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THE INFLUENCE OF SELF-EFFICACY IN THE RELATIONSHIP BETWEEN VARIANTS OF SELF-BLAME AND PSYCHOLOGICAL DISTRESS

Andrea Barrera

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A Thesis

Presented to the

Faculty of

California State University,

San Bernardino

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In Partial Fulfillment

of the Requirements for the Degree

Master of Arts

in

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General Experimental

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by

Andrea Barrera

March 2017

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ABSTRACT

Sexual assault has consistently been found to be associated with depression and posttraumatic stress disorder (PTSD) symptomatology. Research shows that self-blaming attributions are directly linked to distress (Walsh, & Foshee, 1998; Walsh & Bruce, 2011). More specifically, the type of self-blame (i.e., behavioral and characterological) an individual associates with their experienced sexual assault, may influence their perceptions of avoidability of future assault and post-assault recovery. However, the role of self-efficacy in the relationship between behavioral and characterological self-blame in PTSD sexual assault survivors has been unexamined. The purpose of the proposed study is to assess the influence of self-efficacy in the association between variants of self-blame and post-assault distress. The proposed study considers the critical relationship between self-efficacy and self-blame, and aims to evaluate how these factors can ultimately influence posttraumatic adjustment in sexual assault survivors. Results revealed positive associations between behavioral self-blame and depression (r = $.28, p < .05$). Positive associations were also found between characterological self-blame, PTSD ($r =. 42, p < .001$) and depression ($r =. 50, p <. 001$). Findings revealed that characterological self-blame was associated with reduced self-efficacy ($r = -.45, p < .001$) and self-efficacy was positively related to PTSD and depression symptom severity ($r = -.27, p < .05; r = -.54, p < .001$). Mediation was found between characterological self-blame, self-efficacy and depression, b = .11; CI: .04 - .21. Findings for this study can help with implication

for postassault interventions by creating opportunities for therapist to custom-tailor patient treatments to match the self-blame they most associate with. This may lead to treatments that are more effective.

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Finally, I would like to dedicate this study to the many women who have been sexually assaulted. Thank you for your openness and willingness to participate in this research.

DEDICATION

This thesis is dedicated to my parents and to my loving grandparents.

Taide Salazar

11/22/1938 - 04/17/2015

&

Doroteo Barrera

02/06/1934- 02/07/2016

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CHAPTER ONE

LITERATURE REVIEW

Introduction

Sexual assault does not discriminate against gender, age or race. Each year, acts of sexual assault affect the lives of many men, women and children. According to the Rape, Abuse & Incest National Network (RAINN), there is an average of 293,000 sexual assault survivors (ages 12 or older) each year (RAINN, 2015). Research also reveals that approximately 18% of women and 1% of men report a lifetime history of sexual assault (Black et al., 2011). The Center for Disease Control (CDC) and the National Partner and Sexual Violence Survey (Black et al., 2011) report that 1 in 5 women (18.3%) and 1 in 71 men (1.4%) have reported being raped in their lifetime. Altogether, these statistics total a staggering 4.2 million assaulted Americans in the last 20 years (RAINN, 2015). Current incidence estimates do not only demonstrate the prevalence of sexual assault today, but also confirm that sexual assault affects both men and women.

A longitudinal study conducted in 1992 (Rothbaum et al., 1992), assessed posttraumatic stress disorder (PTSD) symptomology among sexual assault survivors and found that 94% of survivors developed the disorder within two weeks post assault and 47% of survivors were diagnosed with the disorder within three months after the assault. These results revealed that having a history of sexual assault is associated with a higher risk for developing PTSD. Current

studies have continued to show support by suggesting that PTSD is one of the more common disorders resulting during the aftermath of sexual assault (Moller et al., 2014). It has also been suggested that the likelihood of developing PTSD increases by a combination of victim vulnerability and the extent of the dramatic nature of the assault (e.g., violence associated with the incident; Moller et al., 2014). For example, women are at greater risk of developing PTSD if more than one person sexually assaulted them, if they were exposed to various acts during the assault, or if they were injured (Moller et al., 2014). Most importantly, this data suggests that the large number of reported sexual assault cases, is accompanied by relatively high emotional and psychological distress in survivors, making this an issue warranting further examination.

Posttraumatic Stress Disorder

The Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5, 2013), defines PTSD as consisting of symptoms of re-experiencing (e.g., distressing memories, thoughts, feelings or external reminders of the event), behavioral avoidance (e.g., efforts to avoid internal and external reminders), negative alterations in cognition and mood (e.g., distorted sense of blame for self or others, anhedonia) and hyperarousal (e.g., reckless or self-destructive behavior, sleep disturbances, hyper vigilance or related problems; American Psychological Association, 2013). Evidence from the last several decades has shown that symptoms of PTSD also may lead to severe disruption in interpersonal and social functioning (Riggs, Byrne, Weathers, & Litz, 1998;

in interpersonal and social functioning (Riggs, Byrne, Weathers, & Litz, 1998;

Robertson, Rushton, Bartum, & Ray, 2004).

Although PTSD is the most commonly researched trauma-related disorder following sexual assault, depression is also known to occur at a comparatively similar rate among survivors of trauma, particularly among those with co-occurring PTSD (Au et al., 2013; Bryant et al., 2010; Shalev et al., 1998). Studies indicate that the vast majority of sexual assault survivors report feeling scared, confused, depressed and restless hours after a sexual assault encounter (Burgess & Holmstrom, 1974; Veronen, Kilpatrick, & Resick, 1979), and nearly half of survivors experience moderate to severe depression within thirty days of the assault (Frank, Turner, & Duffy, 1979; Frank & Stewart, 1984).

It is important to note that not all forms of trauma exposure lead to PTSD symptomatology, but the more complex and severe a stressful life event is, the greater the likelihood is to develop symptoms of PTSD (Wilson, Smith, & Johnson, 1985). A study suggests (Mejo, 1990) that there are three significant variables that indicate the development of PTSD, which include: the pre-existing personality of the survivor (e.g., unstable/borderline personalities), the type of trauma (e.g., including violence witnessed and/or experienced), and the individual's environment (e.g., stressful, harmful, lack of support system). Out of these variables, research stresses the importance of a survivor's support network. It is said that having a strong familial and network support at the time of

the incident, may offset the development of PTSD and lead to improved coping following the event.

These perspectives although not complete in terms of their ability to fully explain the development and continuance of PTSD, do offer a better understanding of the disorder, especially in relation to sexual assault. From the studies mentioned, there is an evident relationship between PTSD and depression in the aftermath of trauma. Some researchers have proposed that PTSD and depression frequently co-occur at relatively high rates after trauma because they are manifestations of a single, underlying posttraumatic psychopathology (Au et al., 2013; Norman et al., 2011; O'Donnell et al., 2004). A number of studies have found support for this hypothesis, by revealing that PTSD and post-traumatic depression share nearly identical risk factors in addition to following a similar time-course (Au et al., 2013; Brewin et al., 2000; Bromet et al., 1998; deRoon-Cassini et al., 2010; Kendler et al., 2002; Norman et al., 2011; O'Donnell et al., 2004).

<u>Sexual Assault</u>

Definitions of sexual assault have varied over the years. Based on the National Crime Victimization Survey, sexual assault is defined as any unwanted sexual contact (Rand & Catalano, 2007). This can comprise of inappropriate or unwanted touching, grabbing, rubbing, kissing and fondling. Also included under the umbrella term of sexual assault, is rape, which encompasses any vaginal, anal or oral penetration, sexual penetration with an object, unwanted sexual

intercourse and molestation (Carlson, Eisenstat, & Ziporyn, 1997). Noncontact sexual abuse similarly exists and consists of sexual comments (usually derogatory in nature), exposure to intimate body parts and obscene phone calls (Faller, 1990).

Sexual assault is not restricted between strangers, but can occur among acquaintances, family members, and intimate partners. Multiple studies have shown that the most frequent type of reported sexual assault often involves a known perpetrator (e.g., acquaintance, friend, intimate partner; Rand & Catalano, 2007). The perpetrator is typically familiar with the survivor whether they be a former husband or wife, cohabiting partner, friend or work acquaintance. Under this definition of sexual assault, it is estimated that a woman (aged 18 or over) is sexually assaulted every two minutes. This means that approximately 720 women are assaulted everyday in the United States (Rand & Catalano, 2007).

The psychological distress following a sexual assault includes a multitude of emotional reactions including guilt, shame, anger, changes in appetite, chronic fatigue, anxiety attacks, and sleep difficulties (Miller, Markman, & Handley, 2007). Sexual assault also affects many aspects of a person's social functioning by possibly increasing or leading to isolation, withdrawal, interpersonal conflicts, and difficulties with trust (Carlson et al., 1997). Because of the psychological and social difficulties commonly experienced, survivors of sexual assault frequently have high levels of depressive and emotional numbing/dysphoria symptoms of PTSD (Carlson et al., 1997; Miller, Markman, & Handley, 2007).

Research suggests that survivors' responses following a sexual assault may be associated with greater vulnerability or resilience to psychological distress depending on a variety of demographic factors and person and event characteristics (Campbell et al., 2009). For example, women who are less educated are more likely to perceive a greater life threat and receive more negative social reactions upon disclosing their sexual assault experience. These characteristics are both associated with greater PTSD symptom severity (Ullman, & Filipas, 2001). Ethnic minority survivors also reportedly perceive more life threat and injury after a sexual assault.

Coping skills also play an important role in the development of symptoms of PTSD in survivors. In 2007, Ullman and colleagues discovered that women who engage in avoidance coping behaviors (i.e., self-distraction, denial, and behavioral disengagement) are more likely to experience symptoms of PTSD. The researchers believed that although some of the avoidance coping responses might be adaptive in the short-term crisis period (i.e., immediately after trauma occurs), ongoing avoidance coping was associated with greater psychological trauma in the long run.

When testing the effect of negative social reactions and self-blame on assault-related PTSD, Ullman's and colleagues' (2007) study revealed that self-blame is strongly related to a survivor's recovery outcomes. Ullman et al., argued that self-blame may arise or be reinforced by the reactions survivors receive from their social networks (Ullman, & Filipas, 2007). Accordingly, a survivor's ability to

cope is highly impacted by the reaction they receive from others. Having a supportive social network allows the survivor to better process their traumatic experience, resulting in better coping skills. If a survivor is receiving supportive behavior and reactions, (e.g., emotional, instrumental and informational support) they also may be less likely to experience PTSD symptomatology. However, if the survivor is being blamed for the assault, is being treated differently (e.g., withdrawing from the survivor), or someone assumes control of the survivor's decisions (e.g., treating the survivor as though she cannot take care of herself), the survivor may experience greater PTSD symptom severity (Ullman, & Filipas, 2007).

Other factors that influence an individual's likelihood of developing PTSD are cognitive appraisals. Findings from Dunmore et al's., (1999) study revealed cognitive factors associated with both the onset and maintenance of PTSD. The cognitive factors include: appraisal of aspects of the assault itself (e.g., mental defeat and mental confusion), appraisal of the sequelae of the assault (e.g., appraisal of symptoms and permanent change) and dysfunctional strategies (e.g., avoidance). The authors suggest that these cognitive factors could directly contribute to PTSD by causing the survivor to generate a sense of ongoing threat (Dunmore et al., 1999). In turn, this will not only influence PTSD by affecting the nature of the traumatic memory, but it could prevent PTSD recovery in a survivor.

A related possible risk factor that may influence the likelihood of a survivor developing mental health conditions such as PTSD is attributional style (e.g.,

Gray et al., 2003). Survivors of trauma typically offer attributions or explanations for their experiences in effort to create meaning of the event. Literature suggests that a pessimistic attributional (i.e., internal, stable, and global attributions) style increases the severity of symptoms following a traumatic event. Specifically, internal attributions about a traumatic event have been associated with greater distress (Gray et al. 2003). For instance, placing blame on the survivor instead of recognizing external factors that may have caused or contributed to the event (e.g., external attributions) lead to greater symptoms of depression (Gray et al., 2003). Consequently, the attributions individuals create about their experience reflect self-blame and serve as a source of vulnerability for PTSD development.

Self-Blame

Self-blame is a psychological mechanism that plays a major role in personal control over one's outcomes (Janoff-Bulman, 1979). Past studies have found that blaming negative events on oneself not only undermine psychological health but have a poor influence on physical health as well (Blodorn, Major, Kaiser, 2016). Other researchers support this claim by stating that having excessive self-blaming emotions leads to decreased self-worth, hopelessness and depressed mood (Zahn et al., 2015).

Research has suggested possible implications of how self-blame affects a person's recovery process in different types of trauma (Miller et al., 2007). Specifically, with sexual assault, self-blame and negative social reactions to disclosures are said to each be associated with increases in the risk of sexual re-

victimization. On the other hand, if a survivor maintains a belief of control, he or she is more likely to believe in future avoidability of sexual assault. For this reason, self-blame can be viewed as one type of cognitive strategy survivors use to cope with an event such as sexual assault.

Self-blame has generally been associated with poorer outcomes among sexual assault populations (Arata, 1999; Blodorn, Major, Kaiser, 2016; Miller et al., 2007; Zahn et al., 2015). For example, a study done by Arata (1999), using a stepwise regression analysis to examine the roles of child sexual abuse history, attribution of blame, and coping strategies, showed that survivors of sexual assault who have high levels of self-blame following their assault incident report greater levels of distress. Miller et al., (2007) uncovered the greater potential of this issue, by claiming that self-blame will not only slow down a survivors recovery but will also increase the risk for re-victimization. He suggested that self-blame is accompanied by a depletion of self-esteem, which in turn, increases sexual vulnerability and thus, the risk of re-victimization. In other words, a survivor's negative evaluations of him/herself may subsequently put them in the same mental state if they encounter future situations.

Although self-blame has generally shown to be associated with poorer recovery following assault, some research suggests that the relative impact may vary depending on the nature of self-blame. That is, the distinctions between the types of self-blame that a survivor adapts, influences the survivor's adaptive qualities. Specifically, Janoff Bulman (1979) proposed that there are two types of

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self-blame, characterological and behavioral. Characterological self-blame refers to blame centered on aspects of one's character and/or their perceived deservingness for the assault (Janoff-Bulman, 1979). Characterological self-blame focuses on the survivors' beliefs that some aspect of their personality caused the assault. For example, the following statement can be identified as a characterological in nature because the person is blaming an aspect of their character as the cause for the assault: "I was sexually assaulted because I am too trusting and that makes me vulnerable." Thus, it pertains to a person's identity and is generally viewed unmodifiable. Since characterological self-blame is viewed emphasizing characteristics that are more enduring, Janoff Bulman (1979) hypothesized that survivors who offer such attributions may have poorer psychological outcomes due to a perceived lack of control over preventing future assaults.

The second variant of self-blame described by Janoff-Bullman (1979) is behavioral self-blame, which refers to blame centered on one's own behavior at the time of the assault. Explaining the cause of the assault with a statement such as, "I let myself drink too much that night" is an example of blaming one's behavior. It reflects survivors' belief that their own behavior led to the assault (Ullman, & Filipas, 2007). This greatly influences the amount of perceived controllability a survivor feels over the situation. Nevertheless, although people hold themselves accountable for the assault incident, like characterological self-blame, this explanatory style is theorized to be more adaptive. Specifically, Janoff

Bulman (1979) hypothesized that behavioral self-blame may afford greater perceptions of controllability because a person's behavior is seen as highly adaptable, making it more amenable to change in the future. Janoff-Bulman hypothesized that because one's behavior is more modifiable, behavioral self-blame can afford greater perceptions of controllability over future assaults potentially making a survivor less likely to experience psychology distress, such as PTSD and anxiety. A survivor experiencing behavioral self-blame may feel they have the power to change their future behavior and actions to avoid circumstances that might jeopardize their safety.

Perceptions of future avoidability over future sexual assault may differ depending on whether the assault experience is attributed to an individual's behavior or character. Behavioral self-blame has been proposed to be associated with heightened perceptions of future avoidability of sexual assault, while characterological self-blame thought to be associated with reduced perceptions of avoidability (Janoff-Bulman, 1979). Research has shown strong empirical evidence supporting the link between characterological self-blame and poor post-sexual adjustment (Breitenbecher, 2006; Frazier & Schauben, 1994). Breitenbecher (2006), for example, conducted an investigation with 224 female survivors of sexual assault and found that behavioral self-blame was associated with perceived avoidability of future assaults; however, it was not associated with lower psychological distress. Characterological self-blame, on the other hand, was positively correlated with higher psychological distress. In a second study,

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conducted by Frazier and Schauben (1994), examined the adaptive value of behavioral and characterological self-blame and found that when survivors attributed the cause of their assault to some aspect of themselves they had poorer recovery. Similarly, Hassija and Gray (2013) reported a study in which they explored self-blame (i.e., behavioral and characterological) and the associations with perception of avoidability over future assault among sexual assault survivors. They found that, both forms of self-blame play a significantly different role in terms of determining perceptions to controllability and postassault adjustment in survivors.

Hassija and Gray (2013) subsequently hypothesized that characterological self-blame would be significantly associated with poorer post-sexual assault adjustment, but behavioral self-blame would be significantly associated with improved post-sexual assault adjustment. They proposed that if behavioral self-blame was found to be associated with reduced psychological distress, the relationships would be mediated by perceptions of future avoidability (Hassija & Gray, 2013). After examining the psychological outcomes associated with behavioral and characterological self blame among a sample of 89 sexual assault survivors, results revealed negative associations between behavioral self-blame and self-reported anxiety, and that the perceptions of future avoidability were found to moderate the relationship between behavioral self-blame and PTSD and depressive symptoms (Hassija & Gray, 2013). Although mixed evidence exists as to whether behavioral self-blame is associated with

perceptions of future negative events (Janoff-Bulman, 1979; Frazier, 1990; Frazier & Schauben, 1994), with support from analytic investigations, Hassija and Gray's (2013) research highlighted the relationship of self-blame by indicating that self-blaming attributions have differential effects on post-assault recovery. Nevertheless, few studies have investigated the role of characterological and behavioral self-blame, in frequency of past victimizations and the association with perceived future availability of assault.

An exception was, Breitenbecher's (2006) study, which conducted a bivariate correlation (between characterological self-blame and behavioral self-blame factors) and found that there was a positive relationship between the two constructs. Results indicated that behavioral self-blame was in fact significantly associated with perceived avoidability of future assaults. Even more interestingly, Breitenbecher's (2006) study found that behavioral self-blame was not associated with lower distress or frequency of past victimizations. In other words, the results confirmed that characterological self-blame and behavioral self-blame are differently related to physiological distress.

This suggests that behavioral self-blame (i.e., blaming one's behavior) may be adaptive among sexual assault survivors and that heightened perceptions of future avoidability, may buffer against PTSD and depressive symptoms. These results are consistent with Koss et al.'s. (2002) research which suggests stronger relationships between characterological self-blame and distress than that of behavioral self-blame and distress.

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<u>Self-Efficacy</u>

While ample research has explored the topic of self-blame and distress, including the intervening role perceptions of future avoidability (e.g., being able to avoid a future assaults) versus future controllability (e.g., feeling a sense of control if the survivor were to be assaulted in the future), not many have focused their work at examining other possible intervening variables that may influence this relationships, such as self-efficacy.

Self-efficacy is best defined as a mechanism for human agency. It is the level of confidence, an individual has that he or she can adequately and successfully perform certain behaviors (Walsh & Foshee, 1998). For example, in the context of this study, we refer to self-efficacy as the confidence a person has that she or he can perform certain behaviors that will minimize any chances of being sexually assaulted. Perceptions of self-efficacy are known to result from four types of learning experiences including: past performance accomplishment and failures, vicarious leaning, verbal persuasion (e.g., other's encouragement or discouragement), and emotional arousal (e.g., having feelings of anxiety or excitement; Bandura, 1986; Lent et al., 1994). Additionally, self-efficacy affects whether individuals think in self-enhancing or self-debilitating ways, including how well they motivate themselves to persevere through difficulties (Benight & Bandura, 2004). Because self-efficacy plays a key role in stress reactions and quality of coping in threatening situations, it not only influences PTSD symptomatology, but depression as well.

A study by Benight and Bandura (2003) linked general self-efficacy to reduced PTSD, by exploring research findings that examined the generalized role of perceived coping self-efficacy, in recovery from different types of traumatic experiences (i.e., sexual assault, terrorist attacks, military combat, and natural disasters). By examining various multivariate analyses, they were better able to support that self-efficacy appears as a focal mediator of posttraumatic recovery. In other words, they claimed that individuals, who have higher self-efficacy, could overcome traumatization significantly better than individuals who have lower self-efficacy. The consistency of the different findings they used in their study, also led them to believe that having a resilient sense of efficacy impacts the quality of psychosocial functioning in a person (Benight & Bandura, 2003). Thus, suggesting that perceived self-efficacy is a common mechanism that survivors of diverse types of trauma can utilize to overcome adverse circumstances such as incidents of sexual assault.

Similarly, a study by Walsh (1998), attempted to examine whether the influence of levels of self-efficacy, self-determination or victim blaming predicted the likelihood sexual assault. To implement this study, a baseline survey was given to all participants, who were later asked to retake the survey six months later. Using logistic regression on sample of college students, Walsh (1998) concluded that self-efficacy was negatively correlated with prior experiences of sexual assault. In the context of this study, Walsh used self-efficacy to refer to the confidence a survivor has that she or he can perform specific behaviors that

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would ultimately minimize any chances of being sexually assaulted or victimized (Walsh & Foshee, 1998).

Results suggested that individuals who had been assaulted in the past had lower self-efficacy then people who had not experienced any form of sexual assault. Moreover, it has been shown that low self-efficacy for performing specific behaviors that would minimize risks of sexual assault actually predict past experience of forced sexual activity (Walsh & Foshee, 1998). In other words, prior victimization was unfortunately indicative of re-victimization. Evidence to support this claim states that females who have already been victimized are less likely to benefit from sexual assault prevention programs and re-experience sexual assault (Walsh & Foshee, 1998). Based on theory, self-efficacy can play a major role in aiding women who have been victimized, regain their sense of control. This can ultimately maximize the results any program that aims to prevent sexual assault or help women avoid re-experiencing sexual assault.

The Present Study

While there is ample evidence that being a survivor of sexual assault is associated with an increased risk of developing PTSD and depression (Elklit, & Christiansen, 2010; Moller, Backstrom, Sondergaard, & Helstrom, 2014; Rosebrock, Au, Dickstein, Steenkamp, & Litz, 2011), the role of self-efficacy, the ability to employ control over one's motivation and behavior, as a potential resilience factor has been understudied. Indirect evidence, from previous studies has shown that one's motivation, including that which we base our future

decisions on is highly influenced by our self-efficacy. It has also been found, that self-perceptions of efficacy play a significant role in influencing patters, actions, and emotional arousal (Bandura, 1982).

Research by Hassija and Gray (2013) support the claim that self-efficacy may account for diverse changes in recovery behavior among survivors of sexual assault. By thoroughly understanding the differences between coping for characterological and behavioral self-blame, including the role that self-efficacy plays in this relationship, clinicians can use this new information to tailor counseling specifically for the type of self blame a sexual assault survivor may feel.

The primary objective of the present study is to examine the role of self-efficacy in the relationship between behavioral and characterological self-blame in PTSD and depressive symptoms among women survivors of sexual assault. We aim to evaluate how these factors can ultimately influence posttraumatic adjustment in sexual assault survivors by building on previous work demonstrating negative associations between behavioral self-blame, and post-sexual assault adjustment (i.e., reduced anxiety symptoms). This study also looks at the positive associations between characterological self-blame and PTSD, anxiety, and depression symptom severity (Hassija & Gray, 2013). Particularly, I will assess the influence of self-efficacy in association with post assault distress and variants of self-blame.

Hypotheses

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We hypothesized that characterological self-blame will be positively associated with distress (i.e., PTSD and depressive symptoms) and negatively associated with self-efficacy, while behavioral self-blame will be negatively associated with psychological distress (i.e., PTSD and depressive symptoms) and positively associated with self-efficacy. We also hypothesized that the relationship between characterological and behavioral self-blame and distress will be mediated by self-efficacy.

CHAPTER TWO

METHOD

Participants and Procedures

A power analysis was used to determine the sample size of our study. 86 participants were then recruited on the campus of California State University, San Bernardino through a participant pool management system (i.e., SONA Systems). The screening was conducted in two phases. The first phase was a screening procedure used to identify which participants were appropriate for the second phase of the study. In the initial phase, as part of mass screening procedure, participants were screened for a history of sexual assault. The survey contained questions regarding the participants' sexual assault experience and took approximately 30 to 45 minutes to complete. At the conclusion of the survey, 82 qualifying participants were given course credit as compensation for their time. No other incentives were offered to participants engaging in the study. Four male participants were removed from the study due to insufficient sample size. The final sample included 82 female participants with a mean age of 23.86 ($SD =$ 7.17). The majority of participants identified as Caucasian or White ($n = 36$; 43.9%) and of Hispanic ethnicity ($n = 62$; 75.6%), with only 20.7% ($n = 17$) of non-Hispanic ethnicity. In terms of marital status, half of participants reported being single ($n = 41$; 50%) and 22% ($n=18$) reported being in a committed relationship. The average income of participants was $0-$14,999 ($n = 58$; 70.7%) and most participants were a junior ($n = 31$; 37.8%) or senior ($n = 31$; 37.8%) in

college. Out of the 82 female participants, 89% reported being sexually assaulted

(*n* =73) and 92.7% (*n* = 76) reported having had an unwanted sexual experience.

Participant anonymity was honored and no names or identities were recorded

from the survey. All participants in the study were treated following the guidelines

of the "Ethical Principles of Psychologists and Code of Conduct" (American

Psychological Association, 2002).

Measures

Demographic Questionnaire

Participants completed a brief demographic questionnaire that assesses

age, gender, ethnicity, marital status, education, and employment status. This

demographic portion of the study was completed during phase two of the study.

These questions are shown in Appendix D.

Life Events Checklist

Participants were prescreened for previous sexual assault history and

then re-assessed during the study to confirm eligibility with a modified version of

the LEC (LEC; Gray, Litz, Hsu, & Lombardo, 2004). The LEC consists of a

checklist of 16 possible traumatic events of which participants were asked to

indicate whether *they directly experienced* any of the events listed. The items

relevant for the present study include the following: sexual assault (i.e., attempt

to rape, made to perform any type of sexual act through force or threat of harm)

and other unwanted or uncomfortable sexual experience. The LEC has been

evaluated among college undergraduates as well as combat veteran populations.

It has demonstrated to possess adequate temporal stability and good convergence with a comparable measure of trauma history, comparable to other well-validated trauma screening instruments (Gray et al., 2004). This measure is shown in Appendix D.

Measure of Self-Blaming Attributions

The MSA scale (MSA; Hassija & Gray, 2013). was created for use in Hassija & Gray's (2013) study on adaptive variants of controllability attributions among survivors of sexual assault. The MSA is used to assess self-blaming attributions for a prior sexual assault experience. Items used to create this scale were derived from previous measures designed to assess the construct of behavioral and characterological self-blame (Breitenbecher, 2006; Hill & Zuatra, 1989; Hassija & Gray, 2013). A sample item for behavioral self-blame is "I didn't scream." Characterological self-blame is assessed with statements such as, "I got what I deserved." A Likert-type scale ranging from one, "*Not at all true,"* to five, being "*Completely true"*, is used by the participants to indicate the extent to which they perceived each item on the scale explains why they were assaulted. Computed Cronbach alpha coefficients for the scale suggest reliability (behavioral self-blame α =.76; characterological self-blame α = .93).

Posttraumatic Stress Disorder Checklist

PTSD symptom severity in participants will be assessed with the PCL (PCL; Weathers, Litz, Huska, & Keane, 1994), a brief self-report questionnaire consisting of 17 items corresponding to symptoms outlined in the fourth edition of

sample revealed a reliability of .93.

Self-Efficacy: The New General Self-Efficacy Scale

To measure self-efficacy in participants, the study will use the new general self-efficacy scale (NGSE; Chen, Gully, & Eden, 2001). The NGSE is an 8-item self-reported measure tested in previous studies, that instructs participants to indicate the extent to which they agree with each item explained. The answer choices range from 1(*not at all true*) to 5 (*exactly true*). Example items on this scale include, "I will be able to achieve most of the goals that I have set for myself," "When facing difficult tasks, I am certain that I will accomplish them," and "In general, I think that I can obtain outcomes that are important to me." The NGSE has been tested for reliability and validity, and has shown that compared to the commonly used Sherer et al., General Self-Efficacy Scale (SGSE), the NGSE has higher construct validity (Chen, Gully, & Eden, 2001). The scale has also proven to be consistent in its internal validity despite being shorter than the SGSE (17 items). Additionally, various studies conducted by Chen et al., (2001) concluded that the NGSE consistently yielded higher predictive validity in comparison to the SGSE. Computation of Cronbach alpha coefficient in our sample revealed a reliability of .93.

Center for Epidemiologic Studies Depression Scale

The Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) was used to measure depressive symptoms in participants. The *CES-D* scale is a short 20 item self-report scale designed to measure depressive

symptomatology. The items of the scale are symptoms associated with depression in nine groups as defined by the DSM-5 (Radloff, 1977). These groups include: Sadness (Dysphoria), Loss of Interest (Anhedonia), Appetite, Sleep, Thinking/ concentration, Guilt (Worthlessness), Tired (Fatigue), Movement (Agitation), and Suicidal ideation. Respondents were asked to indicate the extent to which they felt or behaved in a manner described by the items, within the last week on a 4-point Likert-type scale (*rarely* = less than 1 day, *some* = 1-2 days, *occasionally* = 3-4 days, *most* = 5-7 days). Sample items of this scale include "I felt lonely," "I felt hopeful about the future" and "I felt depressed." Total scores range from 0 to 60, with scores over 16 suggesting clinical levels of depressive symptoms (Hann et al., 1999; Radloff, 1997). In our sample, the Cronbach's alpha was .91.

Proposed Analyses

Correlational analyses conducted using SPSS and the Process macro by Preacher and Hayes (2013) was used to test the direct effects between characterological and behavioral self-blame to distress (e.g., depression, PTSD), as well as potential indirect effects (i.e., mediation) of distress through self-efficacy.

CHAPTER THREE

RESULTS

On measures of psychological distress, participants' mean PCL score was

46.20 (*SD* = 14.76). In terms of depression severity, participants' mean score on

the CESD was 20.54 (*SD* = 11.75). The participants' mean scores for the MSA

behavioral and characterological scales were 23.25 (*SD* = 8.17) and 44.45 (*SD* =

18.98), respectively. The NGSE revealed a mean score of 26.06 (*SD* = 5.13).

Associations Between Variables

Bivariate correlations were computed to determine the relationship

between self-efficacy, characterological and behavioral self-blame, and post

assault distress (see Table 2). Positive associations between behavioral self-

blame and depression were evidenced (*r* = *.28, p* < .05), as well as a positive

association between characterological self-blame and PTSD (*r* =. 42, *p* < .001)

and depression (*r* =. 50, *p* <. 001). Additionally, results revealed that

characterological self-blame was associated with reduced self-efficacy (*r* = -.45, *p*

< .001) and self-efficacy was positively related to PTSD and depression symptom

severity (*r* = -.27, *p* < .05; *r* = -.54, *p* < .001).

Mediation Analyses

In order to test our hypotheses that the relationship between

characterological and behavioral self-blame and depressive symptoms would be

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mediated by self-efficacy, bootstrapping analyses using Preacher and Hayes'

Process (2013) was conducted. In these analyses, mediation is considered

significant if the bias corrected confidence intervals of 95% exclude zero for the

indirect effect (Preacher & Hayes, 2004; Preacher, Rucker, & Hayes, 2007). A

nonparametric resampling method (bias-correlated bootstrap) was employed with

1,000 resamples to derive the 95% confidence interval (CI).

As Figure 1 illustrates, the standardized regression coefficient between

characterological self-blame and self-efficacy was statistically significant, b= -.12,

p < .001, as was the standardized regression coefficient between self-efficacy

and depression, b = -.91, p < .001. Results of the mediational analysis confirmed

the mediating role of self-efficacy in the relationship between characterological

self-blame and depressive symptoms, b = .11; CI: .04 - .21.

Figure 2 illustrates that the standardized coefficients for the relationship

between behavioral self-blame and self-efficacy were not significant b = -.07, p =

.34. However, the coefficients for the relationship between behavioral self-blame

and depressive symptoms were significant, b = -1.18, p < .001, despite that self-

efficacy did not have a mediating role in the relationship between behavioral self-

blame and depressive symptoms b = .08; CI: .-05 - .25.

Figure 3 shows no statistical significance between self-efficacy and PTSD,

b = -.27, p = .40 and a direct effect of .33, which also does not display any

statistical significance. Our last hypothesis displayed in Figure 4 reveals there

was also no statistically significant direct effect between behavioral self-blame

and PTSD (.05).

CHAPTER FOUR

DISCUSSION

Results from the present study illustrate meaningful relationships between behavioral and characterological self-blame, self-efficacy and distress. Although not all hypotheses were supported by the study, further examination of the results can reveal useful information associated with the role self-blame has on distress (i.e., depression and PTSD). The hypotheses supported by the results also highlight the importance of the relationship between the different types of self-blame and future avoidability for survivors of sexual assault.

Consistent with hypothesis 1, characterological self-blame was positively associated with distress (i.e., PTSD and depressive symptoms). This is supported by prior research suggesting that character-blaming attributions are associated with poorer outcomes such as depression because a survivor of sexual assault may find it more difficult to change the nature of his or her personality (Janoff-Bulman, 1979). In other words, survivors of sexual assault who believe their assault was due to some aspect of their character (e.g., too weak or trusting) may feel that they do not have enough control to prevent future incidents of assault. This can make a survivor experience higher distress and display more symptoms of depression.

As hypothesized, results also revealed that characterological self-blame was associated with lower self-efficacy. Accordingly, because self-efficacy is a form of human agency, having decreased self-efficacy can cause an individual to

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feel more helplessness over a sexual assault incident and increase

characteristics of distress. With decreased self-efficacy, a person who has been

sexually assaulted may not have the confidence that he or she can perform

certain behaviors that would ultimately minimize any chances of being sexually

assaulted in the future. Like previous literature argues, this is important because

it suggests that survivors of sexual assault are more likely to experience

revictimization. This finding is crucial because it provides an opportunity for

clinicians to work on increasing survivors' self-efficacy in order to diminish their

chances or revictimization. That is, if a clinician is aware of the type a self-blame

his or her client is demonstrating, they can work with a plan that is more catered

to helping the client increase their self-efficacy and thus help them gain a better

sense of controllability over their lives.

Results were not supportive of our hypothesis regarding behavioral self-

blame. Contrary to our hypothesis, behavioral self-blame was positively

associated with depressive symptoms, and not significantly associated with

PTSD, although results also trended in a positive direction. Accordingly,

behavioral self-blame did not appear to be associated with improved adjustment

among survivors of sexual assault. This could be attributed to the sample size of

our study and perhaps a larger sample size is needed to verify our findings.

Additionally, there was a statistically significant negative association between

self-efficacy and distress was found, suggesting that reduced behavioral self-

blame may be associated with greater perceptions of self-efficacy among

survivors of sexual assault. This implies that with increased self-efficacy, a person is more likely to experience less behavioral self-blame and distress possibly due to an enhanced sense of personal control over their future, which can help a person avoid a future encounter of sexual assault.

Results derived from the study revealed that self-efficacy did not mediate the relationship between both types of self-blame and PTSD symptoms. The only mediation found through our results was between characterological self-blame, self-efficacy and depression. A possible explanation may be that characterological self-blame may be associated with greater depression because a person may harbor negative beliefs about themselves, which influence their self-worth and sense of efficacy.

On another note, individuals with lower self-efficacy could potentially receive more familial and network support. Previous literature (Mejo, 1990) has suggested that the stronger a survivor's support system is the more likely it is to offset the development of PTSD. Research has also suggested that along with a strong support system an individual seems to display improved coping following the event. To clarify, an individual who is a survivor of a sexual assault may have low self-efficacy but a strong support network, ultimately impact a survivor's psychological adjustment. To clarify, because of this strong support network, it may appear that self-efficacy does not act as a mediator between both types of self-blame and PTSD.

An alternative explanation that can be investigated by future studies is

whether a survivor's self-efficacy influences the type of self-blame they experience. In other words, a survivor described as having high self-efficacy may be more likely to display behavioral self-blame after a traumatic event, which in turn may result in the survivor exhibiting less depression and PTSD symptomatology. Congruently, a survivor who is described as having a lower sense of self-efficacy can engage in more characterological self-blame, resulting in higher depression and PTSD symptomatology. It is important to also note that the frequency of the type of blame (either behavioral or characterological) that a survivor attributes their assault with, can significantly affect their post assault recovery. By further researching this, we can investigate the possible consequences of attributing one type of self-blame more than the other.

Additionally, future studies, can further investigate if survivors with lower self-efficacy do in fact appear to have stronger support systems. By knowing this, we can better asses if a person's support network is actually what diminishes PTSD and not necessarily having higher self-efficacy. If findings reveal this to be true, perhaps the implementations of larger support group systems can be used as part of a client's treatment for post assault recovery.

Overall, findings from the proposed study will help with implication for postassault interventions. It may create opportunities for therapist and counselors to custom-tailor patient treatments to match the self-blame they most associate with, which may lead to treatments that are more effective. By being able to identify the specific type of self-blame a survivor is associating their traumatic

experience with, a therapist can also work on improving low self-efficacy in individuals. The results of this study offer a unique insight to the root of why some survivors are experiencing higher rates of depression and PTSD than others. This is important because the amount of sexual assault cases each year is relatively high and although there is no way to assure that sexual assault prevention programs decrease the number of assaults, a way that we can help lower the number of emotional and psychological distress in survivors is by implementing treatment plans tailored to the type of self-blame a survivor is experiencing. By doing this we can help increase a survivor's sense of self-efficacy and significantly reduce the distress following a traumatic sexual assault experience.

Certain limitations must be considered when assessing this study's contribution to PTSD literature. First, this study relied on self-report measures for PTSD, depression and self-blame. These measures may have yielded different results if participants were clinically assessed. Additionally, the findings of the current study are only generalizable to those from a similar population (e.g., college-aged female sexual assault populations). While the findings obtained by the present population are valuable to sexual assault PTSD research and although the sample size met the assumptions for the analyses conducted, a larger sample size and the inclusion of male participants would increase statistical power and generalizability to a larger population. It would also be useful for future studies to recruit participants from places other than college

campuses to avoid generalizing college specific trauma with other types of sexual assault trauma. Lastly, this study contains a missing item on the MSA scale due to transcribing error. The results of the study are based on participant responses with one MSA survey item omitted. Although we feel confident that the omission of the survey item did not alter the results of the study, it is suggested that future research examine possible result changes after including the missing item.

In sum, the findings from the present study have a number of valuable clinical implications that may be used to improve work with sexual assault populations. For example, by being familiar with the nature of a client's self-blame (e.g., behavioral or characterological) one can tailor treatment plans to incorporate techniques that will improve perceptions of self-efficacy and thus future avoidability. In other words, knowing whether a client is experiencing behavioral or characterological self-blame provides a clinician with insight into the client's adaptive function of controllability attributions. By understanding the self-blaming attributions specific to a client's character, clinicians may be able to implement treatments that will work on reducing psychological distress and enhancing self-efficacy among sexual assault survivors.

APPENDIX A

TABLES AND FIGURES

Figure 1 Hypotheses Relationship between Characterological Self-Blame (CSB) and Depression as mediated by Self-Efficacy
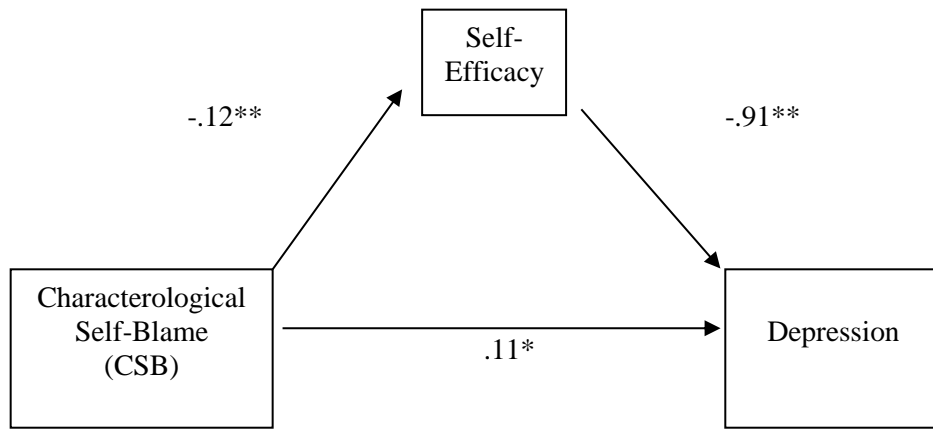
Note. *p* < .05 **p* < .001

Figure 2 Hypotheses Standardized Coefficients for the relationship between Behavioral Self-Blame (BSB) and Depression with no mediation by Self-Efficacy
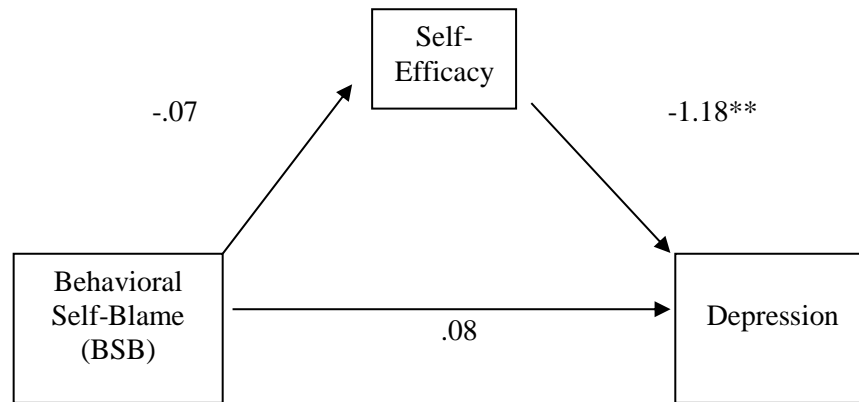
Note. * *p* < .05 **p* < .001

Figure 3 Hypotheses Standardized Regression Coefficients for the Relationship between Characterological Self-Blame (CSB) and PTSD with no mediation by Self-Efficacy
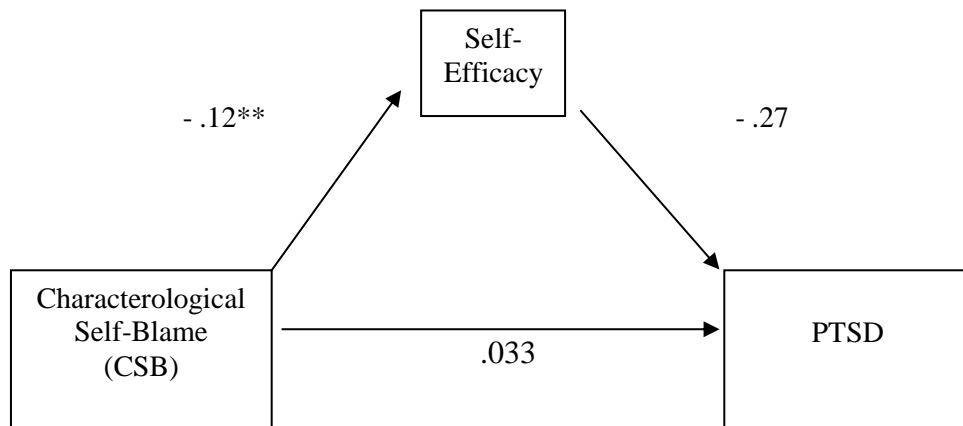

Note * *p* < .05 ***p* < .001

Figure 4 Hypotheses Standardized Regression Coefficients for the Relationship between behavioral Self-Blame (BSB) and PTSD with no Mediation by Self-Efficacy
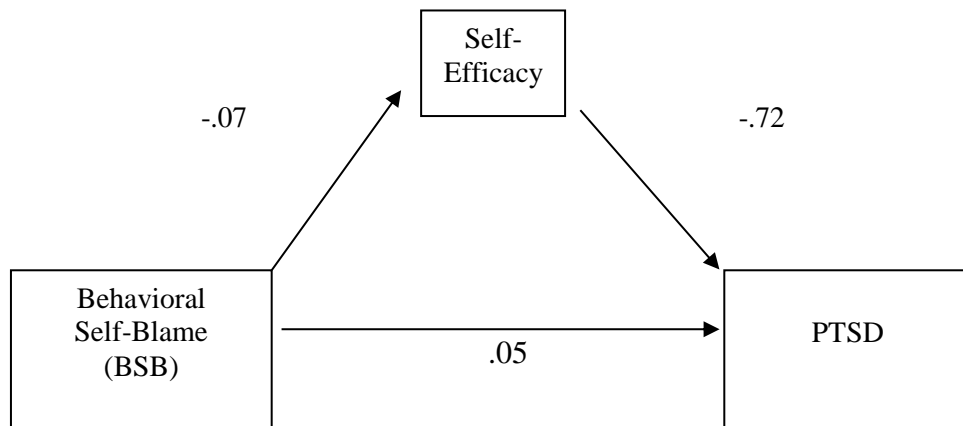

Note. * *p* < .05 **p* < .001

Table 1. Demographics

Characteristic	N	Percentage*
<u>Gender</u>		
Female	82	100
<u>Ethnicity</u>		
Hispanic	62	75.6
Not Hispanic	17	20.7
Unknown	2	2.4
<u>Race</u>		
Caucasian (White)	36	43.9
Asian (Asian American)	2	2.4
African American (Black)	5	6.1
American Indian or Alaskan	5	6.1
Other	28	34.1
<u>Marital Status</u>		
Single	41	50
In a committed relationship	18	22
Living with a significant other	10	12
Married	12	14.6
Divorced or Widow	1	1.2
<u>Income</u>		
$0-$14,999	58	70.7
$15,000-$29,999	14	17.1
$30,000-$44,999	6	7.3
$45,000-$59,999	1	1.2
$60,000-$74,999	1	1.2
$75,000-$89,999	1	1.2
$90,000-$99,999	1	1.2
<u>Year in college</u>		
Freshman	16	19.5
Sophomore	4	4.9
Junior	31	37.8
Senior	31	37.8

<u>Sexual Assault</u>

Happened to you personally	73	89
Did not happen to you personally	9	11

<u>Other unwanted sexual experience</u>

Happened to you personally	76	92.7
Did not happen to you personally	6	7.3

*Note: percentages may not sum to 100 due to rounding

Table 2. Pearson Correlations Between Self-efficacy, Variants of Self-Blame and Post-Assault Distress (N=82)

M (*SD*)		PTSD Symptoms	Depression Symptoms	Behavioral Self-Blame	Characterological Self-Blame
PTSD Symptoms *r*	46.20 (14.76)				
Depression Symptoms *r*	20.54 (11.75)	.52**			
Behavioral Self-Blame *r*	23.25 (8.17)	.19	.28*		
Characterological Self-Blame *r*	44.45 (18.98)	.42**	.50**	.49**	
Self-Efficacy *r*	26.06 (5.13)	-.27*	-.54**	-.11	-.45**

Note. * p < .05, ** p < .001 .
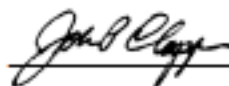
APPENDIX B

IRB APPROVAL

Human Subjects Review Board
Department of Psychology
California State University,
San Bernardino

PI: Hassija, Christina and Barrera, Andrea

From: John P. Clapper, Michael R. Lewin

Project Title: The Influence of Self-Efficacy in the relationship between variants of Self-blame, PTSD and Depressive Symptoms

Project ID: H-15FA-05

Date: 11/6/15

Disposition: Expedited Review

Your IRB proposal is approved to include 101 participants. If you need additional participants, an addendum will be required. The expedited review category is 45 CFR 46.110 category 7, Research on individual and group characteristics or behavior. This approval is valid until 11/6/2016.

Good luck with your research!

John P. Clapper, Co-Chair
Psychology IRB Sub-Committee

Michael R. Lewin, Co-Chair
Psychology IRB Sub-Committee

APPENDIX C

INFORMED CONSENT

Informed Consent

PROJECT TITLE: Sexual Experiences

INVESTIGATOR:

Christina Hassija
Department of Psychology
California State University, San Bernardino
909-537-5481
chassija@csusb.edu

APPROVAL STATEMENT: This study has been approved by the Department of
Psychology Institutional Review Board Sub-Committee of the California State
University, San Bernardino, and a copy of the official Psychology IRB stamp of approval
should appear on this consent form. The University requires that you give your consent
before participating in this study.

DESCRIPTION: Some individuals who experience stressful life events adjust fairly
well, while others have more emotional difficulties. The purpose of this study is to
investigate characteristics of those people who adjust well after such events, as compared
to those who may have more difficulties. In this manner, it may be possible to identify
factors that may need to be addressed in order to lessen emotional distress following a
stressful life event and promote posttraumatic growth. Participation in this study will
require no more than 60 minutes. You will be asked to complete surveys about stressful
life experiences, emotional difficulties that you may be experiencing, and strategies that
you use to deal with difficult situations. Some of the questions may pertain to sexual
assault experiences, which can be potentially difficult for some participants. Please note
that there is no deception in this study, and we could not make this statement if there
were any deception.

RISKS AND BENEFITS: The benefits of participation include the gratifying experience
of assisting in research which might have implications for the treatment of emotional
disorders and difficulties. You will also receive a list of campus and community
resources that may help you with emotional difficulties that you may be experiencing. If
you are a CSUSB student, you may receive 3 points of extra credit in a selected
Psychology class at your instructor's discretion. Minimal risks are possible with your
participation in this study and include the possibility of short-term emotional distress
resulting from recalling and completing surveys about stressful life experiences. It is very
unlikely that any psychological harm will result from participation in this study.
However, if you would like to discuss any distress you have experienced, do not hesitate

to contact the CSUSB Psychological Counseling Center (909 537-5040) or the Rape Crisis Hotline of Riverside at (951) 686-7273.

VOLUNTARY PARTICIPATION: Your participation in this study is entirely voluntary. You are free to withdraw your participation at any time during the study, or refuse to answer any specific question, without penalty or withdrawal of benefit to which you are otherwise entitled.

CONFIDENTIALITY STATEMENT: As no identifying information will be collected, your name cannot be connected with your responses and hence your data will remain completely anonymous. All information gained from this research will be kept confidential. The results from this study will be submitted for professional research presentations and/or publication to a scientific journal. When the study results are presented or published, they will be in the form of group averages as opposed to individual responses so again, your responses will not be identifiable. Results from this study will be available from Dr. Christina Hassija, after January 2016. Your anonymous data will be sent to the researcher in an electronic data file and stored for a period of 5 years on a password protected computer in a locked office and may only be accessed by researchers associated with this project.

RIGHT TO WITHDRAW: You are free to refuse to participate in this study or to withdraw at any time. Your decision to withdraw will not result in any penalty or loss of benefits to which you are entitled. You may withdraw your participation by simply clicking the appropriate button to exit the study. If you choose to withdraw from the study you will still receive credit for your participation. Alternatively, you may also choose to leave objectionable items or inventories blank.
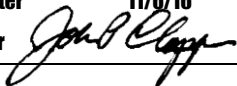
QUESTIONS OR CONCERNS: If you have any questions or concerns regarding this study, please feel free to contact the Human Subjects office at California State University, San Bernardino (909) 537-7588 if you have any further questions or concerns about this study.

I acknowledge that I have been informed of, and understand the true nature and purpose of this study, and I freely consent to participate. I acknowledge that I am at least 18 years of age.

Please indicate your desire to participate by placing and "X" on the line below.

Participant's X _____

Date: _____

California State University		
Psychology Institutional Review Board Sub-Committee		
Approved	11/6/15	Void After	11/6/16
IBB #	H-15FA-05	Chair	

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APPENDIX D

SURVEY

Please answer each question to the best of your knowledge.

1. Age: _____

2. Gender: M ___ F ___ (please check only one)

3. What is your ethnic background:

____Hispanic

____Not Hispanic

____Unknown

4. What is your racial background?

Caucasian (White)____

Asian (Asian American) ____

African American (Black) ____

American Indian or Alaskan Native ____

Native Hawaiian/other Pacific Islander _____

Other ____ (please specify) _____

5.What is your current marital status? (please choose only one)

_____ Single

_____ In a committed relationship

_____ Living with a significant other

_____ Married

_____Divorced or Widowed

6. Student Yearly Income:

$0 - $14,999 _____ $15,000-$29,999 _____

$30,000-$44,999 _____ $45,000-$59,999 _____

$60,000-$74,999 _____ $75,000-$89,999 _____

$90,000-$99,999 _____   Over $100,000 _____

7. Year in College:____ Freshman ____Sophmore ____ Junior _____ Senior

Life Events Checklist (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (1) it happened to you personally or (0) it did not happen to you. Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

1.   Natural disaster (i.e., flood, hurricane, tornado, earthquake).

2.   Fire or explosion.

3.   Transportation accident (i.e., car accident, boat accident, train wreck,

        plane crash).

4.   Serious accident at work, home, or during a recreational activity.

5.   Exposure to toxic substance (i.e., dangerous chemicals, radiation).

6.   Physical assault (i.e., being attacked, hit, slapped, beaten up, kicked).

7.   Assault with a weapon (i.e., being shot, stabbed, threatened with a knife,

        gun, bomb).

8.   Sexual assault (i.e., attempt to rape, made to perform any type of sexual

        act through force or threat of harm).

9.   Other unwanted or uncomfortable sexual experience.

10.   Combat or exposure to a war zone (in the military or as a civilian).

11.   Captivity (i.e., being kidnapped, abducted, held hostage, prisoner of war).

12.   Life threatening illness or injury.

13.   Severe human suffering.

14.   Sudden, violent death (i.e., homicide, suicide).

15.   Sudden, unexpected death of someone close to you.

16.   Serious injury, harm, or death you caused to someone else.

17.   Any other stressful event or experience. (Specify: _____)

a) Which was the WORST event?

_____

b) Did this event happen within the last 5 years?
          YES (1)   NO (2)

c) Did you experience extreme fear, helplessness or horror during this event?
          YES (1)   NO (2)

Weathers, F.W., Blake, D.D., Schnurr, P.P., Kaloupek, D.G., Marx, B.P., &

Keane, T.M. (2013). *The Life Events Checklist for DSM-5 (LEC-5).*

Instrument available from the National Center for PTSD at

www.ptsd.va.gov

Posttraumatic Stress Disorder Checklist (PCL)

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Think about the impact that YOUR MOST stressful life event (from the last survey) has had on you and respond to the following items as they relate to that event. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

1 = Not at all   2= A little bit   3=Moderately   4=Quite a bit

5=Extremely

1.   Repeated, disturbing memories, thoughts, or images of the stressful

experience?

2.   Repeated, disturbing dreams of the stressful experience?

3.   Suddenly acting or feeling as if the stressful experience were happening

again (as if you were reliving it)?

4.   Feeling very upset when something reminded you of the stressful

experience?

5.   Having strong physical reactions (e.g., heart pounding, trouble breathing,

sweating) when something reminded you of the stressful experience?

6.   Avoiding thinking about or talking about the stressful experience or

avoiding having feelings related to it?

7.   Avoiding activities or situations because they reminded you of the stressful

experience?

8.   Trouble remembering important parts of the stressful experience?

9.   Loss of interest in activities that you used to enjoy?

10.   Feeling distant or cut off from other people?

11.   Feeling emotionally numb or being unable to have loving feelings for those

       close to you?

12.   Feeling as if your future somehow will be cut short?

13.   Trouble falling or staying asleep?

14.   Feeling irritable or having angry outbursts?

15.   Having difficulty concentrating?

16.   Being "superalert" or watchful or on guard?

17.   Feeling jumpy or easily startled?

18.   Having strong negative beliefs about yourself, other people, or the world

       (for example, having thoughts such as: I am bad, there is something

       seriously wrong with me, no one can be trusted, the world is completely

       dangerous)?

19.   Blaming yourself or someone else strong for the stressful experience or

       what happened after it?

20.   Having strong negative feelings such as fear, horror anger, guilt or shame?

21.   Taking too many risks or doing things that cause you harm?

Weathers, W., Litz, T., Huska, A., & Keane, M. (1994). PTSD *Checklist–Civilian*

       version (PCL). Boston: National Center for PTSD, Behavioral Science

       Division.

Center for Epidemiological Studies Depression Scale (CES-D)
INSTRUCTIONS FOR QUESTIONS: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week. Please circle the response that best describes how you have felt.

1   Rarely or none of the time (less than one day)

2   Some or a little of the time (1-2 days)

3   Occasionally or a moderate amount of time (3-4 days)

4   Most or all of the time (5-7 days)

During the past week:

1. I was bothered by things that don't usually bother me
         1   2   3   4

2. I did not feel like eating; my appetite was poor.
         1   2   3   4

3. I felt that I could not shake off my blues even with help from my family or friends.
         1   2   3   4

4. I felt that I was just as good as other people.
         1   2   3   4

5. I had trouble keeping my mind on what I was doing.
         1   2   3   4

6. I felt depressed.
         1   2   3   4

7. I felt that everything I did was an effort.
         1   2   3   4

8. I felt hopeful about the future.
         1   2   3   4

9. I thought my life had been a failure.
         1   2   3   4

10. I felt fearful.

1   2   3   4

11. My sleep was restless.
             1   2   3   4

12. I was happy.
             1   2   3   4

13. I talked less than usual.
             1   2   3   4

14. I felt lonely.
             1   2   3   4

15. People were unfriendly.
             1   2   3   4

16. I enjoyed life.
             1   2   3   4

17. I had crying spells.
             1   2   3   4

18. I felt sad.
             1   2   3   4

19. I felt that people dislike me.
             1   2   3   4

20. I could not get "going."
             1   2   3   4

Radloff, S., (1977). The CES-D scale: A self-report depression scale for research

in the general population. *Applied Psychological Measurement*, 1: 385-

401.

Measure of Self-Blaming Attributions (MSA)
Please indicate the extent to which you perceive each item explains what contributed to the cause your sexual assault.

1.   "I ignored my feeling that something was wrong or that I was in trouble"

           Not at all   1   2   3   4   5   A great deal

2.   "I drank too much or got too high"

           Not at all   1   2   3   4   5   A great deal

3.   "I made out with him"

           Not at all   1   2   3   4   5   A great deal

4.   "I didn't scream"

           Not at all   1   2   3   4   5   A great deal

5.   "I flirted and/or teased him"

           Not at all   1   2   3   4   5   A great deal

6.   "I went back to his apartment (house or room) or my apartment (house or room) with him"

           Not at all   1   2   3   4   5   A great deal

7.   "I didn't run away"

           Not at all   1   2   3   4   5   A great deal

8.   "I was alone with him"

           Not at all   1   2   3   4   5   A great deal

9.   "I didn't run away"

           Not at all   1   2   3   4   5   A great deal

10.   "I didn't communicate clearly enough with him"

           Not at all   1   2   3   4   5   A great deal

11.　　"I didn't say no"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

12.　　"I was out alone at night"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

13.　　"I accepted a date with someone I didn't know"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

14.　　"I didn't resist"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

15.　　"I didn't lock my windows/doors"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

16.　　"I was out alone at night"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

17.　　"I didn't have a weapon or mace"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

18.　　"I didn't know how to say no"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

19.　　"I was somewhere where I shouldn't have been"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

20.　　"I didn't leave or go home when I should have"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

21.　　"I am a bad person"

　　　　　Not at all　　1　　2　　3　　4　　5　　A great deal

22.   "I am stupid"

        Not at all   1   2   3   4   5   A great deal

23.   "I got what I deserved"

        Not at all   1   2   3   4   5   A great deal

24.   "I am weak"

        Not at all   1   2   3   4   5   A great deal

25.   "I am reckless"

        Not at all   1   2   3   4   5   A great deal

26.   "I am naïve"

        Not at all   1   2   3   4   5   A great deal

27.   "I have poor judgment"

        Not at all   1   2   3   4   5   A great deal

28.   "I am a poor judge of character"

        Not at all   1   2   3   4   5   A great deal

29.   "I am unassertive"

        Not at all   1   2   3   4   5   A great deal

30.   "I am irresponsible"

        Not at all   1   2   3   4   5   A great deal

31.   "I am a careless person"

        Not at all   1   2   3   4   5   A great deal

32.   "I am too trusting"

        Not at all   1   2   3   4   5   A great deal

33.   "I am passive"

        Not at all   1   2   3   4   5   A great deal

34.   "I am the type of person that attracts rapists"

        Not at all   1   2   3   4   5   A great deal

35.   "I am the victim type"

        Not at all   1   2   3   4   5   A great deal

36.   "I am a gullible person"

        Not at all   1   2   3   4   5   A great deal

37.   "I am a vulnerable person"

        Not at all   1   2   3   4   5   A great deal

38.   "I am unable to take care of myself"

        Not at all   1   2   3   4   5   A great deal

39.   "I am an unlucky person"

        Not at all   1   2   3   4   5   A great deal

40.   "I am incompetent"

        Not at all   1   2   3   4   5   A great deal

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Posttraumatic Cognitions Inventory (PTCI)
We are interested in the kind of thoughts which you may have had after a traumatic experience. Below are a number of statements that may or may not be representative of your thinking.

Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement. People react to traumatic events in many different ways. There are no right or wrong answers to these statements.

1 = Totally disagree

2 = Disagree very much

3 = Disagree slightly

4 = Neutral

5 = Agree slightly

6 = Agree very much

7= Totally agree

1. The event happened because of the way I acted.

2. I can't trust that I will do the right thing.

3. I am a weak person.

4. I will not be able to control my anger and will do something terrible.

5. I can't deal with even the slightest upset.

6. I used to be a happy person but now I am always miserable.

7. People can't be trusted.

8. I have to be on guard all the time.

9. I feel dead inside.

10. You can never know who will harm you.

11. I have to be especially careful because you never know what can happen next.

12. I am inadequate.

13. If I think about the event, I will not be able to handle it.

14. The event happened to me because of the sort of person I am.

15. My reactions since the event mean that I am going crazy.

16. I will never be able to feel normal emotions again.

17. The world is a dangerous place.

18. Somebody else would have stopped the event from happening.

19. I have permanently changed for the worse.

20. I feel like an object, not like a person.

21. Somebody else would not have gotten into this situation.

22. I can't rely on other people.

23. I feel isolated and set apart from others.

24. I have no future.

25. I can't stop bad things from happening to me.

26. People are not what they seem.

27. My life has been destroyed by the trauma.

28. There is something wrong with me as a person.

29. My reactions since the event show that I am a lousy coper.

30. There is something about me that made the event happen.

31. I feel like I don't know myself anymore.

32. I can't rely on myself.

33. Nothing good can happen to me anymore.

Foa, E. B., A. Ehlers, et al. (1999). "The posttraumatic cognitions inventory
(PTCI): Development and validation." Psychological Assessment 11(3):
303-314.

The New General Self-Efficacy (NGSE)

1=Not true at all

2= Barely true

3=Moderately true

4=Exactly true

1. I will be able to achieve most of the goals that I have set for myself.

2. When facing difficult tasks, I am certain that I will accomplish them.

3. In general, I think that I can obtain outcomes that are important to me.

4. I believe I can succeed at most any endeavor to which I set my mind.

5. I will be able to successfully overcome many challenges.

6. I am confident that I can perform effectively on many different tasks.

7. Compared to other people, I can do most tasks very well.

8. Even when things are tough, I can perform quite well.

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