concepts and structure and organizing frame for their data (Charmaz, 2006). I did utilize axial coding to define relationships between domains and specify dimensions of each domain.

**Theoretical coding.** Theoretical coding helps to clarify the relationships between categories that emerge during focused coding (Charmaz, 2006). Theoretical codes “...lend form to the focused codes” and help the researcher to report “an analytic story”

with coherence (Charmaz, 2006, p. 63). I utilized this process, including some codes that I derived from sensitizing concepts in feminist theory, such as power, agency, and resistance.

A researcher using process or action coding uses gerunds to indicate action. Process coding suggests actions “intertwined with the dynamics of time” (Saldaña, 2013, p. 96). Gerunds assist the researcher to see the process, sequence, and connections. The coding and analysis of gerunds facilitates theory construction by highlighting and conceptualizing relationships between experiences and events (Charmaz, 2006). This type of coding was important in this study, as I explored how sexual assault victims/survivors women changed their perceptions and actions of wellbeing across time. (Although only one interview was completed with each participant, they presented their stories of sexual assault as unfolding over time.)

I chose to code this relatively small data set manually because I am a novice researcher. According to Saldaña (2013), the process of learning basics of coding and qualitative analysis while also learning software programs can be overwhelming, so the coding process was conducted on hard copies of the data. Otherwise, novice researchers could sacrifice focus on the coding and analysis to the demands of learning new software (Saldaña, 2013). Instead, I utilized familiar computer software programs Excel, Word, and Power Point to organize and display the codes.

## **Themes**

As I coded, I grouped codes that were related into themes. A theme is an outcome of coding and analytic reflection (Saldaña, 2013). For example, I created a theme of silencing, which contained smaller codes of not asking questions, acting hurt/awkward,

and directly asking the participant to not talk about sexual assault. These themes were grouped into more abstract categories, like hurtful behaviors and actions towards victims/survivors.

### **Categories**

After coding the data and identifying themes, I organized them into categories as a means of data reduction. A category is an aggregation of similar themes, collecting a large amount of material into significant and parsimonious units of analysis (Miles & Huberman, 1994). It is more conceptual than a code or theme, subsuming both of them (Charmaz, 2006). Categories are exhaustive and mutually exclusive (Graneheim & Lundman, 2004). Besides reducing the data into smaller, more manageable units of analysis, categories are also helpful to facilitate earlier and more focused analysis and data collection of the researcher (Miles & Huberman, 1994).

I used several processes to create categories. Miles and Huberman (1994) encourage the researcher to look for recurring similarities and differences among participant interview data. I also utilized the strategy recommended by Charmaz (2006) and Miles and Huberman (1994) of visually representing the data in a network display to see how various categories connect. I utilized my analytic memos, described below, to create and articulate my categories (Charmaz, 2006; Miles & Huberman, 1994). Using the domain analysis in the codebook also was helpful in sorting themes into categories.

There are several properties of a strong category. Strong categories are clearly grounded in data, have clear links to other categories, have precise boundaries, and make the analysis more abstract (Charmaz, 2006). Theoretical sampling assists in creating, deepening, and clarifying categories, and categories become saturated when new data no

longer triggers new theoretical understanding nor demonstrates new properties of core categories (Charmaz, 2006). In this study, saturation occurred at the completion of 22 participant interviews.

### **Memo Writing**

Throughout the study, I wrote analytic memos. According to Miles and Huberman (1994, p. 72), memos are a theorizing written record of different aspects of the data in a “recognizable cluster.” I created these memos from reflective and marginal remarks. I authored memos whenever ideas occurred to me, following suggestions by Miles and Huberman (1994). I did find that memo writing was “liberating,” as suggested by Charmaz (2005, p. 85), as I was able to let my ideas flow, without worry about making sense to anyone but myself. I made sure that all of my memos were sortable (saved as memo followed by number) on my computer file. I did this for two reasons: to assist me in analysis and to maintain an audit trail, as suggested by Miles and Huberman (1994).

I also completed cluster and free-writing memos. Clustering memos allow the researcher to explore data in a non-linear, visual manner (Charmaz, 2006; Miles & Huberman, 1994). I followed Charmaz’ advice by starting with a main idea at the center, working quickly, making the connections clear, continuing branching out until I had exhausted all of my knowledge, and trying several different clusters on the same topic.

### **Data Displays**

I utilized network display throughout the analysis. A network display “...is a collection of nodes or points connected by links or lines that display streams of

participant actions, events, and processes” (Miles, Huberman, & Saldaña, 2014, p.111). Network displays facilitate the focus on multiple variables at the same time. I initiated these network displays as I collected data to assist me in identification of processes of wellbeing, and develop guidelines for further data collection. Moreover, according to Miles and colleagues, (2014), early use of data network displays help encourage focus but they also caution that early displays can lead to early closure of ideas. To avoid this early closure of ideas, I developed different displays with the same variables, continued to change the network displays as I collected more data and the analysis evolves, and checked the displays against the field notes, memos, codes, and transcripts. I shared these displays in an on-going basis with my coding mentor. I maintained an explicit record of my decision rules in choosing the data to be displayed, as suggested by Miles and colleagues (2014).

### **Validation and Verification of Conclusions**

I utilized the suggestions from Miles and Huberman (1994) to assist in making and verifying conclusions. In the section that follows, I discuss how I adapted the tactics suggested by Miles and Huberman (1994) to assist in generating meaning, confirming findings, the standards I used to help ensure a high quality of conclusions.

**Generating meaning.** Miles and Huberman (1994) set forth thirteen strategies for transforming raw data into meaningful interpretations. Following is a discussion of some of these strategies and how I used them.

**Noting patterns and themes.** Miles and Huberman (1994) encourage the researcher to remain open to disconfirming evidence and subject all of the conclusions to skepticism by oneself and others. They caution the researcher to avoid the temptation to



jump to conclusions too quickly. I carefully and systematically noted themes and patterns in my data, and I subjected all of my themes and patterns to my coding mentor during our ongoing phone and e-mail conversations. I also regularly discussed these patterns and themes with my committee members.

**Clustering.** Clustering in qualitative analysis is the grouping and conceptualizing events, processes, and cases. Clustering is a useful technique in early, mid, and late analysis (Miles & Huberman, 1994). Miles and Huberman offer similar advice to the researcher in the clustering phase that they offered earlier – to avoid presumptions and premature closure. One of the main presumptions to avoid is the classification of an outlier that is really not an outlier. I attempted to avoid premature closure by making data displays of my clusters and presenting them to my coding mentor and committee members.

**Metaphors.** Metaphors can assist the researcher in understanding and communicating the richness and complexity of the data. Miles and Huberman (1994) offer five tips for use of metaphors in generating meaning: remaining aware of the metaphors that the research and the participants use, not looking for over-arching metaphors too early in the study, being cognitively playful to help generate metaphors, interacting with others, and knowing when to stop. However, Miles and Huberman caution that looking for these overarching metaphors too early could prevent the researcher from truly staying open to new data.

Throughout the interviews, participants provided rich, illustrative, and poetic metaphors. Early in my data collection, two of the participants described vivid

metaphors, to explain their emotional pain and emotional healing as time passed since the assault. Melanie provided a metaphor of a burn:

Well, it's one of those things that it goes from being this little tiny scar to then occasionally being like a full-body burn...And, then, it can shrink back down. And, it depends on the day (p. 12, lines 7-11).

Adrian provided another metaphor to explain this relationship

I feel like – do you remember the it was like an elastic fall apart toys, where you pushed the button, and they were like a plastic band and they'd fall apart?... It had spring action?... And you could move 'em. You could like—if you pushed 'em, they would collapse, I kinda feel like that a lot, you know?... I feel like I'm doin' a lot, to hold myself together, when really, I just want the bomb to fall out, and I just want to collapse.

I sometimes shared these metaphors with women who expressed the same ideas to see how they agreed or disagreed with the metaphors

My own metaphors also helped me to explain the relationship between various wellbeing domains. Some women described a slow process of improved health in one domain which led to slow, positive changes in a different domain. As I heard women explain this process, I started to visualize osmosis, as particles from a solution (for example mental health) with higher concentration to another solution with a lower concentration (for example, relational health) through a thin membrane (permeable, flexible separation between two domains) equalizing the concentrations (or balance, improvement). This passage from Helen was the first time I visualized this process. She told me how she had experienced improved mental health, as she was sober after many years of alcohol abuse, and this, along with feeling “more whole” allowed her to form the only positive relationship she'd ever had with a man before:

And one time, I pulled together, like, two and a half years...And that was right before I met my husband...So, maybe I was feeling a little more whole, so I found somebody that maybe was more, loving and compassionate...(p. 20, 21-25).

**Counting.** Counting can be used as an analytic technique to generate meaning (Miles & Huberman, 1994; Sandelowski, 2001). Some of the reasons to use counting in qualitative research are to rapidly assess what the researcher has in a large batch of data, verify a hunch or hypothesis, and keep the researcher analytically honest (Miles & Huberman, 1994; Sandelowski, 2001). Sandelowski (2001) cautions against common pitfalls in counting: representational overcounting, analytic overcounting, misleading counting, and acontextual counting. In representational overcounting, researchers discuss numbers and counting so much that it detracts from the overall presentation. Researchers can avoid representational overcounting by integrating the counting when necessary, and not allowing the “numbers take over the presentation” (Sandelowski, 2001, p. 237). Researchers commit analytic overcounting when they use counting to divert attention from creating a complete and nuanced analysis and interpretation (Sandelowski, 2001). Sandelowski gives an example of misleading counting: when a researcher gives percentages of a sample when the sample size is less than twenty five, in which case absolute numbers should be reported instead of percentages. Acontextual counting is evident when a researcher simply counts frequencies of occurrence for a concept or variable and reports that it was the most important one in the study, without a discussion of the ways in which it occurred.

I used counting in several areas of this study. For example, I counted the number of women who felt that sexual assault had an impact on various domains. I then counted

the positive versus positive impacts within each category. When I noticed that a participant used a particular word or phrase more than other participants, I counted this. For example, while many participants occasionally used the word “shame” during their interviews, one participant used the word 17 times. I compared this to three other women who used the word much less frequently (Mean = 3).

**Contrasts and comparisons.** Making contrasts and comparisons is a critical step in increasing the meaningfulness of the data according to Miles and Huberman (1994). They suggest using data displays to assist in the systematic analysis of these comparisons (Miles & Huberman, 1994). I used data displays to help explore some of the differences and similarities in the ways that some participants emphasize certain domains of wellbeing over others.

**Partitioning variables.** Partitioning variables is an important step in generating meaning. Partitioning variables means carefully analyzing and separating variables that may appear to go together, but are actually separate (Miles & Huberman, 1994). In this study, for example, I found that all of the women sought safety. Some women attempted to avoid dark spaces or men that felt creepy or “skeezy,” as one participant told me. These safety seeking behaviors resulted in avoidance of harm, and the benefit of a safer feeling by the participant. However, I found that some of the ways that women sought this safety would be considered “mal” adaptive by most health providers, in that they contributed to objective measures of poor physical health. For example, one of the participants, who was overweight, felt less desirable and therefore safer from sexual assault and harassment. She felt that the benefit of feeling safe was worth the negative physical health outcome/variable. Other women discussed drinking alcohol to help them

feel safe from intrusive and painful memories. One woman drank alcohol before working so that she would be able to perform her job without incapacitating anxiety.

**Subsuming particulars and factoring.** Subsuming particulars into the general and factoring are similar concepts. During these processes, the researcher goes back and forth from first level data to more theoretical categories to construct a frame of general themes with smaller branches of codes or categories (Miles & Huberman, 1994). I used this technique to help organize and sort my data. For example, I had a theme of positive physical health habits, and as branches off it, I had subtypes of positive physical health habits participants discussed, like exercise, eating well, taking supplements, etc.

**Noting relations between variables.** Detecting relationships between variables is a tactic for generating meaning. According to Miles and Huberman (1994), one of the best ways to detect these relationships is through network or matrix displays. This was facilitated by the participants themselves, as many discussed relationships between different domains. For example, one participant, Gabby, discussed how increased confidence in her relational health domain led to confidence and success in healthy weight loss, in the category of physical health.

**Finding intervening variables.** I tried to determine intervening variables, as suggested by Miles and Huberman (1994). The authors suggest comparing and contrasting various two factor relationships. Initially, I hoped to explore if the perception of healthcare sought immediately after the sexual assault would be an intervening factor in later health care seeking and satisfaction with care. I was not able to explore this potential intervening variable as I had hoped, because only three women sought

healthcare immediately after assault. Each of them viewed that process and follow-up health care differently and each one also viewed later health care differently.

Other intervening variables did come from the data. One of these intervening variables is the moment when women realized and named their unwanted sexual encounters as sexual assault. Nearly every participant in the study revised their views of themselves, their assailant, and of the world after this recognition occurred.

**Making conceptual/theoretical coherence.** According to Miles and Huberman (1994), the next step in generating meaning is to "...tie the findings of our study to overarching across-more-than-one-study propositions that can account for the 'how' and 'why' of the phenomena under study" (p. 261). To gain this coherence, I utilized Miles' and Huberman's suggestions of closely examining the data, data displays, looking at literature that both supports and conflicts with my findings, and having discussions with my mentors, academic and clinical colleagues.

### **Tactics for Testing or Confirming Findings**

**Checking for representativeness.** Because "... 'plausibility' is the opiate of the intellectual" (Miles & Huberman, 1994), I utilized tactics to avoid a shallow and incorrect analysis. A common source of error for researchers is to rely too much on accessible and elite information. I attempted to avoid this by actively recruiting participants from diverse backgrounds and standpoints. As stated in my recruitment section, I recruited from many areas throughout the Kalamazoo and Battle Creek areas. I worked with organizations that serve marginalized populations, like the Kalamazoo Gay and Lesbian Resource Center, Ministry with Community, the Douglass Center, and the Hispanic American Council.

**Triangulating.** According to Miles and Huberman (1994, p. 207), triangulation “...is not so much a tactic as a way of life...the verification process will be built into data collection as you go.” I was self-conscious about the data collection, verifying with the participants as I went along. I compared my participants’ interview data with existing literature. I also consulted with experts in sexual assault, such as therapists who specialize in working with sexual assault victims /survivors and I discussed my thoughts and feelings about the data with my coding mentor.

**Outliers, surprises, and negative evidence.** Although it is tempting to ignore the exceptional data to help ensure a smoother analysis, Miles and Huberman (1994) offer the advice that “the outlier is your friend” (p. 269). Outliers can be people, cases, settings, and events that do not fit with the norm in the dataset. Although outliers can make the analysis more difficult, they can also help strengthen the findings by protecting against self-selecting biases (Miles & Huberman, 1994). I did find outliers in each of the above categories: people, cases, and settings. For example, while most women found that time was a factor that helped them integrate their sexual assault, in one woman, time worked in the opposite way. As she grew older, she grew more fearful of romantic relationships with men, concluding that “I have closed that door. There’s no feeling about it. The door is closed. It’s locked and it’s bolted.” (Dinah the Wounded, p. 38, lines 7-8).

Extreme cases can be unusual cases or people with strong biases. Miles and Huberman advise keeping these extreme cases in mind during analysis and weighing the evidence. Surprises “...have more juice than outliers” (p. 270). Surprises, of course, are events and data that are un-expected. According to Miles and Huberman (1994), the data

are less important than following up with reflection and deeper data collection and analysis. As the interviews came close to conclusion, I frequently had surprises. For example, throughout my interview with the participant named Gabby, she told me that her husband had sexually assaulted her a few times, "...more than five, but less than ten..." (Gabby, p. 2, line 24). She went on, during the interview, to describe a few of the assaults, and why some were more hurtful than others. As we were concluding the interview, however, Gabby told me

Besides the three or four times that I felt like I'd been raped, uh, my husband was very, um, abusive in different types of sex. Like, he really preferred anal sex. He really preferred a lot of things that I kind of was not very cool with. So, I really consider all that sexual assault (p. 30, lines 15-18)

I regret that I did not follow up on this revelation which could have led to deeper reflection and understanding by both Gabby and myself. I was both surprised and saddened and I was not sure how to proceed. Gabby still sees her therapist regularly, so I hold hope that she is discussing this assault with her. I, however, did lose an opportunity to deepen my understanding of her experience.

After another surprise revelation, I was able to collect my thoughts and use the information to gain a deeper future understanding. During an interview with Sarah, I was dismayed to hear that she had hit her vulva and introitus with a hammer, saying

...I just wanted to like hurt myself. I wanted to be the one, like causing pain... it was just like 'maybe if I hurt myself, then it will hurt less,' you know? But it didn't... (p. 10, lines 12-21).

I began asking women about self-harm behaviors, and I learned that they were more common than I would have believed.



Looking for negative evidence is a more extreme version of looking for outliers. The researcher must strike a fine balance of discarding the original hypothesis too quickly or too slowly. Instead, the “proportion” of negative and positive evidence should be considered (Miles & Huberman, 1994, p. 271). One of the easiest ways to search for negative evidence is to have a “friendly but curmudgeonly skeptic to take a good look at the conclusion at hand” (p. 271). I feel lucky to have many friendly curmudgeons in my life who gave their opinions without much prompting.

**If-then tests.** If-then statements are more specific and formal than a general hypothesis. An example of an if-then statement is “If p [occurs], then q [also will occur]” (Miles & Huberman, 1994, p. 271). I utilized data displays to help construct if-then statements, discussed the matrix findings frequently with my coding mentor, and also discussed with therapists who worked with sexual assault victims/survivors.

**Ruling out spurious relations.** Ruling out spurious relations is an analytic procedure that is the opposite of finding intervening variables. According to Miles and Huberman (1994), it is important for a researcher to attempt to undo a relationship that looks plausible and strong. I followed their suggestions by using graphical displays to assist in the analysis of the relationships. In addition, I discussed these findings frequently with “friendly skeptics” (Miles & Huberman, 1992, p. 273), such as my committee members, clinical and academic colleagues, experts in different disciplines, such as social work, psychology, and medicine. As I progressed in my research, I was able to find many opportunities for this. For example, I presented my research to fellow doctoral students and faculty during the academic year. I also presented my research in

the form of a poster at a nursing research conference and as part of an academic interview process, where I received questions and feedback during each of these occasions.

**Replicating a finding.** In qualitative research, replicating a finding can be accomplished by collecting similar findings from different participants at different times (Miles & Huberman, 1994). Many patterns may emerge during coding, memos, and meetings. I noted these patterns and directed my data collection and analysis so that I could more easily discover these similar patterns between participants. I also used data displays to aid in the identification of these patterns (Miles & Huberman, 1994). I discussed these findings frequently with my coding mentor, asking for a “replicability check” (Mile & Huberman, 1994, p. 274). One of the patterns that I found among some participants was to have sexual relations, not out of sexual desire, but out of the perceived need for love or attention. Patrice expressed her sexual relations with many men this way “I was such a single, wild girl because I was just looking to be loved” (p. 16, lines 6-7). Anita said “...if we just have sex or if we do something like that, then they'll like me” (p. 18, lines 33-34).

**Checking out rival explanations.** Miles and Huberman (1994) advise holding on to the several possible explanations provided to one’s research question(s) during data collection and analysis until one of them emerges as the strongest - a “... more, stronger, and varied sources of evidence” (p. 275). They caution to not hold on to rival explanations for too short or too long a time. If the researcher holds on to rival explanations for too little time, there is a danger of locking into a way of thinking and ignoring or discounting new evidence. If the researcher holds onto rival explanations too long, she or he may fail to build a case for the best explanation (Miles & Huberman,

1994). I considered rival explanations throughout the data collection and analysis process. I discussed various explanations with my coding mentor as well as professionals in counseling or advocacy.

**Getting feedback from informants.** According to Miles and Huberman (1994), plans for getting feedback from participants must be planned for deliberately before data collection and analysis begins. Getting feedback from participants is important in feminist research, which emphasizes the importance of creating knowledge that is useful and accessible to those who are best able to use it, including study participants. In addition, this research should be reflexive, and cultivate collaboration between the researcher and participants (Hesse-Biber & Piatelli, 2007; Kushner et al., 2003; Wuest, 1995). While I was formulating questions for my semistructured interview, I regularly sought the advice from friends who have experienced sexual assault, to gauge their thoughts and reactions to the questions. I received feedback from my participants throughout the data collection and analytic phases. Throughout my interviews, I discussed some of my thoughts of the research and conclusions with the participants and I recorded their reactions to my thoughts.

After my dissertation has been accepted, I plan to formulate data displays and analysis that will be “user friendly” to interested organizations and individuals in the Kalamazoo and Battle Creek area. It is my hope that both sexual assault victims/survivors who have and have not participated in my study will give me feedback (in person, or anonymously). I also plan to contact the *Battle Creek Enquirer* to see if they would be interested in reporting my findings and recommendations in a way that is more accessible to the public. As suggested by Miles and Huberman (1994), I will work

up from particulars to macro findings very carefully. As overly abstract findings may either be discounted by participants or swallowed whole “...because these read so ‘scientifically’” (p. 276). Miles and Huberman caution not to expect complete agreement from participants. They emphasize, instead, to use this feedback to further reflection and analysis. The reactions are part of the data.

### **Standards for the Quality of Conclusions**

**Objectivity/confirmability.** While it is not possible to be a completely objective researcher, the researcher should make her or his biases explicit. I attempted to make my biases and positions transparent in chapter 1 and evident throughout the data collection and analysis how? In addition, I followed suggestions by Miles and Huberman (1994) to increase the confirmability of the study. For example, I attempted to make all of my methods of data collection and data analysis explicit and detailed; including my coding manual, memos, data displays, and transcripts (with identifying characteristics removed). In addition, I linked my conclusions with displayed data. I also discussed my rival conclusions and hypotheses: what they were, when I considered them, and how I decided that they were not the best conclusion for the study.

**Reliability/dependability/auditability.** I followed several suggestions from Miles and Huberman (1994) to help ensure that the process of my study was consistent. I explicitly described my role and status within the study. I attempted to collect data across the full range of settings, times, and respondents. (See my recruitment strategies for a full description of the recruitment and data collection.) Finally, I have a formalized agreement for reviews of my data collection and analysis with my committee members.

**Internal validity/credibility/authenticity.** In order to conduct a study that demonstrates internal validity, credibility, and authenticity, I followed several recommendations from Miles and Huberman (1994). I made sure that my descriptions were context rich and meaningful and; demonstrated how the triangulation process produced converging conclusions. In areas where I could not reach converging conclusions, I explained the reasons. I identified my areas of uncertainty and discussed negative evidence – how I sought it out, what I found, and how I integrated it into the analysis. Finally, I discussed the reactions of the participants to my data, as well as emerging theories, and how these reactions affected my final theory of the analysis.

**Transferability.** Because little is known about wellbeing after sexual assault, I explored this concept and developed a model based on the findings from this study. This model is grounded by the situatedness of a small group of (mostly) white middle age, middle class women from Battle Creek and Kalamazoo, Michigan. Although this data is not transferable to other populations (Charmaz, 2006; Miles & Huberman, 1994), the model that I constructed is useful in testing in other populations. In chapter five, I discuss other areas where this model may be tested.

**Application/action orientation.** According to Miles and Huberman (1994), and many feminist theorists (Code, 2000; DeVault & Gross, 2007; Harding, 2006; Lather, 1991), a researcher must show what the study does for its participants. Good qualitative research enhances the understanding and ability of participants to take action to improve their situations (Lincoln, 1990, as cited in Miles & Huberman, 1994). Consequently, I attempted to ensure that my research is accessible to users – physically and intellectually - by using graphic displays and rich description. I also hope that my study can be utilized

as a consciousness raising exercise that promotes self-understanding for survivors of sexual assault. As previously noted, Campbell et al. (2010) reported that many of the sexual assault victims and survivors who participated in their research believed that they benefitted from the opportunity to discuss their experiences and potential contributions to the improvement in the lives of other victims/survivors. Many participants in my study also express the hope that their participation would help others.

I hope to work with local stakeholders, such as the Kalamazoo YWCA and the Sexual Assault Services of Calhoun County, to identify further research needs. During the course of this research, we have built a positive relationship, with many hopes and plans for future research. We also hope to work together to implement possible improvements in services that are suggested by the research results.

### **Dissemination**

The results of this study will be disseminated at the local, state, and national levels. I will disseminate the results to the local support organizations for women experiencing intimate partner and sexual violence, such as the local 24 hour help and resource line, battered women's shelters, and SANE organizations. In addition, the information will be disseminated at Grand Rounds at participating health care organizations, such as Bronson and Borgess Hospital. On the state level, results of the study will be shared at conferences such as the Primary Care in Women's Health at the University of Michigan. On the national level, the results will be disseminated in journals such as *Journal of Women's Health* and *Violence and Victims*. In addition, the results will be disseminated at national conferences such as the Academy of Violence and Abuse and International Association of Forensic Nurses conferences.

Table 4

Timeline for Wellbeing June 2014 – July 2015

Activity	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A
Obtain IRB approval from necessary agencies	x	x	x												
Recruit Participants					x	x	x	x	x	x					
Collect Data					x	x	x	x	x	x					
Data Analysis				x	x	x	x	x	x	x	x	x	x		
Write Results						x	x	x	x	x	x	x	x		
Present Results															x

## CHAPTER 4

### FINDINGS

#### Introduction

The purpose of this constructivist grounded theory study is to explore the perceptions of adult female sexual assault victims/survivors regarding their wellbeing; their definitions and descriptions of wellbeing; the impact of the assault on wellbeing; and barriers and facilitators to achieving wellbeing following assault. To fulfill this purpose, I attempted to answer the following questions:

1. How do participants describe and define wellbeing in their lives?
2. How do participants perceive their wellbeing after experiencing adult sexual assault?
3. What factors function as facilitators or barriers to participant achievement of overall wellbeing or certain aspects of wellbeing?

Within this chapter, I discuss the major findings of the study. I discuss each wellbeing domain: physical, mental, financial/educational/career, spiritual, and relational, as well as how the domains interact and influence one another. With the exception of one woman who perceived very little negative impact on her wellbeing, all of the participants in this study experienced negative impact to multiple wellbeing domains, as well as to their overall wellbeing. Despite the negative impact, many participants described positive health outcomes in several domains, as well as in overall wellbeing. I will discuss the journeys of these women to wellbeing, as well as the facilitators and barriers along the way.



It should be noted that the somewhat artificial separation of the data into domains results in unavoidable occasional repetition, as each domain is discussed. In chapter five, where re-storying the data occurs, domains will once again be integrated.

### **Description of Sample**

The racial and ethnic composition of this study was homogenous. Twenty out of the 22 participants were White/Caucasian; two were Black/African American. The only racial categories represented in this study were White (n=20) and Black women (n=2). All of the participants were non-Hispanic. White women were slightly overrepresented in this study, comprising 91% of the sample compared with 82.6% to 83.4% of White individuals in Kalamazoo and Calhoun counties. Black women were slightly underrepresented in this study. They comprised 10% of this study compared to 11.1–11.2% in the Kalamazoo and Calhoun counties (United States Census Bureau, 2013). The majority (n=19) identified as straight/heterosexual. None of the participants identified as transgender. The participants ranged in age from 25 to 77, with a mean of 44 years. A little more than half of the participants were single or divorced (n=12); the remainder were married/in committed relationships (n=10). Married women were underrepresented in this sample study (n=6, 27%), far lower than the national average of married women, 49.9% (Mather & Lavery, 2010). Women who identified themselves as lesbian or gay (n=3, 14%) were overrepresented in this study compared to percentage of the national population of 1.5% (Volokh, 2014). Most of the participants (n=13) had children, with a mean of 1.4 children; the number of children ranged from 0 to 4. Most of the women worked in paid positions (n=16); other participants were unemployed (n=2), unpaid care-takers (=1), volunteers (n=1), retired (n=1), and full-time students

(n=1). The average income of the participants was low (M= \$22,000) compared to the mean income of Americans in 2012 (\$44, 888) (Social Security Administration, n.d.). There was a large range of income (0–\$96,000). Four women declined to report their incomes. The sample was relatively educated, as most women had completed a bachelor’s degree or more (n=13); only one participant did not have some college education. Table 1 in chapter three offers this information.

The high education and low income of the sample was incongruent with most research samples, in which higher education is typically correlated with higher incomes (United States Department of Labor, 2015). The discrepancy in this sample may be due to several factors. Potential explanations for this discrepancy are: loss of income after higher education was achieved, a loss of income as a direct or indirect result of sexual assault, lack of reporting by four participants (18% of sample size), and family care-taking in lieu of paid employment. Three participants lost their jobs after they had completed college and/or law school. Several of the women (n=4) lost their jobs as a direct or an indirect result of the sexual assault, resulting in a lower or absent income. The trauma of the assault resulted in symptoms and behaviors that interfered with their ability to work effectively. Mimi was fired by her boss, who was also her SA perpetrator, in the immediate period after the SA.

Other explanations for this income / education discrepancy may be the absence of reported incomes by four participants and unpaid family caregiving duties by two participants. Two of the participants (Helen and Kris), who declined to report their incomes, may have had higher incomes than others. Helen disclosed that her husband’s income allowed her to concentrate on the unpaid work that she loved: volunteering with

the elderly and creating visual art. Two of the participants, Sophie and Beth, who reported a low and no income respectively, were currently taking care of their family members without pay. Beth had found a low paying part time job as a janitor in addition to her care-taking duties, to help cover some of her expenses.

In order to facilitate comprehension of this chapter, I created a chart with some basic information about each participant, such as age, the types of abuse they experienced in addition to one episode of adult sexual assault, relationship to assailant(s), and how long ago the latest sexual assault occurred. This basic information is available in Table 5.

**Relationship to the assailant.** The relationships between the participants and their assailants were similar to those ascertained by most national studies. Most of the women in this study (19/22) were assaulted by someone they knew. Tjaden and Thoennes (2006), in their large national study of (n=8,000) women, reported that 83.3% of sexual assault victims/survivors were assaulted by someone they knew. Almost a quarter of the women (5/22) were assaulted by a friend; four by a supervisor, and three were assaulted by a stranger. Of the known assailants, the overwhelming majority were the romantic partners (13/19) or ex-romantic partners (1/19) of the participants at the time of the assault. This is also consistent with existing research, in which researchers have reported that sexual assault frequently occurs within a violent romantic partnership (Ellsberg et al., 2008; Temple et al., 2007; Tjaden & Thoennes, 2006).

Table 5

*Summary of Abuse Experiences and Time Since Assault for Participants*

<u>Pseudonym</u>	<u>Age</u>	<u>Most recent ASA</u>	<u>Additional violence experienced in addition to one ASA</u>	<u>Identity of adult assailant(s)</u>
Adrian	30	7 years	CSA – multiple ASA – multiple assailants, multiple assaults	neighbor, acquaintance, others not discussed
Alicia	39	18 years	ASA X2 –different assailants	supervisor, friend
Anita	31	7 years	CSA X 2	friend
Arrica	46	~10 years	IPV CSA – multiple assailants, multiple assaults	husband
Beth	48	> 10 years	IPV, multiple ASA, multiple assailants, CSA – multiple assaults, multiple assailants	boyfriends, brothers
Carmen	34	3 months	CSA x1, 1 assailant	ex-boyfriend
Dinah	58	?	Multiple ASA, multiple assailants	dates, unsure others
Ella	29	8 years	CSA x 1 incident	acquaintance
Gabby	48	4 years	IPV, multiple ASA – same assailant	husband
Hannah	29	5 years	IPV	2 acquaintances
Helen	51	> 10 years	CSA – multiple assaults, multiple assailants, ASA 2 incidences, 2 assailants	boyfriend, acquaintance
Jenny	24	4 months	none	stranger
Jo	46	~4 years	IPV multiple ASA, same assailant	husband
Kris	59	41 years	none	boyfriend
Laura	62	44 years	none	boyfriend
Louise	77	~ 8 years	IPV, CSA x multiple assaults, 1 assailant	husband
Melanie	29	7 years	ASA 2 x one night, 2 assailants	supervisors
Michelle	44	26 years	CSA x 1 assailant, multiple incidences	supervisor
Mimi	25	5 months	ASA x 3 (total), 3 assailants, CSA x 1 assailant, unsure # incidences	Supervisor and landlord, friend of supervisor, boyfriend
Patrice	56	?	ASA – multiple assaults, multiple assailants, CSA x 1 assault with one assailant	boyfriend, co- worker, adolescent boy (CSA)
Sarah	25	3 years	None	stranger
Sophie	53	7 years	IPV -	boyfriend

*Note.* CSA = childhood sexual assault, ASA= adult sexual assault, IPV = intimate partner violence.

**Time since sexual assault.** The time since the sexual assault and time of interview ranged from 3 months to 44 years, with a mean of 11 years. Some of the women told me the date of their most recent (or only) sexual assault, while I estimated others as closely as I could. For example, I calculated the period since most recent sexual assault from time of separation from husbands who regularly sexually assaulted their wives. For Adrian, who told me that she has experienced “multiple ones (sexual assaults)” (p. 40, line 13), I estimated 8 years, since that is the assault that she said was the most traumatic, and the one that she focused on the most during our interviews. Some women, like Patrice and Dinah, did not give me any indication of time since last assault, only that it was “years ago.”

**History of additional violence.** Most of the participants in this study (17/22) experienced additional violence in addition to one adult sexual assault. The most common abuse experienced by the participants was childhood sexual abuse (n=9), followed by intimate partner violence (n=8), multiple adult sexual assaults by different perpetrators (n=8), and multiple assaults by the same perpetrator (n=5).

Slightly fewer than half of the women in this study (n=9) experienced childhood sexual abuse (defined in this study as occurring before the age of 18) in addition to adult sexual assault. One research study found that experiencing sexual assault as a child increases the risk of experiencing sexual assault as an adult (Tjaden & Thoennes, 2006). All but one of the women who had experienced childhood sexual abuse knew their assailants. Table 5 displays the types of abuse experienced in addition to adult sexual assault as well as the relationship to assailants. The assailant types add up to more than nine because some women had more than one assailant as a child. Other perpetrators of

childhood sexual abuse were cousins, uncles, brothers, grandfathers, neighbors, teachers, and family friends.

Table 6

*Types of Abuse Experienced in Addition to ASA and Relationship to Assailant*

<b>Type of abuse</b>	<b>n</b>
Childhood sexual abuse	9
Intimate partner violence	8
Multiple assaults – same perpetrator	5
Multiple assailants, multiple assaults	8
<u>Identity of assailant in adult sexual assault</u>	
Partner	13
Ex-partner	1
Friend	5
Supervisor	4
Stranger	3
<u>Identity of assailant in childhood sexual assault</u>	
Father	4
Mother	1
Other family member	6
Stranger	1
Family friend	1
Teacher	1

**The Cultural Environment of Sexual Assault**

I used feminist principles as sensitizing concepts of this research, because the majority of sexual assault victims/survivors are women, and the majority of sexual assault assailants are men (Tjaden & Thoennes, 2006). Sexual assault is a sexualized form of aggression that can exist only in an environment with male domination (Brownmiller, 1975; Helliwell, 2000; Lorde, 1984). Early in the data collection and

analysis, I began to truly appreciate the feminist scholarship that has explored sexual assault. A feminist framework helped me to understand the role of culture in shaping the patterns of response in the participants, their family and friends, and formal helpers.

In every domain of wellbeing, participants were harmed, directly or indirectly, by rape myths. Rape myths are stereotypical false beliefs that blame the victim, absolve the perpetrator, and trivialize the violence (Brownmiller, 1975; Chapleau, 2007). Rape myths are supported and perpetrated by a larger cultural environment, or rape culture (Brownmiller, 1975; Chapleau et al., 2007; Edwards, 2011; McMahon & Farmer, 2011; Payne, Lonsway, & Fitzgerald Ryan, 1999; Sheldon & Parent, 2012; Valenti, 2010). Both women and men support rape myths and rape culture for many complex reasons. Some theorists have proposed that rape myths serve as protective mechanisms for both men and women (Joseph, Gray, & Mayer, 2013). The idea that victims are responsible for their own assaults—by dressing the wrong way, being in the wrong place at the wrong time, drinking too much, and so forth, allows non-victimized women to feel safe from sexual assault—as long as they do not do anything that is blame-worthy. For men, these myths are beneficial because they give them excuses for sexual assault in ambiguous situations (Joseph et al., 2013). As I discuss the findings in each domain, I will integrate information about the rape culture (which I will refer to from here as sexual assault culture) and rape myths and the influence on the participants. Throughout the chapter, I will also use the Updated Illinois Rape Myth Acceptance Scale (IRMA) to illustrate the influence of culture on the participants. IRMA is a validated instrument with 22 questions that assesses the degree of endorsement of four common rape myths: 1) she asked for it, 2) he didn't really mean to, 3) it wasn't really rape, and 4) she lied

(McMahon & Farmer, 2011) McMahon and Farmer (2011) reported a good reliability of this instrument, with a Cronbach's alpha of 0.87. Construct validity of the IRMA is acceptable, demonstrated by a comparative fit index (CFI) of 0.90 and a root mean square error of approximation (RMSEA) of 0.07 (McMahon & Farmer, 2011).

### **Overall Wellbeing**

Thirteen women told me that their lives were completely changed by sexual assault. Women expressed this impact in many different ways. Some women, like Melanie and Arrica, expressed this impact simply. Melanie said, "It affected everything" (p. 17, line 14). Arrica, who experienced sexual assault as well as physical, emotional, and financial abuse from her husband said, about this time in her life, "I was broken there" (p. 39, line 3). Patrice elaborated a little more on this:

That was a real, it was life, it was life-changing and, you know, it just stole my self-esteem to the core where I just felt like nothing. I felt worthless. I felt damaged. I felt dirty.

Several times, without prompting, participants told me about the different domains that were affected by sexual assault. For example, early in the interview, Helen told me,

It just affected my whole life in so many ways...with my relationship with my daughter, with all my male relationships, with all, you know, my—my work—you know, at work, you know going to the dentist was an issue (p. 5, lines 23-31).

Despite the life-changing nature of sexual assault, seven of these women told me that they had found a way to heal, to become new again. Arrica, who felt that she was broken, expressed the necessity of breaking down in order to become a newer, healthy person, saying, "It's almost like I had to be broke down before I could be built back up



again” (p. 39, line 5-6). Gabby, who had been on her own for 18 months after being physically, sexually, and emotionally abused by her husband for more than 20 years, said, “I feel like a whole new person” (p. 15, line 4). Mimi described her change with the following comment: “I mean I came in in October and was a completely different person than I am now and I kind of just have my confidence back” (p. 27, lines 47-50). Beth endured abuse most of her life, including childhood sexual abuse, intimate partner violence, and adult sexual assault. She found a new and better life after finding support at the agency. As she explained:

I never imagined it [the agency] would change my life... I never imagined it. Because um, I look back at it every day... ‘cause if I hadn’t of never came here, I don’t know where I would’ve been... ‘Cause, you know, I could’ve acted on it. I could’ve took all my pills. You know, I could’ve acted on a lot of things. I could’ve took my life. But instead, God brought me here to, you know, get help, put somebody in my life that could, you know, help me. And which—which it did. It—it changed my life a lot. (pp. 52-53, lines 49-12)

While the process was unique to each person, there were also some patterns. I will discuss these patterns in each of the domains (physical, mental, relational, spiritual, and the work/education/financial domains).

### **Domain 1: Physical Health**

I will begin this chapter with a description of the physical health effects of sexual assault on the participants. I will follow this with a description of their current health, barriers and facilitators to positive physical health. I will conclude the chapter with a discussion of the ways in which the physical health domain interacts with the other wellbeing domains.

Almost three quarters of the participants (n=15) experienced short-term (n=5) and/or long-term physical effects (n=11) from their sexual assaults. Short-term effects persisted for up to 3 months. Two women were conflicted about the connection between their physical health status and its connection to sexual assault.

**Short-term negative physical health impact.** Several women (n=5) had short-term negative physical impacts after the sexual assaults, including pain, bruises, urinary tract infections, anal fissures and difficulty sleeping. Laura's then boyfriend brutally assaulted her. She described her main injury, saying:

So, he grabs me by the hair and then, yanks out like, a hunk of it, cause I found it on the floor the next morning.... Yeah, and then, that didn't work, 'cause you know, the hair came out. So, he grabbed a bigger chunk, and like dragged me up on the bed. (p. 3, lines 5-11).

Research on the prevalence of physical injuries after sexual assault varies. In fact, one researcher found it impossible to complete a meta-analysis on injuries encountered because so many different examination and description techniques exist that the author concluded a meta-analysis was not possible (Kennedy, 2013).

**Long-term physical health impact.**

***Sleep difficulties.*** Researchers have described sexual assault as a significant risk for sleep disruption. Sexual assault victims/survivors are significantly more likely than women who have not experienced sexual assault to experience sleeping difficulties, severe tiredness, difficulty falling asleep, restless sleep, and use of prescription sleep medication (Astbury et al., 2011). Other researchers have described the significant relationship between sexual assault and increased nightmares (Krakow et al., 2002; Krakow et al., 1995). Similar to the short-term sleep disruption, long-term sleep

disruption led to negative outcomes and behaviors in other wellbeing domains like relational, mental, and career/financial health. Eleven of the participants reported having difficulty sleeping that lasted beyond 3 months. Patrice experienced the most extreme case of not sleeping, telling me she “didn’t sleep for months so then I went into psychosis. I thought every bird that landed on my land was going to die” (p. 67, lines 12-14). When this episode happened, Patrice was living away from everyone in her family and was the sole caregiver for her daughter. Luckily, a friend stepped in to help her by taking her to a psychiatric hospital.

Many of the participants had recurring bad dreams. Interestingly, two women out of this sample of 22 women had nearly identical recurring nightmares. Adrian said, “I’ve always had this dream of like a silent scream. Like, you’re in a room full of people, and you’re screaming, and no one can hear you” (p. 11, lines 30-32). Louise told me about her recurring dream “where something would be happening to me, and I would have a silent scream. I would scream, but no noise would come out” (p. 25, lines 28-32).

While trying to help themselves sleep better, some of the women ended up with more problems. Sarah, assaulted 3 years before the interview, acknowledged, “I haven’t slept well since it happened. And, like, I have a lot of nightmares” (p. 13, lines 20-21). She sought help for her sleep difficulties. Unfortunately, although the prescribed medicine helped with her difficulty sleeping, it made her so sleepy that she “just kept falling asleep everywhere I was and.... I overslept for work too many times” (p. 3, lines 23-26) and so was fired from her job as a bank teller. Hannah was one of three women who turned to alcohol to help her sleep better. Unfortunately, the alcohol use turned into abuse (to be discussed in the mental health section). This resulted in the loss of her job

and her house, her dropping out of college, and the loss of custody of her children.

Besides poor sleep, women experienced diverse physical health problems that they attributed to their sexual assault(s).

*Unintended pregnancy.* Researchers have described the risk of unintended pregnancies as a result of sexual assault. Holmes and colleagues conducted a 3-year longitudinal probability study of U.S. women (N=4008) over a 3-year period and reported that 5% of unintended pregnancies were a result of sexual assault. McFarlane et al. (2005) reported that 20% of the participants (N=148) in violent relationships experienced unintended pregnancies as a result of sexual assault. Two women became pregnant as a result of their sexual assault. Gabby, who was sexually assaulted by her husband throughout her 25-year marriage, explained, “My son was actually conceived, um, during a rape” (p. 2, lines 4-5). Patrice’s daughter was also conceived as a result of sexual assault by her soon-to-be husband. Although both women experienced other negative physical, mental, and relational impacts of sexual assault, they did not consider their pregnancies to be a negative impact and found a way to integrate the pregnancy and relationship into their lives. About integrating the sexual assault and pregnancy into her relationship with her husband, Gabby said (p. 5, lines 23-30):

I kind of played off that conception—that we both had a drink, and we had discussed about having a child, and had agreed, and things just got kind of out of hand that night. And, when I asked him to stop, “No,” and he just was not, you know, he chose to ignore all of that.... I really kind of played it off on my fault that I got pregnant, and my fault, that, um. I didn’t really blame that on him until many years later.

Patrice, who decided to marry her assailant and continue the pregnancy, reasoned, “And I was 36 by then. I didn’t have any kids so I was like, ‘I’m not going to ruin the

chance and have an abortion and ruin the chance of having a child” (p.25, lines 37-39). Although having an unintended pregnancy turned out to be a good outcome for Gabby and Patrice, other women attributed chronic health problems to being sexual assaulted.

***Chronic health conditions.*** Several women in this sample experienced varying degrees of chronic health conditions. There were two basic opinions on chronic health conditions/diagnoses in this sample. Some women felt confident about attributing their diagnoses and health conditions to their sexual assault. Some women thought that there might be a connection but were not sure.

***Hepatitis C and genital herpes.*** Kris and Adrian believe that they contracted hepatitis C from their ASA. Both women found out about this potentially life-threatening infection from routine tests. Kris found out about her hepatitis C infection when she donated blood for herself before surgery. She received notification of the infection through a letter and responded badly:

So I just freaked out because that was... Naomi Judd had just come out.... And you know thought she was gonna die in 3 years. And there really wasn't a lot known about it like there is now. There was no cure for it or anything. And so I just started like—I guess what I'm trying to say is that for health-wise it has affected me.

Although there was no way to be absolutely certain that the hepatitis came from her sexual assault, Kris assumed that it did after discussing it with her physicians

I mean there was no way to tell....but from what had happened to me that there was a good chance that that's how I got it.... I never had had a blood transfusion....or anything, I never did IV drugs. (p. 7, lines 12-39)

Adrian disclosed to me that she had also contracted hepatitis C and was successfully treated. She also assumed, but could not prove, that the hepatitis C was transmitted to her

during a sexual assault. Mimi, who was sexually assaulted by her then-boyfriend, attributed her infection with genital herpes to the assault. She said, “He raped me like forcefully, and I ended up getting herpes because of that” (p. 3, lines 32-34).

Despite the fact that three participants attributed their genital herpes or hepatitis C to their sexual assault, there is little evidence to support sexual assault as a cause of such transmission. According to the Centers for Disease Control and Prevention (2010), sexual transmission of hepatitis C is rare. For this reason, routine testing for Hepatitis C is not recommended for female sexual assault victims/survivors unless they are known to already be infected with HIV (Centers for Disease Control and Prevention, 2010). In addition, given that Kris was sexually active with her boyfriend before he assaulted her, it is possible that she contracted hepatitis C before the assault. Mimi stated that she acquired genital herpes during her sexual assault with her then-boyfriend, with whom she had previously been sexually active. It is possible that Mimi was infected with the virus during the sexual assault, but equally as likely that she had been infected prior to the sexual assault. Genital herpes is frequently transmitted from skin that looks normal, without any visible lesions. In addition, most infected individuals are unaware of their infection for years (Mertz, 2008). There is no recommendation of routine testing or treatment for sexually assaulted women (Centers for Disease Control and Prevention, 2010).

*Scar tissue.* Two women had permanent scar tissue as a direct or indirect result of their assault. Kris learned about the scar tissue years after the assault, when her physician suspected ovarian cancer and discovered that it was scar tissue instead. Although neither Kris nor her physician could be sure that the scar tissue was from the sexual assault years

earlier, both thought that it probably was due to “the assault because it was really I mean violent. I don’t know for sure. My doctor thought maybe it was” (p. 5, lines 9-12). Kris considered herself “so lucky” (p. 5, lines 3-4) that it was only scar tissue and not cancer. As discussed earlier, although researchers have reported physical injuries, the methods of assessing for and reporting are not uniform. In the attempted meta-analysis mentioned earlier (Kennedy, 2013), the author found that authors reported that physically verifiable injuries from sexual assault were present in from 6.3% to 82% of sexual assault victims/survivors.

Sarah’s scar tissue was an indirect consequence of her sexual assault. She also learned about the scar tissue from her physician, reporting, “My gynecologist said that I have a ton of scar tissue” (p. 9, line 12). She told me that she had hit herself in the vulva “because after I was raped like, like the day after, I just wanted to like hurt myself. I wanted to be the one, like causing pain” (p. 10, lines 12-13). Other researchers sought to determine risk factors for deliberate self-harm in a group of women (N=240) who had recently (within the previous 6 months) experienced intimate partner violence. Although physical violence did not significantly predict deliberate self-harm, both psychological ( $p=0.027$ ) and adult sexual abuse ( $p=0.002$ ) did significantly predict this behavior (Jaquier, Hellmuth, & Sullivan, 2013). Sarah said she sex painful, but did not know if this was a result of the scar tissue or other factors because “I’ve never had it before then so I don’t know—I can’t like compare it” (p. 10, lines 4-5). Champion and colleagues (2001) reported a significant relationship between sexual assault and dyspareunia or painful intercourse.

*Obesity.* None of the three women (Dinah, Gabby, and Kris) saw extra body weight as a direct result of sexual assault, but instead, it was mediated by other factors. Dinah purposefully gained weight in order to feel safer from sexual assault and harassment. Gabby, who was sexually, physically, and emotionally abused by her husband for several years, and who was morbidly obese, found eating high-calorie foods was a way to comfort herself and feel some measure of control. Kris also said that she was overweight but did not discuss any connection to sexual assault, as she had regarding other health problems.

*GERD, hypertension, and “pre-diabetes.”* Sarah reported that her hypertension and pre-diabetic state were caused by the medications she took for PTSD and depression, saying (p. 9, lines 1-2), “And, um, like I got high blood pressure, the one medicine gave me like pre-diabetes and made my blood sugar high.” Anita had chronic GERD. Researchers have reported that sexually assaulted women are significantly more likely to describe chronic health difficulties like hypertension, diabetes, arthritis, cancer, and overall negative health score (Campbell et al., 2008; Jozkowski & Sanders, 2012; Plichta & Falik, 2001; Street et al., 2008).

*Chronic pain.* Three women discussed long-term pain. Two of the women attributed the pain to their sexual assaults; one woman (Adrian) was unsure. Kris offered, “Like I got punched in the Adam’s apple so that bothered me for years. I mean it was just like it’s hard to swallow sometimes” (p. 16, lines 19-23). Adrian discussed her chronic pain, mostly as it related to her back problems (spinal stenosis) and various surgeries, but did not connect this pain to her childhood or adult sexual assaults. Her pain was part of the reason (combined with her diagnoses of bipolar disorder and PTSD) that



she was on disability. She explained, “I’m on disability right now. I had to go on disability about 4 or 5 years ago with my back. And, also, my bipolar and post-traumatic stress” (p. 4-5, lines 28-1). I discuss Adrian’s opinions about her physical health and sexual assaults later in the chapter, under the discussion of autoimmune disorders. Campbell and colleagues (2008) reported that severity and increased cumulative forms of violence (like childhood sexual abuse, adult sexual abuse, intimate partner violence, etc.) significantly predicted higher pain complaints. Champion and colleagues (2001) reported that sexually assaulted women experienced significantly more abdominal pain and dysmenorrhea than non-sexually assaulted women. Jozkowski and Sanders (2014) reported that sexual assault victims/survivors were significantly more likely to report that their chronic pain interfered with their work and outside activities.

*Autoimmune disorders.* Two women, Arrica and Adrian, who were diagnosed with autoimmune disorders, were reluctant to positively link their sexual assaults and an abusive marriage (Arrica) with their health, but did think that there might be a connection. Adrian, who experienced several incidences of CSA and ASA, said the following when I asked her if she felt that these abuses had an impact on her physical health (p. 17-18, lines 31-12):

You know, I’ve kind of wondered that. I’ve talked about that before at times with my therapist... I wouldn’t say it’s caused, but I would say it could have exacerbated or, you know, I don’t know exactly the correlation, or if there’s any scientific studies, you know, about stress and pain and stress and, you know, and trauma, and physical pain and. ... Do I think it’s possible? Yeah. I think that there could be some overlapping and correlating, you know, things, that have been, I don’t know, it just like—I think maybe it has affected maybe my body’s ability to heal or, I don’t know, something like that. I have always kind of thought about that, but I haven’t ruled it out or somethin’.

Arrica, who was married for several years to a man who physically, sexually, and emotionally abused her, answered “yeah” when asked if she thought the multiple forms of abuse affected her health. She elaborated (p. 21, 22-30):

Yeah. I um (sighs). I have a history of auto-immune disorders... It's the hard core stuff, like I uh. So, I don't have a spleen 'cause I had ITP.... I—my thyroid does not function at all. Um, I started getting autoimmune allergy issues.

Arrica also attributed some of her poor health to restricted access to health care and to inferior care when she did get it.

Research exploring the relationship between autoimmune disorders and sexual assaults is limited. A team of researchers have reported a significant relationship between childhood trauma and later development of auto-immune disorders ( $p < 0.05$ ) from one large ( $N = 15,357$ ) retrospective cohort study (Dube, Shanta Fairweather, Pearson et al., 2009). The researchers included childhood sexual assault among traumas assessed, but did not analyze it separately from other childhood traumas (like witnessing intimate partner violence, experiencing physical abuse, having an incarcerated parent, etc.). Research on adult trauma, and specifically on adult sexual assault in females, is also limited. In one large retrospective cohort study of male and female military veterans from Iraq and Afghanistan ( $N = 666,269$ ,  $n = 79,356$  women), researchers compared the development of auto-immune disorders in women who experienced sexual assault while in the military, women who experienced sexual assault while in the military and also had been diagnosed with PTSD, and women who had not experienced military sexual assault but had been diagnosed with PTSD. Each of these three factors was a significant risk factor for development of autoimmune disorders, but military sexual assault plus PTSD

diagnoses presented the highest risk. Female veterans who had been sexually assaulted during their military service with PTSD were more than twice as likely than female veterans who were not sexually assaulted and without PTSD diagnosis to be diagnosed with auto-immune disorders, adjusted relative risk = 2.40; 95% [2.17–2.65], ( $p < 0.001$ ) (O'Donovan et al., 2015).

Although researchers have demonstrated a significant link between sexual assault and physical health disparities, there is no clear understanding of the underlying mechanisms leading to these health disparities. This is especially true of the chronic health problems not associated with a physical injury from the assault. A new way in which to view a connection between trauma and negative physical health outcomes is through a biopsychosocial evolutionary understanding of trauma. According to Christopher (2004), all trauma leaves a biological mark on an individual. However, the damage the trauma has on the physical health of a person depends on several factors, such as genetics, duration of trauma, and the severity of the trauma. It also depends largely upon the sociocultural environment in which the trauma occurs (Christopher, 2004). Trauma that occurs in the context of emotional sociocultural solidarity can lead to post-traumatic growth, characterized by resiliency, closer relationships with others, greater willingness to accept and provide help, and an increased appreciation of life. Trauma that occurs in the context of isolation can have the opposite effect (Christopher, 2004).

**Formal care seeking.**

*Immediate period after assault.* Only three women in this sample sought healthcare in the period immediately after their assault (within 1 week). Although I did

not specifically ask women why they did not seek this care, one woman told me why she did not seek a medical forensic exam. Sarah was visiting another city and did not think that she could access these services because “I had myself convinced it wasn’t even an option cause we were like visitors” (p. 7, line 30). Another possible explanation for not seeking care could be the amount of time it took many women in the sample to identify their experiences as sexual assault (10 participants described delayed acknowledgement of their sexual assault, from 1 week to several decades—this will be described later in the mental health section). This lack of acknowledgement/identification of sexual assault was a barrier to accessing care in a previous study conducted by Patterson and colleagues (2009).

Each of the three women who did seek health care in the period immediately after the assault received her care at a local community organization that provide medical forensic exams by Sexual Assault Nurse Examiners, with no charge to the sexual assault victim/survivor. Two of these women (Hannah and Jenny) had never heard of these services and were brought or escorted to the agency by their boss and the police, respectively. This situation reflects previous research findings suggesting that a very small portion of women seek emergency care after sexual assaults (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001; Rennison, 2002). Each of the three women who did seek care used the services at the community organizations. If Hannah and Jenny had not been assisted by the police and work supervisor respectively, they might not have found this care. Lack of knowledge about sexual assault services has been cited by previous researchers as one of the main reasons most women do not seek care (Patterson, Greeson,

& Campbell, 2009). Adrian had known about this care and was able to present herself to the agency.

Unlike previous research by Ericksen and colleagues (2002), in which sexual assault victims/survivors reported feeling respected, safe, and well-cared for, the three women in this sample reported feeling vulnerable and exposed. The feelings expressed by these three women match more closely with research reported in five other studies, which assessed perceptions of care in emergency departments (Campbell, 2008; Campbell et al., 2001; Jacques-Tiura et al., 2010; Tkatch, Abbey, & Wegner, 2010). Hannah described her exam as “violating” (p. 3, line 24). Although Jenny acknowledged her nurse as “really amazing” (p. 6, line 47), she remembered feeling vulnerable in terms of “the rape kit and everything because that, for some reason, was really hard.... was just, like, the first person touching me after that happened and, um, so I just remember, like, tears” (p. 7, lines 10-20). In the following quote, Adrian exemplifies the feelings each woman expressed:

I mean, you feel so dirty and... you just can't get rid of that feeling. And, then you're making yourself more vulnerable to another stranger, even though they're there to help you, you know, you're talking about the most terrible thing that has happened to you, probably ever in your life. Your most private areas of your body, your thoughts, your everything is just out there and exposed and stuff. (p. 33, lines 4-16)

In addition to having negative feelings during the medical forensic exam, Adrian and Hannah admitted to avoiding preventive gynecological care after their assaults. Hannah said that she started avoiding this care after her assault, and continued to avoid it “unless I feel like I really, really have to” (p. 11, lines 9-10). For Adrian, pelvic exams actually triggered the unpleasant memory of having medical forensic exams: “I’m

uncomfortable and stuff but I mean. I don't know when you put that up against what I've been through versus like, a rape kit exam, which is what it triggers back to" (p. 33, lines 2-4).

Previous researchers have reported similar findings. In a study of sexual assault victims/survivors (N=81) who sought care immediately after their assaults, 91% of participants reported that their experiences were so negative that they would be reluctant to seek future health care (Campbell et al., 2005). Although these experiences could help to explain the reluctance of these three women to seek preventative health care, knowledge of why other survivors may delay or avoid this care is absent. I will discuss this other group of women next.

***Impact on formal care seeking.*** Several women (n=7) told me that their history of sexual assault had a negative impact on their formal health care seeking. Three women attributed their unwillingness to seek recommended or needed care to their sexual assault. Five participants sought care only from female health care providers. Hannah, when asked whether the sexual assault had any impact on her formal health-seeking behavior, answered affirmatively and then elaborated her care-seeking strategy (p. 11, lines 9-12):

Yeah. I don't go as often, unless I feel like I really, really have to, 'cause I don't—that's not fun to me. I mean, it's not fun to start with, but it's just not something that I want to do, and I always ask for a female doctor.

Helen disclosed one negative gynecological experience, when she said she felt she "was being chastised for being a loose girl or something, you know" (p. 25, lines 14-16).

Helen avoided routine dental care, resulting in poor outcomes. I describe this in more

detail in the barriers to positive physical health section. Pain and discomfort were common reasons other women had difficulty with breast and pelvic exams.

*Painful/uncomfortable exams.* Five women claimed that they experienced discomfort or pain during their pelvic and breast exams. Although they did not connect these feelings directly to their sexual assaults, they also related that their experience might not be the average woman's experience. Beth stated very simply, when asked about these exams, "I don't like—I don't like those at all" (p. 40, line 50). Gabby said, "I would say it gets to be a little more distressing than it should be, yeah" (p. 17, lines 20-21). When asked about how she felt about pelvic exams, Arrica replied, "Very, very painful... And, I find that to be strange 'cause I know it's not for other people" (p. 37, lines 27-30).

**Current physical health.** As I talked to the participants in this study, I learned to appreciate more than ever the complex way that we experience our physical health. The ways in which women obtained wellbeing in spite of physical health obstacles were remarkable: Some women obtained this wellbeing by improving their physical health, while others found ways to obtain overall wellbeing while living with poor physical health diagnoses. Most women grasped the connection between their physical health and other wellbeing domains without my probing. Later in this chapter, I discuss the ways in which women perceive their physical health, facilitators of and barriers to positive physical health, and the intersection of physical health with other wellbeing domains.

If I were completing a quantitative study, the physical health domain would look much like a bell curve. The vast majority (n=15) of the participants thought of their health as fair, with a few health complaints and or diagnoses. Two participants perceived

themselves as having poor health, and five participants described their health as excellent. Some women insisted that despite some of their poor objective health measures, they felt great, better than they had ever felt.

**The health continuum.**

**Poor health.** Two women described poor physical health. Adrian, 30, was on disability due to her current physical and mental health. Beth, 48, had some major health issues. She stated (p. 31, lines 13-17):

My heart is not beating like it should. Um, I have problems with my knees. I have arthritis. Um, it's um, I have asthma, but I stopped taking the medicine. My doctor wasn't happy with that.

**Fair or average health.** Most of the participants (15) described fair or average health. Laura, who described her health as “pretty good” (p. 14, line 9), reported that she has noticed some age-related changes:

I think when I turned 60, I really started noticing physical changes, though, and nobody likes to notice that...but really, up until that year, I would have said “Oh, I think I'm as healthy as I've ever been.” But, I now, I just don't feel as strong. You know? (p. 14, lines 9-15)

**Good to excellent health.** Out of the 22 women, five described their physical health as good, without any non-psychological illnesses or bodily complaints. As I addressed the perceptions of women and did not want to impose my thoughts as a health care provider, I took the women at their word. For example, one woman (Hannah) described her health as good even though she smoked cigarettes. The women who rated their physical health as good were Alicia (39), Carmen (34), Ella (29), Hannah (29), and Louise (77). Louise told me that she had always been health conscious and considered



herself to be healthy now. Her doctor even expressed to her that he wished “all my patients would be as conscious as you are” (p. 41, lines 24-26). Hannah stated that her health was “pretty good... I mean, I haven’t been sick in a long time” (p. 12, lines 14-17).

Although some women had some chronic health problems, many rated their health as the best it has ever been. Gabby said (p. 8, line 22-23), “Um, physically this is also the best I’ve been in a very long time. Um, I’ve lost 110 pounds in the last 13 months.” Arrica said, “Uh, the physical health is coming along—it’s coming along... I haven’t had any issues with my auto-immune...all the medications I am on for my thyroid and all that—it’s all regulated now, which, they couldn’t regulate anything forever” (p. 26-27, lines 30-7).

**Barriers to positive physical health.** Several of the participants discussed barriers to positive physical health. The most common theme was the sometimes inverse relationship between alleviating emotional pain and positive physical health outcomes. Some women found that strategies to improve their mental health led to poor physical health outcomes and behaviors. Other themes discussed by the women were lack of time, their own behaviors (or lack thereof), and attempts to be safe.

***Lack of physical or mental safety.*** Several women discussed the experience of feeling physically or mentally unsafe after their sexual assault. A lack of physical safety was expressed as actual or perceived danger of being sexually assaulted, of physical discomfort, or of unwanted touching. A lack of mental safety was expressed as experiencing negative emotions, including depression, overwhelming anger, and/or fear. Dinah gained weight in order to make herself feel safer, less vulnerable to sexual harassment and assault. When I asked about her physical health, she replied (p. 8, lines

8-15), “I’m not interested in making myself look attractive. I’ve gained a lot of weight. So I’m not so sexy anymore.... I feel safer now.” When asked if she thought that the decline in physical health status was worth the trade-off to feel safer, she replied, “I do.”

Three women talked about drinking alcohol excessively, in part to “numb” their extreme emotional symptoms. Hannah experienced incapacitating fear that interfered with her ability to do daily activities like shopping or performing at her job. Alcohol helped her feel safe enough to function. Alcohol helped her to feel safe around men “I didn’t—at first, I didn’t want to be near a man, and then I guess with drinking and—it helped me feel more comfortable—I guess they say it gives you bravery” (p. 10, lines 5-6). Alcohol enabled her to feel safe while shopping and performing her job:

I came back to work. I was working at (a store) at the time as a cashier. And, I thought I was ready, but the way that the registers were set up, like if it was busy, there’d be people in front of you, behind you, just everywhere, and I couldn’t be enclosed. I didn’t want people around me like that. Or just walking in a store, and this strange man was walking behind me and I’d have to walk faster. I still do that, ‘cause I can’t—or I don’t like strange men standing over me or next to me. Um, I still can’t handle that. I’ll walk faster in the store or I’ll just leave, or it was—it was really bad at a point when I was working there—I had panic attacks and stuff. I couldn’t—I mean that was another reason I drank a lot, because I got panic attacks over every little thing.... I did work at (store) third shift, a couple of years ago, and I would take a couple of shots before I went in to work or, I called in ‘cause I was drunk already. (p. 9, lines 15-31)

Although none of the women who abused alcohol to help them feel safe experienced any negative physical health outcomes, alcohol abuse does increase the risk of physical harms such as liver disease, alcohol-related brain disease, and motor vehicle accidents (Morris, Johnson, & Morrison, 2012; Callaghan et al., 2013; Sutherland, Sheedy, Sheahan, Kaplan, & Kril, 2014). Hannah did crash her car when she was driving under the influence, but she was unhurt: “I did end up totaling my car into a telephone

pole ‘cause I was drunk... I didn’t get in trouble for it, ‘cause I walked away from it” (p. 7, lines 21-25).

Three participants decreased formal care seeking because they felt emotionally and physically vulnerable. Adrian put off her gynecological exams because they reminded her of feeling vulnerable and exposed during her medical-forensic exams. Helen avoided dentists because they triggered memories of childhood abuse.

Men would trigger sexual—like when I was—I would—I had been known to just, like, start bawling in the dentist chair, and at first, I didn’t even know why. I thought it was I was afraid of whatever was going on. Like I had a double fear or whatever, but then, one time, he had me on gas and I was laying there, and I heard my grandfather’s voice in my ear: “Open your mouth wider. I know you can,” and all of a sudden I started bawling and then I knew what was going on, and then one of the next times I was at the dentist, um, and there was a piece of cotton wad in my mouth, I—I flashed back to when, um, like a blanket or a sheet or something had been stuffed into my mouth to keep me quiet... I didn’t know all those years. I mean, I’ve neglected my teeth for years ‘cause I had so much fear. I wouldn’t even be able to go to work the next day. (p. 24, lines 8-31)

Although Helen did experience poor dental health because of her lack of care seeking, the harms associated with the decreased care seeking of the other participants is unknown.

#### **Facilitators of positive physical health.**

***Diet, exercise, and meditation.*** When the participants were asked about what they did to keep themselves healthy, they discussed behaviors they did on their own in addition to seeking assistance from healthcare professionals. Seven participants (Alicia, Ella, Carmen, Adrian, Patrice, Gabby, Anita, Laura, and Louise) named exercise and or eating well as a key to their good physical health. Alicia, 39, stated, “I’m big on eating healthy and exercising a lot... so I work out every day. And I meditate” (p. 25, lines 29-31).

**Formal health care.** Seeking formal healthcare was a common strategy of the participants to maintain their health. Twelve women sought formal health care with the idea that doing so would help improve their physical health. Louise saw her chiropractor regularly. Carmen met her physician in the period immediately after her sexual assault. Carmen's physician helped her with both physical and psychological needs. She tested her for sexually transmitted infections, referred her to the Sexual Assault Services of Battle Creek, and began medicating her for PTSD. She spoke of the help the physician gave her, pointing out how spiritual, physical, and mental health all came together for her:

So, I made an appointment with the doctor, and um, you know, it's really like God, basically. Because, she was asking me questions and, uh, I said, "You don't need to know, I just need to get STD testing."... And I guess she sensed, you know, something isn't right.... It was a good thing, because she referred me to here [Agency].

**Potential role of culture on physical health of participants.** There were no obvious or straightforward links between culture and physical health in this sample. Several women were delayed in acknowledging their unwanted sexual experience as sexual assault. This delay could have led to increased risk of certain sexually transmitted infections as well as to awareness of unintended pregnancies. For example, Carmen did not seek the care of a physician until about 1 week after the assault, too late to receive prophylaxis against pregnancy and sexually transmitted infections, which is available up to 120 hours after assault (United States Department of Justice, 2013; YWCA of Kalamazoo, 2015). She was delayed in acknowledging her sexual assault, expressing endorsement of the myth "If a girl doesn't physically fight back, you can't really say it

was rape” (Brownmiller, 1975; Chapleau et al., 2007; Edwards, 2011; McMahon & Farmer, 2011; Ryan, 2011). About not fighting, Carmen said, “And I struggled with that—why didn’t I fight? You know?.... And so I didn’t feel like I was raped, you know?” (p. 2, lines 13-15).

Luckily, Carmen did not become pregnant or infected with STIs, and her physician referred her to the local agency to help her heal emotionally after her sexual assault. Other participants demonstrated internalization of myths about sexual assault, but they were not the factors that prevented them from seeking timely healthcare specific to preventing harms of sexual assault. Patrice and Gabby became pregnant as a result of their sexual assaults, but both elected to continue their pregnancies. I discuss the role of culture more extensively in the mental and relational health sections.

**Safety.** Five participants told me that they specifically sought out female health care providers because they felt safer and more comfortable with them. Beth elaborated a bit more on her fear and avoidance of male health care providers (p. 41, lines 3-17):

I don’t have too much problem with a lady doctor, but when I have a man. I had a man doctor um, the last couple years I had a man doctor. And—and I had to go in there for a situation, and he had to look at my body. And Lord, I had—oh, man. It was hard. It was hard... I left there and my whole body felt like, whoo, I can’t even describe the feeling. It’s—it was horrible. And—and I’m like okay, I can’t keep doing this, you know. But that’s the first and last time I ever let him touch me.

The preference that female assault victims/survivors have for female health care providers has been reported by other researchers (Ahmad, Gupta, Rawlins, & Stewart, 2002; Janssen & Lagro-Janssen, 2012; Sacks, 2013). These researchers did not assess or report separately for sexual assault victims/survivors. In the systemic review of gender

preferences for gynecologists/obstetricians conducted by Jannssen and Lagro-Janssen (2012), the authors concluded that although women prefer to have females provide their OB/GYN care, that may actually have more to do with a patient-centered style of communication employed more frequently by female providers.

### **Interaction between physical health and other domains.**

#### ***Emotional and physical health.***

*Negative emotional and physical health.* Several women (n=5) found that negative emotions had a negative influence on their physical health. Anita found that her anxiety has a negative impact on her physical health symptoms:

Like I have incredibly bad like heartburn and like GERD. And I think that the anxiety plays a huge role in that. It always gets worse when I'm feeling anxious. I struggle with insomnia, um, mostly again, because of anxiety. (p. 31, lines 47-51)

*Self-soothing behaviors.* Three women told me about how their actions (or lack thereof) helped them feel better emotionally, but resulted in actual or potential physical health outcomes. These behaviors were eating excessively (n=2) and avoiding necessary medications (n=1). Two women told me that they had eaten excessively to help them with their negative emotions: depression, anger, and loss of control. Gabby found that eating helped her with her sadness and loss of control. She explained:

I was unhappy. And, I think it's the only thing I had control over.... I just was exhausted all of the time. ... I would put the kids to bed, and then my husband would go to bed, and I would order a pizza and have them bring it. And I would eat the whole thing. Not necessarily a large, but a whole pizza. And I would do that almost 3-4 times a week. I think it was just a comforting thing. (p. 18, lines 15-23)

Beth, who had several chronic health problems, detailed in the section under poor health, disclosed that she did not take her medication as prescribed. Beth explained that by not taking her medications, she was increasing her risk of dying, which would result in the end of her emotional pain.

I stopped taking the medicine. My doctor wasn't happy with that, but... I just have the attitude we all got to die someday... And sometimes, I just don't care about my health. I just like okay, if I get sick and die, I'm fine... You um, and um, but it just, to me, it just seems like people that's dead, they ain't got to suffer no more. They, you know, all the hurt and pain is gone. You know? I ain't got to worry no more. (pp. 31-32, lines 16-11)

*Positive emotional and physical health.* Seven women told me that exercise, in various forms, was helpful to their mental health and physical health. Two women, Anita and Helen, talked specifically about how yoga helped them. Helen observed that yoga, “when I do it regularly, it really lowers my stress level” (p. 49, lines 44-45). Patrice participated in all kinds of exercise to help her mental and physical health: “I exercise a lot. I take the stairs rather than the elevator and I, I walk whenever I can... I dance. That's my therapy” (p. 51, lines 23-27). Michelle reported that hitting the gym was helpful for her mental health in general. She told me that she planned on going to the gym after our interview: “I most definitely going to the gym today because you got me all emotional distraught... But it's a good thing you know?” (p. 34, lines 10-15).

#### **Relational and physical health.**

*Negative relational and physical health.* Negative relational health contributed to worsening physical health. The participants who were married to their assailants experienced injuries from the physical assaults. These injuries ranged from bruises to injuries severe enough to require health care. These abusive relationships also indirectly

harm the physical health of Arrica and Gabby when they were prevented from seeking healthcare by their husbands. Gabby also noted that the cycle of poor physical health and depression negatively affected her relationship with her son:

I was really depressed. I found it hard to do a few things when I gained some weight. And, I was sick a lot. Like, uh, I had the TMJ, with my jaw. And then I had mono and then I had, you know, Epstein-Barr, and then I had migraine headaches. And like I said, I fell off the lawnmower tractor. And then I fell through the steps, and then we had a car accident. What else? ... About the time my son was a sophomore in high school, I found it very hard to, like to, make all of his ball games. Or all of his football games and I just didn't have the energy, you know? ... I was depressed, I was overweight. (p. 22, lines 17-28)

***Positive relational and physical health.*** Two women in the study, Gabby and Carmen, identified relationships as a positive influence on physical health. Carmen stated that her relationship with her (new) physician helped ensure her physical and mental health and even reinforced her spiritual health. Gabby spoke of three ways in which her relational health had a positive influence on her physical health. First, Gabby cited the success of ending an unhealthy and abusive relationship with her husband, which led to her healthy weight loss. When we talked, Gabby had lost 110 pounds through healthy diet and exercise. She explained how ending her relationship with her husband led to improved physical health:

I feel like I already in my heart and mind had already done this hardest thing by filing for divorce... I thought "Well, I can do this, maybe I can lose weight." (p. 14, lines 12-16)

Gabby also talked about how her relationship with her therapist and friends led to other positive health behaviors. Gabby said that her therapists encouraged her to seek formal health care for the first time in many years.



When I started coming to therapy around (date), one of the first questions that my counselor or therapists had asked was, “Well, when have you been to the doctor?” And, it had been a long time... So, then, she encouraged me to do that. (p. 16, lines 24-30)

Gabby elaborated upon how her relationship with her therapist encouraged her to maintain her physical health by seeking formal health care.

She encourages me to go. Usually, she asks something which is never really bad or out of the ordinary... You know, I know it's her job, but I also feel like she cares, and she wouldn't be encouraging me to go if they weren't good for me. (p. 17, lines 23-27)

Finally, Gabby's relationships with her daughter and friends had a positive impact on her physical health. She celebrated her weight loss successes with her friends and daughter, which helped keep her motivated. She described how she celebrated a weight loss success with her daughter: “I had lost 62 or 63 pounds. So, my daughter and I went zip lining in a cave” (p. 15, lines 10-11).

Kimmerling and Calhoun (1994) conducted a longitudinal assessment of the physical health symptoms and physician visits of sexual assault victims/survivors. Social support was a significant moderator in perception of physical health and healthcare visits 1 year after sexual assault ( $p < 0.001$ ). Participants with more social support perceived themselves to be more physically healthy ( $p = 0.02$ ) and sought care from health care providers significantly less ( $p < 0.0001$ ) than participants with less social support. No similar study has been conducted since 1994.

### **Career/educational/financial and physical health.**

*Negative career/educational/financial and physical health.* Two women described how their financial constraints interfered with their ability to achieve and

maintain optimum physical health. For each of these women, financial constraints interfered with her ability to seek formal health care. Patrice could not afford to take care of some of her dental problems because of financial constraints.

I can't always take care of my teeth though because I can't afford it... Right now I have a bleeding gum from a tooth problem and I just, they told me I need a specialist and Medicaid doesn't pay for that. (p. 51, lines 8-16)

***Positive career/educational/financial and physical health.*** Four women discussed ways in which their job or work environment enhanced their physical health. Carmen and Laura talked about how the physical nature of their jobs helped keep them physically healthy. Carmen noted, "I work out at work... Yeah. I walk a lot. I lift heavy stuff" (p. 14, lines 18-20). Gabby's job had a positive influence on her health by providing flexible enough lunch and break times to allow her to exercise at the workplace. She said, "I try to walk at work during lunch. I can take a little extra lunch. And, you're not supposed to, but I combine my 15-minute break with my lunch" (p. 15, lines 17-19).

**Spiritual and physical health.**

***Negative spiritual and physical health.*** As introduced in chapter 3, I considered spirituality and religion as overt expressions of spirituality (i.e., participants who said that they were Christians, Buddhists, etc.), as well as the implicit expressions and experiences (philosophy of life). Two women, Jo and Louise, were encouraged to stay in their physically, mentally, and sexually abusive marriages by spiritual leaders in their churches. Jo was told that leaving her husband was not an option because "the nuclear family is what God's design is. And marriage is the picture of Christ in the church" (p. 5,

lines 12-17). Jo had received a similar message from her church as a child. When her father was abusing her mother, she tried to get help from her minister but was not believed: “I went and told my pastor. And he was like no. He didn’t believe me” (p. 12, line 9-11). Louise was also encouraged to stay in her marriage despite the abuse. She felt that she should stay married because “I had promised God it was until death do us part” (p. 3, lines 22-23).

***Positive spiritual and physical health.*** Only one woman, Helen, identified a positive interaction between her spirituality and physical health. Earlier, Helen described how yoga helped reduce her chronic pain. Yoga is a part of her Buddhist faith.

**Relative importance of physical health in overall wellbeing.** Several participants said directly or implied that although their physical health was important to their overall wellbeing, it was not as important as safety, emotional, or relational health. In terms of safety, women thoughtfully weighed the consequences of being overweight, delaying or not seeking formal health care, or taking medications that might cause negative side effects, and consistently chose to remain safe and/or without intrusive mental health symptoms. Kris emphasized her relational and mental health while dismissing her physical health:

I think it’s (mental health) probably like the best it’s ever but not physical it’s like horrible because I’m overweight and everything (p. 25, lines 12-14)... I think even like my marriage is better than it ever has been. Just appreciate things a lot more than I ever did. (p. 25, lines 47-49)

In contrast, Alicia maintained excellent physical health for years. She ran marathons and aced elite physical tests for the police academy, but she experienced severe, debilitating anxiety that negatively affected relationships.

[I'm] trying to like, meditate, and run a lot, and exercise a lot, and you know, I got into marathons, and running was like the only thing that kept my anxiety kind of in check. Um. And, it was bad. It was—my anxiety has ruined *a lot* of relationships over the years. Over the last 20 years... (p. 11, lines 16-20)

It was after her anxiety and relationships improved that Alicia found an improvement in her overall wellbeing (her life):

But in 2012, I think, yeah, 2012, my therapist convinced me to at least *try* medication. And I struggled with that—a lot. And my life is like completely different since I started that... But, completely different. Like hardly any anxiety at all. Like, I feel like a completely different person than I have in the last 20 years. (p. 11, lines 22-30)

There are many possible explanations for less emphasis on physical health. The Midwest, where this study was conducted, has a relatively high population of obese and overweight individuals compared to other areas of the country (Wang & Beydoun, 2007). It is possible that because being overweight is common, it is seen as a more negative indicator of physical health in some geographical regions than others. The sexual assaults and the gendered violence may have also had a role in the participants' dissociation from their own bodies, as they have had their "bodies narrowly and negatively used against them" (Moe, 2014, p. 332).

**Summary of physical health domain.** Almost half of the participants in this study experienced negative physical health effects after their sexual assault. Half of these negative impacts were short term (n=5); the other half were long-term effects. The long-term effects, such as GERD, hypertension, and metabolic disturbances, have been reported by other researchers. Some women were reluctant to connect their physical health, like autoimmune disorders, to their history of intimate partner and sexual

violence. Although the underlying mechanisms of these physical health harms are not known, the participants provided some insight into the connection between sexual assault and negative physical health outcomes and behaviors. For example, several women were more reluctant to seek formal health care after their assault. In addition, several participants found that their physical health was strongly influenced by the other wellbeing domains of emotional, relational, career/educational/financial (c/e/f) health, and spiritual health. In addition, the perception of safety had a strong influence on women's physical health.

Negative mental health and symptoms exacerbated the participants' physical health symptoms. The converse was also true—many women found that exercise was beneficial to their emotional and mental health. Negative relational health and poor physical health functioned bi-directionally. Women in negative relationships were more likely to practice habits that were harmful to their physical health, which increased fatigue and decreased the ability to relate to others. Positive relational health facilitated positive physical health behaviors and outcomes like weight loss and exercise. Negative physical health had a negative impact on women's ability to work effectively and maintain their jobs. Positive physical health enabled women to work more effectively. Some work environments facilitated women's physical health by virtue of being a physically oriented job (e.g., wallpapering, factory work) or offering flexible hours in which they could exercise. Two women experienced negative physical health outcomes, in the form of injuries, when they were encouraged to remain in abusive marriages by their religious leaders. One woman found that her spiritual practice of yoga enhanced her physical health. When women did not feel mentally or physically safe, they were less

likely to engage in positive physical health behaviors, such as seeking out formal health care and maintaining a (medically) ideal body weight. Conversely, when the participants felt safe, they were more likely to engage in positive health behaviors, such as maintaining a healthy body weight and seeking formal health care.

Although the participants confirmed that physical health was integral to their overall wellbeing, they appeared to prioritize physical health less than other domains, such as emotional or relational health. In addition, they prioritized feeling safe over theoretical or actual physical health benefits.

## **Domain 2: Mental Health**

Just as it is difficult to untangle the multiple and complex etiologies of physical symptoms and illness, it is also difficult to do so for mental health symptoms and illness. Mental health does not have a unidirectional relationship with sexual assault but is more complex. Although sexual assault can significantly increase the risk of negative mental health symptoms or diagnosis (Campbell et al., 2008; Kimmerling et al., 2010; Street et al., 2008), other mental health symptoms and disorders make women more vulnerable to sexual assault (Katsikidou et al., 2013; Khalifeh et al., 2015). Moreover, some of the women had mental health diagnoses before they were sexually assaulted. Some of the women were diagnosed with mental health disorders after the sexual assault, but these disorders might have existed prior to the (most recent in some cases) sexual assault. All of the women in the study, however, claimed that their sexual assaults had a negative impact on their mental health.

Eight of the women had been diagnosed with a mental health disorder, necessitating treatment with talk therapy and/or medication. Seven of the women had

been diagnosed with depression, six with PTSD, five with an anxiety disorder, two with bipolar disorder, two with alcoholism, and one with schizophrenia. Some women had co-morbidities, such as PTSD and depression. Although all of the women felt that the sexual assault(s) negatively affected their mental health, most of the women (n=14) did not have mental health diagnoses. Women without diagnoses felt negative emotions such as anger, shame, fear, and feeling weird or different. Other women disclosed abusing alcohol to cope with the emotional pain of the sexual assault(s). In the following sections, I discuss the relationships between sexual assault and the diagnoses. I also discuss the ways in which the diagnoses affected the lives of the participants. I follow this with a discussion of the negative impact of sexual assault on the emotions and behaviors of the participants (with and without a diagnosis). I conclude this section with facilitators and barriers to positive mental health outcomes and behavior.

### **Mental health disorders.**

*Depression.* As none of the seven women who had a diagnosis of depression were newly diagnosed immediately after their sexual assault(s), it is difficult to uncover from the data a relationship between the two issues. However, it is possible to note the co-occurrence of depression and sexual assault; more than half (four out of seven) of the women grew up in homes where they were physically, sexually, and/or emotionally abused or neglected. Three women had been physically, emotionally and sexually abused by their husbands for at least 15 years (M=19) as well. Sophie, who did not grow up in an abusive home, did have long-term relationships with several men who abused her physically. On an exceptionally cold day after record levels of snowfall, she used the analogy of snow to illustrate the impact of rape on her depression:

Well of course it (the sexual assault) added another layer okay? It didn't just affect it, it added another—I felt like it added a total—it's like having snow and then all of a sudden getting another 6 to 7 inches. All of a sudden you've buried what you've done you know that's still covered—that's covered in again 'cause you're starting to mine it you're starting to get through it, you're shoveling out and then all of a sudden, boom! You get hit with snow again. (p. 8, lines 14-25)

Jo's husband started physically abusing her on her "wedding night" (p. 3, line 25), but did not sexually assault her until the end of the marriage. Jo remembered, "I think I went to counseling like 2 years after we were married 'cause I couldn't figure out why I was depressed" (p. 3, lines 32-34). As discussed in chapter two, a history of sexual assault is a strong predictor of depression (Kaukinen & DeMaris, 2009; Kaukinen & DeMaris, 2005; Kimerling et al., Lacey et al., 2013; Mendelson et al., 2010; Ramos et al., 2004; Street et al., 2010).

**PTSD.** Six women in this study had been diagnosed with PTSD. In addition, one participant (Patrice) felt that she should have been diagnosed with it, but had not. Five out of these six women had experienced multiple traumas, such as childhood sexual abuse, in addition to adult sexual assault, child abuse, and/or intimate partner violence. Sarah, the only participant who did not experience other traumas, remembered the acute onset of her PTSD symptoms. When I asked her whether the PTSD was a result of her sexual assault, she replied:

Yeah, it started shortly after uh, probably within like two weeks, that's why I started going to the counselor and the psychiatrist... Cause I was like hearing voices and I was still living with my roommate and I would call her at work and say like "Someone's in the house—you need to call the police," and I just like stayed in my room all day. (p. 5, lines 10-16)



Sexual assault is a significant risk factor for development of PTSD (Campbell et al., 2008; McFarlane et al., 2005; Temple et al, 2007). One of the more intrusive and bothersome symptoms of PTSD was the hallucinations (auditory and visual) that two of the women identified. Sarah described these hallucinations in the quotation above.

Adrian also experienced these frightening hallucinations.

Though the hallucinations were frightening to Adrian and Sarah, they labeled these experiences as symptoms of their PTSD. Louise, who was also diagnosed with PTSD, also heard a voice that could not be heard by any others. However, to Louise, this was not a symptom of her PTSD, nor was it frightening. To Louise, this was the voice of her higher power, encouraging her to leave her abusive husband.

He said that I had suffered enough, and I thought, “Where did that come from?” and that I was still in his way of dealing with Gary. Which I knew was scripture—that’s Proverbs 19:19. If you rescue an angry man, He’ll just have to do it again. (pp. 30-31, lines 38-9)

*Anxiety.* Just as it was difficult to pinpoint the etiology of depression, it was also difficult to identify the source of anxiety for the participants. Of the five women who were diagnosed with an anxiety disorder, three were also diagnosed with depression. Three out of the five women had also grown up in abusive homes; one (Jo) had been married to her abuser for 15 years. Although Alicia made a temporal connection between her first sexual assault at age 18 and anxiety symptoms she experienced 2 years later, saying, “Well, my anxiety started in 1995. The assault was in ’93—the first one. And the second one was in ’95” (p. 12, lines 1-2), she also suggested there could be many other factors at play in her anxiety:

Like who knows! So, it's hard to say—is it a result of this, is it a result of this, is it a result of the entire frickin' thing? Like I was robbed by gunpoint at 14—at a dry cleaner's where I worked at. Locked in a bathroom. Yeah! Which I thought was fun at the time, that did not feel traumatizing at all, but like, knowing what I know now. (p. 25, lines 10-16)

Anita did connect her anxiety to the shame she experienced after sexual assault.

The anxiety is really the main piece that I think—the shame plays into that... I think it really creates a lot of anxiety for me about am I making the right decisions? Is this what I'm supposed to be doing? Am I a bad person? ...Or that every decision I make is going to kind of blow up in my face or something bad is going to happen. (p. 22, lines 29-45)

*Alcohol abuse.* Although two women were diagnosed with alcoholism (Hannah and Helen), I will discuss the use of alcohol by four women. I will discuss them together, because each of these women spoke of the negative impact that alcohol use had on her life and/or health. Hannah and Melanie abused alcohol in the first few years after the sexual assault, resulting in damage to other domains of their lives. Hannah experienced many losses as a result of her alcohol abuse

I ended up dropping out. My friend—I ended up giving her custody of my kids for a while, um, cause then I lost my job. And, I lost my apartment. Then, I moved to Otsego with my mom, where I couldn't find a job, cause there weren't any there... It was rough.... Then I just drank more.

Hannah explained that she started drinking excessively after her sexual assault. She remembered, “I couldn't talk to anybody. And, there really wasn't anybody that I had to talk to about it [sexual assault]. And, I ended up drinking a lot” (p. 6, lines 24-26). Drinking helped Hannah cope with her overwhelming fear, anxiety, and panic attacks she experienced in a variety of situations that made her feel vulnerable—like being enclosed and near “strange” men.

Melanie and Helen found drinking helpful in coping with their emotional pain. Melanie, looking back at the year after her assault stated, “I was numbing it all out. Lots of drinking. Lots of drinking. Not thinking about why I was drinking. Looking back now, I think that makes sense.” I will discuss the negative impact of drinking on Melanie’s academic performance in the career/financial health section.

Helen, who abused alcohol for the majority of her life (she started when she was 15 and became sober when she was 43) also drank to anesthetize her pain. “You know, I’d pour it (alcohol) down my throat as fast as I could, you know, just try and numb everything.” Like Hannah and Melanie, Helen’s abuse of alcohol was associated with many losses. One of the biggest losses was a loss of quality time with her husband: “I wasted 5 years of our marriage” (p. 19, line 46).

Although Dinah did not indicate that she abused alcohol, she did hint that it might be a health problem, saying, “I know you’re not gonna like this answer, cause I know my doctor didn’t like this answer—alcohol is wonderful” (p. 13, lines 23-24). She drank alcohol, she said, for the same reason that the other women consumed it: because “alcohol shuts down my brain. Alcohol makes me go off to bed and I can wander in a dream world. Nothing happens” (p. 13, lines 26-27). Substance abuse and sexual assault are strongly correlated (Kaukinen & DeMaris, 2009; Kaukinen & DeMaris, 2009; Kimmerling et al., 2010). Consistent with the patterns of drinking displayed by Hannah and Melanie, Kaukinen and DeMaris (2009) reported that the risk of alcohol abuse was highest in the first 2 years after sexual assault.

***Bipolar disorder.*** Two participants, Adrian and Patrice, had been diagnosed with bipolar disorder. Neither of them mention sexual assault as a causative or exacerbating

factor in their illness. Regrettably, I neglected to ask them. Adrian and Patrice had both been hospitalized for exacerbations in their bipolar disorder, and both had attempted suicide. Adrian managed her bipolar disorder with individual and group therapy along with the occasional hospitalization.

I was hospitalized once earlier this year. All of the hospitalizations have pretty much been—I've never been forced by the courts or anything—I mean, they've always been, you know, my therapist and I or I ask or, it's been a result of a suicide attempt or something like that. (p. 15, lines 11-15)

Adrian could not take medications for her bipolar disorder because she had “paradoxical reactions to all of the medications” (p. 15, line 4).

As I discuss below, Patrice did not agree with her bipolar diagnoses. She thought that it was PTSD. Whatever the diagnosis, Patrice's mental health has interfered with her life in many ways. As discussed earlier, Patrice had to be hospitalized to stabilize her mood and sleeping pattern. She told me that the breakup of relationships with men are the biggest exacerbating factor for her depressive state, which she referred to at one point as making her feel as if she is “deep in the gutter emotionally” (p. 36, line 33). She blamed her deep depressive states on her inability to have steady employment, citing “my mood disorder because, um, I lose jobs in 2 months. I can't keep a job” (p. 30, lines 14-15).

***Disagreement with diagnoses.*** A small minority of women (n=3) disagreed with their mental health diagnoses. Patrice, who was officially diagnosed with bipolar disorder, diagnosed herself with PTSD, saying, “Well, its depression or they think I'm bipolar but I think it's PTSD....PTSD from all the stresses I've dealt with of starting-

overs and the men” (p. 32, lines 24-29). Beth, who was diagnosed with schizophrenia and depression, also doubted her schizophrenia diagnoses, stating,

I always felt like I’m not schizophrenic, ‘cause my brother is schizophrenic.... I’m like, I’m nothing like my brother. You know, I had problems seeing things, hearing things, you know. But I didn’t feel I was schizophrenic (p. 16, lines 3-11).

Beth told me that her therapist also cast doubt on this diagnosis.

And so I talked to a counselor here, so we—lately, me and her been talking about it a lot. And she’s like, “I really don’t think you’re schizophrenic. Depression, yeah. But schizophrenic, no” (p. 16, lines 17-21).

As a child, Dinah was diagnosed with perceptual disorder, emotional disturbance, and a learning disorder. She also disagreed with these diagnoses; instead, she diagnosed herself with Asperger’s Disorder.

I didn’t discover that I had Asperger’s until I was in my twenties, or thirties rather. I am self-diagnosed because I haven’t got the money to get a formal diagnosis. And, I don’t know if it would do me any good, or if it would do me even more harm. (p. 7, lines 14-24)

**Mental illness and increased vulnerability to assault.** Dinah, who, as discussed above, self-diagnosed herself with Asperger’s Disorder, suggested that this disorder, in addition to the formal diagnosis of perceptual disorder she received as a child, made her more vulnerable to sexual assault. As a child, Dinah was told that perceptual disorder meant “the way you see life, the way that you experience life, is not really how it is” (p. 7, lines 3-4). She explained why this diagnosis was harmful to her self-esteem and potentially dangerous.

It’s a very good recipe if you ever want to brainwash a child and have it submit, and destroy their self-confidence.... I got that message—that you can’t trust who

you are—because the way you see life is wrong. And, so it's very hard for you to stand up when things are happening because they're not happening. (p. 7, lines 4-10).

Dinah also feels that Asperger's Syndrome, which she has self-diagnosed, makes her more vulnerable to sexual assault and harassment as an adult. She explained:

“Asperger's people tend to send off waves that people who are predatory would pick up on” (p. 6, lines 31-33). Researchers have reported that individuals with serious mental illness (characterized as illnesses that cause severe functional impairment) are significantly more likely to be sexually assaulted (Katsikidou et al., 2013; Khalifeh et al., 2015). However, researchers have not reported a higher risk for individuals with less severe mental illness.

*Negative effect on mental health without a diagnoses.* The majority (n=14) of the participants did not have a mental health diagnosis. Only one of these women, Laura, did not name negative emotions that she continued to feel, even years after the assault. Laura, who was 62 at the time of the interview, and who had “forgotten” her sexual assault for more than 20 years and was trained as a therapist, stated:

I tell people about it all of the time, that things have an effect on you, whether you remember them or not. So, I guess if I tell them that, I should apply it to myself, right? (p. 10, lines 19-22)

Laura recognized her own cognitive dissonance, but still did not name a feeling or emotion when I asked about any mental health impacts of the sexual assault. She denied any impact, but still questions herself on this: “But I don't really know what it does when it goes percolating around in there when you're not aware of it” (p. 10, lines 18-19).

Like Laura, the other women used negative words to describe their emotions—immediately after the assault as well as long after. The most common descriptions and symptoms that women used were *anger*, *shame*, and *fear*. Next, I discuss some of these common symptoms and emotions and women’s reactions to them.

**Anger.** Fifteen of the participants discussed feeling anger after the sexual assault. For some of the women, anger was intermittent. The prosecuting attorney “pissed me off because she told me she would call me and talk to me” (Melanie, p. 26, lines 26-29).

Although this anger was short lived for some, it could be extremely intense.

Melanie, 29, described her struggles:

Um, I’m probably angrier than I should ever be.... Like, my blood pressure will rise, like instantly, like smash through the roof, like very fight or flighty, and almost always goes into fight... And, I have to like, struggle, to like, keep it back. (p. 19, lines 8-18)

Although most of the women who struggled with anger (n=10) cited their assailant as their primary target of anger, five of the women discussed anger aimed at themselves or at others because of the way that they responded to their assault. Laura, who had forgotten her assault for more than 40 years, expected a kind response when she told her husband about her sexual assault as a college student; instead he joked about it. After 7 years, Laura stated, “I still feel mad at him about it” (p. 8, lines 26-27). Gabby was mostly mad at herself. Beth was mad at her mother for failing to protect her and not believing her. Although Michelle was mad at her assailant and everyone who treated her poorly after her sexual assault (more than 20 years previous) was disclosed, she was focusing on her most recent supervisor in the military in the following passage

I fill this out and—and it’s like you know, “Would you kill someone?” “Hell yeah, my First Sergeant.” “Would you?” “I would.” Then I would just say exactly what I would do to him. Not to mention, you know, I’ve seen dead bodies in trash bags... So trust me, I wish it could’ve been him.... Yeah, but I still could’ve killed his ass. I’m telling you... (pp. 25-26, lines 47-22)

Michelle was surprised to find that the person conducting the health assessment did not think that this was a normal response. She was mandated into counseling at this point. Dinah, who experienced numerous sexual assaults and sexual harassment, said, “It’s made me angry. It’s made me angry toward myself. It’s made me angry toward men” (p. 10, lines 22-24). Jo, who experienced emotional, physical, and sexual abuse from her husband, stated, “I’m a very angry person sometimes, but that’s been my survival tool” (p. 28, lines 48-49). Just as Jo saw anger as both a negative emotion and a survival strategy, other participants found anger to be useful.

Six of the women found that anger was helpful to them. Michelle’s angry (and honest) outburst about her First Sergeant also had good but unintended consequences. During her mandatory counseling, her therapist recommended that she attend a new onsite intensive program at Walter Reed. Michelle stated:

As painful as it was for me to open myself up and to discuss stuff with pure strangers, it was also something that let me realize I wasn’t alone. And then you know, to have those girls to just reach out to after I left. And—and you know, it was just like a, a, a good relationship that you know, I built with—with a lot of them so um. I don’t know, it was, it was bad at first but when I look at it, it, it helped me realize I wasn’t by myself. And then I had people I can reach out and talk to that I had opened up my darkest. I mean there was things I’ve never repeated outside of that room. (p. 12, lines 14-29)

Mimi’s anger at what she perceived as dismissive behavior by the prosecuting attorney initially made her question her future as an attorney. However, she re-focused her goal



and said, “Now I think that I want to go in and I want to do women’s rights” (p. 11, lines 31-32). Jenny too put some of her anger to use. She started a Facebook page devoted to the topic. She tried to help others be aware of the effects of sexual assault and the harm of rape myths, or as she put it, “really shitty things, you know—all those stereotypical things that people would say” (p. 40, lines 47-48). Some of these actions resulted in her feeling empowered: “I just feel more empowered than I did before my rape” (p. 17, lines 43-45). Other researchers have also described anger as a common response after sexual assault (Feeny, Zoellner, & Foa, 2000).

***Shame or guilt.*** Many women (n=14) mentioned a sense of shame or guilt, even years after the assault. Some women can recall the sense of shame they felt after the assault, but do not continue to feel it. For other women, shame continues to play a role in their lives. Though most of the women discussed shame as pertaining to the assault itself, some women felt shame after disclosing the assault to another. For example, Ella felt ashamed when she sensed that her mom was embarrassed by her disclosure of abuse when she was a teen.

I remember we were in a Wendy’s and I just kind of, like, started to blurt it out at the table. And I don’t even remember what I said. And she looked at me, and took me into the bathroom away from the guy. And I kind of felt shameful then... Like that she didn’t want me to, like, embarrass her in front of the guy (p.22, lines 4-16).

Several women felt guilt for what they perceived as their role in the assault. Some of the women, like Melanie and Carmen, questioned their behavior. Melanie told me that she felt “weird... feel like I did something wrong” because she had previously tolerated questionable behavior from her assailants before the assault. She said that she

“put up with them being a little creepy” because she liked the “fact that they were paying attention to me” (p. 13, lines 25-26). Others, like Carmen, felt ashamed because they had been intoxicated and did not fight off the assailant: I felt like I was to blame... Because I didn’t fight. ‘Cause maybe if I hadn’t drank so much, or allowed my cup to be around the wrong people...” (p. 3, lines 3-7). Four of the women discussed feeling as if there was something different about them that attracted sexual assaults. Earlier in this chapter, I discussed Dinah feelings that her Asperger’s Syndrome made her a target for sexual assailants. The remaining three women felt that they had done something wrong to invite this unwanted attention. Alicia, who was first sexually assaulted as an 18-year-old in the Army, wondered what made her sergeant pick her to sexually assault:

What, or how I behave maybe that draws that sort of attention? I think that I struggle mostly with—with the first. It was that, out of hundreds of girls, how I got picked for that. So, it brought a lot of—well—what I am portraying? What am I putting out there? (p. 8, lines 18-22)

Finally, Adrian discussed how her story was doubted by the police, in part because she had experienced sexual assault so many times. She also expressed how experiencing multiple assaults affected her difficulty in seeking help.

‘Cause it’s really hard to come forward with these things, especially when there have been multiple ones. You don’t think I had it in the back of my head that you know, “They’re not gonna believe me cause I’ve reported it before”? (p. 40, lines 10-12)

For Dinah and Adrian, working through the shame and guilt was a process. Dinah stated, “I’m still working through the anger and the guilt and the shame because I was brought up in a Catholic household where this didn’t happen to good Catholic girls” (p. 3, lines 9-11). After years of working with a therapist and participating in support groups

for sexual assault victims/survivors, Adrian said, “There still is some shame and guilt and stuff” (p. 7, line 33).

Anita, who used the word *shame* more than any other participant (14 different times) in the interview, discussed how the assaults she experienced affected her sense of shame in many different areas of her life, such as how she viewed herself, saying: “I don't think I realized how much shame I had and how that affected me. I think it definitely affected my self-worth and how I saw my body and how I saw myself” (p. 18, lines 20-24). She also acknowledged how shame interfered with physical intimacy with others, explaining, “I think that there is just a lot of shame and that when I am doing something physical with someone” (p. 22, lines 19-21). She connected her sense of shame with her difficulty in making decisions, noting, “I think the shame plays a huge part in that, of just not really trusting myself and not really knowing what is right or wrong” (p. 22, lines 45-47).

Shame is a common reaction and socially mediated response after sexual assault. The culture within which sexual assault occurs plays a significant role in the shame response of women, as women are held responsible for causing the assault or not doing enough to prevent it (Brownmiller, 1975; Chapleau et al., 2007; Edwards, 2011; McMahon & Farmer, 2011; Payne et al., 2011; Sheldon & Parent, 2012; Valenti, 2010). For example, Carmen and Melanie felt guilty because they had been drinking alcohol, which corresponds to the IRMA question #1, scale #1: “If a girl is raped while she is drunk, she is at least somewhat responsible for letting things get out of hand” (McMahon & Farmer, 2011; Payne et al., 2011). Although not fighting during a sexual assault is very common, and possibly an evolutionary response to predators (TeBockhorst,

O'Halloran, & Nyline, 2015), media and entertainment consistently portray “real” sexual assault victims/survivors as physically struggling (Easteal, Holland, & Judd, 2015; Bufkin & Eschholz, 2000; Valenti, 2010). The IRMA subscale #3, “It wasn’t really rape,” and item #14 within it, “If a girl doesn’t physically fight back, you can’t really say it was rape” (McMahon & Farmer, 2011; Payne et al., 2011) correspond to this belief, and the resulting shame. The idea that four women expressed—that they must be doing something wrong to attract the sexual assault and harassment—corresponds to IRMA subscale #1: “She asked for it” (McMahon & Farmer, 2011; Payne et al., 2011), although there are no items that correspond to women as attracting assault by some undetectable (to them) characteristic.

Stereotypical images of sexual assault are commonly reinforced in the popular media (Bullock; 2007; 2013; Franiuk et al., 2008; Valenti, 2010) and entertainment industries (Bufkin & Eschholz, 2000). Sarah commented on the insidious and popular messages about sexual assault, saying:

I think that they like blame the victim a lot kind of thing. I’ve been watching all the news with like the Cosby show and stuff, and they’ll just be like “Another allegation has been made,” and it’s like no one would be like would say this to get attention, you know? ... Society just doesn’t really understand. And, I think that there needs to be more awareness of it. You know? ‘Cause, you know, you never blame people with breast cancer for having breast cancer or people that were murdered for being murdered. But, you blame people who were raped for being raped. (p. 18-19, lines 25-5)

***Fear.*** Ten women discussed living with daily intrusive fear. For most of the women (n=7), this fear persisted long term. I had discussed Hannah’s and Adrian’s fear in the earlier sections on alcohol abuse and PTSD. Other participants’ stories are outlined below. For some of the participants, like Alicia and Dinah, the fear is

generalized. Dinah reported, “For a while, I was sleeping with a lead pipe under my pillow” (p. 21, lines 9-10).

Other women, like Carmen, Beth, and Sarah, connected their fear to their assault. They were all particularly fearful of the dark. Beth related her fear about the dark: saying, “I have a problem with darkness, you know. I don’t like bein’ out too late at night... I gotta be somewhere, a lighted area ‘cause, so I can see what’s around me” (p. 11, line 22-29). She connected this fear to being repeatedly sexually assaulted in the dark: “My brother always would jump out at me... My boyfriend that I had problems with, he would jump out at me at night. He’d get behind a tree and jump out at me” (p. 18, lines 31-38).

***Disordered eating.*** Four women spoke of varying degrees of disordered eating patterns. Earlier, in the physical/mental health interaction section, I discussed how two women found that excessive eating helped to soothe their depression and anxiety. In addition, two other women discussed disordered eating/exercise patterns that never received official diagnosis or treatment. Anita experienced both sides of disordered eating – being both underweight and overweight at different points during her adolescence: “I was severely anorexic for a while, also like 14 or 15. Um, I was also extremely overweight for a while. So I kind of like, I...have a, you know, disordered eating for sure” (p. 46, lines 42-48). Gabby disclosed disordered eating/exercise:

I was potentially too healthy an eater. By healthy, I mean I was eating – not – I was still technically eating the number of calories I needed to, but I was working out too much. It was borderline exercise bulimia (p. 30, lines 23-26).

This disordered eating is consistent with extant research. Researchers have reported that women who have experienced ASA and adolescent SA are significantly more likely to practice disordered eating like binge eating, forced vomiting, and taking diet pills compared to non-sexual assault victims/survivors (Ackard & Neumark-Sztainer, 2002). In addition, ASA victims/survivors are significantly more likely than women who have experienced other traumas (like physical assault or robbery) ( $p < 0.001$ ) to practice disordered eating behaviors (Carlo, Alice, Stefano, & Valdo, 2004).

***Coexistence of mental health disorders and positive wellbeing.*** Several participants emphasized that despite their mental illness/symptoms, they were able to experience wellbeing. Although Gabby was diagnosed with depression and continued to take medication and participate in counseling, she said, “Mentally, I think this has probably been the best I’ve been in a long time.... physically this is also the best I’ve been in a very long time” (p. 8, line 19-22). Anita, who was diagnosed with depression, anxiety, and PTSD, also exemplified this idea by telling me that despite these diagnoses, she had positive overall wellbeing. She explained, “I’m very functional... I maintain relationships, I have a job... I’m very content and happy currently in my life... but I do wish that I didn’t struggle with some of those things” (p. 33, lines 16-27).

**Barriers to positive mental health.** The participants discussed a variety of barriers to their mental health. Long-term or multiple forms of abuse served as barriers to positive mental health. A real or perceived lack of safety also precluded positive mental health.

***Multiple forms of abuse.*** Eighteen out of the 22 participants in this study experienced multiple forms of abuse, such as childhood sexual abuse ( $n=9$ ), intimate

partner violence (n=9), and sexual harassment (n=2). In addition, seven women experienced adult sexual assault more than once (three of these women were assaulted by different assailants; four women were assaulted by their partners more than once). The participants found that the multiple types of abuse caused cumulative damage to their mental health. Next, I discuss different types of abuse and how they affected the participant.

*Childhood sexual abuse.* Women who experienced childhood sexual assault in addition to their adult sexual assault experienced cumulative negative mental health impacts. Carmen, who was sexually assaulted as an adult by her ex-boyfriend, sought counseling for the adult sexual assault and was diagnosed with chronic PTSD, as her adult assault “brought up a lot of other things as well,” such as the childhood sexual abuse perpetrated by her cousin (p. 6, lines 6-7). According to Helen and Arrica, experiencing childhood sexual abuse made them feel that they somehow deserved it. When Helen was sexually assaulted by her boyfriend at knifepoint, she never sought help, never told anyone about it, because “I felt like it was my fault, you know...and I didn’t feel worthy to even, you know” (p., 2, line 36-49). Arrica experienced such severe emotional, physical, and emotional sexual abuse as a child that she found the sexual, physical, and emotional abuse by her husband normal, or even an improvement. She told me, “You have to know where—he’s actually a blessing in disguise because even though I went through all this hell, it took me away from my family” (p. 14-15, lines 32-2).

*Intimate partner violence.* Four participants spoke of how intimate partner violence negatively affected their mental health. Jo felt guilty and worried about what would happen to her children if she divorced her husband:

What would happen to the kids if I'm not here? You know, if I'm not here, I can't protect them. I hardly went anywhere for a long time because I didn't want to leave him alone with my kids...And it's just—I think every woman does what she thinks she needs to do, and you feel guilty either way. (p. 24, lines 17-29).

Beth and Arrica both emphasized that they were hurt by all of the intimate partner violence, not just the sexual assaults. Arrica said, "It's not just. It's not just (sighs)—looking back on it, it's not just sexual—it's everything" (p. 21, lines 22-23). Though Beth admitted that all of the sexual assaults negatively affected her, it was a particularly violent relationship with a boyfriend that was "the worst I had to deal with" (p. 29, line 38). She discussed some of the physically, mentally and financially harmful things he did to her.

Me and him dated for seven and a half years. And he was on drugs. And I, you know, he used to take the rent money, take it and use it for drugs or whatever. And he would come in from work and he would just go off. And he used to make me eat off the floor...Um, I mean he just start punching on me for any little stupid thing. If he can't get his drug, I caught the rear end of it. (p. 21, lines 26-37)

*Sexual harassment.* Arrica and Dinah discussed the wearing effect that sexual harassment had on their daily lives. They both felt that they had to constantly be on alert against attacks. Dinah told me that it was difficult because she never felt safe from the sexual harassment. She discussed being sexually harassed while at stores, driving into parking lots, even while sitting in public meetings. She gave an example of being harassed by a stranger at a Lion's club meeting. Dinah also talked about how her history of sexual assaults and harassment made it difficult to differentiate between harmless touching and dangerous touching, and this affected the way that she interacted with others.

I had, last week, at this church, and older woman, she wanted to get by me, and she patted me on the rear... She didn't mean anything by it, but I said to her,



“Don’t do that. Please don’t do that. You don’t know what that person has been through recently. That’s a sexual assault area. If you’re going to touch somebody, let them know, say something to them first, so that they can turn around and look at you. Don’t come up behind somebody and touch them.”...She was very huffy.... Well, I won’t do that again. (p. 30-31, lines 25-4).

*Multiple adult sexual assaults.* Adrian and Beth experienced low self-esteem, self-blame, and shame, in part because they had experienced multiple sexual assaults.

Beth’s self-blame and shame are exemplified in the following quote:

Even though people tell you it’s not your fault, you, you know, it’s—it’s them that’s—they—they did it, but it’s still being in the back of your mind, okay, what did I do to bring this on? Cause some nights, I hear people, like in group, I hear people like oh, I had one abuser, two abuser. I’m like, okay. I don’t have like—I got six, or five, six, seven.... Okay, what’s—what’s my problem? (p. 23, lines 28-39)

*Lack of safety.* Several women talked about how feeling unsafe negatively affected their mental health. Alicia’s sense of being unsafe influenced many of her thoughts and actions.

I also go down and check the windows every night, even when it is winter... I’m afraid of lots of things. Breaking in, me waking up to someone standing over me, or kids being kidnapped in the middle of the night, or I don’t know.... I’m crazy about it. I’m not healthy about it at all. (p. 23, lines 19-31)

Earlier, in the section about fear, I noted that women’s sometimes debilitating fear prevented them from leaving the house after dark. During Michigan winters, this is a severe restriction on activities, when there are only 9 hours of daylight (United States Naval Observatory, 2015). The overwhelming fear that some participants felt sometimes interfered with their ability to function. Carmen spoke of how this fear interfered with her ability complete her tasks and relate with others, saying:

I don't, I don't usually leave my house after dark anymore.... I didn't even realize that I didn't leave my house at night until a couple months after, and like, I had left my house a couple times at night, like with my mom, to go to Bingo... This was the first time I was by myself.... And I was pulling into [a store]... And I parked. And when I parked, I noticed the guy next to me was just sitting in his car. And, so like the whole time I'm in Meijer's I'm freaking out. And I'm thinking, "What if he's gonna kidnap me?" And, you know? I'll just. Crazy thoughts. So, I actually waited like by the door for other people to walk out, you know? (p. 9, lines 8-24)

If victims/survivors are to engage with therapists to improve their mental health, they need to feel safe. The first time Alicia talked to a therapist, it was not by choice, but was mandated by the military. When Alicia decided to leave her husband, who was also in the military, he told the military psychiatrist about suicidal ideation and confessed that he had also physically abused Alicia.

He went to a military psychiatrist and said that he was thinking about hurting himself. So, he told him *everything* that had happened. And, so, it's the military—they don't go by the same rules. That person called his commander, his commander called my commander, my commander called me and said, "Here's the story we know. And, you need to go to therapy. And you will go. And, you'll be there tomorrow morning at eight." (p. 37, lines 11-18)

Alicia found it difficult to feel trust and safety in this counseling, which she called "intrusive" (p. 37, line 29). To guard her safety, she said, "I wanted to keep everything private. You know, I showed up and I was like 'I don't need to be here'" (p. 37, lines 22-24).

**Facilitators to improved mental health.** Despite all of the negative emotional states and diagnoses, some women experienced improved mental states. Some of the facilitators for improvement were "good therapy"—their experience, medications, art, spirituality, and positive relationships. Many women discussed time as a factor, although

there was no consensus on the relationship between the passage of time and improved mental health. For this reason, I discuss time both in this section and in the section on the barriers to improved mental health.

**“Good therapy.”** Twenty-one of the 22 participants participated in mental health counseling or therapy at some point in their lives. Except for Dinah, all of the women sought counseling as an adult, and all of the participants except Jo sought mental health therapy after experiencing sexual assault. Two of these women, Michelle and Alicia, were mandated to receive therapy. Interestingly, only half (n=10) of the women who sought counseling as an adult were seeking it to help deal with sexual assault. The other 10 women discovered the contribution of the sexual assault to their mental health while uncovering other issues.

The participants made distinctions among helpful therapy, unhelpful therapy, and therapy that was harmful. Helpful therapy was described simply as the process of participants talking with a therapist who is engaged with them and during which they are not harmed. In contrast, “bad therapy” was described as a process or person that participants perceived as being harmful to their mental health and/or overall wellbeing. I discuss “good therapy” in this section and “bad therapy” in the barriers section.

*Trust and safety.* Four of the participants discussed their feelings of trust and safety with a therapist. Beth was previously reluctant to talk to anyone about her sexual abuse and assaults, but when she realized that her therapist would not judge her or hurt her emotionally, she was able to open up. Her quote exemplifies the importance of trust and safety.

That's, you know, that's a lot of things that I had, you know, runnin' through my brain at the time. But after I was, my first counselor here, I start dealing with her and I kind of seen like, like "She's not lookin' at me like I'm a dirty person." You know, she... and... she didn't say negative things back to me like, "It's your fault," or "You're the reason they did this to you." You know? She didn't give me no negative feedback at all. So then, I betcha I just start kinda trustin' her then a little bit. And then it kinda worked out. (pp. 10-11, lines 41-4)

In making themselves safe from others, participants built walls that were difficult to take down even when they wanted to. Time helped Anita let down her walls enough to let her therapist in to help her:

I sort of built a lot of walls and really became unavailable, very avoidant, vul-like, when it came to vulnerability or being emotionally open and I think that's just kind of how I protected myself. I didn't really—I've always kind of kept people at arm's length and never really let anyone that close... it even took a long time for me to let therapists come in. (p. 49, lines 10-20)

*EMDR.* Three participants (Anita, Jo, and Sarah) found EMDR (Eye Movement Desensitization and Reprocessing) to be particularly helpful. Jo said, "(My counselor) did some EMDR. That helped me a lot. That seemed to be helpful" (p. 32, lines 4-6).

EMDR is a therapeutic intervention that trained therapists utilize to decrease anxiety, depression, and PTSD in individuals who have experienced trauma (Edmond & Rubin, 2004, Lee et al., 2002; Tarquinio et al., 2012). It consists of a structured eight phase protocol during which the participant focuses on a distressing memory for about 24 seconds while also engaging in eye movements or tactile or auditory stimulation (Maxfield, 2008). While there is some disagreement about why and how the mechanisms of EMDR work, researchers posit that it helps participants to process disturbing memories and bring them to an adaptive resolution (Maxfield, 2008). EMDR may not be significantly better in relieving these symptoms compared to other therapeutic

interventions for trauma such as prolonged exposure (PE) therapy (de Bont, van Minnen, & de Jongh, 2013).

In PE therapy, therapists work with trauma victims/survivors to process their traumatic memories so that these memories no longer cause intense anxiety, depression, or PTSD. At the end of PE, it is hope that participants can distinguish between thinking about traumatic memories and reliving them (Rachamim, Mirochnik, Helpman, Nacasch, & Yadin, 2015). Therapists utilizing PE therapy encourage trauma victims/survivors to confront trauma related situations and stimuli and revisit traumatic memories in the absence of actual danger (McLean, Yeh, Rosenfield, & Foa, 2015; Rachamin, et al., 2015).

*Challenging myths about sexual assault.* Three of the most helpful messages, according to participants, that they received in therapy were “it’s not your fault,” (n=9), validation of the pain (n=3), and “you are not dirty” (n=1). Interestingly, these are direct refutations of the sexual assault myths that the women had internalized and/or had expressed to them by family, friends, and formal supporters.

Richmond and colleagues (2013) discussed the benefit of feminist therapy to sexual assault victims/survivors. Feminist therapy assists sexual assault victims/survivors in connecting their symptoms to the larger cultural environment, actively challenging the myths about sexual assault. According to Richmond and colleagues, feminism influenced the theory and practice guidelines of trauma therapy, and many trauma therapists implicitly incorporate feminist values.

Since almost half of the participants (n=9) utilized services at the local agencies and discussed the healing messages that they received, I wondered if the therapists

considered themselves to be feminists or to be practicing feminist therapy. Two of the therapists told me that although they were guided by feminist principles, that they did not use this word.

We are guided by feminist principles but ... we are not really permitted to state anything that may be construed as political or controversial...while we are internally steeped in feminist practice work for empowerment and social change, we are not always as visible or vocal as we might like to be. (personal communication, May 20, 2015)

Another therapist gave similar feedback, saying, “We don’t much use the word *feminist*, just all these other wonderful words that define it” (personal communication, May 21, 2015).

Whether the therapists at the agencies use the word feminist or not, they are using feminist principles with their clients by recognizing the sexual assault as trauma and deconstructing the cultural messages that negatively affect the mental health of sexual assault victims and survivors. Recognition of trauma and use of trauma-informed methods, like EMDR, by the therapists appeared to be a key element in helping the participants to recover. One wonders if Sarah’s and Jo’s previous counselors did not use these evidence-based techniques because they did not have the necessary training, or if they did not recognize sexual assault as a true trauma, which is a reflection of endorsement of myths about sexual assault (Brownmiller, 1975, Chapleau et al., 2007; Edwards, 2011; McMahon & Farmer, 2011; Payne et al., 2011).

***Support groups.*** Nine of the participants reported that support groups helped improve and support positive mental health. One of the main reasons the participants

found support groups helpful was that they learned they were not alone. Mimi made this sentiment clear, saying,

I went to group that was even more helpful because it was, like, I'm not alone in all this and so..... and when I started talking to them, it was like they knew how to understand what I was going through because they knew somebody who else or they themselves, you know, had it happen to them. And it was just kind of like a huge eye-opener. It was like, oh okay. I'm not the only one. (p. 15, lines 6-29)

In addition to learning that they weren't the "only one" who had experienced sexual assault, participants found it helpful to learn that other victims/survivors had similar reactions. Jo said, "It was more helpful because, um, I realized that this isn't just me. A lot of people have the same, exact symptoms" (p. 13-14, lines 49-5).

**Medications.** Almost half of the participants (n=10) were either currently taking or had taken at least one medication to help with their mental health diagnoses. Of these 10 women, seven believed that the medications were helpful. Alicia, who had an anxiety disorder, tried everything to avoid medication.

I've been huge about natural remedies, and not taking medications, and trying to like, meditate, and run a lot, and exercise a lot, and you know, I got into marathons, and running was like the only thing that kept my anxiety kind of in check. (p. 11, lines 15-18)

Despite all of these strategies, medication was the most effective intervention to help Alicia control her anxiety. She described the difference:

But in 2012, I think, yeah, 2012, my therapist convinced me to at least *try* medication... and I struggled with that—a lot. And, my life is like completely different since I started that... But, completely different. Like hardly any anxiety at all. Like, I feel like a completely different person than I have in the last 20 years. (p. 11, lines 22-30)

Carmen, who was diagnosed with chronic PTSD after her assault, also felt that medications made a positive impact on her mental health. She told me that she noticed an immediate improvement: “You know, I noticed the first day? ...It’s crazy. You know that they say it takes weeks and weeks” (p. 6, lines 15-17).

Other women were more ambivalent about the helpfulness of their psychotropic medications. Although three women (Gabby, Arrica and Sarah) were taking psychotropic medications that they find helpful, they weighed the risks and benefits in each situation. While Arrica was still married to her abusive husband, she sought care for several physical complaints, as well as help in dealing with her husband. She was diagnosed with depression and prescribed an antidepressant medication. Instead of helping her with her underlying problem (abuse), Arrica thought, the health care providers “were just giving me stuff to shut me down” (p. 18, lines 17-18). Sarah reported that although the medications she was taking for depression, anxiety, and PTSD helped with one of her main symptoms, an inability to sleep, they also caused the negative side effect of making her too sleepy. She told me that she was “falling asleep everywhere” (p. 3, line 24). The medications worked so well at helping her to sleep that she actually lost her job because she “overslept for work too many times” (p. 3, line 26).

***Acknowledging the assault.*** Acknowledging their unwanted sexual experiences was a complex process, with many different facilitators and barriers. Although some women identified their sexual assault immediately (n=12), others (n=10) took days, months, and even decades to identify it. Naming their experience came with different consequences, some positive and others negative. For most women, even though naming



their experience as sexual assault was difficult and painful, it facilitated their psychological healing.

Before they named this experience of unwanted sexual assault, many participants thought about it as, as Laura put it, “something icky that happened” (p. 6, line 11). Ten women immediately named at least some of their sexual assaults, while others took days (n=2) or weeks (n=2). Seven women took several years to identify their experience as sexual assault. One woman (Arrica) did not identify a specific time when she named her experiences as sexual assaults.

***Positive consequences of acknowledging sexual assault.*** Although accurately naming the event was associated with a great deal of emotional pain initially, it helped facilitate healing over time. Ella and Kris reported that naming their sexual assault, after years of repressing it or calling it something else, allowed them to heal. Jo spoke of how naming it allowed her to leave an abusive marriage.

Ella “just really repressed it like way down” (p. 23, lines 3-4) and downplayed her two sexual assaults because they did not result in penetration.

Where before, when people talked about sexual assault, I never talked about it ... because I didn't feel like I had a right to. I felt silly. Like you're talking about this traumatic experience and mine doesn't compare. But I realized it does, you know. Because it's not about how it physically made me feel, it's about how emotionally it made me feel. And it really, really messed me up. (p. 15, lines 3-14)

Naming the sexual assault did cause emotional pain, Ella admitted.

Like I was so mad and so sad. Like, all of it. Like all of those emotions that I don't think I ever, like, really got to feel just, like, came bubbling up. And I was so mad at my mom that she didn't like dig deeper and find out and I was mad that like I didn't even tell her, that I had to live with him again. And I was mad at

Robert. And I was mad that nobody ever, like, let me be the victim. And I was mad at myself. (p. 11, lines 26-39)

However, recognizing and naming her experience as sexual assault allowed her to grieve her experiences, which she found healing; “but I think the way that it was most helpful is it let me mourn” (p. 14, lines 48-49).

Kris also found the process of naming her sexual assault to be helpful. More than 20 years after she had been brutally assaulted by her boyfriend, Kris began training to be a sexual assault advocate. Learning that her experience met the legal definition of sexual assault was “huge.” Kris explained this process.

I remember looking at that manual because before that I really hadn't considered it rape. And I thought too if ever told anybody about it or if I went to the police they're not gonna believe me. I live with this jerk... But when I looked at the legal part of it and saw all ... things like from first, second, third, and fourth degree. And what it, what it was. And you know it was like “Oh my gosh this guy could go away for life... I really was raped.” (p. 13, lines 10-28)

*Getting out of a bad relationship.* Jo's husband, who began physically abusing her on her wedding night, continued the physical and emotional abuse throughout their 17-year marriage. Jo did not let this abuse deter her from trying to improve their marriage. She worked with individual and marriage counselors as well as pastoral counseling. She continued to follow their advice, which was “just to hang in there” and that “if I changed my responses, he would improve” (p. 2, lines 47-49). However, when her husband sexually assaulted her, Jo said, “That's when I knew he wasn't normal ... Like, I don't care what he does at this point. There's no coming back from that” (lines 15-20, p. 3). Jo attended a professional conference, where the agency discussed sexual

assault within marriage. Listening to other marital sexual assault victims/survivors tell their stories helped give Jo the courage to initiate the divorce process.

The overall benefit to psychological health of acknowledging the assault is consistent with extant research. In a study of (N=340) sexual assault victims/survivors, women who had acknowledged their sexual assaults were significantly less likely than unacknowledged victims/survivors to report hazardous drinking ( $p<0.001$ ). In addition, acknowledged sexual assault victims/survivors were significantly less likely than unacknowledged victims/survivors to experience another sexual assault within 6 months after the initial assessment (Littleton, Axsom, & Grills-Taquechel, 2009). Clements and Ogle (2009) reported that unacknowledged sexual assault victims/survivors were significantly more likely to meet diagnostic criteria for obsessive compulsive disorder ( $p<0.01$ ), depression ( $p<0.001$ ), phobic anxiety ( $p<0.001$ ), psychosis ( $p<0.001$ ), and a higher global symptom index ( $p<0.01$ ). Yet although acknowledging sexual assault was associated with improved mental health, acknowledgement may negatively influence physical health.

Conoscenti and McNally (2006) reported that acknowledged and unacknowledged victims/survivors had similar rates of PTSD, acknowledged victims/survivors had more severe health complaints ( $p<0.01$ ). In addition, acknowledged victims/survivors sought formal healthcare significantly more often than unacknowledged victims ( $p<0.05$ ). More research is needed to clarify the consequences of acknowledged versus unacknowledged sexual assault.

***Barriers to acknowledging sexual assault.*** Internalization of myths about sexual assaults was responsible for preventing the acknowledgement of sexual assault in nine

out of the 10 women with delayed acknowledgement. Table 7 constitutes a visual display of the participants' time to acknowledgement of the corresponding IRMA rape myth question. I discussed the IRMA instrument, which assesses beliefs and/or endorsement of myths about rape. The table illustrates the ubiquitous nature of rape myths in our culture and the effect on victims' / survivors' perceptions of their own sexual assault.

Table 7

*Victims'/Survivors' Perceptions of Sexual Assault and Corresponding IRMA Question*

<u>Participant</u>	<u>Time to acknowledge ment</u>	<u>Quote</u>	<u>IRMA Question</u>
Alicia	~ 20 years	"I think I was really confused about what part I played in it. And, growing up, thinking that it would be more violent" (p. 2, lines 2-4). "It was like, you know, a frozen 18-year-old girl. You know, I wasn't talking or doing anything. Just, not resisting" (p. 30, lines 11-13).	If a girl doesn't physically fight back, you can't really say it was rape
Anita	a few years	"I like woke up... in the middle of the— of the ex- of like the actual assault happening. Like, she was like having sex with me, but I was completely unaware...of what was going on" (p. 9, lines 38-48)... I guess it was cause I kind of like her. And I guess it was my choice to like take a pill" (p. 10, lines 8-9)	If a girl is raped while she is drunk, she is at least somewhat responsible for letting things get out of hand
Carmen	> 1 week	"And I struggled with that—why didn't I fight? You know?... And so I didn't feel like I was raped, you know?" (p. 2, lines 13-15).	If a girl doesn't physically fight back, you can't really say it was rape.
Carmen		I felt like I was to blame.... Because I didn't fight. 'Cause maybe if I hadn't drank so much, or allowed my cup to be around the wrong people. You know, you just...	If a girl is raped while she is drunk, she is at least somewhat responsible for letting things get out of hand.
Gabby	"several years"	"The day that I came home [after cesarean section] he wanted to have relations. I'm like 'There's just no	When guys rape, it is usually because of their strong desire for sex.

<u>Participant</u>	<u>Time to acknowledge</u>	<u>Quote</u>	<u>IRMA Question</u>
Kris	~20 years	way—there’s all this trauma from the C-section... But he decided that that was something that he needed at that time” (p. 2 lines 15-19). “He flipped out...he told me he had [done drugs]”(p. 3, lines 36-38).	It shouldn’t be considered rape if a guy is chemically altered and didn’t realize what he was doing.
Laura	~40 years	““What were you doing in a motel with this guy if you didn’t want to have sex with him? You know, it’s your fault.’ So, I think that was my feeling about it – that it was my fault” (p. 5, lines 17-19).	If a girl goes to a room alone with a guy at a party, it is her own fault if she is raped.
Melanie	“a few months”	“Yeah, I’m a fucking adult, I could say—I could have said no to these drinks” (p. 3, lines 17-18).	If a girl is raped while she is drunk, she is at least somewhat responsible for letting things get out of hand.
Mimi	10 days	“He ended up in my bedroom and kind of forced himself upon me. And then that happened and I kind of just shrugged it off and didn’t, you know, it wasn’t what I thought rape was” (p. 5, lines 9-15).	If a girl doesn’t physically fight back, you can’t really say it was rape.

(McMahon & Farmer, 2011)

***Facilitators of acknowledging sexual assault.*** Women could more easily name their unwanted sexual experiences as sexual assaults if the assault was stereotypical in that it was committed by a stranger, involved violence, and completed vaginal-penile penetration occurred. Talking with others helped some women identify their experiences as assault.

***Stereotypical sexual assault.*** Most of the women (n=7) out of the 10 who immediately named their sexual assault recognized it because of its elements. For

example, Jenny's sexual assault fit this scenario almost perfectly, with the exception of violence:

This guy that I've never seen before came—just broke into my house, broke my chain lock and my deadbolt and, like—and he—and he raped me, and he left. He didn't take anything. It wasn't anything brutal or I—and I didn't fight because—and I—I hate that I still justify it, but the girls were there. (pp. 1-2, lines 52-6)

*Conversations with others.* Many women (n=8) were helped to name their experiences after dialoguing with friends or therapists. Laura had a sudden memory of her assault more than 30 years after it happened, but she did not name the experience as sexual assault until after she had discussed it with her therapist, whom she was working with for an un-related matter.

And, it wasn't until then that I really went and talked to the psychologist and she goes, "Well, you were sexually assaulted." And, I was like "no, no, it was just something icky that happened." "No," she goes, "you need to know this." (p. 6, lines 9-12)

*Safety.* Several participants found that a sense of safety was key to positive mental health. Earlier, I discussed how a sense of safety was necessary for the participants to engage with their therapists. Recall Beth's worries about how her therapist responded to her. When the therapist did not look at her as if she were dirty and to blame for her assault, she was able to "start kinda trustin' her then a little bit. And then it kinda worked out" (p. 11, lines 1-4). This safety facilitated Beth's long participation with therapy at the agency, which she credited with changing "my life a lot" (p. 53, line 12). Anita and Alicia also discussed the need to feel safe with their therapists to feel like they could open up.

Two women discussed how feeling safe allowed them to tolerate intense emotions like anger and anxiety. When they were able to open up, they were able to heal. Helen had never felt safe when others expressed anger. She grew up in a home where violence routinely followed expressions of anger: “Anger in the past was—it was all physical abuse...so, anger was always followed by, you know, something really nasty” (p. 21, lines 8-26). As an adult, she had a difficult time connecting with and relating to others, like her husband, when they were angry. Through the help of her husband and her therapist, she learned to tolerate anger without shutting down “when anybody—anybody ever started to get angry with me, the wall went up...I didn’t give a shit what you had to say...I had to work on allowing that wall to come down” (p. 21, lines 26-38). Anita found that having routines and expressing her needs helped her feel safe, which in turn helped with her anxiety.

My routine makes me feel safe, even though I think sometimes it also keeps me a little stuck...but I think because of my anxiety I really enjoy like being able to have a routine... being able to learn how to express my needs and things like that is—is making me feel a lot safer. (p. 14, lines 14-24)

***Behaviors and strategies.*** The participants related many strategies that they used to facilitate positive mental health. Earlier, I detailed how engaging in therapy and exercise helped women feel healthier emotionally. In addition, participants found enjoying and creating art to be beneficial to their mental health.

*Art.* Many of the participants (n=11) found that art, in various forms, like music, theater, visual, literature and craft projects, was helpful to their mental health. Some women found that enjoying the art was beneficial. Others said that creating art, in some

form or many, was health promoting. Some of the women discussed the interaction of art, spirituality, and mental health.

Several of the participants (n=8) told me that listening to music helped them in maintaining or improving their mental health. Anita said that listening to music was one of the activities that helped her to “feel safe” (p. 41, line 31). Helen spoke of how listening to one song had a dramatic, positive impact on her relational, spiritual, and mental health:

I woke up one morning and, uh, it's a—an Ani DiFranco song.... And it was a song and it had something to do with she's talking about her, I think—her girlfriend or a friend... and she's talking about how you... carry things around with you and one day, you just put them and found her hands were free, and ... — I woke up and it was like a spiritual experience... I remember I was sitting on the edge of the bed and I heard those lines where the—like those two lines or three lines running through my head about how you can just, you know, set it down, and I—literally, it was a spiritual experience.... I—my anger left. Every bit of anger that I had, left my body. This was after my mother was gone. It was years. And... I never was angry about the abuse again. Never. (p. 8, lines 16-52)

Other women (n=4) talked about the power of literature, from blogs to classic works, to transform their mental state. Half of these women talked about how reading helped them to relax. Two others, Adrian and Dinah, seemed to have found healing in reading about sexual assault. Adrian told me about one book in particular that helped her make the connection between societal expectations and the vulnerability of women to sexual assault (including herself):

I read this book called *The Gift of Fear*—I forget who the author is. But, it talks about like how women are conditioned to be nice and polite and things like that and, and can totally see my, you know, my situation.... I didn't really want to let that guy in my house to fix my floor, but I was a single woman, I couldn't afford to hire a contractor to fix the floor. (p. 41, lines 20-25)



Three of the women discussed film and television as being helpful to their mental health. Kris told me she watched a lot of television, “like a lot of trash TV. It’s just kind of like an escape” (p. 26, lines 2-3). Helen told me that she loved movies and went to them alone about once a month. Documentaries were healing for her: “I think documentaries too—can be really healing depending on if you’re ready to watch... maybe opens your eyes to seeing things from a different viewpoint” (p. 47, lines 35-52).

Eleven women in this sample thought that being a part of an artistic creation was good for their mental health. The most common artistic activity was writing. Almost half (n=5) of the artists wrote. Two of the women (Jenny and Mimi) participated in a therapeutic writing group. Jenny liked writing so much that she was considering writing a book while Louise and Helen both wrote poetry. Helen told me that poetry helped her to “deal with the abuse ‘cause I wrote poetry about the abuse for, you know, a lot of years” (p. 45, lines 35-37). Helen was writing less poetry at the time of the interview and saw this as a sign of improved mental health; “but as I’ve gotten healthier—healthier, I don’t write quite as much I’ve noticed.... Maybe there’s not so much of a need to” (p. 45, lines 28-34). Patrice found writing about her pain and performing music to be beneficial to her mental health.

At clubs, and there’s an open jam at a shop, and a lot of little things. Then I go to clubs. I write my own stuff so a lot of it’s about men, relationships because I’ve been in and out of so many that I thought were the one, you know (p. 29, lines 14-19). ... I get therapeutic benefit from singing and being with other people pretending to know what we’re doing with music... I, this is therapy for me. It’s as therapeutic for me as going to my counseling session or an Al-Anon meeting. (pp. 39-40, lines 40-45)

Researchers have examined the influence of art on mental health in both quantitative and qualitative studies. For example, 66 men and women with various mental health diagnoses (depression, anxiety, bipolar disorder, and schizophrenia) participated in an art program sponsored by the English government. After 6 months of participation, participants demonstrated a significant increase in feelings of empowerment ( $p=0.01$ ), social inclusion ( $p=0.01$ ), and overall mental health ( $p=0.03$ ) (Hacking, Secker, Spandler, Kent, & Shenton, 2008). A recent phenomenological analysis of (N=18) men and women with diverse mental health diagnoses also demonstrated the powerful positive influence of art on mental health. Participants reported increased confidence, control over their lives, and connectedness with others (Van Lith, Fenner, & Schofield, 2011).

**Knowledge.** Knowing themselves, their strengths and resources, was a common theme when discussing mental health facilitators. Several (n=7) women found that simultaneously acknowledging their strengths and weaknesses helped them obtain and maintain positive mental health. Knowing that her intrusive, frightening thoughts were part of her PTSD helped Adrian ground herself when she thought she saw her dead assailant.

I mean, he's dead and even after he died, I wasn't convinced he was dead. I'd still see him at stores and stuff like that. And I'd still see him at places and I would call my mom and say, "He's not dead. I saw him here. I saw him, Mom. He's down the street. I know he's not dead." And, that my PTSD—I found out with my therapist and stuff like that. Um, there's still times when I see someone who looks like him out of the corner of my eye, and wonder, but then I ground myself. (pp. 5-6, lines 30-33)

**Time.** Most women (n=13) found that time passing since their sexual assault was a positive factor in their mental health. However, the impact of time on mental health

was much more complex than merely helpful or unhelpful. None of the women described a gradual, consistent climb to improved mental health with time, but rather a nonlinear and somewhat erratic course. Melanie described how the emotional pain was all consuming on some days, and other days, it was less intense.

Well, it's one of those things that it goes from being this little tiny scar to then occasionally being like a full-body burn.... And, then, it can shrink back down. And, it depends on the day. (p. 12, lines 7-12)

Some women found that it was time combined with other factors that helped them feel more emotionally healthy. Alicia said,

Time has been helpful. I do wish that I hadn't waited so long [for counseling]... ...So, I must not have been ready. I think I was ready when it finally happened and it's probably a culmination of everything coming together. You know, it was probably a combination of the work I was doing and people I was meeting. (p. 15, lines 14-19)

For Ella and Michelle, their mental health appeared stable and unchanging for several years while they repressed their feelings. Recall Ella's description of her white hot anger under the acknowledgement discussion. Shortly after acknowledging her assault and her pain, she confronted her mother, who failed to listen to her and to take her concerns seriously when she was assaulted as an adolescent. The years of anger and pain dissipated in minutes:

I finally talked to my mom and told her the whole story, and that I was angry with her and she bawled and felt like she, like, let me down, you know. And I was, like, mad for a few minutes and then I completely forgave her, you know (p. 12, lines 15-22).

Ella commented about the strange relationship of assault, disclosing, time, and healing:

It's so weird because I feel like the action and the reaction were so far apart, you know what I mean?... Because like it happened. And it wasn't really like I survived through it because it was, like, it happened. And then I just shoved it down, and then everything was normal. And it wasn't until I was, like, in my late 20s that I actually dealt with it. You know what I mean? (p. 25, lines 3-23)

Like Ella, Michelle kept her assault “in a box” (p. 46, line 8) for about 20 years before she participated in an inpatient treatment for PTSD at Walter Reed Medical Center. She told me that the 3-week inpatient treatment did more for her than anything else she had done in the previous 20 years.

Walter Reed was difficult but it was a necessity for me....Because as painful as it was for me to open myself up and to discuss stuff with pure strangers, it was also something that let me realize I wasn't alone. And then you know, to have those girls to just reach out to after I left.... it was just like a good relationship that I built with a lot of them. I don't know, it was, it was bad at first but when I look at it helped me realize I wasn't by myself.... I had people I can reach out and talk to that I had opened up my darkest. I mean there was things I've never repeated outside of that room. (p. 12, lines 9-29)

Adrian summed up the relationship between time and healing perfectly: “It's a journey, and it's not a linear one by any means. I mean there's humps and bumps and twists and turns” (p. 8, lines 21-22).

### **Interaction between mental health and other wellbeing domains.**

***Relational and mental health.*** Several women told me about how the lack of support they received from others negatively impacted their mental health. The lack of support came from several types of relationships, from partners and family members, friends, spiritual community, mental health therapists, law enforcement, and society. The lack of support was apparent in several forms: silencing, dismissing/diminishing the impact of sexual assault, and blaming.

*Blamed.* Some of the participants in this study were blamed for causing the assault or not doing enough to prevent it by their mothers (n=2), friends (n=2), or church counselors (n=2). Being blamed resulted in feeling hurt and angry. In some cases, these reactions resulted in broken relationships. In other situations, the relationships continued but the hurt remained. Jo was repeatedly blamed by church counselors for all of the violence inflicted on her by her husband. They told her “that if I changed my responses, he would improve” (p. 2, line 48-48). Kris described the uncomfortable process of disclosure and her mother’s accusatory response.

She goes, “Were you ever raped?” And I just remember we were outside. And our neighbors we live kind of close. And she goes, “Well, were you?” And it was just like no train, no filter... and I go “Yeah I was.” And then I told her a little bit. I just told her who. I didn’t tell her what had happened or anything. And instead of saying “I’m really sorry that happened to you. It must have been awful,” blah blah blah, it was “Well, you were so stupid. You were just stupid.” And so, you know, end of conversation. (p. 10, lines 20-40)

*Minimized.* Several participants felt that their assaults were downplayed by their partners (n=2), police (n=1), counselors (n=2), friends (n=3), and mothers (n=1). When Laura disclosed the sexual assault that she had endured more than 30 years previously to her husband, he dismissed her, making a joke. Eight years after this conversation, she told me that she still resented him for this reaction.

And, then I told him, and he’s the kind of person who makes jokes of things when he doesn’t know what to say... you know, I said that had been raped like a really long time ago and I had totally forgotten about it and you know, this guy forced me to have sex with him. And, he goes “Oh, wow, no woman’s ever done that for me!” Like it would have been wonderful... I then I just totally shut off and didn’t say anything else. And I still resent him for it. (p. 8, lines 8-23)

Hannah felt that her therapist dismissed the root cause of her excessive drinking, the sexual assault. She said, “I had an alcohol—a substance abuse counselor... And, that didn’t really help... And, she wanted to talk more about the drinking than why... And, that’s the issue—the why” (p. 12, lines 3-12). Sarah’s first therapist was so dismissive that “she’d text during the sessions” (p. 3, line 17).

*Silenced.* Participants felt silenced by their mothers (n=3), fathers (n=1), and friends (n=1). Sarah initially felt silenced by both her mother and her father after disclosing her sexual assault—“They didn’t really say anything or ask anything” (p. 4, lines 13-14)—and her mom continued to silence her mental health pain and symptoms, telling her “‘You need to stop having these panic attacks,’ or ‘Just calm down, just calm down,’ and it’s like ironic cause she’s a social worker” (p. 18, lines 13-15). Because Jenny’s boyfriend became so emotional when she tried to talk to him about the assault, she felt that she had to stop talking about it.

It wasn’t because he was being ignorant. It’s just he, like, literally, just didn’t—couldn’t handle it... I would start talking about it, and there’d be, like, tears... I remember waking up, like, in the 5 minutes that I fell asleep, in these nights that I’m trying to sleep, I remember waking up and, like, he’s next to me, like, sobbing in his sleep, like just...it’s really affected our relationship because just for a lot of reasons. I can’t—because he didn’t listen for so long... (p. 9, lines 17-40)

*Accused of lying.* Participants were accused of lying about the assault by several individuals: moms (n=3), friends (n=2), police (n=3), and church counselor (n=1). Carmen was accused of lying about her sexual assault by her friends: “Yeah, they didn’t believe me, because I had had sex with him before. You know, even though it had been months, and months and months since we had dated” (p. 5, lines 11-13). When Adrian tried to report a sexual assault, the police accused her of lying because she had previously

reported a sexual assault, suggesting “that like, ‘you already have this guy ... and now you expect us to believe you again?’ Like ‘Once you’re raped, you can’t be raped again’” (p. 14, lines 11-14).

*Failure to help.* Three women told me about how their friends failed to help them when they needed it most. After Kris was brutally sexually assaulted by her boyfriend, she called her friend, explained what had happened, and asked for a ride. Her friend told her, “Well, I think I can’t come and pick you up now because my mom and I are going to the mall” (p. 2, lines 48-50). After Hannah’s sexual assault, she began drinking heavily to help her with her emotional pain and to sleep. She thought her friends enabled her instead of helping.

And, there really wasn’t anybody that I had to talk to about it. And, I—I ended up drinking a lot. And, they could’ve—they could have tried to help me or anything, but, I had friends that would give me more drinks. “Here you go,” you know, instead of like “Hey.” (p. 6, lines 24-28)

When Ella woke up mid-assault and confronted her assailant, he “stormed out of the room. He was angry.” Instead of helping Ella, her friends thought that the assailant (a mutual acquaintance) needed more help.

So then they ended up going and talking to him and calming him down. I kind of resented it at that point. That, like, really? ...they’re the one that gets to go freak out and like, I’m just here. You know? Yeah. I’m just dealing. (p. 9, lines 34-42)

*Perpetrators as allies.* Adrian was in a difficult situation, as discussed earlier. Her mother kicked her out of the house at the age of 14 after Adrian told her about being molested by her father. She said that her mother believed and supported her as she

struggled to deal with her other sexual assaults. Adrian's father also tried to support her, but this left Adrian with difficult and conflicting emotions.

It's hard to sit there and have a guy that's done terrible things to you sit there and act all like he's upset about this guy doing it to me. You know, it's really, like "I don't want you to be mad. I don't want you to be upset. I just want you to stay out of it."...Um, it's hard. You know, when I went to there, and you know? You know, my dad, he—it's just—it's hard. It's very awkward to, like, try to have perpetrators be allies. (p. 7, lines 17-26)

These reactions of friends are common (Chapleau et al., 2007; Edwards, 2011; Payne et al., 2011; Valenti, 2010) and are strongly supported by a culture that supports sexual assault. As discussed earlier, myths about sexual assault and rape benefit women in some ways because they allow them to feel safe from victimization if they "do the right thing" (Joseph et al., 2013). However, when someone they know and trust has been assaulted, their world views can be shattered. When college students (N=1,241) were assessed for their reactions to a friend's sexual assault disclosure, women were significantly more likely than men to be afraid for own safety ( $p<0.001$ ), afraid to do things that didn't bother them in the past ( $p<0.01$ ), afraid they might also be assaulted ( $p<0.001$ ), feel a loss of security ( $p<0.001$ ), and experience distress ( $p<.001$ ) (Banyard, Moynihan, Walsh, Cohn, & Ward, 2010).

***Positive relationships.*** Several women spoke about about the positive influence of relationships with others on their mental health. Five of the women talked about relationships with boyfriends or husbands, three women talked about friends, two women discussed their children, two women discussed their moms, and two women discussed their relationship with their dads. Although each of these relationships was unique, there were patterns in the behaviors or "way of being" that participants found especially



helpful to their mental health. Friends and family facilitated positive mental health in the participants by listening to them, respecting their boundaries, sticking by them, and helping them to feel safe.

*Listening without judgement.* Three women found that their friends were helpful to their mental health by listening to them without judgement. While Jo endured the many abuses in her relationships, a few of her friends were always there to listen and provide support: “And they just were like, you know, ‘You have to do whatever you think is best. You don’t deserve that, but whatever you want to do, I’ll support you” (p. 6, lines 46-49). She elaborated as to why this was so helpful: “I was glad she wasn’t pressuring me... ‘cause I wanted to leave. I didn’t even know if I would leave, and I wanted to leave when I knew it was time” (p. 7, lines 27-33). Two women found it emotionally healing when they were able to talk with their moms and dads about the assault(s) and or the emotional consequences. Michelle exemplified how talking to her mom benefited her mental health: “And like me and my mom talking about all of this afterwards you know, it just, amaz –... Yeah ‘cause I had kept it in so long” (pp. 24-25, lines 45-2). Conversations with her father helped Sarah during her panic attacks. She explained, “My dad is (helpful), and it’s helpful because when I have panic attacks and stuff, I can always call him and he’ll just say ‘What triggered it? What’s going on? Talk to me’” (p. 4, lines 20-22).

*Feeling safe.* Arrica warned me before we started the interview that she had been crying all of the time. Although this typically is a sign of emotional pain, she told me that it was different. She explained that these tears were good tears.

The crying started because I'm—in 2009, I married probably the most wonderful man in the world. And, what is this—2014? And in 2014, it finally dawns on me that this is the first time in real life that I've ever been safe. (p. 4, lines 9-12)

Jo told me that her current boyfriend worked very hard to help her feel safe. For example, despite having been together for a few years, they had never had sex. Jo said, “He’s awesome about it” (p. 23, line 12). She mentioned that she stayed with him because “he’s safe. He’s supportive. He’s not angry” (p. 27, lines 2-4).

Two of the participants discussed the importance of their dogs in maintaining their mental health. Both women, Jo and Sarah, told me that their dogs helped make them feel safe. Sarah explained that the presence of her dog was helpful for her panic attacks.

I got a—well, I got a dog and he’s like a—he’s certified as an emotional support animal.... And, so, I spend a lot of time with him... So, I take him with me places and stuff. Like, if I go back home I take him, like if I go to my parents’, I’ll take him and stuff on the plane and just ‘cause like crowded places give me panic attacks. And, he’ll stay at my parents with me and stuff. (pp. 11-12, lines 21-12)

Jo’s Rottweiler is both “babyish sweet” (p. 14, line 43) and “looks scary” (p. 14, line 44). Her presence has helped make Jo feel safe and get better sleep. She told me, “She sleeps in front of my bedroom door.... That’s helped me sleep tremendously, believe it or not—just knowing that she’s there, because I live alone” (pp. 14-15, lines 49-3).

***Encouraged to seek counseling.*** Seven women reported that friends or family members helped them obtain or maintain mental health. It was a work friend who first encouraged Gabby to pursue counseling.

I actually, one of my friends there at work said, “You know, you should try therapy.”... And, so I promised I would go for 6 weeks, and here we are—how many years later! ... Yeah, we are. She laughs every time. She’s an older gal, a

nice gal. She was a social worker, so, but, an amazing woman. An amazing role model. I promised her 6 weeks, and ah, she still—she knew it would be a long time. (p. 2, lines 3-12)

### **Career/educational/financial and mental health.**

*Negative interaction.* As was discussed earlier in the mental and physical health section, both Hannah and Melanie began drinking alcohol excessively to cope with their emotional pain, which resulted in severe career/educational/financial (c/e/f) consequences for both women. Recall that Hannah lost her job, car, and house, and Melanie was removed from her academic program.

Helen experienced such a strong negative emotional reaction to her nightmares that she frequently missed work, which interfered with her advancement and promotion. Below, she details the negative interaction between sexual assault, mental health, and f/c/e health:

I would have nights of dreams of being at, you know—abused, you know, by—by somebody I meet in a bar or a stranger accosting me or whatever and I would dream about, you know—dream about being raped or something... And I'd wake up in the morning and be so depressed by it... I couldn't even go to work, you know? When I had—you know, so sometimes it would be, you know—I wouldn't say I'd be off the whole week but I have a day or two off this week and the next month, a day or two off or something, you know, and after a while, I think, you know, that that kind of held me back. (p. 26, lines 16-40)

Sarah experienced severe negative mental health impacts almost immediately and sought help right away. Unfortunately, although the medications did help her with her intrusive symptoms, they made her so sleepy that she lost her job: “I ended up losing my job over it.... It made me drugged and so... I overslept for work too many times” (p. 3, lines 22-26).

Though Sarah lost her job and economic security pretty quickly after her assault, she was still experiencing c/e/f difficulties 3 years later. She explained her continued c/e/f struggles, saying,

I feel like I'm not really back on my feet yet. Um, just because I'm not like working a job that requires my degree or anything... And, right now, I'm just like working like minimum wage. (p. 8, lines 8-14)

***Positive interaction.*** Women also experienced positive interactions between their mental and c/e/f health. The workplace environment was helpful to women's health by increasing awareness of helpful resources and reinforcing positive messages. Three women (Beth, Gabby, and Jo) learned about the agency that helped them with many of their emotional struggles after experiencing sexual assault(s). Kris, who was sexually assaulted more than 30 years before the interview and worked with sexual assault victims/survivors at the time of the interview still found hearing the phrase "It's not your fault" to be a healing experience. She explained, "To hear them...they're telling somebody it's not, you know, it's not your fault or whatever. It's just every time you hear that, it's like somebody's saying it to you" (p. 14, lines 27-31). Although Sarah was fired after her sexual assault, and was still struggling financially, she had found a job with other women who helped her with her mental health needs.

**Spiritual communities/religion and mental health.**

***Negative interaction.*** Four women discussed different ways in which spiritual communities or religions hurt certain aspects of their mental health. Under the topic of mental health barriers, I discussed how Jo and Louise were emotionally hurt when their church counselors blamed them for their assaults. In addition, Louise was accused of

lying. Two other participants found their religious or spiritual communities to be harmful in terms of the ways in which they responded to or discussed sexual assault. Dinah and Anita mentioned how the Catholic Church made them feel dirty and unlovable because of their sexual assaults. Anita described these feelings, saying, “I just kind of felt like I would be in trouble or that like God wasn't going to love me or something like that. Um, and then I think I just closed myself off” (p. 49, lines 4-6). Dinah said, “I'm still working through the anger and the guilt and the shame because I was brought up in a Catholic household where this didn't happen to good Catholic girls” (p. 3, lines 9-11).

***Positive interaction.*** Nine women talked specifically about how their spirituality and or spiritual practices helped them with their mental health. I talk more extensively about spirituality later in this chapter, but here I address the ways in which participants found spirituality to be helpful to their mental health. Helen, who identified herself as a Buddhist, used her spiritual practices to process thoughts and emotions.

I'm—I'm like pretty heavy into Buddhism, and, um, it talks about how your thoughts are a mental construct, you know?... You know and if you know that, how can you—you know, I still—I feel emotion, and I can let my mind start to spin its wheels but, you know, it doesn't take long and I realize what I'm doing. (p. 9-10, lines 42-6)

Ella and Jo, who identified as Christians, talked specifically about how their higher power's constant presence helped them get through their struggles. Jo said,

Yeah, I know it helped me get through the assault and everything because, uh, I just always felt like no matter what happens, God's going to be with me. No matter what, it's the only thing that will never go away. (p. 11, lines 14-18)

Although Beth and Dinah had very different belief systems—Beth was a Christian and Dinah identified as an atheist—both women found their spirituality helpful in

relieving them of the guilt over the sexual assaults. Beth described how her higher power, working through people, helped alleviate self-blame for her sexual assault.

‘Cause you know, he put some wonderful people in my life, that helped me with this, helped me... understand it more... And also helped me understand that, it wasn't my fault that it happened. (p. 23, lines 20-27)

About her new spiritual community, Dinah said, “It allows you to heal in your own way” (p. 5, lines 9-10).

Adrian and Laura, who identified on the agnostic, atheist spectrum, found nature, where they both felt more spiritual, helpful to their mental health.

I think the only time I get like anything like that feeling is outdoors in nature... You know, you go out and you walk, and it's just like so, I don't know, you know, just like being out there in the fresh air and hearing the birds and seeing—I mean I'm fascinated with leaf shapes and um, I don't read anything further into that.... But, it just like feels so revealing and uplifting. (Laura, p. 16, lines 13-21)

**Summary of mental health domain.** All of the participants in this study experienced some negative impact on their mental health. Some of these effects were short in duration, but most lingered for years. Many of the participants were able to find ways to help in healing from the emotional pain they experienced after sexual assault, such as therapy, art, support groups, relationships with others, spiritual connections, and body-mind healing. The negative emotions experienced after their sexual assaults were heavily influenced by the cultural environment. For example, the internalization of myths about sexual assault contributed to delayed acknowledgement of sexual assault and increased shame and self-blame.

Three women, Kris, Laura, and Louise, who experienced their first sexual assault decades previously, were able to give perspective on the positive cultural changes

surrounding sexual assault. They each told me that increased openness to discussion about sexual assault have made it easier to name their sexual assault. They were grateful that these changes might facilitate wellbeing in younger generations of women. Laura, who “remembered” and disclosed her sexual assault more than 30 years after it happened, described how much more difficult it would have been to have told anyone about it when it happened:

You know, because they used to be to say “Well, what were you wearing?” or “Were you walking somewhere that wasn’t safe?” Um, you know, that kind of thing. Or, women fought to protect themselves against men, because men couldn’t control themselves, and couldn’t be held accountable. Um, and I guess that’s another reason, since I didn’t fight—you know, I haven’t really considered it to be rape so to speak because, after all, I put myself in that motel room, so therefore, it must have been my fault. (p. 26, lines 16-23)

Louise explained:

Oh, I—I just, uh—you know, we had school counselors back then, but I just couldn’t tell them. Now, girls can. And I’m so much—I’m so glad that it’s more open now. That’s what I’m really thankful for—that there are—well, like you’re doing. (p. 51, lines 32-38)

Kris also expressed how it would have been helpful to have the now available resources and relative cultural openness back when she was assaulted, more than 30 years previously.

And you know if it was the way that would’ve been great if it was way back then to you know have places like (the agency) or um rape crisis centers. Therapy was even like really looked down upon years ago. (p. 28, line 30-35).

### **Domain 3: Relational Health**

All of the women experienced some type of negative impact on their relational health after their sexual assault. The duration and severity of impact varied among the

women, as did the type of relationships that were affected. I have already discussed many of the relational harms because there was a strong overlap between mental health and relational health. In the following discussion, I first discuss the negative and positive impacts to relational health. I then devote attention to the ways in which sexual assault affected participants' reactions to romantic relationships. After this, I describe the barriers to and facilitators of positive relational health. Following this, I discuss the ways in which relational health intersects with spiritual health and c/e/f health.

**Negative impact.**

***Broken relationships.*** Ten women lost at least one friend after their sexual assault. All of these friends displayed some type of hurtful behavior discussed above, like blaming, silencing, or accusing the women of lying. Many times, the participants decided to break off the friendship. Ella decided that she no longer wanted to be friends with her friend who defended her assailant, saying, "Her life is...her life has always been a mess. She put me in a lot of bad situations. And, she just has never really grown up" (p. 16, lines 3-6). Other participants were on the receiving end of a friendship break-up. Sarah recalls some of her friends saying, "I can't deal with that; once you're over it, then call me" (p. 2, lines 13-14). Helen was philosophical about some of her broken friendships:

When I started to talk about it, I tried to talk about it with a friend, you know, and, I would hyperventilate... it would almost be like I was gonna have a psychotic break or something... I think that put off a few people, you know, and plus, they weren't my counselor... some of them probably weren't prepared to or could listen—for their own reasons. (p. 41, lines 1-28)



***Damaged relationships.*** Ten participants discussed various stages of damage to their relationships. The most frequently damaged but not broken relationships were with family members. Much of this damage was discussed in the emotional/relational section, as these damaged relationships also came with emotional pain.

***Positive effect.*** Three women found that the sexual assault functioned to strengthen the relationships that they had with others. Sarah told me that although she had always been close to her dad, the support he offered her after the assault (discussed in the mental health/relational section) helped them to become closer. Mimi reported that she and her dad, who was her “biggest supporter” (p. 12, line 20), also bonded further as a result of the experience; she said, “It made me closer to my dad” (p. 16, line 22).

***Romantic relationships.*** Nineteen of the participants reported that sexual assault had a negative impact on their romantic relationships. Sexual assault affected current relationships that included abuse, as well as future romantic relationships.

***Impact of sexual assault on relationship with partner and assailant.*** Five women in this study were assaulted by their romantic partners. Two of those women (Jo and Beth) cited the sexual assaults as factors in the breakups. The other three women told me that reasons for their breakups were more complex. In the mental health section, Jo told how the sexual assault by her husband was the breaking point in their relationship.

The three other women broke up with their partners for other reasons. Kris was assaulted right after she told her boyfriend that she was breaking up with him: “I had wanted to end the relationship and was telling him about it. And later that day it happened” (p. 4, lines 42-45). Louise and Gabby were married to their assailants for 46

and 25 years respectively. During this time, their husbands repeatedly sexually assaulted them. When I asked Gabby about the reason for their divorce, she said,

There were so many reasons for the divorce. Um, there were financial reasons, I was very depressed, there was my sexuality, there is the abuse from my husband. Um, there is so much wrapped up into why that divorce happened. (p. 21, lines 4-8)

Like Jo, Louise fought to keep her marriage together in spite of abuse inflicted on her by her husband. It was her husband's use of pornography, not the physical, sexual, or emotional abuse that pushed Louise to initiate the divorce. She explained, "Pornography had taken over. And he would—he refused me completely. And, um, to me, that was adultery" (p. 13, lines 37-40).

Jenny was the only participant who remained with the partner throughout her sexual assault experience. Jenny had been in a relationship with her boyfriend for 6 weeks when she was assaulted by a stranger. As discussed under the mental and relational interaction section earlier, Jenny and her boyfriend were still romantically involved at the time of the interview, but the sexual assault strained their relationship.

Four women blamed previous and or current lack of interest in romantic relationships on their sexual assault(s). Beth avoided dating men for 10 years "cause I feel like, you know, all the relationships I had, they all were bad" (p. 23, lines 37-39). Carmen simply said, "Right now, men disgust me" (p. 17, line 22). Dinah continued to be disinterested in any type of romantic relationship. She illustrated her opinion with these words:

Because if a guy came to me today, and he was the one—*the one*, and he wanted to get to know me, it's not going to happen. It can't happen. Not now. Because

I'm not receptive anymore... I have closed that door. There's no feeling about it. The door is closed. It's locked and it's bolted. (p. 38, lines 3-8)

*Impact of sexual assault(s) on sexuality.* Ten women disclosed negative impacts of their sexual assaults on their sexuality. Several of these women (n=4) talked about using sex to gain attention and approval after their assaults. Four of the women talked about being uncomfortable with sex or the idea of sex after their assaults.

Four of the women mentioned having sex for all the wrong reasons. As discussed in the mental health section, many women felt shamed, dirty, alienated, and powerless after being sexually assaulted. In an attempt to feel connected, loveable, approved of, and powerful, some of these women used sex. Patrice's quote exemplifies the quest for approval and attention: "Men have used me so much sexually when I didn't even want it, but I did it just because I didn't want them to not like me" (p. 5, lines 34-37). Anita told me about her pattern of sexual relations, which was similar to Patrice's:

I ended up in multiple situations where even if—if it was consensual, it didn't necessarily—it wasn't necessarily what I wanted.... It was just kind of what I thought I needed to do.... But I think whenever I did like anyone, it was like "Well I obviously need to like use my body to get them to like me." (p. 19, lines 3-53)

Helen admitted to a period in her life when she was "sexually promiscuous" (p. 15, line 38). She used sex to gain power. She acknowledged, "You know, the only way I knew how to use—I used what I knew to use for power, you know?... And, um, I slept with a lot of different guys" (p. 16, lines 2-8). Later, Helen admitted to misusing her own power to sexually abuse others.

As a teenage babysitter I did very small, in my mind, you know, like I said—I don't know how to say this. So, I had abused a couple of kids that I babysat. (p. 68, lines 47-52)

She explained her motivations at the time: “I know I was just a teen and I was, you know, angry and—and trying to get a sense of power, um, it doesn't make it right” (p. 69, lines 19-22).

Two women had difficulty differentiating between sex and sexual assault. Carmen stated, “Having sex is something I can't really do without being reminded” (p. 11, lines 26-27). Sarah echoed this sentiment: “Like I was a virgin when it all happened to me, so, I just, I don't know. That's like what I associate with sex, I guess” (Sarah, p. 9, lines 25-26).

As discussed earlier, Jo and Beth found a way to have romantic, supportive, and safe relationships with men without a sexual component. In order to keep herself safe from another violent sexual assault, Patrice developed two strategies. First, Patrice became a willing partner “because I felt I don't want to ever have to fight. So if a guy wants me sexually, then I'll just pretend I want it too” (p. 5, lines 22-25). Second, she found herself looking to date men who were less physically threatening.

I remember literally picking men that was my size. I wouldn't go with a big guy because I was afraid that if we're dating and then after five dates and then we go to his apartment and he wants sex and I don't... (p. 8, lines 32-37)

**Barriers to positive relationships.** I covered many of the barriers to positive relationships in the relational/mental health section. The participants described how hurtful reactions by others to their sexual assaults functioned as barriers to a continued

supportive relationship. In addition, participants also described how a lack of safety prevented them from forming deeply satisfying relationships.

***Lack of safety.*** Almost half of the participants (n=10) reported that after the sexual assault, they became much less trusting of others - Dinah, who was sexually assaulted by men and sexually harassed by both men and women, explained that she did not feel safe with any kind of intimacy: “Friendship at an arm’s length. Two arm’s length. Three arm’s length. Friendship at a distance... There’s that circle you’re not going to penetrate, even then” (p. 38, lines 14-18). Michelle, like many others, found it difficult to feel safe with anyone. She explained, “I would, I probably would say it made me less trusting. I don’t trust people at all. I am always waiting for my other shoe to drop... ‘Cause I hate to tell you, it always drops” (pp. 29-30, lines 43-8).

**Facilitators of positive relationships.** Despite all of the negative impacts of sexual assault on relationships, several participants talked about factors that facilitated positive relationships in their lives. The most common facilitators were forgiveness, logistical support, presence, and avoiding sex. While these factors facilitated deep and positive relationships, some women purposefully withheld truths—about their assaults and the resulting pain—to maintain positive (though somewhat more shallow) connections with others.

***Forgiveness and compassion.*** Three women spoke about the concept of forgiveness and how it helped to heal previously damaged relationships. Recall Ella’s story of forgiving her mom under the mental health section of this chapter. Helen told me that she no longer felt angry toward her mother or brothers for abusing her. This forgiveness and sense of compassion came from her larger belief that “it’s a lot easier to

feel compassionate towards everybody in general when, um, you know—when I realized that nobody wants to be miserable” (p. 27, lines 33-36). Beth had a negative relationship with her mother for most of her life. She recalled being ignored and called a “liar” (p. 26, line 36) when she tried to tell her about her sexual assaults as a child and as an adult. She described her mom as “mean” and “cruel” (p. 33, lines 22-23), yet she still found a way to develop a close relationship with her by showing endless compassion and forgiveness.

I never retaliated back. I mean, she called me like, as soon as I got off work, she’s like go get me my sandwich, or do this, do this just for—I did it. And I’d bring it back to her. And I never did nothing mean. I—everything was—I just kept being nice to her. And so I guess it—I don’t know how it ended up happening. So um, I was always there for her. When she needed something, I was always there. (p. 37, lines 18-28)

***Willingness to hear about pain.*** Several participants talked about the importance of being able to express their thoughts and feelings to facilitate a close relationship. Jenny and her boyfriend had many relationship difficulties after her sexual assault by a stranger. One of the main difficulties was that Jenny felt that she could not talk to him: “It’s really affected our relationship because just for a lot of reasons....because he didn’t listen for so long” (p. 9, lines 36-39). Jenny and her boyfriend were starting to repair this relationship, in part, because he expressed his willingness to listen to her: “My boyfriend’s the only one that’s actually said, you know, ‘You can say anything to me’” (p. 23, lines 33-35). Recall how Helen and Beth became closer to their partners, in part because they were able to listen to them. Helen’s husband listened to her bad dreams that frequently involved sexual assault. Beth’s boyfriend attended therapy sessions with her, where he heard about the impacts of her sexual assaults.

**Logistical support.** Two women talked about how logistical support from their families helped facilitate their relationships. When I asked Hannah what was most healing or helpful after her sexual assault and subsequent battle with alcoholism, loss of her home, care, and custody of her children, she replied, “A roof, and rides to work and stuff” (p. 8, line 9). Hannah received this logistical support from her grandparents.

They’re not like emotionally—they’ve never been like emotional type people.... If they wanted to say “I love you,” or “You did a good job,” you know, they’d give you money, or something you wanted... I mean, I guess the way they show that that they care was that. (p. 8, lines 1-17)

**Avoiding sex to preserve relationships.** Two women told me that they avoided having sex, in part to preserve relationships. Gabby told me that sexual relations ruined some of her relationships.

I find it easy to build rapport with somebody; I find it easy to get close emotionally. And, I have had that in many relationships. But, in the few relationships I’ve had ... I find it very well until we have a sexual encounter. And then I feel guilty. And then, like that shouldn’t have happened. Or it changes things for me. (p. 28, lines 14-19)

Beth, who was in a long-term romantic sexless relationship with a man, simply said, “I got a tendency, like if I have sex with somebody, I hate him...I don’t want to hate him. Yeah, I don’t want to hate him” (pp. 45-46, lines 51-56).

**Safety.** When discussing relationships, many women talked about how important it was for them to feel safe with another before they could deeply engage with them. They needed to know that the other person would not say hurtful things to them—about the assault, or about anything else. Arrica had not formed friendships with others for her entire adult life. She listed many reasons for this: She was too busy, she did not feel the

need, and her ex-husband always made them feel awkward. Now that she felt safe for the first time in her life (discussed above), she allowed herself to have a close friend. She described her friend and the safety she felt with her.

We both, we both come from something in our past that really kind of—so I would say that—(sighs) that my foundation personality and hers—are probably the same... And, feel safe—that what you're saying—you can say anything and feel safe that—this is as far as it's going. (p. 33, lines 5-14)

### **Relational and career health.**

*Negative.* Michelle, who was assaulted by her supervisor in the military, suffered the most extreme negative interaction between her relational and career health. She said that everyone thought that she overreacted and was “ruining this guy’s family, his life” (p. 5, line 15-16). For the next year, Michelle experienced ostracism and threats from her fellow soldiers.

Threats, try to run me over [laughter] with a vehicle when I was walking to work. I mean, just—it was not good. God, I just didn't even think about... People that you thought were one way, they wasn't. It took a long time. Almost a year before—mm you know, before people would socialize with me in public. (p. 5, lines 20-33)

Helen also had difficulties in her work that she connected to her difficulties relating to others in a healthy way after her sexual assaults. Looking back, Helen suggested that her methods of coping with feelings of powerlessness on the job interfered with her ability to function well. She explained,

Certain men that I would work with would trigger, um, kind of like control issues, like, you know, um, I've had great bosses and I've had bosses that were very domineering and, um, almost reminded me of, you know... my abuser, and I didn't want to comply. I wouldn't be compliant, you know? ... I didn't—you know, so, um, I might not get my work done, you know or something for that person. (pp. 26-27, lines 44-48)



**Positive.** Two participants found that their history of sexual assault assisted them in being more successful in their relationships with clients in their paid or volunteer jobs. Louise worked as a volunteer in one of the agencies that serves sexual assault victims/survivors. In the following passage, she described how her history, and her ability to relate with others helped her to be more effective in her position, for example with

a young girl—teenager. And she had been raped. And they thought she was handling it, but she wasn't. And she had, like, tried to commit suicide. And so, I was called to the hospital... Anyway, so she was in the room with us too and her mother and an aunt that she had been living with... some of this stuff hadn't been making sense to her... maybe, it finally did make sense to her when I was able to say to her that I understand how it can be confusing that a lot of things you don't understand that—I said, I too had been raped. “And I know how it messes with your head.” And she just—her eyes popped open and she said, [emotional] “Thank you so much for saying that to me.” (p. 44, lines 4-41)

Two participants told me that their spirituality helped them to interact with their assailants with more kindness. Ella described how her higher power helped her in relating to one of her assailants:

I pray every day and I just, you know, I feel like God really shapes a lot of, you know, how I live my life. And even, like, with “Danny” like what I spoke to about not wanting to hurt him and stuff, I feel like that's the part of me that, like, God teaches me to love, you know. Like even though, you know, I don't want anything to do with him, I want to have enough love and grace for him to just let it go and not like freak out on him and put that all on him. Just let him be. (pp. 25-26, lines 44-45)

### **Relational and spiritual health.**

**Negative interaction.** Three women talked about how they were emotionally wounded by their spiritual/religious communities. Dinah was told by fellow female

congregants that she made their husbands feel uncomfortable when she talked about a recent encounter in which she was sexually harassed.

I was in that church group one time and I was describing what had happened to me at the gourmet food place with that guy sliding his hand up and down my backside... One of the women told me that it made their husband uncomfortable—they didn't know how to react to me. (pp. 12-13, lines 29-1)

Jo did not find her spiritual community hurtful to her with respect to the violence against her, but she found the focus on the superficial nature of her previous congregation as well as Christianity in general to be upsetting:

I think that, um, the problem with the church is everything's so cookie cutter. Like, I looked like I was doing everything right. I mean my husband had a good job. He owned a business. Then he sold it and became a union member. We had a nice home. I had three kids. My kids played soccer. Everything looked just right. But, he was abusing me. It was a sick situation. And I got so much approval 'cause it looked right, but it was not right. (pp. 9-10, lines 49-10)

Jo and Alicia experienced feeling silenced by church leadership when they tried to talk about sexual assault and or intimate partner violence. For Jo, this silencing behavior began as a child, when she confided in her minister that her father was abusive to her family, and he told Jo that he did not believe her: “When I was younger, when I was a kid, my dad was abusive. And I went and told my pastor. And he was like ‘no.’ He didn't believe me” (p. 12, lines 9-12). Jo also experienced this silencing from religious leadership in her education. She explained that she was attending graduate school at a private Christian university because of its convenience “‘cause it's one night a week” (p. 10, line 32). However, she paid for this convenience by having to stifle her anger in the classroom when her Baptist professor talked about traditional nuclear families being the only valid family structure. Sometimes, Jo felt as if she needed to speak up: “I feel like I

can't help it" (p. 26, lines 8-9). She told me that she was working with her therapist to "survive the program and not get in trouble" (p. 25, lines 44-45). Alicia was surprised and hurt when her minister effectively silenced her by telling her that she didn't like to talk about bad things, like sexual assault. Alicia went into more detail:

I did tell the minister about the event [film about sexual assault in the military] that I did... Because she likes to attend events in the community with members of the church are either partaking in or running, or whatever. And, um, so usually she would talk about those things. So I told her about the event that was taking place, and that you, know that I would be speaking at it, and that she should attend. She said, um, "I don't like bad things like that." I was really surprised... I haven't gone much since then... That kind of turned me off a little bit. I was like, "You don't like bad things? You're a minister in this community, and bad things happen to people." You know? (p. 22, lines 1-9)

***Positive interaction.*** Many women found that a close relationship with their higher power was helpful in their healing. This theme was present only in conversations with women who identified themselves as Christians (n=14). Half of the women who identified themselves as Christians felt that they had a close relationship with their God. Although Jo struggled with some authority figures within the Christian community, she noted that her personal relationship with her God helped keep her strong. Jo's quote exemplifies this theme of a personal, protective and reassuring relationship with her higher power:

Yeah, I know it helped me get through the assault and everything because, uh, I just always felt like no matter what happens, God's going to be with me. No matter what, it's the only thing that will never go away. (p. 11, line 11)

Three women emphasized the importance of relationships within their spiritual communities as a positive force. Patrice and Melanie participated in and attended Christian churches, but said very little about their relationship with a higher power.

About God, Melanie simply said, “I interchange calling God the universe, and universe God. To me, they are one and the same” (p. 35, lines 12-13). Although Patrice rejected many of the tenets of the Catholic Church, she enjoyed the sense of community she got from attending and participating in events. She discussed her distaste for the religion itself but love for the community she found there:

I enjoy the community of people that are spiritual, but I don't really believe that, “Oh, if I want to get married in the Catholic Church I have to annul my other marriages” and all that bullshit. I'm like I believe that God doesn't have that strict of a policy of like how I'm accepted in the Kingdom of His heart, you know, that as long as I'm willing to do, um, right by my neighbor and I'm loving and kind that there's not all these strict rules that say, “You can't get in if you didn't pay money to the church and you can't get in because you didn't receive communion. Oh, you can't get in the God's—I don't approve of you because you haven't been to confession,” like the Catholic Church is so strict on all these things that you're supposed to do to be part of the Church... I'm not a member of the Catholic Church. I attend the Catholic Church. I, I volunteered at cook dinners for the college students because I liked that. It's fun and it's a way to give to the community back. Because I don't have money, I'd rather give of my service (p. 43, lines 19-49).

**Summary of relational health.** All of the participants experienced some negative impact on some or all of their relationships as a result of having been sexually assaulted. In the aftermath of sexual assault, many women lost friends and experienced strained relationships but a few women experienced growth and the deepening of their relationships as others gave them emotional and logistical support. An overwhelming majority of women expressed a negative effect of sexual assault on their ability to engage in deeply satisfying romantic relationships. Several participants discussed a sense of fear and or lack of interest in romantic relationships. Many participants experienced confusion about the role of sexuality in relationships while several women discussed using it to gain affection, attention, or power. Feeling unsafe prevented many women

from engaging with others, a sense of safety, however, facilitated positive and deep relationships with others. In addition, forgiveness and compassion and a willingness to listen facilitated positive relationships with others.

Relational health strongly influenced, both positively and negatively, all of the other wellbeing domains. Relational and mental health interacted almost constantly. Negative relational health had a negative influence on work and spiritual health. The opposite was also true. When women had positive relational health at work or with their higher power/spiritual communities, they flourished.

#### **Domain 4: Career/Educational/Financial Health**

Nineteen of the participants perceived some type of impact of their sexual assault on their c/e/f health. Of these 19 women, 15 experienced negative c/e/f impacts after their sexual assault. Six women were actually assaulted either at their place of employment or by their supervisors off their job site. Ten out of these 15 women found ways to ameliorate this impact, but others continued to experience negative c/e/f outcomes years later (n=10). Some women actually experienced a positive c/e/f impact because of their sexual assault (n=2). In this section, I will discuss the impacts of sexual assault on the c/e/f health of women—the good, bad, and qualitative impacts. I will also discuss the strategies women used to improve their c/e/f lives.

**Assaulted on the job by supervisor, co-worker, or boyfriend.** Six women were assaulted either on their jobsite by their boss, co-worker or boyfriend (n=4) or by a supervisor (n=2). Alicia and Michelle were both assaulted by their military supervisors, Helen was sexually assaulted by her boyfriend, and Patrice by a co-worker at a jobsite. Alicia and Michelle had both liked and admired their supervisors before they were

assaulted by them. Alicia said, “He was the perfect drill sergeant” (p. 32, lines 28-32). Michelle said that her assailant was “a good friend, a person that I looked up to. Was like, what I thought was gonna be like a mentor when I first got there. But he wasn’t” (p. 2, lines 33-36). Helen was sexually assaulted by her boyfriend when she was working as a waitress in a bar. Following is her story of how this happened:

One of the assaults took place outside of a bar that I was working in and my boyfriend at the time—I was living with him—he was angry about something and very drunk and he came down to the bar and caused a scene and so, I took him outside ‘cause I didn't want to lose my job... And the bar was right next to an alley. He pulled a knife out...held it to my throat. I thought he was going to kill me... And sexually assaulted me right there. (p. 2, lines 7-27)

Both Melanie and Mimi were assaulted away from their worksites by their supervisors. Melanie recalls being sexually assaulted by two of her supervisors, while a third objected but then left the room. Because she was intoxicated, she only remembered bits and pieces of the assault.

I was blackout drunk... They were technically my bosses to a certain extent. I remember very few things, but I remember being told that I was not ever allowed to tell anyone what happened.... I remember nothing until I woke up naked on a bed with all of them around me... And then I remember saying no and being very distinctly being told that “that wasn’t fair’... the (third boss) didn’t stop anything, but he didn’t do anything though. So, he didn’t do anything technically, but at one point, I remember, being like—he left the room? And, I was really bummed, because he was the one who was being nicest. (pp. 2-3, lines 7-8)

**Back to work after the assault.** With the exception of Melanie, whose job ended just before her assault, each of the women tried to continue her work life as usual.

Mimi’s quote exemplifies this (work) life as usual: “And so, you know, I kind of just, you know, set it to the side until, um, until you know I started asking for that raise” (p. 5, lines

19-21). One of the reasons the women continued working was that, with the exception of Michelle, they did not consider their forced sex as sexual assault. Helen said:

There was nobody I could talk to about it, and I didn't feel worthy to even, you know...as a person back then. I didn't even feel worthy to, um, consider it something that, you know, I should get upset about, you know? (pp. 2-3, lines 48-3).

Michelle planned to continue her military work life as if nothing had happened, but after she disclosed the sexual assault to her father, she lost all control over the situation. She called her dad because she was troubled by the attack: "I just told my dad 'cause I was upset about it and just wanted to—I had just got to a foreign country so..." (p. 3, lines 20-23). Michelle's disclosure to her father led to a cascade effect that changed her military career forever. She was performing her routine military duties when

I just got a call saying to come to the orderly room which is like an office... And my platoon sergeant was standing there and—my uncle was like high ranking like lots of ranking. They were like, "This happened and you didn't tell anybody?" ... I was like, "What?" You know I was kind of confused because only person I talked to was my dad (p. 3, lines 31-44), ... my father who informed my uncle who was in the military. Who informed the higher ups." (p. 3, lines 17-20)

I will return to Michelle's story under the section on short- and long-term impact on work environment.

#### **Negative impact on career/educational/financial health.**

**Loss of job.** Two women (Sarah and Mimi) lost their jobs during the immediate period after the assault. Melanie was kicked out of her academic program soon after her assault. Hannah lost her job, car, and apartment in the first few years after her assault as her drinking escalated. As discussed earlier in the mental health section, Sarah lost her job after she slept in late too many times while taking medications intended to treat the

PTSD and depression that were diagnosed after her sexual assault. Mimi, who was sexually assaulted by her supervisor, was also fired by him soon after her assault. She remembered, “The following Monday I was fired without cause, without reason” (p. 5, lines 31-32). Melanie, who started drinking excessively after her assault to “numb” (p. 6, line 4) everything, began missing class and was kicked out of her academic program as a result:

I had gotten kicked out of my program, like all sorts of stuff like, shit hit the fan. It was a really bad year.... it was my program that I got kicked out of. In our program, we had to go to class—we had very strict attendance [and] I just mentally was not there at all, so... (p. 5, lines 17-24).

***Short-term negative impact on financial/career/educational health.*** Two women, Carmen and Jenny, participated in the study only 3 months after their assaults, which was too early to detect a long-term impact; but both women did tell me that they had difficulty at work related to their sexual assaults. Carmen said,

In the beginning, no, I wasn't able to concentrate the same. And, um, I find that I have some days where everything just seems really bad. Um, and it gets better and better as time goes by, but I just have days where I just cry. Go into the bathroom at work and just cry. Um, it just makes it to where the littlest things can seem so big. You know? And, it could have nothing to do with, you know, the actual act, you know, but, it just makes, kind of like your coping goes down, you know? (p. 12, lines 21-27).

Only time will reveal whether Jenny and Carmen will continue to experience negative impacts on their c/e/f health. Jenny found that functioning at her job was difficult and said, “It's hard for me to even, like, walk around” (p. 14, lines 31-32). She did express hopefulness about her prospects, though, because she disclosed to her boss about the



sexual assault and found that “She was really understanding and awesome about it” (p. 14, lines 36-37).

*Long-term negative effects on c/e/f health.* Two women, Jo and Michelle, told me how their assaults had negatively affected their career and education. Michelle expressed feeling that she had to change her personality to survive:

You just had to survive. And so, that’s always been my instinct in the military is just to survive (p. 11, line 31-33) ... I was a mean bitch. You know... With, I mean, excuse my French but that was what I was. I was like—I was like get down, give me 100 pushups, get up, now go. You know, I was that chick. (p. 17, lines 11-19)

Ironically, although Michelle felt that the Walter Reed program benefited her as a person and as a soldier because she became more sympathetic and able to communicate better with “lower ranking soldiers” (p. 14, line 47), she experienced more tension and even reprimands from her supervisor after attending. She explained how she assisted a female soldier in need and the negative consequences she faced in an environment that cared less about people than about a mission.

This girl was going through something. And I could just see it in her. And I used to just like, you know, “It’s not my problem, it’s not my issue.” And when I—when she—when I got back and when I would reach out and try to talk to her, that’s when I found out she was raped. She was—she really had so many problems before she came in that nothing was gonna help her but counseling. She had a kid which was a product of the rape. And I talked to a counselor and got her seen in, you know like an emergency session and that pretty much saved her. She was just in such a dark place... And they were just trying to kick her out. And nobody was trying to figure out what was going on with her... And then after that I got reprimanded for my—the same First Sergeant was like, “Oh, now we gotta be stuck with her in the military and people gotta escort her. And we’re taking time away from people. I mean I don’t care, she kill herself, she kill herself.” Because that’s their mentality, they don’t care. It’s all about the mission, the mission, the mission. (pp. 14-15, lines 48-39).

Although this new sensitivity and ability to connect with others hurt Michelle in her military career, Michelle did find that these characteristics helped her “transition to become a civilian” (p. 17, lines 30-31). As discussed in the c/e/f and relational section, Jo had a difficult time in her classes because she felt “triggered” by her professor’s emphasis on the traditional family.

***Long-term positive impact on career/educational/financial/educational health.***

Two women found that their sexual abuse and assault helped to make them more effective in their work. Anita found academic success; Louise found herself able to connect better with sexual assault victims/survivors in her volunteer position. Anita found that her history helped her to focus and achieve.

I—actually I think that all of my trauma and stuff, I had to focus on something... And so I focused really, really hard on school. I mean, I graduated school cum laude, with like a 4.0 in college, um, worked like three jobs, maintained relationships. Um, I’ve never—I’ve always been a very good worker. (pp. 34-35, lines 48-5)

In the previous section, under the interaction of relational and c/e/f health, I discussed how Louise’s history of sexual assault assisted her to be more effective in relating to sexual assault victims/survivors in her volunteer position. Louise became a volunteer at one of the agencies and found that she had a unique perspective and ability to help other sexual assault victims/survivors. Her discussion of this experience was related earlier, in the relational and c/e/f section.

***Qualitative impact of sexual assault on financial/career/educational health.***

After experiencing sexual assault, three women changed their career trajectory to be in a career or volunteer position that helped women. Hannah and Carmen both specifically

wanted to help sexual assault victims and survivors, while Mimi wanted to help women in general. Carmen was hoping to do an internship with one of the agencies. Hannah, who was majoring in psychology, planned to go into a field where she could help sexual assault victims/survivors. She said, “I thought, ‘There’s nobody for rape victims to talk to,’ so I will go to school to do that” (p. 7, lines 7-8). Mimi, an attorney who felt angry over the prosecutor’s decision to not try her assailants, told me that she now planned to “go in and do women’s rights” (p. 11, line 31).

**Barriers to positive c/e/f health.**

**Lack of safety.** One of the biggest barriers to positive c/e/f health was a perceived lack of safety. When Michelle was ostracized and others in her military unit attempted to run her over, she reported it to her superiors, who minimized her concerns. She said that their response was, “‘You’re a private, you’re a new person and you just stay out of their way. They’ll calm down’” (p. 6, lines 10-12). As a result, she prioritized just surviving. Jo felt emotionally unsafe in her classroom when she felt traumatized by her professor’s exclusive emphasis on traditional, nuclear families.

We got into family therapy class, and I felt like I couldn’t... I gotta get out of here... I was like, “This is triggering me more than anything, remembering the marriage counseling, listening to my professor. Just coming from a Baptist college, and he’s not, um—he’s very conservative and, you know, listening to his views on family and everything he was teaching us, I just felt so, like, angry. Like, it’s because of shit like this that I ended up like I did. And you’re wrong, and you shouldn’t tell people that that’s the only healthy family structure because it’s not. It triggered so many memories. (p. 25, lines 11-28)

**Rules are rules.** Two participants told me how the strict adherence to rules without consideration of context hurt their c/e/f health. Sarah was fired because the medication she started for her PTSD caused her to sleep in and report to work late too

many times. When I asked her whether her supervisors knew about her sexual assault and the treatment, she said yes but added, “But then they said there wasn’t really anything they could do” (p. 4, lines 2-3). Gabby was not fired, but she was reprimanded for being sick often, which she attributes, at least in part, to the physical, sexual, and emotional abuse she was experiencing. She wished that her supervisor or co-workers would have offered her some assistance, like resources, instead of ignoring her obvious abuse and punishing her. She said:

I wished the people I worked with—a supervisor and a co-worker—would have been more supportive when I was going through some things. And I had a bruise here once (indicates abdomen), and my shirt rode up or something, and a big deal was made about it by a co-worker, you know, we were eating lunch together, and I really felt that my supervisor knew something was going on. But, I wish she said, “Here’s something.” Or, “What do you need?” or you know, “Your health has been really bad, your absenteeism has been bad, is there something we could do?” And not get written up. (p. 27, lines 10-19)

#### **Facilitators of c/e/f health.**

*Meaningful.* Several women (n=6) found that doing a job that was meaningful helped them to enjoy it and thrive. Because Helen’s husband earned enough income, they decided that she could quit working for money and do something that she enjoyed. She found she enjoyed volunteering with the elderly. She explained that working with the elderly “gets me out of my head and helps me focus on other people” (p. 44, lines 12-13). At the time of the interview, she was looking for more ways to help others in the community.

I’d like to work with pregnant teens (p. 66, lines 30-31)... Even if you think at that age you’re happy to have a baby, it’s such a mind—excuse me—it’s a mind fuck.... and then you have people giving you dirty looks all the time. (p. 68, lines 6-14)

**Safety.** One woman, Sarah, emphasized how feeling safe at work helped facilitate her success. However, Sarah noted that she was not back on her “feet again” (p. 8, line 8) after losing her job that paid well after her sexual assault. She was working in a job where she felt safe to express her panic attack symptoms and get assistance without any punishment. She told me,

The store manager, well, all the managers—I’ve told them like what had happened, so when that happens, they like take me to an empty office and they’ll like sit with me and you know, “Do you want to call your dad? Do you want us to call you a cab? Do you want to talk about something else?” like [to] distract me. (p. 8, lines 26-30)

**Being tough.** Dinah mentioned several times throughout the interview about her perceptions of experiencing sexual assaults and maltreatment because of her self-diagnosed Asperger’s. She found this experience to be an asset in tough work environments. She explained:

A lot of people—that environment—broke them. I thrived in that environment because I was already used to dealing with that kind of mentality... So, that didn’t faze me too much. It was like—yeah—they’re nasty, they treat people like crap, and that’s the way I’ve been treated all my life—there’s nothing new to that. Just pay me and let me do my job. (p., lines 18-26)

### **Interaction between spirituality and c/e/f health.**

**Negative interaction.** Jo left her job in the ministry, in part, because of the way that the church dealt with intimate partner and sexual violence. In her new church, where the minister was supportive of victims/survivors of intimate partner and sexual violence, she had another barrier to resuming this career. One of her daughters identified as lesbian, which is contrary to the teachings of her new church. Because of her love and

commitment to her daughter, Jo said that she was unlikely to return to this type of job.

She elaborated:

She was like the star athlete, really popular and blah blah blah. Um, so she went through mental health crisis where she was in and out of ER, blah blah blah. And the end result ended up being that she's gay. And she was afraid to tell me... Of course, I mean I was in ministry. In that church, all they ever heard was how wrong that was, and she was scared to death. I mean, I'm lucky I didn't lose her. So, after that, yeah, my spirituality changed [laughs]... a lot. I don't want to be in ministry, I don't think, anymore. (p. 9, lines 25-38)

**Positive interaction.** Three women spoke about how their spirituality and c/e/f interacted in a positive way. Louise found that her higher power helped to guide her to volunteer with other sexual assault victims/survivors. In addition, she felt that her higher power helped her connect to others.

This is just another thing that God has showed me that I should be doing—that is okay for me to be doing. And he supported me all the way to this... I know it's not a Christian organization, and so I don't try to push things, um, that way. But, whenever it's appropriate, um, I do share—and when it's appropriate, I don't go into details. (p. 43, lines 36-51)

Two other participants spoke about how their jobs (paid and unpaid) helped them live out their values of helping others. Kris told me that she loved her job. Her job also entails helping sexual assault victims/survivors. Her job gives her “a lot of purpose” (p. 27, line 34) and is compatible with her philosophy of life, which is to “give a little every day instead of taking so much” (p. 28, lines 6-7).

**Summary of career/educational/financial domain.** Sexual assault had a negative effect on the c/e/f health of many women. More than a quarter of the participants (n=6) were assaulted at their place of employment or by a co-worker/supervisor away from their job. Some of the recently victimized women spoke of having difficulty coping

or doing minor tasks on their job. Other women lost their jobs or spot in academic programs within a year after their assault. One woman also lost her apartment and car after her assault. A perceived lack of safety and a strict adherence to rules without consideration of context functioned as barriers to success in the workplace. Spirituality interacted negatively with c/e/f health for Jo, when she found that her evolving thoughts about LGTB issues clashed with her church where she had a ministry position.

Some women also found that their history of sexual assault enhanced their academic or career abilities and opportunities. Two women found that sexual assault facilitated their success in their jobs. Louise found that her history of sexual assault enhanced her ability to communicate effectively with other victims/survivors. Anita found the challenges of academic work to be a pleasant distraction from her traumatic history. Several women found that their history of sexual assault helped to steer them toward a career or job in which they could help other sexual assault victims/survivors. Having a sense of safety and purpose helped many women to enjoy and thrive in their work or academic life.

### **Domain 5: Spiritual Health**

Several women spoke about the relationship between their sexual assault(s) and their spiritual health. Some women spoke about how their sexual assault(s) had an impact, either positive or negative, on their spiritual health, while other women talked about how their spirituality and or religion gave them a positive or negative context that guided the way that they responded to their assault(s). While some women spoke about their spirituality and/or religion in the traditional sense, for example Baptist or Buddhist, other women spoke about their sense of spirituality in a more oblique way, sometimes

even telling me that they did not have any sense of spirituality or religion. In terms of religious identity, slightly more than half (n=12) of the participants identified as Christians. The remaining ten participants identified themselves as atheists/agnostics (n=8), Buddhist (n=1), or did not identify their religious identities (n=1). The small sample size limited the rigorous analysis of associations between demographics and spiritual/religious identification. However, based on the small numbers, there was no pattern of demographic variables and identification with religious/spiritual practices/beliefs. The eleven oldest participants were equally as likely to identify as Christians (n=6) as the youngest participants (n=6). The oldest participants were only slightly less likely to identify as atheist/agnostic (n=4) as the youngest participants (n=5). There were no other patterns between demographics and religious/spiritual beliefs. As I discussed in chapter three, one of my advisors encouraged me to think more expansively about spirituality and religion. With this new approach, I relied upon two similar definitions of spirituality and religion, which describe both as philosophies of life that guide us in our thoughts, actions, and connections with others.

Although more than half of the women (n=12) told me that their sexual assaults had no effect on their sense of spirituality or religion, many participants talked about how their overall philosophy of life changed. While conducting interviews and initial data analysis, I interpreted the “no effect” answers literally and did not dig deeper.

**Negative impact on spirituality.**

***Sexual assault(s) and violent relationships – loss of faith.*** Gabby and Beth both talked about how the violence inflicted on them led them to lose faith in their higher power. Gabby still felt ambiguous about her beliefs, though Beth rediscovered her faith



after spending time healing and searching. Gabby told me that she had had a strong Christian faith, but that it changed after experiencing violence from her husband:

I think I had good faith and um until about age 30, um, and then I really felt that my husband was, at that point, a man, and a man of God. But, after really starting therapy and then realizing some of the things and then realizing some of the things that, um, were different in our household, maybe compared to other people do, with sexuality or their relationship, so, or I kind of lost faith a little bit. (p. 10, lines 17-22)

Beth did not mince words about her loss of faith.

It changed—it changed when I was—the first guy. It changed. I—‘cause we was raised in the church, and I blamed God for how he was treating me for a long time. I stopped going to church, I didn’t pray, I didn’t read the Bible. Nothing. It was like, I blamed Him. (p. 25, lines 9-15)

Beth did find a way back to her faith, which will be discussed in the section on positive impacts on spirituality and facilitators of spiritual health.

***Sexual assault(s) and loss of faith in justice.*** Two participants reported that their worldview of justice in general, and in law enforcement in particular, was negatively affected after their assaults. Adrian, who thought she was “doing the right thing” (p. 12, line 34) by reporting her sexual assault committed by a neighbor, became a suspect in his murder when he died suddenly (later ruled a natural death). She talked about how the justice system failed her:

If they had they put an ounce of the effort into my rape case as they did into trying to blame it on me, maybe... things would have been different.... Maybe I wouldn’t have had to go back and beg for justice from the prosecuting attorney. (p. 5, lines 12-18)

Before she was sexually assaulted, Mimi had a lot of faith in justice and the law. That made sense, because she was an attorney. However, the way in which she was

treated by law enforcement and the legal system after her assault caused her to question her beliefs in this system:

It really made me reconsider being an attorney at all. You know this isn't what I want to do if it doesn't actually help people... you know it's—in law school you take the case, no matter what, and you fight it. And to not take cases because there is not enough physical evidence like that. (p. 10, lines 40-47)

*Other causes of loss of faith.* Two women, Dinah, and Jenny, talked about their gradual loss of faith and beliefs in their prior spirituality and religion. Both women told me that they had identified early as Christians. Dinah was raised as a Catholic but considered herself an atheist; she said, “I see nothing around that indicates the kind of God I was taught to believe [in]” (p. 5, lines 29-30). When asked if this loss of faith had anything to do with the sexual assaults and harassment she had experienced, she answered that it was one of the many influences. She said:

It didn't help. It might have gone that way on its own eventually, but it made me question. And, not just the sexual assaults, but having Asperger's and in general and being teased from a very young age, and being made fun of. It just pushed me into this area where “This doesn't make sense—what I'm being told.” (p. 6, lines 6-10)

Jenny began questioning her Christian faith when her 21-year-old boyfriend and father to her two young girls suddenly died. The faith that Jenny had been gradually losing before her sexual assault was completely lost after her assault. She said, “It happens. Stuff like that happens to everybody, and I feel like it's—that person made that conscious decision to do that... I mean, if I would have prayed, he still would have done that” (p. 22, lines 3-17). Another common theme was the negative impact of the sexual assaults on the participants' relationships within their faith communities.

*Negative impact on relationship with spiritual or religious community.* Six women spoke directly about their strained relationships with persons of their spiritual and or faith community after they were assaulted. Some of these negative relationships were with the church leaders, others were with fellow congregants, and some were with family members who had shared their beliefs.

*Religious/spiritual leadership.* Five women spoke about their views of church leadership becoming more negative after their sexual assaults. Three of the women found themselves feeling more negative not only about the way their churches responded to sexual assault, but also about the ways in which they viewed sexual orientation. The main reasons women felt hurt by their spiritual/religious leadership were due to silencing and or blaming of sexual assault victims/survivors.

Dinah, who was raised Catholic, felt silenced even before she was sexually assaulted. She grew up in the Catholic Church learning about Maria Goretti, the patron saint of purity. She suggested that the tale of Maria Goretti serves two purposes in the Catholic Church: to convey the idea that it is better to die than to be raped and thereby made impure, and that being sexually impure, even as a result of being assaulted, means one cannot become a saint or a highly revered person in the church. She told the story of Maria Goretti.

Maria Goretti was an Italian peasant girl. She was 12 years old. And, she was assaulted by somebody in her village—a boy she knew, an older boy. And, he wanted to have sex with her. And he verbally said things that he wanted to have sex with her. And, she said “No. It’s a sin. It’s a sin.” And he got angry, and he took out his knife and he stabbed her. So, he did not rape her. He killed her. She lived long enough to forgive him from her hospital bed. But, she became the patron saint of rape victims... Because she didn’t—he killed her instead of raping her... I have never heard of anybody being canonized that was raped and lived to tell the story about it... She is the patron saint of purity... But, you know, she is

the closest thing to the patron saint of rape victims that there is in the Catholic Church. And, that says nothing to the woman who has gone through the experience and lived to tell about it... You know, to me, that is a very destructive, destructive image. (pp. 32-33, lines 18-16)

Anita echoed this sentiment. Although Anita was “very against religion and things like that,” she actually considered herself to be very “churchy” (p. 37, line 6) for a period in her teens. She described how church gave her a feeling of belonging, saying, “I think I liked it in the sense that I had a group of people and I had friends and it felt like it was the right thing for me at that time” (p. 37, lines 10-12). In addition, she was involved in church because “I think I was just so desperate for someone to help me that I thought well maybe God can do that” (p. 38, lines 48-49). Her connection to the Catholic Church started to weaken after her assaults because she felt as if she wasn’t pure enough for God or her church: “It was like well I’m never gonna be good enough because I’m not a virgin” (p. 38, lines 44-46). Her connection to the church also started to fray because she was coming out as a lesbian, which, according to her church, made her “such a sinner” (p. 38, line 29). Religious leaders were not the only hurtful individuals in religious and spiritual communities. Participants found other members or congregants to be unkind as well, as is discussed in the spiritual/relationship interaction section of this dissertation.

Positive and negative effects on spirituality were not mutually exclusive. Many women who experienced negative changes in their official religion or philosophical beliefs also experienced positive effects. Four women felt a stronger connection with their higher power after the sexual assault because, they explained, their higher power put people and situations in their life to help them learn, grow, become strong, and help

others. Each of these women had felt that she had grown, learned, become stronger, and helped others through this process.

**Positive role spirituality/religion.** As discussed earlier, several women found that their sexual assaults had a negative impact on their spiritual/religious life. And, some of the women felt harmed further by the way that their spiritual/religious communities responded to sexual assault. None of the participants felt that her spirituality or religion was strengthened by experiencing sexual assault. However, several themes emerged that addressed ways in which spiritual/religious beliefs and communities helped the women: coping strategies, close relationships with a higher power, feeling part of a greater plan, and finding a more fitting, supportive spiritual/religious home.

**Religious/spiritual coping strategies.** Eight women talked about how certain spiritual or religious coping strategies helped them heal after their sexual assaults. Most of these women (n=7) discussed the helpfulness of prayer in helping them get through their assaults and other negative issues in their lives. Ella found that praying helped her cope not only with the sexual assault, but also in dealing with one of her assailants, “Danny,” a distant family member. Beth found that praying, reading the Bible, and listening to gospel music help her to cope. She reported:

I pray. I read the Bible sometimes. Um, I listen to gospel music all the time. That helps—that keeps me grounded majorly. Um, ‘cause even when I’m driving, I have to have gospel music on. Um, it helps—it helps keep me focused and grounded ... constantly, every—pretty much like all the chances I do get, I try to pray. I say something to him... You know, because um, ‘cause I feel like that’s what’s keeping me going. That’s what’s keeping me strong to deal with it. (p. 28, lines 25-44)

***God as orchestrator of life.*** The idea that everything that happens is part of God's plan was a theme of several Christian women (n=4). Each of these women felt that God put people and situations in their life to help them learn, grow, become strong, and help others. Despite Mimi's history of being in an abusive relationship and being sexually assaulted multiple times, she expressed the belief that God allowed her to be assaulted so that she could better assist other victims and survivors.

You know coming through and after processing it and seeing how you know it's made me want to speak out and want to, you know, be a voice for people that don't have a voice. You know, well, maybe that was his plan. I had to go through it in order to understand it, in order to fight it. (p. 21, lines 30-35)

Louise simply said, about her move across the country to be closer to family: "God is in the whole thing. He just orchestrated the whole move. Just—there's just no denying it" (p. 35, lines 43-46).

***More fitting spiritual/religious community.*** Four women told me that they found spiritual/religious communities that were beneficial. Recall Jo's traumatic experiences with church counseling, in which she was blamed for her own abuse. Her new church was a dramatic change. Jo remembered the first time that she talked to the minister of her new church.

And she said, "What's going on at home?" which I thought was interesting. That was the first thing she asked. And I told her. I told her. [Laughs]... It's a woman. And she said, "Nobody deserves that. You're never going to hear anybody in this staff say that to you. And if they ever did, they'd be off the staff." And nobody deserves to have curses spoken over them, and I would never—and I—she said, "I would need to apologize to you on behalf of the church." (p. 5-6, lines 45-8)

**Unofficial spirituality.** Some participants claimed to have no religious ties but felt spiritual in their own way. Others told me about their religious affiliation, but had very little or nothing to say about the impact it had on their wellbeing. Instead, some of these women spoke of about parts of life that made them feel transcendent, hopeful, and connected with others and the universe.

**Natural world.** Three women identified as agnostic/atheist and found their spiritual inspiration in nature. Recall how Laura and Adrian discussed their sense of transcendence, connection, and freedom in nature in the mental health and spirituality interaction section. Anita also found her source of spiritual connection in nature, saying:

I think nature plays a huge role. Like I think like large bodies of water, trees, nature, um, all of that stuff I think makes me realize how big everything is. And I just—even thinking about space and the universe and stuff like that, that we're just so little and insignificant but in a good way. (p. 39, lines 34-43)

**Being good.** Two women talked about the idea of simply being good and moral as core to their sense of spirituality. Alicia explained,

You know, I was raised Catholic. But, I'm one of those people that like "Do I believe in God?" I don't know. Maybe. Maybe not. Does it matter? I'm one of those people where—when I look at my life I—am I perfect? God no. But, I live my life in a way that—I've made mistakes. I'll probably continue to. If there is a heaven, I'm pretty certain I'll go there because I think I'm a really good person. If there isn't a heaven, that's okay, too. I can't believe in something wholeheartedly if there's not complete evidence for it. (p. 21, lines 5-13)

Kris, who did not identify with any religion, and said that she was "kind of but not overly" (p. 25, line 3) spiritual, echoed the same theme as Alicia, explaining that her philosophy was "just um maybe give a little every day instead of taking so much" (p. 28, lines 5-7).

***Connections between us.*** A common theme that emerged in the interviews was the sense of spirituality women found in human relations. Three women talked about the connections between themselves and others, or between individuals in general, as providing them with a sense of hope, faith, and rightness with the world. When I asked Melanie what she found to be meaningful to her, she replied, “You know that moment when you’ve like connected with another person or a part of the world? I guess it doesn’t always happen, but when it just kind of snaps, that’s the most important” (p. 35, lines 5-9). However, she did explicitly deny that this is God: “I guess some people call that God. I guess I don’t” (p. 35, lines 9-10). Anita, besides feeling spirituality in nature, found spirituality in the goodness that individuals show to each other “even if I don’t associate it with a god, that like things like—I think that grace exists. Um, or forgiveness...” (p. 36, lines 48-50). Sarah found her sense of hope and inspiration in her nephew, who, she says, is “just kind of like my world” (p. 15, line 17).

***Helping others.*** The idea of spirituality and religion as a philosophy of life, either articulated or articulated, was also evident in the mental health section. As I discussed in chapter four, more than half of the participants (n=16) spoke about their need to be part of improving the world in some way. Each of these participants emphasized her commitment to helping to improve the experiences of other sexual assault victims/survivors. The participants went about this spiritual task in different ways, such as volunteering for one of the agencies that assists sexual assault victims/survivors. Several women (n=16) reported that they were motivated to participate in this study because they wanted to increase understanding of sexual assault to help other sexual



assault victims/survivors. I will address this theme more extensively in the spirituality section. Adrian recalled,

When I heard about what you were doing, I was like, “Well, I’ve gotta help people. I’ve gotta help. As ugly and as bad as my stuff is, terrible as it is, if I could help one person, I’ll do it. You know, I’ll put myself out there to help another person.” (p. 34, lines 29-34).

### **Safety and spirituality.**

*Lack of safety.* Safety emerged as a gatekeeper in women’s engagement with spirituality and religious practices. Four women who were hurt by their spiritual leaders or community after their sexual assaults were prevented from fully engaging in their spiritual lives until they felt safe. Jo said, “I sat there for like a year before I even talked to the pastor” (p. 5, lines 4-43). Dinah, who had left several churches, in part because of the negative messages she received about sexual assault, hesitated to try a new church because she was afraid that she would not feel safe expressing her views in this community. As she put it:

I knew about Unitarianism for a long time, but I was not ready to come, because I wasn’t sure what kind of reception I would get—as someone from the conservative, pro-life perspective... And, I have views that are different from a lot of feminists, obviously, and I didn’t know how well I’d be welcomed by them. (p. 16, lines 25-31)

Although Carmen spoke of her Christian faith and church as guiding forces in her life, she said that she would never confide in anyone at her church about her sexual assault because “it’s shameful” (p. 14, line 7).

*Presence of safety.* A sense of safety facilitated engagement with spirituality. Jo and Louise both found spiritual communities where they felt safe. When Jo finally felt

safe enough to talk to the minister of her new church, she was pleasantly surprised that “She said, ‘What’s going on home?’ which I thought was interesting. That was the first thing she asked. And I told her. I told her.” (p. 5, lines 45-48). Dinah also expressed feeling safe in her new spiritual community: “I have found a spiritual home at (my church) because (my church) does not bring up God. It allows you to heal in your own way” (p. 5, lines 8-10).

### **Summary**

In this chapter, I detailed the many ways in which sexual assault affected the wellbeing of 22 women. Most women experienced negative impacts on their overall wellbeing and on many of the domains within wellbeing. Many of the effects, like PTSD, are consistent with our current knowledge. However, the participants helped to illuminate a deeper understanding of how they perceived these effects and how they cope with them. In the next and final chapter, I discuss and display my theoretical understanding of wellbeing in sexually assaulted women. I also summarize the findings and implications. I conclude with research and practice recommendations based on this research.

## CHAPTER 5

### DISCUSSION

#### Introduction

The purpose of this constructivist grounded theory study is to explore the perceptions of adult female sexual assault victims/survivors about their wellbeing: their definitions and descriptions of wellbeing; the impact of the assault on wellbeing; and barriers and facilitators to achieving wellbeing following assault. To fulfill this purpose, I attempted to answer the following questions: 1.) How do participants describe and define wellbeing in their lives? 2.) How do participants perceive the effects on their wellbeing after experiencing adult sexual assault? 3.) What factors function as facilitators or barriers to participant achievement of overall wellbeing or certain aspects of wellbeing? In chapter 4, I presented the data obtained from this study and compared it to extant knowledge. The principal findings in this study were that 1) sexual assault negatively affected some or all of the wellbeing domains of participants 2) wellbeing in sexual assault victims/survivors is profoundly influenced by our culture 3) wellbeing in sexual assault victims/survivors is similar to wellbeing as described in society in general, which is subjectively rated positive health in most of the wellbeing categories of physical, mental, relational, spiritual, and financial/career/educational health but 4) wellbeing in sexual assault victims/survivors contains an additional category – a safety category and 5) physical health is emphasized less than the other categories in wellbeing.

This exploration of wellbeing in sexually assaulted women is necessary for several reasons. With this study, we are able to understand, in a more holistic manner,

the effects of sexual assault on the lives of women. While it has been established that sexually assaulted women experience significant physical and mental health disparities, we lacked the understanding of the ways in which these disparities interact with other aspects of their lives. We cannot hope to help resolve these health disparities without gaining a perspective of their interactions, meaning, and importance in the lives of sexual assault victims/survivors (Keifer, 2008).

I will begin this chapter with a brief review of methodology utilized in the study. I will then offer the visual representation of the core category of wellbeing as described by participants in this study. For the sake of clarity, I will review the findings in the same order in which I presented them in chapter four. After the review of findings, I will discuss implications across domains. I will conclude with research and clinical recommendations.

## **Methodology**

I utilized constructivist grounded theory methodology to explore wellbeing in sexual assault victims/survivors. As I discussed in chapter three, I chose this methodology for several reasons. We lack a fundamental understanding of wellbeing in sexually assaulted women – how it is experienced, described, facilitated and prevented. Without this understanding, we cannot enhance the wellbeing or its components (physical, mental, relational, spiritual, and educational/career/financial health and safety) of women who have experienced sexual assault. A constructivist grounded theory methodology offered the best method for exploring this phenomenon, because it embraces the “messiness” inherent in research (Charmaz, 2009, p. 142). Examining any phenomenon in adult sexual assault victims/survivors is messy because teasing out the

often confounding influences (childhood sexual abuse, intimate partner violence, mental health before the assault, demographics, etc.) is difficult. The core category of wellbeing is also messy, as each of the categories within it interact and overlap with other domains. However, it is the very messiness of wellbeing that reinforces the need for examination. With this sample, I have found that achieving health in one domain is almost impossible without the influence and support of one or more other domains.

According to Charmaz (2006), the creation of knowledge is not a neutral process, but instead is dependent on one's background. Because of my background as a sexual assault nurse examiner, women's health nurse practitioner, and feminist, I brought in certain assumptions and biases that influenced every part of this research, from forming the question to data analysis and reporting. The constructivist grounded theory approach allowed me to be authentic with myself, my participants, and my readers about my research process – from deciding the purpose to disseminating the results.

The emphasis on the co-construction of theory was critical to explore the impact and processes of creating and experiencing wellbeing after sexual assault. Through the iterative processes of engagement with participants, data analysis, existing data, creative thinking and lively discussions with my mentors and colleagues, a theory of wellbeing after sexual assault was constructed.

The methodology also allowed exploration and description of both the micro and the macro influences on the participants. Extant research highlights the significant role of culture on the mental and relational health after sexual assault and, as I described in chapter four, the cultural environment did have significant effects on each domain of wellbeing in these participants.

As I discussed in detail in chapter three, I created my semistructured interview guide and coding manual based on wellbeing as conceptualized by theorists and researchers (Barksdale, et al., 2013; Centers for Disease Control and Prevention 2013; Din-Dzietham et al., 2004; Keifer, 2008; Rosenkranz et al. 2003). Through the process of coding and analysis, I was able to confirm that the sexually assaulted women in this sample also considered the “core category” of wellbeing as the central construct of recovery/learning to live with the experience of sexual assault. Selective coding enabled the identification of the core category of wellbeing, encompassing five domains, also described in the literature (physical, mental, relational, financial/economic/career, and spiritual). These five domains were essential for wellbeing. The participants also confirmed and expounded in depth on the dynamic, interactive, and overlapping nature of each of the domains of wellbeing and their ability to enhance, maintain, or worsen health status and overall wellbeing.

Axial coding allowed determination of the relationships among the five domains. During this portion of the coding process, a new construct emerged which cut across all domains, that of safety, and the overarching significance of culture was recognized.

### **The Core Category of Wellbeing**

Figure 3 depicts the emerging theory of wellbeing in relation to sexual assault, through the lens of sensitizing concepts from feminist theory. The participants in this study demonstrated that mental and physical health do not occur in isolation, but in concert with relational, financial, spiritual, and relational domains. They found it nearly impossible to describe one wellbeing domain without also describing effects on other domains. Also, as Keifer (2008) said, each group or individual has different

conceptualizations of wellbeing; while the participants in this study emphasized the importance of each domain to their overall wellbeing, they also expressed slightly different conceptualizations of wellbeing, as discussed in detail under each domain.

In the model, each of the domains contains three concentric circles. The area of the outer circle represents the domain itself; the middle shaded circle represents the dynamic relationship between the degree of safety perceived by the participant and the degree of engagement which allows access to the center circle, positive health status. All participants possess and engage with each of the domains on some level, including mental health. The shaded area of the model represents the gatekeeping function of perceived safety. Within this area, the perceived degree of safety and the degree of engagement join in a reciprocal relationship, affecting the capability to move more deeply into the center of the model and fully engage in mental health. Perceptions of safety are highly individual and fluctuate across time and situations. When participants feel safe, they are able to fully engage within this domain of wellbeing. For example, participants felt safe when therapists did not blame them for their abuse or view them as damaged or dirty. They also experienced mental health safety when they met other women who had also experienced sexual assault, and learned that sexual assault is common. For mental health, full engagement may be demonstrated by actively participating in activities that promote mental health, including counseling concerning the SA, or by the absence of negative behaviors such as alcohol abuse. The inset to the figure provides an example of one domain, expanding the visual representation so that the components of the domain can be clearly seen.

If the visual representation could be seen three-dimensionally, it would show that each of the domains intersects and partially overlaps not only with its neighbor but with all other domains, such that all are inextricably linked together. Processes/experiences common to the intersections of domains are represented by arrows in this two-dimensional model, e.g., physical and mental health, mental and spiritual health, etc. Surrounding the spherical/circular display of domains would be the atmosphere of culture, within which the experience of sexual assault is couched.



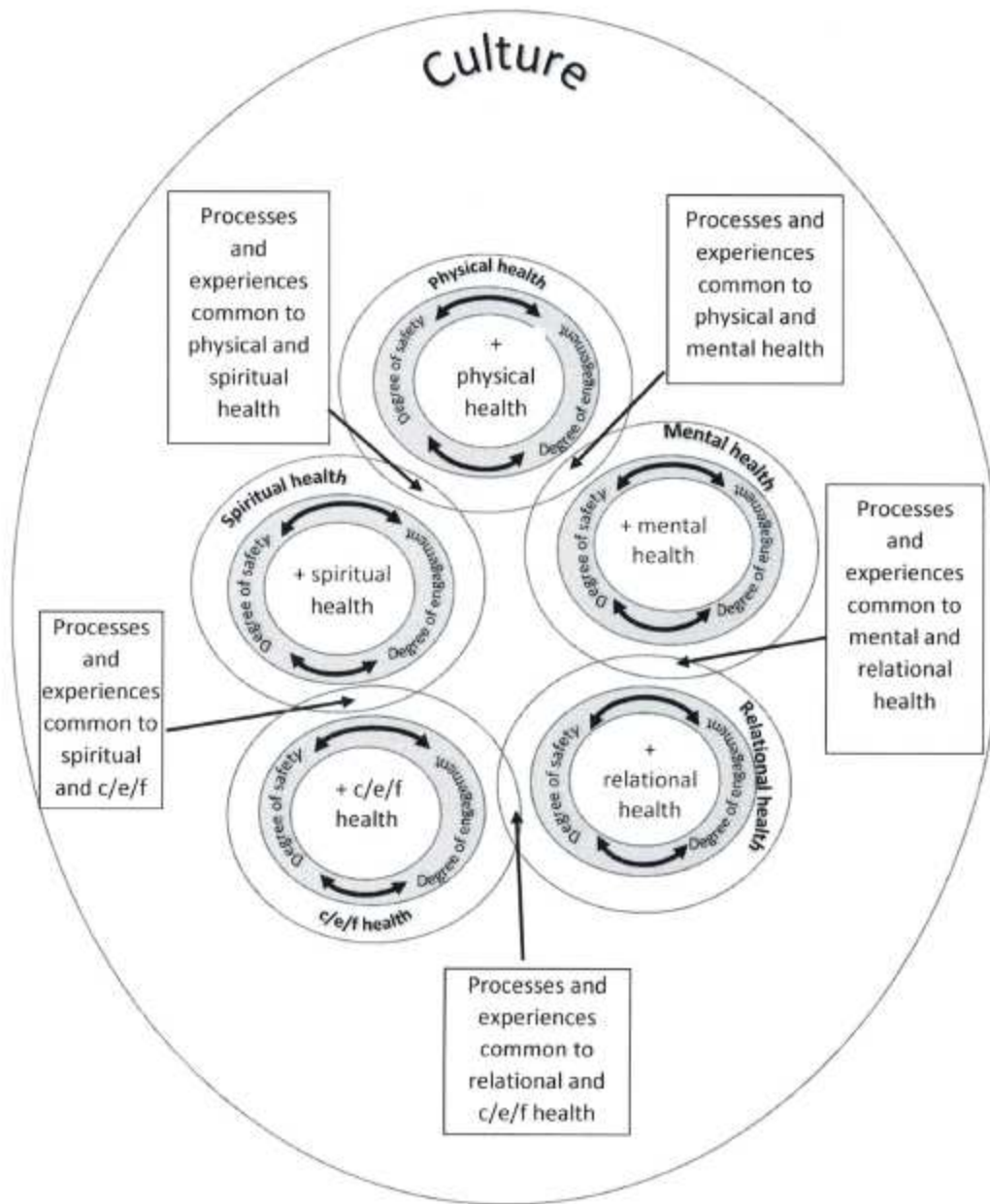
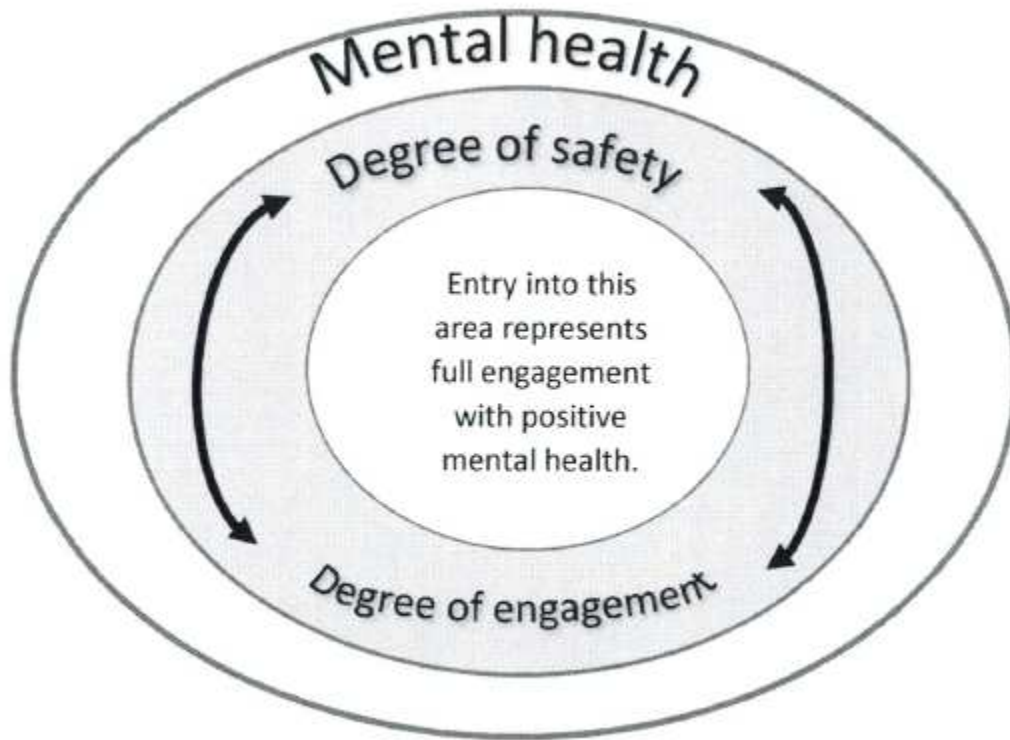


Figure 3. Wellbeing in adult victims/survivors of sexual assault.



*Figure 4.* Mental health domain as example of individual domains.

The influence of the cultural atmosphere in which the participants experienced sexual assault was evident in each of the wellbeing domains. As demonstrated in chapter four, the participants demonstrated internalization of the following myths: they were responsible for their sexual assault (n=8), sexual assault is really not a big deal (n=3), and it is not really sexual assault unless there is a physical struggle (n=2), and that the assailant did not mean it (n=2). Researchers have confirmed that there is widespread acceptance of these myths (Chapleau et al., 2007; Edwards, 2011; Estéal et al., 2015 Sheldon & Parent, 2002). Acceptance of these myths is associated with decreased acknowledgement of sexual assault in women who meet criteria for legal definition of sexual assault (Frasier, 2005; Peterson & Muehlenhard, 2004). As discussed in chapter

four, these myths were also endorsed by family, friends, and formal helpers of the participants. The endorsement of these myths by others was associated with harm to relationships, physical and mental health, and spirituality.

The areas where domains intersect were of particular interest to me in conceptualizing this study because we lack an understanding of these processes. For example, as I discussed in chapter two, we know that sexual assault victims/survivors experience significant physical health disparities in their rates of cervical cancer, chronic pain, unintended pregnancies and accessing health care (Campbell et al., 2008; Coker et al., 2009; Champion et al., 2001; Holmes et al., 1996; DeMaris, 2005; Kimerling et al., 2010; McFarlane et al., 2005; Plichta & Falik, 2001; Street et al. 2008), but we lack the knowledge about the ways that other wellbeing categories, such as relationships, and mental health may function as facilitators or barriers in achieving and maintaining optimum physical health.

## **Discussion of Findings**

### **Overall wellbeing.**

*Effect on overall wellbeing in sexual assault victims/survivors.* As I discussed in chapter four, more than half of the sample (n=13) viewed sexual assault as a life altering event. Many women reported that their entire life changed after their sexual assaults. Spontaneously, several women told me about how their wellbeing was affected in each domain.

*Description of wellbeing after sexual assault.* Despite the powerful negative impacts of sexual assault on the participants' lives, they demonstrated incredible strength and resiliency as they sought wellbeing after the assault. Women described wellbeing

after sexual assault in five domains (physical, mental, relational, spiritual, and financial/educational/career) that interacted with one another. As one domain changed, so did other domains – for better or for worse.

**Safety as gatekeeper.** All of the women in this sample expressed feeling unsafe in all or some of the health domains after being sexually assaulted. This lack of safety prevented them from being able to fully engage within that domain to create optimum health. For example, participants who had been hurt by the ways in which others responded to their sexual assault (by blaming them, for example), were reluctant to engage with others until they demonstrated that they once again felt safe. Some of the participants expressed never feeling emotionally safe with others, and so felt that they were never known deeply by another person.

### **Domain 1: Physical Health**

The participants in this study improved our knowledge about the physical health effects of sexual assault, how these perceived effects correspond to extant research, and the facilitators and barriers to obtaining optimum physical health after sexual assault. In addition, the participants helped to increase our knowledge about the interactive processes and experiences between physical and other health domains. Following, I will review these findings.

**Effects.** Almost three quarters of the participants (n=15) experienced short term (n=5) and/or long term physical effects (n=11) of their assaults. The short term impacts to physical health, such as bruising, urinary tract infections etc. resolved within three months. The long term effects, such as chronic pain, scar tissue and sleep disruption continued to affect women for years, even decades. Two of the participants became

pregnant as a result of their sexual assaults and decided to continue the pregnancies. Several participants (n=7) reported that the sexual assault(s) had an effect on their formal care seeking behavior: seeking care less frequently than they thought they should, feeling more uncomfortable, and feeling physically or mentally unsafe while seeking this care. With the exception of genital herpes and hepatitis C, these physical health effects are consistent with previously reported studies (Ackerson, 2010; Campbell et al., 2008; Centers for Disease Control and Prevention, 2010; Jozkowski & Sanders, 2012; McFarlane et al., 2005; Holmes et al., 1996; Mertz, 2008; Plichta & Falik, 2001; Robohm & Bottenheim, 1996-1997; Street et al., 2008; Weitlauf et al., 2010).

Two of the participants (Arrica and Adrian) with autoimmune conditions were ambivalent about these conditions and their relationship to their sexual assault. Initial research indicates that sexual assault is a significant predictor of later development of auto-immune diseases (O'Donovan et al., 2015). A biopsychosocial-evolutionary response to trauma may be one link between trauma and later onset of physical health disparities (Christopher, 2004).

**Barriers to positive physical health.** Internalization of myths about sexual assault prevented some women from identifying their sexual assault and as a result, prevented them from seeking timely healthcare after their sexual assaults. A lack of knowledge about available resources after sexual assault also prevented some women from seeking this care.

**Facilitators to positive physical health.** Participants identified several strategies and behaviors that helped improve their physical health. Exercise, diet, and meditation

helped to maintain and or improve the physical health of participants. In addition, some participants found that regular, formal health care ensured optimum physical health.

**Interaction between physical and other wellbeing domains.** It was evident that physical health interacted with each wellbeing domain. Positive relationships with others enhanced physical health while negative relationships with others negatively influenced physical health. Negative relationships did not cause poor physical health, but were associated with poor physical health for two women. The spiritual practice of yoga improved physical health for two women. Acceptance of certain spiritual beliefs and practices, i.e. that maintaining a nuclear family is necessary and that women can prevent violence against themselves if they behave correctly, resulted in a prolonged course of physical injuries. Jobs that included physical labor and flexible break times that facilitated opportunities to exercise enhanced physical health behaviors and outcomes. For example, Gabby noticed that as she became more physically healthy, that she also was more productive at work.

Several women (n=7) experienced a synergistic interaction between positive physical and mental health. However, several women (n=7) felt the need to choose between a peaceful or “numb” mind (absence of intrusive thoughts, nightmares, visions) and physical health. In each instance, the participants choose a peaceful mind by consuming alcohol (n=4), eating excessively (n=1), taking prescribed medications which caused negative physical health outcomes (n=1), and not taking prescribed medications to hasten death (n=1) which meant she wouldn’t have “...to suffer no more...” (p. 32, lines 10). With the exception of two women, each of the participants found ways to find peace of mind and improved physical health and wellbeing.

As I discussed in the introduction and in chapter four, participants who did not feel safe physically or emotionally were prevented from fully engaging in and creating positive physical health. For example, Dinah did not feel safe from sexual harassment and assault in her “sexy” body (p. 8, line 9), so she gained an unhealthy amount of weight to make herself unappealing. Women who did not feel safe seeking formal health care experienced actual or potential physical health consequences. Recall how Helen’s frightening experience of hearing her abuser at the dentist led her to neglect her teeth “for years” (p. 24, line 21).

Conversely, when participants felt safe, they were able to more fully engage with and create physical health. For example, five participants reported seeking female health care providers because they felt safer with them. Other researchers have reported that women prefer female healthcare providers (Ahmad et al., 2002; Janssen & Lagro-Janssen, 2012; Sacks, 2013) but no researchers have specifically assessed the gender preferences of sexual assault victims/survivors.

**Relative importance of physical health compared to other domains in overall wellbeing.** While the participants demonstrated the importance of physical health to their overall wellbeing, many suggested that physical health was not as critically important as the other domains. This was expressed by women’s endorsement of wellbeing in the presence of negative physical health indicators (such as being overweight). In addition, some women found that the presence of positive physical health in the absence of relational and mental health was not nearly as satisfying.

## **Domain 2: Mental Health**

**Effect of sexual assault.** Every participant in this study reported that sexual assault negatively affected their mental health in some way. Women attributed new onset mental health diagnoses to their sexual assault(s), as well as worsening of existing mental health diagnoses and negative emotions without a diagnoses to their sexual assault(s). The participants discussed the following mental health diagnoses: depression (n=7), PTSD (n=6), anxiety (n=5), bipolar disorder (n=2), schizoaffective disorder (n=1), and alcoholism n=2). The majority of the participants (n=14) did not have a mental health diagnosis, but had experienced severe effects on their mental health, such as shame, guilt, anger, alcohol abuse (not diagnosed) (n=2), that spilled over into other wellbeing categories. The participants experienced negative mental health effects for years and even decades after their assaults. The results of the mental health impacts reflect current knowledge, that women who have been sexually assaulted are significantly more likely to be diagnosed with depression, anxiety, PTSD, and substance abuse disorders (Ackard et al., 2002; Campbell et al., 2008; Jacques-Tiura et al., 2010; Kaukinen & DeMaris, 2005; Kaukinen & DeMaris, 2009; Kimerling et al., Lacey et al., 2013; Mendelson et al., 2010; Ramos et al., 2004; Street et al., 2010; Temple et al., 2007). However, with this study, we gain a new understanding of the relationship between sexual assault, mental health, wellbeing, the effect of time on mental health, the coexistence of positive wellbeing and mental illness, and facilitators and barriers of positive mental health.

While most of the women had not been diagnosed with mental illnesses, they did all experience negative, sometimes debilitating symptoms that lasted for years. The most common negative emotions were anger (n=15), shame (n=14), and fear (n=10). These



negative emotions had powerful and limiting effect on the way that women lived. For example, several women (n=) restricted their activities because of their new onset of fear after the sexual assault. Like Mimi, many women told me “I wouldn’t leave my house” (p. 15, line 38).

**Barriers to positive mental health.**

*Multiple abuses, lack of safety.* Participants found that a history of multiple abuses, such as childhood sexual abuse, sexual harassment, intimate partner violence, and or multiple adult sexual assaults negatively influenced their ability to obtain mental health. When participants did not feel safe, they were more likely to limit their activities and socializing that they had previously enjoyed. A lack of safety also prevented them from completing necessary tasks, like shopping, without extreme difficulty. Finally, a lack of perceived sense psychological safety made it more difficult for participants to disclose the sexual assaults to their therapists.

*Negative cultural environment surrounding sexual assault.* The internalization of myths about sexual assault influenced self-blaming behaviors of the participants. They expressed guilt because they consumed alcohol or drugs before the assault, went to a hotel with the assailant, and did not actively physically fight off the assailant (Brownmiller, 1975; Chapleau et al., 2007; Edwards, 2011; McMahon & Farmer, 2011). The family, friends, and formal helpers like the police and church counselors reinforced this beliefs, and also accused the participants of lying and making too a big deal out of it. These expressions reflect popular myths about sexual assault that are reinforced by the media and entertainment industry

Kris, Laura, and Louise, who had experienced their first ASA (and only for Kris and Laura) decades ago, have witnessed a change in the cultural environment surrounding sexual assault. While they each said that as a culture, we have a long way to go, we have made positive changes in our response to sexual assault victims/survivors. They each discussed the increased resources for sexual assault victims / survivors, like the two community agencies in Calhoun and Kalamazoo counties, as positive cultural changes. In addition, they each noted that there is less victim blaming by popular culture than there was when they were sexually assaulted as young women.

**Facilitators to positive mental health.**

*Counseling, medications, art, acknowledgement, and time.* The participants named several facilitators to achieving and maintaining positive mental health: acknowledging the assault, time, (n=13), psychotropic medication (n=10), counseling (n=20), and creating or consuming art (n=11). While more than half of the women (n=13) found that while time was helpful in healing their emotional pain, it was not linear; instead it was characterized by “...humps and bumps and twists and turns...” (p. 8, line 22). The time since acknowledgement of their sexual assault and help seeking were better predictors of emotional healing than time itself.

*High participation in counseling* The participation in counseling in this sample was much higher (21/22) than many other samples (Edwards, Dardis,& Gidycz, 2012; Guerette & Caron, 2007; Kilpatrick, Resnick, Ruggiero, Conoscenti, & McCauley; 2007; Littleton, 2010; Nasta, Shah, Brahmanandam, Richman, Wittels, et al., 2005; Prospero & Vohra-Gupta, 2008; Wolitzky-Taylor et al., 2011). This high representation of counseling participants may have been a result of one of my recruitment strategies—to

have counselors refer potential participants to me. In addition, women who were currently or had previously participated in therapy may have had more serious mental health issues leading them to pursue counseling at a higher rate than women who did not seek counseling.

Another difference in this sample compared to other studies is the length of time that the participants had spent in counseling. More than half of the sample (n=14) had spent several years in therapy – continuous or at different periods in their lives. A longer period of participation appeared to be necessary for these participants, as many said it took them time to open up to their therapists. Previous researchers have described a high and early discontinuation rate for sexual assault victims (Alvidrez et al., 2011). This early and high discontinuation rate was observed even for participants when childcare, transportation costs, and counseling costs were covered by the study (Alvidrez et al., 2011). The main motivation for women in this study who have/still are participating in therapy for years was because they found it helpful. As discussed in chapter four, women found certain messages to be especially helpful and healing, such as “it wasn’t your fault” (n=9), validation of negative emotions (n=3), and “you are not dirty because this happened” (n=1). These messages were direct challenges to the myths about sexual assault that the women had expressed about themselves and/or had been told by others, and considered to be critical components of feminist therapy (Richmond et al., 2013). Other aspects of therapy that women found especially helpful in therapy were flexible scheduling (n=2), techniques for calming self (n=3), and EMDR (eye movement desensitization and reprocessing therapy) (n=3).

***Acknowledging and treating the trauma.*** There is no consensus about the most effective type of mental health therapy for sexual assault victims/survivors. Although EMDR is highly effective in reducing anxiety, depression, and PTSD in women who have experienced trauma (Edmond & Rubin, 2004, Tarquinio et al., 2012), it is not significantly better than other therapeutic interventions for trauma, like prolonged exposure (de Bont, van Minnen, & de Jongh, 2013). Richmond and colleagues (2013) point out that recognizing that sexual assault as a trauma and addressing it as such with evidenced based interventions is the crux of treatment. She posits that the recognition of sexual assault as a trauma was influenced by feminist theory, and that therapists who do not recognize sexual assault as a trauma severe enough to warrant these interventions may have internalized cultural myths about sexual assault. Several participants (n=4) had utilized therapists/church counselors who did not treat participants as if they had experienced a trauma, evidenced by not addressing the sexual assault, texting during sessions, accusing them of lying, and encouraging them to “stick with it.”

**Wellbeing and mental illness not mutually exclusive.** Wellbeing and mental illness not mutually exclusive. While it is important to recognize the powerful and negative effect sexual assault has on wellbeing, the participants also demonstrated that they were able to create and maintain wellbeing in spite of these effects. Several participants discussed having a positive overall wellbeing despite the fact they also had been diagnosed with a mental illness and/or experienced negative symptoms after the assault(s).

**Interaction of mental health and other domains.** The mental health of the participants was heavily influenced by their relationships with others. Behaviors that

participants found to be especially hurtful to their mental health were silencing, blaming, minimizing, and joking. Several women still felt angry, sad, and ashamed about the way that they were treated by friends, family, and formal helpers when they disclosed their sexual assault(s). In addition, these reactions and the negative emotions women experienced with them affected future relationships. The participants expressed hesitance about trusting others in the future. Relationships also had the power to help improve the mental health of the participants. These relationships included others who listened, expressed physical affection in respectful ways, and encouraged the participants to seek counseling.

Women found spirituality to be helpful to their mental health in some situations and contexts after sexual assault and harmful in others. Women expressed being hurt by spiritual leaders who blamed them for their assaults (n=2), accused them of lying (n=1), or minimized sexual assault (n=1). One woman (Beth) felt hurt that her higher power would allow her to be sexually assaulted so many times, but has since reconciled her feelings. She now believes that her higher power helped to put helpful people in her life to assist her with her mental health needs.

The participants found many ways that their sense of spirituality helped their mental health. A personal relationship with their higher power helped several women (n=) feel a sense of security and strength. Spiritual rituals/habits such as praying, listening to gospel music, reframing thoughts, being out in nature, helping others, and practicing yoga helped participants' mental health. Several participants talked about their sense of spirituality/religion in the sense of a changed philosophy of life after their sexual assault. These participants found a sense of purpose and pride in helping other sexual

assault victims/survivors. They helped other victims/survivors by working or volunteering at community organizations devoted to helping sexual assault victims/survivors (n=3), publicly disclosing their assaults on social media to increase awareness (n=3), various activist activities about sexual assault (n=3), and planning future careers in which they could assist other sexual assault victims/survivors.

The participants experienced both positive and negative interactions between their career/educational/financial health and mental health. Women's negative mental health had a negative effect on their jobs and academic life. Three women lost their jobs or place in their academic programs after their medication strategies to ease the pain (alcohol for Melanie and Hannah, prescription medications for Sarah) caused side effects incompatible with their jobs/school work. Hannah also lost her car and apartment in her downward spiral of alcohol abuse after her sexual assault. Helen said that the nightmares she had about the sexual assaults caused such severe depression that she had to call in sick frequently, which hurt her chances of advancement.

Women's c/e/f health also had direct and indirect positive influences on the mental health of participants. Many women felt the direct emotional benefit from their jobs when they helped others, and felt that they were making positive changes in the world. Supportive work relationships helped several participants through difficult emotional times. Finally, three women found out about the free counseling and support group services that have helped them with their mental health through their jobs.

### **Domain 3: Relational Health**

Wellbeing experts Kitayama and Markus stated in chapter two, "Wellbeing then is very much a collaborative project, one can't experience wellbeing by one's self..."

(2000, p. 115). Even though every participant experienced some negative effects on one or more relationships after sexual assault, each participant also emphasized the crucial role that relationships had on their wellbeing. Several participants lost friends (n=10), experienced increased distance or damaged relationships (n=10), and fear of engaging in future relationships (n=11). Despite the negative effect on relationships, some participants also experienced strengthened relationships with others (n=3). Other women found ways in which damaged relationships could be repaired.

**Barriers to positive relational health.** Negative relationships or hurtful actions within healthy relationships had the power to negatively affect every domain of wellbeing. Earlier, I discussed the negative bi-directional nature between negative/damaged relationships and mental health and physical health. Negative relations also impacted the connection some women had with their spiritual communities. Women left their spiritual communities after being hurt by spiritual leadership and or fellow congregants. Difficulty relating to others in the workplace led to less job satisfaction, less advancement, and less productivity.

The biggest barrier to relational health, whether it was a parent or romantic partner, was the lack of perceived safety. As discussed in the relational/mental health section in chapter 4, many women were emotionally hurt when others blamed them, silenced them, or accused them of lying after their assaults. Many participants told me that they lost a sense of trust in the people in their lives as well as future relationships.

**Facilitators to positive relational health.** The participants shared many facilitators to positive relationships with others. Compassion and forgiveness facilitated positive relational health between some participants and their mothers, abusers, and

others in general. The ability of others to listen to participants' accounts of pain without judgement facilitated positive relationships. Logistical support, which also was an expression of love, facilitated continued relational health with others. Gabby and Beth found that avoiding sex helped to preserve relationships, which always suffered after this intimacy. Finally, a sense of safety with another facilitated positive relational health. Participants expressed the need to trust that others would not emotionally or physically hurt them before they could deeply engage with them.

**Interaction between relational health and other domains.** Positive relationships improved every wellbeing domain. As discussed in the mental health section, positive relationships functioned synergistically with positive mental health, each domain enhancing the others. Positive relationships with others helped some women to achieve and maintain positive physical health. Positive relationships in the workplace helped to increase satisfaction with their work, and also helped to link them to resources like the two local agencies. Positive relationship with one's spiritual community, faith, and/or higher power helped facilitate improved relationships with others, even the assailant in some cases. Positive relationships with one's higher power gave some participants a sense of security and love.

#### **Domain 4: Financial/Educational/Career**

Nineteen of the participants perceived some type of impact of their sexual assault on their c/e/f health. Of these 19 women, 15 experienced negative c/e/f impacts after their sexual assault. Some women continued to experience negative c/e/f outcomes years later (n=10). Six women were assaulted either at their place of employment or by their



supervisors off their job site. Some women actually experienced a positive c/e/f impact because of their sexual assault (n=2).

**Effects.** Except for Mimi, who was fired after being sexually assaulted by her boss, other women found that sexual assault interfered with their ability to cope on the job. This led to medication (prescription and alcohol) use, which led to job (and academic program spot) losses. For Hannah, this drinking also led to a loss of her apartment and car. Two women, Louise and Anita, told me that their history of sexual assault enhanced their abilities and success at their jobs/academic careers. Louise found that her history of sexual assault helped her to relate to other sexual assault victims/survivors in her volunteer position. Anita's intense focus on school helped distract her from her traumatic history and facilitated academic success. After experiencing sexual assault, several participants shifted their career goals so that they could have a career helping other sexual assault victims/survivors.

**Barriers.** The participants said that a lack of emotional or physical safety made it difficult for them to enjoy and thrive in their jobs/academic learning. The participants also found that a strict adherence to rules without a context harmed their c/e/f health. Sarah was fired and Gabby was disciplined by supervisors who did not display concern about the sexual assault and abuse that they had/were experiencing.

**Facilitators.** The participants named three key factors to their c/e/f success. Doing work that was meaningful to them and feeling safe helped the participants to succeed in and enjoy their jobs. Dinah found that enduring harsh treatment for much of her life toughened her up so that she could survive any harsh workplace.

**Interaction between c/e/f and spiritual health.** Only two women discussed the explicit interactions between their c/e/f and spiritual health. Jo, who had worked previously in the ministry, found that she could no longer do this because of her evolving acceptance of LGTB individuals, whom her church condemned. Louise felt that her belief and faith in her higher power led her to her fulfilling volunteer position working with other sexual assault victims/survivors. Other women (n=2) spoke about how their jobs (paid and volunteer) helped them live out their values.

### **Domain 5: Spirituality**

**Effects.** Sexual assault affected women's sense of spirituality in negative, positive, and qualitative ways. Some participants (n=4) lost faith in their higher power after they were assaulted. Other women (n=6) experienced negative reactions (such as silencing and blame) from their spiritual communities and or leaders after sexual assault. Several participants (n=4) left their spiritual communities because of their loss of faith and or negative reactions. When considering spirituality and religion as a philosophy of life, as suggested by Merullo (2015) and Evans (2015), almost all of the participants experienced negative effects to their spirituality. Several participants discussed viewing the world and the people within it as a constant danger. This lost in trust in the world resulted in many women restricting activities – like not leaving the house after dark.

Women also described spiritual growth and renewal after their assault. Several participants felt reassured that their higher power did not neglect them during their assaults, but was with them, helping them to survive and become stronger. Several women endorsed the idea that their higher power helped them by putting helpful and loving people in their lives. Many women felt that their higher power was in control of

their lives, therefore, being assaulted was part of the plan to help them understand others' experiences so that they could more effectively help others. Several women described positive philosophical changes after their assault. They felt a deeper connection with other sexual assault victims/survivors. In addition, they expressed feeling a sense of purpose in working for this cause. In fact, every participant in this study told me that they were motivated to participate in this study because they wanted to help other sexual assault victims/survivors.

**Barriers to spiritual health.** As in the other domains, safety functioned as a gatekeeper for women's spiritual health. All of participants who were blamed and silenced by their spiritual communities and leaders for their sexual assaults eventually left these communities. Despite feeling a need for a spiritual home, participants were reluctant to engage in other communities, fearing that they would not feel safe – because of their histories of abuse, viewpoints or sexual orientation.

**Facilitators to spiritual health.** When women felt safe, they felt that they could engage in their spirituality. Jo felt a sense of safety that she had not experienced with clergy before when her new minister acknowledged the abuse by her husband and the abuse perpetrated by the church. Dinah felt a sense of safety when she learned that she could heal in her own way.

## **Summary**

The participants in this study were deeply affected by their experiences of sexual assault. With the exception of one woman, all of the participants experienced negative impacts on their overall wellbeing and several domains of wellbeing. In each domain, women experienced factors that detracted from or enhanced positive health. The

presence of safety enhanced engagement with positive health in each domain; its absence detracted from engagement with positive health.

## **Implications**

**Wellbeing in sexual assault victims and survivors.** This study helped to illuminate the full impact of sexual assault on the lives of women. The effects on the wellbeing of these sexual assault victims/survivors are consistent with previous research that highlighted effects of sexual assault on the physical, mental, relational, spiritual and financial health of women. As expected, all of the participants experienced negative effects on some or all of these health domains. Many of these negative effects persist decades later. With this study, we gained a deeper understanding of how sexual assault victims/survivors perceive these disparities, how they prioritize these health domains, and the barriers and facilitators they experience in achieving and maintaining wellbeing. The participants in this study also helped to illustrate that these health disparities do not occur in isolation. Rather, each wellbeing domain affects and is affected and influenced by other domains. In addition, the perception of safety and the socio-political environment in which the participants inhabit has a significant influence on wellbeing. This holistic framework has significant clinical and research implications.

Exploring and analyzing wellbeing in this study was difficult for several reasons. Wellbeing is messy – composed of moving, overlapping, inseparable domains. The participants perceived both the effects of the assault(s) and the healing as a complex process, where physical, mental, relational, spiritual, financial, and safety overlapped and interacted together. As women talked about the effects of sexual assault, they did not cleanly separate them into clean systems or domains. For example, Helen perceived her

chronic pain as an emotional, relational, and physical consequence of her sexual assaults. She said “I have a lot of unexplained pain in my body...some of it is a result of that I think... and your body holds the abuse memory (p. 37, lines 14-24).

Researchers are increasingly reporting the inseparable nature of our wellbeing domains. For example, researchers have reported that the presence and severity of mental health symptomology significantly predicts presence and severity of chronic pain and health seeking behaviors in sexual assault victims/survivors (Campbell et al., 2008; Kimmerling & Calhoun, 1994). The impacts of emotional trauma and emotional symptoms on physical health are increasingly observable via biophysical measurements of inflammation, cardiac activity, and the hypothalamic, pituitary, and adrenal axis (HPA axis) (Bower, Greendale, Crosswell, Garet, & Sternlieb, 2014; Christopher, 2004; Arch et al., 2014; Pinna, Johnson, & Delahanty, 2014; Pullen et al., 2008).

The presence and quality of social support offered to participants affects the presence and severity of both mental and physical health (Borja et al., 2006; Bryant-Davis et al., 2011; Ullman & Najdowski, 2009). The quality and type of support itself depends on the cultural messages that we receive about sexual assault. As demonstrated in this study, there is still widespread acceptance of myths about sexual assault. Other researchers have described the widespread endorsement of these myths (Bufkin & Eschholz, 2000; Chapleau et al., 2007; Edwards, 2011; McMahon & Farmer, 2011; Ryan, 2011; Sheldon & Parent, 2002; Valenti, 2010). The self-internalization of these myths as well as the endorsement by others led to widespread damage to women’s emotional, physical, career/ educational /financial, and spiritual health. Increasingly, researchers are analyzing the effect of culture on physical and mental health, such as the negative effect

of perceived racism on physical and mental health (Hurd, Varner, Caldwell, & Zimmerman, 2015).

Although the exploration of wellbeing is messier and more difficult than the analysis of one domain or body system, it is imperative that we continue to challenge ourselves in this way to truly improve the wellbeing of sexual assault victims/survivors. Just as sexual assault does not only affect a woman's mental health, but her entire wellbeing, healing cannot only involve healing simply mental health. Indeed, if we trace any of the participants' journeys to wellbeing, all of the domains were involved, including safety, which functioned as a gatekeeper to deep engagement in health practices. The influence of culture was also present, almost palpable at times, in each participant's journey. Authentic healing necessarily involved engaging many or all of the wellbeing domains.

**“You're not safe, sweetie. Not anywhere”** (Dinah, p. 35, line 1). The participants in this study expressed feeling unsafe in every wellbeing domain. The lack of safety prevented them from deeply engaging in the process of achieving and maintaining health in the varied domains as well as in overall wellbeing. According to Abraham Maslow, a psychologist who conceptualized the hierarchy of needs, a person who lacks safety is completely absorbed in the task of obtaining it, at the expense of all other needs. Writing about this hierarchy in 1943, Maslow used the term “man” to mean humankind in general.

The organism may equally well be wholly dominated by them. They may serve as the almost exclusive organizers of behavior, recruiting all the capacities of the organism in their service, and we may then fairly describe the whole organism as a safety-seeking mechanism. Again we may say of the receptors, the effectors, of the intellect and the other capacities that they are primarily safety-seeking tools.

Again, as in the hungry man, we find that the dominating goal is a strong determinant not only of his current world-outlook and philosophy but also of his philosophy of the future. Practically everything looks less important than safety, (even sometimes the physiological needs which being satisfied, are now underestimated). A man, in this state, if it is extreme enough and chronic enough, may be characterized as living almost for safety alone (Maslow, 1943, p. 376).

Some participants did display “living almost for safety alone,” especially in the first weeks to years after their sexual assaults. Some participants characterized this period as merely surviving or existing. To exist and survive, some participants felt the need to “numb” themselves with alcohol or food. As Hannah discussed, addressing alcohol abuse without addressing the sexual assault as well as all affected health domains was not helpful.

Within each wellbeing domain, participants who felt unsafe were just surviving or existing. In the physical health domain, a lack of safety meant such things as avoiding formal health care, and gaining an unhealthy amount of weight. In the mental health domain, a lack of safety prevented women from seeking assistance for their mental health needs related to sexual assault. Even when women did seek counseling for mental health, they continued to maintain “walls” (Anita, p 49, line 10) and avoid discussing their sexual assaults until they felt emotionally safe with the therapists. In the relational domain, a lack of safety prevented women from engaging with others on a deep level. In the financial/educational/career domain, the participants underperformed and/or lost their jobs (as well as car and apartment for one participant) when they did not feel emotionally or physical safe.

Wellbeing as conceptualized by many theorists does not include safety, (Centers for Disease Control and Prevention, 2013; Keifer, 2008; Plach & Heidrach, 2002;

Powell-Young, 2012; Putnam, et al., 2003; Ried et al., 2006; Schennach-Wolff et al., 2010). However, this present study, as well as research assessing priorities of individuals using Maslow's model of hierarchy of needs indicates that safety is a critical component of wellbeing. For example, in a qualitative study exploring needs according of sex workers (N=48) in India, Gezinski and Karandikar (2013) reported that their safety and survival was the primary concern. Similar to this sample, physical health was not as important. One participant said, "Health is not a priority for women in Kamathipura. For them, survival is the question" (Gezinski & Karandikar, p. 559). Closer to home, researchers exploring the needs of sex workers in New Mexico reported that the participants named safety as a necessary factor in their lives in order to change their substance abuse and unsafe sex (Yahne, Miller, Irvin-Vitela, & Tonigan, 2002). According to Maslow, a "healthy, normal, fortunate adult in our culture is largely satisfied in [her] safety needs" (1943, p. 378). Because "a running, 'good' society ordinarily makes its members feel safe enough from ... criminals, assault" (p. 379). The question becomes, then, how "good" is our society if sexual assault survivors do not feel safe in it?

When participants in this study did feel safer, they were able to deeply engage within each domain and achieve wellbeing. Across each of the domains, there were some common facilitators of safety. A sense of physical safety allowed women to engage in activities that promoted their physical health, such as exercise, which also benefitted the mental health of many participants. A sense of safety also facilitated formal care seeking. Several participants verbalized the need for a female healthcare provider to facilitate feelings of mental and physical safety. A feeling of emotional



safety allowed women to deeply delve into their emotional pain and begin the healing process. This sense of safety was facilitated by time, an absence of physical and emotional abuse, respect of boundaries, and shared experiences. When women felt spiritually safe, they were able to engage authentically with their spiritual beliefs, practices, and community. The sense of safety in spirituality was enabled by feeling the presence of a higher power (for Christians in the sample), and connectedness with others and/or nature. In addition, participants expressed feeling more safe in their spiritual lives when they did not feel judged or blamed for the violence.

**Cultural environment of sexual assault.** The cultural environment in which sexual assault occurs affects overall wellbeing as well as each domain within wellbeing. Internalization by participants of sexual assault led to negative mental health, by increasing self-blame, delayed acknowledgement of sexual assault, and harmful self-medicating behaviors to sooth the negative emotions associated with self-blame and unacknowledged sexual assault. Internalization of myths about sexual assault by family, friends, and formal helpers of the sexual assault victims/survivors led to harmed relationships and negative mental health consequences as these attitudes were expressed to participants.

Changing the cultural environment that excuses and promotes sexual assault against women is difficult. On an individual level, presenting new information that contradicts long held health beliefs (such as beliefs in myths about sexual assault) is usually insufficient to change beliefs. In order to change the culture that supports sexual assault, we need to explore the benefits of myths about sexual assault. Joseph and colleagues (2013) suggest that the myths might benefit some women by making them feel

safe. If women believe that women are responsible for their own assaults, then the converse is also true – they have the power to protect themselves from sexual assault if they dress conservatively, abstain from alcohol, don't go out after dark, etc. These myths also benefit men, of course, because they give them excuses for sexual assault in ambiguous situations. Three of the women (Louise, Kris, and Laura) in this study were able to give their perspective on the influence of culture, as they had experienced the benefits of a culture in which sexual assault is not as taboo as it was in the past. They have noticed many positive changes, such as the availability of agencies that assist sexual assault victims/survivors, increased public dialogue about sexual assault, and increased acceptance to talking about mental health needs.

The misogynist culture that supports and reinforces myths about sexual assault not only harms sexual assault victims/survivors, but all women. The lack of perceived safety does not only limit the wellbeing of women in this sample. Most women, whether they have been sexually assaulted or not, fear sexual assault (Anderson & Doherty, 2008; Helliwell, 2000). As discussed in chapter four, hearing about another woman's sexual assault significantly increases the fear of doing things that they did not previously fear doing (Banyard et al., 2010). Griffin (1971, p. 35) calls rape of women a kind of gendered terrorism:

Rape is a form of mass terrorism, for the victims of rape are chosen indiscriminately, but the propagandists for male supremacy broadcast that it is women who cause rape by being unchaste or in the wrong place at the wrong time—in essence, by behaving as though they were free.

Branches of the United States military and many colleges and universities are attempting to change the culture of sexual assault on their campuses. These programs

seek to increase awareness of resources for sexual assault victims/survivors, challenge myths about sexual assault, and empower students to prevent sexual assault of others with bystander awareness programs (Department of Defense, 2014; Moynihan et al., 2015; Reed, Hines, Armstrong, & Cameron, 2015). These programs have demonstrated significant increased knowledge about dating violence, significant decreased approval of violence, and (theoretical) willingness to help both strangers and friends who were potentially at risk of being assaulted (Moynihan et al., 2015; Reed et al., 2015). Unfortunately, the students who demonstrated the least accurate understanding of sexual assault pre-intervention did not significantly improve their knowledge or bystander efficacy (Moynihan et al., 2015). Longitudinal research of these changes will assist us in learning ways that we can create cultural change.

### **Research Recommendations**

**More diverse populations.** To gain a deeper understanding of wellbeing after sexual assault, more diverse populations of women (and men) need to be included. As stated in chapter four, the participants in this group were diverse in terms of age, income, time since assault, and relationship to assailant and trauma experience in addition to adult sexual assault. However, this sample was not racially, ethnically, spiritually, or geographically diverse. In addition, there were no women who identified as transgender. Researchers have reported that women from different races and ethnicities experience sexual assault and its aftermath in a different cultural context (Bryant-Davis, Chung, & Tillman, 2009; Wadsworth & Records, 2012; Watson, Robinson, Dispenza, & Narari, 2012). Women from different religious backgrounds may interpret sexual assault in radically different ways (Skjelsbaek, 2006; Weiss, 2010).

**Focused attention on sexual minority women.** While three women who self-identified as lesbians participated in this study, I did not focus on significant differences from heterosexual women in their description of wellbeing, its barriers or facilitators. Researchers have reported that sexual minority women face sexual assault at the same rate or even higher than the rate of heterosexual women (Balsam et al., 2005; Stoddard et al., 2009), but receive more barriers in accessing care (National Coalition of Anti-Violence Coalition, 2010). Anita delayed identification of an assault by another woman, which begs the question if this is also a reflection of the cultural support for myths about sexual assault, with a focus on heterosexuality and vaginal–penile penetration. Anita delayed identification of sexual assaults from male assailants as well. Both Anita and Gabby struggled with others’ views of their spirituality because of their sexual orientation. A study focusing on the wellbeing of sexual minority women would allow the researcher to focus on these needs.

**Assessment of homeless/housing insecure victims/survivors.** While there was a large income range in this sample, none of the participants expressed economic or food insecurity. The experience of women with more income disparity might be very different. As explained in chapter three, I devoted two days to a day shelter trying to recruit women with insecure/no housing, but to no avail. One of the shelter workers told me that in order to survive, the clients had to keep their lives “so compartmentalized” that opening up any of their painful experiences to a stranger would be harmful to them. She reported that only after working five days a week for five months did some clients even begin to open up to her. Examining the experiences of sexual assault survivors who are homeless or experience housing insecurity would help us understand if and how their

experiences differ, and how best to facilitate their wellbeing, particularly in terms of safety. Researchers have reported that women with insecure housing have significantly higher rates of sexual assault than women without housing insecurities (Asberg & Renk, 2015; Hudson, Wright, Bhattacharya, Sinha, Nayamathi, 2010).

**Mixed methods to deepen and expand knowledge of overall wellbeing /domains.** The participants in this study offered rich and detailed information about how and why the sexual assault(s) affected their career/academic/financial health which could not be assessed using quantitative methods. For example, a study that assesses the lost productivity and satisfaction of sexual assault victims/survivors utilizing mixed methods would help us to understand the how and why, as well as actual cost figures.

A combination of qualitative and quantitative methods (Sandelowski, 2000) to assess mental and physical health using qualitative data collection alongside collection and analysis of physiologic data would deepen our understanding of the effects of sexual assault on wellbeing. In addition, these studies might help us to understand why, how, and how much certain interventions improve overall wellbeing or domains within it. Other studies have utilized these analysis to explore the influence of yoga, belly dancing, and other mind-body interventions on physical and mental health outcomes (Arch et al., 2014; Bower, Greendale, Crosswell, Garet, & Sternlieb, 2014; Pullen et al., 2008).

**Focus on safety.** Because safety played a key role in facilitating positive health when it is present and as a barrier when it was absent, we should focus our attention on gaining more knowledge about the role of safety in wellbeing. For example, does safety function as a “gate keeper” for all sexual assault victims/survivors? How do we facilitate a perception of safety in the healthcare setting? How do we facilitate a perception of

safety in the legal system, workplace, and spiritual communities? Does the perception of safety vary by race, ethnicity, age, etc.? A mixed methods study could help us gain a deeper understanding of this phenomenon, which will in turn, assist us to improve outcomes. In addition, development of an instrument that assesses perceived safety could help inform healthcare and legal professionals of the perception of safety in each unique environment. Researchers have created instruments that measure an individual's perception of safety in some situations, such as after natural disasters (Cai et al., 2014), but none have been developed for healthcare, legal systems, work places, or community.

**Longitudinal assessment of wellbeing.** Our understanding about the effects of sexual assault on the lives of women is limited by a dearth of longitudinal studies (Campbell, Sprague, Cottrill, & Sullivan, 2011). A longitudinal study would be helpful in illuminating how overall wellbeing and domains within wellbeing change over time., and help us to more fully understand the relationship between cultural norms and their influence on wellbeing. Within this current study, the participants were able to offer an element of longitudinal knowledge as they discussed their perceptions of how their wellbeing and health domains had evolved over time,

**Community level assessment – role in enhancing or detracting from wellbeing.** Since the communities in which women were living when they assaulted and/or currently living have had an important impact on their access to both helpful and harmful resources, assessment of the environment at the community level may increase our knowledge about this role and how it can further enable the wellbeing of sexual assault victims/survivors. Other researchers have expressed a need to examine the role of community in meeting the needs of intimate partner and sexual violence victims and

survivors (DeGue, Holt, Massetti, Matjasko, Tharp et al. 2012; Greeson & Campbell, 2013; Macy, Giattinab, Sangstera, Crosby, & Montijo, 2009). However, there is scant research about the most effective way to increase awareness of these resources at the community level. Researchers have described interventions that have helped university students to become more aware of the available resources for sexual assault, such as posters and brochures, information within classes, during orientation, and information accessible on the internet (Hayes-Smith & Levett, 2010; Konradi, 2003).

### **Recommendations – Practice**

The participants of this study indicated the necessity of feeling safe in order to access healthcare. Finding ways to facilitate a woman's perception of safety may help them access healthcare more frequently and with increased comfort. Several participants in this study indicated that female healthcare providers made them feel safer and more comfortable, and as a consequence, increased their health-seeking behaviors and comfort. A preference for female healthcare providers, especially with certain types of care (i.e. gynecology) have been described by other researchers (Ahmad et al., 2002; Elstad, 1994; Janssen & Lagro-Janssen, 2012; Sacks, 2013). Having female healthcare providers may be an important strategy to decrease the physical healthcare disparities currently experienced by sexual assault victims/survivors. Another strategy may be to increase the communication skills of healthcare providers. Two research teams have proposed that it is not the gender of the healthcare provider as much as it is the communication styles of the healthcare providers that make women feel more comfortable. Jannssen and Lagro-Janssen (2012) and Elstad (1994) concluded that women's preference for female providers is more reflective of the communication style practiced more frequently by

female healthcare providers—a democratic and patient centered communication style. Whether or not this is true, adopting these communication styles may assist women to feel safer when accessing healthcare and possibly increase their formal healthcare seeking behaviors.

Routine screening for intimate partner violence in the health care setting facilitates positive relationships between the patient and provider, facilitates their acknowledgement of abuse and or assault, and increases access to helpful resources. Gabby said that she wished that her dentist had asked her about her dental injury caused by her husband’s violence. This is consistent with reports by researchers who have reported that intimate partner violence victims/survivors approve of routine screening (Iverson et al., 2014; Wadsworth, Kothari, Lubwmana, & Frank-Benton, 2015). Like Gabby, who said “I don’t know if I would have been really able to share much...if the opportunity would have been there, maybe I might have” (p. 27, lines 24-26), other intimate partner violence victims/survivors may not disclose (Wadsworth, et al., 2015), but will at least have this opportunity. Several organizations have recommended routine screening for intimate partner violence (American College of Obstetricians and Gynecologists, 2012; Emergency Nurses Association & International Association of Forensic Nurses, 2013; United States Preventative Task Force, 2013). Jo appreciates the ability to talk to her midwife about her sexual assaults and appreciates the support she had given her:

She talks to me a lot. And we've talked about it. And we just talked about it recently. And she's super supportive. Yeah, I love her... Yeah, she's really good about it because she understands women and she understands... (p. 23, lines 35-45).



While there is no recommendation for routine screening for sexual assault, sexual assault frequently occurs within the context of intimate partner violence (Temple, et al., 2007; Tjaden & Thoennes, 2006). Several intimate partner screening instruments include questions about sexual assault, such as the Abuse Assessment Screen, The American Medical Association Screening Questions, and the Computer Based IPV Questionnaire (Basile & Hertz, 2007). Women experiencing intimate partner violence are more likely to disclose to the provider if the healthcare provider is compassionate and “tuned in” (Iverson et al., 2014, p. 307) demonstrated by eye contact and using a caring tone of voice. Carmen’s physician appeared to be tuned in when Carmen sought her care to assess for sexually transmitted infections after her assault (which she had not yet acknowledged).

I made an appointment with the doctor, and um, you know, it’s really like God, basically. Because, she was asking me questions and, uh, I said, “you don’t need to know, I just need to get STD testing.”...And I guess she sensed, you know, something isn’t right...But, she said “Was it consensual?” And, my reply was “barely...” and she said ‘ok—now at this point, I have to ask you questions...” I just broke down, you know. Because that at moment, you know, I realized I’ve been raped. (pp. 3-4, lines 29-16)

In addition to screening, posters and brochures about resources for intimate partner violence and sexual assault could be placed strategically around healthcare settings so that women can access this information discreetly (Decker et al., 2012). Because many sexual assault victims/survivors do not acknowledge their sexual assaults as such, more inclusive language might help increase help seeking. For example, using language that unacknowledged sexual assault victims/survivors are more likely to identify with, such as “bad sex” or “hook-up sex” or “unwanted sexual experience”

(Cleere & Lynn, 2013; Littleton et al., 2009; D. Patterson, personal communication, June 6, 2015) might increase acknowledgement and help-seeking. Culturally sensitive posters and brochures addressing intimate partner and sexual violence can be obtained from Futures Without Violence, a non-profit organization who seeks to prevent and end violence against women, children and families (Futures Without Violence, n.d.) at [futurewithoutviolence.org](http://futurewithoutviolence.org). Table 8 lists other helpful resources for clinicians. Table 9 is a list of helpful resources for victims and survivors of intimate partner and sexual violence.

Table 8

*Resources for Clinicians*

<b>Resource</b>	<b>Content</b>
Academy on Violence and Abuse ( <a href="http://www.avahealth.org/welcome.html">http://www.avahealth.org/welcome.html</a> )	Education for clinicians, researches, and educators on violence across the lifespan. Sponsors academic conferences, offers educational content in form of videos and literature.
Centers for Disease Control and Prevention ( <a href="http://www.cdc.gov/std/tg2015/sexual-assault.htm">http://www.cdc.gov/std/tg2015/sexual-assault.htm</a> )	Up to date information on post exposure prophylaxis and follow up care after sexual assault
Futures Without Violence ( <a href="http://www.futureswithoutviolence.org">www.futureswithoutviolence.org</a> )	Free posters, brochures, handouts and videos for clinicians and individuals regarding intimate partner and sexual violence.
International Association of Forensic Nurses ( <a href="http://www.forensicnurses.org">www.forensicnurses.org</a> ).	Technical assistance for exams, location of nearest SANE programs, training and education for SANEs, 24 hour assistance.

Table 9

*Resources for Victims/Survivors of Intimate Partner and Sexual Violence*

<b>Resource</b>	<b>Content</b>
Feminist Majority Foundation (www.feminist.org/)	State specific content information for victims/survivors of sexual assault and abuse.
Office for Victims of Crime (www.ovc.gov/)	Directory for series and rights of victims/survivors of violence.
Rape, Abuse, and Incest National Network (www.rainn.org) 1-800-799-SAFE	Information and resources for sexual assault and abuse victims/survivors Toll free phone number that offers assistance and phone numbers for local shelters to victims/survivors of intimate partner and sexual violence.

Finally, it is imperative for healthcare professionals to be aware of the ways in which politics influence the wellbeing of victims/survivors of sexual assault. In 1994, Congress passed The Violence Against Women Act (VAWA), which provided assistance for victims and survivors of intimate partner and sexual violence and stalking (Carbon, 2011). Although VAWA does provide protection for all victims and survivors of intimate and sexual violence, its name emphasizes the fact that the overwhelming majority of intimate partner and sexual violence survivors are women (Catalano, Smith, Snyder, & Rand, 2009; Sacco, 2013). Before VAWA was originally passed, resources such as shelter and rape crises centers were unevenly distributed and dependent on local and state funding and regulations (U.S. Department of Justice, 2012). Since 1994, this act has provided \$4 billion in cooperative grants and partnerships with state, local, and tribal governments among police, judges, victim advocates, health care providers, faith leaders, and others with programs and services around the country to assist victims and

survivors of sexual and intimate partner violence (Carbon, 2011; Department of Justice, 2012). VAWA had been consistently reauthorized by Congress since 1994 until Congress allowed it to expire in 2011 (Congressional Digest, 2013). In 2013, after intense political battles between Democrats and Republicans, funding for VAWA was reinstated (Weisman, 2013). Adequate funding of shelter and programs for intimate partner and sexual assault victims/survivors is critical to ensure their wellbeing. Several agencies that provided shelter and care for victims/survivors of intimate partner and sexual violence had to decrease their services when they lost funding (Watersong, 2010).

### **Summary**

This constructivist grounded theory study explores the experiences of women who are victims/survivors of sexual assault. The emergence of the core category, wellbeing, was theoretically saturated in an effort to better understand its relationship to sexual assault, and study findings were compared to extant literature on this topic. The core category, as defined by these participants, validated wellbeing described in literature; it consisted of five domains: physical, mental, career/educational/financial, and spirituality (Barksdale et al., 2013; Din-Dzietham et al., 2004; Keifer, 2008; Rosenkranz et al., 2003). The importance of this study, however, rests on its significant contribution to the science through recognition of the pivotal role of safety, which functions as a gatekeeper to health in each of the five identified domains. Theory-building as a basis for innovative future intervention suggests that safety must be addressed across domains for victims / survivors of sexual assault to achieve wellbeing in all domains of their lives.

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APPENDIX A  
IRB DOCUMENTATION



EXEMPTION GRANTED

Elizabeth Reifsnider  
 CONHI - Administration  
 602/496-1394  
 Elizabeth.Reifsnider@asu.edu

Dear Elizabeth Reifsnider:

On 6/13/2014 the ASU IRB reviewed the following protocol:

Type of Review:	Initial Study
Title:	A Grounded Theory Dissertation Proposal to Explore and Explain the Well-Being of Women Who Have Experienced Sexual Assault
Investigator:	Elizabeth Reifsnider
IRB ID:	STUDY00001183
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none"> <li>• Wadsworth Demographic Questionnaire, Category: Consent Form;</li> <li>• Wadsworth Consent - Short Form, Category: Consent Form;</li> <li>• Wadsworth Interview, Category: Consent Form;</li> <li>• Wadsworthprotocol, Category: IRB Protocol;</li> <li>• Additional investigators (non ASU faculty), Category: Other (to reflect anything not captured above);</li> <li>• WMUletter6_13.pdf, Category: Other (to reflect anything not captured above);</li> <li>• Wadsworth Newspaper Recruitment, Category: Recruitment Materials;</li> <li>• Wadsworth Website Recruitment and info, Category: Recruitment Materials;</li> <li>• Wadsworth Recruitment Posters, Category: Recruitment Materials;</li> </ul>



EXEMPTION GRANTED

Elizabeth Reifsnider  
 CONHI - Administration  
 602/496-1394  
 Elizabeth.Reifsnider@asu.edu

Dear Elizabeth Reifsnider:

On 10/2/2014 the ASU IRB reviewed the following protocol:

Type of Review:	Modification
Title:	A Grounded Theory Dissertation Proposal to Explore and Explain the Well-Being of Women Who Have Experienced Sexual Assault
Investigator:	Elizabeth Reifsnider
IRB ID:	STUDY00001183
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none"> <li>• Wadsworth Interview, Category: Consent Form;</li> <li>• Wadsworth Demographic Questionnaire, Category: Consent Form;</li> <li>• Wadsworth Consent - Short Form, Category: Consent Form;</li> <li>• Wadsworthprotocol, Category: IRB Protocol;</li> <li>• WMUletter6_13.pdf, Category: Other (to reflect anything not captured above);</li> <li>• Additional investigators (non ASU faculty), Category: Other (to reflect anything not captured above);</li> <li>• Wadsworth Newspaper Recruitment, Category: Recruitment Materials;</li> <li>• Wadsworth Website Recruitment and info, Category: Recruitment Materials;</li> <li>• Wadsworth Recruitment Posters, Category: Recruitment Materials;</li> </ul>



EXEMPTION GRANTED

Elizabeth Reifsnider  
 CONHI - Administration  
 602/496-1394  
 Elizabeth.Reifsnider@asu.edu

Dear Elizabeth Reifsnider:

On 11/20/2014 the ASU IRB reviewed the following protocol:

Type of Review:	Modification
Title:	A Grounded Theory Dissertation Proposal to Explore and Explain the Well-Being of Women Who Have Experienced Sexual Assault
Investigator:	Elizabeth Reifsnider
IRB ID:	STUDY00001183
Funding:	None
Grant Title:	None
Grant ID:	None
Documents Reviewed:	<ul style="list-style-type: none"> <li>• Wadsworth Interview, Category: Consent Form;</li> <li>• Wadsworth Consent - Short Form, Category: Consent Form;</li> <li>• Wadsworth Demographic Questionnaire, Category: Consent Form;</li> <li>• Wadsworth Protocol 3, Category: IRB Protocol;</li> <li>• WMUletter6_13.pdf, Category: Other (to reflect anything not captured above);</li> <li>• Additional investigators (non ASU faculty), Category: Other (to reflect anything not captured above);</li> <li>• Wadsworth Recruitment Posters, Category: Recruitment Materials;</li> <li>• Wadsworth Website Recruitment and info, Category: Recruitment Materials;</li> <li>• Brochures, Category: Recruitment Materials;</li> <li>• Wadsworth Website Copy, Category: Recruitment Materials;</li> </ul>

APPENDIX B  
IRB APPROVAL

# WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: October 2, 2014

To: Angela Moe, Principal Investigator  
Pamela Wadsworth, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair *Amy Naugle*

Re: HSIRB Project Number 14-09-05

This letter will serve as confirmation that your research project titled "A Grounded Theory Dissertation Proposal to Explore and Explain the Well-Being of Women Who Have Experienced Sexual Assault" has been **approved** under the full category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., *you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study."*) Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: September 16, 2015

251 W. Walbridge East, Kalamazoo, MI 49008-5456  
PHONE: (269) 387-8293 FAX: (269) 387-8270

APPENDIX C

SAMPLE OF RECRUITING POSTER



# Seeking Research Participants

- Have you ever experienced sexual contact that you did not want?
- Seeking research participants to learn more about how sexual assault affects the lives of women.
- If you are interested in learning more about this study or have questions, please call the researcher, Pam Wadsworth at (269) 387-6173.
- Pam Wadsworth is a women’s health nurse practitioner, sexual assault nurse examiner, and a PhD candidate.
- You can also find more information about this study at [www.thewellbeingstudy.com](http://www.thewellbeingstudy.com).



If you need help after sexual assault, please call the Kalamazoo YWCA at (269) 269-345-5595 or the Sexual assault services of Calhoun County at (269) 245-3925

Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>	Wellbeing study Phone (269) 387-6173 <a href="http://www.thewellbeingstudy.com">www.thewellbeingstudy.com</a>
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APPENDIX D  
CONTENT OF WEBSITE

## **Welcome to the Wellbeing Study!**

My name is Pamela Wadsworth. I am a women's health nurse practitioner, sexual assault nurse examiner, and PhD candidate. After working for years with women who have experienced un-wanted sexual contact, sexual assault, and rape, I noticed that as health care providers, we do not see the entire picture of how sexual assault impacts the lives of women. Research has shown that un-wanted sexual contact, sexual assault, and rape have impacts on many areas in the lives of women, such as increased chronic pain, difficulty getting health care, relationships, even obtaining educational and career goals. Some research has also shown that women sometimes feel more caring and creative after experiencing un-wanted sexual contact or rape. However, there is very little research that looks at the whole complex picture. There is even less research where a researcher listens to women tell their point of view and experiences.

I hope that this research will help to create better experiences for women who have experienced sexual assault.

If you are at least 21 years of age or older and have experienced sexual contact when you were at least 21 years old (if you also experienced when you were younger, that is ok, too), please consider taking part in my study about the impact of sexual assault on the lives of adult women.

The study involves a confidential interview between Pam Wadsworth and participants who volunteer for the study. The interview will take place in a private office.

### **Your Rights**

Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty.

### **Confidentiality**

Your responses will be confidential. The results of this study may be used in reports, presentations, or publications but your name will not be used. I will store the digitally recorded interviews as well as the transcribed interviews and questionnaires in a locked cabinet in the Sociology Department at Western Michigan University. I will be the only individual who has access to this information. We will not retain any identifying information. I will retain this data for five years.

## **Benefits of the Study**

We cannot promise any benefits to you or others from your taking part in this research. However, possible benefits include learning about community resources, such as health care providers, shelters, and mental health counselors. The study findings will be used to improve services and programs for other women who have experienced un-wanted sexual contact, sexual assault, or rape.

## **Risks of the Study**

Participating in this research may make you feel uncomfortable, angry, and sad or depressed. I will try to prevent this risk by giving you support and encouragement during your interview. I am not a counselor, but have worked with many women during my career as a nurse practitioner and sexual assault nurse examiner who have experienced sexual assault and intimate partner violence. I will encourage you to take breaks if you need to take a minute to think, get a refreshment, go to the bathroom, or just cry. I will also give you a list of resources where you can talk to someone who can help you work through your negative feelings. If you start to have really severe feelings of depression, or you think you may want to harm yourself or others, I will help you arrange emergency care at a local hospital, if you need it.

There is a small the risk of a breach in confidentiality. I will guard against such a risk by removing identifying information from the data collected and keeping all information in locked storage and password-protected computers. Before the interview, I will ask you to use a pseudonym (pretend name) to use throughout the interview. All of the information requested will be about your life after sexual assault. I will not use your real name in any publications or presentations. I also will not write or talk about experiences where you could be identified by others.

If you are interested in learning more about this study or have questions, please call Pam Wadsworth, RN, WHNP, SANE-A, PhDc at (269) 387-6173 or via e-mail at [pwadswor@asu.edu](mailto:pwadswor@asu.edu). You can also contact her supervising faculty, Dr. Angie Moe at (269) 387-5276 or via e-mail at [Angie.Moe@wmich.edu](mailto:Angie.Moe@wmich.edu)

## **About Sexual Assault**

Sexual assault is defined by the U.S. Department of Justice as "...an act of forcing another person into sexual activity against his or her will..." Most studies estimate that

sexual assault is very common, as about 1 out of every 5 women experience it in their lifetimes. Usually sexual assault occurs between individuals who know each other.

Please see the list of resources below that may be helpful to you if you have experienced sexual assault.

## **LINKS**

The YWCA of Kalamazoo.

<http://www.ywcakalamazoo.org/site/c.8fLLLZPvE6LSH/b.8516007/k.BE0D/Home.htm>

Provides exams and treatment for males and females who have experienced sexual assault (must be at least 13 years old). The treatment involves prevention of sexually transmitted infections and pregnancy. There is no cost to victims or survivors of sexual assault. You do not have to work with law enforcement to have these services.

In addition, the YWCA of Kalamazoo offers shelter, support groups, and counseling.

Sexual Assault Services of Calhoun County

<https://www.bronsonhealth.com/locations/sexual-assault-services-of-calhoun-county>

Provides exams and treatment for children and adults who have experienced sexual assault. The treatment consists of prevention of sexually transmitted infections and pregnancy after sexual assault.

The Sexual Assault Services of Calhoun County also provides counseling, support groups, advocacy, and emergency shelter.

Kalamazoo County Health Department.

<http://www.kalcounty.com/HCS/>

Provides free and reduced cost testing and treatment for sexually transmitted infections. Also provides many services, such as information about contagious illnesses, and vaccines.

Calhoun County Health Department

[http://www.calhouncountymi.gov/government/health\\_department/](http://www.calhouncountymi.gov/government/health_department/)

Provides free and reduced cost testing and treatment for sexually transmitted infections. Also provides many services, such as information about contagious illnesses, and vaccines.

#### Planned Parenthood of South and Mid Michigan

<http://www.plannedparenthood.org/planned-parenthood-mid-south-michigan>

Provides comprehensive contraceptive services, testing and treatment for sexually transmitted infections, and medical and surgical abortions. Some locations also provide prenatal care.

#### Family Health Center of Kalamazoo

<http://www.fhckzoo.com/>

Provides comprehensive care for individuals and family with Medicaid insurance. Also, provides sliding fee assistance for low or no income patients who have no insurance or are under-insured.

#### Family Health Center of Battle Creek

<http://www.fhcbc.org/> ily Health Center of Battle Creek

Provides comprehensive care for individuals and family with Medicaid insurance. Also, provides sliding fee assistance for low or no income patients who have no insurance or are under-insured.

#### RAINN (The rape, abuse, and incest national network).

<https://www.rainn.org/>

Provides on-line information and support for individuals who have experienced sexual assault, sexual abuse, and incest. RAINN also works to improve the criminal justice system for victims and survivors of sexual assault.

APPENDIX E  
DEMOGRAPHIC QUESTIONNAIRE

## Demographic Questionnaire

1. How old are you?
2. Please circle your racial identity. Please mark all that apply.
  - a. White
  - b. Black/African American
  - c. American Indian/Alaskan Native
  - d. Asian
  - e. Native Hawaiian/Other Pacific Islander
3. What is your ethnic identity?
  - a. Hispanic
  - b. Non Hispanic
4. What is the sex you were assigned at birth?
  - a. Male
  - b. Female
  - c. Neither
5. With what gender do you identify?
  - a. Male
  - b. Female
  - c. Other
6. What is your sexual orientation?
  - a. Lesbian
  - b. Bi-sexual
  - c. Trans-gender



- e. Straight/Heterosexual
  - f. Other
7. What is your relationship status?
- a. Single
  - b. Divorced
  - c. Widowed
  - d. In committed relationship
  - e. Married
8. Do you have children?
- a. Yes
  - b. No
9. If you have children, how many do you have? \_\_\_\_\_
10. What is your job/occupation?
11. What is the highest level of education that you have completed?
- a. Grade 1-11. Which grade did you complete?
  - b. Grade 12
  - c. GED
  - d. Some college
  - e. College graduate
  - f. Graduate/Professional School
12. What is your monthly income?
13. In what city/county do you live?

APPENDIX F  
INTERVIEW GUIDE

## Semi Structured Interview Guide

Thank you so much for being willing to meet with me today. We are going to talk about some difficult situation in your life with the goal of helping other women in the future. There are no right or wrong answers to my questions. We are going to talk about your feelings and opinions, and we will stop any time if you feel uncomfortable and do not wish to continue.

In an effort to maintain confidentiality, I am going to ask you to pick a pretend name (sometimes called a pseudonym) for yourself to use during the interview. Besides not using your name, please do not use nicknames that could be used to identify you. In addition, in order to protect the confidentiality of others, please do not use the real names of other individuals whom you may discuss.

Are you feeling comfortable with our arrangements for privacy? Do you have any questions, about anything, before we begin? Is it OK to begin the questions?

1. I would like to learn about the period right after sexual assault. I am going to ask you a few very sensitive questions. I am not going to ask you specifically about the assault itself, but about your thoughts, and feelings after the assault, and how people helped or didn't help you.

Prompts:

- i. How did you know that you had been sexually assaulted?
  - ii. Did you go to anyone for support? Who? Were they supportive?
  - iii. How did you feel physically? Mentally? Spiritually? Socially? Functionally?
  - iv. How long ago did this assault occur?
2. Violence against women and girls is very common. Because of this, many women who experience sexual assault as an adult have also experienced other forms of violence, such as sexual abuse as a child, dating violence, stalking, and physical and psychological abuse. Can you tell me about any other experiences of abuse you have experienced?
3. Can you please tell me your experience in the first few weeks to months after the assault?

Prompts:

- i. Did you go to anyone for support? Who? Were they supportive?
- ii. What helped or didn't help? (art, spirituality, functional or social support?)
- iii. How did you feel physically? Mentally? Spiritually? Socially, Functionally?
- iv. How did this period differ from when you realized that you had been assaulted?

4. Tell me about your life now.

Prompts:

How would you describe your physical, mental, functional, spiritual and creative health/life? How would you describe your relationships with friends, partners, work?

5. Some women say that sexual assault affects their ability to achieve their desired goals in life. What has been your experience with this?

Prompts:

- i. For example, social, spiritual, mental, physical, career?
- ii. What has helped you or prevented you from achieving these goals?

6. Please tell me how the experience of sexual assault has impacted you?

Prompts:

- i. Life in general, physical, social, mental, spiritual, financial health
- ii. Gains/Losses

7. Tell me about how you see yourself in the future

Prompts:

- i. Next year
- ii. 5-10 years
- iii. Physical, mental, social, spiritual, functional, financial health, creative

8. What kinds of things do you do to keep yourself healthy or feeling good about yourself and your life? What kinds of things do you think are important to keep yourself healthy or feeling good?

9. What is meaningful to you?

10. Tell me about your strengths, and how (if) they have changed since your assault?
11. Is there anything else you would like to discuss that I have not asked about, or you think we addressed too briefly?
12. Is there anything you would like to ask me?

THANK YOU SO MUCH FOR YOUR PARTICIPATION

APPENDIX G  
CONSENT FORM

OCT 02 2014

  
HSIRB Office

Western Michigan University  
Department of Sociology  
Arizona State University  
College of Nursing and Health Innovation

**Principal Investigators:** Dr. Angie Moe (WMU) and Dr. Elizabeth Reifinsider (ASU)  
**Student Investigator:** Pam Wadsworth, PhDc. (ASU)  
**Title of Study:** A Grounded Theory Dissertation Proposal to Explore and Explain the Well-Being of Women Who Have Experienced Sexual Assault

You have been invited to participate in a research project titled "A Grounded Theory Dissertation Proposal to Explore and Explain the Well-Being of Women Who Have Experienced Sexual Assault." This project will serve as Pam Wadsworth's dissertation for the requirements of the PhD. This consent document will explain the purpose of this research project and will go over all of the time commitments, the procedures used in the study, and the risks and benefits of participating in this research project. Please read this consent form carefully and completely and please ask any questions if you need more clarification.

**What are we trying to find out in this study?**

With this study, we are trying to learn about the impact of sexual assault from the point of view of victims and survivors, what helps and what hurts them to experience well-being. We hope that this research will eventually help us to develop programs that help women who have experienced sexual assault.

**Who can participate in this study?**

Women who are at least 21 years old, and have experienced un-wanted sexual contact, sexual assault, or rape at or above the age of 21, and can speak and understand English can participate. If women have also experienced unwanted sexual contact when they were children, they can participate as well. Women who are experiencing a high degree of distress or are in imminent danger of hurting themselves cannot participate in the study. Pam Wadsworth will conduct a brief screening interview on the phone to determine if the participant is experiencing too much distress to participate in the interview.

**Where will this study take place?**

This study will take place in a private interview room at the Sexual Assault Services of Battle Creek, the YWCA of Kalamazoo, or in the Sociology Department of Western Michigan University.

**What is the time commitment for participating in this study?**

There is one interview in this study. The time of the interview varies, but will probably take between 30 and 90 minutes.